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ADHD Products

Prior Authorization Guideline

Guideline ID	GL-148172
Guideline Name	ADHD Products
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: (All) Brand Adderall, generic amphetamine/dextroamphetamine, Brand Adderall XR, generic amphetamine/dextroamphetamine ER, Adhansia XR, Adzenys XR-ODT, Brand Aptensio XR, generic methylphenidate ER cap, Azstarys, Brand Concerta, generic methylphenidate ER OSM (generic Concerta), Cotempla XR-ODT, Brand Daytrana, generic methylphenidate patch, Brand Desoxyn, generic methamphetamine, Brand Dexedrine, generic dextroamphetamine ER, Dyanavel XR, Brand Evekeo, generic amphetamine, Evekeo ODT, Brand Focalin, generic dexmethylphenidate, Brand Focalin XR, generic dexmethylphenidate ER, Brand Intuniv, generic guanfacine ER, Jornay PM, Brand Kapvay, generic clonidine ER, Brand Methylin, generic methylphenidate soln, generic methylphenidate chew tabs, Brand Metadate CD, generic methylphenidate ER (CD), generic methylphenidate ER tab, Brand Mydayis, generic amphetamine/dextroamphetamine ER (generic Mydayis), Brand Procentra, generic dextroamphetamine soln, Qelbree, Quillichew ER, Quillivant XR, Brand Relexxii, Brand Methylphenidate ER OSM, generic methylphenidate ER OSM (generic Relexxii), Brand Ritalin, generic methylphenidate tablet, Brand Ritalin LA, generic methylphenidate ER (LA), Brand Strattera, generic atomoxetine, Brand Vyvanse chewable tablets, generic lisdexamfetamine chewable tablets, Brand Vyvanse capsules, generic lisdexamfetamine capsules, Xelstrym, Brand Zenzedi, generic dextroamphetamine

Diagnosis	Members Less than the FDA Approved Minimum Age*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ADDERALL	AMPHETAMINE-DEXTROAMPHETAMINE TAB 5 MG	61109902100305	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE TAB 5 MG	61109902100305	Generic
ADDERALL	AMPHETAMINE-DEXTROAMPHETAMINE TAB 7.5 MG	61109902100307	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE TAB 7.5 MG	61109902100307	Generic
ADDERALL	AMPHETAMINE-DEXTROAMPHETAMINE TAB 10 MG	61109902100310	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE TAB 10 MG	61109902100310	Generic
ADDERALL	AMPHETAMINE-DEXTROAMPHETAMINE TAB 12.5 MG	61109902100312	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE TAB 12.5 MG	61109902100312	Generic
ADDERALL	AMPHETAMINE-DEXTROAMPHETAMINE TAB 15 MG	61109902100315	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE TAB 15 MG	61109902100315	Generic
ADDERALL	AMPHETAMINE-DEXTROAMPHETAMINE TAB 20 MG	61109902100320	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE TAB 20 MG	61109902100320	Generic
ADDERALL	AMPHETAMINE-DEXTROAMPHETAMINE TAB 30 MG	61109902100330	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE TAB 30 MG	61109902100330	Generic

ADDERALL XR	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 5 MG	61109902107005	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 5 MG	61109902107005	Generic
ADDERALL XR	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 10 MG	61109902107010	Brand
AMPHETAMINE/DEXTROAMPHETAMINE ER	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 10 MG	61109902107010	Generic
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 10 MG	61109902107010	Generic
ADDERALL XR	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 15 MG	61109902107015	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 15 MG	61109902107015	Generic
ADDERALL XR	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 20 MG	61109902107020	Brand
AMPHETAMINE/DEXTROAMPHETAMINE ER	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 20 MG	61109902107020	Generic
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 20 MG	61109902107020	Generic
ADDERALL XR	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 25 MG	61109902107025	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 25 MG	61109902107025	Generic
ADDERALL XR	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 30 MG	61109902107030	Brand
AMPHETAMINE/DEXTROAMPHETAMINE ER	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 30 MG	61109902107030	Generic
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 30 MG	61109902107030	Generic
ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 3.1 MG	6110001000H410	Brand

ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 6.3 MG	6110001000H420	Brand
ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 9.4 MG	6110001000H430	Brand
ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 12.5 MG	6110001000H440	Brand
ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 15.7 MG	6110001000H450	Brand
ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 18.8 MG	6110001000H460	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (XR)	61400020107055	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (XR)	61400020107055	Generic
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 15 MG (XR)	61400020107060	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 15 MG (XR)	61400020107060	Generic
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (XR)	61400020107065	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (XR)	61400020107065	Generic
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (XR)	61400020107070	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (XR)	61400020107070	Generic
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (XR)	61400020107075	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (XR)	61400020107075	Generic
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 50 MG (XR)	61400020107080	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 50 MG (XR)	61400020107080	Generic
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (XR)	61400020107085	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (XR)	61400020107085	Generic

AZSTARYS	SERDEXMETHYLPHENIDATE-DEXMETHYLPHENIDATE CAP 26.1-5.2 MG	61409802800120	Brand
AZSTARYS	SERDEXMETHYLPHENIDATE-DEXMETHYLPHENIDATE CAP 39.2-7.8 MG	61409802800130	Brand
AZSTARYS	SERDEXMETHYLPHENIDATE-DEXMETHYLPHENIDATE CAP 52.3-10.4 MG	61409802800140	Brand
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG	61400020100460	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG	61400020100460	Generic
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG	61400020100465	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG	61400020100465	Generic
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG	61400020100470	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG	61400020100470	Generic
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG	61400020100480	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG	61400020100480	Generic
COTEMPLA XR-ODT	METHYLPHENIDATE TAB EXTENDED RELEASE DISINTEGRATING 8.6 MG	6140002000H410	Brand
COTEMPLA XR-ODT	METHYLPHENIDATE TAB EXTENDED RELEASE DISINTEGRATING 17.3 MG	6140002000H420	Brand
COTEMPLA XR-ODT	METHYLPHENIDATE TAB EXTENDED RELEASE DISINTEGRATING 25.9 MG	6140002000H430	Brand
DAYTRANA	METHYLPHENIDATE TD PATCH 10 MG/9HR	61400020005910	Brand
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 10 MG/9HR	61400020005910	Generic
DAYTRANA	METHYLPHENIDATE TD PATCH 15 MG/9HR	61400020005915	Brand

METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 15 MG/9HR	61400020005915	Generic
DAYTRANA	METHYLPHENIDATE TD PATCH 20 MG/9HR	61400020005920	Brand
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 20 MG/9HR	61400020005920	Generic
DAYTRANA	METHYLPHENIDATE TD PATCH 30 MG/9HR	61400020005930	Brand
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 30 MG/9HR	61400020005930	Generic
DESOXYN	METHAMPHETAMINE HCL TAB 5 MG	61100030100305	Brand
METHAMPHETAMINE HCL	METHAMPHETAMINE HCL TAB 5 MG	61100030100305	Generic
DEXEDRINE	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 10 MG	61100020107010	Brand
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 10 MG	61100020107010	Generic
DYANAVEL XR	AMPHETAMINE EXTENDED RELEASE SUSP 2.5 MG/ML	6110001000G120	Brand
DYANAVEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 5 MG	6110001000H210	Brand
DYANAVEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 10 MG	6110001000H220	Brand
DYANAVEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 15 MG	6110001000H230	Brand
DYANAVEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 20 MG	6110001000H240	Brand
AMPHETAMINE SULFATE	AMPHETAMINE SULFATE TAB 5 MG	61100010100310	Generic
EVEKEO	AMPHETAMINE SULFATE TAB 5 MG	61100010100310	Brand
AMPHETAMINE SULFATE	AMPHETAMINE SULFATE TAB 10 MG	61100010100320	Generic
EVEKEO	AMPHETAMINE SULFATE TAB 10 MG	61100010100320	Brand
GUANFACINE ER	GUANFACINE HCL TAB ER 24HR 1 MG (BASE EQUIV)	61353030107520	Generic

INTUNIV	GUANFACINE HCL TAB ER 24HR 1 MG (BASE EQUIV)	61353030107520	Brand
GUANFACINE HYDROCHLORIDE	GUANFACINE HCL TAB ER 24HR 1 MG (BASE EQUIV)	61353030107520	Generic
GUANFACINE HYDROCHLORIDE ER	GUANFACINE HCL TAB ER 24HR 1 MG (BASE EQUIV)	61353030107520	Generic
GUANFACINE ER	GUANFACINE HCL TAB ER 24HR 2 MG (BASE EQUIV)	61353030107530	Generic
INTUNIV	GUANFACINE HCL TAB ER 24HR 2 MG (BASE EQUIV)	61353030107530	Brand
GUANFACINE HYDROCHLORIDE	GUANFACINE HCL TAB ER 24HR 2 MG (BASE EQUIV)	61353030107530	Generic
GUANFACINE HYDROCHLORIDE ER	GUANFACINE HCL TAB ER 24HR 2 MG (BASE EQUIV)	61353030107530	Generic
GUANFACINE ER	GUANFACINE HCL TAB ER 24HR 3 MG (BASE EQUIV)	61353030107540	Generic
INTUNIV	GUANFACINE HCL TAB ER 24HR 3 MG (BASE EQUIV)	61353030107540	Brand
GUANFACINE HYDROCHLORIDE	GUANFACINE HCL TAB ER 24HR 3 MG (BASE EQUIV)	61353030107540	Generic
GUANFACINE HYDROCHLORIDE ER	GUANFACINE HCL TAB ER 24HR 3 MG (BASE EQUIV)	61353030107540	Generic
GUANFACINE ER	GUANFACINE HCL TAB ER 24HR 4 MG (BASE EQUIV)	61353030107550	Generic
INTUNIV	GUANFACINE HCL TAB ER 24HR 4 MG (BASE EQUIV)	61353030107550	Brand
GUANFACINE HYDROCHLORIDE	GUANFACINE HCL TAB ER 24HR 4 MG (BASE EQUIV)	61353030107550	Generic
GUANFACINE HYDROCHLORIDE ER	GUANFACINE HCL TAB ER 24HR 4 MG (BASE EQUIV)	61353030107550	Generic
JORNAY PM	METHYLPHENIDATE HCL CAP DELAYED ER 24HR 20 MG (PM)	61400020107067	Brand
JORNAY PM	METHYLPHENIDATE HCL CAP DELAYED ER 24HR 40 MG (PM)	61400020107077	Brand
JORNAY PM	METHYLPHENIDATE HCL CAP DELAYED ER 24HR 60 MG (PM)	61400020107087	Brand
JORNAY PM	METHYLPHENIDATE HCL CAP DELAYED ER 24HR 80 MG (PM)	61400020107090	Brand

JORNAY PM	METHYLPHENIDATE HCL CAP DELAYED ER 24HR 100 MG (PM)	61400020107094	Brand
CLONIDINE HCL ER	CLONIDINE HCL TAB ER 12HR 0.1 MG	61353020107420	Generic
CLONIDINE HYDROCHLORIDE	CLONIDINE HCL TAB ER 12HR 0.1 MG	61353020107420	Generic
CLONIDINE HYDROCHLORIDE ER	CLONIDINE HCL TAB ER 12HR 0.1 MG	61353020107420	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL SOLN 5 MG/5ML	61400020102020	Generic
METHYLIN	METHYLPHENIDATE HCL SOLN 5 MG/5ML	61400020102020	Brand
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL SOLN 10 MG/5ML	61400020102030	Generic
METHYLIN	METHYLPHENIDATE HCL SOLN 10 MG/5ML	61400020102030	Brand
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL CHEW TAB 2.5 MG	61400020100510	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL CHEW TAB 5 MG	61400020100520	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL CHEW TAB 10 MG	61400020100530	Generic
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 10 MG (CD)	61400020100210	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 10 MG (CD)	61400020100210	Generic
METADATE CD	METHYLPHENIDATE HCL CAP ER 10 MG (CD)	61400020100210	Brand
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 20 MG (CD)	61400020100220	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 20 MG (CD)	61400020100220	Generic
METADATE CD	METHYLPHENIDATE HCL CAP ER 20 MG (CD)	61400020100220	Brand
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 30 MG (CD)	61400020100230	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 30 MG (CD)	61400020100230	Generic
METADATE CD	METHYLPHENIDATE HCL CAP ER 30 MG (CD)	61400020100230	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 40 MG (CD)	61400020100240	Generic

METADATE CD	METHYLPHENIDATE HCL CAP ER 40 MG (CD)	61400020100240	Brand
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 50 MG (CD)	61400020100250	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 50 MG (CD)	61400020100250	Generic
METADATE CD	METHYLPHENIDATE HCL CAP ER 50 MG (CD)	61400020100250	Brand
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 60 MG (CD)	61400020100260	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 60 MG (CD)	61400020100260	Generic
METADATE CD	METHYLPHENIDATE HCL CAP ER 60 MG (CD)	61400020100260	Brand
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 12.5 MG	61109902107060	Brand
AMPHETAMINE/DEXTROAMPHETAMINE ER	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 12.5 MG	61109902107060	Generic
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 25 MG	61109902107065	Brand
AMPHETAMINE/DEXTROAMPHETAMINE ER	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 25 MG	61109902107065	Generic
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 37.5 MG	61109902107070	Brand
AMPHETAMINE/DEXTROAMPHETAMINE ER	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 37.5 MG	61109902107070	Generic
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 50 MG	61109902107075	Brand
AMPHETAMINE/DEXTROAMPHETAMINE ER	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 50 MG	61109902107075	Generic
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE ORAL SOLUTION 5 MG/5ML	61100020102020	Generic
PROCENTRA	DEXTROAMPHETAMINE SULFATE ORAL SOLUTION 5 MG/5ML	61100020102020	Brand

QELBREE	VILOXAZINE HCL CAP ER 24HR 100 MG	61354080207020	Brand
QELBREE	VILOXAZINE HCL CAP ER 24HR 150 MG	61354080207030	Brand
QELBREE	VILOXAZINE HCL CAP ER 24HR 200 MG	61354080207040	Brand
QUILLICHEW ER	METHYLPHENIDATE HCL CHEW TAB EXTENDED RELEASE 20 MG	6140002010H220	Brand
QUILLICHEW ER	METHYLPHENIDATE HCL CHEW TAB EXTENDED RELEASE 30 MG	6140002010H230	Brand
QUILLICHEW ER	METHYLPHENIDATE HCL CHEW TAB EXTENDED RELEASE 40 MG	6140002010H240	Brand
QUILLIVANT XR	METHYLPHENIDATE HCL FOR ER SUSP 25 MG/5ML (5 MG/ML)	6140002010G220	Brand
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG	61400020100460	Brand
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG	61400020100465	Brand
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG	61400020100470	Brand
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 45 MG	61400020100475	Generic
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG	61400020100480	Brand
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 63 MG	61400020100485	Generic
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 72 MG	61400020100490	Brand
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 5 MG	61400020100305	Generic
RITALIN	METHYLPHENIDATE HCL TAB 5 MG	61400020100305	Brand
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 10 MG	61400020100310	Generic
RITALIN	METHYLPHENIDATE HCL TAB 10 MG	61400020100310	Brand

METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 20 MG	61400020100315	Generic
RITALIN	METHYLPHENIDATE HCL TAB 20 MG	61400020100315	Brand
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (LA)	61400020107010	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (LA)	61400020107010	Generic
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (LA)	61400020107020	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (LA)	61400020107020	Generic
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (LA)	61400020107030	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (LA)	61400020107030	Generic
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (LA)	61400020107040	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (LA)	61400020107040	Generic
ATOMOXETINE HYDROCHLORIDE	ATOMOXETINE HCL CAP 10 MG (BASE EQUIV)	61354015100110	Generic
ATOMOXETINE	ATOMOXETINE HCL CAP 10 MG (BASE EQUIV)	61354015100110	Generic
STRATTERA	ATOMOXETINE HCL CAP 10 MG (BASE EQUIV)	61354015100110	Brand
ATOMOXETINE HYDROCHLORIDE	ATOMOXETINE HCL CAP 18 MG (BASE EQUIV)	61354015100118	Generic
ATOMOXETINE	ATOMOXETINE HCL CAP 18 MG (BASE EQUIV)	61354015100118	Generic
STRATTERA	ATOMOXETINE HCL CAP 18 MG (BASE EQUIV)	61354015100118	Brand
ATOMOXETINE HYDROCHLORIDE	ATOMOXETINE HCL CAP 25 MG (BASE EQUIV)	61354015100125	Generic
ATOMOXETINE	ATOMOXETINE HCL CAP 25 MG (BASE EQUIV)	61354015100125	Generic
STRATTERA	ATOMOXETINE HCL CAP 25 MG (BASE EQUIV)	61354015100125	Brand
ATOMOXETINE HYDROCHLORIDE	ATOMOXETINE HCL CAP 40 MG (BASE EQUIV)	61354015100140	Generic
ATOMOXETINE	ATOMOXETINE HCL CAP 40 MG (BASE EQUIV)	61354015100140	Generic

STRATTERA	ATOMOXETINE HCL CAP 40 MG (BASE EQUIV)	61354015100140	Brand
ATOMOXETINE HYDROCHLORIDE	ATOMOXETINE HCL CAP 60 MG (BASE EQUIV)	61354015100160	Generic
ATOMOXETINE	ATOMOXETINE HCL CAP 60 MG (BASE EQUIV)	61354015100160	Generic
STRATTERA	ATOMOXETINE HCL CAP 60 MG (BASE EQUIV)	61354015100160	Brand
ATOMOXETINE HYDROCHLORIDE	ATOMOXETINE HCL CAP 80 MG (BASE EQUIV)	61354015100170	Generic
ATOMOXETINE	ATOMOXETINE HCL CAP 80 MG (BASE EQUIV)	61354015100170	Generic
STRATTERA	ATOMOXETINE HCL CAP 80 MG (BASE EQUIV)	61354015100170	Brand
ATOMOXETINE HYDROCHLORIDE	ATOMOXETINE HCL CAP 100 MG (BASE EQUIV)	61354015100180	Generic
ATOMOXETINE	ATOMOXETINE HCL CAP 100 MG (BASE EQUIV)	61354015100180	Generic
STRATTERA	ATOMOXETINE HCL CAP 100 MG (BASE EQUIV)	61354015100180	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CAP 10 MG	61100025100110	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 10 MG	61100025100110	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CAP 20 MG	61100025100120	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 20 MG	61100025100120	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CAP 30 MG	61100025100130	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 30 MG	61100025100130	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CAP 40 MG	61100025100140	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 40 MG	61100025100140	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CAP 50 MG	61100025100150	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 50 MG	61100025100150	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CAP 60 MG	61100025100160	Generic

VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 60 MG	61100025100160	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CAP 70 MG	61100025100170	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 70 MG	61100025100170	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 10 MG	61100025100510	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 10 MG	61100025100510	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 20 MG	61100025100520	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 20 MG	61100025100520	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 30 MG	61100025100530	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 30 MG	61100025100530	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 40 MG	61100025100540	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 40 MG	61100025100540	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 50 MG	61100025100550	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 50 MG	61100025100550	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 60 MG	61100025100560	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 60 MG	61100025100560	Brand
XELSTRYM	DEXTROAMPHETAMINE TD PATCH 4.5 MG/9HR	61100020005910	Brand
XELSTRYM	DEXTROAMPHETAMINE TD PATCH 9 MG/9HR	61100020005920	Brand
XELSTRYM	DEXTROAMPHETAMINE TD PATCH 13.5 MG/9HR	61100020005930	Brand

XELSTRYM	DEXTROAMPHETAMINE TD PATCH 18 MG/9HR	61100020005940	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 2.5 MG	61100020100303	Generic
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 2.5 MG	61100020100303	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 5 MG	61100020100305	Generic
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 5 MG	61100020100305	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 7.5 MG	61100020100308	Generic
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 7.5 MG	61100020100308	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 10 MG	61100020100310	Generic
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 10 MG	61100020100310	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 15 MG	61100020100315	Generic
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 15 MG	61100020100315	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 20 MG	61100020100330	Generic
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 20 MG	61100020100330	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 30 MG	61100020100350	Generic
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 30 MG	61100020100350	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 45 MG	61400020100475	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 63 MG	61400020100485	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 72 MG	61400020100490	Generic
FOCALIN	DEXMETHYLPHENIDATE HCL TAB 2.5 MG	61400016100320	Brand
DEXMETHYLPHENIDATE HYDROCHLORIDE	DEXMETHYLPHENIDATE HCL TAB 2.5 MG	61400016100320	Generic

FOCALIN	DEXMETHYLPHENIDATE HCL TAB 5 MG	61400016100330	Brand
DEXMETHYLPHENIDATE HYDROCHLORIDE	DEXMETHYLPHENIDATE HCL TAB 5 MG	61400016100330	Generic
DEXMETHYLPHENIDATE HCL	DEXMETHYLPHENIDATE HCL TAB 5 MG	61400016100330	Generic
FOCALIN	DEXMETHYLPHENIDATE HCL TAB 10 MG	61400016100340	Brand
DEXMETHYLPHENIDATE HYDROCHLORIDE	DEXMETHYLPHENIDATE HCL TAB 10 MG	61400016100340	Generic
DEXMETHYLPHENIDATE HCL	DEXMETHYLPHENIDATE HCL TAB 10 MG	61400016100340	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 5 MG	61400016107020	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 5 MG	61400016107020	Brand
DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 5 MG	61400016107020	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 10 MG	61400016107030	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 10 MG	61400016107030	Brand
DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 10 MG	61400016107030	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 15 MG	61400016107035	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 15 MG	61400016107035	Brand
DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 15 MG	61400016107035	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 20 MG	61400016107040	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 20 MG	61400016107040	Brand
DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 20 MG	61400016107040	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG	61400016107045	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG	61400016107045	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG	61400016107045	Brand

DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG	61400016107045	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 30 MG	61400016107050	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 30 MG	61400016107050	Brand
DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 30 MG	61400016107050	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 35 MG	61400016107055	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 35 MG	61400016107055	Brand
DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 35 MG	61400016107055	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG	61400016107060	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG	61400016107060	Brand
DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG	61400016107060	Generic
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 15 MG	61100020107015	Generic
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 5 MG	61100020107005	Generic
EVEKEO ODT	AMPHETAMINE SULFATE ORALLY DISINTEGRATING TAB 5 MG	61100010107210	Brand
EVEKEO ODT	AMPHETAMINE SULFATE ORALLY DISINTEGRATING TAB 10 MG	61100010107220	Brand
EVEKEO ODT	AMPHETAMINE SULFATE ORALLY DISINTEGRATING TAB 15 MG	61100010107230	Brand
EVEKEO ODT	AMPHETAMINE SULFATE ORALLY DISINTEGRATING TAB 20 MG	61100010107240	Brand
ADHANSIA XR	METHYLPHENIDATE HCL CAP ER 24HR 25 MG	61400020107068	Brand
ADHANSIA XR	METHYLPHENIDATE HCL CAP ER 24HR 35 MG	61400020107073	Brand
ADHANSIA XR	METHYLPHENIDATE HCL CAP ER 24HR 45 MG	61400020107078	Brand

ADHANSIA XR	METHYLPHENIDATE HCL CAP ER 24HR 55 MG	61400020107083	Brand
ADHANSIA XR	METHYLPHENIDATE HCL CAP ER 24HR 70 MG	61400020107088	Brand
ADHANSIA XR	METHYLPHENIDATE HCL CAP ER 24HR 85 MG	61400020107091	Brand
DEXEDRINE	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 15 MG	61100020107015	Brand
KAPVAY	CLONIDINE HCL TAB ER 12HR 0.1 MG	61353020107420	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER 24HR 18 MG	61400020107518	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER 24HR 27 MG	61400020107527	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER 24HR 36 MG	61400020107536	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER 24HR 54 MG	61400020107554	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER 10 MG	61400020100403	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER 20 MG	61400020100405	Generic
METHYLPHENIDATE HYDROCHLORIDE ER (LA)	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (LA)	61400020107048	Generic

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder (ADHD/ADD)

OR

1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex

- Clinical Pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - The child is unresponsive to, or has had an inadequate response to behavioral therapy

AND

3 - The child is experiencing moderate-severe continuing disturbance in function despite behavioral therapy

Notes	*See Table 1 in background section for FDA approved min ages.

2 . Background

Benefit/Coverage/Program Information

Table 1: FDA Approved Minimum Age Table

Product name	FDA Approved Minimum Age
All products NOT listed below	6 years of age
Adderall (amphetamine/dextroamphetamine salts)	3 years of age
Dexedrine (dextroamphetamine)	3 years of age
Evekeo ODT/Evekeo (amphetamine) tablet	3 years of age
Mydayis (mixed amphetamine salts) ER capsule	13 years of age
ProCentra (dextroamphetamine) solution	3 years of age
Zenzedi (dextroamphetamine) tablet	3 years of age

3 . Revision History

Date	Notes
6/12/2024	New program.

Aemcolo

Prior Authorization Guideline

Guideline ID	GL-146288
Guideline Name	Aemcolo
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Aemcolo	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AEMCOLO	RIFAMYCIN SODIUM TAB DELAYED RELEASE 194 MG (BASE EQUIV)	16000048200620	Brand

Approval Criteria

1 - Diagnosis of travelers’ diarrhea

AND

2 - ONE of the following:

2.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- Azithromycin (generic Zithromax)
- Ciprofloxacin (generic Cipro)
- Levofloxacin (generic Levaquin)
- Ofloxacin (generic Floxin)

OR

2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Azithromycin (generic Zithromax)
- Ciprofloxacin (generic Cipro)
- Levofloxacin (generic Levaquin)
- Ofloxacin (generic Floxin)

Afrezza

Prior Authorization Guideline

Guideline ID	GL-146289
Guideline Name	Afrezza
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Afrezza	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFREZZA	INSULIN REGULAR (HUMAN) INHALATION POWDER 4 UNIT/CARTRIDGE	27104010002940	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INHALATION POWDER 8 UNIT/CARTRIDGE	27104010002950	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INHALATION POWDER 12 UNIT/CARTRIDGE	27104010002955	Brand

AFREZZA	INSULIN REGULAR (HUMAN) INHAL POWD 90 X 4 UNIT & 90 X 8 UNIT	27104010002978	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INH POWD 90 X 8 UNIT & 90 X 12 UNIT	27104010002988	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INH POWD 60X4 & 60X8 & 60X12 UT/CART	27104010002990	Brand

Approval Criteria

1 - One of the following:

1.1 Diagnosis of type 1 diabetes mellitus and used in combination with a basal insulin or continuous insulin pump

OR

1.2 Diagnosis of type 2 diabetes mellitus

AND

2 - Patient is unable to self-inject medications (e.g. Humalog, Lantus, Levemir) due to ONE of the following:

- Physical impairment
- Visual impairment
- Lipohypertrophy
- Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-5 for specific phobia diagnostic criteria)

AND

3 - Forced Expiratory Volume (FEV1) within the last 60 days is greater than or equal to 70% of expected normal as determined by the physician

AND

4 - Afrezza will not be approved in patients with ONE of the following:

- Who smoke cigarettes
- Who recently quit smoking (within the past 6 months)
- With chronic lung disease (e.g. asthma, chronic obstructive pulmonary disease)

Product Name: Afrezza	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFREZZA	INSULIN REGULAR (HUMAN) INHALATION POWDER 4 UNIT/CARTRIDGE	27104010002940	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INHALATION POWDER 8 UNIT/CARTRIDGE	27104010002950	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INHALATION POWDER 12 UNIT/CARTRIDGE	27104010002955	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INHAL POWD 90 X 4 UNIT & 90 X 8 UNIT	27104010002978	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INH POWD 90 X 8 UNIT & 90 X 12 UNIT	27104010002988	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INH POWD 60X4 & 60X8 & 60X12 UT/CART	27104010002990	Brand

Approval Criteria

1 - Repeat pulmonary function test confirms that patient has NOT experienced a decline of 20% or more in Forced Expiratory Volume (FEV1)

AND

2 - Patient continues to be unable to self-inject short-acting insulin due to ONE of the following:

- Physical impairment
- Visual impairment
- Lipohypertrophy

- Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-5 for specific phobia diagnostic criteria)

AND

3 - Patient continues to not smoke cigarettes

Alinia

Prior Authorization Guideline

Guideline ID	GL-146290
Guideline Name	Alinia
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic nitazoxanide, Brand Alinia	
Diagnosis	Diarrhea caused by Giardia lamblia
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NITAZOXANIDE	NITAZOXANIDE TAB 500 MG	16400060000330	Generic
ALINIA	NITAZOXANIDE TAB 500 MG	16400060000330	Brand
ALINIA	NITAZOXANIDE FOR SUSP 100 MG/5ML	16400060001920	Brand

Approval Criteria

1 - Diagnosis of giardiasis

AND

2 - ONE of the following:

2.1 Failure to metronidazole, as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to metronidazole (please specify contraindication or intolerance)

Product Name: generic nitazoxanide, Brand Alinia	
Diagnosis	Diarrhea caused by Cryptosporidium parvum
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NITAZOXANIDE	NITAZOXANIDE TAB 500 MG	16400060000330	Generic
ALINIA	NITAZOXANIDE TAB 500 MG	16400060000330	Brand
ALINIA	NITAZOXANIDE FOR SUSP 100 MG/5ML	16400060001920	Brand

Approval Criteria

1 - Diagnosis of cryptosporidiosis

Anthelmintics

Prior Authorization Guideline

Guideline ID	GL-146291
Guideline Name	Anthelmintics
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Generic albendazole, Emverm	
Diagnosis	Enterobius vermicularis (pinworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Enterobius vermicularis (pinworm)

AND

2 - ONE of the following:

2.1 Failure of over-the-counter pyrantel pamoate confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to over-the-counter pyrantel pamoate (please specify intolerance or contraindication)

Product Name: Generic albendazole	
Diagnosis	Taenia solium and Taenia saginata (Taeniasis or Cysticercosis/Neurocysticercosis)
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Taeniasis or Cysticercosis/Neurocysticercosis

Product Name: Generic albendazole, Emverm	
Diagnosis	Echinococcosis (Tapeworm)
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Hydatid Disease [Echinococcosis (Tapeworm)]

Product Name: Emverm	
Diagnosis	Ancylostoma/Necatoriasis (Hookworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Ancylostoma/Necatoriasis (Hookworm)

Product Name: Generic albendazole	
Diagnosis	Ancylostoma/Necatoriasis (Hookworm)
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Ancylostoma/Necatoriasis (Hookworm)

Product Name: Generic albendazole, Emverm	
Diagnosis	Ascariasis (Roundworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Ascariasis (Roundworm)

Product Name: Generic albendazole, Emverm	
Diagnosis	Toxocariasis (Roundworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Toxocariasis (Roundworm)

Product Name: Generic albendazole, Emverm	
Diagnosis	Trichinellosis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Trichinellosis

Product Name: Generic albendazole, Emverm	
Diagnosis	Trichuriasis (Whipworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Trichuriasis (Whipworm)

Product Name: Generic albendazole, Emverm	
Diagnosis	Capillariasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Capillariasis

Product Name: Generic albendazole, Emverm	
Diagnosis	Baylisascaris
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Baylisascaris

Product Name: Generic albendazole	
Diagnosis	Clonorchiasis (Liver flukes)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Clonorchiasis (Liver flukes)

Product Name: Generic albendazole	
Diagnosis	Gnathostomiasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Gnathostomiasis

Product Name: Generic albendazole	
Diagnosis	Strongyloidiasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Strongyloidiasis

Product Name: Generic albendazole	
Diagnosis	Loiasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Loiasis

Product Name: Generic albendazole	
Diagnosis	Opisthorchis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Opisthorchis

Product Name: Generic albendazole	
Diagnosis	Anisakiasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Anisakiasis

Product Name: Generic albendazole	
Diagnosis	Microsporidiosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Microsporidiosis not caused by Enterocytozoon bieneusi or Vittaforma corneae

Anticonvulsants

Prior Authorization Guideline

Guideline ID	GL-146292
Guideline Name	Anticonvulsants
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Aptiom, Briviact tabs/oral soln, Xcopri	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
APTIOM	ESLICARBAZEPINE ACETATE TAB 200 MG	72600024100320	Brand
APTIOM	ESLICARBAZEPINE ACETATE TAB 400 MG	72600024100330	Brand
APTIOM	ESLICARBAZEPINE ACETATE TAB 600 MG	72600024100340	Brand
APTIOM	ESLICARBAZEPINE ACETATE TAB 800 MG	72600024100360	Brand
BRIVIACT	BRIVARACETAM TAB 10 MG	72600015000310	Brand
BRIVIACT	BRIVARACETAM TAB 25 MG	72600015000320	Brand

BRIVIACT	BRIVARACETAM TAB 50 MG	72600015000330	Brand
BRIVIACT	BRIVARACETAM TAB 75 MG	72600015000340	Brand
BRIVIACT	BRIVARACETAM TAB 100 MG	72600015000350	Brand
BRIVIACT	BRIVARACETAM ORAL SOLN 10 MG/ML	72600015002020	Brand
XCOPRI	CENOBAMATE TAB TITRATION PACK 14 X 12.5 MG & 14 X 25 MG	7212001000B720	Brand
XCOPRI	CENOBAMATE TAB TITRATION PACK 14 X 50 MG & 14 X 100 MG	7212001000B725	Brand
XCOPRI	CENOBAMATE TAB TITRATION PACK 14 X 150 MG & 14 X 200 MG	7212001000B730	Brand
XCOPRI	CENOBAMATE TAB PACK 100 MG & 150 MG TABS (250 MG DAILY DOSE)	7212001000B738	Brand
XCOPRI	CENOBAMATE TAB PACK 150 MG & 200 MG TABS (350 MG DAILY DOSE)	7212001000B740	Brand
XCOPRI	CENOBAMATE TAB 50 MG	72120010000320	Brand
XCOPRI	CENOBAMATE TAB 100 MG	72120010000325	Brand
XCOPRI	CENOBAMATE TAB 150 MG	72120010000330	Brand
XCOPRI	CENOBAMATE TAB 200 MG	72120010000335	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of partial-onset seizures

AND

2.2 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies) confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)

- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name: Fycompa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FYCOMPA	PERAMPANEL TAB 2 MG	72550060000310	Brand
FYCOMPA	PERAMPANEL TAB 4 MG	72550060000320	Brand
FYCOMPA	PERAMPANEL TAB 6 MG	72550060000330	Brand
FYCOMPA	PERAMPANEL TAB 8 MG	72550060000340	Brand
FYCOMPA	PERAMPANEL TAB 10 MG	72550060000350	Brand
FYCOMPA	PERAMPANEL TAB 12 MG	72550060000360	Brand
FYCOMPA	PERAMPANEL SUSP 0.5 MG/ML	72550060001820	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 ONE of the following:

2.1.1 Diagnosis of partial-onset seizures with or without secondarily generalized seizures

OR

2.1.2 ALL of the following:

- Diagnosis of primary generalized tonic-clonic seizures
- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

2.2 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies) confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name: generic lacosamide tabs/oral soln, Brand Vimpat tabs/oral soln	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LACOSAMIDE	LACOSAMIDE TAB 50 MG	72600036000320	Generic
VIMPAT	LACOSAMIDE TAB 50 MG	72600036000320	Brand
LACOSAMIDE	LACOSAMIDE TAB 100 MG	72600036000330	Generic
VIMPAT	LACOSAMIDE TAB 100 MG	72600036000330	Brand
LACOSAMIDE	LACOSAMIDE TAB 150 MG	72600036000340	Generic
VIMPAT	LACOSAMIDE TAB 150 MG	72600036000340	Brand
LACOSAMIDE	LACOSAMIDE TAB 200 MG	72600036000350	Generic
VIMPAT	LACOSAMIDE TAB 200 MG	72600036000350	Brand

LACOSAMIDE	LACOSAMIDE ORAL SOLUTION 10 MG/ML	72600036002060	Generic
VIMPAT	LACOSAMIDE ORAL SOLUTION 10 MG/ML	72600036002060	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 ONE of the following:

2.1.1 Diagnosis of partial onset seizures

OR

2.1.2 ALL of the following:

- Diagnosis of primary generalized tonic-clonic seizures
- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

2.2 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies) confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)

- Zonisamide (generic Zonegran

Product Name: Epidiolex	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPIDIOLEX	CANNABIDIOL SOLN 100 MG/ML	72600017002020	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - Diagnosis of seizures associated with Dravet syndrome or tuberous sclerosis complex

OR

3 - ALL of the following:

3.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome

AND

3.2 History of greater than or equal to 8 week trial of at least TWO generic anticonvulsants (e.g., divalproex, lamotrigine, topiramate, valproic acid)

Product Name: Brand Onfi, generic clobazam	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ONFI	CLOBAZAM TAB 10 MG	72100007000310	Brand
CLOBAZAM	CLOBAZAM TAB 10 MG	72100007000310	Generic
ONFI	CLOBAZAM TAB 20 MG	72100007000320	Brand
CLOBAZAM	CLOBAZAM TAB 20 MG	72100007000320	Generic
ONFI	CLOBAZAM SUSPENSION 2.5 MG/ML	72100007001830	Brand
CLOBAZAM	CLOBAZAM SUSPENSION 2.5 MG/ML	72100007001830	Generic

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - BOTH of the following:

2.1 ONE of the following:

- Diagnosis of seizures associated with Lennox-Gastaut syndrome
- Diagnosis of refractory partial onset seizures (four or more uncontrolled seizures per month after an adequate trial of at least two antiepileptic drugs)
- Diagnosis of Dravet syndrome

AND

2.2 BOTH of the following:

- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

Product Name: generic rufinamide, Brand Banzel	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RUFINAMIDE	RUFINAMIDE TAB 200 MG	72600065000320	Generic
BANZEL	RUFINAMIDE TAB 200 MG	72600065000320	Brand
RUFINAMIDE	RUFINAMIDE TAB 400 MG	72600065000330	Generic
BANZEL	RUFINAMIDE TAB 400 MG	72600065000330	Brand
RUFINAMIDE	RUFINAMIDE SUSP 40 MG/ML	72600065001820	Generic
BANZEL	RUFINAMIDE SUSP 40 MG/ML	72600065001820	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - Diagnosis of seizures associated with Lennox-Gastaut syndrome

Product Name: generic tiagabine, Brand Gabitril	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 2 MG	72170070100302	Generic
GABITRIL	TIAGABINE HCL TAB 2 MG	72170070100302	Brand
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 4 MG	72170070100305	Generic
GABITRIL	TIAGABINE HCL TAB 4 MG	72170070100305	Brand
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 12 MG	72170070100315	Generic
GABITRIL	TIAGABINE HCL TAB 12 MG	72170070100315	Brand
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 16 MG	72170070100320	Generic
GABITRIL	TIAGABINE HCL TAB 16 MG	72170070100320	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of partial-onset seizures

AND

2.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

2.3 Not used as primary treatment

AND

2.4 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name: Sympazan	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYMPAZAN	CLOBAZAM ORAL FILM 5 MG	72100007008205	Brand
SYMPAZAN	CLOBAZAM ORAL FILM 10 MG	72100007008210	Brand
SYMPAZAN	CLOBAZAM ORAL FILM 20 MG	72100007008220	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS)

AND

2.2 BOTH of the following:

- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

2.3 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Divalproex (e.g., generic Depakote)
- Lamotrigine (e.g., generic Lamictal)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Felbamate (generic Felbatol)

- Rufinamide (generic Banzel)

AND

2.4 Prescriber provides a reason or special circumstance the patient cannot use clobazam (generic Onfi) tablets or suspension

OR

3 - ALL of the following:

3.1 Diagnosis of refractory partial onset seizures (four or more uncontrolled seizures per month after an adequate trial of at least two antiepileptic drugs)

AND

3.2 BOTH of the following:

- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

3.3 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

AND

3.4 Prescriber provides a reason or special circumstance the patient cannot use generic clobazam tablets or suspension

OR

4 - ALL of the following:

- Diagnosis of Dravet syndrome
- Patient is currently taking Diacomit
- Prescriber provides a reason or special circumstance the patient cannot use generic clobazam tablets or suspension

Product Name: Brand Sabril powd pack, Vigadrone powd pack, generic vigabatrin powd pack	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SABRIL	VIGABATRIN POWD PACK 500 MG	72170085003020	Brand
VIGADRONE	VIGABATRIN POWD PACK 500 MG	72170085003020	Generic
VIGABATRIN	VIGABATRIN POWD PACK 500 MG	72170085003020	Generic

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - Diagnosis of infantile spasms

OR

3 - ALL of the following:

3.1 Diagnosis of complex partial seizures

AND

3.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

3.3 Not used as primary treatment

AND

3.4 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name: Brand Sabril tablets, Vigadrone tablets, generic vigabatrin tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SABRIL	VIGABATRIN TAB 500 MG	72170085000320	Brand

VIGABATRIN	VIGABATRIN TAB 500 MG	72170085000320	Generic
VIGADRONE	VIGABATRIN TAB 500 MG	72170085000320	Generic

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of complex partial seizures

AND

2.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

2.3 Not used as primary treatment

AND

2.4 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)

- Zonisamide (generic Zonegran)

Product Name: Diacomit	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DIACOMIT	STIRIPENTOL CAP 250 MG	72600070000120	Brand
DIACOMIT	STIRIPENTOL CAP 500 MG	72600070000130	Brand
DIACOMIT	STIRIPENTOL PACKET 250 MG	72600070003020	Brand
DIACOMIT	STIRIPENTOL PACKET 500 MG	72600070003030	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - Diagnosis of Dravet syndrome and currently taking clobazam

Product Name: Fintepla	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FINTEPLA	FENFLURAMINE HCL ORAL SOLN 2.2 MG/ML	72600028102020	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of seizures associated with Dravet syndrome

AND

2.2 History of greater than or equal to 8-week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Divalproex (e.g., generic Depakote)
- Levetiracetam (e.g., generic Keppra)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

OR

3 - ALL of the following:

3.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome

AND

3.2 ONE of the following:

3.2.1 Failure of a greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Divalproex (e.g., generic Depakote)
- Lamotrigine (e.g., generic Lamictal)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)

OR

3.2.2 History of intolerance or contraindication to ALL of the following (any release formulation qualifies) (please specify intolerance or contraindication):

- Divalproex (e.g., generic Depakote)
- Lamotrigine (e.g., generic Lamictal)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)

Product Name: Ztalmy	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZTALMY	GANAXOLONE SUSP 50 MG/ML	72600033001820	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder confirmed with genetic testing

AND

2.2 History of greater than or equal to 8-week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)

- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Antipsoriatic Agents

Prior Authorization Guideline

Guideline ID	GL-146293
Guideline Name	Antipsoriatic Agents
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic calcipotriene cream, generic calcipotriene ointment, generic calcitriol ointment	
Diagnosis	Psoriasis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CALCIPOTRIENE	CALCIPOTRIENE CREAM 0.005%	90250025003710	Generic
CALCIPOTRIENE	CALCIPOTRIENE OINT 0.005%	90250025004210	Generic
CALCITRIOL	CALCITRIOL OINT 3 MCG/GM	90250028004220	Generic

Approval Criteria
1 - Diagnosis of psoriasis
AND
2 - ONE of the following:
2.1 Failure to TWO medium to high potency corticosteroid topical treatments (see Background) as confirmed by claims history or submission of medical records
OR
2.2 History of intolerance or contraindication to TWO medium to high potency corticosteroid topical treatments (see Background) (please specify intolerance or contraindication)

2 . Background

Benefit/Coverage/Program Information

Table 1. Relative Potency of Selected Topical Corticosteroid Products

Drug	**Dosage Form**	**Strength**
Super-High Potency (group 1)		
Augmented betamethasone dipropionate (Diprolene)	Gel, Ointment, lotion	0.05%
Clobetasol propionate (Clobex, Olux, Temovate, Temovate E)	Cream, Ointment, Gel, Solution, Lotion, Shampoo, Spray Aerosol, Foam Aerosol	0.05%
Fluocinonide (Vanos)	Cream	0.1%
Flurandrenolide (Cordran)	Tape (roll)	4 mcg/cm^2
Halobetasol propionate (Ultravate, Lexette)	Lotion, Cream, Ointment, Foam	0.05%

High Potency (group 2)		
Amcinonide (Amcort)	Ointment	0.1%
Augmented betamethasone dipropionate (Diprolene, Diprolene AF)	Cream, Lotion, Ointment	0.05%
Betamethasone dipropionate	Lotion, Ointment	0.05%
Clobetasol propionate (Impoyz)	Cream	0.025%
Desoximetasone (Topicort)	Cream, Ointment, Spray	0.25%,
	Gel	0.05%
Diflorasone diacetate (Psorcon)	Cream, Ointment	0.05%
Fluocinonide (Lidex, Lidex E)	Cream, Gel, Ointment, Solution	0.05%
Halcinonide (Halog)	Cream, Ointment, Solution	0.1%
Halobetasol propionate (Bryhali)	Lotion	0.01%
High Potency (group 3)		
Amcinonide (Amcort)	Cream, Lotion	0.1%
Betamethasone valerate (Valisone)	Ointment	0.1%
Desoximetasone (Topicort)	Cream, ointment	0.05%
Diflorasone diacetate (Florone, Psorcon)	Cream	0.05%
Fluocinonide (Lidex-E)	Cream	0.05%
Fluticasone propionate (Cutivate)	Ointment	0.005%
Mometasone furoate (Elocon)	Ointment	0.1%
Triamcinolone acetonide (Aristocort HP, Kenalog, Triderm)	Cream, ointment	0.5%

Medium Potency (group 4)		
Betamethasone dipropionate (sernivo)	Spray	0.05%
Clocortolone pivalate (Cloderm)	Cream	0.1%
Fluocinolone acetonide (Synalar)	Cream, Ointment	0.025%
Flurandrenolide (Cordran)	Ointment	0.05%
Fluticasone propionate (Cutivate)	Cream, Lotion	0.05%
Hydrocortisone valerate (Westcort)	Ointment	0.2%
Mometasone furoate (Elocon)	Cream, lotion, Solution	0.1%
Triamcinolone acetonide (Aristocort, Kenalog)	Cream, Lotion Ointment	0.1%
	Ointment	0.05%

Antipsychotics

Prior Authorization Guideline

Guideline ID	GL-148167
Guideline Name	Antipsychotics
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: aripiprazole ODT, aripiprazole oral soln, Abilify Maintena, Abilify MyCite, Brand Abilify, generic aripiprazole tabs, Abilify Asimtufii, Aristada, Aristada Initio, Caplyta, Brand Clozaril, generic clozapine tabs, clozapine ODT, Fanapt, Fanapt Titration Pack, Brand Geodon caps, generic ziprasidone caps, Brand Invega, generic paliperidone ER, Invega Sustenna, Invega Trinza, Invega Hafyera, Brand Latuda, generic lurasidone, Lybalvi, molindone, Perseris, Rexulti, Brand Risperdal, generic risperidone tabs/oral soln, risperidone ODT, Brand Risperdal Consta, generic risperidone ER inj, Rykindo, Brand Saphris, generic asenapine, Secuado, Brand Seroquel, generic quetiapine, Brand Seroquel XR, generic quetiapine ER, Uzedy, Versacloz, Vraylar, Brand Zyprexa tabs, generic olanzapine tabs, Brand Zyprexa Zydis, generic olanzapine ODT	
Diagnosis	Atypical Antipsychotics: Prior Authorization for Minimum Age Edit*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

CAPLYTA	LUMATEPERONE TOSYLATE CAP 10.5 MG	59400022400110	Brand
CAPLYTA	LUMATEPERONE TOSYLATE CAP 21 MG	59400022400115	Brand
CAPLYTA	LUMATEPERONE TOSYLATE CAP 42 MG	59400022400120	Brand
ARIPIPRAZOLE ODT	ARIPIPRAZOLE ORALLY DISINTEGRATING TAB 10 MG	59250015007220	Generic
ARIPIPRAZOLE ODT	ARIPIPRAZOLE ORALLY DISINTEGRATING TAB 15 MG	59250015007230	Generic
ARIPIPRAZOLE	ARIPIPRAZOLE ORAL SOLUTION 1 MG/ML	59250015002020	Generic
ABILIFY MAINTENA	ARIPIPRAZOLE IM FOR ER SUSP PREFILLED SYRINGE 300 MG	5925001500E430	Brand
ABILIFY MAINTENA	ARIPIPRAZOLE IM FOR ER SUSP PREFILLED SYRINGE 400 MG	5925001500E440	Brand
ABILIFY MAINTENA	ARIPIPRAZOLE IM FOR EXTENDED RELEASE SUSP 300 MG	5925001500G230	Brand
ABILIFY MAINTENA	ARIPIPRAZOLE IM FOR EXTENDED RELEASE SUSP 400 MG	5925001500G240	Brand
ABILIFY	ARIPIPRAZOLE TAB 2 MG	59250015000305	Brand
ARIPIPRAZOLE	ARIPIPRAZOLE TAB 2 MG	59250015000305	Generic
ABILIFY	ARIPIPRAZOLE TAB 5 MG	59250015000310	Brand
ARIPIPRAZOLE	ARIPIPRAZOLE TAB 5 MG	59250015000310	Generic
ABILIFY	ARIPIPRAZOLE TAB 10 MG	59250015000320	Brand
ARIPIPRAZOLE	ARIPIPRAZOLE TAB 10 MG	59250015000320	Generic
ABILIFY	ARIPIPRAZOLE TAB 15 MG	59250015000330	Brand
ARIPIPRAZOLE	ARIPIPRAZOLE TAB 15 MG	59250015000330	Generic
ABILIFY	ARIPIPRAZOLE TAB 20 MG	59250015000340	Brand
ARIPIPRAZOLE	ARIPIPRAZOLE TAB 20 MG	59250015000340	Generic
ABILIFY	ARIPIPRAZOLE TAB 30 MG	59250015000350	Brand
ARIPIPRAZOLE	ARIPIPRAZOLE TAB 30 MG	59250015000350	Generic
ABILIFY ASIMTUFII	ARIPIPRAZOLE IM ER SUSP PREFILLED SYRINGE 720 MG/2.4ML	5925001500E455	Brand
ABILIFY ASIMTUFII	ARIPIPRAZOLE IM ER SUSP PREFILLED SYRINGE 960 MG/3.2ML	5925001500E465	Brand
ARISTADA	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 441 MG/1.6ML	5925001520E420	Brand
ARISTADA	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 662 MG/2.4ML	5925001520E430	Brand
ARISTADA	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 882 MG/3.2ML	5925001520E440	Brand

ARISTADA	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 1064 MG/3.9ML	5925001520E450	Brand
ARISTADA INITIO	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 675 MG/2.4ML	5925001520E435	Brand
CLOZAPINE	CLOZAPINE TAB 25 MG	59152020000320	Generic
CLOZARIL	CLOZAPINE TAB 25 MG	59152020000320	Brand
CLOZAPINE	CLOZAPINE TAB 50 MG	59152020000325	Generic
CLOZARIL	CLOZAPINE TAB 50 MG	59152020000325	Brand
CLOZAPINE	CLOZAPINE TAB 100 MG	59152020000330	Generic
CLOZARIL	CLOZAPINE TAB 100 MG	59152020000330	Brand
CLOZAPINE	CLOZAPINE TAB 200 MG	59152020000340	Generic
CLOZARIL	CLOZAPINE TAB 200 MG	59152020000340	Brand
CLOZAPINE ODT	CLOZAPINE ORALLY DISINTEGRATING TAB 12.5 MG	59152020007210	Generic
CLOZAPINE ODT	CLOZAPINE ORALLY DISINTEGRATING TAB 25 MG	59152020007220	Generic
CLOZAPINE ODT	CLOZAPINE ORALLY DISINTEGRATING TAB 100 MG	59152020007230	Generic
CLOZAPINE ODT	CLOZAPINE ORALLY DISINTEGRATING TAB 150 MG	59152020007240	Generic
CLOZAPINE ODT	CLOZAPINE ORALLY DISINTEGRATING TAB 200 MG	59152020007250	Generic
FANAPT	ILOPERIDONE TAB 1 MG	59070035000310	Brand
FANAPT	ILOPERIDONE TAB 2 MG	59070035000320	Brand
FANAPT	ILOPERIDONE TAB 4 MG	59070035000340	Brand
FANAPT	ILOPERIDONE TAB 6 MG	59070035000360	Brand
FANAPT	ILOPERIDONE TAB 8 MG	59070035000380	Brand
FANAPT	ILOPERIDONE TAB 10 MG	59070035000385	Brand
FANAPT	ILOPERIDONE TAB 12 MG	59070035000390	Brand
FANAPT TITRATION PACK	ILOPERIDONE TAB 1 MG & 2 MG & 4 MG & 6 MG TITRATION PAK	59070035006320	Brand
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Generic
GEODON	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Generic
GEODON	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Brand

ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Generic
GEODON	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Generic
GEODON	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Generic
PALIPERIDONE ER	PALIPERIDONE TAB ER 24HR 3 MG	59070050007510	Generic
INVEGA	PALIPERIDONE TAB ER 24HR 3 MG	59070050007510	Brand
PALIPERIDONE ER	PALIPERIDONE TAB ER 24HR 6 MG	59070050007520	Generic
INVEGA	PALIPERIDONE TAB ER 24HR 6 MG	59070050007520	Brand
PALIPERIDONE ER	PALIPERIDONE TAB ER 24HR 9 MG	59070050007530	Generic
INVEGA	PALIPERIDONE TAB ER 24HR 9 MG	59070050007530	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 39 MG/0.25ML	5907005010E626	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 78 MG/0.5ML	5907005010E629	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 117 MG/0.75ML	5907005010E632	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 156 MG/ML	5907005010E635	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 234 MG/1.5ML	5907005010E638	Brand
INVEGA TRINZA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 273 MG/0.88ML	5907005010E643	Brand
INVEGA TRINZA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 410 MG/1.32ML	5907005010E647	Brand
INVEGA TRINZA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 546 MG/1.75ML	5907005010E651	Brand
INVEGA TRINZA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 819 MG/2.63ML	5907005010E655	Brand
INVEGA HAFYERA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 1,092 MG/3.5ML	5907005010E670	Brand
INVEGA HAFYERA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 1,560 MG/5ML	5907005010E675	Brand

LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 20 MG	59400023100310	Generic
LATUDA	LURASIDONE HCL TAB 20 MG	59400023100310	Brand
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 40 MG	59400023100320	Generic
LATUDA	LURASIDONE HCL TAB 40 MG	59400023100320	Brand
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 60 MG	59400023100330	Generic
LATUDA	LURASIDONE HCL TAB 60 MG	59400023100330	Brand
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 80 MG	59400023100340	Generic
LATUDA	LURASIDONE HCL TAB 80 MG	59400023100340	Brand
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 120 MG	59400023100350	Generic
LATUDA	LURASIDONE HCL TAB 120 MG	59400023100350	Brand
LYBALVI	OLANZAPINE-SAMIDORPHAN L-MALATE TAB 5-10 MG	62994802500310	Brand
LYBALVI	OLANZAPINE-SAMIDORPHAN L-MALATE TAB 10-10 MG	62994802500320	Brand
LYBALVI	OLANZAPINE-SAMIDORPHAN L-MALATE TAB 15-10 MG	62994802500330	Brand
LYBALVI	OLANZAPINE-SAMIDORPHAN L-MALATE TAB 20-10 MG	62994802500340	Brand
MOLINDONE HYDROCHLORIDE	MOLINDONE HCL TAB 5 MG	59160050100305	Generic
MOLINDONE HYDROCHLORIDE	MOLINDONE HCL TAB 10 MG	59160050100310	Generic
MOLINDONE HYDROCHLORIDE	MOLINDONE HCL TAB 25 MG	59160050100315	Generic
PERSERIS	RISPERIDONE SUBCUTANEOUS FOR ER SUSP PREFILLED SYR 90 MG	5907007000E420	Brand
PERSERIS	RISPERIDONE SUBCUTANEOUS FOR ER SUSP PREFILLED SYR 120 MG	5907007000E430	Brand
REXULTI	BREXPIPRAZOLE TAB 0.25 MG	59250020000310	Brand
REXULTI	BREXPIPRAZOLE TAB 0.5 MG	59250020000320	Brand
REXULTI	BREXPIPRAZOLE TAB 1 MG	59250020000330	Brand
REXULTI	BREXPIPRAZOLE TAB 2 MG	59250020000340	Brand
REXULTI	BREXPIPRAZOLE TAB 3 MG	59250020000350	Brand
REXULTI	BREXPIPRAZOLE TAB 4 MG	59250020000360	Brand
RISPERIDONE	RISPERIDONE TAB 0.5 MG	59070070000306	Generic

RISPERDAL	RISPERIDONE TAB 0.5 MG	59070070000306	Brand
RISPERIDONE	RISPERIDONE TAB 1 MG	59070070000310	Generic
RISPERDAL	RISPERIDONE TAB 1 MG	59070070000310	Brand
RISPERIDONE	RISPERIDONE TAB 2 MG	59070070000320	Generic
RISPERDAL	RISPERIDONE TAB 2 MG	59070070000320	Brand
RISPERIDONE	RISPERIDONE TAB 3 MG	59070070000330	Generic
RISPERDAL	RISPERIDONE TAB 3 MG	59070070000330	Brand
RISPERIDONE	RISPERIDONE TAB 4 MG	59070070000340	Generic
RISPERDAL	RISPERIDONE TAB 4 MG	59070070000340	Brand
RISPERIDONE	RISPERIDONE SOLN 1 MG/ML	59070070002010	Generic
RISPERDAL	RISPERIDONE SOLN 1 MG/ML	59070070002010	Brand
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 0.25 MG	59070070007210	Generic
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 0.5 MG	59070070007220	Generic
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 1 MG	59070070007230	Generic
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 2 MG	59070070007240	Generic
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 3 MG	59070070007250	Generic
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 4 MG	59070070007260	Generic
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 12.5 MG	5907007010G210	Brand
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 12.5 MG	5907007010G210	Generic
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 25 MG	5907007010G220	Brand
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 25 MG	5907007010G220	Generic
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 37.5 MG	5907007010G230	Brand
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 37.5 MG	5907007010G230	Generic
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 50 MG	5907007010G240	Brand
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 50 MG	5907007010G240	Generic
RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 25 MG	5907007000G220	Brand

RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 37.5 MG	5907007000G230	Brand
RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 50 MG	5907007000G240	Brand
SAPHRIS	ASENAPINE MALEATE SL TAB 2.5 MG (BASE EQUIV)	59155015100710	Brand
ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 2.5 MG (BASE EQUIV)	59155015100710	Generic
SAPHRIS	ASENAPINE MALEATE SL TAB 5 MG (BASE EQUIV)	59155015100720	Brand
ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 5 MG (BASE EQUIV)	59155015100720	Generic
SAPHRIS	ASENAPINE MALEATE SL TAB 10 MG (BASE EQUIV)	59155015100730	Brand
ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 10 MG (BASE EQUIV)	59155015100730	Generic
SECUADO	ASENAPINE TD PATCH 24 HR 3.8 MG/24HR	59155015008520	Brand
SECUADO	ASENAPINE TD PATCH 24 HR 5.7 MG/24HR	59155015008530	Brand
SECUADO	ASENAPINE TD PATCH 24 HR 7.6 MG/24HR	59155015008540	Brand
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 25 MG	59153070100310	Generic
SEROQUEL	QUETIAPINE FUMARATE TAB 25 MG	59153070100310	Brand
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 50 MG	59153070100314	Generic
SEROQUEL	QUETIAPINE FUMARATE TAB 50 MG	59153070100314	Brand
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 100 MG	59153070100320	Generic
SEROQUEL	QUETIAPINE FUMARATE TAB 100 MG	59153070100320	Brand
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 200 MG	59153070100330	Generic
SEROQUEL	QUETIAPINE FUMARATE TAB 200 MG	59153070100330	Brand
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 300 MG	59153070100340	Generic
SEROQUEL	QUETIAPINE FUMARATE TAB 300 MG	59153070100340	Brand
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 400 MG	59153070100350	Generic
SEROQUEL	QUETIAPINE FUMARATE TAB 400 MG	59153070100350	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 50 MG/0.14ML	5907007000E610	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 75 MG/0.21ML	5907007000E618	Brand

UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 100 MG/0.28ML	5907007000E626	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 125 MG/0.35ML	5907007000E634	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 150 MG/0.42ML	5907007000E642	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 200 MG/0.56ML	5907007000E658	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 250 MG/0.7ML	5907007000E674	Brand
VRAYLAR	CARIPRAZINE HCL CAP 1.5 MG (BASE EQUIVALENT)	59400018100120	Brand
VRAYLAR	CARIPRAZINE HCL CAP 3 MG (BASE EQUIVALENT)	59400018100130	Brand
VRAYLAR	CARIPRAZINE HCL CAP 4.5 MG (BASE EQUIVALENT)	59400018100140	Brand
VRAYLAR	CARIPRAZINE HCL CAP 6 MG (BASE EQUIVALENT)	59400018100150	Brand
ZYPREXA	OLANZAPINE TAB 2.5 MG	59157060000305	Brand
OLANZAPINE	OLANZAPINE TAB 2.5 MG	59157060000305	Generic
ZYPREXA	OLANZAPINE TAB 5 MG	59157060000310	Brand
OLANZAPINE	OLANZAPINE TAB 5 MG	59157060000310	Generic
ZYPREXA	OLANZAPINE TAB 7.5 MG	59157060000315	Brand
OLANZAPINE	OLANZAPINE TAB 7.5 MG	59157060000315	Generic
ZYPREXA	OLANZAPINE TAB 10 MG	59157060000320	Brand
OLANZAPINE	OLANZAPINE TAB 10 MG	59157060000320	Generic
ZYPREXA	OLANZAPINE TAB 15 MG	59157060000330	Brand
OLANZAPINE	OLANZAPINE TAB 15 MG	59157060000330	Generic
ZYPREXA	OLANZAPINE TAB 20 MG	59157060000340	Brand
OLANZAPINE	OLANZAPINE TAB 20 MG	59157060000340	Generic
OLANZAPINE ODT	OLANZAPINE ORALLY DISINTEGRATING TAB 5 MG	59157060007210	Generic
ZYPREXA ZYDIS	OLANZAPINE ORALLY DISINTEGRATING TAB 5 MG	59157060007210	Brand
OLANZAPINE ODT	OLANZAPINE ORALLY DISINTEGRATING TAB 10 MG	59157060007220	Generic
ZYPREXA ZYDIS	OLANZAPINE ORALLY DISINTEGRATING TAB 10 MG	59157060007220	Brand
OLANZAPINE ODT	OLANZAPINE ORALLY DISINTEGRATING TAB 15 MG	59157060007230	Generic

ZYPREXA ZYDIS	OLANZAPINE ORALLY DISINTEGRATING TAB 15 MG	59157060007230	Brand
OLANZAPINE ODT	OLANZAPINE ORALLY DISINTEGRATING TAB 20 MG	59157060007240	Generic
ZYPREXA ZYDIS	OLANZAPINE ORALLY DISINTEGRATING TAB 20 MG	59157060007240	Brand
VERSACLOZ	CLOZAPINE SUSP 50 MG/ML	59152020001820	Brand
ABILIFY MYCITE STARTER KIT	ARIPIPRAZOLE TAB 2 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B705	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIPRAZOLE TAB 2 MG WITH SENSOR&STRIPS (FOR POD) MAINT PAK	5925001503B706	Brand
ABILIFY MYCITE STARTER KIT	ARIPIPRAZOLE TAB 5 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B710	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIPRAZOLE TAB 5 MG WITH SENSOR&STRIPS (FOR POD) MAINT PAK	5925001503B711	Brand
ABILIFY MYCITE STARTER KIT	ARIPIPRAZOLE TAB 10 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B720	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIPRAZOLE TAB 10 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK	5925001503B721	Brand
ABILIFY MYCITE STARTER KIT	ARIPIPRAZOLE TAB 15 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B730	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIPRAZOLE TAB 15 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK	5925001503B731	Brand
ABILIFY MYCITE STARTER KIT	ARIPIPRAZOLE TAB 20 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B740	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIPRAZOLE TAB 20 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK	5925001503B741	Brand
ABILIFY MYCITE STARTER KIT	ARIPIPRAZOLE TAB 30 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B750	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIPRAZOLE TAB 30 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK	5925001503B751	Brand
RISPERIDONE	RISPERIDONE TAB 0.25 MG	59070070000303	Generic
PALIPERIDONE ER	PALIPERIDONE TAB ER 24HR 1.5 MG	59070050007505	Generic
QUETIAPINE FUMARATE ER	QUETIAPINE FUMARATE TAB ER 24HR 50 MG	59153070107505	Generic
SEROQUEL XR	QUETIAPINE FUMARATE TAB ER 24HR 50 MG	59153070107505	Brand
QUETIAPINE FUMARATE ER	QUETIAPINE FUMARATE TAB ER 24HR 150 MG	59153070107515	Generic

SEROQUEL XR	QUETIAPINE FUMARATE TAB ER 24HR 150 MG	59153070107515	Brand
QUETIAPINE FUMARATE ER	QUETIAPINE FUMARATE TAB ER 24HR 200 MG	59153070107520	Generic
SEROQUEL XR	QUETIAPINE FUMARATE TAB ER 24HR 200 MG	59153070107520	Brand
QUETIAPINE FUMARATE ER	QUETIAPINE FUMARATE TAB ER 24HR 300 MG	59153070107530	Generic
SEROQUEL XR	QUETIAPINE FUMARATE TAB ER 24HR 300 MG	59153070107530	Brand
QUETIAPINE FUMARATE ER	QUETIAPINE FUMARATE TAB ER 24HR 400 MG	59153070107540	Generic
SEROQUEL XR	QUETIAPINE FUMARATE TAB ER 24HR 400 MG	59153070107540	Brand
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 150 MG	59153070100325	Generic

Approval Criteria

1 - ALL of the following:

1.1 The patient is unresponsive to other treatment modalities, unless contraindication (i.e., other medications or behavioral modification attempted)

AND

1.2 The patient has tried and failed all available preferred** atypical antipsychotics that are Food and Drug Administration (FDA) approved for the patient's age

AND

1.3 ONE of the following:

1.3.1 Patient has ONE of the following diagnoses:

- Schizophrenia or schizoaffective disorder
- Autism
- Bipolar disorder

OR

1.3.2 Patient displays symptoms of aggression as a symptom of developmental delay, Tourette's syndrome or chronic tics, oppositional defiant disorder, or conduct disorder

Notes	*See Table 1 in the Background section for UHC C&S Plan Minimum Age Edits **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Caplyta	
Diagnosis	Caplyta Requests Exceeding Quantity Limit
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
CAPLYTA	LUMATEPERONE TOSYLATE CAP 10.5 MG	59400022400110	Brand
CAPLYTA	LUMATEPERONE TOSYLATE CAP 21 MG	59400022400115	Brand
CAPLYTA	LUMATEPERONE TOSYLATE CAP 42 MG	59400022400120	Brand

Approval Criteria

1 - ONE of the following:

1.1 The requested drug must be used for a Food and Drug Administration (FDA)-approved indication

OR

1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical Pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - ONE of the following:

2.1 The drug is being prescribed within the manufacturer's published dosing guidelines

OR

2.2 The requested dose falls within dosing guidelines found in ONE of the following compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical Pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

3 - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation

AND

4 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program

AND

5 - Physician has provided rationale for needing to exceed the quantity limit of one capsule per day, at a maximum dose of 42 mg (NOTE: The treatment effect of Caplyta at doses higher than 42 mg daily versus placebo was NOT statistically significant in clinical trials)

2 . Background

Benefit/Coverage/Program Information
Table 1: UHC C&S Plan Minimum Age Edits: Based on FDA-approved uses, prior authorization is required for antipsychotic medications for members less than the following ages: • Abilify Discmelt, Abilify oral solution – 6 years of age • Abilify Maintena – 18 years of age • Abilify MyCite – 18 years of age • Abilify oral tablets – 6 years of age • Abilify Asimtufii – 18 years of age • Aristada – 18 years of age • Caplyta – 18 years of age • Clozaril – 18 years of age • Fanapt – 18 years of age • Geodon – 18 years of age • Invega – 12 years of age • Invega Sustenna – 18 years of age • Invega Trinza – 18 years of age • Invega Hafyera – 18 years of age • Latuda – 10 years of age • Lybalvi – 18 years of age • Molindone – 12 years of age • Perseris – 18 years of age • Rexulti – 18 years of age • Risperdal – 5 years of age • Risperdal Consta – 18 years of age • Rykindo – 18 years of age • Saphris – 10 years of age • Secuado – 18 years of age • Seroquel, Seroquel XR – 10 years of age • Uzedy – 18 years of age • Vraylar – 18 years of age • Zyprexa – 13 years of age • Zyprexa Zydis – 6 years of age

3 . Revision History

Date	Notes
6/7/2024	New program.

Azole Antifungals

Prior Authorization Guideline

Guideline ID	GL-147444
Guideline Name	Azole Antifungals
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Systemic Fungal Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ITRACONAZOLE	ITRACONAZOLE CAP 100 MG	11407035000120	Generic
SPORANOX	ITRACONAZOLE CAP 100 MG	11407035000120	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Blastomycosis
- Histoplasmosis
- Aspergillosis

OR

2 - BOTH of the following:

2.1 Diagnosis of coccidioidomycosis

AND

2.2 ONE of the following:

2.2.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

2.2.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Fingernails
Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ITRACONAZOLE	ITRACONAZOLE CAP 100 MG	11407035000120	Generic
SPORANOX	ITRACONAZOLE CAP 100 MG	11407035000120	Brand

Approval Criteria

1 - Diagnosis of fingernail onychomycosis confirmed by ONE of the following:

- KOH (potassium hydroxide) test
- Fungal culture
- Nail biopsy

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Fingernails
Approval Length	2 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ITRACONAZOLE	ITRACONAZOLE CAP 100 MG	11407035000120	Generic
SPORANOX	ITRACONAZOLE CAP 100 MG	11407035000120	Brand

Approval Criteria

1 - Three months have elapsed since completion of initial therapy for fingernail onychomycosis

AND

2 - Documentation of positive clinical response to therapy

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Toenails
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ITRACONAZOLE	ITRACONAZOLE CAP 100 MG	11407035000120	Generic
SPORANOX	ITRACONAZOLE CAP 100 MG	11407035000120	Brand

Approval Criteria

1 - Diagnosis of toenail onychomycosis confirmed by ONE of the following:

- KOH (potassium hydroxide) test
- Fungal culture
- Nail biopsy

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Toenails
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ITRACONAZOLE	ITRACONAZOLE CAP 100 MG	11407035000120	Generic
SPORANOX	ITRACONAZOLE CAP 100 MG	11407035000120	Brand

Approval Criteria

1 - Nine months have elapsed since completion of initial therapy for toenail onychomycosis

AND

2 - Documentation of positive clinical response to therapy

Product Name: Brand Sporanox oral solution, generic itraconazole oral solution

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ITRACONAZOLE	ITRACONAZOLE ORAL SOLN 10 MG/ML	11407035002020	Generic
SPORANOX	ITRACONAZOLE ORAL SOLN 10 MG/ML	11407035002020	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- Oropharyngeal candidiasis
- Esophageal candidiasis

Product Name: Brand Vfend tablets, generic voriconazole tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VORICONAZOLE	VORICONAZOLE TAB 50 MG	11407080000320	Generic
VFEND	VORICONAZOLE TAB 50 MG	11407080000320	Brand
VORICONAZOLE	VORICONAZOLE TAB 200 MG	11407080000340	Generic
VFEND	VORICONAZOLE TAB 200 MG	11407080000340	Brand

Approval Criteria

1 - Diagnosis of invasive aspergillosis including Aspergillus fumigatus

OR

2 - ALL of the following:

2.1 Diagnosis of candidemia

AND

2.2 Patient is non-neutropenic

AND

2.3 ONE of the following:

2.3.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

2.3.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

OR

3 - BOTH of the following:

3.1 ONE of the following diagnoses:

- Candida infection in the abdomen
- Candida infection in the kidney
- Candida infection in the bladder wall
- Candida infection in wounds
- Disseminated Candida infections in skin
- Esophageal candidiasis

AND

3.2 ONE of the following:

3.2.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

3.2.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

OR

4 - Diagnosis of Scedosporium apiospermum infection (asexual form of Pseudallescheria boydii)

OR

5 - Diagnosis of Fusarium spp. infection including Fusarium solani

OR

6 - Diagnosis of Exserohilum species infection

Product Name: Brand Vfend susp, generic voriconazole susp	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VFEND	VORICONAZOLE FOR SUSP 40 MG/ML	11407080001920	Brand
VORICONAZOLE	VORICONAZOLE FOR SUSP 40 MG/ML	11407080001920	Generic

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of invasive aspergillosis including Aspergillus fumigatus

OR

1.2 ALL of the following:

1.2.1 Diagnosis of Candidemia

AND

1.2.2 Patient is non-neutropenic

AND

1.2.3 ONE of the following:

1.2.3.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

1.2.3.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

OR

1.3 BOTH of the following:

1.3.1 ONE of the following diagnoses:

- Candida infection in the abdomen
- Candida infection in the kidney
- Candida infection in the bladder wall
- Candida infection in wounds
- Disseminated Candida infections in skin
- Esophageal candidiasis

AND

1.3.2 ONE of the following:

1.3.2.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

1.3.2.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

OR

1.4 Diagnosis of Scedosporium apiospermum infection (asexual form of Pseudallescheria boydii)

OR

1.5 Diagnosis of Fusarium spp. infection including Fusarium solani

OR

1.6 Diagnosis of Exserohilum species infection

AND

2 - Physician has provided rationale for the patient needing to use voriconazole oral suspension instead of voriconazole tablets

Product Name: Brand Noxafil tablets, generic posaconazole tablets	
Diagnosis	Prophylaxis of Aspergillus or Candida Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

NOXAFIL	POSACONAZOLE TAB DELAYED RELEASE 100 MG	11407060000620	Brand
POSACONAZOLE DR	POSACONAZOLE TAB DELAYED RELEASE 100 MG	11407060000620	Generic

Approval Criteria

1 - Used as prophylaxis of invasive fungal infections caused by ONE of the following:

- Aspergillus
- Candida

AND

2 - ONE of the following conditions:

2.1 Patient is at high risk of infections due to severe immunosuppression from ONE of the following conditions:

2.1.1 Hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD)

OR

2.1.2 Hematologic malignancies with prolonged neutropenia from chemotherapy [e.g., acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]

OR

2.2 Patient has a prior fungal infection requiring secondary prophylaxis

Product Name: Brand Noxafil tablets, generic posaconazole tablets	
Diagnosis	Treatment of Invasive Aspergillosis
Approval Length	84 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

NOXAFIL	POSACONAZOLE TAB DELAYED RELEASE 100 MG	11407060000620	Brand
POSACONAZOLE DR	POSACONAZOLE TAB DELAYED RELEASE 100 MG	11407060000620	Generic

Approval Criteria

1 - Diagnosis of invasive aspergillosis

AND

2 - ONE of the following:

2.1 Failure to voriconazole (generic Vfend) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication, intolerance, or resistance to voriconazole (generic Vfend) (please specify intolerance, contraindication, or resistance)

Product Name: Brand Noxafil suspension, generic posaconazole suspension, Noxafil delayed release suspension packets	
Diagnosis	Prophylaxis of Aspergillus or Candida Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOXAFIL	POSACONAZOLE SUSP 40 MG/ML	11407060001820	Brand
NOXAFIL	POSACONAZOLE FOR DELAYED RELEASE SUSP PACKET 300 MG	11407060003020	Brand
POSACONAZOLE	POSACONAZOLE SUSP 40 MG/ML	11407060001820	Generic

Approval Criteria

1 - Used as prophylaxis of invasive fungal infections caused by ONE of the following:

- Aspergillus
- Candida

AND

2 - ONE of the following conditions:

2.1 Patient is at high risk of infections due to severe immunosuppression from ONE of the following conditions:

2.1.1 Hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD)

OR

2.1.2 Hematologic malignancies with prolonged neutropenia from chemotherapy [e.g., acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]

OR

2.2 Patient has a prior fungal infection requiring secondary prophylaxis

Product Name: Brand Noxafil suspension, generic posaconazole suspension	
Diagnosis	Oropharyngeal Candidiasis (OPC)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOXAFIL	POSACONAZOLE SUSP 40 MG/ML	11407060001820	Brand
POSACONAZOLE	POSACONAZOLE SUSP 40 MG/ML	11407060001820	Generic

Approval Criteria

1 - Diagnosis of oropharyngeal candidiasis (OPC)

AND

2 - ONE of the following:

2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Fluconazole (generic Diflucan)
- Itraconazole (generic Sporanox)

OR

2.2 History of contraindication, intolerance, or resistance to BOTH of the following (please specify intolerance, contraindication, or resistance):

- Fluconazole (generic Diflucan)
- Itraconazole (generic Sporanox)

Product Name: Cresemba	
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CRESEMBA	ISAVUCONAZONIUM SULFATE CAP 186 MG (ISAVUCONAZOLE 100 MG)	11407030100120	Brand
CRESEMBA	ISAVUCONAZONIUM SULFATE CAP 74.5 MG (ISAVUCONAZOLE 40 MG)	11407030100105	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of invasive aspergillosis

AND

1.2 ONE of the following:

1.2.1 Failure to voriconazole (generic Vfend) as confirmed by claims history or submission of medical records

OR

1.2.2 History of contraindication, intolerance, or resistance to voriconazole (generic Vfend) (please specify intolerance, contraindication, or resistance)

OR

2 - Diagnosis of invasive mucormycosis

Product Name: Tolsura	
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TOLSURA	ITRACONAZOLE CAP 65 MG	11407035000113	Brand

Approval Criteria

1 - Diagnosis of ONE of the following fungal infections:

- Blastomycosis
- Histoplasmosis
- Aspergillosis

AND

2 - ONE of the following:

2.1 Failure to itraconazole capsules (generic Sporanox) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to itraconazole capsules (generic Sporanox) (please specify intolerance or contraindication)

Product Name: Brand Sporanox capsules, generic itraconazole capsules, Brand Sporanox oral solution, generic itraconazole oral solution, Brand Vfend tablets, generic voriconazole tablets, Brand Vfend suspension, generic voriconazole suspension, Brand Noxafil tablets, generic posaconazole tablets, Brand Noxafil oral suspension, generic posaconazole oral suspension, Noxafil delayed release suspension packets, Cresemba, Tolsura	
Diagnosis	Infectious Diseases Society of America (IDSA) Recommended Regimens
Approval Length	Based on provider and IDSA recommended treatment durations, up to 12 months
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ITRACONAZOLE	ITRACONAZOLE CAP 100 MG	11407035000120	Generic
SPORANOX	ITRACONAZOLE CAP 100 MG	11407035000120	Brand
ITRACONAZOLE	ITRACONAZOLE ORAL SOLN 10 MG/ML	11407035002020	Generic
SPORANOX	ITRACONAZOLE ORAL SOLN 10 MG/ML	11407035002020	Brand
VORICONAZOLE	VORICONAZOLE TAB 50 MG	11407080000320	Generic
VFEND	VORICONAZOLE TAB 50 MG	11407080000320	Brand
VORICONAZOLE	VORICONAZOLE TAB 200 MG	11407080000340	Generic
VFEND	VORICONAZOLE TAB 200 MG	11407080000340	Brand
VORICONAZOLE	VORICONAZOLE FOR SUSP 40 MG/ML	11407080001920	Generic
VFEND	VORICONAZOLE FOR SUSP 40 MG/ML	11407080001920	Brand
NOXAFIL	POSACONAZOLE TAB DELAYED RELEASE 100 MG	11407060000620	Brand
POSACONAZOLE DR	POSACONAZOLE TAB DELAYED RELEASE 100 MG	11407060000620	Generic
NOXAFIL	POSACONAZOLE SUSP 40 MG/ML	11407060001820	Brand
NOXAFIL	POSACONAZOLE FOR DELAYED RELEASE SUSP PACKET 300 MG	11407060003020	Brand
CRESEMBA	ISAVUCONAZONIUM SULFATE CAP 186 MG (ISAVUCONAZOLE 100 MG)	11407030100120	Brand

TOLSURA	ITRACONAZOLE CAP 65 MG	11407035000113	Brand
POSACONAZOLE	POSACONAZOLE SUSP 40 MG/ML	11407060001820	Generic
CRESEMBA	ISAVUCONAZONIUM SULFATE CAP 74.5 MG (ISAVUCONAZOLE 40 MG)	11407030100105	Brand

Approval Criteria

1 - Use is recognized for treatment of the diagnosis by the Infectious Diseases Society of America (IDSA)

2 . Revision History

Date	Notes
5/16/2024	Updated GPIs (removed obsolete posaconazole tab; added new Cre semba 74.5mg)

Baxdela

Prior Authorization Guideline

Guideline ID	GL-146295
Guideline Name	Baxdela
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Baxdela	
Diagnosis	Community-Acquired Bacterial Pneumonia
Approval Length	10 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BAXDELA	DELAFLOXACIN MEGLUMINE TAB 450 MG (BASE EQUIV)	05000025100320	Brand

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - All of the following:

3.1 Diagnosis of community-acquired bacterial pneumonia (CABP)

AND

3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Baxdela

AND

3.3 One of the following:

3.3.1 Failure to three of the following antibiotics or antibiotic regimens as confirmed by claims history or submission of medical records:

- Amoxicillin
- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

OR

3.3.2 History of intolerance or contraindication to all of the following antibiotics or antibiotic regimens (please specify intolerance or contraindication)

- Amoxicillin

- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

Product Name: Baxdela	
Diagnosis	Acute Bacterial Skin and Skin Structure Infections
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BAXDELA	DELAFLOXACIN MEGLUMINE TAB 450 MG (BASE EQUIV)	05000025100320	Brand

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - All of the following:

3.1 One of the following diagnoses:

3.1.1 Both of the following

3.1.1.1 Acute bacterial skin and skin structure infections

AND

3.1.1.2 Infection caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report

OR

3.1.2 Both of the following:

3.1.2.1 Empirical treatment of patients with acute bacterial skin and skin structure infections

AND

3.1.2.2 Presence of MRSA infection is likely

AND

3.2 ONE of the following:

3.2.1 Failure of linezolid (generic Zyvox) confirmed by claims history or submitted medical records

OR

3.2.2 History of intolerance or contraindication to linezolid (generic Zyvox) (please specify intolerance or contraindication)

AND

3.3 One of the following:

3.3.1 Failure to one of the following antibiotics as confirmed by claims history or submitted medical records:

- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- A tetracycline
- Clindamycin

OR

3.3.2 History of intolerance or contraindication to all of the following (please specify intolerance or contraindication):

- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- A tetracycline
- Clindamycin

OR

4 - All of the following:

4.1 Diagnosis of acute bacterial skin and skin structure infections

AND

4.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Baxdela

AND

4.3 One of the following:

4.3.1 Failure to three of the following antibiotics as confirmed by claims history or submitted medical records:

- A penicillin
- A cephalosporin
- A tetracycline
- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- Clindamycin

OR

4.3.2 History of intolerance or contraindication to all of the following antibiotics (please specify intolerance or contraindication):

- A penicillin

- A cephalosporin
- A tetracycline
- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- Clindamycin

Product Name: Baxdela	
Diagnosis	Off-Label Uses
Approval Length	Based on provider and IDSA recommended treatment durations, up to 6 months.
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BAXDELA	DELAFLOXACIN MEGLUMINE TAB 450 MG (BASE EQUIV)	05000025100320	Brand

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

Belbuca_Butrans

Prior Authorization Guideline

Guideline ID	GL-146296
Guideline Name	Belbuca_Butrans
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	DUR: Opioid Naïve (Not having filled an opioid in the past 60 days) exceeding the 7 day supply limit*
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand

BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - Patient meets ONE of the following:

- Cancer diagnosis
- End of life care, including hospice care
- Palliative care
- Sickle cell anemia

OR

2 - Prescriber attests that the patient has received an opioid within the past 60 days

Notes	*Approval length for cancer, end of life, palliative care, or sickle cell pa in will be issued for 12 months. All other approvals will be issued for th e requested duration, not to exceed one month.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Cancer/Hospice/Sickle Cell Anemia/End of Life related pain
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria	
1 - The patient is being treated for cancer, hospice, sickle cell anemia, or end of life related pain **AND** **2** - If the request is for Belbuca or Brand Butrans, the prescriber provides a reason or special circumstance the patient cannot use generic buprenorphine patches	
Notes	If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization c riteria requirements for treatment with an opioid, a denial should be is sued and a maximum 60-day authorization may be authorized one tim e for the requested drug/strength combination up to the requested qua ntity for transition to an alternative treatment. If the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried generic bu prenorphine patches, a denial should be issued and a maximum 60-d ay authorization may be authorized one time for the requested drug/st rength combination up to the requested quantity for transition to an alt ernative treatment. Additionally, a 12-month authorization should be e ntered for generic buprenorphine patches.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia pain/Non-end of life care pain
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand

BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - Prescriber attests to BOTH of the following:

1.1 Patient has been screened for substance abuse/opioid dependence

AND

1.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

4.1 The patient has a history of failure to a trial of tramadol IR (immediate release) as confirmed by claims history or submission of medical records

OR

4.2 The patient has a contraindication or intolerance to tramadol IR (please specify contraindication or intolerance)

OR

4.3 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time

OR

4.4 Patient is new to plan and currently established on Belbuca or Butrans for at least the past 30 days

AND **5 -** If the request is for neuropathic pain (examples of neuropathic pain include neuralgias and neuropathies), BOTH of the following: **5.1** Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (document date of trial) (if contraindicated, document contraindication) **AND** **5.2** Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose (document drug and date of trial) (if contraindicated, document contraindication) **AND** **6 -** If the request is for Belbuca or Brand Butrans, the prescriber provides a reason or special circumstance the patient cannot use generic buprenorphine patches	
Notes	If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization c riteria requirements for treatment with an opioid, a denial should be is sued and a maximum 60-day authorization may be authorized one tim e for the requested drug/strength combination up to the requested qua ntity for transition to an alternative treatment. If the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried generic bu prenorphine patches, a denial should be issued and a maximum 60-d ay authorization may be authorized one time for the requested drug/st rength combination up to the requested quantity for transition to an alt ernative treatment. Additionally, a 6 month authorization should be ent ered for generic buprenorphine patches.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia pain/Non-end of life care pain
Approval Length	6 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)

AND **2 -** Documented rationale for not tapering and discontinuing opioid if treatment goals are not being met **AND** **3 -** Prescriber attests to BOTH of the following: **3.1** Patient has been screened for substance abuse/opioid dependence **AND** **3.2** Pain is moderate to severe and expected to persist for an extended period of time (chronic) **AND** **4 -** If the request is for Belbuca or Brand Butrans, the prescriber provides a reason or special circumstance the patient cannot use generic buprenorphine patches	
Notes	If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization c riteria requirements for treatment with an opioid, a denial should be is sued and a maximum 60-day authorization may be authorized one tim e for the requested drug/strength combination up to the requested qua ntity for transition to an alternative treatment. If the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried generic bu prenorphine patches, a denial should be issued and a maximum 60-d ay authorization may be authorized one time for the requested drug/st rength combination up to the requested quantity for transition to an alt ernative treatment. Additionally, a 6 month authorization should be ent ered for generic buprenorphine patches.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - The requested dose cannot be achieved by moving to a higher strength of the product

AND

2 - The requested dose is within the FDA (Food and Drug Administration) maximum dose per day, where an FDA maximum dose per day exists	
Notes	Approval durations: 12 months for cancer pain/hospice/sickle cell anemia related pain/end of life related pain. 6 months for non-cancer pain/non-hospice/non-sickle cell anemia related pain/non-end of life related pain.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Cancer/Hospice/End of Life Related Pain/Sickle Cell Anemia Related Pain
Approval Length	12 month(s)
Guideline Type	Morphine Milligram Equivalents (MME)

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand

BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - Patient has cancer pain, hospice pain, an end of life diagnosis, or sickle cell anemia related pain

Notes	The authorization should be entered for an MME of 9999 so as to prev ent future disruptions in therapy if the patient's dose is increased.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Non-cancer/Non-hospice/Non-End of Life Related Pain/Non-Sickle Cell Anemia Related Pain
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Morphine Milligram Equivalents (MME)

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic

BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - Prescriber attests that the patient has been screened for substance abuse/opioid dependence

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND
4 - ONE of the following:
4.1 Opioid medication doses of less than 90 MME (Morphine Milligram Equivalents) have been tried and did not adequately control pain (document drug regimen or MME and dates of therapy)
OR
4.2 Patient is new to plan and currently established on the requested MME for at least the past 30 days

Notes	Authorization will be issued for 6 months for non-cancer/non-hospice/non-sickle cell anemia related pain/non-end of life related pain up to the current requested MME plus 90 MME. If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested MME dose.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Non-cancer/Non-hospice/Non-End of Life Related Pain/Non-Sickle Cell Anemia Related Pain
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Morphine Milligram Equivalents (MME)

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand

BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - Prescriber attests that the patient has been screened for substance abuse/opioid dependence

AND

2 - Documented rationale for not tapering and discontinuing opioid if treatment goals are not being met

AND

3 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)

Notes	Authorization will be issued for 6 months for non-cancer/non-hospice/ non-sickle cell anemia related pain/non-end of life related pain up to th e current requested MME plus 90 MME If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization c riteria requirements, a denial should be issued and a maximum 60-da y authorization may be authorized one time for the requested MME do se.

