Department of Health & Human Services
Integrated Healthcare

Utah Medicaid Fee-for-Service

Preferred Drug List (PDL) & Pharmacy Coverage Resources

Effective November 1, 2026

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• **Drugs Not Listed on PDL:** Covered per Pharmacy Provider Manual. Manuals can be found at https://medicaid.utah.gov/utah-medicaid-official-publications

• **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.

• **Non-Preferred Products:** Documentation of trial and failure of a preferred product with a similar dosage form and indication is required. If a non-preferred strength or dosage form is requested, the corresponding preferred strength or dosage form must be tried first, unless medical necessity is documented by the prescriber. Additional criteria found on Drug Class and Disease Specific PA Forms will also apply. Authorization Criteria can be found at https://medicaid.utah.gov/pharmacy/prior-authorization.

• **Non-Preferred Combination Product**s: If separate single ingredient products are preferred, those must be tried before a non-preferred product will be approved.

• **Non-Preferred Atypical Antipsychotic Products - DAW (Dispense as Written):** Non-preferred atypical antipsychotic medications may bypass the non-preferred drug prior authorization if the prescriber writes “dispense as written” on a prescription and the pharmacy submits a Dispense As Written (DAW) Code of “1” on the claim.

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.

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 non preferred 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.

• **Over-the-Counter (OTC) Products:** A complete listing of covered OTC products is located in this document following the PDL. OTC products are not covered through the pharmacy benefit program for members residing in nursing homes. Nursing-home reimbursement rate covers OTC products.

• **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.

• **Vaccines for Children (VFC**): For Medicaid members age 18 and younger, vaccines eligible through the Vaccines for Children (VFC) Program must be obtained and billed through "the VFC Program. For additional information, refer to the Pharmacy Services Provider Manual or visit: https://immunize.utah.gov/vaccines-for-children-program"

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

Medication/Product Group

Medication/Product Class

Medication/Product Subclass

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note

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Analgesics							
Non-Opioid Analgesics							
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 sodium 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, ER	Preferred	Generic	01/01/21				
Journavx	Preferred	Brand	09/01/25	30 Units / 15 Days with Max 1 Fill Every 60 Days. Min age: 18			NDC: 51167-0548-30 only
ketorolac injection	Preferred	Generic	09/28/09	4 units /day for 5 days 20 units /180 days			
ketorolac tablet	Preferred	Generic	09/28/09	4 units /day for 5 days 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 sodium 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		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
gabapentin (once daily)	Non Preferred	Generic	02/01/24	1800mg /day	Medication Coverage Exception	Gralise	Pregabalin/ Gabapentin combo is restricted
Gralise	Non Preferred	Brand	09/01/18	1800mg /day	Medication Coverage Exception	Gralise	Pregabalin/ Gabapentin combo is restricted
Horizant	Non Preferred	Brand	09/01/18	1200mg /day	Medication Coverage Exception		Pregabalin/ Gabapentin combo is restricted
ibuprofen lysine injection	Non Preferred	Generic	11/01/20		Medication Coverage Exception	Neoprofen	
ibuprofen/famotidine	Non Preferred	Generic	10/01/25		Medication Coverage Exception		
Indocin suppository	Non Preferred	Brand	09/01/18		Medication Coverage Exception		
Indocin suspension	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
indomethacin suppository, 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 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		
Lyrica CR, solution	Non Preferred	Brand	01/01/19	660mg /day	Medication Coverage Exception		Pregabalin/ Gabapentin combo is restricted
Lurbiro	Non Preferred	Brand	10/01/26		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 sodium 275, 550mg tablet	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
naproxen sodium 375, 500mg CR	Non Preferred	Generic	08/01/17		Medication Coverage Exception	Naprelan CR	
naproxen sodium 750mg CR	Non Preferred	Generic	08/01/17		Medication Coverage Exception		
naproxen susp	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
naproxen/esomeprazole	Non Preferred	Generic	10/01/25		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		
pregabalin ER tablet	Non Preferred	Generic	04/01/26	660mg /day	Medication Coverage Exception		Pregabalin/ Gabapentin combo is restricted
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		
Vimovo	Non Preferred	Brand	10/01/25		Medication Coverage Exception		
Vyscoxa susp	Non Preferred	Brand	11/01/25		Medication Coverage Exception		
Zybic susp	Non Preferred	Brand	11/01/25		Medication Coverage Exception		

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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 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 exceeding a 7-day supply (or 3 days for dental providers) require prior authorization. A prescription is considered "initial" if the drug has not been filled for the member within 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
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	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 & 60 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		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
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		
tapentadol tablet	Non Preferred	Generic	04/01/26	90 MME & 3 tablets /day	Opioid		
tapentadol solution	Non Preferred	Generic	08/01/26	90 MME	Opioid		
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 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, 25, 37.5mcg	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	
Diskets tablet	Non Preferred	Brand	02/01/26	90 MME & 15mg /day	Methadone		
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		
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	
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		

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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		
tapentadol ER	Non Preferred	Generic	04/01/26	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		

Opioid Combinations

- **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 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 exceeding a 7-day supply (or 3 days for dental providers) require prior authorization. A prescription is considered "initial" if the drug has not been filled for the member within 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		

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		
Primlev	Non Preferred	Brand	05/01/17	90 MME & 4 tablets /day	Opioid		
Ultracet	Non Preferred	Brand	05/01/17	90 MME & 8 tablets /day	Opioid		

Opioid Use Disorder Treatments

• **Mutually Exclusive:** Vivitrol and buprenorphine are mutually exclusive with each other.

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 1 prefilled syringe/ 26 days	Not Required if within Limits Buprenorphine/Naloxone		Must be dispensed directly to the provider, not the patient.
Brixadi weekly	Preferred	Brand	08/01/23	Minimum Age: 16 Years Old 4 prefilled syringes/ 26 days	Not Required if within Limits Buprenorphine/Naloxone		Must be dispensed directly to the provider, not the patient.
buprenorphine	Preferred	Generic	02/01/21	Minimum Age: 16 Years Old 24 mg/day, see note for unit limits	Not Required if within Limits Buprenorphine/Naloxone		Limits: 2mg: 4 units/day, 8mg: 3units/day
buprenorphine/naloxone tablet	Preferred	Generic	01/01/22	24 mg/day, see note for unit limits	Not Required if within Limits Buprenorphine/Naloxone		Limits: 2-0.5mg: 4 units/day, 8-2mg: 3 units/day
naltrexone tablet	Preferred	Generic	12/01/17				
Sublocade	Preferred	Brand	01/01/19	Minimum Age: 16 Years Old	Not Required if within Limits Buprenorphine/Naloxone		Must be dispensed directly to the provider, not the patient.
Suboxone film	Preferred	Brand	01/01/12	24 mg/day, see note for unit limits	Not Required if within Limits Buprenorphine/Naloxone	Suboxone film	Limits: 2-0.5mg: 4 units/day, 4-1mg: 4 units/day, 8-2mg: 3 units/day, 12-3mg: 2 units/day
Vivitrol	Preferred	Brand	01/01/18	Minimum Age: 18 Years Old 1 unit /28 days	Not Required if within Limits 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, see note for unit limits	Buprenorphine/Naloxone	Suboxone film	Limits: 2-0.5mg: 4 units/day, 4-1mg: 4 units/day, 8-2mg: 3 units/day, 12-3mg: 2 units/day
Zubsolv	Non Preferred	Brand	01/01/17	17.2 mg, see note for unit limits	Buprenorphine/Naloxone		Limits: 1.4-0.36mg: 3 units/day, 2.9-0.71mg: 3 units/day, 5.7-1.4mg: 3 units/day, 8.6-2.1mg: 2 units/day, 11.4-2.9mg: 1 unit/day

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		

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				
ceftriaxone	Preferred	Generic	10/01/26				
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		
Nuzolvence	Non Preferred	Brand	10/01/26	Min age: 12 years old	Medication Coverage Exception		Trial and failure of IM ceftriaxone

Utah Medicaid Preferred Drug List - Effective November 1, 2026

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 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				
tetracycline 250, 500mg capsule	Preferred	Generic	12/01/25				
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 tablet	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Ximino	Non Preferred	Brand	01/01/20		Medication Coverage Exception		

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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
Fiasp	Preferred	Brand	01/01/26	60ml per 30 days			
Humalog U-100	Preferred	Brand	01/01/20	60ml per 30 days			
insulin aspart	Preferred	Generic	01/01/24	60ml per 30 days			
insulin lispro	Preferred	Generic	01/01/26	60ml per 30 days			
Novolog	Preferred	Brand	01/01/26	60ml per 30 days			
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	Regular kit: 90unit/30days; Combo kit: 180unit/30days	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
Apidra	Non Preferred	Brand	01/01/26	60ml per 30 days	Medication Coverage Exception		
Awiqli	Non Preferred	Brand	09/01/26	4.5ml per 30 days	Medication Coverage Exception		Trial and failure of two preferred long acting insulin
Humalog U-200	Non Preferred	Brand	01/01/20	30ml per 30 days	Medication Coverage Exception		
Humulin-R	Non Preferred	Brand	01/01/17	60ml per 30 days	Medication Coverage Exception		
Humulin-R U-500	Non Preferred	Brand	01/01/17	vial: 20ml/30days; pen: 18ml/30days	Humulin R U-500		
Kirsty	Non Preferred	Brand	09/01/25	60ml per 30 days	Medication Coverage Exception		
Lyumjev	Non Preferred	Brand	07/01/20	100u/ml: 60ml/30 days; 200u/ml: 30 ml/30days	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 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**
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 a140-day supply, with a limit of one box for claims over 30-days, in accordance with the FDA's recommendation 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**
insulin glargine-yfgn	Preferred	Generic	08/01/26	60ml per 30 days			
Lantus	Preferred	Brand	01/01/17	60ml per 30 days			
Levemir	Preferred	Brand	09/28/09	60ml per 30 days			
Rezvoglar	Preferred	Brand	08/01/26	60ml per 30 days			
Semglee	Preferred	Brand	01/01/26	60ml per 30 days			
Toujeo 300u/ml	Preferred	Brand	07/01/19	30ml per 30 days			
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	100u/ml: 60ml/30 days; 200u/ml: 27ml/30days	Medication Coverage Exception	Tresiba	
insulin glargine (all other biosims)	Non Preferred	Generic	11/01/21	100u/ml: 60ml/30 days; 300u/ml: 30ml/30days	Medication Coverage Exception	Lantus, Rezvoglar, Toujeo	

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Soliqua	Non Preferred	Brand	02/01/20	15ml per 25 days	Medication Coverage Exception		Trial & Failure of preferred Long Acting Insulin AND GLP-1 Agonist required
Tresiba	Non Preferred	Brand	11/01/25	100u/ml: 60ml/30 days; 200u/ml: 27ml/30days	Medication Coverage Exception	Tresiba	
Xultophy	Non Preferred	Brand	02/01/20	15ml 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 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**
Humalog mix	Preferred	Brand	09/28/09	60ml per 30 days		Humalog 75/25, 50/50	
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	1.25-250mg, 2.5-500mg: 60tab per 30 days; 5-500mg: 120tab per 30days	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	30tab per 30days	Medication Coverage Exception	Duetact	
glipizide/metformin	Non Preferred	Generic	07/01/14	120tab per 30days	Medication Coverage Exception		
pioglitazone/glimepiride	Non Preferred	Generic	10/01/17	30tab per 30days	Medication Coverage Exception	Duetact	

