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, LIRAGLUTIDE 18 MG/3 ML PEN, LIRAGLUTIDE 5-PAK 18 MG/3 ML, 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 8 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

Drug Class: Anti-Obesity Agents

Available dosage forms:

Preferred Prior Authorization Required

•benzphetamine (only available as generic), C-III, Tablet, 50 mg

•diethylpropion (only available as generic), C-IV, Tablet, 25 mg and 75 mg

•Saxenda (liraglutide), Pen Injector, 3mg/0.5mL

•Xenical (orlistat), Capsules, 120 mg

•phendimetrazine (only available as generic), C-III, Tablet, 35 mg

•phendimetrazine ER, Capsule, 105 mg
•phentermine, C-IV, Tablet, 8mg, 37.5 mg
•phentermine, Capsule, 15 mg and 30 mg and 37.5 mg
•Adipex-P (phentermine), Tablet, 37.5 mg
•Lomaira (phentermine), Tablet, 8 mg
•phentermine/topiramate ER (only available as generic), C-IV, Capsule, 3.75-23 mg & 7.5-46 mg & 11.25-69 mg & 15-92 mg
•Wegovy (semaglutide), Pen Injector, 0.25mg/0.5mL & 0.5mg/0.5mL & 1mg/0.5mL & 1.7mg/0.75mL & 2.4mg/0.75mL
•Zepbound, Pen Injector, 2.5mg/0.5mL & 5mg/0.5mL & 7.5mg/0.5mL & 10mg/0.5mL & 12.5mg/0.5mL & 15mg/0.5mL
•Zepbound, Vial, 2.5mg/0.5mL & 5mg/0.5mL & 7.5mg/0.5mL & 10mg/0.5mL & 12.5mg/0.5mL & 15mg/0.5mL
Non-Preferred Prior Authorization Required
•liraglutide (generic for Saxenda), Pen Injector, 3mg/0.5mL Coverage Criteria:
Initial Request

•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 generic liraglutide], or Zepbound) concurrently with a medication that contains a DPP-4 inhibitor (alogliptin, linagliptin, saxagliptin or sitagliptin, AND
•Patient age greater than or equal to 18 years of age, OR
•Patient age greater than or equal to12 years (Wegovy, Xenical, Saxenda, liraglutide, phentermine/topiramate), OR
•Patient age greater than or equal to17 years (phentermine), AND
•Patient age greater than or equal to12 years to less than18 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 than18 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 to18 years (benzphetamine, diethylpropion, phendimetrazine, Zepbound), AND
•Patient age greater than or equal to18 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 to18 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 risk factors:
oHypertension, coronary artery disease, diabetes, dyslipidemia, or sleep apnea, OR
oThis medication is being prescribed for cardiovascular risk reduction in patients with prior myocardial infarction, prior stroke or peripheral arterial disease (Wegovy),
•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
•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.
Non-Preferred Agent Criteria

•All initial request criteria has been met, AND
•Allergy to ALL preferred medications, OR
•Contraindication or drug-drug interaction with ALL preferred medications, OR
•History of unacceptable side effects to ALL preferred medications, OR
•Trial and failure with one-month trial of one preferred medication
MDHHS recommends that prescribers consider the benefits of a diabetes prevention program for their patients.
Renewal Request (Preferred and Non-Preferred Agents)
•For patients 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 patients 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.
Length of Authorization:
•Initial and Renewal = 6 months

Quantity Limits:

liraglutide (generic for Saxenda) 18 mg/3 mL pens15 mL (5 pens) per 30 days
Saxenda (liraglutide) 18 mg/3 mL pens15 mL (5 pens) per 30 days
Xenical (orlistat) 120 mg capsules90 caps per 30 days

Wegovy (semaglutide) 0.25 mg/0.5 mL pens2 mL (4 pens) per 28 days
Wegovy (semaglutide) 0.50 mg/0.5 mL pens2 mL (4 pens) per 28 days
Wegovy (semaglutide) 1 mg/0.5 mL pens2 mL (4 pens) per 28 days
Wegovy (semaglutide) 1.7 mg/0.75 mL pens3 mL (4 pens) per 28 days
Wegovy (semaglutide) 2.4 mg/0.75 mL pens3 mL (4 pens) per 28 days
Zepbound (tirzepatide) 2.5 mg/0.5 mL pens/vials2 mL (4 pens/vials) per 28 days
Zepbound (tirzepatide) 5 mg/0.5 mL pens/vials2 mL (4 pens/vials) per 28 days
Zepbound (tirzepatide) 7.5 mg/0.5 mL pens/vials2 mL (4 pens/vials) per 28 days
Zepbound (tirzepatide) 10 mg/0.5 mL pens/vials2 mL (4 pens/vials) per 28 days
Zepbound (tirzepatide) 12.5 mg/0.5 mL pens2 mL (4 pens) per 28 days
Zepbound (tirzepatide) 15 mg/0.5 mL pens2 mL (4 pens) per 28 days

Updated 11/1/24
Updated 2/1/25
Updated 6/1/25
Updated 10/1/25

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

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

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

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
•Ibuprofen
•Naproxen
Non- Preferred
•Ibuprofen- 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

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, 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

Drug Class: Proton Pump Inhibitors

Available dosage forms:
Non- Preferred Prior Authorization Required
•lansoprazole (Rx), Capsule, 15 mg

•lansoprazole (OTC), Capsule, 15 mg
•omeprazole (OTC), Tablet, 20 mg

Length of Authorization:
•1 year
Non-Preferred 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 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
Updated 10/1/25

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

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