Benefit Determination Mifeprex

Prior Authorization Guideline

Guideline ID	GL-146297
Guideline Name	Benefit Determination Mifeprex
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Mifeprex, generic mifepristone	
Approval Length	1 month(s)
Guideline Type	Benefit Determination

Product Name	Generic Name	GPI	Brand/Generic
MIFEPREX	MIFEPRISTONE TAB 200 MG	30502060000320	Brand
MIFEPRISTONE	MIFEPRISTONE TAB 200 MG	30502060000320	Generic

Approval Criteria

1 - Provider attests patient requires treatment for purposes identified in the Hyde amendment and any applicable state laws and regulations.

Benznidazole

Prior Authorization Guideline

Guideline ID	GL-146298
Guideline Name	Benznidazole
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Benznidazole	
Approval Length	60 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BENZNIDAZOLE	BENZNIDAZOLE TAB 12.5 MG	15000003000320	Brand
BENZNIDAZOLE	BENZNIDAZOLE TAB 100 MG	15000003000340	Brand

Approval Criteria

1 - Diagnosis of Chagas disease (American trypanosomiasis) due to Trypanosoma cruzi

Biktarvy

Prior Authorization Guideline

Guideline ID	GL-146806
Guideline Name	Biktarvy
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Biktarvy	
Diagnosis	Human Immunodeficiency Virus (HIV)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BIKTARVY	BICTEGRAVIR-EMTRICITABINE-TENOFOVIR AF TAB 30-120-15 MG	12109903240320	Brand
BIKTARVY	BICTEGRAVIR-EMTRICITABINE-TENOFOVIR AF TAB 50-200-25 MG	12109903240330	Brand

Approval Criteria

1 - Diagnosis of human immunodeficiency virus (HIV)

Product Name: Biktarvy	
Diagnosis	Post-Exposure Prophylaxis
Approval Length	4 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BIKTARVY	BICTEGRAVIR-EMTRICITABINE-TENOFOVIR AF TAB 30-120-15 MG	12109903240320	Brand
BIKTARVY	BICTEGRAVIR-EMTRICITABINE-TENOFOVIR AF TAB 50-200-25 MG	12109903240330	Brand

Approval Criteria

1 - Diagnosis of post-exposure prophylaxis

2 . Revision History

Date	Notes
4/30/2024	Removed "-New York" from guideline name

Biltricide

Prior Authorization Guideline

Guideline ID	GL-146300
Guideline Name	Biltricide
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Biltricide, generic praziquantel	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BILTRICIDE	PRAZIQUANTEL TAB 600 MG	15000050000305	Brand
PRAZIQUANTEL	PRAZIQUANTEL TAB 600 MG	15000050000305	Generic

Approval Criteria

1 - ONE of the following:

1.1 Infections due to schistosoma

OR

1.2 Infections due to the liver trematodes (flukes), Clonorchis sinensis/Opisthorchis viverrini (i.e., clonorchiasis or opisthorchiasis)

Bonjesta and Diclegis

Prior Authorization Guideline

Guideline ID	GL-146301
Guideline Name	Bonjesta and Diclegis
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic doxylamine/pyridoxine, Brand Diclegis, Bonjesta	
Approval Length	9 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DOXYLAMINE SUCCINATE/PYRIDOXINE HYDROCHLORIDE	DOXYLAMINE-PYRIDOXINE TAB DELAYED RELEASE 10-10 MG	50309902100620	Generic
DICLEGIS	DOXYLAMINE-PYRIDOXINE TAB DELAYED RELEASE 10-10 MG	50309902100620	Brand
BONJESTA	DOXYLAMINE-PYRIDOXINE TAB ER 20-20 MG	50309902100430	Brand

Approval Criteria

1 - Diagnosis of nausea and vomiting associated with pregnancy

AND

2 - Documented failure or contraindication to lifestyle modifications (e.g., diet, avoidance of triggers)

AND

3 - ONE of the following:

3.1 Failure to a five day trial of over-the-counter doxylamine taken together with pyridoxine (i.e., not a combined dosage form, but separate formulations taken concomitantly), as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to over-the-counter doxylamine taken together with pyridoxine (i.e., not a combined dosage form, but separate formulations taken concomitantly) (please specify contraindication or intolerance)

Brexafemme

Prior Authorization Guideline

Guideline ID	GL-146302
Guideline Name	Brexafemme
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brexafemme	
Diagnosis	Vulvovaginal candidiasis
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BREXAFEMME	IBREXAFUNGERP CITRATE TAB 150 MG	11507040100320	Brand

Approval Criteria

1 - Diagnosis of vulvovaginal candidiasis (VVC)

AND

2 - ONE of the following:

2.1 Confirmed azole resistance demonstrated by culture and susceptibility testing

OR

2.2 BOTH of the following:

2.2.1 Other causes (including but not limited to bacterial vaginosis or trichomoniasis) have been ruled out

AND

2.2.2 Failure of a 7-day course of oral fluconazole therapy defined as 100 mg (milligrams), 150 mg, or 200 mg taken orally every third day for a total of 3 doses (days 1,4, and 7), confirmed by claims history or submission of medical records, for the current episode of VVC

AND

3 - Prescribed by or in consultation with ONE of the following:

- Infectious disease physician
- Obstetrician/Gynecologist

Product Name: Brexafemme	
Diagnosis	Recurrent vulvovaginal candidiasis
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BREXAFEMME	IBREXAFUNGERP CITRATE TAB 150 MG	11507040100320	Brand

Approval Criteria

1 - Diagnosis of recurrent vulvovaginal candidiasis (RVVC)

AND

2 - ONE of the following:

2.1 Confirmed azole resistance demonstrated by culture and susceptibility testing

OR

2.2 BOTH of the following:

2.2.1 Other causes (including but not limited to bacterial vaginosis or trichomoniasis) have been ruled out

AND

2.2.2 Failure of a maintenance course of oral fluconazole confirmed by claims history or submission of medical records defined as 100-mg, 150-mg, or 200-mg taken weekly for 6 months

AND

3 - Prescribed by or in consultation with ONE of the following:

- Infectious disease physician
- Obstetrician/Gynecologist

Brilinta and Effient

Prior Authorization Guideline

Guideline ID	GL-146303
Guideline Name	Brilinta and Effient
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brilinta	
Diagnosis	Acute coronary syndrome (ACS)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRILINTA	TICAGRELOR TAB 60 MG	85158470000315	Brand
BRILINTA	TICAGRELOR TAB 90 MG	85158470000320	Brand

Approval Criteria

1 - Diagnosis of acute coronary syndrome (ACS) [e.g., unstable angina (UA), non-ST elevation myocardial infarction (NSTEMI) or ST-segment elevation myocardial infarction (STEMI)]

OR

2 - The medication is being used to reduce the risk of a first myocardial infarction (MI) or stroke in a patient with coronary artery disease (CAD) at high risk for such events [e.g., type 2 diabetes mellitus, hypertension, dyslipidemia, multi-vessel CAD, obesity, heart failure, current smoker or chronic kidney disease]

OR

3 - The medication is being used to reduce the risk of stroke in patients with acute ischemic stroke (NIH Stroke Scale score less than or equal to 5) or high-risk transient ischemic attack (TIA)

Product Name: Brand Effient, generic prasugrel	
Diagnosis	Acute coronary syndrome (ACS)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EFFIENT	PRASUGREL HCL TAB 5 MG (BASE EQUIV)	85158060100320	Brand
PRASUGREL	PRASUGREL HCL TAB 5 MG (BASE EQUIV)	85158060100320	Generic
EFFIENT	PRASUGREL HCL TAB 10 MG (BASE EQUIV)	85158060100330	Brand
PRASUGREL	PRASUGREL HCL TAB 10 MG (BASE EQUIV)	85158060100330	Generic

Approval Criteria

1 - Diagnosis of acute coronary syndrome (ACS) [e.g., unstable angina (UA), non-ST elevation myocardial infarction (NSTEMI) or ST-segment elevation myocardial infarction (STEMI)]

AND

2 - The patient must be managed with percutaneous coronary intervention (PCI)

Bronchitol

Prior Authorization Guideline

Guideline ID	GL-146304
Guideline Name	Bronchitol
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Bronchitol	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRONCHITOL TOLERANCE TEST	MANNITOL INHAL CAP 40 MG	45307060000140	Brand
BRONCHITOL	MANNITOL INHAL CAP 40 MG	45307060000140	Brand

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Used in conjunction with standard CF therapies [e.g., chest physiotherapy, bronchodilators, antibiotics, anti-inflammatory therapy (e.g., ibuprofen, oral/inhaled corticosteroids)]

AND

3 - Patient has passed the Bronchitol Tolerance Test

Product Name: Bronchitol	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRONCHITOL TOLERANCE TEST	MANNITOL INHAL CAP 40 MG	45307060000140	Brand
BRONCHITOL	MANNITOL INHAL CAP 40 MG	45307060000140	Brand

Approval Criteria

1 - Documentation of positive clinical response to Bronchitol therapy

Buprenorphine for Opioid Dependence

Prior Authorization Guideline

Guideline ID	GL-146305
Guideline Name	Buprenorphine for Opioid Dependence
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic buprenorphine/naloxone SL film, buprenorphine/naloxone SL tabs, buprenorphine SL tabs	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV)	65200010208220	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV)	65200010208240	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV)	65200010208230	Generic

BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV)	65200010208250	Generic
BUPRENORPHINE HCL/NALOXONE HCL	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV)	65200010200720	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV)	65200010200720	Generic
BUPRENORPHINE HCL/NALOXONE HCL	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV)	65200010200740	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV)	65200010200740	Generic
BUPRENORPHINE HYDROCHLORIDE	BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV)	65200010100760	Generic
BUPRENORPHINE HCL	BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV)	65200010100760	Generic
BUPRENORPHINE HYDROCHLORIDE	BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV)	65200010100780	Generic
BUPRENORPHINE HCL	BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV)	65200010100780	Generic

Approval Criteria

1 - The patient has a DSM-V-TR (diagnostic and statistical manual, fifth edition, text revision) diagnosis of opioid use disorder

Notes	*Up to 24 mg per day of buprenorphine, or equivalent dosing of an alt ernative medication, will be authorized.

Product Name: Brand Suboxone, Zubsolv, Bunavail	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV)	65200010208220	Brand
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV)	65200010208240	Brand

SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV)	65200010208230	Brand
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV)	65200010208250	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 0.7-0.18 MG (BASE EQ)	65200010200710	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 1.4-0.36 MG (BASE EQ)	65200010200715	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2.9-0.71 MG (BASE EQ)	65200010200725	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 5.7-1.4 MG (BASE EQ)	65200010200732	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8.6-2.1 MG (BASE EQ)	65200010200745	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 11.4-2.9 MG (BASE EQ)	65200010200760	Brand
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 4.2-0.7 MG (BASE EQUIV)	65200010208270	Brand
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 6.3-1 MG (BASE EQUIV)	65200010208280	Brand

Approval Criteria

1 - The patient has a DSM-V-TR (diagnostic and statistical manual, fifth edition, text revision) diagnosis of opioid use disorder

AND

2 - The patient must have a reason or special circumstance that they cannot use BOTH of the following (please specify reason or special circumstance):

- Buprenorphine/naloxone sublingual film (generic Suboxone sublingual film)
- Buprenorphine/naloxone sublingual tablet

Notes	*Up to 24 mg per day of buprenorphine, or equivalent dosing of an alt ernative medication, will be authorized.

Product Name: Brand Suboxone, Zubsolv, Bunavail	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV)	65200010208220	Brand
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV)	65200010208240	Brand
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV)	65200010208230	Brand
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV)	65200010208250	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 0.7-0.18 MG (BASE EQ)	65200010200710	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 1.4-0.36 MG (BASE EQ)	65200010200715	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2.9-0.71 MG (BASE EQ)	65200010200725	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 5.7-1.4 MG (BASE EQ)	65200010200732	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8.6-2.1 MG (BASE EQ)	65200010200745	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 11.4-2.9 MG (BASE EQ)	65200010200760	Brand
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 4.2-0.7 MG (BASE EQUIV)	65200010208270	Brand
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 6.3-1 MG (BASE EQUIV)	65200010208280	Brand

Approval Criteria

1 - The patient has been prescribed a buprenorphine product for the purpose of opioid use disorder maintenance therapy

AND

2 - The patient must have a reason or special circumstance that they cannot use BOTH of the following (please specify reason or special circumstance):

- Buprenorphine/naloxone sublingual film (generic Suboxone sublingual film)
- Buprenorphine/naloxone sublingual tablet

Notes	*Up to 24 mg per day of buprenorphine, or equivalent dosing of an alt ernative medication, will be authorized.

Product Name: generic buprenorphine/naloxone SL film, Brand Suboxone, buprenorphine/naloxone SL tabs, Zubsolv, buprenorphine SL tabs, Bunavail	
Diagnosis	Exceeding 24 mg of buprenorphine or Equivalent
Approval Length	Authorization length will be issued for requested duration of therapy, not to exceed 12 months
Guideline Type	Drug Utilization Review

Product Name	Generic Name	GPI	Brand/Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV)	65200010208220	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV)	65200010208220	Brand
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV)	65200010208240	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV)	65200010208240	Brand
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV)	65200010208230	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV)	65200010208230	Brand
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV)	65200010208250	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV)	65200010208250	Brand
BUPRENORPHINE HCL/NALOXONE HCL	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV)	65200010200720	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV)	65200010200720	Generic
BUPRENORPHINE HCL/NALOXONE HCL	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV)	65200010200740	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV)	65200010200740	Generic

ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 0.7-0.18 MG (BASE EQ)	65200010200710	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 1.4-0.36 MG (BASE EQ)	65200010200715	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2.9-0.71 MG (BASE EQ)	65200010200725	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 5.7-1.4 MG (BASE EQ)	65200010200732	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8.6-2.1 MG (BASE EQ)	65200010200745	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 11.4-2.9 MG (BASE EQ)	65200010200760	Brand
BUPRENORPHINE HYDROCHLORIDE	BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV)	65200010100760	Generic
BUPRENORPHINE HCL	BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV)	65200010100760	Generic
BUPRENORPHINE HYDROCHLORIDE	BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV)	65200010100780	Generic
BUPRENORPHINE HCL	BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV)	65200010100780	Generic
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 4.2-0.7 MG (BASE EQUIV)	65200010208270	Brand
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 6.3-1 MG (BASE EQUIV)	65200010208280	Brand

Approval Criteria

1 - Physician has provided rationale for needing to exceed the 24 mg (milligrams) buprenorphine daily limit

Product Name: generic buprenorphine/naloxone SL film, Brand Suboxone, buprenorphine/naloxone SL tabs, Zubsolv, buprenorphine SL tabs, Bunavail	
Approval Length	Authorization length will be issued for requested duration of therapy, not to exceed 12 months
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV)	65200010208220	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV)	65200010208220	Brand
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV)	65200010208240	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV)	65200010208240	Brand
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV)	65200010208230	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV)	65200010208230	Brand
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV)	65200010208250	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV)	65200010208250	Brand
BUPRENORPHINE HCL/NALOXONE HCL	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV)	65200010200720	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV)	65200010200720	Generic
BUPRENORPHINE HCL/NALOXONE HCL	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV)	65200010200740	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV)	65200010200740	Generic
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 0.7-0.18 MG (BASE EQ)	65200010200710	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 1.4-0.36 MG (BASE EQ)	65200010200715	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2.9-0.71 MG (BASE EQ)	65200010200725	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 5.7-1.4 MG (BASE EQ)	65200010200732	Brand

ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8.6-2.1 MG (BASE EQ)	65200010200745	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 11.4-2.9 MG (BASE EQ)	65200010200760	Brand
BUPRENORPHINE HYDROCHLORIDE	BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV)	65200010100760	Generic
BUPRENORPHINE HCL	BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV)	65200010100760	Generic
BUPRENORPHINE HYDROCHLORIDE	BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV)	65200010100780	Generic
BUPRENORPHINE HCL	BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV)	65200010100780	Generic
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 4.2-0.7 MG (BASE EQUIV)	65200010208270	Brand
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 6.3-1 MG (BASE EQUIV)	65200010208280	Brand

Approval Criteria

1 - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation

OR

2 - Physician has provided rationale for requiring the specific quantity requested

CGRP

Prior Authorization Guideline

Guideline ID	GL-147271
Guideline Name	CGRP
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Ajovy, Emgality 120mg	
Diagnosis	Migraines
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AJOVY	FREMANEZUMAB-VFRM SUBCUTANEOUS SOLN AUTO-INJ 225 MG/1.5ML	6770203020D520	Brand
AJOVY	FREMANEZUMAB-VFRM SUBCUTANEOUS SOLN PREF SYR 225 MG/1.5ML	6770203020E520	Brand
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN AUTO-INJECTOR 120 MG/ML	6770203530D520	Brand

EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 120 MG/ML	6770203530E520	Brand

Approval Criteria

1 - Diagnosis of migraine consistent with The International Classification of Headache Disorders, 3rd edition

AND

2 - ONE of the following:

2.1 4 to 7 migraine days per month and at least ONE of the following:

- Less than 15 headache days per month
- Provider attests this is the patient's predominant headache diagnosis (i.e., primary driver of headaches is not a different, non-migrainous condition)

OR

2.2 Greater than or equal to 8 migraine days per month

AND

3 - ONE of the following:

3.1 Failure (after a trial of at least two months), to TWO of the following prophylactic therapies or classes as confirmed by claims history or submission of medical records:

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan (generic Atacand)*
- Divalproex sodium [generic Depakote/Depakote ER (extended-release)]
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine [generic Effexor/Effexor XR (extended-release)]

OR

3.2 History of intolerance or contraindication to ALL of the following prophylactic therapies or classes (please specify intolerance or contraindication):

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan (generic Atacand)*
- Divalproex sodium [generic Depakote/Depakote ER (extended-release)]
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine [generic Effexor/Effexor XR (extended-release)]

AND

4 - Medication will NOT be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines [e.g., Aimovig, Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti (eptinezumab-jjmr)]

Notes	*Timolol and candesartan are non-preferred and should not be include d in denial to provider. **OnabotulinumtoxinA (generic Botox) might not be covered on your p harmacy prescription drug benefit. Coverage might be available on yo ur medical benefit.

Product Name: Aimovig	
Diagnosis	Migraines
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AIMOVIG	ERENUMAB-AOOE SUBCUTANEOUS SOLN AUTO-INJECTOR 70 MG/ML	6770202010D520	Brand
AIMOVIG	ERENUMAB-AOOE SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	6770202010D540	Brand

Approval Criteria

1 - Diagnosis of migraine consistent with The International Classification of Headache Disorders, 3rd edition

AND

2 - ONE of the following:

2.1 4 to 7 migraine days per month and at least ONE of the following:

- Less than 15 headache days per month
- Provider attests this is the patient's predominant headache diagnosis (i.e., primary driver of headaches is not a different, non-migrainous condition)

OR

2.2 Greater than or equal to 8 migraine days per month

AND

3 - ONE of the following:

3.1 Failure (after a trial of at least two months), to TWO of the following prophylactic therapies or classes as confirmed by claims history or submission of medical records:

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan (generic Atacand)*
- Divalproex sodium [generic Depakote/Depakote ER (extended-release)]
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine [generic Effexor/Effexor XR (extended-release)]

OR

3.2 History of intolerance or contraindication to ALL of the following prophylactic therapies or classes (please specify intolerance or contraindication):

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan (generic Atacand)*
- Divalproex sodium [generic Depakote/Depakote ER (extended-release)]
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)

- Venlafaxine [generic Effexor/Effexor XR (extended-release)]

AND

4 - ONE of the following:

4.1 Failure (after a trial of at least three months), to BOTH of the following as documented by claims history or submission of medical records:

- Ajovy
- Emgality [120 mg (milligram) strength]

OR

4.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Ajovy
- Emgality (120 mg strength)

AND

5 - Medication will not be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines [e.g., Ajovy, Emgality, Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti]

Notes	*Timolol and candesartan are non-preferred and should not be include d in denial to provider. **OnabotulinumtoxinA (generic Botox) might not be covered on your p harmacy prescription drug benefit. Coverage might be available on yo ur medical benefit.

Product Name: Aimovig, Ajovy, Emgality 120mg	
Diagnosis	Migraines
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

AIMOVIG	ERENUMAB-AOOE SUBCUTANEOUS SOLN AUTO-INJECTOR 70 MG/ML	6770202010D520	Brand
AIMOVIG	ERENUMAB-AOOE SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	6770202010D540	Brand
AJOVY	FREMANEZUMAB-VFRM SUBCUTANEOUS SOLN AUTO-INJ 225 MG/1.5ML	6770203020D520	Brand
AJOVY	FREMANEZUMAB-VFRM SUBCUTANEOUS SOLN PREF SYR 225 MG/1.5ML	6770203020E520	Brand
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN AUTO-INJECTOR 120 MG/ML	6770203530D520	Brand
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 120 MG/ML	6770203530E520	Brand

Approval Criteria

1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

AND

2 - Medication will NOT be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines [e.g., Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti]

Product Name: Emgality 100mg	
Diagnosis	Episodic Cluster Headache
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 100 MG/ML	6770203530E515	Brand

Approval Criteria

1 - Diagnosis of episodic cluster headache

AND

2 - Patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months

AND

3 - Medication will NOT be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines [e.g., Aimovig, Ajovy, Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti]

Product Name: Emgality 100mg	
Diagnosis	Episodic Cluster Headache
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 100 MG/ML	6770203530E515	Brand

Approval Criteria

1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

AND

2 - Medication will NOT be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines [e.g., Aimovig, Ajovy, Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti]

2 . Revision History

Date	Notes
5/13/2024	Updated note regarding medical coverage of generic Botox. Added e pisodic to header of cluster headaches section.

Cialis for BPH

Prior Authorization Guideline

Guideline ID	GL-146307
Guideline Name	Cialis for BPH
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Cialis 5 mg, generic tadalafil 5 mg	
Diagnosis	benign prostatic hyperplasia (BPH)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIALIS	TADALAFIL TAB 5 MG	40304080000305	Brand
TADALAFIL	TADALAFIL TAB 5 MG	40304080000305	Generic

Approval Criteria

1 - The patient has a diagnosis of benign prostatic hyperplasia (BPH)

AND

2 - ONE of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Alpha Blockers: (e.g., tamsulosin, afluzosin ER, doxazosin, or terazosin)
- 5-alpha reductase inhibitors (e.g., finasteride)

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Alpha Blockers: (e.g., tamsulosin, afluzosin ER, doxazosin, or terazosin)
- 5-alpha reductase inhibitors (e.g., finasteride)

AND

3 - Dose does not exceed 5 mg (milligrams) once daily

Ciprodex

Prior Authorization Guideline

Guideline ID	GL-146308
Guideline Name	Ciprodex
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Ciprodex, generic ciprofloxacin/dexamethasone	
Approval Length	1 Month
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIPRODEX	CIPROFLOXACIN-DEXAMETHASONE OTIC SUSP 0.3-0.1%	87991002361820	Brand
CIPROFLOXACIN/DEXAMETHASONE	CIPROFLOXACIN-DEXAMETHASONE OTIC SUSP 0.3-0.1%	87991002361820	Generic

Approval Criteria

1 - ONE of the following:

1.1 The patient has a perforated tympanic membrane or tympanostomy tubes

OR

1.2 The patient has had an inadequate response, intolerance or contraindication to ONE preferred alternative confirmed by claims history or submission of medical records (please specify intolerance or contraindication if applicable).

Prior Authorization Guideline

Guideline ID	GL-147277
Guideline Name	Combination Basal Insulin/GLP-1 Receptor Agonist
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Soliqua	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
SOLIQUA 100/33	INSULIN GLARGINE-LIXISENATIDE SOL PEN-INJ 100-33 UNIT-MCG/ML	2799100235D220	Brand

Approval Criteria

1 - Inadequately controlled on ONE of the following as confirmed by claims history or submission of medical records:

- GLP-1 (glucagon-like peptide-1) receptor agonist [e.g. Trulicity (dulaglutide), Victoza (liraglutide), Bydureon BCise (exenatide extended-release), Byetta (exenatide), Ozempic (semaglutide), Rybelsus (semaglutide)]
- Basal insulin (e.g. insulin glargine, insulin degludec, insulin detemir)

Product Name: Xultophy	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XULTOPHY 100/3.6	INSULIN DEGLUDEC-LIRAGLUTIDE SOL PEN-INJ 100-3.6 UNIT-MG/ML	2799100225D220	Brand

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus

AND

2 - Inadequately controlled on ONE of the following as confirmed by claims history or submission of medical records:

- GLP-1 (glucagon-like peptide-1) receptor agonist [e.g. Victoza (liraglutide injection), Ozempic (semaglutide), Rybelsus (semaglutide)]
- Basal insulin (e.g. insulin glargine, insulin degludec, insulin detemir)

AND

3 - One of the following:

3.1 Failure to Soliqua as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to Soliqua (please specify contraindication or intolerance)

Product Name: Xultophy	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XULTOPHY 100/3.6	INSULIN DEGLUDEC-LIRAGLUTIDE SOL PEN-INJ 100-3.6 UNIT-MG/ML	2799100225D220	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xultophy therapy

2 . Revision History

Date	Notes
5/13/2024	New; copy core

Complera

Prior Authorization Guideline

Guideline ID	GL-146310
Guideline Name	Complera
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Complera	
Diagnosis	HIV
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COMPLERA	EMTRICITABINE-RILPIVIRINE-TENOFOVIR DF TAB 200-25-300 MG	12109903400320	Brand

Approval Criteria

1 - Diagnosis of human immunodeficiency virus (HIV)

AND

2 - ONE of the following:

2.1 Patient is NOT an appropriate candidate for ALL of the following (please specify why patient is not a candidate):

- efavirenz/lamivudine/tenofovir disoproxil (generic Symfi or generic Symfi Lo)
- efavirenz/emtricitabine/tenofovir disoproxil (generic Atripla)
- Triumeq (abacavir/dolutegravir/lamivudine)
- Juluca (dolutegravir/rilpivirine)
- Dovato (dolutegravir/lamivudine)

OR

2.2 Patient is currently on Complera therapy

Product Name: Complera	
Diagnosis	Post-Exposure Prophylaxis
Approval Length	4 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COMPLERA	EMTRICITABINE-RILPIVIRINE-TENOFOVIR DF TAB 200-25-300 MG	12109903400320	Brand

Approval Criteria

1 - Diagnosis of post-exposure prophylaxis

Compounds and Bulk Powders

Prior Authorization Guideline

Guideline ID	GL-146311
Guideline Name	Compounds and Bulk Powders
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Compounds or Bulk Powders	
Approval Length	12 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
Bulk Powders			
Compound Preparation			

Approval Criteria

1 - The requested drug component is a covered medication

AND

2 - ONE of the following:

2.1 The requested drug component is to be administered for an FDA (Food and Drug Administration)-approved indication

OR

2.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

3 - If a drug included in the compound requires prior authorization and/or step therapy, all drug specific clinical criteria must also be met

AND

4 - If the drug component is no longer available commercially, it must not have been withdrawn for safety reasons

AND

5 - ONE of the following:

5.1 A unique vehicle is required

OR

5.2 A unique dosage form is required for a commercially available product due to patient's age, weight, or inability to take a solid dosage form

OR

5.3 A unique formulation is required for a commercially available product due to an allergy or intolerance to an inactive ingredient in the commercially available product

OR

5.4 There is a shortage of the commercially available product per the FDA Drug Shortage database or the ASHP (American Society of Health-System Pharmacists) Current Drug Shortages tracking log

AND

6 - Coverage for compounds and bulk powders will NOT be approved for any of the following:

6.1 For topical compound preparations (e.g., creams, ointments, lotions, or gels to be applied to the skin for transdermal, transcutaneous, or any other topical route), if the requested compound contains any FDA approved ingredient that is not FDA approved for TOPICAL use (see Table 1 in Background section)

OR

6.2 If the requested compound contains topical fluticasone, topical fluticasone will NOT be approved unless both of the following are met:

6.2.1 Topical fluticasone is intended to treat a dermatologic condition (scar treatments are considered cosmetic and will not be covered)

AND

6.2.2 Patient has a contraindication to all commercially available topical fluticasone formulations

OR

6.3 Requested compound contains any ingredients when used for cosmetic purposes (see Table 2 in Background section)

OR

6.4 Requested compound contains any ingredient(s) which are on the FDA's Do Not Compound List (see Table 3 in Background section)

2 . Background

Benefit/Coverage/Program Information
Table 1: Example topical compound preparations that contain any FDA approved ingredient that are not FDA approved for TOPICAL use, including but NOT LIMITED TO the following: (1) Ketamine (2) Gabapentin (3) Flurbiprofen (topical ophthalmic use not included) (4) Ketoprofen (5) Morphine (6) Nabumetone (7) Oxycodone (8) Cyclobenzaprine (9) Baclofen

(10) Tramadol

(11) Hydrocodone

(12) Meloxicam

(13) Amitriptyline

(14) Pentoxifylline

(15) Orphenadrine

(16) Piroxicam

(17) Levocetirizine

(18) Amantadine

(19) Oxytocin

(20) Sumatriptan

(21) Chorionic gonadotropin (human)

(22) Clomipramine

(23) Dexamethasone

(24) Hydromorphone

(25) Methadone

(26) Papaverine

(27) Mefenamic acid

(28) Promethazine

(29) Succimer DMSA

(30) Tizanidine

(31) Apomorphine

(32) Carbamazepine

(33) Ketorolac

(34) Dimercaptopropane-sulfonate

(35) Dimercaptosuccinic acid

(36) Duloxetine

(37) Fluoxetine

(38) Bromfenac (topical ophthalmic use not included)

(39) Nepafenac (topical ophthalmic use not included)

Table 2: Example compounds that contain ingredients for cosmetic purposes:

(1) Hydroquinone

(2) Acetyl hexapeptide-8

(3) Tocopheryl Acid Succinate

(4) PracaSil TM-Plus

(5) Chrysaderm Day Cream

(6) Chrysaderm Night Cream

(7) PCCA Spira-Wash

(8) Lipopen Ultra

(9) Versapro

(10) Fluticasone

(11) Mometasone

(12) Halobetasol

(13) Betamethasone

(14) Clobetasol

(15) Triamcinolone

(16) Minoxidil

(17) Tretinoin

(18) Dexamethasone

(19) Spironolactone

(20) Cycloserine

(21) Tamoxifen

(22) Sermorelin

(23) Mederma Cream

(24) PCCA Cosmetic HRT Base

(25) Sanare Scar Therapy Cream

(26) Scarcin Cream

(27) Apothederm

(28) Stera Cream

(29) Copasil

(30) Collagenase

(31) Arbutin Alpha

(32) Nourisil

(33) Freedom Cepapro

(34) Freedom Silomac Andydrous

(35) Retinaldehyde

(36) Apothederm

Table 3: Example ingredients on the FDA's Do Not Compound List:

(1) 3,3′,4′,5-tetrachlorosalicylanilide

(2) Adenosine phosphate

(3) Adrenal cortex

(4) Alatrofloxacin mesylate

(5) Aminopyrine

(6) Astemizole

(7) Azaribine

(8) Benoxaprofen

(9) Bithionol

(10) Camphorated oil

(11) Carbetapentane citrate

(12) Casein, iodinated

(13) Cerivastatin sodium

(14) Chlormadinone acetate

(15) Chloroform

(16) Cisapride

(17) Defenfluramine hydrochloride

(18) Diamthazole dihydrochloride

(19) Dibromsalan

(20) Dihydrostreptomycin sulfate

(21) Dipyrone

(22) Encainide hydrochloride

(23) Etretinate

(24) Fenfluramine hydrochloride

(25) Flosequinan

(26) Glycerol, iodinated

(27) Grepafloxacin

(28) Mepazine

(29) Metabromsalan

(30) Methapyrilene

(31) Methopholine

(32) Methoxyflurane

(33) Mibefradil dihydrochloride

(34) Nomifensine maleate

(35) Novobiocin sodium

(36) Oxyphenisatin acetate

(37) Oxyphenisatin

(38) Pemoline

(39) Pergolide mesylate

(40) Phenacetin

(41) Phenformin hydrochloride

(42) Phenylpropanolamine

(43) Pipamazine

(44) Potassium arsenite

(45) Propoxyphene

(46) Rapacuronium bromide

(47) Rofecoxib

(48) Sibutramine hydrochloride

(49) Sparteine sulfate

(50) Sulfadimethoxine

(51) Sweet spirits of nitre

(52) Tegaserod maleate

(53) Temafloxacin hydrochloride

(54) Terfenadine

(55) Ticrynafen

(56) Tribromsalan

(57) Trichloroethane

(58) Troglitazone

(59) Trovafloxacin mesylate:

(60) Urethane

(61) Valdecoxib

(62) Zomepirac sodium

Constipation Agents

Prior Authorization Guideline

Guideline ID	GL-146312
Guideline Name	Constipation Agents
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic lubiprostone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUBIPROSTONE	LUBIPROSTONE CAP 8 MCG	52450045000110	Generic
LUBIPROSTONE	LUBIPROSTONE CAP 24 MCG	52450045000120	Generic

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Diagnosis of opioid-induced constipation in an adult with chronic, non-cancer pain

OR

1.1.2 Diagnosis of opioid-induced constipation in a patient with chronic pain related to prior cancer diagnosis or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation

AND

1.2 ONE of the following:

1.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

OR

2 - BOTH of the following:

2.1 Diagnosis of chronic idiopathic constipation

AND

2.2 ONE of the following:

2.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

OR

3 - ALL of the following:

3.1 Diagnosis of irritable bowel syndrome with constipation

AND

3.2 Patient was female at birth

AND

3.3 ONE of the following:

3.3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

3.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

Product Name: Brand Amitiza	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AMITIZA	LUBIPROSTONE CAP 8 MCG	52450045000110	Brand
AMITIZA	LUBIPROSTONE CAP 24 MCG	52450045000120	Brand

Approval Criteria

1 - ALL of the following:

1.1 ONE of the following:

1.1.1 Diagnosis of opioid-induced constipation in an adult with chronic, non-cancer pain

OR

1.1.2 Diagnosis of opioid-induced constipation in a patient with chronic pain related to prior cancer diagnosis or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation

AND

1.2 ONE of the following:

1.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

1.3 ONE of the following:

1.3.1 Failure to Movantik as confirmed by claims history or submission of medical records

OR

1.3.2 History of intolerance or contraindication to Movantik (please specify intolerance or contraindication)

AND

1.4 ONE of the following:

1.4.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

1.4.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

OR

2 - ALL of the following:

2.1 Diagnosis of chronic idiopathic constipation

AND

2.2 ONE of the following:

2.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

2.3 ONE of the following:

2.3.1 Failure to Motegrity as confirmed by claims history or submission of medical records

OR

2.3.2 History of intolerance or contraindication to Motegrity (please specify intolerance or contraindication)

AND

2.4 ONE of the following:

2.4.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

2.4.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

OR

3 - ALL of the following:

3.1 Diagnosis of irritable bowel syndrome with constipation

AND

3.2 Patient was female at birth

AND

3.3 ONE of the following:

3.3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

3.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

3.4 ONE of the following:

3.4.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

3.4.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

Product Name: Linzess	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LINZESS	LINACLOTIDE CAP 72 MCG	52557050000110	Brand
LINZESS	LINACLOTIDE CAP 145 MCG	52557050000120	Brand
LINZESS	LINACLOTIDE CAP 290 MCG	52557050000140	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of chronic idiopathic constipation

AND

1.2 ONE of the following:

1.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

1.3 ONE of the following:

1.3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

1.3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

AND

1.4 ONE of the following:

1.4.1 Failure to Motegrity as confirmed by claims history or submission of medical records

OR

1.4.2 History of intolerance or contraindication to Motegrity (please specify intolerance or contraindication)

OR

2 - ALL of the following:

2.1 Diagnosis of irritable bowel syndrome with constipation

AND

2.2 ONE of the following:

2.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

2.3 ONE of the following:

2.3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

2.3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

OR

3 - BOTH of the following:

3.1 Diagnosis of functional constipation

AND

3.2 ONE of the following:

3.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

3.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

Product Name: Trulance	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRULANCE	PLECANATIDE TAB 3 MG	52543060000320	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of chronic idiopathic constipation

AND

1.2 ONE of the following:

1.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

1.3 ONE of the following:

1.3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

1.3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

AND

1.4 ONE of the following:

1.4.1 Failure to Motegrity as confirmed by claims history or submission of medical records

OR

1.4.2 History of intolerance or contraindication to Motegrity (please specify intolerance or contraindication)

OR

2 - ALL of the following:

2.1 Diagnosis of irritable bowel syndrome with constipation

AND

2.2 ONE of the following:

2.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

2.3 ONE of the following:

2.3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

2.3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

Product Name: Motegrity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MOTEGRITY	PRUCALOPRIDE SUCCINATE TAB 1 MG (BASE EQUIVALENT)	52560060200320	Brand
MOTEGRITY	PRUCALOPRIDE SUCCINATE TAB 2 MG (BASE EQUIVALENT)	52560060200330	Brand

Approval Criteria

1 - Diagnosis of chronic idiopathic constipation

AND

2 - ONE of the following:

2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

3 - ONE of the following:

3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

Product Name: Movantik	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MOVANTIK	NALOXEGOL OXALATE TAB 12.5 MG (BASE EQUIVALENT)	52580060300320	Brand
MOVANTIK	NALOXEGOL OXALATE TAB 25 MG (BASE EQUIVALENT)	52580060300330	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of opioid-induced constipation in a patient being treated for chronic, non-cancer pain

OR

1.2 Diagnosis of opioid-induced constipation in a patient with chronic pain related to prior cancer diagnosis or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation

AND

2 - ONE of the following:

2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

3 - ONE of the following:

3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

Product Name: Symproic	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYMPROIC	NALDEMEDINE TOSYLATE TAB 0.2 MG (BASE EQUIVALENT)	52580057200320	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of opioid-induced constipation in a patient being treated for chronic, non-cancer pain

OR

1.2 Diagnosis of opioid-induced constipation in a patient with chronic pain related to prior cancer diagnosis or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation

AND

2 - ONE of the following:

2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

3 - ONE of the following:

3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

AND

4 - ONE of the following:

4.1 Failure to Movantik as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to Movantik (please specify intolerance or contraindication)

Product Name: Zelnorm	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZELNORM	TEGASEROD MALEATE TAB 6 MG (BASE EQUIVALENT)	52555060200320	Brand

Approval Criteria

1 - Diagnosis of irritable bowel syndrome with constipation

AND

2 - Patient was female at birth

AND

3 - ONE of the following:

3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

4 - ONE of the following:

4.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

Product Name: Ibsrela	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IBSRELA	TENAPANOR HCL TAB 50 MG	52558580100320	Brand

Approval Criteria

1 - Diagnosis of irritable bowel syndrome with constipation

AND

2 - ONE of the following:

2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

3 - ONE of the following:

3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

Product Name: Brand Amitiza, generic lubiprostone, Ibsrela, Linzess, Motegrity, Movantik, Symproic, Trulance, Zelnorm	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AMITIZA	LUBIPROSTONE CAP 8 MCG	52450045000110	Brand
LUBIPROSTONE	LUBIPROSTONE CAP 8 MCG	52450045000110	Generic
AMITIZA	LUBIPROSTONE CAP 24 MCG	52450045000120	Brand
LUBIPROSTONE	LUBIPROSTONE CAP 24 MCG	52450045000120	Generic
IBSRELA	TENAPANOR HCL TAB 50 MG	52558580100320	Brand
LINZESS	LINACLOTIDE CAP 72 MCG	52557050000110	Brand
LINZESS	LINACLOTIDE CAP 145 MCG	52557050000120	Brand
LINZESS	LINACLOTIDE CAP 290 MCG	52557050000140	Brand
MOTEGRITY	PRUCALOPRIDE SUCCINATE TAB 1 MG (BASE EQUIVALENT)	52560060200320	Brand
MOTEGRITY	PRUCALOPRIDE SUCCINATE TAB 2 MG (BASE EQUIVALENT)	52560060200330	Brand
MOVANTIK	NALOXEGOL OXALATE TAB 12.5 MG (BASE EQUIVALENT)	52580060300320	Brand
MOVANTIK	NALOXEGOL OXALATE TAB 25 MG (BASE EQUIVALENT)	52580060300330	Brand
SYMPROIC	NALDEMEDINE TOSYLATE TAB 0.2 MG (BASE EQUIVALENT)	52580057200320	Brand
TRULANCE	PLECANATIDE TAB 3 MG	52543060000320	Brand
ZELNORM	TEGASEROD MALEATE TAB 6 MG (BASE EQUIVALENT)	52555060200320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Continuous Glucose Monitors

Prior Authorization Guideline

Guideline ID	GL-146313
Guideline Name	Continuous Glucose Monitors
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Dexcom G6 receiver/sensor/transmitter, Dexcom G7 receiver/sensor, Freestyle Libre reader, Freestyle Libre 14 reader/sensor, Freestyle Libre 2 reader/sensor, Freestyle Libre 3 reader/sensor, Guardian receiver/sensor/transmitter, Enlite sensor, Eversense sensor/transmitter, Minilink transmitter, Minimed 630G Guardian transmitter, Paradigm transmitter	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEXCOM G6 RECEIVER	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
DEXCOM G7 RECEIVER	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand

FREESTYLE LIBRE 14 DAY/READER/FLASH MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
FREESTYLE LIBRE 2/READER/FLASH GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
FREESTYLE LIBRE/READER/FLASH MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
GUARDIAN REAL-TIME REPLACEMENT MONITOR PEDIATRIC	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
DEXCOM G6 SENSOR	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
DEXCOM G7 SENSOR	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
ENLITE GLUCOSE SENSOR	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
EVERSENSE SENSOR/HOLDER	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 14 DAY/SENSOR/FLASH MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 2/SENSOR/FLASH GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 3/SENSOR/GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN SENSOR (3)	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN SENSOR 3	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
DEXCOM G6 TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE SMART TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN CONNECT TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN CONNECT TRANSMITTER KIT	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand

GUARDIAN LINK 3 TRANSMITTER KIT	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
MINILINK REAL-TIME TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
MINIMED 630G GUARDIAN PRESS STARTER TRANSMITTER KIT	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
PARADIGM REAL-TIME TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE E3 SENSOR/HOLDER	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN 4 GLUCOSE SENSOR	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
EVERSENSE E3 SMART TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN 4 TRANSMITTER KIT	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
FREESTYLE LIBRE 3/READER/GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand

Approval Criteria

1 - Diagnosis of diabetes

AND

2 - Patient is on an intensive insulin regimen (3 or more insulin injections per day or uses continuous subcutaneous insulin infusion pump)

AND

3 - Patient regularly monitors blood glucose 4 or more times per day

AND

4 - If the request is for a Guardian Connect Continuous Glucose monitor, Guardian 4

Continuous Glucose monitor, or Freestyle Libre 3 Monitoring system and supplies, ONE of the following:

4.1 BOTH of the following:

4.1.1 Patient has a physical or mental limitation that makes utilization of Dexcom G6 and Dexcom G7 unsafe, inaccurate, or otherwise not feasible (e.g., manual dexterity; document limitation)

AND

4.1.2 Patient has a physical or mental limitation that makes utilization of the preferred Freestyle Libre product unsafe, inaccurate, or otherwise not feasible (e.g., manual dexterity; document limitation)

OR

4.2 Provider submits documentation why the patient requires use of the Guardian Connect Continuous Glucose monitor, Guardian 4 Continuous Glucose monitor, or Freestyle Libre 3 monitoring system for treatment of diabetes

Product Name: Dexcom G6 receiver/sensor/transmitter, Dexcom G7 receiver/sensor, Freestyle Libre reader, Freestyle Libre 14 reader/sensor, Freestyle Libre 2 reader/sensor, Freestyle Libre 3 reader/sensor, Guardian receiver/sensor/transmitter, Enlite sensor, Eversense sensor/transmitter, Minilink transmitter, Minimed 630G Guardian transmitter, Paradigm transmitter	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEXCOM G6 RECEIVER	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
DEXCOM G7 RECEIVER	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
FREESTYLE LIBRE 14 DAY/READER/FLASH MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
FREESTYLE LIBRE 2/READER/FLASH GLUCOSE	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand

MONITORING SYSTEM			
FREESTYLE LIBRE/READER/FLASH MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
GUARDIAN REAL-TIME REPLACEMENT MONITOR PEDIATRIC	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
DEXCOM G6 SENSOR	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
DEXCOM G7 SENSOR	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
ENLITE GLUCOSE SENSOR	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
EVERSENSE SENSOR/HOLDER	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 14 DAY/SENSOR/FLASH MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 2/SENSOR/FLASH GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 3/SENSOR/GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN SENSOR (3)	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN SENSOR 3	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
DEXCOM G6 TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE SMART TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN CONNECT TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN CONNECT TRANSMITTER KIT	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN LINK 3 TRANSMITTER KIT	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
MINILINK REAL-TIME TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
MINIMED 630G GUARDIAN PRESS	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand

STARTER TRANSMITTER KIT			
PARADIGM REAL-TIME TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE E3 SENSOR/HOLDER	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN 4 GLUCOSE SENSOR	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
EVERSENSE E3 SMART TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN 4 TRANSMITTER KIT	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
FREESTYLE LIBRE 3/READER/GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand

Approval Criteria

1 - Documentation of positive clinical response

Corlanor

Prior Authorization Guideline

Guideline ID	GL-146314
Guideline Name	Corlanor
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Corlanor	
Diagnosis	Symptomatic Chronic Heart Failure
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CORLANOR	IVABRADINE HCL TAB 5 MG (BASE EQUIV)	40700035100320	Brand
CORLANOR	IVABRADINE HCL TAB 7.5 MG (BASE EQUIV)	40700035100330	Brand
CORLANOR	IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV)	40700035102020	Brand

Approval Criteria

1 - ALL of the following:

1.1 Worsening heart failure in a diagnosis of stable, symptomatic, chronic [e.g., New York Heart Association (NYHA) class II, III, or IV] heart failure

AND

1.2 Patient has a left ventricular ejection fraction (EF) less than or equal to 35%

AND

1.3 The patient is in sinus rhythm

AND

1.4 Patient has a resting heart rate greater than or equal to 70 beats per minute

AND

1.5 ONE of the following:

1.5.1 Patient is on a stabilized dose and receiving concomitant therapy with maximum tolerated beta blocker (e.g., carvedilol, metoprolol succinate, bisoprolol) as confirmed by claims history or submission of medical records

OR

1.5.2 Patient has a contraindication or intolerance to beta-blocker therapy (please specify contraindication or intolerance)

AND

1.6 ONE of the following:

1.6.1 Patient is on a stabilized dose and receiving concomitant therapy with Farxiga (includes combination products containing dapagliflozin) as confirmed by claims history or submission of medical records

OR

1.6.2 Patient has a contraindication or intolerance to SGLT2 (sodium-glucose co-transporter 2) inhibitor therapy (please specify contraindication or intolerance)

AND

1.7 ONE of the following:

1.7.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following, as confirmed by claims history or submission of medical records:

1.7.1.1 Angiotensin-converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)

OR

1.7.1.2 Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

1.7.1.3 Angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., Entresto)

OR

1.7.2 Patient has a contraindication or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify contraindication or intolerance)

AND

1.8 ONE of the following:

1.8.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated aldosterone antagonist (e.g., eplerenone, spironolactone) as confirmed by claims history or submission of medical records

OR

1.8.2 Patient has a contraindication or intolerance to aldosterone antagonist therapy (please specify contraindication or intolerance)

AND

1.9 Prescribed by or in consultation with a cardiologist

OR

2 - ALL of the following:

2.1 Diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy (DCM)

AND

2.2 Patient is in sinus rhythm

AND

2.3 Patient has an elevated heart rate

AND

2.4 Prescribed by or in consultation with a cardiologist

OR

3 - Patient is currently established on Corlanor therapy

Product Name: Corlanor	
Diagnosis	Inappropriate Sinus Tachycardia (IST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CORLANOR	IVABRADINE HCL TAB 5 MG (BASE EQUIV)	40700035100320	Brand
CORLANOR	IVABRADINE HCL TAB 7.5 MG (BASE EQUIV)	40700035100330	Brand
CORLANOR	IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV)	40700035102020	Brand

Approval Criteria

1 - All of the following

1.1 Diagnosis of inappropriate sinus tachycardia (IST)

AND

1.2 Patient is in sinus rhythm

AND

1.3 One of the following:

- Patient has tried and failed or had an inadequate response to a beta blocker (e.g., carvedilol, metoprolol succinate, bisoprolol) as confirmed by claims history or submission of medical records
- Patient has a contraindication or intolerance to beta-blocker therapy (please specify contraindication or intolerance)

AND

1.4 Prescribed by or in consultation with a cardiologist

OR

2 - Patient is currently established on Corlanor therapy

Product Name: Corlanor	
Diagnosis	Symptomatic Chronic Heart Failure, Inappropriate Sinus Tachycardia (IST)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CORLANOR	IVABRADINE HCL TAB 5 MG (BASE EQUIV)	40700035100320	Brand
CORLANOR	IVABRADINE HCL TAB 7.5 MG (BASE EQUIV)	40700035100330	Brand
CORLANOR	IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV)	40700035102020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Corlanor therapy

Daliresp (roflumilast)

Prior Authorization Guideline

Guideline ID	GL-146315
Guideline Name	Daliresp (roflumilast)
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Daliresp, generic roflumilast	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DALIRESP	ROFLUMILAST TAB 250 MCG	44450065000310	Brand
DALIRESP	ROFLUMILAST TAB 500 MCG	44450065000320	Brand
ROFLUMILAST	ROFLUMILAST TAB 250 MCG	44450065000310	Generic
ROFLUMILAST	ROFLUMILAST TAB 500 MCG	44450065000320	Generic

Approval Criteria

1 - Diagnosis of severe to very severe chronic obstructive pulmonary disease (COPD) (i.e., FEV1 less than or equal to 50% of predicted)

AND

2 - COPD is associated with chronic bronchitis

AND

3 - History of COPD exacerbation(s)

Product Name: Brand Daliresp, generic roflumilast	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DALIRESP	ROFLUMILAST TAB 250 MCG	44450065000310	Brand
DALIRESP	ROFLUMILAST TAB 500 MCG	44450065000320	Brand
ROFLUMILAST	ROFLUMILAST TAB 250 MCG	44450065000310	Generic
ROFLUMILAST	ROFLUMILAST TAB 500 MCG	44450065000320	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

DEKAs Plus

Prior Authorization Guideline

Guideline ID	GL-146316
Guideline Name	DEKAs Plus
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: DEKAs Plus Ocean, DEKAs Plus	
Diagnosis	Cystic Fibrosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEKAS PLUS OCEAN	*MULTIPLE VITAMINS W/ MINERALS CAP**	78310000000100	Brand
DEKAS PLUS	*MULTIPLE VITAMINS W/ MINERALS CAP**	78310000000100	Brand
DEKAS PLUS	*MULTIPLE VITAMINS W/ MINERALS CHEW TAB**	78310000000500	Brand

DEKAS PLUS	*PEDIATRIC MULTIPLE VITAMIN W/ MINERALS LIQUID**	78420000000900	Brand

Approval Criteria

1 - Diagnosis of cystic fibrosis

Descovy

Prior Authorization Guideline

Guideline ID	GL-146317
Guideline Name	Descovy
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Descovy	
Diagnosis	Human Immunodeficiency Virus (HIV)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DESCOVY	EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 200-25 MG	12109902290320	Brand
DESCOVY	EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 120-15 MG	12109902290310	Brand

Approval Criteria

1 - Diagnosis of human immunodeficiency virus (HIV)

AND

2 - ONE of the following:

2.1 Submission of medical records documenting a history of adverse event or intolerance to prior use of emtricitabine/tenofovir disoproxil fumarate (generic Truvada)

OR

2.2 Patient is currently on Descovy therapy

OR

2.3 Submission of medical records documenting an estimated GFR (glomerular filtration rate) below 90 mL/min (milliliters/minute)

OR

2.4 Submission of medical records documenting a diagnosis of osteoporosis as defined by a BMD (bone mineral density) T-score less than or equal to -2.5 based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) [Provider must submit patient specific BMD T-score]

OR

2.5 Submission of medical records documenting a prior low-trauma or non-traumatic fracture

OR

2.6 Patient is less than 20 years of age

OR

2.7 Submission of medical records documenting a diagnosis of osteopenia as defined by a BMD T-score between -1 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) [Provider must submit patient specific BMD T-scores] with evidence of progressive bone loss on serial DEXA (dual-energy X-ray absorptiometry) scan

Product Name: Descovy	
Diagnosis	Post-Exposure Prophylaxis (PEP)
Approval Length	4 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DESCOVY	EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 200-25 MG	12109902290320	Brand
DESCOVY	EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 120-15 MG	12109902290310	Brand

Approval Criteria

1 - Diagnosis of post-exposure prophylaxis (PEP)

Product Name: Descovy 200/25 mg	
Diagnosis	HIV-1 Pre-Exposure Prophylaxis (PrEP)
Approval Length	Authorization will be issued for 12 months at GPI-14 level to approve only the 200/25mg strength
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DESCOVY	EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 200-25 MG	12109902290320	Brand

Approval Criteria

1 - Request is for 200/25 mg strength

AND

2 - Used for HIV-1 pre-exposure prophylaxis (PrEP)

AND

3 - ONE of the following:

3.1 Submission of medical records documenting a history of adverse event or intolerance to prior use of emtricitabine/tenofovir disoproxil fumarate (generic Truvada)

OR

3.2 Submission of medical records documenting an estimated GFR (glomerular filtration rate) below 90 mL/min (milliliters/minute)

OR

3.3 Submission of medical records documenting a diagnosis of osteoporosis as defined by a BMD (bone mineral density) T-score less than or equal to -2.5 based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) [Provider must submit patient specific BMD T-score]

OR

3.4 Submission of medical records documenting a prior low-trauma or non-traumatic fracture

OR

3.5 Patient is less than 20 years of age

OR

3.6 Submission of medical records documenting a diagnosis of osteopenia as defined by a BMD T-score between -1 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) [Provider must submit patient specific BMD T-scores] with evidence of progressive bone loss on serial DEXA (dual-energy X-ray absorptiometry) scan

Dificid

Prior Authorization Guideline

Guideline ID	GL-146318
Guideline Name	Dificid
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Dificid	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DIFICID	FIDAXOMICIN TAB 200 MG	03530025000320	Brand
DIFICID	FIDAXOMICIN FOR SUSP 40 MG/ML	03530025001920	Brand

Approval Criteria

1 - Diagnosis of Clostridioides difficile-associated diarrhea (CDAD) [previously known as Clostridium difficile-associated diarrhea]

AND

2 - ONE of the following:

2.1 Failure to Firvanq (vancomycin) oral solution confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to Firvanq (vancomycin) oral solution (please specify intolerance or contraindication)

OR

2.3 For continuation of prior Dificid therapy

Dojolvi

Prior Authorization Guideline

Guideline ID	GL-149530
Guideline Name	Dojolvi
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/3/2024

1 . Criteria

Product Name: Dojolvi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DOJOLVI	TRIHEPTANOIN ORAL LIQUID 100%	80200080000920	Brand

Approval Criteria

1 - Submission of medical records confirming the diagnosis of long-chain fatty acid oxidation disorders (LC-FAOD) with at least two of the following diagnostic criteria: • Disease specific elevation of acyl-carnitines on a newborn blood spot or in plasma • Low enzyme activity in cultured fibroblasts • Genetic testing demonstrating one or more pathogenic mutations in a gene associated with long-chain fatty acid oxidation disorders (e.g., CPT2, ACADVL, HADHA, or HADHB) **AND** **2 -** Patient is not receiving Dojolvi in combination with any other medium-chain triglyceride (MCT) products **AND** **3 -** Prescribed by a board certified medical geneticist experienced in the treatment of long-chain fatty acid oxidation disorders (LC-FAOD) **AND** **4 -** Target recommended daily dosage does not exceed 35% of the patient's total prescribed daily caloric intake (DCI) **AND** **5 -** Patient is receiving disease related dietary management **AND** **6 -** If not diagnosed by newborn screening, patient has a history of clinical manifestations of long-chain fatty acid oxidation disorders LC-FAOD (e.g., rhabdomyolysis)

Product Name: Dojolvi	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DOJOLVI	TRIHEPTANOIN ORAL LIQUID 100%	80200080000920	Brand

Approval Criteria

1 - Documentation of positive clinical response to Dojolvi therapy (e.g., increased cardiac efficiency, decreased left ventricular wall mass, decreased incidence of rhabdomyolysis, etc.)

AND

2 - Patient is not receiving Dojolvi in combination with any other medium-chain triglyceride (MCT) product

AND

3 - Prescribed by a board certified medical geneticist experienced in the treatment of long-chain fatty acid oxidation disorders (LC-FAOD)

AND

4 - Target recommended daily dosage does not exceed 35% of the patient's total prescribed daily caloric intake (DCI)

AND

5 - Patient is receiving disease related dietary management

2 . Revision History

Date	Notes

7/3/2024	New guideline.

Donepezil 23mg

Prior Authorization Guideline

Guideline ID	GL-146319
Guideline Name	Donepezil 23mg
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic donepezil 23 mg	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
DONEPEZIL HYDROCHLORIDE	DONEPEZIL HYDROCHLORIDE TAB 23 MG	62051025100330	Generic
DONEPEZIL HCL	DONEPEZIL HYDROCHLORIDE TAB 23 MG	62051025100330	Generic

Approval Criteria

1 - Failure to donepezil at a minimum dose of 10 mg (milligrams) daily for 90 days, as confirmed by claims history or submission of medical records **OR** **2 -** History of contraindication or intolerance to donepezil 10 mg (please specify contraindication or intolerance)

DPP-4 Inhibitors

Prior Authorization Guideline

Guideline ID	GL-146320
Guideline Name	DPP-4 Inhibitors
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nesina, Alogliptin, Kazano, Alogliptin/metformin, Oseni, Alogliptin/pioglitazone	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NESINA	ALOGLIPTIN BENZOATE TAB 6.25 MG (BASE EQUIV)	27550010100310	Generic
NESINA	ALOGLIPTIN BENZOATE TAB 12.5 MG (BASE EQUIV)	27550010100320	Generic
NESINA	ALOGLIPTIN BENZOATE TAB 25 MG (BASE EQUIV)	27550010100330	Generic
KAZANO	ALOGLIPTIN-METFORMIN HCL TAB 12.5-500 MG	27992502100320	Generic

KAZANO	ALOGLIPTIN-METFORMIN HCL TAB 12.5-1000 MG	27992502100330	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-15 MG	27994002100320	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-30 MG	27994002100325	Generic
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-45 MG	27994002100330	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-45 MG	27994002100330	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 25-15 MG	27994002100340	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 25-30 MG	27994002100345	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 25-45 MG	27994002100350	Generic
ALOGLIPTIN	ALOGLIPTIN BENZOATE TAB 6.25 MG (BASE EQUIV)	27550010100310	Brand
ALOGLIPTIN	ALOGLIPTIN BENZOATE TAB 12.5 MG (BASE EQUIV)	27550010100320	Brand
ALOGLIPTIN	ALOGLIPTIN BENZOATE TAB 25 MG (BASE EQUIV)	27550010100330	Brand
ALOGLIPTIN/METFORMIN HCL	ALOGLIPTIN-METFORMIN HCL TAB 12.5-500 MG	27992502100320	Brand
ALOGLIPTIN/METFORMIN HYDROCHLORIDE	ALOGLIPTIN-METFORMIN HCL TAB 12.5-1000 MG	27992502100330	Brand
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-30 MG	27994002100325	Brand
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 25-15 MG	27994002100340	Brand
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 25-30 MG	27994002100345	Brand
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 25-45 MG	27994002100350	Brand

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - One of the following:

2.1 Suboptimal response (i.e. suboptimal glycemic control) to metformin at a minimum dose of 1500 mg daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

Product Name: Januvia, Janumet, Janumet XR, Brand Onglyza, generic saxagliptin, Brand Kombiglyze XR, generic saxagliptin/metformin ER, Tradjenta, Jentadueto, Jentadueto XR, Zituvimet, Zituvio	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KOMBIGLYZE XR	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27992502607540	Brand
KOMBIGLYZE XR	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-500 MG	27992502607530	Brand
KOMBIGLYZE XR	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27992502607520	Brand
JANUMET	SITAGLIPTIN-METFORMIN HCL TAB 50-500 MG	27992502700320	Brand
JANUMET	SITAGLIPTIN-METFORMIN HCL TAB 50-1000 MG	27992502700340	Brand
JANUMET XR	SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 50-1000 MG	27992502707530	Brand
JANUMET XR	SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 100-1000 MG	27992502707540	Brand
JANUMET XR	SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 50-500 MG	27992502707520	Brand
JANUVIA	SITAGLIPTIN PHOSPHATE TAB 25 MG (BASE EQUIV)	27550070100320	Brand
JANUVIA	SITAGLIPTIN PHOSPHATE TAB 50 MG (BASE EQUIV)	27550070100330	Brand
JANUVIA	SITAGLIPTIN PHOSPHATE TAB 100 MG (BASE EQUIV)	27550070100340	Brand
JENTADUETO	LINAGLIPTIN-METFORMIN HCL TAB 2.5-500 MG	27992502400320	Brand
JENTADUETO	LINAGLIPTIN-METFORMIN HCL TAB 2.5-850 MG	27992502400330	Brand

JENTADUETO	LINAGLIPTIN-METFORMIN HCL TAB 2.5-1000 MG	27992502400340	Brand
JENTADUETO XR	LINAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27992502407530	Brand
JENTADUETO XR	LINAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27992502407520	Brand
ONGLYZA	SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV)	27550065100320	Brand
ONGLYZA	SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV)	27550065100330	Brand
TRADJENTA	LINAGLIPTIN TAB 5 MG	27550050000320	Brand
SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27992502607520	Generic
SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-500 MG	27992502607530	Generic
SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27992502607540	Generic
SAXAGLIPTIN HYDROCHLORIDE	SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV)	27550065100320	Generic
SAXAGLIPTIN HYDROCHLORIDE	SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV)	27550065100330	Generic
ZITUVIO	SITAGLIPTIN TAB 25 MG	27550070000320	Brand
ZITUVIO	SITAGLIPTIN TAB 50 MG	27550070000330	Brand
ZITUVIO	SITAGLIPTIN TAB 100 MG	27550070000340	Brand
ZITUVIMET			

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 Suboptimal response (i.e. suboptimal glycemic control) to metformin at a minimum dose of 1500 mg daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Failure to a 90 day trial with ONE of the following as confirmed by claims history or submission of medical records:

- Alogliptin (generic Nesina)
- Alogliptin/metformin (generic Kazano)
- Alogliptin/pioglitazone (generic Oseni)

OR

3.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication)

- Alogliptin (generic Nesina)
- Alogliptin/metformin (generic Kazano)
- Alogliptin/pioglitazone (generic Oseni)

Dry Eye Disease

Prior Authorization Guideline

Guideline ID	GL-146321
Guideline Name	Dry Eye Disease
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Restasis Multidose, Brand Restasis, generic cyclosporine, Cequa, Tyrvaya, Vevye, Miebo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RESTASIS MULTIDOSE	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Brand
RESTASIS	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Brand
CEQUA	CYCLOSPORINE (OPHTH) SOLN 0.09% (PF)	86720020002040	Brand
TYRVAYA	VARENICLINE TARTRATE NASAL SOLN 0.03 MG/ACT	86280080202020	Brand

CYCLOSPORINE	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Generic
MIEBO	PERFLUOROHEXYLOCTANE OPHTH SOLN 1.338 GM/ML	868070180020	Brand
VEVYE	CYCLOSPORINE (OPHTH) SOLN 0.1%	86720020002043	Brand

Approval Criteria

1 - Tear deficiency associated with ocular inflammation due to ONE of the following:

- Moderate to severe keratoconjunctivitis sicca
- Moderate to severe dry eye disease

AND

2 - Not prescribed to manage dry eyes peri-operative elective eye surgery [e.g., LASIK (laser-assisted in situ keratomileusis)]

AND

3 - Failure to at least one OTC (over-the-counter) artificial tear product (e.g., Systane Ultra, Akwa Tears, Refresh Optive, Soothe XP) as confirmed by claims history or submission of medical records

AND

4 - Prescribed by or in consultation with ONE of the following:

- Ophthalmologist
- Optometrist
- Rheumatologist

AND

5 - ONE of the following:

5.1 Failure to Xiidra as confirmed by claims history or submission of medical records

OR

5.2 History of contraindication or intolerance to Xiidra (please specify contraindication or intolerance)

Product Name: Xiidra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIIDRA	LIFITEGRAST OPHTH SOLN 5%	86734050002020	Brand

Approval Criteria

1 - Tear deficiency associated with ocular inflammation due to ONE of the following:

- Moderate to severe keratoconjunctivitis sicca
- Moderate to severe dry eye disease

AND

2 - Not prescribed to manage dry eyes peri-operative elective eye surgery [e.g., LASIK (laser-assisted in situ keratomileusis)]

AND

3 - Failure to at least one OTC (over-the-counter) artificial tear product (e.g., Systane Ultra, Akwa Tears, Refresh Optive, Soothe XP) as confirmed by claims history or submission of medical records

AND

4 - Prescribed by or in consultation with ONE of the following:

- Ophthalmologist
- Optometrist
- Rheumatologist

Product Name: Restasis Multidose, Brand Restasis, generic cyclosporine, Xiidra, Cequa, Tyrvaya, Vevye, Miebo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RESTASIS MULTIDOSE	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Brand
RESTASIS	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Brand
XIIDRA	LIFITEGRAST OPHTH SOLN 5%	86734050002020	Brand
CEQUA	CYCLOSPORINE (OPHTH) SOLN 0.09% (PF)	86720020002040	Brand
TYRVAYA	VARENICLINE TARTRATE NASAL SOLN 0.03 MG/ACT	86280080202020	Brand
CYCLOSPORINE	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Generic
MIEBO	PERFLUOROHEXYLOCTANE OPHTH SOLN 1.338 GM/ML	86807018002020	Brand
VEVYE	CYCLOSPORINE (OPHTH) SOLN 0.1%	86720020002043	Brand

Approval Criteria

1 - Patient has demonstrated clinically significant improvement with therapy

Duexis and Vimovo

Prior Authorization Guideline

Guideline ID	GL-146887
Guideline Name	Duexis and Vimovo
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Duexis, generic ibuprofen/famotidine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUEXIS	IBUPROFEN-FAMOTIDINE TAB 800-26.6 MG	66109902320340	Brand
IBUPROFEN/FAMOTIDINE	IBUPROFEN-FAMOTIDINE TAB 800-26.6 MG	66109902320340	Generic

Approval Criteria

1 - ONE of the following risk factors for NSAID (non-steroidal anti-inflammatory drug)-induced adverse GI (gastrointestinal) events:

- Patient is greater than or equal to 65 years of age
- Prior history of peptic, gastric, or duodenal ulcer
- History of NSAID-related ulcer
- History of clinically significant GI bleeding
- Untreated or active H. Pylori (helicobacter pylori) gastritis
- Concurrent use of oral corticosteroids (e.g., prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (e.g., warfarin, heparin)
- Concurrent use of antiplatelets (e.g., aspirin including low-dose, clopidogrel)

AND

2 - ONE of the following:

2.1 Failure to THREE combinations of preferred* NSAIDS, one of which must be celecoxib (generic Celebrex), taken concomitantly with preferred* H2-receptor antagonists, as confirmed by claims history or submitted medical records

OR

2.2 History of contraindication or intolerance to ALL preferred* NSAIDs and ALL preferred* H2-receptor antagonists (please specify contraindication or intolerance)

AND

3 - Physician has provided rationale for needing to use fixed-dose combination therapy with Duexis instead of taking individual products in combination

Notes	*PDL links in Background

Product Name: Brand Vimovo, generic naproxen/esomeprazole	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIMOVO	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 375-20 MG	66109902440620	Brand

NAPROXEN/ESOMEPRAZOLE MAGNESIUM	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 375-20 MG	66109902440620	Generic
VIMOVO	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 500-20 MG	66109902440640	Brand
NAPROXEN/ESOMEPRAZOLE MAGNESIUM	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 500-20 MG	66109902440640	Generic

Approval Criteria

1 - ONE of the following risk factors for NSAID (non-steroidal anti-inflammatory drug)-induced adverse GI (gastrointestinal) events:

- Patient is greater than or equal to 65 years of age
- Prior history of peptic, gastric, or duodenal ulcer
- History of NSAID-related ulcer
- History of clinically significant GI bleeding
- Untreated or active H. Pylori (helicobacter pylori) gastritis
- Concurrent use of oral corticosteroids (e.g., prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (e.g., warfarin, heparin)
- Concurrent use of antiplatelets (e.g., aspirin including low-dose, clopidogrel)

AND

2 - ONE of the following:

2.1 Failure to THREE combinations of preferred* NSAIDS, one of which must be celecoxib (generic Celebrex), taken concomitantly with preferred* proton pump inhibitors, as confirmed by claims history or submitted medical records

OR

2.2 History of contraindication or intolerance to ALL preferred* NSAIDs and ALL preferred* proton pump inhibitors (please specify contraindication or intolerance)

AND

3 - Physician has provided rationale for needing to use fixed-dose combination therapy with Vimovo instead of taking individual products in combination

Notes	*PDL links in Background

2 . Background

Benefit/Coverage/Program Information
PDL links NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
4/30/2024	Updated PDL link

Duopa

Prior Authorization Guideline

Guideline ID	GL-146323
Guideline Name	Duopa
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Duopa	
Diagnosis	Parkinson's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUOPA	CARBIDOPA-LEVODOPA ENTERAL SUSP 4.63-20 MG/ML	73209902101820	Brand

Approval Criteria

1 - Diagnosis of advanced Parkinson's disease

AND

2 - Patient is levodopa-responsive

AND

3 - Patient experiences disabling “off” periods for a minimum of 3 hours per day

AND

4 - Disabling “off" periods occur despite therapy with BOTH of the following, as confirmed by claims history or submission of medical records:

- Oral levodopa-carbidopa
- One drug from a different class of anti-Parkinson's disease therapy (e.g., COMT [catechol-O-methyltransferase] inhibitor [entacapone, tolcapone], MAO-B [monoamine oxidase-B] inhibitor [selegiline, rasagiline], dopamine agonist [pramipexole, ropinirole])

AND

5 - Has undergone or has planned placement of a procedurally-placed tube

AND

6 - Prescribed by or in consultation with a neurologist

Product Name: Duopa	
Diagnosis	Parkinson's disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUOPA	CARBIDOPA-LEVODOPA ENTERAL SUSP 4.63-20 MG/ML	73209902101820	Brand

Approval Criteria

1 - Documentation of positive clinical response to Duopa therapy

Elidel-Protopic

Prior Authorization Guideline

Guideline ID	GL-148510
Guideline Name	Elidel-Protopic
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Elidel, generic pimecrolimus, generic tacrolimus 0.03%	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ELIDEL	PIMECROLIMUS CREAM 1%	90784060003720	Brand
PIMECROLIMUS	PIMECROLIMUS CREAM 1%	90784060003720	Generic
TACROLIMUS	TACROLIMUS OINT 0.03%	90784075004210	Generic

Approval Criteria

1 - The patient is 2 years of age or older

AND

2 - ONE of the following:

2.1 Failure to one topical corticosteroid in the past 90 days as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to one topical corticosteroid (please specify contraindication or intolerance)

OR

2.3 Drug is being prescribed for the facial or groin area

Product Name: Generic tacrolimus 0.1%	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TACROLIMUS	TACROLIMUS OINT 0.1%	90784075004230	Generic

Approval Criteria

1 - The patient is 16 years of age or older

AND

2 - ONE of the following:

2.1 Failure to one topical corticosteroid in the past 90 days as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to one topical corticosteroid (please specify contraindication or intolerance)

OR

2.3 Drug is being prescribed for the facial or groin area

2 . Revision History

Date	Notes
6/13/2024	Removed Protopic from GPI table since it is obsolete.

