

Pennsylvania Employees Benefit Trust Fund (PEBTF) and Non-Medicare Eligible Retired Employees Health Program (REHP) Prior Authorization, Step Therapy and Quantity Limit List

Prior Authorization

Prescriptions for certain medications require a prior authorization – also known as a coverage review – to help ensure the medication is cost-effective and clinically appropriate. The review uses both formulary and clinical guidelines to determine if the plan will pay for certain medications. The prior authorization process helps ensure that you are receiving the appropriate drugs for the treatment of specific conditions and in quantities approved by the U.S. Food and Drug Administration (FDA).

For prior authorization review, **your doctor** should call CVS Caremark® at 1-800-294-5979 before you go to the pharmacy. The prior authorization line is for your doctor's use only.

Drug Class	Products Requiring Prior Authorization (PA) - Includes brands and generics, where available - Some products may also be subject to quantity limits - May also be subject to formulary PA coverage
Attention Deficit Hyperactivity Disorder (ADHD) – PA required for age 20+	- Amphetamine products: such as amphetamine, amphetamine mixture, dextroamphetamine, lisdexamfetamine, methamphetamine and all products of the following brands: Adderall, Adderall XR, Adzenys ER, Adzenys XR-ODT, Desoxyn, Dexedrine, Dynavel XR, Evekeo, Mydayis, ProCentra, Vyvanse, Xelstryl, Zenzedi - Methylphenidate products: such as methylphenidate, dextmethylphenidate, serdexmethylphenidate and all products of the following brands: Adhansia, Aptensio, Concerta, Cotempla, Daytrana, Focalin, Jornay, Metadate, Methylin, Quillichew, Quillivant, Relaxxii, Ritalin - Other products: Azstarys (serdexmethylphenidate/dextmethylphenidate), Qelbree (viloxazine), Strattera (atomoxetine)
Cardiology	Tryvio (aproclitentan)
Compound Products*	Select medications (check with the pharmacy) *A compound medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available.

Dermatology	- Acne - Topical Retinoids (<i>PA required for age 20+</i>): tretinoin products including Altreno, Atralin, Avita, Retin-A, Retin-A Micro, Twynéo (tretinoin/benzoyl peroxide), Veltin (clindamycin/tretinoin), Ziana (clindamycin/tretinoin) - Atopic Dermatitis/Eczema: Opzelura Topical Antifungal Agents: Penlac (ciclopirox)
Diabetes	- Disposable Insulin Pumps and Supplies - GLP-1/GIP-GLP-1 Receptor Agonists: Adlyxin (lixisenatide), Bydureon (exenatide extended-release), Bydureon Bcise (exenatide extended-release), Byetta (exenatide), Ozempic (semaglutide), Rybelsus (semaglutide), Trulicity (dulaglutide), Victoza (liraglutide), Mounjaro (tirzepatide)
Endocrine and Metabolic, other	- Eohilia (budesonide) - Rezdiffra (resmetirom)
Gastroenterology	Voquezna (vonoprazan)
Heart Failure	Entresto (sacubitril/valsartan)
Insomnia	- Belsomra (suvorexant) - Dayvigo (lemborexant) - Quviviq (daridorexant)
Ophthalmology	Xdemvy (lotilaner)
Pain	Oral-Intranasal Fentanyl (Actiq, Fentora, Subsys)
Miscellaneous	- Regranex (becaplermin) - Arava (leflunomide)
Respiratory	Ohtuvayre (ensifentrine)

Specialty Guideline Management – Prior Authorization for Specialty Drugs

Your doctor needs to get prior authorization for specialty drugs before they will be covered by your prescription benefit plan. The prior authorization process ensures that you are receiving the appropriate drugs for the treatment of specific conditions.

For a full list of specialty drugs, refer to **CVSSpecialty.com**. For specialty drug prior authorization review, your **doctor** should call CVS Specialty® at **1-866-814-5506** before you go to the pharmacy. The prior authorization line is for your doctor's use only. *Note: some products on the specialty list may also be subject to formulary coverage prior authorization and quantity limits.*

Step Therapy

Before your prescription drug plan will cover one of the drugs listed below, you will need to try one of the covered options available for that drug. Please consult with your doctor about what covered medications are right for you. Your doctor should call CVS Caremark at 1-800-294-5979 to request prior authorization if medically necessary. The prior authorization line is for your doctor's use only.

