

# PDL & Resources

## Preferred Drug List & Pharmacy Coverage Resources

Effective August 1, 2025

### Preferred Drug List (PDL)

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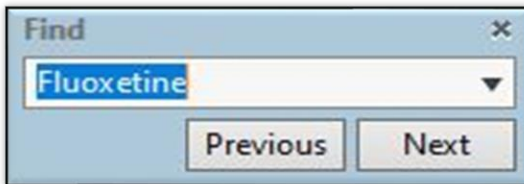
Search Tip: Use the keyboard shortcut Ctrl+F to open the Find menu. Type a word/medication to find in the document.

# How to Navigate Resources

Headers and Classifications: Products are listed by Group, followed by Class/Sub-Class.

| Medication/Product Group     |
|------------------------------|
| Medication/Product Class     |
| Medication/Product Sub-Class |

## Search Document:



- Open Find Menu, use the keyboard shortcut Ctrl+F (Command+F for Mac).
- Type a word/medication to find in document.  
Note: Display format will vary depending upon browser/software used to view document.
- Select "Next" or Arrow Buttons to view multiple results.

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Drugs Not Listed on PDL: Covered per Pharmacy Provider Manual. Manuals can be found at <a href="https://medicaid.utah.gov/utah-medicaid-official-publications">https://medicaid.utah.gov/utah-medicaid-official-publications</a></li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <ul style="list-style-type: none"> <li>• Listed Drug Name: When only the generic name is listed, this includes all generic strengths, dosage forms, and formulations for that drug and in that class. The same principle applies to brand name drugs. When the strength and/or dosage form is included in a name listing, this narrows the listing to those particular strengths and/or dosage forms. A comma may be used to delineate multiple strengths, dosage forms, or formulations.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <ul style="list-style-type: none"> <li>• Non-Preferred Products: Non-preferred products require an appropriate trial and failure of a preferred product with similar dosage form and use/indication. If a non-preferred strength/dosage form is requested, the preferred strength/dosage form must be tried before the non-preferred strength/ dosage form will be approved. Or the prescriber must demonstrate medical necessity for non-preferred. Additional criteria found on Drug Class and Disease Specific PA Forms will also apply. Authorization Criteria can be found at <a href="https://medicaid.utah.gov/pharmacy/prior-authorization">https://medicaid.utah.gov/pharmacy/prior-authorization</a>.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <ul style="list-style-type: none"> <li>• Non-Preferred Combination Products: If separate single ingredient products are preferred, those must be tried before a non-preferred product will be approved.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <ul style="list-style-type: none"> <li>• Non-Preferred Atypical Antipsychotic Products - DAW (Dispense as Written): Non-preferred atypical antipsychotic medications may bypass the non-preferred drug prior authorization if a prescriber writes "dispense as written" on a prescription and the pharmacy submits a Dispense As Written (DAW) Code of "1" on the claim.</li> </ul> <p>Note: In accordance with UCA 58-17b-606 (4) and (5), the DAW Code will not allow claims for the brand-name version of multisource drugs to bypass the prior authorization requirement, even if the brand-name version of the drug is listed as non-preferred and the prescriber writes "dispense as written" on the prescription. An exception to this is when a brand-name drug is listed on the Brand Over Generic reference; in that case, the DAW Code will only override the brand-name drug.</p> <p>Note: In order for a prescription to be eligible for the pharmacy to submit the DAW Code of "1" to bypass the edit for a nonpreferred medication the prescriber must write "dispense as written" on the physical prescription. Check boxes or pre-printed forms that include "dispense as written" are not acceptable substitutes for the prescriber writing "dispense as written" on the prescription. Electronic prescriptions must state "dispense as written" as either a note or as part of the prescription drug order to satisfy this requirement. Verbal orders that include "dispense as written" must be reduced to writing on the prescription by the pharmacist accepting the verbal order and documented in the member's medical record.</p> |
| <ul style="list-style-type: none"> <li>• Over-the-Counter (OTC) Products: PDL listing is for legend drugs and does not include all covered over-the-counter (OTC) products. A complete listing of covered OTC products is located in this document following the PDL. Please note, OTC products are not covered through the outpatient pharmacy benefit program for members residing in nursing homes. The nursing-home reimbursement rate includes payment for OTC products.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <ul style="list-style-type: none"> <li>• Updates: PDL changes will be posted monthly, changes effective in the posted month are highlighted in yellow. This may include changes to the status (preferred/non-preferred) or a change to the way the drug is listed. A date older than the release of a new form of a drug does not mean the newer form is excluded from that listing.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <ul style="list-style-type: none"> <li>• Vaccines for children: Claims for pediatric Medicaid members (age 18 and younger) for vaccines eligible through the Vaccines for Children Program must be submitted through the Vaccines for Children Program. For additional information, please refer to the Pharmacy Services Provider Manual or visit <a href="https://immunize.utah.gov/vaccines-for-children-program/">https://immunize.utah.gov/vaccines-for-children-program/</a></li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Analgesics                                     |               |         |             |                                               |                                   |                |                                                           |
|------------------------------------------------|---------------|---------|-------------|-----------------------------------------------|-----------------------------------|----------------|-----------------------------------------------------------|
| Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) |               |         |             |                                               |                                   |                |                                                           |
| Preferred Drugs                                | Status        | Type    | Last Update | Limits                                        | Mandatory 3-Month                 | Brand Required | Additional Note                                           |
| celecoxib                                      | Preferred     | Generic | 09/01/20    |                                               |                                   |                |                                                           |
| diclofenac gel                                 | Preferred     | Generic | 11/01/19    |                                               |                                   |                |                                                           |
| diclofenac Na DR 50, 75mg                      | Preferred     | Generic | 01/01/12    |                                               |                                   |                |                                                           |
| diclofenac patch                               | Preferred     | Generic | 12/01/24    |                                               |                                   |                |                                                           |
| diclofenac potassium 50mg                      | Preferred     | Generic | 07/01/12    |                                               |                                   |                |                                                           |
| flurbiprofen                                   | Preferred     | Generic | 01/01/12    |                                               |                                   |                |                                                           |
| ibuprofen                                      | Preferred     | Generic | 09/28/09    |                                               |                                   |                |                                                           |
| indomethacin                                   | Preferred     | Generic | 01/01/21    |                                               |                                   |                |                                                           |
| ketorolac injection                            | Preferred     | Generic | 09/28/09    | 4 units /day for 5 days<br>20 units /180 days |                                   |                | Covered under medical benefit using appropriate HCPCS     |
| ketorolac tablet                               | Preferred     | Generic | 09/28/09    | 4 units /day for 5 days<br>20 units /180 days |                                   |                | Limits apply to oral, nasal, and injectable formulations. |
| meloxicam tablet                               | Preferred     | Generic | 09/28/09    |                                               |                                   |                |                                                           |
| nabumetone                                     | Preferred     | Generic | 09/28/09    |                                               |                                   |                |                                                           |
| naproxen tablet, EC                            | Preferred     | Generic | 09/28/09    |                                               |                                   |                |                                                           |
| Pennsaid                                       | Preferred     | Brand   | 01/01/18    |                                               |                                   |                |                                                           |
| sulindac                                       | Preferred     | Generic | 01/01/12    |                                               |                                   |                |                                                           |
| Non Preferred Drugs                            | Status        | Type    | Last Update | Limits                                        | Required Prior Authorization Form | Brand Required | Additional Note                                           |
| Caldolor                                       | Non Preferred | Brand   | 12/01/22    |                                               | Medication Coverage Exception     |                |                                                           |
| Celebrex                                       | Non Preferred | Brand   | 09/01/20    |                                               | Medication Coverage Exception     |                |                                                           |
| Daypro                                         | Non Preferred | Brand   | 02/01/16    |                                               | Medication Coverage Exception     |                |                                                           |
| diclofenac Na DR 25mg, 100mg                   | Non Preferred | Generic | 01/01/13    |                                               | Medication Coverage Exception     |                |                                                           |
| diclofenac ER                                  | Non Preferred | Generic | 01/01/22    |                                               | Medication Coverage Exception     |                |                                                           |
| diclofenac potassium 25mg                      | Non Preferred | Generic | 01/01/23    |                                               | Medication Coverage Exception     |                |                                                           |
| diclofenac solution                            | Non Preferred | Generic | 05/30/14    |                                               | Medication Coverage Exception     |                |                                                           |
| etodolac                                       | Non Preferred | Generic | 01/01/24    |                                               | Medication Coverage Exception     |                |                                                           |
| etodolac ER                                    | Non Preferred | Generic | 05/30/14    |                                               | Medication Coverage Exception     |                |                                                           |
| Feldene                                        | Non Preferred | Brand   | 01/01/13    |                                               | Medication Coverage Exception     |                |                                                           |
| fenoprofen                                     | Non Preferred | Generic | 01/01/13    |                                               | Medication Coverage Exception     |                |                                                           |
| Flector                                        | Non Preferred | Brand   | 07/01/25    |                                               | Medication Coverage Exception     |                |                                                           |

## Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Drug / Product Name                                                                                                                                                                                                                    | Status        | Type    | Updated  | Limits                                        | PA Form / 3-Month Req'd       | Brand Req'd | Additional Note                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------|----------|-----------------------------------------------|-------------------------------|-------------|-----------------------------------------------------------|
| ibuprofen lysine injection                                                                                                                                                                                                             | Non Preferred | Generic | 11/01/20 |                                               | Medication Coverage Exception | Neoprofen   |                                                           |
| Indocin suppository                                                                                                                                                                                                                    | Non Preferred | Brand   | 09/01/18 |                                               | Medication Coverage Exception |             |                                                           |
| Indocin suspension                                                                                                                                                                                                                     | Non Preferred | Brand   | 01/01/20 |                                               | Medication Coverage Exception |             |                                                           |
| indomethacin suspension                                                                                                                                                                                                                | Non Preferred | Generic | 03/01/24 |                                               | Medication Coverage Exception |             |                                                           |
| ketoprofen, ER                                                                                                                                                                                                                         | Non Preferred | Generic | 01/01/19 |                                               | Medication Coverage Exception |             |                                                           |
| ketorolac nasal                                                                                                                                                                                                                        | Non Preferred | Generic | 06/01/20 | 4 units /day for 5 days<br>20 units /180 days | Medication Coverage Exception |             | Limits apply to oral, nasal, and injectable formulations. |
| Licart                                                                                                                                                                                                                                 | Non Preferred | Brand   | 06/01/20 |                                               | Medication Coverage Exception |             |                                                           |
| meclofenamate                                                                                                                                                                                                                          | Non Preferred | Generic | 01/01/13 |                                               | Medication Coverage Exception |             |                                                           |
| mefenamic acid                                                                                                                                                                                                                         | Non Preferred | Generic | 01/01/13 |                                               | Medication Coverage Exception |             |                                                           |
| meloxicam capsule                                                                                                                                                                                                                      | Non Preferred | Generic | 09/01/22 |                                               | Medication Coverage Exception |             |                                                           |
| Mobic                                                                                                                                                                                                                                  | Non Preferred | Brand   | 01/01/13 |                                               | Medication Coverage Exception |             |                                                           |
| Nalfon                                                                                                                                                                                                                                 | Non Preferred | Brand   | 01/01/13 |                                               | Medication Coverage Exception |             |                                                           |
| Naprelan CR                                                                                                                                                                                                                            | Non Preferred | Brand   | 08/01/17 |                                               | Medication Coverage Exception | Naprelan CR |                                                           |
| naproxen Na                                                                                                                                                                                                                            | Non Preferred | Generic | 01/01/19 |                                               | Medication Coverage Exception |             |                                                           |
| naproxen Na CR                                                                                                                                                                                                                         | Non Preferred | Generic | 08/01/17 |                                               | Medication Coverage Exception | Naprelan CR |                                                           |
| naproxen susp                                                                                                                                                                                                                          | Non Preferred | Generic | 01/01/20 |                                               | Medication Coverage Exception |             |                                                           |
| Neoprofen                                                                                                                                                                                                                              | Non Preferred | Brand   | 11/01/20 |                                               | Medication Coverage Exception | Neoprofen   |                                                           |
| oxaprozin                                                                                                                                                                                                                              | Non Preferred | Generic | 02/01/16 |                                               | Medication Coverage Exception |             |                                                           |
| piroxicam                                                                                                                                                                                                                              | Non Preferred | Generic | 01/01/13 |                                               | Medication Coverage Exception |             |                                                           |
| Relafen                                                                                                                                                                                                                                | Non Preferred | Brand   | 10/01/19 |                                               | Medication Coverage Exception |             |                                                           |
| Tolectin                                                                                                                                                                                                                               | Non Preferred | Brand   | 11/01/24 |                                               | Medication Coverage Exception |             |                                                           |
| tolmetin                                                                                                                                                                                                                               | Non Preferred | Generic | 01/01/13 |                                               | Medication Coverage Exception |             |                                                           |
| Short Acting Opioids                                                                                                                                                                                                                   |               |         |          |                                               |                               |             |                                                           |
| • Cancer Pain: MME and quantity limits may be overridden if the prescriber writes Diagnosis Code (G89.3 Neoplasm related pain) for cancer related pain on the face of the prescription.                                                |               |         |          |                                               |                               |             |                                                           |
| • Children: 18 years of age and younger, short-acting opioid prescriptions that exceed a 7 day supply require prior authorization.                                                                                                     |               |         |          |                                               |                               |             |                                                           |
| • Initial Fill: Initial prescriptions that exceed a 7 day supply or 3 day for dental providers require prior authorization. A prescription is considered "initial" if the drug has not been filled for the member in the past 60 days. |               |         |          |                                               |                               |             |                                                           |
| • MME: In addition to the drug-specific limits below, 90 MME limit applies for any combination of opioids.                                                                                                                             |               |         |          |                                               |                               |             |                                                           |
| • Pregnancy: Pregnant women, short-acting opioid prescriptions that exceed a 7 day supply require prior authorization.                                                                                                                 |               |         |          |                                               |                               |             |                                                           |

## Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Preferred Drugs                     | Status        | Type    | Last Update | Limits                        | Required Prior Authorization Form | Brand Required | Additional Note |
|-------------------------------------|---------------|---------|-------------|-------------------------------|-----------------------------------|----------------|-----------------|
| Actiq                               | Preferred     | Brand   | 01/01/15    | Cancer-related pain only      | Opioid                            | Actiq          |                 |
| codeine tablet                      | Preferred     | Generic | 01/01/15    | 90 MME & 6 tablets /day       | Opioid                            |                |                 |
| hydromorphone liquid                | Preferred     | Generic | 01/01/15    | 90 MME & 16 ml /day           | Opioid                            |                |                 |
| hydromorphone tablet                | Preferred     | Generic | 01/01/15    | 90 MME & 6 tablets /day       | Opioid                            |                |                 |
| morphine conc. (10mg/ml)            | Preferred     | Generic | 01/01/15    | 90 MME & 8 ml /day            | Opioid                            |                |                 |
| morphine conc. (20mg/ml)            | Preferred     | Generic | 01/01/15    | 90 MME & 4 ml /day            | Opioid                            |                |                 |
| morphine tablet                     | Preferred     | Generic | 01/01/15    | 90 MME & 3 tablets /day       | Opioid                            |                |                 |
| oxycodone 20mg, 30mg                | Preferred     | Generic | 01/01/15    | 90 MME & 3 tablets /day       | Opioid                            |                |                 |
| oxycodone 5mg, 10mg, 15mg           | Preferred     | Generic | 01/01/15    | 90 MME & 6 tablets /day       | Opioid                            |                |                 |
| oxycodone solution (1mg/ml)         | Preferred     | Generic | 01/01/15    | 90 MME & 20 ml /day           | Opioid                            |                |                 |
| tramadol tablet (25mg, 50mg, 100mg) | Preferred     | Generic | 01/01/15    | 90 MME & 400mg /day           | Opioid                            |                |                 |
| Non Preferred Drugs                 | Status        | Type    | Last Update | Limits                        | Required Prior Authorization Form | Brand Required | Additional Note |
| Dilaudid                            | Non Preferred | Brand   | 10/01/19    | 90 MME & 6 tablets /day       | Opioid                            |                |                 |
| fentanyl lozenge                    | Non Preferred | Generic | 01/01/15    | Cancer-related pain only      | Opioid                            | Actiq          |                 |
| fentanyl tablet                     | Non Preferred | Generic | 07/01/19    | Cancer-related pain only      | Opioid                            | Fentora        |                 |
| Fentora                             | Non Preferred | Brand   | 01/01/20    | Cancer-related pain only      | Opioid                            | Fentora        |                 |
| hydromorphone suppository           | Non Preferred | Generic | 09/01/21    | 90 MME & 3 suppositories /day | Opioid                            |                |                 |
| meperidine solution                 | Non Preferred | Generic | 01/01/15    | 90 MME & 8 ml /day            | Opioid                            |                |                 |
| meperidine tablet                   | Non Preferred | Generic | 01/01/15    | 90 MME & 1.8 tablets /day     | Opioid                            |                |                 |
| morphine suppository                | Non Preferred | Generic | 01/01/15    | 90 MME & 3 suppository/day    | Opioid                            |                |                 |
| Olinvyk                             | Non Preferred | Brand   | 12/01/20    | 90 MME                        | Opioid                            |                |                 |
| Oxaydo                              | Non Preferred | Brand   | 10/01/15    | 90 MME & 3 tablets /day       | Opioid                            |                |                 |
| oxycodone capsule 5mg               | Non Preferred | Generic | 10/01/19    | 90 MME & 4 capsules /day      | Opioid                            |                |                 |
| oxycodone conc (20mg/ml)            | Non Preferred | Generic | 10/01/19    | 90 MME & 4 ml /day            | Opioid                            |                |                 |
| oxymorphone                         | Non Preferred | Generic | 08/01/17    | 90 MME & 3 tablets /day       | Opioid                            |                |                 |
| Roxicodone 30mg                     | Non Preferred | Brand   | 09/01/18    | 90 MME & 3 tablets /day       | Opioid                            |                |                 |
| Roxicodone 5mg, 15mg                | Non Preferred | Brand   | 09/01/18    | 90 MME & 6 tablets /day       | Opioid                            |                |                 |
| RoxyBond                            | Non Preferred | Brand   | 06/01/22    | 90 MME & 4 tablets /day       | Opioid                            |                |                 |
| tramadol solution                   | Non Preferred | Generic | 02/01/23    | 90 MME & 400mg /day           | Opioid                            |                |                 |
| tramadol tablet (75mg)              | Non Preferred | Generic | 12/01/24    | 90 MME & 400mg /day           | Opioid                            |                |                 |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Long Acting Opioids                                                                                                                                                                     |               |         |             |                             |                                   |                |                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------|-------------|-----------------------------|-----------------------------------|----------------|-----------------|
| • Cancer Pain: MME and quantity limits may be overridden if the prescriber writes Diagnosis Code (G89.3 Neoplasm related pain) for cancer related pain on the face of the prescription. |               |         |             |                             |                                   |                |                 |
| • Benzodiazepine and Opioid Combination: Concurrent long-acting opioids and benzodiazepines (within 45 days of each other) require prior authorization.                                 |               |         |             |                             |                                   |                |                 |
| • MME: In addition to the drug-specific limits below, 90 MME limit applies for any combination of opioids.                                                                              |               |         |             |                             |                                   |                |                 |
| • Mutually Exclusive: Methadone and Fentanyl are mutually exclusive with each other and all long acting opioids. All other opioids are not.                                             |               |         |             |                             |                                   |                |                 |
| • Short before Long: Short acting opioid fill (within 30 days) is required before initiation of long acting opioid therapy.                                                             |               |         |             |                             |                                   |                |                 |
| Preferred Drugs                                                                                                                                                                         | Status        | Type    | Last Update | Limits                      | Required Prior Authorization Form | Brand Required | Additional Note |
| Butrans                                                                                                                                                                                 | Preferred     | Brand   | 01/01/20    | 90 MME & 4 patches /28 days | Opioid                            | Butrans        |                 |
| Conzip ER                                                                                                                                                                               | Preferred     | Brand   | 06/01/23    | 90 MME & 1 capsule /day     | Opioid                            | Conzip ER      |                 |
| fentanyl patch 12, 25mcg                                                                                                                                                                | Preferred     | Generic | 01/01/19    | 90 MME & 1 patch /3 days    | Opioid                            |                |                 |
| fentanyl patch 50, 75, 100mcg                                                                                                                                                           | Preferred     | Generic | 01/01/19    | Cancer-related pain only    | Opioid                            |                |                 |
| morphine ER tablet 15mg                                                                                                                                                                 | Preferred     | Generic | 01/01/14    | 90 MME & 3 tablets /day     | Opioid                            |                |                 |
| morphine ER tablet >15mg                                                                                                                                                                | Preferred     | Generic | 01/01/14    | 90 MME & 2 tablets /day     | Opioid                            |                |                 |
| OxyContin                                                                                                                                                                               | Preferred     | Brand   | 01/01/20    | 90 MME & 2 tablets /day     | Opioid                            | OxyContin      |                 |
| Non Preferred Drugs                                                                                                                                                                     | Status        | Type    | Last Update | Limits                      | Required Prior Authorization Form | Brand Required | Additional Note |
| Belbuca                                                                                                                                                                                 | Non Preferred | Brand   | 01/01/16    | 90 MME & 2 films /day       | Opioid                            |                |                 |
| buprenorphine films                                                                                                                                                                     | Non Preferred | Generic | 10/01/21    | 90 MME & 2 films /day       | Opioid                            | Belbuca        |                 |
| buprenorphine patch                                                                                                                                                                     | Non Preferred | Generic | 10/30/14    | 90 MME & 4 patches /28 days | Opioid                            | Butrans        |                 |
| fentanyl patch 37.5, 62.5, 87.5mcg                                                                                                                                                      | Non Preferred | Generic | 09/28/09    | 90 MME & 1 patch /3 days    | Opioid                            |                |                 |
| hydrocodone ER capsule                                                                                                                                                                  | Non Preferred | Generic | 01/01/20    | 90 MME & 1 capsule /day     | Opioid                            | Zohydro ER     |                 |
| hydrocodone ER tablet                                                                                                                                                                   | Non Preferred | Generic | 01/01/20    | 90 MME & 1 capsule /day     | Opioid                            | Hysingla ER    |                 |
| hydromorphone ER                                                                                                                                                                        | Non Preferred | Generic | 01/01/15    | 90 MME & 1 tablet /day      | Opioid                            |                |                 |
| Hysingla ER                                                                                                                                                                             | Non Preferred | Brand   | 12/15/14    | 90 MME & 2 tablets /day     | Opioid                            | Hysingla ER    |                 |
| Kadian                                                                                                                                                                                  | Non Preferred | Brand   | 01/01/17    | 90 MME & 1 capsule /day     | Opioid                            | Kadian         |                 |
| levorphanol                                                                                                                                                                             | Non Preferred | Generic | 01/01/15    | 90 MME                      | Opioid                            |                |                 |
| methadone                                                                                                                                                                               | Non Preferred | Generic | 01/01/16    | 90 MME & 15mg /day          | Methadone                         |                |                 |
| Methadose                                                                                                                                                                               | Non Preferred | Brand   | 01/01/16    | 90 MME & 15mg /day          | Methadone                         |                |                 |
| morphine ER capsule                                                                                                                                                                     | Non Preferred | Generic | 09/28/09    | 90 MME & 1 tablet/ day      | Opioid                            | Kadian         |                 |

## Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Drug / Product Name                                                                                                                                                                                                                    | Status        | Type    | Updated     | Limits                  | PA Form / 3-Month Req'd           | Brand Req'd    | Additional Note |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------|-------------|-------------------------|-----------------------------------|----------------|-----------------|
| MS Contin 15mg                                                                                                                                                                                                                         | Non Preferred | Brand   | 09/01/16    | 90 MME & 3 tablets /day |                                   |                |                 |
| MS Contin >15mg                                                                                                                                                                                                                        | Non Preferred | Brand   | 09/01/16    | 90 MME & 2 tablets /day | Opioid                            |                |                 |
| oxycodone ER                                                                                                                                                                                                                           | Non Preferred | Generic | 01/01/20    | 90 MME & 2 tablets /day | Opioid                            | OxyContin      |                 |
| oxymorphone ER                                                                                                                                                                                                                         | Non Preferred | Generic | 07/01/17    | 90 MME & 2 tablets /day | Opioid                            |                |                 |
| tramadol ER capsule                                                                                                                                                                                                                    | Non Preferred | Generic | 01/01/16    | 90 MME & 1 tablet /day  | Opioid                            | Conzip ER      |                 |
| tramadol ER tablet                                                                                                                                                                                                                     | Non Preferred | Generic | 01/01/16    | 90 MME & 1 tablet /day  | Opioid                            |                |                 |
| Zohydro ER                                                                                                                                                                                                                             | Non Preferred | Brand   | 01/01/14    | 90 MME & 2 tablets /day | Opioid                            | Zohydro ER     |                 |
| <b>Opioid Combinations</b>                                                                                                                                                                                                             |               |         |             |                         |                                   |                |                 |
| • Cancer Pain: MME and quantity limits may be overridden if the prescriber writes Diagnosis Code (G89.3 Neoplasm related pain) for cancer related pain on the face of the prescription.                                                |               |         |             |                         |                                   |                |                 |
| • Children: 18 years of age and younger, short-acting opioid prescriptions that exceed a 7 day supply require prior authorization.                                                                                                     |               |         |             |                         |                                   |                |                 |
| • Initial Fill: Initial prescriptions that exceed a 7 day supply or 3 day for dental providers require prior authorization. A prescription is considered "initial" if the drug has not been filled for the member in the past 60 days. |               |         |             |                         |                                   |                |                 |
| • MME: In addition to the drug-specific limits below, 90 MME limit applies for any combination of opioids.                                                                                                                             |               |         |             |                         |                                   |                |                 |
| • Pregnancy: Pregnant women, short-acting opioid prescriptions that exceed a 7 day supply require prior authorization.                                                                                                                 |               |         |             |                         |                                   |                |                 |
| Preferred Drugs                                                                                                                                                                                                                        | Status        | Type    | Last Update | Limits                  | Required Prior Authorization Form | Brand Required | Additional Note |
| apap/codeine liquid                                                                                                                                                                                                                    | Preferred     | Generic | 05/01/17    | 90 MME & 15 ml /day     | Opioid                            |                |                 |
| apap/codeine tablet                                                                                                                                                                                                                    | Preferred     | Generic | 05/01/17    | 90 MME & 6 tablets /day | Opioid                            |                |                 |
| hydrocodone/apap liquid                                                                                                                                                                                                                | Preferred     | Generic | 05/01/17    | 90 MME & 60 ml /day     | Opioid                            |                |                 |
| hydrocodone/apap tablet                                                                                                                                                                                                                | Preferred     | Generic | 05/01/17    | 90 MME & 6 tablets /day | Opioid                            |                |                 |
| oxycodone/apap liquid                                                                                                                                                                                                                  | Preferred     | Generic | 05/01/17    | 90 MME & 20 ml /day     | Opioid                            |                |                 |
| oxycodone/apap tablet                                                                                                                                                                                                                  | Preferred     | Generic | 05/01/17    | 90 MME & 6 tablets /day | Opioid                            |                |                 |
| tramadol/apap                                                                                                                                                                                                                          | Preferred     | Generic | 05/01/17    | 90 MME & 8 tablets /day | Opioid                            |                |                 |
| Non Preferred Drugs                                                                                                                                                                                                                    | Status        | Type    | Last Update | Limits                  | Required Prior Authorization Form | Brand Required | Additional Note |
| Apadaz                                                                                                                                                                                                                                 | Non Preferred | Brand   | 03/01/19    | 90 MME & 4 tablets /day | Opioid                            |                |                 |
| benzhydrocodone/apap                                                                                                                                                                                                                   | Non Preferred | Generic | 01/01/21    | 90 MME & 4 tablets /day | Opioid                            |                |                 |
| dihydrocodeine/apap/caf                                                                                                                                                                                                                | Non Preferred | Generic | 01/01/19    | 90 MME & 4 tablets /day | Opioid                            |                |                 |
| hydrocodone/ibu                                                                                                                                                                                                                        | Non Preferred | Generic | 05/01/17    | 90 MME & 4 tablets /day | Opioid                            |                |                 |
| Lortab solution                                                                                                                                                                                                                        | Non Preferred | Brand   | 05/01/17    | 90 MME & 60 ml /day     | Opioid                            |                |                 |



## Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Drug / Product Name  | Status        | Type    | Updated  | Limits                  | PA Form / 3-Month Req'd | Brand Req'd | Additional Note |
|----------------------|---------------|---------|----------|-------------------------|-------------------------|-------------|-----------------|
| pentazocine/naloxone | Non Preferred | Generic | 01/01/22 | 90 MME & 4 tablets /day | Opioid                  |             |                 |
| Percocet             | Non Preferred | Brand   | 05/01/17 | 90 MME & 6 tablets /day | Opioid                  |             |                 |
| Primlev              | Non Preferred | Brand   | 05/01/17 | 90 MME & 4 tablets /day | Opioid                  |             |                 |
| Seglents             | Non Preferred | Brand   | 03/01/22 | 90 MME & 4 tablets /day | Opioid                  |             |                 |
| Ultracet             | Non Preferred | Brand   | 05/01/17 | 90 MME & 8 tablets /day | Opioid                  |             |                 |

### Opioid Use Disorder Treatments

| Preferred Drugs               | Status        | Type    | Last Update | Limits                                                     | Required Prior Authorization Form                       | Brand Required | Additional Note                                              |
|-------------------------------|---------------|---------|-------------|------------------------------------------------------------|---------------------------------------------------------|----------------|--------------------------------------------------------------|
| Brixadi monthly               | Preferred     | Brand   | 08/01/23    | Minimum Age: 16 Years Old<br>1 prefilled syringe/ 26 days  | Not Required if within Limits<br>Buprenorphine/Naloxone |                | Must be dispensed directly to the provider, not the patient. |
| Brixadi weekly                | Preferred     | Brand   | 08/01/23    | Minimum Age: 16 Years Old<br>4 prefilled syringes/ 26 days | Not Required if within Limits<br>Buprenorphine/Naloxone |                | Must be dispensed directly to the provider, not the patient. |
| buprenorphine                 | Preferred     | Generic | 02/01/21    | Minimum Age: 16 Years Old<br>24 mg & 3 units/day           | Not Required if within Limits<br>Buprenorphine/Naloxone |                |                                                              |
| buprenorphine/naloxone tablet | Preferred     | Generic | 01/01/22    | 24 mg & 3 units/day                                        | Not Required if within Limits<br>Buprenorphine/Naloxone |                |                                                              |
| naltrexone tablet             | Preferred     | Generic | 12/01/17    |                                                            |                                                         |                |                                                              |
| Sublocade                     | Preferred     | Brand   | 01/01/19    | Minimum Age: 16 Years Old                                  | Not Required if within Limits<br>Buprenorphine/Naloxone |                | Must be dispensed directly to the provider, not the patient. |
| Suboxone film                 | Preferred     | Brand   | 01/01/12    | 24 mg & 3 units/day                                        | Not Required if within Limits<br>Buprenorphine/Naloxone | Suboxone film  |                                                              |
| Vivitrol                      | Preferred     | Brand   | 01/01/18    | Minimum Age: 18 Years Old<br>1 unit /28 days               | Not Required if within Limits<br>Buprenorphine/Naloxone |                | Must be dispensed directly to the provider, not the patient. |
| Non Preferred Drugs           | Status        | Type    | Last Update | Limits                                                     | Required Prior Authorization Form                       | Brand Required | Additional Note                                              |
| buprenorphine/naloxone film   | Non Preferred | Generic | 01/01/15    | 24 mg & 3 units/day                                        | Buprenorphine/Naloxone                                  | Suboxone film  |                                                              |
| Zubsolv                       | Non Preferred | Brand   | 01/01/17    | 24 mg & 3 units/day                                        | Buprenorphine/Naloxone                                  |                |                                                              |

### Androgens

#### Topical Androgens

| Preferred Drugs  | Status    | Type    | Last Update | Limits    | Required Prior Authorization Form | Brand Required | Additional Note |
|------------------|-----------|---------|-------------|-----------|-----------------------------------|----------------|-----------------|
| Androderm        | Preferred | Brand   | 01/01/19    | Male only | Androgens                         |                |                 |
| AndroGel         | Preferred | Brand   | 01/01/24    | Male only | Androgens                         |                |                 |
| Testim           | Preferred | Brand   | 01/01/24    | Male only | Androgens                         |                |                 |
| testosterone gel | Preferred | Generic | 07/01/23    | Male only | Androgens                         |                |                 |

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| Non Preferred Drugs           | Status        | Type    | Last Update | Limits    | Required Prior Authorization Form | Brand Required | Additional Note                                       |
|-------------------------------|---------------|---------|-------------|-----------|-----------------------------------|----------------|-------------------------------------------------------|
| Fortesta                      | Non Preferred | Brand   | 06/01/12    | Male only | Androgens                         |                |                                                       |
| Natesto                       | Non Preferred | Brand   | 07/01/20    | Male only | Androgens                         |                |                                                       |
| testosterone solution         | Non Preferred | Generic | 06/24/14    | Male only | Androgens                         |                |                                                       |
| Vogelxo                       | Non Preferred | Brand   | 06/09/14    | Male only | Androgens                         |                |                                                       |
| Misc Androgens                |               |         |             |           |                                   |                |                                                       |
| Preferred Drugs               | Status        | Type    | Last Update | Limits    | Required Prior Authorization Form | Brand Required | Additional Note                                       |
| testosterone cypionate        | Preferred     | Generic | 06/01/16    | Male only | Androgens                         |                |                                                       |
| Non Preferred Drugs           | Status        | Type    | Last Update | Limits    | Required Prior Authorization Form | Brand Required | Additional Note                                       |
| Aveed                         | Non Preferred | Brand   | 03/17/14    | Male only | Androgens                         |                |                                                       |
| Azmiro                        | Non Preferred | Brand   | 12/01/24    | Male only | Androgens                         |                |                                                       |
| danazol                       | Non Preferred | Generic | 10/01/24    |           | Androgens                         |                |                                                       |
| Depo-Testosterone             | Non Preferred | Brand   | 06/01/16    | Male only | Androgens                         |                |                                                       |
| Jatenzo                       | Non Preferred | Brand   | 01/01/20    | Male only | Androgens                         |                |                                                       |
| Methitest                     | Non Preferred | Brand   | 01/01/13    | Male only | Androgens                         |                |                                                       |
| methyltestosterone            | Non Preferred | Generic | 02/15/16    | Male only | Androgens                         |                |                                                       |
| oxandrolone                   | Non Preferred | Generic | 01/01/13    | Male only | Androgens                         |                |                                                       |
| Testopel                      | Non Preferred | Brand   | 01/01/15    | Male only | Androgens                         |                | Covered under medical benefit using appropriate HCPCS |
| testosterone enanthate        | Non Preferred | Generic | 12/01/18    | Male only | Androgens                         |                |                                                       |
| Tlando                        | Non Preferred | Brand   | 05/01/22    | Male only | Androgens                         |                |                                                       |
| Xyosted                       | Non Preferred | Brand   | 12/01/18    | Male only | Androgens                         |                |                                                       |
| Antibiotics                   |               |         |             |           |                                   |                |                                                       |
| 3rd Generation Cephalosporins |               |         |             |           |                                   |                |                                                       |
| Preferred Drugs               | Status        | Type    | Last Update | Limits    | Mandatory 3-Month                 | Brand Required | Additional Note                                       |
| cefdinir                      | Preferred     | Generic | 02/01/10    |           |                                   |                |                                                       |
| Non Preferred Drugs           | Status        | Type    | Last Update | Limits    | Required Prior Authorization Form | Brand Required | Additional Note                                       |
| cefixime                      | Non Preferred | Generic | 01/01/20    |           | Medication Coverage Exception     |                |                                                       |
| cefpodoxime                   | Non Preferred | Generic | 01/01/20    |           | Medication Coverage Exception     |                |                                                       |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Quinolones                                |               |         |             |        |                                   |                |                 |
|-------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Preferred Drugs                           | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Cipro suspension                          | Preferred     | Brand   | 02/01/10    |        |                                   | Cipro susp     |                 |
| ciprofloxacin 250, 500, 750mg tablet      | Preferred     | Generic | 02/01/10    |        |                                   |                |                 |
| levofloxacin                              | Preferred     | Generic | 02/01/16    |        |                                   |                |                 |
| moxifloxacin                              | Preferred     | Generic | 01/01/21    |        |                                   |                |                 |
| Non Preferred Drugs                       | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Baxdela                                   | Non Preferred | Brand   | 10/01/17    |        | Medication Coverage Exception     |                |                 |
| Cipro tablet                              | Non Preferred | Brand   | 02/01/10    |        | Medication Coverage Exception     |                |                 |
| ciprofloxacin 100mg tablet                | Non Preferred | Generic | 01/01/22    |        | Medication Coverage Exception     |                |                 |
| ciprofloxacin suspension                  | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     | Cipro susp     |                 |
| ofloxacin tablet                          | Non Preferred | Generic | 02/01/10    |        | Medication Coverage Exception     |                |                 |
| Tetracyclines                             |               |         |             |        |                                   |                |                 |
| Preferred Drugs                           | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| doxycycline monohydrate 50, 100mg capsule | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| doxycycline hyclate 50, 100mg             | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| minocycline 50, 75, 100mg capsule         | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| Non Preferred Drugs                       | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| demeclocycline                            | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Doryx                                     | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| doxycycline (unless listed preferred)     | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Emrosi                                    | Non Preferred | Brand   | 12/01/24    |        | Medication Coverage Exception     |                |                 |
| minocycline ER capsule                    | Non Preferred | Generic | 12/01/22    |        | Medication Coverage Exception     |                |                 |
| minocycline tablet                        | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Minolira                                  | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Nuzyra                                    | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Solodyn                                   | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| tetracycline                              | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Vibramycin                                | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Ximino                                    | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Anticoagulants                                                                                                                                                                                                                                                                                                           |               |         |             |                  |                                   |                |                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------|-------------|------------------|-----------------------------------|----------------|-----------------|
| Oral                                                                                                                                                                                                                                                                                                                     |               |         |             |                  |                                   |                |                 |
| Preferred Drugs                                                                                                                                                                                                                                                                                                          | Status        | Type    | Last Update | Limits           | Mandatory 3-Month                 | Brand Required | Additional Note |
| Eliquis                                                                                                                                                                                                                                                                                                                  | Preferred     | Brand   | 01/01/14    |                  |                                   |                |                 |
| Pradaxa                                                                                                                                                                                                                                                                                                                  | Preferred     | Brand   | 01/01/14    |                  |                                   | Pradaxa        |                 |
| Xarelto                                                                                                                                                                                                                                                                                                                  | Preferred     | Brand   | 01/01/13    |                  |                                   |                |                 |
| warfarin                                                                                                                                                                                                                                                                                                                 | Preferred     | Generic | 06/01/20    |                  |                                   |                |                 |
| Non Preferred Drugs                                                                                                                                                                                                                                                                                                      | Status        | Type    | Last Update | Limits           | Required Prior Authorization Form | Brand Required | Additional Note |
| dabigatran                                                                                                                                                                                                                                                                                                               | Non Preferred | Generic | 08/01/22    |                  | Medication Coverage Exception     | Pradaxa        |                 |
| rivaroxaban                                                                                                                                                                                                                                                                                                              | Non Preferred | Generic | 08/01/25    |                  | Medication Coverage Exception     | Xarelto        |                 |
| Savaysa                                                                                                                                                                                                                                                                                                                  | Non Preferred | Brand   | 01/20/15    |                  | Medication Coverage Exception     |                |                 |
| Injectable                                                                                                                                                                                                                                                                                                               |               |         |             |                  |                                   |                |                 |
| Preferred Drugs                                                                                                                                                                                                                                                                                                          | Status        | Type    | Last Update | Limits           | Mandatory 3-Month                 | Brand Required | Additional Note |
| enoxaparin                                                                                                                                                                                                                                                                                                               | Preferred     | Generic | 01/01/19    |                  |                                   |                |                 |
| Non Preferred Drugs                                                                                                                                                                                                                                                                                                      | Status        | Type    | Last Update | Limits           | Required Prior Authorization Form | Brand Required | Additional Note |
| Arixtra                                                                                                                                                                                                                                                                                                                  | Non Preferred | Brand   | 01/01/13    |                  | Medication Coverage Exception     |                |                 |
| fondaparinux                                                                                                                                                                                                                                                                                                             | Non Preferred | Generic | 01/01/13    |                  | Medication Coverage Exception     |                |                 |
| Fragmin                                                                                                                                                                                                                                                                                                                  | Non Preferred | Brand   | 01/01/18    |                  | Medication Coverage Exception     |                |                 |
| Lovenox                                                                                                                                                                                                                                                                                                                  | Non Preferred | Brand   | 01/01/19    |                  | Medication Coverage Exception     |                |                 |
| Antidiabetics                                                                                                                                                                                                                                                                                                            |               |         |             |                  |                                   |                |                 |
| Short Acting Insulin                                                                                                                                                                                                                                                                                                     |               |         |             |                  |                                   |                |                 |
| • Insulin Pen Day Supply: Insulin pens may be billed for up to a140-day supply, with a limit of one box for claims over 30-days, in accordance with the FDA's recommendation "dispense in original sealed carton". Day supply on submitted claims should reflect the actual days the medication will last and/or expire. |               |         |             |                  |                                   |                |                 |
| Preferred Drugs                                                                                                                                                                                                                                                                                                          | Status        | Type    | Last Update | Limits           | Mandatory 3-Month                 | Brand Required | Additional Note |
| Apidra                                                                                                                                                                                                                                                                                                                   | Preferred     | Brand   | 01/01/17    | 60ml per 30 days |                                   |                |                 |
| Humalog U-100                                                                                                                                                                                                                                                                                                            | Preferred     | Brand   | 01/01/20    | 60ml per 30 days |                                   | Humalog        |                 |
| insulin aspart                                                                                                                                                                                                                                                                                                           | Preferred     | Generic | 01/01/24    | 60ml per 30 days |                                   |                |                 |
| Novolog                                                                                                                                                                                                                                                                                                                  | Preferred     | Brand   | 02/01/10    | 60ml per 30 days |                                   |                |                 |

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| Non Preferred Drugs                                                                                                                                                                                                                                                                                                       | Status        | Type    | Last Update | Limits           | Required Prior Authorization Form | Brand Required | Additional Note |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------|-------------|------------------|-----------------------------------|----------------|-----------------|
| Admelog                                                                                                                                                                                                                                                                                                                   | Non Preferred | Brand   | 02/01/18    | 60ml per 30 days | Medication Coverage Exception     |                |                 |
| Afrezza                                                                                                                                                                                                                                                                                                                   | Non Preferred | Brand   | 07/01/17    | 60ml per 30 days | Medication Coverage Exception     |                |                 |
| Fiasp                                                                                                                                                                                                                                                                                                                     | Non Preferred | Brand   | 02/01/18    | 60ml per 30 days | Medication Coverage Exception     |                |                 |
| Humalog U-200                                                                                                                                                                                                                                                                                                             | Non Preferred | Brand   | 01/01/20    | 60ml per 30 days | Medication Coverage Exception     |                |                 |
| Humulin-R                                                                                                                                                                                                                                                                                                                 | Non Preferred | Brand   | 01/01/17    | 60ml per 30 days | Medication Coverage Exception     |                |                 |
| insulin lispro                                                                                                                                                                                                                                                                                                            | Non Preferred | Generic | 05/01/19    | 60ml per 30 days | Medication Coverage Exception     | Humalog        |                 |
| Lyumjev                                                                                                                                                                                                                                                                                                                   | Non Preferred | Brand   | 07/01/20    | 60ml per 30 days | Medication Coverage Exception     |                |                 |
| Merilog                                                                                                                                                                                                                                                                                                                   | Non Preferred | Brand   | 07/01/25    | 60ml per 30 days | Medication Coverage Exception     |                |                 |
| Myxredlin                                                                                                                                                                                                                                                                                                                 | Non Preferred | Brand   | 09/01/19    | 60ml per 30 days | Medication Coverage Exception     |                |                 |
| Novolin-R                                                                                                                                                                                                                                                                                                                 | Non Preferred | Brand   | 01/01/17    | 60ml per 30 days | Medication Coverage Exception     |                |                 |
| Intermediate Acting Insulin                                                                                                                                                                                                                                                                                               |               |         |             |                  |                                   |                |                 |
| • Insulin Pen Day Supply: Insulin pens may be billed for up to a 140-day supply, with a limit of one box for claims over 30-days, in accordance with the FDA's recommendation "dispense in original sealed carton". Day supply on submitted claims should reflect the actual days the medication will last and/or expire. |               |         |             |                  |                                   |                |                 |
| Preferred Drugs                                                                                                                                                                                                                                                                                                           | Status        | Type    | Last Update | Limits           | Mandatory 3-Month                 | Brand Required | Additional Note |
| Novolin-N                                                                                                                                                                                                                                                                                                                 | Preferred     | Brand   | 01/01/21    | 60ml per 30 days |                                   |                |                 |
| Non Preferred Drugs                                                                                                                                                                                                                                                                                                       | Status        | Type    | Last Update | Limits           | Required Prior Authorization Form | Brand Required | Additional Note |
| Humulin-N                                                                                                                                                                                                                                                                                                                 | Non Preferred | Brand   | 01/01/21    | 60ml per 30 days | Medication Coverage Exception     |                |                 |
| Long Acting Insulin                                                                                                                                                                                                                                                                                                       |               |         |             |                  |                                   |                |                 |
| • Insulin Pen Day Supply: Insulin pens may be billed for up to a 140-day supply, with a limit of one box for claims over 30-days, in accordance with the FDA's recommendation "dispense in original sealed carton". Day supply on submitted claims should reflect the actual days the medication will last and/or expire. |               |         |             |                  |                                   |                |                 |
| Preferred Drugs                                                                                                                                                                                                                                                                                                           | Status        | Type    | Last Update | Limits           | Mandatory 3-Month                 | Brand Required | Additional Note |
| Lantus                                                                                                                                                                                                                                                                                                                    | Preferred     | Brand   | 01/01/17    | 60ml per 30 days |                                   |                |                 |
| Levemir                                                                                                                                                                                                                                                                                                                   | Preferred     | Brand   | 09/28/09    | 60ml per 30 days |                                   |                |                 |
| Toujeo                                                                                                                                                                                                                                                                                                                    | Preferred     | Brand   | 07/01/19    | 60ml per 30 days |                                   |                |                 |