Elmiron

Prior Authorization Guideline

Guideline ID	GL-146325
Guideline Name	Elmiron
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Elmiron	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ELMIRON	PENTOSAN POLYSULFATE SODIUM CAPS 100 MG	56500060100110	Brand

Approval Criteria

1 - Patient has a documented diagnosis of bladder pain or discomfort associated with interstitial cystitis

Endari

Prior Authorization Guideline

Guideline ID	GL-146326
Guideline Name	Endari
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Endari	
Diagnosis	Sickle cell disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENDARI	GLUTAMINE (SICKLE CELL) POWD PACK 5 GM	82801020003020	Brand

Approval Criteria

1 - BOTH of the following:

- Diagnosis of sickle cell disease
- Used to reduce acute complications of sickle cell disease

AND

2 - ONE of the following:

- Patient is using Endari with concurrent hydroxyurea therapy
- Patient is unable to take hydroxyurea due to a contraindication or intolerance (please specify contraindication or intolerance)

AND

3 - Patient has had 2 or more painful sickle cell crises within the past 12 months

Product Name: Endari	
Diagnosis	Sickle cell disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENDARI	GLUTAMINE (SICKLE CELL) POWD PACK 5 GM	82801020003020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Endari therapy

Entocort

Prior Authorization Guideline

Guideline ID	GL-146327
Guideline Name	Entocort
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: budesonide caps	
Diagnosis	Crohn's Disease
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BUDESONIDE	BUDESONIDE DELAYED RELEASE PARTICLES CAP 3 MG	22100012006720	Generic

Approval Criteria

1 - Used for the treatment of Crohn's disease

Entresto

Prior Authorization Guideline

Guideline ID	GL-146328
Guideline Name	Entresto
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Entresto	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENTRESTO	SACUBITRIL-VALSARTAN TAB 24-26 MG	40992002600320	Brand
ENTRESTO	SACUBITRIL-VALSARTAN TAB 49-51 MG	40992002600330	Brand
ENTRESTO	SACUBITRIL-VALSARTAN TAB 97-103 MG	40992002600340	Brand

Approval Criteria

1 - Request is for continuation of therapy initiated during an inpatient stay

OR

2 - BOTH of the following:

2.1 Diagnosis of pediatric heart failure with systemic left ventricular systolic dysfunction which is symptomatic

AND

2.2 Prescribed by or in consultation with a cardiologist

OR

3 - ALL of the following:

3.1 Diagnosis of heart failure (with or without hypertension)

AND

3.2 ONE of the following:

3.2.1 Ejection fraction is less than or equal to 40 percent

OR

3.2.2 BOTH of the following:

3.2.2.1 Ejection fraction is greater than 40 percent

AND

3.2.2.2 Patient has structural heart disease [i.e., left atrial enlargement (LAE) or left ventricular hypertrophy (LVH)]

<table>
<tr><td colspan="2">

AND

3.3 Heart failure is classified as ONE of the following:

- New York Heart Association Class II
- New York Heart Association Class III
- New York Heart Association Class IV

AND

3.4 Patient does not have a history of angioedema

AND

3.5 Patient will discontinue any use of concomitant ACE (angiotensin converting enzyme) Inhibitor or ARB (angiotensin II receptor blocker) before initiating treatment with Entresto*

AND

3.6 Patient is not concomitantly on aliskiren therapy

AND

3.7 Entresto is prescribed by, or in consultation with, a cardiologist
</td></tr>
<tr><td>Notes</td><td>*ACE inhibitors must be discontinued at least 36 hours prior to initiatio n of Entresto.</td></tr>
</table>

Product Name: Entresto	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ENTRESTO	SACUBITRIL-VALSARTAN TAB 24-26 MG	40992002600320	Brand
ENTRESTO	SACUBITRIL-VALSARTAN TAB 49-51 MG	40992002600330	Brand
ENTRESTO	SACUBITRIL-VALSARTAN TAB 97-103 MG	40992002600340	Brand

Approval Criteria

1 - The Entresto dose has been titrated to a dose of 97 mg (milligrams)/103 mg twice daily or the maximum labeled dose for pediatric patients, or to a maximum dose as tolerated by the patient

AND

2 - Documentation of positive clinical response to therapy

Epaned

Prior Authorization Guideline

Guideline ID	GL-146329
Guideline Name	Epaned
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic enalapril oral soln, Brand Epaned	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENALAPRIL MALEATE	ENALAPRIL MALEATE ORAL SOLN 1 MG/ML	36100020102020	Generic
EPANED	ENALAPRIL MALEATE ORAL SOLN 1 MG/ML	36100020102020	Brand

Approval Criteria

1 - Patient is less than 8 years of age

OR

2 - BOTH of the following:

2.1 ONE of the following diagnoses:

- Hypertension
- Heart failure
- Asymptomatic left ventricular dysfunction, defined as left ventricular ejection fraction less than or equal to 35%

AND

2.2 ONE of the following:

2.2.1 Failure to TWO formulary oral anti-hypertensives [e.g., angiotensin-converting enzyme (ACE) inhibitor, ACE inhibitor combination, angiotensin-receptor blocker (ARB), ARB combination, thiazide diuretic] as confirmed by claims history or submission of medical records

OR

2.2.2 History of contraindication or intolerance to ALL formulary oral anti-hypertensives (e.g., ACE inhibitor, ACE inhibitor combination, ARB, ARB combination, thiazide diuretic) (please specify contraindication or intolerance)

OR

2.2.3 Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Oral/motor difficulties
- Dysphagia

Eucrisa

Prior Authorization Guideline

Guideline ID	GL-146330
Guideline Name	Eucrisa
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Eucrisa	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
EUCRISA	CRISABOROLE OINT 2%	90230025004220	Brand

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to ONE topical corticosteroid [e.g., mometasone furoate, fluocinolone acetonide (generic Synalar), fluocinonide] as confirmed by claims history or submission of medical records

OR

1.1.2 History of contraindication or intolerance ONE topical corticosteroid [e.g., mometasone furoate, fluocinolone acetonide (generic Synalar), fluocinonide] (please specify contraindication or intolerance)

AND

1.2 ONE of the following:

1.2.1 Patient is less than 2 years of age

OR

1.2.2 Patient is greater than or equal to 2 years of age and ONE of the following:

- Failure to ONE topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)] as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to ONE topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)] (Please specify contraindication or intolerance)

OR

2 - Patient is currently on Eucrisa therapy as confirmed by claims history or submission of medical records

Febuxostat

Prior Authorization Guideline

Guideline ID	GL-146331
Guideline Name	Febuxostat
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic febuxostat	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
FEBUXOSTAT	FEBUXOSTAT TAB 40 MG	68000030000320	Generic
FEBUXOSTAT	FEBUXOSTAT TAB 80 MG	68000030000330	Generic

Approval Criteria

1 - Failure to allopurinol (generic Zyloprim) as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to allopurinol (generic Zyloprim) (please specify contraindication or intolerance)

Fentanyl IR

Prior Authorization Guideline

Guideline ID	GL-146332
Guideline Name	Fentanyl IR
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Fentanyl citrate lozenges (generic Actiq)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 200 MCG	65100025108450	Generic
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 400 MCG	65100025108455	Generic
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 600 MCG	65100025108460	Generic

FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 800 MCG	65100025108465	Generic
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 1200 MCG	65100025108475	Generic
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 1600 MCG	65100025108485	Generic

Approval Criteria

1 - Submission of medical records demonstrating use is for the management of breakthrough pain associated with a cancer diagnosis (cancer diagnosis must be documented)

AND

2 - Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids (Document drug and date of trial):

- Morphine sulfate at a doses of greater than or equal to 60 milligrams per day
- Fentanyl transdermal patch at a dose of greater than or equal to 25 micrograms per hour
- Oxycodone at a dose of greater than or equal to 30 milligrams per day
- Oral hydromorphone at a dose of greater than or equal to 8 milligrams per day
- Oral oxymorphone at a dose of greater than or equal to 25 milligrams per day
- An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 milligrams per day)

AND

3 - The patient is currently taking a long-acting opioid around the clock for cancer pain (Document drug)

AND

4 - ONE of the following:

4.1 The patient is not concurrently receiving an alternative fentanyl transmucosal product

OR

4.2 BOTH of the following:

4.2.1 The patient is currently receiving an alternative transmucosal fentanyl product

AND

4.2.2 The prescriber is requesting the termination of all current authorizations for alternative transmucosal fentanyl products in order to begin treatment with the requested medication (Only one transmucosal fentanyl product will be approved at a time. If previous authorizations cannot be terminated, the PA request will be denied)

Product Name: Brand Actiq, Brand Fentora, generic fentanyl citrate buccal tablet, Lazanda, Subsys	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 100 MCG (BASE EQUIV)	65100025100310	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 100 MCG (BASE EQUIV)	65100025100310	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 200 MCG (BASE EQUIV)	65100025100320	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 200 MCG (BASE EQUIV)	65100025100320	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 400 MCG (BASE EQUIV)	65100025100330	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 400 MCG (BASE EQUIV)	65100025100330	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 600 MCG (BASE EQUIV)	65100025100340	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 600 MCG (BASE EQUIV)	65100025100340	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 800 MCG (BASE EQUIV)	65100025100350	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 800 MCG (BASE EQUIV)	65100025100350	Generic

LAZANDA	FENTANYL CITRATE NASAL SPRAY 100 MCG/ACT (BASE EQUIV)	65100025102050	Brand
LAZANDA	FENTANYL CITRATE NASAL SPRAY 400 MCG/ACT (BASE EQUIV)	65100025102060	Brand
SUBSYS	FENTANYL SUBLINGUAL SPRAY 100 MCG	65100025000910	Brand
SUBSYS	FENTANYL SUBLINGUAL SPRAY 200 MCG	65100025000920	Brand
SUBSYS	FENTANYL SUBLINGUAL SPRAY 400 MCG	65100025000930	Brand
SUBSYS	FENTANYL SUBLINGUAL SPRAY 600 MCG	65100025000940	Brand
SUBSYS	FENTANYL SUBLINGUAL SPRAY 800 MCG	65100025000950	Brand
SUBSYS	FENTANYL SUBLINGUAL SPRAY 1200 MCG (600 MCG X 2)	65100025000960	Brand
SUBSYS	FENTANYL SUBLINGUAL SPRAY 1600 MCG (800 MCG X 2)	65100025000970	Brand
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 200 MCG	65100025108450	Brand
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 400 MCG	65100025108455	Brand
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 600 MCG	65100025108460	Brand
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 800 MCG	65100025108465	Brand
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 1200 MCG	65100025108475	Brand
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 1600 MCG	65100025108485	Brand

Approval Criteria

1 - Submission of medical records demonstrating use is for the management of breakthrough pain associated with a cancer diagnosis (cancer diagnosis must be documented)

AND

2 - Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids (Document drug and date of trial):

- Morphine sulfate at a doses of greater than or equal to 60 milligrams per day
- Fentanyl transdermal patch at a dose of greater than or equal to 25 micrograms per hour
- Oxycodone at a dose of greater than or equal to 30 milligrams per day
- Oral hydromorphone at a dose of greater than or equal to 8 milligrams per day

- Oral oxymorphone at a dose of greater than or equal to 25 milligrams per day
- An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 milligrams per day)

AND

3 - The patient is currently taking a long-acting opioid around the clock for cancer pain (Document drug)

AND

4 - ONE of the following:

4.1 The patient is not concurrently receiving an alternative fentanyl transmucosal product

OR

4.2 BOTH of the following:

4.2.1 The patient is currently receiving an alternative transmucosal fentanyl product

AND

4.2.2 The prescriber is requesting the termination of all current authorizations for alternative transmucosal fentanyl products in order to begin treatment with the requested medication (Only one transmucosal fentanyl product will be approved at a time. If previous authorizations cannot be terminated, the PA request will be denied)

AND

5 - History of failure, contraindication, or intolerance to Fentanyl citrate lozenges (generic Actiq) [Document date of trial]

Filsuvez

Prior Authorization Guideline

Guideline ID	GL-147343
Guideline Name	Filsuvez
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Filsuvez	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FILSUVEZ	BIRCH TRITERPENES GEL 10%	90944020004030	Brand

Approval Criteria

1 - Patient is at least 6 months of age or older

AND

2 - One of the following diagnoses:

- Dystrophic epidermolysis bullosa (DEB)
- Junctional epidermolysis bullosa (JEB)

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) confirming a genetic mutation associated with DEB or JEB (i.e., COL7A1, LAMA3, LAMB3, LAMC2, COL17A1, ITGA6, ITGB4, ITGA3)

AND

4 - Patient has at least one partial thickness wound that meets ALL of the following criteria:

- 10-50 cm2 in size
- Present for at least 3 weeks
- Adequate granulation tissue
- Excellent vascularization
- No evidence of active wound infection
- No evidence or history of basal or squamous cell carcinomas (SCC)

AND

5 - Prescribed by, or in consultation with, a dermatologist with expertise in the treatment of epidermolysis bullosa (EB)

AND

6 - Patient is NOT receiving Filsuvez in combination with Vyjuvek on the same wound(s)

Product Name: Filsuvez	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FILSUVEZ	BIRCH TRITERPENES GEL 10%	90944020004030	Brand

Approval Criteria

1 - Documentation of positive clinical response to Filsuvez therapy (e.g., complete wound closure, reduction in wound size, decrease in procedural pain, less frequent dressing changes, decreased total body wound burden)

AND

2 - Wound(s) being treated meets ALL of the following criteria:

- Adequate granulation tissue
- Excellent vascularization
- No evidence of active wound infection
- No evidence or history of basal or squamous cell carcinomas (SCC)

AND

3 - Filsuvez is prescribed by, or in consultation with, a dermatologist with expertise in the treatment of epidermolysis bullosa (EB)

AND

4 - Patient is not receiving Filsuvez in combination with Vyjuvek on the same wound(s)

2 . Revision History

Date	Notes
5/13/2024	Copy core

Fortamet, Glumetza

Prior Authorization Guideline

Guideline ID	GL-146333
Guideline Name	Fortamet, Glumetza
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic metformin extended-release (generic Fortamet)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
METFORMIN HYDROCHLORIDE ER	METFORMIN HCL TAB ER 24HR OSMOTIC 500 MG	27250050007560	Generic
METFORMIN HYDROCHLORIDE ER	METFORMIN HCL TAB ER 24HR OSMOTIC 1000 MG	27250050007570	Generic
Fortamet			

Approval Criteria

1 - History of greater than or equal to 12-week trial of metformin extended-release (generic Glucophage XR) as confirmed by claims history or submission of medical records

AND

2 - One of the following:

2.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin extended-release (generic Glucophage XR) as evidenced by the hemoglobin A1c level being above the patient's goal

OR

2.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

Product Name: Brand Glumetza, generic metformin extended-release (generic Glumetza)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
METFORMIN HYDROCHLORIDE ER	METFORMIN HCL TAB ER 24HR MODIFIED RELEASE 500 MG	27250050007580	Generic
METFORMIN HYDROCHLORIDE ER	METFORMIN HCL TAB ER 24HR MODIFIED RELEASE 1000 MG	27250050007590	Generic
GLUMETZA	METFORMIN HCL TAB ER 24HR MODIFIED RELEASE 500 MG	27250050007580	Brand
GLUMETZA	METFORMIN HCL TAB ER 24HR MODIFIED RELEASE 1000 MG	27250050007590	Brand

Approval Criteria

1 - History of greater than or equal to 12 week trial of metformin extended-release (generic Glucophage XR) as confirmed by claims history or submission of medical records

AND

2 - One of the following:

2.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin extended-release (generic Glucophage XR) as evidenced by the hemoglobin A1c level being above the patient's goal

OR

2.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

AND

3 - History of greater than or equal to 12 week trial of metformin extended-release (generic Fortamet) as confirmed by claims history or submission of medical records

AND

4 - One of the following:

4.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin extended-release (generic Fortamet) as evidenced by the hemoglobin A1c level being above the patient's goal

OR

4.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Fortamet) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

AND

5 - Submission of article(s) published in the peer-reviewed medical literature showing that the requested drug is likely to be more efficacious to this patient than metformin extended-release (generic Glucophage XR AND generic Fortamet)

Furoscix

Prior Authorization Guideline

Guideline ID	GL-146334
Guideline Name	Furoscix
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Furoscix	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FUROSCIX	FUROSEMIDE SUBCUTANEOUS CARTRIDGE KIT 80 MG/10ML	3720003000F720	Brand

Approval Criteria

1 - Diagnosis of chronic heart failure

AND

2 - Heart failure is classified as ONE of the following:

2.1 New York Heart Association (NYHA) class II heart failure

OR

2.2 New York Heart Association (NYHA) class III heart failure

AND

3 - Patient has signs or symptoms of congestion due to fluid overload

AND

4 - Patient is established on background loop diuretic therapy (e.g., furosemide, torsemide, bumetanide)

AND

5 - Both of the following:

5.1 Patient does not require ongoing emergency care or hospitalization for heart failure, acute pulmonary edema, or other conditions

AND

5.2 Patient is currently a candidate for parenteral diuresis outside of the hospital

AND

6 - Patient has an estimated creatine clearance greater than 30ml/min

AND
7 - Furoscix is prescribed by or in consultation with a cardiologist

Genvoya and Stribild

Prior Authorization Guideline

Guideline ID	GL-146335
Guideline Name	Genvoya and Stribild
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Genvoya, Stribild	
Diagnosis	Human Immunodeficiency Virus (HIV)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GENVOYA	ELVITEGRAV-COBIC-EMTRICITAB-TENOFOV AF TAB 150-150-200-10 MG	12109904290315	Brand
STRIBILD	ELVITEGRAV-COBIC-EMTRICITAB-TENOFOVDF TAB 150-150-200-300 MG	12109904300320	Brand

Approval Criteria

1 - Diagnosis of human immunodeficiency virus (HIV)

AND

2 - ONE of the following:

2.1 Patient is not an appropriate candidate for ALL of the following (please specify why patient is not a candidate):

- efavirenz/emtricitabine/tenofovir disoproxil (generic Atripla)
- Triumeq (abacavir/dolutegravir/lamivudine)
- Juluca (dolutegravir/rilpivirine)
- Dovato (dolutegravir/lamivudine)

OR

2.2 Patient is currently on Genvoya or Stribild therapy

Product Name: Genvoya, Stribild	
Diagnosis	Post-Exposure Prophylaxis
Approval Length	4 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GENVOYA	ELVITEGRAV-COBIC-EMTRICITAB-TENOFOV AF TAB 150-150-200-10 MG	12109904290315	Brand
STRIBILD	ELVITEGRAV-COBIC-EMTRICITAB-TENOFOVDF TAB 150-150-200-300 MG	12109904300320	Brand

Approval Criteria

1 - Diagnosis of post-exposure prophylaxis

Prior Authorization Guideline

Guideline ID	GL-146336
Guideline Name	GLP-1 & Dual GIP/GLP-1 Receptor Agonists
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Victoza 1.2mg per day (2 Pen Pack), Mounjaro, Ozempic, Rybelsus	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VICTOZA	LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML)	2717005000D220	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 2.5 MG/0.5ML	2717308000D210	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 5 MG/0.5ML	2717308000D215	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 7.5 MG/0.5ML	2717308000D220	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 10 MG/0.5ML	2717308000D225	Brand

MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 12.5 MG/0.5ML	2717308000D230	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 15 MG/0.5ML	2717308000D235	Brand
OZEMPIC	SEMAGLUTIDE SOLN PEN-INJ 0.25 OR 0.5 MG/DOSE (2 MG/3ML)	2717007000D221	Brand
OZEMPIC	SEMAGLUTIDE SOLN PEN-INJ 1 MG/DOSE (4 MG/3ML)	2717007000D222	Brand
OZEMPIC	SEMAGLUTIDE SOLN PEN-INJ 2 MG/DOSE (8 MG/3ML)	2717007000D225	Brand
RYBELSUS	SEMAGLUTIDE TAB 3 MG	27170070000310	Brand
RYBELSUS	SEMAGLUTIDE TAB 7 MG	27170070000320	Brand
RYBELSUS	SEMAGLUTIDE TAB 14 MG	27170070000330	Brand

Approval Criteria

1 - Confirmation of type 2 diabetes mellitus via medical records (i.e., medical documentation confirming type 2 diabetes mellitus, medical claims history) or prescriber attestation

AND

2 - ONE of the following:

2.1 Suboptimal response (i.e., suboptimal glycemic control) to one product, or a combination thereof, from ONE of the following drugs/classes for 90 days in the past 365 days, as confirmed by claims history or submission of medical records

- Metformin
- Metformin combinations
- DPP-4 inhibitors
- DPP-4 inhibitor combinations
- SGLT2 inhibitors
- SGLT2 inhibitor combinations
- Sulfonylureas

OR

2.2 History of contraindication or intolerance to ONE product from any of the following drugs/classes: (please specify contraindication or intolerance)

- Metformin
- Metformin combinations

- DPP-4 inhibitors
- DPP-4 inhibitor combinations
- SGLT2 inhibitors
- SGLT2 inhibitor combinations
- Sulfonylureas

Product Name: Victoza 1.8mg per day (3 Pen Pack)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VICTOZA	LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML)	2717005000D220	Brand

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus confirmed by submission of medical records (i.e., chart notes, medical claims history)

AND

2 - ONE of the following:

2.1 Suboptimal response to metformin (i.e., suboptimal glycemic control) at a minimum dose of 1500mg daily for 90 days, as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to metformin (please specify contraindication or intolerance)

AND

3 - History of failure to achieve acceptable glycemic control with Victoza 1.2mg per day for 90 days (2 Pen Pack), as confirmed by claims history or submission of medical records

Product Name: Bydureon BCise, Byetta, Trulicity	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BYDUREON BCISE	EXENATIDE EXTENDED RELEASE SUSP AUTO-INJECTOR 2 MG/0.85ML	2717002000D420	Brand
BYETTA	EXENATIDE SOLN PEN-INJECTOR 5 MCG/0.02ML	2717002000D220	Brand
BYETTA	EXENATIDE SOLN PEN-INJECTOR 10 MCG/0.04ML	2717002000D240	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 0.75 MG/0.5ML	2717001500D220	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 1.5 MG/0.5ML	2717001500D230	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 3 MG/0.5ML	2717001500D240	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 4.5 MG/0.5ML	2717001500D250	Brand

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus confirmed by submission of medical records (i.e., chart notes, medical claims history)

AND

2 - ONE of the following:

2.1 Suboptimal response to metformin (i.e., suboptimal glycemic control) at a minimum dose of 1500mg daily for 90 days, as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to metformin (please specify contraindication or intolerance)

AND

3 - ONE of the following:

3.1 Suboptimal response (i.e., suboptimal glycemic control) to both of the following, each for a minimum of 90 days, as confirmed by claims history or submission of medical records:

- A commercially available semaglutide product indicated for type 2 diabetes mellitus (e.g., Ozempic, Rybelsus)
- Mounjaro

OR

3.2 History of contraindication or intolerance to both of the following (please specify contraindication or intolerance)

- A commercially available semaglutide product indicated for type 2 diabetes mellitus (e.g., Ozempic, Rybelsus)
- Mounjaro

Hemangeol

Prior Authorization Guideline

Guideline ID	GL-146337
Guideline Name	Hemangeol
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Hemangeol	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HEMANGEOL	PROPRANOLOL HCL ORAL SOLN 4.28 MG/ML (3.75 MG/ML BASE EQUIV)	33100040102080	Brand

Approval Criteria

1 - Diagnosis of proliferating infantile hemangioma

AND

2 - Prescriber provides a reason or special circumstance the patient cannot use generic propranolol oral solution

Hyftor

Prior Authorization Guideline

Guideline ID	GL-146338
Guideline Name	Hyftor
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Hyftor	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HYFTOR	SIROLIMUS GEL 0.2%	90784070004020	Brand

Approval Criteria

1 - Diagnosis of tuberous sclerosis

AND

2 - One of the following:

2.1 One or more of the following major features:

- Hypomelanotic macules (At least 3; at least 5 mm diameter)
- Angiofibroma (At least 3) or fibrous cephalic plaque
- Ungual fibromas (At least 2)
- Shagreen patch
- Multiple retinal hamartomas
- Multiple cortical tubers and/or radial migration lines
- Subependymal nodule (At least 2)
- Subependymal giant cell astrocytoma
- Cardiac rhabdomyoma
- Lymphangiomyomatosis (LAM)
- Angiomyolipomas (At least 2)

OR

2.2 Two or more of the following minor features:

- “Confetti” skin lesions
- Dental enamel pits (At least 3)
- Intraoral fibromas (At least 2)
- Retinal achromic patch
- Multiple renal cysts
- Nonrenal hamartomas
- Sclerotic bone lesions

OR

2.3 Confirmed presence of a mutation in the TSC1 or TSC2 gene

AND

3 - Patient has facial angiofibroma associated with tuberous sclerosis

AND

4 - Patient is not receiving Hyftor in combination with a systemic mTOR (mechanistic target of rapamycin) inhibitor [e.g., Rapamune (sirolimus), Afinitor (everolimus)]

AND

5 - Hyftor is being prescribed by, or in consultation, with a dermatologist, neurologist, or oncologist

Product Name: Hyftor	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HYFTOR	SIROLIMUS GEL 0.2%	90784070004020	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., improvement in skin lesions)

AND

2 - Patient is not receiving Hyftor in combination with a systemic mTOR inhibitor [e.g., Rapamune (sirolimus), Afinitor (everolimus)]

AND

3 - Hyftor is being prescribed by, or in consultation, with a dermatologist, neurologist, or oncologist

ICS.LABA Combination Products

Prior Authorization Guideline

Guideline ID	GL-146339
Guideline Name	ICS.LABA Combination Products
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic budesonide/formoterol, generic Breyna	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BREYNA	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT	44209902413220	Generic
BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT	44209902413220	Generic
BREYNA	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT	44209902413240	Generic

BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT	44209902413240	Generic

Approval Criteria

1 - One of the following:

1.1 BOTH of the following:

1.1.1 Diagnosis of COPD

AND

1.1.2 ONE of the following:

1.1.2.1 Failure of ONE of the following confirmed by claims history or submitted medical records

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

1.1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of asthma

AND

1.2.2 ONE of the following:

1.2.2.1 Patient is less than 12 years of age

OR

1.2.2.2 ONE of the following:

1.2.2.2.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

1.2.2.2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

Product Name: fluticasone/vilanterol (authorized generic of Breo Ellipta)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FLUTICASONE FUROATE/VILANTEROL ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 100-25 MCG/ACT	44209902758020	Generic
FLUTICASONE FUROATE/VILANTEROL ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 200-25 MCG/ACT	44209902758030	Generic

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of asthma

AND

1.2 BOTH of the following:

1.2.1 ONE of the following:

1.2.1.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

1.2.1.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

1.2.2 ONE of the following:

1.2.2.1 Failure of Breyna or budesonide/formoterol (generic of Symbicort) confirmed by claims history or submitted medical records

OR

1.2.2.2 History of intolerance or contraindication to Breyna or budesonide/formoterol (generic of Symbicort) (please specify intolerance or contraindication)

OR

2 - ALL of the following:

2.1 Diagnosis of COPD

AND

2.2 ONE of the following:

2.2.1 Failure of ONE of the following confirmed by claims history or submitted medical records

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

2.3 ONE of the following:

2.3.1 Failure of Breyna or budesonide/formoterol (generic of Symbicort) confirmed by claims history or submitted medical records

OR

2.3.2 History of intolerance or contraindication to Breyna or budesonide/formoterol (generic of Symbicort) (please specify intolerance or contraindication)

Product Name: Advair HFA, fluticasone-salmeterol (authorized generic of Advair HFA), Dulera, AirDuo Digihaler, AirDuo Respiclick *	
Approval Length	12 month(s)

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DULERA	MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 50-5 MCG/ACT	44209902903210	Brand
DULERA	MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 100-5 MCG/ACT	44209902903220	Brand
DULERA	MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 200-5 MCG/ACT	44209902903240	Brand
AIRDUO RESPICLICK 55/14	FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT	44209902708010	Generic
AIRDUO RESPICLICK 113/14	FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT	44209902708015	Generic
AIRDUO RESPICLICK 232/14	FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT	44209902708025	Generic
AIRDUO DIGIHALER 55/14	FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT W/ SENSOR	44209902718020	Brand
AIRDUO DIGIHALER 113/14	FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT W/SENSOR	44209902718030	Brand
AIRDUO DIGIHALER 232/14	FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT W/SENSOR	44209902718040	Brand
FLUTICASONE PROPIONATE/SALMETEROL HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 45-21 MCG/ACT	44209902703250	Generic
ADVAIR HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 45-21 MCG/ACT	44209902703250	Generic
FLUTICASONE PROPIONATE/SALMETEROL HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 115-21 MCG/ACT	44209902703260	Generic
ADVAIR HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 115-21 MCG/ACT	44209902703260	Generic
FLUTICASONE PROPIONATE/SALMETEROL HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 230-21 MCG/ACT	44209902703270	Generic
ADVAIR HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 230-21 MCG/ACT	44209902703270	Generic

Approval Criteria

1 - Diagnosis of asthma

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AND

2 - ONE of the following:

2.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

3 - ONE of the following:

3.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

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<tr><td>Notes</td><td>*Policy applies to Brand Necessary requests</td></tr>
</table>

Product Name: Brand Symbicort, Brand Advair Diskus*	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ADVAIR DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT	44209902708020	Brand
ADVAIR DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT	44209902708030	Brand
ADVAIR DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT	44209902708040	Brand
SYMBICORT	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT	44209902413220	Brand
SYMBICORT	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT	44209902413240	Brand

Approval Criteria

1 - All of the following:

1.1 Diagnosis of asthma

AND

1.2 ONE of the following:

1.2.1 BOTH of the following:

1.2.1.1 Patient is less than 12 years of age

AND

1.2.1.2 ONE of the following:

1.2.1.2.1 Failure of Breyna or budesonide/formoterol (generic of Symbicort) confirmed by claims history or submitted medical records

OR

1.2.1.2.2 History of intolerance or contraindication to Breyna or budesonide/formoterol (generic of Symbicort) (please specify intolerance or contraindication)

OR

1.2.2 BOTH of the following:

1.2.2.1 ONE of the following:

1.2.2.1.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

1.2.2.1.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

1.2.2.2 ONE of the following:

1.2.2.2.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

1.2.2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

2 - All of the following:

2.1 Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

2.2 ONE of the following:

2.2.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

2.3 ONE of the following:

2.3.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

2.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

Notes	*Policy applies to Brand Necessary requests

Product Name: Breo Ellipta*	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BREO ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 100-25 MCG/ACT	44209902758020	Generic
BREO ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 200-25 MCG/ACT	44209902758030	Generic

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of asthma

AND

1.2 BOTH of the following:

1.2.1 ONE of the following:

1.2.1.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

1.2.1.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

1.2.2 ONE of the following:

1.2.2.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

1.2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Breyna or budesonide/formoterol (generic of Symbicort))
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

2 - ALL of the following:

2.1 Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

2.2 ONE of the following:

2.2.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

2.3 ONE of the following:

2.3.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

2.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

Notes	*Policy applies to Brand Necessary requests

Impavido

Prior Authorization Guideline

Guideline ID	GL-146340
Guideline Name	Impavido
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Impavido	
Approval Length	28 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMPAVIDO	MILTEFOSINE CAP 50 MG	16000036000120	Brand

Approval Criteria

1 - Patient has a diagnosis of ONE of the following:

- Visceral leishmaniasis due to Leishmania donovani
- Cutaneous leishmaniasis due to Leishmania braziliensis, Leishmania guyanensis, or Leishmania panamensis
- Mucosal leishmaniasis due to Leishmania braziliensis
- Primary Amebic Meningoencephalitis (PAM)
- Keratitis due to Acanthamoeba
- Amebic encephalitis due to Balamuthia mandrillaris

Inbrija

Prior Authorization Guideline

Guideline ID	GL-146342
Guideline Name	Inbrija
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Inbrija	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INBRIJA	LEVODOPA INHAL POWDER CAP 42 MG	73200040000160	Brand

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Inbrija will be used as intermittent treatment for OFF episodes

AND

3 - Prescribed by, or in consultation with, a neurologist or specialist in the treatment of Parkinson's disease

AND

4 - Patient is currently on a stable dose of a carbidopa/levodopa-containing medication and will continue receiving treatment with a carbidopa/levodopa-containing medication while on therapy

AND

5 - Patient continues to experience greater than or equal to 2 hours of OFF time per day despite optimal management of carbidopa/levodopa therapy including BOTH of the following:

- Taking carbidopa/levodopa on an empty stomach or at least one half-hour or more before or one hour after a meal or avoidance of high protein diet
- Dose and dosing interval optimization

AND

6 - ONE of the following:

6.1 Failure to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes confirmed by claims history or submission of medical records (trial must be from two different classes):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., selegiline)

OR

6.2 History of contraindication or intolerance to ALL anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (please specify intolerance or contraindication):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., selegiline)

Product Name: Inbrija	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INBRIJA	LEVODOPA INHAL POWDER CAP 42 MG	73200040000160	Brand

Approval Criteria

1 - Documentation of positive clinical response to Inbrija therapy

AND

2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication

Inhaled Corticosteroids

Prior Authorization Guideline

Guideline ID	GL-149518
Guideline Name	Inhaled Corticosteroids
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/4/2024

1 . Criteria

Product Name: Asmanex HFA, Asmanex Twisthaler	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ASMANEX HFA	MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 100 MCG/ACT	44400036203220	Brand
ASMANEX HFA	MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 200 MCG/ACT	44400036203230	Brand
ASMANEX HFA	MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 50 MCG/ACT	44400036203210	Brand
ASMANEX TWISTHALER	MOMETASONE FUROATE INHAL POWD 110 MCG/ACT (BREATH ACTIVATED)	44400036208010	Brand

30 METERED DOSES			
ASMANEX TWISTHALER 14 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand
ASMANEX TWISTHALER 60 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand
ASMANEX TWISTHALER 120 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand
ASMANEX TWISTHALER 30 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand

Approval Criteria

1 - Diagnosis of asthma

AND

2 - ONE of the following:

2.1 Failure of Brand Fluticasone propionate HFA confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to Brand Fluticasone propionate HFA (please specify intolerance or contraindication)

Product Name: Alvesco, ArmonAir Digihaler, Arnuity Ellipta, Flovent Diskus, Brand Flovent HFA, Pulmicort Flexhaler, Qvar RediHaler	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FLOVENT DISKUS	FLUTICASONE PROPIONATE AER POW BA 50 MCG/BLISTER	44400033208010	Brand
FLOVENT DISKUS	FLUTICASONE PROPIONATE AER POW BA 100 MCG/BLISTER	44400033208020	Brand
FLOVENT DISKUS	FLUTICASONE PROPIONATE AER POW BA 250 MCG/BLISTER	44400033208030	Brand
PULMICORT FLEXHALER	BUDESONIDE INHAL AERO POWD 90 MCG/ACT (BREATH ACTIVATED)	44400015008009	Brand
PULMICORT FLEXHALER	BUDESONIDE INHAL AERO POWD 180 MCG/ACT (BREATH ACTIVATED)	44400015008018	Brand
ALVESCO	CICLESONIDE INHAL AEROSOL 80 MCG/ACT	44400017003420	Brand
ALVESCO	CICLESONIDE INHAL AEROSOL 160 MCG/ACT	44400017003440	Brand
ARMONAIR DIGIHALER	FLUTICASONE PROPIONATE AER POW BA 55 MCG/ACT WITH SENSOR	44400033218020	Brand
ARMONAIR DIGIHALER	FLUTICASONE PROPIONATE AER POW BA 113 MCG/ACT WITH SENSOR	44400033218030	Brand
ARMONAIR DIGIHALER	FLUTICASONE PROPIONATE AER POW BA 232 MCG/ACT WITH SENSOR	44400033218040	Brand
ARNUITY ELLIPTA	FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 50 MCG/ACT	44400033108010	Brand
ARNUITY ELLIPTA	FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 100 MCG/ACT	44400033108020	Brand
ARNUITY ELLIPTA	FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 200 MCG/ACT	44400033108030	Brand
FLOVENT HFA	FLUTICASONE PROPIONATE HFA INHAL AERO 44 MCG/ACT (50/VALVE)	44400033223220	Generic
FLOVENT HFA	FLUTICASONE PROPIONATE HFA INHAL AER 110 MCG/ACT (125/VALVE)	44400033223230	Generic
FLOVENT HFA	FLUTICASONE PROPIONATE HFA INHAL AER 220 MCG/ACT (250/VALVE)	44400033223240	Generic
QVAR REDIHALER	BECLOMETHASONE DIPROP HFA BREATH ACT INH AER 40 MCG/ACT	44400010128120	Brand
QVAR REDIHALER	BECLOMETHASONE DIPROP HFA BREATH ACT INH AER 80 MCG/ACT	44400010128140	Brand

Approval Criteria

1 - Diagnosis of asthma

AND

2 - ONE of the following:

2.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Brand Fluticasone propionate HFA
- Asmanex HFA or Asmanex Twisthaler

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Brand Fluticasone propionate HFA
- Asmanex HFA or Asmanex Twisthaler

Insulin Pen Needles and Syringes

Prior Authorization Guideline

Guideline ID	GL-146888
Guideline Name	Insulin Pen Needles and Syringes
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Non-preferred insulin pen needles and insulin syringes	
Diagnosis	Non-Preferred
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EASY TOUCH SAFETY PEN NEEDLES/29G X 5MM	INSULIN PEN NEEDLE 29 G X 5 MM (1/5" OR 3/16")	97051050146318	Brand
MAXI-COMFORT SAFETY PEN NEEDLE/29G X 3/16"	INSULIN PEN NEEDLE 29 G X 5 MM (1/5" OR 3/16")	97051050146318	Brand
EASY TOUCH SAFETY PEN NEEDLES/29G X 8MM	INSULIN PEN NEEDLE 29 G X 8 MM (1/3" OR 5/16")	97051050146322	Brand
MAXI-COMFORT SAFETY PEN NEEDLE/29G X 5/16"	INSULIN PEN NEEDLE 29 G X 8 MM (1/3" OR 5/16")	97051050146322	Brand

DROPLET PEN NEEDLES 29GX10MM	INSULIN PEN NEEDLE 29 G X 10 MM	97051050146326	Brand
TECHLITE PEN NEEDLES 29G X 10MM	INSULIN PEN NEEDLE 29 G X 10 MM	97051050146326	Brand
AURORA PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREFINE PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREONE UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CARETOUCH PEN NEEDLE 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DROPLET PEN NEEDLES 29G X1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DROPLET PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DRUG MART UNIFINE PENTIPS29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EASY TOUCH PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EXEL COMFORT POINT INSULIN PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
GLOBAL EASE INJECT PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
H-E-B INCONTROL PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
HEALTHWISE PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
INSUPEN 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
KROGER PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
MARATHON MEDICAL PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
MEDICINE SHOPPE PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
MEIJER PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PC UNIFINE PENTIPS 29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand

PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PEN NEEDLES/29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PENTIPS 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PREFERRED PLUS UNIFINE PENTIPS 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PX PEN NEEDLE 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
QC PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
RAYA SURE PEN NEEDLE 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
RELION PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
SHOPKO UNIFINE PENTIPS PEN NEEDLES/ORIGINAL/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
SHOPKO UNIFINE PENTIPS PLUS PEN NEEDLES/REMOVER/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TECHLITE PEN NEEDLES 29G X 12 MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TODAYS HEALTH ORIGINAL PEN NEEDLES 29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TRUEPLUS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
ULTRA FLO INSULIN PEN NEEDLES	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
UNIFINE PENTIPS PLUS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VALUMARK PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VIDA MIA UNIFINE PENTIPS ORIGINAL 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
1ST TIER UNIFINE PENTIPS PLUS/ORIGINAL/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
1ST TIER UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
ADVOCATE INSULIN PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand

BD PEN NEEDLE/ORIGINAL/ULTRA-FINE/29G X 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
LITETOUCH PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
SURE COMFORT PEN NEEDLES 29GX1/2" 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTICARE ORIGINAL PEN NEEDLES ULTI-FINE	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTICARE PEN NEEDLES/29G X 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTIGUARD SAFEPACK PEN NEEDLE/29G X 1/2"/SHARPS CONTAINER	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTILET PEN NEEDLE 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTRA-THIN II PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
BD AUTOSHIELD DUO 30G X 5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
EASY TOUCH PEN NEEDLE/30 G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
PEN NEEDLES 30GX5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
SAFETY PEN NEEDLES/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
ULTICARE MINI SAFETY PEN NEEDLES 30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE PENTIPS PLUS/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE PENTIPS/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE SAFECONTROL PEN NEEDLE/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
EASY TOUCH SAFETY PEN NEEDLES/30G X 1/4"	INSULIN PEN NEEDLE 30 G X 6 MM (1/4" OR 15/64")	97051050146341	Brand
ABOUTTIME PEN NEEDLES 30GX 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
ASSURE ID SAFETY PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
CAREFINE PEN NEEDLES 30GX5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
DROPLET PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand

EASY TOUCH PEN NEEDLE 30 G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
EASY TOUCH SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
INSUPEN ULTRAFIN 30GX8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
NOVOFINE AUTOCOVER PEN NEEDLE 30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
PEN NEEDLES 30GX8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SECURESAFE SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SURE COMFORT PEN NEEDLES 30GX5/16" SHORT	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
ULTICARE SHORT SAFETY PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
UNIFINE SAFECONTROL PEN NEEDLE/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
AUM SAFETY PEN NEEDLE/31 G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
COMFORT TOUCH PEN NEEDLES/31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
RAYA SURE PEN NEEDLE 31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
ABOUTTIME PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ADVOCATE INSULIN PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AUM SAFETY PEN NEEDLE/31 G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AURORA UNIFINE PENTIPS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
BD PEN NEEDLE/MINI/ULTRA-FINE/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CAREONE UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CARETOUCH PEN NEEDLES 31GX 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CLICKFINE PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

COMFORT EZ/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
COMFORT TOUCH PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DIATHRIVE PEN NEEDLE/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPLET PEN NEEDLES 31G X3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPLET PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPSAFE SAFETY PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DRUG MART UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EASY COMFORT PEN NEEDLES 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EASY TOUCH PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FIFTY50 PEN NEEDLES 31G X3/16" (5MM)	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FIFTY50 PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FREDS PHARMACY UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GLOBAL EASE INJECT PEN NEEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GNP ULTICARE PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GNP ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GOODSENSE CLICKFINE SAFETY PEN NEEDLE/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL PEN NEEDLE 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
HEALTHWISE SHORT PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
HM ULTICARE MINI PEN NEEDLES/31G X 5MM (3/16")	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
INSUPEN 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
KROGER PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LEADER UNIFINE PENTIPS PLUS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LEADER UNIFINE PENTIPS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LITETOUCH PEN NEEDLES/31 G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LITETOUCH PEN NEEDLES/31G X 5MM/MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
MARATHON MEDICAL PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
MM PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PC UNIFINE PENTIPS 31G X 5MM MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PENTIPS 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PREFERRED PLUS UNIFINE PENTIPS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PX MINI PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
RA PEN NEEDLES 31G X 5MM 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
RAYA SURE PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
SHOPKO UNIFINE PENTIPS PEN NEEDLES/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
SHOPKO UNIFINE PENTIPS PLUS PEN NEEDLES/MINI/REMOVER/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

SURE COMFORT PEN NEEDLES 31GX3/16" (5MM)	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TECHLITE PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TECHLITE PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT PRO PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUEPLUS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTICARE PEN NEEDLES 31G X 5MM/MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTIGUARD SAFEPACK MINI PEN NEEDLE/31G X 3/16"/SHARPS CONTAI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 3/16"/SHARPS CONTAI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTILET PEN NEEDLE 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTILET SHORT PEN NEEDLES31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRA FLO INSULIN PEN NEEDLE 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRA-THIN II MINI PEN NEEEDLES/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRACARE PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE ULTRA PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
WEGMANS UNIFINE PENTIPS PLUS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ZEVRX PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
1ST TIER UNIFINE PENTIPS /MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

1ST TIER UNIFINE PENTIPS PLUS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AURORA PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREFINE PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREONE UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CARETOUCH PEN NEEDLES 31 G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLICKFINE PEN NEEDLE UNIVERSAL/31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLICKFINE PEN NEEDLES 31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
COMFORT EZ/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
COMFORT TOUCH PEN NEEDLES/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DIATHRIVE PEN NEEDLE/31 G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DROPLET PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DROPSAFE SAFTEY PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DRUG MART UNIFINE PENTIPS31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EASY COMFORT PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EASY TOUCH PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EXEL COMFORT POINT INSULIN PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
GNP CLICKFINE UNIVERSAL PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
HEALTHWISE MINI PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand

INCONTROL ULTICARE MINI PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
INSUPEN ULTRAFIN 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
KROGER PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
KROGER PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
LITETOUCH PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
LITETOUCH PEN NEEDLES 31G X 6MM/ULTRA SHORT	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MAXICOMFORT II PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MEDICINE SHOPPE PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MEIJER PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MICRODOT PEN NEEDLE/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MM PEN NEEDLES 31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PC UNIFINE PENTIPS 31G X 6MM ULTRA SHORT	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES 31GX6MM (1/4")	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
BD INSULIN SYRINGE/U-500/0.5ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-500 0.5 ML 31G X 6MM (15/64")	97051030956330	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.3ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD INSULIN SYRINGE/0.3ML/29G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
DROPLET INSULIN SYRINGE 0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
EQL INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand

EXEL COMFORT POINT INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
GNP INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
KROGER INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
LEADER INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.3ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
ULTICARE INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
VP INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand

DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EASY TOUCH INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EQL INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLOBAL INSULIN SYRINGES/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GNP INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GNP INSULIN SYRINGES/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
INSULIN SYRINGE/NEEDLE 0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
KROGER INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LEADER INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MEDIC INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MM INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MONOJECT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
PRECISION SURE-DOSE INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand

PREFERRED PLUS INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTICARE INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
B-D INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.3ML/30G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
BD INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
CAREONE INSULIN SYRINGES/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
GLOBAL INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand

SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTICARE INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTICARE INSULIN SYRINGE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 0.3ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.3ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
INSULIN SYRINGES/0.5ML/27GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
MAXICOMFORT INSULIN SYRINGES 27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
B-D INSULIN SYRINGE ULTRAFINE II/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.5ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD INSULIN SYRINGE ULTRAFINE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CAREONE INSULIN SYRINGES/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CARETOUCH INSULIN SYRINGE/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
COMFORT EZ INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
DROPLET INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
EASY COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand

EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
EQL INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GNP INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
KINRAY INSULIN SYRINGE PREFERRED PLUS/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
KROGER INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LEADER INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LITETOUCH INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LONGS INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MM INSULIN SYRINGE/U-100/1/2ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MS INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
PRO COMFORT INSULIN SYRINGES/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
PRODIGY INSULIN SYRINGE/1/2ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand

RELION INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/31G X 5/16	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUE COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTIGUARD SAFEPACK/SYRINGE/NEEDLE/31G X 5/16"/SHARPS CONTAIN	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD LO-DOSE INSULIN SYRINGE MICROFINE IV/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
BD INSULIN SYRINGE MICROFINE IV/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
GNP INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand

INSULIN SYRINGES/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
LEADER INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MAXI-COMFORT INSULIN SYRINGE/U-100/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT INSULIN SYRINGE/PERM NEEDLE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT INSULIN SYRINGE/SOFTPACK/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
REALITY INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
ULTICARE INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD INSULIN SYRINGE/0.5ML/29G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD SAFETY-GLIDE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
DROPLET INSULIN SYRINGE 0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand

EASY TOUCH INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EQL INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GNP INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GNP INSULIN SYRINGES/1/2ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGES/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
KINRAY INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
KROGER INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
LEADER INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
RA INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
REALITY INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
RELION INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
SB INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
SECURESAFE SAFETY INSULIN SYRINGES/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand

SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTICARE INSULIN SAFETY SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTICARE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTRA-THIN II INSULIN SYRINGE/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
VALUE HEALTH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
BD SAFETYGLIDE INSULIN SYSYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CARETOUCH INSULIN SYRINGE0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY TOUCH INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EQL INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
KMART VALU PLUS INSULIN SYRINGE/0.3ML/30G	INSULIN SYRINGE (DISP) U-100 0.3 ML	97051030056305	Brand

KMART VALU PLUS INSULIN SYRINGE/0.5ML/29G	INSULIN SYRINGE (DISP) U-100 1/2 ML	97051030056310	Brand
KMART VALU PLUS INSULIN SYRINGE/0.5ML/30G	INSULIN SYRINGE (DISP) U-100 1/2 ML	97051030056310	Brand
BD INSULIN SYRINGE LUER-LOK/U-100/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
BD INSULIN SYRINGE SLIP TIP/U-100/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
KMART VALU PLUS INSULIN SYRINGE/1ML/29G	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
KMART VALU PLUS INSULIN SYRINGE/1ML/30G	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
MONOJECT INSULIN SYRINGE REGULAR LUER TIP/SOFTPACK/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
MONOJECT INSULIN SYRINGE/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 0.5ML	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
VERIFINE INSULIN SYRINGE 0.5ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/U-100/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
INSULIN SYRINGES/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
VERIFINE INSULIN SYRINGE 0.5ML/29G X 12MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
AQ INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
GNP INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
INSULIN SYRINGES/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
KROGER INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand

LEADER INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
LITETOUCH INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MEDIC INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MM INSULIN SYRINGE/U-100/1/2ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MONOJECT INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
PRO COMFORT INSULIN SYRINGES/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
RA INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
SB INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTICARE INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand

VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ZEVRX INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CAREONE INSULIN SYRINGES/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
DROPLET INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
EASY COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
PRO COMFORT INSULIN SYRINGES/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
PX INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
TRUE COMFORT PRO INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTICARE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTICARE INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1/2ML 30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.5ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand

ZEVRX INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
MONOJECT INSULIN SYRINGE/DETACH NEEDLE/1ML/25G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 25 X 5/8"	97051030906330	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/0.3ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/1/2 UNIT/0.3ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPLET INSULIN SYRINGE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 0.3ML	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
RELION INSULIN SYRINGE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
INSULIN SYRINGES 0.3ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31GX1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/HALF UNIT/0.3ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/0.3ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/0.3ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
INSULIN SYRINGES 0.5ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand
SURE COMFORT INSULIN SYRINGES/0.5ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand

ULTICARE U-100 INSULIN SYRINGES/0.5ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand
INSULIN SYRINGE 1ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
SURE COMFORT INSULIN SYRINGES/U-100/1ML/31GX6MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
ULTICARE U-100 INSULIN SYRINGES/1ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
VANISHPOINT INSULIN SYRINGE/1ML/30G X 3/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 3/16" (5 MM)	97051030906338	Brand
EASY COMFORT INSULIN SYRINGE/0.3ML/31G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/2"	97051030906341	Brand
EASY COMFORT INSULIN SYRINGES/0.5ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 32 X 5/16"	97051030906343	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/32G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 32 X 5/16"	97051030906343	Brand
EASY COMFORT INSULIN SYRINGE/1ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 32 X 5/16"	97051030906344	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 32 X 5/16"	97051030906344	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
INSULIN SYRINGES/U-100/1ML/27GX/1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MAXICOMFORT INSULIN SYRINGES 27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MONOJECT INSULIN SYRINGE/DETACH NEEDLE/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MONOJECT INSULIN SYRINGE/SOFTPACK/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 3/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 30 X 3/16" (5 MM)	97051030906355	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 15/64"	97051030906359	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/27G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8"	97051030906360	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 30 X 15/64"	97051030906361	Brand
DROPLET INSULIN SYRINGE U-100/1ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 15/64"	97051030906362	Brand
CARETOUCH INSULIN SYRINGE/U-100/1ML/28G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 5/16"	97051030906368	Brand

BD INSULIN SYRINGE MICROFINE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GNP INSULIN SYRINGES/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GNP ULTRA COMFORT INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
INSULIN SYRINGES/U-100/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
LEADER INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MAXI-COMFORT INSULIN SYRINGE/U-100/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT INSULIN SYRINGE/PERM NEEDLE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
PRODIGY INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
REALITY INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
ULTICARE INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
AQ INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand

DROPLET INSULIN SYRINGE 1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 29GX12.5MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EQL INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GNP INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GNP INSULIN SYRINGES/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/NEEDLE 1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGES/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
KROGER INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
LEADER INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand

RA INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
REALITY INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SB INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SECURESAFE SAFETY INSULIN SYRINGES/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TRUEPLUS INSULIN SYRINGE /U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTICARE INSULIN SAFETY SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTICARE INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTRA FLO INSULIN SYRINGE 1M/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTRA-THIN II INSULIN SYRINGE/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VALUE HEALTH INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VANISHPOINT INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VERIFINE INSULIN SYRINGE 1ML/29G X 12MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
CARETOUCH INSULIN SYRINGE/U-100/1ML/29G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 5/16"	97051030906382	Brand
VANISHPOINT INSULIN SYRINGE/1ML/29G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 5/16"	97051030906382	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
CARETOUCH INSULIN SYRINGE/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
DROPLET INSULIN SYRINGE U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY COMFORT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand

EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY TOUCH INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EQL INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GNP INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GNP INSULIN SYRINGES/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
HEALTHWISE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/NEEDLE 1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
KROGER INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LEADER INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LITETOUCH INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MM INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MONOJECT INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
PRO COMFORT INSULIN SYRINGES/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
RA INSULIN SYRINGE/U-100/1 ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand

SB INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTICARE INSULIN SYRINGE/SHORT/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTICARE INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRA FLO INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
VANISHPOINT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ZEVRX INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
BD INSULIN SYRINGE ULTRA FINE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
BD INSULIN SYRINGE ULTRA-FINE/1ML/30G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
BD INSULIN SYRINGE ULTRAFINE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
CAREONE INSULIN SYRINGES/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1.0ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
DROPLET INSULIN SYRINGE U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY COMFORT INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand

EASY TOUCH INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH SHEATHLOCK SAFETY SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
HM ULTICARE INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
INSULIN SYRINGES/U-100/1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
PRO COMFORT INSULIN SYRINGES/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
TRUE COMFORT PRO INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTICARE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTICARE INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1ML 30G X 1/2"/SHARPS CON	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTRA FLO INSULIN SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ZEVRX INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
AQ INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
BD INSULIN SYRINGE ULTRA-FINE/1ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
CAREONE INSULIN SYRINGES/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
CARETOUCH INSULIN SYRINGE/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand

CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
COMFORT EZ INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPLET INSULIN SYRINGE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EQL INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GNP INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
HEALTHWISE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGE/NEEDLE 1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGES/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
KINRAY INSULIN SYRINGE PREFERRED PLUS/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
KROGER INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
LEADER INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand

LITETOUCH INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MM INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MONOJECT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MS INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
PRO COMFORT INSULIN SYRINGES/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
RELION INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
SB INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUE COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE/SHORT/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1ML 31G X 5/16"/SHARPS CO	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRA FLO INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
VERIFINE INSULIN SYRINGE 1ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand

CAREONE INSULIN SYRINGES/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
CARETOUCH INSULIN SYRINGE/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
COMFORT ASSIST INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPLET INSULIN SYRINGE U-100/0.3/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPLET INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 0.3ML	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EASY COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EASY TOUCH INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EQL INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLOBAL EASY GLIDE INSULINSYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GNP INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GNP INSULIN SYRINGES/3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
HM ULTICARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
INSULIN SYRINGE/NEEDLE 0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand

KINRAY INSULIN SYRINGE PREFERRED PLUS/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
KROGER INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LEADER INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MM INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MS INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
PRODIGY INSULIN SYRING/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
RELION INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31G X 5/16	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.3ML/31G X 5/16"/SHARPS	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand

ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
VERIFINE INSULIN SYRINGE 0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ASSURE ID INSULIN SAFETY SYRINGE U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
DROPLET INSULIN SYRINGE/U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 0.5ML	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
RELION INSULIN SYRINGE 0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
ASSURE ID INSULIN SAFETY SYRINGE/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPLET INSULIN SYRINGE U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
RELION INSULIN SYRINGE 1ML/31GX15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
RELION INSULIN SYRINGE/U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
EMBRACE PEN NEEDLES/29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VERIFINE INSULIN PEN NEEDLE 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EMBRACE PEN NEEDLES/30G X 5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
EMBRACE PEN NEEDLES/30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand

PEN NEEDLES	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
AUM INSULIN SAFETY PEN NEEDLE/31GX4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
AQINJECT PEN NEEDLE/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AUM INSULIN SAFETY PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EMBRACE PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PIP PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PURE COMFORT SAFETY PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT SAFETY PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
VERIFINE INSULIN PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
VERIFINE PLUS INSULIN PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EMBRACE PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PREVENT DROPSAFE SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PREVENT SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PURE COMFORT SAFETY PEN NEEDLE 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PX EXTRA SHORT PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
QC PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RAYA SURE PEN NEEDLE 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand

RELION MINI PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
SURE COMFORT AUTOKEEPER SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TECHLITE PEN NEEDLES/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TOPCARE CLICKFINE UNIVERSAL PEN EEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUE COMFORT PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUE COMFORT PRO PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUE COMFORT SAFETY PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUEPLUS PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MICRO PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES ULTI-FINE IV	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 1/4"/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 6MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTRACARE PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
UNIFINE PENTIPS PLUS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand

UNIFINE ULTRA PEN NEEDLE/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
WEGMANS UNIFINE PENTIPS PLUS/ULTRA SHORT/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ZEVRX PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
1ST TIER UNIFINE PENTIPS PLUS/ULTRA SHORT/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
1ST TIER UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ABOUTTIME PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ADVOCATE INSULIN PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
AURORA PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CAREFINE PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CARETOUCH PEN NEEDLES 31GX 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLEVER CHOICE COMFORT EZ INSULIN PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLE UNIVERSAL/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
COMFORT EZ SHORT/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
COMFORT TOUCH PEN NEEDLES/31G X 8 MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DIATHRIVE PEN NEEDLE/31 GX 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DROPLET PEN NEEDLES 31G X5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DROPLET PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DROPSAFE SAFETY PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

DRUG MART UNIFINE PENTIPS31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EASY COMFORT PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EASY TOUCH PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EMBRACE PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
FIFTY50 PEN NEEDLES 31G X5/16" (8MM)	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
FIFTY50 PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GLOBAL EASE INJECT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP ULTICARE PEN NEEDLES /31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
HEALTHWISE SHORT PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
HM ULTICARE SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INCONTROL ULTICARE MINI PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INSUPEN ULTRAFIN 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INSUPEN 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
KROGER PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
KROGER PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
LEADER UNIFINE PENTIPS PLUS/SHORT/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
LITETOUCH PEN NEEDLES 31GX8MM SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

LITETOUCH PEN NEEDLES/31G X 8MM/SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MARATHON MEDICAL PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MEDICINE SHOPPE PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MEIJER PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MM PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PC UNIFINE PENTIPS 31G X 8MM SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX8MM (5/16")	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PENTIPS 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PREVENT DROPSAFE SAFETY PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PREVENT SAFETY PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PRO COMFORT PEN NEEDLES/ 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PX PEN NEEDLE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PX SHORTLENGTH PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
QC PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RA PEN NEEDLES 31G X 8MM 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RAYA SURE PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

RELION PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
SURE COMFORT PEN NEEDLES 31GX5/16" (8MM)	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TECHLITE PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TODAYS HEALTH SHORT PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TOPCARE CLICKFINE UNIVERSAL PEN EEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUE COMFORT PRO PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUEPLUS PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE MICRO PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE MICRO PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES ULTI-FINE IV	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31G X 5/16"/SHARPS CONTA	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31G X 8MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTILET PEN NEEDLE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTILET SHORT PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRA FLO INSULIN PEN NEELE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRA-THIN II PEN NEEDLES/SHORT/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRACARE PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
UNIFINE PENTIPS PLUS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

UNIFINE PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
UNIFINE ULTRA PEN NEEDLE/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
VERIFINE INSULIN PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
VERIFINE PLUS INSULIN PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
WEGMANS UNIFINE PENTIPS PLUS/SHORT/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ZEVRX PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
1ST TIER UNIFINE PENTIPS PLUS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
1ST TIER UNIFINE PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ABOUTTIME PEN NEEDLE 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AQINJECT PEN NEEDLE/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM MINI INSULIN PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM READYGARD DUO SAFETY PEN NEEDLE/32GX4MM/DUAL AUTO PROTEC	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CAREFINE PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CARETOUCH PEN NEEDLES 32GX 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLICKFINE PEN NEEDLE 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLICKFINE PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
COMFORT EZ MICRO/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
COMFORT TOUCH PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DIATHRIVE PEN NEEDLE/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

DROPLET PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DROPLET PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DRUG MART UNIFINE PENTIPSPLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DRUG MART UNIFINE PENTIPS32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EASY COMFORT PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EASY TOUCH PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EMBRACE PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
FIFTY50 PEN NEEDLES/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GLOBAL EASE INJECT PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GLOBAL EASY GLIDE PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GNP ULTICARE PEN NEEDLES/32GX 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GNP ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL PEN NEEDLES/NANO/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
HEALTHWISE MICRON PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INCONTROL ULTICARE MINI PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INSUPEN PEN NEEDLES 32G X4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INSUPEN 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
KROGER PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
LEADER UNIFINE PENTIPS/NANO/32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

LEADER UNIFINE PENTIPS/PLUS/32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
LITETOUCH INSULIN PEN NEEDLES/32G X 4MM/MINI	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MARATHON MEDICAL PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MICRODOT PEN NEEDLE/32G X 4 MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MM PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
NOVOFINE PLUS PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PENTIPS 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PIP PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PRO COMFORT PEN NEEDLES/ 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PURE COMFORT PEN NEEDLE/32G X4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PURE COMFORT SAFETY PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
QC UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT AUTOKEEPER SAFETY PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT PEN NEEDLES 32GX5/32" (4MM)	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TECHLITE PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

TRUE COMFORT PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUE COMFORT SAFETY PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUEPLUS PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 4 MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 4MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"/SHARPS CNTR	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"/SHARPS CONTA	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTILET PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTILET PEN NEEDLE 32GX4MM/SHORT	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRA FLO INSULIN PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRA THIN PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRACARE PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE SAFECONTROL PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE ULTRA PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

VERIFINE INSULIN PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
VERIFINE PLUS INSULIN PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
WEGMANS UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ZEVRX PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
1ST TIER UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
1ST TIER UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM MINI INSULIN PEN NEEDLE/32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
AUM PEN NEEDLE/32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CAREFINE PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CARETOUCH PEN NEEDLES 32GX 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
COMFORT TOUCH PEN NEEDLES/32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
DROPLET PEN NEEDLES 32G X 3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
DROPLET PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
EASY TOUCH PEN NEEDLES 32GX3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
EASY TOUCH 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PEN NEEDLES 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PRO COMFORT PEN NEEDLES/ 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PURE COMFORT PEN NEEDLE/32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
ULTRACARE PEN NEEDLES/32G X 3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
AUM MINI INSULIN PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
AUM PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand

CAREFINE PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
COMFORT TOUCH PEN NEEDLES/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
DROPLET PEN NEEDLES 32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
DROPLET PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
EASY TOUCH PEN NEEDLES 32GX1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
EASY TOUCH 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
FIFTY50 PEN NEEDLES/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GNP ULTICARE PEN NEEDLES/32GX1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GNP ULTIGUARD SAFEPACK/MINI PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
INSUPEN SENSITIVE 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
NOVOFINE PEN NEEDLE 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PEN NEEDLES 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PRO COMFORT PEN NEEDLES/ 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PURE COMFORT PEN NEEDLE 32G X6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
SURE COMFORT PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
TECHLITE PEN NEEDLES/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
ULTICARE MINI PEN NEEDLES/32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/32G X 1/4"/SHARPS CONTAIN	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand

ULTRACARE PEN NEEDLES/32G X 1/14"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
UNIFINE PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
VERIFINE INSULIN PEN NEEDLE 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
BD PEN NEEDLE/MICRO/ULTRA-FINE/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
1ST TIER UNIFINE PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
AUM MINI INSULIN PEN NEEDLE/32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
COMFORT TOUCH PEN NEEDLES/32G X 8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
DROPLET PEN NEEDLES 32G X 5/16"	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
DROPLET PEN NEEDLES 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
INSUPEN SENSITIVE 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
PURE COMFORT PEN NEEDLE 32G X8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
TECHLITE PEN NEEDLES/32G X 8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
ADVOCATE INSULIN PEN NEEDLES	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM MINI INSULIN PEN NEEDLE/33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM PEN NEEDLE/33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CARETOUCH PEN NEEDLE 33GX5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CLEVER CHOICE COMFORT EZ INSULIN PEN NEEDLES 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
COMFORT TOUCH PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
EASY COMFORT PEN NEEDLES 33G X 4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
EASY GLIDE PEN NEEDLES 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand

H-E-B IN CONTROL UNIFINE PENTIPS PLUS 33GX5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
INSUPEN 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
KROGER PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
MICRODOT PEN NEEDLE/33G X 4 MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
PEN NEEDLES 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
ULTRA FLO INSULIN PEN NEEDLE 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
ULTRACARE PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS PLUS 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS PLUS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
1ST TIER UNIFINE PENTIPS PLUS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
1ST TIER UNIFINE PENTIPS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM MINI INSULIN PEN NEEDLE/33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
AUM PEN NEEDLE/33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
COMFORT TOUCH PEN NEEDLES/33GX 3/16"	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
EASY COMFORT PEN NEEDLES 33G X 5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
AUM MINI INSULIN PEN NEEDLE/33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
AUM PEN NEEDLE/33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
COMFORT TOUCH PEN NEEDLES/33GX1/4"	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand

EASY COMFORT PEN NEEDLES 33G X 6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX8MM	INSULIN PEN NEEDLE 33 G X 8 MM (1/3" OR 5/16")	97051050146380	Brand
DROPLET MICRON 34G X 9/64"	INSULIN PEN NEEDLE 34 G X 3.5 MM (9/64")	97051050146385	Brand
B-D INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.5ML/30G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
BD INSULIN SYRINGE MICROFINE IV/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
B-D INSULIN SYRINGE ULTRAFINE II/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRA-FINE/1/2 UNIT/0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRAFINE HALF-UNIT/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRAFINE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE/U-100/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
BD INSULIN SYRINGE/1ML/27G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
BD INSULIN SYRINGE MICROFINE IV/U-100/1ML/27G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8"	97051030906360	Brand
BD INSULIN SYRINGE MICROFINE/U-100/1ML/27G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8"	97051030906360	Brand
BD INSULIN SYRINGE SAFETYGLIDE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
BD INSULIN SYRINGE/1ML/29G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
BD INSULIN SYRINGE/U-100/2ML/27.5G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 2 ML 27.5 X 5/8"	97051030906390	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
BD VEO INSULIN SYRINGE ULTR-FINE/U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand

BD VEO INSULIN SYRINGE ULTRA-FINE/0.5ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
BD SAFETYGLIDE INSULIN SYRINGE/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/1ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
BD PEN NEEDLE/SHORT/ULTRA-FINE/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
BD PEN NEEDLE/NANO 2ND GEN/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
BD PEN NEEDLE/NANO 2ND GEN/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
BD PEN NEEDLE/NANO/ULTRA - FINE/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

Approval Criteria

1 - If the request is non-preferred*, history of failure to a preferred* BD (Becton Dickinson) insulin pen needle or syringe as confirmed by claims history or submission of medical records

OR

2 - If the request is non-preferred*, physician has provided documentation as to why the patient is unable to use a preferred* BD product (document rationale)

Notes	*PDL links are listed in Background.