Drug Class	Products Requiring Step Therapy
	• Includes brands and generics, where available • Some products may also be subject to quantity limits • May also be subject to formulary PA coverage
Dermatology	• Axillary hyperhidrosis: Qbrexza (glycopyrronium topical), Sofdra (sofpironium)
Pain	• COX-2 Inhibitors: Celebrex (celecoxib) • Opioids: Immediate-release (IR) use prior to extended-release (ER) use for members new to ER opioid therapy

Quantity Limits

The drugs listed on the following pages have limits based on FDA-approved prescribing information, approved medical guidelines and/or the average utilization quantity for the drugs.

The limits listed below affect only the amount of medication that the prescription benefit plan pays for, not whether you can get a greater quantity. The final decision about the amount of medication you receive remains between you and your doctor.

Note: Some of the quantity limits have a prior authorization available if you exceed the drug's initial limit. Those drugs with a prior authorization available are noted in chart on the following pages. If your doctor has determined that a greater amount is appropriate, your **doctor** should call CVS Caremark at **1-800-294-5979** to request prior authorization for a larger quantity. The prior authorization line is for your doctor's use only. *Note: The list below includes brand and generics, where available. Some products may also be subject to formulary coverage prior authorization.*

Quantity Limits	Quantity Per 30-day Supply	Quantity Per 90-day Supply	Prior Authorization Available (To Exceed Initial Quantity Limit)
Anti-Migraine (quantities accumulate across the class)			
Amerge (naratriptan)	12 tablets	36 tablets	Yes
Axert (almotriptan)	12 tablets	36 tablets	Yes
Frova (frovatriptan)	18 tablets	54 tablets	Yes
Imitrex (sumatriptan) 4 mg Injection Syringes	18 units (9 mL)	54 units (27 mL)	Yes
Imitrex (sumatriptan) 6 mg Injection Syringes	12 units (6 mL)	36 units (18 mL)	Yes
Imitrex (sumatriptan) 6 mg Injection Vials	12 units (6 mL)	40 units (20 mL)	Yes
Imitrex (sumatriptan) 5 mg nasal spray (NS)	24 nasal units	72 nasal units	Yes
Imitrex (sumatriptan) 20 mg nasal spray (NS)	12 nasal units	36 nasal units	Yes
Imitrex (sumatriptan) oral	12 tablets	36 tablets	Yes
Maxalt, Maxalt MLT (rizatriptan)	18 tablets	54 tablets	Yes
Migranal (dihydroergotamine nasal spray)	8 nasal units	24 nasal units	No
Onzetra Xsail (sumatriptan nasal)	16 nasal units (1 kit)	64 nasal units (4 kits)	Yes
Relpax (eletriptan)	12 tablets	36 tablets	Yes
RizaFilm (rizatriptan)	18 units	54 units	Yes
Tosymra (sumatriptan nasal) 10mg	18 units	54 units	Yes
Treximet 85/500 mg (sumatriptan/ naproxen sodium)	9 tablets	36 tablets	Yes
Trudhesa (dihydroergotamine mesylate)	12 mL	36 mL	Yes
Zembrace SymTouch (sumatriptan)	24 injectors	72 injectors	Yes
Zomig nasal spray (zolmitriptan)	12 nasal units	36 nasal units	Yes
Zomig/Zomig ZMT (zolmitriptan)	12 tablets	36 tablets	Yes
Antiviral Agents – Influenza/COVID-19			
Paxlovid (nirmatrelvir/ritonavir) 300mg/100mg	60 tablets per 30 days		No
Paxlovid (nirmatrelvir/ritonavir) 150mg/100mg	40 tablets per 30 days		No
Relenza Caps (zanamivir inhalation)	40 blisters per 90 days		Yes

