

# ANTICONVULSANTS

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## Products Affected

### Step 2:

- APTIOM 200 MG TABLET
- APTIOM 400 MG TABLET
- APTIOM 600 MG TABLET
- APTIOM 800 MG TABLET
- BANZEL 200 MG TABLET
- BANZEL 40 MG/ML ORAL SUSPENSION
- BANZEL 400 MG TABLET
- FYCOMPA 0.5 MG/ML ORAL SUSPENSION
- FYCOMPA 10 MG TABLET
- FYCOMPA 12 MG TABLET
- FYCOMPA 2 MG TABLET
- FYCOMPA 4 MG TABLET
- FYCOMPA 6 MG TABLET
- FYCOMPA 8 MG TABLET
- OXTELLAR XR 150 MG TABLET,EXTENDED RELEASE
- OXTELLAR XR 300 MG TABLET,EXTENDED RELEASE
- OXTELLAR XR 600 MG TABLET,EXTENDED RELEASE
- POTIGA 200 MG TABLET
- POTIGA 300 MG TABLET
- POTIGA 400 MG TABLET
- POTIGA 50 MG TABLET
- TROKENDI XR 100 MG CAPSULE, EXTENDED RELEASE
- TROKENDI XR 200 MG CAPSULE, EXTENDED RELEASE
- TROKENDI XR 25 MG CAPSULE,EXTENDED RELEASE
- TROKENDI XR 50 MG CAPSULE, EXTENDED RELEASE
- VIMPAT 10 MG/ML ORAL SOLUTION
- VIMPAT 100 MG TABLET
- VIMPAT 150 MG TABLET
- VIMPAT 200 MG TABLET
- VIMPAT 200 MG/20 ML INTRAVENOUS SOLUTION
- VIMPAT 50 MG TABLET

## Details

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<b>Criteria</b>	PRIOR CLAIM FOR GENERIC ANTICONVULSANT AGENT (CARBAMAZEPINE, DIVALPROEX SODIUM, GABAPENTIN, LAMOTRIGINE, LEVETIRACETAM, OXCARBAZEPINE, TIAGABINE, TOPIRAMATE, VALPROIC ACID, OR ZONISAMIDE), WITHIN THE PAST 120 DAYS.
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# ANTIDEPRESSANTS

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## Products Affected

### Step 2:

- TRINTELLIX 10 MG TABLET
- TRINTELLIX 20 MG TABLET
- TRINTELLIX 5 MG TABLET
- VIIBRYD 10 MG (7)-20 MG (23)
- TABLETS IN A DOSE PACK
- VIIBRYD 10 MG TABLET
- VIIBRYD 20 MG TABLET
- VIIBRYD 40 MG TABLET

## Details

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<b>Criteria</b>	PRIOR CLAIM FOR PAROXETINE, FLUOXETINE, SERTRALINE, DULOXETINE, CITALOPRAM, MIRTAZAPINE, ESCITALOPRAM, OR BUPROPION (IR, SR, XL) WITHIN THE PAST 120 DAYS.
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# ANTIDEPRESSANTS II

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## Products Affected

### Step 2:

- FETZIMA 120 MG CAPSULE,EXTENDED RELEASE
- FETZIMA 20 MG (2)-40 MG (26) CAPSULE,EXTENDED RELEASE,24 HR,DOSE PACK
- FETZIMA 20 MG CAPSULE,EXTENDED RELEASE
- FETZIMA 40 MG CAPSULE,EXTENDED RELEASE
- FETZIMA 80 MG CAPSULE,EXTENDED RELEASE

## Details

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Criteria	PRIOR CLAIM FOR TRINTELLIX AND VIIBRYD WITHIN THE PAST 365 DAYS.
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# ANTIDIABETIC AGENTS - MISCELLANEOUS