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GLP-1 Agonists							
• **Type 2 diabetes mellitus:** GLP-1 Agonists are only covered for type 2 diabetes mellitus. The prescriber should write the diagnosis Code (E11.## type 2 Diabetes mellitus) on the							
• **Mutually Exclusive:** All GLP-1 Agonists are mutually exclusive with each other. Only one GLP-1 per month may be covered.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Mounjaro	Preferred	Brand	09/01/26	2ml per 28 days, min age of 10 years old			Diagnosis Code Required for FDA approved indication
Ozempic inj	Preferred	Brand	01/01/26	3ml per 28 days, min age of 18 years old			
Trulicity	Preferred	Brand	01/01/21	2ml per 28 days; min age: 10 years old			
Victoza	Preferred	Brand	01/01/14	9ml per 28 days; min age: 10 years old		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	3.4ml/30days; min age: 18yrs old	Medication Coverage Exception		Diagnosis Code Required for FDA approved indication
Byetta	Non Preferred	Brand	01/01/16	5mcg/0.02ml: 1.2ml/30days; 10mcg/0.04ml: 2.4ml/30days. Min age: 18years old	Medication Coverage Exception		
exenatide inj	Non Preferred	Generic	05/01/25		Medication Coverage Exception		
liraglutide	Non Preferred	Generic	01/01/26	9ml/28 days;min age:10yrs old	Medication Coverage Exception	Victoza	
Ozempic tablet	Non Preferred	Brand	05/01/26	30tab/30days;min age:18yrs old	Medication Coverage Exception		
Rybelsus	Non Preferred	Brand	10/01/19	30tab/30days;min age:18yrs old	Medication Coverage Exception		
Soliqua	Non Preferred	Brand	02/01/20	15ml/25days	Medication Coverage Exception		Trial & Failure of preferred Long Acting Insulin AND GLP-1 Agonist required.
Xultophy	Non Preferred	Brand	02/01/20	15ml/30days	Medication Coverage Exception		
DPP- 4 Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Januvia	Preferred	Brand	09/28/09	30tabs per 30 days	90 Day Supply Required		
Tradjenta	Preferred	Brand	11/01/16	30tabs per 30 days	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	30tabs per 30 days	Medication Coverage Exception	Nesina	
Brynovin solution	Non Preferred	Brand	09/01/25		Medication Coverage Exception		
Nesina	Non Preferred	Brand	04/01/16	30tabs per 30 days	Medication Coverage Exception	Nesina	
saxagliptin 2.5mg	Non Preferred	Generic	01/01/26	30tabs per 30 days	Medication Coverage Exception		
saxagliptin 5mg	Non Preferred	Generic	01/01/26	30tabs per 30 days	Medication Coverage Exception		
sitagliptin	Non Preferred	Generic	07/01/24	30tabs per 30 days	Medication Coverage Exception	Januvia	
Zituvio	Non Preferred	Brand	01/01/24	30tabs per 30 days	Medication Coverage Exception		

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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	IR: 60tab/30days; 50-500mg, 50-1000mg XR:60tab/30days, 100-1000mg XR: 30tab/30days	90 Day Supply Required	Janumet	
Jentadueto, XR	Preferred	Brand	01/01/20	IR: 60tab/30days; 2.5-1000ER: 60tab/30days; 5-1000mg ER: 30tab/30days	90 Day Supply Required	Jentadueto	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
alogliptin/pioglitazone	Non Preferred	Generic	01/01/19	30tab/30days	Medication Coverage Exception		
alogliptin/metformin	Non Preferred	Generic	01/01/20	60tab/30days	Medication Coverage Exception		
dapagliflozin/saxagliptin	Non Preferred	Generic	05/01/26	30tab/30days	Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Glyxambi	Non Preferred	Brand	02/11/15	30tab/30days	Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Kazano	Non Preferred	Brand	02/01/18	60tab/30days	Medication Coverage Exception		
linagliptin/metformin	Non Preferred	Generic	12/01/25	see Jentadueto	Medication Coverage Exception	Jentadueto	
Qtern	Non Preferred	Brand	12/01/17	30tab/30days	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	2.5-1000mg: 60tab/30days; 5-500, 5-1000mg: 30tab/30days	Medication Coverage Exception		
sitagliptin/metformin, XR	Non Preferred	Generic	08/01/26	see Janumet	Medication Coverage Exception	Janumet	
sitagliptin/metformin, XR (free base)	Non Preferred	Generic	07/01/24	see Zituvimet	Medication Coverage Exception	Zituvimet	
Steglujan	Non Preferred	Brand	02/01/18	30tab/30days	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	30tab/30days	Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Zituvimet, XR	Non Preferred	Brand	11/01/24	IR: 60tab/30days; 50-500mg, 50-1000mg XR:60tab/30days, 100-1000mg XR: 30tab/30days	Medication Coverage Exception	Zituvimet	
SGLT-2 Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Farxiga	Preferred	Brand	01/01/18	30tab/30days	90 Day Supply Required	Farxiga	
Jardiance	Preferred	Brand	01/01/19	30tab/30days	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	30tab/30days	Medication Coverage Exception	Farxiga	
Inpefa	Non Preferred	Brand	07/01/23	30tab/30days	Medication Coverage Exception		
Invokana	Non Preferred	Brand	11/01/24	30tab/30days	Medication Coverage Exception		
Steglatro	Non Preferred	Brand	02/01/18	30tab/30days	Medication Coverage Exception		

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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	25-1000mg ER: 30tab/30days; all other: 60tab/30days	90 Day Supply Required		
Xigduo XR	Preferred	Brand	01/01/18	30tab/30days	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	30tab/30days	Medication Coverage Exception	Xigduo XR	
dapagliflozin/saxagliptin	Non Preferred	Generic	05/01/26	30tab/30days	Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Glyxambi	Non Preferred	Brand	02/11/15	30tab/30days	Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib AND SGLT-2 Inhib required
Invokamet	Non Preferred	Brand	11/01/24	60tab/30days	Medication Coverage Exception		
Invokamet XR	Non Preferred	Brand	01/01/18	60tab/30days	Medication Coverage Exception		
Qtern	Non Preferred	Brand	12/01/17	30tab/30days	Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib AND SGLT-2 Inhib required
Segluromet	Non Preferred	Brand	03/01/18	60tab/30days	Medication Coverage Exception		
Steglujan	Non Preferred	Brand	02/01/18	30tab/30days	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	30tab/30days	Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib AND SGLT-2 Inhib required
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		

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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**
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	10/01/25		Medication Coverage Exception		
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		

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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		
Rebinyn	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**
cyproheptadine	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, Corphena solution	Non Preferred	Brand	02/01/26		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

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Clarinex	Non Preferred	Brand	07/01/14		Medication Coverage Exception		
desloratadine tablet, solution	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		
Sovuna	Non Preferred	Brand	07/01/26		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		
Nuvessa	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		
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	60 tab per 30 days			
Selzentry solution	Preferred	Brand	07/01/17	900 ml per 30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Rukobia	Non Preferred	Brand	08/01/20	60 tab per 30 days	Rukobia		
Selzentry tablet	Non Preferred	Generic	10/01/25	60 tab per 30 days	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**
Apretude	Preferred	Brand	10/01/25	Initiation: 3ml/30days; maintenance: 3ml/60 days			
Isentress	Preferred	Brand	07/01/17	Tab: 60tab/30 days; chewable: 180tab/30days; powder: 60pk/30days			
Tivicay	Preferred	Brand	07/01/17	10mg: 30tab/30days; 25g: 30tab/30days; 50mg: 60tab/30days; 5mg: 120tab/30days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Vocabria	Non Preferred	Brand	07/01/25		Medication Coverage Exception		
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	50, 600mg: 30/30days; 200mg: 60/30days			
etravirine	Preferred	Generic	01/01/26	100mg: 120/30days; 200mg: 60/30days			
nevirapine tablet	Preferred	Generic	07/01/17	60/30days	90 Day Supply Required		
nevirapine ER tablet	Preferred	Generic	07/01/17	30/30days			
nevirapine suspension	Preferred	Generic	07/01/17	1200ml/30days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Edurant	Non Preferred	Brand	01/01/24	Oral tab: 30/30days, PD tab: 180/30days	Medication Coverage Exception		
Intelence	Non Preferred	Brand	01/01/26	25, 100mg: 120/30days; 200mg: 60/30days	Medication Coverage Exception		
Pifeltro	Non Preferred	Brand	01/01/22	30 tab per 30 days	Medication Coverage Exception		
Rilpivirine	Non Preferred	Generic	03/01/26	30tab/30days; 180ml/30days	Medication Coverage Exception		

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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	900ml per 30 days			See NIH Guidelines
abacavir tablet	Preferred	Generic	07/01/17	60 tab per 30 days	90 Day Supply Required		See NIH Guidelines
emtricitabine	Preferred	Generic	10/01/25	30 cap per 30 days			See NIH Guidelines
lamivudine	Preferred	Generic	07/01/17	150mg: 60/30days; 300mg: 30/30days; soln: 900ml/30days			See NIH Guidelines
tenofovir disoproxil 300mg	Preferred	Generic	07/01/18	30 tab per 30 days			See NIH Guidelines
Viread (all except 300mg)	Preferred	Brand	07/01/18	30 tab per 30 days			See NIH Guidelines
zidovudine capsules	Preferred	Generic	07/01/17	180 capsules per 30 days			See NIH Guidelines
zidovudine syrup	Preferred	Generic	07/01/17	1800 ml per 30 days			See NIH Guidelines
zidovudine tablet	Preferred	Generic	07/01/17	60 tab per 30 days	90 Day Supply Required		See NIH Guidelines
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Emtriva	Non Preferred	Brand	10/01/25	30tab/30days; 720ml/30days	Medication Coverage Exception		See NIH Guidelines
Epivir	Non Preferred	Brand	07/01/17	150mg: 60/30days; 300mg: 30/30days; soln: 900ml/30days	Medication Coverage Exception		See NIH Guidelines
Retrovir	Non Preferred	Brand	07/01/17	cap: 180/30days; solun: 1800ml/30days	Medication Coverage Exception		See NIH Guidelines
Viread 300mg	Non Preferred	Generic	07/01/18	30 tab per 30 days	Medication Coverage Exception		See NIH Guidelines
Viread powder	Non Preferred	Generic	07/01/18	240/30days	Medication Coverage Exception		See NIH Guidelines
Ziagen solution	Non Preferred	Brand	10/01/25	900ml per 30 days	Medication Coverage Exception		See NIH Guidelines
Protease Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
atazanavir capsule	Preferred	Generic	06/01/21	150mg: 30/30days; 200mg: 60/30days; 300mg: 30/30days			
darunavir	Preferred	Generic	07/01/23	600mg: 60/30days; 800mg: 30/30days			
Norvir powder	Preferred	Brand	01/01/16	360 each per 30 days			
Prezista	Preferred	Brand	01/01/16	600mg: 60/30days; 800mg: 30/30days			
Reyataz powder	Preferred	Brand	01/01/20	180 each per 30 days			
ritonavir tablet	Preferred	Generic	01/01/21	360 tab per 30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Aptivus	Non Preferred	Brand	01/01/16	120 caps per 30 days	Medication Coverage Exception		
fosamprenavir	Non Preferred	Generic	01/01/16	120 tabs per 30 days	Medication Coverage Exception		
Norvir tablet	Non Preferred	Brand	01/01/21	360 tabs per 30 days	Medication Coverage Exception		
Reyataz capsule	Non Preferred	Brand	06/01/21	30 caps per 30 days	Medication Coverage Exception		
Viracept	Non Preferred	Brand	01/01/16	250mg: 90/30days; 625mg: 60/30days	Medication Coverage Exception		