Quantity Limits	Quantity Per 30-day Supply	Quantity Per 90-day Supply	Prior Authorization Available (To Exceed Initial Quantity Limit)
Tamiflu 30 mg Caps (oseltamivir)	40 capsules per 90 days		Yes
Tamiflu 45 mg, 75 mg Caps (oseltamivir)	20 capsules per 90 days		Yes
Tamiflu 30 mg/5 mL Oral Liquid (oseltamivir)	360 mL per 90 days		Yes
Xofluza (baloxavir marboxil) 20 mg per tablet (2 tablets per blister card)	4 tablets per 90 days		Yes
Xofluza (baloxavir marboxil) 40 mg per tablet (1 tablet per blister card)	2 tablets per 90 days		Yes
Xofluza (baloxavir marboxil) 40 mg per tablet (2 tablets per blister card)	4 tablets per 90 days		Yes
Xofluza (baloxavir marboxil) 80 mg per tablet (1 tablet per blister card)	2 tablets per 90 days		Yes
Xofluza (baloxavir marboxil) 40mg/20 mL Suspension	80 mL per 90 days		Yes
Cardiology			
Tryvio (aprocitentan)	30 tablets per 25 days		No
Dermatology			
Qbrexza (glycopyrronium topical)	30 cloths (1 carton) per 25 days		Yes
Sofdra (sofipironium)	50 mL (60 actuations) per 25 days		Yes
Endocrine/Metabolic			
Eohilia (budesonide)	60 packets (600 mL) per 25 days		No
GLP-1 Cumulative Fill Limit Bydureon BCise, Byetta, Mounjaro, Ozempic, Rybelsus, Trulicity, Victoza	1 fill per 25 days		No [†]
Gastroenterology			
Voquezna (vonoprazan)			
Maintenance of healing of erosive esophagitis (EE) and treatment of healing of EE	30 tablets per 25 days		No

Quantity Limits	Quantity Per 30-day Supply	Quantity Per 90-day Supply	Prior Authorization Available (To Exceed Initial Quantity Limit)
Relief of heartburn associated with non-erosive gastroesophageal reflux (NERD)	28 tablets per 28 days		No
Treatment of <i>H. Pylori</i>	28 tablets per 14 days		No
Lidocaine – Topical Products			
Emla 2.5%-2.5% cream (lidocaine -prilocaine 2.5-2.5% cream)	30 gm per 25 days		Yes
Lidocaine 2% gel	30 gm per 25 days		Yes
Lidocaine 4% gel	30 gm per 25 days		Yes
Lidocaine 5% ointment	50 gm per 25 days		Yes
Lidocaine 4% solution	50 mL per 25 days		Yes
Lidocaine-collagen-aloe vera 2%	30 gm per 25 days		Yes
Lidocaine urethral/mucosal 2% gel	60 mL per 25 days		Yes
Pliaglis 7-7% cream/ (Lidocaine-tetracaine 7-7% cream)	30 gm per 25 days		Yes
Synera 70-70 mg patch (Lidocaine-tetracaine 70-70 mg patch)	2 patches per 25 days		Yes
Ophthalmology			
Xdemvy (lotilaner)	1 bottle (10 mL) per 6 weeks		No
Pain – Nasal Spray			
butorphanol (Stadol NS)	2 bottles	6 bottles	No
Pain – Non-Opioid			
Journavx (suzetrigine)	29 tablets	Does Not Apply	Yes
Pain – Opioids			

