Uniform PDL Management Guidance
Discussion Item:

Uniform PDL Management Guidance – DRAFT

Due to numerous and unexpected changes in drug availability at the state and federal level, the Drug Formulary Committee recommends DHS manages the Uniform PDL in a timely manner according to the following guidelines:

When a drug listed on the Uniform PDL is discontinued, the following steps are recommended:

1. If the drug is nonpreferred, remove the drug from the Uniform PDL.
2. If the drug is multisource and preferred, remove the drug from the Uniform PDL and consider preferring the nonpreferred brand or generic formulation as a replacement if the discontinuation will result in 1 or fewer preferred drugs on the Uniform PDL.
3. If preferring the nonpreferred brand or generic formulation is not feasible, or the discontinued drug is single source, consider preferring an alternative with same or similar mechanism of action or a different dosage form with the same active ingredient as the discontinued drug.
4. If preferring an alternative drug with the same or similar mechanism of action, or different dosage form with the same active ingredient, is not possible, consider preferring an alternative drug within the PDL therapeutic class.
5. If a drug is moved from nonpreferred status to preferred status, DHS is to inform the DFC of the action taken at a next DFC meeting.

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Leqembi® - DRAFT

(April 2024)

Drug	**Leqembi® (lecanemab-irmb) [**Eisai Inc.**]**
Therapeutic Area	Alzheimer's Agents

Initial approval criteria:

- Patient is ≥ 18 years of age; AND
- Patient has a diagnosis of mild cognitive impairment (MCI) due to Alzheimer's disease (AD) or mild Alzheimer's dementia as evidenced by all of the following:
    - Clinical Dementia Rating (CDR)-Global score of 0.5 to 1
    - Memory Box score ≥ 0.5
    - Mini-Mental State Examination (MMSE) score 22 to 30
    - Objective evidence of cognitive impairment at screening
    - Positron emission tomography (PET) scan or cerebrospinal fluid (CSF) assessment of amyloid beta (1-42) is positive for amyloid beta plaque; AND
- Prescriber attests that other conditions causing similar symptoms have been ruled out (e.g., vascular dementia, dementia with Lewy bodies, frontotemporal dementia, normal pressure hydrocephalus); AND
- Prescribed by, or in consultation with, a specialist in neurology or gerontology; AND
- Patient does not have risk factors for intracerebral hemorrhage (e.g., prior cerebral hemorrhage > 1 cm in greatest diameter, more than 4 microhemorrhages, superficial siderosis, evidence of vasogenic edema, evidence of cerebral contusion, aneurysm, vascular malformation, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory, severe small vessel or white matter disease); AND
- Patient has not had a stroke, transient ischemia attack (TIA), or seizure in the last 12 months; AND
- Patient has not demonstrated clinically significant and unstable psychiatric illness in the last 6 months; AND
- Testing for apolipoprotein E Ɛ4 (ApoE Ɛ4) carrier status has been conducted; AND
- Prescriber attests to conducting a careful risk-benefit analysis prior to prescribing lecanemab-irmb for patients who are homozygous for ApoE Ɛ4, and for those receiving anti-platelet agents (with the exception of prophylactic aspirin or clopidogrel), anticoagulants (e.g., Factor Xa inhibitors), or anti-thrombins (e.g., heparin); AND
- Brain magnetic resonance imaging (MRI) has been obtained prior to treatment initiation; AND
- Baseline disease severity has been assessed using an objective measure/tool (e.g., MMSE, Alzheimer's Disease Assessment Scale Cognitive Subscale [ADAS-Cog-13], Alzheimer's Disease Cooperative Study-Activities of Daily Living Inventory-Mild Cognitive Impairment version [ADCS-ADL-MCI], Clinical Dementia Rating-Sum of Boxes [CDR-SB]).
- Prescriber attests that the patient and/or caregiver understands the risks and benefits of Leqembi therapy AND
- Prescriber attests that the patient and/or caregiver understands and is committed to receiving scheduled doses and enhanced clinical vigilance during the first 14 weeks of treatment
- The following documentation must be provided at time of requests:
    - Healthcare facility's written processes and procedures to support enhanced clinical vigilance during the first 14 weeks of treatment; AND
    - Patient's educational materials to empower patient and caregiver during the enhanced clinical vigilance period and thereafter including ways to contact prescriber and other relevant clinical staff
- Initial approval is for 6 months

Renewal criteria:

- Scoring on an objective measure/tool (e.g., ADAS-Cog 13; ADCSADL-MCI; MMSE; CDR-SB) demonstrates improvement, stability, or slowing in cognitive and/or functional impairment; AND
- Patient has not experienced any treatment-restricting adverse effects (e.g., severe hypersensitivity reactions); AND
- Patient has undergone MRI prior to the 5th, 7th, and 14th infusions to monitor for ARIA with edema (ARIA-E) or ARIA with hemosiderin deposition (ARIA-H); AND
- Leqembi administration will be suspended and not resumed until MRI demonstrates radiographic resolution and stabilization of symptoms in the event of any of the following:
    - ARIA-E that is asymptomatic or mildly symptomatic with moderate to severe radiographic severity
    - ARIA-E with moderate to severe symptoms and any degree of radiographic severity
    - ARIA-H that is asymptomatic with moderate radiographic severity
    - ARIA-H with moderate to severe symptoms and any degree of radiographic severity
    - ARIA-E or ARIA-H with severe radiographic severity
- Renewal approval is for 6 months

Billing for Leqembi
Leqembi must be billed as a medical claim

Quantity limits
- 10 mg/kg every 14 days
- Patient's most recent weight (in kg) must be submitted at time of request

MHCP Provider Resource Center (651) 431-2700 or 1-800-366-5411

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Vowst™ - DRAFT

(April 2024)

Drug	**Vowst™ (fecal microbiota spores, live-brpk) [**Seres Therapeutics, Inc.**]**
Therapeutic Area	Antibiotics, GI

Approval criteria:

- Patient ≥ 18 years of age; AND
- Patient has a confirmed diagnosis of recurrent *Clostridioides difficile* infection (CDI) with a total of ≥3 episodes of CDI within 12 months; AND
- Antibiotic treatment for recurrent CDI must be completed 2 to 4 days prior to initiation of Vowst therapy; AND
- Vowst must not be taken concurrently with antibacterials; AND
- Patient will take 10 oz of magnesium citrate (or 250 mL polyethylene glycol electrolyte solution for patients with impaired kidney function) the evening prior to initiation of Vowst therapy; AND
- Patient must not have absolute neutrophil count (ANC) < 500 cells/mm^3, toxic megacolon, or small bowel ileus AND
- Vowst is prescribed by, or in consultation with an infectious disease or gastrointestinal specialist

Quantity limits

- 12 capsules per 3-day course

Background

Vowst is not indicated for treatment of CDI.

