

UPHP DUALS - 2ND GEN ANTIHISTAMINES

MEDICATION(S)

CETIRIZINE HCL 10 MG CHEW TAB, CETIRIZINE HCL 5 MG CHEW TAB, CETIRIZINE HCL 5 MG/5 ML CUP, CHILD CETIRIZINE 10 MG CHEW TB, CHILD CETIRIZINE 5 MG CHEW TAB

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIHISTAMINES – 2ND GENERATION

Drug Class: Antihistamines – 2nd Generation

Preferred Agents: No Prior Authorization required

cetirizine tablets

cetirizine 1mg/ml solution

fexofenadine suspension

fexofenadine tablets

levocetirizine tablets

loratadine/loratadine ODT

Non-Preferred Agents: Prior Authorization Criteria below

cetirizine chewable tabs, soft gels

cetirizine 5mg/5ml solution (cups)

Clarinex®
desloratadine
levocetirizine solution

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Trial and failure on one preferred second-generation antihistamine or clinical rationale why they cannot be tried

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/21

Updated 8/1/22

Updated 11/1/24

UPHP DUALS - ANTI-OBESITY AGENTS

MEDICATION(S)

ADIPEX-P 37.5 MG TABLET, BENZPHETAMINE HCL, DIETHYLPROPION 25 MG TABLET, DIETHYLPROPION HCL ER, LOMAIRA, ORLISTAT 120 MG CAPSULE, PHENDIMETRAZINE TARTRATE, PHENDIMETRAZINE TARTRATE ER, PHENTERMINE 15 MG CAPSULE, PHENTERMINE 30 MG CAPSULE, PHENTERMINE 37.5 MG CAPSULE, PHENTERMINE 37.5 MG TABLET, SAXENDA, WEGOVY, XENICAL, ZEPBOUND

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTI-OBESITY AGENTS

Drug Class: Anti-Obesity Agents

Preferred Agents: Clinical Prior Authorization below

Adipex-P (phentermine), C-IV
benzphetamine (only available as generic), C-III
diethylpropion (only available as generic), C-IV
Lomaira (phentermine), C-IV
orlistat

phendimetrazine (only available as generic), C-III

phentermine, C-IV

Saxenda (liraglutide)

Wegovy (semaglutide)

Xenical (orlistat)

Zepbound®

Clinical Prior Authorization

Initial

- Prescriber attests that the patient will not use more than one weight loss medication in this drug class concurrently, AND
- Patient age greater than or equal to 12 years (Wegovy, Xenical, Saxenda), OR
- Patient age greater than or equal to 17 years (phentermine), AND
- Patient age greater than or equal to 12 years to less than 18 years must have an initial BMI per CDC growth charts at the 95th percentile or greater for age and sex (obesity), OR
- Patient age greater than or equal to 12 years to less than 18 years with BMI in the 85th – 94th percentile (overweight) per CDC growth charts and has at least one of the following weight-related coexisting conditions:
 - diabetes, sleep apnea, hypertension, or dyslipidemia, OR
 - Patient age greater than or equal to 18 years (benzphetamine, diethylpropion, phendimetrazine, Zepbound®), AND
 - Patient age greater than or equal to 18 years must have an initial body mass index [BMI] greater than or equal to 30 kg/m², OR
 - Patient age greater than or equal to 18 years must have an initial body mass index [BMI] greater than or equal to 27 kg/m² but less than 30 kg/m² and at least one of the following:
 - hypertension, coronary artery disease, diabetes, dyslipidemia, or sleep apnea, OR
 - This medication is being prescribed for cardiovascular risk reduction in members with prior myocardial infarction, prior stroke, or peripheral arterial disease (Wegovy), AND
 - For patients with an eating disorder, prescriber attests that treatment has been optimized and confirms the safety and appropriateness of this anti-obesity treatments, AND
 - Prescriber attests that metabolic or other reason(s) for obesity/symptoms have been ruled out or diagnosed and treated (e.g., thyroid dysfunction, diabetes, sleep apnea, etc.), AND

Clinical Prior Authorization Initial, Continued

- Prescriber attests to patient's absence of any contraindications to use of the requested product, including pregnancy, lactation, a personal or family history of medullary thyroid cancer or multiple endocrine neoplasia type II, AND
- Prescriber attests medication therapy is part of a total treatment plan including diet and exercise/activity as

appropriate for the patient's ability, AND

- Prescriber attests that patient has been informed weight may return with cessation of medication unless healthy lifestyle diet and activity changes, as appropriate for the patient's ability, are permanently adopted.