Quantity Limits	Quantity Per 30-day Supply	Quantity Per 90-day Supply	Prior Authorization Available (To Exceed Initial Quantity Limit)
Opioid pain medications have quantity and duration limits based on morphine milligram equivalency (MME), and immediate-release (IR) prior to extended-release (ER) use requirements, aligned with Centers for Disease Control and Prevention (CDC) opioid prescribing guidelines.* The quantity limits may accumulate across other opioid products. Coverage for quantities above the initial limits may be provided through prior authorization when coverage conditions are met. The duration limit for acute pain is 7 days. If a new user requires more than 7 days of therapy, coverage may be provided through prior authorization when coverage conditions are met. An IR opioid must be used prior to an ER opioid for members new to ER therapy. If a new ER user requires ER therapy prior to IR use, coverage may be provided through prior authorization when coverage conditions are met. For member-specific questions about Opioid pain limits, contact CVS Caremark Customer Care at 1-888-321-3261. *doi: 10.15585/mmwr.rr7103a1			
Sedative/hypnotics (<i>quantities accumulate across the class</i>)			
<i>Benzodiazepines</i>			
Doral (quazepam)	15 tablets	45 tablets	No
estazolam (Prosom)	15 tablets	45 tablets	No
flurazepam (Dalmane)	15 capsules	45 capsules	No
temazepam (Restoril, Strazepam)	15 capsules	45 capsules	No
triazolam (Halcion)	10 tablets	30 tablets	No
<i>Non-Benzodiazepines</i>			
Lunesta (eszopiclone)	15 tablets	45 tablets	Yes
Rozerem (ramelteon)	15 tablets	45 tablets	Yes
zaleplon (Sonata)	15 capsules	45 capsules	Yes
zolpidem (Ambien/Ambien CR)	15 tablets	45 tablets	Yes
Respiratory – SHORT-ACTING Beta 2 Agonist/Combinations			
Airsupra (albuterol and budesonide)	3 containers (10.7 gm each)	9 containers (10.7 gm each)	No
Albuterol HFA	2 containers	6 containers	No
Albuterol inhalation solution (AccuNeb) 0.63 mg/3 mL and 1.25 mg/3 mL	120 - 125 vials (360 - 375 mL), varies by package size	360 - 375 vials (1,180 - 1,125 mL), varies by package size	No

Quantity Limits	Quantity Per 30-day Supply	Quantity Per 90-day Supply	Prior Authorization Available (To Exceed Initial Quantity Limit)
Albuterol inhalation solution 0.083%	120 - 125 vials (360 - 375 mL), varies by package size	360 - 375 vials (1,180 - 1,125 mL), varies by package size	No
Albuterol inhalation solution 0.5%	3 (20 mL) containers or 120 vials	9 (20 mL) containers or 360 vials	No
ProAir Digihaler (albuterol)	2 containers	6 containers	No
ProAir HFA inhaler (albuterol)	2 containers	6 containers	No
ProAir RespiClick (albuterol)	2 containers	6 containers	No
Proventil HFA inhaler (albuterol)	2 containers	6 containers	No
Ventolin HFA inhaler (albuterol) – 8 gram container (60 inhalations/container)	6 containers (48 gm)	18 containers (144 gm)	No
Ventolin HFA inhaler (albuterol) – 18 gram container (200 inhalations/container)	2 containers (36 gm)	6 containers (108 gm)	No
Xopenex HFA inhaler (levalbuterol) – 15 gram container (200 inhalations/container)	2 containers (30 gm)	6 containers (90 gm)	No
Xopenex inhalation solution 0.31 mg/3 mL, 0.63 mg/3mL, 1.25 mg/3mL (levalbuterol)	90 - 100 vials (270 - 300 mL), varies by package size	270 - 300 vials (810 - 900 mL), varies by package size	No
Xopenex inhalation soln conc 1.25 mg/ 0.5 mL (levalbuterol)	90 vials (90 ea)	270 vials (270 ea)	No
Respiratory – LONG-ACTING Beta 2 Agonist/Combinations			
Advair Diskus (fluticasone/salmeterol)	1 container (60 ea)	3 containers (180 ea)	No
Advair HFA (fluticasone/salmeterol)	1 container (12 g)	3 containers (36 g)	No
AirDuo Digihaler (fluticasone/salmeterol)	1 container (60 ea)	3 containers (180 ea)	No
AirDuo RespiClick (fluticasone/salmeterol)	1 container (60 ea)	3 containers (180 ea)	No
Anoro Ellipta (umeclidinium/vilanterol)	1 container (60 ea)	3 containers (180 ea)	No