MHCP Provider Resource Center (651) 431-2700 or 1-800-366-5411

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Rebyota™ - DRAFT

(April 2024)

Drug	**Rebyota™ (fecal microbiota, live - jslm) [**Ferring Pharmaceuticals Inc.**]**
Therapeutic Area	Antibiotics, GI

Approval criteria:

- Patient ≥ 18 years of age; AND
- Patient has a confirmed diagnosis of recurrent *Clostridioides difficile* infection (CDI) with a total of ≥ 3 episodes of CDI within 12 months; AND
- Antibiotic treatment for recurrent CDI must be completed 24 to 72 hours prior to initiation of Rebyota therapy; AND
- Rebyota is prescribed by, or in consultation with, an infectious disease or gastrointestinal specialist.

Quantity limits

- 150 mL as a single dose

Billing for Rebyota

Rebyota must be billed as a medical claim.

Background

Rebyota is not indicated for treatment of CDI.

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Veozah™ - DRAFT

(April 2024)

Drug **Veozah™ (fezolinetant) [**Astellas Pharma US, Inc.**]**

Initial approval criteria:

- Patient is at least 18 years of age; AND
- Patient has a diagnosis of menopause with moderate to severe vasomotor symptoms; AND
- Patient does not have cirrhosis; AND
- Patient does not have severe renal impairment or end-stage renal disease; AND
- Patient will avoid concomitant therapy with weak, moderate, or strong CYP1A2 inhibitors (e.g., fluvoxamine, mexiletine, cimetidine); AND
- Prescriber attests that baseline liver function tests have been conducted and total bilirubin, alanine aminotransferase (ALT), and aspartate aminotransferase (AST) levels are not elevated ≥ 2 times the upper limit of normal (ULN); AND
- Initial approval is for 3 months

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient must have symptom improvement; AND
- Patient has not experienced any treatment-restricting adverse effects (e.g., ALT or AST > 3 times the ULN).
- Renewal approval is for 12 months

Quantity limits

- 34 tablets per 34 days

MHCP Provider Resource Center (651) 431-2700 or 1-800-366-5411

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Rystiggo® - DRAFT

(April 2024)

Drug	**Rystiggo® (rozanolixizumab-noli) [**UCB Inc.**]**
Therapeutic Area	Immunomadulators, Miscellaneous

Initial approval criteria:

- Patient is ≥ 18 years of age; AND
- Patient weighs ≥ 35 kg; AND
- Patient has a clinical diagnosis of generalized myasthenia gravis (gMG) with a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II to IV disease; AND
- Patient has a positive serologic test for anti-acetylcholine receptor (AChR) antibodies or anti-muscle specific kinase protein (MuSK) antibodies; AND
- Physician has assessed objective signs of neurological weakness and fatiguability on a baseline neurological examination (e.g., Quantitative Myasthenia Gravis [QMG] score); AND
- Patient has a baseline MG-Activities of Daily Living (MG-ADL) total score ≥ 3; AND
- For patients with AChR-positive disease with thymomas OR nonthymomatous patients who are ≤ 50 years of age, patient has had a thymectomy; AND
- One of the following applies:
    - For patients with AChR+ disease, the patient had an inadequate response to a trial of concurrent use with ≥ 2 immunosuppressive therapies (e.g., corticosteroids plus an immunosuppressant such as azathioprine, cyclosporine, mycophenolate) for ≥ 1 year; OR
    - For patients with MuSK+ disease, the patient had an inadequate response to a trial of immunosuppressive therapy (e.g., corticosteroids, azathioprine, mycophenolate) and rituximab for ≥ 1 year; OR
    - Patient required ≥ 1 acute or chronic treatment with plasmapheresis or plasma exchange (PE) or intravenous immunoglobulin (IVIG) in addition to their background therapy above; AND
- Patient does NOT have a deficiency of immunoglobulin G (IgG) necessitating supplementation with IgG; AND
- Patient does NOT have an active infection, including clinically important localized infections; AND
- Patient is up to date with all vaccinations in accordance with current vaccination guidelines, and live-attenuated or live vaccines will NOT be administered during treatment; AND
- Rozanolixizumab-noli will NOT be used in combination with other immunomodulatory biologic therapies (e.g., efgartigimod alfa-fcab, efgartigimod alfa/hyaluronidase-qvfc, rituximab, eculizumab, ravulizumab, pegcetacoplan, satralizumab, inebilizumab); AND
- Patient will avoid, or use with caution, medications known to worsen or exacerbate symptoms of MG (e.g., certain antibiotics, beta-blockers, botulinum toxins, hydroxychloroquine).
- Initial approval is for 4 months

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient must have disease improvement as indicated by a reduction in MG-ADL total score of ≥ 1 point from baseline*; AND
- Patient has experienced improvement in muscle strength testing with fatigue maneuvers as evidenced on neurologic examination when compared to baseline; AND
- Patient requires continuous treatment, after an initial beneficial response, due to new or worsening disease activity (Note: a minimum of 63 days must have elapsed from the start of the previous treatment cycle); AND
- Patient has not experienced unacceptable toxicity from the drug (e.g., infection, severe hypersensitivity reactions, aseptic meningitis).
- Renewal approval is for 6 months

*May substitute an improvement of ≥ 1 point from baseline in the Quantitative Myasthenia Gravis (QMG) total score sustained, if available.

Quantity limits

- 36 mL (18 vials) per 63 days (3 vials per week for 6 doses per 63 days)
- Maximum recommended dosage: 840 mg/6 mL per week for 6 doses per 63 days
- Patient's most current weight (in kg) must be submitted at time of request

Billing for Rystiggo
Rystiggo must be billed as a medical claim

MHCP Provider Resource Center (651) 431-2700 or 1-800-366-5411

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Hemady® - DRAFT

(April 2024)

Drug	**Hemady® (dexamethasone) [**Edenbridge Pharmaceuticals, LLC.**]**
Therapeutic Area	Glucocorticoids, Oral

Initial approval criteria:

- Patient must be at least 18 years of age AND
- Patient must have a diagnosis of multiple myeloma AND
- Hemady must be prescribed in combination with other anti-myeloma products AND
- Patient must not be experiencing a systemic fungal infection AND
- Hemady is prescribed by, or in consultation, with an oncologist AND
- Patient has had a trial and failure, intolerance, or contraindication to generic dexamethasone oral tablets.