MDHHS recommends that prescribers consider the benefits of a diabetes prevention program for their patients.

Renewal

- For patient's age greater than or equal to 12 years to less than 18 years, prescriber provides clinical documentation showing that the patient has maintained or improved BMI percentile per CDC growth charts from baseline weight at initiation of therapy.

- For adults age greater than or equal to 18 years, prescriber provides clinical documentation showing that the patient has maintained a weight loss of greater than or equal to 5% from baseline weight at initiation of therapy.

- Duration of Approval: Initial = 6 months, Renewal = 6 months

Updated 11/1/24

UPHP DUALS - NASAL CORTICOSTEROIDS

MEDICATION(S)

24 HOUR ALLERGY, 24 HOUR ALLERGY RELIEF, ALLERGY RELIEF 50 MCG SPRAY, EQ ALLERGY RELIEF 50 MCG SPRAY, FT ALLERGY RELIEF 50 MCG SPRAY, HM ALLERGY RELIEF 50 MCG SPRAY, QC ALLERGY RELIEF 50 MCG SPRAY, SM ALLERGY RELIEF 50 MCG SPRAY, BUDESONIDE 32 MCG NASAL SPRAY, CVS BUDESONIDE 32 MCG SPRAY, GNP BUDESONIDE 32 MCG SPRAY, RA BUDESONIDE 32 MCG SPRAY, CVS FLUTICASONE PROP 50 MCG SP, EQL FLUTICASONE PROP 50 MCG SP, FLUTICASONE PROP 50 MCG SPRAY, GNP FLUTICASONE PROP 50 MCG SP

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

NASAL CORTICOSTEROIDS

Drug Class: NASAL CORTICOSTEROIDS

Preferred Agents: No Prior Authorization required
fluticasone (Rx)

Non-Preferred Agents: Prior Authorization Criteria below
Beconase AQ®
budesonide
flunisolide
fluticasone (OTC)

mometasone spray (RX)
mometasone 24hr (OTC)
Nasonex 24hr (OTC)
Omnaris®
Qnasl®
triamcinolone
Xhance®
Zetonna®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Therapeutic failure with a one-month trial with a preferred medication
- See additional medication-specific criteria below:

XHANCE® (FLUTICASONE)

- Diagnosis of chronic rhinosinusitis with or without nasal polyps in adults
- Therapeutic failure with a three-month trial with a preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/24

UPHP DUALS - PPI

MEDICATION(S)

CVS LANSOPRAZOLE DR 15 MG CAP, EQ LANSOPRAZOLE DR 15 MG CAP, EQL LANSOPRAZOLE DR 15 MG CAP, GNP LANSOPRAZOLE DR 15 MG CAP, GS LANSOPRAZOLE DR 15 MG CAP, HM LANSOPRAZOLE DR 15 MG CAP, KRO LANSOPRAZOLE DR 15 MG CAP, LANSOPRAZOLE DR 15 MG CAPSULE, QC LANSOPRAZOLE DR 15 MG CAP, RA LANSOPRAZOLE DR 15 MG CAP, SM LANSOPRAZOLE DR 15 MG CAP, CVS OMEPRAZOLE DR 20 MG TABLET, EQ OMEPRAZOLE DR 20 MG TABLET, EQL OMEPRAZOLE DR 20 MG TABLET, FT OMEPRAZOLE DR 20 MG TABLET, GNP OMEPRAZOLE DR 20 MG TABLET, GS OMEPRAZOLE DR 20 MG TABLET, HM OMEPRAZOLE DR 20 MG TABLET, KRO OMEPRAZOLE DR 20 MG TABLET, OMEPRAZOLE DR 20 MG TABLET, PUB OMEPRAZOLE DR 20 MG TABLET, RA OMEPRAZOLE DR 20 MG TABLET, SM OMEPRAZOLE DR 20 MG TABLET, SW OMEPRAZOLE DR 20 MG TABLET, CVS OMEPRAZOLE MAG DR 20 MG CP, EQ OMEPRAZOLE MAG DR 20.6 MG, GNP OMEPRAZOLE MAG DR 20 MG CP, OMEPRAZOLE MAG DR 20 MG CAP, OMEPRAZOLE MAG DR 20.6 MG CAP, QC OMEPRAZOLE MAG DR 20.6 MG