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Antiretrovirals- Combination Products							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
abacavir/lamivudine	Preferred	Generic	07/01/17	30 tab per 30 days			
Biktarvy	Preferred	Brand	03/01/18	30 tab per 30 days			
Cabenuva	Preferred	Brand	03/01/27	400-600mg: 4/30days; 600-900mg: 6/60days	Cabenuva		
Cimduo	Preferred	Brand	05/01/18	30 tab per 30 days			
Delstrigo	Preferred	Brand	01/01/21	30 tab per 30 days			
Descovy	Preferred	Brand	07/01/17	30 tab per 30 days			
Dovato	Preferred	Brand	05/01/19	30 tab per 30 days			
efavirenz/emtricitabine/tenofovir	Preferred	Generic	01/01/22	30 tab per 30 days			
emtricitabine/tenofovir	Preferred	Generic	01/01/22	30 tab per 30 days			
Evotaz	Preferred	Brand	01/01/17	30 tab per 30 days			
Genvoya	Preferred	Brand	07/01/17	30 tab per 30 days			
lamivudine/zidovudine	Preferred	Generic	07/01/17	60 tab per 30 days			
lopinavir/ritonavir	Preferred	Generic	07/01/21	100-25mg: 240/30days; 200-50mg: 120/30days; solution: 300ml/30days			
Prezcobix	Preferred	Brand	07/01/17	30 tab per 30 days			
Symfi	Preferred	Brand	05/01/18	30 tab per 30 days		Symfi	
Triumeq	Preferred	Brand	07/01/17	Oral tab: 30/30days, PD tab: 180/30days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Bixlenvo	Non Preferred	Brand	10/01/26	30 tab per 30 days	Medication Coverage Exception		
Bixlenvo/Sunlenca pak	Non Preferred	Brand	11/01/26		Medication Coverage Exception		
Complera	Non Preferred	Brand	07/01/17	30 tab per 30 days	Medication Coverage Exception		
efavirenz/lamivudine/tenofovir 400-300-300 MG	Non Preferred	Generic	09/01/20	30 tab per 30 days	Medication Coverage Exception		
efavirenz/lamivudine/tenofovir 600-300-300 MG	Non Preferred	Generic	09/01/20	30 tab per 30 days	Medication Coverage Exception	Symfi	
emtricitabine/rilpivirine/tenofovir	Non Preferred	Generic	07/01/25	30 tab per 30 days	Medication Coverage Exception	Complera	
Idvynso	Non Preferred	Brand	06/01/26	30 tab per 30 days	Medication Coverage Exception		
Juluca	Non Preferred	Brand	12/01/17	30 tab per 30 days	Medication Coverage Exception		
Kaletra	Non Preferred	Brand	07/01/21	100-25mg: 240/30days; 200-50mg: 120/30days; solution: 300ml/30days	Medication Coverage Exception		
Odefsey	Non Preferred	Brand	01/01/26	30 tab per 30 days	Medication Coverage Exception		
Stribild	Non Preferred	Brand	07/01/17	30 tab per 30 days	Medication Coverage Exception		
Sunlenca	Non Preferred	Brand	08/01/25	Tab: 5/180days; Inj: 3ml/180days	Sunlenca		
Symtuza	Non Preferred	Brand	08/01/18	30 tab per 30 days	Medication Coverage Exception		
Truvada	Non Preferred	Brand	01/01/22	30 tab per 30 days	Medication Coverage Exception		
Yeztugo	Non Preferred	Brand	10/01/25	Tab: 5/180days; Inj: 3ml/180days	Yeztugo		

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	84 tabs per 28 days; pak: 150/28days	Hepatitis C		
sofosbuvir/velpatasvir	Preferred	Generic	04/01/21	30 tabs per 30 days	Hepatitis C		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Epclusa	Non Preferred	Brand	04/01/21	30 tabs/30days; 200-50mg pak: 60/30days	Hepatitis C		
Harvoni	Non Preferred	Brand	01/01/20	30 tabs per 30 days	Hepatitis C	Harvoni	
sofosbuvir/ledipasvir	Non Preferred	Generic	01/01/20	30 tabs per 30 days	Hepatitis C	Harvoni	
Sovaldi	Non Preferred	Brand	01/01/18	200mg: 60tab/30days; 400mg: 30tab/30days; 150mg pak: 30/30days; 200mg pak: 60/30days	Hepatitis C		
Vosevi	Non Preferred	Brand	08/01/17	30 tabs per 30 days	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		
Livtencity	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

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		
denosumab (Bilprevda, Bildyos, Enoby, Xtrenbo)	Preferred	Brand	10/01/26				Covered under medical benefit using appropriate HCPCS: Q5167, Q5162

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	Forteo	
calcitonin	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
denosumab (all other biosimilars)	Non Preferred	Brand	02/01/26		Medication Coverage Exception		Aukelso, Bomyntra, Bosaya, Conexxence, Jubbonti, Jubereq, Osenvelt, Ospomyv, Osvyrti, Prolia, Stoboclo, Wyost, Xgeva
Evenity	Non Preferred	Brand	05/01/19		Parathyroid Hormone Analogs		
Forteo	Non Preferred	Brand	10/01/20		Parathyroid Hormone Analogs		

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
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		
Miacalcin	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
pamidronate	Non Preferred	Generic	10/01/09		Medication Coverage Exception		
risedronate	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
Reclast	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
teriparatide	Non Preferred	Generic	12/01/20		Parathyroid Hormone Analogs	Forteo	
Tymlos	Non Preferred	Brand	06/01/17		Parathyroid Hormone Analogs		
Xgeva	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
Yorvipath	Non Preferred	Brand	10/01/24		Yorvipath (Palopegteriparatide)		
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		
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		

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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	Generic	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		
Lipfendra	Non Preferred	Brand	09/01/26		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		
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		
enalapril solution	Preferred	Generic	03/01/26				
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		
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		
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			Edarbi	
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		90 Day Supply Required		
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**
Arbli suspension	Non Preferred	Brand	04/01/26		Medication Coverage Exception		
Atacand	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
Avapro	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
azilsartan	Non Preferred	Generic	05/01/26		Medication Coverage Exception	Edarbi	
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				
irbesartan/hydrochlorothiazide	Preferred	Generic	01/01/14		90 Day Supply Required		
losartan/hydrochlorothiazide	Preferred	Generic	09/28/09		90 Day Supply Required		
olmesartan/hydrochlorothiazide	Preferred	Generic	08/01/17		90 Day Supply Required		
valsartan/hydrochlorothiazide	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				
amlodipine/olmesartan/HCTZ	Preferred	Generic	08/01/17				
amlodipine/valsartan	Preferred	Generic	01/01/19				
Entresto tablet	Preferred	Brand	06/01/20				
sacubitril-valsartan	Preferred	Generic	06/01/26				
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	Brand	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		
telmisartan/amlodipine	Non Preferred	Generic	01/01/12		Medication Coverage Exception		
Tribenzor	Non Preferred	Brand	08/01/17		Medication Coverage Exception		
Widaplik	Non Preferred	Brand	05/01/26		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 (except 12.5mg)	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		
Kapspargo	Non Preferred	Brand	08/01/18		Medication Coverage Exception		
Lopressor	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
metoprolol tartrate 12.5mg	Non Preferred	Generic	02/01/26		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 ER 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 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 CD	Non Preferred	Brand	09/28/09		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		
Sdamlo	Non Preferred	Brand	02/01/26		Medication Coverage Exception		
Sular	Non Preferred	Brand	04/01/13		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		
Enbumyst nasal spray	Non Preferred	Brand	11/01/25		Medication Coverage Exception		
ethacrynic acid	Non Preferred	Generic	11/01/17		Medication Coverage Exception		
Froscix kit	Non Preferred	Brand	09/01/26		Medication Coverage Exception		
Lasix	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Lasix Onyu	Non Preferred	Brand	09/01/26		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				
Kerendia	Preferred	Brand	10/01/25				
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		
Inspra	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		
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				
ticagrelor	Preferred	Generic	08/01/26				
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		
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		

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		
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		
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

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		

Utah Medicaid Preferred Drug List - Effective November 1, 2026

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 tablet	Preferred	Generic	07/01/20	Minimum Age: 4 Years Old			
amphetamine sulfate tablet	Preferred	Generic	01/01/26	Minimum Age: 4 Years Old			
dexmethylphenidate	Preferred	Generic	01/01/22	Minimum Age: 4 Years Old			
dextroamphetamine 5, 10mg	Preferred	Generic	10/01/26	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		ProCentra	
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		
Dexedrine	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
dextroamphetamine 2.5, 7.5, 15, 20, 30mg	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	ProCentra	
Evekeo	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	Generic	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			
amphetamine/dextroamphetamine ER cap	Preferred	Generic	01/01/26	Minimum Age: 4 Years Old			
Concerta	Preferred	Brand	07/01/20	Minimum Age: 4 Years Old			
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			
lisdexamfetamine capsule	Preferred	Generic	09/01/23	Minimum Age: 4 Years Old			
methylphenidate HCl ER 10, 20 mg tablet	Preferred	Generic	05/01/26	Minimum Age: 4 Years Old			NDC: 00406-1445-01, 10702-0075-01, 70010-0042-01, 00406-1473-01, 10702-0076-01, 70010-0043-01

Utah Medicaid Preferred Drug List - Effective November 1, 2026

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
methylphenidate ER (osmotic release) 18mg, 27mg, 36mg, 54mg	Preferred	Generic	09/01/25	Minimum Age: 4 Years Old			Generic of Concerta
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 capsule(except for chewable)	Preferred	Brand	11/01/25	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	Adzenys	
amphetamine ER ODT	Non Preferred	Generic	10/01/25	Minimum Age: 6 Years Old	Medication Coverage Exception	Adzenys	
amphetamine/dextroamphetamine 3-bead cap ER 24HR	Non Preferred	Generic	11/01/23	Minimum Age: 4 Years Old	Medication Coverage Exception		
Aptensio XR	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
Arynta solution	Non Preferred	Brand	04/01/26	Minimum Age: 6 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		
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 chewable	Non Preferred	Generic	05/01/26	Minimum Age: 4 Years Old	Medication Coverage Exception		
methylphenidate CD	Non Preferred	Generic	03/01/26	Minimum Age: 4 Years Old	Medication Coverage Exception		Generic of Metadate CD
methylphenidate ER (biphasic)	Non Preferred	Generic	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		Generic of Ritalin LA
methylphenidate (osmotic release) 45mg, 63mg, 72mg	Non Preferred	Generic	09/01/25	Minimum Age: 4 Years Old	Medication Coverage Exception		Generic of Relexxi
methylphenidate 18mg, 27mg, 36mg, 54mg ER tablet	Non Preferred	Generic	03/01/26	Minimum Age: 4 Years Old	Medication Coverage Exception		NDC: 62175-0310-37, 62175-0311-37, 602175-0312-37, 62175-0313-37
methylphenidate ER capsule	Non Preferred	Generic	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		Generic of Aptensio XR
methylphenidate ER ODT tablet	Non Preferred	Generic	08/01/26	Minimum Age: 6 Years Old	Medication Coverage Exception		Generic of Cotempla XR ODT
methylphenidate patch	Non Preferred	Generic	08/01/22	Minimum Age: 4 Years Old	Medication Coverage Exception		
Mydayis	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
Relexxii	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
Ritalin LA	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
Vyvanse chewable	Non Preferred	Brand	11/01/25	Minimum Age: 4 Years Old	Medication Coverage Exception		Generic preferred
Xelstrym	Non Preferred	Brand	11/01/22	Minimum Age: 6 Years Old	Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective November 1, 2026

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				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Atoncy	Non Preferred	Brand	07/01/26		Medication Coverage Exception		
atomoxetine solution	Non Preferred	Generic	08/01/26		Medication Coverage Exception		
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	02/01/26		Qelbree (viloxazine)		
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			Briviact	
carbamazepine chewable	Preferred	Generic	01/01/17		90 Day Supply Required		
carbamazepine ER	Preferred	Generic	08/01/17				
Celontin	Preferred	Brand	01/01/17				
clobazam	Preferred	Generic	01/01/20	Cumulative across class: 120 units /30 days			
clonazepam (except 0.25mg tab)	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
eslicarbazepine	Preferred	Generic	07/01/26				
ethosuximide	Preferred	Generic	06/01/19				
gabapentin	Preferred	Generic	10/01/16	3600mg /day			Pregabalin/ Gabapentin combo is restricted
lacosamide	Preferred	Generic	01/01/23				
lamotrigine chewable, tablet	Preferred	Generic	11/01/16		90 Day Supply Required		
lamotrigine ER	Preferred	Generic	05/01/26				
levetiracetam	Preferred	Generic	10/01/16				
Lyrica capsule	Preferred	Brand	01/01/19	600mg /day			Pregabalin/ Gabapentin combo is restricted
methsuximide	Preferred	Generic	12/01/25				
Nayzilam	Preferred	Brand	01/01/21				