Product Name: All insulin pen needles and insulin syringes	
Diagnosis	Requests exceeding 6 pen needles or syringes per day*
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
EASY TOUCH SAFETY PEN NEEDLES/29G X 5MM	INSULIN PEN NEEDLE 29 G X 5 MM (1/5" OR 3/16")	97051050146318	Brand
MAXI-COMFORT SAFETY PEN NEEDLE/29G X 3/16"	INSULIN PEN NEEDLE 29 G X 5 MM (1/5" OR 3/16")	97051050146318	Brand

EASY TOUCH SAFETY PEN NEEDLES/29G X 8MM	INSULIN PEN NEEDLE 29 G X 8 MM (1/3" OR 5/16")	97051050146322	Brand
MAXI-COMFORT SAFETY PEN NEEDLE/29G X 5/16"	INSULIN PEN NEEDLE 29 G X 8 MM (1/3" OR 5/16")	97051050146322	Brand
DROPLET PEN NEEDLES 29GX10MM	INSULIN PEN NEEDLE 29 G X 10 MM	97051050146326	Brand
TECHLITE PEN NEEDLES 29G X 10MM	INSULIN PEN NEEDLE 29 G X 10 MM	97051050146326	Brand
AURORA PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREFINE PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREONE UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CARETOUCH PEN NEEDLE 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DROPLET PEN NEEDLES 29G X1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DROPLET PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DRUG MART UNIFINE PENTIPS29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EASY TOUCH PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EXEL COMFORT POINT INSULIN PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
GLOBAL EASE INJECT PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
H-E-B INCONTROL PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
HEALTHWISE PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
INSUPEN 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
KROGER PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
MARATHON MEDICAL PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
MEDICINE SHOPPE PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand

MEIJER PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PC UNIFINE PENTIPS 29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PEN NEEDLES/29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PENTIPS 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PREFERRED PLUS UNIFINE PENTIPS 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PX PEN NEEDLE 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
QC PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
RAYA SURE PEN NEEDLE 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
RELION PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
SHOPKO UNIFINE PENTIPS PEN NEEDLES/ORIGINAL/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
SHOPKO UNIFINE PENTIPS PLUS PEN NEEDLES/REMOVER/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TECHLITE PEN NEEDLES 29G X 12 MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TODAYS HEALTH ORIGINAL PEN NEEDLES 29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TRUEPLUS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
ULTRA FLO INSULIN PEN NEEDLES	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
UNIFINE PENTIPS PLUS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VALUMARK PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VIDA MIA UNIFINE PENTIPS ORIGINAL 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
1ST TIER UNIFINE PENTIPS PLUS/ORIGINAL/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand

1ST TIER UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
ADVOCATE INSULIN PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
BD PEN NEEDLE/ORIGINAL/ULTRA-FINE/29G X 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
LITETOUCH PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
SURE COMFORT PEN NEEDLES 29GX1/2" 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTICARE ORIGINAL PEN NEEDLES ULTI-FINE	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTICARE PEN NEEDLES/29G X 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTIGUARD SAFEPACK PEN NEEDLE/29G X 1/2"/SHARPS CONTAINER	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTILET PEN NEEDLE 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTRA-THIN II PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
BD AUTOSHIELD DUO 30G X 5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
EASY TOUCH PEN NEEDLE/30 G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
PEN NEEDLES 30GX5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
SAFETY PEN NEEDLES/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
ULTICARE MINI SAFETY PEN NEEDLES 30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE PENTIPS PLUS/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE PENTIPS/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE SAFECONTROL PEN NEEDLE/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
EASY TOUCH SAFETY PEN NEEDLES/30G X 1/4"	INSULIN PEN NEEDLE 30 G X 6 MM (1/4" OR 15/64")	97051050146341	Brand
ABOUTTIME PEN NEEDLES 30GX 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
ASSURE ID SAFETY PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand

CAREFINE PEN NEEDLES 30GX5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
DROPLET PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
EASY TOUCH PEN NEEDLE 30 G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
EASY TOUCH SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
INSUPEN ULTRAFIN 30GX8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
NOVOFINE AUTOCOVER PEN NEEDLE 30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
PEN NEEDLES 30GX8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SECURESAFE SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SURE COMFORT PEN NEEDLES 30GX5/16" SHORT	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
ULTICARE SHORT SAFETY PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
UNIFINE SAFECONTROL PEN NEEDLE/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
AUM SAFETY PEN NEEDLE/31 G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
COMFORT TOUCH PEN NEEDLES/31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
RAYA SURE PEN NEEDLE 31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
ABOUTTIME PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ADVOCATE INSULIN PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AUM SAFETY PEN NEEDLE/31 G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AURORA UNIFINE PENTIPS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
BD PEN NEEDLE/MINI/ULTRA-FINE/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CAREONE UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CARETOUCH PEN NEEDLES 31GX 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CLICKFINE PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
COMFORT EZ/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
COMFORT TOUCH PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DIATHRIVE PEN NEEDLE/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPLET PEN NEEDLES 31G X3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPLET PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPSAFE SAFETY PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DRUG MART UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EASY COMFORT PEN NEEDLES 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EASY TOUCH PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FIFTY50 PEN NEEDLES 31G X3/16" (5MM)	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FIFTY50 PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FREDS PHARMACY UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GLOBAL EASE INJECT PEN NEEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GNP ULTICARE PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GNP ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GOODSENSE CLICKFINE SAFETY PEN NEEDLE/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL PEN NEEDLE 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
HEALTHWISE SHORT PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
HM ULTICARE MINI PEN NEEDLES/31G X 5MM (3/16")	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
INSUPEN 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
KROGER PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LEADER UNIFINE PENTIPS PLUS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LEADER UNIFINE PENTIPS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LITETOUCH PEN NEEDLES/31 G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LITETOUCH PEN NEEDLES/31G X 5MM/MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
MARATHON MEDICAL PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
MM PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PC UNIFINE PENTIPS 31G X 5MM MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PENTIPS 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PREFERRED PLUS UNIFINE PENTIPS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PX MINI PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
RA PEN NEEDLES 31G X 5MM 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
RAYA SURE PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
SHOPKO UNIFINE PENTIPS PEN NEEDLES/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

SHOPKO UNIFINE PENTIPS PLUS PEN NEEDLES/MINI/REMOVER/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
SURE COMFORT PEN NEEDLES 31GX3/16" (5MM)	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TECHLITE PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TECHLITE PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT PRO PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUEPLUS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTICARE PEN NEEDLES 31G X 5MM/MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTIGUARD SAFEPACK MINI PEN NEEDLE/31G X 3/16"/SHARPS CONTAI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 3/16"/SHARPS CONTAI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTILET PEN NEEDLE 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTILET SHORT PEN NEEDLES31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRA FLO INSULIN PEN NEEDLE 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRA-THIN II MINI PEN NEEEDLES/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRACARE PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE ULTRA PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
WEGMANS UNIFINE PENTIPS PLUS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

ZEVRX PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
1ST TIER UNIFINE PENTIPS /MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
1ST TIER UNIFINE PENTIPS PLUS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AURORA PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREFINE PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREONE UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CARETOUCH PEN NEEDLES 31 G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLICKFINE PEN NEEDLE UNIVERSAL/31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLICKFINE PEN NEEDLES 31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
COMFORT EZ/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
COMFORT TOUCH PEN NEEDLES/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DIATHRIVE PEN NEEDLE/31 G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DROPLET PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DROPSAFE SAFTEY PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DRUG MART UNIFINE PENTIPS31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EASY COMFORT PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EASY TOUCH PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EXEL COMFORT POINT INSULIN PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
GNP CLICKFINE UNIVERSAL PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand

HEALTHWISE MINI PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
INCONTROL ULTICARE MINI PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
INSUPEN ULTRAFIN 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
KROGER PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
KROGER PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
LITETOUCH PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
LITETOUCH PEN NEEDLES 31G X 6MM/ULTRA SHORT	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MAXICOMFORT II PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MEDICINE SHOPPE PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MEIJER PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MICRODOT PEN NEEDLE/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MM PEN NEEDLES 31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PC UNIFINE PENTIPS 31G X 6MM ULTRA SHORT	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES 31GX6MM (1/4")	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
BD INSULIN SYRINGE/U-500/0.5ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-500 0.5 ML 31G X 6MM (15/64")	97051030956330	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.3ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD INSULIN SYRINGE/0.3ML/29G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand

DROPLET INSULIN SYRINGE 0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
EQL INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
GNP INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
KROGER INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
LEADER INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.3ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
ULTICARE INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
VP INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand

ADVOCATE INSULIN SYRINGE/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EASY TOUCH INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EQL INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLOBAL INSULIN SYRINGES/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GNP INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GNP INSULIN SYRINGES/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
INSULIN SYRINGE/NEEDLE 0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
KROGER INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LEADER INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MEDIC INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MM INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MONOJECT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand

MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
PRECISION SURE-DOSE INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTICARE INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
B-D INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.3ML/30G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
BD INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
CAREONE INSULIN SYRINGES/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand

GLOBAL INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTICARE INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTICARE INSULIN SYRINGE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 0.3ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.3ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
INSULIN SYRINGES/0.5ML/27GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
MAXICOMFORT INSULIN SYRINGES 27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
B-D INSULIN SYRINGE ULTRAFINE II/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.5ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD INSULIN SYRINGE ULTRAFINE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CAREONE INSULIN SYRINGES/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CARETOUCH INSULIN SYRINGE/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
COMFORT EZ INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand

DROPLET INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
EASY COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
EQL INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GNP INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
KINRAY INSULIN SYRINGE PREFERRED PLUS/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
KROGER INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LEADER INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LITETOUCH INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LONGS INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MM INSULIN SYRINGE/U-100/1/2ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MS INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand

PRO COMFORT INSULIN SYRINGES/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
PRODIGY INSULIN SYRINGE/1/2ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
RELION INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/31G X 5/16	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUE COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTIGUARD SAFEPACK/SYRINGE/NEEDLE/31G X 5/16"/SHARPS CONTAIN	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD LO-DOSE INSULIN SYRINGE MICROFINE IV/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
BD INSULIN SYRINGE MICROFINE IV/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand

GNP INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
INSULIN SYRINGES/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
LEADER INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MAXI-COMFORT INSULIN SYRINGE/U-100/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT INSULIN SYRINGE/PERM NEEDLE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT INSULIN SYRINGE/SOFTPACK/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
REALITY INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
ULTICARE INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD INSULIN SYRINGE/0.5ML/29G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD SAFETY-GLIDE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
DROPLET INSULIN SYRINGE 0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand

EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EASY TOUCH INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EQL INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GNP INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GNP INSULIN SYRINGES/1/2ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGES/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
KINRAY INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
KROGER INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
LEADER INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
RA INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
REALITY INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
RELION INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand

SB INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
SECURESAFE SAFETY INSULIN SYRINGES/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTICARE INSULIN SAFETY SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTICARE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTRA-THIN II INSULIN SYRINGE/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
VALUE HEALTH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
BD SAFETYGLIDE INSULIN SYSYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CARETOUCH INSULIN SYRINGE0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY TOUCH INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EQL INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand

GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
KMART VALU PLUS INSULIN SYRINGE/0.3ML/30G	INSULIN SYRINGE (DISP) U-100 0.3 ML	97051030056305	Brand
KMART VALU PLUS INSULIN SYRINGE/0.5ML/29G	INSULIN SYRINGE (DISP) U-100 1/2 ML	97051030056310	Brand
KMART VALU PLUS INSULIN SYRINGE/0.5ML/30G	INSULIN SYRINGE (DISP) U-100 1/2 ML	97051030056310	Brand
BD INSULIN SYRINGE LUER-LOK/U-100/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
BD INSULIN SYRINGE SLIP TIP/U-100/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
KMART VALU PLUS INSULIN SYRINGE/1ML/29G	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
KMART VALU PLUS INSULIN SYRINGE/1ML/30G	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
MONOJECT INSULIN SYRINGE REGULAR LUER TIP/SOFTPACK/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
MONOJECT INSULIN SYRINGE/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 0.5ML	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
VERIFINE INSULIN SYRINGE 0.5ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/U-100/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
INSULIN SYRINGES/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
VERIFINE INSULIN SYRINGE 0.5ML/29G X 12MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
AQ INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
GNP INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand

INSULIN SYRINGES/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
KROGER INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
LEADER INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
LITETOUCH INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MEDIC INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MM INSULIN SYRINGE/U-100/1/2ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MONOJECT INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
PRO COMFORT INSULIN SYRINGES/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
RA INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
SB INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTICARE INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand

ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ZEVRX INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CAREONE INSULIN SYRINGES/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
DROPLET INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
EASY COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
PRO COMFORT INSULIN SYRINGES/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
PX INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
TRUE COMFORT PRO INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTICARE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTICARE INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1/2ML 30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.5ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand

ULTRACARE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ZEVRX INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
MONOJECT INSULIN SYRINGE/DETACH NEEDLE/1ML/25G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 25 X 5/8"	97051030906330	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/0.3ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/1/2 UNIT/0.3ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPLET INSULIN SYRINGE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 0.3ML	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
RELION INSULIN SYRINGE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
INSULIN SYRINGES 0.3ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31GX1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/HALF UNIT/0.3ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/0.3ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/0.3ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
INSULIN SYRINGES 0.5ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand

SURE COMFORT INSULIN SYRINGES/0.5ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand
ULTICARE U-100 INSULIN SYRINGES/0.5ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand
INSULIN SYRINGE 1ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
SURE COMFORT INSULIN SYRINGES/U-100/1ML/31GX6MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
ULTICARE U-100 INSULIN SYRINGES/1ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
VANISHPOINT INSULIN SYRINGE/1ML/30G X 3/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 3/16" (5 MM)	97051030906338	Brand
EASY COMFORT INSULIN SYRINGE/0.3ML/31G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/2"	97051030906341	Brand
EASY COMFORT INSULIN SYRINGES/0.5ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 32 X 5/16"	97051030906343	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/32G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 32 X 5/16"	97051030906343	Brand
EASY COMFORT INSULIN SYRINGE/1ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 32 X 5/16"	97051030906344	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 32 X 5/16"	97051030906344	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
INSULIN SYRINGES/U-100/1ML/27GX/1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MAXICOMFORT INSULIN SYRINGES 27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MONOJECT INSULIN SYRINGE/DETACH NEEDLE/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MONOJECT INSULIN SYRINGE/SOFTPACK/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 3/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 30 X 3/16" (5 MM)	97051030906355	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 15/64"	97051030906359	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/27G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8"	97051030906360	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 30 X 15/64"	97051030906361	Brand

DROPLET INSULIN SYRINGE U-100/1ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 15/64"	97051030906362	Brand
CARETOUCH INSULIN SYRINGE/U-100/1ML/28G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 5/16"	97051030906368	Brand
BD INSULIN SYRINGE MICROFINE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GNP INSULIN SYRINGES/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GNP ULTRA COMFORT INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
INSULIN SYRINGES/U-100/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
LEADER INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MAXI-COMFORT INSULIN SYRINGE/U-100/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT INSULIN SYRINGE/PERM NEEDLE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
PRODIGY INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
REALITY INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
ULTICARE INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand

AQ INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
DROPLET INSULIN SYRINGE 1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 29GX12.5MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EQL INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GNP INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GNP INSULIN SYRINGES/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/NEEDLE 1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGES/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
KROGER INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
LEADER INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand

MONOJECT ULTRA COMFORT INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
RA INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
REALITY INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SB INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SECURESAFE SAFETY INSULIN SYRINGES/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TRUEPLUS INSULIN SYRINGE /U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTICARE INSULIN SAFETY SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTICARE INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTRA FLO INSULIN SYRINGE 1M/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTRA-THIN II INSULIN SYRINGE/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VALUE HEALTH INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VANISHPOINT INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VERIFINE INSULIN SYRINGE 1ML/29G X 12MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
CARETOUCH INSULIN SYRINGE/U-100/1ML/29G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 5/16"	97051030906382	Brand
VANISHPOINT INSULIN SYRINGE/1ML/29G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 5/16"	97051030906382	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
CARETOUCH INSULIN SYRINGE/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand

DROPLET INSULIN SYRINGE U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY COMFORT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY TOUCH INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EQL INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GNP INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GNP INSULIN SYRINGES/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
HEALTHWISE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/NEEDLE 1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
KROGER INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LEADER INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LITETOUCH INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MM INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MONOJECT INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand

PRO COMFORT INSULIN SYRINGES/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
RA INSULIN SYRINGE/U-100/1 ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
SB INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTICARE INSULIN SYRINGE/SHORT/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTICARE INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRA FLO INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
VANISHPOINT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ZEVRX INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
BD INSULIN SYRINGE ULTRA FINE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
BD INSULIN SYRINGE ULTRA-FINE/1ML/30G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
BD INSULIN SYRINGE ULTRAFINE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
CAREONE INSULIN SYRINGES/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1.0ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
DROPLET INSULIN SYRINGE U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY COMFORT INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand

EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH SHEATHLOCK SAFETY SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
HM ULTICARE INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
INSULIN SYRINGES/U-100/1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
PRO COMFORT INSULIN SYRINGES/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
TRUE COMFORT PRO INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTICARE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTICARE INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1ML 30G X 1/2"/SHARPS CON	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTRA FLO INSULIN SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ZEVRX INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
AQ INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
BD INSULIN SYRINGE ULTRA-FINE/1ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
CAREONE INSULIN SYRINGES/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand

CARETOUCH INSULIN SYRINGE/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
COMFORT EZ INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPLET INSULIN SYRINGE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EQL INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GNP INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
HEALTHWISE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGE/NEEDLE 1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGES/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
KINRAY INSULIN SYRINGE PREFERRED PLUS/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
KROGER INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand

LEADER INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MM INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MONOJECT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MS INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
PRO COMFORT INSULIN SYRINGES/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
RELION INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
SB INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUE COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE/SHORT/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1ML 31G X 5/16"/SHARPS CO	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRA FLO INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
VERIFINE INSULIN SYRINGE 1ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand

ADVOCATE INSULIN SYRINGE/U-100/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
CAREONE INSULIN SYRINGES/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
CARETOUCH INSULIN SYRINGE/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
COMFORT ASSIST INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPLET INSULIN SYRINGE U-100/0.3/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPLET INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 0.3ML	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EASY COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EASY TOUCH INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EQL INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLOBAL EASY GLIDE INSULINSYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GNP INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GNP INSULIN SYRINGES/3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
HM ULTICARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
INSULIN SYRINGE/NEEDLE 0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand

INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
KINRAY INSULIN SYRINGE PREFERRED PLUS/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
KROGER INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LEADER INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MM INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MS INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
PRODIGY INSULIN SYRING/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
RELION INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31G X 5/16	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.3ML/31G X 5/16"/SHARPS	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand

ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
VERIFINE INSULIN SYRINGE 0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ASSURE ID INSULIN SAFETY SYRINGE U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
DROPLET INSULIN SYRINGE/U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 0.5ML	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
RELION INSULIN SYRINGE 0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
ASSURE ID INSULIN SAFETY SYRINGE/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPLET INSULIN SYRINGE U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
RELION INSULIN SYRINGE 1ML/31GX15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
RELION INSULIN SYRINGE/U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
EMBRACE PEN NEEDLES/29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VERIFINE INSULIN PEN NEEDLE 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EMBRACE PEN NEEDLES/30G X 5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand

EMBRACE PEN NEEDLES/30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
PEN NEEDLES	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
AUM INSULIN SAFETY PEN NEEDLE/31GX4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
AQINJECT PEN NEEDLE/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AUM INSULIN SAFETY PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EMBRACE PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PIP PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PURE COMFORT SAFETY PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT SAFETY PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
VERIFINE INSULIN PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
VERIFINE PLUS INSULIN PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EMBRACE PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PREVENT DROPSAFE SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PREVENT SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PURE COMFORT SAFETY PEN NEEDLE 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PX EXTRA SHORT PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
QC PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand

RAYA SURE PEN NEEDLE 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION MINI PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
SURE COMFORT AUTOKEEPER SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TECHLITE PEN NEEDLES/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TOPCARE CLICKFINE UNIVERSAL PEN EEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUE COMFORT PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUE COMFORT PRO PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUE COMFORT SAFETY PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUEPLUS PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MICRO PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES ULTI-FINE IV	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 1/4"/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 6MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTRACARE PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
UNIFINE PENTIPS PLUS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand

UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
UNIFINE ULTRA PEN NEEDLE/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
WEGMANS UNIFINE PENTIPS PLUS/ULTRA SHORT/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ZEVRX PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
1ST TIER UNIFINE PENTIPS PLUS/ULTRA SHORT/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
1ST TIER UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ABOUTTIME PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ADVOCATE INSULIN PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
AURORA PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CAREFINE PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CARETOUCH PEN NEEDLES 31GX 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLEVER CHOICE COMFORT EZ INSULIN PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLE UNIVERSAL/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
COMFORT EZ SHORT/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
COMFORT TOUCH PEN NEEDLES/31G X 8 MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DIATHRIVE PEN NEEDLE/31 GX 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DROPLET PEN NEEDLES 31G X5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DROPLET PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

DROPSAFE SAFETY PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DRUG MART UNIFINE PENTIPS31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EASY COMFORT PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EASY TOUCH PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EMBRACE PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
FIFTY50 PEN NEEDLES 31G X5/16" (8MM)	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
FIFTY50 PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GLOBAL EASE INJECT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP ULTICARE PEN NEEDLES /31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
HEALTHWISE SHORT PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
HM ULTICARE SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INCONTROL ULTICARE MINI PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INSUPEN ULTRAFIN 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INSUPEN 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
KROGER PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
KROGER PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
LEADER UNIFINE PENTIPS PLUS/SHORT/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

LITETOUCH PEN NEEDLES 31GX8MM SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
LITETOUCH PEN NEEDLES/31G X 8MM/SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MARATHON MEDICAL PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MEDICINE SHOPPE PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MEIJER PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MM PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PC UNIFINE PENTIPS 31G X 8MM SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX8MM (5/16")	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PENTIPS 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PREVENT DROPSAFE SAFETY PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PREVENT SAFETY PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PRO COMFORT PEN NEEDLES/ 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PX PEN NEEDLE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PX SHORTLENGTH PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
QC PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RA PEN NEEDLES 31G X 8MM 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RAYA SURE PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

RELION PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
SURE COMFORT PEN NEEDLES 31GX5/16" (8MM)	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TECHLITE PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TODAYS HEALTH SHORT PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TOPCARE CLICKFINE UNIVERSAL PEN EEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUE COMFORT PRO PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUEPLUS PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE MICRO PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE MICRO PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES ULTI-FINE IV	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31G X 5/16"/SHARPS CONTA	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31G X 8MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTILET PEN NEEDLE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTILET SHORT PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRA FLO INSULIN PEN NEELE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRA-THIN II PEN NEEDLES/SHORT/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRACARE PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

UNIFINE PENTIPS PLUS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
UNIFINE PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
UNIFINE ULTRA PEN NEEDLE/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
VERIFINE INSULIN PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
VERIFINE PLUS INSULIN PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
WEGMANS UNIFINE PENTIPS PLUS/SHORT/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ZEVRX PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
1ST TIER UNIFINE PENTIPS PLUS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
1ST TIER UNIFINE PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ABOUTTIME PEN NEEDLE 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AQINJECT PEN NEEDLE/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM MINI INSULIN PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM READYGARD DUO SAFETY PEN NEEDLE/32GX4MM/DUAL AUTO PROTEC	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CAREFINE PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CARETOUCH PEN NEEDLES 32GX 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLICKFINE PEN NEEDLE 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLICKFINE PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
COMFORT EZ MICRO/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
COMFORT TOUCH PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

DIATHRIVE PEN NEEDLE/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DROPLET PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DROPLET PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DRUG MART UNIFINE PENTIPSPLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DRUG MART UNIFINE PENTIPS32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EASY COMFORT PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EASY TOUCH PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EMBRACE PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
FIFTY50 PEN NEEDLES/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GLOBAL EASE INJECT PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GLOBAL EASY GLIDE PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GNP ULTICARE PEN NEEDLES/32GX 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GNP ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL PEN NEEDLES/NANO/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
HEALTHWISE MICRON PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INCONTROL ULTICARE MINI PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INSUPEN PEN NEEDLES 32G X4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INSUPEN 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
KROGER PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

LEADER UNIFINE PENTIPS/NANO/32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
LEADER UNIFINE PENTIPS/PLUS/32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
LITETOUCH INSULIN PEN NEEDLES/32G X 4MM/MINI	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MARATHON MEDICAL PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MICRODOT PEN NEEDLE/32G X 4 MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MM PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
NOVOFINE PLUS PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PENTIPS 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PIP PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PRO COMFORT PEN NEEDLES/ 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PURE COMFORT PEN NEEDLE/32G X4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PURE COMFORT SAFETY PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
QC UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT AUTOKEEPER SAFETY PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT PEN NEEDLES 32GX5/32" (4MM)	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

TECHLITE PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUE COMFORT PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUE COMFORT SAFETY PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUEPLUS PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 4 MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 4MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"/SHARPS CNTR	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"/SHARPS CONTA	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTILET PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTILET PEN NEEDLE 32GX4MM/SHORT	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRA FLO INSULIN PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRA THIN PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRACARE PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE SAFECONTROL PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

UNIFINE ULTRA PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
VERIFINE INSULIN PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
VERIFINE PLUS INSULIN PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
WEGMANS UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ZEVRX PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
1ST TIER UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
1ST TIER UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM MINI INSULIN PEN NEEDLE/32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
AUM PEN NEEDLE/32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CAREFINE PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CARETOUCH PEN NEEDLES 32GX 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
COMFORT TOUCH PEN NEEDLES/32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
DROPLET PEN NEEDLES 32G X 3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
DROPLET PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
EASY TOUCH PEN NEEDLES 32GX3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
EASY TOUCH 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PEN NEEDLES 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PRO COMFORT PEN NEEDLES/ 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PURE COMFORT PEN NEEDLE/32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
ULTRACARE PEN NEEDLES/32G X 3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
AUM MINI INSULIN PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand

AUM PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
CAREFINE PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
COMFORT TOUCH PEN NEEDLES/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
DROPLET PEN NEEDLES 32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
DROPLET PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
EASY TOUCH PEN NEEDLES 32GX1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
EASY TOUCH 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
FIFTY50 PEN NEEDLES/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GNP ULTICARE PEN NEEDLES/32GX1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GNP ULTIGUARD SAFEPACK/MINI PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
INSUPEN SENSITIVE 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
NOVOFINE PEN NEEDLE 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PEN NEEDLES 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PRO COMFORT PEN NEEDLES/ 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PURE COMFORT PEN NEEDLE 32G X6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
SURE COMFORT PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
TECHLITE PEN NEEDLES/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
ULTICARE MINI PEN NEEDLES/32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand

ULTIGUARD SAFEPACK/MINI PEN NEEDLE/32G X 1/4"/SHARPS CONTAIN	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
ULTRACARE PEN NEEDLES/32G X 1/14"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
UNIFINE PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
VERIFINE INSULIN PEN NEEDLE 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
BD PEN NEEDLE/MICRO/ULTRA-FINE/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
1ST TIER UNIFINE PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
AUM MINI INSULIN PEN NEEDLE/32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
COMFORT TOUCH PEN NEEDLES/32G X 8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
DROPLET PEN NEEDLES 32G X 5/16"	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
DROPLET PEN NEEDLES 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
INSUPEN SENSITIVE 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
PURE COMFORT PEN NEEDLE 32G X8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
TECHLITE PEN NEEDLES/32G X 8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
ADVOCATE INSULIN PEN NEEDLES	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM MINI INSULIN PEN NEEDLE/33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM PEN NEEDLE/33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CARETOUCH PEN NEEDLE 33GX5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CLEVER CHOICE COMFORT EZ INSULIN PEN NEEDLES 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
COMFORT TOUCH PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand

EASY COMFORT PEN NEEDLES 33G X 4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
EASY GLIDE PEN NEEDLES 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 33GX5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
INSUPEN 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
KROGER PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
MICRODOT PEN NEEDLE/33G X 4 MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
PEN NEEDLES 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
ULTRA FLO INSULIN PEN NEEDLE 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
ULTRACARE PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS PLUS 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS PLUS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
1ST TIER UNIFINE PENTIPS PLUS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
1ST TIER UNIFINE PENTIPS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM MINI INSULIN PEN NEEDLE/33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
AUM PEN NEEDLE/33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
COMFORT TOUCH PEN NEEDLES/33GX 3/16"	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
EASY COMFORT PEN NEEDLES 33G X 5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
AUM MINI INSULIN PEN NEEDLE/33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
AUM PEN NEEDLE/33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand

CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
COMFORT TOUCH PEN NEEDLES/33GX1/4"	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
EASY COMFORT PEN NEEDLES 33G X 6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX8MM	INSULIN PEN NEEDLE 33 G X 8 MM (1/3" OR 5/16")	97051050146380	Brand
DROPLET MICRON 34G X 9/64"	INSULIN PEN NEEDLE 34 G X 3.5 MM (9/64")	97051050146385	Brand
B-D INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.5ML/30G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
BD INSULIN SYRINGE MICROFINE IV/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
B-D INSULIN SYRINGE ULTRAFINE II/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRA-FINE/1/2 UNIT/0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRAFINE HALF-UNIT/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRAFINE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE/U-100/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
BD INSULIN SYRINGE/1ML/27G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
BD INSULIN SYRINGE MICROFINE IV/U-100/1ML/27G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8"	97051030906360	Brand
BD INSULIN SYRINGE MICROFINE/U-100/1ML/27G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8"	97051030906360	Brand
BD INSULIN SYRINGE SAFETYGLIDE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
BD INSULIN SYRINGE/1ML/29G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
BD INSULIN SYRINGE/U-100/2ML/27.5G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 2 ML 27.5 X 5/8"	97051030906390	Brand

BD SAFETYGLIDE INSULIN SYRINGE/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
BD VEO INSULIN SYRINGE ULTR-FINE/U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/0.5ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
BD SAFETYGLIDE INSULIN SYRINGE/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/1ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
BD PEN NEEDLE/SHORT/ULTRA-FINE/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
BD PEN NEEDLE/NANO 2ND GEN/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
BD PEN NEEDLE/NANO 2ND GEN/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
BD PEN NEEDLE/NANO/ULTRA - FINE/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

Approval Criteria

1 - Physician confirmation that the patient requires a greater quantity because of more frequent delivery of insulin

Notes	*The quantity limit for both pen needles and syringes is 6 of each per day.

2 . Background

Benefit/Coverage/Program Information
PDL links NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
4/30/2024	Updated PDL links

Insulins

Prior Authorization Guideline

Guideline ID	GL-146815
Guideline Name	Insulins
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Admelog vial, Apidra vial, Humalog 100U/ml vial, Insulin Aspart vial, Lyumjev vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
APIDRA	INSULIN GLULISINE INJ 100 UNIT/ML	27104004002022	Brand
INSULIN ASPART	INSULIN ASPART INJ SOLN 100 UNIT/ML	27104002002022	Brand
ADMELOG	INSULIN LISPRO INJ SOLN 100 UNIT/ML	27104005002022	Brand
HUMALOG	INSULIN LISPRO INJ SOLN 100 UNIT/ML	27104005002022	Brand
LYUMJEV	INSULIN LISPRO-AABC INJ 100 UNIT/ML	27104005052020	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to insulin lispro vial confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to insulin lispro vial (please specify intolerance or contraindication)

Product Name: Novolog vial, Fiasp vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOVOLOG	INSULIN ASPART INJ SOLN 100 UNIT/ML	27104002002022	Brand
FIASP	INSULIN ASPART (WITH NIACINAMIDE) INJ 100 UNIT/ML	27104002202020	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- insulin lispro vial
- Insulin Aspart vial

OR

1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication):

- insulin lispro vial
- Insulin Aspart vial

Product Name: Novolog Mix 70/30 vial, Novolog Mix 70/30 Relion vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOVOLOG MIX 70/30	INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30)	27104070001820	Brand
NOVOLOG MIX 70/30 RELION	INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30)	27104070001820	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to Insulin Aspart mix vial confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to Insulin Aspart mix vial (please specify intolerance or contraindication)

Product Name: Humalog Mix 75/25 vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMALOG MIX 75/25	INSULIN LISPRO PROT & LISPRO INJ 100 UNIT/ML (75-25)	27104080001820	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to Insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to Insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML (please specify intolerance or contraindication)

Product Name: Humulin R U-500 vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMULIN R U-500 (CONCENTRATED)	INSULIN REGULAR (HUMAN) INJ 500 UNIT/ML	27104010002015	Brand

Approval Criteria

1 - Patient requires more than 200 units of insulin per day

Product Name: Insulin Lispro Kwikpen, Insulin Lispro Junior Kwikpen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INSULIN LISPRO JUNIOR KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (0.5 UNIT DIAL)	2710400500D221	Brand
INSULIN LISPRO KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL)	2710400500D222	Brand

Approval Criteria

1 - ONE of the following:

1.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

1.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

1.3 History of failure to insulin lispro vial as demonstrated by poorly controlled diabetes based on hemoglobin A1c

OR

1.4 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name: Apidra Solostar pen, Humalog cartridge, Humalog Kwikpen, Humalog Junior Kwikpen, Insulin Aspart Penfill, Insulin Aspart Flexpen, Admelog Solostar pen, Lyumjev Kwikpen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
APIDRA SOLOSTAR	INSULIN GLULISINE SOLN PEN-INJECTOR INJ 100 UNIT/ML	2710400400D220	Brand
INSULIN ASPART FLEXPEN	INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML	2710400200D220	Brand

INSULIN ASPART PENFILL	INSULIN ASPART SOLN CARTRIDGE 100 UNIT/ML	2710400200E220	Brand
ADMELOG SOLOSTAR	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL)	2710400500D222	Brand
HUMALOG JUNIOR KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (0.5 UNIT DIAL)	2710400500D221	Brand
HUMALOG KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL)	2710400500D222	Brand
HUMALOG KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 200 UNIT/ML	2710400500D230	Brand
HUMALOG	INSULIN LISPRO SOLN CARTRIDGE 100 UNIT/ML	2710400500E220	Brand
LYUMJEV KWIKPEN	INSULIN LISPRO-AABC SOLN PEN-INJ 100 UNIT/ML (1 UNIT DIAL)	2710400505D222	Brand
LYUMJEV KWIKPEN	INSULIN LISPRO-AABC SOLN PEN-INJECTOR 200 UNIT/ML	2710400505D230	Brand

Approval Criteria

1 - ONE of the following:

1.1 One of the following:

1.1.1 Failure to insulin lispro vial confirmed by claims history or submission of medical records

OR

1.1.2 History of contraindication or intolerance to insulin lispro vial (please specify intolerance or contraindication)

OR

1.2 ONE of the following:

1.2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

1.2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

1.2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

AND

2 - ONE of the following:

2.1 Failure to insulin lispro Kwikpen confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to insulin lispro Kwikpen (please specify intolerance or contraindication)

Product Name: Humalog Tempo Pen, Lyumjev Tempo Pen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMALOG TEMPO PEN	INSULIN LISPRO SOLN PEN-INJ W/TRANSMITTER PORT 100 UNIT/ML	2710400500D224	Brand
LYUMJEV TEMPO PEN	INSULIN LISPRO-AABC SOLN PEN-INJ W/TRANSMIT PORT 100 UNIT/ML	2710400505D224	Brand

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to insulin lispro Kwikpen confirmed by claims history or submission of medical records

OR

1.1.2 History of contraindication or intolerance to insulin lispro Kwikpen (please specify intolerance or contraindication)

AND

1.2 Prescriber provides a reason or special circumstance the patient has to use the Tempo product

Product Name: Novolog Penfill, Novolog Flexpen, Fiasp Penfill, Fiasp Pumpcart, Fiasp FlexTouch	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOVOLOG FLEXPEN	INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML	2710400200D220	Brand
NOVOLOG PENFILL	INSULIN ASPART SOLN CARTRIDGE 100 UNIT/ML	2710400200E220	Brand
FIASP FLEXTOUCH	INSULIN ASPART (WITH NIACINAMIDE) SOL PEN-INJ 100 UNIT/ML	2710400220D220	Brand
FIASP PENFILL	INSULIN ASPART (WITH NIACINAMIDE) SOLN CARTRIDGE 100 UNIT/ML	2710400220E220	Brand
FIASP PUMPCART	INSULIN ASPART (WITH NIACINAMIDE) SOLN CARTRIDGE 100 UNIT/ML	2710400220E220	Brand

Approval Criteria

1 - One of the following:

1.1 One of the following:

1.1.1 Failure to insulin lispro vial confirmed by claims history or submission of medical records

OR

1.1.2 History of contraindication or intolerance to insulin lispro vial (please specify intolerance or contraindication)

OR

1.2 ONE of the following:

- A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin
- A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin
- The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

AND

2 - One of the following:

2.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Insulin lispro Kwikpen
- Insulin aspart pen or cartridge

OR

2.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication):

- Insulin lispro Kwikpen
- Insulin aspart pen or cartridge

Product Name: Novolin R Flexpen, Novolin R Flexpen Relion	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOVOLIN R FLEXPEN RELION	INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 100 UNIT/ML	2710401000D220	Brand
NOVOLIN R FLEXPEN	INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 100 UNIT/ML	2710401000D220	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Humulin R U-100 vial
- Novolin R U-100 vial

OR

1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication):

- Humulin R U-100 vial
- Novolin R U-100 vial

OR

2 - ONE of the following:

2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name: Humulin R U-500 Kwikpen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMULIN R U-500 KWIKPEN	INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 500 UNIT/ML	2710401000D250	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Patient requires more than 200 units of insulin per day

AND

1.2 ONE of the following:

1.2.1 Failure to Humulin R U-500 vial confirmed by claims history or submission of medical records

OR

1.2.2 History of contraindication or intolerance to Humulin R U-500 vial (please specify intolerance or contraindication)

OR

2 - BOTH of the following:

2.1 Patient requires more than 200 units of insulin per day

AND

2.2 ONE of the following:

2.2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

2.2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

2.2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name: Humulin N Kwikpen, Novolin N Flexpen, Novolin N Flexpen Relion	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMULIN N KWIKPEN	INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML	2710402000D320	Brand
NOVOLIN N FLEXPEN RELION	INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML	2710402000D320	Brand

NOVOLIN N FLEXPEN	INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML	2710402000D320	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Humulin N U-100 vial
- Novolin N U-100 vial

OR

1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication):

- Humulin N U-100 vial
- Novolin N U-100 vial

OR

2 - ONE of the following:

2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name: Humalog Mix Kwikpen 50/50, Insulin Aspart Flexpen 70/30, Humulin Kwikpen 70/30, Novolin Flexpen 70/30, Novolin Flexpen Relion 70/30	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMALOG MIX 50/50 KWIKPEN	INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (50-50)	2710408000D340	Brand
INSULIN ASPART PROTAMINE/INSULIN ASPART FLEXPEN	INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30)	2710407000D320	Brand
HUMULIN 70/30 KWIKPEN	INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30)	2710409000D320	Brand
NOVOLIN 70/30 FLEXPEN	INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30)	2710409000D320	Brand
NOVOLIN 70/30 FLEXPEN RELION	INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30)	2710409000D320	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to the corresponding preferred insulin mix vial confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to the corresponding preferred insulin mix vial (please specify intolerance or contraindication)

OR

2 - ONE of the following:

2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name: Novolog Mix 70/30 Flexpen, Novolog Mix 70/30 Flexpen Relion	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30)	2710407000D320	Brand
NOVOLOG MIX 70/30 PREFILLED FLEXPEN RELION	INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30)	2710407000D320	Brand

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following:

- Failure to the corresponding preferred insulin mix vial confirmed by claims history or submission of medical records
- History of contraindication or intolerance to the corresponding preferred insulin mix vial (please specify intolerance or contraindication)

OR

1.2 ONE of the following:

- A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin
- A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin
- The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

AND

2 - ONE of the following:

- Failure to Insulin Aspart Flexpen 70/30 100U/ML confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Insulin Aspart Flexpen 70/30 100U/ML (please specify intolerance or contraindication)

Product Name: Humalog Mix Kwikpen 72/25	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMALOG MIX 75/25 KWIKPEN	INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (75-25)	2710408000D320	Brand

Approval Criteria

1 - One of the following:

1.1 ONE of the following:

- Failure to the corresponding preferred insulin mix vial confirmed by claims history or submission of medical records

- History of contraindication or intolerance to the corresponding preferred insulin mix vial (please specify intolerance or contraindication)

OR

1.2 ONE of the following:

- A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin
- A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin
- The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

AND

2 - One of the following:

- Failure to insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML (please specify intolerance or contraindication)

Product Name: Basaglar Kwikpen, Insulin Glargine Solostar 100U/ml, Insulin glargine-yfgn Pen, Semglee yfgn Pen Injector	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SEMGLEE	INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML	2710400390D220	Brand
INSULIN GLARGINE SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand
BASAGLAR KWIKPEN	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand
INSULIN GLARGINE-YFGN	INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML	2710400390D220	Brand

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

1.2 The provider has given clinical justification why the patient is unable to use the preferred insulin glargine products

Product Name: Basaglar Tempo Pen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BASAGLAR TEMPO PEN	INSULIN GLARGINE PEN-INJ WITH TRANSMITTER PORT 100 UNIT/ML	2710400300D222	Brand

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

1.2 Prescriber provides a reason or special circumstance the patient has to use the Tempo product

Product Name: Toujeo Solostar, Insulin Glargine Solostar 300U/ml, Toujeo Max Solostar, Insulin Glargine Max Solostar 300U/ml	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TOUJEO SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL)	2710400300D233	Brand
TOUJEO MAX SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL)	2710400300D236	Brand
INSULIN GLARGINE SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL)	2710400300D233	Brand
INSULIN GLARGINE MAX SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL)	2710400300D236	Brand

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.3 The provider has given clinical justification why the patient needs a concentrated glargine formulation

AND

1.2 If the request is for Toujeo Solostar or Toujeo Solostar Max, ONE of the following:

1.2.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Insulin glargine Solostar 300U/ml
- Insulin glargine Max Solostar 300U/ml

OR

1.2.2 History of intolerance or contraindication to ONE of the following (please specify intolerance or contraindication):

- Insulin glargine Solostar 300U/ml
- Insulin glargine Max Solostar 300U/ml

Product Name: Levemir Flexpen, Insulin Degludec Flextouch 100U/mL	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INSULIN DEGLUDEC FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML	2710400700D210	Brand
LEVEMIR FLEXPEN	INSULIN DETEMIR SOLN PEN-INJECTOR 100 UNIT/ML	2710400600D220	Brand

Approval Criteria

1 - Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

2 - History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

Product Name: Tresiba Flextouch 100U/mL	
Approval Length	12 month(s)

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRESIBA FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML	2710400700D210	Brand

Approval Criteria

1 - One of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

2 - The provider has given clinical justification why the patient is unable to use the insulin degludec flextouch product

Product Name: Insulin Degludec Flextouch 200U/mL	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INSULIN DEGLUDEC FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML	2710400700D220	Brand

Approval Criteria

1 - Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

2 - History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

3 - The provider has given clinical justification why the patient needs a concentrated formulation

Product Name: Tresiba Flextouch 200U/mL	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRESIBA FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML	2710400700D220	Brand

Approval Criteria

1 - One of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.3 The provider has given clinical justification why the patient needs a concentrated formulation

AND

2 - The provider has given clinical justification why the patient is unable to use the insulin degludec flextouch product

Product Name: Insulin Glargine vial, Insulin glargine-yfgn vial, Semglee yfgn vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SEMGLEE	INSULIN GLARGINE-YFGN INJ 100 UNIT/ML	27104003902020	Brand
INSULIN GLARGINE	INSULIN GLARGINE INJ 100 UNIT/ML	27104003002020	Brand
INSULIN GLARGINE-YFGN	INSULIN GLARGINE-YFGN INJ 100 UNIT/ML	27104003902020	Brand

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

1.2 The provider has given clinical justification why the patient is unable to use the preferred insulin glargine products

Product Name: Levemir vial, Insulin Degludec vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LEVEMIR	INSULIN DETEMIR INJ 100 UNIT/ML	27104006002020	Brand
INSULIN DEGLUDEC	INSULIN DEGLUDEC INJ 100 UNIT/ML	27104007002020	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

Product Name: Tresiba vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRESIBA	INSULIN DEGLUDEC INJ 100 UNIT/ML	27104007002020	Brand

Approval Criteria

1 - One of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

2 - The provider has given clinical justification why the patient is unable to use the insulin degludec product

Product Name: Admelog Solostar, Apidra, Insulin Aspart vial, Insulin Lispro vial, Humalog vial, Novolog vial, Novolog Relion vial, Fiasp vial, Lyumjev vial, Novolog Mix 70/30 vial, Novolog Mix 70/30 Relion vial, Humulin R U-500 vial, Apidra Solostar, Insulin Aspart Flexpen, Insulin Aspart Penfill, Insulin Lispro Junior Kwikpen, Insulin Lispro Kwikpen, Humalog Junior Kwikpen, Humalog Kwikpen, Humalog Tempo Pen, Novolog Flexpen, Novolog Flexpen Relion, Novolog Penfill, Fiasp Flextouch, Fiasp Penfill, Fiasp Pumpcart, Lyumjev Kwikpen, Lyumjev Tempo Pen, Novolin R Flexpen Relion, Novolin R Flexpen, Humulin R U-500 Kwikpen, Humulin N Kwikpen, Novolin N Flexpen Relion, Novolin N Flexpen, Humalog Mix 75/25 Kwikpen, Insulin Lispro Mix Kwikpen 72/25, Humalog Mix 50/50 Kwikpen, Insulin Aspart Protamine/Insulin Aspart 70/30 Flexpen, Humulin 70/30 Kwikpen, Novolin 70/30 Flexpen, Novolin 70/30 Flexpen Relion, Novolog Mix 70/30 Flexpen, Novolog Mix 70/30 Flexpen Relion, Lantus Solostar, Basaglar Tempo Pen, Toujeo Solostar, Insulin Glargine Solostar 300U/ml, Toujeo Max Solostar, Insulin Glargine Max Solostar 300U/ml, Semglee yfgn Pen Injector, Semglee yfgn vial Levemir Flexpen, Tresiba Flextouch, Insulin Degludec Flextouch, Semglee vial, Lantus vial, Levemir vial, Tresiba vial, Insulin Degludec vial, Basaglar Kwikpen, Insulin Glargine vial, Insulin Glargine-YFGN pen and vial, Insulin Glargine Solostar 100U/ml, Humulin R vial, Novolin R vial, Novolin R Relion vial, Humulin N vial, Novolin N Relion vial, Novolin N vial, Insulin Aspart Protamine/Insulin Aspart 70/30 vial, Humalog Mix 75/25 vial, Humalog Mix 50/50 vial, Humulin 70/30 vial, Novolin 70/30 Relion vial, Novolin 70/30 vial, Admelog vial, Humalog Cartridge, Rezvoglar Kwikpen

Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
ADMELOG SOLOSTAR	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL)	2710400500D222	Brand
APIDRA	INSULIN GLULISINE INJ 100 UNIT/ML	27104004002022	Brand
INSULIN ASPART	INSULIN ASPART INJ SOLN 100 UNIT/ML	27104002002022	Brand
INSULIN LISPRO	INSULIN LISPRO INJ SOLN 100 UNIT/ML	27104005002022	Brand
HUMALOG	INSULIN LISPRO INJ SOLN 100 UNIT/ML	27104005002022	Brand
NOVOLOG	INSULIN ASPART INJ SOLN 100 UNIT/ML	27104002002022	Brand
FIASP	INSULIN ASPART (WITH NIACINAMIDE) INJ 100 UNIT/ML	27104002202020	Brand
LYUMJEV	INSULIN LISPRO-AABC INJ 100 UNIT/ML	27104005052020	Brand
NOVOLOG MIX 70/30	INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30)	27104070001820	Brand

HUMULIN R U-500 (CONCENTRATED)	INSULIN REGULAR (HUMAN) INJ 500 UNIT/ML	27104010002015	Brand
APIDRA SOLOSTAR	INSULIN GLULISINE SOLN PEN-INJECTOR INJ 100 UNIT/ML	2710400400D220	Brand
INSULIN ASPART FLEXPEN	INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML	2710400200D220	Brand
INSULIN ASPART PENFILL	INSULIN ASPART SOLN CARTRIDGE 100 UNIT/ML	2710400200E220	Brand
INSULIN LISPRO JUNIOR KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (0.5 UNIT DIAL)	2710400500D221	Brand
INSULIN LISPRO KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL)	2710400500D222	Brand
HUMALOG JUNIOR KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (0.5 UNIT DIAL)	2710400500D221	Brand
HUMALOG KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL)	2710400500D222	Brand
HUMALOG KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 200 UNIT/ML	2710400500D230	Brand
HUMALOG	INSULIN LISPRO SOLN CARTRIDGE 100 UNIT/ML	2710400500E220	Brand
NOVOLOG FLEXPEN	INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML	2710400200D220	Brand
NOVOLOG PENFILL	INSULIN ASPART SOLN CARTRIDGE 100 UNIT/ML	2710400200E220	Brand
FIASP FLEXTOUCH	INSULIN ASPART (WITH NIACINAMIDE) SOL PEN-INJ 100 UNIT/ML	2710400220D220	Brand
FIASP PENFILL	INSULIN ASPART (WITH NIACINAMIDE) SOLN CARTRIDGE 100 UNIT/ML	2710400220E220	Brand
LYUMJEV KWIKPEN	INSULIN LISPRO-AABC SOLN PEN-INJ 100 UNIT/ML (1 UNIT DIAL)	2710400505D222	Brand
LYUMJEV KWIKPEN	INSULIN LISPRO-AABC SOLN PEN-INJECTOR 200 UNIT/ML	2710400505D230	Brand
NOVOLIN R FLEXPEN RELION	INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 100 UNIT/ML	2710401000D220	Brand
NOVOLIN R FLEXPEN	INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 100 UNIT/ML	2710401000D220	Brand
HUMULIN R U-500 KWIKPEN	INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 500 UNIT/ML	2710401000D250	Brand
HUMULIN N KWIKPEN	INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML	2710402000D320	Brand
NOVOLIN N FLEXPEN RELION	INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML	2710402000D320	Brand
NOVOLIN N FLEXPEN	INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML	2710402000D320	Brand
HUMALOG MIX 75/25 KWIKPEN	INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (75-25)	2710408000D320	Brand

HUMALOG MIX 50/50 KWIKPEN	INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (50-50)	2710408000D340	Brand
INSULIN ASPART PROTAMINE/INSULIN ASPART FLEXPEN	INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30)	2710407000D320	Brand
HUMULIN 70/30 KWIKPEN	INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30)	2710409000D320	Brand
NOVOLIN 70/30 FLEXPEN	INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30)	2710409000D320	Brand
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30)	2710407000D320	Brand
LANTUS SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand
TOUJEO SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL)	2710400300D233	Brand
TOUJEO MAX SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL)	2710400300D236	Brand
SEMGLEE	INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML	2710400390D220	Brand
TRESIBA FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML	2710400700D210	Brand
TRESIBA FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML	2710400700D220	Brand
LANTUS	INSULIN GLARGINE INJ 100 UNIT/ML	27104003002020	Brand
SEMGLEE	INSULIN GLARGINE-YFGN INJ 100 UNIT/ML	27104003902020	Brand
LEVEMIR	INSULIN DETEMIR INJ 100 UNIT/ML	27104006002020	Brand
TRESIBA	INSULIN DEGLUDEC INJ 100 UNIT/ML	27104007002020	Brand
BASAGLAR KWIKPEN	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand
HUMULIN R	INSULIN REGULAR (HUMAN) INJ 100 UNIT/ML	27104010002005	Brand
NOVOLIN R	INSULIN REGULAR (HUMAN) INJ 100 UNIT/ML	27104010002005	Brand
NOVOLIN R RELION	INSULIN REGULAR (HUMAN) INJ 100 UNIT/ML	27104010002005	Brand
HUMULIN N	INSULIN NPH (HUMAN) (ISOPHANE) INJ 100 UNIT/ML	27104020001805	Brand
NOVOLIN N RELION	INSULIN NPH (HUMAN) (ISOPHANE) INJ 100 UNIT/ML	27104020001805	Brand
NOVOLIN N	INSULIN NPH (HUMAN) (ISOPHANE) INJ 100 UNIT/ML	27104020001805	Brand
INSULIN ASPART PROTAMINE/INSULIN ASPART	INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30)	27104070001820	Brand

HUMALOG MIX 75/25	INSULIN LISPRO PROT & LISPRO INJ 100 UNIT/ML (75-25)	27104080001820	Brand
HUMALOG MIX 50/50	INSULIN LISPRO PROTAMINE & LISPRO INJ 100 UNIT/ML (50-50)	27104080001840	Brand
HUMULIN 70/30	INSULIN NPH ISOPHANE & REGULAR HUMAN INJ 100 UNIT/ML (70-30)	27104090001810	Brand
NOVOLIN 70/30 RELION	INSULIN NPH ISOPHANE & REGULAR HUMAN INJ 100 UNIT/ML (70-30)	27104090001810	Brand
NOVOLIN 70/30	INSULIN NPH ISOPHANE & REGULAR HUMAN INJ 100 UNIT/ML (70-30)	27104090001810	Brand
ADMELOG	INSULIN LISPRO INJ SOLN 100 UNIT/ML	27104005002022	Brand
INSULIN GLARGINE SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand
INSULIN GLARGINE	INSULIN GLARGINE INJ 100 UNIT/ML	27104003002020	Brand
SEMGLEE	INSULIN GLARGINE INJ 100 UNIT/ML	27104003002020	Brand
NOVOLOG MIX 70/30 RELION	INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30)	27104070001820	Brand
HUMALOG TEMPO PEN	INSULIN LISPRO SOLN PEN-INJ W/TRANSMITTER PORT 100 UNIT/ML	2710400500D224	Brand
LYUMJEV TEMPO PEN	INSULIN LISPRO-AABC SOLN PEN-INJ W/TRANSMIT PORT 100 UNIT/ML	2710400505D224	Brand
NOVOLOG FLEXPEN RELION	INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML	2710400200D220	Brand
BASAGLAR TEMPO PEN	INSULIN GLARGINE PEN-INJ WITH TRANSMITTER PORT 100 UNIT/ML	2710400300D222	Brand
LEVEMIR FLEXPEN	INSULIN DETEMIR SOLN PEN-INJECTOR 100 UNIT/ML	2710400600D220	Brand
INSULIN DEGLUDEC FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML	2710400700D210	Brand
INSULIN DEGLUDEC FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML	2710400700D220	Brand
INSULIN DEGLUDEC	INSULIN DEGLUDEC INJ 100 UNIT/ML	27104007002020	Brand
NOVOLOG RELION	INSULIN ASPART INJ SOLN 100 UNIT/ML	27104002002022	Brand
NOVOLOG MIX 70/30 PREFILLED FLEXPEN RELION	INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30)	2710407000D320	Brand
INSULIN LISPRO PROTAMINE/INSULIN LISPRO KWIKPEN	INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (75-25)	2710408000D320	Brand
NOVOLIN 70/30 FLEXPEN RELION	INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30)	2710409000D320	Brand
REZVOGLAR KWIKPEN	INSULIN GLARGINE-AGLR SOLN PEN-INJECTOR 100 UNIT/ML	2710400305D220	Brand

FIASP PUMPCART	INSULIN ASPART (WITH NIACINAMIDE) SOLN CARTRIDGE 100 UNIT/ML	2710400220E220	Brand
INSULIN GLARGINE-YFGN	INSULIN GLARGINE-YFGN INJ 100 UNIT/ML	27104003902020	Brand
INSULIN GLARGINE-YFGN	INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML	2710400390D220	Brand
INSULIN GLARGINE SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL)	2710400300D233	Brand
INSULIN GLARGINE MAX SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL)	2710400300D236	Brand

Approval Criteria

1 - Quantity requests exceeding the limited amount will be approved based on physician confirmation that the patient requires a greater quantity due to poorly controlled diabetes based on blood glucose and/or hemoglobin A1c

2 . Background

Benefit/Coverage/Program Information
PDL Link: NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
4/30/2024	Removed PDL links for CORE markets and added PDL link for NM in background section.

Irritable Bowel Syndrome - Diarrhea

Prior Authorization Guideline

Guideline ID	GL-146347
Guideline Name	Irritable Bowel Syndrome - Diarrhea
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic alosetron, Brand Lotronex	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALOSETRON HYDROCHLORIDE	ALOSETRON HCL TAB 0.5 MG (BASE EQUIV)	52554015100310	Generic
LOTRONEX	ALOSETRON HCL TAB 0.5 MG (BASE EQUIV)	52554015100310	Brand
ALOSETRON HYDROCHLORIDE	ALOSETRON HCL TAB 1 MG (BASE EQUIV)	52554015100320	Generic
LOTRONEX	ALOSETRON HCL TAB 1 MG (BASE EQUIV)	52554015100320	Brand

Approval Criteria

1 - Diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) with symptoms for at least six months

AND

2 - Patient was female at birth

AND

3 - ONE of the following:

3.1 Failure to a tricyclic antidepressant (e.g., amitriptyline) as confirmed by claims history or submitted medical records

OR

3.2 History of intolerance or contraindication to a tricyclic antidepressant (e.g., amitriptyline) (please specify intolerance or contraindication)

AND

4 - Anatomic or biochemical abnormalities of the GI (gastrointestinal) tract have been excluded

Product Name: generic alosetron, Brand Lotronex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALOSETRON HYDROCHLORIDE	ALOSETRON HCL TAB 0.5 MG (BASE EQUIV)	52554015100310	Generic

LOTRONEX	ALOSETRON HCL TAB 0.5 MG (BASE EQUIV)	52554015100310	Brand
ALOSETRON HYDROCHLORIDE	ALOSETRON HCL TAB 1 MG (BASE EQUIV)	52554015100320	Generic
LOTRONEX	ALOSETRON HCL TAB 1 MG (BASE EQUIV)	52554015100320	Brand

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

Product Name: Viberzi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIBERZI	ELUXADOLINE TAB 75 MG	52558020000330	Brand
VIBERZI	ELUXADOLINE TAB 100 MG	52558020000340	Brand

Approval Criteria

1 - Diagnosis of irritable bowel syndrome with diarrhea (IBS-D)

AND

2 - ONE of the following:

2.1 Failure to a tricyclic antidepressant (e.g., amitriptyline) as confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to a tricyclic antidepressant (e.g., amitriptyline) (please specify intolerance or contraindication)

Product Name: Viberzi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIBERZI	ELUXADOLINE TAB 75 MG	52558020000330	Brand
VIBERZI	ELUXADOLINE TAB 100 MG	52558020000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Viberzi therapy

Isotretinoin

Prior Authorization Guideline

Guideline ID	GL-146823
Guideline Name	Isotretinoin
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Accutane, Myorisan, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	Oncology Uses (Off Label)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYORISAN	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
MYORISAN	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 20 MG	90050013000120	Generic

MYORISAN	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
MYORISAN	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
CLARAVIS	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
CLARAVIS	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
CLARAVIS	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
CLARAVIS	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
AMNESTEEM	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
AMNESTEEM	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
AMNESTEEM	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ZENATANE	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ZENATANE	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ZENATANE	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ZENATANE	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ABSORICA	ISOTRETINOIN CAP 10 MG	90050013000110	Brand
ABSORICA	ISOTRETINOIN CAP 20 MG	90050013000120	Brand
ABSORICA	ISOTRETINOIN CAP 25 MG	90050013000125	Brand
ISOTRETINOIN	ISOTRETINOIN CAP 25 MG	90050013000125	Generic
ABSORICA	ISOTRETINOIN CAP 30 MG	90050013000130	Brand
ABSORICA	ISOTRETINOIN CAP 35 MG	90050013000135	Brand
ISOTRETINOIN	ISOTRETINOIN CAP 35 MG	90050013000135	Generic
ABSORICA	ISOTRETINOIN CAP 40 MG	90050013000140	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 8 MG	90050013100110	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 16 MG	90050013100115	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 24 MG	90050013100125	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 32 MG	90050013100135	Brand
ACCUTANE	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ACCUTANE	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ACCUTANE	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ACCUTANE	ISOTRETINOIN CAP 40 MG	90050013000140	Generic

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN)

OR

2 - Use is supported by ONE of the following compendia:

- American Hospital Formulary Service Drug Information
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

Product Name: Accutane, Myorisan, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	Acne
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYORISAN	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
MYORISAN	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
MYORISAN	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
MYORISAN	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
CLARAVIS	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
CLARAVIS	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
CLARAVIS	ISOTRETINOIN CAP 30 MG	90050013000130	Generic

CLARAVIS	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
AMNESTEEM	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
AMNESTEEM	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
AMNESTEEM	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ZENATANE	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ZENATANE	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ZENATANE	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ZENATANE	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ABSORICA	ISOTRETINOIN CAP 10 MG	90050013000110	Brand
ABSORICA	ISOTRETINOIN CAP 20 MG	90050013000120	Brand
ABSORICA	ISOTRETINOIN CAP 25 MG	90050013000125	Brand
ISOTRETINOIN	ISOTRETINOIN CAP 25 MG	90050013000125	Generic
ABSORICA	ISOTRETINOIN CAP 30 MG	90050013000130	Brand
ABSORICA	ISOTRETINOIN CAP 35 MG	90050013000135	Brand
ISOTRETINOIN	ISOTRETINOIN CAP 35 MG	90050013000135	Generic
ABSORICA	ISOTRETINOIN CAP 40 MG	90050013000140	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 8 MG	90050013100110	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 16 MG	90050013100115	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 24 MG	90050013100125	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 32 MG	90050013100135	Brand
ACCUTANE	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ACCUTANE	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ACCUTANE	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ACCUTANE	ISOTRETINOIN CAP 40 MG	90050013000140	Generic

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of severe recalcitrant nodular acne unresponsive to conventional therapy

OR

1.2 Diagnosis of treatment resistant acne **AND** **2 -** ONE of the following: **2.1** Failure to an adequate trial on TWO of the following conventional therapy regimens confirmed by claims history or submission of medical records: • Topical retinoid or retinoid-like agent [e.g., Retin-A/Retin-A Micro (tretinoin)] • Oral antibiotic [e.g., Ery-Tab (erythromycin), Biaxin (clarithromycin), Minocin (minocycline)] • Topical antibiotic with or without benzoyl peroxide [e.g., Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)] **OR** **2.2** History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): • Topical retinoid or retinoid-like agent [e.g., Retin-A/Retin-A Micro (tretinoin)] • Oral antibiotic [e.g., Ery-Tab (erythromycin), Biaxin (clarithromycin), Minocin (minocycline)] • Topical antibiotic with or without benzoyl peroxide [e.g., Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)] **AND** **3 -** If the request is non-preferred*, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication (please specify reason or special circumstance)	
Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Accutane, Myorisan, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	Acne

Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYORISAN	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
MYORISAN	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
MYORISAN	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
MYORISAN	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
CLARAVIS	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
CLARAVIS	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
CLARAVIS	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
CLARAVIS	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
AMNESTEEM	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
AMNESTEEM	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
AMNESTEEM	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ZENATANE	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ZENATANE	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ZENATANE	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ZENATANE	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ABSORICA	ISOTRETINOIN CAP 10 MG	90050013000110	Brand
ABSORICA	ISOTRETINOIN CAP 20 MG	90050013000120	Brand
ABSORICA	ISOTRETINOIN CAP 25 MG	90050013000125	Brand
ISOTRETINOIN	ISOTRETINOIN CAP 25 MG	90050013000125	Generic
ABSORICA	ISOTRETINOIN CAP 30 MG	90050013000130	Brand
ABSORICA	ISOTRETINOIN CAP 35 MG	90050013000135	Brand
ISOTRETINOIN	ISOTRETINOIN CAP 35 MG	90050013000135	Generic
ABSORICA	ISOTRETINOIN CAP 40 MG	90050013000140	Brand

ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 8 MG	90050013100110	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 16 MG	90050013100115	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 24 MG	90050013100125	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 32 MG	90050013100135	Brand
ACCUTANE	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ACCUTANE	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ACCUTANE	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ACCUTANE	ISOTRETINOIN CAP 40 MG	90050013000140	Generic

Approval Criteria

1 - After greater than or equal to 2 months OFF therapy, persistent or recurring severe recalcitrant nodular acne is still present

OR

2 - Total cumulative dose for total duration of therapy is less than 150 milligrams/kilogram (mg/kg) (will be approved up to a total of 150 mg/kg)

2 . Revision History

Date	Notes
4/30/2024	Removed PDL links for CORE markets in background section and ad ded PDL link for NM in notes section, where applicable.

Jesduvroq

Prior Authorization Guideline

Guideline ID	GL-146350
Guideline Name	Jesduvroq
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Jesduvroq	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JESDUVROQ	DAPRODUSTAT TAB 1 MG	82402520000310	Brand
JESDUVROQ	DAPRODUSTAT TAB 2 MG	82402520000315	Brand
JESDUVROQ	DAPRODUSTAT TAB 4 MG	82402520000320	Brand
JESDUVROQ	DAPRODUSTAT TAB 6 MG	82402520000325	Brand
JESDUVROQ	DAPRODUSTAT TAB 8 MG	82402520000330	Brand

Approval Criteria

1 - Diagnosis of anemia due to chronic kidney disease (CKD)

AND

2 - Patient has been receiving dialysis for at least four months

AND

3 - BOTH of the following:

- Ferritin greater than 100 mcg/L (micrograms per liter)
- Transferrin saturation (TSAT) greater than 20%

AND

4 - Hemoglobin level is less than 11 g/dL (grams per deciliter)

AND

5 - ONE of the following:

5.1 Failure to an erythropoietin stimulating agent (ESA) [e.g., Aranesp (darbepoetin), Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)] as confirmed by claims history or submission of medical records

OR

5.2 History of contraindication or intolerance to an erythropoietin stimulating agent (ESA) (please specify contraindication or intolerance)

AND

6 - Prescribed by or in consultation with ONE of the following:

- Hematologist
- Nephrologist

Product Name: Jesduvroq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JESDUVROQ	DAPRODUSTAT TAB 1 MG	82402520000310	Brand
JESDUVROQ	DAPRODUSTAT TAB 2 MG	82402520000315	Brand
JESDUVROQ	DAPRODUSTAT TAB 4 MG	82402520000320	Brand
JESDUVROQ	DAPRODUSTAT TAB 6 MG	82402520000325	Brand
JESDUVROQ	DAPRODUSTAT TAB 8 MG	82402520000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Jesduvroq therapy (e.g., clinically meaningful increase in hemoglobin level)

AND

2 - Adequate iron stores confirmed by both of the following:

- Ferritin greater than 100 mcg/L (micrograms per liter)
- Transferrin saturation (TSAT) greater than 20%

AND

3 - Hemoglobin level does not exceed 12 g/dL (grams per deciliter)

AND

4 - Patient is not on concurrent treatment with an erythropoietin stimulating agent (ESA) [e.g., Aranesp (darbepoetin), Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)]

AND

5 - Prescribed by or in consultation with ONE of the following:

- Hematologist
- Nephrologist

Kerendia

Prior Authorization Guideline

Guideline ID	GL-146351
Guideline Name	Kerendia
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Kerendia	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KERENDIA	FINERENONE TAB 10 MG	30354030000310	Brand
KERENDIA	FINERENONE TAB 20 MG	30354030000320	Brand

Approval Criteria

1 - Diagnosis of chronic kidney disease

AND

2 - Both of the following:

2.1 UACR (urinary albumin-to-creatinine ratio) greater than or equal to 30 mg/g

AND

2.2 eGFR (estimated glomerular filtration rate) greater than or equal to 25 mL/min/1.73 m2

AND

3 - History of type 2 diabetes

AND

4 - Kerendia is being used to reduce the risk of at least ONE of the following:

- Sustained eGFR decline
- End-stage kidney disease
- Cardiovascular death
- Non-fatal myocardial infarction
- Hospitalization for heart failure

AND

5 - Serum potassium level is less than or equal to 5 mEQ/L (milliequivalents/liter) prior to initiating treatment

AND

6 - ONE of the following:

6.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

6.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication, or intolerance)

AND

7 - ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a SGLT2 inhibitor (e.g., Farxiga)
- Failure to a SGLT2 inhibitor (e.g., Farxiga) confirmed by claims history or submitted medical records
- History of intolerance or contraindication to a SGLT2 inhibitor (e.g., Farxiga) (please specify intolerance or contraindication)

Product Name: Kerendia	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KERENDIA	FINERENONE TAB 10 MG	30354030000310	Brand
KERENDIA	FINERENONE TAB 20 MG	30354030000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Lampit

Prior Authorization Guideline

Guideline ID	GL-146352
Guideline Name	Lampit
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Lampit	
Diagnosis	Chagas disease (American trypanosomiasis)
Approval Length	60 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LAMPIT	NIFURTIMOX TAB 30 MG	16400055000320	Brand
LAMPIT	NIFURTIMOX TAB 120 MG	16400055000340	Brand

Approval Criteria

1 - Diagnosis of Chagas disease (American trypanosomiasis) caused by Trypanosoma cruzi

Lidoderm

Prior Authorization Guideline

Guideline ID	GL-146353
Guideline Name	Lidoderm
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic lidocaine 5% patch, Brand Lidocan III, Brand Lidoderm, Brand Lidocan	
Diagnosis	Post-Herpetic Neuralgia
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LIDOCAINE	LIDOCAINE PATCH 5%	90850060005930	Generic
LIDOCAN III	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDODERM	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDOCAN	LIDOCAINE PATCH 5%	90850060005930	Brand

LIDOCAINE PATCH 5%	LIDOCAINE PATCH 5%	90850060005930	Generic

Approval Criteria

1 - Diagnosis of post-herpetic neuralgia

Product Name: generic lidocaine 5% patch, Brand Lidocan III, Brand Lidoderm, Brand Lidocan	
Diagnosis	Neuropathic Pain
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LIDOCAINE	LIDOCAINE PATCH 5%	90850060005930	Generic
LIDOCAN III	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDODERM	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDOCAN	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDOCAINE PATCH 5%	LIDOCAINE PATCH 5%	90850060005930	Generic

Approval Criteria

1 - Diagnosis of neuropathic pain

AND

2 - ONE of the following:

2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- Tricyclic anti-depressant (e.g., amitriptyline)

- SNRI (serotonin and norepinephrine reuptake inhibitor) anti-depressant (e.g., duloxetine, venlafaxine)
- Anticonvulsant (e.g., gabapentin, pregabalin)

OR

2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Tricyclic anti-depressant (e.g., amitriptyline)
- SNRI anti-depressant (e.g., duloxetine, venlafaxine)
- Anticonvulsant (e.g., gabapentin, pregabalin)

Product Name: generic lidocaine 5% patch, Brand Lidocan III, Brand Lidoderm, Brand Lidocan	
Diagnosis	Neuropathic Pain
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LIDOCAINE	LIDOCAINE PATCH 5%	90850060005930	Generic
LIDOCAN III	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDODERM	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDOCAN	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDOCAINE PATCH 5%	LIDOCAINE PATCH 5%	90850060005930	Generic

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

Lokelma, Veltassa

Prior Authorization Guideline

Guideline ID	GL-146354
Guideline Name	Lokelma, Veltassa
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Lokelma, Veltassa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LOKELMA	SODIUM ZIRCONIUM CYCLOSILICATE FOR SUSP PACKET 5 GM	99450020003020	Brand
LOKELMA	SODIUM ZIRCONIUM CYCLOSILICATE FOR SUSP PACKET 10 GM	99450020003040	Brand
VELTASSA	PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 8.4 GM (BASE EQ)	99450060203020	Brand

VELTASSA	PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 16.8 GM (BASE EQ)	99450060203030	Brand
VELTASSA	PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 25.2 GM (BASE EQ)	99450060203040	Brand

Approval Criteria

1 - Diagnosis of non-life threatening hyperkalemia

AND

2 - Where clinically appropriate, medications known to cause hyperkalemia [e.g., angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, aldosterone antagonist, non-steroidal anti-inflammatory drugs (NSAIDs)] have been discontinued or reduced to the lowest effective dose

AND

3 - Where clinically appropriate, loop or thiazide diuretic therapy for potassium removal has failed

AND

4 - Patient follows a low potassium diet (less than or equal to 3 grams per day)

Product Name: Lokelma, Veltassa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LOKELMA	SODIUM ZIRCONIUM CYCLOSILICATE FOR SUSP PACKET 5 GM	99450020003020	Brand
LOKELMA	SODIUM ZIRCONIUM CYCLOSILICATE FOR SUSP PACKET 10 GM	99450020003040	Brand

VELTASSA	PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 8.4 GM (BASE EQ)	99450060203020	Brand
VELTASSA	PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 16.8 GM (BASE EQ)	99450060203030	Brand
VELTASSA	PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 25.2 GM (BASE EQ)	99450060203040	Brand

Approval Criteria

1 - Patient has a positive clinical response to Lokelma or Veltassa therapy

AND

2 - Patient continues to require treatment for hyperkalemia

AND

3 - Where clinically appropriate, medications known to cause hyperkalemia [e.g., angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, aldosterone antagonist, non-steroidal anti-inflammatory drugs (NSAIDs)] have been discontinued or reduced to the lowest effective dose

AND

4 - Patient follows a low potassium diet (less than or equal to 3 grams per day)

Prior Authorization Guideline

Guideline ID	GL-146355
Guideline Name	Long-Acting Opioid Products
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, methadone tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER	
Diagnosis	DUR: Opioid Naïve (Not having filled an opioid in the past 60 days) exceeding the 7 day supply limit*
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic

MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic
FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic

OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand

HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic

OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic
FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic

METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG	65100095107560	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG	65100095107570	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG	65100095107580	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic

MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - ONE of the following:

- Cancer diagnosis
- End of life care, including hospice care
- Palliative care
- Sickle cell anemia

OR

2 - Prescriber attests that the patient has received an opioid within the past 60 days

Notes	*Approval length for cancer, end of life, palliative care, or sickle cell pa in will be issued for 12 months. All other approvals will be issued for th e requested duration, not to exceed one month.

Product Name: generic morphine sulfate ER/CR tabs, fentanyl 12, 25, 50, 75, 100 mcg/hr patches	
Diagnosis	Cancer/Hospice/Sickle Cell Anemia/End of Life Related Pain*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic
FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic

Approval Criteria

1 - Patient is being treated for cancer related pain

OR

2 - Patient is in hospice or is receiving end of life care

OR

3 - Patient is being treated for sickle cell anemia related pain

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment.

Product Name: hydrocodone bitartrate ER caps, oxymorphone ER	
Diagnosis	Cancer/Hospice/Sickle Cell Anemia/End of Life Related Pain*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic
OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic

Approval Criteria

1 - ONE of the following:

1.1 Patient is being treated for cancer related pain

OR

1.2 Patient is in hospice or is receiving end of life care

OR

1.3 Patient is being treated for sickle cell anemia related pain

AND

2 - ONE of the following:

2.1 The patient has failed a trial of at least ONE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

OR

2.2 The patient has a history of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

OR

2.3 BOTH of the following:

2.3.1 Patient is established on pain therapy with the requested medication for cancer-related pain, hospice related pain, sickle cell anemia related pain, or end of life care related pain **AND** **2.3.2** The medication is not a new regimen for treatment of cancer-related pain, hospice, sickle cell anemia related pain, or end of life care pain (document date regimen was started)	
Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the request is for oxymorphone ER-non crush resistant (generic) or hydrocodone extended-release capsules (generic Zohydro ER) and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 12 month authorization should be entered for morphine sulfate controlled release tablets (generic MS Contin) and preferred fentanyl transdermal.

Product Name: morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, fentanyl 37.5, 62.5, 87.5 mcg/hr patches, methadone tabs/soln, generic methadone conc, Brand Methadose conc, Brand Zohydro ER	
Diagnosis	Cancer/Hospice/Sickle Cell Anemia/End of Life Related Pain*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic

MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand

HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	6510005510O415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	6510005510O432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	6510005510O445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	6510005510O460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	6510005510O480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	6510009110 7420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	6510009110 7430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	6510009110 7440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	6510009110 7450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	6510009110 7460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic

OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic
FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic

METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - ONE of the following:

1.1 Patient is being treated for cancer related pain

OR

1.2 Patient is in hospice or is receiving end of life care

OR

1.3 Patient is being treated for sickle cell anemia related pain

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AND

2 - ONE of the following:

2.1 The patient has failed a trial of at least THREE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- oxymorphone ER non-crush resistant (generic)
- hydrocodone extended-release capsules (generic Zohydro ER)

OR

2.2 The patient has a history of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- oxymorphone ER non-crush resistant (generic)
- hydrocodone extended-release capsules (generic Zohydro ER)

OR

2.3 BOTH of the following:

2.3.1 Patient is established on pain therapy with the requested medication for cancer-related pain, hospice related pain, sickle cell anemia related pain, or end of life care related pain

AND

2.3.2 The medication is not a new regimen for treatment of cancer-related pain, hospice, sickle cell anemia related pain, or end of life care pain (Document date regimen was started)
</td></tr>
<tr><td>Notes</td><td>*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be i ssued and a maximum 60-day authorization may be authorized one ti me for the requested drug/strength combination up to the requested q</td></tr>
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	uantity for transition to an alternative treatment. If the request is for a non-preferred product and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treat ment with an opioid, but has not tried the preferred alternatives, a deni al should be issued and a maximum 60-day authorization may be auth orized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionall y, a 12 month authorization should be entered for preferred products, depending on what the patient has already tried: • If the patient has tried morphine sulfate controlled release tablets (ge neric MS Contin) or preferred fentanyl transdermal, an authorization s hould be entered for oxymorphone ER-non crush resistant (generic) a nd hydrocodone extended-release capsules (generic Zohydro ER). • If the patient has not tried any of the preferred products [morphine s ulfate controlled release tablets (generic MS Contin), preferred fentan yl transdermal, oxymorphone ER-non crush resistant (generic) or hydr ocodone extended-release capsules (generic Zohydro ER)], an author ization should be entered for morphine sulfate controlled release table ts (generic MS Contin) and preferred fentanyl transdermal.

Product Name: generic morphine sulfate ER/CR tabs, fentanyl 12, 25, 50, 75, 100 mcg/hr patches	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic

MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic
FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic

Approval Criteria

1 - Prescriber attests to BOTH of the following:

1.1 Patient has been screened for substance abuse/opioid dependence

AND

1.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

4.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days [document drug(s) and date of trial]

OR

4.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain

OR

4.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

OR

4.4 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

5 - If the request is for neuropathic pain (examples of neuropathic pain include neuralgias and neuropathies), ONE of the following:

5.1 BOTH of the following:

5.1.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (document date of trial) (if contraindicated, document contraindication)

AND
5.1.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose (document drug and date of trial) (if contraindicated, document contraindication)
OR
5.2 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment.

Product Name: hydrocodone bitartrate ER caps, oxymorphone ER	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic

OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic
OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic

Approval Criteria

1 - Prescriber attests to BOTH of the following:

1.1 Patient has been screened for substance abuse/opioid dependence

AND

1.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

4.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days [document drug(s) and date of trial]

OR

4.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain

OR

4.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

OR

4.4 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

5 - If the request is for neuropathic pain (examples of neuropathic pain include neuralgias and neuropathies), ONE of the following:

5.1 BOTH of the following:

5.1.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8

<table>
<tr><td colspan="2">weeks of treatment with gabapentin titrated to a therapeutic dose (document date of trial) (if contraindicated, document contraindication)

AND

5.1.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose (document drug and date of trial) (if contraindicated, document contraindication)

OR

5.2 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

6 - ONE of the following:

6.1 Patient has failed a trial of at least ONE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials):
• morphine sulfate controlled release tablets (generic MS Contin)
• preferred fentanyl transdermal

OR

6.2 Patient has a history of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):
• morphine sulfate controlled release tablets (generic MS Contin)
• preferred fentanyl transdermal</td></tr>
<tr><td>Notes</td><td>*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be i ssued and a maximum 60-day authorization may be authorized one ti me for the requested drug/strength combination up to the requested q uantity for transition to an alternative treatment.
If the request is for oxymorphone ER-non crush resistant (generic) or hydrocodone extended-release capsules (generic Zohydro ER) and th</td></tr>
</table>

	e patient is currently taking the requested long-acting opioid for at leas t 30 days and has met the medical necessity authorization criteria req uirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authori zation may be authorized one time for the requested drug/strength co mbination up to the requested quantity for transition to an alternative tr eatment. Additionally, a 6 month authorization should be entered for morphine sulfate controlled release tablets (generic MS Contin) and pr eferred fentanyl transdermal.

Product Name: morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, fentanyl 37.5, 62.5, 87.5 mcg/hr patches, methadone tabs/soln, generic methadone conc, Brand Methadose conc, Brand Zohydro ER	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic

HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand

NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand

XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic
FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand

ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - Prescriber attests to BOTH of the following:

1.1 Patient has been screened for substance abuse/opioid dependence

AND

1.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

4.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days [document drug(s) and date of trial]

OR

4.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain

OR

4.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

OR

4.4 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

5 - If the request is for neuropathic pain (examples of neuropathic pain include neuralgias and neuropathies), ONE of the following:

5.1 BOTH of the following:

5.1.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (document date of trial) (if contraindicated, document contraindication)

AND

5.1.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose (document drug and date of trial) (if contraindicated, document contraindication)

<table>
<tr><td colspan="2">

OR

5.2 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

6 - ONE of the following:

6.1 Patient has failed a trial of at least THREE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- oxymorphone ER non-crush resistant (generic)
- hydrocodone extended-release capsules (generic Zohydro ER)

OR

6.2 Patient has a history of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- oxymorphone ER non-crush resistant (generic)
- hydrocodone extended-release capsules (generic Zohydro ER)

</td></tr>
<tr><td>Notes</td><td>*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment.
If the request is for a non-preferred product and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 6 month authorization should be entered for preferred products, depending on what the patient has already tried:</td></tr>
</table>

	• If the patient has tried morphine sulfate controlled release tablets (generic MS Contin) or preferred fentanyl transdermal, an authorization should be entered for oxymorphone ER-non crush resistant (generic) and hydrocodone extended-release capsules (generic Zohydro ER). • If the patient has not tried any of the preferred products [morphine sulfate controlled release tablets (generic MS Contin), preferred fentanyl transdermal, oxymorphone ER-non crush resistant (generic) or hydrocodone extended-release capsules (generic Zohydro ER)], an authorization should be entered for morphine sulfate controlled release tablets (generic MS Contin) and preferred fentanyl transdermal.

Product Name: generic morphine sulfate ER/CR tabs, fentanyl 12, 25, 50, 75, 100 mcg/hr patches	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain*
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic

FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic

Approval Criteria

1 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)

AND

2 - Document rationale for not tapering or discontinuing opioid if treatment goals are not being met

AND

3 - Prescriber attests to BOTH of the following:

3.1 Patient has been screened for substance abuse/opioid dependence

AND

3.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be i ssued and a maximum 60-day authorization may be authorized one ti me for the requested drug/strength combination up to the requested q uantity for transition to an alternative treatment.

Product Name: hydrocodone bitartrate ER caps, oxymorphone ER	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain*
Approval Length	6 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic
OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic

Approval Criteria

1 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)

AND

2 - Document rationale for not tapering or discontinuing opioid if treatment goals are not being met

AND

3 - Prescriber attests to BOTH of the following:

3.1 Patient has been screened for substance abuse/opioid dependence

AND

3.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

4 - ONE of the following:

4.1 Patient has failed a trial of at least ONE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

OR

4.2 Patient has a history of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the request is for oxymorphone ER-non crush resistant (generic) or

	hydrocodone extended-release capsules (generic Zohydro ER) and th e patient is currently taking the requested long-acting opioid for at leas t 30 days and has met the medical necessity authorization criteria req uirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authori zation may be authorized one time for the requested drug/strength co mbination up to the requested quantity for transition to an alternative tr eatment. Additionally, a 6 month authorization should be entered for morphine sulfate controlled release tablets (generic MS Contin) and pr eferred fentanyl transdermal.

Product Name: morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, fentanyl 37.5, 62.5, 87.5 mcg/hr patches, methadone tabs/soln, generic methadone conc, Brand Methadose conc, Brand Zohydro ER	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain*
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic

HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand

NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand

XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic
FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand

ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)

AND

2 - Document rationale for not tapering or discontinuing opioid if treatment goals are not being met

AND

3 - Prescriber attests to BOTH of the following:

3.1 Patient has been screened for substance abuse/opioid dependence

AND

3.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

4 - ONE of the following:

4.1 Patient has failed a trial of at least THREE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials):

- morphine sulfate controlled release tablets (generic MS Contin)

• preferred fentanyl transdermal • oxymorphone ER non-crush resistant (generic) • hydrocodone extended-release capsules (generic Zohydro ER) **OR** **4.2** Patient has a history of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance): • morphine sulfate controlled release tablets (generic MS Contin) • preferred fentanyl transdermal • oxymorphone ER non-crush resistant (generic) • hydrocodone extended-release capsules (generic Zohydro ER)

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be i ssued and a maximum 60-day authorization may be authorized one ti me for the requested drug/strength combination up to the requested q uantity for transition to an alternative treatment. If the request is for a non-preferred product and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treat ment with an opioid, but has not tried the preferred alternatives, a deni al should be issued and a maximum 60-day authorization may be auth orized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionall y, a 6 month authorization should be entered for preferred products, d epending on what the patient has already tried: • If the patient has tried morphine sulfate controlled release tablets (ge neric MS Contin) or preferred fentanyl transdermal, an authorization s hould be entered for oxymorphone ER-non crush resistant (generic) a nd hydrocodone extended-release capsules (generic Zohydro ER). • If the patient has not tried any of the preferred products [morphine s ulfate controlled release tablets (generic MS Contin), preferred fentan yl transdermal, oxymorphone ER-non crush resistant (generic) or hydr ocodone extended-release capsules (generic Zohydro ER)], an author ization should be entered for morphine sulfate controlled release table ts (generic MS Contin) and preferred fentanyl transdermal.

Product Name: tramadol ER, Conzip	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG	65100095107560	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG	65100095107570	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG	65100095107580	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic

Approval Criteria

1 - ONE of the following:

1.1 The patient has failed a trial of tramadol IR (immediate release) as confirmed by claims history or submission of medical records

OR

1.2 The patient has a history of contraindication or intolerance to tramadol IR (please specify contraindication or intolerance)

OR

2 - BOTH of the following:

2.1 ONE of the following:

2.1.1 Patient is being treated for cancer related pain

OR

2.1.2 Patient is in hospice or is receiving end of life care

OR

2.1.3 Patient is being treated for sickle cell anemia related pain

AND

2.2 BOTH of the following:

2.2.1 Patient is established on pain therapy with the requested medication for cancer-related pain, hospice related pain, sickle cell anemia related pain, or end of life care related pain

AND

2.2.2 The medication is not a new regimen for treatment of cancer-related pain, hospice, sickle cell anemia related pain, or end of life care pain (document date regimen was started)

Product Name: generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, methadone tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER

Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic
FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic

OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic
OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand

HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic

OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic
FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic

METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG	65100095107560	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG	65100095107570	Generic

TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG	65100095107580	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - The requested dose cannot be achieved by moving to a higher strength of the product

AND

2 - The requested dose is within the Food and Drug Administration (FDA) maximum dose per day, where an FDA maximum dose per day exists

Notes	Authorization will be issued for: • 12 months for cancer pain/hospice/sickle cell anemia related pain/end of life related pain. • 12 months for all Tramadol ER requests. • 6 months for non-cancer pain/non-hospice/non-sickle cell anemia related pain/non-end of life related pain.

Product Name: generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, methadone tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER	
Diagnosis	Cancer/Hospice/Sickle Cell Anemia/End of Life Related Pain
Approval Length	12 Months*
Guideline Type	Morphine Milligram Equivalent (MME)

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic
FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic

OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic
OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic

HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand

NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic

FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic

TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG	65100095107560	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG	65100095107570	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG	65100095107580	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - Doses exceeding the cumulative morphine milligram equivalent (MME) of 90 milligrams (mg) will be approved up to the requested amount for ALL opioid products if the patient has cancer pain, hospice pain, end of life diagnosis, or sickle cell anemia

Notes	*Authorization will be issued for 12 months for cancer pain/hospice/sic kle cell anemia/end of life related pain. The authorization should be en tered for an MME of 9999 so as to prevent future disruptions in therap y if the patient’s dose is increased.

Product Name: generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, methadone tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER	
Diagnosis	Non-cancer pain/non-hospice/non-sickle cell anemia/non-end of life related pain
Approval Length	6 Months*
Therapy Stage	Initial Authorization
Guideline Type	Morphine Milligram Equivalent (MME)

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic
FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic

HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic
OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic

HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand

NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand

XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic
FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic

TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG	65100095107560	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG	65100095107570	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG	65100095107580	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - If the dose exceeds the maximum cumulative morphine milligram equivalent (MME) of 90 mg, ALL of the following:

<table>
<tr><td colspan="2">

1.1 Prescriber attests the patient has been screened for substance abuse/opioid dependence

AND

1.2 Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

1.3 BOTH of the following:

1.3.1 Patient has been screened for underlying depression and/or anxiety

AND

1.3.2 If applicable, any underlying conditions have been or will be addressed

AND

1.4 ONE of the following:

1.4.1 Opioid medication doses of less than 90 MME have been tried and did not adequately control pain (document drug regimen or MME and dates of therapy)

OR

1.4.2 Patient is new to plan and currently established on the requested MME for at least the past 30 days

</td></tr>
<tr><td>Notes</td><td>*Authorization will be issued for 6 months for non-cancer/non-hospice/non-sickle cell anemia/non-end of life related pain up to the current requested MME plus 90 MME.
If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested MME dose.</td></tr>
</table>

Product Name: generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, methadone tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER	
Diagnosis	Non-cancer pain/non-hospice/non-sickle cell anemia/non-end of life related pain
Approval Length	6 Months*
Therapy Stage	Reauthorization
Guideline Type	Morphine Milligram Equivalent (MME)

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic
FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic

HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic
OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic

HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand

NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand

XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic
FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic

TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG	65100095107560	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG	65100095107570	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG	65100095107580	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - If the dose exceeds the maximum cumulative morphine milligram equivalent (MME) of 90 milligrams, ALL of the following:

<table>
<tr><td colspan="2">

1.1 Prescriber attests the patient has been screened for substance abuse/opioid dependence

AND

1.2 Document rationale for not tapering or discontinuing opioid if treatment goals are not being met

AND

1.3 Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)

</td></tr>
<tr><td>Notes</td><td>*Authorization will be issued for 6 months for non-cancer/non-hospice/non-sickle cell anemia/non-end of life related pain up to the current requested MME plus 90 MME.
If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested MME dose.</td></tr>
</table>

Lonhala and Yupelri

Prior Authorization Guideline

Guideline ID	GL-146356
Guideline Name	Lonhala and Yupelri
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Lonhala Magnair (Starter Kit and Refill Kit), Yupelri	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LONHALA MAGNAIR REFILL KIT	GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML	44100020102030	Brand
LONHALA MAGNAIR STARTER KIT	GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML	44100020102030	Brand

YUPELRI	REVEFENACIN INHALATION SOLUTION 175 MCG/3ML	44100075002020	Brand

Approval Criteria

1 - Diagnosis of moderate to severe chronic obstructive pulmonary disease (COPD)

AND

2 - ONE of the following:

2.1 One of the following:

- Failure of Incruse Ellipta confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Incruse Ellipta (please specify intolerance or contraindication)

OR

2.2 BOTH of the following:

2.2.1 Patient is unable to use a metered-dose, dry powder or slow mist inhaler (e.g. Incruse Ellipta) to control his/her COPD due to ONE of the following:

- Cognitive or physical impairment limiting coordination of handheld devices (e.g., cognitive decline, arthritis in the hands) (Document impairment)
- Patient is unable to generate adequate inspiratory force (e.g., peak inspiratory flow rate (PIFR) resistance is less than 60 liters per minute)

AND

2.2.2 One of the following:

- Failure of ipratropium nebulized solution (generic Atrovent) confirmed by claims history or submitted medical records
- History of intolerance or contraindication to ipratropium nebulized solution (generic Atrovent) (please specify intolerance or contraindication)

Product Name: Lonhala Magnair (Starter Kit and Refill Kit), Yupelri

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LONHALA MAGNAIR STARTER KIT	GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML	44100020102030	Brand
LONHALA MAGNAIR REFILL KIT	GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML	44100020102030	Brand
YUPELRI	REVEFENACIN INHALATION SOLUTION 175 MCG/3ML	44100075002020	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Lovenox

Prior Authorization Guideline

Guideline ID	GL-146357
Guideline Name	Lovenox
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	Continuation of Therapy Upon Hospital Discharge
Approval Length	35 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic

LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic
LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - Will be approved as continuation of therapy upon hospital discharge

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	Prophylaxis of DVT - Orthopedic Surgery
Approval Length	35 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand

ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic
LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - For deep vein thrombosis (DVT) prophylaxis

AND

2 - Patient is undergoing ONE of the following:

- Hip fracture surgery
- Hip replacement surgery
- Knee replacement surgery

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	Prophylaxis of DVT - Abdominal Surgery
Approval Length	2 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic
LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - For deep vein thrombosis (DVT) prophylaxis following abdominal surgery

AND

2 - Patient is at risk for thromboembolic complications

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	Prophylaxis of DVT - Restricted Mobility
Approval Length	2 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic

LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - For deep vein thrombosis (DVT) prophylaxis in patients at risk for thromboembolic complications due to severely restricted mobility during acute illness

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	DVT Treatment
Approval Length	2 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic

LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic
LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - For the treatment of acute deep vein thrombosis (DVT)

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	Prophylaxis of Ischemic Complications
Approval Length	2 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand

ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic
LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - For prophylaxis of ischemic complications in ONE of the following:

- Unstable angina
- Non-Q-Wave myocardial infarction

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	Acute ST-Segment Elevation Myocardial Infarction
Approval Length	2 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic

LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic
LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - For the treatment of acute ST-segment elevation myocardial infarction (STEMI)

AND

2 - ONE of the following:

- Managed medically
- Managed with subsequent percutaneous coronary intervention

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	Off-Label Uses
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand

ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic
LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program

Notes	Authorization will be issued for the compendia recommended duration of therapy, not to exceed 12 months.