Renewal criteria:

- Patient continues to meet the initial approval criteria AND
- Documentation of positive clinical response is provided at time of request

Quantity limits

- 20 mg or 40 mg orally once daily, on specific days depending on the protocol regimen
- Documentation of the protocol regimen must be provided at time of request

MHCP Provider Resource Center (651) 431-2700 or 1-800-366-5411

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Zurzuvae™ - DRAFT

(April 2024)

Drug	**Zurzuvae™ (zuranolone) [**Biogen Inc.**]**
Therapeutic Area	Antidepressants, Other

Approval criteria:

- Patient is ≥ 18 years of age; AND
- Patient has a diagnosis of postpartum depression (PPD) based on Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for a major depressive episode (DSM-5); AND
- Baseline PPD severity has been assessed using a standardized, validated depression rating scale (e.g., Hamilton Rating Scale for Depression [HAM-D], Patient Health Questionnaire-9 [PHQ-9], Montgomery-Åsberg Depression Rating Scale [MADRS]); AND
- Patient is not currently pregnant and is using effective contraception; AND
- Patient has ceased lactating or has agreed to refrain from providing breast milk to the infant prior to receiving the first dose until 7 days after the last dose; AND
- Prescriber attests that the patient has been counseled:
    - To refrain from engaging in potentially hazardous activities requiring mental alertness, including driving, for ≥ 12 hours after each zuranolone dose; AND
    - To take the medication with 400 to 1,000 calories of food containing 25% to 50% fat; AND
- If patient is taking another oral antidepressant medication, the dose has been stable for ≥ 30 days; AND
- Prescriber attests to assessing concomitant medications for potential drug interactions and adjusting zuranolone dosage according to labeling (e.g., CNS depressants, CYP3A4 inhibitors, CYP3A4 inducers); AND
- Baseline renal and hepatic function have been assessed and dosing is appropriate according to labeling; AND
- Patient has an estimated glomerular filtration rate (eGFR) ≥ 15 mL/min/1.73 m^2 and does not require dialysis; AND
- Prescriber attests that the clinic has established protocol for follow-up care including patient safety monitoring, reporting and dosage adjustments.

Renewal criteria:

Zuranolone treatment has not been evaluated for more than 1 course of treatment per pregnancy. Safety and efficacy of retreatment for a postpartum depression (PPD) episode have not been established.

Quantity limits

- One time fill of 28 capsules/14 days
    - Capsules of lower strengths needed for subsequent dose adjustments are provided by the manufacturer and will not be covered.
- Maximum dose = 50 mg (2 capsules) once daily

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Elevidys - DRAFT

(April 2024)

Drug	**Elevidys (delandistrogene moxeparvovec-rokl)) [**Sarepta Therapeutics Inc.**]**
Therapeutic Area	Duchene muscular dystrophy (DMD)

Approval criteria:

- Age 4 through 5 years; AND
- Diagnosis of Duchenne muscular dystrophy (DMD); AND
- Patient has a confirmed mutation of the DMD gene between exons 18 to 58; AND
- Patient does not have any deletion in exon 8 and/or exon 9 in the DMD gene; AND
- Patient must have a baseline anti-AAVrh74 total binding antibody titer of < 1:400 as measured by ELISA; AND
- Patient is ambulatory as confirmed by the North Star Ambulatory Assessment (NSAA) scale (score of ≥ 1); AND
- Patient is not on concomitant therapy with DMD-directed antisense oligonucleotides (e.g., golodirsen, casimersen, viltolarsen, eteplirsen);
    - Current authorization for any DMD-directed antisense oligonucleotides will be discontinued upon Elevidys approval
- Patient has not received a DMD-directed antisense oligonucleotide within the past 30 days; AND
- Patient does not have an active infection, including clinically important localized infections; AND
- Patient has been on a stable dose of a corticosteroid, unless contraindicated or intolerance, prior to start of therapy and will be used concomitantly with a corticosteroid regimen pre- and postinfusion (refer to the package insert for recommended corticosteroid dosing during therapy); AND
- Patient's troponin-I levels will be monitored at baseline and subsequently as clinically indicated; AND
- Patient will have liver function assessed prior to and following therapy for at least 3 months and as indicated; AND
- Prescriber attests that multidisciplinary rehabilitation assessments are conducted every 6-12 months AND
- Approval is for one time administration and may not be renewed
    - Authorization will be for up to 14 days from approval or until the day before the patient's 6th birthday, whichever comes first

Quantity limits

- 1 kit based on patient weight
- Patient's most current weight (in kg) must be submitted at time of request

Billing for Elevidys

Elevidys must be billed as a medical claim

Background

Elevidys is an adeno-associated virus vector-based gene therapy indicated for the treatment of ambulatory pediatric patients aged 4 through 5 years with Duchenne muscular dystrophy (DMD) with a confirmed mutation in the DMD gene. This indication is approved under accelerated approval based on expression of Elevidys microdystrophin in skeletal muscle observed in patients treated with Elevidys. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

MHCP Provider Resource Center (651) 431-2700 or 1-800-366-5411

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Vevye™ - DRAFT

(April 2024)

Drug	**Vevye™ (cyclosporine) [**Harrow Eye, LLC.**]**
Therapeutic Area	Ophthalmics, Anti-Inflammatory/Immunomodulators

Initial approval criteria:

- Patient must be at least 18 years old AND
- Has a diagnosis of dry eye disease (DED) AND
- Must have one of the following signs of DED
    - Corneal fluoresceine staining score of ≥ 2 points in any field on a 0 to 4 point scale OR
    - Schirmer tear test (STT) of 1 to 10mm in 5 minutes AND
- Patient has trialed and failed, or has a contraindication to Restasis or its generic equivalent AND
- Patient must not have current use of any of the following:
    - Another ophthalmic cyclosporine product (e.g., Cequa, Restatis) OR
    - Miebo OR
    - Tyrvaya OR
    - Xiidra

Renewal criteria:

- Patient must have documented improvement in signs of DED as measured by at least ONE of the following:
    - Decrease in corneal fluoresceine staining score OR
    - Increase in number of mm per 5 minutes using Schirmer tear test AND
- Patient must not have current use of any of the following:
    - Another ophthalmic cyclosporine product (e.g., Cequa, Restatis) OR
    - Miebo OR
    - Tyrvaya OR
    - Xiidra

