

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Fee-for-Service[†] (FFS) Pharmacy General Prior Authorization Requirements:

<https://www.pa.gov/agencies/dhs/resources/pharmacy-services/pharmacy-prior-authorization-general-requirements>

FFS[†] Pharmacy Prior Authorization Clinical Guidelines:

<https://www.pa.gov/agencies/dhs/resources/pharmacy-services/clinical-guidelines>

FFS[†] Pharmacy Prior Authorization Fax Forms:

<https://www.pa.gov/agencies/dhs/resources/pharmacy-services/pharmacy-services-fax-forms>

FFS[†] Pharmacy Quantity Limits/Daily Dose Limits:

<https://www.pa.gov/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits>

[†]This information is specific to FFS. Please refer to each managed care organization's (MCO) website for MCO prior authorization procedures, prior authorization fax request forms, and quantity limits.

[†]Prior authorization guidelines for drugs and products included in the Statewide PDL apply to FFS and the Pennsylvania Medical Assistance MCOs. Prior authorization guidelines for drugs and products not included in the Statewide PDL are specific to FFS. Please refer to each MCO's website for MCO-specific prior authorization requirements for drugs and products not included in the Statewide PDL.

ACNE AGENTS, ORAL

Preferred Agents	Non-Preferred Agents
Amnesteem (<i>isotretinoin</i>) Capsule ^{PA}	Absorica (<i>isotretinoin</i>) Capsule
Claravis (<i>isotretinoin</i>) Capsule ^{PA}	Absorica LD (<i>isotretinoin, micronized</i>) Capsule
Isotretinoin 10 mg, 20 mg, 30 mg, 40 mg Capsule ^{PA}	Isotretinoin 25 mg, 35 mg Capsule
Zenatane (<i>isotretinoin</i>) Capsule ^{PA}	

ACNE AGENTS, TOPICAL

Preferred Agents	Non-Preferred Agents
Adapalene 0.1% Gel ^{AR}	Aczone (<i>dapsone</i>) 7.5% Gel Pump
Adapalene 0.3% Gel (Tube) ^{AR}	Adapalene 0.1% Cream ^{AR}
Adapalene-Benzoyl Peroxide 0.1%-2.5% Gel Pump (<i>generic EpiDuo</i>) ^{AR}	Adapalene 0.3% Gel Pump ^{AR}
Adapalene-Benzoyl Peroxide 0.3%-2.5% Gel Pump (<i>generic EpiDuo Forte</i>) ^{AR}	Aklief (<i>trifarotene</i>) Cream ^{AR}
Benzoyl Peroxide Gel 2.5%	Avita (<i>tretinoin</i>) Gel ^{AR}
Benzoyl Peroxide Gel 5%	Benzefoam (<i>benzoyl peroxide</i>) Foam
Benzoyl Peroxide Gel 10%	BP (<i>sodium sulfacetamide-sulfur</i>) 10-1 Wash
Benzoyl Peroxide Lotion 5%	BP (<i>sodium sulfacetamide-sulfur-urea</i>) Cleansing Wash
Benzoyl Peroxide Lotion 10%	BPO (<i>benzoyl peroxide</i>) Foaming Cloths
Benzoyl Peroxide Wash 5%	Cleocin T (<i>clindamycin</i>) Lotion
Benzoyl Peroxide Wash 10%	Clindacin ETZ (<i>clindamycin</i>) Kit
Clindamycin 1% Gel	Clindacin ETZ (<i>clindamycin</i>) Pledget
Clindamycin 1% Lotion	Clindacin (<i>clindamycin</i>) Foam
Clindamycin 1% Pledget/Swab	Clindacin P (<i>clindamycin</i>) Pledget
Clindamycin 1% Solution	Clindacin Pac (<i>clindamycin</i>) Kit
Clindamycin-Benzoyl Peroxide 1%-5% Gel (<i>generic Benzacclin</i>)	Clindamycin 1% Daily Gel (<i>generic Clindagel</i>)
Clindamycin-Benzoyl Peroxide 1.2%-5% Gel (<i>generic Duac, Neuac</i>)	Clindamycin Foam
Differin (<i>adapalene</i>) 0.1% Cream ^{AR}	Clindamycin-Benzoyl Peroxide 1%-5% Gel Pump (<i>generic Benzacclin Gel Pump</i>)
Differin (<i>adapalene</i>) 0.1% Gel ^{AR}	Clindamycin-Benzoyl Peroxide 1.2%-2.5% Gel Pump (<i>generic Acanya</i>)
Ery (<i>erythromycin</i>) Pads	Clindamycin-Benzoyl Peroxide 1.2%-3.75% Gel Pump (<i>generic Onexton</i>)