Lyrica

Prior Authorization Guideline

Guideline ID	GL-146358
Guideline Name	Lyrica
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Lyrica	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYRICA	PREGABALIN CAP 25 MG	72600057000110	Brand
LYRICA	PREGABALIN CAP 50 MG	72600057000115	Brand
LYRICA	PREGABALIN CAP 75 MG	72600057000120	Brand
LYRICA	PREGABALIN CAP 100 MG	72600057000125	Brand
LYRICA	PREGABALIN CAP 150 MG	72600057000135	Brand
LYRICA	PREGABALIN CAP 200 MG	72600057000145	Brand

LYRICA	PREGABALIN CAP 225 MG	72600057000150	Brand
LYRICA	PREGABALIN CAP 300 MG	72600057000160	Brand
LYRICA	PREGABALIN SOLN 20 MG/ML	72600057002020	Brand

Approval Criteria

1 - Requested for the treatment of a seizure disorder

OR

2 - BOTH of the following:

2.1 Diagnosis of ONE of the following:

- Fibromyalgia
- Diabetic peripheral neuropathy (DPN)
- Post herpetic neuralgia (PHN)
- Neuropathic pain associated with spinal cord injury

AND

2.2 ONE of the following:

2.2.1 Failure to generic pregabalin at a minimum dose of 300 mg (milligrams) daily for 4 weeks as confirmed by claims history or submission of medical records

OR

2.2.2 History of intolerance or contraindication to generic pregabalin (please specify intolerance or contraindication)

Product Name: Brand Lyrica CR, generic pregabalin ER	
Diagnosis	Diabetic Peripheral Neuropathy (DPN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYRICA CR	PREGABALIN TAB ER 24HR 82.5 MG	62540060007520	Brand
LYRICA CR	PREGABALIN TAB ER 24HR 165 MG	62540060007530	Brand
LYRICA CR	PREGABALIN TAB ER 24HR 330 MG	62540060007540	Brand
PREGABALIN ER	PREGABALIN TAB ER 24HR 82.5 MG	62540060007520	Generic
PREGABALIN ER	PREGABALIN TAB ER 24HR 165 MG	62540060007530	Generic
PREGABALIN ER	PREGABALIN TAB ER 24HR 330 MG	62540060007540	Generic

Approval Criteria

1 - Diagnosis of diabetic peripheral neuropathy (DPN)

AND

2 - ONE of the following:

2.1 Failure to gabapentin (generic Neurontin) at a minimum dose of 1800 mg daily for 4 weeks as confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to gabapentin (generic Neurontin) (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Failure to treatment with ONE of the following classes of medications as confirmed by claims history or submission of medical records:

- Tricyclic antidepressant at the maximum tolerated dose for 6 to 8 weeks, or intolerance to a tricyclic antidepressant

- Serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressant (e.g., duloxetine, venlafaxine)

OR

3.2 History of intolerance or contraindication to treatment from BOTH classes of medications (please specify intolerance or contraindication)

- Tricyclic antidepressant at the maximum tolerated dose for 6 to 8 weeks, or intolerance to a tricyclic antidepressant
- SNRI antidepressant (e.g., duloxetine, venlafaxine)

AND

4 - ONE of the following:

4.1 Failure to generic pregabalin immediate-release capsules or generic pregabalin suspension as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to generic pregabalin immediate-release capsules or generic pregabalin suspension (please specify intolerance or contraindication)

Product Name: Brand Lyrica CR, generic pregabalin ER	
Diagnosis	Post Herpetic Neuralgia (PHN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYRICA CR	PREGABALIN TAB ER 24HR 82.5 MG	62540060007520	Brand
LYRICA CR	PREGABALIN TAB ER 24HR 165 MG	62540060007530	Brand
LYRICA CR	PREGABALIN TAB ER 24HR 330 MG	62540060007540	Brand
PREGABALIN ER	PREGABALIN TAB ER 24HR 82.5 MG	62540060007520	Generic
PREGABALIN ER	PREGABALIN TAB ER 24HR 165 MG	62540060007530	Generic

PREGABALIN ER	PREGABALIN TAB ER 24HR 330 MG	62540060007540	Generic

Approval Criteria

1 - Diagnosis of post herpetic neuralgia (PHN)

AND

2 - ONE of the following:

2.1 Failure to gabapentin (generic Neurontin) at a minimum dose of 1800 mg daily for 4 weeks as confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to gabapentin (generic Neurontin) (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Failure to a tricyclic antidepressant at the maximum tolerated dose for 6 to 8 weeks as confirmed by claims history of submission of medical records

OR

3.2 History of intolerance of contraindication to a tricyclic antidepressant (please specify intolerance or contraindication)

AND

4 - ONE of the following:

4.1 Failure to generic pregabalin immediate-release capsules or generic pregabalin suspension as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to generic pregabalin immediate-release capsules or generic pregabalin suspension (please specify intolerance or contraindication)

Lysteda

Prior Authorization Guideline

Guideline ID	GL-146359
Guideline Name	Lysteda
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Lysteda, generic tranexamic acid	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYSTEDA	TRANEXAMIC ACID TAB 650 MG	84100040000320	Brand
TRANEXAMIC ACID	TRANEXAMIC ACID TAB 650 MG	84100040000320	Generic

Approval Criteria

1 - Diagnosis of cyclic heavy menstrual bleeding

Marinol, Syndros

Prior Authorization Guideline

Guideline ID	GL-146360
Guideline Name	Marinol, Syndros
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Syndros	
Diagnosis	Chemotherapy-induced nausea and vomiting
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYNDROS	DRONABINOL SOLN 5 MG/ML	50300030002020	Brand

Approval Criteria

1 - Patient is receiving cancer chemotherapy

AND

2 - ONE of the following:

2.1 Failure to formulary generic dronabinol as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to formulary generic dronabinol (please specify contraindication or intolerance)

OR

2.3 Patient is unable to swallow capsules

AND

3 - ONE of the following:

3.1 Failure to a 5HT-3 (5-hydroxytriptamine) receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to a 5HT-3 receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] (please specify contraindication or intolerance)

AND

4 - ONE of the following:

4.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lorazepam (generic Ativan)
- Prochlorperazine (generic Compazine)
- Dexamethasone (generic Decadron)
- Haloperidol (generic Haldol)
- Promethazine (generic Phenergan)
- Metoclopramide (generic Reglan)
- Olanzapine (generic Zyprexa)

OR

4.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Lorazepam (generic Ativan)
- Prochlorperazine (generic Compazine)
- Dexamethasone (generic Decadron)
- Haloperidol (generic Haldol)
- Promethazine (generic Phenergan)
- Metoclopramide (generic Reglan)
- Olanzapine (generic Zyprexa)

Product Name: Brand Marinol, generic dronabinol	
Diagnosis	Chemotherapy-induced nausea and vomiting
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MARINOL	DRONABINOL CAP 2.5 MG	50300030000110	Brand
DRONABINOL	DRONABINOL CAP 2.5 MG	50300030000110	Generic
DRONABINOL	DRONABINOL CAP 5 MG	50300030000115	Generic
DRONABINOL	DRONABINOL CAP 10 MG	50300030000120	Generic

Approval Criteria

1 - Patient is receiving cancer chemotherapy

AND

2 - ONE of the following:

2.1 Failure to a 5HT-3 (5-hydoxytriptamine) receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to a 5HT-3 receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] (please specify contraindication or intolerance)

AND

3 - ONE of the following:

3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lorazepam (generic Ativan)
- Prochlorperazine (generic Compazine)
- Dexamethasone (generic Decadron)
- Haloperidol (generic Haldol)
- Promethazine (generic Phenergan)
- Metoclopramide (generic Reglan)
- Olanzapine (generic Zyprexa)

OR

3.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Lorazepam (generic Ativan)
- Prochlorperazine (generic Compazine)
- Dexamethasone (generic Decadron)
- Haloperidol (generic Haldol)
- Promethazine (generic Phenergan)
- Metoclopramide (generic Reglan)

- Olanzapine (generic Zyprexa)

Product Name: Syndros	
Diagnosis	Anorexia in a patient with AIDS
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYNDROS	DRONABINOL SOLN 5 MG/ML	50300030002020	Brand

Approval Criteria

1 - Diagnosis of anorexia with weight loss in a patient with AIDS (acquired immunodeficiency syndrome)

AND

2 - Patient is on antiretroviral therapy

AND

3 - ONE of the following:

3.1 Patient is 65 years of age or greater

OR

3.2 BOTH of the following:

3.2.1 Patient is less than 65 years of age

AND

3.2.2 ONE of the following:

3.2.2.1 Failure to megestrol (generic Megace) as confirmed by claims history or submission of medical records

OR

3.2.2.2 History of intolerance or contraindication to megestrol (generic Megace) (please specify intolerance or contraindication)

AND

4 - ONE of the following:

4.1 Failure to formulary generic dronabinol as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to formulary generic dronabinol (please specify contraindication or intolerance)

OR

4.3 Patient is unable to swallow capsules

Product Name: Brand Marinol, generic dronabinol	
Diagnosis	Anorexia in a patient with AIDS
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MARINOL	DRONABINOL CAP 2.5 MG	50300030000110	Brand
DRONABINOL	DRONABINOL CAP 2.5 MG	50300030000110	Generic

DRONABINOL	DRONABINOL CAP 5 MG	50300030000115	Generic
DRONABINOL	DRONABINOL CAP 10 MG	50300030000120	Generic

Approval Criteria

1 - Diagnosis of anorexia with weight loss in a patient with AIDS (acquired immunodeficiency syndrome)

AND

2 - Patient is on antiretroviral therapy

AND

3 - ONE of the following:

3.1 Patient is 65 years of age or greater

OR

3.2 BOTH of the following:

3.2.1 Patient is less than 65 years of age

AND

3.2.2 ONE of the following:

3.2.2.1 Failure to megestrol (generic Megace) as confirmed by claims history or submission of medical records

OR

3.2.2.2 History of intolerance or contraindication to megestrol (generic Megace) (please specify intolerance or contraindication)

Mepron

Prior Authorization Guideline

Guideline ID	GL-146361
Guideline Name	Mepron
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Mepron, generic atovaquone	
Diagnosis	Pneumocystis Jirovecii Pneumonia (PCP) Prophylaxis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEPRON	ATOVAQUONE SUSP 750 MG/5ML	16400020001820	Brand
ATOVAQUONE	ATOVAQUONE SUSP 750 MG/5ML	16400020001820	Generic

Approval Criteria

1 - The patient has a diagnosis [e.g., HIV (human immunodeficiency virus)] warranting PCP (pneumocystis jirovecii pneumonia) infection prophylaxis

AND

2 - The patient has a documented intolerance or contraindication to trimethoprim-sulfamethoxazole (TMP-SMX) and dapsone (please specify intolerance or contraindication)

Product Name: Brand Mepron, generic atovaquone	
Diagnosis	Pneumocystis Jirovecii Pneumonia (PCP) Treatment
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEPRON	ATOVAQUONE SUSP 750 MG/5ML	16400020001820	Brand
ATOVAQUONE	ATOVAQUONE SUSP 750 MG/5ML	16400020001820	Generic

Approval Criteria

1 - The patient has a diagnosis of mild to moderate pneumonia caused by pneumocystis jirovecii

AND

2 - ONE of the following:

2.1 Failure of trimethoprim-sulfamethoxazole (TMP-SMX) confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to TMP-SMX (please specify intolerance or contraindication)

Migranal, Trudhesa

Prior Authorization Guideline

Guideline ID	GL-146363
Guideline Name	Migranal, Trudhesa
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Migranal, generic dihydroergotamine mesylate nasal spray, Trudhesa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DIHYDROERGOTAMINE MESYLATE	DIHYDROERGOTAMINE MESYLATE NASAL SPRAY 4 MG/ML	67000030102060	Generic
MIGRANAL	DIHYDROERGOTAMINE MESYLATE NASAL SPRAY 4 MG/ML	67000030102060	Brand
TRUDHESA	DIHYDROERGOTAMINE MESYLATE HFA NASAL AEROSOL 0.725 MG/ACT	67000030113420	Brand

Approval Criteria

1 - Diagnosis of migraine headaches with or without aura

AND

2 - ONE of the following:

2.1 Failure to THREE preferred 5-HT1 receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan with step therapy), one of which must be sumatriptan nasal spray, confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to THREE preferred 5-HT1 receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan with step therapy), one of which must be sumatriptan nasal spray (please specify intolerance or contraindication)

Product Name: Brand Migranal, generic dihydroergotamine mesylate nasal spray, Trudhesa	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
DIHYDROERGOTAMINE MESYLATE	DIHYDROERGOTAMINE MESYLATE NASAL SPRAY 4 MG/ML	67000030102060	Generic
MIGRANAL	DIHYDROERGOTAMINE MESYLATE NASAL SPRAY 4 MG/ML	67000030102060	Brand
TRUDHESA	DIHYDROERGOTAMINE MESYLATE HFA NASAL AEROSOL 0.725 MG/ACT	67000030113420	Brand

Approval Criteria

1 - Diagnosis of migraine headaches with or without aura

AND

2 - Prescribed by, or in consultation with, ONE of the following:

- Neurologist

- Pain management specialist

AND

3 - Currently receiving prophylactic therapy with at least ONE of the following:

- Amitriptyline (Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol*)
- Candesartan (generic Atacand)*
- Divalproex sodium (Depakote/Depakote ER)
- OnabotulinumtoxinA (Botox)**
- Topiramate (Topamax)
- Venlafaxine (Effexor/Effexor XR)
- Calcitonin gene-related peptide (CGRP) receptor antagonists [e.g., Aimovig (erenumab), Emgality (galcanezumab)]

AND

4 - BOTH of the following:

4.1 ONE of the following:

4.1.1 Higher dose or quantity is supported by the manufacturer's prescribing information

OR

4.1.2 Higher dose or quantity is supported by ONE of the following compendia:

- American Hospital Formulary Service Drug Information
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

OR

4.1.3 Physician provides evidence from published biomedical literature to support safety and additional efficacy at doses/quantities greater than those approved by the Food and Drug Administration (FDA) for the diagnosis indicated

AND **4.2** Physician acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity	
Notes	*Timolol and candesartan are non-preferred and should not be included in denial to provider. **This is a medical benefit, should not be included in denial to provider.

Multaq

Prior Authorization Guideline

Guideline ID	GL-146364
Guideline Name	Multaq
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Multaq	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MULTAQ	DRONEDARONE HCL TAB 400 MG (BASE EQUIVALENT)	35400028100320	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Paroxysmal Atrial Fibrillation (AF)
- Persistent AF defined as AF less than 6 months duration

AND

1.2 ONE of the following:

- Patient is in sinus rhythm
- Patient is planned to undergo cardioversion to sinus rhythm

AND

1.3 Patient does NOT have New York Heart Association (NYHA) Class IV heart failure

AND

1.4 Patient does NOT have symptomatic heart failure with recent decompensation requiring hospitalization

OR

2 - For continuation of current therapy

Mytesi

Prior Authorization Guideline

Guideline ID	GL-146365
Guideline Name	Mytesi
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Mytesi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYTESI	CROFELEMER TAB DELAYED RELEASE 125 MG	47250025000620	Brand

Approval Criteria

1 - Diagnosis of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) associated diarrhea

Prior Authorization Guideline

Guideline ID	GL-146367
Guideline Name	Namzaric
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Namzaric	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NAMZARIC	MEMANTINE HCL-DONEPEZIL HCL CAP ER 24HR 14-10 MG	62059902507030	Brand
NAMZARIC	MEMANTINE HCL-DONEPEZIL HCL CAP ER 24HR 28-10 MG	62059902507050	Brand
NAMZARIC	MEMANTINE HCL-DONEPEZIL HCL CAP ER 24HR 7-10 MG	62059902507020	Brand
NAMZARIC	MEMANTINE HCL-DONEPEZIL HCL CAP ER 24HR 21-10 MG	62059902507040	Brand

NAMZARIC	MEMANTINE-DONEPEZIL CAP ER 24HR 7 & 14 & 21 & 28-10 MG PACK	6205990250B630	Brand

Approval Criteria

1 - BOTH of the following:

1.1 History of BOTH of the following as confirmed by claims history or submission of medical records:

1.1.1 Memantine (generic Namenda)

AND

1.1.2 Donepezil (generic Aricept)

AND

1.2 Patient is stabilized on 10mg of donepezil once daily as confirmed by claims history or submission of medical records

Nayzilam and Valtoco

Prior Authorization Guideline

Guideline ID	GL-148227
Guideline Name	Nayzilam and Valtoco
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nayzilam	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NAYZILAM	MIDAZOLAM NASAL SPRAY SOLN 5 MG/0.1 ML	72100060002010	Brand

Approval Criteria

1 - Diagnosis of epilepsy

AND

2 - Nayzilam is being prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern

AND

3 - The prescriber provides a reason or special circumstance that precludes the use of diazepam rectal gel

Product Name: Nayzilam	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NAYZILAM	MIDAZOLAM NASAL SPRAY SOLN 5 MG/0.1 ML	72100060002010	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Valtoco	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VALTOCO 15 MG DOSE	DIAZEPAM NASAL SPRAY THER PACK 2 X 7.5 MG/0.1ML (15 MG DOSE)	7210003000C440	Brand

VALTOCO 20 MG DOSE	DIAZEPAM NASAL SPRAY THER PACK 2 X 10 MG/0.1ML (20 MG DOSE)	7210003000C450	Brand
VALTOCO 5 MG DOSE	DIAZEPAM NASAL SPRAY 5 MG/0.1 ML	72100030000920	Brand
VALTOCO 10 MG DOSE	DIAZEPAM NASAL SPRAY 10 MG/0.1 ML	72100030000930	Brand

Approval Criteria

1 - Diagnosis of epilepsy

AND

2 - Valtoco is being prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern

AND

3 - The prescriber provides a reason or special circumstance that precludes the use of diazepam rectal gel

AND

4 - ONE of the following:

4.1 Patient is less than 12 years of age

OR

4.2 ONE of the following:

4.2.1 Failure of Nayzilam confirmed by claims history or submitted medical records

OR

4.2.2 History of contraindication or intolerance to Nayzilam (please specify contraindication or intolerance)

Product Name: Valtoco	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VALTOCO 15 MG DOSE	DIAZEPAM NASAL SPRAY THER PACK 2 X 7.5 MG/0.1ML (15 MG DOSE)	7210003000C440	Brand
VALTOCO 20 MG DOSE	DIAZEPAM NASAL SPRAY THER PACK 2 X 10 MG/0.1ML (20 MG DOSE)	7210003000C450	Brand
VALTOCO 5 MG DOSE	DIAZEPAM NASAL SPRAY 5 MG/0.1 ML	72100030000920	Brand
VALTOCO 10 MG DOSE	DIAZEPAM NASAL SPRAY 10 MG/0.1 ML	72100030000930	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
6/10/2024	Revised drug table for Valtoco name change.

Nexletol, Nexlizet

Prior Authorization Guideline

Guideline ID	GL-146369
Guideline Name	Nexletol, Nexlizet
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nexletol, Nexlizet	
Diagnosis	Hyperlipidemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXLETOL	BEMPEDOIC ACID TAB 180 MG	39380020000320	Brand
NEXLIZET	BEMPEDOIC ACID-EZETIMIBE TAB 180-10 MG	39991002200320	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- Heterozygous familial hypercholesterolemia (HeFH)
- Atherosclerotic cardiovascular disease (ASCVD)

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) confirming ONE of the following [prescription claims history may be used in conjunction as confirmation of medication use, dose, and duration]:

2.1 Patient has been receiving at least 12 consecutive weeks of high intensity statin therapy [i.e., atorvastatin 40-80 mg (milligrams), rosuvastatin 20-40 mg] and will continue to receive a high intensity statin at maximally tolerated dose

OR

2.2 BOTH of the following:

2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia [muscle symptoms without CK (creatine kinase) elevations]
- Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)]

AND

2.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to 10 mg, pravastatin greater than or equal to 10 mg, lovastatin 20-40 mg, fluvastatin extended-release 80 mg, fluvastatin 20-40 mg up to 40mg twice daily or Livalo (pitavastatin) greater than or equal to 1 mg] and will continue to receive a low-intensity or moderate-intensity statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate low or moderate-, and high-intensity statins as evidenced by ONE of the following:

2.3.1 ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times ULN)

OR

2.3.2 Patient has a labeled contraindication to all statins as documented in medical records

OR

2.3.3 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3 - ONE of the following:

3.1 Submission of medical records (e.g., laboratory values) confirming ONE of the following LDL-C (low-density lipoprotein cholesterol) values while on maximally tolerated lipid lowering therapy within the last 120 days:

- LDL-C greater than or equal to 100 mg/dL (milligrams/deciliter) with ASCVD
- LDL-C greater than or equal to 130 mg/dL without ASCVD

OR

3.2 BOTH of the following:

3.2.1 Submission of medical records (e.g., laboratory values) confirming ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days:

- LDL-C between 70 mg/dL and 99 mg/dL with ASCVD
- LDL-C between 100 mg/dL and 129 mg/dL without ASCVD

AND

3.2.2 Submission of medical records (e.g., chart notes, laboratory values) confirming ONE of the following [prescription claims history may be used in conjunction as confirmation of medication use, dose, and duration]:

3.2.2.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

3.2.2.2 Patient has a history of contraindication, or intolerance to ezetimibe

Product Name: Nexletol, Nexlizet	
Diagnosis	Hyperlipidemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXLETOL	BEMPEDOIC ACID TAB 180 MG	39380020000320	Brand
NEXLIZET	BEMPEDOIC ACID-EZETIMIBE TAB 180-10 MG	39991002200320	Brand

Approval Criteria

1 - Documentation of a positive clinical response to therapy

AND

2 - Patient continues to receive statin at maximally tolerated dose (unless patient has documented inability to take statins)

Nocdurna

Prior Authorization Guideline

Guideline ID	GL-146371
Guideline Name	Nocdurna
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nocdurna	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOCDURNA	DESMOPRESSIN ACETATE SUBLINGUAL TAB 27.7 MCG	30201010100710	Brand
NOCDURNA	DESMOPRESSIN ACETATE SUBLINGUAL TAB 55.3 MCG	30201010100715	Brand

Approval Criteria

1 - Diagnosis of nocturia due to nocturnal polyuria (as defined by nighttime urine production that exceeds one-third of the 24-hour urine production)

AND

2 - Patient wakes at least twice per night on a reoccurring basis to void

AND

3 - Documented serum sodium level is currently within normal limits of the normal laboratory reference range and has been within normal limits over the previous six months

AND

4 - The patient has been evaluated for other medical causes and has either not responded to, tolerated, or has a contraindication to treatments for identifiable medical causes [e.g., overactive bladder, benign prostatic hyperplasia/lower urinary tract symptoms (BPH/LUTS), elevated post-void residual urine, and heart failure]

AND

5 - Prescriber attests that the risks have been assessed and benefits outweigh the risks

Product Name: Nocdurna	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOCDURNA	DESMOPRESSIN ACETATE SUBLINGUAL TAB 27.7 MCG	30201010100710	Brand
NOCDURNA	DESMOPRESSIN ACETATE SUBLINGUAL TAB 55.3 MCG	30201010100715	Brand

Approval Criteria

1 - Documentation of positive clinical response to Nocdurna therapy

AND

2 - Patient has routine monitoring for serum sodium levels

AND

3 - Prescriber attests that the risks of hyponatremia have been assessed and benefits outweigh the risks

Prior Authorization Guideline

Guideline ID	GL-146833
Guideline Name	Non-Preferred Drugs
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Non-Preferred Drugs	
Approval Length	12 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
multi-source brand medication			
multi-source brand			
non-preferred			
non preferred			

Approval Criteria

1 - If the requested medication is a behavioral health medication, ONE of the following:

1.1 The patient has been receiving treatment with the requested non-preferred behavioral health medication and is new to the plan (enrollment effective date within the past 90 days)

OR

1.2 The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge

OR

2 - ALL of the following:

2.1 One of the following:

2.1.1 Both of the following:

2.1.1.1 One of the following:

- History of failure to at least THREE preferred alternatives as confirmed by claims history or submission of medical records.* NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of failure to all of the preferred products.
- History of contraindication or intolerance to THREE preferred alternatives (please specify contraindication or intolerance).* NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of contraindication or intolerance to all of the preferred products.

AND

2.1.1.2 One of the following:

2.1.1.2.1 If the request is for a multi-source brand medication, OR a branded medication with an authorized generic, one of the following:

- The brand is being requested because of an adverse reaction, allergy or sensitivity to a generic/authorized generic equivalent (specify the adverse reaction, allergy, or sensitivity)

- The brand is being requested due to an incomplete response with a generic/authorized generic equivalent, as documented by submission of medical records
- The brand is being requested because transition to a generic/authorized generic equivalent could result in destabilization of the patient.
- Special clinical circumstances exist that preclude the use of a generic/authorized generic equivalent of the brand medication for the patient (document special clinical circumstances)

OR

2.1.1.2.2 If the request is for a generic when there is a brand available and the brand is the preferred formulation, one of the following:

- The generic is being requested because of an adverse reaction, allergy or sensitivity to the brand (specify the adverse reaction, allergy, or sensitivity).
- The generic is being requested due to an incomplete response with the brand, as documented by submission of medical records.
- The generic is being requested because transition to the brand could result in destabilization of the patient.
- Special clinical circumstances exist that preclude the use of the brand equivalent of the generic medication for the patient (document special clinical circumstances).

OR

2.1.2 There are no preferred formulary alternatives for the requested drug.

AND

2.2 One of the following:

2.2.1 The requested drug must be used for an FDA-approved indication

OR

2.2.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex

<table>
<tr><td colspan="2">

- Clinical pharmacology
- United States Pharmacopeia-National Formulary (USP-NF)

AND

2.3 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program.

</td></tr>
<tr><td>Notes</td><td>*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html
Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request.</td></tr>
</table>

2 . Revision History

Date	Notes
4/30/2024	Removed PDL links for CORE markets in background section and added PDL link for NM in notes section.

Nourianz

Prior Authorization Guideline

Guideline ID	GL-146374
Guideline Name	Nourianz
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nourianz	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOURIANZ	ISTRADEFYLLINE TAB 20 MG	73401025000320	Brand
NOURIANZ	ISTRADEFYLLINE TAB 40 MG	73401025000340	Brand

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Used as adjunctive treatment to levodopa/carbidopa in patients experiencing "off" episodes

AND

3 - ONE of the following:

3.1 Failure to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (trial must be from two different classes) as confirmed by claims history or submission of medical records:

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., rasagiline, selegiline)

OR

3.2 History of contraindication or intolerance to ALL anti-Parkinson's disease therapy from the following adjunctive pharmacotherapy classes (trial must be from all classes) (please specify intolerance or contraindication):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., rasagiline, selegiline)

Product Name: Nourianz	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOURIANZ	ISTRADEFYLLINE TAB 20 MG	73401025000320	Brand

NOURIANZ	ISTRADEFYLLINE TAB 40 MG	73401025000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Nourianz therapy

AND

2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication

Nuedexta

Prior Authorization Guideline

Guideline ID	GL-146375
Guideline Name	Nuedexta
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nuedexta	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUEDEXTA	DEXTROMETHORPHAN HBR-QUINIDINE SULFATE CAP 20-10 MG	62609902300120	Brand

Approval Criteria

1 - Diagnosis of pseudobulbar affect (PBA)

Nuplazid

Prior Authorization Guideline

Guideline ID	GL-146376
Guideline Name	Nuplazid
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nuplazid	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUPLAZID	PIMAVANSERIN TARTRATE CAP 34 MG (BASE EQUIVALENT)	59400028200120	Brand
NUPLAZID	PIMAVANSERIN TARTRATE TAB 10 MG (BASE EQUIVALENT)	59400028200310	Brand

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Patient is currently experiencing hallucinations and delusions associated with Parkinson's disease psychosis (i.e., hallucination and delusion symptoms started after Parkinson's disease diagnosis)

Product Name: Nuplazid	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUPLAZID	PIMAVANSERIN TARTRATE CAP 34 MG (BASE EQUIVALENT)	59400028200120	Brand
NUPLAZID	PIMAVANSERIN TARTRATE TAB 10 MG (BASE EQUIVALENT)	59400028200310	Brand

Approval Criteria

1 - Documentation of positive clinical response to Nuplazid therapy

Nurtec, Qulipta, Ubrelvy, Zavzpret

Prior Authorization Guideline

Guideline ID	GL-146838
Guideline Name	Nurtec, Qulipta, Ubrelvy, Zavzpret
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nurtec ODT	
Diagnosis	Acute Treatment of Migraine
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NURTEC	RIMEGEPANT SULFATE TAB DISINT 75 MG	67701060707220	Brand

Approval Criteria

1 - Used for acute treatment of migraine

AND

2 - One of the following:

2.1 Failure (after at least 3 migraine episodes and a minimum of a 30-day trial) to TWO of the following as confirmed by claims history or submission of medical records:

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

AND

3 - One of the following:

3.1 Patient is currently treated with ONE of the following prophylactic therapies or classes as confirmed by claims history or submission of medical records:

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan* (generic Atacand)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Qulipta*, Vyepti**] ***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)

OR

3.2 Patient has less than 4 migraine days per month **OR** **3.3** Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to ALL of the following prophylactic therapies or classes (please specify contraindication or intolerance): • Amitriptyline (generic Elavil) • A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)* • Candesartan* (generic Atacand) • A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Qulipta*, Vyepti**] *** • Divalproex sodium (generic Depakote/Depakote ER) • OnabotulinumtoxinA** (generic Botox) • Topiramate (generic Topamax) • Venlafaxine (generic Effexor/Effexor XR) **AND** **4** - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonists (e.g., Ubrelvy, Zavzpret)	
Notes	* Timolol, candesartan, Ajovy and Qulipta are non-preferred and shoul d not be included in denial to provider **Vyepti, OnabotulinumtoxinA are medical benefits and should not be i ncluded in denial to provider. ***CGRP antagonists for preventive treatment of migraines require a p rior authorization.

Product Name: Nurtec ODT	
Diagnosis	Preventive Treatment of Episodic Migraine
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NURTEC	RIMEGEPANT SULFATE TAB DISINT 75 MG	67701060707220	Brand

Approval Criteria

1 - Diagnosis of episodic migraines with greater than or equal to 4 migraine days per month

AND

2 - Used for preventive treatment of migraines

AND

3 - One of the following:

3.1 Failure (after a trial of at least two months), to TWO of the following prophylactic therapies as confirmed by claims history or submission of medical records:

- Amitriptyline (generic Elavil)
- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol*
- Candesartan* (generic Atacand)
- Divalproex sodium (generic Depakote/Depakote ER)
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)

OR

3.2 History of contraindication or intolerance to ALL of the following prophylactic therapies (please specify contraindication or intolerance):

- Amitriptyline (generic Elavil)
- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol*
- Candesartan* (generic Atacand)
- Divalproex sodium (generic Depakote/Depakote ER)
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)

AND

4 - Medication will not be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines (e.g. Aimovig, Ajovy, Emgality, Vyepti)

Notes	* Timolol and candesartan are non-preferred and should not be includ ed in denial to provider

Product Name: Nurtec ODT	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NURTEC	RIMEGEPANT SULFATE TAB DISINT 75 MG	67701060707220	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - ONE of the following:

2.1 Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonist (e.g., Ubrelvy, Zavzpret)

OR

2.2 Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines (e.g. Aimovig, Ajovy, Emgality, Vyepti)

Product Name: Zavzpret	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZAVZPRET	ZAVEGEPANT HCL NASAL SPRAY 10 MG/ACT	67701090202020	Brand

Approval Criteria

1 - Used for acute treatment of migraine

AND

2 - One of the following:

2.1 Failure (after at least 3 migraine episodes and a minimum of a 30-day trial) to BOTH of the following as confirmed by claims history or submission of medical records:

2.1.1 TWO preferred 5-HT1 receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan with step therapy), one of which must be sumatriptan nasal spray

AND

2.1.2 ONE of the following:

- Nurtec ODT
- Ubrelvy

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

2.2.1 TWO preferred 5-HT1 receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan with step therapy), one of which must be sumatriptan nasal spray

AND

2.2.2 Nurtec ODT

AND

2.2.3 Ubrelvy

AND

3 - One of the following:

3.1 Patient is currently treated with ONE of the following prophylactic therapies or classes as confirmed by claims history or submission of medical records:

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan* (generic Atacand)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Qulipta*, Vyepti**] ***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)

OR

3.2 Patient has less than 4 migraine days per month

OR

3.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to ALL of the following prophylactic therapies or classes (please specify contraindication or intolerance):

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan* (generic Atacand)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Qulipta*, Vyepti**] ***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- Topiramate (generic Topamax)

- Venlafaxine (generic Effexor/Effexor XR)

AND

4 - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonists (e.g., Nurtec ODT, Ubrelvy)

Notes	* Timolol, candesartan, Ajovy and Qulipta are non-preferred and should not be included in denial to provider **Vyepti, OnabotulinumtoxinA are medical benefits and should not be included in denial to provider. ***CGRP antagonists for preventive treatment of migraines require a prior authorization.

Product Name: Ubrelvy	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
UBRELVY	UBROGEPANT TAB 50 MG	67701080000320	Brand
UBRELVY	UBROGEPANT TAB 100 MG	67701080000340	Brand

Approval Criteria

1 - Used for acute treatment of migraine

AND

2 - One of the following:

2.1 Failure (after at least 3 migraine episodes and a minimum of a 30-day trial) to TWO of the following as confirmed by claims history or submission of medical records:

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance)

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

AND

3 - One of the following:

3.1 Patient is currently treated with ONE of the following prophylactic therapies or classes as confirmed by claims or submission of medical records:

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan* (generic Atacand)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Qulipta*, Vyepti**] ***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)

OR

3.2 Patient has less than 4 migraine days per month

OR

3.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to ALL of the following prophylactic therapies or classes (please specify contraindication or intolerance):

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan* (generic Atacand)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Qulipta*, Vyepti**] ***

- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)

AND

4 - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonists (e.g., Nurtec ODT, Zavzpret)

Notes	* Timolol, Ajovy, Qulipta and candesartan are non-preferred and shoul d not be included in denial to provider **Vyepti, OnabotulinumtoxinA are medical benefit and should not be i ncluded in denial to provider. ***CGRP antagonists for preventive treatment of migraines require a p rior authorization.

Product Name: Ubrelvy, Zavzpret	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZAVZPRET	ZAVEGEPANT HCL NASAL SPRAY 10 MG/ACT	67701090202020	Brand
UBRELVY	UBROGEPANT TAB 50 MG	67701080000320	Brand
UBRELVY	UBROGEPANT TAB 100 MG	67701080000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonist (e.g., Nurtec ODT)

Product Name: Qulipta	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
QULIPTA	ATOGEPANT TAB 10 MG	67701010000310	Brand
QULIPTA	ATOGEPANT TAB 30 MG	67701010000320	Brand
QULIPTA	ATOGEPANT TAB 60 MG	67701010000330	Brand

Approval Criteria

1 - Diagnosis of migraine consistent with The International Classification of Headache Disorders, 3rd edition

AND

2 - ONE of the following:

2.1 Patient has 4 to 7 migraine days per month and at least ONE of the following:

2.1.1 Less than 15 headache days per month

OR

2.1.2 Provider attests this is the member's predominant headache diagnosis (i.e., primary driver of headaches is not different, non-migrainous condition)

OR

2.2 Greater than or equal to 8 migraine days per month

AND

3 - One of the following:

3.1 Failure (after a trial of at least two months) to TWO of the following prophylactic therapies as confirmed by claims history or submission of medical records:

- Amitriptyline (Elavil)
- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol*
- Candesartan* (Atacand)
- Divalproex sodium (Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- Topiramate (Topamax)
- Venlafaxine (Effexor/Effexor XR)

OR

3.2 History of contraindication or intolerance to ALL of the following prophylactic therapies (please specify contraindication or intolerance):

- Amitriptyline (Elavil)
- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol*
- Candesartan* (Atacand)
- Divalproex sodium (Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- Topiramate (Topamax)
- Venlafaxine (Effexor/Effexor XR)

AND

4 - One of the following:

4.1 Failure (after a trial of at least three months) to Nurtec ODT as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to Nurtec ODT (please specify contraindication or intolerance)

AND

5 - Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines (e.g. Aimovig, Ajovy, Emgality, Nurtec ODT, Vyepti)

Notes	* Timolol, candesartan are non-preferred and should not be included in denial to provider **OnabotulinumtoxinA is a medical benefit and should not be included in denial to provider.

Product Name: Qulipta	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
QULIPTA	ATOGEPANT TAB 10 MG	67701010000310	Brand
QULIPTA	ATOGEPANT TAB 30 MG	67701010000320	Brand
QULIPTA	ATOGEPANT TAB 60 MG	67701010000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines (e.g., Aimovig, Ajovy, Emgality, Nurtec ODT, Vyepti)

2 . Background

Benefit/Coverage/Program Information

PDL Link:

NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
4/30/2024	Removed PDL links for CORE markets and added PDL link for NM in background section.

Nuzyra

Prior Authorization Guideline

Guideline ID	GL-146378
Guideline Name	Nuzyra
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nuzyra tablets	
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUZYRA	OMADACYCLINE TOSYLATE TAB 150 MG (BASE EQUIVALENT)	04200050200320	Brand

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - ALL of the following:

3.1 Diagnosis of community-acquired bacterial pneumonia (CABP)

AND

3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Nuzyra

AND

3.3 ONE of the following:

3.3.1 Failure to THREE of the following antibiotics or antibiotic regimens, as confirmed by claims history or submitted medical records:

- Amoxicillin
- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

OR

3.3.2 History of intolerance or contraindication to ALL of the following antibiotics or antibiotic regimens (please specify intolerance or contraindication):

- Amoxicillin
- A macrolide
- Doxycycline

- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

OR

4 - ALL of the following:

4.1 ONE of the following diagnoses:

4.1.1 BOTH of the following:

4.1.1.1 Acute bacterial skin and skin structure infections

AND

4.1.1.2 Infection caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report

OR

4.1.2 BOTH of the following:

4.1.2.1 Empirical treatment of a patient with acute bacterial skin and skin structure infections

AND

4.1.2.2 Presence of MRSA infection is likely

AND

4.2 ONE of the following:

4.2.1 Failure to linezolid (generic Zyvox) as confirmed by claims history or submitted medical records

OR

4.2.2 History of intolerance or contraindication to linezolid (generic Zyvox) (please specify intolerance or contraindication)

AND

4.3 ONE of the following:

4.3.1 Failure to ONE of the following antibiotics as confirmed by claims history or submitted medical records:

- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- A tetracycline
- Clindamycin

OR

4.3.2 History of intolerance or contraindication to ALL of the following antibiotics (please specify intolerance or contraindication):

- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- A tetracycline
- Clindamycin

OR

5 - ALL of the following:

5.1 Diagnosis of acute bacterial skin and skin structure infections

AND

5.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Nuzyra

<table>
<tr><td colspan="2">

AND

5.3 ONE of the following:

5.3.1 Failure to THREE of the following antibiotics confirmed by claims history or submitted medical records:

- A penicillin
- A cephalosporin
- A tetracycline
- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- Clindamycin

OR

5.3.2 History of intolerance or contraindication to ALL of the following antibiotics (please specify intolerance or contraindication):

- A penicillin
- A cephalosporin
- A tetracycline
- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- Clindamycin

OR

6 - The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

</td></tr>
<tr><td>Notes</td><td>Authorization duration for CABP and acute bacterial skin and skin structure infections will be issued for up to 14 days. For all IDSA recognized indications, authorization duration is based on provider and IDSA recommended treatment durations, up to 6 months.</td></tr>
</table>

OAB Agents

Prior Authorization Guideline

Guideline ID	GL-149508
Guideline Name	OAB Agents
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/3/2024

1 . Criteria

Product Name: generic tolterodine IR	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
TOLTERODINE TARTRATE	TOLTERODINE TARTRATE TAB 1 MG	54100060200320	Generic
TOLTERODINE TARTRATE	TOLTERODINE TARTRATE TAB 2 MG	54100060200330	Generic

Approval Criteria

1 - Failure to treatment with oxybutynin immediate release as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to oxybutynin immediate release (please specify contraindication or intolerance)

Product Name: generic tolterodine ER	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
TOLTERODINE TARTRATE ER	TOLTERODINE TARTRATE CAP ER 24HR 2 MG	54100060207020	Generic
TOLTERODINE TARTRATE ER	TOLTERODINE TARTRATE CAP ER 24HR 4 MG	54100060207030	Generic

Approval Criteria

1 - Failure to treatment with oxybutynin extended-release as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to oxybutynin extended-release (please specify contraindication or intolerance)

Product Name: Brand Detrol LA, Brand Ditropan XL, darifenacin ER, Gelnique, Gemtesa, trospium ER, Brand Vesicare	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DETROL LA	TOLTERODINE TARTRATE CAP ER 24HR 2 MG	54100060207020	Brand

DETROL LA	TOLTERODINE TARTRATE CAP ER 24HR 4 MG	54100060207030	Brand
DITROPAN XL	OXYBUTYNIN CHLORIDE TAB ER 24HR 5 MG	54100045207520	Brand
DITROPAN XL	OXYBUTYNIN CHLORIDE TAB ER 24HR 10 MG	54100045207530	Brand
DARIFENACIN HYDROBROMIDE ER	DARIFENACIN HYDROBROMIDE TAB ER 24HR 7.5 MG (BASE EQUIV)	54100010207520	Generic
DARIFENACIN HYDROBROMIDE ER	DARIFENACIN HYDROBROMIDE TAB ER 24HR 15 MG (BASE EQUIV)	54100010207530	Generic
GELNIQUE	OXYBUTYNIN CHLORIDE TD GEL 10%	54100045204030	Brand
TROSPIUM CHLORIDE ER	TROSPIUM CHLORIDE CAP ER 24HR 60 MG	54100065207020	Generic
VESICARE	SOLIFENACIN SUCCINATE TAB 5 MG	54100055200320	Brand
VESICARE	SOLIFENACIN SUCCINATE TAB 10 MG	54100055200330	Brand
GEMTESA	VIBEGRON TAB 75 MG	54200080000320	Brand

Approval Criteria

1 - Failure to a trial of THREE of the following confirmed by claims history or submission of medical records:

- oxybutynin extended-release tablet (generic Ditropan XL)
- tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

OR

2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oxybutynin extended-release tablet (generic Ditropan XL)
- tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

Product Name: Oxytrol (Rx)	
Approval Length	12 month(s)

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OXYTROL	OXYBUTYNIN TD PATCH TWICE WEEKLY 3.9 MG/24HR	54100045008720	Brand

Approval Criteria

1 - Failure to a trial of THREE of the following, confirmed by claims history or submission of medical records:

- Oxytrol for Women (oxybutynin OTC) patch
- tolterodine immediate release (generic Detrol) or tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

OR

2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Oxytrol for Women (oxybutynin OTC) patch
- tolterodine immediate release (generic Detrol) or tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

Product Name: flavoxate, oxybutynin oral solution, Brand Detrol	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DETROL	TOLTERODINE TARTRATE TAB 1 MG	54100060200320	Brand
DETROL	TOLTERODINE TARTRATE TAB 2 MG	54100060200330	Brand
FLAVOXATE HCL	FLAVOXATE HCL TAB 100 MG	54400025100310	Generic

OXYBUTYNIN CHLORIDE	OXYBUTYNIN CHLORIDE SOLUTION 5 MG/5ML	54100045202010	Generic

Approval Criteria

1 - Failure to a trial of ALL of the following, confirmed by claims history or submission of medical records:

- oxybutynin syrup or tablet
- tolterodine tablet (generic Detrol)
- trospium tablet

OR

2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oxybutynin syrup or tablet
- tolterodine tablet (generic Detrol)
- trospium tablet

Product Name: Vesicare LS	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VESICARE LS	SOLIFENACIN SUCCINATE SUSP 5 MG/5ML (1 MG/ML)	54100055201820	Brand

Approval Criteria

1 - Diagnosis of neurogenic detrusor overactivity (NDO) (neurogenic bladder)

AND

2 - ONE of the following:

2.1 Failure to a trial of ONE of the following, as confirmed by claims history or submission of medical records:

- oxybutynin syrup
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oxybutynin syrup
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

Product Name: Brand Myrbetriq tabs, generic mirabegron tabs, generic fesoterodine ER, Brand Toviaz	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYRBETRIQ	MIRABEGRON TAB ER 24 HR 25 MG	54200050007520	Brand
MYRBETRIQ	MIRABEGRON TAB ER 24 HR 50 MG	54200050007530	Brand
FESOTERODINE FUMARATE ER	FESOTERODINE FUMARATE TAB ER 24HR 4 MG	54100020207520	Generic
TOVIAZ	FESOTERODINE FUMARATE TAB ER 24HR 4 MG	54100020207520	Brand
FESOTERODINE FUMARATE ER	FESOTERODINE FUMARATE TAB ER 24HR 8 MG	54100020207530	Generic
TOVIAZ	FESOTERODINE FUMARATE TAB ER 24HR 8 MG	54100020207530	Brand
MIRABEGRON ER	MIRABEGRON TAB ER 24 HR 25 MG	54200050007520	Generic
MIRABEGRON ER	MIRABEGRON TAB ER 24 HR 50 MG	54200050007530	Generic

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of overactive bladder (OAB)

AND

1.2 ONE of the following:

1.2.1 Failure to a trial of THREE of the following confirmed by claims history or submission of medical records:

- oxybutynin extended-release tablet (generic Ditropan XL)
- tolterodine immediate release (generic Detrol) or tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

OR

1.2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oxybutynin extended-release tablet (generic Ditropan XL)
- tolterodine immediate release (generic Detrol) or tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

OR

2 - BOTH of the following:

2.1 Diagnosis of neurogenic detrusor overactivity (NDO) (neurogenic bladder)

AND

2.2 ONE of the following:

2.2.1 Failure to a trial of ONE of the following, as confirmed by claims history or submission of medical records:

- oxybutynin syrup
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

OR

2.2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oxybutynin syrup
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

Product Name: Myrbetriq granules	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYRBETRIQ	MIRABEGRON GRANULES FOR ORAL EXTENDED RELEASE SUSP 8 MG/ML	5420005000G220	Brand

Approval Criteria

1 - Diagnosis of neurogenic detrusor overactivity (NDO) (neurogenic bladder)

AND

2 - ONE of the following:

2.1 Failure to a trial of ONE of the following, as confirmed by claims history or submission of medical records:

- oxybutynin syrup
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oxybutynin syrup
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

AND

3 - ONE of the following:

3.1 Patient is 3 years of age to (including) 17 years of age

OR

3.2 BOTH of the following:

3.2.1 Physician has provided rationale for needing to use this medication in an unapproved age range

AND

3.2.2 The use of this medication for a patient outside the FDA (Food and Drug Administration) approved age range is supported by information from ONE of the following appropriate compendia:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia - National Formulary (USP-NF)

2 . Revision History

Date	Notes
7/3/2024	Copy core

Omega

Prior Authorization Guideline

Guideline ID	GL-146380
Guideline Name	Omega
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Lovaza, generic omega-3-acid ethyl esters, Brand Vascepa, generic icosapent ethyl	
Diagnosis	Severe Hypertriglyceridemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LOVAZA	OMEGA-3-ACID ETHYL ESTERS CAP 1 GM	39500045200130	Brand
OMEGA-3-ACID ETHYL ESTERS	OMEGA-3-ACID ETHYL ESTERS CAP 1 GM	39500045200130	Generic

VASCEPA	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Generic
VASCEPA	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Generic

Approval Criteria

1 - Diagnosis of severe hypertriglyceridemia [pre-treatment triglyceride level of greater than or equal to 500 milligrams/deciliter (mg/dL)]

AND

2 - Patient is on an appropriate lipid-lowering diet and exercise regimen

AND

3 - ONE of the following:

3.1 Failure to at least 90 days of a fibric acid derivative, as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to a fibric acid derivative (please specify contraindication or intolerance)

AND

4 - If the request is for a non-preferred* product, ONE of the following:

4.1 Failure to omega-3-acid ethyl esters (generic Lovaza), as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to omega-3-acid ethyl esters (generic Lovaza) (please specify contraindication or intolerance)

Notes	*Omega 3-acid esters (generic Lovaza) is preferred. Other omega-3 a cid derivatives are non-preferred.

Product Name: Brand Lovaza, generic omega-3-acid ethyl esters, Brand Vascepa, generic icosapent ethyl	
Diagnosis	Severe Hypertriglyceridemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LOVAZA	OMEGA-3-ACID ETHYL ESTERS CAP 1 GM	39500045200130	Brand
OMEGA-3-ACID ETHYL ESTERS	OMEGA-3-ACID ETHYL ESTERS CAP 1 GM	39500045200130	Generic
VASCEPA	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Generic
VASCEPA	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is on an appropriate lipid-lowering diet and exercise regimen

Product Name: Brand Vascepa, generic icosapent ethyl	
Diagnosis	Cardiovascular Risk Reduction
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VASCEPA	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Generic
VASCEPA	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Generic

Approval Criteria

1 - Diagnosis of hypertriglyceridemia [pre-treatment triglyceride level greater than or equal to 150 milligrams/deciliter (mg/dL)]

AND

2 - Patient currently has or is considered high or very high risk for cardiovascular disease (CVD) as evidenced by ONE of the following:

2.1 BOTH of the following:

2.1.1 At least 45 years of age

AND

2.1.2 Established CVD confirmed by ONE of the following:

- Acute coronary syndrome
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack

- Peripheral arterial disease

OR

2.2 ALL of the following:

2.2.1 Diagnosis of Type 2 diabetes

AND

2.2.2 TWO of the following risk factors for developing cardiovascular disease:

- Men at least 55 years and women at least 65 years
- Cigarette smoker or stopped smoking within the past 3 months
- Hypertension [pretreatment blood pressure greater than or equal to 140 millimeters of mercury (mmHg) systolic or greater than or equal to 90 mmHg diastolic]
- HDL-C (high-density lipoprotein cholesterol) less than or equal to 40 mg/dL for men or less than or equal to 50 mg/dL for women
- High-sensitivity C-reactive protein greater than 3.0 mg/L (liter)
- Creatinine clearance greater than 30 and less than 60 milliliters/minute (mL/min)
- Retinopathy
- Micro- or macro-albuminuria
- Ankle-brachial index (ABI) less than 0.9 without symptoms of intermittent claudication

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

3.1 Patient has been receiving at least 12 consecutive weeks of high-intensity statin therapy (i.e., atorvastatin 40-80 mg, rosuvastatin 20-40 mg) and will continue to receive a high-intensity statin at maximally tolerated dose

OR

3.2 BOTH of the following:

3.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia [muscle symptoms without creatine kinase (CK) elevations]
- Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)]

AND

3.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to 10 mg, pravastatin greater than or equal to 10 mg, lovastatin 20-40 mg, fluvastatin XL 80 mg, fluvastatin 20-40 mg up to 40 mg twice daily, or Livalo (pitavastatin) greater than or equal to 1 mg] and will continue to receive a low-intensity or moderate-intensity statin at maximally tolerated dose

AND

4 - Submission of medical record (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

4.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (generic Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

4.2 History of contraindication or intolerance to ezetimibe (please specify contraindication or intolerance)

OR

4.3 Patient has an LDL-C (low density lipoprotein cholesterol) less than 100 mg/dL while on maximally tolerated statin therapy

AND

5 - Used as an adjunct to a low-fat diet and exercise

AND

6 - Prescribed by or in consultation with ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

Product Name: Brand Vascepa, generic icosapent ethyl	
Diagnosis	Cardiovascular Risk Reduction
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VASCEPA	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Generic
VASCEPA	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is on an appropriate low-fat diet and exercise regimen

AND

3 - Patient is receiving maximally tolerated statin therapy

Omnipod 5

Prior Authorization Guideline

Guideline ID	GL-147315
Guideline Name	Omnipod 5
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Omnipod 5	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OMNIPOD 5 G6 PODS (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand
OMNIPOD 5 G6 INTRO KIT (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand

OMNIPOD 5 G7 PODS (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand
OMNIPOD 5 G7 INTRO KIT (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand

Approval Criteria

1 - Diagnosis of diabetes

AND

2 - ALL of the following:

2.1 Patient has done ONE of the following for at least 8 weeks:

- Regularly tests blood glucose at least 4 times/day
- Utilizes a continuous glucose monitor (CGM)

AND

2.2 Patient has completed a diabetes management program

AND

2.3 Patient injects insulin at least 3 times/day

AND

3 - ONE of the following:

- Unexplained, nocturnal, or severe hypoglycemia
- Hypoglycemia unawareness
- Dawn phenomenon blood glucose greater than 200 mg/dL (milligrams/deciliter)
- Wide and unpredictable (erratic) swings in blood glucose levels
- Glycemic targets within individualized range but lifestyle requires increased flexibility of insulin pump use

- HbA1C greater than 7% or outside individualized targets

AND

4 - BOTH of the following:

4.1 Patient or caregiver is motivated to assume responsibility for self-care and insulin management

AND

4.2 Patient or caregiver demonstrates knowledge of importance of nutrition including carbohydrate counting and meal planning

AND

5 - Prescriber attests that there is a reason or special circumstance the patient cannot use external insulin pumps obtained on the medical benefit

Notes	If patient meets criteria, approve using NDC List OMNIPOD5

Product Name: Omnipod 5	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OMNIPOD 5 G6 PODS (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand
OMNIPOD 5 G6 INTRO KIT (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand
OMNIPOD 5 G7 PODS (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand
OMNIPOD 5 G7	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand

INTRO KIT (GEN 5)			

Approval Criteria

1 - Documentation of positive clinical response

Notes	If patient meets criteria, approve using NDC List OMNIPOD5

Product Name: Omnipod 5 G6 or G7 pods	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
OMNIPOD 5 G6 PODS (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand
OMNIPOD 5 G7 PODS (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand

Approval Criteria

1 - Physician confirmation that the patient requires a greater quantity

Notes	Authorization for quantity limit overrides should be entered at the NDC level for the requested Omnipod 5 G6 or G7 pods, for the requested quantity.

2 . Revision History

Date	Notes
5/13/2024	Added Omnipod 5 G7 products.

Ophthalmic Antihistamine

Prior Authorization Guideline

Guideline ID	GL-146382
Guideline Name	Ophthalmic Antihistamine
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: azelastine ophth soln	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
AZELASTINE HCL	AZELASTINE HCL OPHTH SOLN 0.05%	86802006102020	Generic
AZELASTINE HYDROCHLORIDE	AZELASTINE HCL OPHTH SOLN 0.05%	86802006102020	Generic

Approval Criteria

1 - Failure to Pataday OTC (over-the-counter), as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to Pataday OTC (please specify contraindication or intolerance)

Product Name: olopatadine ophth soln (Rx formulation)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OLOPATADINE HYDROCHLORIDE	OLOPATADINE HCL OPHTH SOLN 0.1% (BASE EQUIVALENT)	86802065102020	Generic
OLOPATADINE HCL	OLOPATADINE HCL OPHTH SOLN 0.1% (BASE EQUIVALENT)	86802065102020	Generic
OLOPATADINE HYDROCHLORIDE	OLOPATADINE HCL OPHTH SOLN 0.2% (BASE EQUIVALENT)	86802065102030	Generic

Approval Criteria

1 - ONE of the following:

1.1 Failure to Pataday OTC (over-the-counter), as confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to Pataday OTC (please specify contraindication or intolerance)

AND

2 - ONE of the following:

2.1 Failure to ONE of the following, as confirmed by claims history or submission of medical records:

- Azelastine ophthalmic solution
- Ketotifen
- Cromolyn

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Azelastine ophthalmic solution
- Ketotifen
- Cromolyn

Opzelura

Prior Authorization Guideline

Guideline ID	GL-146383
Guideline Name	Opzelura
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Opzelura	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OPZELURA	RUXOLITINIB PHOSPHATE CREAM 1.5%	90272060503720	Brand

Approval Criteria

1 - Diagnosis of mild to moderate atopic dermatitis*

AND

2 - ONE of the following:

2.1 Failure to TWO of the following topical therapeutic classes as confirmed by claims history or submission of medical records:

2.1.1 ONE of the following:

2.1.1.1 For mild atopic dermatitis: a topical corticosteroid [e.g., DesOwen (desonide), hydrocortisone] (any potency)

OR

2.1.1.2 For moderate atopic dermatitis: a topical corticosteroid of at least a medium- to high-potency [e.g., Elocon (mometasone furoate), Synalar (fluocinolone acetonide), Lidex (fluocinonide)]

OR

2.1.2 One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]

OR

2.1.3 Eucrisa (crisaborole)

OR

2.2 History of intolerance or contraindication to ALL of the following topical therapeutic classes (please specify intolerance or contraindication):

2.2.1 ONE of the following:

2.2.1.1 For mild atopic dermatitis: a topical corticosteroid [e.g., DesOwen (desonide), hydrocortisone] (any potency)

<table>
<tr><td colspan="2">

OR

2.2.1.2 For moderate atopic dermatitis: a topical corticosteroid of at least a medium- to high-potency topical corticosteroid [e.g., Elocon (mometasone furoate), Synalar (fluocinolone acetonide), Lidex (fluocinonide)]

AND

2.2.2 One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]

AND

2.2.3 Eucrisa (crisaborole)

OR

2.3 Patient is currently on Opzelura therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Opzelura in combination with another biologic medication [e.g., Dupixent (dupilumab), Xolair (omalizumab), Rituxan (rituximab), Enbrel (etanercept), Avsola/Inflectra (infliximab)] nor JAK inhibitor [e.g., Jakafi (ruxolitinib), Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

AND

4 - Patient is NOT receiving Opzelura in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)

</td></tr>
<tr><td>Notes</td><td>*Medications for the treatment of Nonsegmental Vitiligo are considere d cosmetic, are excluded, and are to be denied as a benefit exclusion.</td></tr>
</table>

Product Name: Opzelura

Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OPZELURA	RUXOLITINIB PHOSPHATE CREAM 1.5%	90272060503720	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is NOT receiving Opzelura in combination with another biologic medication [e.g., Dupixent (dupilumab), Xolair (omalizumab), Rituxan (rituximab), Enbrel (etanercept), Avsola/Inflectra (infliximab)] nor JAK inhibitor [e.g., Jakafi (ruxolitinib, Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

AND

3 - Patient is NOT receiving Opzelura in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)

Oriahnn_MyFembree

Prior Authorization Guideline

Guideline ID	GL-146385
Guideline Name	Oriahnn_MyFembree
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Oriahnn, MyFembree	
Diagnosis	Uterine Fibroids
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORIAHNN	ELAGOLIX-ESTRAD-NORETH 300-1-0.5MG & ELAGOLIX 300MG CAP PACK	2499350340B220	Brand
MYFEMBREE	RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TAB 40-1-0.5 MG	24993503800320	Brand

Approval Criteria

1 - Diagnosis of uterine fibroids (leiomyomas)

AND

2 - Used for the management of heavy menstrual bleeding

AND

3 - ONE of the following:

3.1 Failure after a three-month trial to ONE of the following as confirmed by claims history or submission of medical records:

- Estrogen/progestin contraceptive (e.g., Loestrin FE)
- Progestin-releasing intrauterine devices (IUDs) (e.g., Mirena)*
- Progestin-only contraceptive [e.g., norethindrone (generic Aygestin)]

OR

3.2 Contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Estrogen/progestin contraceptive (e.g., Loestrin FE)
- Progestin-releasing intrauterine devices (IUDs) (e.g., Mirena)*
- Progestin-only contraceptive [e.g., norethindrone (generic Aygestin)]

AND

4 - ONE of the following:

4.1 Failure after a three-month trial of tranexamic acid (e.g., Lysteda) as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to tranexamic acid (e.g., Lysteda) (please specify contraindication or intolerance)

AND

5 - Prescribed by or in consultation with ONE of the following:

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

Notes	*This is a medical benefit, should not be included in denial to provider.

Product Name: Oriahnn, MyFembree	
Diagnosis	Uterine Fibroids
Approval Length	12 months*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORIAHNN	ELAGOLIX-ESTRAD-NORETH 300-1-0.5MG & ELAGOLIX 300MG CAP PACK	2499350340B220	Brand
MYFEMBREE	RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TAB 40-1-0.5 MG	24993503800320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Impact to bone mineral density has been considered

AND

3 - Treatment duration has not exceeded a total of 24 months*	
Notes	*Authorization will be issued for 12 months up to a maximum treatmen t duration of 24 months. Oriahnn and MyFembree are indicated for a maximum treatment duration of 24 months.

Product Name: MyFembree	
Diagnosis	Pain Associated with Endometriosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYFEMBREE	RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TAB 40-1-0.5 MG	24993503800320	Brand

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - ONE of the following:

2.1 Failure (e.g., inadequate pain relief) to a three-month trial of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) (please specify contraindication or intolerance)

AND

3 - ONE of the following:

3.1 Failure to a three-month trial of ONE of the following, as confirmed by claims history or submission of medical records:

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

OR

3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

AND

4 - Prescribed by or in consultation with ONE of the following:

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

Notes	*This is a medical benefit, should not be included in denial to provider.

Product Name: MyFembree	
Diagnosis	Pain Associated with Endometriosis
Approval Length	12 months*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYFEMBREE	RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TAB 40-1-0.5 MG	24993503800320	Brand

Approval Criteria

<table>
<tr><td colspan="2">1 - Documentation of positive clinical response to therapy

AND

2 - Impact to bone mineral density has been considered

AND

3 - Treatment duration has not exceeded a total of 24 months*</td></tr>
<tr><td>Notes</td><td>*Authorization will be issued for 12 months up to a maximum treatment duration of 24 months. MyFembree are indicated for a maximum treatment duration of 24 months.</td></tr>
</table>

Orilissa

Prior Authorization Guideline

Guideline ID	GL-146387
Guideline Name	Orilissa
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Orilissa 150 mg	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORILISSA	ELAGOLIX SODIUM TAB 150 MG (BASE EQUIV)	30090030100320	Brand

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - ONE of the following:

2.1 Failure (e.g., inadequate pain relief) to a three month trial of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) (please specify contraindication or intolerance)

AND

3 - ONE of the following:

3.1 Failure to a three month trial to ONE of the following as confirmed by claims history or submission of medical records:

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance)

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

AND

4 - Treatment duration of Orilissa 150 mg once daily has not exceeded a total of 24 months, as confirmed by claims history or submission of medical records

AND

5 - Prescribed by or in consultation with ONE of the following:

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

Product Name: Orilissa 150 mg	
Approval Length	12 months up to a maximum treatment duration of 24 months
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORILISSA	ELAGOLIX SODIUM TAB 150 MG (BASE EQUIV)	30090030100320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Impact to bone mineral density has been considered

AND

3 - Treatment duration has not exceeded a total of 24 months, as confirmed by claims history or submission of medical records

Product Name: Orilissa 200 mg	
Approval Length	Up to a maximum of 6 months
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORILISSA	ELAGOLIX SODIUM TAB 200 MG (BASE EQUIV)	30090030100330	Brand

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - ONE of the following:

2.1 Failure (e.g., inadequate pain relief) to a three month trial of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen), as confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Failure after a three month trial to ONE of the following as confirmed by claims history or submission of medical records:

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Hormonal contraceptives

- Progestins [e.g., norethindrone (generic Aygestin)]

AND

4 - Treatment duration of Orilissa 200 mg twice daily has not exceeded a total of 6 months, as confirmed by claims history or submission of medical records

AND

5 - Prescribed by or in consultation with ONE of the following:

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

Osphena

Prior Authorization Guideline

Guideline ID	GL-146849
Guideline Name	Osphena
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Osphena	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OSPHENA	OSPEMIFENE TAB 60 MG	30053050000330	Brand

Approval Criteria

1 - Treatment of moderate to severe vaginal dryness, a symptom of vulvar and vaginal atrophy (VVA), due to menopause*

AND

2 - ONE of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Estradiol vaginal cream
- Estradiol vaginal tablet

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Estradiol vaginal cream
- Estradiol vaginal tablet

Notes	*Treatment of dyspareunia is a benefit exclusion.

Product Name: Osphena	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OSPHENA	OSPEMIFENE TAB 60 MG	30053050000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
4/30/2024	Removed reference to other states in GL name

Panretin

Prior Authorization Guideline

Guideline ID	GL-146389
Guideline Name	Panretin
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Panretin	
Diagnosis	Kaposi's Sarcoma
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PANRETIN	ALITRETINOIN GEL 0.1%	90376015004020	Brand

Approval Criteria

1 - Diagnosis of AIDS (acquired immunodeficiency syndrome)-related Kaposi's Sarcoma (KS)

AND

2 - Patient is not receiving systemic anti-KS treatment

Product Name: Panretin	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PANRETIN	ALITRETINOIN GEL 0.1%	90376015004020	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Panretin	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PANRETIN	ALITRETINOIN GEL 0.1%	90376015004020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Panretin therapy

PPI (Proton Pump Inhibitors)

Prior Authorization Guideline

Guideline ID	GL-146390
Guideline Name	PPI (Proton Pump Inhibitors)
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic lansoprazole ODT, generic esomeprazole magnesium susp packets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
LANSOPRAZOLE ODT	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Generic
LANSOPRAZOLE ODT	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Generic

ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270025103010	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG	49270025103020	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270025103040	Generic

Approval Criteria

1 - The patient is less than 2 years of age

OR

2 - ONE of the following:

2.1 Failure to lansoprazole DR capsule as sprinkle administration, as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to lansoprazole DR capsule as sprinkle administration (please specify contraindication or intolerance)

Product Name: generic esomeprazole magnesium caps (OTC)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
EQ ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
ESOMEPRAZOLE MAGNESIUM DR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic

GNP ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
GOODSENSE ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
HM ESOMEPRAZOLE MAGNESIUM DELAYED RELEASE	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
KLS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
QC ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
RA ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
SM ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic

Approval Criteria

1 - Failure to at least a 30 day trial of TWO of the following as confirmed by claims history or submission of medical records:

- Omeprazole capsule (generic Prilosec)
- Pantoprazole tablet (generic Protonix)
- Lansoprazole delayed release (DR) capsule (generic Prevacid)

OR

2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Omeprazole capsule (generic Prilosec)
- Pantoprazole tablet (generic Protonix)
- Lansoprazole delayed release (DR) capsule (generic Prevacid)

Product Name: Prilosec OTC, omeprazole tabs, Brand Protonix tabs, Brand Prevacid, Prevacid 24HR, Nexium caps, Brand Aciphex, generic rabeprazole tabs, Brand Dexilant, Esomeprazole Strontium, generic dexlansoprazole, Brand Nexium caps, Nexium 24HR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRILOSEC OTC	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Brand
CVS OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
EQ OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
EQL OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
GNP OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
HM OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
KLS OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
PX OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
RA OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
SB OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
SM OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
PROTONIX	PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV)	49270070100610	Brand
PROTONIX	PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV)	49270070100620	Brand
PREVACID	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Brand
PREVACID 24HR	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Brand
PREVACID	LANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270040006520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ)	49270025106540	Brand
ACIPHEX	RABEPRAZOLE SODIUM EC TAB 20 MG	49270076100620	Brand

RABEPRAZOLE SODIUM	RABEPRAZOLE SODIUM EC TAB 20 MG	49270076100620	Generic
DEXILANT	DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270020006520	Brand
DEXILANT	DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG	49270020006530	Brand
OMEPRAZOLE	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
ESOMEPRAZOLE STRONTIUM	ESOMEPRAZOLE STRONTIUM CAP DELAYED RELEASE 49.3 MG	49270025306550	Brand
ACID REDUCER	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
OMEPRAZOLE DR	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270020006520	Generic
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG	49270020006530	Generic
QC OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR CLEAR MINIS	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand

Approval Criteria

1 - Failure to at least a 30 day trial of THREE of the following as confirmed by claims history or submission of medical records:

- Omeprazole capsule (generic Prilosec)
- Pantoprazole tablet (generic Protonix)
- Lansoprazole delayed release (DR) capsule (generic Prevacid)
- Esomeprazole magnesium OTC capsule (Prior authorization required)

OR

2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Omeprazole capsule (generic Prilosec)

- Pantoprazole tablet (generic Protonix)
- Lansoprazole DR capsule (generic Prevacid)
- Esomeprazole magnesium OTC capsule

Product Name: Prilosec, Brand Protonix susp packets, Brand Prevacid Solutab, Nexium susp packets, Brand Nexium susp packets, Aciphex Sprinkle, generic pantoprazole susp packets, Rabeprazole Sprinkle	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRILOSEC	OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 2.5 MG	49270060103020	Brand
PRILOSEC	OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270060103030	Brand
PROTONIX	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Brand
PREVACID SOLUTAB	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Brand
PREVACID SOLUTAB	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACK 2.5 MG	49270025103004	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 5 MG	49270025103007	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270025103010	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG	49270025103020	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270025103040	Brand
ACIPHEX SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 5 MG	49270076106805	Brand
ACIPHEX SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	Generic
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Generic
RABEPRAZOLE SODIUM DR SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	Brand

Approval Criteria

1 - Failure to at least a 30 day trial to ALL of the following products as confirmed by claims history or submission of medical records:

- Lansoprazole DR capsule as sprinkle administration (generic Prevacid)
- Lansoprazole oral disintegrating tablet (generic Prevacid Solutab) (Prior authorization required)
- Esomeprazole magnesium granule suspension (generic Nexium granule suspension) (Prior authorization required)

OR

2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Lansoprazole DR capsule as sprinkle administration (generic Prevacid)
- Lansoprazole oral disintegrating tablet (generic Prevacid Solutab)
- Esomeprazole magnesium granule suspension (generic Nexium granule suspension)

Product Name: omeprazole caps, Prilosec, Prilosec OTC, omeprazole tabs, generic pantoprazole tabs/susp packets, Brand Protonix tabs/susp packets, generic lansoprazole, Brand Prevacid, Prevacid 24HR, generic lansoprazole ODT, Brand Prevacid Solutab, generic esomeprazole magnesium caps, Nexium, Brand Aciphex, generic rabeprazole, Aciphex Sprinkle, Brand Dexilant, generic esomeprazole magnesium susp packets, Esomeprazole Strontium, generic dexlansoprazole, Brand Nexium, Nexium 24HR, Rabeprazole Sprinkle

Therapy Stage	Initial Authorization
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
OMEPRAZOLE	OMEPRAZOLE CAP DELAYED RELEASE 10 MG	49270060006510	Generic
OMEPRAZOLE DR	OMEPRAZOLE CAP DELAYED RELEASE 10 MG	49270060006510	Generic
OMEPRAZOLE	OMEPRAZOLE CAP DELAYED RELEASE 20 MG	49270060006520	Generic
OMEPRAZOLE	OMEPRAZOLE CAP DELAYED RELEASE 40 MG	49270060006530	Generic
OMEPRAZOLE DR	OMEPRAZOLE CAP DELAYED RELEASE 40 MG	49270060006530	Generic
PRILOSEC	OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 2.5 MG	49270060103020	Brand

PRILOSEC	OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270060103030	Brand
PRILOSEC OTC	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Brand
CVS OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
EQ OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
EQL OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
GNP OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
HM OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
KLS OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
PX OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
RA OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
SB OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
SM OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV)	49270070100610	Generic
PANTOPRAZOLE SODIUM DR	PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV)	49270070100610	Generic
PROTONIX	PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV)	49270070100610	Brand
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV)	49270070100620	Generic
PROTONIX	PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV)	49270070100620	Brand
PROTONIX	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Brand
CVS LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
EQ LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
GNP LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
GOODSENSE LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic

HM LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
PREVACID	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Brand
PREVACID 24HR	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Brand
SM LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270040006520	Generic
PREVACID	LANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270040006520	Brand
LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
LANSOPRAZOLE ODT	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
PREVACID SOLUTAB	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Brand
LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Generic
LANSOPRAZOLE ODT	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Generic
PREVACID SOLUTAB	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Brand
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ)	49270025106540	Generic
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ)	49270025106540	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACK 2.5 MG	49270025103004	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 5 MG	49270025103007	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270025103010	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG	49270025103020	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270025103040	Brand
ACIPHEX	RABEPRAZOLE SODIUM EC TAB 20 MG	49270076100620	Brand
RABEPRAZOLE SODIUM	RABEPRAZOLE SODIUM EC TAB 20 MG	49270076100620	Generic
ACIPHEX SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 5 MG	49270076106805	Brand

ACIPHEX SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	Generic
DEXILANT	DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270020006520	Brand
DEXILANT	DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG	49270020006530	Brand
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270025103010	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG	49270025103020	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270025103040	Generic
OMEPRAZOLE	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
ESOMEPRAZOLE STRONTIUM	ESOMEPRAZOLE STRONTIUM CAP DELAYED RELEASE 49.3 MG	49270025306550	Brand
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Generic
QC LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
CVS LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
ACID REDUCER	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
OMEPRAZOLE DR	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
PANTOPRAZOLE SODIUM DR	PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV)	49270070100620	Generic
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270020006520	Generic
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG	49270020006530	Generic
QC OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
ACID REDUCER	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
CVS OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
EQ OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
GNP OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
KP OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic

OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
QC OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
EQ ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
ESOMEPRAZOLE MAGNESIUM DR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
GNP ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
GOODSENSE ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
HM ESOMEPRAZOLE MAGNESIUM DELAYED RELEASE	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
KLS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR CLEAR MINIS	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
QC ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
RA ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
SM ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
RABEPRAZOLE SODIUM DR SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	Brand

Approval Criteria

1 - The patient did not exhibit an adequate response to treatment within the quantity limit*

OR **2 -** The patient has documented erosive disease* **OR** **3 -** The patient has documented symptoms of complicated disease (e.g., dysphagia, bleeding, weight loss, choking, chest pain)* **OR** **4 -** The patient has a pathological hypersecretory condition such as Zollinger-Ellison syndrome, Barrett's Esophagus, multiple endocrine adenomas, or systemic mastocytosis**	
Notes	Authorization will be issued based on circumstance. *Authorization will be issued for 8 weeks. **Authorization of therapy will be issued for 12 months.