Quantity limits

- 3 bottles per 30 days
- Requested quantity (in mL and number of bottles) and the corresponding days supplied must be clearly stated on the prior authorization request form

MHCP Provider Resource Center (651) 431-2700 or 1-800-366-5411

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Voquezna®, Voquezna DualPak® Voquezna TriplePak® - DRAFT

(April 2024)

Drug	**Voquezna® (vonoprazan) [**Phatom Pharmaceuticals**]** **Voquezna DualPak® (vonoprazan, amoxicillin) [**Phatom Pharmaceuticals**]** **Voquezna TriplePak® (vonoprazan, amoxicillin, clarithromycin) [**Phatom Pharmaceuticals**]**
Therapeutic Area	H. Pylori treatment

Approval criteria:

Voquezna

- Patient is 18 years of age or older; AND
- Patient has a diagnosis of erosive esophagitis; AND
- Patient has a trial and failure, contraindication, or intolerance to the preferred proton pump inhibitors (PPIs) (e.g., omeprazole esomeprazole, pantoprazole, lansoprazole); AND
- Voquezna is prescribed by, or in consultation with, a gastrointestinal specialist

Voquezna DualPak or Voquezna TriplePak

- Patient is 18 years of age or older; AND
- Patient has a diagnosis of *H. Pylori*
- Patient has a trial and failure, contraindication, or intolerance to one of the following first line treatment regimens:
    - Clarithromycin based therapy (e.g., clarithromycin based triple therapy, clarithromycin based concomitant therapy) OR
    - Bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI]) AND
- Voquezna DualPak or Voquezna TriplePak is prescribed by, or in consultation with, a gastrointestinal specialist

Quantity limits

Voquezna

- Healing of erosive esophagitis: 20 mg once daily for 8 weeks.
- Maintenance of healed erosive esophagitis: 10 mg once daily for up to 6 months.
- Requested tablet strength(s), quantity, refills, and the corresponding days supplied must be clearly stated on the prior authorization request form.

Voquezna DualPak or Voquezna TriplePak

- One carton of 14 daily administration packs

Discussion Items

ACNE AGENTS, TOPICAL section reviewed 4-17-2024

Preferred	Nonpreferred
ADAPALENE GEL (TOPICAL)	ACANYA W/PUMP (TOPICAL)
BENZACLIN W/PUMP (TOPICAL)	ADAPALENE / BENZOYL PEROXIDE (EPIDUO) (TOPICAL)
BENZOYL PEROXIDE 10% WASH OTC (TOPICAL)	ADAPALENE CREAM (TOPICAL)
BENZOYL PEROXIDE 3% CLEANSER OTC (TOPICAL)	ADAPALENE GEL PUMP (TOPICAL)
BENZOYL PEROXIDE 5% WASH OTC (TOPICAL)	AKLIEF (TOPICAL)
BENZOYL PEROXIDE 6% CLEANSER OTC (TOPICAL)	ALTRENO (TOPICAL)
BENZOYL PEROXIDE 9% CLEANSER OTC (TOPICAL)	AMZEEQ (TOPICAL)
BENZOYL PEROXIDE GEL (TOPICAL)	ARAZLO (TOPICAL)
BENZOYL PEROXIDE LOTION OTC (TOPICAL)	ATRALIN (TOPICAL)
CLINDAMYCIN / BENZOYL PEROXIDE (ACANYA) W/PUMP (AG) (TOPICAL)	AVAR CLEANSER (TOPICAL)
	AVITA CREAM (TOPICAL)
CLINDAMYCIN / BENZOYL PEROXIDE (BENZACLIN) (TOPICAL)	AVITA GEL (TOPICAL)
	~~BENZACLIN (TOPICAL)~~
CLINDAMYCIN / BENZOYL PEROXIDE (DUAC) (TOPICAL)	BENZOYL PEROXIDE CLEANSER OTC (TOPICAL)
CLINDAMYCIN PHOSPHATE GEL (TOPICAL)	BENZOYL PEROXIDE FOAM OTC (TOPICAL)
CLINDAMYCIN PHOSPHATE LOTION (TOPICAL)	BENZOYL PEROXIDE TOWELETTE OTC (TOPICAL)
CLINDAMYCIN PHOSPHATE MED. SWAB (TOPICAL)	BP 10-1 (TOPICAL)
CLINDAMYCIN PHOSPHATE SOLUTION (TOPICAL)	CABTREO (TOPICAL)
ERYTHROMYCIN GEL (TOPICAL)	CLEOCIN T GEL (TOPICAL)
ERYTHROMYCIN MED. SWAB (TOPICAL)	CLEOCIN LOTION (TOPICAL)
ERYTHROMYCIN SOLUTION (TOPICAL)	CLINDACIN PAC KIT
ERYTHROMYCIN-BENZOYL PEROXIDE (TOPICAL)	~~CLINDAGEL (TOPICAL)~~
RETIN-A CREAM (TOPICAL)	CLINDAMYCIN / BENZOYL PEROXIDE (ACANYA) W/PUMP (TOPICAL)
RETIN-A GEL (TOPICAL)	
SULFACETAMIDE/SULFUR CLEANSER (TOPICAL	CLINDAMYCIN / BENZOYL PEROXIDE (BENZACLIN) W/PUMP (TOPICAL)
SULFACETAMIDE SODIUM/SULFUR (TOPICAL)	
SULFACETAMIDE SUSPENSION (TOPICAL)	CLINDAMYCIN / BENZOYL PEROXIDE (ONEXTON) W/PUMP (TOPICAL)
	CLINDAMYCIN / TRETINOIN (TOPICAL)
	CLINDAMYCIN PHOSPHATE FOAM (TOPICAL)
	CLINDAMYCIN PHOSPHATE GEL (CLINDAGEL) (TOPICAL)
	DAPSONE GEL
	FABIOR (TOPICAL)
	NEUAC (TOPICAL)
	NEUAC KIT (TOPICAL)
	ONEXTON GEL (TOPICAL)
	ONEXTON W/PUMP (TOPICAL)
	OVACE PLUS CREAM ER (TOPICAL)
	OVACE PLUS SHAMPOO (TOPICAL)
	RETIN-A MICRO 0.04%, 0.1% (TOPICAL)
	RETIN-A MICRO 0.04%, 0.1% PUMP (TOPICAL)
	RETIN-A MICRO 0.06% PUMP (TOPICAL)
	RETIN-A MICRO 0.08% PUMP (TOPICAL)
	SULFACETAMIDE/SULFUR SUSPENSION (TOPICAL)
	TAZAROTENE CREAM (TOPICAL)
	TAZAROTENE FOAM (TOPICAL)
	TAZAROTENE GEL (TOPICAL)