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| Non Preferred Drugs                                                                                                                                                                                                                                                                                                       | Status        | Type    | Last Update | Limits           | Required Prior Authorization Form | Brand Required | Additional Note                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------|-------------|------------------|-----------------------------------|----------------|-----------------------------------------------------------------------------|
| Basaglar                                                                                                                                                                                                                                                                                                                  | Non Preferred | Brand   | 12/01/16    | 60ml per 30 days | Medication Coverage Exception     |                |                                                                             |
| insulin degludec                                                                                                                                                                                                                                                                                                          | Non Preferred | Generic | 05/01/23    | 60ml per 30 days | Medication Coverage Exception     |                |                                                                             |
| insulin glargine                                                                                                                                                                                                                                                                                                          | Non Preferred | Generic | 11/01/21    | 60ml per 30 days | Medication Coverage Exception     |                |                                                                             |
| Rezvoglar                                                                                                                                                                                                                                                                                                                 | Non Preferred | Brand   | 04/01/23    | 60ml per 30 days | Medication Coverage Exception     |                |                                                                             |
| Semglee                                                                                                                                                                                                                                                                                                                   | Non Preferred | Brand   | 01/01/21    | 60ml per 30 days | Medication Coverage Exception     |                |                                                                             |
| Soliqua                                                                                                                                                                                                                                                                                                                   | Non Preferred | Brand   | 02/01/20    | 60ml per 30 days | Medication Coverage Exception     |                | Trial & Failure of preferred Long Acting Insulin AND GLP-1 Agonist required |
| Tresiba                                                                                                                                                                                                                                                                                                                   | Non Preferred | Brand   | 03/15/16    | 60ml per 30 days | Medication Coverage Exception     |                |                                                                             |
| Xultophy                                                                                                                                                                                                                                                                                                                  | Non Preferred | Brand   | 02/01/20    | 60ml per 30 days | Medication Coverage Exception     |                | Trial & Failure of preferred Long Acting Insulin AND GLP-1 Agonist required |
| Insulin Mixtures                                                                                                                                                                                                                                                                                                          |               |         |             |                  |                                   |                |                                                                             |
| • Insulin Pen Day Supply: Insulin pens may be billed for up to a 140-day supply, with a limit of one box for claims over 30-days, in accordance with the FDA's recommendation "dispense in original sealed carton". Day supply on submitted claims should reflect the actual days the medication will last and/or expire. |               |         |             |                  |                                   |                |                                                                             |
| Preferred Drugs                                                                                                                                                                                                                                                                                                           | Status        | Type    | Last Update | Limits           | Mandatory 3-Month                 | Brand Required | Additional Note                                                             |
| Humalog mix                                                                                                                                                                                                                                                                                                               | Preferred     | Brand   | 09/28/09    | 60ml per 30 days |                                   | Humalog 75/25  |                                                                             |
| Humulin 70/30                                                                                                                                                                                                                                                                                                             | Preferred     | Brand   | 01/01/20    | 60ml per 30 days |                                   | Humulin        |                                                                             |
| insulin aspart protamine/aspart                                                                                                                                                                                                                                                                                           | Preferred     | Generic | 01/01/24    | 60ml per 30 days |                                   |                |                                                                             |
| Novolog 70/30                                                                                                                                                                                                                                                                                                             | Preferred     | Brand   | 02/01/10    | 60ml per 30 days |                                   |                |                                                                             |
| Non Preferred Drugs                                                                                                                                                                                                                                                                                                       | Status        | Type    | Last Update | Limits           | Required Prior Authorization Form | Brand Required | Additional Note                                                             |
| Novolin 70/30                                                                                                                                                                                                                                                                                                             | Non Preferred | Brand   | 01/01/19    | 60ml per 30 days | Medication Coverage Exception     |                |                                                                             |
| insulin lispro protamine/lispro                                                                                                                                                                                                                                                                                           | Non Preferred | Generic | 05/01/20    | 60ml per 30 days | Medication Coverage Exception     | Humalog 75/25  |                                                                             |
| Sulfonylurea Combinations                                                                                                                                                                                                                                                                                                 |               |         |             |                  |                                   |                |                                                                             |
| Preferred Drugs                                                                                                                                                                                                                                                                                                           | Status        | Type    | Last Update | Limits           | Mandatory 3-Month                 | Brand Required | Additional Note                                                             |
| glyburide/metformin                                                                                                                                                                                                                                                                                                       | Preferred     | Generic | 07/01/14    |                  | 90 Day Supply Required            |                |                                                                             |
| Non Preferred Drugs                                                                                                                                                                                                                                                                                                       | Status        | Type    | Last Update | Limits           | Required Prior Authorization Form | Brand Required | Additional Note                                                             |
| Duetact                                                                                                                                                                                                                                                                                                                   | Non Preferred | Brand   | 10/01/17    |                  | Medication Coverage Exception     |                |                                                                             |
| glipizide/metformin                                                                                                                                                                                                                                                                                                       | Non Preferred | Generic | 07/01/14    |                  | Medication Coverage Exception     |                |                                                                             |
| pioglitazone/glimepiride                                                                                                                                                                                                                                                                                                  | Non Preferred | Generic | 10/01/17    |                  | Medication Coverage Exception     |                |                                                                             |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| GLP-1 Agonists      |               |         |             |        |                                   |                |                                                                              |
|---------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|------------------------------------------------------------------------------|
| Preferred Drugs     | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                                                              |
| Trulicity           | Preferred     | Brand   | 01/01/21    |        |                                   |                |                                                                              |
| Victoza             | Preferred     | Brand   | 01/01/14    |        |                                   | Victoza        |                                                                              |
| Non Preferred Drugs | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                                                              |
| Bydureon BCise      | Non Preferred | Brand   | 01/01/21    |        | Medication Coverage Exception     |                |                                                                              |
| Byetta              | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                                                                              |
| exenatide inj       | Non Preferred | Generic | 05/01/25    |        | Medication Coverage Exception     |                |                                                                              |
| liraglutide         | Non Preferred | Generic | 08/01/24    |        | Medication Coverage Exception     | Victoza        |                                                                              |
| Mounjaro            | Non Preferred | Brand   | 06/01/22    |        | Medication Coverage Exception     |                |                                                                              |
| Ozempic             | Non Preferred | Brand   | 01/01/21    |        | Medication Coverage Exception     |                |                                                                              |
| Rybelsus            | Non Preferred | Brand   | 10/01/19    |        | Medication Coverage Exception     |                |                                                                              |
| Soliqua             | Non Preferred | Brand   | 02/01/20    |        | Medication Coverage Exception     |                | Trial & Failure of preferred Long Acting Insulin AND GLP-1 Agonist required. |
| Xultophy            | Non Preferred | Brand   | 02/01/20    |        | Medication Coverage Exception     |                | Trial & Failure of preferred Long Acting Insulin AND GLP-1 Agonist required. |
| DPP- 4 Inhibitors   |               |         |             |        |                                   |                |                                                                              |
| Preferred Drugs     | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                                                              |
| Januvia             | Preferred     | Brand   | 09/28/09    |        | 90 Day Supply Required            |                |                                                                              |
| Tradjenta           | Preferred     | Brand   | 11/01/16    |        | 90 Day Supply Required            |                |                                                                              |
| Non Preferred Drugs | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                                                              |
| alogliptin          | Non Preferred | Generic | 04/01/16    |        | Medication Coverage Exception     | Nesina         |                                                                              |
| Nesina              | Non Preferred | Brand   | 04/01/16    |        | Medication Coverage Exception     | Nesina         |                                                                              |
| saxagliptin         | Non Preferred | Generic | 09/01/23    |        | Medication Coverage Exception     |                |                                                                              |
| sitagliptin         | Non Preferred | Generic | 07/01/24    |        | Medication Coverage Exception     |                |                                                                              |
| Zituvio             | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                                                                              |



# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| DPP- 4 Inhibitor Combinations |               |         |             |        |                                   |                |                                                                            |
|-------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|----------------------------------------------------------------------------|
| Preferred Drugs               | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                                                            |
| Janumet, XR                   | Preferred     | Brand   | 11/01/16    |        | 90 Day Supply Required            |                |                                                                            |
| Jentadueto, XR                | Preferred     | Brand   | 01/01/20    |        | 90 Day Supply Required            |                |                                                                            |
| Kombiglyze XR                 | Preferred     | Brand   | 08/01/21    |        | 90 Day Supply Required            | Kombiglyze XR  |                                                                            |
| Non Preferred Drugs           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                                                            |
| alogliptin/pioglitazone       | Non Preferred | Generic | 01/01/19    |        | Medication Coverage Exception     | Oseni          |                                                                            |
| alogliptin/metformin          | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     |                |                                                                            |
| Glyxambi                      | Non Preferred | Brand   | 02/11/15    |        | Medication Coverage Exception     |                | Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required. |
| Kazano                        | Non Preferred | Brand   | 02/01/18    |        | Medication Coverage Exception     |                |                                                                            |
| Oseni                         | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     | Oseni          |                                                                            |
| Qtern                         | Non Preferred | Brand   | 12/01/17    |        | Medication Coverage Exception     |                | Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required. |
| saxagliptin/metformin         | Non Preferred | Generic | 09/01/23    |        | Medication Coverage Exception     | Kombiglyze XR  |                                                                            |
| sitagliptin/metformin         | Non Preferred | Generic | 07/01/24    |        | Medication Coverage Exception     | Janumet        |                                                                            |
| Steglujan                     | Non Preferred | Brand   | 02/01/18    |        | Medication Coverage Exception     |                | Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required. |
| Trijardy XR                   | Non Preferred | Brand   | 04/01/20    |        | Medication Coverage Exception     |                | Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required. |
| SGLT-2 Inhibitors             |               |         |             |        |                                   |                |                                                                            |
| Preferred Drugs               | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                                                            |
| Farxiga                       | Preferred     | Brand   | 01/01/18    |        | 90 Day Supply Required            | Farxiga        |                                                                            |
| Jardiance                     | Preferred     | Brand   | 01/01/19    |        | 90 Day Supply Required            |                |                                                                            |
| Non Preferred Drugs           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                                                            |
| dapagliflozin                 | Non Preferred | Generic | 02/01/24    |        | Medication Coverage Exception     | Farxiga        |                                                                            |
| Inpefa                        | Non Preferred | Brand   | 07/01/23    |        | Medication Coverage Exception     |                |                                                                            |
| Invokana                      | Non Preferred | Brand   | 11/01/24    |        | Medication Coverage Exception     |                |                                                                            |
| Steglatro                     | Non Preferred | Brand   | 02/01/18    |        | Medication Coverage Exception     |                |                                                                            |



# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| SGLT-2 Inhibitor Combinations |               |         |             |        |                                   |                |                                                                         |
|-------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-------------------------------------------------------------------------|
| Preferred Drugs               | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                                                         |
| Synjardy, XR                  | Preferred     | Brand   | 01/01/18    |        | 90 Day Supply Required            |                |                                                                         |
| Xigduo XR                     | Preferred     | Brand   | 01/01/18    |        | 90 Day Supply Required            | Xigduo XR      |                                                                         |
| Non Preferred Drugs           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                                                         |
| dapagliflozin/metformin       | Non Preferred | Generic | 02/01/24    |        | Medication Coverage Exception     | Xigduo XR      |                                                                         |
| Glyxambi                      | Non Preferred | Brand   | 02/11/15    |        | Medication Coverage Exception     |                | Trial and Failure of a preferred DPP- 4 Inhib AND SGLT-2 Inhib required |
| Invokamet                     | Non Preferred | Brand   | 11/01/24    |        | Medication Coverage Exception     |                |                                                                         |
| Invokamet XR                  | Non Preferred | Brand   | 01/01/18    |        | Medication Coverage Exception     |                |                                                                         |
| Qtern                         | Non Preferred | Brand   | 12/01/17    |        | Medication Coverage Exception     |                | Trial and Failure of a preferred DPP- 4 Inhib AND SGLT-2 Inhib required |
| Segluromet                    | Non Preferred | Brand   | 03/01/18    |        | Medication Coverage Exception     |                |                                                                         |
| Steglujan                     | Non Preferred | Brand   | 02/01/18    |        | Medication Coverage Exception     |                | Trial and Failure of a preferred DPP- 4 Inhib AND SGLT-2 Inhib required |
| Trijardy XR                   | Non Preferred | Brand   | 04/01/20    |        | Medication Coverage Exception     |                | Trial and Failure of a preferred DPP- 4 Inhib AND SGLT-2 Inhib required |
| Zituvimet                     | Non Preferred | Brand   | 11/01/24    |        | Medication Coverage Exception     |                |                                                                         |
| Glucagon Products             |               |         |             |        |                                   |                |                                                                         |
| Preferred Drugs               | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                                                         |
| Baqsimi                       | Preferred     | Brand   | 01/01/23    |        |                                   |                |                                                                         |
| glucagon                      | Preferred     | Generic | 05/01/25    |        |                                   |                |                                                                         |
| Zegalogue                     | Preferred     | Brand   | 01/01/22    |        |                                   |                |                                                                         |
| Non Preferred Drugs           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                                                         |
| Gvoke                         | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                                                                         |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Antifungals                |               |         |             |        |                                   |                |                 |
|----------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Oral                       |               |         |             |        |                                   |                |                 |
| Preferred Drugs            | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| clotrimazole lozenge       | Preferred     | Generic | 10/01/11    |        |                                   |                |                 |
| fluconazole                | Preferred     | Generic | 10/01/11    |        |                                   |                |                 |
| griseofulvin suspension    | Preferred     | Generic | 01/01/13    |        |                                   |                |                 |
| itraconazole 100mg capsule | Preferred     | Generic | 01/01/24    |        |                                   |                |                 |
| ketoconazole tablet        | Preferred     | Generic | 01/15/12    |        |                                   |                |                 |
| nystatin                   | Preferred     | Generic | 10/01/11    |        |                                   |                |                 |
| terbinafine                | Preferred     | Generic | 10/01/11    |        |                                   |                |                 |
| voriconazole               | Preferred     | Generic | 10/01/15    |        |                                   |                |                 |
| Non Preferred Drugs        | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Ancobon                    | Non Preferred | Brand   | 01/01/23    |        | Medication Coverage Exception     | Ancobon        |                 |
| Brexafemme                 | Non Preferred | Brand   | 08/01/21    |        | Medication Coverage Exception     |                |                 |
| Cresemba                   | Non Preferred | Brand   | 04/01/15    |        | Medication Coverage Exception     |                |                 |
| Diflucan                   | Non Preferred | Brand   | 01/01/13    |        | Medication Coverage Exception     |                |                 |
| flucytosine                | Non Preferred | Generic | 08/01/16    |        | Medication Coverage Exception     | Ancobon        |                 |
| Fulvicin P/G 165           | Non Preferred | Brand   | 03/01/25    |        | Medication Coverage Exception     |                |                 |
| griseofulvin tablet        | Non Preferred | Generic | 10/01/11    |        | Medication Coverage Exception     |                |                 |
| itraconazole solution      | Non Preferred | Generic | 04/01/13    |        | Medication Coverage Exception     | Sporanox       |                 |
| Noxafil                    | Non Preferred | Brand   | 08/01/19    |        | Medication Coverage Exception     | Noxafil        |                 |
| posaconazole               | Non Preferred | Generic | 08/01/19    |        | Medication Coverage Exception     | Noxafil        |                 |
| Sporanox                   | Non Preferred | Brand   | 04/01/13    |        | Medication Coverage Exception     |                |                 |
| Tolsura                    | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| Vfend                      | Non Preferred | Brand   | 01/01/13    |        | Medication Coverage Exception     |                |                 |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Antihemophilia                    |               |       |             |        |                                   |                |                 |
|-----------------------------------|---------------|-------|-------------|--------|-----------------------------------|----------------|-----------------|
| Factor VIII                       |               |       |             |        |                                   |                |                 |
| Preferred Drugs                   | Status        | Type  | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Adynovate                         | Preferred     | Brand | 10/01/18    |        |                                   |                |                 |
| Hemofil M                         | Preferred     | Brand | 01/01/23    |        |                                   |                |                 |
| Jivi                              | Preferred     | Brand | 01/01/23    |        |                                   |                |                 |
| Kovaltry                          | Preferred     | Brand | 01/01/23    |        |                                   |                |                 |
| Novoeight                         | Preferred     | Brand | 10/01/18    |        |                                   |                |                 |
| Xyntha                            | Preferred     | Brand | 10/01/18    |        |                                   |                |                 |
| Non Preferred Drugs               | Status        | Type  | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Advate                            | Non Preferred | Brand | 01/01/24    |        | Medication Coverage Exception     |                |                 |
| Afstyla                           | Non Preferred | Brand | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Altuviiio                         | Non Preferred | Brand | 04/01/23    |        | Medication Coverage Exception     |                |                 |
| Eloctate                          | Non Preferred | Brand | 10/01/18    |        | Medication Coverage Exception     |                |                 |
| Esperoct                          | Non Preferred | Brand | 02/01/20    |        | Medication Coverage Exception     |                |                 |
| Koate, DVI                        | Non Preferred | Brand | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| Nuwiq                             | Non Preferred | Brand | 10/01/18    |        | Medication Coverage Exception     |                |                 |
| Obizur                            | Non Preferred | Brand | 07/01/20    |        | Medication Coverage Exception     |                |                 |
| Recombinate                       | Non Preferred | Brand | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Factor VIII/von Willebrand Factor |               |       |             |        |                                   |                |                 |
| Preferred Drugs                   | Status        | Type  | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Alphanate                         | Preferred     | Brand | 01/01/19    |        |                                   |                |                 |
| Humate P                          | Preferred     | Brand | 01/01/19    |        |                                   |                |                 |
| Wilate                            | Preferred     | Brand | 01/01/19    |        |                                   |                |                 |
| Non Preferred Drugs               | Status        | Type  | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Vonvendi                          | Non Preferred | Brand | 01/01/19    |        | Medication Coverage Exception     |                |                 |

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| Factor IX                 |               |         |             |        |                                   |                |                                     |
|---------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-------------------------------------|
| Preferred Drugs           | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                     |
| Alphanine                 | Preferred     | Brand   | 01/01/19    |        |                                   |                |                                     |
| Alprolix                  | Preferred     | Brand   | 01/01/21    |        |                                   |                |                                     |
| Benefix                   | Preferred     | Brand   | 01/01/19    |        |                                   |                |                                     |
| Feiba                     | Preferred     | Brand   | 01/01/19    |        |                                   |                |                                     |
| Profilnine                | Preferred     | Brand   | 01/01/24    |        |                                   |                |                                     |
| Rixubis                   | Preferred     | Brand   | 01/01/19    |        |                                   |                |                                     |
| Non Preferred Drugs       | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                     |
| Idelvion                  | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                                     |
| Ixinity                   | Non Preferred | Brand   | 01/01/21    |        | Medication Coverage Exception     |                |                                     |
| Rebinyon                  | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                                     |
| Antihistamines            |               |         |             |        |                                   |                |                                     |
| 1st Generation            |               |         |             |        |                                   |                |                                     |
| Preferred Drugs           | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                     |
| cypheptadine              | Preferred     | Generic | 07/01/14    |        |                                   |                | See OTC list for additional options |
| diphenhydramine           | Preferred     | Generic | 07/01/14    |        |                                   |                | See OTC list for additional options |
| hydroxyzine hydrochloride | Preferred     | Generic | 07/01/14    |        |                                   |                | See OTC list for additional options |
| hydroxyzine pamoate       | Preferred     | Generic | 07/01/14    |        |                                   |                | See OTC list for additional options |
| Non Preferred Drugs       | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                     |
| carbinoxamine             | Non Preferred | Generic | 07/01/14    |        | Medication Coverage Exception     |                |                                     |
| clemastine                | Non Preferred | Generic | 07/01/14    |        | Medication Coverage Exception     |                |                                     |
| Karbinal suspension       | Non Preferred | Brand   | 12/01/20    |        | Medication Coverage Exception     |                |                                     |
| Ryclora                   | Non Preferred | Brand   | 10/01/19    |        | Medication Coverage Exception     |                |                                     |
| Ryvent                    | Non Preferred | Brand   | 12/01/20    |        | Medication Coverage Exception     |                |                                     |
| Vistaril                  | Non Preferred | Brand   | 07/01/14    |        | Medication Coverage Exception     |                |                                     |
| 2nd Generation            |               |         |             |        |                                   |                |                                     |
| Preferred Drugs           | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                     |
| cetirizine solution       | Preferred     | Generic | 01/01/18    |        |                                   |                | See OTC list for additional options |
| levocetirizine tablet     | Preferred     | Generic | 01/01/19    |        |                                   |                | See OTC list for additional options |

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| Non Preferred Drugs              | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
|----------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Clarinet                         | Non Preferred | Brand   | 07/01/14    |        | Medication Coverage Exception     |                |                 |
| desloratadine                    | Non Preferred | Generic | 07/01/14    |        | Medication Coverage Exception     |                |                 |
| levocetirizine solution          | Non Preferred | Generic | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| Anti-infectives (NOS)            |               |         |             |        |                                   |                |                 |
| Amebicide & Antiprotozoal Agents |               |         |             |        |                                   |                |                 |
| Preferred Drugs                  | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| atovaquone                       | Preferred     | Generic | 10/01/21    |        |                                   |                |                 |
| metronidazole 250, 500 tab       | Preferred     | Generic | 01/01/22    |        |                                   |                |                 |
| tinidazole                       | Preferred     | Generic | 05/15/16    |        |                                   |                |                 |
| Non Preferred Drugs              | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Flagyl                           | Non Preferred | Brand   | 01/01/22    |        | Medication Coverage Exception     |                |                 |
| Lampit                           | Non Preferred | Brand   | 12/01/20    |        | Medication Coverage Exception     |                |                 |
| Mepron                           | Non Preferred | Brand   | 10/01/21    |        | Medication Coverage Exception     |                |                 |
| metronidazole 125 mg tab         | Non Preferred | Generic | 02/01/25    |        | Medication Coverage Exception     |                |                 |
| Nebupent                         | Non Preferred | Brand   | 01/01/15    |        | Medication Coverage Exception     |                |                 |
| nitazoxanide                     | Non Preferred | Generic | 01/01/21    |        | Medication Coverage Exception     |                |                 |
| paromomycin                      | Non Preferred | Generic | 01/01/15    |        | Medication Coverage Exception     |                |                 |
| Pentam                           | Non Preferred | Brand   | 01/01/21    |        | Medication Coverage Exception     |                |                 |
| pentamidine                      | Non Preferred | Generic | 01/01/21    |        | Medication Coverage Exception     |                |                 |
| Solosec                          | Non Preferred | Brand   | 02/01/18    |        | Medication Coverage Exception     |                |                 |
| Antimalarials                    |               |         |             |        |                                   |                |                 |
| Preferred Drugs                  | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| hydroxychloroquine               | Preferred     | Generic | 01/01/18    |        |                                   |                |                 |
| primaquine                       | Preferred     | Generic | 01/01/16    |        |                                   |                |                 |
| Non Preferred Drugs              | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Arakoda                          | Non Preferred | Brand   | 07/01/25    |        | Medication Coverage Exception     |                |                 |
| Artesunate                       | Non Preferred | Brand   | 11/01/24    |        | Medication Coverage Exception     |                |                 |
| atovaquone/proguanil             | Non Preferred | Generic | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| chloroquine                      | Non Preferred | Generic | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| Coartem                          | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Daraprim                         | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Krintafel                        | Non Preferred | Brand   | 02/01/19    |        | Medication Coverage Exception     |                |                 |
| Malarone                         | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                 |

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| Drug / Product Name       | Status        | Type    | Updated     | Limits | PA Form / 3-Month Req'd           | Brand Req'd    | Additional Note                     |
|---------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-------------------------------------|
| mefloquine                | Non Preferred | Generic | 01/01/16    |        | Medication Coverage Exception     |                |                                     |
| pyrimethamine             | Non Preferred | Generic | 10/01/21    |        | Medication Coverage Exception     |                |                                     |
| Qualaquin                 | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                                     |
| quinine                   | Non Preferred | Generic | 01/01/19    |        | Medication Coverage Exception     |                |                                     |
| Vaginal                   |               |         |             |        |                                   |                |                                     |
| Preferred Drugs           | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                     |
| clindamycin vaginal cream | Preferred     | Generic | 03/01/16    |        |                                   |                | See OTC list for additional options |
| metronidazole vaginal     | Preferred     | Generic | 04/18/13    |        |                                   |                | See OTC list for additional options |
| Vandazole                 | Preferred     | Generic | 01/01/13    |        |                                   |                | See OTC list for additional options |
| Non Preferred Drugs       | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                     |
| Cleocin                   | Non Preferred | Brand   | 03/01/16    |        | Medication Coverage Exception     |                |                                     |
| Clindesse                 | Non Preferred | Brand   | 11/01/16    |        | Medication Coverage Exception     |                |                                     |
| Gynazole-1                | Non Preferred | Brand   | 10/01/11    |        | Medication Coverage Exception     |                |                                     |
| Nuessa                    | Non Preferred | Brand   | 03/06/15    |        | Medication Coverage Exception     |                |                                     |
| terconazole               | Non Preferred | Generic | 10/01/11    |        | Medication Coverage Exception     |                |                                     |
| Xaciato                   | Non Preferred | Generic | 02/01/23    |        | Medication Coverage Exception     |                |                                     |
| Antivirals                |               |         |             |        |                                   |                |                                     |
| Anti-Influenza - Oral     |               |         |             |        |                                   |                |                                     |
| Preferred Drugs           | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                     |
| oseltamivir               | Preferred     | Generic | 01/01/20    |        |                                   |                |                                     |
| Non Preferred Drugs       | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                     |
| Relenza                   | Non Preferred | Brand   | 01/01/23    |        | Medication Coverage Exception     |                |                                     |
| ribavirin (inhaled)       | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     |                |                                     |
| rimantadine               | Non Preferred | Generic | 06/01/13    |        | Medication Coverage Exception     |                |                                     |
| Tamiflu                   | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                                     |
| Virazole                  | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                                     |
| Xofluza                   | Non Preferred | Brand   | 11/01/18    |        | Medication Coverage Exception     |                |                                     |

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| Antiretrovirals - Entry, Fusion Inhibitors                                 |               |         |             |        |                                   |                |                                    |
|----------------------------------------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|------------------------------------|
| Preferred Drugs                                                            | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                    |
| maraviroc                                                                  | Preferred     | Generic | 10/01/24    |        |                                   |                |                                    |
| Selzentry 25mg, 75mg tablet                                                | Preferred     | Brand   | 07/01/17    |        |                                   |                |                                    |
| Selzentry solution                                                         | Preferred     | Brand   | 07/01/17    |        |                                   |                |                                    |
| Non Preferred Drugs                                                        | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                    |
| Fuzeon                                                                     | Non Preferred | Brand   | 07/01/17    |        | Medication Coverage Exception     |                |                                    |
| Rukobia                                                                    | Non Preferred | Brand   | 08/01/20    |        | Rukobia                           |                |                                    |
| Selzentry 150mg, 300mg tablet                                              | Non Preferred | Generic | 10/01/24    |        | Medication Coverage Exception     |                |                                    |
| Trogarzo                                                                   | Non Preferred | Brand   | 10/01/19    |        | Medication Coverage Exception     |                |                                    |
| Antiretrovirals - Integrase Inhibitors                                     |               |         |             |        |                                   |                |                                    |
| Preferred Drugs                                                            | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                    |
| Isentress                                                                  | Preferred     | Brand   | 07/01/17    |        |                                   |                |                                    |
| Tivicay                                                                    | Preferred     | Brand   | 07/01/17    |        |                                   |                |                                    |
| Antiretrovirals - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs) |               |         |             |        |                                   |                |                                    |
| Preferred Drugs                                                            | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                    |
| efavirenz                                                                  | Preferred     | Generic | 05/01/23    |        |                                   |                |                                    |
| Intelence                                                                  | Preferred     | Brand   | 07/01/17    |        |                                   | Intelence      |                                    |
| nevirapine                                                                 | Preferred     | Generic | 07/01/17    |        | 90 Day Supply Required            |                |                                    |
| Non Preferred Drugs                                                        | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                    |
| Edurant                                                                    | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                                    |
| etravirine                                                                 | Non Preferred | Generic | 07/01/21    |        | Medication Coverage Exception     | Intelence      |                                    |
| Pifeltro                                                                   | Non Preferred | Brand   | 01/01/22    |        | Medication Coverage Exception     |                |                                    |
| Viramune                                                                   | Non Preferred | Brand   | 07/01/17    |        | Medication Coverage Exception     |                |                                    |
| Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs)             |               |         |             |        |                                   |                |                                    |
| Preferred Drugs                                                            | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                    |
| abacavir solution                                                          | Preferred     | Brand   | 12/01/20    |        |                                   |                | <a href="#">See NIH Guidelines</a> |
| abacavir tablet                                                            | Preferred     | Generic | 07/01/17    |        | 90 Day Supply Required            |                | <a href="#">See NIH Guidelines</a> |
| Emtriva                                                                    | Preferred     | Brand   | 07/01/17    |        |                                   | Emtriva        | <a href="#">See NIH Guidelines</a> |
| lamivudine                                                                 | Preferred     | Generic | 07/01/17    |        |                                   |                | <a href="#">See NIH Guidelines</a> |
| tenofovir disoproxil 300mg                                                 | Preferred     | Generic | 07/01/18    |        |                                   |                | <a href="#">See NIH Guidelines</a> |
| Viread (all except 300mg)                                                  | Preferred     | Brand   | 07/01/18    |        |                                   |                | <a href="#">See NIH Guidelines</a> |
| zidovudine                                                                 | Preferred     | Generic | 07/01/17    |        | 90 Day Supply Required            |                | <a href="#">See NIH Guidelines</a> |



# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Non Preferred Drugs                   | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                    |
|---------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|------------------------------------|
| didanosine                            | Non Preferred | Generic | 07/01/17    |        | Medication Coverage Exception     |                | <a href="#">See NIH Guidelines</a> |
| emtricitabine                         | Non Preferred | Generic | 10/01/20    |        | Medication Coverage Exception     | Emtriva        | <a href="#">See NIH Guidelines</a> |
| Epivir                                | Non Preferred | Brand   | 07/01/17    |        | Medication Coverage Exception     |                | <a href="#">See NIH Guidelines</a> |
| Retrovir                              | Non Preferred | Brand   | 07/01/17    |        | Medication Coverage Exception     |                | <a href="#">See NIH Guidelines</a> |
| stavudine                             | Non Preferred | Generic | 07/01/17    |        | Medication Coverage Exception     |                | <a href="#">See NIH Guidelines</a> |
| Viread 300mg                          | Non Preferred | Generic | 07/01/18    |        | Medication Coverage Exception     |                | <a href="#">See NIH Guidelines</a> |
| Ziagen                                | Non Preferred | Brand   | 12/01/20    |        | Medication Coverage Exception     |                | <a href="#">See NIH Guidelines</a> |
| Protease Inhibitors                   |               |         |             |        |                                   |                |                                    |
| Preferred Drugs                       | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                    |
| atazanavir capsule                    | Preferred     | Generic | 06/01/21    |        |                                   |                |                                    |
| darunavir                             | Preferred     | Generic | 07/01/23    |        |                                   |                |                                    |
| Norvir powder                         | Preferred     | Brand   | 01/01/16    |        |                                   |                |                                    |
| Prezista                              | Preferred     | Brand   | 01/01/16    |        |                                   |                |                                    |
| Reyataz powder                        | Preferred     | Brand   | 01/01/20    |        |                                   |                |                                    |
| ritonavir tablet                      | Preferred     | Generic | 01/01/21    |        |                                   |                |                                    |
| Non Preferred Drugs                   | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                    |
| Aptivus                               | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                                    |
| fosamprenavir                         | Non Preferred | Generic | 01/01/16    |        | Medication Coverage Exception     | Lexiva         |                                    |
| Invirase                              | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                                    |
| Lexiva                                | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     | Lexiva         |                                    |
| Norvir tablet                         | Non Preferred | Brand   | 01/01/21    |        | Medication Coverage Exception     |                |                                    |
| Reyataz capsule                       | Non Preferred | Brand   | 06/01/21    |        | Medication Coverage Exception     |                |                                    |
| Viracept                              | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                                    |
| Antiretrovirals- Combination Products |               |         |             |        |                                   |                |                                    |
| Preferred Drugs                       | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                    |
| abacavir/lamivudine                   | Preferred     | Generic | 07/01/17    |        |                                   |                |                                    |
| Biktarvy                              | Preferred     | Brand   | 03/01/18    |        |                                   |                |                                    |
| Cimduo                                | Preferred     | Brand   | 05/01/18    |        |                                   |                |                                    |
| Delstrigo                             | Preferred     | Brand   | 01/01/21    |        |                                   |                |                                    |
| Descovy                               | Preferred     | Brand   | 07/01/17    |        |                                   |                |                                    |
| Dovato                                | Preferred     | Brand   | 05/01/19    |        |                                   |                |                                    |

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| Drug / Product Name                 | Status        | Type    | Updated     | Limits | PA Form / 3-Month Req'd           | Brand Req'd    | Additional Note |
|-------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| efavirenz/emtricitabine/tenofovir   | Preferred     | Generic | 01/01/22    |        |                                   |                |                 |
| emtricitabine/tenofovir             | Preferred     | Generic | 01/01/22    |        |                                   |                |                 |
| Evotaz                              | Preferred     | Brand   | 01/01/17    |        |                                   |                |                 |
| Genvoya                             | Preferred     | Brand   | 07/01/17    |        |                                   |                |                 |
| lamivudine/zidovudine               | Preferred     | Generic | 07/01/17    |        |                                   |                |                 |
| lopinavir/ritonavir                 | Preferred     | Generic | 07/01/21    |        |                                   |                |                 |
| Odefsey                             | Preferred     | Brand   | 07/01/17    |        |                                   |                |                 |
| Prezcobix                           | Preferred     | Brand   | 07/01/17    |        |                                   |                |                 |
| Symfi                               | Preferred     | Brand   | 05/01/18    |        |                                   | Symfi          |                 |
| Symfi Lo                            | Preferred     | Brand   | 05/01/18    |        |                                   | Symfi Lo       |                 |
| Triumeq                             | Preferred     | Brand   | 07/01/17    |        |                                   |                |                 |
| Non Preferred Drugs                 | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| abacavir/lamivudine/zidovudine      | Non Preferred | Generic | 07/01/17    |        | Medication Coverage Exception     | Trizivir       |                 |
| Apertude                            | Non Preferred | Brand   | 02/01/22    |        | Medication Coverage Exception     |                |                 |
| Atripla                             | Non Preferred | Brand   | 01/01/22    |        | Medication Coverage Exception     |                |                 |
| Cabenuva                            | Non Preferred | Brand   | 03/01/21    |        | Cabenuva                          |                |                 |
| Combivir                            | Non Preferred | Brand   | 07/01/17    |        | Medication Coverage Exception     |                |                 |
| Complera                            | Non Preferred | Brand   | 07/01/17    |        | Medication Coverage Exception     |                |                 |
| efavirenz/lamivudine/tenofovir      | Non Preferred | Generic | 09/01/20    |        | Medication Coverage Exception     | Symfi,Lo       |                 |
| emtricitabine/rilpivirine/tenofovir | Non Preferred | Generic | 07/01/25    |        | Medication Coverage Exception     | Complera       |                 |
| Epzicom                             | Non Preferred | Brand   | 07/01/17    |        | Medication Coverage Exception     |                |                 |
| Juluca                              | Non Preferred | Brand   | 12/01/17    |        | Medication Coverage Exception     |                |                 |
| Kaletra                             | Non Preferred | Generic | 07/01/21    |        | Medication Coverage Exception     |                |                 |
| Stribild                            | Non Preferred | Brand   | 07/01/17    |        | Medication Coverage Exception     |                |                 |
| Sunlenca                            | Non Preferred | Brand   | 08/01/25    |        | Sunlenca                          |                |                 |
| Symtuza                             | Non Preferred | Brand   | 08/01/18    |        | Medication Coverage Exception     |                |                 |
| Trizivir                            | Non Preferred | Brand   | 07/01/17    |        | Medication Coverage Exception     | Trizivir       |                 |
| Truvada                             | Non Preferred | Brand   | 01/01/22    |        | Medication Coverage Exception     |                |                 |
| Vocabria                            | Non Preferred | Brand   | 07/01/25    |        | Medication Coverage Exception     |                |                 |
| Yeztugo                             | Non Preferred | Brand   | 07/01/25    |        | Medication Coverage Exception     |                |                 |
| Hepatitis C                         |               |         |             |        |                                   |                |                 |
| Direct Acting Antivirals (DAAs)     |               |         |             |        |                                   |                |                 |
| Preferred Drugs                     | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Mavyret                             | Preferred     | Brand   | 09/01/17    |        | Hepatitis C                       |                |                 |
| sofosbuvir/velpatasvir              | Preferred     | Generic | 04/01/21    |        | Hepatitis C                       |                |                 |

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| Non Preferred Drugs                                 | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                 |
|-----------------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|---------------------------------|
| Epclusa                                             | Non Preferred | Brand   | 04/01/21    |        | Hepatitis C                       |                |                                 |
| Harvoni                                             | Non Preferred | Brand   | 01/01/20    |        | Hepatitis C                       | Harvoni        |                                 |
| sofosbuvir/ledipasvir                               | Non Preferred | Generic | 01/01/20    |        | Hepatitis C                       | Harvoni        |                                 |
| Sovaldi                                             | Non Preferred | Brand   | 01/01/18    |        | Hepatitis C                       |                |                                 |
| Viekira Pak                                         | Non Preferred | Brand   | 01/01/18    |        | Hepatitis C                       |                |                                 |
| Vosevi                                              | Non Preferred | Brand   | 08/01/17    |        | Hepatitis C                       |                |                                 |
| Zepatier                                            | Non Preferred | Brand   | 01/01/20    |        | Hepatitis C                       |                |                                 |
| Herpes Simplex, Varicella Zoster, & Cytomegalovirus |               |         |             |        |                                   |                |                                 |
| Preferred Drugs                                     | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                 |
| acyclovir                                           | Preferred     | Generic | 01/01/14    |        |                                   |                |                                 |
| valacyclovir                                        | Preferred     | Generic | 01/01/14    |        |                                   |                |                                 |
| valganciclovir tablet                               | Preferred     | Generic | 01/01/22    |        |                                   |                |                                 |
| Non Preferred Drugs                                 | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                 |
| cidofovir                                           | Non Preferred | Generic | 01/01/22    |        | Medication Coverage Exception     |                |                                 |
| famciclovir                                         | Non Preferred | Generic | 06/01/13    |        | Medication Coverage Exception     |                |                                 |
| foscarnet                                           | Non Preferred | Generic | 01/01/22    |        | Medication Coverage Exception     |                |                                 |
| ganciclovir                                         | Non Preferred | Generic | 07/01/21    |        | Medication Coverage Exception     |                |                                 |
| Livtency                                            | Non Preferred | Brand   | 01/01/22    |        | Medication Coverage Exception     |                |                                 |
| Prevymis                                            | Non Preferred | Brand   | 01/01/18    |        | Medication Coverage Exception     |                |                                 |
| Sitavig                                             | Non Preferred | Brand   | 03/01/16    |        | Medication Coverage Exception     |                |                                 |
| Valcyte                                             | Non Preferred | Brand   | 06/01/13    |        | Medication Coverage Exception     |                |                                 |
| valganciclovir sol                                  | Non Preferred | Generic | 06/01/13    |        | Medication Coverage Exception     |                |                                 |
| Valtrex                                             | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                                 |
| Zovirax                                             | Non Preferred | Brand   | 06/01/13    |        | Medication Coverage Exception     |                |                                 |
| Appetite Stimulants                                 |               |         |             |        |                                   |                |                                 |
| Preferred Drugs                                     | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                 |
| megestrol                                           | Preferred     | Generic | 01/01/15    |        |                                   |                | All strengths except 625 mg/5ml |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Non Preferred Drugs     | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
|-------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| dronabinol              | Non Preferred | Generic | 01/01/15    |        | Medication Coverage Exception     |                |                 |
| Marinol                 | Non Preferred | Brand   | 01/01/15    |        | Medication Coverage Exception     |                |                 |
| megestrol 625 mg/5ml    | Non Preferred | Generic | 01/01/22    |        | Medication Coverage Exception     |                |                 |
| Bile Acid Sequestrants  |               |         |             |        |                                   |                |                 |
| Preferred Drugs         | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| cholestyramine          | Preferred     | Generic | 01/01/15    |        |                                   |                |                 |
| colesevelam             | Preferred     | Generic | 01/01/24    |        |                                   |                |                 |
| Colestid tablet         | Preferred     | Brand   | 01/01/23    |        |                                   |                |                 |
| colestipol granule      | Preferred     | Generic | 02/01/23    |        |                                   |                |                 |
| colestipol tablet       | Preferred     | Generic | 02/01/23    |        |                                   |                |                 |
| Non Preferred Drugs     | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Colestid granule        | Non Preferred | Brand   | 11/01/23    |        | Medication Coverage Exception     |                |                 |
| Colestid powder         | Non Preferred | Brand   | 11/01/23    |        | Medication Coverage Exception     |                |                 |
| Questran                | Non Preferred | Brand   | 01/01/15    |        | Medication Coverage Exception     |                |                 |
| Welchol                 | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                 |
| Bone Density Regulators |               |         |             |        |                                   |                |                 |
| Preferred Drugs         | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| alendronate tablet      | Preferred     | Generic | 10/01/09    |        | 84 Day Supply Required            |                |                 |
| Non Preferred Drugs     | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Actonel                 | Non Preferred | Brand   | 01/01/18    |        | Medication Coverage Exception     |                |                 |
| alendronate solution    | Non Preferred | Generic | 01/01/22    |        | Medication Coverage Exception     |                |                 |
| Atelvia                 | Non Preferred | Brand   | 01/01/18    |        | Medication Coverage Exception     | Atelvia        |                 |
| Boniva                  | Non Preferred | Brand   | 04/15/13    |        | Medication Coverage Exception     |                |                 |
| Bonsity                 | Non Preferred | Brand   | 07/01/25    |        | Parathyroid Hormone Analogs       |                |                 |
| Bomyntra                | Non Preferred | Brand   | 08/01/25    |        | Medication Coverage Exception     |                |                 |
| calcitonin              | Non Preferred | Generic | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Conexence               | Non Preferred | Brand   | 08/01/25    |        | Medication Coverage Exception     |                |                 |
| Evenity                 | Non Preferred | Brand   | 05/01/19    |        | Parathyroid Hormone Analogs       |                |                 |
| Forteo                  | Non Preferred | Brand   | 10/01/20    |        | Parathyroid Hormone Analogs       |                |                 |
| Fosamax                 | Non Preferred | Brand   | 10/01/09    |        | Medication Coverage Exception     |                |                 |
| Fosamax-D               | Non Preferred | Brand   | 10/01/09    |        | Medication Coverage Exception     |                |                 |
| ibandronate             | Non Preferred | Generic | 04/15/13    |        | Medication Coverage Exception     |                |                 |

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| Drug / Product Name | Status        | Type    | Updated  | Limits | PA Form / 3-Month Req'd       | Brand Req'd | Additional Note |
|---------------------|---------------|---------|----------|--------|-------------------------------|-------------|-----------------|
| Jubbonti            | Non Preferred | Brand   | 06/01/25 |        | Medication Coverage Exception |             |                 |
| Miacalcin           | Non Preferred | Generic | 01/01/16 |        | Medication Coverage Exception |             |                 |
| Osenvelt            | Non Preferred | Brand   | 07/01/25 |        | Medication Coverage Exception |             |                 |
| pamidronate         | Non Preferred | Generic | 10/01/09 |        | Medication Coverage Exception |             |                 |
| Prolia              | Non Preferred | Brand   | 01/01/14 |        | Medication Coverage Exception |             |                 |
| risedronate         | Non Preferred | Generic | 01/01/18 |        | Medication Coverage Exception |             |                 |
| Reclast             | Non Preferred | Brand   | 01/01/22 |        | Medication Coverage Exception |             |                 |
| Stoboclo            | Non Preferred | Brand   | 07/01/25 |        | Medication Coverage Exception |             |                 |
| teriparatide        | Non Preferred | Generic | 12/01/20 |        | Parathyroid Hormone Analogs   | Forteo      |                 |
| Tymlos              | Non Preferred | Brand   | 06/01/17 |        | Parathyroid Hormone Analogs   |             |                 |
| Wyost               | Non Preferred | Brand   | 06/01/25 |        | Medication Coverage Exception |             |                 |
| Xgeva               | Non Preferred | Brand   | 10/15/15 |        | Medication Coverage Exception |             |                 |
| Yorvipath           | Non Preferred | Brand   | 10/01/24 |        | Parathyroid Hormone Analogs   |             |                 |
| zoledronic acid     | Non Preferred | Generic | 01/01/22 |        | Medication Coverage Exception |             |                 |

## Cardiovascular

### Antianginal Agents

| Preferred Drugs             | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
|-----------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| isosorbide dinitrate        | Preferred     | Generic | 01/01/16    |        |                                   |                |                 |
| isosorbide mononitrate      | Preferred     | Generic | 01/01/16    |        |                                   |                |                 |
| isosorbide mononitrate ER   | Preferred     | Generic | 01/01/16    |        | 90 Day Supply Required            |                |                 |
| nitroglycerin patch         | Preferred     | Generic | 01/01/18    |        |                                   |                |                 |
| nitroglycerin sublingual    | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| ranolazine                  | Preferred     | Generic | 01/01/24    |        |                                   |                |                 |
| Non Preferred Drugs         | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Aspruzyo                    | Non Preferred | Brand   | 11/01/24    |        | Medication Coverage Exception     |                |                 |
| Gonitro powder              | Non Preferred | Brand   | 11/01/17    |        | Medication Coverage Exception     |                |                 |
| Isordil                     | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Nitro-Bid ointment          | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Nitro-Dur patch             | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| nitroglycerin lingual spray | Non Preferred | Generic | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Nitrolingual                | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Nitrostat                   | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Ranexa                      | Non Preferred | Brand   | 10/01/19    |        | Medication Coverage Exception     |                |                 |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Antihyperlipidemics                       |               |         |             |        |                                   |                |                 |
|-------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| HMG Co-A Reductase Inhibitors ("Statins") |               |         |             |        |                                   |                |                 |
| Preferred Drugs                           | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| atorvastatin                              | Preferred     | Generic | 02/01/22    |        | 90 Day Supply Required            |                |                 |
| Lipitor                                   | Preferred     | Brand   | 01/01/22    |        | 90 Day Supply Required            |                |                 |
| lovastatin                                | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| pravastatin                               | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| rosuvastatin                              | Preferred     | Generic | 08/01/20    |        | 90 Day Supply Required            |                |                 |
| simvastatin                               | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| Non Preferred Drugs                       | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Altoprev                                  | Non Preferred | Brand   | 01/01/13    |        | Medication Coverage Exception     |                |                 |
| Atorvaliq                                 | Non Preferred | Brand   | 03/01/24    |        | Medication Coverage Exception     |                |                 |
| Crestor                                   | Non Preferred | Brand   | 08/01/20    |        | Medication Coverage Exception     |                |                 |
| Ezallor                                   | Non Preferred | Brand   | 07/01/19    |        | Medication Coverage Exception     |                |                 |
| fluvastatin                               | Non Preferred | Generic | 10/01/18    |        | Medication Coverage Exception     |                |                 |
| fluvastatin ER                            | Non Preferred | Generic | 10/01/18    |        | Medication Coverage Exception     | Lescol XL      |                 |
| Lescol XL                                 | Non Preferred | Brand   | 10/01/18    |        | Medication Coverage Exception     | Lescol XL      |                 |
| Livalo                                    | Non Preferred | Brand   | 01/01/13    |        | Medication Coverage Exception     |                |                 |
| pitavastatin                              | Non Preferred | Brand   | 03/01/24    |        | Medication Coverage Exception     |                |                 |
| Zocor                                     | Non Preferred | Brand   | 01/01/13    |        | Medication Coverage Exception     |                |                 |
| Zypitamag                                 | Non Preferred | Brand   | 04/01/18    |        | Medication Coverage Exception     |                |                 |
| Cholesterol-Lowering Combinations         |               |         |             |        |                                   |                |                 |
| Preferred Drugs                           | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Caduet                                    | Preferred     | Brand   | 01/01/21    |        |                                   | Caduet         |                 |
| ezetimibe/simvastatin                     | Preferred     | Generic | 01/01/22    |        |                                   |                |                 |
| Non Preferred Drugs                       | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| amlodipine/atorvastatin                   | Non Preferred | Generic | 01/01/21    |        | Medication Coverage Exception     | Caduet         |                 |
| Nexlizet                                  | Non Preferred | Brand   | 06/01/20    |        | Medication Coverage Exception     |                |                 |
| Vytorin                                   | Non Preferred | Brand   | 01/01/22    |        | Medication Coverage Exception     |                |                 |
| PCSK-9 Inhibitors                         |               |         |             |        |                                   |                |                 |
| Preferred Drugs                           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Repatha                                   | Preferred     | Brand   | 01/01/25    |        | PCSK9 Inhibitor                   |                |                 |

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| Non Preferred Drugs                | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
|------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Leqvio                             | Non Preferred | Brand   | 02/01/22    |        | PCSK9 Inhibitor                   |                |                 |
| Praluent                           | Non Preferred | Brand   | 01/01/25    |        | PCSK9 Inhibitor                   |                |                 |
| Fibrates                           |               |         |             |        |                                   |                |                 |
| Preferred Drugs                    | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Antara                             | Preferred     | Brand   | 01/01/22    |        |                                   |                |                 |
| fenofibrate 48, 50, 54, 134mg      | Preferred     | Generic | 01/01/23    |        |                                   |                |                 |
| fenofibrate 145, 150, 160, 200mg   | Preferred     | Generic | 01/01/23    |        |                                   |                |                 |
| gemfibrozil                        | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| Non Preferred Drugs                | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| choline fenofibrate                | Non Preferred | Generic | 01/01/17    |        | Medication Coverage Exception     |                |                 |
| fenofibrate 40, 43, 67, 120, 130mg | Non Preferred | Generic | 01/01/17    |        | Medication Coverage Exception     |                |                 |
| fenofibrate micronized             | Non Preferred | Generic | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| fenofibric acid                    | Non Preferred | Generic | 01/01/13    |        | Medication Coverage Exception     |                |                 |
| Fenoglide                          | Non Preferred | Brand   | 07/01/15    |        | Medication Coverage Exception     |                |                 |
| Lipofen                            | Non Preferred | Brand   | 05/14/14    |        | Medication Coverage Exception     |                |                 |
| Lopid                              | Non Preferred | Brand   | 01/01/13    |        | Medication Coverage Exception     |                |                 |
| Tricor                             | Non Preferred | Brand   | 01/01/17    |        | Medication Coverage Exception     |                |                 |
| Trilipix                           | Non Preferred | Brand   | 01/01/17    |        | Medication Coverage Exception     |                |                 |
| Miscellaneous Antihyperlipidemics  |               |         |             |        |                                   |                |                 |
| Preferred Drugs                    | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| ezetimibe                          | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| omega-3 acid ethyl esters          | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| Non Preferred Drugs                | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| icosapent ethyl                    | Non Preferred | Generic | 12/01/20    |        | Medication Coverage Exception     |                |                 |
| Juxtapid                           | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Lovaza                             | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Nexletol                           | Non Preferred | Brand   | 04/01/20    |        | Medication Coverage Exception     |                |                 |
| Zetia                              | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |



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| Antihypertensives                              |               |         |             |        |                                   |                |                 |
|------------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Alpha/Beta-Adrenergic Blocking Agents          |               |         |             |        |                                   |                |                 |
| Preferred Drugs                                | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| carvedilol                                     | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| labetalol 100mg, 200mg, 300mg                  | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| Non Preferred Drugs                            | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| carvedilol ER                                  | Non Preferred | Generic | 12/01/17    |        | Medication Coverage Exception     |                |                 |
| Coreg                                          | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| Coreg CR                                       | Non Preferred | Brand   | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| labetalol 400mg                                | Non Preferred | Generic | 01/01/25    |        | Medication Coverage Exception     |                |                 |
| Angiotensin Converting Enzyme (ACE) Inhibitors |               |         |             |        |                                   |                |                 |
| Preferred Drugs                                | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| benazepril                                     | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| enalapril                                      | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| fosinopril                                     | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| lisinopril                                     | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| quinapril                                      | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| ramipril                                       | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| trandolapril                                   | Preferred     | Generic | 01/01/14    |        | 90 Day Supply Required            |                |                 |
| Non Preferred Drugs                            | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Accupril                                       | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| Altace                                         | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| captopril                                      | Non Preferred | Generic | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| Epaned                                         | Non Preferred | Brand   | 04/18/14    |        | Medication Coverage Exception     |                |                 |
| Lotensin                                       | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| moexipril                                      | Non Preferred | Generic | 01/01/13    |        | Medication Coverage Exception     |                |                 |
| perindopril                                    | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Qbrelis                                        | Non Preferred | Brand   | 09/01/16    |        | Medication Coverage Exception     |                |                 |
| Vasotec                                        | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| Zestril                                        | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                 |

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| Angiotensin Converting Enzyme (ACE) Inhibitor Combinations |               |         |             |        |                                   |                |                 |
|------------------------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Preferred Drugs                                            | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| amlodipine/benazepril                                      | Preferred     | Generic | 11/01/19    |        |                                   |                |                 |
| benazepril/hctz                                            | Preferred     | Generic | 07/01/20    |        |                                   |                |                 |
| enalapril/hctz                                             | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| lisinopril/hctz                                            | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| Non Preferred Drugs                                        | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Accuretic                                                  | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| captopril/hydrochlorothiazide                              | Non Preferred | Generic | 01/01/21    |        | Medication Coverage Exception     |                |                 |
| fosinopril/hydrochlorothiazide                             | Non Preferred | Generic | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| Lotrel                                                     | Non Preferred | Brand   | 11/01/19    |        | Medication Coverage Exception     |                |                 |
| quinapril/hydrochlorothiazide                              | Non Preferred | Generic | 01/01/22    |        | Medication Coverage Exception     |                |                 |
| trandolapril/verapamil                                     | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Vaseretic                                                  | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| Zestoretic                                                 | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| Angiotensin Receptor Blockers (ARBs)                       |               |         |             |        |                                   |                |                 |
| Preferred Drugs                                            | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Edarbi                                                     | Preferred     | Brand   | 01/01/19    |        |                                   |                |                 |
| irbesartan                                                 | Preferred     | Generic | 10/15/15    |        |                                   |                |                 |
| losartan                                                   | Preferred     | Generic | 04/01/12    |        | 90 Day Supply Required            |                |                 |
| olmesartan                                                 | Preferred     | Generic | 01/01/21    |        | 90 Day Supply Required            |                |                 |
| telmisartan                                                | Preferred     | Generic | 01/01/23    |        |                                   |                |                 |
| valsartan                                                  | Preferred     | Generic | 08/01/21    |        | 90 Day Supply Required            |                |                 |
| Non Preferred Drugs                                        | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Atacand                                                    | Non Preferred | Brand   | 10/15/15    |        | Medication Coverage Exception     |                |                 |
| Avapro                                                     | Non Preferred | Brand   | 10/15/15    |        | Medication Coverage Exception     |                |                 |
| Benicar                                                    | Non Preferred | Brand   | 01/01/21    |        | Medication Coverage Exception     |                |                 |
| candesartan                                                | Non Preferred | Generic | 10/15/15    |        | Medication Coverage Exception     |                |                 |
| Cozaar                                                     | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| Diovan                                                     | Non Preferred | Brand   | 08/01/21    |        | Medication Coverage Exception     |                |                 |
| Micardis                                                   | Non Preferred | Brand   | 01/01/23    |        | Medication Coverage Exception     |                |                 |

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| Angiotensin Receptor Blocker (ARB) + Thiazide Combinations |               |         |             |        |                                   |                |                 |
|------------------------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Preferred Drugs                                            | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Edarbyclor                                                 | Preferred     | Brand   | 01/01/19    |        |                                   |                |                 |
| <b>irbesartan/hydrochlorothiazide</b>                      | Preferred     | Generic | 01/01/14    |        | 90 Day Supply Required            |                |                 |
| <b>losartan/hydrochlorothiazide</b>                        | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                 |
| <b>olmesartan/hydrochlorothiazide</b>                      | Preferred     | Generic | 08/01/17    |        | 90 Day Supply Required            |                |                 |
| <b>valsartan/hydrochlorothiazide</b>                       | Preferred     | Generic | 10/15/15    |        | 90 Day Supply Required            |                |                 |
| Non Preferred Drugs                                        | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Atacand HCT                                                | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Avalide                                                    | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Benicar HCT                                                | Non Preferred | Brand   | 08/01/17    |        | Medication Coverage Exception     |                |                 |
| candesartan/hydrochlorothiazide                            | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Diovan HCT                                                 | Non Preferred | Brand   | 10/15/15    |        | Medication Coverage Exception     |                |                 |
| Hyzaar                                                     | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| Micardis HCT                                               | Non Preferred | Brand   | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| telmisartan/hydrochlorothiazide                            | Non Preferred | Generic | 03/01/23    |        | Medication Coverage Exception     |                |                 |
| Angiotensin Receptor Blocker (ARB) Combinations - Other    |               |         |             |        |                                   |                |                 |
| Preferred Drugs                                            | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| amlodipine/olmesartan                                      | Preferred     | Generic | 08/01/17    |        |                                   |                |                 |
| <b>amlodipine/olmesartan/HCTZ</b>                          | Preferred     | Generic | 08/01/17    |        |                                   |                |                 |
| amlodipine/valsartan                                       | Preferred     | Generic | 01/01/19    |        |                                   |                |                 |
| Entresto tablet                                            | Preferred     | Brand   | 06/01/20    |        |                                   | Entresto       |                 |
| Non Preferred Drugs                                        | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| amlodipine/valsartan/HCTZ                                  | Non Preferred | Generic | 06/01/24    |        | Medication Coverage Exception     |                |                 |
| Azor                                                       | Non Preferred | Generic | 08/01/17    |        | Medication Coverage Exception     |                |                 |
| Entresto Sprinkle                                          | Non Preferred | Brand   | 08/01/24    |        | Medication Coverage Exception     |                |                 |
| Exforge                                                    | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| Exforge HCT                                                | Non Preferred | Brand   | 03/01/21    |        | Medication Coverage Exception     |                |                 |
| sacubitril-Valsartan                                       | Non Preferred | Generic | 02/01/25    |        | Medication Coverage Exception     | Entresto       |                 |
| telmisartan/amlodipine                                     | Non Preferred | Generic | 01/01/12    |        | Medication Coverage Exception     |                |                 |
| Tribenzor                                                  | Non Preferred | Brand   | 08/01/17    |        | Medication Coverage Exception     |                |                 |

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| Beta-Adrenergic Blocking Agents - Cardio Selective    |               |         |             |        |                                   |                |                                                       |
|-------------------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-------------------------------------------------------|
| Preferred Drugs                                       | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                                       |
| atenolol                                              | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required            |                |                                                       |
| Bystolic                                              | Preferred     | Brand   | 01/01/19    |        | 90 Day Supply Required            | Bystolic       |                                                       |
| metoprolol succinate                                  | Preferred     | Generic | 10/15/15    |        | 90 Day Supply Required            |                |                                                       |
| metoprolol tartrate                                   | Preferred     | Generic | 01/01/20    |        | 90 Day Supply Required            |                |                                                       |
| Rapiblyk inj                                          | Preferred     | Brand   | 04/01/25    |        |                                   |                | Covered under medical benefit using appropriate HCPCS |
| Non Preferred Drugs                                   | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                                       |
| acebutolol                                            | Non Preferred | Generic | 08/01/17    |        | Medication Coverage Exception     |                |                                                       |
| betaxolol                                             | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     |                |                                                       |
| bisoprolol                                            | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     |                |                                                       |
| First-Atenol                                          | Non Preferred | Brand   | 11/01/19    |        | Medication Coverage Exception     |                |                                                       |
| First-Meto                                            | Non Preferred | Brand   | 02/01/19    |        | Medication Coverage Exception     |                |                                                       |
| Kapsargo                                              | Non Preferred | Brand   | 08/01/18    |        | Medication Coverage Exception     |                |                                                       |
| Lopressor                                             | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                                                       |
| nebivolol                                             | Non Preferred | Generic | 10/01/21    |        | Medication Coverage Exception     | Bystolic       |                                                       |
| Tenormin                                              | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                                                       |
| Toprol XL                                             | Non Preferred | Brand   | 10/15/15    |        | Medication Coverage Exception     |                |                                                       |
| Beta-Adrenergic Blocking Agents - Cardio Nonselective |               |         |             |        |                                   |                |                                                       |
| Preferred Drugs                                       | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                                       |
| nadolol                                               | Preferred     | Generic | 10/15/15    |        | 90 Day Supply Required            |                |                                                       |
| propranolol                                           | Preferred     | Generic | 04/01/13    |        | 90 Day Supply Required            |                |                                                       |
| propranolol SR                                        | Preferred     | Generic | 03/01/16    |        |                                   |                |                                                       |
| sotalol                                               | Preferred     | Generic | 01/01/14    |        | 90 Day Supply Required            |                |                                                       |
| sotalol AF                                            | Preferred     | Generic | 01/01/19    |        |                                   |                |                                                       |
| Non Preferred Drugs                                   | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                                       |
| Betapace                                              | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                                                       |
| Betapace AF                                           | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                                                       |
| Corgard                                               | Non Preferred | Brand   | 10/15/15    |        | Medication Coverage Exception     |                |                                                       |
| Hemangeol                                             | Non Preferred | Brand   | 05/07/14    |        | Medication Coverage Exception     |                |                                                       |
| Inderal XL                                            | Non Preferred | Brand   | 03/01/16    |        | Medication Coverage Exception     |                |                                                       |
| Inderal LA                                            | Non Preferred | Brand   | 03/01/16    |        | Medication Coverage Exception     |                |                                                       |

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| Drug / Product Name                         | Status        | Type    | Updated     | Limits | PA Form / 3-Month Req'd                                         | Brand Req'd    | Additional Note |
|---------------------------------------------|---------------|---------|-------------|--------|-----------------------------------------------------------------|----------------|-----------------|
| Innopran XL                                 | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception                                   |                |                 |
| pindolol                                    | Non Preferred | Brand   | 01/01/23    |        | Medication Coverage Exception                                   |                |                 |
| Sotylize                                    | Non Preferred | Brand   | 02/19/15    |        | Medication Coverage Exception                                   |                |                 |
| timolol                                     | Non Preferred | Generic | 01/01/21    |        | Medication Coverage Exception                                   |                |                 |
| Beta-Adrenergic Blocking Agent Combinations |               |         |             |        |                                                                 |                |                 |
| Preferred Drugs                             | Status        | Type    | Last Update | Limits | Mandatory 3-Month                                               | Brand Required | Additional Note |
| atenolol/chlorthalidone                     | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required                                          |                |                 |
| bisoprolol/HCTZ                             | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required                                          |                |                 |
| Non Preferred Drugs                         | Status        | Type    | Last Update | Limits | Required Prior Authorization Form                               | Brand Required | Additional Note |
| metoprolol/hydrochlorothiazide              | Non Preferred | Generic | 01/01/13    |        | Medication Coverage Exception                                   |                |                 |
| Tenoretic                                   | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception                                   |                |                 |
| Ziac                                        | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception                                   |                |                 |
| Calcium Channel Blocking Agents             |               |         |             |        |                                                                 |                |                 |
| Preferred Drugs                             | Status        | Type    | Last Update | Limits | Mandatory 3-Month                                               | Brand Required | Additional Note |
| amlodipine                                  | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required                                          |                |                 |
| diltiazem capsule                           | Preferred     | Generic | 09/28/09    |        |                                                                 |                |                 |
| diltiazem solution                          | Preferred     | Generic | 09/28/09    |        |                                                                 |                |                 |
| diltiazem tablet                            | Preferred     | Generic | 09/28/09    |        |                                                                 |                |                 |
| felodipine ER                               | Preferred     | Generic | 09/28/09    |        | 90 Day Supply Required                                          |                |                 |
| nifedipine                                  | Preferred     | Generic | 01/01/14    |        |                                                                 |                |                 |
| nifedipine ER                               | Preferred     | Generic | 01/01/14    |        |                                                                 |                |                 |
| verapamil tablet                            | Preferred     | Generic | 09/28/09    |        | 80 mg: 90 Day Supply Required<br>120 mg: 90 Day Supply Required |                |                 |
| Non Preferred Drugs                         | Status        | Type    | Last Update | Limits | Required Prior Authorization Form                               | Brand Required | Additional Note |
| Calan SR                                    | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception                                   |                |                 |
| Cardizem                                    | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception                                   |                |                 |
| Cardizem CD                                 | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception                                   |                |                 |
| Cardizem LA                                 | Non Preferred | Brand   | 03/01/16    |        | Medication Coverage Exception                                   |                |                 |
| diltiazem ER tablet                         | Non Preferred | Generic | 03/01/16    |        | Medication Coverage Exception                                   |                |                 |
| isradipine                                  | Non Preferred | Generic | 01/01/19    |        | Medication Coverage Exception                                   |                |                 |
| Katerzia                                    | Non Preferred | Brand   | 08/01/19    |        | Medication Coverage Exception                                   |                |                 |

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| Drug / Product Name                         | Status        | Type    | Updated     | Limits | PA Form / 3-Month Req'd           | Brand Req'd    | Additional Note |
|---------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| levamlodipine                               | Non Preferred | Generic | 06/01/22    |        | Medication Coverage Exception     |                |                 |
| nicardipine                                 | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| nimodipine                                  | Non Preferred | Generic | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| nisoldipine                                 | Non Preferred | Generic | 04/01/13    |        | Medication Coverage Exception     |                |                 |
| Norliqva                                    | Non Preferred | Brand   | 10/01/22    |        | Medication Coverage Exception     |                |                 |
| Norvasc                                     | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| Nymalize                                    | Non Preferred | Brand   | 07/08/13    |        | Medication Coverage Exception     |                |                 |
| Procardia XL                                | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Sular                                       | Non Preferred | Brand   | 04/01/13    |        | Medication Coverage Exception     |                |                 |
| Tiazac                                      | Non Preferred | Brand   | 03/01/16    |        | Medication Coverage Exception     |                |                 |
| verapamil capsule                           | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Verelan                                     | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Verelan PM                                  | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Diuretics - Loop                            |               |         |             |        |                                   |                |                 |
| Preferred Drugs                             | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| bumetanide                                  | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| furosemide                                  | Preferred     | Generic | 01/01/16    |        |                                   |                |                 |
| torsemide                                   | Preferred     | Generic | 01/01/16    |        | 90 Day Supply Required            |                |                 |
| Non Preferred Drugs                         | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Bumex                                       | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Edocrin                                     | Non Preferred | Brand   | 11/01/17    |        | Medication Coverage Exception     |                |                 |
| ethacrynic acid                             | Non Preferred | Generic | 11/01/17    |        | Medication Coverage Exception     |                |                 |
| Lasix                                       | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Diuretics - Potassium Sparing & Combination |               |         |             |        |                                   |                |                 |
| Preferred Drugs                             | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| amiloride                                   | Preferred     | Generic | 01/01/19    |        |                                   |                |                 |
| amiloride/HCTZ                              | Preferred     | Generic | 01/01/16    |        | 90 Day Supply Required            |                |                 |
| eplerenone                                  | Preferred     | Generic | 01/01/23    |        |                                   |                |                 |
| spironolactone                              | Preferred     | Generic | 01/01/16    |        |                                   |                |                 |
| spironolactone/HCTZ                         | Preferred     | Generic | 01/01/16    |        |                                   |                |                 |
| triamterene/HCTZ                            | Preferred     | Generic | 01/01/16    |        | 90 Day Supply Required            |                |                 |

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| Non Preferred Drugs                                         | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
|-------------------------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Aldactazide                                                 | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Aldactone                                                   | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| CaroSpir                                                    | Non Preferred | Brand   | 11/01/17    |        | Medication Coverage Exception     | CaroSpir       |                 |
| Inspira                                                     | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Maxzide                                                     | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| spironolactone 25mg/5ml                                     | Non Preferred | Generic | 11/01/23    |        | Medication Coverage Exception     | CaroSpir       |                 |
| triamterene                                                 | Non Preferred | Generic | 09/01/19    |        | Medication Coverage Exception     |                |                 |
| Platelet Aggregation Inhibitors                             |               |         |             |        |                                   |                |                 |
| Preferred Drugs                                             | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| clopidogrel 75mg                                            | Preferred     | Generic | 06/01/12    |        | 90 Day Supply Required            |                |                 |
| prasugrel                                                   | Preferred     | Generic | 07/01/18    |        |                                   |                |                 |
| Non Preferred Drugs                                         | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Brilinta                                                    | Non Preferred | Brand   | 01/01/13    |        | Medication Coverage Exception     |                |                 |
| clopidogrel 300mg                                           | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| dipyridamole                                                | Non Preferred | Generic | 06/01/12    |        | Medication Coverage Exception     |                |                 |
| Effient                                                     | Non Preferred | Brand   | 07/01/18    |        | Medication Coverage Exception     |                |                 |
| Plavix                                                      | Non Preferred | Brand   | 01/01/13    |        | Medication Coverage Exception     |                |                 |
| ticagrelor                                                  | Non Preferred | Generic | 05/01/25    |        | Medication Coverage Exception     |                |                 |
| Zontivity                                                   | Non Preferred | Brand   | 10/01/15    |        | Medication Coverage Exception     |                |                 |
| Platelet Aggregation Inhibitors-Miscellaneous, Combinations |               |         |             |        |                                   |                |                 |
| Preferred Drugs                                             | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| asa/dipyridamole                                            | Preferred     | Generic | 06/01/20    |        |                                   |                |                 |
| cilostazol                                                  | Preferred     | Generic | 11/01/12    |        |                                   |                |                 |
| pentoxifylline                                              | Preferred     | Generic | 07/01/12    |        |                                   |                |                 |
| Non Preferred Drugs                                         | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Agrylin                                                     | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| anagrelide                                                  | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     |                |                 |



# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Central Nervous System                                                                                                                                  |               |         |             |                                                       |                                   |                |                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------|-------------|-------------------------------------------------------|-----------------------------------|----------------|--------------------------------|
| Antidementia Agents - Oral                                                                                                                              |               |         |             |                                                       |                                   |                |                                |
| Preferred Drugs                                                                                                                                         | Status        | Type    | Last Update | Limits                                                | Mandatory 3-Month                 | Brand Required | Additional Note                |
| donepezil 5, 10mg                                                                                                                                       | Preferred     | Generic | 10/01/13    |                                                       | 90 Day Supply Required            |                |                                |
| donepezil ODT                                                                                                                                           | Preferred     | Generic | 01/01/19    |                                                       |                                   |                |                                |
| memantine tablet                                                                                                                                        | Preferred     | Generic | 02/01/16    |                                                       | 90 Day Supply Required            |                |                                |
| rivastigmine capsule                                                                                                                                    | Preferred     | Generic | 05/15/16    |                                                       |                                   |                |                                |
| Non Preferred Drugs                                                                                                                                     | Status        | Type    | Last Update | Limits                                                | Required Prior Authorization Form | Brand Required | Additional Note                |
| Aricept                                                                                                                                                 | Non Preferred | Brand   | 01/15/13    |                                                       | Medication Coverage Exception     |                |                                |
| donepezil 23mg                                                                                                                                          | Non Preferred | Generic | 10/01/13    |                                                       | Medication Coverage Exception     |                |                                |
| galantamine ER                                                                                                                                          | Non Preferred | Generic | 09/28/09    |                                                       | Medication Coverage Exception     |                |                                |
| memantine ER                                                                                                                                            | Non Preferred | Generic | 03/01/18    |                                                       | Medication Coverage Exception     | Namenda XR     |                                |
| memantine solution                                                                                                                                      | Non Preferred | Generic | 03/15/16    |                                                       | Medication Coverage Exception     |                |                                |
| memantine/donepezil ER capsule                                                                                                                          | Non Preferred | Generic | 02/01/25    |                                                       | Medication Coverage Exception     | Namzaric       |                                |
| Namenda tablet                                                                                                                                          | Non Preferred | Brand   | 02/01/16    |                                                       | Medication Coverage Exception     |                |                                |
| Namenda XR                                                                                                                                              | Non Preferred | Brand   | 03/01/18    |                                                       | Medication Coverage Exception     | Namenda XR     |                                |
| Namzaric                                                                                                                                                | Non Preferred | Brand   | 04/15/15    |                                                       | Medication Coverage Exception     |                |                                |
| Zunveyl                                                                                                                                                 | Non Preferred | Brand   | 04/01/25    |                                                       | Medication Coverage Exception     |                |                                |
| Antidementia Agents - Topical                                                                                                                           |               |         |             |                                                       |                                   |                |                                |
| Preferred Drugs                                                                                                                                         | Status        | Type    | Last Update | Limits                                                | Mandatory 3-Month                 | Brand Required | Additional Note                |
| Exelon                                                                                                                                                  | Preferred     | Brand   | 09/28/09    |                                                       |                                   | Exelon         |                                |
| Non Preferred Drugs                                                                                                                                     | Status        | Type    | Last Update | Limits                                                | Required Prior Authorization Form | Brand Required | Additional Note                |
| Adlarity                                                                                                                                                | Non Preferred | Brand   | 07/01/22    |                                                       | Medication Coverage Exception     |                |                                |
| rivastigmine patch                                                                                                                                      | Non Preferred | Generic | 09/15/15    |                                                       | Medication Coverage Exception     | Exelon         |                                |
| Hypnotics - Benzodiazepines                                                                                                                             |               |         |             |                                                       |                                   |                |                                |
| • Cumulative limit: 30 units in 30 days. Cumulative limits apply across all hypnotic classes.                                                           |               |         |             |                                                       |                                   |                |                                |
| • Benzodiazepine and Opioid Combination: Concurrent long-acting opioids and benzodiazepines (within 45 days of each other) require prior authorization. |               |         |             |                                                       |                                   |                |                                |
| Preferred Drugs                                                                                                                                         | Status        | Type    | Last Update | Limits                                                |                                   | Brand Required | Additional Note                |
| temazepam 15, 30mg                                                                                                                                      | Preferred     | Generic | 06/01/13    | cumulative across hypnotic classes: 30 units /30 days |                                   |                | Benzo/Opioid Combo Requires PA |

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| Non Preferred Drugs                                                                           | Status        | Type    | Last Update | Limits                                                | Required Prior Authorization Form | Brand Required | Additional Note                |
|-----------------------------------------------------------------------------------------------|---------------|---------|-------------|-------------------------------------------------------|-----------------------------------|----------------|--------------------------------|
| estazolam                                                                                     | Non Preferred | Generic | 06/01/13    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                | Benzo/Opioid Combo Requires PA |
| flurazepam                                                                                    | Non Preferred | Generic | 11/01/24    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                | Benzo/Opioid Combo Requires PA |
| Halcion                                                                                       | Non Preferred | Brand   | 06/01/13    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                | Benzo/Opioid Combo Requires PA |
| midazolam syrup                                                                               | Non Preferred | Generic | 11/01/16    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                | Benzo/Opioid Combo Requires PA |
| Restoril                                                                                      | Non Preferred | Brand   | 06/01/13    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                | Benzo/Opioid Combo Requires PA |
| temazepam 7.5, 22.5mg                                                                         | Non Preferred | Generic | 06/01/13    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                | Benzo/Opioid Combo Requires PA |
| triazolam                                                                                     | Non Preferred | Generic | 06/01/13    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                | Benzo/Opioid Combo Requires PA |
| Hypnotics - Non Benzodiazepines, Non Barbiturates                                             |               |         |             |                                                       |                                   |                |                                |
| • Cumulative limit: 30 units in 30 days. Cumulative limits apply across all hypnotic classes. |               |         |             |                                                       |                                   |                |                                |
| Preferred Drugs                                                                               | Status        | Type    | Last Update | Limits                                                |                                   | Brand Required | Additional Note                |
| eszopiclone                                                                                   | Preferred     | Generic | 01/01/20    | cumulative across hypnotic classes: 30 units /30 days |                                   |                |                                |
| ramelteon                                                                                     | Preferred     | Generic | 01/01/23    | cumulative across hypnotic classes: 30 units /30 days |                                   |                |                                |
| zaleplon                                                                                      | Preferred     | Generic | 10/15/15    | cumulative across hypnotic classes: 30 units /30 days |                                   |                |                                |
| zolpidem tablet                                                                               | Preferred     | Generic | 01/01/20    | cumulative across hypnotic classes: 30 units /30 days |                                   |                |                                |
| zolpidem CR tablet                                                                            | Preferred     | Generic | 01/01/20    | cumulative across hypnotic classes: 30 units /30 days |                                   |                |                                |
| Non Preferred Drugs                                                                           | Status        | Type    | Last Update | Limits                                                | Required Prior Authorization Form | Brand Required | Additional Note                |
| Ambien                                                                                        | Non Preferred | Brand   | 06/01/13    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                |                                |
| Ambien CR                                                                                     | Non Preferred | Brand   | 06/01/13    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                |                                |
| Belsomra                                                                                      | Non Preferred | Brand   | 12/10/14    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                |                                |
| Dayvigo                                                                                       | Non Preferred | Brand   | 05/01/20    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                |                                |
| doxepin tablet                                                                                | Non Preferred | Generic | 01/01/20    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                |                                |
| Edluar                                                                                        | Non Preferred | Brand   | 06/01/13    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                |                                |
| Hetlioz                                                                                       | Non Preferred | Brand   | 10/01/20    | cumulative: 30 units /30 days                         | Hetlioz                           |                |                                |
| Lunesta                                                                                       | Non Preferred | Brand   | 04/28/14    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                |                                |
| Quviviq                                                                                       | Non Preferred | Brand   | 06/01/22    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                |                                |
| Rozerem                                                                                       | Non Preferred | Brand   | 01/01/23    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                |                                |
| zolpidem 7.5mg capsule                                                                        | Non Preferred | Generic | 06/01/23    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                |                                |
| zolpidem SL                                                                                   | Non Preferred | Generic | 11/01/18    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                |                                |
| Zolpimist                                                                                     | Non Preferred | Brand   | 06/01/13    | cumulative: 30 units /30 days                         | Medication Coverage Exception     |                |                                |

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| Mental Health                                                                                                                                   |               |         |             |                          |                                   |                |                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------|-------------|--------------------------|-----------------------------------|----------------|-----------------|
| Short Acting ADHD Stimulants                                                                                                                    |               |         |             |                          |                                   |                |                 |
| • Concurrent Use: Concurrent use of both amphetamine and methylphenidate drug classes, requires prior authorization for members under 18 years. |               |         |             |                          |                                   |                |                 |
| • Max Allowed: A maximum of two (2) ADHD stimulants is allowed. Use of three (3) or more ADHD stimulants, requires prior authorization.         |               |         |             |                          |                                   |                |                 |
| Preferred Drugs                                                                                                                                 | Status        | Type    | Last Update | Limits                   | Required Prior Authorization Form | Brand Required | Additional Note |
| amphetamine/dextroamphetamine table                                                                                                             | Preferred     | Generic | 07/01/20    | Minimum Age: 4 Years Old |                                   |                |                 |
| dexmethylphenidate                                                                                                                              | Preferred     | Generic | 01/01/22    | Minimum Age: 4 Years Old |                                   |                |                 |
| Methylin solution                                                                                                                               | Preferred     | Brand   | 07/01/20    | Minimum Age: 4 Years Old |                                   |                |                 |
| methylphenidate solution                                                                                                                        | Preferred     | Generic | 07/01/20    | Minimum Age: 4 Years Old |                                   |                |                 |
| methylphenidate tablet                                                                                                                          | Preferred     | Generic | 07/01/20    | Minimum Age: 4 Years Old |                                   |                |                 |
| procentra solution                                                                                                                              | Preferred     | Generic | 01/01/22    | Minimum Age: 4 Years Old |                                   |                |                 |
| Non Preferred Drugs                                                                                                                             | Status        | Type    | Last Update | Limits                   | Required Prior Authorization Form | Brand Required | Additional Note |
| Adderall                                                                                                                                        | Non Preferred | Brand   | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                 |
| amphetamine sulfate tablet                                                                                                                      | Non Preferred | Generic | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     | Evekeo         |                 |
| Dexedrine                                                                                                                                       | Non Preferred | Brand   | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                 |
| dextroamphetamine                                                                                                                               | Non Preferred | Generic | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                 |
| dextroamphetamine solution                                                                                                                      | Non Preferred | Generic | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                 |
| Evekeo                                                                                                                                          | Non Preferred | Brand   | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     | Evekeo         |                 |
| Evekeo ODT                                                                                                                                      | Non Preferred | Brand   | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                 |
| Focalin                                                                                                                                         | Non Preferred | Brand   | 01/01/22    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                 |
| methamphetamine                                                                                                                                 | Non Preferred | Brand   | 07/01/20    | Minimum Age: 6 Years Old | Medication Coverage Exception     |                |                 |
| methylphenidate chewable                                                                                                                        | Non Preferred | Generic | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                 |
| Ritalin                                                                                                                                         | Non Preferred | Brand   | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                 |
| Zenzedi                                                                                                                                         | Non Preferred | Brand   | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                 |
| Long Acting ADHD Stimulants                                                                                                                     |               |         |             |                          |                                   |                |                 |
| • Concurrent Use: Concurrent use of both amphetamine and methylphenidate drug classes, requires prior authorization for members under 18 years. |               |         |             |                          |                                   |                |                 |
| • Max Allowed: A maximum of two (2) ADHD stimulants is allowed. Use of three (3) or more ADHD stimulants, requires prior authorization.         |               |         |             |                          |                                   |                |                 |
| Preferred Drugs                                                                                                                                 | Status        | Type    | Last Update | Limits                   | Mandatory 3-Month                 | Brand Required | Additional Note |
| Adderall XR                                                                                                                                     | Preferred     | Brand   | 01/01/22    | Minimum Age: 4 Years Old |                                   | Adderall XR    |                 |
| Concerta                                                                                                                                        | Preferred     | Brand   | 07/01/20    | Minimum Age: 4 Years Old |                                   | Concerta       |                 |
| dexmethylphenidate ER                                                                                                                           | Preferred     | Generic | 01/01/24    | Minimum Age: 4 Years Old |                                   |                |                 |
| Dyanavel XR suspension                                                                                                                          | Preferred     | Brand   | 07/01/20    | Minimum Age: 6 Years Old |                                   |                |                 |

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| Drug / Product Name                  | Status        | Type    | Updated     | Limits                   | PA Form / 3-Month Req'd           | Brand Req'd    | Additional Note                                               |
|--------------------------------------|---------------|---------|-------------|--------------------------|-----------------------------------|----------------|---------------------------------------------------------------|
| Quillichew ER                        | Preferred     | Brand   | 07/01/20    | Minimum Age: 4 Years Old |                                   |                |                                                               |
| Quillivant suspension                | Preferred     | Brand   | 07/01/20    | Minimum Age: 4 Years Old |                                   |                | Must be dispensed in original container with full bottle qty. |
| Vyvanse cap                          | Preferred     | Brand   | 07/01/20    | Minimum Age: 4 Years Old |                                   |                |                                                               |
| Non Preferred Drugs                  | Status        | Type    | Last Update | Limits                   | Required Prior Authorization Form | Brand Required | Additional Note                                               |
| Adzenys XR ODT                       | Non Preferred | Brand   | 07/01/20    | Minimum Age: 6 Years Old | Medication Coverage Exception     |                |                                                               |
| amphet/dextroamphet 3-bead cap       | Non Preferred | Generic | 11/01/23    | Minimum Age: 4 Years Old | Medication Coverage Exception     | Mydayis        |                                                               |
| amphet/dextroamphet ER cap           | Non Preferred | Generic | 01/01/22    | Minimum Age: 4 Years Old | Medication Coverage Exception     | Adderall XR    |                                                               |
| Aptensio XR                          | Non Preferred | Brand   | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                                                               |
| Azstarys                             | Non Preferred | Brand   | 08/01/21    | Minimum Age: 6 Years Old | Medication Coverage Exception     |                |                                                               |
| Cotempla XR ODT                      | Non Preferred | Brand   | 07/01/20    | Minimum Age: 6 Years Old | Medication Coverage Exception     |                |                                                               |
| Daytrana                             | Non Preferred | Brand   | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     | Daytrana       |                                                               |
| Dexedrine Spansule                   | Non Preferred | Brand   | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                                                               |
| dextroamphetamine ER                 | Non Preferred | Generic | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                                                               |
| Dyanavel XR chewable                 | Non Preferred | Brand   | 08/01/22    | Minimum Age: 6 Years Old | Medication Coverage Exception     |                |                                                               |
| Focalin XR                           | Non Preferred | Brand   | 01/01/24    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                                                               |
| Jornay PM                            | Non Preferred | Brand   | 06/01/19    | Minimum Age: 6 Years Old | Medication Coverage Exception     |                |                                                               |
| lisdexamfetamine                     | Non Preferred | Generic | 09/01/23    | Minimum Age: 4 Years Old | Medication Coverage Exception     | Vyvanse        |                                                               |
| methylphenidate ER (biphasic)        | Non Preferred | Generic | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                                                               |
| methylphenidate ER (osmotic release) | Non Preferred | Generic | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     | Concerta       |                                                               |
| methylphenidate ER capsule           | Non Preferred | Generic | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                                                               |
| methylphenidate patch                | Non Preferred | Generic | 08/01/22    | Minimum Age: 4 Years Old | Medication Coverage Exception     | Daytrana       |                                                               |
| Mydayis                              | Non Preferred | Brand   | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     | Mydayis        |                                                               |
| Relexxii                             | Non Preferred | Brand   | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                                                               |
| Ritalin LA                           | Non Preferred | Generic | 07/01/20    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                                                               |
| Vyvanse chewable                     | Non Preferred | Brand   | 01/01/22    | Minimum Age: 4 Years Old | Medication Coverage Exception     |                |                                                               |
| Xelstrym                             | Non Preferred | Brand   | 11/01/22    | Minimum Age: 6 Years Old | Medication Coverage Exception     |                |                                                               |
| Non-Stimulants for ADHD              |               |         |             |                          |                                   |                |                                                               |
| Preferred Drugs                      | Status        | Type    | Last Update | Limits                   | Mandatory 3-Month                 | Brand Required | Additional Note                                               |
| atomoxetine                          | Preferred     | Generic | 10/01/17    |                          |                                   |                |                                                               |
| clonidine ER                         | Preferred     | Generic | 04/01/23    |                          |                                   |                |                                                               |
| guanfacine ER                        | Preferred     | Generic | 04/01/23    |                          |                                   |                |                                                               |

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| Non Preferred Drugs    | Status        | Type    | Last Update | Limits                                      | Required Prior Authorization Form | Brand Required | Additional Note                            |
|------------------------|---------------|---------|-------------|---------------------------------------------|-----------------------------------|----------------|--------------------------------------------|
| Intuniv                | Non Preferred | Brand   | 04/01/23    |                                             | Medication Coverage Exception     |                |                                            |
| Onyda XR               | Non Preferred | Brand   | 10/01/24    |                                             | Medication Coverage Exception     |                |                                            |
| Qelbree                | Non Preferred | Brand   | 05/01/21    |                                             | Medication Coverage Exception     |                |                                            |
| Strattera              | Non Preferred | Brand   | 10/01/17    |                                             | Medication Coverage Exception     |                |                                            |
| Anticonvulsants        |               |         |             |                                             |                                   |                |                                            |
| Preferred Drugs        | Status        | Type    | Last Update | Limits                                      | Mandatory 3-Month                 | Brand Required | Additional Note                            |
| Aptiom                 | Preferred     | Brand   | 01/01/17    |                                             |                                   |                |                                            |
| Briviact               | Preferred     | Brand   | 01/01/23    |                                             |                                   |                |                                            |
| carbamazepine chewable | Preferred     | Generic | 01/01/17    |                                             | 90 Day Supply Required            |                |                                            |
| carbamazepine ER       | Preferred     | Generic | 08/01/17    |                                             |                                   |                |                                            |
| Celontin               | Preferred     | Brand   | 01/01/17    |                                             |                                   | Celontin       |                                            |
| clobazam               | Preferred     | Generic | 01/01/20    | Cumulative across class: 120 units /30 days |                                   |                |                                            |
| clonazepam             | Preferred     | Generic | 01/01/17    | Cumulative across class: 120 units /30 days |                                   |                |                                            |
| diazepam rectal        | Preferred     | Generic | 03/01/24    | Cumulative across class: 120 units /30 days |                                   |                |                                            |
| Dilantin 30mg          | Preferred     | Brand   | 01/01/17    |                                             |                                   |                |                                            |
| divalproex             | Preferred     | Generic | 01/01/17    |                                             | 90 Day Supply Required            |                | Included in more than one class            |
| ethosuximide           | Preferred     | Generic | 06/01/19    |                                             |                                   |                |                                            |
| gabapentin             | Preferred     | Generic | 10/01/16    | 3600mg /day                                 |                                   |                | Pregabalin/ Gabapentin combo is restricted |
| Gabitril               | Preferred     | Brand   | 01/01/18    |                                             |                                   |                |                                            |
| lacosamide             | Preferred     | Generic | 01/01/23    |                                             |                                   |                |                                            |
| lamotrigine chewable   | Preferred     | Generic | 11/01/16    |                                             | 90 Day Supply Required            |                |                                            |
| lamotrigine tablet     | Preferred     | Generic | 11/01/16    |                                             | 90 Day Supply Required            |                |                                            |
| levetiracetam          | Preferred     | Generic | 10/01/16    |                                             |                                   |                |                                            |
| Lyrica capsule         | Preferred     | Brand   | 01/01/19    | 600mg /day                                  |                                   |                | Pregabalin/ Gabapentin combo is restricted |
| Nayzilam               | Preferred     | Brand   | 01/01/21    | Cumulative:120 units /30 days               |                                   |                |                                            |
| oxcarbazepine tablet   | Preferred     | Generic | 10/01/16    |                                             | 90 Day Supply Required            |                |                                            |
| Peganone               | Preferred     | Brand   | 10/01/16    |                                             |                                   |                |                                            |
| phenytoin              | Preferred     | Generic | 01/01/17    |                                             |                                   |                |                                            |
| pregabalin             | Preferred     | Generic | 12/01/24    | 600mg /day                                  |                                   |                | Pregabalin/ Gabapentin combo is restricted |
| primidone              | Preferred     | Generic | 01/01/17    |                                             |                                   |                |                                            |

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| Drug / Product Name      | Status        | Type    | Updated     | Limits                        | PA Form / 3-Month Req'd           | Brand Req'd    | Additional Note                            |
|--------------------------|---------------|---------|-------------|-------------------------------|-----------------------------------|----------------|--------------------------------------------|
| Tegretol solution        | Preferred     | Brand   | 01/01/17    |                               |                                   | Tegretol       |                                            |
| Tegretol tablet          | Preferred     | Brand   | 01/01/17    |                               | 90 Day Supply Required            | Tegretol       |                                            |
| tiagabine                | Preferred     | Generic | 02/01/21    |                               |                                   |                |                                            |
| topiramate capsule       | Preferred     | Generic | 01/01/19    |                               |                                   |                | Included in more than one class            |
| topiramate tablet        | Preferred     | Generic | 01/01/19    |                               | 90 Day Supply Required            |                | Included in more than one class            |
| valproic acid            | Preferred     | Generic | 01/01/17    |                               |                                   |                |                                            |
| Valtoco                  | Preferred     | Brand   | 05/01/20    |                               |                                   |                |                                            |
| Xcopri                   | Preferred     | Brand   | 01/01/21    |                               |                                   |                |                                            |
| Zonisade                 | Preferred     | Brand   | 07/01/24    |                               |                                   |                |                                            |
| zonisamide               | Preferred     | Generic | 10/01/16    |                               | 90 Day Supply Required            |                |                                            |
| Non Preferred Drugs      | Status        | Type    | Last Update | Limits                        | Required Prior Authorization Form | Brand Required | Additional Note                            |
| Banzel                   | Non Preferred | Brand   | 10/01/16    |                               | Medication Coverage Exception     | Banzel         |                                            |
| carbamazepine suspension | Non Preferred | Generic | 01/01/17    |                               | Medication Coverage Exception     | Tegretol       |                                            |
| carbamazepine tablet     | Non Preferred | Generic | 01/01/17    |                               | Medication Coverage Exception     | Tegretol       |                                            |
| Carbatrol                | Non Preferred | Brand   | 01/01/17    |                               | Medication Coverage Exception     |                |                                            |
| clonazepam ODT           | Non Preferred | Generic | 01/01/17    | Cumulative:120 units /30 days | Medication Coverage Exception     |                |                                            |
| Depakote                 | Non Preferred | Brand   | 01/01/17    |                               | Medication Coverage Exception     |                | Included in more than one class            |
| Diacomit                 | Non Preferred | Brand   | 07/01/19    |                               | Medication Coverage Exception     |                |                                            |
| Dilantin 100mg           | Non Preferred | Brand   | 01/01/17    |                               | Medication Coverage Exception     |                |                                            |
| Dilantin chewable        | Non Preferred | Brand   | 01/01/17    |                               | Medication Coverage Exception     |                |                                            |
| Elepsia XR               | Non Preferred | Brand   | 05/01/21    |                               | Medication Coverage Exception     |                |                                            |
| Epidiolex                | Non Preferred | Brand   | 01/01/19    |                               | Epidiolex Prior Auth Form         |                |                                            |
| Eprontia                 | Non Preferred | Brand   | 12/01/21    |                               | Medication Coverage Exception     |                |                                            |
| eslicarbazepine          | Non Preferred | Generic | 06/01/25    |                               | Medication Coverage Exception     | Aptiom         |                                            |
| felbamate                | Non Preferred | Generic | 10/01/16    |                               | Medication Coverage Exception     | Felbatol       |                                            |
| Felbatol                 | Non Preferred | Brand   | 10/01/16    |                               | Medication Coverage Exception     | Felbatol       |                                            |
| Fintepla                 | Non Preferred | Brand   | 08/01/20    |                               | Medication Coverage Exception     |                |                                            |
| Fycompa                  | Non Preferred | Brand   | 01/01/19    |                               | Medication Coverage Exception     |                |                                            |
| gabapentin (once daily)  | Non Preferred | Generic | 02/01/24    | 3600mg /day                   | Medication Coverage Exception     | Gralise        | Pregabalin/ Gabapentin combo is restricted |
| Gabarone                 | Non Preferred | Brand   | 02/01/25    | 3600mg /day                   | Medication Coverage Exception     |                | Pregabalin/ Gabapentin combo is restricted |
| Gralise                  | Non Preferred | Brand   | 09/01/18    | 3600mg /day                   | Medication Coverage Exception     | Gralise        | Pregabalin/ Gabapentin combo is restricted |
| Horizant                 | Non Preferred | Brand   | 09/01/18    | 3600mg /day                   | Medication Coverage Exception     |                | Pregabalin/ Gabapentin combo is restricted |
| Keppra                   | Non Preferred | Brand   | 10/01/16    |                               | Medication Coverage Exception     |                |                                            |
| Klonopin                 | Non Preferred | Brand   | 01/01/17    | Cumulative:120 units /30 days | Medication Coverage Exception     |                |                                            |



# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Drug / Product Name                  | Status        | Type    | Updated  | Limits     | PA Form / 3-Month Req'd       | Brand Req'd  | Additional Note                            |
|--------------------------------------|---------------|---------|----------|------------|-------------------------------|--------------|--------------------------------------------|
| Lamictal                             | Non Preferred | Brand   | 10/01/16 |            | Medication Coverage Exception |              |                                            |
| Lamictal ODT                         | Non Preferred | Brand   | 10/01/16 |            | Medication Coverage Exception | Lamictal ODT |                                            |
| Lamictal XR                          | Non Preferred | Brand   | 10/01/16 |            | Medication Coverage Exception |              |                                            |
| lamotrigine ER                       | Non Preferred | Generic | 10/01/16 |            | Medication Coverage Exception |              |                                            |
| lamotrigine ODT                      | Non Preferred | Generic | 10/01/16 |            | Medication Coverage Exception | Lamictal ODT |                                            |
| levetiracetam Disintegrating Soluble | Non Preferred | Generic | 02/01/25 |            | Medication Coverage Exception | Spritam      |                                            |
| Libervant                            | Non Preferred | Brand   | 07/01/24 |            | Medication Coverage Exception |              |                                            |
| Lyrica CR                            | Non Preferred | Brand   | 01/01/19 | 600mg /day | Medication Coverage Exception |              | Pregabalin/ Gabapentin combo is restricted |
| Lyrica solution                      | Non Preferred | Brand   | 01/01/19 | 600mg /day | Medication Coverage Exception |              | Pregabalin/ Gabapentin combo is restricted |
| methsuximide                         | Non Preferred | Generic | 12/01/23 |            | Medication Coverage Exception | Celontin     |                                            |
| Motpoly XR                           | Non Preferred | Brand   | 11/01/23 |            | Medication Coverage Exception |              |                                            |
| Mysoline                             | Non Preferred | Brand   | 01/01/17 |            | Medication Coverage Exception |              |                                            |
| Neurontin                            | Non Preferred | Brand   | 10/01/16 |            | Medication Coverage Exception |              |                                            |
| Onfi                                 | Non Preferred | Brand   | 11/01/18 |            | Medication Coverage Exception |              |                                            |
| oxcarbazepine ER tablet              | Non Preferred | Generic | 10/01/24 |            | Medication Coverage Exception | Oxtellar XR  |                                            |
| oxcarbazepine suspension             | Non Preferred | Generic | 10/01/16 |            | Medication Coverage Exception |              |                                            |
| Oxtellar XR                          | Non Preferred | Brand   | 10/01/16 |            | Medication Coverage Exception | Oxtellar XR  |                                            |
| perampanel                           | Non Preferred | Generic | 07/01/25 |            | Medication Coverage Exception | Fycompa      |                                            |
| Phenytek                             | Non Preferred | Brand   | 01/01/17 |            | Medication Coverage Exception |              |                                            |
| pregabalin solution                  | Non Preferred | Brand   | 04/01/25 |            | Medication Coverage Exception |              |                                            |
| Qudexy XR                            | Non Preferred | Brand   | 01/01/19 |            | Medication Coverage Exception |              | Included in more than one class            |
| rufinamide                           | Non Preferred | Generic | 12/01/20 |            | Medication Coverage Exception | Banzel       |                                            |
| Sabril                               | Non Preferred | Brand   | 09/01/17 |            | Medication Coverage Exception |              |                                            |
| Spritam                              | Non Preferred | Brand   | 10/01/16 |            | Medication Coverage Exception | Spritam      |                                            |
| Sympazan                             | Non Preferred | Brand   | 12/01/18 |            | Medication Coverage Exception |              |                                            |
| Tegretol XR                          | Non Preferred | Brand   | 08/01/17 |            | Medication Coverage Exception |              |                                            |
| Topamax                              | Non Preferred | Brand   | 10/01/16 |            | Medication Coverage Exception |              |                                            |
| topiramate ER                        | Non Preferred | Generic | 01/01/19 |            | Medication Coverage Exception | Trokendi XR  | Included in more than one class            |
| topiramate solution                  | Non Preferred | Generic | 08/01/25 |            | Medication Coverage Exception |              |                                            |
| Trileptal                            | Non Preferred | Brand   | 10/01/16 |            | Medication Coverage Exception |              |                                            |
| Trileptal suspension                 | Non Preferred | Brand   | 10/01/16 |            | Medication Coverage Exception |              |                                            |
| Trokendi XR                          | Non Preferred | Brand   | 10/01/16 |            | Medication Coverage Exception | Trokendi XR  | Included in more than one class            |
| vigabatrin                           | Non Preferred | Generic | 09/01/17 |            | Medication Coverage Exception |              |                                            |
| Vigafyde                             | Non Preferred | Brand   | 09/01/24 |            | Medication Coverage Exception |              |                                            |
| Vimpat                               | Non Preferred | Brand   | 01/01/23 |            | Medication Coverage Exception |              |                                            |
| Zarontin                             | Non Preferred | Brand   | 06/01/19 |            | Medication Coverage Exception |              |                                            |
| Ztalmu                               | Non Preferred | Brand   | 02/01/23 |            | Medication Coverage Exception |              |                                            |



## Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Atypical Antipsychotics                                                                                                                                                                                                                                                                                                  |           |         |             |                                                           |                                   |                |                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|---------|-------------|-----------------------------------------------------------|-----------------------------------|----------------|--------------------------------------------------------------|
| • Children under 18: Utah Medicaid restricts the use of multiple antipsychotics in children under 18 years old.                                                                                                                                                                                                          |           |         |             |                                                           |                                   |                |                                                              |
| • Children under 6: Prior Authorization is required for all antipsychotics prescribed to children under 6 years old.                                                                                                                                                                                                     |           |         |             |                                                           |                                   |                |                                                              |
| • DAW (Dispense as written) : Non-preferred atypical antipsychotic medications listed on PDL may bypass non-preferred drug prior authorization if a prescriber writes “dispense as written” on prescription and pharmacy submits a Dispense As Written (DAW) Code of “1” on the claim. See Pg.3 Explanation for details. |           |         |             |                                                           |                                   |                |                                                              |
| Preferred Drugs                                                                                                                                                                                                                                                                                                          | Status    | Type    | Last Update | Limits                                                    | Required Prior Authorization Form | Brand Required | Additional Note                                              |
| Abilify Asimtufii                                                                                                                                                                                                                                                                                                        | Preferred | Brand   | 01/01/24    | Minimum Age: 18 Years Old                                 | Antipsychotics in Children        |                | Must be dispensed directly to the provider, not the patient. |
| Abilify Maintena                                                                                                                                                                                                                                                                                                         | Preferred | Brand   | 10/01/16    | Minimum Age: 18 Years Old                                 | Antipsychotics in Children        |                | Must be dispensed directly to the provider, not the patient. |
| aripiprazole tablet                                                                                                                                                                                                                                                                                                      | Preferred | Generic | 01/01/18    | age 6-11 years: 15mg /day<br>age 12-17 years: 30mg /day   | Antipsychotics in Children        |                |                                                              |
| Aristada                                                                                                                                                                                                                                                                                                                 | Preferred | Brand   | 05/01/18    | Minimum Age: 18 Years Old                                 | Antipsychotics in Children        |                | Must be dispensed directly to the provider, not the patient. |
| clozapine tablet                                                                                                                                                                                                                                                                                                         | Preferred | Generic | 10/01/16    | age 8-11 years: 300mg /day<br>age 12-17 years: 600mg /day | Antipsychotics in Children        |                |                                                              |
| Invega Hafyera                                                                                                                                                                                                                                                                                                           | Preferred | Brand   | 10/01/21    | Minimum Age: 18 Years Old                                 | Antipsychotics in Children        |                | Must be dispensed directly to the provider, not the patient. |
| Invega Sustenna                                                                                                                                                                                                                                                                                                          | Preferred | Brand   | 05/01/18    | Minimum Age: 18 Years Old                                 | Antipsychotics in Children        |                | Must be dispensed directly to the provider, not the patient. |
| Invega Trinza                                                                                                                                                                                                                                                                                                            | Preferred | Brand   | 05/01/18    | Minimum Age: 18 Years Old                                 | Antipsychotics in Children        |                | Must be dispensed directly to the provider, not the patient. |
| lurasidone                                                                                                                                                                                                                                                                                                               | Preferred | Generic | 02/01/23    | age 10-17 years: 80mg /day                                | Antipsychotics in Children        |                |                                                              |
| olanzapine                                                                                                                                                                                                                                                                                                               | Preferred | Generic | 10/01/16    | age 6-17 years: 20mg /day                                 | Antipsychotics in Children        |                |                                                              |
| olanzapine ODT                                                                                                                                                                                                                                                                                                           | Preferred | Generic | 01/01/20    | age 6-17 years: 20mg /day                                 | Antipsychotics in Children        |                |                                                              |
| Perseris                                                                                                                                                                                                                                                                                                                 | Preferred | Brand   | 01/01/19    | Minimum Age: 18 Years Old                                 | Antipsychotics in Children        |                | Must be dispensed directly to the provider, not the patient. |
| quetiapine                                                                                                                                                                                                                                                                                                               | Preferred | Generic | 01/01/19    | age 6-9 years: 400mg /day<br>age 10-17 years: 800mg /day  | Antipsychotics in Children        |                |                                                              |
| quetiapine ER                                                                                                                                                                                                                                                                                                            | Preferred | Generic | 01/01/19    | age 6-9 years: 400mg /day<br>age 10-17 years: 800mg /day  | Antipsychotics in Children        |                |                                                              |
| risperidone solution                                                                                                                                                                                                                                                                                                     | Preferred | Generic | 01/01/18    | age 6-11 years: 3mg /day<br>age 12-17 years: 6mg /day     | Antipsychotics in Children        |                |                                                              |
| risperidone tablet                                                                                                                                                                                                                                                                                                       | Preferred | Generic | 01/01/18    | age 6-11 years: 3mg /day<br>age 12-17 years: 6mg /day     | Antipsychotics in Children        |                |                                                              |
| Rykindo                                                                                                                                                                                                                                                                                                                  | Preferred | Brand   | 01/01/25    | Minimum Age: 18 Years Old                                 | Antipsychotics in Children        |                | Must be dispensed directly to the provider, not the patient. |

## Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Drug / Product Name   | Status        | Type    | Updated     | Limits                                                    | PA Form / 3-Month Req'd                                     | Brand Req'd    | Additional Note                                              |
|-----------------------|---------------|---------|-------------|-----------------------------------------------------------|-------------------------------------------------------------|----------------|--------------------------------------------------------------|
| Saphris               | Preferred     | Brand   | 01/01/18    | age 10-17 years: 20mg /day                                | Antipsychotics in Children                                  | Saphris        |                                                              |
| Zyprexa Relprevv      | Preferred     | Brand   | 01/01/21    | Minimum Age: 18 Years Old                                 | Antipsychotics in Children                                  |                | Must be dispensed directly to the provider, not the patient. |
| ziprasidone           | Preferred     | Generic | 01/01/18    | age 7-9 years: 60mg /day<br>age 10-17 years: 160mg /day   | Antipsychotics in Children                                  |                |                                                              |
| Non Preferred Drugs   | Status        | Type    | Last Update | Limits                                                    | Required Prior Authorization Form                           | Brand Required | Additional Note                                              |
| Abilify               | Non Preferred | Brand   | 01/01/18    | age 6-11 years: 15mg /day<br>age 12-17 years: 30mg /day   | Antipsychotics in Children or Medication Coverage Exception |                |                                                              |
| Abilify Mycite        | Non Preferred | Brand   | 07/01/20    | Minimum Age: 18 Years Old                                 | Abilify Mycite Prior Auth                                   |                |                                                              |
| aripiprazole ODT      | Non Preferred | Generic | 01/01/18    | age 6-11 years: 15mg /day<br>age 12-17 years: 30mg /day   | Antipsychotics in Children or Medication Coverage Exception |                |                                                              |
| aripiprazole solution | Non Preferred | Generic | 01/01/18    | age 6-11 years: 15mg /day<br>age 12-17 years: 30mg /day   | Antipsychotics in Children or Medication Coverage Exception |                |                                                              |
| asenapine SL tablet   | Non Preferred | Generic | 01/01/21    | age 10-17 years: 20mg /day                                | Antipsychotics in Children or Medication Coverage Exception | Saphris        |                                                              |
| Caplyta               | Non Preferred | Generic | 02/01/20    | Minimum Age: 18 Years Old                                 | Antipsychotics in Children or Medication Coverage Exception |                |                                                              |
| clozapine ODT         | Non Preferred | Generic | 10/01/16    | age 8-11 years: 300mg /day<br>age 12-17 years: 600mg /day | Antipsychotics in Children or Medication Coverage Exception |                |                                                              |
| Clozaril              | Non Preferred | Brand   | 10/01/16    | age 8-11 years: 300mg /day<br>age 12-17 years: 600mg /day | Antipsychotics in Children or Medication Coverage Exception |                |                                                              |
| Cobenfy               | Non Preferred | Brand   | 11/01/24    | Minimum Age: 18 Years Old                                 | Antipsychotics in Children or Medication Coverage Exception |                |                                                              |
| Erzofri               | Non Preferred | Brand   | 12/01/24    | Minimum Age: 18 Years Old                                 | Antipsychotics in Children or Medication Coverage Exception |                |                                                              |
| Fanapt                | Non Preferred | Brand   | 10/01/16    | Minimum Age: 18 Years Old                                 | Antipsychotics in Children or Medication Coverage Exception |                |                                                              |
| Geodon capsule        | Non Preferred | Brand   | 01/01/18    | age 10-17 years: 160mg /day                               | Antipsychotics in Children or Medication Coverage Exception |                |                                                              |
| Geodon injection      | Non Preferred | Brand   | 04/01/20    | age 10-17 years: 160mg /day                               | Antipsychotics in Children or Medication Coverage Exception |                |                                                              |
| Invega                | Non Preferred | Brand   | 10/01/16    | age 12-17 years: 12mg                                     | Antipsychotics in Children or Medication Coverage Exception |                |                                                              |
| Latuda                | Non Preferred | Brand   | 05/01/23    | age 10-17 years: 80mg /day                                | Antipsychotics in Children or Medication Coverage Exception |                |                                                              |

## Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Drug / Product Name   | Status        | Type    | Updated  | Limits                                                    | PA Form / 3-Month Req'd                                     | Brand Req'd      | Additional Note                                                                      |
|-----------------------|---------------|---------|----------|-----------------------------------------------------------|-------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------|
| Lybalvi               | Non Preferred | Brand   | 10/01/21 | Minimum Age: 18 Years Old                                 | Antipsychotics in Children or Medication Coverage Exception |                  |                                                                                      |
| olanzapine injection  | Non Preferred | Generic | 10/01/16 | Minimum Age: 18 Years Old                                 | Antipsychotics in Children or Medication Coverage Exception |                  | Must be dispensed directly to the provider, not the patient.                         |
| Opipza                | Non Preferred | Brand   | 02/01/25 | age 6-11 years: 15mg /day<br>age 12-17 years: 30mg /day   | Antipsychotics in Children or Medication Coverage Exception |                  |                                                                                      |
| paliperidone          | Non Preferred | Generic | 10/01/16 | age 12-17 years: 12mg                                     | Antipsychotics in Children or Medication Coverage Exception |                  |                                                                                      |
| Rexulti               | Non Preferred | Brand   | 10/01/16 | age 12-17 years: 4mg /day                                 | Antipsychotics in Children or Medication Coverage Exception |                  |                                                                                      |
| Risperdal             | Non Preferred | Brand   | 10/01/16 | age 6-11 years: 3mg /day<br>age 12-17 years: 6mg /day     | Antipsychotics in Children or Medication Coverage Exception |                  |                                                                                      |
| Risperdal Consta      | Non Preferred | Brand   | 10/01/23 | Minimum Age: 18 Years Old                                 | Antipsychotics in Children or Medication Coverage Exception |                  | Must be dispensed directly to the provider, not the patient.                         |
| risperidone injection | Non Preferred | Generic | 10/01/16 | Minimum Age: 18 Years Old                                 | Antipsychotics in Children or Medication Coverage Exception | Risperdal Consta | Must be dispensed directly to the provider, not the patient.                         |
| risperidone ODT       | Non Preferred | Generic | 10/01/16 | age 6-11 years: 3mg /day<br>age 12-17 years: 6mg /day     | Antipsychotics in Children or Medication Coverage Exception |                  |                                                                                      |
| Secuado               | Non Preferred | Brand   | 01/01/20 | Minimum Age: 18 Years Old                                 | Antipsychotics in Children or Medication Coverage Exception |                  |                                                                                      |
| Seroquel              | Non Preferred | Brand   | 10/01/16 | age 6-9 years: 400mg /day<br>age 10-17 years: 800mg /day  | Antipsychotics in Children or Medication Coverage Exception |                  |                                                                                      |
| Seroquel XR           | Non Preferred | Brand   | 10/01/16 | age 6-9 years: 400mg /day<br>age 10-17 years: 800mg /day  | Antipsychotics in Children or Medication Coverage Exception |                  |                                                                                      |
| Uzedy                 | Non Preferred | Brand   | 06/01/23 | Minimum Age: 18 Years Old                                 | Antipsychotics in Children or Medication Coverage Exception |                  |                                                                                      |
| Vraylar               | Non Preferred | Brand   | 02/01/25 | Minimum Age: 18 Years Old                                 | Antipsychotics in Children or Medication Coverage Exception |                  | For acute major depressive disorder, trial and failure of at least 2 antidepressants |
| Versacloz             | Non Preferred | Brand   | 10/01/16 | age 8-11 years: 300mg /day<br>age 12-17 years: 600mg /day | Antipsychotics in Children or Medication Coverage Exception |                  |                                                                                      |
| Ziprasidone injection | Non Preferred | Generic | 04/01/20 | age 10-17 years: 160mg /day                               | Antipsychotics in Children or Medication Coverage Exception |                  |                                                                                      |
| Zyprexa               | Non Preferred | Brand   | 10/01/16 | age 6-17 years: 20mg /day                                 | Antipsychotics in Children or Medication Coverage Exception |                  |                                                                                      |
| Zyprexa Zydis         | Non Preferred | Brand   | 10/01/16 | age 6-17 years: 20mg /day                                 | Antipsychotics in Children or Medication Coverage Exception |                  |                                                                                      |

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| Antidepressants - SSRI/SNRI |               |         |             |        |                                   |                |                            |
|-----------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|----------------------------|
| Preferred Drugs             | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note            |
| citalopram tablet           | Preferred     | Generic | 02/01/17    |        | 90 Day Supply Required            |                |                            |
| desvenlafaxine succinate    | Preferred     | Generic | 10/01/23    |        | 90 Day Supply Required            |                |                            |
| duloxetine 20, 30, 60mg     | Preferred     | Generic | 10/01/16    |        | 90 Day Supply Required            |                |                            |
| escitalopram tablet         | Preferred     | Generic | 10/01/16    |        | 90 Day Supply Required            |                |                            |
| fluoxetine capsule          | Preferred     | Generic | 10/01/16    |        | 90 Day Supply Required            |                |                            |
| fluoxetine solution         | Preferred     | Generic | 10/01/16    |        |                                   |                |                            |
| fluoxetine tablet           | Preferred     | Generic | 01/01/24    |        |                                   |                |                            |
| paroxetine [non-ER] tablet  | Preferred     | Generic | 10/01/16    |        | 90 Day Supply Required            |                | All strengths except 7.5mg |
| sertraline tablet           | Preferred     | Generic | 10/01/16    |        | 90 Day Supply Required            |                |                            |
| venlafaxine ER capsule      | Preferred     | Generic | 10/01/16    |        | 90 Day Supply Required            |                |                            |
| venlafaxine tablet [non-ER] | Preferred     | Generic | 01/01/19    |        |                                   |                |                            |
| Non Preferred Drugs         | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note            |
| Brisdelle                   | Non Preferred | Brand   | 10/01/17    |        | Medication Coverage Exception     | Brisdelle      |                            |
| Celexa                      | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                            |
| citalopram capsule          | Non Preferred | Generic | 03/01/22    |        | Medication Coverage Exception     |                |                            |
| citalopram solution         | Non Preferred | Generic | 10/01/16    |        | Medication Coverage Exception     |                |                            |
| Cymbalta                    | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                            |
| desvenlafaxine (base)       | Non Preferred | Generic | 10/01/16    |        | Medication Coverage Exception     |                |                            |
| Drizalma                    | Non Preferred | Brand   | 10/01/19    |        | Medication Coverage Exception     |                |                            |
| duloxetine 40mg             | Non Preferred | Generic | 10/01/16    |        | Medication Coverage Exception     |                |                            |
| Effexor XR                  | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                            |
| escitalopram solution       | Non Preferred | Generic | 10/01/16    |        | Medication Coverage Exception     |                |                            |
| Fetzima                     | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                            |
| fluoxetine weekly (90mg)    | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                            |
| fluvoxamine                 | Non Preferred | Generic | 10/01/16    |        | Medication Coverage Exception     |                |                            |
| fluvoxamine ER              | Non Preferred | Generic | 10/01/16    |        | Medication Coverage Exception     |                |                            |
| Lexapro                     | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                            |
| olanzapine/fluoxetine       | Non Preferred | Generic | 10/01/16    |        | Medication Coverage Exception     |                |                            |

## Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Drug / Product Name            | Status        | Type    | Updated     | Limits | PA Form / 3-Month Req'd           | Brand Req'd    | Additional Note                 |
|--------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|---------------------------------|
| paroxetine 7.5mg               | Non Preferred | Generic | 10/01/17    |        | Medication Coverage Exception     | Brisdelle      |                                 |
| paroxetine ER tablet           | Non Preferred | Generic | 10/01/16    |        | Medication Coverage Exception     |                |                                 |
| paroxetine suspension          | Non Preferred | Generic | 06/01/22    |        | Medication Coverage Exception     |                |                                 |
| Paxil CR                       | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                                 |
| Paxil tablet, suspension       | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                                 |
| Pexeva                         | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                                 |
| Pristiq                        | Non Preferred | Brand   | 11/01/24    |        | Medication Coverage Exception     |                |                                 |
| Prozac                         | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                                 |
| sertraline capsule             | Non Preferred | Generic | 11/01/21    |        | Medication Coverage Exception     |                |                                 |
| sertraline concentrate         | Non Preferred | Generic | 10/01/16    |        | Medication Coverage Exception     |                |                                 |
| Symbyax                        | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                                 |
| venlafaxine ER tablet          | Non Preferred | Generic | 10/01/16    |        | Medication Coverage Exception     |                |                                 |
| Zoloft                         | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                                 |
| Antidepressants -TCAs          |               |         |             |        |                                   |                |                                 |
| Preferred Drugs                | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                 |
| amitriptyline                  | Preferred     | Generic | 01/01/18    |        |                                   |                | Included in more than one class |
| doxepin capsule, concentrate   | Preferred     | Generic | 01/01/18    |        |                                   |                |                                 |
| imipramine HCl tablet          | Preferred     | Generic | 01/01/18    |        |                                   |                |                                 |
| nortriptyline capsule          | Preferred     | Generic | 01/01/18    |        |                                   |                |                                 |
| Non Preferred Drugs            | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                 |
| amitriptyline/chlordiazepoxide | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                                 |
| amitriptyline/perphenazine     | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                                 |
| amoxapine                      | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                                 |
| Anafranil                      | Non Preferred | Brand   | 01/01/18    |        | Medication Coverage Exception     |                |                                 |
| clomipramine                   | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                                 |
| desipramine                    | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                                 |
| imipramine pamoate capsule     | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                                 |
| Norpramin                      | Non Preferred | Brand   | 01/01/18    |        | Medication Coverage Exception     |                |                                 |
| nortriptyline solution         | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                                 |
| Pamelor                        | Non Preferred | Brand   | 01/01/18    |        | Medication Coverage Exception     |                |                                 |
| protriptyline                  | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                                 |
| trimipramine                   | Non Preferred | Generic | 01/01/19    |        | Medication Coverage Exception     |                |                                 |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Antidepressants - Miscellaneous |               |         |             |        |                                   |                |                 |
|---------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Preferred Drugs                 | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Aplenzin                        | Preferred     | Brand   | 01/01/24    |        |                                   |                |                 |
| bupropion                       | Preferred     | Generic | 10/19/16    |        |                                   |                |                 |
| bupropion SR                    | Preferred     | Generic | 10/19/16    |        | 90 Day Supply Required            |                |                 |
| bupropion XL 150, 300mg         | Preferred     | Generic | 10/19/16    |        | 90 Day Supply Required            |                |                 |
| Marplan                         | Preferred     | Brand   | 01/01/18    |        |                                   |                |                 |
| mirtazapine 7.5mg               | Preferred     | Generic | 06/01/23    |        |                                   |                |                 |
| mirtazapine 15, 30, 45mg        | Preferred     | Generic | 10/01/16    |        | 90 Day Supply Required            |                |                 |
| mirtazapine ODT                 | Preferred     | Generic | 10/01/16    |        |                                   |                |                 |
| phenelzine                      | Preferred     | Generic | 01/01/18    |        |                                   |                |                 |
| trazodone 50, 100, 150mg        | Preferred     | Generic | 10/01/16    |        | 90 Day Supply Required            |                |                 |
| trazodone 300mg                 | Preferred     | Generic | 06/01/23    |        |                                   |                |                 |
| Non Preferred Drugs             | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Auvelity                        | Non Preferred | Brand   | 02/01/23    |        | Medication Coverage Exception     |                |                 |
| bupropion 450mg ER              | Non Preferred | Generic | 10/01/18    |        | Medication Coverage Exception     | Forfivo XL     |                 |
| Emsam                           | Non Preferred | Brand   | 01/01/18    |        | Medication Coverage Exception     |                |                 |
| Forfivo XL                      | Non Preferred | Brand   | 10/01/18    |        | Medication Coverage Exception     | Forfivo XL     |                 |
| Nardil                          | Non Preferred | Brand   | 01/01/18    |        | Medication Coverage Exception     |                |                 |
| nefazodone                      | Non Preferred | Generic | 10/01/16    |        | Medication Coverage Exception     |                |                 |
| Raldesy Solution                | Non Preferred | Brand   | 04/01/25    |        | Medication Coverage Exception     |                |                 |
| Remeron                         | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                 |
| Remeron ODT                     | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                 |
| tranylcypromine                 | Non Preferred | Generic | 03/01/19    |        | Medication Coverage Exception     |                |                 |
| Trintellix                      | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                 |
| Viibryd                         | Non Preferred | Brand   | 10/01/16    |        | Medication Coverage Exception     |                |                 |
| vilazodone                      | Non Preferred | Generic | 07/01/22    |        | Medication Coverage Exception     |                |                 |
| Wellbutrin                      | Non Preferred | Brand   | 10/19/16    |        | Medication Coverage Exception     |                |                 |



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| Anxiolytic Benzodiazepines                                                      |               |         |             |                                             |                                   |                |                 |
|---------------------------------------------------------------------------------|---------------|---------|-------------|---------------------------------------------|-----------------------------------|----------------|-----------------|
| • Cumulative limit: 120 units in 30 days. Cumulative limits apply across class. |               |         |             |                                             |                                   |                |                 |
| Preferred Drugs                                                                 | Status        | Type    | Last Update | Limits                                      |                                   | Brand Required | Additional Note |
| alprazolam tablet                                                               | Preferred     | Generic | 01/01/17    | Cumulative across class: 120 units /30 days |                                   |                |                 |
| chlordiazepoxide                                                                | Preferred     | Generic | 01/01/17    | Cumulative across class: 120 units /30 days |                                   |                |                 |
| diazepam tablet                                                                 | Preferred     | Generic | 01/01/17    | Cumulative across class: 120 units /30 days |                                   |                |                 |
| lorazepam tablet                                                                | Preferred     | Generic | 01/01/17    | Cumulative across class: 120 units /30 days |                                   |                |                 |
| Non Preferred Drugs                                                             | Status        | Type    | Last Update | Limits                                      | Required Prior Authorization Form | Brand Required | Additional Note |
| alprazolam concentrate                                                          | Non Preferred | Generic | 01/01/17    | Cumulative: 120 units /30 days              | Medication Coverage Exception     |                |                 |
| alprazolam ODT                                                                  | Non Preferred | Generic | 01/01/17    | Cumulative: 120 units /30 days              | Medication Coverage Exception     |                |                 |
| Ativan                                                                          | Non Preferred | Brand   | 01/01/17    | Cumulative: 120 units /30 days              | Medication Coverage Exception     |                |                 |
| clorazepate                                                                     | Non Preferred | Generic | 01/01/17    | Cumulative: 120 units /30 days              | Medication Coverage Exception     |                |                 |
| diazepam concentrate                                                            | Non Preferred | Generic | 01/01/17    | Cumulative: 120 units /30 days              | Medication Coverage Exception     |                |                 |
| diazepam solution                                                               | Non Preferred | Generic | 01/01/17    | Cumulative: 120 units /30 days              | Medication Coverage Exception     |                |                 |
| lorazepam concentrate                                                           | Non Preferred | Generic | 01/01/17    | Cumulative: 120 units /30 days              | Medication Coverage Exception     |                |                 |
| Loreev XR                                                                       | Non Preferred | Brand   | 10/01/21    | Cumulative: 120 units /30 days              | Medication Coverage Exception     |                |                 |
| oxazepam                                                                        | Non Preferred | Generic | 01/01/17    | Cumulative: 120 units /30 days              | Medication Coverage Exception     |                |                 |
| Xanax                                                                           | Non Preferred | Brand   | 01/01/17    | Cumulative: 120 units /30 days              | Medication Coverage Exception     |                |                 |
| Wakefulness Promoting Agents                                                    |               |         |             |                                             |                                   |                |                 |
| Preferred Drugs                                                                 | Status        | Type    | Last Update | Limits                                      | Required Prior Authorization Form | Brand Required | Additional Note |
| armodafinil                                                                     | Preferred     | Generic | 01/01/22    |                                             | Wakefulness Promoting Agents      |                |                 |
| modafinil                                                                       | Preferred     | Generic | 01/01/22    |                                             | Wakefulness Promoting Agents      |                |                 |
| Nuvigil                                                                         | Preferred     | Brand   | 01/01/24    |                                             | Wakefulness Promoting Agents      |                |                 |
| Provigil                                                                        | Preferred     | Brand   | 01/01/24    |                                             | Wakefulness Promoting Agents      |                |                 |
| Non Preferred Drugs                                                             | Status        | Type    | Last Update | Limits                                      | Required Prior Authorization Form | Brand Required | Additional Note |
| Sunosi                                                                          | Non Preferred | Brand   | 01/01/23    |                                             | Wakefulness Promoting Agents      |                |                 |
| Wakix                                                                           | Non Preferred | Brand   | 01/01/22    |                                             | Wakefulness Promoting Agents      |                |                 |



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| Contraceptives                   |           |         |             |             |                        |                |                 |
|----------------------------------|-----------|---------|-------------|-------------|------------------------|----------------|-----------------|
| Low Dose and Mono-phasic - Oral  |           |         |             |             |                        |                |                 |
| Preferred Drugs                  | Status    | Type    | Last Update | Limits      | Mandatory 3-Month      | Brand Required | Additional Note |
| afirmelle                        | Preferred | Generic | 11/01/19    | Female only | 84 Day Supply Required |                |                 |
| altavera                         | Preferred | Generic | 01/01/12    | Female only | 84 Day Supply Required |                |                 |
| alyacen 1/35                     | Preferred | Generic | 01/01/13    | Female only | 84 Day Supply Required |                |                 |
| apri                             | Preferred | Generic | 01/01/14    | Female only | 84 Day Supply Required |                |                 |
| aubra                            | Preferred | Generic | 05/05/15    | Female only | 84 Day Supply Required |                |                 |
| aurovela 1/20                    | Preferred | Generic | 01/01/21    | Female only | 84 Day Supply Required |                |                 |
| aurovela 24 FE 1/20              | Preferred | Generic | 01/01/24    | Female only | 84 Day Supply Required |                |                 |
| aurovela FE 1.5/30, 1/20         | Preferred | Generic | 01/01/21    | Female only | 84 Day Supply Required |                |                 |
| aviane                           | Preferred | Generic | 03/15/16    | Female only | 84 Day Supply Required |                |                 |
| ayuna                            | Preferred | Generic | 07/01/19    | Female only | 84 Day Supply Required |                |                 |
| balziva                          | Preferred | Generic | 01/01/20    | Female only | 84 Day Supply Required |                |                 |
| Beyaz                            | Preferred | Brand   | 01/01/21    | Female only | 84 Day Supply Required |                |                 |
| blisovi FE 1/20, 1.5/30          | Preferred | Generic | 11/01/16    | Female only | 84 Day Supply Required |                |                 |
| charlotte 24 FE chew             | Preferred | Generic | 01/01/24    | Female only | 84 Day Supply Required |                |                 |
| chateal                          | Preferred | Generic | 01/01/14    | Female only | 84 Day Supply Required |                |                 |
| cyred                            | Preferred | Generic | 01/01/16    | Female only | 84 Day Supply Required |                |                 |
| dasetta 1/35                     | Preferred | Generic | 01/01/13    | Female only | 84 Day Supply Required |                |                 |
| desogestrel/ee                   | Preferred | Generic | 12/01/20    | Female only | 84 Day Supply Required |                |                 |
| drospirenone/ee                  | Preferred | Generic | 01/01/21    | Female only | 84 Day Supply Required |                |                 |
| enskyce                          | Preferred | Generic | 01/01/14    | Female only | 84 Day Supply Required |                |                 |
| estarylla                        | Preferred | Generic | 01/01/14    | Female only | 84 Day Supply Required |                |                 |
| falmina                          | Preferred | Generic | 01/01/13    | Female only | 84 Day Supply Required |                |                 |
| feirza 1.5/30, 1/20              | Preferred | Generic | 03/01/25    | Female only | 84 Day Supply Required |                |                 |
| femynor                          | Preferred | Generic | 03/01/18    | Female only | 84 Day Supply Required |                |                 |
| finzala FE chew 1/20             | Preferred | Generic | 01/24/23    | Female only | 84 Day Supply Required |                |                 |
| gianvi                           | Preferred | Generic | 01/01/21    | Female only | 84 Day Supply Required |                |                 |
| hailey FE 1/20, FE 1.5/30, 24 FE | Preferred | Generic | 01/01/23    | Female only | 84 Day Supply Required |                |                 |
| isibloom                         | Preferred | Generic | 07/01/18    | Female only | 84 Day Supply Required |                |                 |
| jasmiel                          | Preferred | Generic | 01/01/21    | Female only | 84 Day Supply Required |                |                 |
| juleber                          | Preferred | Generic | 05/15/16    | Female only | 84 Day Supply Required |                |                 |
| Junel 1/20                       | Preferred | Generic | 04/01/25    | Female only | 84 Day Supply Required |                |                 |
| junel FE 1/20, 1.5/30            | Preferred | Generic | 01/01/16    | Female only | 84 Day Supply Required |                |                 |
| junel FE 24 1/20                 | Preferred | Generic | 01/24/23    | Female only | 84 Day Supply Required |                |                 |
| kalliga                          | Preferred | Generic | 11/01/19    | Female only | 84 Day Supply Required |                |                 |
| kurvelo                          | Preferred | Generic | 01/01/14    | Female only | 84 Day Supply Required |                |                 |
| larin 1/20                       | Preferred | Generic | 01/01/21    | Female only | 84 Day Supply Required |                |                 |

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| Drug / Product Name              | Status    | Type    | Updated  | Limits      | PA Form / 3-Month Req'd | Brand Req'd | Additional Note |
|----------------------------------|-----------|---------|----------|-------------|-------------------------|-------------|-----------------|
| larin FE 1/20, 1.5/30            | Preferred | Generic | 01/01/22 | Female only | 84 Day Supply Required  |             |                 |
| larin FE 24 1/20                 | Preferred | Generic | 01/01/24 | Female only | 84 Day Supply Required  |             |                 |
| larissia                         | Preferred | Generic | 09/01/17 | Female only | 84 Day Supply Required  |             |                 |
| lessina                          | Preferred | Generic | 10/01/11 | Female only | 84 Day Supply Required  |             |                 |
| levonorgestrel/ee                | Preferred | Generic | 01/01/16 | Female only | 84 Day Supply Required  |             |                 |
| levora                           | Preferred | Generic | 03/15/16 | Female only | 84 Day Supply Required  |             |                 |
| lillow                           | Preferred | Generic | 09/01/17 | Female only | 84 Day Supply Required  |             |                 |
| loestrin 1/20-21                 | Preferred | Generic | 01/01/22 | Female only | 84 Day Supply Required  |             |                 |
| loestrin 21 1.5/30               | Preferred | Generic | 01/01/22 | Female only | 84 Day Supply Required  |             |                 |
| loestrin FE 1.5/30, 1/20         | Preferred | Generic | 12/01/22 | Female only | 84 Day Supply Required  |             |                 |
| loryna                           | Preferred | Generic | 01/01/19 | Female only | 84 Day Supply Required  |             |                 |
| lo-zumandimine                   | Preferred | Generic | 01/01/21 | Female only | 84 Day Supply Required  |             |                 |
| luteru                           | Preferred | Generic | 10/01/11 | Female only | 84 Day Supply Required  |             |                 |
| marlissa                         | Preferred | Generic | 01/01/13 | Female only | 84 Day Supply Required  |             |                 |
| melodetta 24 chewable            | Preferred | Generic | 01/01/24 | Female only | 84 Day Supply Required  |             |                 |
| mibelas 24 chew                  | Preferred | Generic | 01/01/24 | Female only | 84 Day Supply Required  |             |                 |
| microgestin 1/20                 | Preferred | Generic | 01/01/24 | Female only | 84 Day Supply Required  |             |                 |
| microgestin 24 FE 1/20           | Preferred | Generic | 01/01/24 | Female only | 84 Day Supply Required  |             |                 |
| microgestin FE 1/20, FE 1.5/30   | Preferred | Generic | 01/01/21 | Female only | 84 Day Supply Required  |             |                 |
| mili                             | Preferred | Generic | 06/01/18 | Female only | 84 Day Supply Required  |             |                 |
| mono-lynyah                      | Preferred | Generic | 04/01/13 | Female only | 84 Day Supply Required  |             |                 |
| necon 0.5/35                     | Preferred | Generic | 01/01/24 | Female only | 84 Day Supply Required  |             |                 |
| nikki                            | Preferred | Generic | 01/01/21 | Female only | 84 Day Supply Required  |             |                 |
| norethindrone/ee 1/20            | Preferred | Generic | 01/01/23 | Female only | 84 Day Supply Required  |             |                 |
| norethindrone/ee FE 1/20, 1.5/30 | Preferred | Generic | 01/01/21 | Female only | 84 Day Supply Required  |             |                 |
| norethindrone/ee FE capsule      | Preferred | Generic | 01/01/24 | Female only | 84 Day Supply Required  |             |                 |
| norethindrone/ee FE chewable     | Preferred | Generic | 01/01/24 | Female only | 84 Day Supply Required  |             |                 |
| norgestimate/ee                  | Preferred | Generic | 01/01/13 | Female only | 84 Day Supply Required  |             |                 |
| nortrel 1/35                     | Preferred | Generic | 01/01/24 | Female only | 84 Day Supply Required  |             |                 |
| nylia                            | Preferred | Generic | 01/01/22 | Female only | 84 Day Supply Required  |             |                 |
| nymyo                            | Preferred | Generic | 01/01/21 | Female only | 84 Day Supply Required  |             |                 |
| ocella                           | Preferred | Generic | 01/01/19 | Female only | 84 Day Supply Required  |             |                 |
| philith                          | Preferred | Generic | 01/01/20 | Female only | 84 Day Supply Required  |             |                 |
| pirmella 1/35                    | Preferred | Generic | 01/01/20 | Female only | 84 Day Supply Required  |             |                 |
| portia                           | Preferred | Generic | 01/01/12 | Female only | 84 Day Supply Required  |             |                 |
| previfem                         | Preferred | Generic | 01/01/13 | Female only | 84 Day Supply Required  |             |                 |
| reclipsen                        | Preferred | Generic | 01/01/14 | Female only | 84 Day Supply Required  |             |                 |

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| Drug / Product Name          | Status        | Type    | Updated     | Limits      | PA Form / 3-Month Req'd           | Brand Req'd    | Additional Note |
|------------------------------|---------------|---------|-------------|-------------|-----------------------------------|----------------|-----------------|
| sprintec                     | Preferred     | Generic | 10/01/11    | Female only | 84 Day Supply Required            |                |                 |
| sronyx                       | Preferred     | Generic | 10/01/11    | Female only | 84 Day Supply Required            |                |                 |
| syeda                        | Preferred     | Generic | 01/01/19    | Female only | 84 Day Supply Required            |                |                 |
| tarina FE, 24                | Preferred     | Generic | 01/01/24    | Female only | 84 Day Supply Required            |                |                 |
| Tyblume                      | Preferred     | Brand   | 01/01/24    | Female only | 84 Day Supply Required            |                |                 |
| vestura                      | Preferred     | Generic | 01/01/22    | Female only | 84 Day Supply Required            |                |                 |
| vienva                       | Preferred     | Generic | 12/01/16    | Female only | 84 Day Supply Required            |                |                 |
| vyfemla                      | Preferred     | Generic | 01/01/20    | Female only | 84 Day Supply Required            |                |                 |
| vylibra                      | Preferred     | Generic | 03/01/18    | Female only | 84 Day Supply Required            |                |                 |
| Yasmin                       | Preferred     | Brand   | 01/01/21    | Female only | 84 Day Supply Required            |                |                 |
| Yaz                          | Preferred     | Brand   | 01/01/21    | Female only | 84 Day Supply Required            |                |                 |
| zumandimine                  | Preferred     | Generic | 01/01/21    | Female only | 84 Day Supply Required            |                |                 |
| Non Preferred Drugs          | Status        | Type    | Last Update | Limits      | Required Prior Authorization Form | Brand Required | Additional Note |
| aurovela 1.5/30              | Non Preferred | Generic | 01/01/21    | Female only | Medication Coverage Exception     |                |                 |
| Averi                        | Non Preferred | Brand   | 07/01/25    | Female only | Medication Coverage Exception     |                |                 |
| Balcoltra                    | Non Preferred | Brand   | 05/01/18    | Female only | Medication Coverage Exception     |                |                 |
| blisovi 24 FE 1/20           | Non Preferred | Generic | 03/15/16    | Female only | Medication Coverage Exception     |                |                 |
| briellyn                     | Non Preferred | Generic | 01/01/21    | Female only | Medication Coverage Exception     |                |                 |
| cryselle                     | Non Preferred | Generic | 01/01/22    | Female only | Medication Coverage Exception     |                |                 |
| drospirenone/ee/levomefolate | Non Preferred | Generic | 11/01/19    | Female only | Medication Coverage Exception     |                |                 |
| elinest                      | Non Preferred | Generic | 01/01/22    | Female only | Medication Coverage Exception     |                |                 |
| ethynodiol/ee                | Non Preferred | Generic | 01/01/18    | Female only | Medication Coverage Exception     |                |                 |
| FaLessa kit                  | Non Preferred | Brand   | 01/01/16    | Female only | Medication Coverage Exception     |                |                 |
| Femlyv                       | Non Preferred | Brand   | 10/01/24    | Female only | Medication Coverage Exception     |                |                 |
| gemmily                      | Non Preferred | Generic | 12/01/20    | Female only | Medication Coverage Exception     |                |                 |
| hailey 1.5/30                | Non Preferred | Generic | 09/01/19    | Female only | Medication Coverage Exception     |                |                 |
| joyeaux                      | Non Preferred | Generic | 09/01/23    | Female only | Medication Coverage Exception     |                |                 |
| junel 1.5/30                 | Non Preferred | Generic | 01/01/18    | Female only | Medication Coverage Exception     |                |                 |
| kaitlib                      | Non Preferred | Generic | 10/01/18    | Female only | Medication Coverage Exception     |                |                 |
| kelnor 1/35, 1/50            | Non Preferred | Generic | 01/01/22    | Female only | Medication Coverage Exception     |                |                 |
| larin 1.5/30                 | Non Preferred | Generic | 01/01/21    | Female only | Medication Coverage Exception     |                |                 |
| layolis                      | Non Preferred | Generic | 01/01/16    | Female only | Medication Coverage Exception     |                |                 |
| low-ogestrel                 | Non Preferred | Generic | 12/01/21    | Female only | Medication Coverage Exception     |                |                 |
| merzee                       | Non Preferred | Generic | 02/01/21    | Female only | Medication Coverage Exception     |                |                 |
| microgestin 1.5/30           | Non Preferred | Generic | 01/01/22    | Female only | Medication Coverage Exception     |                |                 |
| Minastrin 24 FE chewable     | Non Preferred | Generic | 11/01/19    | Female only | Medication Coverage Exception     |                |                 |
| Nextstellis                  | Non Preferred | Generic | 03/01/24    | Female only | Medication Coverage Exception     |                |                 |

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| Drug / Product Name     | Status        | Type    | Updated     | Limits      | PA Form / 3-Month Req'd           | Brand Req'd    | Additional Note |
|-------------------------|---------------|---------|-------------|-------------|-----------------------------------|----------------|-----------------|
| norethindrone/ee 1.5/30 | Non Preferred | Generic | 12/01/23    | Female only | Medication Coverage Exception     |                |                 |
| nortrel 0.5/35          | Non Preferred | Generic | 02/01/19    | Female only | Medication Coverage Exception     |                |                 |
| Safyral                 | Non Preferred | Brand   | 01/01/19    | Female only | Medication Coverage Exception     |                |                 |
| taysofy                 | Non Preferred | Generic | 12/01/22    | Female only | Medication Coverage Exception     |                |                 |
| Taytulla                | Non Preferred | Brand   | 10/01/16    | Female only | Medication Coverage Exception     |                |                 |
| tydemy                  | Non Preferred | Generic | 04/01/18    | Female only | Medication Coverage Exception     |                |                 |
| wera                    | Non Preferred | Generic | 01/01/18    | Female only | Medication Coverage Exception     |                |                 |
| wymzya                  | Non Preferred | Generic | 01/01/13    | Female only | Medication Coverage Exception     |                |                 |
| valtya 1/50             | Non Preferred | Generic | 03/01/25    | Female only | Medication Coverage Exception     |                |                 |
| zovia                   | Non Preferred | Generic | 01/01/19    | Female only | Medication Coverage Exception     |                |                 |
| Bi-phasic - Oral        |               |         |             |             |                                   |                |                 |
| Preferred Drugs         | Status        | Type    | Last Update | Limits      | Mandatory 3-Month                 | Brand Required | Additional Note |
| azurette                | Preferred     | Generic | 01/01/18    | Female only | 84 Day Supply Required            |                |                 |
| bekyree                 | Preferred     | Generic | 01/01/18    | Female only | 84 Day Supply Required            |                |                 |
| desogestrel/ee          | Preferred     | Generic | 01/01/18    | Female only | 84 Day Supply Required            |                |                 |
| kariva                  | Preferred     | Generic | 01/01/22    | Female only | 84 Day Supply Required            |                |                 |
| pimtrea                 | Preferred     | Generic | 01/01/18    | Female only | 84 Day Supply Required            |                |                 |
| simliya                 | Preferred     | Generic | 01/01/23    | Female only | 84 Day Supply Required            |                |                 |
| viorele                 | Preferred     | Generic | 01/01/23    | Female only | 84 Day Supply Required            |                |                 |
| volnea                  | Preferred     | Generic | 02/01/20    | Female only | 84 Day Supply Required            |                |                 |
| Non Preferred Drugs     | Status        | Type    | Last Update | Limits      | Required Prior Authorization Form | Brand Required | Additional Note |
| Lo Loestrin             | Non Preferred | Brand   | 01/01/12    | Female only | Medication Coverage Exception     |                |                 |
| Mircette                | Non Preferred | Brand   | 01/01/16    | Female only | Medication Coverage Exception     |                |                 |

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| Tri-phasic and Multi-phasic - Oral   |               |         |             |             |                                   |                |                 |
|--------------------------------------|---------------|---------|-------------|-------------|-----------------------------------|----------------|-----------------|
| Preferred Drugs                      | Status        | Type    | Last Update | Limits      | Mandatory 3-Month                 | Brand Required | Additional Note |
| Natazia                              | Preferred     | Brand   | 01/01/16    | Female only | 84 Day Supply Required            |                |                 |
| norgestimate/ee                      | Preferred     | Generic | 01/01/16    | Female only | 84 Day Supply Required            |                |                 |
| tri femynor                          | Preferred     | Generic | 06/01/17    | Female only | 84 Day Supply Required            |                |                 |
| tri-estaryll, tri-lo-estaryll        | Preferred     | Generic | 11/01/19    | Female only | 84 Day Supply Required            |                |                 |
| tri-linyah                           | Preferred     | Generic | 04/01/13    | Female only | 84 Day Supply Required            |                |                 |
| tri-lo-marzia                        | Preferred     | Generic | 02/01/20    | Female only | 84 Day Supply Required            |                |                 |
| tri-mili, tri-lo-mili                | Preferred     | Generic | 07/01/19    | Female only | 84 Day Supply Required            |                |                 |
| tri-nymo                             | Preferred     | Generic | 12/01/23    | Female only | 84 Day Supply Required            |                |                 |
| tri-previfem                         | Preferred     | Generic | 01/01/13    | Female only | 84 Day Supply Required            |                |                 |
| tri-sprintec, tri-lo-sprintec        | Preferred     | Generic | 03/15/16    | Female only | 84 Day Supply Required            |                |                 |
| tri-vylibra                          | Preferred     | Generic | 03/01/18    | Female only | 84 Day Supply Required            |                |                 |
| Non Preferred Drugs                  | Status        | Type    | Last Update | Limits      | Required Prior Authorization Form | Brand Required | Additional Note |
| alyacen 7/7/7                        | Non Preferred | Generic | 01/01/24    | Female only | Medication Coverage Exception     |                |                 |
| aranelle                             | Non Preferred | Generic | 01/01/23    | Female only | Medication Coverage Exception     |                |                 |
| dasetta 7/7/7                        | Non Preferred | Generic | 01/01/24    | Female only | Medication Coverage Exception     |                |                 |
| enpresse                             | Non Preferred | Generic | 01/01/24    | Female only | Medication Coverage Exception     |                |                 |
| leena                                | Non Preferred | Generic | 01/01/24    | Female only | Medication Coverage Exception     |                |                 |
| levonest                             | Non Preferred | Generic | 01/01/22    | Female only | Medication Coverage Exception     |                |                 |
| levonorgestrel/ee                    | Non Preferred | Generic | 01/01/22    | Female only | Medication Coverage Exception     |                |                 |
| nortrel 7/7/7                        | Non Preferred | Generic | 01/01/24    | Female only | Medication Coverage Exception     |                |                 |
| nylia 7/7/7                          | Non Preferred | Generic | 01/01/24    | Female only | Medication Coverage Exception     |                |                 |
| pirmella 7/7/7                       | Non Preferred | Generic | 01/01/24    | Female only | Medication Coverage Exception     |                |                 |
| tilia FE                             | Non Preferred | Generic | 01/01/11    | Female only | Medication Coverage Exception     |                |                 |
| tri-legest FE                        | Non Preferred | Generic | 01/01/11    | Female only | Medication Coverage Exception     |                |                 |
| trivora                              | Non Preferred | Generic | 01/01/22    | Female only | Medication Coverage Exception     |                |                 |
| velivet                              | Non Preferred | Generic | 09/01/17    | Female only | Medication Coverage Exception     |                |                 |
| xarah FE                             | Non Preferred | Generic | 04/01/25    | Female only | Medication Coverage Exception     |                |                 |
| Extended and Continuous Cycle - Oral |               |         |             |             |                                   |                |                 |
| Preferred Drugs                      | Status        | Type    | Last Update | Limits      | Mandatory 3-Month                 | Brand Required | Additional Note |
| amethia                              | Preferred     | Generic | 01/01/24    | Female only | 91 Day Supply Required            |                |                 |
| ashlyna                              | Preferred     | Generic | 01/01/24    | Female only | 91 Day Supply Required            |                |                 |

## Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Drug / Product Name        | Status        | Type    | Updated     | Limits      | PA Form / 3-Month Req'd           | Brand Req'd    | Additional Note |
|----------------------------|---------------|---------|-------------|-------------|-----------------------------------|----------------|-----------------|
| camrese                    | Preferred     | Generic | 01/01/22    | Female only | 91 Day Supply Required            |                |                 |
| camrese Lo                 | Preferred     | Generic | 01/01/22    | Female only | 91 Day Supply Required            |                |                 |
| daysee                     | Preferred     | Generic | 01/01/24    | Female only | 91 Day Supply Required            |                |                 |
| iclevia                    | Preferred     | Generic | 01/01/22    | Female only | 91 Day Supply Required            |                |                 |
| jaimiess                   | Preferred     | Generic | 01/01/24    | Female only | 91 Day Supply Required            |                |                 |
| jolessa                    | Preferred     | Generic | 01/01/16    | Female only | 91 Day Supply Required            |                |                 |
| levonorgestrel/ee [91 day] | Preferred     | Generic | 01/01/19    | Female only | 91 Day Supply Required            |                |                 |
| Loseasonique               | Preferred     | Brand   | 01/01/13    | Female only | 91 Day Supply Required            |                |                 |
| Seasonique                 | Preferred     | Brand   | 01/01/24    | Female only | 91 Day Supply Required            |                |                 |
| setlakin                   | Preferred     | Generic | 01/01/17    | Female only | 91 Day Supply Required            |                |                 |
| simpesse                   | Preferred     | Generic | 01/01/24    | Female only | 91 Day Supply Required            |                |                 |
| Non Preferred Drugs        | Status        | Type    | Last Update | Limits      | Required Prior Authorization Form | Brand Required | Additional Note |
| amethyst                   | Non Preferred | Generic | 01/01/13    | Female only | Medication Coverage Exception     |                |                 |
| dolishale                  | Non Preferred | Generic | 05/01/21    | Female only | Medication Coverage Exception     |                |                 |
| fayosim                    | Non Preferred | Generic | 05/01/17    | Female only | Medication Coverage Exception     |                |                 |
| introvale                  | Non Preferred | Generic | 01/01/24    | Female only | Medication Coverage Exception     |                |                 |
| jaimiess Lo                | Non Preferred | Generic | 02/01/20    | Female only | Medication Coverage Exception     |                |                 |
| levonorgestrel/ee [84 day] | Non Preferred | Generic | 01/01/20    | Female only | Medication Coverage Exception     |                |                 |
| norethindrone/ee FE        | Non Preferred | Generic | 12/01/23    | Female only | Medication Coverage Exception     |                |                 |
| Quartette                  | Non Preferred | Brand   | 01/01/14    | Female only | Medication Coverage Exception     |                |                 |
| rivelsa                    | Non Preferred | Generic | 05/01/17    | Female only | Medication Coverage Exception     |                |                 |
| rosyrah                    | Non Preferred | Generic | 07/01/25    | Female only | Medication Coverage Exception     |                |                 |
| Cytokine Modulators        |               |         |             |             |                                   |                |                 |
| Immunomodulators           |               |         |             |             |                                   |                |                 |
| Preferred Drugs            | Status        | Type    | Last Update | Limits      | Mandatory 3-Month                 | Brand Required | Additional Note |
| Avsola                     | Preferred     | Brand   | 01/01/23    |             |                                   |                |                 |
| Enbrel                     | Preferred     | Brand   | 02/01/10    |             |                                   |                |                 |
| Humira                     | Preferred     | Brand   | 02/01/10    |             |                                   |                |                 |
| Otezla                     | Preferred     | Brand   | 01/01/22    |             |                                   |                |                 |
| Taltz                      | Preferred     | Brand   | 01/01/23    |             |                                   |                |                 |
| Xeljanz                    | Preferred     | Brand   | 01/01/22    |             |                                   |                |                 |
| Xeljanz XR                 | Preferred     | Brand   | 01/01/22    |             |                                   |                |                 |



# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Non Preferred Drugs           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                                       |
|-------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-------------------------------------------------------|
| Actemra                       | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                                                       |
| adalimumab (all biosimilars)  | Non Preferred | Generic | 08/01/23    |        | Medication Coverage Exception     | Humira         |                                                       |
| Arcalyst                      | Non Preferred | Brand   | 11/01/19    |        | Medication Coverage Exception     |                |                                                       |
| Bimzelx                       | Non Preferred | Brand   | 11/01/23    |        | Medication Coverage Exception     |                |                                                       |
| Cimzia                        | Non Preferred | Brand   | 01/01/13    |        | Medication Coverage Exception     |                |                                                       |
| Cosentyx                      | Non Preferred | Brand   | 01/01/21    |        | Medication Coverage Exception     |                |                                                       |
| Entyvio                       | Non Preferred | Brand   | 09/01/20    |        | Medication Coverage Exception     |                | Covered under medical benefit using appropriate HCPCS |
| Ilaris                        | Non Preferred | Brand   | 11/01/19    |        | Medication Coverage Exception     |                |                                                       |
| Ilumya                        | Non Preferred | Brand   | 09/01/18    |        | Medication Coverage Exception     |                |                                                       |
| Inflectra                     | Non Preferred | Brand   | 11/01/19    |        | Medication Coverage Exception     |                |                                                       |
| infliximab                    | Non Preferred | Generic | 12/01/21    |        | Medication Coverage Exception     |                |                                                       |
| Kevzara                       | Non Preferred | Brand   | 11/01/17    |        | Medication Coverage Exception     |                |                                                       |
| Kineret                       | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                                                       |
| Leqselvi                      | Non Preferred | Brand   | 07/01/25    |        | Medication Coverage Exception     |                |                                                       |
| Litfulo                       | Non Preferred | Brand   | 08/01/23    |        | Medication Coverage Exception     |                |                                                       |
| Nemluvio                      | Non Preferred | Brand   | 09/01/24    |        | Medication Coverage Exception     |                |                                                       |
| Olumiant                      | Non Preferred | Brand   | 07/01/18    |        | Medication Coverage Exception     |                |                                                       |
| Omvoh                         | Non Preferred | Brand   | 12/01/23    |        | Medication Coverage Exception     |                |                                                       |
| Orencia                       | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                                                       |
| Remicade                      | Non Preferred | Brand   | 11/01/19    |        | Medication Coverage Exception     |                |                                                       |
| Renflexis                     | Non Preferred | Brand   | 11/01/19    |        | Medication Coverage Exception     |                |                                                       |
| Rinvoq                        | Non Preferred | Brand   | 09/01/19    |        | Medication Coverage Exception     |                | Included in more than one class                       |
| Siliq                         | Non Preferred | Brand   | 05/01/19    |        | Medication Coverage Exception     |                |                                                       |
| Simponi                       | Non Preferred | Brand   | 02/01/10    |        | Medication Coverage Exception     |                |                                                       |
| Skyrizi                       | Non Preferred | Brand   | 05/01/19    |        | Medication Coverage Exception     |                |                                                       |
| Sotyktu                       | Non Preferred | Brand   | 10/01/22    |        | Medication Coverage Exception     |                |                                                       |
| Spevigo                       | Non Preferred | Brand   | 09/01/23    |        | Rare Disease Medications          |                |                                                       |
| Stelara                       | Non Preferred | Brand   | 10/01/11    |        | Medication Coverage Exception     |                |                                                       |
| tocilizumab (all biosimilars) | Non Preferred | Generic | 07/01/24    |        | Medication Coverage Exception     |                |                                                       |
| Tremfya                       | Non Preferred | Brand   | 05/01/19    |        | Medication Coverage Exception     |                |                                                       |
| ustekinumab (all biosimilars) | Non Preferred | Generic | 02/01/25    |        | Medication Coverage Exception     |                |                                                       |
| Velsipity                     | Non Preferred | Brand   | 11/01/23    |        | Medication Coverage Exception     |                |                                                       |
| Wezlana                       | Non Preferred | Brand   | 06/01/24    |        | Medication Coverage Exception     |                |                                                       |
| Zymfentra                     | Non Preferred | Brand   | 06/01/24    |        | Medication Coverage Exception     |                |                                                       |



# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Dermatological                                     |               |         |             |        |                                   |                |                 |
|----------------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Topical Acne Products - Antibiotics & Combinations |               |         |             |        |                                   |                |                 |
| Preferred Drugs                                    | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| adapalene/benzoyl peroxide gel                     | Preferred     | Generic | 01/01/24    |        |                                   |                |                 |
| benzoyl peroxide/erythromycin                      | Preferred     | Generic | 01/01/13    |        |                                   |                |                 |
| clindamycin gel                                    | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| clindamycin lotion                                 | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| clindamycin pad                                    | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| clindamycin solution                               | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| clindamycin/benzoyl peroxide                       | Preferred     | Generic | 01/01/19    |        |                                   |                |                 |
| erythromycin 2% gel                                | Preferred     | Generic | 01/01/13    |        |                                   |                |                 |
| erythromycin 2% solution                           | Preferred     | Generic | 01/01/13    |        |                                   |                |                 |
| Onexton                                            | Preferred     | Brand   | 01/01/16    |        |                                   |                |                 |
| Ziana                                              | Preferred     | Brand   | 01/01/13    |        |                                   | Ziana          |                 |
| Non Preferred Drugs                                | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Acanya                                             | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| adapalene/benzoyl peroxide pad                     | Non Preferred | Generic | 02/01/21    |        | Medication Coverage Exception     |                |                 |
| Benzamycin                                         | Non Preferred | Brand   | 08/01/11    |        | Medication Coverage Exception     |                |                 |
| Cabtreo                                            | Non Preferred | Brand   | 12/01/23    |        | Medication Coverage Exception     |                |                 |
| Cleocin T lotion                                   | Non Preferred | Brand   | 08/01/11    |        | Medication Coverage Exception     |                |                 |
| Clindacin kit                                      | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Clindagel                                          | Non Preferred | Brand   | 08/01/11    |        | Medication Coverage Exception     |                |                 |
| clindamycin foam                                   | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| clindamycin/tretinoin                              | Non Preferred | Generic | 08/01/17    |        | Medication Coverage Exception     | Ziana          |                 |
| dapsone                                            | Non Preferred | Generic | 11/01/17    |        | Medication Coverage Exception     |                |                 |
| EryGel                                             | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| erythromycin pad                                   | Non Preferred | Generic | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Klaron                                             | Non Preferred | Brand   | 05/15/16    |        | Medication Coverage Exception     |                |                 |
| sulfacetamide sodium lotion                        | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                 |

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| Topical Acne Products - Retinoids     |               |         |             |        |                                   |                |                 |
|---------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Preferred Drugs                       | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Retin-A                               | Preferred     | Brand   | 01/01/14    |        |                                   | Retin-A        |                 |
| Non Preferred Drugs                   | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| adapalene                             | Non Preferred | Generic | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| Altreno                               | Non Preferred | Brand   | 05/01/19    |        | Medication Coverage Exception     |                |                 |
| Arazlo                                | Non Preferred | Brand   | 12/01/20    |        | Medication Coverage Exception     |                |                 |
| Atralin                               | Non Preferred | Brand   | 11/01/17    |        | Medication Coverage Exception     |                |                 |
| Fabior                                | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Retin-A Micro                         | Non Preferred | Brand   | 08/01/11    |        | Medication Coverage Exception     |                |                 |
| tazarotene                            | Non Preferred | Brand   | 01/01/21    |        | Medication Coverage Exception     |                |                 |
| tretinoin                             | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     | Retin-A        |                 |
| Topical Acne Products - Miscellaneous |               |         |             |        |                                   |                |                 |
| Preferred Drugs                       | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| sulfacetamide/sulfur cleanser         | Preferred     | Generic | 08/01/25    |        |                                   |                |                 |
| sulfacetamide/sulfur emulsion         | Preferred     | Generic | 12/01/16    |        |                                   |                |                 |
| sulfacetamide/sulfur liquid           | Preferred     | Generic | 12/01/16    |        |                                   |                |                 |
| sulfacetamide/sulfur suspension       | Preferred     | Generic | 12/01/16    |        |                                   |                |                 |
| Non Preferred Drugs                   | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| azelaic acid gel                      | Non Preferred | Generic | 12/01/18    |        | Medication Coverage Exception     |                |                 |
| brimonidine gel                       | Non Preferred | Generic | 02/01/23    |        | Medication Coverage Exception     |                |                 |
| selenium sulfide                      | Non Preferred | Generic | 04/01/12    |        | Medication Coverage Exception     |                |                 |
| sulfacetamide gel                     | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                 |
| sulfacetamide/sulfur cream            | Non Preferred | Generic | 12/01/16    |        | Medication Coverage Exception     |                |                 |
| sulfacetamide/sulfur foam             | Non Preferred | Generic | 12/01/16    |        | Medication Coverage Exception     |                |                 |
| Sumadan XLT kit                       | Non Preferred | Brand   | 10/01/17    |        | Medication Coverage Exception     |                |                 |
| Winlevi                               | Non Preferred | Brand   | 07/01/23    |        | Medication Coverage Exception     |                |                 |
| ZMA                                   | Non Preferred | Brand   | 12/01/23    |        | Medication Coverage Exception     |                |                 |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Oral Acne Products            |               |         |             |        |                                   |                |                 |
|-------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Preferred Drugs               | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| amnestem 10, 20, 30, 40mg     | Preferred     | Generic | 03/01/24    |        |                                   |                |                 |
| claravis 10, 20, 30, 40mg     | Preferred     | Generic | 03/01/24    |        |                                   |                |                 |
| isotretinoin 10, 20, 30, 40mg | Preferred     | Generic | 01/01/23    |        |                                   |                |                 |
| zenatane 10, 20, 30, 40mg     | Preferred     | Generic | 03/01/24    |        |                                   |                |                 |
| Non Preferred Drugs           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Absorica                      | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| isotretinoin 25, 35mg         | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Topical Antifungals           |               |         |             |        |                                   |                |                 |
| Preferred Drugs               | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| ciclopirox cream              | Preferred     | Generic | 08/01/17    |        |                                   |                |                 |
| ciclopirox gel                | Preferred     | Generic | 08/01/17    |        |                                   |                |                 |
| ciclopirox shampoo            | Preferred     | Generic | 08/01/17    |        |                                   |                |                 |
| ciclopirox suspension         | Preferred     | Generic | 08/01/17    |        |                                   |                |                 |
| clotrimazole cream            | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| clotrimazole solution         | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| Ertaczo                       | Preferred     | Brand   | 01/01/14    |        |                                   |                |                 |
| ketoconazole cream            | Preferred     | Generic | 10/01/11    |        |                                   |                |                 |
| ketoconazole shampoo          | Preferred     | Generic | 10/01/11    |        |                                   |                |                 |
| nystatin                      | Preferred     | Generic | 11/01/18    |        |                                   |                |                 |
| Non Preferred Drugs           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| ciclopirox solution           | Non Preferred | Generic | 10/01/11    |        | Medication Coverage Exception     |                |                 |
| econazole                     | Non Preferred | Generic | 04/01/13    |        | Medication Coverage Exception     |                |                 |
| Exelderm                      | Non Preferred | Brand   | 12/01/22    |        | Medication Coverage Exception     |                |                 |
| Jublia                        | Non Preferred | Brand   | 09/15/14    |        | Medication Coverage Exception     |                |                 |
| Kerydin                       | Non Preferred | Brand   | 09/15/14    |        | Medication Coverage Exception     | Kerydin        |                 |
| ketoconazole foam             | Non Preferred | Generic | 10/01/11    |        | Medication Coverage Exception     |                |                 |
| Loprox                        | Non Preferred | Brand   | 08/01/17    |        | Medication Coverage Exception     |                |                 |
| luliconazole                  | Non Preferred | Generic | 03/01/19    |        | Medication Coverage Exception     |                |                 |

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| Drug / Product Name               | Status        | Type    | Updated     | Limits | PA Form / 3-Month Req'd                | Brand Req'd    | Additional Note                 |
|-----------------------------------|---------------|---------|-------------|--------|----------------------------------------|----------------|---------------------------------|
| Luzu                              | Non Preferred | Brand   | 03/01/19    |        | Medication Coverage Exception          |                |                                 |
| Mentax                            | Non Preferred | Brand   | 10/01/11    |        | Medication Coverage Exception          |                |                                 |
| naftifine                         | Non Preferred | Generic | 08/01/17    |        | Medication Coverage Exception          |                |                                 |
| Naftin                            | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception          |                |                                 |
| oxiconazole                       | Non Preferred | Generic | 10/01/11    |        | Medication Coverage Exception          |                |                                 |
| Oxistat                           | Non Preferred | Brand   | 10/01/11    |        | Medication Coverage Exception          |                |                                 |
| tavaborole                        | Non Preferred | Generic | 11/01/20    |        | Medication Coverage Exception          | Kerydin        |                                 |
| Topical Antivirals                |               |         |             |        |                                        |                |                                 |
| Preferred Drugs                   | Status        | Type    | Last Update | Limits | Mandatory 3-Month                      | Brand Required | Additional Note                 |
| acyclovir ointment                | Preferred     | Generic | 01/01/23    |        |                                        |                |                                 |
| Non Preferred Drugs               | Status        | Type    | Last Update | Limits | Required Prior Authorization Form      | Brand Required | Additional Note                 |
| acyclovir cream                   | Non Preferred | Generic | 03/01/19    |        | Medication Coverage Exception          |                |                                 |
| Denavir                           | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception          | Denavir        |                                 |
| penciclovir                       | Non Preferred | Generic | 12/01/22    |        | Medication Coverage Exception          | Denavir        |                                 |
| Xerese                            | Non Preferred | Brand   | 06/01/13    |        | Medication Coverage Exception          |                |                                 |
| Zelsuvmi                          | Non Preferred | Brand   | 07/01/25    |        | Medication Coverage Exception          |                |                                 |
| Zovirax                           | Non Preferred | Brand   | 01/01/23    |        | Medication Coverage Exception          |                |                                 |
| Atopic Dermatitis (Non-Steroidal) |               |         |             |        |                                        |                |                                 |
| Preferred Drugs                   | Status        | Type    | Last Update | Limits | Required Prior Authorization Form      | Brand Required | Additional Note                 |
| Adbry                             | Preferred     | Brand   | 08/01/25    |        | Immunomodulators for Atopic Dermatitis |                |                                 |
| Dupixent                          | Preferred     | Brand   | 08/01/25    |        | Immunomodulators for Atopic Dermatitis |                | Included in more than one class |
| Elidel                            | Preferred     | Brand   | 01/01/23    |        |                                        | Elidel         |                                 |
| tacrolimus                        | Preferred     | Generic | 08/01/22    |        |                                        |                |                                 |
| Non Preferred Drugs               | Status        | Type    | Last Update | Limits | Required Prior Authorization Form      | Brand Required | Additional Note                 |
| Cibinqo                           | Non Preferred | Brand   | 08/01/25    |        | Immunomodulators for Atopic Dermatitis |                |                                 |
| Ebglyss                           | Non Preferred | Brand   | 10/01/24    |        | Medication Coverage Exception          |                |                                 |
| Eucrisa                           | Non Preferred | Brand   | 09/01/18    |        | Medication Coverage Exception          |                |                                 |
| Hyftor                            | Non Preferred | Brand   | 07/01/25    |        | Medication Coverage Exception          |                |                                 |
| Nemludio                          | Non Preferred | Brand   | 08/01/25    |        | Medication Coverage Exception          |                |                                 |
| Opzelura                          | Non Preferred | Brand   | 04/01/22    |        | Medication Coverage Exception          |                |                                 |
| pimecrolimus                      | Non Preferred | Generic | 01/01/23    |        | Medication Coverage Exception          | Elidel         |                                 |
| Rinvoq                            | Non Preferred | Brand   | 09/01/19    |        | Medication Coverage Exception          |                | Included in more than one class |
| Zoryve                            | Non Preferred | Brand   | 09/01/24    |        | Medication Coverage Exception          |                |                                 |

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| Very Potent - Corticosteroids     |               |         |             |        |                                   |                |                 |
|-----------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Preferred Drugs                   | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| betamethasone augmented cream     | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |
| betamethasone dipropionate cream  | Preferred     | Generic | 01/01/18    |        |                                   |                |                 |
| betamethasone dipropionate lotion | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |
| clobetasol cream                  | Preferred     | Generic | 01/01/18    |        |                                   |                |                 |
| clobetasol ointment               | Preferred     | Generic | 01/01/18    |        |                                   |                |                 |
| clobetasol shampoo                | Preferred     | Brand   | 08/01/20    |        |                                   |                |                 |
| clobetasol solution               | Preferred     | Generic | 01/01/18    |        |                                   |                |                 |
| halobetasol cream                 | Preferred     | Generic | 11/01/19    |        |                                   |                |                 |
| halobetasol ointment              | Preferred     | Generic | 11/01/19    |        |                                   |                |                 |
| Non Preferred Drugs               | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Apexicon E                        | Non Preferred | Brand   | 10/01/13    |        | Medication Coverage Exception     |                |                 |
| betamethasone augmented gel       | Non Preferred | Generic | 10/01/13    |        | Medication Coverage Exception     |                |                 |
| betamethasone augmented lotion    | Non Preferred | Generic | 10/01/13    |        | Medication Coverage Exception     |                |                 |
| betamethasone augmented ointment  | Non Preferred | Generic | 10/01/13    |        | Medication Coverage Exception     |                |                 |
| betamethasone ointment            | Non Preferred | Generic | 10/01/13    |        | Medication Coverage Exception     |                |                 |
| Bryhali                           | Non Preferred | Brand   | 12/01/18    |        | Medication Coverage Exception     |                |                 |
| clobetasol foam                   | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                 |
| clobetasol gel                    | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                 |
| clobetasol lotion                 | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                 |
| clobetasol spray                  | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     |                |                 |
| diflorasone                       | Non Preferred | Generic | 11/01/17    |        | Medication Coverage Exception     |                |                 |
| Diprolene                         | Non Preferred | Brand   | 10/01/13    |        | Medication Coverage Exception     |                |                 |
| fluocinonide 0.1%                 | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| flurandrenolide                   | Non Preferred | Generic | 03/01/17    |        | Medication Coverage Exception     |                |                 |
| halobetasol foam                  | Non Preferred | Generic | 11/01/19    |        | Medication Coverage Exception     |                |                 |
| Impeklo                           | Non Preferred | Brand   | 09/01/21    |        | Medication Coverage Exception     |                |                 |
| Lexette                           | Non Preferred | Brand   | 12/01/18    |        | Medication Coverage Exception     |                |                 |
| Olux-E                            | Non Preferred | Brand   | 12/01/22    |        | Medication Coverage Exception     |                |                 |
| Psorcon                           | Non Preferred | Brand   | 11/01/17    |        | Medication Coverage Exception     |                |                 |
| Tovet                             | Non Preferred | Brand   | 07/01/20    |        | Medication Coverage Exception     |                |                 |
| Ultravate                         | Non Preferred | Brand   | 11/01/19    |        | Medication Coverage Exception     |                |                 |
| Vanos                             | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                 |

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| Potent - Corticosteroids      |               |         |             |        |                                   |                |                 |
|-------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Preferred Drugs               | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| desoximetasone 0.25%          | Preferred     | Generic | 01/01/24    |        |                                   |                |                 |
| fluocinonide 0.05% cream      | Preferred     | Generic | 01/01/19    |        |                                   |                |                 |
| fluocinonide 0.05% gel        | Preferred     | Generic | 01/01/24    |        |                                   |                |                 |
| fluocinonide 0.05% ointment   | Preferred     | Generic | 01/01/19    |        |                                   |                |                 |
| fluocinonide 0.05% solution   | Preferred     | Generic | 01/01/19    |        |                                   |                |                 |
| Halog                         | Preferred     | Brand   | 01/01/20    |        |                                   | Halog          |                 |
| mometasone 0.1% ointment      | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |
| triamcinolone 0.5%            | Preferred     | Generic | 11/01/19    |        |                                   |                |                 |
| Non Preferred Drugs           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| amcinonide                    | Non Preferred | Generic | 10/01/13    |        | Medication Coverage Exception     |                |                 |
| halcinonide                   | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     | Halog          |                 |
| Topicort                      | Non Preferred | Brand   | 10/01/13    |        | Medication Coverage Exception     |                |                 |
| Midstrength - Corticosteroids |               |         |             |        |                                   |                |                 |
| Preferred Drugs               | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| betamethasone val             | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| fluticasone cream             | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| fluticasone ointment          | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| mometasone 0.1% cream         | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |
| mometasone 0.1% solution      | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |
| triamcinolone 0.1% ointment   | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |
| triamcinolone 0.1% cream      | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |
| triamcinolone 0.1% lotion     | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |

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| Non Preferred Drugs              | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
|----------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Beser                            | Non Preferred | Brand   | 07/01/20    |        | Medication Coverage Exception     |                |                 |
| cloctortolone                    | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Cloderm                          | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| desoximetasonone 0.05%           | Non Preferred | Generic | 10/01/13    |        | Medication Coverage Exception     |                |                 |
| fluocinolone 0.025% cream        | Non Preferred | Generic | 01/01/22    |        | Medication Coverage Exception     | Synalar        |                 |
| fluocinolone 0.025% ointment     | Non Preferred | Generic | 01/01/22    |        | Medication Coverage Exception     | Synalar        |                 |
| fluticasone lotion               | Non Preferred | Generic | 01/01/21    |        | Medication Coverage Exception     | Cutivate       |                 |
| hydrocortisone val 0.2% cream    | Non Preferred | Generic | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| hydrocortisone val 0.2% ointment | Non Preferred | Generic | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Kenalog spray                    | Non Preferred | Brand   | 04/01/20    |        | Medication Coverage Exception     |                |                 |
| Luxiq                            | Non Preferred | Brand   | 10/01/17    |        | Medication Coverage Exception     |                |                 |
| Pandel                           | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| prednicarbate                    | Non Preferred | Generic | 01/01/15    |        | Medication Coverage Exception     |                |                 |
| Synalar cream                    | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                 |
| Synalar ointment                 | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                 |
| Topicort                         | Non Preferred | Brand   | 10/01/13    |        | Medication Coverage Exception     |                |                 |
| triamcinolone topical spray      | Non Preferred | Generic | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| Mild - Corticosteroids           |               |         |             |        |                                   |                |                 |
| Preferred Drugs                  | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Capex                            | Preferred     | Brand   | 10/01/13    |        |                                   |                |                 |
| desonide                         | Preferred     | Generic | 11/01/16    |        |                                   |                |                 |
| fluocinolone 0.01% cream         | Preferred     | Generic | 01/01/16    |        |                                   |                |                 |
| fluocinolone 0.01% oil           | Preferred     | Generic | 01/01/22    |        |                                   |                |                 |
| hydrocortisone 1% cream          | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |
| hydrocortisone 1% ointment       | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |
| hydrocortisone 2.5% cream        | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |
| hydrocortisone 2.5% lotion       | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |
| hydrocortisone 2.5% ointment     | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |
| hydrocortisone 2.5% rectal cream | Preferred     | Generic | 01/01/22    |        |                                   |                |                 |
| hydrocortisone enema             | Preferred     | Generic | 01/01/22    |        |                                   |                |                 |
| triamcinolone 0.025% cream       | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |
| triamcinolone 0.025% lotion      | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |
| triamcinolone 0.025% ointment    | Preferred     | Generic | 10/01/13    |        |                                   |                |                 |



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| Non Preferred Drugs                   | Status        | Type    | Last Update | Limits              | Required Prior Authorization Form | Brand Required | Additional Note |
|---------------------------------------|---------------|---------|-------------|---------------------|-----------------------------------|----------------|-----------------|
| alclometasone                         | Non Preferred | Generic | 01/01/20    |                     | Medication Coverage Exception     |                |                 |
| Anusol-HC                             | Non Preferred | Brand   | 01/01/22    |                     | Medication Coverage Exception     |                |                 |
| budesonide rectal foam                | Non Preferred | Generic | 05/01/23    |                     | Medication Coverage Exception     | Uceris         |                 |
| Cortenema                             | Non Preferred | Brand   | 01/01/22    |                     | Medication Coverage Exception     |                |                 |
| Derma-Smoothe/FS                      | Non Preferred | Brand   | 01/01/25    |                     | Medication Coverage Exception     |                |                 |
| fluocinolone 0.01% solution           | Non Preferred | Generic | 11/01/19    |                     | Medication Coverage Exception     | Synalar        |                 |
| hydrocortisone 2.5% solution          | Non Preferred | Generic | 01/01/25    |                     | Medication Coverage Exception     | Texacort       |                 |
| hydrocortisone butyrate               | Non Preferred | Generic | 11/01/19    |                     | Medication Coverage Exception     |                |                 |
| Locoid                                | Non Preferred | Brand   | 11/01/19    |                     | Medication Coverage Exception     |                |                 |
| Synalar solution                      | Non Preferred | Brand   | 11/01/19    |                     | Medication Coverage Exception     |                |                 |
| Texacort                              | Non Preferred | Brand   | 10/01/13    |                     | Medication Coverage Exception     | Texacort       |                 |
| triamcinolone 0.05% ointment          | Non Preferred | Generic | 01/01/22    |                     | Medication Coverage Exception     |                |                 |
| Uceris                                | Non Preferred | Brand   | 01/01/22    |                     | Medication Coverage Exception     | Uceris         |                 |
| Steroid/Antifungal Combinations       |               |         |             |                     |                                   |                |                 |
| Preferred Drugs                       | Status        | Type    | Last Update | Limits              | Mandatory 3-Month                 | Brand Required | Additional Note |
| clotrimazole/betamethasone cre        | Preferred     | Generic | 12/01/19    |                     |                                   |                |                 |
| nystatin/triamcinolone                | Preferred     | Generic | 01/01/22    |                     |                                   |                |                 |
| Non Preferred Drugs                   | Status        | Type    | Last Update | Limits              | Required Prior Authorization Form | Brand Required | Additional Note |
| clotrimazole/betamethasone lotion     | Non Preferred | Generic | 12/01/19    |                     | Medication Coverage Exception     |                |                 |
| Mycozyl HC                            | Non Preferred | Brand   | 02/01/24    |                     | Medication Coverage Exception     |                |                 |
| Local Anesthetic Agents               |               |         |             |                     |                                   |                |                 |
| Preferred Drugs                       | Status        | Type    | Last Update | Limits              | Mandatory 3-Month                 | Brand Required | Additional Note |
| lidocaine cream (except 4.12%)        | Preferred     | Generic | 01/01/15    | 60 grams /30 days   |                                   |                |                 |
| lidocaine gel                         | Preferred     | Generic | 01/01/15    | 60 grams /30 days   |                                   |                |                 |
| lidocaine ointment                    | Preferred     | Generic | 01/01/15    | 60 grams /30 days   |                                   |                |                 |
| lidocaine patch                       | Preferred     | Generic | 03/01/23    | 90 patches /30 days |                                   |                |                 |
| lidocaine solution                    | Preferred     | Generic | 01/01/15    | 60 ml /30 days      |                                   |                |                 |
| lidocaine/hydrocortisone rectal cream | Preferred     | Generic | 01/01/15    | 60 grams /30 days   |                                   |                |                 |
| lidocaine/prilocaine                  | Preferred     | Generic | 11/01/16    | 60 grams /30 days   |                                   |                |                 |
| Lidoderm                              | Preferred     | Brand   | 11/01/21    | 90 patches /30 days |                                   |                |                 |

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| Non Preferred Drugs                 | Status        | Type    | Last Update | Limits                   | Required Prior Authorization Form | Brand Required | Additional Note |
|-------------------------------------|---------------|---------|-------------|--------------------------|-----------------------------------|----------------|-----------------|
| Bruselix                            | Non Preferred | Brand   | 07/01/24    | 60 grams /30 days        | Medication Coverage Exception     |                |                 |
| Epifoam                             | Non Preferred | Brand   | 01/01/15    |                          | Medication Coverage Exception     |                |                 |
| lidocaine 4.12% cream               | Non Preferred | Generic | 01/01/24    | 60 grams /30 days        | Medication Coverage Exception     |                |                 |
| lidocaine/hydrocortisone rectal gel | Non Preferred | Generic | 01/01/15    | 60 grams /30 days        | Medication Coverage Exception     |                |                 |
| Lidogel                             | Non Preferred | Brand   | 09/01/21    | 60 grams /30 days        | Medication Coverage Exception     |                |                 |
| Lidorex                             | Non Preferred | Brand   | 12/01/23    | 60 grams /30 days        | Medication Coverage Exception     |                |                 |
| Lidotral                            | Non Preferred | Brand   | 12/01/23    | 60 grams /30 days        | Medication Coverage Exception     |                |                 |
| Lidotral/hydrocortisone             | Non Preferred | Brand   | 07/01/24    | 60 grams /30 days        | Medication Coverage Exception     |                |                 |
| Lidotran                            | Non Preferred | Brand   | 12/01/23    | 60 grams /30 days        | Medication Coverage Exception     |                |                 |
| Pliaglis                            | Non Preferred | Brand   | 11/01/18    | 60 grams /30 days        | Medication Coverage Exception     |                |                 |
| Proctofoam                          | Non Preferred | Brand   | 01/01/15    |                          | Medication Coverage Exception     |                |                 |
| Qutenza                             | Non Preferred | Brand   | 12/01/22    | 4/fill, one fill/90 days | Medication Coverage Exception     |                |                 |
| Synera                              | Non Preferred | Brand   | 01/01/15    | 5 patches /30 days       | Medication Coverage Exception     |                |                 |
| Ztlido                              | Non Preferred | Brand   | 02/01/19    | 3 patches /day           | Medication Coverage Exception     |                |                 |
| Scabicides/Pediculicides            |               |         |             |                          |                                   |                |                 |
| Preferred Drugs                     | Status        | Type    | Last Update | Limits                   | Mandatory 3-Month                 | Brand Required | Additional Note |
| Natroba                             | Preferred     | Generic | 01/01/22    |                          |                                   | Natroba        |                 |
| permethrin                          | Preferred     | Generic | 01/01/15    |                          |                                   |                |                 |
| Vanalice                            | Preferred     | Brand   | 01/01/20    |                          |                                   |                |                 |
| Non Preferred Drugs                 | Status        | Type    | Last Update | Limits                   | Required Prior Authorization Form | Brand Required | Additional Note |
| Crotan                              | Non Preferred | Brand   | 11/01/18    |                          | Medication Coverage Exception     |                |                 |
| Eurax                               | Non Preferred | Brand   | 11/01/18    |                          | Medication Coverage Exception     |                |                 |
| ivermectin lotion                   | Non Preferred | Generic | 01/01/22    |                          | Medication Coverage Exception     |                |                 |
| lindane                             | Non Preferred | Generic | 01/01/16    |                          | Medication Coverage Exception     |                |                 |
| malathion                           | Non Preferred | Generic | 01/01/15    |                          | Medication Coverage Exception     |                |                 |
| Ovide                               | Non Preferred | Brand   | 01/01/15    |                          | Medication Coverage Exception     |                |                 |
| spinosad                            | Non Preferred | Generic | 01/01/15    |                          | Medication Coverage Exception     | Natroba        |                 |

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| Diagnostic Products                                                                                                                               |               |       |             |                         |                                                                                          |                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-------|-------------|-------------------------|------------------------------------------------------------------------------------------|---------------------------------------------|
| Diabetic Continuous Glucose Monitors                                                                                                              |               |       |             |                         |                                                                                          |                                             |
| Preferred Product                                                                                                                                 | Status        | Type  | Last Update | Limits                  | Required Prior Authorization Form                                                        | Covered NDCs                                |
| Dexcom G6 Receiver                                                                                                                                | Preferred     | Brand | 04/01/21    | 1 receiver /365 days    | Continuous Glucose Monitor                                                               | 08627-0091-11                               |
| Dexcom G6 Sensor                                                                                                                                  | Preferred     | Brand | 04/01/21    | 3 sensors /30 days      | Continuous Glucose Monitor                                                               | 08627-0053-03                               |
| Dexcom G6 Transmitter                                                                                                                             | Preferred     | Brand | 04/01/21    | 1 transmitter /90 days  | Continuous Glucose Monitor                                                               | 08627-0016-01                               |
| Dexcom G7 Receiver                                                                                                                                | Preferred     | Brand | 01/01/23    | 1 receiver /365 days    | Continuous Glucose Monitor                                                               | 08627-0078-01                               |
| Dexcom G7 Sensor                                                                                                                                  | Preferred     | Brand | 01/01/23    | 3 sensors /30 days      | Continuous Glucose Monitor                                                               | 08627-0077-01                               |
| Non Preferred Product                                                                                                                             | Status        | Type  | Last Update | Limits                  | Required Prior Authorization Form                                                        | Covered NDCs                                |
| FreeStyle Libre Reader                                                                                                                            | Non Preferred | Brand | 04/01/21    | 1 reader /365 days      | Continuous Glucose Monitor                                                               | 57599-0000-21, 57599-0002-00, 57599-0803-00 |
| FreeStyle Libre Sensor                                                                                                                            | Non Preferred | Brand | 08/01/25    | 2 sensors/28 days       | Continuous Glucose Monitor                                                               | 57599-0000-19, 57599-0001-01, 57599-0800-00 |
| Guardian Connect Transmitter                                                                                                                      | Non Preferred | Brand | 04/01/21    | 1 transmitter /365 days | Continuous Glucose Monitor                                                               | 63000-0285-85                               |
| Guardian 4 Transmitter                                                                                                                            | Non Preferred | Brand | 01/01/25    | 1 transmitter /365 days | Continuous Glucose Monitor                                                               | 63000-0445-15, 63000-0445-16                |
| Guardian Sensor 3                                                                                                                                 | Non Preferred | Brand | 04/01/21    | 1 pack /30 days         | Continuous Glucose Monitor                                                               | 63000-0358-44                               |
| Guardian Sensor 4                                                                                                                                 | Non Preferred | Brand | 01/01/25    | 1 pack /30 days         | Continuous Glucose Monitor                                                               | 63000-0413-38, 63000-0519-68                |
| Diabetic Glucose Meters                                                                                                                           |               |       |             |                         |                                                                                          |                                             |
| • Nursing Home Members - OTC Diabetic test supplies are not covered through the outpatient pharmacy benefit program for members in nursing homes. |               |       |             |                         |                                                                                          |                                             |
| • DME - Non-preferred products must be approved and billed through Durable Medical Equipment (DME).                                               |               |       |             |                         |                                                                                          |                                             |
| Preferred Product                                                                                                                                 | Status        | Type  | Last Update | Limits                  | Covered NDCs                                                                             |                                             |
| FreeStyle                                                                                                                                         | Preferred     | Brand | 01/01/18    |                         | 99073-0709-14, 99073-0708-05                                                             |                                             |
| Precision                                                                                                                                         | Preferred     | Brand | 01/01/18    |                         | 57599-8814-01, 57599-5175-01                                                             |                                             |
| Non Preferred Product                                                                                                                             | Status        | Type  | Last Update | Limits                  | Additional Note                                                                          |                                             |
| All other Glucose Meters                                                                                                                          | Non Preferred | All   | 01/01/18    |                         | Must be approved and billed through DME.                                                 |                                             |
| Diabetic Testing Strips                                                                                                                           |               |       |             |                         |                                                                                          |                                             |
| • Nursing Home Members - OTC Diabetic test supplies are not covered through the outpatient pharmacy benefit program for members in nursing homes. |               |       |             |                         |                                                                                          |                                             |
| • DME - Non-preferred products must be approved and billed through Durable Medical Equipment (DME).                                               |               |       |             |                         |                                                                                          |                                             |
| Preferred Product                                                                                                                                 | Status        | Type  | Last Update | Limits                  | Covered NDCs                                                                             |                                             |
| Freestyle Test Strips                                                                                                                             | Preferred     | Brand | 01/01/18    | 200 strips /30 days     | 99073-0120-50, 99073-0121-01, 99073-0708-22, 99073-0708-27, 99073-0712-27, 99073-0712-31 |                                             |
| Precision Test Strips                                                                                                                             | Preferred     | Brand | 01/01/18    | 200 strips /30 days     | 57599-9728-04, 57599-9877-05, 57599-1577-01, 57599-1579-04                               |                                             |
| Non Preferred Product                                                                                                                             | Status        | Type  | Last Update | Limits                  | Additional Note                                                                          |                                             |
| All other diabetic test strips                                                                                                                    | Non Preferred | All   | 01/01/18    |                         | Must be approved and billed through DME.                                                 |                                             |

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| Diabetic Testing Lancets                                                                                                                           |               |         |             |                    |                                                                                                                                                                                                                                                                                             |                |                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------|-------------|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------|
| • Nursing Home Members - OTC Diabetic test supplies are not covered through the outpatient pharmacy benefit program for members in nursing homes.  |               |         |             |                    |                                                                                                                                                                                                                                                                                             |                |                 |
| • DME - Non-preferred products must be approved and billed through Durable Medical Equipment (DME).                                                |               |         |             |                    |                                                                                                                                                                                                                                                                                             |                |                 |
| Preferred Product                                                                                                                                  | Status        | Type    | Last Update | Limits             | Covered NDCs                                                                                                                                                                                                                                                                                |                |                 |
| Autolet lancing device                                                                                                                             | Preferred     | Brand   | 01/01/22    |                    | 08470-0270-01                                                                                                                                                                                                                                                                               |                |                 |
| Unilet lancets                                                                                                                                     | Preferred     | Brand   | 01/01/22    | 200 units /30 days | 08470-0565-01, 08470-0575-01, 08470-0585-01                                                                                                                                                                                                                                                 |                |                 |
| Unistik lancets                                                                                                                                    | Preferred     | Brand   | 01/01/22    | 200 units /30 days | 08470-1002-01, 08470-1004-01, 08470-1012-01, 08470-1014-01, 08470-1022-01, 08470-1024-01, 08470-1042-01, 08470-1044-01, 08470-1402-01, 08470-1404-01, 08470-1412-01, 08470-1414-01, 08470-1422-01, 08470-1424-01, 08470-1442-01, 08470-1444-01, 08470-1614-01, 08470-1634-01, 08470-1644-01 |                |                 |
| Non Preferred Product                                                                                                                              | Status        | Type    | Last Update | Limits             | Additional Note                                                                                                                                                                                                                                                                             |                |                 |
| All other lancets                                                                                                                                  | Non Preferred | All     | 01/01/18    |                    | Must be approved and billed through DME.                                                                                                                                                                                                                                                    |                |                 |
| Epinephrine                                                                                                                                        |               |         |             |                    |                                                                                                                                                                                                                                                                                             |                |                 |
| Injection Devices                                                                                                                                  |               |         |             |                    |                                                                                                                                                                                                                                                                                             |                |                 |
| Preferred Drugs                                                                                                                                    | Status        | Type    | Last Update | Limits             | Covered NDCs                                                                                                                                                                                                                                                                                |                |                 |
| Mylan epinephrine                                                                                                                                  | Preferred     | Generic | 01/01/18    |                    | 49502-0102-01, 4950-0102-02, 49502-0101-01, 49502-0101-02                                                                                                                                                                                                                                   |                |                 |
| Non Preferred Drugs                                                                                                                                | Status        | Type    | Last Update | Limits             | Required Prior Authorization Form                                                                                                                                                                                                                                                           | Brand Required | Additional Note |
| Auvi-Q                                                                                                                                             | Non Preferred | Brand   | 06/01/23    |                    | Medication Coverage Exception                                                                                                                                                                                                                                                               |                |                 |
| epinephrine                                                                                                                                        | Non Preferred | Generic | 01/01/18    |                    | Medication Coverage Exception                                                                                                                                                                                                                                                               |                |                 |
| EpiPen                                                                                                                                             | Non Preferred | Brand   | 01/01/18    |                    | Medication Coverage Exception                                                                                                                                                                                                                                                               |                |                 |
| Neffy                                                                                                                                              | Non Preferred | Brand   | 05/01/25    |                    | Medication Coverage Exception                                                                                                                                                                                                                                                               |                |                 |
| Symjepi                                                                                                                                            | Non Preferred | Brand   | 08/01/19    |                    | Medication Coverage Exception                                                                                                                                                                                                                                                               |                |                 |
| Estrogens                                                                                                                                          |               |         |             |                    |                                                                                                                                                                                                                                                                                             |                |                 |
| • Gender Dysphoria: When used for the treatment of Gender Dysphoria, the Hormone Therapy for Gender Dysphoria prior authorization form is required |               |         |             |                    |                                                                                                                                                                                                                                                                                             |                |                 |
| Oral Single Ingredient                                                                                                                             |               |         |             |                    |                                                                                                                                                                                                                                                                                             |                |                 |
| Preferred Drugs                                                                                                                                    | Status        | Type    | Last Update | Limits             | Mandatory 3-Month                                                                                                                                                                                                                                                                           | Brand Required | Additional Note |
| estradiol                                                                                                                                          | Preferred     | Generic | 10/01/11    | Female only        | 84 Day Supply Required                                                                                                                                                                                                                                                                      |                |                 |
| Premarin                                                                                                                                           | Preferred     | Brand   | 01/01/17    | Female only        | 84 Day Supply Required                                                                                                                                                                                                                                                                      |                |                 |

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| Non Preferred Drugs            | Status        | Type    | Last Update | Limits      | Required Prior Authorization Form   | Brand Required | Additional Note |
|--------------------------------|---------------|---------|-------------|-------------|-------------------------------------|----------------|-----------------|
| Estrace tablet                 | Non Preferred | Brand   | 10/01/11    | Female only | Medication Coverage Exception       |                |                 |
| Menest                         | Non Preferred | Brand   | 01/01/20    | Female only | Medication Coverage Exception       |                |                 |
| Oral Combination               |               |         |             |             |                                     |                |                 |
| Preferred Drugs                | Status        | Type    | Last Update | Limits      | Mandatory 3-Month                   | Brand Required | Additional Note |
| Angeliq                        | Preferred     | Brand   | 01/01/19    | Female only | 84 Day Supply Required              |                |                 |
| Premphase                      | Preferred     | Brand   | 01/01/17    | Female only | 84 Day Supply Required              |                |                 |
| Prempro                        | Preferred     | Brand   | 10/01/11    | Female only | 84 Day Supply Required              |                |                 |
| Non Preferred Drugs            | Status        | Type    | Last Update | Limits      | Required Prior Authorization Form   | Brand Required | Additional Note |
| Abigale Lo                     | Non Preferred | Generic | 08/01/25    | Female only | Medication Coverage Exception       |                |                 |
| Activella                      | Non Preferred | Brand   | 01/01/19    | Female only | Medication Coverage Exception       |                |                 |
| amabelz                        | Non Preferred | Generic | 01/01/18    | Female only | Medication Coverage Exception       |                |                 |
| Bijuva                         | Non Preferred | Brand   | 03/01/19    | Female only | Medication Coverage Exception       |                |                 |
| Duavee                         | Non Preferred | Brand   | 11/01/16    | Female only | Medication Coverage Exception       |                |                 |
| estradiol/norethindrone        | Non Preferred | Generic | 01/01/18    | Female only | Medication Coverage Exception       |                |                 |
| estrogens/methyltestosterone   | Non Preferred | Generic | 06/01/23    | Female only | Medication Coverage Exception       |                |                 |
| fyavolv                        | Non Preferred | Generic | 11/01/16    | Female only | Medication Coverage Exception       |                |                 |
| jinteli                        | Non Preferred | Generic | 10/01/11    | Female only | Medication Coverage Exception       |                |                 |
| mimvey                         | Non Preferred | Generic | 10/01/11    | Female only | Medication Coverage Exception       |                |                 |
| Prefest                        | Non Preferred | Brand   | 10/01/11    | Female only | Medication Coverage Exception       |                |                 |
| Topical & Miscellaneous        |               |         |             |             |                                     |                |                 |
| Preferred Drugs                | Status        | Type    | Last Update | Limits      | Mandatory 3-Month/ Required PA Form | Brand Required | Additional Note |
| Climara Pro                    | Preferred     | Brand   | 01/01/16    | Female only | 84 Day Supply Required              |                |                 |
| Combipatch patch               | Preferred     | Brand   | 01/01/14    | Female only | 84 Day Supply Required              |                |                 |
| Elestrin gel                   | Preferred     | Brand   | 01/01/18    | Female only |                                     |                |                 |
| Evamist spray                  | Preferred     | Brand   | 01/01/19    | Female only |                                     |                |                 |
| Minivelle patch                | Preferred     | Brand   | 01/01/25    | Female only |                                     |                |                 |
| Vivelle-Dot patch              | Preferred     | Brand   | 05/01/25    | Female only |                                     |                |                 |
| Non Preferred Drugs            | Status        | Type    | Last Update | Limits      | Required Prior Authorization Form   | Brand Required | Additional Note |
| Climara patch                  | Non Preferred | Brand   | 01/01/16    | Female only | Medication Coverage Exception       |                |                 |
| Divigel                        | Non Preferred | Brand   | 01/01/23    | Female only | Medication Coverage Exception       |                |                 |
| estradiol gel                  | Non Preferred | Generic | 11/01/24    | Female only | Medication Coverage Exception       |                |                 |
| estradiol patch (once weekly)  | Non Preferred | Generic | 10/01/11    | Female only | Medication Coverage Exception       |                |                 |
| estradiol patch (twice weekly) | Non Preferred | Generic | 10/01/11    | Female only | Medication Coverage Exception       |                |                 |
| Menostar                       | Non Preferred | Brand   | 01/01/22    | Female only | Medication Coverage Exception       |                |                 |