Quantity Limits	Quantity Per 30-day Supply	Quantity Per 90-day Supply	Prior Authorization Available (To Exceed Initial Quantity Limit)
Arcapta Neohaler (indacaterol)	1 container (30 ea)	3 containers (90 ea)	No
Bevespi Aerosphere (glycopyrrolate/formoterol fumarate)	1 container (10.7 g)	3 containers (32.1 g)	No
Breo Ellipta (fluticasone furoate/vilanterol)	1 container (60 ea)	3 containers (180 ea)	No
Breztri Aerosphere (budesonide/glycopyrrolate/formoterol fumarate)	1 container (10.7 gm)	3 containers (32.1 gm)	No
Brovana inhalation solution (arformoterol tartrate)	60 vials (120 mL)	180 vials (360 mL)	No
Duaklir Pressair (aclidinium bromide/formoterol fumarate)	1 container (60 ea)	3 containers (180 ea)	No
Dulera Inhalation Aerosol 100 mcg/5 mcg and 200 mcg/5 mcg (mometasone/ formoterol)	1 container (13 gm)	3 containers (39 gm)	No
Perforomist inhalation solution (formoterol)	60 vials (120 mL)	180 vials (360 mL)	No
Serevent Diskus (salmeterol)	1 container (60 ea)	3 containers (180 ea)	No
Stiolto Respimat (tiotropium bromide/olodaterol)	1 container (4 gm)	3 containers (12 gm)	No
Striverdi Respimat (olodaterol)	1 container (4 gm)	3 containers (12 gm)	No
Symbicort inhalation aerosol (budesonide/formoterol)	3 containers (30.6 gm)	9 containers (91.8 gm)	No
Symbicort inhalation Aerosphere (budesonide/ formoterol)	1 container (10.7 gm)	3 containers (32.1 gm)	No
Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)	1 container (60 ea)	3 containers (180 ea)	No
Utibron Neohaler (indacaterol/ glycopyrrolate)	1 package (60 capsules)	3 packages (180 capsules)	No
Respiratory – Mast Cell Stabilizers and Anticholinergics			
Atrovent HFA Inhaler (ipratropium bromide)	2 containers (26 gm)	6 containers (78 gm)	No

Quantity Limits	Quantity Per 30-day Supply	Quantity Per 90-day Supply	Prior Authorization Available (To Exceed Initial Quantity Limit)
Combivent Respimat Inhaler (ipratropium/albuterol)	2 containers (8 gm)	6 containers (24 gm)	No
Cromolyn Inhalation Solution (cromolyn)	120 units (240 mL)	360 units (720 mL)	No
DuoNeb Inhalation Solution (ipratropium/albuterol)	180 vials (540 mL)	540 vials (1620 mL)	No
Incruse Ellipta (umeclidinium) Inhaler	1 package (30 blisters)	3 packages (90 blisters)	No
Ipratropium Inhalation Solution (ipratropium bromide)	120 - 125 units (300 - 313 mL)	360 - 375 units (900 - 938 mL)	No
Ipratropium bromide/albuterol sulfate inhalation solution	180 vials	540 vials	No
Lonhala Magnair Starter and Refill Kit (glycopyrrolate)	1 container (60 vials)	3 containers (180 vials)	No
Spiriva Handihaler (tiotropium)	30 units + 1 Handihaler device	90 units + 1 Handihaler device	No
Spiriva Respimat (tiotropium bromide)	1 container (4 gm)	3 containers (12 gm)	No
Tudorza Pressair Inhaler (aclidinium bromide)	1 -2 containers (varies by package size)	3 - 6 containers (varies by package size)	No
Yupelri (revefenacin)	1 package (30 ea)	3 packages (90 ea)	No
Respiratory – Inhaled Corticosteroids			
Alvesco inhalation 80 mcg (ciclesonide)	3 containers	9 containers	No
Alvesco inhalation 160 mcg (ciclesonide)	2 containers	6 containers	No
ArmonAir Digihaler 30 mcg (fluticasone propionate)	1 container	3 containers	No
ArmonAir Digihaler 55 mcg (fluticasone propionate)	1 container	3 containers	No
ArmonAir Digihaler 113 mcg (fluticasone propionate)	1 container	3 containers	No