Utah Medicaid Preferred Drug List - Effective November 1, 2026

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
oxcarbazepine tablet	Preferred	Generic	10/01/16		90 Day Supply Required		
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				
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	
brivaracetam	Non Preferred	Generic	04/01/26		Medication Coverage Exception	Briviact	
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		
clonazepam 0.25 tablet	Non Preferred	Generic	10/01/26	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		
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 200mg capsule	Non Preferred	Generic	07/01/26		Medication Coverage Exception		Pregabalin/ Gabapentin combo is restricted
Gabarone	Non Preferred	Brand	02/01/25	3600mg /day	Medication Coverage Exception		Pregabalin/ Gabapentin combo is restricted

Utah Medicaid Preferred Drug List - Effective November 1, 2026

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
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		
Lamictal	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Lamictal ODT	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Lamictal XR	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
lamotrigine ODT	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
levetiracetam Disintegrating Soluble	Non Preferred	Generic	02/01/25		Medication Coverage Exception		
Libervant	Non Preferred	Brand	07/01/24		Medication Coverage Exception		
Motpoly XR	Non Preferred	Brand	11/01/23		Medication Coverage Exception		
Neurontin	Non Preferred	Brand	10/01/16	3600mg /day	Medication Coverage Exception		Pregabalin/ Gabapentin combo is restricted
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		
Relgaabi	Non Preferred	Brand	05/01/26	1800mg/day	Medication Coverage Exception		Pregabalin/ Gabapentin combo is restricted
rufinamide	Non Preferred	Generic	12/01/20		Medication Coverage Exception	Banzel	
Sabril	Non Preferred	Brand	09/01/17		Medication Coverage Exception		
Subvenite suspension	Non Preferred	Brand	12/01/25		Medication Coverage Exception		
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 tablet, 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		
Vigadrone	Non Preferred	Brand	02/01/26		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		
Ztalmy	Non Preferred	Brand	02/01/23		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective November 1, 2026

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.2 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 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 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 age 10-17 years:800mg /day	Antipsychotics in Children		
quetiapine ER	Preferred	Generic	01/01/19	age 6-9 years: 400mg /day age 10-17 years: 800mg/day	Antipsychotics in Children		
risperidone solution	Preferred	Generic	01/01/18	age 6-11 years: 3mg /day age 12-17 years: 6mg /day	Antipsychotics in Children		
risperidone tablet	Preferred	Generic	01/01/18	age 6-11 years: 3mg /day 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.

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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	
Uzedy	Preferred	Brand	03/01/26	Minimum Age: 18 Years Old	Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
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 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 age 12-17 years: 30mg /day	Antipsychotics in Children or Medication Coverage Exception		
aripiprazole ODT	Non Preferred	Generic	01/01/18	age 6-11 years: 15mg /day 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 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	
Bysanti	Non Preferred	Brand	06/01/26	Minimum Age: 18 Years Old	Antipsychotics in Children or Medication Coverage Exception		
Caplyta	Non Preferred	Brand	02/01/20	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
clozapine ODT	Non Preferred	Generic	10/01/16	age 8-11 years: 300mg /day 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 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		

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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.
olanzapine/fluoxetine	Non Preferred	Generic	01/01/26	age 10-17 years: 12mg/day	Antipsychotics in Children or Medication Coverage Exception		
Opipza	Non Preferred	Brand	02/01/25	age 6-11 years: 15mg /day 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 13-17 years: 4mg /day	Antipsychotics in Children or Medication Coverage Exception		
Risperdal	Non Preferred	Brand	10/01/16	age 6-11 years: 3mg /day 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 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 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 age 10-17 years: 800mg/day	Antipsychotics in Children or Medication Coverage Exception		
Vraylar	Non Preferred	Brand	12/01/25	Minimum Age: 10 Years Old. Max 30 units/30days	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 age 12-17 years: 600mg/day	Antipsychotics in Children or Medication Coverage Exception		
Weltruza injection	Non Preferred	Brand	11/01/26	Minimum Age: 18 Years Old	Antipsychotics in Children or Medication Coverage Exception		Must be dispensed directly to the provider, not the patient.
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		
duloxetine 40mg	Preferred	Generic	05/01/26				
escitalopram tablet	Preferred	Generic	10/01/16		90 Day Supply Required		
fluoxetine capsule, tablet	Preferred	Generic	10/01/16		90 Day Supply Required		
fluoxetine solution	Preferred	Generic	10/01/16				
fluvoxamine IR	Preferred	Generic	01/01/26				
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		
sertraline concentrate	Preferred	Generic	10/01/25				
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**
Celexa	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
citalopram capsule, solution	Non Preferred	Generic	03/01/22		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	01/01/26	Members with feeding tube	Medication Coverage Exception		
Duloxetine 80, 90,120mg caps	Non Preferred	Generic	08/01/26		Medication Coverage Exception		
Effexor XR	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
escitalopram capsule, solution	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Fetzima	Non Preferred	Brand	10/01/16		Novel and Multi-Modal Antidepressants		
fluoxetine weekly (90mg)	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
fluvoxamine ER	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Lexapro	Non Preferred	Brand	10/01/16		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
paroxetine 7.5mg tablet, ER tablet, suspension	Non Preferred	Generic	10/01/17		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		
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		
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		

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Antidepressants - Miscellaneous							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
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				Except NDC 72336-0032-01
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		Novel and Multi-Modal Antidepressants		
bupropion 450mg ER	Non Preferred	Generic	10/01/18		Medication Coverage Exception		
Emsam	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Exxua	Non Preferred	Brand	11/01/25		Medication Coverage Exception		
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		
trazodone 25, 75mg	Non Preferred	Generic	10/01/26		Medication Coverage Exception		
Trintellix	Non Preferred	Brand	10/01/16		Novel and Multi-Modal Antidepressants		
Viibryd	Non Preferred	Brand	10/01/16		Novel and Multi-Modal Antidepressants		
vilazodone	Non Preferred	Generic	07/01/22		Novel and Multi-Modal Antidepressants		
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	01/01/26	30 units /30 days			
modafinil	Preferred	Generic	01/01/26	30 units /30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Nuvigil	Non Preferred	Brand	01/01/26		Medication Coverage Exception		
Provigil	Non Preferred	Brand	01/01/26		Medication Coverage Exception		
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		
cryselle	Preferred	Generic	04/01/26	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		
elinest	Preferred	Generic	04/01/26	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		
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		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
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		
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 (monophasic)	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		
low-ogestrel	Preferred	Generic	04/01/26	Female only	84 Day Supply Required		
lo-zumandimine	Preferred	Generic	01/01/21	Female only	84 Day Supply Required		
luizza 1/20	Preferred	Generic	10/01/25	Female only	84 Day Supply Required		
lutera	Preferred	Generic	10/01/11	Female only	84 Day Supply Required		
marlissa	Preferred	Generic	01/01/13	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-linyah	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		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
previfem	Preferred	Generic	01/01/13	Female only	84 Day Supply Required		
reclipsen	Preferred	Generic	01/01/14	Female only	84 Day Supply Required		
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		
turqoz	Preferred	Generic	04/01/26	Female only	84 Day Supply Required		
Tyblume	Preferred	Brand	01/01/24	Female only	84 Day Supply Required		
valtya 1/35	Preferred	Generic	09/01/24	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		
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, levonorgestrel/ee/FE, minzoya 0.1/20	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		
luizza 1.5/30	Non Preferred	Generic	10/01/25	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
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		
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		
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 (tri-phasic)	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		
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		

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
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	Required Prior Authorization Form	Brand Required	Additional Note
Avsola	Preferred	Brand	01/01/23	Avsola (infliximab) and Biosimilars		
Cyltezo 40mg/0.8ml	Preferred	Brand	01/01/26	Humira (adalimumab) and Biosimilars		
Enbrel	Preferred	Brand	02/01/10	Enbrel (etanercept)		
Hadlima 40mg/0.8ml	Preferred	Brand	01/01/26	Humira (adalimumab) and Biosimilars		
Humira	Preferred	Brand	02/01/10	Humira (adalimumab) and Biosimilars		
Otezla	Preferred	Brand	01/01/22	Otezla (apremilast)		
Pyzchiva	Preferred	Brand	01/01/26	Pyzchiva (ustekinumab-ttwe) and Biosimilars		
Rivoq, Rinvoq LQ	Preferred	Brand	01/01/26	Rinvoq, Rinvoq LQ (upadacitinib)		Included in more than one class
Simlandi	Preferred	Brand	01/01/26	Humira (adalimumab) and Biosimilars		
Steqeyma	Preferred	Brand	01/01/26	Pyzchiva (ustekinumab-ttwe) and Biosimilars		
Taltz	Preferred	Brand	01/01/23	Taltz (ixekizumab)		
Tyenne	Preferred	Brand	01/01/26	Tyenne (tocilizumab-aazg) and Biosimilars		
Xeljanz	Preferred	Brand	01/01/22	Xeljanz, Xeljanz XR, Xeljanz solution (tofacitinib)	Xeljanz	
Xeljanz XR	Preferred	Brand	01/01/22	Xeljanz, Xeljanz XR, Xeljanz solution (tofacitinib)	Xeljanz	

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
adalimumab (all biosimilars)	Non Preferred	Generic	11/01/25		Humira (adalimumab) and Biosimilars	Cyltezo, Hadlima, Humira, Simlandi	Abrilada, Amjevita, Cyltezo (all other concentration), Hadlima 40mg/0.4ml, Hulio, Hyrimoz, Idacio, Yuflyma, Yusimry
Arcalyst	Non Preferred	Brand	11/01/19		Non-preferred Immunomodulators		
Bimzelx	Non Preferred	Brand	11/01/23		Non-preferred Immunomodulators		
Cimzia	Non Preferred	Brand	01/01/13		Non-preferred Immunomodulators		
Cosentyx	Non Preferred	Brand	01/01/21		Non-preferred Immunomodulators		
Entyvio	Non Preferred	Brand	09/01/20		Non-preferred Immunomodulators		
Humira high concentration kit	Non Preferred	Brand	01/01/26		Humira (adalimumab) and Biosimilars		NDC: 00074-1539-03
Icotyde	Non Preferred	Brand	05/01/26		Non-preferred Immunomodulators		
Ilaris	Non Preferred	Brand	11/01/19		Non-preferred Immunomodulators		
Ilumya	Non Preferred	Brand	09/01/18		Non-preferred Immunomodulators		
infliximab (all biosimilar)	Non Preferred	Generic	09/01/18		Avsola (infliximab) and Biosimilars	Avsola	Inflectra, Remicade, Renflexis, Zymfentra
Kevzara	Non Preferred	Brand	11/01/17		Non-preferred Immunomodulators		
Kineret	Non Preferred	Brand	01/01/16		Non-preferred Immunomodulators		
Leqselvi	Non Preferred	Brand	07/01/25		Non-preferred Immunomodulators		
Litfulo	Non Preferred	Brand	08/01/23		Non-preferred Immunomodulators		
Nemluvio	Non Preferred	Brand	09/01/24		Non-preferred Immunomodulators		
Olumiant	Non Preferred	Brand	07/01/18		Non-preferred Immunomodulators		
Omvoh	Non Preferred	Brand	12/01/23		Non-preferred Immunomodulators		
Orencia	Non Preferred	Brand	01/01/14		Non-preferred Immunomodulators		
Otezla pak	Non Preferred	Brand	11/01/25		Otezla (apremilast)		
Simponi	Non Preferred	Brand	02/01/10		Non-preferred Immunomodulators		
Skyrizi	Non Preferred	Brand	05/01/19		Non-preferred Immunomodulators		
Sotyktu	Non Preferred	Brand	10/01/22		Non-preferred Immunomodulators		
Spevigo	Non Preferred	Brand	09/01/23		Non-preferred Immunomodulators		
tocilizumab (reference product and biosimilars)	Non Preferred	Generic	11/01/25		Actemra (tocilizumab) and Biosimilars	Tyenne	Actemra, Avtozma, Tofidence, Tyenne
tofacitinib	Non Preferred	Generic	07/01/26		Xeljanz, Xeljanz XR, Xeljanz solution (tofacitinib)	Xeljanz	
Tremfya	Non Preferred	Brand	05/01/19		Non-preferred Immunomodulators		
ustekinumab (reference product and biosimilars)	Non Preferred	Generic	12/01/25		Pyzchiva (ustekinumab) and Biosimilars	Pyzchiva, Steqeyma	Imuldosa, Otulfi, Selarsdi, Starjemza, Stelara, Wezlana, Yesintek
Velsipity	Non Preferred	Brand	11/01/23		Non-preferred Immunomodulators		