Product Name: omeprazole caps, Prilosec, Prilosec OTC, omeprazole tabs, generic pantoprazole tabs/susp packets, Brand Protonix tabs/susp packets, generic lansoprazole, Brand Prevacid, Prevacid 24HR, generic lansoprazole ODT, Brand Prevacid Solutab, generic esomeprazole magnesium caps, Nexium, Brand Aciphex, generic rabeprazole, Aciphex Sprinkle, Brand Dexilant, generic esomeprazole magnesium susp packets, Esomeprazole Strontium, generic dexlansoprazole, Brand Nexium, Nexium 24HR, Rabeprazole Sprinkle	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
OMEPRAZOLE	OMEPRAZOLE CAP DELAYED RELEASE 10 MG	49270060006510	Generic
OMEPRAZOLE DR	OMEPRAZOLE CAP DELAYED RELEASE 10 MG	49270060006510	Generic
OMEPRAZOLE	OMEPRAZOLE CAP DELAYED RELEASE 20 MG	49270060006520	Generic
OMEPRAZOLE	OMEPRAZOLE CAP DELAYED RELEASE 40 MG	49270060006530	Generic
OMEPRAZOLE DR	OMEPRAZOLE CAP DELAYED RELEASE 40 MG	49270060006530	Generic

PRILOSEC	OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 2.5 MG	49270060103020	Brand
PRILOSEC	OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270060103030	Brand
PRILOSEC OTC	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Brand
CVS OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
EQ OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
EQL OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
GNP OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
HM OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
KLS OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
PX OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
RA OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
SB OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
SM OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV)	49270070100610	Generic
PANTOPRAZOLE SODIUM DR	PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV)	49270070100610	Generic
PROTONIX	PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV)	49270070100610	Brand
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV)	49270070100620	Generic
PROTONIX	PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV)	49270070100620	Brand
PROTONIX	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Brand
CVS LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
EQ LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
GNP LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic

GOODSENSE LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
HM LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
PREVACID	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Brand
PREVACID 24HR	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Brand
SM LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270040006520	Generic
PREVACID	LANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270040006520	Brand
LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
LANSOPRAZOLE ODT	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
PREVACID SOLUTAB	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Brand
LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Generic
LANSOPRAZOLE ODT	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Generic
PREVACID SOLUTAB	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Brand
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ)	49270025106540	Generic
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ)	49270025106540	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACK 2.5 MG	49270025103004	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 5 MG	49270025103007	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270025103010	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG	49270025103020	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270025103040	Brand
ACIPHEX	RABEPRAZOLE SODIUM EC TAB 20 MG	49270076100620	Brand
RABEPRAZOLE SODIUM	RABEPRAZOLE SODIUM EC TAB 20 MG	49270076100620	Generic

ACIPHEX SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 5 MG	49270076106805	Brand
ACIPHEX SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	Generic
DEXILANT	DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270020006520	Brand
DEXILANT	DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG	49270020006530	Brand
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270025103010	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG	49270025103020	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270025103040	Generic
OMEPRAZOLE	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
ESOMEPRAZOLE STRONTIUM	ESOMEPRAZOLE STRONTIUM CAP DELAYED RELEASE 49.3 MG	49270025306550	Brand
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Generic
QC LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
CVS LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
ACID REDUCER	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
OMEPRAZOLE DR	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
PANTOPRAZOLE SODIUM DR	PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV)	49270070100620	Generic
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270020006520	Generic
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG	49270020006530	Generic
QC OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
ACID REDUCER	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
CVS OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
EQ OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
GNP OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
KP OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic

OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
QC OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
EQ ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
ESOMEPRAZOLE MAGNESIUM DR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
GNP ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
GOODSENSE ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
HM ESOMEPRAZOLE MAGNESIUM DELAYED RELEASE	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
KLS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR CLEAR MINIS	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
QC ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
RA ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
SM ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
RABEPRAZOLE SODIUM DR SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	Brand

Approval Criteria

1 - The patient is continuing therapy for a pathological hypersecretory condition such as Zollinger-Ellison syndrome, Barrett's Esophagus, multiple adenomas, or systemic mastocytosis

Pradaxa

Prior Authorization Guideline

Guideline ID	GL-146391
Guideline Name	Pradaxa
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: dabigatran etexilate, Pradaxa	
Diagnosis	Continuation of Therapy Upon Hospital Discharge
Approval Length	35 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand

DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand

Approval Criteria

1 - For continuation of therapy upon hospital discharge

Product Name: dabigatran etexilate, Pradaxa	
Diagnosis	Stroke and Systemic Embolism Prevention in an Adult Patient with Non-Valvular Atrial Fibrillation (AF)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand

PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand

Approval Criteria

1 - Diagnosis of atrial fibrillation (AF)

AND

2 - Patient does not have an artificial heart valve

AND

3 - ONE of the following:

3.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Eliquis
- Savaysa

OR

3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Eliquis
- Savaysa

OR

3.3 Continuation of prior Pradaxa therapy

Product Name: dabigatran etexilate, Pradaxa	
Diagnosis	Prophylaxis of Venous Thromboembolism (VTE) and Pulmonary Embolism (PE) after Orthopedic Surgery in an Adult Patient (Hip Replacement: Labeled; Knee Replacement: Off-Label)
Approval Length	35 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand

Approval Criteria

1 - ONE of the following:

- Patient has or is scheduled to have total knee replacement surgery
- Patient has or is scheduled to have total hip replacement surgery

AND

2 - Patient does not have an artificial heart valve

AND

3 - ONE of the following:

3.1 Failure of Eliquis confirmed by claims history or submitted medical records

OR

3.2 History of intolerance or contraindication to Eliquis (please specify intolerance or contraindication)

OR

3.3 Continuation of prior Pradaxa therapy

Product Name: dabigatran etexilate, Pradaxa	
Diagnosis	Treatment of Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) in an Adult Patient
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand

PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Deep vein thrombosis (DVT)
- Pulmonary embolism (PE)

AND

2 - Patient does not have an artificial heart valve

AND

3 - ONE of the following:

3.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Eliquis
- Savaysa

OR

3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Eliquis

- Savaysa

OR

3.3 Continuation of prior Pradaxa therapy

Product Name: dabigatran etexilate, Pradaxa	
Diagnosis	Reduction in the Risk of Recurrence of Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) in an Adult Patient
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand

Approval Criteria

1 - Previous diagnosis of ONE of the following:

- Deep vein thrombosis (DVT)
- Pulmonary embolism (PE)

AND

2 - Patient does not have an artificial heart valve

AND

3 - Patient must have been treated with an anticoagulant [e.g., warfarin, Eliquis (apixiban)] for at least 3 months prior to request

AND

4 - ONE of the following:

4.1 Failure of Eliquis confirmed by claims history or submitted medical records

OR

4.2 History of intolerance or contraindication to Eliquis (please specify intolerance or contraindication)

OR

4.3 Continuation of prior Pradaxa therapy

Product Name: dabigatran etexilate, Pradaxa	
Diagnosis	Treatment of Venous Thromboembolic Events (VTE) in a Pediatric Patient
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand

Approval Criteria

1 - Diagnosis of venous thromboembolic events (VTE)

AND

2 - Patient does not have an artificial heart valve

Product Name: dabigatran etexilate, Pradaxa	
Diagnosis	Reduction in the Risk of Recurrence of VTE in a Pediatric Patient
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic

PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand

Approval Criteria

1 - Diagnosis of venous thromboembolic events (VTE)

AND

2 - Patient does not have an artificial heart valve

AND

3 - Patient must have been treated with an anticoagulant (e.g., warfarin) for at least 3 months prior to request

Praluent

Prior Authorization Guideline

Guideline ID	GL-146834
Guideline Name	Praluent
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Praluent (all labelers)	
Diagnosis	Primary Hyperlipidemia (Including Heterozygous Familial Hypercholesterolemia (HeFH) and Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML	3935001000D520	Brand
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	3935001000D530	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

1.1 Heterozygous familial hypercholesterolemia (HeFH) as confirmed by ONE of the following:

1.1.1 BOTH of the following:

1.1.1.1 Pre-treatment low density lipoprotein cholesterol (LDL-C) of ONE of the following:

- Greater than or equal to 190 milligrams/deciliter (mg/dL)
- Greater than or equal to 155 mg/dL if less than 16 years of age

AND

1.1.1.2 ONE of the following:

- Family history of myocardial infarction in first-degree relative less than 60 years of age
- Family history of myocardial infarction in second-degree relative less than 50 years of age
- Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative
- Family history of heterozygous or homozygous familial hypercholesterolemia in first- or second-degree relative
- Family history of tendinous xanthomata and/or arcus cornealis in first- or second degree relative

OR

1.1.2 BOTH of the following:

1.1.2.1 Pre-treatment LDL-C of ONE of the following:

- Greater than or equal to 190 mg/dL
- Greater than or equal to 155 mg/dL if less than 16 years of age

AND

1.1.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

- Functional mutation in LDL (low density lipoprotein), apoB (apolipoprotein B), or PCSK9 (proprotein convertase subtilisin/kexin type 9) gene
- Tendinous xanthomata
- Arcus cornealis before age 45

OR

1.2 Atherosclerotic cardiovascular disease (ASCVD) as confirmed by ONE of the following:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

OR

1.3 Primary hyperlipidemia with pre-treatment LDL-C greater than or equal to 190 mg/dL

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

2.1 Patient has been receiving at least 12 consecutive weeks of high-intensity statin therapy [i.e., atorvastatin 40-80 milligrams (mg), rosuvastatin 20-40 mg] and will continue to receive high intensity statin at maximally tolerated dose

OR

2.2 BOTH of the following:

2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia [muscle symptoms without creatine kinase (CK) elevations]

- Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)]

AND

2.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to 10 mg, pravastatin greater than or equal to 10 mg, lovastatin 20-40 mg, fluvastatin XL 80 mg, fluvastatin 20-40 mg up to 40 mg twice daily, or Livalo (pitavastatin) greater than or equal to 1 mg] and will continue to receive a low-intensity or moderate-intensity statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate low- or moderate-, and high-intensity statins as evidenced by ONE of the following:

2.3.1 ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times ULN)

OR

2.3.2 Patient has a labeled contraindication to all statins as documented in medical records

OR

2.3.3 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3 - ONE of the following:

3.1 Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C greater than or equal to 100 mg/dL with ASCVD
- LDL-C greater than or equal to 130 mg/dL without ASCVD

OR

3.2 BOTH of the following:

3.2.1 Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C between 55 mg/dL and 99 mg/dL with ASCVD
- LDL-C between 100 mg/dL and 129 mg/dL without ASCVD

AND

3.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

3.2.2.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

3.2.2.2 Patient has a history of contraindication or intolerance to ezetimibe (please specify intolerance or contraindication)

AND

4 - Patient has received comprehensive counseling regarding appropriate diet

AND

5 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist

- Lipid specialist

AND

6 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

AND

7 - Not used in combination with Leqvio (inclisiran)

Product Name: Praluent (all labelers)	
Diagnosis	Primary Hyperlipidemia (Including Heterozygous Familial Hypercholesterolemia (HeFH) and Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML	3935001000D520	Brand
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	3935001000D530	Brand

Approval Criteria

1 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting low density lipoprotein cholesterol (LDL-C) reduction while on Praluent therapy

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

AND

4 - Not used in combination with Leqvio (inclisiran)

Product Name: Praluent (all labelers)	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML	3935001000D520	Brand
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	3935001000D530	Brand

Approval Criteria

1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

1.1 Submission of medical records (e.g., chart notes, laboratory values) confirming genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus

OR

1.2 BOTH of the following:

1.2.1 Pre-treatment low density lipoprotein cholesterol (LDL-C) greater than 400 milligrams/deciliter (mg/dL)

AND

1.2.2 ONE of the following:

1.2.2.1 Xanthoma before 10 years of age

OR

1.2.2.2 Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

AND

2 - Patient has received comprehensive counseling regarding appropriate diets

AND

3 - Patient is receiving other lipid-lowering therapy confirmed by claims history or submitted medical records (e.g., statin, ezetimibe, LDL apheresis)

AND

4 - Prescribed by one of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

5 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

AND

6 - Not used in combination with Juxtapid (lomitapide)

Product Name: Praluent (all labelers)	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML	3935001000D520	Brand
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	3935001000D530	Brand

Approval Criteria

1 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting low density lipoprotein cholesterol (LDL-C) reduction while on Praluent therapy

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

AND

4 - Not used in combination with Juxtapid (lomitapide)

Product Name: Praluent (Non-72733 labelers)	
Diagnosis	Non-Preferred*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML	3935001000D520	Brand
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	3935001000D530	Brand

Approval Criteria

1 - History of failure to at least THREE preferred alternatives as confirmed by claims history or submission of medical records.* NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of failure to all of the preferred products.

OR

2 - History of contraindication or intolerance to THREE preferred alternatives (please specify contraindication or intolerance).* NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of contraindication or intolerance to all of the preferred products.

Notes	*Reference Non-Preferred Drugs policy. Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request. PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

2 . Revision History

Date	Notes
4/30/2024	Updated PDL link

Preferred Non-Solid Dosage Forms

Prior Authorization Guideline

Guideline ID	GL-146840
Guideline Name	Preferred Non-Solid Dosage Forms
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Diagnosis	Requests for Non-Solid Dosage Forms
Approval Length	12 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
Non-solid dosage forms			
Non solid dosage forms			
Solid oral dosage forms			

Approval Criteria

1 - ONE of the following:

1.1 Requested drug must be used for an FDA (Food and Drug Administration)-approved indication

OR

1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopeia-National Formulary (USP-NF)

AND

2 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 The patient is able to swallow a solid dosage form

AND

3.1.2 ONE of the following:

3.1.2.1 History of failure, contraindication, or intolerance to at least THREE preferred* solid oral dosage forms (Prior trials of formulary/PDL (preferred drug list) alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request. NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of failure, contraindication, or intolerance to ALL of the preferred products.)

OR **3.1.2.2** There are no preferred formulary alternatives for the requested drug **OR** **3.2** Patient is unable to swallow a solid dosage form **OR** **3.3** Patient utilizes a feeding tube for medication administration **OR** **3.4** Request is for a nebulized formulation of an inhaled medication for a patient who has an inability to effectively utilize an agent in an inhaler formulation due to neuromuscular or cognitive disability, or other evidence of lack of response to the inhaled formulation supported by clinical documentation	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

2 . Revision History

Date	Notes
4/30/2024	Updated PDL link

Pretomanid

Prior Authorization Guideline

Guideline ID	GL-146395
Guideline Name	Pretomanid
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Pretomanid	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRETOMANID	PRETOMANID TAB 200 MG	09000063000320	Brand

Approval Criteria

1 - One of the following:

1.1 Diagnosis of pulmonary extensively drug resistant (XDR) tuberculosis (TB)

OR

1.2 Treatment-intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB)

AND

2 - Pretomanid will be used in combination with bedaquiline and linezolid

Progesterone - Non-Oral

Prior Authorization Guideline

Guideline ID	GL-146396
Guideline Name	Progesterone - Non-Oral
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Crinone, Endometrin	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CRINONE	PROGESTERONE VAGINAL GEL 4%	55370060004010	Brand
CRINONE	PROGESTERONE VAGINAL GEL 8%	55370060004020	Brand
ENDOMETRIN	PROGESTERONE VAGINAL INSERT 100 MG	55370060009910	Brand

Approval Criteria

1 - Treatment is for non-infertility use (e.g., secondary amenorrhea, reduce the risk of recurrent spontaneous preterm birth)

Progesterone - Oral

Prior Authorization Guideline

Guideline ID	GL-146397
Guideline Name	Progesterone - Oral
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Prometrium, generic progesterone caps	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PROGESTERONE	PROGESTERONE CAP 100 MG	26000040000120	Generic
PROMETRIUM	PROGESTERONE CAP 100 MG	26000040000120	Brand
PROGESTERONE	PROGESTERONE CAP 200 MG	26000040000140	Generic
PROMETRIUM	PROGESTERONE CAP 200 MG	26000040000140	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Amenorrhea
- Endometrial hyperplasia or prevention of endometrial hyperplasia
- Abnormal uterine or vaginal bleeding
- History of preterm birth
- Prevention of preterm delivery for current pregnancy

Provigil, Nuvigil

Prior Authorization Guideline

Guideline ID	GL-146398
Guideline Name	Provigil, Nuvigil
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Provigil, generic modafinil, Brand Nuvigil, generic armodafinil	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MODAFINIL	MODAFINIL TAB 100 MG	61400024000310	Generic
PROVIGIL	MODAFINIL TAB 100 MG	61400024000310	Brand
MODAFINIL	MODAFINIL TAB 200 MG	61400024000320	Generic
PROVIGIL	MODAFINIL TAB 200 MG	61400024000320	Brand
ARMODAFINIL	ARMODAFINIL TAB 50 MG	61400010000310	Generic
NUVIGIL	ARMODAFINIL TAB 50 MG	61400010000310	Brand

ARMODAFINIL	ARMODAFINIL TAB 150 MG	61400010000330	Generic
NUVIGIL	ARMODAFINIL TAB 150 MG	61400010000330	Brand
ARMODAFINIL	ARMODAFINIL TAB 200 MG	61400010000335	Generic
NUVIGIL	ARMODAFINIL TAB 200 MG	61400010000335	Brand
ARMODAFINIL	ARMODAFINIL TAB 250 MG	61400010000340	Generic
NUVIGIL	ARMODAFINIL TAB 250 MG	61400010000340	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- Narcolepsy
- Excessive sleepiness due to obstructive sleep apnea
- Excessive sleepiness due to shift work disorder (circadian rhythm sleep disorder, shift work type)
- Idiopathic hypersomnia
- Diagnosis of multiple sclerosis (MS)
- Diagnosis of major depressive disorder or bipolar depression

Qbrexza

Prior Authorization Guideline

Guideline ID	GL-146399
Guideline Name	Qbrexza
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Qbrexza	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
QBREXZA	GLYCOPYRRONIUM TOSYLATE PAD 2.4% (BASE EQUIVALENT)	90970030204320	Brand

Approval Criteria

1 - Diagnosis of primary axillary hyperhidrosis

AND

2 - ONE of the following:

2.1 Failure to Xerac-AC as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to Xerac-AC (please specify contraindication or intolerance)

Qlosi, Vuity

Prior Authorization Guideline

Guideline ID	GL-146400
Guideline Name	Qlosi, Vuity
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Vuity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VUITY	PILOCARPINE HCL OPHTH SOLN 1.25%	86501030102017	Brand

Approval Criteria

1 - Diagnosis of presbyopia

AND

2 - Patient is between the ages of 40 to 55

AND

3 - Patient is unable to use corrective lenses (e.g., glasses, contacts) (document medical rationale why patient is unable to use corrective lenses)

AND

4 - Prescribed by ONE of the following:

- Optometrist
- Ophthalmologist

Product Name: Vuity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VUITY	PILOCARPINE HCL OPHTH SOLN 1.25%	86501030102017	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Age less than 55

AND

3 - Prescribed by ONE of the following:

- Optometrist
- Ophthalmologist

Product Name: Qlosi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
Qlosi			

Approval Criteria

1 - Diagnosis of presbyopia

AND

2 - Patient is between the ages of 45 to 64

AND

3 - Patient is unable to use corrective lenses (e.g., glasses, contacts) (document medical rationale why patient is unable to use corrective lenses)

AND

4 - Prescribed by ONE of the following:

- Optometrist

- Ophthalmologist

Product Name: Qlosi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
Qlosi			

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Age less than 64

AND

3 - Prescribed by ONE of the following:

- Optometrist
- Ophthalmologist

Quantity Limits

Prior Authorization Guideline

Guideline ID	GL-146401
Guideline Name	Quantity Limits
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Quantity Limit, Prescription Limit	
Diagnosis	Quantity limit review (General)
Approval Length	12 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
Quantity Limit			
Prescription Limit			

Approval Criteria

1 - ONE of the following:

1.1 The requested drug must be used for an FDA (Food and Drug Administration)-approved indication

OR

1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - ONE of the following:

2.1 The drug is being prescribed within the manufacturer's published dosing guidelines

OR

2.2 The request falls within dosing guidelines found in ONE of the following compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

3 - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation.

AND

4 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program.

Product Name: Quantity Limit, Prescription Limit	
Diagnosis	Quantity limit review for the treatment of gender dysphoria*
Approval Length	12 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
Quantity Limit			
Prescription Limit			

Approval Criteria

1 - The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - The drug is being prescribed for an indication that is recognized as a covered benefit by the applicable health plans' program.

Notes	* If the above criteria are not met, then refer for clinical review by an a ppropriate trained professional (physician or pharmacist) based on the applicable regulatory requirement.

Product Name: Quantity Limit, Prescription Limit

Diagnosis	Monthly prescription limit review for migraine therapy, benzodiazepines, or muscle relaxants
Approval Length	1 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
Quantity Limit			
Prescription Limit			

Approval Criteria

1 - Medical necessity rationale provided for why the member requires 5 or more fills of the same drug or drug class within a month.

Notes	*If deemed medically necessary, longer authorization duration is perm itted

Product Name: Quantity Limit, Prescription Limit	
Diagnosis	Topical products exceeding the allowable package size per fill OR the allowable quantity per month
Approval Length	12 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
Quantity Limit			
Prescription Limit			

Approval Criteria

1 - The physician attests that a larger quantity is needed for treatment of a larger surface area.

Rayos

Prior Authorization Guideline

Guideline ID	GL-146402
Guideline Name	Rayos
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Rayos	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RAYOS	PREDNISONE TAB DELAYED RELEASE 1 MG	22100045000610	Brand
RAYOS	PREDNISONE TAB DELAYED RELEASE 2 MG	22100045000620	Brand
RAYOS	PREDNISONE TAB DELAYED RELEASE 5 MG	22100045000630	Brand

Approval Criteria

1 - ONE of the following:

1.1 Rayos must be used for a Food and Drug Administration (FDA)-approved indication

OR

1.2 The intended use of Rayos is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - Rayos is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting an intolerance to generic prednisone tablets which is unable to be resolved with attempts to minimize the adverse effects where appropriate

AND

4 - ONE of the following:

4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- Dexamethasone tablet/oral solution
- Hydrocortisone tablet
- Methylprednisolone tablet
- Prednisolone tablet/oral solution

OR

4.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Dexamethasone tablet/oral solution
- Hydrocortisone tablet
- Methylprednisolone tablet
- Prednisolone tablet/oral solution

Rectiv

Prior Authorization Guideline

Guideline ID	GL-146403
Guideline Name	Rectiv
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Rectiv	
Diagnosis	Pain Associated with Chronic Anal Fissures
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RECTIV	NITROGLYCERIN OINT 0.4%	89254060004220	Brand

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with chronic anal fissures

Regranex

Prior Authorization Guideline

Guideline ID	GL-146404
Guideline Name	Regranex
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Regranex	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REGRANEX	BECAPLERMIN GEL 0.01%	90945020004020	Brand

Approval Criteria

1 - Patient has a lower extremity diabetic neuropathic ulcer

Relistor

Prior Authorization Guideline

Guideline ID	GL-146405
Guideline Name	Relistor
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Relistor Injection	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RELISTOR	METHYLNALTREXONE BROMIDE INJ 8 MG/0.4ML (20 MG/ML)	52580050102015	Brand
RELISTOR	METHYLNALTREXONE BROMIDE INJ 12 MG/0.6ML (20 MG/ML)	52580050102020	Brand

Approval Criteria

1 - Documentation (e.g. chart notes) demonstrating a diagnosis of opioid induced constipation in a patient with advanced illness receiving palliative care

OR

2 - Documentation (e.g. chart notes) demonstrating BOTH of the following:

2.1 ONE of the following:

2.1.1 Diagnosis of opioid induced constipation with chronic, non-cancer pain

OR

2.1.2 Diagnosis of opioid induced constipation in patients with chronic pain related to prior cancer diagnosis or cancer treatment who do not require frequent (e.g., weekly) opioid dosage escalation

AND

2.2 ONE of the following:

2.2.1 The patient is not able to swallow oral medications

OR

2.2.2 ALL of the following:

2.2.2.1 ONE of the following:

2.2.2.1.1 Failure to ONE of the following as confirmed by claims history or submitted medical records

- Lactulose
- Polyethylene glycol (Miralex)

OR

2.2.2.1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication)

- Lactulose
- Polyethylene glycol (Miralex)

AND

2.2.2.2 ONE of the following:

2.2.2.2.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

2.2.2.2.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

AND

2.2.2.3 ONE of the following:

2.2.2.3.1 Failure to Movantik as confirmed by claims history or submitted medical records

OR

2.2.2.3.2 History of contraindication or intolerance to Movantik (please specify intolerance or contraindication)

Product Name: Relistor Injection	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

RELISTOR	METHYLNALTREXONE BROMIDE INJ 8 MG/0.4ML (20 MG/ML)	52580050102015	Brand
RELISTOR	METHYLNALTREXONE BROMIDE INJ 12 MG/0.6ML (20 MG/ML)	52580050102020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Relistor Injection therapy

Product Name: Relistor tablet	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RELISTOR	METHYLNALTREXONE BROMIDE TAB 150 MG	52580050100320	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of opioid induced constipation with chronic, non-cancer pain

OR

1.2 Diagnosis of opioid induced constipation in patients with chronic pain related to prior cancer diagnosis or cancer treatment who do not require frequent (e.g., weekly) opioid dosage escalation

AND

2 - ALL of the following:

2.1 ONE of the following:

2.1.1 Failure to ONE of the following as confirmed by claims history or submitted medical records

- Lactulose
- Polyethylene glycol (Miralex)

OR

2.1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication)

- Lactulose
- Polyethylene glycol (Miralex)

AND

2.2 ONE of the following:

2.2.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

2.2.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

AND

2.3 ONE of the following:

2.3.1 Failure to Movantik as confirmed by claims history or submitted medical records

OR

2.3.2 History of contraindication or intolerance to Movantik (please specify intolerance or contraindication)

Product Name: Relistor tablet	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RELISTOR	METHYLNALTREXONE BROMIDE TAB 150 MG	52580050100320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Relistor Tablet therapy

Repatha

Prior Authorization Guideline

Guideline ID	GL-146407
Guideline Name	Repatha
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Repatha	
Diagnosis	Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia) and ASCVD
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REPATHA	EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML	3935002000E520	Brand
REPATHA PUSHTRONEX SYSTEM	EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML	3935002000E230	Brand

REPATHA SURECLICK	EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	3935002000D520	Brand

Approval Criteria

1 - ONE of the following diagnoses:

1.1 Heterozygous familial hypercholesterolemia (HeFH) as confirmed by ONE of the following:

1.1.1 BOTH of the following:

1.1.1.1 Pre-treatment LDL-C (low-density lipoprotein cholesterol) is ONE of the following:

- Greater than or equal to 190 milligrams/deciliter (mg/dL)
- Greater than or equal to 155 mg/dL if less than 16 years of age

AND

1.1.1.2 ONE of the following:

- Family history of myocardial infarction in first-degree relative less than 60 years of age
- Family history of myocardial infarction in second-degree relative less than 50 years of age
- Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative
- Family history of heterozygous or homozygous familial hypercholesterolemia in first- or second-degree relative
- Family history of tendinous xanthomata and/or arcus cornealis in first- or second-degree relative

OR

1.1.2 BOTH of the following:

1.1.2.1 Pre-treatment LDL-C is ONE of the following:

- Greater than or equal to 190 mg/dL
- Greater than or equal to 155 mg/dL if less than 16 years of age

AND

1.1.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

- Functional mutation in LDL (low-density lipoprotein), apoB (Apolipoprotein B), or PCSK9 (Proprotein convertase subtilisin/kexin type 9) gene
- Tendinous xanthomata
- Arcus cornealis before age 45

OR

1.2 Atherosclerotic cardiovascular disease (ASCVD) as confirmed by ONE of the following:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

OR

1.3 Primary hyperlipidemia with pre-treatment LDL-C greater than or equal to 190 mg/dL

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

2.1 Patient has been receiving at least 12 consecutive weeks of high-intensity statin therapy (i.e., atorvastatin 40-80 mg, rosuvastatin 20-40 mg) and will continue to receive high-intensity statin at maximally tolerated dose

OR

2.2 BOTH of the following:

2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia [muscle symptoms without creatine kinase (CK) elevations]
- Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)]

AND

2.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to 10 mg, pravastatin greater than or equal to 10 mg, lovastatin 20-40 mg, fluvastatin XL 80 mg, fluvastatin 20-40 mg up to 40 mg twice daily or Livalo (pitavastatin) greater than or equal to 1 mg] and will continue to receive a low-intensity or moderate-intensity statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate low- or moderate-, and high-intensity statins as evidenced by ONE of the following:

2.3.1 ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low- or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)]

OR

2.3.2 Patient has a labeled contraindication to all statins as confirmed by medical records

OR

2.3.3 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3 - ONE of the following:

3.1 Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C greater than or equal to 100 mg/dL with ASCVD
- LDL-C greater than or equal to 130 mg/dL without ASCVD

OR

3.2 BOTH of the following:

3.2.1 Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C between 55 mg/dL and 99 mg/dL with ASCVD
- LDL-C between 100 mg/dL and 129 mg/dL without ASCVD

AND

3.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

3.2.2.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

3.2.2.2 Patient has a history of contraindication or intolerance to ezetimibe (please specify intolerance or contraindication)

AND

4 - Patient has received comprehensive counseling regarding appropriate diet

AND

5 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

6 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

AND

7 - Not used in combination with Leqvio (inclisiran)

Product Name: Repatha	
Diagnosis	Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia) and ASCVD
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REPATHA	EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML	3935002000E520	Brand
REPATHA PUSHTRONEX SYSTEM	EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML	3935002000E230	Brand
REPATHA SURECLICK	EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	3935002000D520	Brand

Approval Criteria

1 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist

- Lipid specialist

AND

2 - Submission of medical records (e.g. chart notes, laboratory values) documenting LDL-C (low-density lipoprotein cholesterol) reduction while on Repatha therapy

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

AND

4 - Not used in combination with Leqvio (inclisiran)

Product Name: Repatha	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REPATHA	EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML	3935002000E520	Brand
REPATHA PUSHTRONEX SYSTEM	EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML	3935002000E230	Brand
REPATHA SURECLICK	EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	3935002000D520	Brand

Approval Criteria

1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

1.1 Genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus

OR

1.2 BOTH of the following:

1.2.1 Pre-treatment LDL-C (low-density lipoprotein cholesterol) greater than 400 mg/dL (milligrams/deciliter)

AND

1.2.2 ONE of the following:

- Xanthoma before 10 years of age
- Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

AND

2 - Patient has received comprehensive counseling regarding appropriate diet

AND

3 - Patient is receiving other lipid-lowering therapy confirmed by claims history or submitted medical records (e.g., statin, ezetimibe, LDL apheresis)

AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

5 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

AND

6 - Not used in combination with Juxtapid (lomitapide)

Product Name: Repatha	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REPATHA	EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML	3935002000E520	Brand
REPATHA PUSHTRONEX SYSTEM	EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML	3935002000E230	Brand
REPATHA SURECLICK	EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	3935002000D520	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting LDL-C (low-density lipoprotein cholesterol) reduction while on Repatha therapy

AND

2 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid Specialist

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

AND

4 - Not used in combination with Juxtapid (lomitapide)

Reyvow

Prior Authorization Guideline

Guideline ID	GL-146408
Guideline Name	Reyvow
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Reyvow	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REYVOW	LASMIDITAN SUCCINATE TAB 50 MG	67406540600310	Brand
REYVOW	LASMIDITAN SUCCINATE TAB 100 MG	67406540600320	Brand

Approval Criteria

1 - Used for acute treatment of migraine

AND

2 - Patient is 18 years of age or older

AND

3 - ONE of the following:

3.1 History of a therapeutic failure (after at least 3 migraine episodes and a minimum of a 30-day trial), to BOTH of the following as confirmed by claims history or submission of medical records:

3.1.1 TWO of the following:

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

AND

3.1.2 ONE of the following:

- Nurtec ODT
- Ubrelvy

OR

3.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)
- Nurtec ODT
- Ubrelvy

AND

4 - Prescribed by or in consultation with ONE of the following specialists with expertise in the acute treatment of migraine:

- Neurologist
- Pain Specialist
- Headache Specialist [Headache specialists are physicians certified by the United Council for Neurologic Subspecialties (UCNS)]

AND

5 - Prescriber attests to BOTH of the following:

5.1 Patient has been informed the use of Reyvow may result in significant CNS (central nervous system) impairment, and may impact the patient's ability to drive or operate machinery for 8 hours after each dose

AND

5.2 If used concurrently with a benzodiazepine or other drugs that could potentially cause CNS depression, the prescriber has acknowledged that they have completed an assessment of increased risk for sedation and other cognitive and/or neuropsychiatric adverse events

AND

6 - ONE of the following:

6.1 Patient is currently treated with ONE of the following prophylactic therapies:

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol*)
- Candesartan (generic Atacand)*
- A calcitonin gene-related peptide receptor (CGRP) antagonist for preventive treatment of migraine [i.e., Aimovig (erenumab), Ajovy (fremanezumab)*, Emgality (galcanezumab), Nurtec ODT, Qulipta*, Vyepti (eptinezumab-jjmr)**]***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)

OR

6.2 Patient has less than 4 migraine days per month

OR

6.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to ONE of the following prophylactic therapies:

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol*)
- Candesartan (generic Atacand)*
- A calcitonin gene-related peptide receptor (CGRP) antagonist for preventive treatment of migraine [i.e., Aimovig (erenumab), Ajovy (fremanezumab)*, Emgality (galcanezumab), Nurtec ODT, Qulipta*, Vyepti (eptinezumab-jjmr)**]***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)

Notes	*Timolol, candesartan, Ajovy, and Qulipta are non-preferred and should not be included in denial to provider. **Vyepti and OnabotulinumtoxinA (generic Botox) are medical benefit, should not be included in denial to provider. ***CGRP antagonists for preventive treatment of migraines require a prior authorization.

Product Name: Reyvow	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REYVOW	LASMIDITAN SUCCINATE TAB 50 MG	67406540600310	Brand
REYVOW	LASMIDITAN SUCCINATE TAB 100 MG	67406540600320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Rozerem

Prior Authorization Guideline

Guideline ID	GL-146409
Guideline Name	Rozerem
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Rozerem, generic ramelteon	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RAMELTEON	RAMELTEON TAB 8 MG	60250060000320	Generic
ROZEREM	RAMELTEON TAB 8 MG	60250060000320	Brand

Approval Criteria

1 - Failure of at least 2 weeks to ALL of the following sedative-hypnotic alternatives confirmed by claims history or submitted medical records:

- Zolpidem or zolpidem ER (generic Ambien, generic Ambien CR)
- Zaleplon (generic Sonata)
- Eszopiclone (generic Lunesta)

OR

2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Zolpidem or zolpidem ER (generic Ambien, generic Ambien CR)
- Zaleplon (generic Sonata)
- Eszopiclone (generic Lunesta)

OR

3 - History of or potential for a substance abuse disorder

Rukobia

Prior Authorization Guideline

Guideline ID	GL-146410
Guideline Name	Rukobia
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Rukobia	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RUKOBIA	FOSTEMSAVIR TROMETHAMINE TAB ER 12HR 600 MG	12102330407420	Brand

Approval Criteria

1 - Patient has been diagnosed with multidrug-resistant HIV-1 (human immunodeficiency virus) infection

AND

2 - Patient is currently taking or will be prescribed an optimized background antiretroviral regimen

Sensipar

Prior Authorization Guideline

Guideline ID	GL-146411
Guideline Name	Sensipar
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Sensipar, generic cinacalcet	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CINACALCET HYDROCHLORIDE	CINACALCET HCL TAB 30 MG (BASE EQUIV)	30905225100320	Generic
SENSIPAR	CINACALCET HCL TAB 30 MG (BASE EQUIV)	30905225100320	Brand
CINACALCET HYDROCHLORIDE	CINACALCET HCL TAB 60 MG (BASE EQUIV)	30905225100330	Generic
SENSIPAR	CINACALCET HCL TAB 60 MG (BASE EQUIV)	30905225100330	Brand

CINACALCET HYDROCHLORIDE	CINACALCET HCL TAB 90 MG (BASE EQUIV)	30905225100340	Generic
SENSIPAR	CINACALCET HCL TAB 90 MG (BASE EQUIV)	30905225100340	Brand

Approval Criteria

1 - Prescribed by or in consultation with an oncologist, endocrinologist, or nephrologist

AND

2 - ONE of the following:

2.1 Diagnosis of hypercalcemia with parathyroid carcinoma

OR

2.2 ALL of the following:

2.2.1 Diagnosis of primary hyperparathyroidism (HPT)

AND

2.2.2 Severe hypercalcemia [serum calcium level greater than 12.5 mg/dL (milligrams/deciliter)] due to primary HPT

AND

2.2.3 Patient is unable to undergo parathyroidectomy

OR

2.3 ALL of the following:

2.3.1 Diagnosis of secondary hyperparathyroidism with chronic kidney disease

AND

2.3.2 Patient is on dialysis

AND

2.3.3 BOTH of the following:

2.3.3.1 ONE of the following:

- Patient has therapeutic failure to ONE phosphate binder (e.g., PhosLo, Fosrenol, Renvela, Renagel, etc.) confirmed by claims history or submitted medical records
- Patient has intolerance or contraindication to ONE phosphate binders (e.g., PhosLo, Fosrenol, Renvela, Renagel, etc.) (please specify intolerance or contraindication)

AND

2.3.3.2 ONE of the following:

- Patient has therapeutic failure to ONE vitamin D analog (e.g., calcitriol, Hectorol, Zemplar, etc.) confirmed by claims history or submitted medical records
- Patient has intolerance or contraindication to ONE vitamin D analogs (e.g., calcitriol, Hectorol, Zemplar, etc.) (please specify intolerance or contraindication)

Product Name: Brand Sensipar, generic cinacalcet	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CINACALCET HYDROCHLORIDE	CINACALCET HCL TAB 30 MG (BASE EQUIV)	30905225100320	Generic
SENSIPAR	CINACALCET HCL TAB 30 MG (BASE EQUIV)	30905225100320	Brand
CINACALCET HYDROCHLORIDE	CINACALCET HCL TAB 60 MG (BASE EQUIV)	30905225100330	Generic
SENSIPAR	CINACALCET HCL TAB 60 MG (BASE EQUIV)	30905225100330	Brand

CINACALCET HYDROCHLORIDE	CINACALCET HCL TAB 90 MG (BASE EQUIV)	30905225100340	Generic
SENSIPAR	CINACALCET HCL TAB 90 MG (BASE EQUIV)	30905225100340	Brand

Approval Criteria

1 - Patient has experienced a reduction in serum calcium from baseline

Sevelamer carbonate

Prior Authorization Guideline

Guideline ID	GL-146412
Guideline Name	Sevelamer carbonate
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Generic sevelamer carbonate tablets	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
SEVELAMER CARBONATE	SEVELAMER CARBONATE TAB 800 MG	52800070050340	Generic

Approval Criteria

1 - The patient did not exhibit an adequate response to treatment with at least an 8-week trial of calcium acetate as supported by claims history or submitted medical records

OR

2 - The patient experienced an intolerance/adverse reaction to previous therapy with calcium acetate (please indicate intolerance/adverse reaction)

OR

3 - The patient has a documented contraindication to treatment with calcium acetate (please indicate contraindication)

SGLT2 Inhibitors

Prior Authorization Guideline

Guideline ID	GL-146413
Guideline Name	SGLT2 Inhibitors
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Steglatro, Segluromet			
Approval Length	12 month(s)		
Guideline Type	Prior Authorization		

Product Name	Generic Name	GPI	Brand/Generic
STEGLATRO	ERTUGLIFLOZIN L-PYROGLUTAMIC ACID TAB 5 MG (BASE EQUIV)	27700055200320	Brand
STEGLATRO	ERTUGLIFLOZIN L-PYROGLUTAMIC ACID TAB 15 MG (BASE EQUIV)	27700055200340	Brand
SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 2.5-500 MG	27996002450310	Brand
SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 2.5-1000 MG	27996002450320	Brand

SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 7.5-500 MG	27996002450330	Brand
SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 7.5-1000 MG	27996002450340	Brand

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 Suboptimal response to metformin at a minimum dose of 1500 milligrams daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

Product Name: Jardiance	
Diagnosis	Type 2 Diabetes Mellitus*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JARDIANCE	EMPAGLIFLOZIN TAB 10 MG	27700050000310	Brand
JARDIANCE	EMPAGLIFLOZIN TAB 25 MG	27700050000320	Brand

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 Suboptimal response to metformin at a minimum dose of 1500 milligrams daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 ONE of the following:

3.1.1 Failure to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) for 90 days confirmed by claims history or submission of medical records

OR

3.1.2 History of intolerance or contraindication to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) (please specify intolerance or contraindication)

OR

3.2 BOTH of the following:

3.2.1 ONE of the following:

3.2.1.1 Documented history of heart failure

OR

3.2.1.2 Documented history of chronic kidney disease

OR

3.2.1.3 Documented history of atherosclerotic cardiovascular disease defined as having ONE or more of the following:

- History of an acute coronary syndrome or myocardial infarction
- Stable or unstable angina
- Coronary heart disease with or without revascularization
- Other arterial revascularization
- Stroke
- Peripheral artery disease assumed to be atherosclerotic in origin

AND

3.2.2 ONE of the following:

3.2.2.1 Failure to Farxiga (dapagliflozin) for 90 days confirmed by claims history or submission of medical records

OR

3.2.2.2 History of intolerance or contraindication to Farxiga (dapagliflozin) (please specify intolerance or contraindication)

Notes	*Patients with heart failure, CKD (chronic kidney disease), or ASCVD (atherosclerotic cardiovascular disease) WITH type 2 diabetes should use these criteria.

Product Name: Jardiance	
Diagnosis	Heart Failure WITHOUT Diabetes Type 2*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JARDIANCE	EMPAGLIFLOZIN TAB 10 MG	27700050000310	Brand

JARDIANCE	EMPAGLIFLOZIN TAB 25 MG	27700050000320	Brand

Approval Criteria

1 - The patient has a diagnosis of heart failure WITHOUT diabetes type 2 [NYHA (New York Heart Association) class II-IV*]

AND

2 - ONE of the following:

2.1 Failure to Farxiga (dapagliflozin) as confirmed by claims history or submission of medical records.

OR

2.2 History of intolerance or contraindication to Farxiga (dapagliflozin) (please specify intolerance or contraindication)

Notes	*Patients with heart failure, CKD (chronic kidney disease), or ASCVD (atherosclerotic cardiovascular disease) WITH type 2 diabetes should use Type 2 Diabetes Mellitus criteria.

Product Name: Jardiance	
Diagnosis	Chronic Kidney Disease (CKD), at risk of progression WITHOUT Diabetes Type 2*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JARDIANCE	EMPAGLIFLOZIN TAB 10 MG	27700050000310	Brand
JARDIANCE	EMPAGLIFLOZIN TAB 25 MG	27700050000320	Brand

Approval Criteria

1 - The patient has a diagnosis of chronic kidney disease (CKD) at risk of progression WITHOUT diabetes type 2 **AND** **2 -** ONE of the following: **2.1** Patient is currently taking an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB), as confirmed by claims history or submission of medical records. **OR** **2.2** Patient has documentation of intolerance or contraindication to ACE inhibitor or ARB (please specify intolerance or contraindication) **AND** **3 -** ONE of the following: **3.1** Failure to Farxiga (dapagliflozin) as confirmed by claims history or submission of medical records. **OR** **3.2** History of intolerance or contraindication to Farxiga (dapagliflozin) (please specify intolerance or contraindication)	
Notes	*Patients with heart failure, CKD (chronic kidney disease), or ASCVD (atherosclerotic cardiovascular disease) WITH type 2 diabetes should use Type 2 Diabetes Mellitus criteria.

Product Name: Invokana	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

INVOKANA	CANAGLIFLOZIN TAB 100 MG	27700020000320	Brand
INVOKANA	CANAGLIFLOZIN TAB 300 MG	27700020000330	Brand

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 Suboptimal response to metformin at a minimum dose of 1500 milligrams daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 ONE of the following:

3.1.1 Failure to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) for 90 days, confirmed by claims history or submission of medical records

OR

3.1.2 History of contraindication or intolerance to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) (please specify contraindication or intolerance)

OR

3.2 Documented history of diabetic nephropathy with albuminuria

OR

3.3 BOTH of the following:

3.3.1 ONE of the following:

3.3.1.1 Documented history of heart failure

OR

3.3.1.2 Documented history of chronic kidney disease

OR

3.3.1.3 Documented history of atherosclerotic cardiovascular disease defined as having ONE or more of the following:

- History of an acute coronary syndrome or myocardial infarction
- Stable or unstable angina
- Coronary heart disease with or without revascularization
- Other arterial revascularization
- Stroke
- Peripheral artery disease assumed to be atherosclerotic in origin

AND

3.3.2 ONE of the following:

3.3.2.1 Failure to Farxiga (dapagliflozin) for 90 days confirmed by claims history or submission of medical records

OR

3.3.2.2 History of contraindication or intolerance to Farxiga (dapagliflozin) (please specify contraindication or intolerance)

Product Name: Farxiga, Dapagliflozin	
Diagnosis	Type 2 Diabetes Mellitus*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 Suboptimal response to metformin at a minimum dose of 1500 milligrams daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Documented history of heart failure

OR

3.2 Documented history of chronic kidney disease

OR

3.3 Documented history of atherosclerotic cardiovascular disease defined as having ONE or more of the following:

- History of an acute coronary syndrome or myocardial infarction
- Stable or unstable angina
- Coronary heart disease with or without revascularization
- Other arterial revascularization
- Stroke
- Peripheral artery disease assumed to be atherosclerotic in origin

OR

3.4 TWO of the following risk factors for developing cardiovascular disease:

- Men greater than or equal to 55 years or women greater than or equal to 65 years
- Cigarette smoker or stopped smoking within the past 3 months
- Hypertension [pretreatment blood pressure greater than or equal to 140 millimeters of mercury (mmHg) systolic or greater than or equal to 90 mmHg diastolic]
- HDL-C less than or equal to 40 milligrams/deciliter (mg/dL) for men or less than or equal to 50 mg/dL for women
- High-sensitivity C-reactive protein greater than 3.0 milligrams/liter (mg/L)
- Creatinine clearance greater than 30 and less than 60 milliliters/minute (mL/min)
- Retinopathy
- Micro- or macro-albuminuria
- Ankle-brachial index (ABI) less than 0.9 without symptoms of intermittent claudication

OR

3.5 ONE of the following:

3.5.1 Failure to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) for 90 days confirmed by claims history or submission of medical records

OR
3.5.2 History of contraindication or intolerance to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) (please specify contraindication or intolerance)

Notes	*Patients with heart failure, CKD (chronic kidney disease), ASCVD (at herosclerotic cardiovascular disease), or ASCVD risk factors WITH ty pe 2 diabetes should use these criteria.

Product Name: Farxiga, Dapagliflozin	
Diagnosis	Heart Failure WITHOUT Diabetes Type 2*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic

Approval Criteria

1 - The patient has a diagnosis of heart failure WITHOUT diabetes type 2 [NYHA (New York Heart Association) class II-IV*]

Notes	*Patients with heart failure, CKD (chronic kidney disease), ASCVD (at herosclerotic cardiovascular disease), or ASCVD risk factors WITH ty pe 2 diabetes should use Type 2 Diabetes Mellitus criteria.

Product Name: Farxiga, Dapagliflozin	
Diagnosis	Chronic Kidney Disease WITHOUT Diabetes Type 2*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic

Approval Criteria

1 - Patient has a diagnosis of chronic kidney disease WITHOUT diabetes type 2*

AND

2 - ONE of the following:

2.1 Patient currently taking an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) confirmed by claims history or submission of medical records

OR

2.2 Patient has documentation of intolerance or contraindication to ACE inhibitor or ARB (please specify intolerance or contraindication)

Notes	*Patients with heart failure, CKD (chronic kidney disease), ASCVD (at herosclerotic cardiovascular disease), or ASCVD risk factors WITH ty pe 2 diabetes should use Type 2 Diabetes Mellitus criteria.

Product Name: Brenzavvy, Bexagliflozin, Synjardy, Synjardy XR, Invokamet, Invokamet XR, Xigduo XR, Dapagliflozin/Metformin ER	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 50-500 MG	27996002200320	Brand

INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 50-1000 MG	27996002200330	Brand
INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 150-500 MG	27996002200340	Brand
INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 150-1000 MG	27996002200350	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 5-500 MG	27996002400310	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 5-1000 MG	27996002400315	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 12.5-500 MG	27996002400320	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 12.5-1000 MG	27996002400325	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 50-500 MG	27996002207520	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 50-1000 MG	27996002207530	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 150-500 MG	27996002207540	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 150-1000 MG	27996002207550	Brand
SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002407530	Brand
SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002407540	Brand
SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 12.5-1000 MG	27996002407550	Brand
SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 25-1000 MG	27996002407560	Brand
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27996002307507	Brand
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-500 MG	27996002307510	Brand
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002307515	Generic
DAPAGLIFLOZIN PROPANEDIOL/METFORMIN HYDROCHLORIDE	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002307515	Generic
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-500 MG	27996002307520	Brand

XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002307525	Generic
DAPAGLIFLOZIN PROPANEDIOL/METFORMIN HYDROCHLORIDE	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002307525	Generic
BEXAGLIFLOZIN	BEXAGLIFLOZIN TAB 20 MG	27700010000320	Generic
BRENZAVVY	BEXAGLIFLOZIN TAB 20 MG	27700010000320	Generic

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 Suboptimal response to metformin at a minimum dose of 1500 milligrams daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Failure to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) for 90 days confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) (please specify intolerance or contraindication)

Product Name: Inpefa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INPEFA	SOTAGLIFLOZIN TAB 200 MG	40750010000320	Brand
INPEFA	SOTAGLIFLOZIN TAB 400 MG	40750010000340	Brand

Approval Criteria

1 - ONE of the following:

1.1 The patient has a diagnosis of heart failure

OR

1.2 ALL of the following:

1.2.1 Diagnosis of type 2 diabetes mellitus

AND

1.2.2 Diagnosis of chronic kidney disease

AND

1.2.3 At least ONE additional cardiovascular risk factor such as:

- History of heart failure
- Obesity
- Dyslipidemia
- Hypertension
- Elevated cardiac and inflammatory biomarkers

AND

2 - ONE of the following:

2.1 Failure to Farxiga (dapagliflozin) confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to Farxiga (dapagliflozin) (please specify contraindication or intolerance)

Prior Authorization Guideline

Guideline ID	GL-146846
Guideline Name	Short-Acting Opioid Products
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: butorphanol nasal sol, carisoprodol/aspirin/codeine, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Roxybond	
Diagnosis	DUR: Non-cough and cold Opioid Naïve (Not having filled an opioid in the past 60 days) exceeding the 7 day supply limit and/or 50-90MME limit*

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BUTORPHANOL TARTRATE	BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML	65200020102050	Generic
CARISOPRODOL/ASPIRIN/CODEINE	CARISOPRODOL W/ ASPIRIN & CODEINE TAB 200-325-16 MG	75990003100310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML	65991002052020	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE #3	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
CODEINE/ACETAMINOPHEN	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Generic
FIORICET/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Brand

ASCOMP/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 10 MG	65100055105210	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 20 MG	65100055105215	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 30 MG	65100055105220	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	Generic
LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG	65991702100322	Generic

HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 10-200 MG	65991702500330	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	65991702500320	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Generic
XODOL	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 5-200 MG	65991702500315	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic

OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML)	65100075101320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL SOLN 5 MG/5ML	65100075102005	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Brand

OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	65100080100310	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	65100080100305	Generic
TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	65100095101920	Brand
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand
NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	Brand
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG	49109902155210	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS &	49109902155220	Generic

	OPIUM SUPPOS 16.2-60 MG		
OPIUM	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
OPIUM TINCTURE	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN	65990002202020	Generic

	SOLN 10-300 MG/5ML		
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
OXAYDO	OXYCODONE HCL TAB 7.5 MG	65100075100315	Brand
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 15 MG	65100020200305	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 30 MG	65100020200310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 60 MG	65100020200315	Generic
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	65100075100310	Generic
ROXICODONE	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	65100075100330	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	65100075100340	Generic
ROXICODONE	OXYCODONE HCL TAB 30 MG	65100075100340	Brand
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic

OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG	65200040300310	Generic
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	65100095100340	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
MEPERIDINE HYDROCHLORIDE	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	65100095100310	Generic

Approval Criteria

1 - Opioid naïve patients (defined as not having filled an opioid in the past 60 days) may receive greater than the 7 day supply limit and/or greater than 50 morphine milligram equivalents (MME) based on ALL of the following:

1.1 If the request is for greater than the 7 day supply limit, ONE of the following:

1.1.1 Cancer diagnosis

OR

1.1.2 End of life care, including hospice care

OR

1.1.3 Palliative care

OR

1.1.4 Sickle cell anemia

OR

1.1.5 BOTH of the following:

1.1.5.1 ONE of the following:

- Traumatic injury
- Post-surgical procedures, excluding dental procedures
- Prescriber attests that the patient has received an opioid within the past 60 days

AND

1.1.5.2 Prescriber attests if requested for traumatic injury or post-surgical procedure, that based on injury or surgical procedure performed the patient requires greater than a 7 day supply of short-acting opioid to adequately control pain

AND

1.2 If the request is for 50 MME to 90 MME, ONE of the following (NOTE: If the request exceeds 90 MME please skip this section and proceed to the MME Reviews section):

1.2.1 Diagnosis of ONE of the following: • Cancer • End of life pain (including hospice care) • Palliative care • Sickle cell anemia **OR** **1.2.2** Patient is currently exceeding 50 MME and prescriber attests patient has been on opioids in the past 60 days **OR** **1.2.3** Document ALL of the following: • The diagnosis is associated with the need for pain management with opioids • If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression • The prescriber has acknowledged that they have completed an addiction risk and risk of overdose assessment • Prescriber attests the patient requires more than 50 MME per day to adequately control pain

Notes	*This section does NOT apply to cough and cold products. **Approval length for cancer, end of life, palliative care, or sickle cell p ain will be issued for 12 months. All other approvals will be issued for t he requested duration, not to exceed one month.

Product Name: butorphanol nasal sol, carisoprodol/aspirin/codeine, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic

belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Roxybond	
Diagnosis	Non-Preferred Reviews*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BUTORPHANOL TARTRATE	BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML	65200020102050	Generic
CARISOPRODOL/ASPIRIN/CODEINE	CARISOPRODOL W/ ASPIRIN & CODEINE TAB 200-325-16 MG	75990003100310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML	65991002052020	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE #3	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
CODEINE/ACETAMINOPHEN	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-	65991004100113	Generic

	CAFF W/ COD CAP 50-300-40-30 MG		
FIORICET/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Brand
ASCOMP/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 10 MG	65100055105210	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 20 MG	65100055105215	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 30 MG	65100055105220	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	Generic
LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic

HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG	65991702100322	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 10-200 MG	65991702500330	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	65991702500320	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Generic
XODOL	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 5-200 MG	65991702500315	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic

OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML)	65100075101320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL SOLN 5 MG/5ML	65100075102005	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic

PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Brand
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	65100080100310	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	65100080100305	Generic
TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	65100095101920	Brand
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand
NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	Brand
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS &	49109902155210	Generic

	OPIUM SUPPOS 16.2-30 MG		
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG	49109902155220	Generic
OPIUM	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
OPIUM TINCTURE	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic

PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
OXAYDO	OXYCODONE HCL TAB 7.5 MG	65100075100315	Brand
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 15 MG	65100020200305	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 30 MG	65100020200310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 60 MG	65100020200315	Generic
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	65100075100310	Generic
ROXICODONE	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	65100075100330	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	65100075100340	Generic
ROXICODONE	OXYCODONE HCL TAB 30 MG	65100075100340	Brand
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic

OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG	65200040300310	Generic
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	65100095100340	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
MEPERIDINE HYDROCHLORIDE	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	65100095100310	Generic

Approval Criteria

1 - ONE of the following:

1.1 If the request is for tramadol 100 mg (milligram) tablets, the physician has provided rationale for needing to use the 100 mg tramadol tablet instead of two 50 mg tramadol tablets

OR

1.2 If the request is for tramadol 25 mg tablets, the physician has provided rationale why the patient is unable to use half of a 50 mg tramadol tablet

OR

1.3 If the request is for Qdolo (tramadol soln), ONE of the following:

1.3.1 Failure of tramadol 50mg tablets as confirmed by claims history or submission of medical records

OR

1.3.2 History of intolerance or contraindication to tramadol 50mg tablets (please specify intolerance or contraindication)

OR

1.3.3 Patient is unable to swallow a solid dosage form

OR

1.3.4 Patient utilizes a feeding tube for medication administration

OR

1.4 If the request is for another non-preferred medication**, then ONE of the following:

1.4.1 Failure of at least three unique active ingredients from the preferred short-acting opioids list as confirmed by claims history or submission of medical records

OR **1.4.2** History of intolerance or contraindication to three unique active ingredients from the preferred short-acting opioids list (please specify intolerance or contraindication)

Notes	*This section does NOT apply to cough and cold products. **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: butorphanol nasal sol, carisoprodol/aspirin/codeine, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Roxybond	
Diagnosis	Cancer/Hospice/End of Life/Sickle Cell Anemia Related Pain Exceeding the 90 MME Cumulative Threshold*
Guideline Type	Morphine Milligram Equivalents (MME) Reviews**

Product Name	Generic Name	GPI	Brand/Generic
BUTORPHANOL TARTRATE	BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML	65200020102050	Generic
CARISOPRODOL/ASPIRIN/CODEINE	CARISOPRODOL W/ ASPIRIN & CODEINE TAB 200-325-16 MG	75990003100310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML	65991002052020	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic

ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE #3	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
CODEINE/ACETAMINOPHEN	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Generic
FIORICET/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Brand
ASCOMP/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 10 MG	65100055105210	Generic

MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 20 MG	65100055105215	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 30 MG	65100055105220	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	Generic
LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG	65991702100322	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 10-200 MG	65991702500330	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	65991702500320	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Generic
XODOL	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic

HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 5-200 MG	65991702500315	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML)	65100075101320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL SOLN 5 MG/5ML	65100075102005	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand

ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	6599000220032 7	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	6599000220032 7	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	6599000220032 7	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	6599000220030 5	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	6599000220030 5	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	6599000220030 5	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	6599000220031 0	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	6599000220031 0	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	6599000220031 0	Brand
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	6510008010031 0	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	6510008010030 5	Generic
TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	6510009510032 0	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	6510009510032 0	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	6510009510032 0	Brand
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	6510009510192 0	Brand
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	6599500220032 0	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	6599500220032 0	Brand

NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	Brand
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG	49109902155210	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG	49109902155220	Generic
OPIUM	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
OPIUM TINCTURE	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-	65990002020320	Brand

	ACETAMINOPHEN TAB 6.12-325 MG		
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
OXAYDO	OXYCODONE HCL TAB 7.5 MG	65100075100315	Brand
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 15 MG	65100020200305	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 30 MG	65100020200310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 60 MG	65100020200315	Generic
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Brand

HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	65100075100310	Generic
ROXICODONE	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	65100075100330	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	65100075100340	Generic
ROXICODONE	OXYCODONE HCL TAB 30 MG	65100075100340	Brand
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG	65200040300310	Generic
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Brand

ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A56 0	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	6599000220200 5	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	6510009510034 0	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	6599130305011 5	Brand
MEPERIDINE HYDROCHLORIDE	MEPERIDINE HCL TAB 50 MG	6510004510030 5	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	6510009510031 0	Generic

Approval Criteria

1 - Patient has ONE of the following:

- Cancer pain
- End of life diagnosis (hospice care)
- Sickle cell anemia related pain

Notes	*This section does NOT apply to cough and cold products. **Approval length will be issued for up to the requested amount for 12 months for cancer pain/hospice/end of life/sickle cell anemia related p ain. The authorization should be entered for an MME of 9999 so as to prevent future disruptions in therapy if the patient's dose is increased.

Product Name: butorphanol nasal sol, carisoprodol/aspirin/codeine, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Roxybond

Diagnosis	Non-cancer/non-hospice/non-end of life/non-sickle cell anemia related pain Exceeding the 90 MME Cumulative Threshold *
Therapy Stage	Initial Authorization
Guideline Type	Morphine Milligram Equivalents (MME)**

Product Name	Generic Name	GPI	Brand/Generic
BUTORPHANOL TARTRATE	BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML	65200020102050	Generic
CARISOPRODOL/ASPIRIN/CODEINE	CARISOPRODOL W/ ASPIRIN & CODEINE TAB 200-325-16 MG	75990003100310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML	65991002052020	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE #3	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
CODEINE/ACETAMINOPHEN	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Generic

FIORICET/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Brand
ASCOMP/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 10 MG	65100055105210	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 20 MG	65100055105215	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 30 MG	65100055105220	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	Generic
LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic

HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG	65991702100322	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 10-200 MG	65991702500330	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	65991702500320	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Generic
XODOL	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 5-200 MG	65991702500315	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic

OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML)	65100075101320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL SOLN 5 MG/5ML	65100075102005	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic

PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Brand
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	65100080100310	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	65100080100305	Generic
TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	65100095101920	Brand
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand
NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	Brand
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS &	49109902155210	Generic

	OPIUM SUPPOS 16.2-30 MG		
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG	49109902155220	Generic
OPIUM	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
OPIUM TINCTURE	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic

PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	6599000220033 3	Generic
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	6599000220202 0	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	6599000220202 0	Generic
OXAYDO	OXYCODONE HCL TAB 7.5 MG	6510007510031 5	Brand
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 4 MG	6510003510032 0	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 2 MG	6510003510031 0	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 15 MG	6510002020030 5	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 30 MG	6510002020031 0	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 60 MG	6510002020031 5	Generic
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	6510003510092 0	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	6510003510092 0	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL LIQD 1 MG/ML	6510003510092 0	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	6510007510031 0	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	6510007510031 0	Generic
ROXICODONE	OXYCODONE HCL TAB 5 MG	6510007510031 0	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	6510007510033 0	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	6510007510034 0	Generic
ROXICODONE	OXYCODONE HCL TAB 30 MG	6510007510034 0	Brand
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	6599000220030 3	Generic

OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG	65200040300310	Generic
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	65100095100340	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
MEPERIDINE HYDROCHLORIDE	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	65100095100310	Generic

Approval Criteria

1 - Prescriber attests the patient has been screened for substance abuse/opioid dependence

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - BOTH of the following:

- Patient has tried and failed non-opioid pain medication (document drug name and date of trial)
- Opioid medication doses of less than 90 morphine milligram equivalents (MME) have been tried and did not adequately control pain (document drug regimen or MME and dates of therapy)***

Notes	*This section does NOT apply to cough and cold products. **Approval length will be issued for 6 months for non-cancer/non-hospice/non-end of life/non-sickle cell anemia related pain up to the current requested MME plus 90 MME ***If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested MME dose.

Product Name: butorphanol nasal sol, carisoprodol/aspirin/codeine, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp,

tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Roxybond	
Diagnosis	Non-cancer/non-hospice/non-end of life/non-sickle cell anemia related pain Exceeding the 90 MME Cumulative Threshold*
Therapy Stage	Reauthorization
Guideline Type	Morphine Milligram Equivalents (MME)**

Product Name	Generic Name	GPI	Brand/Generic
BUTORPHANOL TARTRATE	BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML	65200020102050	Generic
CARISOPRODOL/ASPIRIN/CODEINE	CARISOPRODOL W/ ASPIRIN & CODEINE TAB 200-325-16 MG	75990003100310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML	65991002052020	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE #3	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic

CODEINE/ACETAMINOPHEN	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Generic
FIORICET/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Brand
ASCOMP/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 10 MG	65100055105210	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 20 MG	65100055105215	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 30 MG	65100055105220	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	Generic

LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG	65991702100322	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 10-200 MG	65991702500330	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	65991702500320	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Generic
XODOL	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 5-200 MG	65991702500315	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand

HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML)	65100075101320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL SOLN 5 MG/5ML	65100075102005	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic

PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Brand
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	65100080100310	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	65100080100305	Generic
TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	65100095101920	Brand
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand
NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	Brand
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic

LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG	49109902155210	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG	49109902155220	Generic
OPIUM	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
OPIUM TINCTURE	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic

PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
OXAYDO	OXYCODONE HCL TAB 7.5 MG	65100075100315	Brand
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 15 MG	65100020200305	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 30 MG	65100020200310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 60 MG	65100020200315	Generic
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	65100075100310	Generic
ROXICODONE	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	65100075100330	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	65100075100340	Generic

ROXICODONE	OXYCODONE HCL TAB 30 MG	65100075100340	Brand
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG	65200040300310	Generic
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	65100095100340	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
MEPERIDINE HYDROCHLORIDE	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	65100095100310	Generic

Approval Criteria **1 -** Prescriber attests the patient has been screened for substance abuse/opioid dependence **AND** **2 -** Documented rationale for not tapering or discontinuing opioid if treatment goals are not met **AND** **3 -** Documented meaningful improvement in pain and function when assessed against treatment goals (Document improvement in function or pain score improvement)***	
Notes	*This section does NOT apply to cough and cold products. **Approval length will be issued for 6 months for non-cancer/non-hospice/non-end of life/non-sickle cell anemia related pain up to the current requested MME plus 90 MME ***If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested MME dose.

Product Name: butorphanol nasal sol, carisoprodol/aspirin/codeine, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Roxybond	
Diagnosis	Criteria for Quantity Limit Reviews*
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
BUTORPHANOL TARTRATE	BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML	65200020102050	Generic
CARISOPRODOL/ASPIRIN/CODEINE	CARISOPRODOL W/ ASPIRIN & CODEINE TAB 200-325-16 MG	75990003100310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML	65991002052020	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE #3	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
CODEINE/ACETAMINOPHEN	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Generic
FIORICET/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Brand
ASCOMP/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/	65991004300115	Generic

	CODEINE CAP 50-325-40-30 MG		
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 10 MG	65100055105210	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 20 MG	65100055105215	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 30 MG	65100055105220	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	Generic
LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG	65991702100322	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic

HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 10-200 MG	65991702500330	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	65991702500320	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Generic
XODOL	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 5-200 MG	65991702500315	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML)	65100075101320	Generic

OXYCODONE HYDROCHLORIDE	OXYCODONE HCL SOLN 5 MG/5ML	65100075102005	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Brand
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	65100080100310	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	65100080100305	Generic

TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	65100095101920	Brand
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand
NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	Brand
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG	49109902155210	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG	49109902155220	Generic
OPIUM	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic

OPIUM TINCTURE	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic

OXAYDO	OXYCODONE HCL TAB 7.5 MG	65100075100315	Brand
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 15 MG	65100020200305	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 30 MG	65100020200310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 60 MG	65100020200315	Generic
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	65100075100310	Generic
ROXICODONE	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	65100075100330	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	65100075100340	Generic
ROXICODONE	OXYCODONE HCL TAB 30 MG	65100075100340	Brand
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic

PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG	65200040300310	Generic
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	65100095100340	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
MEPERIDINE HYDROCHLORIDE	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	65100095100310	Generic

Approval Criteria

1 - The requested dose cannot be achieved by a higher strength formulary product

AND

2 - The requested dose is within FDA (Food and Drug Administration) maximum dose per day, where an FDA maximum dose per day exists**

Notes	*This section does NOT apply to cough and cold products. **Authorization will be issued for: • 12 months for cancer pain/hospice/sickle cell anemia related pain/end of life related pain • 6 months for non-cancer pain/non-hospice/non-sickle cell anemia related pain/non-end of life related pain

Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC

Diagnosis	DUR: Cough and Cold Opioid Naïve (Not having filled an opioid in the past 60 days) exceeding the 7 day supply limit*
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TUZISTRA XR	CODEINE POLIST-CHLORPHEN POLIST ER SUSP 14.7-2.8 MG/5ML	4399520231G120	Brand
HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX	HYDROCOD POLST-CHLORPHEN POLST ER SUSP 10-8 MG/5ML	4399520236G110	Generic
M-END PE	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML	43995303110916	Brand
PRO-RED AC	PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML	43995303171220	Brand
HISTEX-AC	PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML	43995303361220	Brand
PROMETHAZINE/CODEINE	PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML	43995202341210	Generic
PROMETHAZINE VC/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic

PROMETHAZINE/PHENYLEPHRINE/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic
MAR-COF BP	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML	43995303190940	Brand
NINJACOF-XG	GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML	43997002280942	Brand
MAR-COF CG EXPECTORANT	GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML	43997002280947	Brand
TUXARIN ER	CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG	43995202327430	Brand
CODEINE/GUAIFENESIN	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
G TUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIATUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN/CODEINE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
MAXI-TUSS AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
VIRTUSSIN A/C	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Generic
HYCODAN	HYDROCODONE BITART-	43101010102010	Brand

	HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML		
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYDROCODONE/HOMATROPINE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYDROMET	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
M-CLEAR WC	GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML	43997002282018	Brand
CAPCOF	PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML	43995303141220	Brand
CODITUSSIN AC	GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML	43997002280945	Generic
GUAIFENESIN/CODEINE PHOSPHATE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
POLY-TUSSIN AC	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303110935	Generic
MAXI-TUSS CD	PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303140913	Generic
RYDEX	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML	43995303190922	Brand
CODITUSSIN DAC	PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML	43997303300938	Generic
TUSNEL C	PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML	43997303301225	Brand

Approval Criteria

1 - ONE of the following:

1.1 Cancer diagnosis

OR

1.2 End of life care, including hospice care

OR

1.3 Palliative care

OR

1.4 Sickle cell anemia

OR

1.5 BOTH of the following:

1.5.1 ONE of the following:

- Traumatic injury
- Post-surgical procedures, excluding dental procedures
- Prescriber attests that the patient has received an opioid within the past 60 days

AND

1.5.2 Prescriber attests if requested for traumatic injury or post-surgical procedure, that based on injury or surgical procedure performed the patient requires greater than a 7 day supply of short-acting opioid to adequately control pain

Notes	*Approval length for cancer, end of life, palliative care, or sickle cell pain will be issued for 12 months. All other approvals will be issued for the requested duration, not to exceed one month.

Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC	
Diagnosis	Cough and Cold Products Exceeding the 90 MME Cumulative Threshold
Guideline Type	Morphine Milligram Equivalents (MME)*

Product Name	Generic Name	GPI	Brand/Generic
TUZISTRA XR	CODEINE POLIST-CHLORPHEN POLIST ER SUSP 14.7-2.8 MG/5ML	4399520231G120	Brand
HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX	HYDROCOD POLST-CHLORPHEN POLST ER SUSP 10-8 MG/5ML	4399520236G110	Generic
M-END PE	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML	43995303110916	Brand
PRO-RED AC	PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML	43995303171220	Brand
HISTEX-AC	PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML	43995303361220	Brand
PROMETHAZINE/CODEINE	PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML	43995202341210	Generic
PROMETHAZINE VC/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic
PROMETHAZINE/PHENYLEPHRINE/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic

MAR-COF BP	PSEUDOEPHEDRINE -BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML	43995303190940	Brand
NINJACOF-XG	GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML	43997002280942	Brand
MAR-COF CG EXPECTORANT	GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML	43997002280947	Brand
TUXARIN ER	CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG	43995202327430	Brand
CODEINE/GUAIFENESIN	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
G TUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIATUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN/CODEINE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
MAXI-TUSS AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
VIRTUSSIN A/C	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic

HYDROMET	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Brand
HYDROCODONE/HOMATROPINE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
M-CLEAR WC	GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML	43997002282018	Brand
CAPCOF	PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML	43995303141220	Brand
CODITUSSIN AC	GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML	43997002280945	Generic
GUAIFENESIN/CODEINE PHOSPHATE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
POLY-TUSSIN AC	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303110935	Generic
MAXI-TUSS CD	PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303140913	Generic
RYDEX	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML	43995303190922	Brand
CODITUSSIN DAC	PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML	43997303300938	Generic
TUSNEL C	PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML	43997303301225	Brand

Approval Criteria

1 - The prescriber attests they are aware of patient's current opioid therapy and morphine milligram equivalents (MME) dose and feels the treatment with the requested product is medically necessary

Notes	*Approval length will be issued for up to 30 days for cough and cold related treatment. The authorization should be entered for the MME requested.

Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC	
Diagnosis	Under the Age of 18 Years for Cough and Cold Products
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TUZISTRA XR	CODEINE POLIST-CHLORPHEN POLIST ER SUSP 14.7-2.8 MG/5ML	4399520231G120	Brand
HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX	HYDROCOD POLST-CHLORPHEN POLST ER SUSP 10-8 MG/5ML	4399520236G110	Generic
M-END PE	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML	43995303110916	Brand
PRO-RED AC	PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML	43995303171220	Brand
HISTEX-AC	PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML	43995303361220	Brand
PROMETHAZINE/CODEINE	PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML	43995202341210	Generic
PROMETHAZINE VC/CODEINE	PROMETHAZINE-PHENYLEPHRINE-	43995303101210	Generic

	CODEINE SYRUP 6.25-5-10 MG/5ML		
PROMETHAZINE/PHENYLEPHRINE/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic
MAR-COF BP	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML	43995303190940	Brand
NINJACOF-XG	GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML	43997002280942	Brand
MAR-COF CG EXPECTORANT	GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML	43997002280947	Brand
TUXARIN ER	CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG	43995202327430	Brand
CODEINE/GUAIFENESIN	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
G TUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIATUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN/CODEINE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
MAXI-TUSS AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
VIRTUSSIN A/C	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Generic

HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYDROCODONE/HOMATROPINE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYDROMET	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
M-CLEAR WC	GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML	43997002282018	Brand
CAPCOF	PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML	43995303141220	Brand
CODITUSSIN AC	GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML	43997002280945	Generic
GUAIFENESIN/CODEINE PHOSPHATE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
POLY-TUSSIN AC	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303110935	Generic
MAXI-TUSS CD	PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303140913	Generic
RYDEX	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML	43995303190922	Brand
CODITUSSIN DAC	PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML	43997303300938	Generic
TUSNEL C	PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML	43997303301225	Brand

Approval Criteria

1 - Prescriber attests they are aware of Food and Drug Administration (FDA) labeled contraindications regarding use of opioid containing cough and cold products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

AND

2 - Patient does not have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index > 30)

AND

3 - Patient has tried and failed at least one non-opioid containing cough and cold remedy

Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC	
Diagnosis	Cough and Cold Products Exceeding 120mL per fill and/or 360mL per 30 days*
Approval Length	30 days**
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
TUZISTRA XR	CODEINE POLIST-CHLORPHEN POLIST ER SUSP 14.7-2.8 MG/5ML	4399520231G120	Brand
HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX	HYDROCOD POLST-CHLORPHEN POLST ER SUSP 10-8 MG/5ML	4399520236G110	Generic

M-END PE	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML	43995303110916	Brand
PRO-RED AC	PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML	43995303171220	Brand
HISTEX-AC	PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML	43995303361220	Brand
PROMETHAZINE/CODEINE	PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML	43995202341210	Generic
PROMETHAZINE VC/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic
PROMETHAZINE/PHENYLEPHRINE/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic
MAR-COF BP	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML	43995303190940	Brand
NINJACOF-XG	GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML	43997002280942	Brand
MAR-COF CG EXPECTORANT	GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML	43997002280947	Brand
TUXARIN ER	CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG	43995202327430	Brand
CODEINE/GUAIFENESIN	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
G TUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIATUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic

GUAIFENESIN/CODEINE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
MAXI-TUSS AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
VIRTUSSIN A/C	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYDROCODONE/HOMATROPINE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYDROMET	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
M-CLEAR WC	GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML	43997002282018	Brand
CAPCOF	PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML	43995303141220	Brand
CODITUSSIN AC	GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML	43997002280945	Generic
GUAIFENESIN/CODEINE PHOSPHATE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic

POLY-TUSSIN AC	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303110935	Generic
MAXI-TUSS CD	PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303140913	Generic
RYDEX	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML	43995303190922	Brand
CODITUSSIN DAC	PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML	43997303300938	Generic
TUSNEL C	PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML	43997303301225	Brand

Approval Criteria

1 - Prescriber attests that a larger quantity is medically necessary

AND

2 - The requested dose is within the Food and Drug Administration (FDA) maximum dose per day, where an FDA maximum dose per day exists

Notes	*Quantity Limit Rules in place: • 120mL/fill • 360mL/30 days **Authorization will be issued for up to 30 days. The authorization sho uld be entered for the quantity requested.

Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC	
Diagnosis	Non-Preferred Cough and Cold Products
Approval Length	30 Day(s)

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TUZISTRA XR	CODEINE POLIST-CHLORPHEN POLIST ER SUSP 14.7-2.8 MG/5ML	4399520231G120	Brand
HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX	HYDROCOD POLST-CHLORPHEN POLST ER SUSP 10-8 MG/5ML	4399520236G110	Generic
M-END PE	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML	43995303110916	Brand
PRO-RED AC	PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML	43995303171220	Brand
HISTEX-AC	PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML	43995303361220	Brand
PROMETHAZINE/CODEINE	PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML	43995202341210	Generic
PROMETHAZINE VC/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic
PROMETHAZINE/PHENYLEPHRINE/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic
MAR-COF BP	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML	43995303190940	Brand
NINJACOF-XG	GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML	43997002280942	Brand
MAR-COF CG EXPECTORANT	GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML	43997002280947	Brand
TUXARIN ER	CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG	43995202327430	Brand

CODEINE/GUAIFENESIN	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
G TUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIATUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN/CODEINE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
MAXI-TUSS AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
VIRTUSSIN A/C	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYDROMET	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Brand
HYDROCODONE/HOMATROPINE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic

M-CLEAR WC	GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML	43997002282018	Brand
CAPCOF	PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML	43995303141220	Brand
CODITUSSIN AC	GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML	43997002280945	Generic
GUAIFENESIN/CODEINE PHOSPHATE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
POLY-TUSSIN AC	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303110935	Generic
MAXI-TUSS CD	PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303140913	Generic
RYDEX	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML	43995303190922	Brand
CODITUSSIN DAC	PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML	43997303300938	Generic
TUSNEL C	PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML	43997303301225	Brand

Approval Criteria

1 - If the request is for a non-preferred* medication, then ONE of the following:

1.1 Failure of at least three unique active ingredients from the preferred cough and cold products list as confirmed by claims history or submission of medical records

OR

1.2 History of intolerance or contraindication to at least three unique active ingredients from the preferred cough and cold products list (please specify intolerance or contraindication)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

2 . Revision History

Date	Notes
4/30/2024	Updated PDL link

Sivextro

Prior Authorization Guideline

Guideline ID	GL-146416
Guideline Name	Sivextro
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Sivextro	
Diagnosis	Skin and Skin Structure Infections
Approval Length	6 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SIVEXTRO	TEDIZOLID PHOSPHATE TAB 200 MG	16230070200320	Generic

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - ALL of the following:

3.1 Diagnosis of acute bacterial skin and skin structure infection (including diabetic foot infections)

AND

3.2 ONE of the following:

3.2.1 Infection is caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report

OR

3.2.2 Presence of MRSA infection is likely and empiric treatment is warranted

AND

3.3 ONE of the following:

3.3.1 Failure of linezolid (generic Zyvox) confirmed by claims history or submitted medical records

OR

3.3.2 History of intolerance or contraindication to linezolid (generic Zyvox) (please specify intolerance or contraindication)

AND

3.4 ONE of the following:

3.4.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A tetracycline
- Clindamycin

OR

3.4.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A tetracycline
- Clindamycin

OR

4 - ALL of the following:

4.1 Diagnosis of acute bacterial skin and skin structure infection (including diabetic foot infections)

AND

4.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Sivextro

AND

4.3 ONE of the following:

4.3.1 Failure of linezolid (generic Zyvox) confirmed by claims history or submitted medical records

OR

4.3.2 History of intolerance or contraindication to linezolid (generic Zyvox) (please specify intolerance or contraindication)

AND

4.4 ONE of the following:

4.4.1 Failure of TWO of the following confirmed by claims history or submitted medical records:

- A penicillin
- A cephalosporin
- A tetracycline
- Clindamycin
- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A fluoroquinolone

OR

4.4.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- A Penicillin
- A cephalosporin
- A tetracycline
- Clindamycin
- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A fluoroquinolone

Product Name: Sivextro	
Diagnosis	Off-Label Uses
Approval Length	Based on provider and IDSA recommended treatment durations, up to 6 months.
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SIVEXTRO	TEDIZOLID PHOSPHATE TAB 200 MG	16230070200320	Generic

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - BOTH of the following:

3.1 The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

AND

3.2 ONE of the following:

3.2.1 Failure of linezolid (generic Zyvox) confirmed by claims history or submitted medical records, if susceptibility is confirmed by culture

OR

3.2.2 History of intolerance or contraindication to linezolid (generic Zyvox), if susceptibility is confirmed by culture (please specify intolerance or contraindication)

Soriatane

Prior Authorization Guideline

Guideline ID	GL-146417
Guideline Name	Soriatane
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: acitretin	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACITRETIN	ACITRETIN CAP 10 MG	90250510000110	Generic
ACITRETIN	ACITRETIN CAP 17.5 MG	90250510000115	Generic
ACITRETIN	ACITRETIN CAP 25 MG	90250510000125	Generic

Approval Criteria

1 - Diagnosis of severe psoriasis

AND

2 - Prescribed by or in consultation with a dermatologist

AND

3 - ONE of the following:

3.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose, as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

AND

4 - ONE of the following:

- Greater than or equal to 10% body surface area involvement
- Palmoplantar, facial, or genital involvement
- Severe scalp psoriasis

Product Name: acitretin	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACITRETIN	ACITRETIN CAP 10 MG	90250510000110	Generic

ACITRETIN	ACITRETIN CAP 17.5 MG	90250510000115	Generic
ACITRETIN	ACITRETIN CAP 25 MG	90250510000125	Generic

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

AND

2 - Prescribed by or in consultation with a dermatologist

Stromectol

Prior Authorization Guideline

Guideline ID	GL-146418
Guideline Name	Stromectol
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Stromectol, generic ivermectin tabs	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STROMECTOL	IVERMECTIN TAB 3 MG	15000007000310	Brand
IVERMECTIN	IVERMECTIN TAB 3 MG	15000007000310	Generic

Approval Criteria

1 - Diagnosis of ONE of the following:

- Onchocerciasis due to nematode parasite
- Pediculosis
- Strongyloidiasis
- Ascariasis
- Scabies (including crusted scabies)
- Cutaneous larva migrans (hook worm disease)
- Enterobiasis
- Filariasis
- Trichuriasis
- Gnathostomiasis

Sublingual Immunotherapy (SLIT)

Prior Authorization Guideline

Guideline ID	GL-146419
Guideline Name	Sublingual Immunotherapy (SLIT)
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Grastek	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GRASTEK	TIMOTHY GRASS POLLEN ALLERGEN EXT SL TAB 2800 BAU	20100048000740	Brand

Approval Criteria

1 - Diagnosis of moderate to severe grass pollen-induced allergic rhinitis defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance)

AND

2 - Diagnosis confirmed by ONE of the following:

2.1 Positive skin test to Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop)

OR

2.2 In vitro testing for pollen-specific IgE (immunoglobulin E) antibodies for Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop)

AND

3 - Treatment is started or will be started at least 12 weeks before the beginning of the grass pollen season

AND

4 - ONE of the following:

4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

4.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

AND

5 - Not received in combination with similar cross-reactive grass pollen immunotherapy (e.g., Oralair)

AND

6 - Patient does not have unstable and/or uncontrolled asthma

AND

7 - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name: Grastek	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GRASTEK	TIMOTHY GRASS POLLEN ALLERGEN EXT SL TAB 2800 BAU	20100048000740	Brand

Approval Criteria

1 - Documentation of positive clinical response to Grastek therapy

Product Name: Oralair	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORALAIR CHILDREN/ADOLESCENTS STARTER PACK	*GRASS MIXED POLLEN EXT SL TAB 100 IR (INDEX OF REACTIVITY)*	20109905200720	Brand
ORALAIR	*GRASS MIXED POLLEN EXT SL TAB 300 IR (INDEX OF REACTIVITY)*	20109905200730	Brand
ORALAIR ADULT STARTER PACK	*GRASS MIXED POLLEN EXT SL TAB 300 IR (INDEX OF REACTIVITY)*	20109905200730	Brand

Approval Criteria

1 - Diagnosis of moderate to severe grass pollen-induced allergic rhinitis defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance)

AND

2 - Diagnosis confirmed by ONE of the following:

2.1 Positive skin test to any of the five grass species contained in Oralair [(i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens) or cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)]

OR

2.2 In vitro testing for pollen-specific IgE (immunoglobulin E) antibodies for any of the five grass species contained in Oralair [(i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens) or cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)]

AND

3 - Treatment is started or will be started at least 4 months before the beginning of the grass pollen season

AND

4 - ONE of the following:

4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

4.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

AND

5 - Not received in combination with similar cross-reactive grass pollen immunotherapy (e.g., Grastek)

AND

6 - Patient does not have unstable and/or uncontrolled asthma

AND

7 - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name: Oralair

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORALAIR CHILDREN/ADOLESCENTS STARTER PACK	*GRASS MIXED POLLEN EXT SL TAB 100 IR (INDEX OF REACTIVITY)*	20109905200720	Brand
ORALAIR	*GRASS MIXED POLLEN EXT SL TAB 300 IR (INDEX OF REACTIVITY)*	20109905200730	Brand
ORALAIR ADULT STARTER PACK	*GRASS MIXED POLLEN EXT SL TAB 300 IR (INDEX OF REACTIVITY)*	20109905200730	Brand

Approval Criteria

1 - Documentation of positive clinical response to Oralair therapy

Product Name: Ragwitek	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RAGWITEK	SHORT RAGWEED POLLEN ALLERGEN EXTRACT SL TAB 12 AMB A 1-U	20100060200720	Brand

Approval Criteria

1 - Diagnosis of moderate to severe short ragweed pollen-induced allergic rhinitis defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance)

AND

2 - Diagnosis confirmed by ONE of the following:

- Positive skin test to short ragweed pollen

- In vitro testing for pollen-specific IgE (immunoglobulin E) antibodies for short ragweed pollen

AND

3 - Treatment is started or will be started at least 12 weeks before the beginning of the short ragweed pollen season

AND

4 - ONE of the following:

4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

4.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

AND

5 - Patient does not have unstable and/or uncontrolled asthma

AND

6 - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name: Ragwitek	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RAGWITEK	SHORT RAGWEED POLLEN ALLERGEN EXTRACT SL TAB 12 AMB A 1-U	20100060200720	Brand

Approval Criteria

1 - Documentation of positive clinical response to Ragwitek therapy

Product Name: Odactra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ODACTRA	*DUST MITE MIXED EXT SL TAB 12 SQ-HDM***	20109902220740	Brand

Approval Criteria

1 - Diagnosis of house dust mite (HDM)-induced allergic rhinitis

AND

2 - Diagnosis confirmed by ONE of the following:

- Positive skin test to licensed house dust mite allergen extracts
- In vitro testing for IgE (immunoglobulin E) antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites

AND

3 - ONE of the following:

3.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

3.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

AND

4 - Patient does not have unstable and/or uncontrolled asthma

AND

5 - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name: Odactra	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ODACTRA	*DUST MITE MIXED EXT SL TAB 12 SQ-HDM***	20109902220740	Brand

Approval Criteria

1 - Documentation of positive clinical response to Odactra therapy

Sunosi

Prior Authorization Guideline

Guideline ID	GL-146421
Guideline Name	Sunosi
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Sunosi	
Diagnosis	Narcolepsy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUNOSI	SOLRIAMFETOL HCL TAB 75 MG (BASE EQUIV)	61370070200320	Brand
SUNOSI	SOLRIAMFETOL HCL TAB 150 MG (BASE EQUIV)	61370070200340	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of narcolepsy with BOTH of the following:

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months.