Preferred	Nonpreferred
	TRETINOIN CREAM (TOPICAL) TRETINOIN GEL (AVITA, RETIN-A) (TOPICAL) TRETINOIN GEL (ATRALIN) (TOPICAL) TRETINOIN MICROSPHERES GEL 0.04%, 0.1% (TOPICAL) TRETINOIN MICROSPHERES GEL 0.04%, 0.06%, 0.08%, 0.1% PUMP (TOPICAL) WINLEVI (TOPICAL) ZIANA (TOPICAL)

ALZHEIMER'S AGENTS section reviewed 4-17-2024

Preferred	Nonpreferred
DONEPEZIL ODT (ORAL) DONEPEZIL TABLET (ORAL) MEMANTINE TABLET (ORAL)	ADLARITY (TRANSDERM) ARICEPT (ORAL) ARICEPT 23 MG (ORAL) ARICEPT ODT (ORAL) DONEPEZIL 23 MG (ORAL) EXELON (TRANSDERM.) EXELON CAPSULES (ORAL) GALANTAMINE ER (ORAL) GALANTAMINE SOLUTION (ORAL) GALANTAMINE TABLET (ORAL) MEMANTINE ER (ORAL) MEMANTINE SOLUTION (ORAL) MEMANTINE TABLET DOSE PACK (AG) (ORAL) NAMENDA TABLET (ORAL) NAMENDA TABLET DOSE PACK (ORAL) NAMENDA XR (ORAL) NAMZARIC (ORAL) NAMZARIC DOSE PACK (ORAL) ~~RAZADYNE ER (ORAL)~~ ~~RAZADYNE TABLET (ORAL)~~ RIVASTIGMINE (AG) (TRANSDERM.) RIVASTIGMINE (TRANSDERM.) RIVASTIGMINE CAPSULES (ORAL)

ANALGESICS, NARCOTICS LONG section reviewed 4-17-2024

Preferred	Nonpreferred
BELBUCA (BUCCAL) MORPHINE ER TABLET (ORAL) FENTANYL (25, 50MCG) TRANSDERM	ARYMO ER (ORAL) BUPRENORPHINE (TRANSDERM) BUPRENORPHINE (BUCCAL) CONZIP (ORAL) DURAGESIC MATRIX (TRANSDERM.) EMBEDA (ORAL) EXALGO (ORAL) FENTANYL (12, 37.5, 62.5, 87.5 MG, 75, 100MCG) (TRANSDERM) HYDROCODONE ER (HYSINGLA ER) (ORAL) HYDROCODONE ER (ZOHYDRO ER) (ORAL) HYDROMORPHONE ER (ORAL) HYSINGLA ER (ORAL) ~~KADIAN (ORAL)~~ METHADONE TABLET (ORAL)

Preferred	Nonpreferred
	MORPHABOND ER (ORAL) MORPHINE ER CAPSULE (AVINZA) (ORAL) MORPHINE ER CAPSULE (KADIAN) (ORAL) MS CONTIN (ORAL) NUCYNTA ER (ORAL) OPANA ER (ORAL) OXYCONTIN (ORAL) OXYCODONE ER (ORAL) OXYMORPHONE ER (ORAL) TRAMADOL ER (CONZIP) (ORAL) TRAMADOL ER (RYZOLT) (ORAL) TRAMADOL ER (ULTRAM ER) (ORAL) XTAMPZA ER (ORAL) ZOHYDRO ER (ORAL)

ERYTHROPOIESIS STIMULATING PROTEINS section reviewed 4-17-2024

Preferred	Nonpreferred
ARANESP DISP SYRIN (INJECTION) ARANESP VIAL (INJECTION) EPOGEN (INJECTION) RETACRIT (INJECTION)	JESDUVROQ (ORAL) MIRCERA (INJECTION) PROCRIT (INJECTION) REBLOZYL (SUBCUTANEOUS) RETACRIT (VIFOR) (INJECTION)

GROWTH HORMONE section reviewed 4-17-2024

Preferred	Nonpreferred
GENOTROPIN CARTRIDGE (INJECTION) GENOTROPIN DISP SYRIN (INJECTION) NORDITROPIN PEN (INJECTION) NUTROPIN AQ PEN (INJECTION)	~~GENOTROPIN CARTRIDGE (INJECTION)~~ ~~GENOTROPIN DISP SYRIN (INJECTION)~~ HUMATROPE CARTRIDGE (INJECTION) HUMATROPE VIAL (INJECTION) NGENLA (INJECTION) OMNITROPE CARTRIDGE (INJECTION) OMNITROPE VIAL (INJECTION) SAIZEN CARTRIDGE (INJECTION) SAIZEN VIAL (INJECTION) SEROSTIM VIAL (INJECTION) SKYTROFA CARTRIDGE (SUBCUTANEOUS) SOGROYA (SUBCUTANEOUS) ZOMACTON VIAL (INJECTION) ZORBTIVE VIAL (INJECTION)

HYPOGLYCEMICS, SGLT2 section reviewed 4-17-2024

Preferred	Nonpreferred
FARXIGA (ORAL) INVOKANA (ORAL) JARDIANCE (ORAL)	DAPAGLIFLOZIN (ORAL) DAPAGLIFLOZIN/MEFORMIN ER (ORAL) INPEFA (ORAL) INVOKAMET (ORAL) INVOKAMET XR (ORAL) SEGLUROMET (ORAL) STEGLATRO (ORAL) SYNJARDY (ORAL) SYNJARDY XR (ORAL) XIGDUO XR (ORAL)