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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				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
adapalene/benzoyl peroxide pad	Non Preferred	Generic	02/01/21		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		
clindamycin foam	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
clindamycin/tretinoin	Non Preferred	Generic	08/01/17		Medication Coverage Exception		
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		
Twyneo	Non Preferred	Brand	09/01/25		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**
tretinoin (all other formulation)	Preferred	Generic	10/01/25				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Aklief cream	Non Preferred	Brand	01/01/25		Medication Coverage Exception		
adapalene	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Fabior	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
tazarotene	Non Preferred	Brand	01/01/21		Medication Coverage Exception		
tretinoin microsphere gel	Non Preferred	Generic	01/01/21		Medication Coverage Exception		
Topical Acne Products - Miscellaneous							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Mirvaso gel	Preferred	Brand	01/01/25			Mirvaso	
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	Mirvaso	
selenium sulfide	Non Preferred	Generic	04/01/12		Medication Coverage Exception		
sulfacetamide gel	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
sulfacetamide sodium lotion	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		

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Oral Acne Products							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
amnesteem 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 solution	Preferred	Generic	10/01/11				
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**
Clotic solution	Non Preferred	Brand	09/01/26		Medication Coverage Exception		
econazole	Non Preferred	Generic	04/01/13		Medication Coverage Exception		
Exelderm	Non Preferred	Brand	12/01/22		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		
Luzu	Non Preferred	Brand	03/01/19		Medication Coverage Exception		
Mentax	Non Preferred	Brand	10/01/11		Medication Coverage Exception		

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
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	
Zelsuvmi	Non Preferred	Brand	07/01/25		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	10/01/25	150mg/ml: 2ml/28days; 300mg/2ml: 4ml/28days	Monoclonal Antibodies for Atopic Dermatitis		
Dupixent	Preferred	Brand	10/01/25	100mg/0.67ml: 1.34ml/28days; 200mg/1.14ml: 2.28ml/28days; 300mg/2ml: 4ml/28days	Monoclonal Antibodies for Atopic Dermatitis		Included in more than one class
Opzelura cream	Preferred	Brand	01/01/26	60g per 30 days	Opzelura (ruxolitinib cream)		
pimecrolimus	Preferred	Generic	10/01/25	100g per 30 days			
Rinvoq, Rinvoq LQ	Preferred	Brand	01/01/26	30 tab per 30 days, 360 ml per 30 days	Rinvoq, Rinvoq LQ (upadacitinib)		Included in more than one class
tacrolimus	Preferred	Generic	08/01/22	100g per 30 days; min age: 16 years for 0.1% ointment			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Adquey ointment	Non Preferred	Brand	10/01/26	85g per 30 days	Medication Coverage Exception		
Anzupgo cream	Non Preferred	Brand	09/01/25	60g per 30 days	Medication Coverage Exception		
Cibinqo	Non Preferred	Brand	08/01/25	30 tab per 30 days	Medication Coverage Exception		
Ebglyss	Non Preferred	Brand	10/01/25	2ml per 28 days	Monoclonal Antibodies for Atopic Dermatitis		
Eucrisa ointment	Non Preferred	Brand	09/01/18	100g per 30 days	Medication Coverage Exception		
Hyftor gel	Non Preferred	Brand	07/01/25	30g per 30 days	Medication Coverage Exception		
Nemluvio	Non Preferred	Brand	10/01/25	2ml per 28 days	Monoclonal Antibodies for Atopic Dermatitis		
Vtama	Non Preferred	Brand	11/01/25		Medication Coverage Exception		
Zoryve 0.05%, 0.15% cream	Non Preferred	Brand	09/01/24	60g per 30 days	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 (except 0.025%)	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				
Clobex shampoo	Preferred	Brand	06/01/26				
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		
clobetasol 0.025% cream	Non Preferred	Generic	06/01/26		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		
Clobex lotion, spray	Non Preferred	Brand	01/01/25		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		
halobetasol lotion	Non Preferred	Generic	04/01/26		Medication Coverage Exception		
Impeklo	Non Preferred	Brand	09/01/21		Medication Coverage Exception		
Lexette	Non Preferred	Brand	12/01/18		Medication Coverage Exception		
Tovet	Non Preferred	Brand	07/01/20		Medication Coverage Exception		
Ultravate	Non Preferred	Brand	11/01/19		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	
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		
clocortolone	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
Cloderm	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
desoximetasone 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		
budesonide rectal foam	Non Preferred	Generic	05/01/23		Medication Coverage Exception		
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 2% gel	Non Preferred	Generic	05/01/26		Medication Coverage Exception		
hydrocortisone butyrate	Non Preferred	Generic	11/01/19		Medication Coverage Exception		
Hydroxym 2%, Hyroxate 2% gel	Non Preferred	Brand	05/01/26		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		
Steroid/Antifungal Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
clotrimazole/betamethasone cream	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
Ana-Lex	Non Preferred	Brand	01/12/26	60 grams /30 days	Medication Coverage Exception		
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		
lidocaine/hydrocortisone rectal kit	Non Preferred	Generic	01/12/26	60 grams /30 days	Medication Coverage Exception		
Lidocort	Non Preferred	Brand	01/12/26	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		
Lydexa	Non Preferred	Brand	01/12/26	60 grams /30 days	Medication Coverage Exception		
Neurozyl	Non Preferred	Brand	01/12/26	60 grams /30 days	Medication Coverage Exception		
Pliaglis	Non Preferred	Brand	11/01/18	60 grams /30 days	Medication Coverage Exception		
Proxivol gel	Non Preferred	Brand	01/12/26	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		
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				See OTC list for additional options
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		
ivermectin lotion	Non Preferred	Generic	01/01/22		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 Receiver	Preferred	Brand	04/01/21	1 receiver /365 days	Continuous Glucose Monitor	08627-0091-11, 08627-0078-01
Dexcom Sensor	Preferred	Brand	04/01/21	3 sensors /30 days	Continuous Glucose Monitor	08627-0053-03, 08627-0077-01
Dexcom G7 15 day Sensor	Preferred	Brand	01/01/26	2 sensors /30 days; min age: 18 years of age	Continuous Glucose Monitor	08627-0079-01
Dexcom G6 Transmitter	Preferred	Brand	04/01/21	1 transmitter /90 days	Continuous Glucose Monitor	08627-0016-01
FreeStyle Libre Reader	Preferred	Brand	01/01/26	1 reader /365 days	Continuous Glucose Monitor	57599-0002-00, 57599-0803-00, 57599-0820-00
FreeStyle Libre Sensor	Preferred	Brand	01/01/26	Libre 2,3, Libre14days: 2 sensor/28days; Libre 2plus, 3plus: 2 sensors/ 30 days	Continuous Glucose Monitor	57599-0001-01, 57599-0800-00, 57599-0818-00, 57599-0835-00, 57599-0844-00
Non Preferred Product	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Covered NDCs**
Guardian Transmitter	Non Preferred	Brand	01/01/26	1 transmitter /365 days	Continuous Glucose Monitor	43169-0955-68, 63000-0286-77, 63000-0286-78, 63000-0316-99, 63000-0357-51, 63000-0445-15, 63000-0445-16, 76300-0239-82
Guardian Sensor	Non Preferred	Brand	01/01/26	1 pack /30 days	Continuous Glucose Monitor	43169-0704-05, 63000-0179-62, 63000-0336-98, 63000-0358-44, 63000-0413-38, 63000-0519-68
Minimed Instinct Sensor	Non Preferred	Brand	04/01/26	2 sensor /30 days	Continuous Glucose Monitor	57599-0880-00

Diabetic Glucose Meters

• **Nursing Home Members -** OTC Diabetic test supplies are not covered through the outpatient pharmacy benefit program for members in nursing homes.

Preferred Product	Status	Type	Last Update	Limits	Covered NDCs
FreeStyle	Preferred	Brand	01/01/18	1 unit/365 days	99073-0709-14, 99073-0708-05
Precision	Preferred	Brand	01/01/18	1 unit/365 days	57599-8814-01, 57599-5175-01
Non Preferred Product	**Status**	**Type**	**Last Update**	**Limits**	Covered NDCs
Contour Next	Non Preferred	Brand	04/01/26	1 unit/365 days	00193-7553-01, 00193-7383-01, 00193-7917-01, 00193-7922-01, 50090-7079-00
Relion Premier Voice	Non Preferred	Brand	04/01/26	1 unit/365 days	08317-7800-01
True Metrix	Non Preferred	Brand	04/01/26	1 unit/365 days	11917-0166-89, 11917-0173-89, 50090-5584-00, 50090-5584-01, 56151-1950-02

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Diabetic Testing Strips					
• **Nursing Home Members -** OTC Diabetic test supplies are not covered through the outpatient pharmacy benefit program for members in nursing homes.					
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
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**	Covered NDCs
Contour Next Test Strips	Non Preferred	Brand	04/01/26	200 strips /30 days	00193-7070-25, 00193-7080-50, 00193-7090-21, 00193-7311-50, 00193-7312-21
Relion Premier Test Strips	Non Preferred	Brand	04/01/26	200 strips /30 days	08317-7800-50, 08317-7801-00
True Metrix Test Strips	Non Preferred	Brand	04/01/26	200 strips /30 days	56151-1460-01, 56151-1460-04, 56151-1460-05

Diabetic Testing Lancets

• **Nursing Home Members -** OTC Diabetic test supplies are not covered through the outpatient pharmacy benefit program for members in nursing homes.