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| Vaginal                         |               |         |             |             |                                   |                |                 |
|---------------------------------|---------------|---------|-------------|-------------|-----------------------------------|----------------|-----------------|
| Preferred Drugs                 | Status        | Type    | Last Update | Limits      | Mandatory 3-Month                 | Brand Required | Additional Note |
| Estring                         | Preferred     | Brand   | 01/01/20    | Female only | 90 Day Supply Required            |                |                 |
| Femring                         | Preferred     | Brand   | 01/02/20    | Female only | 90 Day Supply Required            |                |                 |
| Premarin cream                  | Preferred     | Brand   | 10/01/11    | Female only |                                   |                |                 |
| Vagifem                         | Preferred     | Brand   | 01/01/17    | Female only |                                   | Vagifem        |                 |
| Non Preferred Drugs             | Status        | Type    | Last Update | Limits      | Required Prior Authorization Form | Brand Required | Additional Note |
| Estrace cream                   | Non Preferred | Brand   | 02/01/18    | Female only | Medication Coverage Exception     |                |                 |
| estradiol cream                 | Non Preferred | Generic | 02/01/18    | Female only | Medication Coverage Exception     |                |                 |
| estradiol vaginal tablet        | Non Preferred | Generic | 01/01/17    | Female only | Medication Coverage Exception     | Vagifem        |                 |
| Gastrointestinal (GI)           |               |         |             |             |                                   |                |                 |
| Antiemetics - Anticholinergics  |               |         |             |             |                                   |                |                 |
| Preferred Drugs                 | Status        | Type    | Last Update | Limits      | Mandatory 3-Month                 | Brand Required | Additional Note |
| Diclegis                        | Preferred     | Brand   | 01/01/21    |             |                                   | Diclegis       |                 |
| meclizine                       | Preferred     | Generic | 11/01/16    |             |                                   |                |                 |
| prochlorperazine tablet         | Preferred     | Generic | 01/01/15    |             |                                   |                |                 |
| promethazine 12.5mg suppository | Preferred     | Generic | 12/01/23    |             |                                   |                |                 |
| promethazine 25mg suppository   | Preferred     | Generic | 01/01/15    |             |                                   |                |                 |
| promethazine injection          | Preferred     | Generic | 12/01/23    |             |                                   |                |                 |
| promethazine syrup              | Preferred     | Generic | 12/01/23    |             |                                   |                |                 |
| promethazine tablet             | Preferred     | Generic | 01/01/15    |             |                                   |                |                 |
| Tigan capsule                   | Preferred     | Brand   | 01/01/15    |             |                                   | Tigan          |                 |
| Non Preferred Drugs             | Status        | Type    | Last Update | Limits      | Required Prior Authorization Form | Brand Required | Additional Note |
| Antivert                        | Non Preferred | Brand   | 12/01/22    |             | Medication Coverage Exception     |                |                 |
| Bonjesta                        | Non Preferred | Brand   | 01/01/22    |             | Medication Coverage Exception     |                |                 |
| Compro suppository              | Non Preferred | Brand   | 01/01/15    |             | Medication Coverage Exception     |                |                 |
| dimenhydrinate injection        | Non Preferred | Generic | 01/01/15    |             | Medication Coverage Exception     |                |                 |
| doxylamine/pyridoxine           | Non Preferred | Generic | 07/01/19    |             | Medication Coverage Exception     | Diclegis       |                 |
| Phenergan                       | Non Preferred | Brand   | 01/01/15    |             | Medication Coverage Exception     |                |                 |
| prochlorperazine suppository    | Non Preferred | Generic | 01/01/15    |             | Medication Coverage Exception     |                |                 |



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| Drug / Product Name                 | Status        | Type    | Updated     | Limits                     | PA Form / 3-Month Req'd           | Brand Req'd    | Additional Note                                       |
|-------------------------------------|---------------|---------|-------------|----------------------------|-----------------------------------|----------------|-------------------------------------------------------|
| prochlorperazine injection          | Non Preferred | Generic | 12/01/21    |                            | Medication Coverage Exception     |                | Covered under medical benefit using appropriate HCPCS |
| promethazine 50mg suppository       | Non Preferred | Generic | 12/01/22    |                            | Medication Coverage Exception     |                |                                                       |
| scopolamine                         | Non Preferred | Generic | 06/01/16    |                            | Medication Coverage Exception     |                |                                                       |
| Tigan injection                     | Non Preferred | Brand   | 01/01/15    |                            | Medication Coverage Exception     |                |                                                       |
| Transderm-SC                        | Non Preferred | Brand   | 06/01/16    |                            | Medication Coverage Exception     |                |                                                       |
| trimethobenzamide capsule           | Non Preferred | Generic | 01/01/15    |                            | Medication Coverage Exception     | Tigan          |                                                       |
| Bowel Evacuant Combinations         |               |         |             |                            |                                   |                |                                                       |
| Preferred Drugs                     | Status        | Type    | Last Update | Limits                     | Mandatory 3-Month                 | Brand Required | Additional Note                                       |
| Clenpiq                             | Preferred     | Brand   | 01/01/25    |                            |                                   |                |                                                       |
| gavilyte-c                          | Preferred     | Generic | 01/01/18    |                            |                                   |                |                                                       |
| gavilyte-g                          | Preferred     | Generic | 01/01/18    |                            |                                   |                |                                                       |
| gavilyte-n                          | Preferred     | Generic | 01/01/18    |                            |                                   |                |                                                       |
| Moviprep                            | Preferred     | Brand   | 06/01/21    |                            |                                   | Moviprep       |                                                       |
| Golytely                            | Preferred     | Brand   | 01/01/16    |                            |                                   |                |                                                       |
| PEG-3350/electrolytes               | Preferred     | Generic | 01/01/18    | Cumulative: 1054g /30 days |                                   |                |                                                       |
| Non Preferred Drugs                 | Status        | Type    | Last Update | Limits                     | Required Prior Authorization Form | Brand Required | Additional Note                                       |
| NaSO4 / KSO4 / MgSO4                | Non Preferred | Generic | 08/01/22    |                            | Medication Coverage Exception     |                |                                                       |
| PEG 3350/electrolytes/ascorbic acid | Non Preferred | Generic | 10/01/20    |                            | Medication Coverage Exception     |                |                                                       |
| PEG/NASUL, NaCl/K                   | Non Preferred | Generic | 06/01/21    |                            | Medication Coverage Exception     | Moviprep       |                                                       |
| Plenvu                              | Non Preferred | Brand   | 09/01/18    |                            | Medication Coverage Exception     |                |                                                       |
| Suflave                             | Non Preferred | Brand   | 08/01/23    |                            | Medication Coverage Exception     |                |                                                       |
| Suprep                              | Non Preferred | Brand   | 01/01/16    |                            | Medication Coverage Exception     |                |                                                       |
| Sutab                               | Non Preferred | Brand   | 12/01/20    |                            | Medication Coverage Exception     |                |                                                       |
| PAMORAs                             |               |         |             |                            |                                   |                |                                                       |
| Preferred Drugs                     | Status        | Type    | Last Update | Limits                     | Required Prior Authorization Form | Brand Required | Additional Note                                       |
| Movantik                            | Preferred     | Brand   | 01/01/20    |                            | PAMORA                            |                |                                                       |
| Relistor inject                     | Preferred     | Brand   | 01/01/19    |                            | PAMORA                            |                |                                                       |
| Non Preferred Drugs                 | Status        | Type    | Last Update | Limits                     | Required Prior Authorization Form | Brand Required | Additional Note                                       |
| Relistor tablet                     | Non Preferred | Brand   | 01/01/19    |                            | PAMORA                            |                |                                                       |
| Symproic                            | Non Preferred | Brand   | 11/01/17    |                            | PAMORA                            |                |                                                       |



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| Oral - Inflammatory Bowel Agents   |               |         |             |        |                                   |                |                                 |
|------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|---------------------------------|
| Preferred Drugs                    | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                 |
| Apriso                             | Preferred     | Brand   | 01/01/20    |        |                                   | Apriso         |                                 |
| balsalazide                        | Preferred     | Generic | 07/01/14    |        |                                   |                |                                 |
| Delzicol                           | Non Preferred | Brand   | 09/01/21    |        |                                   | Delzicol       |                                 |
| Dipentum                           | Preferred     | Brand   | 01/01/19    |        |                                   |                |                                 |
| Lialda                             | Preferred     | Brand   | 01/01/18    |        |                                   | Lialda         |                                 |
| Pentasa                            | Preferred     | Brand   | 01/01/17    |        |                                   | Pentasa        |                                 |
| sulfasalazine                      | Preferred     | Generic | 07/01/14    |        |                                   |                |                                 |
| Non Preferred Drugs                | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                 |
| Azulfidine                         | Non Preferred | Brand   | 07/01/14    |        | Medication Coverage Exception     |                |                                 |
| Colazal                            | Non Preferred | Brand   | 07/01/14    |        | Medication Coverage Exception     |                |                                 |
| mesalamine DR capsule              | Non Preferred | Generic | 06/01/19    |        | Medication Coverage Exception     | Delzicol       |                                 |
| mesalamine DR tablet 1.2g          | Non Preferred | Generic | 01/01/18    |        | Medication Coverage Exception     | Lialda         |                                 |
| mesalamine DR tablet 800mg         | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     |                |                                 |
| mesalamine ER capsule 0.375g       | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     | Apriso         |                                 |
| mesalamine ER capsule 500mg        | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     | Pentasa        |                                 |
| Zeposia                            | Non Preferred | Brand   | 12/01/20    |        | Medication Coverage Exception     |                | Included in more than one class |
| Rectal - Inflammatory Bowel Agents |               |         |             |        |                                   |                |                                 |
| Preferred Drugs                    | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                 |
| mesalamine enema                   | Preferred     | Generic | 11/01/20    |        |                                   |                |                                 |
| mesalamine suppository             | Preferred     | Generic | 01/01/24    |        |                                   |                |                                 |
| SfRowasa enema                     | Preferred     | Brand   | 01/01/20    |        |                                   |                |                                 |
| Non Preferred Drugs                | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                 |
| Canasa suppository                 | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                                 |
| mesalamine kit                     | Non Preferred | Generic | 07/01/14    |        | Medication Coverage Exception     |                |                                 |
| Rowasa                             | Non Preferred | Brand   | 07/01/14    |        | Medication Coverage Exception     |                |                                 |
| Irritable Bowel Syndrome Agents    |               |         |             |        |                                   |                |                                 |
| Preferred Drugs                    | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                 |
| alosetron                          | Preferred     | Generic | 01/01/24    |        |                                   |                |                                 |
| Linzess                            | Preferred     | Brand   | 01/01/16    |        |                                   |                |                                 |
| lubiprostone                       | Preferred     | Generic | 01/01/24    |        |                                   |                |                                 |

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| Non Preferred Drugs     | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
|-------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Amitiza                 | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                 |
| Ibsrela                 | Non Preferred | Brand   | 05/01/22    |        | Medication Coverage Exception     |                |                 |
| Lotronex                | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                 |
| Trulance                | Non Preferred | Brand   | 03/01/17    |        | Medication Coverage Exception     |                |                 |
| Viberzi                 | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Pancreatic Enzymes      |               |         |             |        |                                   |                |                 |
| Preferred Drugs         | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Creon                   | Preferred     | Brand   | 08/01/11    |        |                                   |                |                 |
| Zenpep                  | Preferred     | Brand   | 08/01/11    |        |                                   |                |                 |
| Non Preferred Drugs     | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Pertzye                 | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Viokace                 | Non Preferred | Brand   | 12/01/17    |        | Medication Coverage Exception     |                |                 |
| Phosphate Binders       |               |         |             |        |                                   |                |                 |
| Preferred Drugs         | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| calcium acetate         | Preferred     | Generic | 10/15/15    |        |                                   |                |                 |
| Fosrenol chewable       | Preferred     | Brand   | 01/01/19    |        |                                   | Fosrenol       |                 |
| Phoslyra solution       | Preferred     | Brand   | 07/01/14    |        |                                   |                |                 |
| sevelamer carbonate     | Preferred     | Generic | 07/01/25    |        |                                   |                |                 |
| Non Preferred Drugs     | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Auryxia                 | Non Preferred | Brand   | 10/15/15    |        | Medication Coverage Exception     |                |                 |
| Fosrenol powder         | Non Preferred | Brand   | 05/01/23    |        | Medication Coverage Exception     |                |                 |
| lanthanum               | Non Preferred | Generic | 01/01/19    |        | Medication Coverage Exception     | Fosrenol       |                 |
| sevelamer carbonate     | Non Preferred | Generic | 01/01/21    |        | Medication Coverage Exception     | Renvela        |                 |
| sevelamer hydrochloride | Non Preferred | Generic | 03/01/19    |        | Medication Coverage Exception     |                |                 |
| Velphoro                | Non Preferred | Brand   | 07/01/14    |        | Medication Coverage Exception     |                |                 |

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| Proton Pump Inhibitors         |               |         |             |                                                  |                                   |                 |                 |
|--------------------------------|---------------|---------|-------------|--------------------------------------------------|-----------------------------------|-----------------|-----------------|
| Preferred Drugs                | Status        | Type    | Last Update | Limits                                           | Mandatory 3-Month                 | Brand Required  | Additional Note |
| Dexilant                       | Preferred     | Brand   | 01/01/18    |                                                  |                                   | Dexilant        |                 |
| esomeprazole capsule           | Preferred     | Generic | 04/01/18    |                                                  |                                   |                 |                 |
| lansoprazole ODT               | Preferred     | Generic | 01/01/23    | Members under 12 years old or with feeding tube. |                                   |                 |                 |
| omeprazole                     | Preferred     | Generic | 01/01/19    |                                                  | 90 Day Supply Required            |                 |                 |
| pantoprazole tablet, injection | Preferred     | Generic | 01/01/13    |                                                  | 90 Day Supply Required            |                 |                 |
| Non Preferred Drugs            | Status        | Type    | Last Update | Limits                                           | Required Prior Authorization Form | Brand Required  | Additional Note |
| Aciphex                        | Non Preferred | Brand   | 01/01/16    |                                                  | Medication Coverage Exception     |                 |                 |
| dexlansoprazole                | Non Preferred | Generic | 01/01/22    |                                                  | Medication Coverage Exception     | Dexilant        |                 |
| esomeprazole granules          | Non Preferred | Generic | 05/01/21    | Members under 12 years old or with feeding tube. | Medication Coverage Exception     | Nexium granules |                 |
| esomeprazole injection         | Non Preferred | Generic | 12/01/22    |                                                  | Medication Coverage Exception     |                 |                 |
| Konvomep                       | Non Preferred | Brand   | 06/01/23    |                                                  | Medication Coverage Exception     |                 |                 |
| lansoprazole capsule           | Non Preferred | Generic | 02/01/10    |                                                  | Medication Coverage Exception     |                 |                 |
| Nexium capsule                 | Non Preferred | Brand   | 04/01/18    |                                                  | Medication Coverage Exception     |                 |                 |
| Nexium granules                | Non Preferred | Brand   | 01/01/23    | Members under 12 years old or with feeding tube. | Medication Coverage Exception     | Nexium granules |                 |
| Nexium IV                      | Non Preferred | Brand   | 12/01/22    |                                                  | Medication Coverage Exception     |                 |                 |
| omeprazole/sodium bicarb ODT   | Non Preferred | Generic | 01/01/14    |                                                  | Medication Coverage Exception     |                 |                 |
| pantoprazole pak               | Non Preferred | Brand   | 06/01/18    |                                                  | Medication Coverage Exception     | Protonix pak    |                 |
| Prevacid capsule               | Non Preferred | Brand   | 02/01/10    |                                                  | Medication Coverage Exception     |                 |                 |
| Prevacid Solutabs              | Non Preferred | Brand   | 02/01/10    | Members under 12 years old or with feeding tube. | Medication Coverage Exception     |                 |                 |
| Prilosec                       | Non Preferred | Brand   | 01/01/18    |                                                  | Medication Coverage Exception     |                 |                 |
| Protonix pak                   | Non Preferred | Brand   | 06/01/18    |                                                  | Medication Coverage Exception     | Protonix pak    |                 |
| Protonix tablet, injection     | Non Preferred | Brand   | 06/01/18    |                                                  | Medication Coverage Exception     |                 |                 |
| rabeprazole                    | Non Preferred | Generic | 01/01/16    |                                                  | Medication Coverage Exception     |                 |                 |
| Voquezna                       | Non Preferred | Brand   | 11/01/24    |                                                  | Medication Coverage Exception     |                 |                 |
| Yosprala                       | Non Preferred | Brand   | 08/01/19    |                                                  | Medication Coverage Exception     |                 |                 |
| Zegerid                        | Non Preferred | Brand   | 01/01/14    |                                                  | Medication Coverage Exception     |                 |                 |
| Gout                           |               |         |             |                                                  |                                   |                 |                 |
| Acute Gout                     |               |         |             |                                                  |                                   |                 |                 |
| Preferred Drugs                | Status        | Type    | Last Update | Limits                                           | Mandatory 3-Month                 | Brand Required  | Additional Note |
| colchicine tablet              | Preferred     | Brand   | 01/01/24    |                                                  |                                   |                 |                 |
| probenecid/colchicine          | Preferred     | Generic | 01/01/19    |                                                  |                                   |                 |                 |

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| Non Preferred Drugs                      | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
|------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| colchicine capsule                       | Non Preferred | Generic | 01/01/19    |        | Medication Coverage Exception     | Mitigare       |                 |
| Colcrys                                  | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                 |
| Mitigare                                 | Non Preferred | Brand   | 01/01/21    |        | Medication Coverage Exception     | Mitigare       |                 |
| Chronic Gout                             |               |         |             |        |                                   |                |                 |
| Preferred Drugs                          | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| allopurinol tablet                       | Preferred     | Generic | 07/01/17    |        | 90 Day Supply Required            |                |                 |
| febuxostat                               | Preferred     | Generic | 01/01/24    |        |                                   |                |                 |
| probenecid                               | Preferred     | Generic | 07/01/17    |        |                                   |                |                 |
| Non Preferred Drugs                      | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| allopurinol injection                    | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     | Aloprim        |                 |
| Aloprim                                  | Non Preferred | Brand   | 12/01/20    |        | Medication Coverage Exception     | Aloprim        |                 |
| Uloric                                   | Non Preferred | Brand   | 08/01/19    |        | Medication Coverage Exception     |                |                 |
| Growth Hormone                           |               |         |             |        |                                   |                |                 |
| Preferred Drugs                          | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Genotropin                               | Preferred     | Brand   | 10/01/10    |        | Growth Hormone                    |                |                 |
| Norditropin                              | Preferred     | Brand   | 01/01/14    |        | Growth Hormone                    |                |                 |
| Non Preferred Drugs                      | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Humatrope                                | Non Preferred | Brand   | 01/01/15    |        | Growth Hormone                    |                |                 |
| Ngenla                                   | Non Preferred | Brand   | 09/01/23    |        | Growth Hormone                    |                |                 |
| Nutropin                                 | Non Preferred | Brand   | 01/01/13    |        | Growth Hormone                    |                |                 |
| Omnitrope                                | Non Preferred | Brand   | 01/01/13    |        | Growth Hormone                    |                |                 |
| Saizen                                   | Non Preferred | Brand   | 11/01/19    |        | Growth Hormone                    |                |                 |
| Serostim                                 | Non Preferred | Brand   | 10/01/10    |        | Growth Hormone                    |                |                 |
| Skytrofa                                 | Non Preferred | Brand   | 12/01/21    |        | Growth Hormone                    |                |                 |
| Sogroya                                  | Non Preferred | Brand   | 06/01/23    |        | Growth Hormone                    |                |                 |
| Zomacton                                 | Non Preferred | Brand   | 11/01/16    |        | Growth Hormone                    |                |                 |
| Hematopoietics                           |               |         |             |        |                                   |                |                 |
| Erythropoiesis Stimulating Agents (ESAs) |               |         |             |        |                                   |                |                 |
| Preferred Drugs                          | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Epogen                                   | Preferred     | Brand   | 01/01/18    |        |                                   |                |                 |
| Mircera                                  | Preferred     | Brand   | 01/01/22    |        |                                   |                |                 |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Non Preferred Drugs                             | Status        | Type  | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
|-------------------------------------------------|---------------|-------|-------------|--------|-----------------------------------|----------------|-----------------|
| Aranesp                                         | Non Preferred | Brand | 01/01/21    |        | Medication Coverage Exception     |                |                 |
| Procrit                                         | Non Preferred | Brand | 01/01/18    |        | Medication Coverage Exception     |                |                 |
| Retacrit                                        | Non Preferred | Brand | 01/01/22    |        | Medication Coverage Exception     |                |                 |
| Granulocyte Colony Stimulating Factors (G-CSFs) |               |       |             |        |                                   |                |                 |
| Preferred Drugs                                 | Status        | Type  | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Neupogen                                        | Preferred     | Brand | 01/01/23    |        |                                   |                |                 |
| Nyvepria                                        | Preferred     | Brand | 01/01/23    |        |                                   |                |                 |
| Non Preferred Drugs                             | Status        | Type  | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Fulphila                                        | Non Preferred | Brand | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| Fylmetra                                        | Non Preferred | Brand | 12/01/24    |        | Medication Coverage Exception     |                |                 |
| Granix                                          | Non Preferred | Brand | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| Leukine                                         | Non Preferred | Brand | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| Neulasta                                        | Non Preferred | Brand | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| Nivestym                                        | Non Preferred | Brand | 01/01/24    |        | Medication Coverage Exception     |                |                 |
| Releuko                                         | Non Preferred | Brand | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| Rolvedon                                        | Non Preferred | Brand | 11/01/23    |        | Medication Coverage Exception     |                |                 |
| Ryzneuta                                        | Non Preferred | Brand | 06/01/25    |        | Medication Coverage Exception     |                |                 |
| Stimufend                                       | Non Preferred | Brand | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| Udenyca                                         | Non Preferred | Brand | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| Zarxio                                          | Non Preferred | Brand | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| Ziextenzo                                       | Non Preferred | Brand | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| Immune Globulin                                 |               |       |             |        |                                   |                |                 |
| Preferred Drugs                                 | Status        | Type  | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Gamastan                                        | Preferred     | Brand | 07/01/20    |        | Immunoglobulin Therapy            |                |                 |
| Gammagard                                       | Preferred     | Brand | 07/01/20    |        | Immunoglobulin Therapy            |                |                 |
| Gammagard S/D                                   | Preferred     | Brand | 07/01/20    |        | Immunoglobulin Therapy            |                |                 |
| Gamunex-C                                       | Preferred     | Brand | 07/01/20    |        | Immunoglobulin Therapy            |                |                 |
| Non Preferred Drugs                             | Status        | Type  | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Alyglo                                          | Non Preferred | Brand | 07/01/24    |        | Immunoglobulin Therapy            |                |                 |
| Asceniv                                         | Non Preferred | Brand | 07/01/20    |        | Immunoglobulin Therapy            |                |                 |
| Bivigam                                         | Non Preferred | Brand | 07/01/20    |        | Immunoglobulin Therapy            |                |                 |
| Cutaquig                                        | Non Preferred | Brand | 07/01/20    |        | Immunoglobulin Therapy            |                |                 |
| Cuvitru                                         | Non Preferred | Brand | 07/01/20    |        | Immunoglobulin Therapy            |                |                 |
| Flebogamma                                      | Non Preferred | Brand | 07/01/20    |        | Immunoglobulin Therapy            |                |                 |

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| Drug / Product Name | Status        | Type  | Updated  | Limits | PA Form / 3-Month Req'd | Brand Req'd | Additional Note |
|---------------------|---------------|-------|----------|--------|-------------------------|-------------|-----------------|
| Gammaked            | Non Preferred | Brand | 07/01/20 |        | Immunoglobulin Therapy  |             |                 |
| Gammaplex           | Non Preferred | Brand | 07/01/20 |        | Immunoglobulin Therapy  |             |                 |
| Hizentra            | Non Preferred | Brand | 07/01/20 |        | Immunoglobulin Therapy  |             |                 |
| Hyqvia              | Non Preferred | Brand | 07/01/20 |        | Immunoglobulin Therapy  |             |                 |
| Nypozi              | Non Preferred | Brand | 12/01/24 |        | Immunoglobulin Therapy  |             |                 |
| Octagam             | Non Preferred | Brand | 07/01/20 |        | Immunoglobulin Therapy  |             |                 |
| Panzyga             | Non Preferred | Brand | 07/01/20 |        | Immunoglobulin Therapy  |             |                 |
| Privigen            | Non Preferred | Brand | 07/01/20 |        | Immunoglobulin Therapy  |             |                 |
| Xembify             | Non Preferred | Brand | 07/01/20 |        | Immunoglobulin Therapy  |             |                 |

### Prenatal Vitamins

| Preferred Drugs                  | Status        | Type    | Last Update | Limits                  | Mandatory 3-Month                 | Brand Required | Additional Note |
|----------------------------------|---------------|---------|-------------|-------------------------|-----------------------------------|----------------|-----------------|
| Select-OB+DHA                    | Preferred     | Brand   | 01/01/18    | Member must be pregnant |                                   |                |                 |
| Vitafol Fe+                      | Preferred     | Brand   | 01/01/17    | Member must be pregnant |                                   |                |                 |
| Vitafol Gummies                  | Preferred     | Brand   | 01/01/19    | Member must be pregnant |                                   |                |                 |
| Vitafol One                      | Preferred     | Brand   | 01/01/18    | Member must be pregnant |                                   |                |                 |
| Vitafol Ultra                    | Preferred     | Brand   | 01/01/17    | Member must be pregnant |                                   |                |                 |
| Vitafol-OB+DHA                   | Preferred     | Brand   | 04/01/17    | Member must be pregnant |                                   |                |                 |
| ALL OTHER Prenatal w/ DHA/Folate | Preferred     | Generic | 01/01/16    | Member must be pregnant |                                   |                |                 |
| Non Preferred Drugs              | Status        | Type    | Last Update | Limits                  | Required Prior Authorization Form | Brand Required | Additional Note |
| ALL NON-DHA/Folate products      | Non Preferred | Generic | 01/01/16    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| Citranatal 90 DHA                | Non Preferred | Brand   | 01/01/24    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| Citranatal Assure                | Non Preferred | Brand   | 01/01/24    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| Citranatal Bloom                 | Non Preferred | Brand   | 01/01/24    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| Citranatal DHA                   | Non Preferred | Brand   | 04/01/23    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| Citranatal Harmony               | Non Preferred | Brand   | 01/01/24    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| C-Nate DHA                       | Non Preferred | Brand   | 01/01/19    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| Enbrace HR                       | Non Preferred | Brand   | 11/01/19    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| Nestabs One                      | Non Preferred | Brand   | 01/01/19    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| OB Complete, Gold, Petite, DHA   | Non Preferred | Brand   | 01/01/19    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| PNV DHA                          | Non Preferred | Brand   | 01/01/21    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| PNV Omega                        | Non Preferred | Brand   | 01/01/19    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| Prenaisance                      | Non Preferred | Brand   | 01/01/19    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| Prenate DHA                      | Non Preferred | Brand   | 01/01/15    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| Prenate Enhance                  | Non Preferred | Brand   | 01/01/18    | Member must be pregnant | Medication Coverage Exception     |                |                 |
| Prenate Essential                | Non Preferred | Brand   | 01/01/15    | Member must be pregnant | Medication Coverage Exception     |                |                 |



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| Drug / Product Name | Status        | Type  | Updated  | Limits                  | PA Form / 3-Month Req'd       | Brand Req'd | Additional Note |
|---------------------|---------------|-------|----------|-------------------------|-------------------------------|-------------|-----------------|
| Prenate Max         | Non Preferred | Brand | 05/01/25 | Member must be pregnant | Medication Coverage Exception |             |                 |
| Prenate Mini        | Non Preferred | Brand | 01/01/16 | Member must be pregnant | Medication Coverage Exception |             |                 |
| Prenate Pixie       | Non Preferred | Brand | 01/01/15 | Member must be pregnant | Medication Coverage Exception |             |                 |
| Prenate Restore     | Non Preferred | Brand | 01/01/17 | Member must be pregnant | Medication Coverage Exception |             |                 |
| Relnate DHA         | Non Preferred | Brand | 01/01/19 | Member must be pregnant | Medication Coverage Exception |             |                 |
| Taron-C DHA         | Non Preferred | Brand | 01/01/24 | Member must be pregnant | Medication Coverage Exception |             |                 |
| Taron-Prex          | Non Preferred | Brand | 01/01/20 | Member must be pregnant | Medication Coverage Exception |             |                 |
| Tristart DHA, One   | Non Preferred | Brand | 01/01/19 | Member must be pregnant | Medication Coverage Exception |             |                 |
| Tri-tabs DHA        | Non Preferred | Brand | 01/01/21 | Member must be pregnant | Medication Coverage Exception |             |                 |
| Vinate DHA          | Non Preferred | Brand | 01/01/15 | Member must be pregnant | Medication Coverage Exception |             |                 |
| Virt-C DHA          | Non Preferred | Brand | 01/01/24 | Member must be pregnant | Medication Coverage Exception |             |                 |
| Virt-Nate           | Non Preferred | Brand | 01/01/19 | Member must be pregnant | Medication Coverage Exception |             |                 |
| Wescap-C DHA        | Non Preferred | Brand | 01/01/24 | Member must be pregnant | Medication Coverage Exception |             |                 |
| Wesnate             | Non Preferred | Brand | 01/01/23 | Member must be pregnant | Medication Coverage Exception |             |                 |
| Zatean -PN          | Non Preferred | Brand | 01/01/19 | Member must be pregnant | Medication Coverage Exception |             |                 |

### Muscle Relaxants

#### Antispasmodic Agents

| Preferred Drugs              | Status        | Type    | Last Update | Limits                         | Mandatory 3-Month                 | Brand Required | Additional Note                                           |
|------------------------------|---------------|---------|-------------|--------------------------------|-----------------------------------|----------------|-----------------------------------------------------------|
| cyclobenzaprine 5, 10mg      | Preferred     | Generic | 09/28/09    | Cumulative: 90 units /30 days  |                                   |                |                                                           |
| methocarbamol 500 mg, 750 mg | Preferred     | Generic | 01/01/19    | Cumulative: 240 units /30 days |                                   |                | Inj covered under medical benefit using appropriate HCPCS |
| orphenadrine                 | Preferred     | Generic | 01/01/21    | Cumulative: 60 units /30 days  |                                   |                |                                                           |
| Non Preferred Drugs          | Status        | Type    | Last Update | Limits                         | Required Prior Authorization Form | Brand Required | Additional Note                                           |
| Amrix                        | Non Preferred | Brand   | 09/28/09    | Cumulative: 90 units /30 days  | Medication Coverage Exception     |                |                                                           |
| carisoprodol                 | Non Preferred | Generic | 01/01/14    | Cumulative:120 units /30 days  | Medication Coverage Exception     |                |                                                           |
| chlorzoxazone                | Non Preferred | Generic | 01/01/21    | Cumulative:120 units /30 days  | Medication Coverage Exception     |                |                                                           |
| cyclobenzaprine 7.5mg        | Non Preferred | Generic | 01/01/14    | Cumulative: 90 units /30 days  | Medication Coverage Exception     |                |                                                           |
| cyclobenzaprine ER           | Non Preferred | Generic | 01/01/22    | Cumulative: 90 units /30 days  | Medication Coverage Exception     |                |                                                           |
| Fexmid                       | Non Preferred | Brand   | 01/01/14    | Cumulative: 90 units /30 days  | Medication Coverage Exception     |                |                                                           |
| Lorzone                      | Non Preferred | Brand   | 01/01/14    | Cumulative:120 units /30 days  | Medication Coverage Exception     |                |                                                           |
| metaxalone                   | Non Preferred | Generic | 01/01/16    | Cumulative:120 units /30 days  | Medication Coverage Exception     |                |                                                           |
| methacarbamol 1000 mg        | Non Preferred | Generic | 01/04/25    | Cumulative: 240 units /30 days | Medication Coverage Exception     |                |                                                           |
| Robaxin injection            | Non Preferred | Brand   | 12/01/22    |                                | Medication Coverage Exception     |                | Covered under medical benefit using appropriate HCPCS     |
| Soma                         | Non Preferred | Brand   | 01/01/14    | Cumulative:120 units /30 days  | Medication Coverage Exception     |                |                                                           |
| Tanlor 1000 mg               | Non Preferred | Generic | 01/04/25    | Cumulative: 240 units /30 days | Medication Coverage Exception     |                |                                                           |



# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Antispasticity Agents           |               |                   |             |                               |                                   |                |                                                       |
|---------------------------------|---------------|-------------------|-------------|-------------------------------|-----------------------------------|----------------|-------------------------------------------------------|
| Preferred Drugs                 | Status        | Type              | Last Update | Limits                        | Mandatory 3-Month                 | Brand Required | Additional Note                                       |
| baclofen injection              | Preferred     | Brand/<br>Generic | 09/28/09    |                               |                                   |                | Covered under medical benefit using appropriate HCPCS |
| baclofen suspension             | Preferred     | Generic           | 08/01/22    |                               |                                   |                |                                                       |
| baclofen 5mg, 10mg, 20mg tablet | Preferred     | Generic           | 09/28/09    |                               |                                   |                |                                                       |
| tizanidine                      | Preferred     | Generic           | 04/01/22    | Cumulative:180 units /30 days |                                   |                |                                                       |
| Non Preferred Drugs             | Status        | Type              | Last Update | Limits                        | Required Prior Authorization Form | Brand Required | Additional Note                                       |
| baclofen 15mg tablet            | Non Preferred | Generic           | 07/01/24    |                               | Medication Coverage Exception     |                |                                                       |
| Dantrium                        | Non Preferred | Brand             | 01/01/13    | Cumulative:120 units /30 days | Medication Coverage Exception     |                |                                                       |
| dantrolene                      | Non Preferred | Generic           | 01/01/13    | Cumulative:120 units /30 days | Medication Coverage Exception     |                |                                                       |
| Fleqsuvy                        | Non Preferred | Brand             | 12/01/22    |                               | Medication Coverage Exception     |                |                                                       |
| Lioresal injection              | Non Preferred | Brand             | 04/01/23    |                               | Medication Coverage Exception     |                | Covered under medical benefit using appropriate HCPCS |
| Lyvispah                        | Non Preferred | Brand             | 06/01/22    |                               | Medication Coverage Exception     |                |                                                       |
| Zanaflex                        | Non Preferred | Brand             | 09/28/09    | Cumulative: 90 units /30 days | Medication Coverage Exception     |                |                                                       |
| Nasal                           |               |                   |             |                               |                                   |                |                                                       |
| Nasal - Antihistamines          |               |                   |             |                               |                                   |                |                                                       |
| Preferred Drugs                 | Status        | Type              | Last Update | Limits                        | Mandatory 3-Month                 | Brand Required | Additional Note                                       |
| azelastine 0.1%                 | Preferred     | Generic           | 01/01/19    |                               |                                   |                |                                                       |
| olopatadine                     | Preferred     | Generic           | 01/01/24    |                               |                                   |                |                                                       |
| Non Preferred Drugs             | Status        | Type              | Last Update | Limits                        | Required Prior Authorization Form | Brand Required | Additional Note                                       |
| azelastine 0.15%                | Non Preferred | Generic           | 01/01/19    |                               | Medication Coverage Exception     |                |                                                       |
| Nasal - Corticosteroids         |               |                   |             |                               |                                   |                |                                                       |
| Preferred Drugs                 | Status        | Type              | Last Update | Limits                        | Mandatory 3-Month                 | Brand Required | Additional Note                                       |
| Beconase AQ                     | Preferred     | Brand             | 01/01/13    |                               |                                   |                |                                                       |
| fluticasone                     | Preferred     | Generic           | 10/01/09    |                               |                                   |                |                                                       |
| mometasone                      | Preferred     | Generic           | 11/01/18    |                               |                                   |                |                                                       |
| Omnaris                         | Preferred     | Brand             | 01/01/22    |                               |                                   |                |                                                       |
| Non Preferred Drugs             | Status        | Type              | Last Update | Limits                        | Required Prior Authorization Form | Brand Required | Additional Note                                       |
| flunisolide                     | Non Preferred | Generic           | 01/01/19    |                               | Medication Coverage Exception     |                |                                                       |
| Qnasl                           | Non Preferred | Brand             | 01/01/13    |                               | Medication Coverage Exception     |                |                                                       |

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| Drug / Product Name                        | Status        | Type    | Updated     | Limits | PA Form / 3-Month Req'd           | Brand Req'd    | Additional Note |
|--------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Sinuva                                     | Non Preferred | Brand   | 06/01/20    |        | Medication Coverage Exception     |                |                 |
| Xhance                                     | Non Preferred | Brand   | 12/01/18    |        | Medication Coverage Exception     |                |                 |
| Zetonna                                    | Non Preferred | Brand   | 01/01/22    |        | Medication Coverage Exception     |                |                 |
| Neurological                               |               |         |             |        |                                   |                |                 |
| Parkinson - COMT Inhibitors & Combinations |               |         |             |        |                                   |                |                 |
| Preferred Drugs                            | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| amantadine                                 | Preferred     | Generic | 01/01/14    |        |                                   |                |                 |
| bromocriptine                              | Preferred     | Generic | 11/01/21    |        |                                   |                |                 |
| carbidopa/levodopa                         | Preferred     | Generic | 01/01/14    |        | 90 Day Supply Required            |                |                 |
| carbidopa/levodopa ER                      | Preferred     | Generic | 01/01/14    |        |                                   |                |                 |
| Duopa                                      | Preferred     | Brand   | 01/01/20    |        |                                   |                |                 |
| entacapone                                 | Preferred     | Generic | 01/01/19    |        |                                   |                |                 |
| Non Preferred Drugs                        | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| carbidopa                                  | Non Preferred | Generic | 11/01/16    |        | Medication Coverage Exception     |                |                 |
| carbidopa/levodopa ODT                     | Non Preferred | Generic | 10/01/09    |        | Medication Coverage Exception     |                |                 |
| carbidopa/levodopa/entacapone              | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Comtan                                     | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| Crexont                                    | Non Preferred | Brand   | 09/01/24    |        | Medication Coverage Exception     |                |                 |
| Dhivy                                      | Non Preferred | Brand   | 12/01/22    |        | Medication Coverage Exception     |                |                 |
| droxidopa                                  | Non Preferred | Generic | 03/01/21    |        | Medication Coverage Exception     |                |                 |
| Gocovri                                    | Non Preferred | Brand   | 10/01/17    |        | Medication Coverage Exception     |                |                 |
| Inbrija                                    | Non Preferred | Brand   | 03/01/19    |        | Medication Coverage Exception     |                |                 |
| Lodosyn                                    | Non Preferred | Brand   | 11/01/16    |        | Medication Coverage Exception     |                |                 |
| Northera                                   | Non Preferred | Brand   | 08/15/14    |        | Medication Coverage Exception     |                |                 |
| Ongentys                                   | Non Preferred | Brand   | 10/01/20    |        | Medication Coverage Exception     |                |                 |
| Osmolex ER                                 | Non Preferred | Brand   | 06/01/18    |        | Medication Coverage Exception     |                |                 |
| Parlodel                                   | Non Preferred | Brand   | 11/01/21    |        | Medication Coverage Exception     |                |                 |
| Rytary                                     | Non Preferred | Brand   | 10/01/15    |        | Medication Coverage Exception     |                |                 |
| Sinemet                                    | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Stalevo                                    | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Tasmar                                     | Non Preferred | Brand   | 10/01/09    |        | Medication Coverage Exception     |                |                 |
| tolcapone                                  | Non Preferred | Generic | 10/01/09    |        | Medication Coverage Exception     |                |                 |
| Vyalev                                     | Non Preferred | Brand   | 11/01/24    |        | Medication Coverage Exception     |                |                 |

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| Parkinson - MAO Inhibitors                                          |               |         |             |                                 |                                   |                |                                 |
|---------------------------------------------------------------------|---------------|---------|-------------|---------------------------------|-----------------------------------|----------------|---------------------------------|
| Preferred Drugs                                                     | Status        | Type    | Last Update | Limits                          | Mandatory 3-Month                 | Brand Required | Additional Note                 |
| Azilect                                                             | Preferred     | Brand   | 01/01/19    |                                 |                                   | Azilect        |                                 |
| selegiline                                                          | Preferred     | Generic | 02/01/10    |                                 |                                   |                |                                 |
| Non Preferred Drugs                                                 | Status        | Type    | Last Update | Limits                          | Required Prior Authorization Form | Brand Required | Additional Note                 |
| rasagiline                                                          | Non Preferred | Generic | 01/01/19    |                                 | Medication Coverage Exception     | Azilect        |                                 |
| Xadago                                                              | Non Preferred | Brand   | 06/01/17    |                                 | Medication Coverage Exception     |                |                                 |
| Zelapar                                                             | Non Preferred | Brand   | 01/01/24    |                                 | Medication Coverage Exception     |                |                                 |
| Parkinson - Non-ergot Derived Dopamine Receptor Agonists and Others |               |         |             |                                 |                                   |                |                                 |
| Preferred Drugs                                                     | Status        | Type    | Last Update | Limits                          | Mandatory 3-Month                 | Brand Required | Additional Note                 |
| pramipexole                                                         | Preferred     | Generic | 12/02/11    |                                 | 90 Day Supply Required            |                |                                 |
| ropinirole                                                          | Preferred     | Generic | 10/01/09    |                                 | 90 Day Supply Required            |                |                                 |
| Non Preferred Drugs                                                 | Status        | Type    | Last Update | Limits                          | Required Prior Authorization Form | Brand Required | Additional Note                 |
| Apokyn                                                              | Non Preferred | Brand   | 04/01/22    |                                 | Medication Coverage Exception     |                |                                 |
| apomorphine                                                         | Non Preferred | Generic | 04/01/22    |                                 | Medication Coverage Exception     |                |                                 |
| Kynmobi                                                             | Non Preferred | Brand   | 07/01/20    |                                 | Medication Coverage Exception     |                |                                 |
| Mirapex ER                                                          | Non Preferred | Generic | 01/01/20    |                                 | Medication Coverage Exception     | Mirapex ER     |                                 |
| Neupro patch                                                        | Non Preferred | Brand   | 10/01/09    |                                 | Medication Coverage Exception     |                |                                 |
| Nourianz                                                            | Non Preferred | Brand   | 10/01/19    |                                 | Medication Coverage Exception     |                |                                 |
| Nuplazid                                                            | Non Preferred | Brand   | 06/01/17    |                                 | Nuplazid                          |                |                                 |
| pramipexole ER                                                      | Non Preferred | Generic | 01/01/20    |                                 | Medication Coverage Exception     | Mirapex ER     |                                 |
| ropinirole ER                                                       | Non Preferred | Generic | 10/01/09    |                                 | Medication Coverage Exception     |                |                                 |
| Migraine - Abortive Therapy                                         |               |         |             |                                 |                                   |                |                                 |
| Preferred Drugs                                                     | Status        | Type    | Last Update | Limits                          | Required Prior Authorization Form | Brand Required | Additional Note                 |
| Nurtec ODT                                                          | Preferred     | Brand   | 06/01/20    | Cumulative: 8 units /30 days    | CGRP Prior Auth                   |                | Included in more than one class |
| Relpax                                                              | Preferred     | Brand   | 01/01/13    | Cumulative: 9 units /30 days    |                                   | Relpax         |                                 |
| rizatriptan                                                         | Preferred     | Generic | 01/01/17    | Cumulative: 9 units /30 days    |                                   |                |                                 |
| sumatriptan tablet                                                  | Preferred     | Generic | 01/01/13    | Cumulative: 9 units /30 days    |                                   |                |                                 |
| Non Preferred Drugs                                                 | Status        | Type    | Last Update | Limits                          | Required Prior Authorization Form | Brand Required | Additional Note                 |
| almotriptan                                                         | Non Preferred | Generic | 01/01/13    | Cumulative: 9 units /30 days    | Medication Coverage Exception     |                |                                 |
| butalbital/apap/caf/codeine                                         | Non Preferred | Generic | 05/01/17    | 20 tablets or capsules /30 days | Medication Coverage Exception     |                |                                 |
| butalbital/asa/caf/codeine                                          | Non Preferred | Brand   | 05/01/17    | 20 tablets or capsules /30 days | Medication Coverage Exception     |                |                                 |
| butorphanol nasal spray                                             | Non Preferred | Generic | 08/01/19    | 2.5ml /30 days                  | Medication Coverage Exception     |                |                                 |
| diclofenac powder                                                   | Non Preferred | Generic | 01/01/23    | Cumulative: 9 units /30 days    | Medication Coverage Exception     |                |                                 |
| dihydroergotamine                                                   | Non Preferred | Generic | 12/01/17    |                                 | Medication Coverage Exception     |                |                                 |

## Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Drug / Product Name             | Status        | Type    | Updated     | Limits                        | PA Form / 3-Month Req'd                | Brand Req'd    | Additional Note                 |
|---------------------------------|---------------|---------|-------------|-------------------------------|----------------------------------------|----------------|---------------------------------|
| eletriptan                      | Non Preferred | Generic | 09/01/17    | Cumulative: 9 units /30 days  | Medication Coverage Exception          | Relpax         |                                 |
| Elyxyb                          | Non Preferred | Brand   | 12/01/21    |                               | Medication Coverage Exception          |                |                                 |
| Fioricet/codeine                | Non Preferred | Brand   | 05/01/17    | 20 tablets/caps /30 days      | Medication Coverage Exception          |                |                                 |
| Frova                           | Non Preferred | Brand   | 04/01/16    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| frovatriptan                    | Non Preferred | Generic | 04/01/16    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| Imitrex injection               | Non Preferred | Brand   | 01/01/17    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| Imitrex spray                   | Non Preferred | Brand   | 01/01/17    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| Imitrex tablet                  | Non Preferred | Brand   | 01/01/12    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| Maxalt                          | Non Preferred | Brand   | 01/01/14    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| Migergot                        | Non Preferred | Brand   | 06/01/20    |                               | Medication Coverage Exception          |                |                                 |
| Migranal spray                  | Non Preferred | Brand   | 12/01/17    |                               | Medication Coverage Exception          |                |                                 |
| naratriptan                     | Non Preferred | Generic | 01/01/13    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| Reyvow                          | Non Preferred | Brand   | 02/01/20    | Cumulative: 8 units /30 days  | Reyvow Prior Auth                      |                |                                 |
| sumatriptan injection           | Non Preferred | Generic | 01/01/17    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| sumatriptan spray               | Non Preferred | Generic | 01/01/17    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| sumatriptan/naproxen            | Non Preferred | Generic | 09/28/09    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| Symbravo                        | Non Preferred | Brand   | 05/01/25    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| Tosymra                         | Non Preferred | Brand   | 10/01/19    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| Trudhesa                        | Non Preferred | Brand   | 10/01/21    | Cumulative: 8 units /30 days  | Medication Coverage Exception          |                |                                 |
| Ubrelyv                         | Non Preferred | Brand   | 02/01/20    | Cumulative: 16 units /30 days | CGRP Prior Auth                        |                |                                 |
| Zembrace                        | Non Preferred | Brand   | 04/01/16    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| zolmitriptan                    | Non Preferred | Generic | 06/01/13    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| Zavzpret                        | Non Preferred | Brand   | 06/01/23    | Cumulative: 8 units /30 days  | CGRP Prior Auth                        |                |                                 |
| Zomig                           | Non Preferred | Brand   | 06/01/13    | Cumulative: 9 units /30 days  | Medication Coverage Exception          |                |                                 |
| Migraine - Prophylactic Therapy |               |         |             |                               |                                        |                |                                 |
| Preferred Drugs                 | Status        | Type    | Last Update | Limits                        | Required PA Form/<br>Mandatory 3-Month | Brand Required | Additional Note                 |
| Aimovig                         | Preferred     | Brand   | 01/01/24    |                               | CGRP Prior Auth                        |                |                                 |
| Ajovy                           | Preferred     | Brand   | 01/01/21    |                               | CGRP Prior Auth                        |                |                                 |
| amitriptyline                   | Preferred     | Generic | 01/01/18    |                               |                                        |                | Included in more than one class |
| divalproex                      | Preferred     | Generic | 01/01/17    |                               | 90 Day Supply Required                 |                | Included in more than one class |
| propranolol                     | Preferred     | Generic | 04/01/13    |                               | 90 Day Supply Required                 |                | Included in more than one class |
| propranolol SR                  | Preferred     | Generic | 03/01/16    |                               |                                        |                | Included in more than one class |
| topiramate capsule              | Preferred     | Generic | 01/01/19    |                               |                                        |                | Included in more than one class |
| topiramate tablet               | Preferred     | Generic | 01/01/19    |                               | 90 Day Supply Required                 |                | Included in more than one class |

## Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Non Preferred Drugs                              | Status        | Type    | Last Update | Limits                        | Required Prior Authorization Form | Brand Required | Additional Note                                       |
|--------------------------------------------------|---------------|---------|-------------|-------------------------------|-----------------------------------|----------------|-------------------------------------------------------|
| Botox                                            | Non Preferred | Brand   | 01/01/19    |                               | Botox Prior Auth                  |                | Covered under medical benefit using appropriate HCPCS |
| Depakote                                         | Non Preferred | Brand   | 01/01/17    |                               | Medication Coverage Exception     |                | Included in more than one class                       |
| Emgality                                         | Non Preferred | Brand   | 01/01/19    |                               | CGRP Prior Auth                   |                |                                                       |
| Inderal LA                                       | Non Preferred | Brand   | 03/01/16    |                               | Medication Coverage Exception     |                | Included in more than one class                       |
| Inderal XL                                       | Non Preferred | Brand   | 03/01/16    |                               | Medication Coverage Exception     |                | Included in more than one class                       |
| Innopran XL                                      | Non Preferred | Brand   | 09/28/09    |                               | Medication Coverage Exception     |                | Included in more than one class                       |
| Nurtec ODT                                       | Non Preferred | Brand   | 09/01/22    | Cumulative: 16 units /30 days | CGRP Prior Auth                   |                | Included in more than one class                       |
| Qudexy XR                                        | Non Preferred | Brand   | 01/01/19    |                               | Medication Coverage Exception     |                | Included in more than one class                       |
| Qulipta                                          | Non Preferred | Brand   | 11/01/21    |                               | CGRP Prior Auth                   |                |                                                       |
| timolol                                          | Non Preferred | Generic | 01/01/21    |                               | Medication Coverage Exception     |                | Included in more than one class                       |
| Topamax                                          | Non Preferred | Generic | 10/01/16    |                               | Medication Coverage Exception     |                | Included in more than one class                       |
| topiramate ER capsule                            | Non Preferred | Generic | 01/01/19    |                               | Medication Coverage Exception     | Trokendi XR    | Included in more than one class                       |
| topiramate ER sprinkle capsule                   | Non Preferred | Generic | 01/01/19    |                               | Medication Coverage Exception     |                | Included in more than one class                       |
| Trokendi XR                                      | Non Preferred | Brand   | 10/01/16    |                               | Medication Coverage Exception     | Trokendi XR    | Included in more than one class                       |
| Vyepti                                           | Non Preferred | Brand   | 04/01/20    |                               | CGRP Prior Auth                   |                |                                                       |
| Movement Disorder Treatments - VMAT-2 Inhibitors |               |         |             |                               |                                   |                |                                                       |
| Preferred Drugs                                  | Status        | Type    | Last Update | Limits                        | Mandatory 3-Month                 | Brand Required | Additional Note                                       |
| Austedo, XR                                      | Preferred     | Brand   | 06/01/23    |                               |                                   |                |                                                       |
| tetrabenazine                                    | Preferred     | Generic | 01/01/20    |                               |                                   |                |                                                       |
| Non Preferred Drugs                              | Status        | Type    | Last Update | Limits                        | Required Prior Authorization Form | Brand Required | Additional Note                                       |
| Ingrezza                                         | Non Preferred | Brand   | 07/01/18    |                               | Medication Coverage Exception     |                |                                                       |
| Xenazine                                         | Non Preferred | Brand   | 01/01/20    |                               | Medication Coverage Exception     |                |                                                       |
| Multiple Sclerosis Agents                        |               |         |             |                               |                                   |                |                                                       |
| Preferred Drugs                                  | Status        | Type    | Last Update | Limits                        | Mandatory 3-Month                 | Brand Required | Additional Note                                       |
| Avonex                                           | Preferred     | Brand   | 02/01/10    |                               |                                   |                |                                                       |
| Copaxone 20mg                                    | Preferred     | Brand   | 09/28/09    |                               |                                   | Copaxone       |                                                       |
| dalfampridine                                    | Preferred     | Generic | 01/01/21    |                               |                                   |                |                                                       |
| dimethyl fumarate                                | Preferred     | Generic | 01/01/22    |                               |                                   |                |                                                       |
| teriflunomide                                    | Preferred     | Generic | 04/01/23    |                               |                                   |                |                                                       |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Non Preferred Drugs                   | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                 |
|---------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|---------------------------------|
| Ampyra                                | Non Preferred | Brand   | 01/01/13    |        | Medication Coverage Exception     |                |                                 |
| Aubagio                               | Non Preferred | Brand   | 01/01/13    |        | Medication Coverage Exception     |                |                                 |
| Bafiertam                             | Non Preferred | Brand   | 11/01/21    |        | Medication Coverage Exception     |                |                                 |
| Betaseron                             | Non Preferred | Brand   | 01/01/23    |        | Medication Coverage Exception     |                |                                 |
| Briumvi                               | Non Preferred | Brand   | 09/01/23    |        | Medication Coverage Exception     |                |                                 |
| Copaxone 40mg                         | Non Preferred | Brand   | 05/30/14    |        | Medication Coverage Exception     | Copaxone       |                                 |
| Extavia                               | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                                 |
| ingolimod                             | Non Preferred | Generic | 11/01/23    |        | Medication Coverage Exception     |                |                                 |
| Gilenya                               | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                                 |
| glatiramer                            | Non Preferred | Generic | 07/01/15    |        | Medication Coverage Exception     | Copaxone       |                                 |
| Kesimpta                              | Non Preferred | Brand   | 12/01/20    |        | Medication Coverage Exception     |                |                                 |
| Lemtrada                              | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                                 |
| Mavenclad                             | Non Preferred | Brand   | 05/01/19    |        | Mavenclad PA                      |                |                                 |
| Mayzent                               | Non Preferred | Brand   | 04/01/19    |        | Medication Coverage Exception     |                |                                 |
| Ocrevus                               | Non Preferred | Brand   | 10/01/20    |        | Medication Coverage Exception     |                |                                 |
| Plegridy                              | Non Preferred | Brand   | 05/01/19    |        | Medication Coverage Exception     |                |                                 |
| Ponvory                               | Non Preferred | Brand   | 04/01/21    |        | Medication Coverage Exception     |                |                                 |
| Rebif                                 | Non Preferred | Brand   | 01/01/15    |        | Medication Coverage Exception     |                |                                 |
| Tascenso ODT                          | Non Preferred | Brand   | 09/01/22    |        | Medication Coverage Exception     |                |                                 |
| Tecfidera                             | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                                 |
| Tysabri                               | Non Preferred | Brand   | 11/01/21    |        | Medication Coverage Exception     |                |                                 |
| Vumerity                              | Non Preferred | Brand   | 01/01/22    |        | Medication Coverage Exception     |                |                                 |
| Zeposia                               | Non Preferred | Brand   | 12/01/20    |        | Medication Coverage Exception     |                | Included in more than one class |
| Therapies for Spinal Muscular Atrophy |               |         |             |        |                                   |                |                                 |
| Preferred Drugs                       | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                 |
| Evrysdi                               | Preferred     | Brand   | 12/01/20    |        | Evrysdi                           |                |                                 |
| Spinraza                              | Preferred     | Brand   | 10/01/19    |        | Spinraza                          |                |                                 |
| Zolgensma                             | Preferred     | Brand   | 10/01/19    |        | Zolgensma                         |                |                                 |



# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Ophthalmics                       |               |         |             |        |                                   |                |                 |
|-----------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Anti-Glaucoma - Alpha Adrenergics |               |         |             |        |                                   |                |                 |
| Preferred Drugs                   | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Alphagan P 0.1%                   | Preferred     | Brand   | 01/01/14    |        |                                   |                |                 |
| Alphagan P 0.15%                  | Preferred     | Brand   | 01/01/13    |        |                                   | Alphagan       |                 |
| brimonidine 0.2%                  | Preferred     | Generic | 10/01/10    |        |                                   |                |                 |
| Simbrinza                         | Preferred     | Brand   | 01/01/24    |        |                                   |                |                 |
| Non Preferred Drugs               | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| apraclonidine                     | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| brimonidine 0.1%                  | Non Preferred | Generic | 10/01/23    |        | Medication Coverage Exception     | Alphagan       |                 |
| brimonidine 0.15%                 | Non Preferred | Generic | 10/01/10    |        | Medication Coverage Exception     | Alphagan       |                 |
| lopidine                          | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Anti-Glaucoma - Beta Blockers     |               |         |             |        |                                   |                |                 |
| Preferred Drugs                   | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Betoptic-S                        | Preferred     | Brand   | 01/01/19    |        |                                   |                |                 |
| Combigan                          | Preferred     | Brand   | 01/01/19    |        |                                   | Combigan       |                 |
| dorzolamide/timolol               | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| timolol solution                  | Preferred     | Generic | 04/01/16    |        |                                   |                |                 |
| Non Preferred Drugs               | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| betaxolol                         | Non Preferred | Generic | 04/01/16    |        | Medication Coverage Exception     |                |                 |
| Betimol                           | Non Preferred | Brand   | 01/01/22    |        | Medication Coverage Exception     |                |                 |
| brimonidine/timolol               | Non Preferred | Generic | 12/01/22    |        | Medication Coverage Exception     | Combigan       |                 |
| carteolol                         | Non Preferred | Generic | 04/01/16    |        | Medication Coverage Exception     |                |                 |
| Cosopt PF                         | Non Preferred | Brand   | 02/01/19    |        | Medication Coverage Exception     |                |                 |
| dorzolamide/timolol PF            | Non Preferred | Generic | 02/01/19    |        | Medication Coverage Exception     |                |                 |
| Istalol                           | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     | Istalol        |                 |
| levobunolol                       | Non Preferred | Generic | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| timolol gel                       | Non Preferred | Generic | 04/01/16    |        | Medication Coverage Exception     |                |                 |
| timolol once daily                | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     | Istalol        |                 |
| timolol preservative free         | Non Preferred | Generic | 04/01/16    |        | Medication Coverage Exception     |                |                 |
| Timoptic                          | Non Preferred | Brand   | 04/01/16    |        | Medication Coverage Exception     |                |                 |
| Timoptic Occudose                 | Non Preferred | Brand   | 04/01/16    |        | Medication Coverage Exception     |                |                 |
| Timoptic-XE                       | Non Preferred | Brand   | 04/01/16    |        | Medication Coverage Exception     |                |                 |



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| Anti-Glaucoma - Prostaglandins        |               |         |             |        |                                   |                |                 |
|---------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Preferred Drugs                       | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Iatanoprost                           | Preferred     | Generic | 12/02/11    |        |                                   |                |                 |
| Lumigan                               | Preferred     | Brand   | 01/01/19    |        |                                   |                |                 |
| Non Preferred Drugs                   | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| bimatoprost                           | Non Preferred | Generic | 05/06/15    |        | Medication Coverage Exception     |                |                 |
| Durysta                               | Non Preferred | Brand   | 10/01/20    |        | Medication Coverage Exception     |                |                 |
| Iyuzeh                                | Non Preferred | Brand   | 09/01/23    |        | Medication Coverage Exception     |                |                 |
| tafluprost                            | Non Preferred | Generic | 12/01/22    |        | Medication Coverage Exception     | Zioptan        |                 |
| Travatan Z                            | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                 |
| travoprost                            | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Vyzulta                               | Non Preferred | Brand   | 12/01/17    |        | Medication Coverage Exception     |                |                 |
| Xalatan                               | Non Preferred | Brand   | 12/02/11    |        | Medication Coverage Exception     |                |                 |
| Xelpros                               | Non Preferred | Brand   | 11/01/19    |        | Medication Coverage Exception     |                |                 |
| Zioptan                               | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     | Zioptan        |                 |
| Ophthalmic - Antibiotics - Quinolones |               |         |             |        |                                   |                |                 |
| Preferred Drugs                       | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Besivance                             | Preferred     | Brand   | 01/01/18    |        |                                   |                |                 |
| Ciloxan oint                          | Preferred     | Brand   | 01/01/21    |        |                                   |                |                 |
| ciprofloxacin drops                   | Preferred     | Generic | 06/01/12    |        |                                   |                |                 |
| moxifloxacin (TID formulation)        | Preferred     | Generic | 01/01/22    |        |                                   |                |                 |
| ofloxacin                             | Preferred     | Generic | 01/01/23    |        |                                   |                |                 |
| Non Preferred Drugs                   | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Ciloxan drops                         | Non Preferred | Brand   | 11/01/16    |        | Medication Coverage Exception     |                |                 |
| gatifloxacin                          | Non Preferred | Generic | 11/01/19    |        | Medication Coverage Exception     |                |                 |
| moxifloxacin (BID formulation)        | Non Preferred | Generic | 08/01/17    |        | Medication Coverage Exception     |                |                 |
| Ocuflox                               | Non Preferred | Brand   | 06/01/12    |        | Medication Coverage Exception     |                |                 |
| Vigamox                               | Non Preferred | Brand   | 01/01/18    |        | Medication Coverage Exception     |                |                 |
| Zymaxid                               | Non Preferred | Brand   | 11/01/19    |        | Medication Coverage Exception     |                |                 |

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| Ophthalmic - Antibiotics - Non Quinolones        |               |         |             |        |                                   |                |                 |
|--------------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Preferred Drugs                                  | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| bacitracin/polymyxin B                           | Preferred     | Generic | 01/01/23    |        |                                   |                |                 |
| erythromycin ointment                            | Preferred     | Generic | 12/01/17    |        |                                   |                |                 |
| gentamicin drops                                 | Preferred     | Generic | 06/01/12    |        |                                   |                |                 |
| polymyxin B/trimethoprim                         | Preferred     | Generic | 06/01/12    |        |                                   |                |                 |
| sodium sulfacetamide drops                       | Preferred     | Generic | 12/01/17    |        |                                   |                |                 |
| tobramycin drops                                 | Preferred     | Generic | 01/01/19    |        |                                   |                |                 |
| Non Preferred Drugs                              | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Azasite                                          | Non Preferred | Brand   | 06/01/12    |        | Medication Coverage Exception     |                |                 |
| Baciguent                                        | Non Preferred | Brand   | 09/01/20    |        | Medication Coverage Exception     |                |                 |
| bacitracin                                       | Non Preferred | Generic | 06/01/12    |        | Medication Coverage Exception     |                |                 |
| neomycin/bacitracin/polymyxin                    | Non Preferred | Generic | 01/01/13    |        | Medication Coverage Exception     |                |                 |
| neomycin/polymyxin/gramicidin                    | Non Preferred | Generic | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| Polytrim                                         | Non Preferred | Brand   | 01/01/13    |        | Medication Coverage Exception     |                |                 |
| sodium sulfacetamide ointment                    | Non Preferred | Generic | 12/01/17    |        | Medication Coverage Exception     |                |                 |
| Tobrex ointment                                  | Non Preferred | Brand   | 01/01/13    |        | Medication Coverage Exception     |                |                 |
| Ophthalmic - Antihistamines                      |               |         |             |        |                                   |                |                 |
| Preferred Drugs                                  | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Bepreve                                          | Preferred     | Brand   | 01/01/18    |        |                                   | Bepreve        |                 |
| cromolyn                                         | Preferred     | Generic | 01/01/14    |        |                                   |                |                 |
| Non Preferred Drugs                              | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Alocril                                          | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| Alomide                                          | Non Preferred | Brand   | 01/01/22    |        | Medication Coverage Exception     |                |                 |
| azelastine                                       | Non Preferred | Generic | 10/01/10    |        | Medication Coverage Exception     |                |                 |
| bepotastine                                      | Non Preferred | Generic | 07/01/21    |        | Medication Coverage Exception     | Bepreve        |                 |
| epinastine                                       | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| olopatadine                                      | Non Preferred | Generic | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Zerviate                                         | Non Preferred | Brand   | 05/01/20    |        | Medication Coverage Exception     |                |                 |
| Ophthalmic - Anti-Inflammatory - Corticosteroids |               |         |             |        |                                   |                |                 |
| Preferred Drugs                                  | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Alrex                                            | Preferred     | Brand   | 06/01/12    |        |                                   | Alrex          |                 |
| Flarex                                           | Preferred     | Brand   | 06/01/12    |        |                                   |                |                 |
| FML Liquifilm                                    | Preferred     | Brand   | 01/01/22    |        |                                   | FML Liquifilm  |                 |
| FML ointment                                     | Preferred     | Brand   | 01/01/18    |        |                                   |                |                 |

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| Drug / Product Name                     | Status        | Type    | Updated     | Limits | PA Form / 3-Month Req'd           | Brand Req'd    | Additional Note |
|-----------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Lotemax drops                           | Preferred     | Brand   | 06/01/19    |        |                                   | Lotemax        |                 |
| Maxidex                                 | Preferred     | Brand   | 06/01/12    |        |                                   |                |                 |
| prednisolone 1% suspension              | Preferred     | Generic | 02/01/25    |        | Medication Coverage Exception     |                |                 |
| Pred Mild                               | Preferred     | Brand   | 06/01/12    |        |                                   |                |                 |
| Non Preferred Drugs                     | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| dexamethasone sodium phos PF            | Non Preferred | Generic | 01/01/13    |        | Medication Coverage Exception     |                |                 |
| difluprednate                           | Non Preferred | Generic | 10/01/21    |        | Medication Coverage Exception     | Durezol        |                 |
| Durezol                                 | Non Preferred | Brand   | 06/01/12    |        | Medication Coverage Exception     | Durezol        |                 |
| Eysuvis                                 | Non Preferred | Brand   | 12/01/20    |        | Medication Coverage Exception     |                |                 |
| fluorometholone                         | Non Preferred | Generic | 01/01/22    |        | Medication Coverage Exception     | FML Liquifilm  |                 |
| FML Forte                               | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                 |
| Inveltys                                | Non Preferred | Brand   | 11/01/19    |        | Medication Coverage Exception     |                |                 |
| Lotemax gel                             | Non Preferred | Brand   | 06/01/12    |        | Medication Coverage Exception     |                |                 |
| Lotemax ointment                        | Non Preferred | Brand   | 06/01/12    |        | Medication Coverage Exception     |                |                 |
| loteprednol 0.2%                        | Non Preferred | Generic | 03/01/24    |        | Medication Coverage Exception     | Alrex          |                 |
| loteprednol 0.5% gel                    | Non Preferred | Generic | 03/01/21    |        | Medication Coverage Exception     | Lotemax        |                 |
| loteprednol 0.5% suspension             | Non Preferred | Generic | 06/01/19    |        | Medication Coverage Exception     | Lotemax        |                 |
| prednisolone sodium phosphate           | Non Preferred | Generic | 06/01/12    |        | Medication Coverage Exception     |                |                 |
| Ophthalmic - Anti-Inflammatory - NSAIDs |               |         |             |        |                                   |                |                 |
| Preferred Drugs                         | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| diclofenac                              | Preferred     | Generic | 06/01/12    |        |                                   |                |                 |
| ketorolac 0.5%                          | Preferred     | Generic | 01/01/19    |        |                                   |                |                 |
| Non Preferred Drugs                     | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Acular                                  | Non Preferred | Brand   | 06/01/12    |        | Medication Coverage Exception     |                |                 |
| Acular LS                               | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| Acuvail                                 | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                 |
| bromfenac                               | Non Preferred | Generic | 01/01/13    |        | Medication Coverage Exception     |                |                 |
| Bromsite                                | Non Preferred | Brand   | 11/01/16    |        | Medication Coverage Exception     |                |                 |
| flurbiprofen                            | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Ilevro                                  | Non Preferred | Brand   | 01/01/14    |        | Medication Coverage Exception     |                |                 |
| ketorolac 0.4%                          | Non Preferred | Generic | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| Nevanac                                 | Non Preferred | Brand   | 06/01/12    |        | Medication Coverage Exception     |                |                 |
| Prolensa                                | Non Preferred | Brand   | 04/16/13    |        | Medication Coverage Exception     |                |                 |

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| Ophthalmic - Anti-Inflammatory - Combinations |               |         |             |        |                                   |                |                 |
|-----------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Preferred Drugs                               | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| neomycin/poly/dexameth                        | Preferred     | Generic | 06/01/12    |        |                                   |                |                 |
| Tobradex ointment                             | Preferred     | Brand   | 01/01/16    |        |                                   |                |                 |
| Non Preferred Drugs                           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Maxitrol                                      | Non Preferred | Brand   | 12/01/18    |        | Medication Coverage Exception     |                |                 |
| neomycin/poly/bac/hc                          | Non Preferred | Generic | 06/01/12    |        | Medication Coverage Exception     |                |                 |
| neomycin/poly/hc                              | Non Preferred | Generic | 06/01/12    |        | Medication Coverage Exception     |                |                 |
| sodium sulfacetamide /prednise drops          | Non Preferred | Generic | 06/01/12    |        | Medication Coverage Exception     |                |                 |
| Tobradex ST                                   | Non Preferred | Brand   | 01/01/18    |        | Medication Coverage Exception     |                |                 |
| tobramycin/dexamethasone                      | Non Preferred | Generic | 06/01/12    |        | Medication Coverage Exception     |                |                 |
| Zylet                                         | Non Preferred | Brand   | 01/01/24    |        | Medication Coverage Exception     |                |                 |
| Otics                                         |               |         |             |        |                                   |                |                 |
| Otic - Antibiotics                            |               |         |             |        |                                   |                |                 |
| Preferred Drugs                               | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| ciprofloxacin otic sol 0.2%                   | Preferred     | Generic | 01/01/16    |        |                                   |                |                 |
| ofloxacin otic drops                          | Preferred     | Generic | 01/01/19    |        |                                   |                |                 |
| Non Preferred Drugs                           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Floxin otic                                   | Non Preferred | Brand   | 01/01/19    |        | Medication Coverage Exception     |                |                 |
| Otic - Antibiotic Combinations                |               |         |             |        |                                   |                |                 |
| Preferred Drugs                               | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| Cortisporin TC                                | Preferred     | Brand   | 11/01/19    |        |                                   |                |                 |
| neomycin/polymyxin/hc susp                    | Preferred     | Generic | 11/01/15    |        |                                   |                |                 |
| Non Preferred Drugs                           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Cipro HC                                      | Non Preferred | Brand   | 01/01/23    |        | Medication Coverage Exception     |                |                 |
| ciprofloxacin/dexamethasone                   | Non Preferred | Generic | 01/01/21    |        | Medication Coverage Exception     |                |                 |
| ciprofloxacin/fluocinolone                    | Non Preferred | Generic | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| neomycin/polymyxin/hc sol                     | Non Preferred | Generic | 11/01/15    |        | Medication Coverage Exception     |                |                 |

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| Prostatic Hypertrophy Agents |               |         |             |           |                                   |                |                                 |
|------------------------------|---------------|---------|-------------|-----------|-----------------------------------|----------------|---------------------------------|
| Preferred Drugs              | Status        | Type    | Last Update | Limits    | Mandatory 3-Month                 | Brand Required | Additional Note                 |
| alfuzosin                    | Preferred     | Generic | 01/01/14    | Male only |                                   |                |                                 |
| doxazosin                    | Preferred     | Generic | 10/01/11    | Male only | 90 Day Supply Required            |                |                                 |
| dutasteride                  | Preferred     | Generic | 01/01/18    | Male only | 90 Day Supply Required            |                |                                 |
| finasteride 5mg              | Preferred     | Generic | 10/01/11    | Male only | 90 Day Supply Required            |                |                                 |
| prazosin                     | Preferred     | Generic | 12/01/18    | Male only |                                   |                |                                 |
| silodosin                    | Preferred     | Generic | 09/01/20    | Male only |                                   |                |                                 |
| tamsulosin                   | Preferred     | Generic | 01/01/12    | Male only | 90 Day Supply Required            |                |                                 |
| terazosin                    | Preferred     | Generic | 10/01/11    | Male only | 90 Day Supply Required            |                |                                 |
| Non Preferred Drugs          | Status        | Type    | Last Update | Limits    | Required Prior Authorization Form | Brand Required | Additional Note                 |
| Avodart                      | Non Preferred | Brand   | 01/01/18    | Male only | Medication Coverage Exception     |                |                                 |
| Cardura                      | Non Preferred | Brand   | 04/01/12    | Male only | Medication Coverage Exception     |                |                                 |
| Cardura XL                   | Non Preferred | Brand   | 04/01/12    | Male only | Medication Coverage Exception     |                |                                 |
| Cialis 5mg                   | Non Preferred | Brand   | 06/01/20    | Male only | Cialis Prior Auth form            | Cialis 5 mg    |                                 |
| dutasteride/tamsulosin       | Non Preferred | Generic | 10/01/11    | Male only | Medication Coverage Exception     |                |                                 |
| Entadfi                      | Non Preferred | Brand   | 02/01/23    | Male only | Medication Coverage Exception     |                |                                 |
| Flomax                       | Non Preferred | Brand   | 10/01/11    | Male only | Medication Coverage Exception     |                |                                 |
| Jalyn                        | Non Preferred | Brand   | 10/01/11    | Male only | Medication Coverage Exception     |                |                                 |
| Minipress                    | Non Preferred | Brand   | 12/01/18    | Male only | Medication Coverage Exception     |                |                                 |
| Proscar                      | Non Preferred | Brand   | 10/01/11    | Male only | Medication Coverage Exception     |                |                                 |
| Rapaflo                      | Non Preferred | Brand   | 09/01/20    | Male only | Medication Coverage Exception     |                |                                 |
| tadalafil 5mg                | Non Preferred | Generic | 06/01/20    | Male only | Cialis Prior Auth form            | Cialis 5 mg    |                                 |
| Tezruly Sol                  | Non Preferred | Brand   | 09/01/20    | Male only | Medication Coverage Exception     |                |                                 |
| Pulmonary Hypertension       |               |         |             |           |                                   |                |                                 |
| Endothelin Antagonists       |               |         |             |           |                                   |                |                                 |
| Preferred Drugs              | Status        | Type    | Last Update | Limits    | Required Prior Authorization Form | Brand Required | Additional Note                 |
| ambrisentan                  | Preferred     | Generic | 01/01/23    |           | Pulmonary Arterial HTN            |                |                                 |
| bosentan                     | Preferred     | Generic | 01/01/24    |           | Pulmonary Arterial HTN            |                |                                 |
| Non Preferred Drugs          | Status        | Type    | Last Update | Limits    | Required Prior Authorization Form | Brand Required | Additional Note                 |
| Letairis                     | Non Preferred | Brand   | 01/01/23    |           | Pulmonary Arterial HTN            |                |                                 |
| Opsumit                      | Non Preferred | Brand   | 10/01/13    |           | Pulmonary Arterial HTN            |                |                                 |
| Opsynvi                      | Non Preferred | Brand   | 07/01/24    |           | Pulmonary Arterial HTN            |                | Included in more than one class |
| Tracleer                     | Non Preferred | Brand   | 01/01/24    |           | Pulmonary Arterial HTN            |                |                                 |

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| Phosphodiesterase-5 Enzyme (PDE-5) Inhibitors |               |         |             |        |                                                        |                |                                 |
|-----------------------------------------------|---------------|---------|-------------|--------|--------------------------------------------------------|----------------|---------------------------------|
| Preferred Drugs                               | Status        | Type    | Last Update | Limits | Required Prior Authorization Form                      | Brand Required | Additional Note                 |
| sildenafil                                    | Preferred     | Generic | 09/01/13    |        | Pulmonary Arterial HTN                                 |                |                                 |
| tadalafil                                     | Preferred     | Generic | 01/01/20    |        | Pulmonary Arterial HTN                                 |                |                                 |
| Non Preferred Drugs                           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form                      | Brand Required | Additional Note                 |
| Adcirca                                       | Non Preferred | Brand   | 01/01/20    |        | Pulmonary Arterial HTN                                 |                |                                 |
| Opsynvi                                       | Non Preferred | Brand   | 07/01/24    |        | Pulmonary Arterial HTN                                 |                | Included in more than one class |
| Revatio                                       | Non Preferred | Brand   | 09/01/13    |        | Pulmonary Arterial HTN                                 |                |                                 |
| Tadliq                                        | Non Preferred | Brand   | 10/01/22    |        | Pulmonary Arterial HTN                                 |                |                                 |
| Prostacyclins                                 |               |         |             |        |                                                        |                |                                 |
| Preferred Drugs                               | Status        | Type    | Last Update | Limits | Required Prior Authorization Form                      | Brand Required | Additional Note                 |
| epoprostenol                                  | Preferred     | Generic | 06/01/12    |        | Pulmonary Arterial HTN                                 |                |                                 |
| Non Preferred Drugs                           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form                      | Brand Required | Additional Note                 |
| Flolan                                        | Non Preferred | Brand   | 06/01/12    |        | Pulmonary Arterial HTN                                 |                |                                 |
| Orenitram                                     | Non Preferred | Brand   | 04/02/14    |        | Pulmonary Arterial HTN                                 |                |                                 |
| Remodulin                                     | Non Preferred | Brand   | 10/01/19    |        | Pulmonary Arterial HTN                                 | Remodulin      |                                 |
| treprostinil                                  | Non Preferred | Brand   | 10/01/19    |        | Pulmonary Arterial HTN                                 | Remodulin      |                                 |
| Tyvaso                                        | Non Preferred | Brand   | 06/01/12    |        | Pulmonary Arterial HTN                                 |                |                                 |
| Uptravi                                       | Non Preferred | Brand   | 01/15/16    |        | Pulmonary Arterial HTN                                 |                |                                 |
| Velettri                                      | Non Preferred | Brand   | 06/01/12    |        | Pulmonary Arterial HTN                                 |                |                                 |
| Ventavis                                      | Non Preferred | Brand   | 01/01/14    |        | Pulmonary Arterial HTN                                 |                |                                 |
| Yutrepia                                      | Non Preferred | Brand   | 07/01/25    |        | Pulmonary Arterial HTN                                 |                |                                 |
| Respiratory                                   |               |         |             |        |                                                        |                |                                 |
| Monoclonal Antibodies for Asthma              |               |         |             |        |                                                        |                |                                 |
| Preferred Drugs                               | Status        | Type    | Last Update | Limits | Required Prior Authorization Form                      | Brand Required | Additional Note                 |
| Cinqair                                       | Preferred     | Brand   | 01/01/21    |        | Monoclonal Antibodies for Asthma and Other Indications |                |                                 |
| Dupixent                                      | Preferred     | Brand   | 01/01/22    |        | Monoclonal Antibodies for Asthma and Other Indications |                | Included in more than one class |
| Fasenra                                       | Preferred     | Brand   | 01/01/21    |        | Monoclonal Antibodies for Asthma and Other Indications |                |                                 |
| Xolair                                        | Preferred     | Brand   | 01/01/21    |        | Monoclonal Antibodies for Asthma and Other Indications |                |                                 |
| Non Preferred Drugs                           | Status        | Type    | Last Update | Limits | Required Prior Authorization Form                      | Brand Required | Additional Note                 |
| Nucala                                        | Non Preferred | Brand   | 01/01/21    |        | Monoclonal Antibodies for Asthma and Other Indications |                |                                 |
| Tezspire                                      | Non Preferred | Brand   | 03/01/22    |        | Monoclonal Antibodies for Asthma and Other Indications |                |                                 |



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| Asthma & COPD - Anticholinergics                  |               |         |             |                    |                                   |                    |                 |
|---------------------------------------------------|---------------|---------|-------------|--------------------|-----------------------------------|--------------------|-----------------|
| Preferred Drugs                                   | Status        | Type    | Last Update | Limits             | Mandatory 3-Month                 | Brand Required     | Additional Note |
| Atrovent HFA                                      | Preferred     | Brand   | 04/01/12    | 2 inhalers/30 days |                                   |                    |                 |
| ipratropium                                       | Preferred     | Generic | 04/01/12    | 2 inhalers/30 days |                                   |                    |                 |
| Spiriva                                           | Preferred     | Brand   | 01/01/20    | 1 inhaler/30 days  |                                   | Spiriva            |                 |
| Non Preferred Drugs                               | Status        | Type    | Last Update | Limits             | Required Prior Authorization Form | Brand Required     | Additional Note |
| Incruse Ellipta                                   | Non Preferred | Brand   | 01/01/15    | 1 inhaler/30 days  | Medication Coverage Exception     |                    |                 |
| tiotropium                                        | Non Preferred | Generic | 09/01/23    | 1 inhaler/30 days  | Medication Coverage Exception     | Spiriva            |                 |
| Tudorza Pressair                                  | Non Preferred | Brand   | 01/01/20    | 1 inhaler/30 days  | Medication Coverage Exception     |                    |                 |
| Yupelri                                           | Non Preferred | Brand   | 01/01/22    |                    | Medication Coverage Exception     |                    |                 |
| Asthma & COPD - Short Acting Beta Agonists (SABA) |               |         |             |                    |                                   |                    |                 |
| Preferred Drugs                                   | Status        | Type    | Last Update | Limits             | Mandatory 3-Month                 | Brand Required     | Additional Note |
| albuterol nebulizer                               | Preferred     | Generic | 01/01/13    |                    |                                   |                    |                 |
| levalbuterol nebulizer                            | Preferred     | Generic | 05/15/16    |                    |                                   |                    |                 |
| ProAir HFA                                        | Preferred     | Brand   | 01/01/20    | 2 inhalers/30 days |                                   | ProAir HFA         |                 |
| Proventil HFA                                     | Preferred     | Brand   | 01/01/24    | 2 inhalers/30 days |                                   | Proventil HFA      |                 |
| Ventolin HFA                                      | Preferred     | Brand   | 05/01/20    | 2 inhalers/30 days |                                   | Ventolin HFA       |                 |
| Non Preferred Drugs                               | Status        | Type    | Last Update | Limits             | Required Prior Authorization Form | Brand Required     | Additional Note |
| Airsupra                                          | Non Preferred | Brand   | 01/03/25    | 1 inhaler/30 days  | Medication Coverage Exception     |                    |                 |
| albuterol HFA                                     | Non Preferred | Generic | 05/01/19    | 2 inhalers/30 days | Medication Coverage Exception     | Ventolin or ProAir |                 |
| albuterol powder                                  | Non Preferred | Generic | 10/01/24    | 2 inhalers/30 days | Medication Coverage Exception     |                    |                 |
| levalbuterol HFA                                  | Non Preferred | Generic | 01/01/24    | 2 inhalers/30 days | Medication Coverage Exception     |                    |                 |
| ProAir RespiClick                                 | Non Preferred | Brand   | 01/01/21    | 2 inhalers/30 days | Medication Coverage Exception     |                    |                 |
| Xopenex HFA                                       | Non Preferred | Brand   | 01/01/23    | 2 inhalers/30 days | Medication Coverage Exception     |                    |                 |
| Asthma & COPD - Long Acting Beta Agonists (LABA)  |               |         |             |                    |                                   |                    |                 |
| Preferred Drugs                                   | Status        | Type    | Last Update | Limits             | Mandatory 3-Month                 | Brand Required     | Additional Note |
| Serevent Diskus                                   | Preferred     | Brand   | 09/28/09    | 1 inhaler/30 days  |                                   |                    |                 |
| Non Preferred Drugs                               | Status        | Type    | Last Update | Limits             | Required Prior Authorization Form | Brand Required     | Additional Note |
| arformoterol                                      | Non Preferred | Generic | 07/01/21    |                    | Medication Coverage Exception     | Brovana            |                 |
| Brovana                                           | Non Preferred | Brand   | 01/01/16    |                    | Medication Coverage Exception     | Brovana            |                 |
| formoterol                                        | Non Preferred | Generic | 07/01/21    |                    | Medication Coverage Exception     | Perforomist        |                 |
| Perforomist                                       | Non Preferred | Brand   | 01/01/20    |                    | Medication Coverage Exception     | Perforomist        |                 |
| Striverdi                                         | Non Preferred | Brand   | 01/01/21    | 1 inhaler/30 days  | Medication Coverage Exception     |                    |                 |



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| Asthma & COPD - Corticosteroids                  |               |         |             |                    |                                   |                |                 |
|--------------------------------------------------|---------------|---------|-------------|--------------------|-----------------------------------|----------------|-----------------|
| Preferred Drugs                                  | Status        | Type    | Last Update | Limits             | Mandatory 3-Month                 | Brand Required | Additional Note |
| Arnuity Ellipta                                  | Preferred     | Brand   | 01/01/19    | 1 inhaler/30 days  |                                   |                |                 |
| budesonide nebulizer                             | Preferred     | Brand   | 01/01/21    |                    |                                   |                |                 |
| fluticasone                                      | Preferred     | Generic | 03/01/25    | 1 inhaler/30 days  |                                   |                |                 |
| Pulmicort Flexhaler                              | Preferred     | Brand   | 01/01/13    | 1 inhaler/30 days  |                                   |                |                 |
| Non Preferred Drugs                              | Status        | Type    | Last Update | Limits             | Required Prior Authorization Form | Brand Required | Additional Note |
| Alvesco                                          | Non Preferred | Brand   | 01/01/19    | 1 inhaler/30 days  | Medication Coverage Exception     |                |                 |
| Armonair                                         | Non Preferred | Brand   | 09/01/17    | 1 inhaler/30 days  | Medication Coverage Exception     |                |                 |
| Asmanex                                          | Non Preferred | Brand   | 01/01/15    | 1 inhaler/30 days  | Medication Coverage Exception     |                |                 |
| Pulmicort nebulizer                              | Non Preferred | Brand   | 01/01/21    |                    | Medication Coverage Exception     |                |                 |
| Qvar                                             | Non Preferred | Brand   | 01/01/19    | 1 inhaler/30 days  | Medication Coverage Exception     |                |                 |
| Asthma & COPD - Leukotriene Receptor Antagonists |               |         |             |                    |                                   |                |                 |
| Preferred Drugs                                  | Status        | Type    | Last Update | Limits             | Mandatory 3-Month                 | Brand Required | Additional Note |
| montelukast 4mg chewable                         | Preferred     | Generic | 01/01/13    | 2 years and older  |                                   |                |                 |
| montelukast 5mg chewable                         | Preferred     | Generic | 01/01/13    | 6 years and older  |                                   |                |                 |
| montelukast tablet                               | Preferred     | Generic | 01/01/13    | 15 years and older |                                   |                |                 |
| Non Preferred Drugs                              | Status        | Type    | Last Update | Limits             | Required Prior Authorization Form | Brand Required | Additional Note |
| Accolate                                         | Non Preferred | Brand   | 01/01/18    |                    | Medication Coverage Exception     |                |                 |
| montelukast granules                             | Non Preferred | Generic | 01/01/13    |                    | Medication Coverage Exception     |                |                 |
| Singulair                                        | Non Preferred | Brand   | 01/01/13    |                    | Medication Coverage Exception     |                |                 |
| zafirlukast                                      | Non Preferred | Generic | 01/01/18    |                    | Medication Coverage Exception     |                |                 |
| zileuton CR                                      | Non Preferred | Generic | 10/15/15    |                    | Medication Coverage Exception     |                |                 |
| Zyflo CR                                         | Non Preferred | Brand   | 10/15/15    |                    | Medication Coverage Exception     |                |                 |
| Asthma & COPD - Oral Beta Agonists               |               |         |             |                    |                                   |                |                 |
| Preferred Drugs                                  | Status        | Type    | Last Update | Limits             | Mandatory 3-Month                 | Brand Required | Additional Note |
| albuterol syrup                                  | Preferred     | Generic | 01/01/19    |                    |                                   |                |                 |
| Non Preferred Drugs                              | Status        | Type    | Last Update | Limits             | Required Prior Authorization Form | Brand Required | Additional Note |
| albuterol tablet                                 | Non Preferred | Generic | 01/01/19    |                    | Medication Coverage Exception     |                |                 |
| terbutaline                                      | Non Preferred | Generic | 01/01/19    |                    | Medication Coverage Exception     |                |                 |

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| Asthma & COPD - Combination Products   |               |         |             |                    |                                   |                |                 |
|----------------------------------------|---------------|---------|-------------|--------------------|-----------------------------------|----------------|-----------------|
| Preferred Drugs                        | Status        | Type    | Last Update | Limits             | Mandatory 3-Month                 | Brand Required | Additional Note |
| Advair                                 | Preferred     | Brand   | 06/01/19    | 1 inhaler/30 days  |                                   | Advair         |                 |
| Combivent                              | Preferred     | Brand   | 01/01/21    | 2 inhalers/30 days |                                   |                |                 |
| Dulera                                 | Preferred     | Brand   | 05/23/11    | 1 inhaler/30 days  |                                   |                |                 |
| ipratropium/albuterol                  | Preferred     | Generic | 01/01/14    | 2 inhalers/30 days |                                   |                |                 |
| ipratropium/albuterol nebulizer        | Preferred     | Generic | 08/01/25    |                    |                                   |                |                 |
| Symbicort                              | Preferred     | Brand   | 01/01/13    | 1 inhaler/30 days  |                                   | Symbicort      |                 |
| Non Preferred Drugs                    | Status        | Type    | Last Update | Limits             | Required Prior Authorization Form | Brand Required | Additional Note |
| AirDuo                                 | Non Preferred | Brand   | 09/01/19    | 1 inhaler/30 days  | Medication Coverage Exception     | AirDuo         |                 |
| Breo Ellipta                           | Non Preferred | Brand   | 01/01/19    | 1 inhaler/30 days  | Medication Coverage Exception     | Breo Ellipta   |                 |
| Breyna                                 | Non Preferred | Generic | 11/01/24    | 1 inhaler/30 days  | Medication Coverage Exception     | Symbicort      |                 |
| budesonide/formoterol                  | Non Preferred | Generic | 07/01/20    | 1 inhaler/30 days  | Medication Coverage Exception     | Symbicort      |                 |
| fluticasone/salmeterol                 | Non Preferred | Generic | 09/01/19    | 1 inhaler/30 days  | Medication Coverage Exception     | Advair         |                 |
| fluticasone/salmeterol                 | Non Preferred | Generic | 05/01/17    | 1 inhaler/30 days  | Medication Coverage Exception     | AirDuo         |                 |
| fluticasone/vilanterol                 | Non Preferred | Generic | 12/01/22    | 1 inhaler/30 days  | Medication Coverage Exception     | Breo Ellipta   |                 |
| Wixela                                 | Non Preferred | Brand   | 08/01/25    | 1 inhaler/30 days  | Medication Coverage Exception     | Advair         |                 |
| Asthma & COPD - LABA/LAMA Combinations |               |         |             |                    |                                   |                |                 |
| Preferred Drugs                        | Status        | Type    | Last Update | Limits             | Mandatory 3-Month                 | Brand Required | Additional Note |
| Anoro Ellipta                          | Preferred     | Brand   | 09/01/17    | 1 inhaler/30 days  |                                   |                |                 |
| Stiolto                                | Preferred     | Brand   | 01/01/22    | 1 inhaler/30 days  |                                   |                |                 |
| Trelegy Ellipta                        | Preferred     | Brand   | 08/01/25    | 1 inhaler/30 days  |                                   |                |                 |
| Non Preferred Drugs                    | Status        | Type    | Last Update | Limits             | Required Prior Authorization Form | Brand Required | Additional Note |
| Bevespi                                | Non Preferred | Brand   | 01/01/22    | 1 inhaler/30 days  | Medication Coverage Exception     |                |                 |
| Breztri                                | Non Preferred | Brand   | 08/01/20    | 1 inhaler/30 days  | Medication Coverage Exception     |                |                 |
| Duaklir                                | Non Preferred | Brand   | 02/01/20    | 1 inhaler/30 days  | Medication Coverage Exception     |                |                 |
| umeclidinium/vilanterol                | Non Preferred | Generic | 05/01/25    | 1 inhaler/30 days  | Medication Coverage Exception     |                |                 |
| Cystic Fibrosis: CFTR Modulators       |               |         |             |                    |                                   |                |                 |
| Preferred Drugs                        | Status        | Type    | Last Update | Limits             | Required Prior Authorization Form | Brand Required | Additional Note |
| Kalydeco                               | Preferred     | Brand   | 01/01/21    |                    | Cystic Fibrosis CFTR Modulators   |                |                 |
| Orkambi                                | Preferred     | Brand   | 01/01/21    |                    | Cystic Fibrosis CFTR Modulators   |                |                 |
| Trikafta                               | Preferred     | Brand   | 01/01/21    |                    | Cystic Fibrosis CFTR Modulators   |                |                 |
| Non Preferred Drugs                    | Status        | Type    | Last Update | Limits             | Required Prior Authorization Form | Brand Required | Additional Note |
| Alyftrek                               | Non Preferred | Brand   | 02/01/25    |                    | Cystic Fibrosis CFTR Modulators   |                |                 |
| Symdeko                                | Non Preferred | Brand   | 01/01/21    |                    | Cystic Fibrosis CFTR Modulators   |                |                 |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Cystic Fibrosis: Inhaled Aminoglycosides |               |         |             |        |                                   |                |                 |
|------------------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-----------------|
| Preferred Drugs                          | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| tobramycin 300mg/5ml nebulizer           | Preferred     | Generic | 01/01/22    |        |                                   |                |                 |
| Non Preferred Drugs                      | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Arikayce                                 | Non Preferred | Brand   | 11/01/18    |        | Medication Coverage Exception     |                |                 |
| Bethkis                                  | Non Preferred | Brand   | 01/01/20    |        | Medication Coverage Exception     |                |                 |
| Kitabis Pak                              | Non Preferred | Brand   | 01/01/22    |        | Medication Coverage Exception     |                |                 |
| Tobi nebulizer                           | Non Preferred | Brand   | 01/01/16    |        | Medication Coverage Exception     |                |                 |
| Tobi Podhaler capsule                    | Non Preferred | Brand   | 01/01/18    |        | Medication Coverage Exception     |                |                 |
| tobramycin 300mg/4ml nebulizer           | Non Preferred | Generic | 01/01/24    |        | Medication Coverage Exception     |                |                 |
| Urinary                                  |               |         |             |        |                                   |                |                 |
| Short Acting Antispasmodics              |               |         |             |        |                                   |                |                 |
| Preferred Drugs                          | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| bethanechol                              | Preferred     | Generic | 01/01/20    |        |                                   |                |                 |
| oxybutynin                               | Preferred     | Generic | 09/28/09    |        |                                   |                |                 |
| tropium                                  | Preferred     | Generic | 01/01/24    |        |                                   |                |                 |
| Non Preferred Drugs                      | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note |
| Detrol                                   | Non Preferred | Brand   | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| flavoxate                                | Non Preferred | Generic | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| tolterodine                              | Non Preferred | Generic | 09/28/09    |        | Medication Coverage Exception     |                |                 |
| Long Acting Antispasmodics               |               |         |             |        |                                   |                |                 |
| Preferred Drugs                          | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note |
| fesoterodine                             | Preferred     | Generic | 12/01/24    |        |                                   |                |                 |
| Myrbetriq                                | Preferred     | Brand   | 12/01/24    |        |                                   | Myrbetriq      |                 |
| oxybutynin ER                            | Preferred     | Generic | 02/01/10    |        |                                   |                |                 |
| Oxytrol Rx                               | Preferred     | Brand   | 01/01/19    |        |                                   |                |                 |
| solifenacin                              | Preferred     | Generic | 08/01/20    |        |                                   |                |                 |

# Utah Medicaid Preferred Drug List - Effective August 1, 2025

| Non Preferred Drugs            | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                                       |
|--------------------------------|---------------|---------|-------------|--------|-----------------------------------|----------------|-------------------------------------------------------|
| darifenacin                    | Non Preferred | Generic | 04/01/16    |        | Medication Coverage Exception     |                |                                                       |
| Detrol LA                      | Non Preferred | Brand   | 02/01/10    |        | Medication Coverage Exception     |                |                                                       |
| Ditropan XL                    | Non Preferred | Brand   | 01/01/12    |        | Medication Coverage Exception     |                |                                                       |
| Gelnique                       | Non Preferred | Brand   | 05/01/17    |        | Medication Coverage Exception     |                |                                                       |
| Gemtesa                        | Non Preferred | Brand   | 02/01/21    |        | Medication Coverage Exception     |                |                                                       |
| mirabegron                     | Non Preferred | Generic | 07/01/24    |        | Medication Coverage Exception     | Myrbetriq      |                                                       |
| tolterodine ER                 | Non Preferred | Generic | 01/01/14    |        | Medication Coverage Exception     |                |                                                       |
| Toviaz                         | Non Preferred | Brand   | 12/01/24    |        | Medication Coverage Exception     |                |                                                       |
| tropium ER                     | Non Preferred | Generic | 10/01/13    |        | Medication Coverage Exception     |                |                                                       |
| Vesicare                       | Non Preferred | Brand   | 08/01/20    |        | Medication Coverage Exception     |                |                                                       |
| Vitamin D Analogs              |               |         |             |        |                                   |                |                                                       |
| Preferred Drugs                | Status        | Type    | Last Update | Limits | Mandatory 3-Month                 | Brand Required | Additional Note                                       |
| calcitriol capsule             | Preferred     | Generic | 01/01/18    |        |                                   |                |                                                       |
| calcitriol injection           | Preferred     | Generic | 05/01/22    |        |                                   |                | Covered under medical benefit using appropriate HCPCS |
| doxercalciferol injection      | Preferred     | Generic | 05/01/22    |        |                                   |                | Covered under medical benefit using appropriate HCPCS |
| paricalcitol injection         | Preferred     | Generic | 05/01/22    |        |                                   |                | Covered under medical benefit using appropriate HCPCS |
| calcitrol solution             | Preferred     | Brand   | 05/01/25    |        |                                   |                |                                                       |
| vitamin D 125mg (50,000 units) | Preferred     | Generic | 01/01/15    |        |                                   |                |                                                       |
| Non Preferred Drugs            | Status        | Type    | Last Update | Limits | Required Prior Authorization Form | Brand Required | Additional Note                                       |
| doxercalciferol capsule        | Non Preferred | Generic | 01/01/15    |        | Medication Coverage Exception     |                |                                                       |
| Drisdol                        | Non Preferred | Brand   | 11/01/16    |        | Medication Coverage Exception     |                |                                                       |
| Hectorol                       | Non Preferred | Brand   | 01/01/18    |        | Medication Coverage Exception     |                |                                                       |
| paricalcitol capsule           | Non Preferred | Generic | 01/01/15    |        | Medication Coverage Exception     |                |                                                       |
| Rocaltrol capsule              | Non Preferred | Brand   | 01/01/18    |        | Medication Coverage Exception     |                |                                                       |
| Royaldee                       | Non Preferred | Brand   | 07/01/24    |        | Medication Coverage Exception     |                |                                                       |
| Zemlar                         | Non Preferred | Brand   | 01/01/15    |        | Medication Coverage Exception     |                |                                                       |