OPHTHALMICS, ANTI-INFLAMMATORIES section reviewed 4-17-2024

Preferred	Nonpreferred
DICLOFENAC (OPHTHALMIC)	ACULAR (OPHTHALMIC)
FLUOROMETHOLONE (OPHTHALMIC)	ACULAR LS (OPHTHALMIC)
KETOROLAC (OPHTHALMIC)	ACUVAIL (OPHTHALMIC)
KETOROLAC LS (OPHTHALMIC)	BROMFENAC (OPHTHALMIC)
PREDNISOLONE ACETATE (OPHTHALMIC)	BROMSITE (OPHTHALMIC)
TRIESENCE (INTRAOCULR)	DEXTENZA (INTRAOCULAR)
	DEXYCU (INTRAOCULAR)
	DIFLUPREDNATE (OPHTHALMIC)
	DIFLUPREDNATE (AG) (OPHTHALMIC)
	DUREZOL (OPHTHALMIC)
	FLURBIPROFEN (OPHTHALMIC)
	ILEVRO (OPHTHALMIC)
	ILUVIEN (INTRAOCULAR)
	INVELTYS (OPHTHALMIC)
	LOTEMAX DROPS (OPHTHALMIC)
	LOTEMAX GEL (OPHTHALMIC)
	LOTEMAX OINTMENT (OPHTHALMIC)
	LOTEPREDNOL GEL (AG) (OPHTHALMIC)
	LOTEPREDNOL GEL (OPHTHALMIC)
	LOTEPREDNOL DROPS (AG) (OPHTHALMIC)
	LOTEPREDNOL DROPS (OPHTHALMIC)
	NEVANAC (OPHTHALMIC)
	OZURDEX (INTRAOCULR)
	PROLENSA (OPHTHALMIC)
	RETISERT (INTRAOCULR)
	XIPERE (SUPRACHOROIDAL INJECTION)
	YUTIQ (INTRAOCULR)

OPHTHALMICS, GLAUCOMA AGENTS section reviewed 4-17-2024

Preferred	Nonpreferred
ALPHAGAN P 0.1% (OPHTHALMIC)	APRACLONIDINE (OPHTHALMIC)
ALPHAGAN P 0.15% (OPHTHALMIC)	AZOPT (OPHTHALMIC)
BRIMONIDINE (OPHTHALMIC)	BETAGAN (OPHTHALMIC)
COMBIGAN (OPHTHALMIC)	BETAXOLOL (OPHTHALMIC)
DORZOLAMIDE (OPHTHALMIC)	BETIMOL (OPHTHALMIC)
DORZOLAMIDE / TIMOLOL (OPHTHALMIC)	BETOPTIC S (OPHTHALMIC)
LATANOPROST 2.5 ML (OPHTHALMIC)	BIMATOPROST 2.5ML (OPHTHALMIC)
TIMOLOL (OPHTHALMIC)	BIMATOPROST 5ML (OPHTHALMIC)
TRAVATAN Z 2.5 ML (OPHTHALMIC)	BIMATOPROST 7.5ML (OPHTHALMIC)
TRAVATAN Z 5 ML (OPHTHALMIC)	BRIMONIDINE P 0.15% (OPHTHALMIC)
	BRIMONIDINE TARTRATE/TIMOLOL DROPS (OPHTHALMIC)
	BRINZOLAMIDE (OPHTHALMIC)
	CARTEOLOL (OPHTHALMIC)
	COSOPT (OPHTHALMIC)
	COSOPT PF (OPHTHALMIC)
	DORZOLAMIDE / TIMOLOL/PF DROPS (OPHTHALMIC)
	DURYSTA IMPLANT (INTRACAMERAL)
	IDOSE TR IMPLANT (INTRACAMERAL)
	IOPIDINE (OPHTHALMIC)
	IYUZEH (OPHTHALMIC)

Preferred	Nonpreferred
	ISTALOL (OPHTHALMIC) LEVOBUNOLOL (OPHTHALMIC) LUMIGAN 2.5ML (OPHTHALMIC) LUMIGAN 5ML (OPHTHALMIC) LUMIGAN 7.5ML (OPHTHALMIC) RHOPRESSA (OPHTHALMIC) ROCKLATAN (OPHTHALMIC) SIMBRINZA (OPHTHALMIC) TAFLUPROST (OPHTHALMIC) TIMOLOL (ISTALOL) (OPHTHALMIC) TIMOLOL (TIMOPTIC OCCUDOSE) (OPHTHALMIC) TIMOPTIC (OPHTHALMIC) TIMOPTIC OCUDOSE (OPHTHALMIC) TIMOPTIC-XE (OPHTHALMIC) TRAVOPROST 2.5 ML (OPHTHALMIC) TRAVOPROST 5 ML (OPHTHALMIC) TRUSOPT (OPHTHALMIC) VYZULTA (OPHTHALMIC) XALATAN 2.5 ML (OPHTHALMIC) XELPROS (OPHTHALMIC) ZIOPTAN (OPHTHALMIC)

PAH AGENTS, ORAL AND INHALED section reviewed 4-17-2024

Preferred	Nonpreferred
AMBRISENTAN (ORAL) SILDENAFIL (ORAL) SILDENAFIL SUSPENSION (ORAL) SILDENAFIL SUSPENSION (AG) (ORAL) TRACLEER TABLET (ORAL)	ADCIRCA (ORAL) ADEMPAS (ORAL) BOSENTAN (ORAL) LETAIRIS (ORAL) LIQREV SUSPENSION (ORAL) OPSUMIT (ORAL) ORENITRAM ER (ORAL) ORENITRAM TITRATION KIT (ORAL) REVATIO SUSPENSION (ORAL) REVATIO TABLET (ORAL) TALADAFIL (ADCIRCA) (ORAL) TRACLEER SUSPENSION (ORAL) TYVASO (INHALATION) TYVASO DPI (INHALATION) UPTRAVI (ORAL) UPTRAVI TABLET DOSE PACK (ORAL) VENTAVIS (INHALATION)

SEDATIVE HYPNOTICS section reviewed 4-17-2024

Preferred	Nonpreferred
ESZOPICLONE (ORAL) ROZEREM (ORAL) ZALEPLON (ORAL) ZOLPIDEM (ORAL)	AMBIEN (ORAL) AMBIEN CR (ORAL) BELSOMRA (ORAL) DAYVIGO (ORAL) EDLUAR (SUBLINGUAL) HETLIOZ (ORAL) HETLIOZ LQ (ORAL) LUNESTA (ORAL)

Preferred	Nonpreferred
	QUVIVIQ (ORAL) RAMELTEON (ORAL) TASIMELTEON (ORAL) ZOLPIDEM (SUBLINGUAL) ZOLPIDEM CAPSULE (ORAL) ZOLPIDEM ER (ORAL)