Preferred Product	Status	Type	Last Update	Limits	Covered NDCs
Autolet lancing device	Preferred	Brand	01/01/22	1 unit/365 days	08470-0270-01
Truedraw lancing device	Preferred	Brand	01/01/26	1 unit/365 days	56151-0142-01
Trueplus lancets	Preferred	Brand	01/01/26	200 units /30 days	56151-0142-60, 56151-0144-01, 56151-0144-02, 56151-0147-01
Unilet lancets	Preferred	Brand	01/01/22	200 units /30 days	08470-0565-01, 08470-0575-01, 08470-0585-01
Non Preferred Product	**Status**	**Type**	**Last Update**	**Limits**	Additional Note
Microlet lancing device	Non Preferred	Brand	04/01/26	1 unit/365 days	00193-6702-01
Microlet lancets	Non Preferred	Brand	04/01/26	200 units /30 days	00193-6586-21

Insulin Pump

Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Covered NDCs
Omnipod 5 Introkit	Preferred	Brand	01/01/26	1 kit/365 days	Omnipod 5	08508-3000-01, 08508-3000-88
Omnipod 5 Reservoir	Preferred	Brand	01/01/26		Omnipod 5	08508-3000-21, 08508-3000-42

Epinephrine

Self- Administration 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		
Estrogen, conjugated tablet	Non Preferred	generic	11/01/25	Female only	Medication Coverage Exception	Premarin	
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	a		
Estratest	Non Preferred	Brand	01/12/26	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 patch	Preferred	Brand	01/01/16	Female only	84 Day Supply Required		
Climara patch	Preferred	Brand	05/01/26	Female only			
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		Minivelle, Vivelle-Dot	
Vivelle-Dot patch	Preferred	Brand	05/01/25	Female only		Minivelle, Vivelle-Dot	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Divigel	Non Preferred	Brand	01/01/23	Female only	Medication Coverage Exception		
Dotti, Lyllana, estradiol patch	Non Preferred	Generic	01/01/26	Female only	Medication Coverage Exception	Minivelle, Vivelle-Dot	
estradiol gel	Non Preferred	Generic	11/01/24	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**
estradiol cream	Preferred	Generic	05/01/26	Female only			
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 vaginal tablet	Non Preferred	Generic	01/01/17	Female only	Medication Coverage Exception	Vagifem	

Gastrointestinal (GI)

Antiemetics

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 solution	Preferred	Generic	12/01/23				
promethazine tablet	Preferred	Generic	01/01/15				
trimethobenzamide capsule	Preferred	Generic	07/01/26				
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	
meclizine chewable	Non Preferred	Generic	05/01/26		Medication Coverage Exception		
Nereus	Non Preferred	Brand	05/01/26		Medication Coverage Exception		
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		
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				
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	10/01/25		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		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
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**
balsalazide	Preferred	Generic	07/01/14				
Dipentum	Preferred	Brand	01/01/19				
mesalamine DR tablet 1.2g	Preferred	Generic	01/01/18				
mesalamine ER capsule 0.375g	Preferred	Generic	10/09/25				
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		
mesalamine DR capsule	Non Preferred	Generic	06/01/19		Medication Coverage Exception		
Lialda	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
mesalamine DR tablet 800mg	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
mesalamine ER capsule 250, 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		
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	
Renvela	Preferred	Brand	07/01/25				
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 hydrochloride	Non Preferred	Generic	03/01/19		Medication Coverage Exception		
Velphoro	Non Preferred	Brand	07/01/14		Medication Coverage Exception		

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	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		

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				

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		
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				

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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**
Armlupeg	Non Preferred	Brand	06/01/26		Medication Coverage Exception		
Filkri	Non Preferred	Brand	06/01/26		Medication Coverage Exception		
Fulphila	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Fylnetra	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		
Nypozi	Non Preferred	Brand	02/01/26		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		

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Flebogamma	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
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		
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		
Qivigy	Non Preferred	Brand	03/01/26		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, 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		
Prenaissance	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		

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		
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		
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		
Atmeski suspension	Non Preferred	Brand	05/01/26	Minimum age: 16 Years Old	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		
Tonmya sublingual	Non Preferred	Brand	12/01/25	Cumulative: 60 units /30 days	Medication Coverage Exception		

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Antispasticity Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
baclofen suspension	Preferred	Generic	08/01/22				Exclude NDC: 68134-0403-16
baclofen 5mg, 10mg, 20mg tab	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		
baclofen susp NDC: 68134-0403-16	Non Preferred	Generic	09/01/26		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		
Lyvispah	Non Preferred	Brand	06/01/22		Medication Coverage Exception		
Ontralfy	Non Preferred	Brand	03/01/26		Medication Coverage Exception		
Ozobax DS	Non Preferred	Brand	10/01/25		Medication Coverage Exception		
tizanidine 8mg capsules	Non Preferred	Generic	03/01/26	Cumulative:180 units /30 days	Medication Coverage Exception		
Zanaflex tablets	Non Preferred	Brand	09/28/09	Cumulative:180 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		
Ryaltris	Non Preferred	Brand	03/01/26		Medication Coverage Exception		Trial & failure of preferred nasal antihistamines and corticosteroids

Nasal - Corticosteroids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
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		
Ryaltris	Non Preferred	Brand	03/01/26		Medication Coverage Exception		Trial & failure of preferred nasal antihistamines and corticosteroids
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		
Gocovri	Non Preferred	Brand	10/01/17		Medication Coverage Exception		
Inbrija	Non Preferred	Brand	03/01/19		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		
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		
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		
Juvmo	Non Preferred	Brand	11/01/26		Medication Coverage Exception		
Kynmobi	Non Preferred	Brand	07/01/20		Medication Coverage Exception		
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		
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		
Brekiya	Non Preferred	Brand	10/01/25		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	Generic	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		
Cafergot	Non Preferred	Brand	05/01/26		Medication Coverage Exception		
diclofenac powder	Non Preferred	Generic	01/01/23	Cumulative: 9 units /30 days	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
dihydroergotamine	Non Preferred	Generic	12/01/17		Medication Coverage Exception		
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		
naratriptan	Non Preferred	Generic	01/01/13	Cumulative: 9 units /30 days	Medication Coverage Exception		
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: 12 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		
Ubrelvy	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/ 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 DR, ER	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

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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 DR, ER	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
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 20mg	
dalfampridine	Preferred	Generic	01/01/21				
dimethyl fumarate	Preferred	Generic	01/01/22				
teriflunomide	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
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		generic, glatiramer 40mg, is preferred
cladribine	Non Preferred	Generic	01/01/26		Mavenclad PA	Mavenclad	
Extavia	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
fingolimod	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 20mg	
Glatopa	Non Preferred	Generic	09/01/19		Medication Coverage Exception	Copaxone 20mg	
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	Mavenclad	
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		
Tyruko	Non Preferred	Brand	11/01/25		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		

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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	
brimonidine/bimatoprost/dorzolamide	Non Preferred	Generic	10/01/25		Medication Coverage Exception		
lopidine	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Yuvezzi	Non Preferred	Brand	04/01/26		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		

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Anti-Glaucoma - Prostaglandins							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
latanoprost	Preferred	Generic	12/02/11				
Lumigan	Preferred	Brand	01/01/19			Lumigan	
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	Lumigan	
brimonidine/bimatoprost/dorzolamide	Non Preferred	Generic	10/01/25		Medication Coverage Exception		
Durysta	Non Preferred	Brand	10/01/20		Medication Coverage Exception		
Iyuzeh	Non Preferred	Brand	09/01/23		Medication Coverage Exception		
Omlonti	Non Preferred	Brand	01/01/26		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	
Zolymbus gel	Non Preferred	Brand	06/01/26		Medication Coverage Exception		
Ophthalmic - Antibiotics - Quinolones							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Besivance	Preferred	Brand	01/01/18			Besivance	
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**
besifloxacin	Non Preferred	Generic	02/01/26		Medication Coverage Exception	Besivance	
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		

Utah Medicaid Preferred Drug List - Effective November 1, 2026

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
Loteprednol 0.5% suspension	Preferred	Generic	09/01/25				
Maxidex	Preferred	Brand	06/01/12				
prednisolone 1% suspension	Preferred	Generic	02/01/25				
Pred Mild	Preferred	Brand	06/01/12				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Byqlovi	Non Preferred	Brand	05/01/26		Medication Coverage Exception		
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	
prednisolone sodium phosphate solution	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		

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**
loteprednol/tobramycin susp	Non Preferred	Generic	02/01/26		Medication Coverage Exception	Zylet	
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	Zylet	

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				

Otic - Antibiotic Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Cipro HC	Preferred	Brand	05/01/26			Cipro HC	
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**
ciprofloxacin/dexamethasone	Non Preferred	Generic	01/01/21		Medication Coverage Exception		
ciprofloxacin/fluocinolone	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
ciprofloxacin/hydrocortisone	Non Preferred	Generic	01/01/26		Medication Coverage Exception	Cipro HC	
neomycin/polymyxin/hc sol	Non Preferred	Generic	11/01/15		Medication Coverage Exception		

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		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		
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 for Benign Prostatic Hyperplasia Prior Auth form		See Pulmonary Hypertension Prior Auth for pulmonary hypertension indication
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 for Benign Prostatic Hyperplasia Prior Auth form		See Pulmonary Hypertension Prior Auth for pulmonary hypertension indication
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 Hypertension		
bosentan	Preferred	Generic	01/01/24		Pulmonary Hypertension		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Letairis	Non Preferred	Brand	01/01/23		Pulmonary Hypertension		
Opsumit	Non Preferred	Brand	10/01/13		Pulmonary Hypertension		
Opsynvi	Non Preferred	Brand	07/01/24		Pulmonary Hypertension		Included in more than one class
Tracleer	Non Preferred	Brand	01/01/24		Pulmonary Hypertension		

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 Hypertension		
tadalafil	Preferred	Generic	01/01/20		Pulmonary Hypertension		See Cialis Prior Auth for benign prostatic hyperplasia (BPH) indication
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Adcirca	Non Preferred	Brand	01/01/20		Pulmonary Hypertension		
Opsynvi	Non Preferred	Brand	07/01/24		Pulmonary Hypertension		Included in more than one class
Revatio	Non Preferred	Brand	09/01/13		Pulmonary Hypertension		
Tadliq	Non Preferred	Brand	10/01/22		Pulmonary Hypertension		
Prostacyclins							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
epoprostenol	Preferred	Generic	06/01/12		Pulmonary Hypertension		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Flolan	Non Preferred	Brand	06/01/12		Pulmonary Hypertension		
Orenitram	Non Preferred	Brand	04/02/14		Pulmonary Hypertension		
Remodulin	Non Preferred	Brand	10/01/19		Pulmonary Hypertension	Remodulin	
treprostinil	Non Preferred	Brand	10/01/19		Pulmonary Hypertension	Remodulin	
Tyvaso	Non Preferred	Brand	06/01/12		Pulmonary Hypertension		
Uptravi	Non Preferred	Brand	01/15/16		Pulmonary Hypertension		
Veletri	Non Preferred	Brand	06/01/12		Pulmonary Hypertension		
Ventavis	Non Preferred	Brand	01/01/14		Pulmonary Hypertension		
Yutrepia	Non Preferred	Brand	07/01/25		Pulmonary Hypertension		
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				Included in more than one class
Fasenra	Preferred	Brand	01/01/21				
Xolair	Preferred	Brand	01/01/21				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Exdensur	Non Preferred	Brand	01/01/26		Monoclonal Antibodies for Asthma and Other Indications		
Nucala	Non Preferred	Brand	01/01/21				
Omlyclo	Non Preferred	Brand	09/01/26				
Tezspire	Non Preferred	Brand	03/01/22				

Utah Medicaid Preferred Drug List - Effective November 1, 2026

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		Atrovent	
ipratropium nebulizer soln	Preferred	Generic	04/01/12	300mL/30days			
Spiriva Handihaler, Respimat	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		
Iptratroum HFA	Non Preferred	Generic	04/01/26	2 inhalers/30 days	Medication Coverage Exception	Atrovent	
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		
umeclidinium ellipta	Non Preferred	Generic	05/01/26	1 inhaler/30 days	Medication Coverage Exception		
Yupelri	Non Preferred	Brand	01/01/22	90mL/30 days	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 soln	Preferred	Generic	01/01/13	0.083%, 0.63mg/3ml, 1.25mg/3ml: 360mL/30days; 0.5%: 60mL/30days			
levalbuterol nebulizer soln	Preferred	Generic	05/15/16	0.31mg, 0.63mg, 1.25mg: 270ml/30days; 1.25mg/0.5ml: 45mL/30days			
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**
albuterol HFA	Non Preferred	Generic	05/01/19	2 inhalers/30 days	Medication Coverage Exception	Ventolin HFA	
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	120ml/30days	Medication Coverage Exception		
Brovana	Non Preferred	Brand	01/01/16	120ml/30days	Medication Coverage Exception		
formoterol	Non Preferred	Generic	07/01/21	120ml/30days	Medication Coverage Exception	Perforomist	
Perforomist	Non Preferred	Brand	01/01/20	120ml/30days	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		Arnuity	
Asmanex	Preferred	Brand	01/01/26	1 inhaler/30 days			
budesonide nebulizer	Preferred	generic	01/01/21	0.25mg/2ml, 0.5mg/2ml: 240ml/30days; 1mg/2ml: 120ml/30days			
fluticasone propionate	Preferred	Generic	10/01/25	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	80mcg/act: 1 inhaler/30 days; 160mcg/act: 2 inhaler/30 days	Medication Coverage Exception		
beclomethasone	Non Preferred	Generic	04/01/26	40mcg/act: 1 inhaler/30 days; 80mcg/act: 2 inhaler/30 days	Medication Coverage Exception	Qvar	
fluticasone furoate	Non Preferred	Generic	10/01/25	1 inhaler/30 days	Medication Coverage Exception	Arnuity	
Pulmicort nebulizer	Non Preferred	Brand	01/01/21	0.25mg/2ml, 0.5mg/2ml: 240ml/30days; 1mg/2ml: 120ml/30days	Medication Coverage Exception		
Qvar	Non Preferred	Brand	01/01/19	40mcg/act: 1 inhaler/30 days; 80mcg/act: 2 inhaler/30 days	Medication Coverage Exception	Qvar	
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 ER	Non Preferred	Generic	10/01/25		Medication Coverage Exception		
Zyflo	Non Preferred	Brand	10/01/25		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		