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

PROTON PUMP INHIBITORS

Drug Class: PROTON PUMP INHIBITORS

Preferred Agents: No Prior Authorization required

Nexium susp pkts

omeprazole (Rx) capsules
pantoprazole tablets
Protonix® suspension

Non-Preferred Agents: Prior Authorization Criteria below

Aciphex® tabs
Dexilant® caps
dexlansoprazole
esomeprazole magnesium capsules, susp pkts
esomeprazole magnesium OTC caps, tabs
Konvomep®
lansoprazole caps, ODT
lansoprazole OTC caps
Nexium® capsules
omeprazole OTC caps, tabs, ODT
omeprazole/sodium bicarbonate caps, susp pkts
pantoprazole suspension
Prevacid caps, solutabs
Prilosec® susp
Protonix® tablets
Rabeprazole tabs
Zegerid® caps, susp pkts

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure after one-month trial with one preferred medication.

Duration of Approval: 1 year

Effective 10/1/20

Update 1/13/22

Update 9/1/22

Update 11/1/22

Updated 11/1/24

UPHP DUALS - TOPICAL ANTIFUNGALS

MEDICATION(S)

LOTRIMIN AF 1% CREAM, MICOTRIN AC, MYCOZYL AC

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIFUNGALS – TOPICAL

Drug Class: Antifungals – Topical

Preferred Agents: No Prior Authorization required

ciclopirox 8% soln (generic Ciclodan)

ciclopirox 0.77% cream (generic for Loprox and Ciclodan)

clotrimazole OTC cream, solution

clotrimazole Rx cream

clotrimazole/betamethasone cream

ketoconazole

miconazole nitrate

nystatin

nystatin/triamcinolone cream, ointment

tolnaftate cream, powder

Non-Preferred Agents: Prior Authorization Criteria below

butenafine

Ciclodan®

ciclopirox suspension (generic for Loprox)

ciclopirox gel, shampoo, kit

clotrimazole / betamethasone lotion

econazole nitrate

Ertaczo®

Extina®

Jublia®

Kerydin®

ketoconazole foam

Ketodan®

Loprox®

Lotrimin AF®

luliconazole

Luzu®

Mentax®

miconazole/zinc oxide/petrolatum

Mycozyl AC

Naftin®

naftifine

Oxistat®

tavaborole

Vusion®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Trial and failure with two weeks with two preferred medications OR
- Organism resistant to the preferred medications OR
- See additional medication-specific criteria below:

CICLOPIROX SHAMPOO

- Bypass trial and failure of two preferred medications and instead allow a trial and failure of two weeks with one preferred shampoo medication

JUBLIA®(efinaconazole)

- Diagnosis of toenail onychomycosis, and patient age 6 years or older, and trial and failure on ciclopirox or

allergy to ciclopirox

KERYDIN® (TAVABOROLE)

•Diagnosis of toenail onychomycosis, and patient must be 6 years or older, and documented trial and failure on ciclopirox or allergy to ciclopirox (applies to brand and generic)

Duration of Approval: For the duration of the prescription up to 6 months

Effective 10/1/20

Updated 8/1/21

Updated 5/1/22

Updated 9/11/24

Updated 10/18/24

UPHP DUALS- OPHTHALMIC ANTIHISTAMINES

MEDICATION(S)

ZADITOR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OPHTHALMIC ANTIHISTAMINES

Drug Class: OPHTHALMIC ANTIHISTAMINES

Preferred Agents: No Prior Authorization required

azelastine

ketotifen fumarate (OTC Only)

olopatadine (OTC Only)

Non-Preferred Agents: Prior Authorization Criteria below

alcaftadine

Alrex®

bepotastine

Bepreve®

epinastine

Lastacaft®

loteprednol (generic for Alrex)

olopatadine RX

Pataday®

Zaditor®

Zerviate®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Therapeutic failure with a one-month trial with one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 5/1/21

Updated 11/1/24