ULCERATIVE COLITIS AGENTS section reviewed 4-17-2024

Preferred	Nonpreferred
APRISO (ORAL) BALSALAZIDE (ORAL) ~~CANASA (RECTAL)~~ ~~DELZICOL (ORAL)~~ LIALDA (ORAL) MESALAMINE (CANASA) (RECTAL) PENTASA (ORAL) ROWASA (RECTAL) SFROWASA (RECTAL) SULFASALAZINE (ORAL) SULFASALAZINE DR (ORAL)	~~ASACOL HD (ORAL)~~ AZULFIDINE TABLET (ORAL) AZULFIDINE TABLET DR (ORAL) BUDESONIDE (RECTAL) BUDESONIDE DR (ORAL) CANASA (RECTAL) COLAZAL (ORAL) DIPENTUM (ORAL) MESALAMINE (ASACOL HD) (ORAL) ~~MESALAMINE (CANASA) (RECTAL)~~ MESALAMINE (DELZICOL) (ORAL) ~~MESALAMINE (LIALDA) (ORAL)~~ MESALAMINE (ROWASA) (RECTAL) MESALAMINE (SFROWASA) (RECTAL) MESALAMINE ER (APRISO) (ORAL) MESALAMINE ER (PENTASA) (ORAL) UCERIS (ORAL) UCERIS (RECTAL)

Consent Agenda Items

ANDROGENIC AGENTS section reviewed 4-17-2024

Preferred	Nonpreferred
TESTOSTERONE GEL PUMP (ANDROGEL) (TRANSDERM) TESTIM (TRANSDERM.)	~~FORTESTA (TRANSDERM)~~ ~~NATESTO (NASAL)~~ ~~TESTIM (TRANSDERM.)~~ TESTOSTERONE GEL (FORTESTA) (TRANSDERM) TESTOSTERONE GEL (TESTIM) (TRANSDERM) TESTOSTERONE GEL (VOGELXO) (TRANSDERM) TESTOSTERONE GEL PACKET (ANDROGEL) (TRANSDERM) TESTOSTERONE GEL PUMP (AXIRON) (TRANSDERM) VOGELXO GEL (TRANSDERM) VOGELXO GEL PACKET (TRANSDERM) VOGELXO GEL PUMP (TRANSDERM)

BETA-BLOCKERS section reviewed 4-17-2024

Preferred	Nonpreferred
ATENOLOL (ORAL) BISOPROLOL (ORAL) CARVEDILOL (ORAL) LABETALOL (ORAL) METOPROLOL (ORAL) METOPROLOL XL (ORAL) NADOLOL (ORAL) PINDOLOL (ORAL) PROPRANOLOL ER (ORAL) PROPRANOLOL SOLUTION (ORAL) PROPRANOLOL TABLET (ORAL) PROPRANOLOL/HCTZ (ORAL) SOTALOL (ORAL)	ACEBUTOLOL (ORAL) ATENOLOL/CHLORTHALIDONE (ORAL) BETAPACE / AF (ORAL) BETAXOLOL (ORAL) BISOPROLOL HCTZ (ORAL) ~~BYSTOLIC (ORAL)~~ CARVEDILOL ER (ORAL) COREG (ORAL) ~~COREG CR (ORAL)~~ CORGARD (ORAL) ~~CORZIDE (ORAL)~~ ~~DUTOPROL (ORAL)~~ HEMANGEOL (ORAL) INDERAL LA (ORAL) INDERAL XL (ORAL) INNOPRAN XL (ORAL) KAPSPARGO (ORAL) ~~LEVATOL (ORAL)~~ LOPRESSOR (ORAL) LOPRESSOR HCT (ORAL) METOPROLOL/HCTZ (ORAL) NEBIVOLOL (ORAL) SOTYLIZE (ORAL) TENORETIC (ORAL) TENORMIN (ORAL) TIMOLOL (ORAL) TOPROL XL (ORAL) ZIAC (ORAL)

BLADDER RELAXANT PREPARATIONS section reviewed 4-17-2024

Preferred	Nonpreferred
OXYBUTYNIN ER (ORAL) OXYBUTYNIN ER (AG) (ORAL) OXYBUTYNIN SYRUP (ORAL) OXYBUTYNIN TABLET (ORAL)	DARIFENACIN ER (ORAL) DETROL (ORAL) ~~DETROL LA (ORAL)~~ DITROPAN XL (ORAL)

Preferred	Nonpreferred
OXYTROL (TRANSDERM.)	ENABLEX (ORAL)
SOLIFENACIN (ORAL)	FESOTERODINE ER (ORAL)
TOLTERODINE (ORAL)	FLAVOXATE (ORAL)
TOLTERODINE ER (ORAL)	~~GELNIQUE (TRANSDERM.)~~
TOVIAZ (ORAL)	GELNIQUE GEL PUMP (TRANSDERMAL)
	GEMTESA (ORAL)
	MYRBETRIQ (ORAL)
	MYRBETRIQ GRANULES (ORAL)
	TROSPIUM (ORAL)
	TROSPIUM ER (ORAL)
	VESICARE (ORAL)
	VESICARE LS (ORAL)

IMMUNOMODULATORS, ATOPIC DERMATITIS section reviewed 4-17-2024 no change

Preferred	Nonpreferred
DUPIXENT (SUBCUTANE.)	ADBRY (SUBCUTANEOUS)
	EUCRISA (TOPICAL)
	OPZELURA (TOPICAL)

INTRANASAL RHINITIS AGENTS section reviewed 4-17-2024

Preferred	Nonpreferred
AZELASTINE (ASTELIN) (NASAL)	AZELASTINE/FLUTICASONE (NASAL)
AZELASTINE (ASTEPRO) (NASAL)	AZELASTINE/FLUTICASONE (AG) (NASAL)
FLUTICASONE (NASAL)	~~BECONASE AQ (NASAL)~~
IPRATROPIUM (NASAL)	DYMISTA (NASAL)
MOMETASONE (NASAL)	FLUNISOLIDE (NASAL)
	NASONEX (NASAL)
	~~OLOPATADINE (NASAL)~~
	OMNARIS (NASAL)
	~~PATANASE (NASAL)~~
	QNASL 40 (NASAL)
	QNASL 80 (NASAL)
	RYALTRIS (NASAL)
	SINUVA (SINUS IMPLANT)
	TICANASE (NASAL)
	VERAMYST (NASAL)
	XHANCE (NASAL)
	ZETONNA (NASAL)

