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

MEDICATION(S)

ADIPEX-P, 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, PHENTERMINE-TOPIRAMATE ER, SAXENDA, WEGOVY, XENICAL, ZEPBOUND 10 MG/0.5 ML PEN, ZEPBOUND 10 MG/0.5 ML VIAL, ZEPBOUND 12.5 MG/0.5 ML PEN, ZEPBOUND 15 MG/0.5 ML PEN, ZEPBOUND 2.5 MG/0.5 ML PEN, ZEPBOUND 2.5 MG/0.5 ML VIAL, ZEPBOUND 5 MG/0.5 ML PEN, ZEPBOUND 5 MG/0.5 ML VIAL, ZEPBOUND 7.5 MG/0.5 ML PEN, ZEPBOUND 7.5 MG/0.5 ML VIAL

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
phentermine/topiramate (only available as generic), 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
•Prescriber attests that the patient will not use an anti-obesity GLP-1 agonist (Wegovy, Saxenda or Zepbound) concurrently with a DPP4 inhibitor, AND
•Patient age greater than or equal to 12 years (Wegovy, Xenical, Saxenda, , phentermine/topiramate), 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 to12 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 than 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 than 27 kg/m2 but less than30 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 to12 years to less than18 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 to18 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
Updated 2/1/25
Updated 6/1/25

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, EQ 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

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, 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
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
Updated 4/18/25

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
econazole nitrate
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
clotrimazole RX solution
Ertaczo®
Extina®
Jublia ®
ketoconazole foam
Ketodan®
Loprox®
Lotrimin AF®
luliconazole
Luzu®
miconazole/zinc oxide/petrolatum
Micotrin AC®
Mycozyl AC®
Naftin®
naftifine
oxiconazole
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

(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)

VUSION® (MICONAZOLE NITRATE/ZINC OXIDE/PETROLATUM)
•Maximum patient age = 16 years

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
Updated 2/1/25
Updated 5/1/25
Updated 8/1/25

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