AND

1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) are found on a multiple sleep latency test (MSLT) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT.

AND

2 - Physician attestation that other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - ONE of the following:

3.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

3.1.1 ONE of the following:

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant

AND

3.1.2 ONE of the following:

- Modafinil (generic Provigil)

- Armodafinil (generic Nuvigil)

OR

3.2 History of contraindication or intolerance to ALL of the following drugs or classes (please specify contraindication or intolerance):

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant
- Modafinil (generic Provigil)
- Armodafinil (generic Nuvigil)

AND

4 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist
- Pulmonologist

Product Name: Sunosi	
Diagnosis	Narcolepsy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUNOSI	SOLRIAMFETOL HCL TAB 75 MG (BASE EQUIV)	61370070200320	Brand
SUNOSI	SOLRIAMFETOL HCL TAB 150 MG (BASE EQUIV)	61370070200340	Brand

Approval Criteria

1 - Reduction in symptoms of excessive daytime sleepiness associated with Sunosi therapy

Product Name: Sunosi	
Diagnosis	Obstructive Sleep Apnea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUNOSI	SOLRIAMFETOL HCL TAB 75 MG (BASE EQUIV)	61370070200320	Brand
SUNOSI	SOLRIAMFETOL HCL TAB 150 MG (BASE EQUIV)	61370070200340	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of obstructive sleep apnea with ONE of the following:

1.1 Fifteen or more obstructive respiratory events per hour of sleep confirmed by a sleep study

OR

1.2 BOTH of the following:

1.2.1 Five or more obstructive respiratory events per hour of sleep confirmed by a sleep study

AND

1.2.2 ONE or more of the following signs/symptoms are present:

- Daytime sleepiness
- Nonrestorative sleep
- Fatigue
- Insomnia
- Waking up with breath holding, gasping, or choking
- Habitual snoring noted by bed partner or other observer
- Observed apnea

AND

2 - BOTH of the following:

2.1 Standard treatments for the underlying airway obstruction [e.g., continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP)] have been used for one month or longer

AND

2.2 Patient is fully compliant with ongoing treatment(s) for the underlying airway obstruction

AND

3 - ONE of the following:

3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Modafinil (generic Provigil)
- Armodafinil (generic Nuvigil)

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Modafinil (generic Provigil)
- Armodafinil (generic Nuvigil)

AND

4 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist
- Pulmonologist

Product Name: Sunosi	
Diagnosis	Obstructive Sleep Apnea
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUNOSI	SOLRIAMFETOL HCL TAB 75 MG (BASE EQUIV)	61370070200320	Brand
SUNOSI	SOLRIAMFETOL HCL TAB 150 MG (BASE EQUIV)	61370070200340	Brand

Approval Criteria

1 - Reduction in symptoms of excessive daytime sleepiness associated with Sunosi therapy

AND

2 - Patient continues to be fully compliant with ongoing treatment(s) for the underlying airway obstruction (e.g., CPAP, BiPAP)

Tasmar

Prior Authorization Guideline

Guideline ID	GL-146422
Guideline Name	Tasmar
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic tolcapone, Brand Tasmar	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TOLCAPONE	TOLCAPONE TAB 100 MG	73152070000320	Generic
TASMAR	TOLCAPONE TAB 100 MG	73152070000320	Brand

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Patient is currently on a stable dose of a carbidopa/levodopa-containing medication and will continue receiving treatment with a carbidopa/levodopa-containing medication while on therapy

AND

3 - ONE of the following:

3.1 Failure to TWO of the following anti-Parkinson's disease adjunctive pharmacotherapy classes (trial must be from TWO different classes) as confirmed by claims history or submission of medical records:

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., selegiline)

OR

3.2 History of intolerance or contraindication to ALL of the following anti-Parkinson's disease adjunctive pharmacotherapy classes (please specify intolerance or contraindication):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., selegiline)

AND

4 - Patient has received baseline liver function tests to rule out the presence of underlying liver disease

AND

5 - Prescribed by or in consultation with a neurologist or specialist in the treatment of Parkinson's disease

AND

6 - Prescriber attests they have had complete discussion with the patient about the risks and benefits of Tasmar (tolcapone) use, including the risk of liver failure

Product Name: generic tolcapone, Brand Tasmar	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TOLCAPONE	TOLCAPONE TAB 100 MG	73152070000320	Generic
TASMAR	TOLCAPONE TAB 100 MG	73152070000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tasmar (tolcapone) therapy

AND

2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication

AND

3 - Patient has received periodic evaluation of liver function tests to rule out liver failure associated with Tasmar (tolcapone) use

Test Strips

Prior Authorization Guideline

Guideline ID	GL-146425
Guideline Name	Test Strips
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Non-preferred Test Strips	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACCU-CHEK AVIVA PLUS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ACCU-CHEK GUIDE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ACCU-CHEK SMARTVIEW STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ACCUTREND GLUCOSE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

ADVANCE INTUITION TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVANCE MICRO-DRAW TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVOCATE REDI-CODE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVOCATE REDI-CODE+ TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVOCATE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX AMP NO CODE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX JAZZ TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX KEYNOTE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX PRESTO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE II	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE II CHECK STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE II TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE PLATINUM TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE PRISM MULTI TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE PRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE 3 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE 4 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
BIOSCANNER GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

BLOOD GLUCOSE TEST STRIPS PREMIUM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CAREONE BLOOD GLUCOSE TEST STRIPS/PREMIUM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CAREONE BLOOD GLUCOSE TEST STRIPS/VALUE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CARESENS N BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CARETOUCH BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHEK AUTO-CODE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHEK AUTO-CODE VOICE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHEK TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHOICE AUTO-CODE PRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHOICE MICRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHOICE NO CODING TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHOICE TALK NO CODING TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CONTOUR BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CONTOUR NEXT BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
COOL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CVS ADVANCED GLUCOSE METER TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
D-CARE BLOOD GLUCOSE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

DIATHRIVE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
DIATRUE PLUS BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
DUO-CARE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY PLUS II BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY STEP TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TALK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TOUCH GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TOUCH HEALTHPRO GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TRAK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYGLUCO	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYMAX TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYMAX 15 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYPRO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYPRO PLUS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ELEMENT COMPACT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ELEMENT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE EVO BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

EMBRACE PRO BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE TALK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EQ BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EVOLUTION AUTOCODE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FIFTY50 GLUCOSE TEST STRIP 2.0	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA D15G BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA D20 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA D40/G31 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA GD20 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA GD50 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA GTEL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA G20 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA G30/PREMIUM V10 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA TN'G/TN'G VOICE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA V10 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

FORA V12 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA V20 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA V30A BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORACARE GD40	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORACARE PREMIUM V10 TESTSTRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORACARE TEST N GO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORTISCARE BLOOD GLUCOSE TEST STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE INSULINX BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE INSULINX BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE LITE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE PRECISION NEO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GENULTIMATE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GE100 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GHT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCO PERFECT 3 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD EXPRESSION BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD SHINE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

GLUCOCARD VITAL TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD X-SENSOR	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD 01 SENSOR PLUS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD 01 SENSOR PLUS TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCOM TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCONAVII BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOSE METER TEST STRIPS ADVANCED	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP EASY TOUCH GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GOODSENSE PREMIUM BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
HW EMBRACE PRO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
HW EMBRACE TALK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
IGLUCOSE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
IN TOUCH BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
INFINITY BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
INFINITY VOICE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
KROGER BLOOD GLUCOSE TESTSTRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
KROGER PREMIUM BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

LIBERTY NEXT GENERATION BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
LIBERTY TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER BLOOD GLUCOSE TESTSTRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER ESSENTIAL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER PREMIUM BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER TRUETEST BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER TRUETRACK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MICRODOT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MM EASY TOUCH GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MYGLUCOHEALTH BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
NEUTEK 2TEK TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
NOVA MAX GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ONE DROP BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
OPTIUMEZ TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PHARMACIST CHOICE AUTOCODE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PHARMACIST CHOICE NO CODING BLOOD	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

GLUCOSE TEST STRIPS			
POCKETCHEM EZ BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PRECISION XTRA BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PREMIUM BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PRO VOICE V8/V9 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PRODIGY NO CODING BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PTS PANELS GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
QUICKTEK TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
QUINTET AC BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
QUINTET BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
REFUAH PLUS BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION CONFIRM/MICRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION PREMIER BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION PRIME BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION ULTIMA BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
REXALL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RIGHTEST GS100 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

RIGHTEST GS300 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RIGHTEST GS550 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SMART SENSE PREMIUM BLOODGLUCOSE STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SMART SENSE VALUE BLOOD GLUCOSE STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SMARTEST BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SOLUS V2 AUDIBLE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SUPREME TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TGT BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TGT BLOOD GLUCOSE TEST STRIPS PREMIUM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE FOCUS SELF MONITORING BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE METRIX BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE METRIX SELF MONITORING BLOOD GLUCOSE STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUETRACK BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUETRACK TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
UNISTRIP1 GENERIC	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

BLULINK GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CVS GLUCOSE METER TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
DIATHRIVE+ BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TRAK II BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA TN'G ADVANCE PRO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA 6 CONNECT	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GOJJI BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GOJJI BLOOD GLUCOSE TEST STRIPS/GOJJI STERILE LANCETS 30G	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
KROGER HEALTHPRO GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MICRODOT XTRA TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION TRUE METRIX BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE METRIX PRO GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
VERASENS BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
VIVAGUARD INO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TALK PLUS II BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

FORTISCARE G1 BLOOD GLUCOSE TEST STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP TRUE METRIX SELF MONITORING BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP TRUETRACK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP TRUETRACK SMART SYSTEM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RIGHTEST GS333 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
BLOOD GLUCOSE TEST STRIPS333	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ON CALL EXPRESS BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ONETOUCH VERIO IN VITRO MEDI-CAL	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PIP BLOOD GLUCOSE TEST STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure of both of the following confirmed by claims history or submitted medical records:

- OneTouch Ultra Test Strips
- OneTouch Verio Test Strips

OR

1.2 History of intolerance or contraindication to both of the following (please specify intolerance or contraindication):

- OneTouch Ultra Test Strips

- OneTouch Verio Test Strips

OR

2 - Patient is on an insulin pump

Product Name: All Test Strips	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
ACCU-CHEK AVIVA PLUS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ACCU-CHEK GUIDE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ACCU-CHEK SMARTVIEW STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ACCUTREND GLUCOSE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVANCE INTUITION TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVANCE MICRO-DRAW TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVOCATE REDI-CODE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVOCATE REDI-CODE+ TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVOCATE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX AMP NO CODE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX JAZZ TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX KEYNOTE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX PRESTO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

ASSURE II	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE II CHECK STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE II TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE PLATINUM TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE PRISM MULTI TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE PRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE 3 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE 4 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
BIOSCANNER GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
BLOOD GLUCOSE TEST STRIPS PREMIUM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CAREONE BLOOD GLUCOSE TEST STRIPS/PREMIUM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CAREONE BLOOD GLUCOSE TEST STRIPS/VALUE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CARESENS N BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CARETOUCH BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHEK AUTO-CODE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHEK AUTO-CODE VOICE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHEK TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

CLEVER CHOICE AUTO-CODE PRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHOICE MICRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHOICE NO CODING TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHOICE TALK NO CODING TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CONTOUR BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CONTOUR NEXT BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
COOL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CVS ADVANCED GLUCOSE METER TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
D-CARE BLOOD GLUCOSE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
DIATHRIVE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
DIATRUE PLUS BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
DUO-CARE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY PLUS II BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY STEP TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TALK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TOUCH GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TOUCH HEALTHPRO GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

EASY TRAK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYGLUCO	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYMAX TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYMAX 15 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYPRO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYPRO PLUS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ELEMENT COMPACT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ELEMENT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE EVO BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE PRO BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE TALK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EQ BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EVOLUTION AUTOCODE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FIFTY50 GLUCOSE TEST STRIP 2.0	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA D15G BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA D20 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

FORA D40/G31 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA GD20 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA GD50 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA GTEL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA G20 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA G30/PREMIUM V10 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA TN'G/TN'G VOICE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA V10 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA V12 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA V20 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA V30A BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORACARE GD40	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORACARE PREMIUM V10 TESTSTRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORACARE TEST N GO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORTISCARE BLOOD GLUCOSE TEST STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE INSULINX BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE INSULINX BLOOD	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

GLUCOSE TEST STRIPS			
FREESTYLE LITE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE PRECISION NEO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GENULTIMATE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GE100 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GHT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCO PERFECT 3 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD EXPRESSION BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD SHINE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD VITAL TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD X-SENSOR	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD 01 SENSOR PLUS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD 01 SENSOR PLUS TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCOM TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCONAVII BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOSE METER TEST STRIPS ADVANCED	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP EASY TOUCH GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GOODSENSE PREMIUM BLOOD	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

GLUCOSE TEST STRIPS			
HW EMBRACE PRO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
HW EMBRACE TALK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
IGLUCOSE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
IN TOUCH BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
INFINITY BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
INFINITY VOICE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
KROGER BLOOD GLUCOSE TESTSTRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
KROGER PREMIUM BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
LIBERTY NEXT GENERATION BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
LIBERTY TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER BLOOD GLUCOSE TESTSTRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER ESSENTIAL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER PREMIUM BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER TRUETEST BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER TRUETRACK	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

BLOOD GLUCOSE TEST STRIPS			
MICRODOT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MM EASY TOUCH GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MYGLUCOHEALTH BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
NEUTEK 2TEK TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
NOVA MAX GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ONE DROP BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ONETOUCH VERIO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
OPTIUMEZ TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PHARMACIST CHOICE AUTOCODE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PHARMACIST CHOICE NO CODING BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
POCKETCHEM EZ BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PRECISION XTRA BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PREMIUM BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PRO VOICE V8/V9 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PRODIGY NO CODING BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

PTS PANELS GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
QUICKTEK TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
QUINTET AC BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
QUINTET BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
REFUAH PLUS BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION CONFIRM/MICRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION PREMIER BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION PRIME BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION ULTIMA BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
REXALL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RIGHTEST GS100 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RIGHTEST GS300 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RIGHTEST GS550 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SMART SENSE PREMIUM BLOODGLUCOSE STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SMART SENSE VALUE BLOOD GLUCOSE STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SMARTEST BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SOLUS V2 AUDIBLE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

SUPREME TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TGT BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TGT BLOOD GLUCOSE TEST STRIPS PREMIUM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE FOCUS SELF MONITORING BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE METRIX BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE METRIX SELF MONITORING BLOOD GLUCOSE STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUETRACK BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUETRACK TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
UNISTRIP1 GENERIC	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
BLULINK GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CVS GLUCOSE METER TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
DIATHRIVE+ BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TRAK II BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA TN'G ADVANCE PRO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA 6 CONNECT	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

GOJJI BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GOJJI BLOOD GLUCOSE TEST STRIPS/GOJJI STERILE LANCETS 30G	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
KROGER HEALTHPRO GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MICRODOT XTRA TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ONETOUCH ULTRA	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION TRUE METRIX BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE METRIX PRO GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
VERASENS BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
VIVAGUARD INO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TALK PLUS II BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORTISCARE G1 BLOOD GLUCOSE TEST STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP TRUE METRIX SELF MONITORING BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP TRUETRACK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP TRUETRACK SMART SYSTEM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RIGHTEST GS333 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

BLOOD GLUCOSE TEST STRIPS333	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ON CALL EXPRESS BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ONETOUCH VERIO IN VITRO MEDI-CAL	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PIP BLOOD GLUCOSE TEST STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

Approval Criteria

1 - If the patient is insulin dependent or pregnant, the physician must confirm the patient requires a greater quantity because of more frequent blood glucose testing (e.g., patients on intravenous insulin infusions)

OR

2 - If the patient is not insulin dependent nor pregnant, ONE the following:

2.1 The patient is experiencing or is prone to hypoglycemia or hyperglycemia and requires additional testing to achieve glycemic control

OR

2.2 The patient's physician is adjusting medications and the patient requires additional blood glucose testing during this time

OR

2.3 The patient's physician is adjusting MNT (medical nutrition therapy) and the patient requires additional blood glucose testing during this time

OR

2.4 The patient requires additional testing due to fluctuations in blood glucose due to physical activity/exercise **OR** **2.5** Other circumstances where prescribing physician confirms that the patient requires a greater quantity because of more frequent blood glucose testing (clinical review required by UnitedHealthcare reviewing pharmacist and/or medical director)	
Notes	The quantity limit for insulin-dependent and pregnant patients is 6 test strips/day. The quantity limit for non-insulin dependent and non-pregnant patients is 2 test strips/day.

Testosterone

Prior Authorization Guideline

Guideline ID	GL-148271
Guideline Name	Testosterone
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Androderm, generic testosterone gel, Brand Androgel, generic testosterone gel pump, Brand Androgel Pump, testosterone soln, Brand Fortesta, generic testosterone TD gel, Natesto, Brand Testim, Brand Vogelxo, Brand Vogelxo Pump, Xyosted, Jatenzo, Kyzatrex, Tlando, Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ANDRODERM	TESTOSTERONE TD PATCH 24HR 2 MG/24HR	23100030008503	Brand
ANDRODERM	TESTOSTERONE TD PATCH 24HR 4 MG/24HR	23100030008510	Brand

TESTOSTERONE	TESTOSTERONE TD GEL 25 MG/2.5GM (1%)	23100030004025	Generic
ANDROGEL	TESTOSTERONE TD GEL 25 MG/2.5GM (1%)	23100030004025	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Generic
ANDROGEL	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Generic
ANDROGEL	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Generic
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Generic
ANDROGEL PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Brand
TESTOSTERONE	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
TESTOSTERONE TOPICAL SOLUTION	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
FORTESTA	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Generic
TESTIM	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
VOGELXO	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Generic
VOGELXO PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%)	23100030004044	Generic
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 50 MG/0.5ML	2310003020D520	Brand
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 75 MG/0.5ML	2310003020D530	Brand
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 100 MG/0.5ML	2310003020D540	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 158 MG	23100030800130	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 198 MG	23100030800135	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 237 MG	23100030800140	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 100 MG	23100030800124	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 150 MG	23100030800128	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 200 MG	23100030800136	Brand

TLANDO	TESTOSTERONE UNDECANOATE CAP 112.5 MG	23100030800125	Brand
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Brand
DEPO-TESTOSTERONE	TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML	23100030102010	Brand
TESTOSTERONE CYPIONATE	TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML	23100030102010	Generic
DEPO-TESTOSTERONE	TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML	23100030102015	Brand
TESTOSTERONE CYPIONATE	TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML	23100030102015	Generic
TESTOSTERONE ENANTHATE	TESTOSTERONE ENANTHATE IM INJ IN OIL 200 MG/ML	23100030202010	Generic

Approval Criteria

1 - ONE of the following:

1.1 TWO pre-treatment serum total testosterone levels less than 300 ng/dL (nanograms/deciliter) [less than 10.4 nmol/L (nanomoles/liter)] or less than the reference range for the lab, taken at separate times (This may require treatment to be temporarily held. Document lab value and date for both levels)

OR

1.2 BOTH of the following:

1.2.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) [e.g., thyroid disorder, HIV (human immunodeficiency virus) disease, liver disorder, diabetes, obesity]

AND

1.2.2 ONE pre-treatment calculated free or bioavailable testosterone level less than 50 pg/mL (picograms/milliliter) (< 5 ng/dL or < 0.17 nmol/L) or less than the reference range for the lab (This may require treatment to be temporarily held. Document lab value and date)

OR

1.3 Patient has a history of ONE of the following:

- Bilateral orchiectomy
- Panhypopituitarism
- A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

AND

2 - Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

AND

3 - Patient is NOT taking any aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

AND

4 - Patient was male at birth

AND

5 - Diagnosis of hypogonadism

AND

6 - ONE of the following:

- Significant reduction in weight (less than 90% ideal body weight) [e.g., AIDS (acquired immunodeficiency syndrome) wasting syndrome]

- Osteopenia
- Osteoporosis
- Decreased bone density
- Decreased libido
- Organic cause of testosterone deficiency (e.g., injury, tumor, infection, or genetic defects)

AND

7 - ONE of the following:

7.1 If the request is for a non-preferred** topical testosterone (gel, solution) or testosterone transdermal systems (patches), ONE of the following:

7.1.1 Failure to ONE of the following, confirmed by claims history or submitted medical records

- generic testosterone 1% topical gel
- testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

7.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- generic testosterone 1% topical gel
- testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

7.2 If the request is for Xyosted, BOTH of the following:

7.2.1 ONE of the following:

7.2.1.1 Failure to testosterone cypionate injection (generic Depo-Testosterone), confirmed by claims history or submitted medical records

OR

7.2.1.2 History of intolerance or contraindication to testosterone cypionate injection (generic Depo-Testosterone) (please specify intolerance or contraindication)

AND

7.2.2 ONE of the following:

7.2.2.1 Failure to intramuscular testosterone enanthate injection, confirmed by claims history or submitted medical records

OR

7.2.2.2 History of intolerance or contraindication to intramuscular testosterone enanthate injection (please specify intolerance or contraindication)

OR

7.3 If the request is for Jatenzo, Kyzatrex, or Tlando, ONE of the following:

7.3.1 Failure to ALL of the following:

- testosterone cypionate vials
- testosterone enanthate vials
- testosterone gel - tube, pack, or pump bottle, or testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

7.3.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- testosterone cypionate vials
- testosterone enanthate vials
- testosterone gel - tube, pack, or pump bottle or testosterone 1.62% pump (generic Androgel 1.62% pump)

Notes	*Patients that have previously received injectable testosterone open a ccess should be reviewed using reauthorization criteria **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Androderm, generic testosterone gel, Brand Androgel, generic testosterone gel pump, Brand Androgel Pump, testosterone soln, Brand Fortesta, generic testosterone TD gel, Natesto, Brand Testim, Brand Vogelxo, Brand Vogelxo Pump, Xyosted, Jatenzo, Kyzatrex, Tlando, Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate	
Diagnosis	Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ANDRODERM	TESTOSTERONE TD PATCH 24HR 2 MG/24HR	23100030008503	Brand
ANDRODERM	TESTOSTERONE TD PATCH 24HR 4 MG/24HR	23100030008510	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 25 MG/2.5GM (1%)	23100030004025	Generic
ANDROGEL	TESTOSTERONE TD GEL 25 MG/2.5GM (1%)	23100030004025	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Generic
ANDROGEL	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Generic
ANDROGEL	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Generic
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Generic
ANDROGEL PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Brand
TESTOSTERONE	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
TESTOSTERONE TOPICAL SOLUTION	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
FORTESTA	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Generic
TESTIM	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
VOGELXO	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Generic
VOGELXO PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%)	23100030004044	Generic

XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 50 MG/0.5ML	2310003020D520	Brand
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 75 MG/0.5ML	2310003020D530	Brand
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 100 MG/0.5ML	2310003020D540	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 158 MG	23100030800130	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 198 MG	23100030800135	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 237 MG	23100030800140	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 100 MG	23100030800124	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 150 MG	23100030800128	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 200 MG	23100030800136	Brand
TLANDO	TESTOSTERONE UNDECANOATE CAP 112.5 MG	23100030800125	Brand
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Brand
DEPO-TESTOSTERONE	TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML	23100030102010	Brand
TESTOSTERONE CYPIONATE	TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML	23100030102010	Generic
DEPO-TESTOSTERONE	TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML	23100030102015	Brand
TESTOSTERONE CYPIONATE	TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML	23100030102015	Generic
TESTOSTERONE ENANTHATE	TESTOSTERONE ENANTHATE IM INJ IN OIL 200 MG/ML	23100030202010	Generic

Approval Criteria

1 - Patient is using hormones to change physical characteristics

AND

2 - Patient must be diagnosed with gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

AND

3 - Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

AND

4 - Patient is NOT taking any aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

AND

5 - ONE of the following:

5.1 If the request is for a non-preferred** topical testosterone (gel, solution) or testosterone transdermal systems (patches), ONE of the following:

5.1.1 Failure to ONE of the following, confirmed by claims history or submitted medical records:

- generic testosterone 1% topical gel
- testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

5.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- generic testosterone 1% topical gel
- testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

5.2 If the request is for Xyosted, BOTH of the following:

5.2.1 ONE of the following:

5.2.1.1 Failure to testosterone cypionate injection (generic Depo-Testosterone), confirmed by claims history or submitted medical records

OR

5.2.1.2 History of intolerance or contraindication to testosterone cypionate injection (generic Depo-Testosterone) (please specify intolerance or contraindication)

AND

5.2.2 ONE of the following:

5.2.2.1 Failure to intramuscular testosterone enanthate injection, confirmed by claims history or submitted medical records

OR

5.2.2.2 History of intolerance or contraindication to intramuscular testosterone enanthate injection (please specify intolerance or contraindication)

OR

5.3 If the request is for Jatenzo, Kyzatrex, or Tlando, ONE of the following:

5.3.1 Failure to ALL of the following:

- testosterone cypionate vials
- testosterone enanthate vials
- testosterone gel - tube, pack, or pump bottle or testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

5.3.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

<table>
<tr><td colspan="2">

- testosterone cypionate vials
- testosterone enanthate vials
- testosterone gel - tube, pack, or pump bottle or testosterone 1.62% pump (generic Androgel 1.62% pump)

</td></tr>
<tr><td>Notes</td><td>*Patients that have previously received injectable testosterone open a ccess should be reviewed using reauthorization criteria
**PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html</td></tr>
</table>

Product Name: Androderm, generic testosterone gel, Brand Androgel, generic testosterone gel pump, Brand Androgel Pump, testosterone soln, Brand Fortesta, generic testosterone TD gel, Natesto, Brand Testim, Brand Vogelxo, Brand Vogelxo Pump, Xyosted, Jatenzo, Kyzatrex, Tlando, Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate	
Diagnosis	Hypogonadism, Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ANDRODERM	TESTOSTERONE TD PATCH 24HR 2 MG/24HR	23100030008503	Brand
ANDRODERM	TESTOSTERONE TD PATCH 24HR 4 MG/24HR	23100030008510	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 25 MG/2.5GM (1%)	23100030004025	Generic
ANDROGEL	TESTOSTERONE TD GEL 25 MG/2.5GM (1%)	23100030004025	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Generic
ANDROGEL	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Generic
ANDROGEL	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Generic
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Generic
ANDROGEL PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Brand
TESTOSTERONE	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic

TESTOSTERONE TOPICAL SOLUTION	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
FORTESTA	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Generic
TESTIM	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
VOGELXO	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Generic
VOGELXO PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%)	23100030004044	Generic
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 50 MG/0.5ML	2310003020D520	Brand
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 75 MG/0.5ML	2310003020D530	Brand
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 100 MG/0.5ML	2310003020D540	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 158 MG	23100030800130	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 198 MG	23100030800135	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 237 MG	23100030800140	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 100 MG	23100030800124	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 150 MG	23100030800128	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 200 MG	23100030800136	Brand
TLANDO	TESTOSTERONE UNDECANOATE CAP 112.5 MG	23100030800125	Brand
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Brand
DEPO-TESTOSTERONE	TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML	23100030102010	Brand
TESTOSTERONE CYPIONATE	TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML	23100030102010	Generic
DEPO-TESTOSTERONE	TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML	23100030102015	Brand
TESTOSTERONE CYPIONATE	TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML	23100030102015	Generic
TESTOSTERONE ENANTHATE	TESTOSTERONE ENANTHATE IM INJ IN OIL 200 MG/ML	23100030202010	Generic

Approval Criteria

1 - ONE of the following:

1.1 Patient has a history of ONE of the following:

- Bilateral orchiectomy
- Panhypopituitarism
- A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

OR

1.2 BOTH of the following:

1.2.1 Patient has a diagnosis of ONE of the following:

- Hypogonadism
- Gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

AND

1.2.2 ONE of the following:

1.2.2.1 Follow-up total serum testosterone level drawn within the past 12 months is within or below the normal male limits of the reporting lab (document value and date)

OR

1.2.2.2 Follow-up total serum testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)

OR

1.2.2.3 BOTH of the following:

1.2.2.3.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) [e.g., thyroid disorder, HIV (human immunodeficiency virus) disease, liver disorder, diabetes, obesity]

AND

1.2.2.3.2 ONE of the following:

- Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is within or below the normal male limits of the reporting lab (document lab value and date)
- Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)

AND

2 - Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

AND

3 - Patient is NOT taking any aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

2 . Revision History

Date	Notes
6/7/2024	Updated Natesto GPI. Added injectable testosterone agents that wer e previously open access to clinical review. Updated Initial auth notes and T/F options. Updated reauth criteria.

Therapeutic Duplication (Subtype A)

Prior Authorization Guideline

Guideline ID	GL-148740
Guideline Name	Therapeutic Duplication (Subtype A)
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Generic arformoterol nebulizer solution, Brand Brovana nebulizer, generic formoterol nebulizer solution, Brand Perforomist nebulizer, Striverdi Respimat, Serevent Diskus, Incruse Ellipta, Brand Spiriva Handihaler, generic tiotropium, Spiriva Respimat, Tudorza Pressair, generic ipratropium inhalation solution, Atrovent HFA, Anoro Ellipta, Stiolto Respimat, Bevespi Aerosphere, Duaklir Pressair, Breztri Aerosphere, Glyxambi, Steglujan, Qtern, Trijardy XR, Brand Pulmicort suspension, generic budesonide suspension, Victoza, Adlyxin, Trulicity, Bydureon BCise, Byetta, Ozempic, Rybelsus, Januvia, Janumet, Janumet XR, Brand Onglyza, generic saxagliptin, Brand Kombiglyze XR, generic saxagliptin/metformin ER, Tradjenta, Jentadueto, Jentadueto XR, Nesina, alogliptin, Kazano, alogliptin/metformin, Oseni, alogliptin/pioglitazone, Mounjaro, Xultophy, Soliqua, Invokana, brand Farxiga, generic dapagliflozin, Jardiance, Invokamet, Invokamet XR, brand Xigduo XR, generic dapagliflozin/metformin ER, Synjardy, Synjardy XR, Steglatro, Segluromet, Zituvio, Brand Flovent HFA, Fluticasone propionate HFA, Flovent Diskus, Brand Fluticasone propionate Diskus, Brand Pulmicort Flexhaler, Airsupra, Alvesco, ArmonAir Digihaler, Asmanex Twisthaler, Asmanex HFA, Arnuity Ellipta, Qvar RediHaler, Lonhala Magnair, Trelegy Ellipta, Brand Advair Diskus, generic fluticasone propionate/salmeterol diskus (generic Advair Diskus), generic Wixela Inhub (generic Advair Diskus), AirDuo Respiclick,

fluticasone/salmeterol (authorized generic of AirDuo), Brand Advair HFA, Brand Fluticasone/salmeterol HFA, Brand Symbicort, generic budesonide/formoterol, Breyna, AirDuo Digihaler, Dulera, Breo Ellipta, Brand fluticasone/vilanterol Ellipta, Basaglar Tempo pen, Basaglar Kwikpen, Insulin Glargine Solostar, Lantus Solostar, Toujeo Solostar, Toujeo Max Solostar, Semglee Pen Injector, Insulin Glargine-YFGN pen, Lantus vial, Insulin Glargine vial, Semglee vial, Insulin Glargine-YFGN vial, Levemir vial, Levemir Flextouch, Levemir Flexpen, Tresiba vial, Insulin Degludec vial, Tresiba Flextouch, Insulin Degludec Flextouch, Rezvoglar, Baclofen tabs, generic baclofen suspension, Brand Fleqsuvy, Brand Ozobax DS, brand Ozobax, Brand Baclofen solution, brand Lioresal intrathecal, generic baclofen intrathecal, brand Gablofen intrathecal, baclofen intrathecal solution, Lyvispah, generic carisoprodol tab, brand Soma, brand Vanadom tab, generic chlorzoxazone, brand Lorzone, generic cyclobenzaprine, brand Fexmid, generic cyclobenzaprine ER, brand Amrix, metaxalone, methocarbamol, orphenadrine CR/ER, generic tizanidine caps/tabs, brand Zanaflex caps/tabs, brand Dantrium, generic dantrolene, brand Norgesic, generic orphenadrine/aspirin/caffeine, norgesic forte, orphengesic forte, Brand Neurontin caps/tabs/soln, generic gabapentin caps/tabs/soln, gabapentin tinytabs, brand Lyrica caps/soln, generic pregabalin caps/soln, brand Gralise, brand Lyrica CR, generic pregabalin ER, Horizant, Zorvolex, brand Zipsor, generic diclofenac caps, brand Lofena, generic diclofenac tabs, diclofenac DR/ER, brand Cambia, generic diclofenac packet (migraine), etodolac cap, brand Lodine, generic etodolac tab, etodolac ER, brand Nalfon caps/tabs, generic fenoprofen caps/tabs, flurbiprofen, ibuprofen caps/tabs/chewable (includes All Manufactures), Brand Advil, ibuprofen suspension (40 mg/ml & 100 mg/5ml), indomethacin caps, indomethacin ER/SR caps, indocin susp, indocin suppository, indomethacin suppository, ketoprofen cap, ketoprofen ER cap, ketorolac tabs, meclofenamate cap, mefenamic acid, meloxicam cap/tab, brand Relafen DS, generic nabumetone, generic naproxen tab/susp/caps (includes All Manufactures), brand naprosyn tab/susp, brand Aleve, brand Anaprox DS, brand EC-Naprosyn, generic naproxen DR, generic EC-naproxen, brand Naprelan, generic naproxen CR/ER, Brand Daypro, generic oxaprozin, brand Feldene, generic piroxicam, sulindac, tolmetin, brand Celebrex, generic celecoxib, Elyxyb, brand Arthrotec, generic diclofenac sodium/misoprostol, brand Duexis, generic ibuprofen/famotidine, brand Vimovo, generic naproxen/esomeprazole, brand Advil PM, generic ibuprofen/diphenhydramine, brand Aleve PM, generic naproxen/diphenhydramine, hydrocodone/ibuprofen, brand Treximet, generic sumatriptan/naproxen, Motrin Dual Action/Tylenol, Advil Dual Action/acetaminophen, acetaminophen/ibuprofen, Naproxen/capsaicin cream (Naprotin), Inpefa, Saxenda, Wegovy, Brand Brenzavvy, Brand Bexagliflozin, Zepbound, Coxanto, Jantoven, warfarin tabs, Pradaxa, generic dabigatran, Eliquis, Savaysa, Xarelto, Brand Lunesta, generic eszopiclone, zaleplon, Zolpidem, Brand Ambien, generic zolpidem, Brand Ambien CR, generic zolpidem CR. Edluar, Zolpimist, Brand Rozerem, generic ramelteon, Brand Silenor, generic doxepin (sleep) 3mg and 6 mg tabs, Belsomra, Dayvigo, Quviviq, Brand Precedex, generic dexmedetomidine, Dexmedetomidine, Igalmi, Brand Hetlioz, generic tasimelteon, Hetlioz LQ, Brand Restoril, generic temazepam, Brand Halcion, generic triazolam, Brand Doral, generic quazepam, flurazepam, estazolam, Sitagliptin/metformin	
Diagnosis	DUR: Therapeutic Duplication
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ARFORMOTEROL TARTRATE	ARFORMOTEROL TARTRATE SOLN NEBU 15 MCG/2ML (BASE EQUIV)	44201012102520	Generic
BROVANA	ARFORMOTEROL TARTRATE SOLN NEBU 15 MCG/2ML (BASE EQUIV)	44201012102520	Brand
FORMOTEROL FUMARATE	FORMOTEROL FUMARATE SOLN NEBU 20 MCG/2ML	44201027102520	Generic
PERFOROMIST	FORMOTEROL FUMARATE SOLN NEBU 20 MCG/2ML	44201027102520	Brand
STRIVERDI RESPIMAT	OLODATEROL HCL INHAL AEROSOL SOLN 2.5 MCG/ACT (BASE EQUIV)	44201052203410	Brand
SPIRIVA HANDIHALER	TIOTROPIUM BROMIDE MONOHYDRATE INHAL CAP 18 MCG (BASE EQUIV)	44100080100120	Brand
SPIRIVA RESPIMAT	TIOTROPIUM BROMIDE MONOHYDRATE INHAL AEROSOL 1.25 MCG/ACT	44100080103410	Brand
SPIRIVA RESPIMAT	TIOTROPIUM BROMIDE MONOHYDRATE INHAL AEROSOL 2.5 MCG/ACT	44100080103420	Brand
TUDORZA PRESSAIR	ACLIDINIUM BROMIDE AEROSOL POWD BREATH ACTIVATED 400 MCG/ACT	44100007108020	Brand
IPRATROPIUM BROMIDE	IPRATROPIUM BROMIDE INHAL SOLN 0.02%	44100030102020	Generic
ATROVENT HFA	IPRATROPIUM BROMIDE HFA INHAL AEROSOL 17 MCG/ACT	44100030123420	Brand
STIOLTO RESPIMAT	TIOTROPIUM BR-OLODATEROL INHAL AERO SOLN 2.5-2.5 MCG/ACT	44209902923420	Brand
BEVESPI AEROSPHERE	GLYCOPYRROLATE-FORMOTEROL FUMARATE AEROSOL 9-4.8 MCG/ACT	44209902543220	Brand
DUAKLIR PRESSAIR	ACLIDINIUM BR-FORMOTEROL FUM AERO POW BR ACT 400-12 MCG/ACT	44209902268030	Brand
GLYXAMBI	EMPAGLIFLOZIN-LINAGLIPTIN TAB 10-5 MG	27996502300320	Brand
GLYXAMBI	EMPAGLIFLOZIN-LINAGLIPTIN TAB 25-5 MG	27996502300330	Brand
STEGLUJAN	ERTUGLIFLOZIN-SITAGLIPTIN TAB 5-100 MG	27996502350320	Brand
STEGLUJAN	ERTUGLIFLOZIN-SITAGLIPTIN TAB 15-100 MG	27996502350330	Brand

QTERN	DAPAGLIFLOZIN-SAXAGLIPTIN TAB 5-5 MG	27996502200320	Brand
QTERN	DAPAGLIFLOZIN-SAXAGLIPTIN TAB 10-5 MG	27996502200330	Brand
TRIJARDY XR	EMPAGLIFLOZIN-LINAGLIPTIN-METFORMIN TAB ER 24HR 5-2.5-1000MG	27996703407510	Brand
TRIJARDY XR	EMPAGLIFLOZIN-LINAGLIPTIN-METFORMIN TAB ER 24HR 10-5-1000 MG	27996703407520	Brand
TRIJARDY XR	EMPAGLIFLOZIN-LINAGLIP-METFORMIN TAB ER 24HR 12.5-2.5-1000MG	27996703407530	Brand
TRIJARDY XR	EMPAGLIFLOZIN-LINAGLIPTIN-METFORMIN TAB ER 24HR 25-5-1000 MG	27996703407540	Brand
BREZTRI AEROSPHERE	BUDESONIDE-GLYCOPYRROLATE-FORMOTEROL AERS 160-9-4.8 MCG/ACT	44209903303220	Brand
PULMICORT	BUDESONIDE INHALATION SUSP 0.25 MG/2ML	44400015001830	Brand
BUDESONIDE	BUDESONIDE INHALATION SUSP 0.25 MG/2ML	44400015001830	Generic
PULMICORT	BUDESONIDE INHALATION SUSP 0.5 MG/2ML	44400015001840	Brand
BUDESONIDE	BUDESONIDE INHALATION SUSP 0.5 MG/2ML	44400015001840	Generic
PULMICORT	BUDESONIDE INHALATION SUSP 1 MG/2ML	44400015001850	Brand
BUDESONIDE	BUDESONIDE INHALATION SUSP 1 MG/2ML	44400015001850	Generic
ADLYXIN	LIXISENATIDE SOLN PEN-INJECTOR 20 MCG/0.2ML (100 MCG/ML)	2717005600D230	Brand
VICTOZA	LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML)	2717005000D220	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 0.75 MG/0.5ML	2717001500D220	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 1.5 MG/0.5ML	2717001500D230	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 3 MG/0.5ML	2717001500D240	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 4.5 MG/0.5ML	2717001500D250	Brand

BYDUREON BCISE	EXENATIDE EXTENDED RELEASE SUSP AUTO-INJECTOR 2 MG/0.85ML	2717002000D420	Brand
BYETTA	EXENATIDE SOLN PEN-INJECTOR 5 MCG/0.02ML	2717002000D220	Brand
BYETTA	EXENATIDE SOLN PEN-INJECTOR 10 MCG/0.04ML	2717002000D240	Brand
OZEMPIC	SEMAGLUTIDE SOLN PEN-INJ 0.25 OR 0.5 MG/DOSE (2 MG/1.5ML)	2717007000D210	Brand
OZEMPIC	SEMAGLUTIDE SOLN PEN-INJ 0.25 OR 0.5 MG/DOSE (2 MG/3ML)	2717007000D221	Brand
OZEMPIC	SEMAGLUTIDE SOLN PEN-INJ 1 MG/DOSE (4 MG/3ML)	2717007000D222	Brand
OZEMPIC	SEMAGLUTIDE SOLN PEN-INJ 2 MG/DOSE (8 MG/3ML)	2717007000D225	Brand
RYBELSUS	SEMAGLUTIDE TAB 3 MG	27170070000310	Brand
RYBELSUS	SEMAGLUTIDE TAB 7 MG	27170070000320	Brand
RYBELSUS	SEMAGLUTIDE TAB 14 MG	27170070000330	Brand
JANUVIA	SITAGLIPTIN PHOSPHATE TAB 25 MG (BASE EQUIV)	27550070100320	Brand
JANUVIA	SITAGLIPTIN PHOSPHATE TAB 50 MG (BASE EQUIV)	27550070100330	Brand
JANUVIA	SITAGLIPTIN PHOSPHATE TAB 100 MG (BASE EQUIV)	27550070100340	Brand
JANUMET	SITAGLIPTIN-METFORMIN HCL TAB 50-500 MG	27992502700320	Brand
JANUMET	SITAGLIPTIN-METFORMIN HCL TAB 50-1000 MG	27992502700340	Brand
JANUMET XR	SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 50-500 MG	27992502707520	Brand
JANUMET XR	SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 50-1000 MG	27992502707530	Brand
JANUMET XR	SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 100-1000 MG	27992502707540	Brand
ONGLYZA	SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV)	27550065100320	Brand
ONGLYZA	SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV)	27550065100330	Brand
KOMBIGLYZE XR	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27992502607520	Brand

KOMBIGLYZE XR	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-500 MG	27992502607530	Brand
KOMBIGLYZE XR	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27992502607540	Brand
TRADJENTA	LINAGLIPTIN TAB 5 MG	27550050000320	Brand
JENTADUETO	LINAGLIPTIN-METFORMIN HCL TAB 2.5-500 MG	27992502400320	Brand
JENTADUETO	LINAGLIPTIN-METFORMIN HCL TAB 2.5-850 MG	27992502400330	Brand
JENTADUETO	LINAGLIPTIN-METFORMIN HCL TAB 2.5-1000 MG	27992502400340	Brand
JENTADUETO XR	LINAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27992502407520	Brand
JENTADUETO XR	LINAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27992502407530	Brand
ALOGLIPTIN	ALOGLIPTIN BENZOATE TAB 6.25 MG (BASE EQUIV)	27550010100310	Generic
NESINA	ALOGLIPTIN BENZOATE TAB 6.25 MG (BASE EQUIV)	27550010100310	Generic
ALOGLIPTIN	ALOGLIPTIN BENZOATE TAB 12.5 MG (BASE EQUIV)	27550010100320	Generic
NESINA	ALOGLIPTIN BENZOATE TAB 12.5 MG (BASE EQUIV)	27550010100320	Generic
ALOGLIPTIN	ALOGLIPTIN BENZOATE TAB 25 MG (BASE EQUIV)	27550010100330	Generic
NESINA	ALOGLIPTIN BENZOATE TAB 25 MG (BASE EQUIV)	27550010100330	Generic
ALOGLIPTIN/METFORMIN HCL	ALOGLIPTIN-METFORMIN HCL TAB 12.5-500 MG	27992502100320	Generic
KAZANO	ALOGLIPTIN-METFORMIN HCL TAB 12.5-500 MG	27992502100320	Generic
ALOGLIPTIN/METFORMIN HYDROCHLORIDE	ALOGLIPTIN-METFORMIN HCL TAB 12.5-1000 MG	27992502100330	Generic
KAZANO	ALOGLIPTIN-METFORMIN HCL TAB 12.5-1000 MG	27992502100330	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-15 MG	27994002100320	Brand
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-30 MG	27994002100325	Generic

OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-30 MG	27994002100325	Generic
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-45 MG	27994002100330	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-45 MG	27994002100330	Generic
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 25-15 MG	27994002100340	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 25-15 MG	27994002100340	Generic
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 25-30 MG	27994002100345	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 25-30 MG	27994002100345	Generic
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 25-45 MG	27994002100350	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 25-45 MG	27994002100350	Generic
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 2.5 MG/0.5ML	2717308000D210	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 5 MG/0.5ML	2717308000D215	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 7.5 MG/0.5ML	2717308000D220	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 10 MG/0.5ML	2717308000D225	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 12.5 MG/0.5ML	2717308000D230	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 15 MG/0.5ML	2717308000D235	Brand
XULTOPHY 100/3.6	INSULIN DEGLUDEC-LIRAGLUTIDE SOL PEN-INJ 100-3.6 UNIT-MG/ML	2799100225D220	Brand
SOLIQUA 100/33	INSULIN GLARGINE-LIXISENATIDE SOL PEN-INJ 100-33 UNIT-MCG/ML	2799100235D220	Brand
INVOKANA	CANAGLIFLOZIN TAB 100 MG	27700020000320	Brand

INVOKANA	CANAGLIFLOZIN TAB 300 MG	27700020000330	Brand
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Brand
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Brand
JARDIANCE	EMPAGLIFLOZIN TAB 10 MG	27700050000310	Brand
JARDIANCE	EMPAGLIFLOZIN TAB 25 MG	27700050000320	Brand
INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 50-500 MG	27996002200320	Brand
INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 50-1000 MG	27996002200330	Brand
INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 150-500 MG	27996002200340	Brand
INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 150-1000 MG	27996002200350	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 50-500 MG	27996002207520	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 50-1000 MG	27996002207530	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 150-500 MG	27996002207540	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 150-1000 MG	27996002207550	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 5-500 MG	27996002400310	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 5-1000 MG	27996002400315	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 12.5-500 MG	27996002400320	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 12.5-1000 MG	27996002400325	Brand

SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002407530	Brand
SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002407540	Brand
SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 12.5-1000 MG	27996002407550	Brand
SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 25-1000 MG	27996002407560	Brand
STEGLATRO	ERTUGLIFLOZIN L-PYROGLUTAMIC ACID TAB 5 MG (BASE EQUIV)	27700055200320	Brand
STEGLATRO	ERTUGLIFLOZIN L-PYROGLUTAMIC ACID TAB 15 MG (BASE EQUIV)	27700055200340	Brand
SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 2.5-500 MG	27996002450310	Brand
SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 2.5-1000 MG	27996002450320	Brand
SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 7.5-500 MG	27996002450330	Brand
SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 7.5-1000 MG	27996002450340	Brand
FLOVENT HFA	FLUTICASONE PROPIONATE HFA INHAL AERO 44 MCG/ACT (50/VALVE)	44400033223220	Generic
FLOVENT HFA	FLUTICASONE PROPIONATE HFA INHAL AER 110 MCG/ACT (125/VALVE)	44400033223230	Generic
FLOVENT HFA	FLUTICASONE PROPIONATE HFA INHAL AER 220 MCG/ACT (250/VALVE)	44400033223240	Generic
FLOVENT DISKUS	FLUTICASONE PROPIONATE AER POW BA 50 MCG/ACT	44400033208010	Brand
FLOVENT DISKUS	FLUTICASONE PROPIONATE AER POW BA 100 MCG/ACT	44400033208020	Brand

FLOVENT DISKUS	FLUTICASONE PROPIONATE AER POW BA 250 MCG/ACT	44400033208030	Brand
ALVESCO	CICLESONIDE INHAL AEROSOL 80 MCG/ACT	44400017003420	Brand
ALVESCO	CICLESONIDE INHAL AEROSOL 160 MCG/ACT	44400017003440	Brand
ARMONAIR DIGIHALER	FLUTICASONE PROPIONATE AER POW BA 55 MCG/ACT WITH SENSOR	44400033218020	Brand
ARMONAIR DIGIHALER	FLUTICASONE PROPIONATE AER POW BA 113 MCG/ACT WITH SENSOR	44400033218030	Brand
ARMONAIR DIGIHALER	FLUTICASONE PROPIONATE AER POW BA 232 MCG/ACT WITH SENSOR	44400033218040	Brand
ASMANEX HFA	MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 50 MCG/ACT	44400036203210	Brand
ASMANEX HFA	MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 100 MCG/ACT	44400036203220	Brand
ASMANEX HFA	MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 200 MCG/ACT	44400036203230	Brand
ASMANEX TWISTHALER 30 METERED DOSES	MOMETASONE FUROATE INHAL POWD 110 MCG/ACT (BREATH ACTIVATED)	44400036208010	Brand
ASMANEX TWISTHALER 120 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand
ASMANEX TWISTHALER 14 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand
ASMANEX TWISTHALER 30 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand
ASMANEX TWISTHALER 60 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand
ARNUITY ELLIPTA	FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 50 MCG/ACT	44400033108010	Brand

ARNUITY ELLIPTA	FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 100 MCG/ACT	44400033108020	Brand
ARNUITY ELLIPTA	FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 200 MCG/ACT	44400033108030	Brand
QVAR REDIHALER	BECLOMETHASONE DIPROP HFA BREATH ACT INH AER 40 MCG/ACT	44400010128120	Brand
QVAR REDIHALER	BECLOMETHASONE DIPROP HFA BREATH ACT INH AER 80 MCG/ACT	44400010128140	Brand
LONHALA MAGNAIR REFILL KIT	GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML	44100020102030	Brand
LONHALA MAGNAIR STARTER KIT	GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML	44100020102030	Brand
TRELEGY ELLIPTA	FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 100-62.5-25 MCG/ACT	44209903408020	Brand
TRELEGY ELLIPTA	FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 200-62.5-25 MCG/ACT	44209903408040	Brand
AIRDUO RESPICLICK 55/14	FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT	44209902708010	Generic
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT	44209902708010	Generic
AIRDUO RESPICLICK 113/14	FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT	44209902708015	Generic
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT	44209902708015	Generic
ADVAIR DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT	44209902708020	Brand
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT	44209902708020	Generic

FLUTICASONE PROPIONATE/SALMETEROL DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT	44209902708020	Generic
WIXELA INHUB	FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT	44209902708020	Generic
AIRDUO RESPICLICK 232/14	FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT	44209902708025	Generic
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT	44209902708025	Generic
ADVAIR DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT	44209902708030	Brand
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT	44209902708030	Generic
FLUTICASONE PROPIONATE/SALMETEROL DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT	44209902708030	Generic
WIXELA INHUB	FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT	44209902708030	Generic
ADVAIR DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT	44209902708040	Brand
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT	44209902708040	Generic
FLUTICASONE PROPIONATE/SALMETEROL DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT	44209902708040	Generic
WIXELA INHUB	FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT	44209902708040	Generic
BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT	44209902413220	Generic

BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT	44209902413240	Generic
AIRDUO DIGIHALER 55/14	FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT W/ SENSOR	44209902718020	Brand
AIRDUO DIGIHALER 113/14	FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT W/SENSOR	44209902718030	Brand
AIRDUO DIGIHALER 232/14	FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT W/SENSOR	44209902718040	Brand
DULERA	MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 50-5 MCG/ACT	44209902903210	Brand
DULERA	MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 100-5 MCG/ACT	44209902903220	Brand
DULERA	MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 200-5 MCG/ACT	44209902903240	Brand
BREO ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 100-25 MCG/ACT	44209902758020	Generic
FLUTICASONE FUROATE/VILANTEROL ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 100-25 MCG/ACT	44209902758020	Generic
BREO ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 200-25 MCG/ACT	44209902758030	Generic
FLUTICASONE FUROATE/VILANTEROL ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 200-25 MCG/ACT	44209902758030	Generic
BASAGLAR TEMPO PEN	INSULIN GLARGINE PEN-INJ WITH TRANSMITTER PORT 100 UNIT/ML	2710400300D222	Brand
BASAGLAR KWIKPEN	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand
INSULIN GLARGINE SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand
LANTUS SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand

TOUJEO SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL)	2710400300D233	Brand
TOUJEO MAX SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL)	2710400300D236	Brand
INSULIN GLARGINE	INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML	2710400390D220	Brand
SEMGLEE	INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML	2710400390D220	Brand
INSULIN GLARGINE	INSULIN GLARGINE INJ 100 UNIT/ML	27104003002020	Brand
LANTUS	INSULIN GLARGINE INJ 100 UNIT/ML	27104003002020	Brand
SEMGLEE	INSULIN GLARGINE INJ 100 UNIT/ML	27104003002020	Brand
SEMGLEE	INSULIN GLARGINE-YFGN INJ 100 UNIT/ML	27104003902020	Brand
LEVEMIR	INSULIN DETEMIR INJ 100 UNIT/ML	27104006002020	Brand
LEVEMIR FLEXPEN	INSULIN DETEMIR SOLN PEN-INJECTOR 100 UNIT/ML	2710400600D220	Brand
LEVEMIR FLEXTOUCH	INSULIN DETEMIR SOLN PEN-INJECTOR 100 UNIT/ML	2710400600D220	Brand
INSULIN DEGLUDEC	INSULIN DEGLUDEC INJ 100 UNIT/ML	27104007002020	Brand
TRESIBA	INSULIN DEGLUDEC INJ 100 UNIT/ML	27104007002020	Brand
INSULIN DEGLUDEC FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML	2710400700D210	Brand
TRESIBA FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML	2710400700D210	Brand
INSULIN DEGLUDEC FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML	2710400700D220	Brand
TRESIBA FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML	2710400700D220	Brand
REZVOGLAR KWIKPEN	INSULIN GLARGINE-AGLR SOLN PEN-INJECTOR 100 UNIT/ML	2710400305D220	Brand
BACLOFEN	BACLOFEN TAB 5 MG	75100010000303	Generic

BACLOFEN	BACLOFEN TAB 10 MG	75100010000305	Generic
BACLOFEN	BACLOFEN TAB 20 MG	75100010000310	Generic
BACLOFEN	BACLOFEN SUSP 25 MG/5ML	75100010001825	Generic
LIORESAL INTRATHECAL	BACLOFEN INTRATHECAL INJ 0.05 MG/ML (50 MCG/ML)	75100010002020	Brand
BACLOFEN	BACLOFEN INTRATHECAL INJ 10 MG/20ML (500 MCG/ML)	75100010002034	Generic
GABLOFEN	BACLOFEN INTRATHECAL INJ 10 MG/20ML (500 MCG/ML)	75100010002034	Brand
LIORESAL INTRATHECAL	BACLOFEN INTRATHECAL INJ 10 MG/20ML (500 MCG/ML)	75100010002034	Brand
BACLOFEN	BACLOFEN INTRATHECAL INJ 20 MG/20ML (1000 MCG/ML)	75100010002039	Generic
GABLOFEN	BACLOFEN INTRATHECAL INJ 20 MG/20ML (1000 MCG/ML)	75100010002039	Brand
LIORESAL INTRATHECAL	BACLOFEN INTRATHECAL INJ 10 MG/5ML (2000 MCG/ML)	75100010002046	Brand
BACLOFEN	BACLOFEN INTRATHECAL INJ 40 MG/20ML (2000 MCG/ML)	75100010002050	Generic
GABLOFEN	BACLOFEN INTRATHECAL INJ 40 MG/20ML (2000 MCG/ML)	75100010002050	Brand
LIORESAL INTRATHECAL	BACLOFEN INTRATHECAL INJ 40 MG/20ML (2000 MCG/ML)	75100010002050	Brand
BACLOFEN	BACLOFEN ORAL SOLN 5 MG/5ML	75100010002070	Generic
OZOBAX	BACLOFEN ORAL SOLN 5 MG/5ML	75100010002070	Generic
LYVISPAH	BACLOFEN GRANULES PACKET 5 MG	75100010003010	Brand
LYVISPAH	BACLOFEN GRANULES PACKET 10 MG	75100010003020	Brand
LYVISPAH	BACLOFEN GRANULES PACKET 20 MG	75100010003030	Brand
CARISOPRODOL	CARISOPRODOL TAB 250 MG	75100020000304	Generic

SOMA	CARISOPRODOL TAB 250 MG	75100020000304	Brand
CARISOPRODOL	CARISOPRODOL TAB 350 MG	75100020000305	Generic
SOMA	CARISOPRODOL TAB 350 MG	75100020000305	Brand
VANADOM	CARISOPRODOL TAB 350 MG	75100020000305	Brand
CHLORZOXAZONE	CHLORZOXAZONE TAB 250 MG	75100040000305	Generic
CHLORZOXAZONE	CHLORZOXAZONE TAB 375 MG	75100040000307	Generic
LORZONE	CHLORZOXAZONE TAB 375 MG	75100040000307	Brand
CHLORZOXAZONE	CHLORZOXAZONE TAB 500 MG	75100040000310	Generic
CHLORZOXAZONE	CHLORZOXAZONE TAB 750 MG	75100040000320	Generic
LORZONE	CHLORZOXAZONE TAB 750 MG	75100040000320	Brand
CYCLOBENZAPRINE HYDROCHLORIDE	CYCLOBENZAPRINE HCL TAB 5 MG	75100050100303	Generic
CYCLOBENZAPRINE HYDROCHLORIDE	CYCLOBENZAPRINE HCL TAB 7.5 MG	75100050100304	Generic
FEXMID	CYCLOBENZAPRINE HCL TAB 7.5 MG	75100050100304	Brand
CYCLOBENZAPRINE HYDROCHLORIDE	CYCLOBENZAPRINE HCL TAB 10 MG	75100050100305	Generic
AMRIX	CYCLOBENZAPRINE HCL CAP ER 24HR 15 MG	75100050107015	Brand
CYCLOBENZAPRINE HYDROCHLORIDE ER	CYCLOBENZAPRINE HCL CAP ER 24HR 15 MG	75100050107015	Generic
AMRIX	CYCLOBENZAPRINE HCL CAP ER 24HR 30 MG	75100050107030	Brand
CYCLOBENZAPRINE HYDROCHLORIDE ER	CYCLOBENZAPRINE HCL CAP ER 24HR 30 MG	75100050107030	Generic
METAXALONE	METAXALONE TAB 400 MG	75100060000310	Generic
METAXALONE	METAXALONE TAB 800 MG	75100060000320	Generic
METHOCARBAMOL	METHOCARBAMOL TAB 500 MG	75100070000305	Generic
METHOCARBAMOL	METHOCARBAMOL TAB 750 MG	75100070000310	Generic
METHOCARBAMOL	METHOCARBAMOL TAB 1000 MG	75100070000320	Generic

ORPHENADRINE CITRATE CR	ORPHENADRINE CITRATE TAB ER 12HR 100 MG	75100080107410	Generic
ORPHENADRINE CITRATE ER	ORPHENADRINE CITRATE TAB ER 12HR 100 MG	75100080107410	Generic
TIZANIDINE HCL	TIZANIDINE HCL CAP 2 MG (BASE EQUIVALENT)	75100090100110	Generic
ZANAFLEX	TIZANIDINE HCL CAP 2 MG (BASE EQUIVALENT)	75100090100110	Brand
TIZANIDINE HCL	TIZANIDINE HCL CAP 4 MG (BASE EQUIVALENT)	75100090100120	Generic
ZANAFLEX	TIZANIDINE HCL CAP 4 MG (BASE EQUIVALENT)	75100090100120	Brand
TIZANIDINE HCL	TIZANIDINE HCL CAP 6 MG (BASE EQUIVALENT)	75100090100130	Generic
ZANAFLEX	TIZANIDINE HCL CAP 6 MG (BASE EQUIVALENT)	75100090100130	Brand
TIZANIDINE HCL	TIZANIDINE HCL TAB 2 MG (BASE EQUIVALENT)	75100090100310	Generic
TIZANIDINE HYDROCHLORIDE	TIZANIDINE HCL TAB 4 MG (BASE EQUIVALENT)	75100090100320	Generic
ZANAFLEX	TIZANIDINE HCL TAB 4 MG (BASE EQUIVALENT)	75100090100320	Brand
DANTRIUM	DANTROLENE SODIUM CAP 25 MG	75200010100105	Brand
DANTROLENE SODIUM	DANTROLENE SODIUM CAP 25 MG	75200010100105	Generic
DANTROLENE SODIUM	DANTROLENE SODIUM CAP 50 MG	75200010100110	Generic
DANTROLENE SODIUM	DANTROLENE SODIUM CAP 100 MG	75200010100115	Generic
NORGESIC	ORPHENADRINE W/ ASPIRIN & CAFFEINE TAB 25-385-30 MG	75990003200310	Brand
ORPHENADRINE/ASPIRIN/CAFFEINE	ORPHENADRINE W/ ASPIRIN & CAFFEINE TAB 25-385-30 MG	75990003200310	Generic
NORGESIC FORTE	ORPHENADRINE W/ ASPIRIN & CAFFEINE TAB 50-770-60 MG	75990003200320	Generic
ORPHENGESIC FORTE	ORPHENADRINE W/ ASPIRIN & CAFFEINE TAB 50-770-60 MG	75990003200320	Generic
GABAPENTIN	GABAPENTIN CAP 100 MG	72600030000110	Generic
NEURONTIN	GABAPENTIN CAP 100 MG	72600030000110	Brand
GABAPENTIN	GABAPENTIN CAP 300 MG	72600030000130	Generic

NEURONTIN	GABAPENTIN CAP 300 MG	72600030000130	Brand
GABAPENTIN	GABAPENTIN CAP 400 MG	72600030000140	Generic
NEURONTIN	GABAPENTIN CAP 400 MG	72600030000140	Brand
GABAPENTIN TINYTABS	GABAPENTIN TAB 25 MG	72600030000303	Brand
GABAPENTIN TINYTABS	GABAPENTIN TAB 50 MG	72600030000305	Brand
GABAPENTIN	GABAPENTIN TAB 600 MG	72600030000330	Generic
NEURONTIN	GABAPENTIN TAB 600 MG	72600030000330	Brand
GABAPENTIN	GABAPENTIN TAB 800 MG	72600030000340	Generic
NEURONTIN	GABAPENTIN TAB 800 MG	72600030000340	Brand
GABAPENTIN	GABAPENTIN ORAL SOLN 250 MG/5ML	72600030002020	Generic
NEURONTIN	GABAPENTIN ORAL SOLN 250 MG/5ML	72600030002020	Brand
LYRICA	PREGABALIN CAP 25 MG	72600057000110	Brand
PREGABALIN	PREGABALIN CAP 25 MG	72600057000110	Generic
LYRICA	PREGABALIN CAP 50 MG	72600057000115	Brand
PREGABALIN	PREGABALIN CAP 50 MG	72600057000115	Generic
LYRICA	PREGABALIN CAP 75 MG	72600057000120	Brand
PREGABALIN	PREGABALIN CAP 75 MG	72600057000120	Generic
LYRICA	PREGABALIN CAP 100 MG	72600057000125	Brand
PREGABALIN	PREGABALIN CAP 100 MG	72600057000125	Generic
LYRICA	PREGABALIN CAP 150 MG	72600057000135	Brand
PREGABALIN	PREGABALIN CAP 150 MG	72600057000135	Generic
LYRICA	PREGABALIN CAP 200 MG	72600057000145	Brand
PREGABALIN	PREGABALIN CAP 200 MG	72600057000145	Generic
LYRICA	PREGABALIN CAP 225 MG	72600057000150	Brand
PREGABALIN	PREGABALIN CAP 225 MG	72600057000150	Generic
LYRICA	PREGABALIN CAP 300 MG	72600057000160	Brand
PREGABALIN	PREGABALIN CAP 300 MG	72600057000160	Generic
LYRICA	PREGABALIN SOLN 20 MG/ML	72600057002020	Brand
PREGABALIN	PREGABALIN SOLN 20 MG/ML	72600057002020	Generic
GRALISE	GABAPENTIN (ONCE-DAILY) TAB 300 MG	62540030000320	Brand

GRALISE	GABAPENTIN (ONCE-DAILY) TAB 450 MG	62540030000325	Brand
GRALISE	GABAPENTIN (ONCE-DAILY) TAB 600 MG	62540030000330	Brand
GRALISE	GABAPENTIN (ONCE-DAILY) TAB 750 MG	62540030000345	Brand
GRALISE	GABAPENTIN (ONCE-DAILY) TAB 900 MG	62540030000360	Brand
GRALISE	GABAPENTIN (ONCE-DAILY) TAB PACK 300 MG (9) & 600 MG (24)	62540030006330	Brand
LYRICA CR	PREGABALIN TAB ER 24HR 82.5 MG	62540060007520	Brand
PREGABALIN ER	PREGABALIN TAB ER 24HR 82.5 MG	62540060007520	Generic
LYRICA CR	PREGABALIN TAB ER 24HR 165 MG	62540060007530	Brand
PREGABALIN ER	PREGABALIN TAB ER 24HR 165 MG	62540060007530	Generic
LYRICA CR	PREGABALIN TAB ER 24HR 330 MG	62540060007540	Brand
PREGABALIN ER	PREGABALIN TAB ER 24HR 330 MG	62540060007540	Generic
HORIZANT	GABAPENTIN ENACARBIL TAB ER 300 MG	62560030200420	Brand
HORIZANT	GABAPENTIN ENACARBIL TAB ER 600 MG	62560030200430	Brand
ZORVOLEX	DICLOFENAC CAP 18 MG	66100007000120	Brand
ZORVOLEX	DICLOFENAC CAP 35 MG	66100007000130	Brand
DICLOFENAC POTASSIUM	DICLOFENAC POTASSIUM TAB 25 MG	66100007100320	Generic
LOFENA	DICLOFENAC POTASSIUM TAB 25 MG	66100007100320	Brand
DICLOFENAC POTASSIUM	DICLOFENAC POTASSIUM TAB 50 MG	66100007100330	Generic
DICLOFENAC POTASSIUM	DICLOFENAC POTASSIUM CAP 25 MG	66100007100120	Generic
ZIPSOR	DICLOFENAC POTASSIUM CAP 25 MG	66100007100120	Brand
DICLOFENAC SODIUM DR	DICLOFENAC SODIUM TAB DELAYED RELEASE 25 MG	66100007200610	Generic
DICLOFENAC SODIUM DR	DICLOFENAC SODIUM TAB DELAYED RELEASE 50 MG	66100007200620	Generic
DICLOFENAC SODIUM DR	DICLOFENAC SODIUM TAB DELAYED RELEASE 75 MG	66100007200630	Generic

DICLOFENAC SODIUM ER	DICLOFENAC SODIUM TAB ER 24HR 100 MG	66100007207530	Generic
CAMBIA	DICLOFENAC POTASSIUM (MIGRAINE) PACKET 50 MG	67600040103020	Brand
DICLOFENAC POTASSIUM	DICLOFENAC POTASSIUM (MIGRAINE) PACKET 50 MG	67600040103020	Generic
ETODOLAC	ETODOLAC CAP 200 MG	66100008000120	Generic
ETODOLAC	ETODOLAC CAP 300 MG	66100008000130	Generic
ETODOLAC	ETODOLAC TAB 400 MG	66100008000310	Generic
LODINE	ETODOLAC TAB 400 MG	66100008000310	Brand
ETODOLAC	ETODOLAC TAB 500 MG	66100008000320	Generic
ETODOLAC ER	ETODOLAC TAB ER 24HR 400 MG	66100008007520	Generic
ETODOLAC ER	ETODOLAC TAB ER 24HR 500 MG	66100008007530	Generic
ETODOLAC ER	ETODOLAC TAB ER 24HR 600 MG	66100008007540	Generic
FENOPROFEN CALCIUM	FENOPROFEN CALCIUM CAP 200 MG	66100010100105	Generic
FENOPROFEN CALCIUM	FENOPROFEN CALCIUM CAP 400 MG	66100010100120	Generic
NALFON	FENOPROFEN CALCIUM CAP 400 MG	66100010100120	Brand
FENOPROFEN CALCIUM	FENOPROFEN CALCIUM TAB 600 MG	66100010100305	Generic
NALFON	FENOPROFEN CALCIUM TAB 600 MG	66100010100305	Brand
FLURBIPROFEN	FLURBIPROFEN TAB 50 MG	66100012000310	Generic
FLURBIPROFEN	FLURBIPROFEN TAB 100 MG	66100012000315	Generic
IBUPROFEN	IBUPROFEN CAP 200 MG	66100020000105	Generic
IBUPROFEN	IBUPROFEN TAB 200 MG	66100020000305	Generic
IBUPROFEN	IBUPROFEN TAB 400 MG	66100020000320	Generic
IBUPROFEN	IBUPROFEN TAB 600 MG	66100020000330	Generic
IBUPROFEN	IBUPROFEN TAB 800 MG	66100020000340	Generic
IBUPROFEN	IBUPROFEN CHEW TAB 100 MG	66100020000520	Generic
IBUPROFEN INFANTS	IBUPROFEN SUSP 40 MG/ML	66100020001810	Generic

CHILDRENS IBUPROFEN	IBUPROFEN SUSP 100 MG/5ML	66100020001820	Generic
INDOMETHACIN	INDOMETHACIN CAP 25 MG	66100030000105	Generic
INDOMETHACIN	INDOMETHACIN CAP 50 MG	66100030000110	Generic
INDOMETHACIN ER	INDOMETHACIN CAP ER 75 MG	66100030000205	Generic
INDOMETHACIN SR	INDOMETHACIN CAP ER 75 MG	66100030000205	Generic
INDOCIN	INDOMETHACIN SUSP 25 MG/5ML	66100030001805	Brand
INDOCIN	INDOMETHACIN SUPPOS 50 MG	66100030005205	Brand
INDOMETHACIN	INDOMETHACIN SUPPOS 100 MG	66100030005210	Brand
KETOPROFEN	KETOPROFEN CAP 25 MG	66100035000103	Generic
KETOPROFEN	KETOPROFEN CAP 50 MG	66100035000105	Generic
KETOPROFEN ER	KETOPROFEN CAP ER 24HR 200 MG	66100035007030	Generic
KETOROLAC TROMETHAMINE	KETOROLAC TROMETHAMINE TAB 10 MG	66100037100320	Generic
MECLOFENAMATE SODIUM	MECLOFENAMATE SODIUM CAP 50 MG	66100040100105	Generic
MECLOFENAMATE SODIUM	MECLOFENAMATE SODIUM CAP 100 MG	66100040100110	Generic
MEFENAMIC ACID	MEFENAMIC ACID CAP 250 MG	66100050000105	Generic
MELOXICAM	MELOXICAM CAP 5 MG	66100052000115	Generic
MELOXICAM	MELOXICAM CAP 10 MG	66100052000125	Generic
MELOXICAM	MELOXICAM TAB 7.5 MG	66100052000320	Generic
MELOXICAM	MELOXICAM TAB 15 MG	66100052000330	Generic
NABUMETONE	NABUMETONE TAB 500 MG	66100055000320	Generic
NABUMETONE	NABUMETONE TAB 750 MG	66100055000330	Generic
RELAFEN DS	NABUMETONE TAB 1000 MG	66100055000340	Brand
NAPROXEN	NAPROXEN TAB 250 MG	66100060000305	Generic
NAPROXEN	NAPROXEN TAB 375 MG	66100060000310	Generic
NAPROSYN	NAPROXEN TAB 500 MG	66100060000315	Brand
NAPROXEN	NAPROXEN TAB 500 MG	66100060000315	Generic

EC-NAPROSYN	NAPROXEN TAB EC 375 MG	66100060000610	Brand
EC-NAPROXEN	NAPROXEN TAB EC 375 MG	66100060000610	Generic
NAPROXEN	NAPROXEN TAB EC 375 MG	66100060000610	Generic
EC-NAPROSYN	NAPROXEN TAB EC 500 MG	66100060000615	Brand
EC-NAPROXEN	NAPROXEN TAB EC 500 MG	66100060000615	Generic
NAPROXEN	NAPROXEN TAB EC 500 MG	66100060000615	Generic
NAPROSYN	NAPROXEN SUSP 125 MG/5ML	66100060001805	Brand
NAPROXEN	NAPROXEN SUSP 125 MG/5ML	66100060001805	Generic
NAPROXEN SODIUM	NAPROXEN SODIUM CAP 220 MG	66100060100127	Generic
NAPROXEN	NAPROXEN SODIUM TAB 220 MG	66100060100303	Generic
NAPROXEN SODIUM	NAPROXEN SODIUM TAB 275 MG	66100060100305	Generic
NAPROXEN SODIUM	NAPROXEN SODIUM TAB 550 MG	66100060100310	Generic
NAPRELAN	NAPROXEN SODIUM TAB ER 24HR 375 MG (BASE EQUIV)	66100060107520	Brand
NAPROXEN SODIUM CR	NAPROXEN SODIUM TAB ER 24HR 375 MG (BASE EQUIV)	66100060107520	Generic
NAPROXEN SODIUM ER	NAPROXEN SODIUM TAB ER 24HR 375 MG (BASE EQUIV)	66100060107520	Generic
NAPRELAN	NAPROXEN SODIUM TAB ER 24HR 500 MG (BASE EQUIV)	66100060107540	Brand
NAPROXEN SODIUM ER	NAPROXEN SODIUM TAB ER 24HR 500 MG (BASE EQUIV)	66100060107540	Generic
NAPRELAN	NAPROXEN SODIUM TAB ER 24HR 750 MG (BASE EQUIV)	66100060107550	Brand
NAPROXEN SODIUM	NAPROXEN SODIUM TAB ER 24HR 750 MG (BASE EQUIV)	66100060107550	Generic
DAYPRO	OXAPROZIN TAB 600 MG	66100065000320	Brand
OXAPROZIN	OXAPROZIN TAB 600 MG	66100065000320	Generic

FELDENE	PIROXICAM CAP 10 MG	66100070000105	Brand
PIROXICAM	PIROXICAM CAP 10 MG	66100070000105	Generic
FELDENE	PIROXICAM CAP 20 MG	66100070000110	Brand
PIROXICAM	PIROXICAM CAP 20 MG	66100070000110	Generic
SULINDAC	SULINDAC TAB 150 MG	66100080000305	Generic
SULINDAC	SULINDAC TAB 200 MG	66100080000310	Generic
TOLMETIN SODIUM	TOLMETIN SODIUM TAB 600 MG	66100090100320	Generic
CELEBREX	CELECOXIB CAP 50 MG	66100525000110	Brand
CELECOXIB	CELECOXIB CAP 50 MG	66100525000110	Generic
CELEBREX	CELECOXIB CAP 100 MG	66100525000120	Brand
CELECOXIB	CELECOXIB CAP 100 MG	66100525000120	Generic
CELEBREX	CELECOXIB CAP 200 MG	66100525000130	Brand
CELECOXIB	CELECOXIB CAP 200 MG	66100525000130	Generic
CELEBREX	CELECOXIB CAP 400 MG	66100525000140	Brand
CELECOXIB	CELECOXIB CAP 400 MG	66100525000140	Generic
ELYXYB	CELECOXIB ORAL SOLN 120 MG/4.8ML (25 MG/ML)	67604030002020	Brand
ARTHROTEC 50	DICLOFENAC W/ MISOPROSTOL TAB DELAYED RELEASE 50-0.2 MG	66109902200620	Brand
DICLOFENAC SODIUM/MISOPROSTOL	DICLOFENAC W/ MISOPROSTOL TAB DELAYED RELEASE 50-0.2 MG	66109902200620	Generic
ARTHROTEC 75	DICLOFENAC W/ MISOPROSTOL TAB DELAYED RELEASE 75-0.2 MG	66109902200630	Brand
DICLOFENAC SODIUM/MISOPROSTOL	DICLOFENAC W/ MISOPROSTOL TAB DELAYED RELEASE 75-0.2 MG	66109902200630	Generic
DUEXIS	IBUPROFEN-FAMOTIDINE TAB 800-26.6 MG	66109902320340	Brand
IBUPROFEN/FAMOTIDINE	IBUPROFEN-FAMOTIDINE TAB 800-26.6 MG	66109902320340	Generic
NAPROXEN/ESOMEPRAZOLE MAGNESIUM	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 375-20 MG	66109902440620	Generic