LIPOTROPICS, OTHER section reviewed 4-17-2024

Preferred	Nonpreferred
CHOLESTYRAMINE/ASPARTAME (ORAL)	ANTARA (ORAL)
CHOLESTYRAMINE/SUCROSE (ORAL)	COLESEVELAM (ORAL)
COLESTIPOL GRANULES (ORAL)	COLESEVELAM POWDER PACK (ORAL)
COLESTIPOL TABLET (ORAL)	~~COLESTID GRANULES (ORAL)~~
EZETIMIBE (ORAL)	COLESTID TABLET (ORAL)
FENOFIBRATE CAPSULE (LOFIBRA) (ORAL)	EVKEEZA (INTRAVENOUS)
FENOFIBRATE TABLET (LOFIBRA) (ORAL)	FENOFIBRATE (ANTARA) (ORAL)
FENOFIBRATE TABLET (TRICOR) (ORAL)	FENOFIBRATE (FENOGLIDE) (ORAL)
GEMFIBROZIL (ORAL)	FENOFIBRATE (TRIGLIDE) (ORAL)
NIASPAN (ORAL)	FENOFIBRATE CAPSULE (LIPOFEN) (ORAL)
NIACIN TABLET OTC (ORAL)	FENOFIBRIC ACID (FIBRICOR) (ORAL)

Preferred	Nonpreferred
NIACIN CAPSULE ER OTC (ORAL) NIACIN ER (ORAL) NIACIN TABLET ER OTC (ORAL) OMEGA-3 ACID ETHYL ESTERS (ORAL)	FENOFIBRIC ACID (TRILIPIX) (ORAL) FENOGLIDE (ORAL) FIBRICOR (ORAL) ICOSAPENT ETHYL (ORAL) LEQVIO (SUBCUTANEOUS) LOPID LIPOFEN (ORAL) LOVAZA (ORAL) NEXLETOL (ORAL) NEXLIZET (ORAL) NIACOR (ORAL) ~~OMEGA-3 ACID ETHYL ESTERS (ORAL)~~ PRALUENT PEN (SUBCUTANEOUS) QUESTRAN (ORAL) QUESTRAN LIGHT (ORAL) REPATHA PUSHTRONEX (SUBCUTANEOUS) REPATHA SURECLICK (SUBCUTANEOUS) REPATHA SYRINGE (SUBCUTANEOUS) TRICOR (ORAL) TRIGLIDE (ORAL) TRILIPIX (ORAL) VASCEPA (ORAL) WELCHOL POWDER PACK (ORAL) WELCHOL TABLET (ORAL) ZETIA (ORAL)

NEUROPATHIC PAIN section reviewed 4-17-2024

Preferred	Nonpreferred
DULOXETINE (CYMBALTA GEN.) (ORAL) GABAPENTIN CAPSULE (ORAL) GABAPENTIN SOLUTION (ORAL) GABAPENTIN TABLET (ORAL) PREGABALIN CAPSULE (ORAL) SAVELLA (ORAL) SAVELLA DOSE PACK (ORAL)	CYMBALTA (ORAL) DRIZALMA SPRINKLE (ORAL) DULOXETINE (IRENKA) (ORAL) GRALISE (ORAL) HORIZANT (ORAL) LIDOCAINE (TOPICAL) ~~LIDODERM (TOPICAL)~~ LYRICA CAPSULE (ORAL) LYRICA CR (ORAL) LYRICA SOLUTION (ORAL) NEURONTIN CAPSULE (ORAL) NEURONTIN SOLUTION (ORAL) NEURONTIN TABLET (ORAL) PREGABALIN ER (ORAL) PREGABALIN SOLUTION (ORAL) QUTENZA KIT (TOPICAL) ZTLIDO (TOPICAL)

NSAIDS section reviewed 4-17-2024

Preferred	Nonpreferred
CELECOXIB (ORAL) DICLOFENAC GEL (TOPICAL) IBUPROFEN 400 MG, 600 MG, 800 MG (ORAL) MELOXICAM TABLET (ORAL)	ARTHROTEC (ORAL) CELEBREX (ORAL) DICLOFENAC PATCH (AG) (TRANSDERMAL) DICLOFENAC SODIUM/MISOPROSTOL (ORAL)

Preferred	Nonpreferred
NAPROXEN TABLET (ORAL)	~~DUEXIS (ORAL)~~
FLURIBIPROFEN (ORAL)	FENOPROFEN (ORAL)
INDOMETHACIN CAPSULE (ORAL)	FLECTOR (TOPICAL)
DICLOFENAC SODIUM (ORAL)	IBUPROFEN/FAMOTIDINE TABLET (ORAL)
DICLOFENAC SR (ORAL)	KETOPROFEN ER (ORAL)
SULINDAC (ORAL)	KETOROLAC (SPRIX) (NASAL)
NAPROXEN EC (ORAL)	LICART PATCH (TRANSDERMAL)
NABUMETONE (ORAL)	MOBIC TABLET (ORAL)
KETOPROFEN (ORAL)	MEFENAMIC ACID (ORAL)
KETOROLAC (ORAL)	MELOXICAM CAPSULE (ORAL)
NAPROXEN SODIUM (ORAL)	MECLOFENAMATE (ORAL)
	NALFON (ORAL)
	NAPRELAN (ORAL)
	NAPROXEN CR (ORAL)
	NAPROXEN/ESOMEPRAZOLE (ORAL)
	OXAPROZIN (ORAL)
	RELAFEN DS (ORAL)
	~~VIMOVO (ORAL)~~
	ZIPSOR (ORAL)
	ZORVOLEX (ORAL)

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS section reviewed 4-17-2024

Preferred	Nonpreferred
ALREX (OPHTHALMIC)	~~ALOCRIL (OPHTHALMIC)~~
BEPREVE (OPHTHALMIC)	ALOMIDE (OPHTHALMIC)
CROMOLYN SODIUM (OPHTHALMIC)	~~ALREX (OPHTHALMIC)~~
KETOTIFEN OTC (OPHTHALMIC)	AZELASTINE (OPHTHALMIC)
OLOPATADINE (PATANOL) (OPHTHALMIC)	BEPOTASTINE (OPHTHALMIC)
OLOPATADINE DROPS (PATADAY) (OPHTHALMIC)	~~BEPREVE (OPHTHALMIC)~~
	~~ELESTAT (OPHTHALMIC)~~
	~~EMADINE (OPHTHALMIC)~~
	EPINASTINE (OPHTHALMIC)
	~~LASTACAFT (OPHTHALMIC)~~
	ZADITOR OTC (OPHTHALMIC)
	ZERVIATE (OPHTHALMIC)

PANCREATIC ENZYMES section reviewed 4-17-2024 no change

Preferred	Nonpreferred
CREON (ORAL)	PANCREAZE (ORAL)
ZENPEP (ORAL)	PERTZYE (ORAL)
	VIOKACE (ORAL)