## Utah Medicaid Covered Over-the-Counter Drugs - Effective August 1, 2025

|                                                                                                                                              |          |                    |                                                                                               |                 |
|----------------------------------------------------------------------------------------------------------------------------------------------|----------|--------------------|-----------------------------------------------------------------------------------------------|-----------------|
| • Nursing Home Members - OTC products are not covered through the outpatient pharmacy benefit program for members residing in nursing homes. |          |                    |                                                                                               |                 |
| Anti-Fungals                                                                                                                                 |          |                    |                                                                                               |                 |
| Drugs                                                                                                                                        | Updated  | Limits             | Mandatory 3-Month                                                                             | Additional Note |
| clotrimazole 1% topical cream, vaginal cream                                                                                                 | 12/01/20 |                    |                                                                                               |                 |
| miconazole 2% vaginal cream                                                                                                                  | 04/01/17 |                    |                                                                                               |                 |
| miconazole 4% vaginal cream                                                                                                                  | 04/01/17 |                    |                                                                                               |                 |
| 1st Generation Antihistamines                                                                                                                |          |                    |                                                                                               |                 |
| Drugs                                                                                                                                        | Updated  | Limits             | Mandatory 3-Month                                                                             | Additional Note |
| chlorpheniramine 4mg tablet                                                                                                                  | 04/01/17 |                    |                                                                                               |                 |
| diphenhydramine 12.5mg chew                                                                                                                  | 06/01/21 |                    |                                                                                               |                 |
| diphenhydramine 12.5mg/5ml liquid                                                                                                            | 04/01/17 |                    |                                                                                               |                 |
| diphenhydramine 25mg capsule                                                                                                                 | 04/01/17 |                    |                                                                                               |                 |
| diphenhydramine 25mg tablet                                                                                                                  | 04/01/17 |                    |                                                                                               |                 |
| diphenhydramine 50mg/30ml                                                                                                                    | 04/01/17 |                    |                                                                                               |                 |
| 2nd Generation Antihistamines                                                                                                                |          |                    |                                                                                               |                 |
| Drugs                                                                                                                                        | Updated  | Limits             | Mandatory 3-Month                                                                             | Additional Note |
| cetirizine 10 mg tablet                                                                                                                      | 04/01/17 |                    | 90 Day Supply Required                                                                        |                 |
| cetirizine 5mg tablet                                                                                                                        | 04/01/17 |                    |                                                                                               |                 |
| cetirizine 5mg/5ml solution                                                                                                                  | 04/01/17 |                    |                                                                                               |                 |
| loratadine 10mg tablet                                                                                                                       | 04/01/17 |                    | 90 Day Supply Required                                                                        |                 |
| loratadine 5mg chewable tablet                                                                                                               | 04/01/17 |                    |                                                                                               |                 |
| loratadine 5mg/5ml solution                                                                                                                  | 04/01/17 |                    |                                                                                               |                 |
| Contraceptives                                                                                                                               |          |                    |                                                                                               |                 |
| Emergency                                                                                                                                    |          |                    |                                                                                               |                 |
| Drugs                                                                                                                                        | Updated  | Limits             | Covered Generic Products                                                                      |                 |
| levonorgestrel 1.5 mg tablet                                                                                                                 | 07/01/23 | 4 tabs per 30 days | Curae, Econtr, FallBack, Her Style, My Choice, My Way, New Day, Opcicon, Option 2,Take Action |                 |

## Utah Medicaid Covered Over-the-Counter Drugs - Effective August 1, 2025

| Non-Emergency                                  |          |        |                        |                 |
|------------------------------------------------|----------|--------|------------------------|-----------------|
| Products                                       | Updated  | Limits | Mandatory 3-Month      | Additional Note |
| condoms - female                               | 04/01/17 |        |                        |                 |
| condoms - male                                 | 04/01/17 |        |                        |                 |
| nonoxynol-9 spermicides                        | 04/01/17 |        |                        |                 |
| Opill                                          | 07/01/24 |        | 84 Day Supply Required |                 |
| Dermatological                                 |          |        |                        |                 |
| Corticosteroids                                |          |        |                        |                 |
| Drugs                                          | Updated  | Limits | Mandatory 3-Month      | Additional Note |
| hydrocortisone 0.5% cream                      | 04/01/17 |        |                        |                 |
| hydrocortisone 0.5% ointment                   | 04/01/17 |        |                        |                 |
| hydrocortisone 1% cream                        | 04/01/17 |        |                        |                 |
| hydrocortisone 1% ointment                     | 04/01/17 |        |                        |                 |
| Anti-Lice                                      |          |        |                        |                 |
| Drugs                                          | Updated  | Limits | Mandatory 3-Month      | Additional Note |
| permethrin 1% liquid                           | 04/01/17 |        |                        |                 |
| permethrin 1% lotion                           | 04/01/17 |        |                        |                 |
| pyrethrins/piperonyl butoxide 0.33%/4% shampoo | 04/01/17 |        |                        |                 |
| Vanallice 0.3-3.5% gel                         | 01/01/20 |        |                        |                 |
| Fever Reducers and Pain Relievers              |          |        |                        |                 |
| Acetaminophen                                  |          |        |                        |                 |
| Drugs                                          | Updated  | Limits | Mandatory 3-Month      | Additional Note |
| acetaminophen 160mg/5ml liquid                 | 04/01/17 |        |                        |                 |
| acetaminophen 160mg/5ml suspension             | 04/01/17 |        |                        |                 |
| acetaminophen 160mg/5ml solution               | 04/01/17 |        |                        |                 |
| acetaminophen 120mg suppository                | 04/01/17 |        |                        |                 |
| acetaminophen 325mg suppository                | 04/01/17 |        |                        |                 |
| acetaminophen 650mg suppository                | 04/01/17 |        |                        |                 |
| acetaminophen 160mg chewable tablet            | 04/01/17 |        |                        |                 |
| acetaminophen 160mg dispersible tablet         | 04/01/17 |        |                        |                 |
| acetaminophen 325mg tablet                     | 04/01/17 |        |                        |                 |
| acetaminophen 500mg capsule                    | 04/01/17 |        |                        |                 |
| acetaminophen 500mg tablet                     | 04/01/17 |        |                        |                 |
| acetaminophen 650mg tablet                     | 04/01/17 |        |                        |                 |



## Utah Medicaid Covered Over-the-Counter Drugs - Effective August 1, 2025

| Aspirin                                   |          |                      |                        |                 |
|-------------------------------------------|----------|----------------------|------------------------|-----------------|
| Drugs                                     | Last     | Limits               | Mandatory 3-Month      | Additional Note |
| aspirin 81mg tablet                       | 04/01/17 |                      |                        |                 |
| aspirin 81mg chewable tablet              | 04/01/17 |                      | 90 Day Supply Required |                 |
| aspirin 81mg oral disintegrating tablet   | 04/01/17 |                      |                        |                 |
| aspirin 81mg enteric coated tablet        | 04/01/17 |                      | 90 Day Supply Required |                 |
| aspirin 325mg enteric coated tablet       | 04/01/17 |                      |                        |                 |
| aspirin 325mg tablet                      | 04/01/17 |                      |                        |                 |
| Non-Steroidal Anti-Inflammatorys (NSAIDs) |          |                      |                        |                 |
| Drugs                                     | Updated  | Limits               | Mandatory 3-Month      | Additional Note |
| diclofenac gel                            | 01/01/25 |                      |                        |                 |
| ibuprofen 100mg/5ml suspension            | 04/01/17 |                      |                        |                 |
| ibuprofen 50mg/1.25ml suspension          | 04/01/17 |                      |                        |                 |
| ibuprofen 100mg chewable tablet           | 01/01/19 |                      |                        |                 |
| ibuprofen 200mg tablet                    | 04/01/17 |                      |                        |                 |
| naproxen Na 220mg tablet                  | 04/01/17 |                      |                        |                 |
| Gastrointestinal (GI)                     |          |                      |                        |                 |
| Anti-Diarrheals                           |          |                      |                        |                 |
| Drugs                                     | Updated  | Limits               | Mandatory 3-Month      | Additional Note |
| loperamide 2mg capsule                    | 04/01/17 | 240 caps per 30 days |                        |                 |
| loperamide 2mg tablet                     | 04/01/17 | 240 tabs per 30 days |                        |                 |
| loperamide 1mg/7.5ml suspension           | 04/01/17 |                      |                        |                 |
| Laxatives - Bulk                          |          |                      |                        |                 |
| Drugs                                     | Updated  | Limits               | Mandatory 3-Month      | Additional Note |
| psyllium                                  | 04/01/17 |                      |                        |                 |
| Laxatives - Osmotic                       |          |                      |                        |                 |
| Drugs                                     | Updated  | Limits               | Mandatory 3-Month      | Additional Note |
| polyethylene glycol 3350 powder           | 04/01/17 | 1054g per 30 days    |                        |                 |
| Laxatives - Saline                        |          |                      |                        |                 |
| Drugs                                     | Updated  | Limits               | Mandatory 3-Month      | Additional Note |
| magnesium hydroxide 400mg/ml suspension   | 11/01/18 |                      |                        |                 |

## Utah Medicaid Covered Over-the-Counter Drugs - Effective August 1, 2025

| Laxatives - Surfactant                                             |          |        |                        |                 |
|--------------------------------------------------------------------|----------|--------|------------------------|-----------------|
| Drugs                                                              | Updated  | Limits | Mandatory 3-Month      | Additional Note |
| docusate calcium 240mg capsules                                    | 04/01/17 |        |                        |                 |
| docusate Na 100mg, 200mg capsules                                  | 01/01/19 |        | 90 Day Supply Required |                 |
| docusate Na 50mg/5ml liquid                                        | 04/01/17 |        |                        |                 |
| Laxatives - Stimulant                                              |          |        |                        |                 |
| Drugs                                                              | Updated  | Limits | Mandatory 3-Month      | Additional Note |
| bisacodyl 10mg suppository                                         | 04/01/17 |        |                        |                 |
| bisacodyl EC 5mg tablets                                           | 04/01/17 |        |                        |                 |
| sennosides 8.6mg tablets                                           | 01/01/19 |        |                        |                 |
| sennosides 8.8mg/5ml syrup                                         | 12/01/23 |        |                        |                 |
| sennosides/docusate 8.6/50mg tablets                               | 01/01/19 |        |                        |                 |
| Ulcer Drugs - Antacids                                             |          |        |                        |                 |
| Drugs                                                              | Updated  | Limits | Mandatory 3-Month      | Additional Note |
| aluminum hydroxide/mag carbonate 160/104mg chewable                | 04/01/17 |        |                        |                 |
| aluminum hydroxide/mag carbonate 95/358mg/15ml suspension          | 04/01/17 |        |                        |                 |
| aluminum hydroxide/mag hydroxide/simethicone 200/200/25mg chewable | 04/01/17 |        |                        |                 |
| aluminum hydroxide/mag hydroxide/simethicone 200/200/20mg/5ml susp | 04/01/17 |        |                        |                 |
| aluminum hydroxide/mag hydroxide/simethicone 400/400/40mg/5ml susp | 04/01/17 |        |                        |                 |
| calcium carbonate 500mg                                            | 04/01/17 |        |                        |                 |
| calcium carbonate 1000mg                                           | 04/01/17 |        |                        |                 |
| calcium carbonate suspension 1250/5ml                              | 04/01/17 |        |                        |                 |
| Ulcer Drugs - Stomach Acid Reducers                                |          |        |                        |                 |
| Drugs                                                              | Updated  | Limits | Mandatory 3-Month      | Additional Note |
| famotidine 10mg tablet                                             | 06/01/21 |        |                        |                 |
| famotidine 20mg tablet                                             | 04/01/17 |        |                        |                 |

## Utah Medicaid Covered Over-the-Counter Drugs - Effective August 1, 2025

| Opioid Overdose Treatments                                    |          |        |                        |                 |
|---------------------------------------------------------------|----------|--------|------------------------|-----------------|
| Drugs                                                         | Updated  | Limits | Mandatory 3-Month      | Additional Note |
| naloxone nasal spray                                          | 12/01/23 |        |                        |                 |
| Smoking Deterrents                                            |          |        |                        |                 |
| Drugs                                                         | Updated  | Limits | Mandatory 3-Month      | Additional Note |
| nicotine 2mg gum                                              | 04/01/17 |        |                        |                 |
| nicotine 4mg gum                                              | 04/01/17 |        |                        |                 |
| nicotine 2mg lozenge                                          | 04/01/17 |        |                        |                 |
| nicotine 4mg lozenge                                          | 04/01/17 |        |                        |                 |
| nicotine 7mg/24hr patch                                       | 04/01/17 |        |                        |                 |
| nicotine 14mg/24hr patch                                      | 04/01/17 |        |                        |                 |
| nicotine 21mg/24hr patch                                      | 04/01/17 |        |                        |                 |
| Supplements                                                   |          |        |                        |                 |
| Iron                                                          |          |        |                        |                 |
| Drugs                                                         | Updated  | Limits | Mandatory 3-Month      | Additional Note |
| ferrous gluconate 324mg (37.5/38mg elemental Fe) tablet       | 04/01/17 |        |                        |                 |
| ferrous sulfate drops 75 mg/ml (15 mg/ml elemental Fe) liquid | 04/01/17 |        |                        |                 |
| ferrous sulfate 220mg/5ml (44mg/5ml elemental Fe) liquid      | 04/01/17 |        |                        |                 |
| ferrous sulfate ER (45mg elemental fe) tablet                 | 07/01/24 |        | 90 Day Supply Required |                 |
| ferrous sulfate 325mg (65mg elemental fe) tablet              | 01/01/19 |        | 90 Day Supply Required |                 |
| ferrous sulfate CR 325mg (65mg elemental fe) tablet           | 04/01/17 |        | 90 Day Supply Required |                 |
| Sleep Aids                                                    |          |        |                        |                 |
| Drugs                                                         | Updated  | Limits | Mandatory 3-Month      | Additional Note |
| melatonin 2.5mg chew                                          | 09/01/24 |        | 90 Day Supply Required |                 |
| melatonin 3mg tablet                                          | 09/01/24 |        | 90 Day Supply Required |                 |
| melatonin 5mg tablet                                          | 09/01/24 |        | 90 Day Supply Required |                 |

## Utah Medicaid Additional Brand Required Over Generic Drugs - Effective August 1, 2025

| • Policy: Drugs listed on this list or on the PDL as preferred, are exceptions to Utah Medicaid's Mandatory Generic Drug Policy. |                                              |               |        |             |                              |
|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|---------------|--------|-------------|------------------------------|
| Preferred Brand Name Drugs                                                                                                       | Non-Preferred Generic Drugs                  | Updated       | Limits | Prior Auth  | Additional Note              |
| Afinitor                                                                                                                         | everolimus tab                               | 02/01/25      |        |             |                              |
| Aptiom                                                                                                                           | eslicarbazepine                              | 06/01/25      |        |             |                              |
| Azopt                                                                                                                            | brinzolamide                                 | 07/01/21      |        |             |                              |
| Bidil                                                                                                                            | isosorbide dinitrate/hydralazine             | 05/01/22      |        |             |                              |
| Biltricide                                                                                                                       | praziquantel                                 | Not Available |        |             |                              |
| Buphenyl                                                                                                                         | sodium phenylbutyrate                        | Not Available |        | PA Required | Rare Disease Medication Form |
| Camptosar 300mg                                                                                                                  | irinotecan 300mg                             | 03/01/20      |        |             |                              |
| Cellcept suspension                                                                                                              | mycophenolate suspension                     | Not Available |        |             |                              |
| Condylox gel                                                                                                                     | podofilox gel                                | 01/01/24      |        |             |                              |
| DDAVP injection                                                                                                                  | desmopressin injection                       | 09/01/23      |        |             |                              |
| Demser                                                                                                                           | metyrosine                                   | 08/01/20      |        |             |                              |
| Fareston                                                                                                                         | toremifene                                   | 02/01/19      |        |             |                              |
| Forteo                                                                                                                           | teriparatide                                 | 05/01/25      |        | PA Required | Parathyroid Hormone Analogs  |
| Glumetza                                                                                                                         | Metformin ER 24HR Modified Release           | 08/01/23      |        |             |                              |
| Glyset                                                                                                                           | miglitol                                     | Not Available |        |             |                              |
| Hemabate                                                                                                                         | carboprost                                   | 03/01/22      |        |             |                              |
| Hepsera                                                                                                                          | adefovir                                     | Not Available |        |             |                              |
| Keveyis                                                                                                                          | dichlorphenamide                             | 02/01/23      |        |             |                              |
| Korlym                                                                                                                           | mifepristone 300mg tablet                    | 02/01/24      |        |             |                              |
| Kristalose Pak                                                                                                                   | Lactulose Oral Crystal Packet                | 03/01/25      |        |             |                              |
| Mesna                                                                                                                            | mesna                                        | 02/01/25      |        |             |                              |
| Motegrity                                                                                                                        | prucalopride                                 | 02/01/25      |        |             |                              |
| Mycamine                                                                                                                         | micafungin                                   | 05/01/20      |        |             |                              |
| Nexavar                                                                                                                          | sorafenib                                    | 07/01/22      |        |             |                              |
| Niaspan                                                                                                                          | niacin ER                                    | Not Available |        |             |                              |
| Orfadin, Nityr                                                                                                                   | nitisinone cap                               | 08/01/25      |        |             |                              |
| Proglycem                                                                                                                        | diazoxide                                    | 04/01/20      |        |             |                              |
| Purixan Sus 20MG/ML                                                                                                              | Mercaptopurine Susp 2000 MG/100ML (20 MG/ML) | 04/01/25      |        |             |                              |
| Restasis                                                                                                                         | cyclosporine (ophth) emulsion                | 09/01/24      |        |             |                              |
| Revlimid                                                                                                                         | lenalidomide                                 | 04/01/22      |        |             |                              |
| Ridaura                                                                                                                          | auranofin                                    | 03/01/25      |        |             |                              |
| Riomet                                                                                                                           | metformin solution                           | 04/01/21      |        |             |                              |
| Samsca, Jynarque                                                                                                                 | tolvaptan                                    | 09/01/21      |        |             |                              |
| Sorilux foam                                                                                                                     | calcipotriene foam                           | Not Available |        |             |                              |

## Utah Medicaid Additional Brand Required Over Generic Drugs - Effective August 1, 2025

| Preferred Brand Name Drugs | Non-Preferred Generic Drugs | Updated       | Limits | Prior Auth | Additional Note |
|----------------------------|-----------------------------|---------------|--------|------------|-----------------|
| Sutent                     | sunitinib                   | 09/01/22      |        |            |                 |
| Syprine                    | trientine                   | Not Available |        |            |                 |
| Tarceva                    | erlotinib                   | 06/01/19      |        |            |                 |
| Tekturna                   | aliskiren                   | 04/01/19      |        |            |                 |
| Torisel                    | temsirolimus                | 10/01/20      |        |            |                 |
| Tykerb                     | lapatinib                   | 11/01/20      |        |            |                 |
| Valstar                    | valrubicin                  | 05/01/19      |        |            |                 |
| Votrient                   | pazopanib                   | 04/01/25      |        |            |                 |
| Xyrem                      | sodium oxybate              | 06/01/23      |        |            |                 |
| Zavesca                    | miglustat                   | 02/01/19      |        |            |                 |
| Zyclara                    | imiquimod 3.75%             | 09/01/18      |        |            |                 |

## Utah Medicaid Additional 3 Month Supply Required Drugs- Effective August 1, 2025

| <ul style="list-style-type: none"> <li>• <b>Policy:</b> Utah Medicaid has instituted a mandatory 3 month supply for maintenance medications, following a two-month window for dose titration and stabilization.</li> <li>• <b>Copays:</b> For a 3 month supply, Utah Medicaid fee for service members who are subject to cost-sharing will pay a single copay.</li> <li>• <b>Day Supply:</b> 3 Month supply is defined as a 90 day supply. Exceptions to this are hormonal contraceptives. For continuous cycle contraceptives it is defined as 91 days; for all other hormonal contraceptives it is defined as 84 days.</li> <li>• <b>Dispensing Fees:</b> Pharmacies will receive a single dispensing fee on prescriptions filled for a 3 Month supply.</li> <li>• <b>Exemptions:</b> Mandatory three month policy applies to most members. Exemptions from this program as determined based on the member Category of Aid. Note: The mandatory 3 Month policy does not apply to Indian Health Service providers, or Medicaid members receiving long term services and supports in nursing facilities, intermediate care facilities, or home and community based waiver programs. While not mandatory, 3 Month supply fills remains optional for these groups.</li> <li>• <b>Exceptions:</b> Requests for exceptions may be submitted by the prescriber through Prior Authorization.</li> </ul> |                                                           |                                  |                |          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------|----------------|----------|
| Drugs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Strength(s)                                               | Status                           | Type           | Updated  |
| amiodarone hydrochloride                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 200mg                                                     | Mandatory Generic Policy Applies | Generic        | 08/01/18 |
| amlodipine/benazepril                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2.5/10mg, 5/10mg, 5/20mg, 5/40mg, 10/20mg, 10/40mg        | Mandatory Generic Policy Applies | Generic        | 08/01/18 |
| anastrozole                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1mg, 2mg                                                  | Mandatory Generic Policy Applies | Generic        | 08/01/18 |
| aspirin chew & EC tablet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 81mg                                                      | Mandatory Generic Policy Applies | Generic        | 07/01/16 |
| clonidine tablet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 0.1mg, 0.2mg, 0.3mg                                       | Mandatory Generic Policy Applies | Generic        | 07/01/16 |
| contraceptives                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | barrier, injectable, progestin only, transdermal, vaginal | Mandatory Generic Policy Applies | Brand/ Generic | 05/01/19 |
| dapsone tablet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 25mg, 100mg                                               | Mandatory Generic Policy Applies | Generic        | 08/01/18 |
| dicyclomine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 20mg                                                      | Mandatory Generic Policy Applies | Generic        | 07/01/16 |
| docusate Na                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 100mg, 250mg                                              | Mandatory Generic Policy Applies | Generic        | 07/01/16 |
| ferrous sulfate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 325mg                                                     | Mandatory Generic Policy Applies | Generic        | 07/01/16 |
| fludrocortisone                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0.1mg                                                     | Mandatory Generic Policy Applies | Generic        | 08/01/21 |
| folic acid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1mg                                                       | Mandatory Generic Policy Applies | Generic        | 07/01/16 |
| glimepiride                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1mg, 2mg, 4mg                                             | Mandatory Generic Policy Applies | Generic        | 07/01/16 |
| glipizide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 5mg, 10mg                                                 | Mandatory Generic Policy Applies | Generic        | 02/01/18 |
| glipizide ER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2.5mg, 5mg, 10mg                                          | Mandatory Generic Policy Applies | Generic        | 07/01/16 |
| glyburide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2.5mg, 5mg                                                | Mandatory Generic Policy Applies | Generic        | 08/01/18 |
| glyburide micronized                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1.5mg, 3mg, 6mg                                           | Mandatory Generic Policy Applies | Generic        | 08/01/18 |
| glyburide/metformin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1.25/250mg, 2.5/500mg, 5/500mg                            | Mandatory Generic Policy Applies | Generic        | 08/01/18 |
| hydrochlorothiazide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 12.5mg, 25mg, 50mg                                        | Mandatory Generic Policy Applies | Generic        | 07/01/16 |
| indapamide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1.25mg, 2.5mg                                             | Mandatory Generic Policy Applies | Generic        | 02/01/18 |
| isoniazid syrup                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 50mg/5ml                                                  | Mandatory Generic Policy Applies | Generic        | 08/01/18 |
| isoniazid tablet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 100mg, 300mg                                              | Mandatory Generic Policy Applies | Generic        | 08/01/18 |

## Utah Medicaid Additional 3 Month Supply Required Drugs- Effective August 1, 2025

| Drugs                                  | Strength(s)                                                                                | Status                           | Type           | Updated       |
|----------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------|----------------|---------------|
| letrozole                              | 2.5mg                                                                                      | Mandatory Generic Policy Applies | Generic        | 07/01/16      |
| levothyroxine                          | 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg | Mandatory Generic Policy Applies | Generic        | 08/01/21      |
| lithium                                | 150mg, 300mg, 600mg, 300mg ER, 450mg ER                                                    | Mandatory Generic Policy Applies | Generic        | 08/01/18      |
| medroxyprogesterone                    | 2.5mg, 5mg, 10mg                                                                           | Mandatory Generic Policy Applies | Generic        | 08/01/18      |
| metformin                              | 500mg, 850mg, 1000mg                                                                       | Mandatory Generic Policy Applies | Generic        | 07/01/16      |
| metformin ER (except modified release) | 500mg, 750mg, 1000mg                                                                       | Mandatory Generic Policy Applies | Generic        | 08/01/23      |
| norethindrone acetate                  | 5mg                                                                                        | Mandatory Generic Policy Applies | Generic        | 08/01/21      |
| pediatric vitamins                     | ADC, multi- w/o Fl & Fe                                                                    | Mandatory Generic Policy Applies | Brand/ Generic | 05/01/19      |
| Prempro                                | 0.3/1.5mg, 0.45/1.5mg, 0.625/2.5mg, 0.625/5mg                                              | Mandatory Generic Policy Applies | Brand          | 08/01/18      |
| segesterone/ethinyl estradiol          | 0.15/0.013mg per 24 hr                                                                     | Mandatory Generic Policy Applies | Brand          | Not available |
| tamoxifen                              | 10mg, 20mg                                                                                 | Mandatory Generic Policy Applies | Generic        | 08/01/18      |
| trihexyphenidyl                        | 2mg, 5mg                                                                                   | Mandatory Generic Policy Applies | Generic        | 02/01/18      |



## Utah Medicaid Additional Drug Limits - Effective July 1, 2025

| Antineoplastics                             |                  |               |                    |                 |
|---------------------------------------------|------------------|---------------|--------------------|-----------------|
| Generic Name Drugs                          | Brand Name Drugs | Updated       | Limits             | Additional Note |
| apalutamide                                 | Erleada          | Not Available | Male only          |                 |
| bicalutamide                                | Casodex          | Not Available | Male only          |                 |
| darolutamide                                | Nubeqa           | Not Available | Male only          |                 |
| enzalutamide                                | Xtandi           | Not Available | Male only          |                 |
| exemestane                                  | Aromasin         | Not Available | Female only        |                 |
| flutamide                                   |                  | Not Available | Male only          |                 |
| nilutamide                                  |                  | Not Available | Male only          |                 |
| Central Nervous System - Smoking Deterrents |                  |               |                    |                 |
| Generic Name Drugs                          | Brand Name Drugs | Updated       | Limits             | Additional Note |
| Nicotine Replacement Products               | All              | Not Available | 12 years and older |                 |
| Varenicline                                 | Chantix          | 04/01/19      | 16 years and older |                 |
| Contraceptives                              |                  |               |                    |                 |
| Generic Name Drugs                          | Brand Name Drugs | Updated       | Limits             | Additional Note |
| drospirenone                                | Slynd            | Not Available | Female only        |                 |
| etonogestrel/ethinyl estradiol ring         | Nuvaring         | Not Available | Female only        |                 |
| lactic/citric/potassium vaginal gel         | Phexxi           | Not Available | Female only        |                 |
| levonorgestrel/ethinyl estradiol patch      | Twirla           | Not Available | Female only        |                 |
| norelgestromin/ethinyl estradiol patch      |                  | Not Available | Female only        |                 |
| norethindrone                               |                  | Not Available | Female only        |                 |
| Cough and Cold Preparations                 |                  |               |                    |                 |
| Generic Name Drugs                          | Brand Name Drugs | Updated       | Limits             | Additional Note |
| codeine/guaifenesin combinations            |                  | 11/01/21      | 12 years and older |                 |
| COVID-19 Tests                              |                  |               |                    |                 |
| Products                                    |                  | Updated       | Limits             | Additional Note |
| COVID-19 Tests                              |                  | 02/01/22      | 8 tests /30 days   |                 |
| Emergency Contraceptives                    |                  |               |                    |                 |
| Generic Name Drugs                          | Brand Name Drugs | Updated       | Limits             | Additional Note |
| Ulipristal                                  | Ella             | Not Available | 2 kits /30 days    |                 |

## Utah Medicaid Additional Drug Limits - Effective July 1, 2025

| Gastrointestinal (GI) - Antidiarrheals |                  |               |                                     |                                         |
|----------------------------------------|------------------|---------------|-------------------------------------|-----------------------------------------|
| Generic Name Drugs                     | Brand Name Drugs | Updated       | Limits                              | Additional Note                         |
| diphenoxylate/atropine                 | Lomotil          | 05/01/23      | Cumulative limit: 240 tab /30 days  |                                         |
| loperamide                             |                  | 05/01/23      | Cumulative limit: 240 tab /30 days  |                                         |
| Hematopoietic Growth Factors           |                  |               |                                     |                                         |
| Generic Name Drugs                     | Brand Name Drugs | Updated       | Limits                              | Additional Note                         |
| eltrombopag                            | Alvaiz, Promacta | 11/01/18      | Cumulative limit: 30 tab /30 days   |                                         |
| Migraine Agents                        |                  |               |                                     |                                         |
| Generic Name Drugs                     | Brand Name Drugs | Updated       | Limits                              | Additional Note                         |
| butalbital/apap                        | Allzital         | 10/01/19      | Cumulative limit: 20 units /30 days | Restricted to members age 18 and older. |
| butalbital/apap/caf                    | Fioricet, Esgic  | 10/01/19      | Cumulative limit: 20 units /30 days | Restricted to members age 18 and older. |
| butalbital/apap/caf/codeine            |                  | 10/01/19      | Cumulative limit: 20 units /30 days | Restricted to members age 18 and older. |
| butalbital/asa/caf                     | Fiorinal         | 10/01/19      | Cumulative limit: 20 units /30 days | Restricted to members age 18 and older. |
| butalbital/asa/caf/codeine             | Fiorinal/codeine | 10/01/19      | Cumulative limit: 20 units /30 days | Restricted to members age 18 and older. |
| Minerals and Vitamins                  |                  |               |                                     |                                         |
| Generic Name Drugs                     | Brand Name Drugs | Updated       | Limits                              | Additional Note                         |
| Pediatric vitamins                     |                  | Not Available | 5 years and under                   |                                         |
| sodium fluoride chew                   |                  | 06/01/24      | 16 years and under                  |                                         |
| sodium fluoride liquid                 |                  | Not Available | 5 years and under                   |                                         |
| Progesterones                          |                  |               |                                     |                                         |
| Generic Name Drugs                     | Brand Name Drugs | Updated       | Limits                              | Additional Note                         |
| hydroxyprogesterone caproate           | Makena           | Not Available | Female only                         |                                         |
| medroxyprogesterone tablet             | Provera          | Not Available | Female only                         |                                         |
| norethindrone tablet                   | Aygestin         | Not Available | Female only                         |                                         |
| progesterone capsule                   | Prometrium       | Not Available | Female only                         |                                         |
| progesterone injection                 | Depo-Provera     | Not Available | Female only                         |                                         |

## Utah Medicaid Prior Authorizations - Effective August 1, 2025

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------|
| • Pharmacy Prior Authorization Forms: Can be found on the Utah Medicaid website. <a href="https://medicaid.utah.gov/pharmacy/prior-authorization">https://medicaid.utah.gov/pharmacy/prior-authorization</a> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       |          |
| • Submission: Fax completed and signed form with documentation, including chart notes, letter of medical necessity and laboratory results to 855-828-4992.                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       |          |
| • Substitution: Authorizations will be processed for the preferred Generic/Brand equivalent unless specified “Do Not Substitute”.                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       |          |
| Non Drug Specific PA Forms                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       |          |
| Form                                                                                                                                                                                                         | Notes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                       | Updated  |
| Exception to 3 Month Supply                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       | 05/01/24 |
| Medication Coverage Exception Request                                                                                                                                                                        | Incorporates Brand Name, Combination Products, Dosing Kits, Non-Preferred Medications, Off-Label Use, Quantity/Dose/Age Limit Exceptions, and Step Therapy Requests                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                       | 08/01/25 |
| New to Market Drug                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       | 07/01/25 |
| Rare Disease Medications- Medications that require prior authorization but do not belong to another PA class due to the disease or indication being uncommon, including but not limited to:                  | Adcetris, Adzynma, Aldurazyme, Ammonul, Amondys 45, Amvuttra, Andembry, Aralast, Atgam, Attruby, Ayvakit, Besremi, Bkempv, Brineura, Buphenyl, Bylvay, Carbaglu, Cinryze, Crenessity, Cuvrior, Dojolvi, Elaprase, Empaveli, Enjaymo, Enspryng, Epysqli, Exondys 51, Filspari, Gamifant, Givlaari, Glassia, Gomekli, Haegarda, Hemady, Imcivree, Isturisa, Joenja, Kanuma, Lamzede, Livmarli, Lumizyme, Mepsevii, Myalept, Naglazyme, Nexavar, Nexviazyme, Nuedexta, Nulibry, Onpattro, Opfolda, Orladeyo, Oxlumo, Palinzyq, Pheburane, Piasky, Pombiliti, Prolastin, Provenge, Ravicti, Reblozyl, Rivfloza, Ryplazim, sodium benzoate/sodium phenylacetate, Pyrukynd, Soliris, Spevigo, Strensiq, Sutent, Sylvant, Takhzyro, Tavneos, Tegsedi, Tepezza, Terlivaz, Tryngolza, Ultomiris, Uplizna, Veopoz, Vioice, Viltepso, Vimizim, Voxzogo, Xenpozyme, Xolremdi, Zemaira |                                                       | 07/01/25 |
| Drug Class or Disease Specific PA Forms                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       |          |
| • Policy: Non-Preferred products, per Utah Medicaid’s PDL, require trial and failure of a preferred product or the prescriber must demonstrate medical necessity.                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       |          |
| Form                                                                                                                                                                                                         | Products                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Notes                                                 | Updated  |
| Acute HAE                                                                                                                                                                                                    | Berinert, Ekterly, Firazyr, Kalbitor, Ruconest                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                       | 08/01/25 |
| ADHD Stimulants                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       | 04/01/25 |
| Amondys 45, Exondys 51, Vyondys 53, Viltepso                                                                                                                                                                 | Amondys 45, Excondys 51, Vyondys 53, Viltepso                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                       | 02/01/25 |
| Androgens                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       | 10/01/24 |
| Antipsychotics in Children                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       | 04/01/25 |
| Anti-vascular Endothelial Growth Factor Therapy                                                                                                                                                              | Alymsys, Avastin, Beovu, Cimerli, Cyramza, Eylea, Lucentis, Macugen, Mvasi, Pavblu, Susvimo, Vabvsmo, Zaltrap, Zirabev                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Covered under medical benefit using appropriate HCPCS | 3/1/2025 |

## Utah Medicaid Prior Authorizations - Effective August 1, 2025

| Form                                                       | Products                                                                                                   | Notes                                                 | Updated  |
|------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------|
| Botulinum Toxin                                            | Botox, Dysport, Myobloc, Xeomin                                                                            | Covered under medical benefit using appropriate HCPCS | 05/01/25 |
| Buprenorphine & Buprenorphine_Naloxone Products (Oral)     | Bunavail, buprenorphine, buprenorphine/naloxone, Suboxone, Zubsolv                                         |                                                       | 06/01/24 |
| CGRP Antagonist                                            | Aimovig, Ajovy, Emgality, Nurtec, Qulipta, Ubrelvy, Vyepti                                                 |                                                       | 11/01/24 |
| Continuous Glucose Monitors                                | Dexcom, FreeStyle Libre, Guardian                                                                          |                                                       | 08/01/25 |
| Cystic Fibrosis CFTR Modulators                            | Kalydeco, Orkambi, Symdeko, Trikafta                                                                       |                                                       | 05/01/25 |
| Drugs to Promote Fertility                                 | cetorelix, follitropin alpha, follitropin beta, ganirelix acetate                                          |                                                       | 07/01/25 |
| Fabry Disease                                              | Elfabrio, Fabrazyme, Galafold                                                                              |                                                       | 02/01/25 |
| Gaucher Disease                                            | Cerdelga, Cerezyme, Elelyso, VPRIB, Zavesca                                                                |                                                       | 12/01/24 |
| GLP-1 Medications for Weight Loss                          | Saxenda, Wegovy, Zepbound                                                                                  |                                                       | 07/01/25 |
| Gonadotropin-Releasing Hormone                             | Camcevi, Eligard, Fensolvi, Firmagon, Lupron, Orgovyx, Orvidrel, Supprelin, Synarel, Trelstar, Triptodur   | Orilissa has a separate PA form                       | 07/01/25 |
| Growth Hormone                                             |                                                                                                            |                                                       | 07/01/24 |
| Hepatitis C                                                |                                                                                                            |                                                       | 08/01/25 |
| Hormone Therapy for Gender Dysphoria                       |                                                                                                            |                                                       | 01/01/25 |
| Immunoglobulin Therapy                                     |                                                                                                            |                                                       | 01/01/25 |
| Monoclonal Antibodies for Asthma and Other Indications     | CinQair, Dupixent, Fasenra, Nucala, Tezspire, Xolair                                                       |                                                       | 08/01/25 |
| Ophthalmic Corticosteroid Intravitreal Implants/Injections | Iluvien, Ozurdex, Retisert, Triesence, Xipere, Yutiq                                                       | Covered under medical benefit using appropriate HCPCS | 08/01/25 |
| Opioid and Opioid Benzodiazepine Combination               |                                                                                                            |                                                       | 02/01/25 |
| PAMORAs                                                    |                                                                                                            |                                                       | 08/01/25 |
| Parathyroid Hormone Analogs                                | Evenity (romosozumab-aqqg), Forteo (teriparatide), Tymlos (abaloparatide), Yorvipath (palopegteriparatide) |                                                       | 07/01/25 |
| PCSK9 Inhibitors                                           | Praluent, Repatha                                                                                          |                                                       | 3/1/2025 |
| Pulmonary Hypertension                                     |                                                                                                            |                                                       | 05/01/24 |
| Wakefulness Promoting Agents                               | Nuvigil (armodafinil), Provigil (modafinil), Sunosi (solriamfetol), Wakix (pitolisant)                     |                                                       | 08/01/25 |

# Utah Medicaid Prior Authorizations - Effective August 1, 2025

| Drug Specific PA Forms |                                                                 |                                |          |
|------------------------|-----------------------------------------------------------------|--------------------------------|----------|
| Brand Name             | Generic Name                                                    | Notes                          | Updated  |
| Abecma                 | idecabtagene vicleucel                                          |                                | 3/1/2025 |
| Abilify Mycite         | aripiprazole tablets with sensor                                |                                | 08/01/24 |
| Adakveo                | crizanlizumab                                                   |                                | 04/01/25 |
| Aucatzyl               | obecabtagene autoleucel                                         |                                | 4/1/2025 |
| Braftovi, Mektovi      | encorafenib and binimetinib                                     |                                | 10/01/24 |
| Breyanzi               | lisocabtagene maraleucel                                        |                                | 04/01/25 |
| Cabenuva               | cabotegravir/rilpivirine extended-release injectable suspension |                                | 08/01/25 |
| Carvykti               | ciltacabtagene autoleucel                                       |                                | 3/1/2025 |
| Casgevy                | (exagamglogene autotemcel)                                      |                                | 07/01/24 |
| Cialis                 | tadalafil                                                       |                                | 05/01/24 |
| Crysvita               | burosumab-twza                                                  |                                | 11/01/24 |
| Daybue                 | trofinetide                                                     |                                | 02/01/25 |
| Doptelet               | avatrombopag                                                    |                                | 10/01/24 |
| Elevidys               | delandistrogene moxeparvovec-rokl                               |                                | 12/01/24 |
| Emflaza                | deflazacort                                                     |                                | 10/01/24 |
| Epidiolex              | cannabidiol                                                     |                                | 07/01/25 |
| Evkeeza                | evinacumab-dgnb                                                 |                                | 07/01/24 |
| Evrysdi                | risdiplam                                                       |                                | 11/01/24 |
| Hemgenix               | etranacogene dezaparvovec-drlb                                  |                                | 11/01/24 |
| Hemlibra               | emicizumab-kxwh                                                 |                                | 09/01/24 |
| Hetlioz                | tasimelteon                                                     |                                | 02/01/25 |
| Humulin R U-500        | concentrated insulin human injection                            |                                | 08/01/25 |
| Jakafi                 | ruxolitinib                                                     |                                | 03/01/24 |
| Jynarque               | tolvaptan                                                       |                                | 11/01/24 |
| Krystexxa              | Pegloticase                                                     |                                | 09/01/24 |
| Kymriah                | tisagenlecleucel                                                |                                | 04/01/25 |
| Lantidra               | donislecel-jujn                                                 |                                | 02/01/25 |
| Lenmeldy               | atidarsagene autotemcel                                         |                                | 03/01/25 |
| Legembi                | lecanemab-irmb                                                  |                                | 06/01/25 |
| Lucemyra               | lofexidine hydrochloride                                        |                                | 07/01/25 |
| Luxturna               | voretigene neparvovec-rzyl                                      |                                | 10/01/24 |
| Lyfgenia               | lovotibeglogene autotemcel                                      |                                | 07/01/24 |
| Mavenclad              | cladribine                                                      |                                | 11/01/24 |
| Methadone              | Methadone                                                       | Treatment of chronic pain only | 01/01/25 |
| Mifeprex               | mifepristone                                                    |                                | 06/01/25 |
| Novarel, Pregnyl       | chorionic gonadotropin                                          |                                | 06/01/25 |

## Utah Medicaid Prior Authorizations - Effective August 1, 2025

| Brand Name        | Generic Name                                                                                          | Notes                                     | Updated  |
|-------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------------|----------|
| Nuplazid          | pimavanserin                                                                                          |                                           | 08/01/25 |
| Oralair           | Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens Allergen Extract |                                           | 08/01/25 |
| Orilissa          | elagolix                                                                                              |                                           | 08/01/25 |
| Palforzia         | Peanut (Arachis hypogaea) Allergen Powder-dnfp                                                        |                                           | 01/01/25 |
| Reyvow            | lasmiditan                                                                                            |                                           | 01/01/25 |
| Rezdiffra         | resmetirom                                                                                            |                                           | 12/01/24 |
| Roctavian         | valoctocogene roxaparvovec                                                                            |                                           | 10/01/24 |
| Rukobia           | fostemsavir                                                                                           |                                           | 08/01/25 |
| Samsca            | tolvaptan                                                                                             |                                           | 12/01/24 |
| Sirturo           | bedaquiline fumarate                                                                                  |                                           | 09/01/24 |
| Skyclarys         | Omaveloxolone                                                                                         |                                           | 07/01/25 |
| Spinraza          | nusinersen                                                                                            |                                           | 12/01/24 |
| Spravato          | esketamine nasal spray                                                                                |                                           | 05/01/25 |
| Sunlenca, Yeztugo | lenacapavir                                                                                           |                                           | 08/01/25 |
| Synagis           | Palivizumab                                                                                           |                                           | 12/01/24 |
| Tecartus          | brexucabtagene autoleucel                                                                             |                                           | 04/01/25 |
| Trodelyv          | sacituzumab govitecan                                                                                 |                                           | 12/01/24 |
| Tryvio            | aprocitentan                                                                                          |                                           | 07/01/25 |
| Tzield            | teplizumab-mzwv                                                                                       |                                           | 09/01/24 |
| Verquvo           | vericiguat                                                                                            |                                           | 05/01/25 |
| Vyjuvek           | beremagene geperpavec-svdt                                                                            |                                           | 02/01/25 |
| Wegovy            | semaglutide                                                                                           |                                           | 11/01/24 |
| Xifaxan           | rifaximin                                                                                             |                                           | 12/01/24 |
| Xyrem, Xywav      | (sodium oxybate), (calcium, magnesium, potassium, and sodium oxybates)                                |                                           | 08/01/25 |
| Yescarta          | axicabtagene ciloleucel                                                                               |                                           | 03/01/25 |
| Zepbound          | tirzepatide                                                                                           | Treatment of obstructive sleep apnea only | 07/01/25 |
| Zolgensma         | onasemnogene abeparvovec-xioi                                                                         |                                           | 06/01/25 |
| Zynteglo          | betibeglogene autotemcel                                                                              |                                           | 07/01/25 |
| Zurzuvae          | zuranolone capsule                                                                                    |                                           | 02/01/25 |

## Utah Medicaid Ultra High Cost Drugs - Effective August 1, 2025

| • Policy: Drugs listed on this list are considered Ultra High Cost and are carved out to Fee For Service Medicaid. |                                   |          |                   |           |                                                                                                                                                                              |
|--------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------|-------------------|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Brand Name                                                                                                         | Generic Name                      | Updated  | HCPCS or CPT Code | PA Form   | Population and Dx Codes                                                                                                                                                      |
| Beqvez                                                                                                             | fidanacogene elaparvovec-dzkt     | 10/01/24 | TBD               | Beqvez    | Adults with moderate to severe hemophilia B (congenital factor IX deficiency)                                                                                                |
| Casgevy                                                                                                            | exagamlogene autotemcel           | 01/01/24 | TBD               | Casgevy   | Sickle Cell Disease (SCD) in patients 12 years and older with recurrent vaso-occlusive crises                                                                                |
| Elevidys                                                                                                           | delandistrogene moxeparvovec-rokl | 08/01/23 | J1413             | Elevidys  | Ambulatory pediatric patients aged 4 through 5 years with Duchenne muscular dystrophy (DMD) with a confirmed mutation in the DMD gene                                        |
| Hemgenix                                                                                                           | etranacogene dezaparvovec-drlb    | 07/01/23 | J1411             | Hemgenix  | Adults with Hemophilia B (congenital Factor IX deficiency)                                                                                                                   |
| Lenmeldy                                                                                                           | atidarsagene autotemcel           | 08/01/24 | TBD               | Lenmeldy  | Children with pre-symptomatic late infantile (PSLI), pre-symptomatic early juvenile (PSEJ) or early symptomatic early juvenile (ESEJ) metachromatic leukodystrophy (MLD)     |
| Lyfgenia                                                                                                           | lovotibeglogene autotemcel        | 01/01/24 | J3394             | Lyfgenia  | Sickle Cell Disease (SCD) in patients 12 years and older with a history of vaso-occlusive events                                                                             |
| Roctavian                                                                                                          | valoctocogene roxaparvovec-rvox   | 08/01/23 | J1412             | Roctavian | Adults with severe hemophilia A (congenital factor VIII deficiency with factor VIII activity < 1 IU/dL) without pre-existing antibodies to adeno-associated virus serotype 5 |
| Skysona                                                                                                            | elivaldogene autotemcel           | 09/01/23 | TBD               | TBD       | Boys aged 4-17 years with Early, active cerebral adrenoleukodystrophy (CALD)                                                                                                 |
| Zolgensma                                                                                                          | onasemnogene abeparvovec-xioi     | 03/01/25 | J3399             | Zolgensma | Children <2yrs of age with Spinal Muscular Atrophy (SMA)                                                                                                                     |
| Zynteglo                                                                                                           | Betibeglogene autotemcel          | 09/01/23 | J3393             | TBD       | Adult and pediatric patients with $\beta$ -thalassemia who require regular red blood cell (RBC) transfusions                                                                 |