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Erythromycin 2% Solution	Clindamycin-Tretinoin Gel (<i>generic Veltin, Ziana</i>) ^{AR}
Erythromycin-Benzoyl Peroxide Gel (<i>generic Benzamycin</i>)	Dapsone 5% Gel
Sodium Sulfacetamide-Sulfur 8%-4% Suspension	Dapsone 7.5% Gel
Sodium Sulfacetamide-Sulfur 9%-4.5% Wash	Dapsone 7.5% Gel Pump
Sodium Sulfacetamide-Sulfur 10%-5% Cleanser	Differin (<i>adapalene</i>) 0.1% Lotion ^{AR}
SSS (<i>sodium sulfacetamide-sulfur</i>) 10%-5% Cream	Differin (<i>adapalene</i>) 0.3% Gel Pump ^{AR}
Tretinoin Cream ^{AR}	Epiduo Forte (<i>adapalene-benzoyl peroxide</i>) Gel Pump ^{AR}
	Erygel (<i>erythromycin</i>) Gel
	Erythromycin Gel
	Fabior (<i>tazarotene</i>) Foam ^{AR}
	Lintera (<i>benzoyl peroxide</i>) Wash
	Neuac (<i>clindamycin-benzoyl peroxide</i>) Gel
	Neuac (<i>clindamycin-benzoyl peroxide</i>) Kit
	Sodium Sulfacetamide 10% Cleansing Gel
	Sodium Sulfacetamide 10% Lotion
	Sodium Sulfacetamide 10% Wash
	Sodium Sulfacetamide-Sulfur 9%-4% Wash
	Sodium Sulfacetamide-Sulfur 9%-4.25% Suspension
	Sodium Sulfacetamide-Sulfur 9.8%-4.8% Cleanser
	Sodium Sulfacetamide-Sulfur 9.8%-4.8% Lotion
	Sodium Sulfacetamide-Sulfur 10%-2% Cleanser
	Sodium Sulfacetamide-Sulfur 10%-2% Cream
	Sodium Sulfacetamide-Sulfur 10%-4% Medicated Pad
	Sodium Sulfacetamide-Sulfur 10%-5% Cream
	Sodium Sulfacetamide-Sulfur-Urea 10%-5%-10% Cleanser
	SSS (<i>sodium sulfacetamide-sulfur</i>) 10%-5% Foam
	Sulfacetamide Sodium 10% Suspension
	Sumadan (<i>sodium sulfacetamide-sulfur</i>) Kit ^{QL}
	Sumadan (<i>sodium sulfacetamide-sulfur</i>) Wash
	Sumadan XLT (<i>sodium sulfacetamide-sulfur</i>) Kit
	Sumaxin (<i>sodium sulfacetamide-sulfur</i>) Cleansing Pad
	Sumaxin CP (<i>sodium sulfacetamide-sulfur</i>) Kit ^{QL}
	Tazarotene Cream ^{AR}
	Tazarotene Foam ^{AR}
	Tazarotene Gel ^{AR}
	Tretinoin Gel ^{AR}
	Tretinoin Micro Gel ^{AR}
	Tretinoin Micro Gel Pump ^{AR}
	Twynéo Cream Pump ^{AR}
	Winlevi (<i>clascoterone</i>) Cream

ALCOHOL USE DISORDER AGENTS

Preferred Agents	Non-Preferred Agents
Acamprosate DR Tablet ^{QL}	
Disulfiram Tablet ^{QL}	
Naltrexone Tablet	
Vivitrol Vial ^{QL}	

ALZHEIMER'S AGENTS

Preferred Agents	Non-Preferred Agents
Donepezil ODT ^{QL}	Adlarity Patch ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Donepezil 5 mg, 10 mg Tablet ^{QL}	Aricept Tablet ^{QL}
Galantamine Tablet ^{QL}	Donepezil 23 mg Tablet ^{QL}
Galantamine ER Capsule ^{QL}	Exelon Patch ^{QL}
Memantine Tablet ^{QL}	Galantamine Solution ^{QL}
Memantine ER Capsule ^{QL}	Memantine Solution ^{QL}
Rivastigmine Capsule ^{QL}	Memantine-Donepezil ER Capsule ^{QL}
	Namzaric Capsule ^{QL}
	Rivastigmine Patch ^{QL}
	Zunveyl DR Tablet ^{QL}

ANALGESICS, ACUTE PAIN AGENTS

Preferred Agents	Non-Preferred Agents
	Journavx Tablet ^{QL}

ANALGESICS, NON-OPIOID BARBITURATE COMBINATIONS

Preferred Agents	Non-Preferred Agents
Butalbital-Acetaminophen-Caffeine 50-325-40 mg Tablet ^{PA, QL}	Butalbital-Acetaminophen 50-300 mg Capsule ^{QL}
Butalbital-Aspirin-Caffeine 50-325-40 mg Capsule ^{PA, QL}	Butalbital-Acetaminophen 50-300 mg Tablet ^{QL}
	Butalbital-Acetaminophen 50-325 mg Tablet ^{QL}
	Butalbital-Acetaminophen-Caffeine 50-300-40 mg Capsule ^{QL}
	Butalbital-Acetaminophen-Caffeine 50-325-40 mg Capsule ^{QL}
	Fioricet 50-300-40 mg Capsule ^{QL}