Quantity Limits	Quantity Per 30-day Supply	Quantity Per 90-day Supply	Prior Authorization Available (To Exceed Initial Quantity Limit)
ArmonAir Digihaler 232 mcg (fluticasone propionate)	1 container	3 containers	No
Arnuity Ellipta 50 mcg (fluticasone furoate)	1 container	3 containers	No
Arnuity Ellipta 100 mcg (fluticasone furoate)	1 container	3 containers	No
Arnuity Ellipta 200 mcg (fluticasone furoate)	1 container	3 containers	No
Asmanex HFA 50 mcg (mometasone furoate)	1 package	3 packages	No
Asmanex HFA 100 mcg (mometasone furoate)	1 package	3 packages	No
Asmanex HFA 200 mcg (mometasone furoate)	1 package	3 packages	No
Asmanex Twisthaler 110 mcg (mometasone furoate)	2 packages	6 packages	No
Asmanex Twisthaler 220 mcg (mometasone furoate)	1 – 4 packages (Varies by package size)	3 – 12 packages (Varies by package size)	No
Flovent Diskus 50 mcg mcg/inhalation (fluticasone)	3 packages	9 packages	No
Flovent Diskus 100 mcg/inhalation (fluticasone)	4 packages	12 packages	No
Flovent Diskus 250 mcg/inhalation (fluticasone)	4 packages	12 packages	No
Flovent HFA 44 mcg/inhalation (fluticasone)	2 containers	6 containers	No
Flovent HFA 110 mcg/inhalation (fluticasone)	2 containers	6 containers	No
Flovent HFA 220 mcg/inhalation (fluticasone)	2 containers	6 containers	No
Pulmicort Flexhaler 180 mcg/inhalation (budesonide)	2 containers	6 containers	No
Pulmicort Flexhaler 90 mcg/inhalation (budesonide)	3 containers	9 containers	No
Pulmicort Respules 0.25 mg per respule (budesonide)	90 respules	270 respules	No

Quantity Limits	Quantity Per 30-day Supply	Quantity Per 90-day Supply	Prior Authorization Available (To Exceed Initial Quantity Limit)
Pulmicort Respules 0.5 mg per respule (budesonide)	60 respules	180 respules	No
Pulmicort Respules 1 mg per respule (budesonide)	30 respules	90 respules	No
Qvar Redihaler 40 mcg (beclomethasone)	2 containers	6 containers	No
Qvar Redihaler 80 mcg (beclomethasone)	2 containers	6 containers	No
Allergy – Intranasal Steroids/Antihistamines			
Azelastine	2 containers	6 containers	No
Beconase AQ (beclomethasone)	2 containers	6 containers	No
Dymista (azelastine/fluticasone)	1 container	3 containers	No
Flunisolide (flunisolide)	3 containers	9 containers	No
Fluticasone propionate	1 container	3 containers	No
Nasonex (mometasone)	2 containers	6 containers	No
Omnaris (ciclesonide)	1 container	3 containers	No
Patanase (olopatadine)	1 container	3 containers	No
Qnasl (beclomethasone)	1 container	3 containers	No
Ryaltris (olopatadine/mometasone)	1 container	3 containers	No
Xhance (fluticasone propionate)	2 containers	6 containers	No
Zetonna (ciclesonide)	1 container	3 containers	No

Specialty Quantity Limits

Specialty medications may have a quantity limit in addition to prior authorization to help ensure dosages dispensed do not exceed the upper limit of safe and appropriate thresholds based on each drug's FDA-approved dosing limits. If a specialty medication user requires a dosage above the quantity limit, coverage may be provided for most specialty medications through prior authorization when coverage conditions are met. For member-specific questions about specialty medication quantity limits, contact CVS Caremark Customer Care at 1-888-321-3261.



Log in to **Caremark.com** to check coverage and copay* information for a specific medicine. For more information, contact a CVS Caremark Customer Care Representative at **1-888-321-3261**.

*Copay, copayment or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

†May contact CVS Caremark Customer Care representative at 1-888-321-3261 for exceeded fill limit.

Listed products are for informational purposes only and are not intended to replace the clinical judgement of the doctor. There may be additional drugs subject to utilization management or other plan design restrictions.

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