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## Products Affected

### Step 2:

- GLYXAMBI 10 MG-5 MG TABLET
- GLYXAMBI 25 MG-5 MG TABLET
- INVOKAMET 150 MG-1,000 MG TABLET
- INVOKAMET 150 MG-500 MG TABLET
- INVOKAMET 50 MG-1,000 MG TABLET
- INVOKAMET 50 MG-500 MG TABLET
- INVOKAMET XR 150 MG-1,000 MG TABLET, EXTENDED RELEASE
- INVOKAMET XR 150 MG-500 MG TABLET, EXTENDED RELEASE
- INVOKAMET XR 50 MG-1,000 MG TABLET, EXTENDED RELEASE
- INVOKAMET XR 50 MG-500 MG TABLET, EXTENDED RELEASE
- INVOKANA 100 MG TABLET
- INVOKANA 300 MG TABLET
- JARDIANCE 10 MG TABLET
- JARDIANCE 25 MG TABLET
- SYNJARDY 12.5 MG-1,000 MG TABLET
- SYNJARDY 12.5 MG-500 MG TABLET
- SYNJARDY 5 MG-1,000 MG TABLET
- SYNJARDY 5 MG-500 MG TABLET
- SYNJARDY XR 10 MG-1,000 MG TABLET, EXTENDED RELEASE
- SYNJARDY XR 12.5 MG-1,000 MG TABLET, EXTENDED RELEASE
- SYNJARDY XR 25 MG-1,000 MG TABLET, EXTENDED RELEASE
- SYNJARDY XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE

## Details

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<b>Criteria</b>	PRIOR CLAIM FOR METFORMIN, METFORMIN ER, A SULFONYLUREA AGENT (GLYBURIDE, GLIPIZIDE, GLIMEPIRIDE, TOLAZAMIDE, TOLBUTAMIDE), PIOGLITAZONE, COMBINATION OF A SULFONYLUREA-METFORMIN, PIOGLITAZONE-METFORMIN, OR PIOGLITAZONE-GLIMEPIRIDE WITHIN THE PAST 120 DAYS.
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# ANTI-INFLAMMATORY AGENTS - GI

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## Products Affected

### Step 2:

- DIPENTUM 250 MG CAPSULE

## Details

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<b>Criteria</b>	PRIOR CLAIM FOR ANY 1 OF THE FOLLOWING: BALSALAZIDE, APRISO, DELZICOL, MESALAMINE DR 800 MG TAB, OR FORMULARY MESALAMINE 1.2 G DR TAB WITHIN THE PAST 120 DAYS.
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# ANTIPSYCHOTIC AGENTS

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## Products Affected

### Step 2:

- *clozapine 100 mg disintegrating tablet*
- *clozapine 12.5 mg disintegrating tablet*
- *clozapine 150 mg disintegrating tablet*
- *clozapine 200 mg disintegrating tablet*
- *clozapine 25 mg disintegrating tablet*
- FANAPT 1 MG TABLET
- FANAPT 10 MG TABLET
- FANAPT 12 MG TABLET
- FANAPT 1MG(2)-2 MG(2)-4MG(2)-6 MG(2) TABLETS IN A DOSE PACK
- FANAPT 2 MG TABLET
- FANAPT 4 MG TABLET
- FANAPT 6 MG TABLET
- FANAPT 8 MG TABLET
- SAPHRIS 10 MG SUBLINGUAL TABLET
- SAPHRIS 2.5 MG SUBLINGUAL TABLET
- SAPHRIS 5 MG SUBLINGUAL TABLET
- VERSACLOZ 50 MG/ML ORAL SUSPENSION
- VRAYLAR 1.5 MG (1)-3 MG (6) CAPSULES IN A DOSE PACK
- VRAYLAR 1.5 MG CAPSULE
- VRAYLAR 3 MG CAPSULE
- VRAYLAR 4.5 MG CAPSULE
- VRAYLAR 6 MG CAPSULE

## Details

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Criteria
PRIOR CLAIM FOR FORMULARY VERSIONS OF ANY TWO ORAL ANTIPSYCHOTICS: RISPERIDONE, CLOZAPINE TABLET, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIRAZOLE WITHIN THE PAST 365 DAYS.