Utah Medicaid Preferred Drug List - Effective November 1, 2026

Asthma & COPD - Combination Products							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Advair HFA	Preferred	Brand	06/01/19	1 inhaler/30 days		Advair HFA	
Combivent	Preferred	Brand	01/01/21	1 inhaler/20 days			
Dulera	Preferred	Brand	05/23/11	2 inhaler/30 days			
fluticasone/salmeterol powder	Preferred	Generic	01/01/26	1 inhaler/30 days			generic of Advair Diskus
ipratropium/albuterol nebulizer	Preferred	Generic	08/01/25	540ml/30 days			
Symbicort	Preferred	Brand	01/01/13	2 inhaler/30 days		Symbicort	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Advair Diskus	Non Preferred	Brand	01/01/26	1 inhaler/30 days	Medication Coverage Exception		
Airsupra	Non Preferred	Brand	01/01/26	3 inhaler/30 days	Airsupra Prior Authorization		
Breo Ellipta	Non Preferred	Brand	01/01/19	1 inhaler/30 days	Medication Coverage Exception	Breo Ellipta	
Breyna	Non Preferred	Generic	11/01/24	2 inhaler/30 days	Medication Coverage Exception	Symbicort	
budesonide/formoterol	Non Preferred	Generic	07/01/20	2 inhaler/30 days	Medication Coverage Exception	Symbicort	
fluticasone/salmeterol 55/14, 113/14, 232/14 powder	Non Preferred	Generic	01/01/26	1 inhaler/30 days	Medication Coverage Exception		Generic of Airduo
fluticasone/salmeterol HFA	Non Preferred	Generic	01/01/25	1 inhaler/30 days	Medication Coverage Exception	Advair HFA	
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		
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		

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Cystic Fibrosis: CFTR Modulators							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Alyftrek	Preferred	Brand	07/01/26		Cystic Fibrosis CFTR Modulators		
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**
Symdeko	Non Preferred	Brand	01/01/21		Cystic Fibrosis CFTR Modulators		

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 neb (all other conc.)	Non Preferred	Generic	01/01/24		Medication Coverage Exception		300mg/4ml, 500mg/4ml

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				
trospium	Preferred	Generic	01/01/24				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
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				

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		
trospium 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				
ergocalciferol (vitamin D2) 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		
Rayaldee	Non Preferred	Brand	07/01/24		Medication Coverage Exception		
Zemplar	Non Preferred	Brand	01/01/15		Medication Coverage Exception		

Utah Medicaid Covered Over-the-Counter Drugs - Effective November 1, 2026

• **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 tablet	12/01/25			
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	01/01/26	4 tabs per 30 days	Curae, Econtra, FallBack, Her Style, My Choice, My Way, New Day, Opcicon, Option 2, Shewise, Take Action

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Non-Emergency				
Products	**Updated**	**Limits**	**Mandatory 3-Month**	**Additional Note**
cervical cap	10/01/26			
condoms - female	04/01/17			
condoms - male	04/01/17			
diaphragm	10/01/26			
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
pyrethrins/piperonyl butoxide 0.33%/4% shampoo	04/01/17			
Vanalice 0.3-3.5% gel	01/01/20			NDC: 58809-0650-08

Diabetic supplies

Drugs	Updated	Limits	Mandatory 3-Month	Additional Note
Alcohol swab pads	12/01/25			
Insulin syringes	12/01/25			

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 November 1, 2026

Aspirin				
Drugs	**Last Update**	**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**
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			

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Laxatives - Surfactant				
Drugs	Updated	Limits	Mandatory 3-Month	Additional Note
docusate calcium 240mg capsules	04/01/17			
docusate Na 100mg, 250mg capsules	10/01/25		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			

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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	Min age: 12 years old		
nicotine 4mg gum	04/01/17	Min age: 12 years old		
nicotine 4mg inhaler	11/01/25	Min age: 12 years old		
nicotine 2mg lozenge	04/01/17	Min age: 12 years old		
nicotine 4mg lozenge	04/01/17	Min age: 12 years old		
nicotine 10mg/ml nasal spray	11/01/25	Min age: 12 years old		
nicotine 7mg/24hr patch	04/01/17	Min age: 12 years old		
nicotine 14mg/24hr patch	04/01/17	Min age: 12 years old		
nicotine 21mg/24hr patch	04/01/17	Min age: 12 years old		
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 November 1, 2026

• **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 Required	Additional Note
Afinitor Disperz	everolimus tablet for suspension	02/01/25			
Aptiom	eslicarbazepine	06/01/25			
Astagraf XL	tacrolimus ER capsule	06/01/26			
Azopt	brinzolamide	07/01/21			
Besivance	besifloxacin	02/01/26			
Bidil	isosorbide dinitrate/hydralazine	05/01/22			
Briviact	brivaracetam	04/01/26			
Bosulif 100mg, 400mg	bosutinib Tab 100 MG, 400mg	07/01/26			
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			
Risperdal Consta	risperidone injection	10/01/23			
DDAVP injection	desmopressin injection	09/01/23			
Dificid	fidaxomicin	03/01/26			
Duetact	pioglitazone/glimepiride	11/01/25			
Fareston	toremifene	02/01/19			
Forteo	teriparatide	05/01/25		PA Required	Parathyroid Hormone Analogs
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			
Minivelle, Vivelle-Dot patch	Dotti, Lyllana, estradiol patch	03/01/26			
Motegrity	prucalopride	02/01/25			
Nexavar	sorafenib	07/01/22			
Niaspan	niacin ER	Not Available			
Orfadin, Nityr	nitisinone cap	08/01/25			
Oracea	doxycycline 40mg capsule	Not Available			
Proglycem	diazoxide	04/01/20			
Promacta	eltrombopag	10/01/25			
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			

Utah Medicaid Additional Brand Required Over Generic Drugs - Effective November 1, 2026

Preferred Brand Name Drugs	Non-Preferred Generic Drugs	Updated	Limits	Prior Auth Required	Additional Note
Ridaura	auranofin	03/01/25			
Riomet	metformin solution	04/01/21			
Samsca, Jynarque	tolvaptan	09/01/21			
Savella	milnacipran	Not Available			
Sutent	sunitinib	09/01/22			
Syprine	trientine	Not Available			
Tarceva	erlotinib	06/01/19			
Tekturna	aliskiren	04/01/19			
Torisel	temsirolimus	10/01/20			
Tresiba	insulin degludec	11/01/25			
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			
Zylet	loteprednol/tobramycin suspension	02/01/26			

Utah Medicaid Additional 3 Month Supply Required Drugs- Effective October 1, 2026

• **Policy:** Utah Medicaid has instituted a mandatory 3 month supply for maintenance medications, following a two-month window for dose titration and stabilization.

• **Copays:** For a 3 month supply, Utah Medicaid fee for service members who are subject to cost-sharing will pay a single copay**.**

• **Day Supply:** 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.

• **Dispensing Fees:** Pharmacies will receive a single dispensing fee on prescriptions filled for a 3 Month supply.

• **Exemptions:** 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.

• **Exceptions**: Requests for exceptions may be submitted by the prescriber through Prior Authorization.

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 October 1, 2026

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
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
telmisartan	20, 40, 80mg	Mandatory Generic Policy Applies	Generic	01/01/26
trihexyphenidyl	2mg, 5mg	Mandatory Generic Policy Applies	Generic	02/01/18

Utah Medicaid Additional Drug Limits - Effective November 1, 2026

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	

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 November 1, 2026

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/asa/caf		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	
progesterone vaginal insert	Endometrin	11/01/25	Female only	

Utah Medicaid Prior Authorizations - Effective November 1, 2026

• **Pharmacy Prior Authorization Forms:** Can be found on the Utah Medicaid website. https://medicaid.utah.gov/pharmacy/prior-authorization

• **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
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	02/01/26
New to Market Drug (also include in-progress prior authorization forms)	Acthar, Alpha-1-proteinase inhibitors (Aralast NP, Glassia, Prolastin-C, Zemaira), Amtagvi, Avmapki-Fakzynja, Baxfendy, Brinsupri, Cardamyst, Cortrophin, Decnupaz, Egrifta, Blujepa, Harliku, Hepcludex, Increlex, Inlexzo, Iqirvo and Livdelzi, Lifyorli, Lynavoy, Lynozyfic, Mimrylo, Miplyffa and Aqneursa, Mucopolysaccharidosis (Aldurazyme, Elaprase, Mepsevii, Naglazyme, Vimizim), Omisirge, Orlynvah, Otarmeni, Prednisone DR, Sephience, Syfovre, Urea Cycle Disorders (Ammonul, Buphenyl, Carbaglu, L-Citrulline, Olpruva, Pheburane, Ravicti), Vanrafia, Winrevair, Zoryve 0.3% cream/foam	10/01/26
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, Aldurazyme, Amvuttra, Aqvesme, Aralast, Atebrioz, Atgam, Attruby, Avlayah, Ayvakit, Besremi, Bkemv, Brineura, Buphenyl, Carbaglu, Crenessity, Cuvrior, Elaprase, Empaveli, Enjaymo, Epioxa, Epysqli, Fabhalta, Filspari, Forzinity, Gamifant, Givlaari, Glassia, Gomekli, Imcivree, Isembyld, Isturisa, Izervay, Jascayd, Joenja, Kanuma, Kygevvi, Lamzede, Loargys, Lumizyme, Mepsevii, Myalept, Naglazyme, Nexavar, Nexviazyme, Niktimvo, Nulibry, Onpattro, Opfolda, Oxlumo, Palinzyq, Papzimeos, Pasatru, Pheburane, Piasky, Pombiliti, Prolastin, Provenge, Ravicti (glycerol phenylbutyrate), Reblozyl, Redemplo, Rhapsido, Rivfloza, Ryplazim, sodium benzoate/sodium phenylacetate, Pyrukynd, Soliris, Strensiq, Sutent, Sylvant, Tavneos, Tegsedi, Tepezza, Terlivaz, Tryngolza, Ultomiris, Uplizna, Veopoz, Vijoice, Viltepso, Vimizim, Voxzogo, Voyxact, Vyvgart Hytrulo, Wainua, Waskyra, Wayrilz, Xenpozyme, Xolremdi, Yartemlea, Yuviwel, Zanvastro, Zemaira, Zokinvy, Zycubo	11/01/26

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		12/01/25
Attention Deficit Hyperactivity Disorder (ADHD) Stimulants			05/01/26
Amondys 45, Exondys 51, Vyondys 53, Viltepso	Amondys 45, Exondys 51, Vyondys 53, Viltepso		01/01/26
Androgens			05/01/26
Antipsychotics in Children			05/01/26
Botulinum Toxin	Botox, Daxxify, Dysport, Myobloc, Xeomin	Covered under medical benefit using appropriate HCPCS	06/01/26
Buprenorphine & Buprenorphine_Naloxone Products (Oral)	Bunavail, buprenorphine, buprenorphine/naloxone, Suboxone, Zubsolv		04/01/26
CGRP Antagonist	Aimovig, Ajovy, Emgality, Nurtec, Qulipta, Ubrelvy, Vyepti		02/01/26
Continuous Glucose Monitors (CGM)	Dexcom, FreeStyle Libre, Guardian, Minimed Instinct		04/01/26
Cystic Fibrosis CFTR Modulators	Kalydeco, Orkambi, Symdeko, Trikafta		06/01/26