VIMOVO	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 375-20 MG	66109902440620	Brand
NAPROXEN/ESOMEPRAZOLE MAGNESIUM	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 500-20 MG	66109902440640	Generic
VIMOVO	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 500-20 MG	66109902440640	Brand
QC IBUPROFEN/DIPHENHYDRAMINE	IBUPROFEN-DIPHENHYDRAMINE HCL CAP 200-25 MG	60309902420120	Generic
ALEVE PM	NAPROXEN SODIUM-DIPHENHYDRAMINE HCL TAB 220-25 MG	60309902600320	Brand
RA NAPROXEN SODIUM PM	NAPROXEN SODIUM-DIPHENHYDRAMINE HCL TAB 220-25 MG	60309902600320	Generic
ADVIL PM	IBUPROFEN-DIPHENHYDRAMINE HCL CAP 200-25 MG	60309902420120	Brand
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 5-200 MG	65991702500315	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	65991702500320	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 10-200 MG	65991702500330	Generic
SUMATRIPTAN/NAPROXEN SODIUM	SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG	67992002600320	Generic
TREXIMET	SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG	67992002600320	Brand
ADVIL DUAL ACTION /ACETAMINOPHEN	IBUPROFEN-ACETAMINOPHEN TAB 125-250 MG	66109902300305	Brand
MOTRIN DUAL ACTION/TYLENOL	IBUPROFEN-ACETAMINOPHEN TAB 125-250 MG	66109902300305	Brand
NAPROTIN	NAPROXEN TAB 500 MG & CAPSAICIN CREAM 0.025% KIT	66109902476420	Brand
SM IBUPROFEN JR	IBUPROFEN TAB 100 MG	66100020000303	Generic
ALEVE	NAPROXEN SODIUM CAP 220 MG	66100060100127	Brand

ALEVE	NAPROXEN SODIUM TAB 220 MG	66100060100303	Brand
ANAPROX DS	NAPROXEN SODIUM TAB 550 MG	66100060100310	Brand
INPEFA	SOTAGLIFLOZIN TAB 200 MG	40750010000320	Brand
SAXENDA	LIRAGLUTIDE (WEIGHT MNGMT) SOLN PEN-INJ 18 MG/3ML (6 MG/ML)	6125205000D220	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.25 MG/0.5ML	6125207000D520	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.5 MG/0.5ML	6125207000D525	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1 MG/0.5ML	6125207000D530	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1.7 MG/0.75ML	6125207000D535	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 2.4 MG/0.75ML	6125207000D540	Brand
TOLMETIN SODIUM	TOLMETIN SODIUM CAP 400 MG	66100090100105	Generic
BREO ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 50-25 MCG/ACT	44209902758010	Brand
AIRSUPRA	ALBUTEROL-BUDESONIDE INHALATION AEROSOL 90-80 MCG/ACT	44209902783220	Brand
FLUTICASONE PROPIONATE/SALMETEROL HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 45-21 MCG/ACT	44209902703250	Generic
ADVAIR HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 45-21 MCG/ACT	44209902703250	Generic
FLUTICASONE PROPIONATE/SALMETEROL HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 115-21 MCG/ACT	44209902703260	Generic
ADVAIR HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 115-21 MCG/ACT	44209902703260	Generic
FLUTICASONE PROPIONATE/SALMETEROL HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 230-21 MCG/ACT	44209902703270	Generic

ADVAIR HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 230-21 MCG/ACT	44209902703270	Generic
FLEQSUVY	BACLOFEN SUSP 25 MG/5ML	75100010001825	Brand
PULMICORT FLEXHALER	BUDESONIDE INHAL AERO POWD 90 MCG/ACT (BREATH ACTIVATED)	44400015008009	Generic
PULMICORT FLEXHALER	BUDESONIDE INHAL AERO POWD 180 MCG/ACT (BREATH ACTIVATED)	44400015008018	Generic
BREYNA	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT	44209902413220	Generic
SYMBICORT	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT	44209902413220	Brand
BREYNA	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT	44209902413240	Generic
SYMBICORT	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT	44209902413240	Brand
ANORO ELLIPTA	UMECLIDINIUM-VILANTEROL AERO POWD BA 62.5-25 MCG/ACT	44209902958020	Brand
INCRUSE ELLIPTA	UMECLIDINIUM BR AERO POWD BREATH ACT 62.5 MCG/ACT (BASE EQ)	44100090208030	Brand
SEREVENT DISKUS	SALMETEROL XINAFOATE AER POW BA 50 MCG/ACT (BASE EQUIV)	44201058108020	Brand
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27996002307507	Brand
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-500 MG	27996002307510	Brand
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002307515	Brand
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-500 MG	27996002307520	Brand

XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002307525	Brand
INSULIN GLARGINE-YFGN	INSULIN GLARGINE-YFGN INJ 100 UNIT/ML	27104003902020	Brand
INDOMETHACIN	INDOMETHACIN SUPPOS 50 MG	66100030005205	Generic
SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27992502607520	Generic
SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-500 MG	27992502607530	Generic
SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27992502607540	Generic
SAXAGLIPTIN HYDROCHLORIDE	SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV)	27550065100320	Generic
SAXAGLIPTIN HYDROCHLORIDE	SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV)	27550065100330	Generic
TIOTROPIUM BROMIDE	TIOTROPIUM BROMIDE MONOHYDRATE INHAL CAP 18 MCG (BASE EQUIV)	44100080100120	Generic
INPEFA	SOTAGLIFLOZIN TAB 400 MG	40750010000340	Brand
BACLOFEN	BACLOFEN ORAL SOLN 10 MG/5ML	75100010002075	Generic
OZOBAX DS	BACLOFEN ORAL SOLN 10 MG/5ML	75100010002075	Generic
BEXAGLIFLOZIN	BEXAGLIFLOZIN TAB 20 MG	27700010000320	Generic
FLUTICASONE PROPIONATE DISKUS	FLUTICASONE PROPIONATE AER POW BA 50 MCG/ACT	44400033208010	Brand
FLUTICASONE PROPIONATE DISKUS	FLUTICASONE PROPIONATE AER POW BA 100 MCG/ACT	44400033208020	Brand
FLUTICASONE PROPIONATE DISKUS	FLUTICASONE PROPIONATE AER POW BA 250 MCG/ACT	44400033208030	Brand
FLUTICASONE PROPIONATE HFA	FLUTICASONE PROPIONATE HFA INHAL AERO 44 MCG/ACT (50/VALVE)	44400033223220	Brand
FLUTICASONE PROPIONATE HFA	FLUTICASONE PROPIONATE HFA INHAL AER 110 MCG/ACT (125/VALVE)	44400033223230	Brand

FLUTICASONE PROPIONATE HFA	FLUTICASONE PROPIONATE HFA INHAL AER 220 MCG/ACT (250/VALVE)	44400033223240	Brand
NAPROXEN DR	NAPROXEN TAB EC 500 MG	66100060000615	Generic
ACETAMINOPHEN/IBUPROFEN	IBUPROFEN-ACETAMINOPHEN TAB 125-250 MG	66109902300305	Generic
BRENZAVVY	BEXAGLIFLOZIN TAB 20 MG	27700010000320	Generic
ADVIL JUNIOR STRENGTH	IBUPROFEN TAB 100 MG	66100020000303	Brand
ZEPBOUND	TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 2.5 MG/0.5ML	6125258000D520	Brand
ZEPBOUND	TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 5 MG/0.5ML	6125258000D525	Brand
ZEPBOUND	TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 7.5 MG/0.5ML	6125258000D530	Brand
ZEPBOUND	TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 10 MG/0.5ML	6125258000D535	Brand
ZEPBOUND	TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 12.5 MG/0.5ML	6125258000D540	Brand
ZEPBOUND	TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 15 MG/0.5ML	6125258000D545	Brand
COXANTO	OXAPROZIN CAP 300 MG	66100065000120	Brand
JANTOVEN	WARFARIN SODIUM TAB 1 MG	83200030200303	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 1 MG	83200030200303	Generic
JANTOVEN	WARFARIN SODIUM TAB 2 MG	83200030200305	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 2 MG	83200030200305	Generic
JANTOVEN	WARFARIN SODIUM TAB 2.5 MG	83200030200310	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 2.5 MG	83200030200310	Generic
JANTOVEN	WARFARIN SODIUM TAB 3 MG	83200030200311	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 3 MG	83200030200311	Generic

JANTOVEN	WARFARIN SODIUM TAB 4 MG	83200030200313	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 4 MG	83200030200313	Generic
JANTOVEN	WARFARIN SODIUM TAB 5 MG	83200030200315	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 5 MG	83200030200315	Generic
JANTOVEN	WARFARIN SODIUM TAB 6 MG	83200030200317	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 6 MG	83200030200317	Generic
JANTOVEN	WARFARIN SODIUM TAB 7.5 MG	83200030200320	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 7.5 MG	83200030200320	Generic
JANTOVEN	WARFARIN SODIUM TAB 10 MG	83200030200325	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 10 MG	83200030200325	Generic
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand

PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand
ELIQUIS	APIXABAN TAB 2.5 MG	83370010000320	Brand
ELIQUIS	APIXABAN TAB 5 MG	83370010000330	Brand
SAVAYSA	EDOXABAN TOSYLATE TAB 15 MG (BASE EQUIVALENT)	83370030200315	Brand
SAVAYSA	EDOXABAN TOSYLATE TAB 30 MG (BASE EQUIVALENT)	83370030200330	Brand
SAVAYSA	EDOXABAN TOSYLATE TAB 60 MG (BASE EQUIVALENT)	83370030200350	Brand
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand
ESZOPICLONE	ESZOPICLONE TAB 1 MG	60204035000320	Generic
LUNESTA	ESZOPICLONE TAB 1 MG	60204035000320	Brand
ESZOPICLONE	ESZOPICLONE TAB 2 MG	60204035000330	Generic
LUNESTA	ESZOPICLONE TAB 2 MG	60204035000330	Brand
ESZOPICLONE	ESZOPICLONE TAB 3 MG	60204035000340	Generic
LUNESTA	ESZOPICLONE TAB 3 MG	60204035000340	Brand
ZALEPLON	ZALEPLON CAP 5 MG	60204070000120	Generic
ZALEPLON	ZALEPLON CAP 10 MG	60204070000130	Generic
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE CAP 7.5 MG	60204080100120	Brand
AMBIEN	ZOLPIDEM TARTRATE TAB 5 MG	60204080100310	Brand
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE TAB 5 MG	60204080100310	Generic

AMBIEN	ZOLPIDEM TARTRATE TAB 10 MG	60204080100315	Brand
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE TAB 10 MG	60204080100315	Generic
AMBIEN CR	ZOLPIDEM TARTRATE TAB ER 6.25 MG	60204080100410	Brand
ZOLPIDEM TARTRATE ER	ZOLPIDEM TARTRATE TAB ER 6.25 MG	60204080100410	Generic
AMBIEN CR	ZOLPIDEM TARTRATE TAB ER 12.5 MG	60204080100420	Brand
ZOLPIDEM TARTRATE ER	ZOLPIDEM TARTRATE TAB ER 12.5 MG	60204080100420	Generic
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE SL TAB 1.75 MG	60204080100708	Generic
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE SL TAB 3.5 MG	60204080100715	Generic
EDLUAR	ZOLPIDEM TARTRATE SL TAB 5 MG	60204080100720	Brand
EDLUAR	ZOLPIDEM TARTRATE SL TAB 10 MG	60204080100730	Brand
RAMELTEON	RAMELTEON TAB 8 MG	60250060000320	Generic
ROZEREM	RAMELTEON TAB 8 MG	60250060000320	Brand
DOXEPIN HYDROCHLORIDE	DOXEPIN HCL (SLEEP) TAB 3 MG (BASE EQUIV)	60400030100320	Generic
SILENOR	DOXEPIN HCL (SLEEP) TAB 3 MG (BASE EQUIV)	60400030100320	Brand
DOXEPIN HYDROCHLORIDE	DOXEPIN HCL (SLEEP) TAB 6 MG (BASE EQUIV)	60400030100330	Generic
SILENOR	DOXEPIN HCL (SLEEP) TAB 6 MG (BASE EQUIV)	60400030100330	Brand
BELSOMRA	SUVOREXANT TAB 5 MG	60500070000305	Brand
BELSOMRA	SUVOREXANT TAB 10 MG	60500070000310	Brand
BELSOMRA	SUVOREXANT TAB 15 MG	60500070000315	Brand
BELSOMRA	SUVOREXANT TAB 20 MG	60500070000320	Brand
DAYVIGO	LEMBOREXANT TAB 5 MG	60500040000320	Brand
DAYVIGO	LEMBOREXANT TAB 10 MG	60500040000340	Brand
QUVIVIQ	DARIDOREXANT HCL TAB 25 MG	60500020100320	Brand
QUVIVIQ	DARIDOREXANT HCL TAB 50 MG	60500020100340	Brand
DEXMEDETOMIDINE HCL	DEXMEDETOMIDINE HCL IV SOLN 200 MCG/2ML	60206030102020	Generic

DEXMEDETOMIDINE HYDROCHLORIDE	DEXMEDETOMIDINE HCL IV SOLN 200 MCG/2ML	60206030102020	Generic
PRECEDEX	DEXMEDETOMIDINE HCL IV SOLN 200 MCG/2ML	60206030102020	Brand
DEXMEDETOMIDINE HCL	DEXMEDETOMIDINE HCL IV SOLN 400 MCG/4ML	60206030102030	Brand
DEXMEDETOMIDINE HCL	DEXMEDETOMIDINE HCL IV SOLN 1000 MCG/10ML	60206030102040	Brand
IGALMI	DEXMEDETOMIDINE HCL FILM 120 MCG	60206030108220	Brand
IGALMI	DEXMEDETOMIDINE HCL FILM 180 MCG	60206030108230	Brand
HETLIOZ	TASIMELTEON CAPSULE 20 MG	60250070000130	Brand
TASIMELTEON	TASIMELTEON CAPSULE 20 MG	60250070000130	Generic
HETLIOZ LQ	TASIMELTEON ORAL SUSP 4 MG/ML	60250070001820	Brand
RESTORIL	TEMAZEPAM CAP 7.5 MG	60201030000103	Brand
TEMAZEPAM	TEMAZEPAM CAP 7.5 MG	60201030000103	Generic
RESTORIL	TEMAZEPAM CAP 15 MG	60201030000105	Brand
TEMAZEPAM	TEMAZEPAM CAP 15 MG	60201030000105	Generic
RESTORIL	TEMAZEPAM CAP 22.5 MG	60201030000108	Brand
TEMAZEPAM	TEMAZEPAM CAP 22.5 MG	60201030000108	Generic
RESTORIL	TEMAZEPAM CAP 30 MG	60201030000110	Brand
TEMAZEPAM	TEMAZEPAM CAP 30 MG	60201030000110	Generic
TRIAZOLAM	TRIAZOLAM TAB 0.125 MG	60201040000305	Generic
HALCION	TRIAZOLAM TAB 0.25 MG	60201040000310	Brand
TRIAZOLAM	TRIAZOLAM TAB 0.25 MG	60201040000310	Generic
DORAL	QUAZEPAM TAB 15 MG	60201028000310	Brand
QUAZEPAM	QUAZEPAM TAB 15 MG	60201028000310	Generic
FLURAZEPAM HYDROCHLORIDE	FLURAZEPAM HCL CAP 15 MG	60201010100105	Generic
FLURAZEPAM HYDROCHLORIDE	FLURAZEPAM HCL CAP 30 MG	60201010100110	Generic
ESTAZOLAM	ESTAZOLAM TAB 1 MG	60201005000310	Generic
ESTAZOLAM	ESTAZOLAM TAB 2 MG	60201005000320	Generic
ZITUVIO	SITAGLIPTIN TAB 25 MG	27550070000320	Brand
ZITUVIO	SITAGLIPTIN TAB 50 MG	27550070000330	Brand

ZITUVIO	SITAGLIPTIN TAB 100 MG	27550070000340	Brand
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002307515	Generic
DAPAGLIFLOZIN PROPANEDIOL/METFORMIN HYDROCHLORIDE	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002307515	Generic
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002307525	Generic
DAPAGLIFLOZIN PROPANEDIOL/METFORMIN HYDROCHLORIDE	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002307525	Generic
COXANTO	OXAPROZIN CAP 300 MG	66100065000120	Generic
OXAPROZIN	OXAPROZIN CAP 300 MG	66100065000120	Generic
BACLOFEN	BACLOFEN TAB 15 MG	75100010000308	Generic
SITAGLIPTIN/METFORMIN HYDROCHLORIDE	SITAGLIPTIN FREE BASE-METFORMIN HCL TAB 50-500 MG	27992502690320	Brand
SITAGLIPTIN/METFORMIN HYDROCHLORIDE	SITAGLIPTIN FREE BASE-METFORMIN HCL TAB 50-1000 MG	27992502690330	Brand

Approval Criteria

1 - The requested medication will be used exclusively, and the previously prescribed medication will be discontinued

OR

2 - All of the following:

2.1 The requested medication combination is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2.2 The drug combination is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program

AND

2.3 The provider attests that they are aware that the patient is using duplicate therapy

AND

2.4 Special clinical circumstances exist that necessitate the need for duplicate therapy (document special circumstances)

AND

2.5 Provider attests that the necessity for continued concomitant therapy and safety will be periodically assessed

2 . Revision History

Date	Notes
6/20/2024	copy core

Topical NSAIDs

Prior Authorization Guideline

Guideline ID	GL-146920
Guideline Name	Topical NSAIDs
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand diclofenac epolamine patch, Brand Flector	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DICLOFENAC EPOLAMINE	DICLOFENAC EPOLAMINE PATCH 1.3%	90210030205920	Generic
FLECTOR	DICLOFENAC EPOLAMINE PATCH 1.3%	90210030205920	Generic

Approval Criteria

1 - Diagnosis of acute pain due to minor strains, sprains, or contusions **AND** **2 -** The patient did not receive adequate pain relief when treated with at least TWO preferred* non-steroidal anti-inflammatory drugs (NSAIDs), one of which must be celecoxib (generic for Celebrex), as confirmed by claims history or submitted medical records. An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy **AND** **3 -** ONE of the following: **3.1** Failure to ONE of the following, as confirmed by claims history or submission of medical records: • diclofenac topical gel 1% [Rx (prescription) formulation] • diclofenac topical gel 1% [OTC (over-the-counter) formulation] **OR** **3.2** History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication): • diclofenac topical gel 1% (Rx formulation) • diclofenac topical gel 1% (OTC formulation)	
Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Brand Pennsaid, generic diclofenac sodium soln 2%, diclofenac sodium soln 1.5%	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

PENNSAID	DICLOFENAC SODIUM SOLN 2%	90210030302030	Brand
DICLOFENAC SODIUM	DICLOFENAC SODIUM SOLN 1.5%	90210030302025	Generic
DICLOFENAC SODIUM	DICLOFENAC SODIUM SOLN 2%	90210030302030	Generic

Approval Criteria

1 - Patient has a diagnosis of pain due to osteoarthritis of the knee(s)

AND

2 - The patient did not receive adequate pain relief when treated with at least TWO preferred* non-steroidal anti-inflammatory drugs (NSAIDs), one of which must be celecoxib (generic for Celebrex), as confirmed by claims history or submitted medical records. An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy

AND

3 - ONE of the following:

3.1 If the request is for Pennsaid (diclofenac sodium soln 2%), ONE of the following:

3.1.1 Failure of BOTH of the following, as confirmed by claims history or submitted medical records:

- diclofenac topical gel 1% [Rx (prescription) or OTC (over the counter) formulation] (generic for Voltaren)
- diclofenac 1.5% topical solution

OR

3.1.2 History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication):

- diclofenac topical gel 1% (Rx or OTC formulation) (generic for Voltaren)
- diclofenac 1.5% topical solution

OR

3.2 If the request is for diclofenac topical solution 1.5%, ONE of the following:

3.2.1 Failure of ONE of the following, as confirmed by claims history or submitted medical records:

- diclofenac topical gel 1% (Rx formulation) (generic for Voltaren)
- diclofenac topical gel 1% (OTC formulation) (generic for Voltaren)

OR

3.2.2 History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication):

- diclofenac topical gel 1% (Rx formulation) (generic for Voltaren)
- diclofenac topical gel 1% (OTC formulation) (generic for Voltaren)

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Voltaren (Rx and OTC formulations)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOLTAREN	DICLOFENAC SODIUM GEL 1% (1.16% DIETHYLAMINE EQUIV)	90210030304020	Brand

Approval Criteria

1 - The patient has a diagnosis of pain due to osteoarthritis of joints amenable to topical treatment, including but not limited to the hands, knees, ankles, elbows, feet, and wrists

AND

2 - ONE of the following:

2.1 If the request is for the Rx (prescription) formulation, BOTH of the following:

2.1.1 The patient did not receive adequate pain relief when treated with at least TWO preferred* non-steroidal anti-inflammatory drugs (NSAIDs), one of which must be celecoxib (generic for Celebrex), as confirmed by claims history or submitted medical records. An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to BOTH of the following, as confirmed by claims history or submission of medical records:

- diclofenac topical gel 1% [Rx or OTC (over-the-counter) formulation] (generic Voltaren)
- Brand Voltaren topical gel 1% (OTC formulation)

OR

2.1.2.2 History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication):

- diclofenac topical gel 1% (Rx or OTC formulation) (generic Voltaren)
- Brand Voltaren topical gel 1% (OTC formulation)

OR

2.2 If the request is for the OTC formulation, ONE of the following:

2.2.1 Failure to ONE of the following, as confirmed by claims history or submission of medical records:

- diclofenac topical gel 1% (Rx formulation) (generic Voltaren)
- diclofenac topical gel 1% (OTC formulation) (generic Voltaren)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication): • diclofenac topical gel 1% (Rx formulation) (generic Voltaren) • diclofenac topical gel 1% (OTC formulation) (generic Voltaren)	
Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

2 . Revision History

Date	Notes
5/1/2024	Added NM PDL Link

Topical Retinoid Products

Prior Authorization Guideline

Guideline ID	GL-148971
Guideline Name	Topical Retinoid Products
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic tretinoin microsphere, Retin-A Micro, Brand Differin cream, generic adapalene cream, Differin gel (Rx only)/lotion, adapalene gel/soln/pads, Fabior, tazarotene foam, Tazorac, generic tazarotene, adapalene/benzoyl peroxide, Brand Epiduo, Brand Epiduo Forte, Brand Atralin, generic tretinoin gel, Avita, Brand Retin-A, Altreno, Aklief, Arazlo	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRETINOIN MICROSPHERE	TRETINOIN MICROSPHERE GEL 0.04%	90050030204015	Generic
TRETINOIN MICROSPHERE PUMP	TRETINOIN MICROSPHERE GEL 0.04%	90050030204015	Generic
RETIN-A MICRO PUMP	TRETINOIN MICROSPHERE GEL 0.04%	90050030204015	Brand
RETIN-A MICRO	TRETINOIN MICROSPHERE GEL 0.04%	90050030204015	Brand

TRETINOIN MICROSPHERE	TRETINOIN MICROSPHERE GEL 0.1%	90050030204030	Generic
TRETINOIN MICROSPHERE PUMP	TRETINOIN MICROSPHERE GEL 0.1%	90050030204030	Generic
RETIN-A MICRO PUMP	TRETINOIN MICROSPHERE GEL 0.1%	90050030204030	Brand
RETIN-A MICRO	TRETINOIN MICROSPHERE GEL 0.1%	90050030204030	Brand
DIFFERIN	ADAPALENE CREAM 0.1%	90050003003710	Brand
ADAPALENE	ADAPALENE CREAM 0.1%	90050003003710	Generic
DIFFERIN	ADAPALENE GEL 0.1%	90050003004010	Brand
ADAPALENE	ADAPALENE GEL 0.1%	90050003004010	Generic
ADAPALENE TREATMENT	ADAPALENE GEL 0.1%	90050003004010	Generic
DIFFERIN	ADAPALENE GEL 0.3%	90050003004030	Brand
ADAPALENE	ADAPALENE GEL 0.3%	90050003004030	Generic
ADAPALENE PUMP	ADAPALENE GEL 0.3%	90050003004030	Generic
DIFFERIN	ADAPALENE LOTION 0.1%	90050003004110	Brand
ADAPALENE	ADAPALENE SOLN 0.1%	90050003002010	Brand
ADAPALENE	ADAPALENE PADS 0.1%	90050003004310	Brand
TAZAROTENE	TAZAROTENE (ACNE) FOAM 0.1%	90050027003930	Brand
FABIOR	TAZAROTENE (ACNE) FOAM 0.1%	90050027003930	Brand
TAZORAC	TAZAROTENE CREAM 0.1%	90250070003730	Brand
TAZAROTENE	TAZAROTENE CREAM 0.1%	90250070003730	Generic
TAZORAC	TAZAROTENE GEL 0.05%	90250070004020	Brand
TAZAROTENE	TAZAROTENE GEL 0.05%	90250070004020	Generic
TAZORAC	TAZAROTENE GEL 0.1%	90250070004030	Brand
TAZAROTENE	TAZAROTENE GEL 0.1%	90250070004030	Generic
TAZORAC	TAZAROTENE CREAM 0.05%	90250070003720	Brand
ADAPALENE/BENZOYL PEROXIDE	ADAPALENE-BENZOYL PEROXIDE GEL 0.1-2.5%	90059902034020	Generic
EPIDUO	ADAPALENE-BENZOYL PEROXIDE GEL 0.1-2.5%	90059902034020	Brand
ADAPALENE/BENZOYL PEROXIDE	ADAPALENE-BENZOYL PEROXIDE GEL 0.3-2.5%	90059902034030	Generic
EPIDUO FORTE	ADAPALENE-BENZOYL PEROXIDE GEL 0.3-2.5%	90059902034030	Brand
ADAPALENE/BENZOYL PEROXIDE	ADAPALENE-BENZOYL PEROXIDE PAD 0.1-2.5%	90059902034320	Brand

ATRALIN	TRETINOIN GEL 0.05%	90050030004015	Brand
TRETINOIN	TRETINOIN GEL 0.05%	90050030004015	Generic
AVITA	TRETINOIN CREAM 0.025%	90050030003703	Brand
RETIN-A	TRETINOIN CREAM 0.025%	90050030003703	Brand
AVITA	TRETINOIN GEL 0.025%	90050030004010	Brand
RETIN-A	TRETINOIN GEL 0.025%	90050030004010	Brand
TRETINOIN	TRETINOIN GEL 0.025%	90050030004010	Generic
RETIN-A	TRETINOIN CREAM 0.05%	90050030003705	Brand
RETIN-A	TRETINOIN CREAM 0.1%	90050030003710	Brand
RETIN-A	TRETINOIN GEL 0.01%	90050030004005	Brand
TRETINOIN	TRETINOIN GEL 0.01%	90050030004005	Generic
RETIN-A MICRO	TRETINOIN MICROSPHERE GEL 0.06%	90050030204017	Brand
RETIN-A MICRO PUMP	TRETINOIN MICROSPHERE GEL 0.08%	90050030204020	Brand
ALTRENO	TRETINOIN LOTION 0.05%	90050030004130	Brand
AKLIEF	TRIFAROTENE CREAM 0.005%	90050035003720	Brand
ARAZLO	TAZAROTENE (ACNE) LOTION 0.045%	90050027004120	Brand
TRETINOIN MICROSPHERE	TRETINOIN MICROSPHERE GEL 0.08%	90050030204020	Generic

Approval Criteria

1 - The patient has a non-cosmetic medical condition (e.g., acne vulgaris, psoriasis, precancerous skin lesions) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

AND

2 - Medication is not being requested solely for cosmetic purposes (e.g., photo-aging, wrinkling, hyperpigmentation, sun damage, melasma) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Patient has a diagnosis of acne vulgaris

AND

3.1.2 ONE of the following:

3.1.2.1 Failure to a trial of BOTH of the following as confirmed by claims history or submission of medical records:

- Differin OTC (over the counter)
- Tretinoin cream (generic Retin-A cream)

OR

3.1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Differin OTC
- Tretinoin cream (generic Retin-A cream)

OR

3.2 BOTH of the following:

3.2.1 Patient does NOT have a diagnosis of acne vulgaris

AND

3.2.2 ONE of the following:

3.2.2.1 Failure to a trial of at least THREE preferred* products as confirmed by claims history or submission of medical records

OR

3.2.2.2 History of intolerance or contraindication to ALL preferred* products (please specify intolerance or contraindication)	
Notes	*Step therapy is not limited to topical steroids. In instances where there are fewer than three preferred alternatives, the patient must have a history of failure, contraindication, or intolerance to ALL of the preferred products. *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: generic tretinoin cream	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRETINOIN	TRETINOIN CREAM 0.025%	90050030003703	Generic
TRETINOIN	TRETINOIN CREAM 0.05%	90050030003705	Generic
TRETINOIN	TRETINOIN CREAM 0.1%	90050030003710	Generic

Approval Criteria

1 - Patient is less than 18 years old

OR

2 - ALL of the following:

2.1 Patient is 18 years of age or older

AND

2.2 Patient has a non-cosmetic medical condition (e.g., acne vulgaris, psoriasis, precancerous skin lesions) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

AND

2.3 Medication is not being requested solely for cosmetic purposes (e.g., photo-aging, wrinkling, hyperpigmentation, sun damage, melasma) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

2 . Background

Benefit/Coverage/Program Information

Table 1: Examples of non-cosmetic medical conditions include, but are not limited to, the following:

Acanthosis nigricans	Keratoderma
Acne	Keratoderma palmaris et plantaris
Acne keloidalis nuchae	Keratosis rubra figurata
Acne rosacea	Kyrle's disease
Acne vulgaris	Lamellar ichthyosis
Actinic cheilitis	Leukoplakia
Actinic dermatitis	Lichen planus
Actinic keratosis	Mal de Meleda
	Malignancy
Basal cell carcinoma	Mendes da Costa syndrome
Bowen's disease	Molluscum contagiosum
Cystic acne	Non-bullous congenital ichthyosis
Darier's disease	Papillon-Lefevre syndrome
Darier-White Disease	Porokeratosis
Dermal mucinosis	Pseudofollicular barbae
Discoid lupus erythematosus	Pseudoacanthosis nigricans
Epidermoid cysts	Psoriasis
Epidermolytic hyperkeratosis	Psoriasis erythrodermic, palmoplantar

Erythrokeratoderma variabilis	Psoriasis pustular
Favre Racouchot disease	Psoriatic arthritis
Flat warts	Rosacea
Folliculitis	Sebaceous cysts
Fox Fordyce disease	Senile keratosis
Grover's disease	Solar keratosis
Hidradenitis suppurativa	Squamous cell carcinoma
Hyperkeratosis	Systematized epidermal nevus
Hyperkeratosis follicularis	Transient acantholytic dermatosis
Hyperkeratotic eczema	Tylotic eczema
Ichthyoses	X-linked ichthyosis
Ichthyosis vulgaris	Verruca planae
Keloid scar	Von Zumbusch pustular
Keratoacanthoma	Warts
Keratosis follicularis	Wound healing (mild)

3 . Revision History

Date	Notes
6/26/2024	Table in background was missing. Added back.

Trelegy Ellipta, Breztri

Prior Authorization Guideline

Guideline ID	GL-146429
Guideline Name	Trelegy Ellipta, Breztri
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Trelegy Ellipta, Breztri Aerosphere	
Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRELEGY ELLIPTA	FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 100-62.5-25 MCG/ACT	44209903408020	Brand
TRELEGY ELLIPTA	FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 200-62.5-25 MCG/ACT	44209903408040	Brand
BREZTRI AEROSPHERE	BUDESONIDE-GLYCOPYRROLATE-FORMOTEROL AERS 160-9-4.8 MCG/ACT	44209903303220	Brand

Approval Criteria

1 - Diagnosis of chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema

AND

2 - ONE of the following:

2.1 Failure to a 30 day trial of ONE of the following combinations as confirmed by claims history or submission of medical records:

2.1.1 ONE of the following long-acting muscarinic antagonist (LAMA) plus long-acting beta2-agonist (LABA)

- Anoro Ellipta (umeclidinium/vilanterol)
- Stiolto Respimat (tiotropium/olodaterol)

OR

2.1.2 ONE of the following inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA)

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify intolerance or contraindication):

- Anoro Ellipta (umeclidinium/vilanterol)
- Stiolto Respimat (tiotropium/olodaterol)
- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.3 Eosinophil count greater than or equal to 300 cells/microliter as confirmed by submission of medical records

Product Name: Trelegy Ellipta, Breztri Aerosphere	
Diagnosis	Asthma
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRELEGY ELLIPTA	FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 100-62.5-25 MCG/ACT	44209903408020	Brand
TRELEGY ELLIPTA	FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 200-62.5-25 MCG/ACT	44209903408040	Brand
BREZTRI AEROSPHERE	BUDESONIDE-GLYCOPYRROLATE-FORMOTEROL AERS 160-9-4.8 MCG/ACT	44209903303220	Brand

Approval Criteria

1 - Diagnosis of asthma

AND

2 - ONE of the following:

2.1 Failure to treatment with at least a 30-day trial of ONE of the following, confirmed by claims history or submission of medical records:

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify intolerance or contraindication):

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

Triptans

Prior Authorization Guideline

Guideline ID	GL-146927
Guideline Name	Triptans
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic naratriptan	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
NARATRIPTAN HCL	NARATRIPTAN HCL TAB 1 MG (BASE EQUIV)	67406050100310	Generic
NARATRIPTAN HCL	NARATRIPTAN HCL TAB 2.5 MG (BASE EQUIV)	67406050100320	Generic

Approval Criteria

1 - Diagnosis of migraine headaches with or without aura

AND

2 - ONE of the following:

2.1 Failure to sumatriptan (generic Imitrex) tablets at a minimum dose of 50 mg (milligrams) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to sumatriptan (generic Imitrex) tablets (please specify intolerance or contraindication)

Product Name: almotriptan, generic eletriptan, Brand Relpax, generic frovatriptan, Brand Frova, Onzetra XSail, generic rizatriptan, Brand Maxalt, generic rizatriptan ODT, Brand Maxalt-MLT, Imitrex Statdose System, sumatriptan auto-inj, Brand Imitrex nasal spr/tabs, generic sumatriptan nasal spr/tabs/inj, Brand Imitrex Statdose Refill, generic sumatriptan refill, generic sumatriptan/naproxen, Brand Treximet, Zembrace Symtouch, generic zolmitriptan tabs/nasal spr, Brand Zomig tabs/nasal spr, Brand Zolmitriptan nasal spr, zolmitriptan ODT, Tosymra, Brand Amerge	
Diagnosis	Non-Preferred Products*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALMOTRIPTAN	ALMOTRIPTAN MALATE TAB 6.25 MG	67406010100320	Generic
ALMOTRIPTAN MALATE	ALMOTRIPTAN MALATE TAB 6.25 MG	67406010100320	Generic
ALMOTRIPTAN	ALMOTRIPTAN MALATE TAB 12.5 MG	67406010100330	Generic
ALMOTRIPTAN MALATE	ALMOTRIPTAN MALATE TAB 12.5 MG	67406010100330	Generic
ELETRIPTAN HYDROBROMIDE	ELETRIPTAN HYDROBROMIDE TAB 20 MG (BASE EQUIVALENT)	67406025100320	Generic
RELPAX	ELETRIPTAN HYDROBROMIDE TAB 20 MG (BASE EQUIVALENT)	67406025100320	Brand
ELETRIPTAN HYDROBROMIDE	ELETRIPTAN HYDROBROMIDE TAB 40 MG (BASE EQUIVALENT)	67406025100340	Generic

RELPAX	ELETRIPTAN HYDROBROMIDE TAB 40 MG (BASE EQUIVALENT)	67406025100340	Brand
FROVATRIPTAN SUCCINATE	FROVATRIPTAN SUCCINATE TAB 2.5 MG (BASE EQUIVALENT)	67406030100320	Generic
FROVA	FROVATRIPTAN SUCCINATE TAB 2.5 MG (BASE EQUIVALENT)	67406030100320	Brand
ONZETRA XSAIL	SUMATRIPTAN SUCCINATE EXHALER POWDER 11 MG/NOSEPIECE	6740607010G420	Brand
RIZATRIPTAN BENZOATE	RIZATRIPTAN BENZOATE TAB 5 MG (BASE EQUIVALENT)	67406060100310	Generic
MAXALT	RIZATRIPTAN BENZOATE TAB 10 MG (BASE EQUIVALENT)	67406060100320	Brand
RIZATRIPTAN BENZOATE	RIZATRIPTAN BENZOATE TAB 10 MG (BASE EQUIVALENT)	67406060100320	Generic
RIZATRIPTAN BENZOATE ODT	RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 5 MG (BASE EQ)	67406060107220	Generic
MAXALT-MLT	RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 10 MG (BASE EQ)	67406060107230	Brand
RIZATRIPTAN BENZOATE ODT	RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 10 MG (BASE EQ)	67406060107230	Generic
IMITREX STATDOSE SYSTEM	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML	6740607010D510	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML	6740607010D510	Generic
IMITREX STATDOSE SYSTEM	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML	6740607010D520	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML	6740607010D520	Generic
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE INJ 6 MG/0.5ML	67406070102010	Generic
IMITREX	SUMATRIPTAN NASAL SPRAY 5 MG/ACT	67406070002010	Brand
SUMATRIPTAN	SUMATRIPTAN NASAL SPRAY 5 MG/ACT	67406070002010	Generic
IMITREX	SUMATRIPTAN NASAL SPRAY 20 MG/ACT	67406070002040	Brand
SUMATRIPTAN	SUMATRIPTAN NASAL SPRAY 20 MG/ACT	67406070002040	Generic
IMITREX	SUMATRIPTAN SUCCINATE TAB 25 MG	67406070100305	Brand

SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE TAB 25 MG	67406070100305	Generic
IMITREX	SUMATRIPTAN SUCCINATE TAB 50 MG	67406070100310	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE TAB 50 MG	67406070100310	Generic
IMITREX	SUMATRIPTAN SUCCINATE TAB 100 MG	67406070100320	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE TAB 100 MG	67406070100320	Generic
IMITREX STATDOSE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML	6740607010E210	Brand
SUMATRIPTAN SUCCINATE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML	6740607010E210	Generic
IMITREX STATDOSE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML	6740607010E220	Brand
SUMATRIPTAN SUCCINATE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML	6740607010E220	Generic
SUMATRIPTAN/NAPROXEN SODIUM	SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG	67992002600320	Generic
TREXIMET	SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG	67992002600320	Brand
ZEMBRACE SYMTOUCH	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 3 MG/0.5ML	6740607010D505	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN TAB 2.5 MG	67406080000320	Generic
ZOMIG	ZOLMITRIPTAN TAB 2.5 MG	67406080000320	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN TAB 5 MG	67406080000330	Generic
ZOMIG	ZOLMITRIPTAN TAB 5 MG	67406080000330	Brand
ZOLMITRIPTAN ODT	ZOLMITRIPTAN ORALLY DISINTEGRATING TAB 2.5 MG	67406080007220	Generic
ZOLMITRIPTAN ODT	ZOLMITRIPTAN ORALLY DISINTEGRATING TAB 5 MG	67406080007230	Generic
ZOMIG	ZOLMITRIPTAN NASAL SPRAY 2.5 MG/SPRAY UNIT	67406080002010	Brand
ZOMIG	ZOLMITRIPTAN NASAL SPRAY 5 MG/SPRAY UNIT	67406080002020	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN NASAL SPRAY 5 MG/SPRAY UNIT	67406080002020	Generic
TOSYMRA	SUMATRIPTAN NASAL SPRAY 10 MG/ACT	67406070002020	Brand
AMERGE	NARATRIPTAN HCL TAB 1 MG (BASE EQUIV)	67406050100310	Brand

AMERGE	NARATRIPTAN HCL TAB 2.5 MG (BASE EQUIV)	67406050100320	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN NASAL SPRAY 2.5 MG/SPRAY UNIT	67406080002010	Generic

Approval Criteria

1 - If the requested medication is non-preferred*, BOTH of the following:

1.1 Diagnosis of migraine headaches with or without aura

AND

1.2 ONE of the following:

1.2.1 Patient has failure to ALL of the following as confirmed by claims history or submission of medical records:

- Naratriptan
- Rizatriptan
- One of the following sumatriptan formulations: tablets, nasal spray, 4 mg injection, or 6 mg injection

OR

1.2.2 Patient has a history of contraindication or intolerance to ALL of the following (please specify intolerance or contraindication):

- Naratriptan
- Rizatriptan
- One of the following sumatriptan formulations: tablets, nasal spray, 4 mg injection, or 6 mg injection

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Imitrex Statdose System, sumatriptan auto-inj, sumatriptan inj, Brand Imitrex Statdose Refill, generic sumatriptan refill	
Diagnosis	Migraine Headaches

Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
IMITREX STATDOSE SYSTEM	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML	6740607010D510	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML	6740607010D510	Generic
IMITREX STATDOSE SYSTEM	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML	6740607010D520	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML	6740607010D520	Generic
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE INJ 6 MG/0.5ML	67406070102010	Generic
IMITREX STATDOSE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML	6740607010E210	Brand
SUMATRIPTAN SUCCINATE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML	6740607010E210	Generic
IMITREX STATDOSE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML	6740607010E220	Brand
SUMATRIPTAN SUCCINATE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML	6740607010E220	Generic

Approval Criteria

1 - Diagnosis of migraine headaches with or without aura

AND

2 - Currently receiving prophylactic therapy with at least ONE of the following as confirmed by claims history or submission of medical records:

- Amitriptyline (generic Elavil)
- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol*
- Candesartan* (generic Atacand)
- Divalproex sodium (generic Depakote/Depakote ER)

- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)
- Calcitonin gene-related peptide (CGRP) receptor antagonists [e.g., Aimovig (erenumab), Emgality (galcanezumab)]

AND

3 - ONE of the following:

3.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

3.2 Higher dose or quantity is supported by one of the following compendia:

- American Hospital Formulary Service Drug Information
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

OR

3.3 Provider provides evidence from published biomedical literature to support safety and additional efficacy at doses/quantities greater than those approved by the FDA for the diagnosis indicated

AND

4 - Provider acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes	See Table 1 in Background *Timolol, candesartan are non-preferred and should not be included in denial to provider. **This is a medical benefit, should not be included in denial to provider.

Product Name: Imitrex Statdose System, sumatriptan auto-inj, sumatriptan inj, Brand Imitrex Statdose Refill, generic sumatriptan refill	
Diagnosis	Cluster Headaches
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
IMITREX STATDOSE SYSTEM	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML	6740607010D510	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML	6740607010D510	Generic
IMITREX STATDOSE SYSTEM	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML	6740607010D520	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML	6740607010D520	Generic
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE INJ 6 MG/0.5ML	67406070102010	Generic
IMITREX STATDOSE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML	6740607010E210	Brand
SUMATRIPTAN SUCCINATE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML	6740607010E210	Generic
IMITREX STATDOSE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML	6740607010E220	Brand
SUMATRIPTAN SUCCINATE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML	6740607010E220	Generic

Approval Criteria

1 - Diagnosis of cluster headaches

AND

2 - Patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months

<table>
<tr><td colspan="2">

AND

3 - ONE of the following:

3.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

3.2 Higher dose or quantity is supported by one of the following compendia:

- American Hospital Formulary Service Drug Information
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

OR

3.3 Provider provides evidence from published biomedical literature to support safety and additional efficacy at doses/quantities greater than those approved by the FDA for the diagnosis indicated

AND

4 - Provider acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity
</td></tr>
<tr><td>Notes</td><td>See Table 1 in Background</td></tr>
</table>

Product Name: almotriptan, generic eletriptan, Brand Relpax, generic frovatriptan, Brand Frova, Onzetra XSail, generic rizatriptan, Brand Maxalt, generic rizatriptan ODT, Brand Maxalt-MLT, Brand Imitrex nasal spr/tabs, generic sumatriptan nasal spr/tabs, generic sumatriptan/naproxen, Brand Treximet, Zembrace Symtouch, generic zolmitriptan tabs/nasal spr, Brand Zomig tabs/nasal spr, Brand Zolmitriptan nasal spr, zolmitriptan ODT, Tosymra, Brand Amerge	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
ALMOTRIPTAN	ALMOTRIPTAN MALATE TAB 6.25 MG	67406010100320	Generic
ALMOTRIPTAN MALATE	ALMOTRIPTAN MALATE TAB 6.25 MG	67406010100320	Generic
ALMOTRIPTAN	ALMOTRIPTAN MALATE TAB 12.5 MG	67406010100330	Generic
ALMOTRIPTAN MALATE	ALMOTRIPTAN MALATE TAB 12.5 MG	67406010100330	Generic
ELETRIPTAN HYDROBROMIDE	ELETRIPTAN HYDROBROMIDE TAB 20 MG (BASE EQUIVALENT)	67406025100320	Generic
RELPAX	ELETRIPTAN HYDROBROMIDE TAB 20 MG (BASE EQUIVALENT)	67406025100320	Brand
ELETRIPTAN HYDROBROMIDE	ELETRIPTAN HYDROBROMIDE TAB 40 MG (BASE EQUIVALENT)	67406025100340	Generic
RELPAX	ELETRIPTAN HYDROBROMIDE TAB 40 MG (BASE EQUIVALENT)	67406025100340	Brand
FROVATRIPTAN SUCCINATE	FROVATRIPTAN SUCCINATE TAB 2.5 MG (BASE EQUIVALENT)	67406030100320	Generic
FROVA	FROVATRIPTAN SUCCINATE TAB 2.5 MG (BASE EQUIVALENT)	67406030100320	Brand
NARATRIPTAN HCL	NARATRIPTAN HCL TAB 1 MG (BASE EQUIV)	67406050100310	Generic
NARATRIPTAN HCL	NARATRIPTAN HCL TAB 2.5 MG (BASE EQUIV)	67406050100320	Generic
ONZETRA XSAIL	SUMATRIPTAN SUCCINATE EXHALER POWDER 11 MG/NOSEPIECE	6740607010G420	Brand
RIZATRIPTAN BENZOATE	RIZATRIPTAN BENZOATE TAB 5 MG (BASE EQUIVALENT)	67406060100310	Generic
MAXALT	RIZATRIPTAN BENZOATE TAB 10 MG (BASE EQUIVALENT)	67406060100320	Brand
RIZATRIPTAN BENZOATE	RIZATRIPTAN BENZOATE TAB 10 MG (BASE EQUIVALENT)	67406060100320	Generic
RIZATRIPTAN BENZOATE ODT	RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 5 MG (BASE EQ)	67406060107220	Generic
MAXALT-MLT	RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 10 MG (BASE EQ)	67406060107230	Brand
RIZATRIPTAN BENZOATE ODT	RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 10 MG (BASE EQ)	67406060107230	Generic
IMITREX	SUMATRIPTAN NASAL SPRAY 5 MG/ACT	67406070002010	Brand

SUMATRIPTAN	SUMATRIPTAN NASAL SPRAY 5 MG/ACT	67406070002010	Generic
IMITREX	SUMATRIPTAN NASAL SPRAY 20 MG/ACT	67406070002040	Brand
SUMATRIPTAN	SUMATRIPTAN NASAL SPRAY 20 MG/ACT	67406070002040	Generic
IMITREX	SUMATRIPTAN SUCCINATE TAB 25 MG	67406070100305	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE TAB 25 MG	67406070100305	Generic
IMITREX	SUMATRIPTAN SUCCINATE TAB 50 MG	67406070100310	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE TAB 50 MG	67406070100310	Generic
IMITREX	SUMATRIPTAN SUCCINATE TAB 100 MG	67406070100320	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE TAB 100 MG	67406070100320	Generic
SUMATRIPTAN/NAPROXEN SODIUM	SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG	67992002600320	Generic
TREXIMET	SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG	67992002600320	Brand
ZEMBRACE SYMTOUCH	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 3 MG/0.5ML	6740607010D505	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN TAB 2.5 MG	67406080000320	Generic
ZOMIG	ZOLMITRIPTAN TAB 2.5 MG	67406080000320	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN TAB 5 MG	67406080000330	Generic
ZOMIG	ZOLMITRIPTAN TAB 5 MG	67406080000330	Brand
ZOLMITRIPTAN ODT	ZOLMITRIPTAN ORALLY DISINTEGRATING TAB 2.5 MG	67406080007220	Generic
ZOLMITRIPTAN ODT	ZOLMITRIPTAN ORALLY DISINTEGRATING TAB 5 MG	67406080007230	Generic
ZOMIG	ZOLMITRIPTAN NASAL SPRAY 2.5 MG/SPRAY UNIT	67406080002010	Brand
ZOMIG	ZOLMITRIPTAN NASAL SPRAY 5 MG/SPRAY UNIT	67406080002020	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN NASAL SPRAY 5 MG/SPRAY UNIT	67406080002020	Generic
TOSYMRA	SUMATRIPTAN NASAL SPRAY 10 MG/ACT	67406070002020	Brand
AMERGE	NARATRIPTAN HCL TAB 1 MG (BASE EQUIV)	67406050100310	Brand

AMERGE	NARATRIPTAN HCL TAB 2.5 MG (BASE EQUIV)	67406050100320	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN NASAL SPRAY 2.5 MG/SPRAY UNIT	67406080002010	Generic

Approval Criteria

1 - Diagnosis of migraine headaches with or without aura

AND

2 - Currently receiving prophylactic therapy with at least ONE of the following as confirmed by claims history or submission of medical records:

- Amitriptyline (generic Elavil)
- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol*
- Candesartan* (generic Atacand)
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)
- Calcitonin gene-related peptide (CGRP) receptor antagonists [e.g., Aimovig (erenumab), Emgality (galcanezumab)]

AND

3 - ONE of the following:

3.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

3.2 Higher dose or quantity is supported by one of the following compendia:

- American Hospital Formulary Service Drug Information
- Thomson Micromedex DrugDex
- Clinical pharmacology

• United States Pharmacopoeia-National Formulary (USP-NF) **OR** **3.3** Provider provides evidence from published biomedical literature to support safety and additional efficacy at doses/quantities greater than those approved by the FDA for the diagnosis indicated **AND** **4** - Provider acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes	See Table 1 in Background *Timolol, candesartan are non-preferred and should not be included in denial to provider. **This is a medical benefit, should not be included in denial to provider .

2 . Background

Benefit/Coverage/Program Information

Table 1. Quantity Limits

Drug Name	Strength	Quantity Limit
Brand Amerge generic naratriptan	1mg, 2.5mg	9 tabs/month
Brand Frova Generic frovatriptan	2.5mg	9 tabs/month

Brand Imitrex tablets Generic sumatriptan tablets	25mg, 50mg, 100mg	9 tabs/month
Brand Maxalt Generic rizatriptan	5mg, 10mg	9 tabs/month
Brand Maxalt MLT Generic rizatriptan ODT	5mg, 10mg	9 tabs/month
Generic almotriptan	6.25mg, 12.5mg	6 tabs/month
Relpax Generic eletriptan	20mg, 40mg	6 tabs/month
Brand Zomig Generic zolmitriptan	2.5mg, 5mg	6 tabs/month
Brand Zomig ZMT Generic zolmitriptan ODT	2.5mg, 5mg	6 tabs/month
Brand Imitrex nasal spray Generic sumatriptan nasal spray	5mg, 20mg	6 spray devices/month
Zomig nasal spray	2.5mg, 5mg	6 spray devices/month
Treximet Generic sumatriptan/naproxen	85mg/500 mg, 10mg/60mg	9 tabs/month
Onzetra Xsail	11mg	1 box (8 units)/month
Zembrace SymTouch	3mg/0.5mL	2 boxes (8 units)/month

Brand Imitrex Generic Sumatriptan Autoinjector/Cartridge Refills	4mg/0.5mL 6mg/0.5mL	8 autoinjectors or cartridge refills/month (4 boxes/month)
Brand Imitrex Generic Sumatriptan Vials	6mg/0.5mL	10 vials/month (2 boxes/month)
Generic Sumatriptan Pre-filled Syringe	6mg/0.5mL	8 prefilled syringes (4 boxes/month)
Tosymra nasal spray	10mg	6 units per month

3. Revision History

Date	Notes
5/1/2024	Added NM PDL Link

Upneeq

Prior Authorization Guideline

Guideline ID	GL-146431
Guideline Name	Upneeq
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Upneeq	
Diagnosis	Acquired Blepharoptosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
UPNEEQ	OXYMETAZOLINE HCL OPHTH SOLN 0.1%	86802236102020	Brand

Approval Criteria

1 - Diagnosis of acquired blepharoptosis

AND

2 - Patient has a functional impairment related to the position of the eyelid

AND

3 - ONE of the following:

3.1 Marginal reflex distance-1 (MRD-1) is less than or equal to 2 millimeters (mm) in primary gaze

OR

3.2 Marginal reflex distance-1 (MRD-1) is less than or equal to 2 mm in down gaze

OR

3.3 Superior visual field loss of at least 12 degrees or 24 percent

AND

4 - Other treatable causes of blepharoptosis have been ruled out (e.g., recent botulinum toxin injections, myasthenia gravis)

Product Name: Upneeq	
Diagnosis	Acquired Blepharoptosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

UPNEEQ	OXYMETAZOLINE HCL OPHTH SOLN 0.1%	86802236102020	Brand

Approval Criteria

1 - Documentation of a positive clinical response to therapy

Vancomycin

Prior Authorization Guideline

Guideline ID	GL-146432
Guideline Name	Vancomycin
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Firvanq, Brand Vancomycin oral soln, Brand Vancocin, generic vancomycin caps	
Diagnosis	Clostridioides Difficile-Associated Diarrhea (CDAD) [Previously Known as Clostridium Difficile-Associated Diarrhea]
Approval Length	10 Day(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL FOR ORAL SOLN 25 MG/ML (BASE EQUIVALENT)	16280080102160	Generic
FIRVANQ	VANCOMYCIN HCL FOR ORAL SOLN 25 MG/ML (BASE EQUIVALENT)	16280080102160	Generic

VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL FOR ORAL SOLN 50 MG/ML (BASE EQUIVALENT)	16280080102170	Generic
FIRVANQ	VANCOMYCIN HCL FOR ORAL SOLN 50 MG/ML (BASE EQUIVALENT)	16280080102170	Generic
VANCOCIN	VANCOMYCIN HCL CAP 125 MG (BASE EQUIVALENT)	16280080100110	Brand
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL CAP 125 MG (BASE EQUIVALENT)	16280080100110	Generic
VANCOCIN	VANCOMYCIN HCL CAP 250 MG (BASE EQUIVALENT)	16280080100120	Brand
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL CAP 250 MG (BASE EQUIVALENT)	16280080100120	Generic

Approval Criteria

1 - Diagnosis of Clostridioides difficile-associated diarrhea (CDAD) [previously known as Clostridium difficile-associated diarrhea]

AND

2 - If the request is for Brand Vancocin, generic vancomycin capsules, or vancomycin oral solution, the prescriber provides a reason or special circumstance the patient cannot use Firvanq* (document reason why patient is unable to use Firvanq)

Notes	*Brand Vancocin, generic vancomycin capsules, and vancomycin oral solution are non-preferred. Firvanq is preferred.

Product Name: Firvanq, Brand Vancomycin oral soln, Brand Vancocin, generic vancomycin caps	
Diagnosis	Clostridioides Difficile-Associated Diarrhea (CDAD) [Previously Known as Clostridium Difficile-Associated Diarrhea]
Approval Length	12 Week(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL FOR ORAL SOLN 25 MG/ML (BASE EQUIVALENT)	16280080102160	Generic
FIRVANQ	VANCOMYCIN HCL FOR ORAL SOLN 25 MG/ML (BASE EQUIVALENT)	16280080102160	Generic

VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL FOR ORAL SOLN 50 MG/ML (BASE EQUIVALENT)	16280080102170	Generic
FIRVANQ	VANCOMYCIN HCL FOR ORAL SOLN 50 MG/ML (BASE EQUIVALENT)	16280080102170	Generic
VANCOCIN	VANCOMYCIN HCL CAP 125 MG (BASE EQUIVALENT)	16280080100110	Brand
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL CAP 125 MG (BASE EQUIVALENT)	16280080100110	Generic
VANCOCIN	VANCOMYCIN HCL CAP 250 MG (BASE EQUIVALENT)	16280080100120	Brand
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL CAP 250 MG (BASE EQUIVALENT)	16280080100120	Generic

Approval Criteria

1 - Recurrence of Clostridioides difficile infection [previously known as Clostridium difficile-associated diarrhea] after prior treatment with oral vancomycin

AND

2 - If the request is for Brand Vancocin, generic vancomycin capsules, or vancomycin oral solution, the prescriber provides a reason or special circumstance the patient cannot use Firvanq* (document reason why patient is unable to use Firvanq)

Notes	*Brand Vancocin, generic vancomycin capsules, and vancomycin oral solution are non-preferred. Firvanq is preferred.

Product Name: Firvanq, Brand Vancomycin oral soln, Brand Vancocin, generic vancomycin caps	
Diagnosis	Staphylococcal Enterocolitis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL FOR ORAL SOLN 25 MG/ML (BASE EQUIVALENT)	16280080102160	Generic
FIRVANQ	VANCOMYCIN HCL FOR ORAL SOLN 25 MG/ML (BASE EQUIVALENT)	16280080102160	Generic
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL FOR ORAL SOLN 50 MG/ML (BASE EQUIVALENT)	16280080102170	Generic

FIRVANQ	VANCOMYCIN HCL FOR ORAL SOLN 50 MG/ML (BASE EQUIVALENT)	16280080102170	Generic
VANCOCIN	VANCOMYCIN HCL CAP 125 MG (BASE EQUIVALENT)	16280080100110	Brand
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL CAP 125 MG (BASE EQUIVALENT)	16280080100110	Generic
VANCOCIN	VANCOMYCIN HCL CAP 250 MG (BASE EQUIVALENT)	16280080100120	Brand
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL CAP 250 MG (BASE EQUIVALENT)	16280080100120	Generic

Approval Criteria

1 - Diagnosis of enterocolitis due to Staphylococcus aureus

AND

2 - If the request is for Brand Vancocin, generic vancomycin capsules, or vancomycin oral solution, the prescriber provides a reason or special circumstance the patient cannot use Firvanq* (document reason why patient is unable to use Firvanq)

Notes	*Brand Vancocin, generic vancomycin capsules, and vancomycin oral solution are non-preferred. Firvanq is preferred.

Veozah

Prior Authorization Guideline

Guideline ID	GL-146433
Guideline Name	Veozah
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Veozah	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VEOZAH	FEZOLINETANT TAB 45 MG	30606030000320	Brand

Approval Criteria

1 - Diagnosis of moderate to severe vasomotor symptoms due to menopause

AND

2 - One of the following:

2.1 Failure (after a 30-day trial) to ONE of the following as confirmed by claims history or submission of medical records:

- Hormonal therapy (e.g., estradiol, Premarin, Prempro)
- Non-hormonal therapy [e.g., clonidine, gabapentin, selective serotonin inhibitors (e.g., paroxetine), serotonin and norepinephrine reuptake inhibitors (e.g., venlafaxine)]

OR

2.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Hormonal therapy (e.g., estradiol, Premarin, Prempro)
- Non-hormonal therapy [e.g., clonidine, gabapentin, selective serotonin inhibitors (e.g., paroxetine), serotonin and norepinephrine reuptake inhibitors (e.g., venlafaxine)]

Product Name: Veozah	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VEOZAH	FEZOLINETANT TAB 45 MG	30606030000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., decrease in frequency and severity of vasomotor symptoms from baseline)

Verkazia

Prior Authorization Guideline

Guideline ID	GL-146434
Guideline Name	Verkazia
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Verkazia, Cyclosporine in Klarity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERKAZIA	CYCLOSPORINE (OPHTH) EMULSION 0.1%	86720020001630	Brand
CYCLOSPORINE IN KLARITY	CYCLOSPORINE (OPHTH) EMULSION 0.1%	86720020001630	Brand

Approval Criteria

1 - Diagnosis of moderate to severe vernal keratoconjunctivitis

AND

2 - ONE of the following:

2.1 Failure to TWO of the following categories as confirmed by claims history or submission of medical records:

- Ophthalmic antihistamines (e.g., azelastine, olopatadine)
- Ophthalmic mast cell stabilizers (e.g., cromolyn sodium)
- Ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluorometholone)

OR

2.2 History of intolerance or contraindication to ALL of the following categories (please specify intolerance or contraindication):

- Ophthalmic antihistamines (e.g., azelastine, olopatadine)
- Ophthalmic mast cell stabilizers (e.g., cromolyn sodium)
- Ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluorometholone)

Product Name: Verkazia, Cyclosporine in Klarity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERKAZIA	CYCLOSPORINE (OPHTH) EMULSION 0.1%	86720020001630	Brand
CYCLOSPORINE IN KLARITY	CYCLOSPORINE (OPHTH) EMULSION 0.1%	86720020001630	Brand

Approval Criteria

1 - Documentation of positive clinical response

Verquvo

Prior Authorization Guideline

Guideline ID	GL-146436
Guideline Name	Verquvo
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Verquvo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERQUVO	VERICIGUAT TAB 2.5 MG	40900085000321	Brand
VERQUVO	VERICIGUAT TAB 5 MG	40900085000330	Brand
VERQUVO	VERICIGUAT TAB 10 MG	40900085000340	Brand

Approval Criteria

1 - Diagnosis of heart failure

AND

2 - Ejection fraction is less than 45 percent

AND

3 - Heart failure is classified as ONE of the following:

- New York Heart Association Class II
- New York Heart Association Class III
- New York Heart Association Class IV

AND

4 - ONE of the following:

4.1 Hospitalization for heart failure within the past six months

OR

4.2 Outpatient IV (intravenous) diuretics for heart failure within the past three months

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated beta-blocker (e.g., bisoprolol, carvedilol, metoprolol) confirmed by claims history or submission of medical records

OR

5.2 Patient has a contraindication or intolerance to beta-blocker therapy (please specify intolerance or contraindication)

AND

6 - ONE of the following:

6.1 Patient is on a stabilized dose and receiving concomitant therapy with one of the following confirmed by claims history or submission of medical records:

- Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Angiotensin II receptor blocker (ARB) (e.g., losartan)
- Angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., Entresto)

OR

6.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify intolerance or contraindication)

AND

7 - ONE of the following:

7.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated aldosterone antagonist (e.g., spironolactone) confirmed by claims history or submission of medical records

OR

7.2 Patient has a contraindication or intolerance to aldosterone antagonist therapy (please specify intolerance or contraindication)

AND

8 - ONE of the following:

8.1 Patient is on a stabilized dose and receiving concomitant therapy with a sodium-glucose

cotransporter 2 (SGLT2) inhibitor indicated for heart failure (e.g., Farxiga) confirmed by claims history or submission of medical records

OR

8.2 Patient has a contraindication or intolerance to SGLT2 inhibitor therapy (please specify intolerance or contraindication)

AND

9 - Verquvo is prescribed by or in consultation with a cardiologist

Product Name: Verquvo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERQUVO	VERICIGUAT TAB 2.5 MG	40900085000321	Brand
VERQUVO	VERICIGUAT TAB 5 MG	40900085000330	Brand
VERQUVO	VERICIGUAT TAB 10 MG	40900085000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Vivjoa

Prior Authorization Guideline

Guideline ID	GL-146437
Guideline Name	Vivjoa
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Vivjoa	
Approval Length	4 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIVJOA	OTESECONAZOLE CAP THERAPY PACK 150 MG (12 WEEKS)	1140805000B220	Brand

Approval Criteria

1 - Diagnosis of recurrent vulvovaginal candidiasis

AND

2 - Patient is not of reproductive potential (i.e., persons who are biological females who are postmenopausal or have another reason for permanent infertility [(e.g., tubal ligation, hysterectomy, salpingo-oophorectomy)]

AND

3 - BOTH of the following:

3.1 Other causes (including but not limited to bacterial vaginosis or trichomoniasis) have been ruled out

AND

3.2 Failure of a maintenance course of oral fluconazole defined as 100-mg, 150-mg, or 200-mg taken weekly for 6 months confirmed by claims history or submission of medical records.

AND

4 - Prescribed by, or in consultation with, one of the following:

- Infectious disease physician
- Obstetrician/Gynecologist

Vtama

Prior Authorization Guideline

Guideline ID	GL-146438
Guideline Name	Vtama
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Vtama	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VTAMA	TAPINAROF CREAM 1%	90250075003720	Brand

Approval Criteria

1 - Diagnosis of plaque psoriasis

AND

2 - ONE of the following:

2.1 Failure to a minimum duration of a 4-week trial to TWO of the following topical therapies as confirmed by claims history or submission of medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

2.2 History of intolerance or contraindication to ALL of the following topical therapies (please specify intolerance or contraindication):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

3 - Patient is NOT receiving Vtama in combination with any a Targeted Immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

4 - Prescribed by, or in consultation with, a dermatologist

Product Name: Vtama

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VTAMA	TAPINAROF CREAM 1%	90250075003720	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is NOT receiving Vtama in combination with a Targeted Immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

Xarelto

Prior Authorization Guideline

Guideline ID	GL-146440
Guideline Name	Xarelto
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Continuation of Therapy Upon Hospital Discharge
Approval Length	35 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand

XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Xarelto will be approved as continuation of therapy upon hospital discharge

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Stroke and Systemic Embolism Prevention in Adult Patients with Non-Valvular Atrial Fibrillation (AF)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Diagnosis of atrial fibrillation (AF)

AND

2 - Patient does not have an artificial heart valve

AND

3 - ONE of the following:

3.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Eliquis
- Savaysa

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Eliquis
- Savaysa

OR

3.3 Continuation of prior Xarelto therapy

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Prophylaxis of Venous Thromboembolism (VTE) after Orthopedic Surgery (Hip Replacement or Knee Replacement) in Adult Patients
Approval Length	35 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - ONE of the following:

1.1 Patient has or is scheduled to have total knee replacement surgery

OR

1.2 Patient has or is scheduled to have total hip replacement surgery

AND

2 - Patient does not have an artificial heart valve

AND

3 - ONE of the following:

3.1 Xarelto is being prescribed as continuation of therapy following hospitalization after orthopedic surgery

OR

3.2 Provider provides reason or special circumstance why the patient is unable to use Eliquis

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Treatment of Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) in Adult Patients
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Deep vein thrombosis (DVT)
- Pulmonary embolism (PE)

AND

2 - Patient does not have an artificial heart valve

AND

3 - ONE of the following:

3.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Eliquis
- Savaysa

OR

3.2 History on intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Eliquis
- Savaysa

OR

3.3 Continuation of prior Xarelto therapy

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Reduction in the Risk of Recurrence of Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) in Adult Patients
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Previous diagnosis of ONE of the following:

- Deep vein thrombosis (DVT)
- Pulmonary embolism (PE)

AND

2 - Patient does not have an artificial heart valve

AND

2 - Patient must have been treated with an anticoagulant [e.g., warfarin, Eliquis (apixaban)] for

at least 6 months prior to request as confirmed by claims history or submission of medical records

AND

4 - ONE of the following:

4.1 Failure to Eliquis as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to Eliquis (please specify intolerance or contraindication)

OR

4.3 Continuation of prior Xarelto therapy

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Reduction in the Risk of Major Cardiovascular Events [Cardiovascular (CV) Death, Myocardial Infarction (MI) and Stroke] in Adult Patients with Chronic Coronary Artery Disease (CAD) or Peripheral Artery Disease (PAD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Chronic coronary artery disease (CAD)
- Peripheral artery disease (PAD)

AND

2 - Patient does not have an artificial heart valve

AND

3 - Patient is on concurrent aspirin therapy

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Prophylaxis of Venous Thromboembolism (VTE) in Acutely Ill Medical Adult Patients at Risk for Thromboembolic Complications Not at High Risk of Bleeding
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Patient was admitted to the hospital for an acute medical illness

AND

2 - Patient does not have an artificial heart valve

AND

2 - Patient is at risk of thromboembolic complications due to moderate or severe restricted mobility

AND

4 - Patient is not at high risk of bleeding

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Thromboprophylaxis in Pediatric Patients with Congenital Heart Disease After the Fontan Procedure
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Diagnosis of congenital heart disease

AND

2 - Patient does not have an artificial heart valve

AND

3 - Patient is at risk of thromboembolic complications due to Fontan procedure

AND

4 - Patient is 2 years to 17 years of age

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Treatment of VTE and Reduction in the Risk of Recurrent VTE in Pediatric Patients
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - The requested medication is being used for the treatment of venous thromboembolism (VTE) or the reduction in the risk of recurrent VTE

AND

2 - Patient does not have an artificial heart valve

AND

2 - Patient has received at least 5 days of initial parenteral anticoagulant treatment

AND

4 - Patient is 0 years to 17 years of age

Xdemvy

Prior Authorization Guideline

Guideline ID	GL-146441
Guideline Name	Xdemvy
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Xdemvy	
Approval Length	6 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XDEMVY	LOTILANER OPHTH SOLN 0.25%	86106050002020	Brand

Approval Criteria

1 - Diagnosis of Demodex blepharitis

AND

2 - Patient demonstrates ONE of the following signs of Demodex infestation:

- Cylindrical cuff at the root of the eyelashes
- Lid margin erythema
- Eyelash anomalies (e.g., eyelash misdirection, eyelash loss)

AND

3 - Patient demonstrates TWO of the following symptoms of Demodex infestation:

- Itching/Burning
- Foreign body sensation
- Crusting/matted lashes
- Blurry vision
- Discomfort/irritation
- Tearing/lacrimation
- Dryness
- Purulence/discharge

AND

4 - Patient is practicing good eye-lid hygiene (e.g., non-prescription tree-tea oil)

AND

5 - Prescribed by or in consultation with ONE of the following:

- Ophthalmologist
- Optometrist

Xenleta

Prior Authorization Guideline

Guideline ID	GL-146442
Guideline Name	Xenleta
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Xenleta	
Diagnosis	Community-acquired bacterial pneumonia
Approval Length	7 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XENLETA	LEFAMULIN ACETATE TAB 600 MG	16240040100320	Brand

Approval Criteria

1 - One of the following:

1.1 For continuation of therapy upon hospital discharge

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 All of the following:

1.3.1 Diagnosis of community-acquired bacterial pneumonia (CABP)

AND

1.3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Xenleta

AND

1.3.3 One of the following:

1.3.3.1 Failure to three of the following antibiotics or antibiotic regimens confirmed by claims history or submitted medical records:

- Amoxicillin
- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

OR

1.3.3.2 History of contraindication or intolerance to all of the following antibiotics or antibiotic regimens (please specify intolerance or contraindication):

- Amoxicillin

- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

Product Name: Xenleta	
Diagnosis	Off-Label Uses
Approval Length	Based on provider and IDSA recommended treatment durations, not to exceed 6 months
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XENLETA	LEFAMULIN ACETATE TAB 600 MG	16240040100320	Brand

Approval Criteria

1 - One of the following:

1.1 For continuation of therapy upon hospital discharge

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

Xifaxan

Prior Authorization Guideline

Guideline ID	GL-148288
Guideline Name	Xifaxan
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Xifaxan 200mg	
Diagnosis	Travelers' Diarrhea
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 200 MG	16000049000320	Brand

Approval Criteria

1 - Diagnosis of travelers' diarrhea

AND

2 - ONE of the following:

2.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- Azithromycin (generic Zithromax)
- Ciprofloxacin (generic Cipro)
- Levofloxacin (generic Levaquin)
- Ofloxacin (generic Floxin)

OR

2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Azithromycin (generic Zithromax)
- Ciprofloxacin (generic Cipro)
- Levofloxacin (generic Levaquin)
- Ofloxacin (generic Floxin)

Product Name: Xifaxan 550mg	
Diagnosis	Hepatic Encephalopathy (HE)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 550 MG	16000049000340	Brand

Approval Criteria

1 - Used for prophylaxis of hepatic encephalopathy (HE) recurrence

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Used as add-on therapy to lactulose, confirmed by claims history or submitted medical records
- Patient is unable to achieve an optimal clinical response with lactulose monotherapy, confirmed by claims history or submitted medical records

OR

2.2 History of contraindication or intolerance to lactulose (please specify intolerance or contraindication)

Product Name: Xifaxan 550mg	
Diagnosis	Hepatic Encephalopathy (HE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 550 MG	16000049000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xifaxan therapy

Product Name: Xifaxan 550mg	
Diagnosis	Irritable Bowel Syndrome with Diarrhea (IBS-D)
Approval Length	1 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 550 MG	16000049000340	Brand

Approval Criteria

1 - Diagnosis of irritable bowel syndrome with diarrhea (IBS-D)

AND

2 - ONE of the following:

2.1 Failure of ONE tricyclic antidepressant (e.g. amitriptyline) confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to tricyclic antidepressants (e.g. amitriptyline) (please specify intolerance or contraindication)

Product Name: Xifaxan 550mg	
Diagnosis	Irritable Bowel Syndrome with Diarrhea (IBS-D)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 550 MG	16000049000340	Brand

Approval Criteria

1 - Patient continues to need Xifaxan and has experienced positive results with prior use

Product Name: Xifaxan 200mg	
Diagnosis	Inflammatory Bowel Disease (e.g. Crohn's Disease, Ulcerative Colitis, Diverticulitis) (Off-label)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 200 MG	16000049000320	Brand

Approval Criteria

1 - Diagnosis of inflammatory bowel disease

AND

2 - ONE of the following:

2.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Ciprofloxacin (generic Cipro)
- Metronidazole (generic Flagyl)

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Ciprofloxacin (generic Cipro)
- Metronidazole (generic Flagyl)

Product Name: Xifaxan 200mg	
Diagnosis	Inflammatory Bowel Disease (e.g. Crohn's Disease, Ulcerative Colitis, Diverticulitis) (Off-label)

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 200 MG	16000049000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xifaxan therapy

2 . Revision History

Date	Notes
6/7/2024	Updated language from “Diagnosis of hepatic encephalopathy” to “Used for prophylaxis of hepatic encephalopathy (HE) recurrence” to align with PI; Minor cosmetic updates.

Xopenex Respules

Prior Authorization Guideline

Guideline ID	GL-146444
Guideline Name	Xopenex Respules
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Xopenex inhalation soln, generic levalbuterol inhalation soln	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
LEVALBUTEROL HCL	LEVALBUTEROL HCL SOLN NEBU 0.31 MG/3ML (BASE EQUIV)	44201045102510	Generic
LEVALBUTEROL HYDROCHLORIDE	LEVALBUTEROL HCL SOLN NEBU 0.31 MG/3ML (BASE EQUIV)	44201045102510	Generic
XOPENEX	LEVALBUTEROL HCL SOLN NEBU 0.31 MG/3ML (BASE EQUIV)	44201045102510	Brand
LEVALBUTEROL HCL	LEVALBUTEROL HCL SOLN NEBU 0.63 MG/3ML (BASE EQUIV)	44201045102520	Generic

LEVALBUTEROL HYDROCHLORIDE	LEVALBUTEROL HCL SOLN NEBU 0.63 MG/3ML (BASE EQUIV)	44201045102520	Generic
XOPENEX	LEVALBUTEROL HCL SOLN NEBU 0.63 MG/3ML (BASE EQUIV)	44201045102520	Brand
LEVALBUTEROL HCL	LEVALBUTEROL HCL SOLN NEBU 1.25 MG/3ML (BASE EQUIV)	44201045102530	Generic
LEVALBUTEROL HYDROCHLORIDE	LEVALBUTEROL HCL SOLN NEBU 1.25 MG/3ML (BASE EQUIV)	44201045102530	Generic
XOPENEX	LEVALBUTEROL HCL SOLN NEBU 1.25 MG/3ML (BASE EQUIV)	44201045102530	Brand
LEVALBUTEROL	LEVALBUTEROL HCL SOLN NEBU CONC 1.25 MG/0.5ML (BASE EQUIV)	44201045102560	Generic
XOPENEX CONCENTRATE	LEVALBUTEROL HCL SOLN NEBU CONC 1.25 MG/0.5ML (BASE EQUIV)	44201045102560	Brand

Approval Criteria

1 - Failure to treatment with albuterol inhalation solution, as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to albuterol inhalation solution (please specify contraindication or intolerance)

Zoryve

Prior Authorization Guideline

Guideline ID	GL-146446
Guideline Name	Zoryve
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Zoryve cream	
Diagnosis	Plaque Psoriasis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZORYVE	ROFLUMILAST CREAM 0.3%	90250045003720	Brand

Approval Criteria

1 - Diagnosis of plaque psoriasis

AND

2 - ONE of the following:

2.1 Submission of medical records or claims history confirming failure to a minimum duration of a 4-week trial to TWO of the following topical therapies:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

2.2 History of intolerance or contraindication to ALL of the following topical therapies (please specify intolerance or contraindication):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

3 - Patient is not receiving Zoryve cream in combination with ONE of the following:

- Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (Secukinumab), Stelara (Ustekinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

4 - Prescribed by, or in consultation with, a dermatologist

Product Name: Zoryve cream	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZORYVE	ROFLUMILAST CREAM 0.3%	90250045003720	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is not receiving Zoryve cream in combination with ONE of the following:

- Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (Secukinumab), Stelara (Ustekinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Product Name: Zoryve foam	
Diagnosis	Seborrheic dermatitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ZORYVE	ROFLUMILAST FOAM 0.3%	90300045003920	Brand

Approval Criteria

1 - Diagnosis of seborrheic dermatitis

AND

2 - ONE of the following:

2.1 Submission of medical records or claims history confirming failure to a minimum duration of a 4-week trial to TWO of the following topical therapies:

- Topical corticosteroids (e.g., betamethasone, hydrocortisone)
- Topical, shampoo, or systemic antifungals (e.g., ketoconazole, ciclopirox, itraconazole)
- Topical calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

OR

2.2 History of intolerance or contraindication to ALL of the following topical therapies (please specify intolerance or contraindication):

- Topical corticosteroids (e.g., betamethasone, hydrocortisone)
- Topical, shampoo, or systemic antifungals (e.g., ketoconazole, ciclopirox, itraconazole)
- Topical calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

3 - Patient is not receiving Zoryve foam in combination with ONE of the following:

- Biologic immunomodulator [e.g., Dupixent (dupilumab), Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

4 - Prescribed by, or in consultation with, one of the following:

- Dermatologist
- Allergist
- Immunologist

Product Name: Zoryve foam	
Diagnosis	Seborrheic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZORYVE	ROFLUMILAST FOAM 0.3%	90300045003920	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is not receiving Zoryve foam in combination with ONE of the following:

- Biologic immunomodulator [e.g., Dupixent (dupilumab), Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Zurzuvae

Prior Authorization Guideline

Guideline ID	GL-146447
Guideline Name	Zurzuvae
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Zurzuvae	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZURZUVAE	ZURANOLONE CAP 20 MG	58060090000120	Brand
ZURZUVAE	ZURANOLONE CAP 25 MG	58060090000125	Brand
ZURZUVAE	ZURANOLONE CAP 30 MG	58060090000130	Brand

Approval Criteria

1 - Diagnosis of postpartum depression (PPD) **AND** **2 -** Onset of current depressive episode was during the third trimester or within 4 weeks postpartum

Zyvox

Prior Authorization Guideline

Guideline ID	GL-146448
Guideline Name	Zyvox
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Zyvox, generic linezolid	
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZYVOX	LINEZOLID TAB 600 MG	16230040000330	Brand
LINEZOLID	LINEZOLID TAB 600 MG	16230040000330	Generic
ZYVOX	LINEZOLID FOR SUSP 100 MG/5ML	16230040001920	Brand
LINEZOLID	LINEZOLID FOR SUSP 100 MG/5ML	16230040001920	Generic

Approval Criteria

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1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - ONE of the following diagnoses:

- Nosocomial pneumonia
- Community-acquired pneumonia
- Skin and skin structure infections (complicated and uncomplicated)

OR

4 - Invasive infection caused by or likely to be caused by vancomycin-resistant Enterococcus faecium (VRE)

OR

5 - The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

</td></tr>
<tr><td>Notes</td><td>Approval Duration: For vancomycin-resistant Enterococcus faecium, a uthorization will be issued for 28 days. For osteomyelitis, authorization will be issued for the requested duration, not to exceed 6 weeks. All o ther approvals are for 14 days.</td></tr>
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