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# ANTIPSYCHOTIC AGENTS II

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## Products Affected

### Step 2:

- REXULTI 0.25 MG TABLET
- REXULTI 0.5 MG TABLET
- REXULTI 1 MG TABLET
- REXULTI 2 MG TABLET
- REXULTI 3 MG TABLET
- REXULTI 4 MG TABLET

## Details

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<b>Criteria</b>	PRIOR CLAIM FOR TWO (2) OF THE FOLLOWING FORMULARY ORAL VERSIONS OF ATYPICAL ANTIPSYCHOTICS (RISPERIDONE, CLOZAPINE, OLANZAPINE, QUETIAPINE, ARIPIPRAZOLE OR ZIPRASIDONE) OR SSRI (CITALOPRAM, ESCITALOPRAM, FLUOXETINE, PAROXETINE OR SERTRALINE) OR SNRI (DESVENLAFAXINE, DULOXETINE OR VENLAFAXINE) WITHIN THE PAST 365 DAYS
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# B VERSUS D ADMINISTRATIVE STEP

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## Products Affected

### Step 2:

- CYCLOPHOSPHAMIDE 25 MG CAPSULE
- CYCLOPHOSPHAMIDE 50 MG CAPSULE
- *methotrexate sodium 2.5 mg tablet*
- TREXALL 10 MG TABLET
- TREXALL 15 MG TABLET
- TREXALL 5 MG TABLET
- TREXALL 7.5 MG TABLET
- XATMEP 2.5 MG/ML ORAL SOLUTION

## Details

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<b>Criteria</b>	IN ORDER TO ASSIST IN A PART B VS. D PAYMENT DETERMINATION, A PRIOR CLAIM SEEN FOR A RHEUMATOID ARTHRITIS, PSORIASIS OR ACTIVE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS DRUG WITHIN THE PAST 120 DAYS WILL QUALIFY FOR PART D PAYMENT. ALL OTHER INDICATIONS WILL HAVE A PART B VS. D PAYMENT DETERMINATION MADE THROUGH THE FORMULARY EXCEPTION PROCESS PRIOR TO THE APPROVAL OF THE DRUG.
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# ELUXADOLINE

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## Products Affected

### Step 2:

- VIBERZI 100 MG TABLET
- VIBERZI 75 MG TABLET

## Details

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<b>Criteria</b>	PRIOR CLAIM FOR DICYCLOMINE AND XIFAXAN 550MG WITHIN THE PAST 365 DAYS.
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# FIDAXOMICIN

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## Products Affected

### Step 2:

- DIFICID 200 MG TABLET

## Details

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<b>Criteria</b>	PRIOR CLAIM FOR 2 OF THE FOLLOWING (ONE FROM EACH GROUP): A) ORAL METRONIDAZOLE TABLETS AND B) VANCOMYCIN CAPSULES IN PAST 365 DAYS.
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# INSULIN/GLP-1 ANALOG

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## Products Affected

### Step 2:

- SOLIQUA 100/33 100 UNIT-33 MCG/ML MG/ML (3 ML) SUBCUTANEOUS  
SUBCUTANEOUS INSULIN PEN INSULIN PEN
- XULTOPHY 100/3.6 100 UNIT-3.6

## Details

<b>Criteria</b>	TRIAL OF 2 (1 FROM EACH):(1) VICTOZA, LANTUS, OZEMPIC OR TOUJEO AND(2)METFORMIN/ER, SULFONYLUREA-(SU) (GLYBURIDE, GLIPIZIDE, GLIMEPIRIDE), SU-MET, PIOGLITAZONE, PIO-MET, OR PIO-GLIMEPIR IN PAST YR.
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# LESINURAD

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## Products Affected

### Step 2:

- ZURAMPIC 200 MG TABLET

## Details

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<b>Criteria</b>	PRIOR CLAIM FOR ULORIC OR ALLOPURINOL TABLETS WITHIN THE PAST 120 DAYS.
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# NOVEL ORAL ANTICOAGULANTS

