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

Ioratadine/Ioratadine 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, 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-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 2.5 MG/0.5 ML PEN, ZEPBOUND 5 MG/0.5 ML VIAL, ZEPBOUND 7.5 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 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 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 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 Updated 2/1/25 Updated 6/1/25

UPHP DUALS - DIFFERIN/ADAPALENE

MEDICATION(S)

ADAPALENE 0.1% CREAM, ADAPALENE 0.1% GEL, ADAPALENE 0.3% GEL PUMP, CVS ADAPALENE 0.1% GEL, GNP ADAPALENE 0.1% GEL, DIFFERIN 0.1% CREAM, DIFFERIN 0.1% LOTION, DIFFERIN 0.3% GEL PUMP

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

DIFFERIN (ADAPALENE)

Length of Authorization: For the duration of the prescription up to 1 year

CRITERIA TO APPROVE

- Acne unresponsive to a tretinoin product or clinical rationale why tretinoin product not appropriate

Updated 10/1/25

UPHP DUALS - FABIOR

MEDICATION(S)

FABIOR

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

FABIOR (TAZAROTENE)

Length of Authorization: 1 year

CRITERIA TO APPROVE

- Diagnosis of acne vulgaris AND
- Therapeutic failure of at least two preferred topical acne products

Updated 10/1/25

UPHP DUALS - IMCIVREE

MEDICATION(S)

IMCIVREE

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

IMCIVREE (SETMELANOTIDE)

Length of Authorization: Initial requests 16 weeks, renewal up to 12 months.

CRITERIA TO APPROVE

INITIAL REQUEST

- Patient is greater than or equal to 2 years of age, AND
- Genetic testing demonstrates homozygous or compound heterozygous mutations in one of the following genes: POMC, PCSK1, or LEPR, AND
- The genetic variant is interpreted as pathogenic, likely pathogenic, or of uncertain significance, OR
- Patient has a diagnosis of Bardet-Biedl Syndrome, AND
- If patient greater than or equal 18 years of age: body mass index (BMI) greater than or equal 30 kg/m2 OR
- If patient is 2 to 17 years of age: BMI greater than or equal 95th percentile for age and sex, AND
- Prescribed by or in consultation with an endocrinologist, a geneticist, or a physician who specializes in metabolic disorders.

RENEWAL REQUEST

- Patient has achieved a weight loss of greater than or equal to 5% of baseline weight, OR
- Patient has achieved at least a 5% reduction in baseline BMI for patients with continued growth potential

Updated 10/1/25

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, 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

Available dosage forms:

- Budesonide, Nasal Spray, 32 mcg
- •Fluticasone Propionate, Nasal Spray, 50 mcg
- •24 Hour Allergy (Fluticasone Propionate), Nasal Spray, 50 mcg
- •Allergy Relief (Fluticasone Propionate), Nasal Spray, 50 mcg

Length of Authorization:

•1 year

Coverage 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 a preferred medication

Duration of Approval: 1 year

Effective 10/1/20 Updated 8/1/24 Updated 9/1/25

UPHP DUALS - NSAIDS

MEDICATION(S)

DUAL ACTION PAIN RELIEF, DUAL ACTION PAIN RELIEVER

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

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS)

Drug Class: Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)

Available dosage forms:

Preferred Agents No Prior Authorization Required

- •lbuprofen
- Naproxen

Non-Preferred

- •lbuprofen- Acetaminophen, Tablet, 125-250 mg
- •Dual Action Pain Reliever (OTC -ibuprofen/apap), Tablet, 125-250 mg

Length of Authorization:

•For the duration of the prescription up to 1 year

Coverage 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 of one month each with two preferred medications

Updated 9/1/25

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 CAP, SM 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, 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 DR 20 MG CP, EQ OMEPRAZOLE MAG DR 20.6 MG, GNP OMEPRAZOLE MAG DR 20 MG CP, 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

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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

UPHP DUALS - RAYALDEE

MEDICATION(S)

RAYALDEE

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

RAYALDEE (CALCIFEDIOL)

Length of Authorization: Initial = 3 months, Renewal = 1 year

CRITERIA TO APPROVE

INITIAL REQUESTS

- Diagnosis of secondary hyperparathyroidism in adult with stage 3 or 4 chronic kidney disease, AND
- Serum total 25-hydroxyvitamin D level less than 30 ng/mL (document level), AND
- Serum calcium level below 9.8 mg/dL (document level), AND
- Previous treatment, intolerance or contraindication to generic calcitriol and paricalcitol or doxercalciferol

RENEWAL REQUESTS

- Intact parathyroid hormone (PTH) is above treatment goal, AND
- Serum total 25-hydroxyvitamin D level less than 100 ng/mL (document level), AND
- Serum calcium level below 9.8 mg/dL (document level)

Updated 10/1/25

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

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

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