Utah Medicaid Prior Authorizations - Effective November 1, 2026

Form	Products	Notes	Updated
Drugs to Promote Fertility	cetrorelix, follitropin alpha, follitropin beta, ganirelix acetate		08/01/26
Fabry Disease	Elfabrio, Fabrazyme, Galafold		02/01/26
Gaucher Disease	Cerdelga, Cerezyme, Elelyso, VPRIB, Zavesca		03/01/26
GLP-1 Medications for Weight-related Comorbidities	Saxenda, Wegovy, Zepbound		01/01/26
Gonadotropin-Releasing Hormone	Camcevi, Eligard, Fensolvi, Firmagon, Lupron, Orgovyx, Supprelin, Synarel, Trelstar, Triptodur, Vabrinty	Orilissa has a separate PA form	08/01/26
Growth Hormone Agonists			09/01/25
Hepatitis C			08/01/25
Hormone Therapy for Gender Dysphoria			08/01/26
IBAT Inhibitors	Bylvay, Livmarli		05/01/26
Immunoglobulin Therapy			01/01/26
Monoclonal Antibodies for Asthma and Other Indications	CinQair, Exdensur, Dupixent, Fasenra, Nucala, Omlyclo, Tezspire, Xolair		09/01/26
Monoclonal Antibodies for Atopic Dermatitis	Adbry, Dupixent, Ebglyss, Nemluvio		10/01/25
Neonatal Fc Receptor Antagonists	Imaavy, Rystiggo, Vyvgart, and Vyvgart Hytrulo*	*For Vyvgart Hytrulo for chronic inflammatory demyelinating polyneuropathy (CIDP) indication, please submit Rare Disease Medications prior authorization form.	08/01/26
Non-preferred Immunomodulators	Arcalyst, Bimzelx, Cimzia, Cosentyx, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Leqselvi, Litfulo, Nemluvio, Olumiant, Omvoh, Orencia, Simponi, Skyrizi, Sotyktu, Spevigo, Tremfya, Velsipity		01/01/26
Novel and Multi-Modal Antidepressants	Auvelity, Fetzima, Trintellix, Viibryd		02/01/26
Omnipod 5	Omnipod 5 introkit, Omnipod 5 Reservoir		01/01/26
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			04/01/26
PAMORAs	Movantik (naloxegol), Symproic (naldemedine)		11/01/25
Parathyroid Hormone Analogs	Bonsity (teriparatide), Evenity (romosozumab-aqqg), Forteo (teriparatide), Tymlos (abaloparatide)		07/01/25
PCSK9 Inhibitors	Praluent, Leqvio, Lipfendra, Repatha		09/01/26
Pompe Disease	Lumizyme, Nexviazyme, Pombiliti, Opfolda		04/01/26
Prophylaxis HAE	Andembry, Cinryze, Danazol, Dawnzera, Haegarda, Orladeyo, Takhzyro		10/01/25
Pulmonary Hypertension	Adempas (riociguat), Adcirca (tadalafil), Alyq (tadalafil), ambrisentan, bosentan, epoprostenol, Flolan (epoprostenol), Letairis (ambrisentan), Opsumit (macitentan), Orenitram (treprostinil), Remodulin (treprostinil), Revatio (sildenafil), sildenafil, tadalafil, Tracleer (bosentan), Tyvaso (treprostinil), Uptravi (selexipag), Veletri (epoprostenol), Ventravis (iloprost)		05/01/24
Sapropterin	Javygtor, Kuvan, Zelvysia		03/01/26
Wakefulness Promoting Agents	Sunosi (solriamfetol), Wakix (pitolisant)		06/01/26

Utah Medicaid Prior Authorizations - Effective November 1, 2026

Drug Specific PA Forms			
Brand Name	**Generic Name**	**Notes**	**Updated**
Abecma	idecabtagene vicleucel		04/01/26
Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry	adalimumab		01/01/26
Actemra, Avtozma, Tofidence, Tyenne	tocilizumab		01/01/26
Adakveo	crizanlizumab		05/01/26
Adzynma	apadamtase alfa		09/01/25
Agamree	vamorolone		05/01/26
Airsupra	albuterol/budesonide		01/01/26
Alhemo	Concizumab-mtci		05/01/25
Aucatzyl	obecabtogene autoleucel		05/01/26
Avsola, Inflectra, Remicade, Renflexis, Zymfentra	infliximab	Covered under medical benefit using appropriate HCPCS	01/01/26
Braftovi, Mektovi	encorafenib and binimetinib		10/01/25
Breyanzi	lisocabtagene maraleucel		05/01/26
Cabenuva	cabotegravir/rilpivirine extended-release injectable suspension		08/01/25
Cablivi	caplacizumab		12/01/25
Carvykti	ciltacabtagene autoleucel		04/01/26
Casgevy	(exagamglogene autotemcel)		11/01/25
Cialis for Benign Prostatic Hyperplasia	tadalafil		06/01/26
Crysvita	burosumab-twza		11/01/25
Daybue	trofinetide		02/01/26
Doptelet	avatrombopag		10/01/25
Dojolvi	triheptanoin		08/01/26
Elevidys	delandistrogene moxeparvovec-rokl		12/01/25
Emflaza, Jaythari	deflazacort		10/01/25
Enbrel	etanercept		01/01/25
Encelto	revakinagene taroretcel		04/01/26
Enspryng	satralizumab-mwge		04/01/26
Epidiolex	cannabidiol		11/01/25
Evkeeza	evinacumab-dgnb		09/01/25
Evrysdi	risdiplam		11/01/25
Filsuvez	birch triterpenes		02/01/26
Hemady	dexamethasone		08/01/26
Hemgenix	etranacogene dezaparvovec-drlb		11/01/25
Hemlibra	emicizumab-kxwh		10/01/25
Hetlioz	tasimelteon		04/01/26
Humulin R U-500	concentrated insulin human injection		08/01/25

Utah Medicaid Prior Authorizations - Effective November 1, 2026

Hympavzi	marstacimab		11/01/25
iDose	travoprost intracameral implant		05/01/26
Imuldosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Wezlana, Yesintek	ustekinumab		01/01/26
Jakafi	ruxolitinib		05/01/26
Jynarque	tolvaptan		11/01/25
Kebilidi	Eladocagene Exuparvovec		09/01/25
Kisunla	donanemab-azbt		09/01/26
Krystexxa	pegloticase		11/01/25
Kymriah	tisagenlecleucel		05/01/26
Lenmeldy	atidarsagene autotemcel		04/01/26
Leqembi	lecanemab-irmb		09/01/26
Lucemyra	lofexidine hydrochloride		08/01/26
Luxturna	voretigene neparvovec-rzyl		10/01/25
Lyfgenia	lovotibeglogene autotemcel		11/01/25
Mavenclad	cladribine		11/01/25
Methadone	Methadone	Treatment of chronic pain only	01/01/26
Miebo	perfluorohexyloctane		08/01/26
Mifeprex	mifepristone		06/01/25
Novarel, Ovidrel, Pregnyl	chorionic gonadotropin		06/01/26
Nuplazid	pimavanserin		08/01/25
Nuedexta	dextromethorphan/quinidine		11/01/25
Opzelura	ruxolitinib cream		01/01/26
Oralair	Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens Allergen Extract		08/01/25
Orilissa	elagolix		08/01/25
Otezla, Otezla pak	apremilast		01/01/26
Palynziq	pegvaliase-pqpz		05/01/26
Pivya	pivmecillinam		06/01/26
Qelbree	viloxazine extended-release		05/01/26
Qfitlia	fitusiran		04/01/26
Rezdiffra	resmetirom		12/01/25
Rinvoq, Rinvoq LQ	upadacitinib		01/01/26
Roctavian	valoctocogene roxaparvovec		10/01/24
Rukobia	fostemsavir		08/01/25
Ryoncil	remestemcel-L-rknd		08/01/26
Samsca	tolvaptan		12/01/25
Sirturo	bedaquiline fumarate		10/01/25

Utah Medicaid Prior Authorizations - Effective November 1, 2026

Brand Name	Generic Name	Notes	Updated
Skyclarys	omaveloxolone		07/01/25
Skysona	Elivaldogene Autotemcel		09/01/25
Spinraza	nusinersen		06/01/26
Spravato	esketamine nasal spray		09/01/26
Sunlenca	lenacapavir		08/01/25
Synagis	palivizumab		12/01/24
Taltz	ixekizumab		01/01/26
Tecartus	brexucabtagene autoleucel		05/01/26
Trodelvy	sacituzumab govitecan		12/01/25
Tryvio	aprocitentan		07/01/25
Tzield	teplizumab-mzwv		09/01/26
Verquvo	vericiguat		06/01/26
Vyjuvek	beremagene geperpavec-svdt		05/01/26
Xeljanz, Xeljanz XR, Xeljanz solution	tofacitinib		01/01/26
Xyrem, Xywav	(sodium oxybate), (calcium, magnesium, potassium, and sodium oxybates)		08/01/25
Yescarta	axicabtagene ciloleucel		04/01/26
Yeztugo	lenacapavir		10/01/25
Yorvipath	Palopegteriparatide		09/01/26
Zevaskyn	prademagene zamikeracel cellular sheet		11/01/25
Zolgensma, Itvisma	onasemnogene abeparvovec-xioi, Onasemnogene abeparvovec-brve		06/01/26
Zynteglo	betibeglogene autotemcel		11/01/25
Zurzuvae	zuranolone capsule		05/01/26

Utah Medicaid Ultra High Cost Drugs - Effective November 1, 2026

• **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
Casgevy	exagamglogene autotemcel	01/01/24	J3392	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
Fayuvi	rebisufligene etisparvovec	11/01/26	TBD	TBD	For the treatment of neurologic manifestations of mucopolysaccharidosis type IIIA (MPS IIIA, Sanfilippo syndrome type A) in pediatric patients with preserved neurodevelopmental function.
Genglycos	pariglasgene brecaparvovec	10/01/26	TBD	TBD	Reduce daily cornstarch intake as an adjunct to nutritional management in adult and pediatric patients 8 years of age and older with glycogen storage disease type Ia (GSDIa)
Hemgenix	etranacogene dezaparvovec-drlb	07/01/23	J1411	Hemgenix	Adults with Hemophilia B (congenital Factor IX deficiency)
Itvisma	Onasemnogene abeparvovec-brve	01/01/26	J3405	Zolgensma and Itvisma	Treatment of spinal muscular atrophy (SMA) in adult and pediatric patients 2 years of age and older with confirmed mutation in SMN1 gene
Lenmeldy	atidarsagene autotemcel	08/01/24	J3391	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	J3387	Skysona	Boys aged 4-17 years with Early, active cerebral adrenoleukodystrophy (CALD)
Waskyra	etuvetidigene autotemcel	01/01/26	J3386	TBD	Pediatric patients ≥6 months of age and adults with Wiskott-Aldrich syndrome (WAS) who have a mutation in the WAS gene and for whom hematopoietic stem cell transplantation is appropriate and no suitable human leukocyte antigen-matched related stem cell donor is available
Zevaskyn	prademagene zamikeracel cellular sl	11/01/25	J3389	Zevaskyn	Patients with recessive dystrophic epidermolysis bullosa (RDEB) confirmed by genetic testing
Zolgensma	onasemnogene abeparvovec-xioi	03/01/25	J3399	Zolgensma and Itvisma	Children <2yrs of age with Spinal Muscular Atrophy (SMA)
Zynteglo	Betibeglogene autotemcel	09/01/23	J3393	Zynteglo	Adult and pediatric patients with β-thalassemia who require regular red blood cell (RBC) transfusions