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## Products Affected

### Step 2:

- PRADAXA 110 MG CAPSULE
- PRADAXA 150 MG CAPSULE
- PRADAXA 75 MG CAPSULE

## Details

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<b>Criteria</b>	PRIOR CLAIM FOR ELIQUIS AND XARELTO IN THE PAST 365 DAYS.
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# OPHTHALMIC ANTIHISTAMINES - NO OTC

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## Products Affected

### Step 2:

- ALREX 0.2 % EYE DROPS,SUSPENSION

## Details

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<b>Criteria</b>	PRIOR CLAIM FOR FEDERAL LEGEND LEVOCETIRIZINE , CROMOLYN SODIUM, EPINASTINE, OR FORMULARY OLOPATADINE EYE DROPS WITHIN THE PAST 120 DAYS.
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# OSMOLEX

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## Products Affected

### Step 2:

- OSMOLEX ER 129 MG TABLET, EXTENDED RELEASE
- OSMOLEX ER 193 MG TABLET, EXTENDED RELEASE
- OSMOLEX ER 258 MG TABLET, EXTENDED RELEASE

## Details

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<b>Criteria</b>	PRIOR CLAIM FOR AMANTADINE HCL IMMEDIATE RELEASE WITHIN THE PAST 120 DAYS.
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# RENIN ANGIOTENSIN SYSTEM INHIBITORS

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## Products Affected

### Step 2:

- DIOVAN 160 MG TABLET
- DIOVAN 320 MG TABLET
- DIOVAN 40 MG TABLET
- DIOVAN 80 MG TABLET
- DIOVAN HCT 160 MG-12.5 MG TABLET
- DIOVAN HCT 160 MG-25 MG TABLET
- DIOVAN HCT 320 MG-12.5 MG TABLET
- DIOVAN HCT 320 MG-25 MG TABLET
- DIOVAN HCT 80 MG-12.5 MG TABLET
- TEKAMLO 150 MG-10 MG TABLET
- TEKAMLO 150 MG-5 MG TABLET
- TEKAMLO 300 MG-10 MG TABLET
- TEKAMLO 300 MG-5 MG TABLET
- TEKTURNA 150 MG TABLET
- TEKTURNA 300 MG TABLET
- TEKTURNA HCT 150 MG-12.5 MG TABLET
- TEKTURNA HCT 150 MG-25 MG TABLET
- TEKTURNA HCT 300 MG-12.5 MG TABLET
- TEKTURNA HCT 300 MG-25 MG TABLET

## Details

<b>Criteria</b>	PRIOR CLAIM FOR AN ANGIOTENSIN CONVERTING ENZYME INHIBITOR (ACE INHIBITOR), OR ACE INHIBITOR COMBINATION OR A GENERIC ANGIOTENSIN RECEPTOR BLOCKER (ARB), OR GENERIC ARB COMBINATION WITHIN THE PAST 120 DAYS.
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# SPRITAM

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## Products Affected

### Step 2:

- SPRITAM 1,000 MG TABLET FOR ORAL SUSPENSION
- SPRITAM 250 MG TABLET FOR ORAL SUSPENSION
- SPRITAM 500 MG TABLET FOR ORAL SUSPENSION
- SPRITAM 750 MG TABLET FOR ORAL SUSPENSION

## Details

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<b>Criteria</b>	PRIOR CLAIM FOR LEVETIRACETAM SOLUTION IN THE PAST 120 DAYS
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# ZARXIO

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## Products Affected

### Step 2:

- ZARXIO 300 MCG/0.5 ML INJECTION SYRINGE
- ZARXIO 480 MCG/0.8 ML INJECTION SYRINGE

## Details

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<b>Criteria</b>	PRIOR CLAIM FOR NEUPOGEN WITHIN THE PAST 120 DAYS.
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VIMPAT 10 MG/ML ORAL	
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