ANALGESICS, OPIOID LONG-ACTING

Preferred Agents	Non-Preferred Agents
Belbuca Film ^{PA, QL}	Butrans Patch ^{QL}
Buprenorphine Patch ^{PA, QL}	Fentanyl 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr Patch ^{QL}
Fentanyl 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr Patch ^{PA, QL}	Hydrocodone ER (12H) Capsule (<i>generic Zohydro ER</i>) ^{QL}
Morphine ER (CAP ER PEL) Capsule (<i>generic Kadian ER</i>) ^{PA, QL}	Hydrocodone ER (24H) Tablet (<i>generic Hysingla ER</i>) ^{QL}
Morphine ER Tablet (<i>generic MS Contin</i>) ^{PA, QL}	Hydromorphone ER (24H) Tablet (<i>generic Exalgo</i>) ^{QL}
Oxycodone ER (12H) Tablet (<i>generic Oxycontin</i>) ^{PA, QL}	Hysingla ER Tablet ^{QL}
Oxycontin Tablet ^{PA, QL}	Methadone Intensol/Concentrate Solution ^{QL}
Tramadol ER (24H) Tablet (<i>generic Ultram ER</i>) ^{AR, PA, QL}	Methadone Solution ^{QL}
	Methadone Tablet ^{QL}
	Morphine ER (CPMP 24HR) Capsule (<i>generic Avinza</i>) ^{QL}
	MS Contin Tablet ^{QL}
	Oxymorphone ER (12H) Tablet ^{QL}
	Tramadol ER (CPBP) Capsule (<i>generic Conzip</i>) ^{AR, QL}

ANALGESICS, OPIOID SHORT-ACTING

Preferred Agents	Non-Preferred Agents
Acetaminophen-Codeine Solution ^{AR, QL}	Acetaminophen-Caffeine-Dihydrocodeine Capsule ^{QL}
Acetaminophen-Codeine Tablet ^{AR, QL}	Aspirin-Butalbital-Caffeine-Codeine #3 Capsule ^{AR, QL}
Endocet Tablet ^{QL}	Ascomp With Codeine Capsule ^{AR, QL}
Hydrocodone-Acetaminophen 2.5-108 mg/5 mL Solution ^{QL}	Butalbital-Caffeine-Acetaminophen-Codeine 50-300-30 mg Capsule ^{AR, QL}
Hydrocodone-Acetaminophen 5-217 mg/10 mL Solution ^{QL}	Butalbital-Caffeine-Acetaminophen-Codeine 50-325-30 mg Capsule ^{AR, QL}
Hydrocodone-Acetaminophen 7.5-325 mg/15 mL Solution ^{QL}	Butalbital Compound with Codeine #3 Capsule ^{AR, QL}
Hydrocodone-Acetaminophen Tablet ^{QL}	Butorphanol Tartrate Nasal Spray ^{QL}
Morphine Sulfate Concentrate Solution ^{QL}	
Morphine Sulfate 5 mg/0.25 mL ENFit Syringe	

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Morphine Sulfate 10 mg/0.5 mL Oral Syringe ^{QL}	Codeine Tablet ^{AR, QL}
Morphine Sulfate Solution ^{QL}	Dilaudid Liquid ^{QL}
Morphine Sulfate Tablet ^{QL}	Dilaudid Tablet ^{QL}
Oxycodone 5 mg/5 mL Solution ^{QL}	Fentanyl Citrate Buccal Tablet (<i>generic Fentora</i>) ^{QL}
Oxycodone Tablet ^{QL}	Fentanyl Citrate OTFC Lozenge (<i>generic Actiq</i>) ^{QL}
Oxycodone-Acetaminophen Solution ^{QL}	Fioricet with Codeine 50-300-30 mg Capsule ^{AR, QL}
Oxycodone-Acetaminophen Tablet (<i>generic Percocet</i>) ^{QL}	Hydrocodone-Acetaminophen 10-300 mg/15 mL Solution ^{QL}
Tramadol 50 mg, 100 mg Tablet ^{AR, QL}	Hydrocodone-Acetaminophen 10-325 mg/15 mL Solution ^{QL}
Tramadol-Acetaminophen Tablet ^{AR, QL}	Hydrocodone-Ibuprofen Tablet ^{QL}
	Hydromorphone Rectal Suppository ^{QL}
	Hydromorphone Solution ^{QL}
	Hydromorphone Tablet ^{QL}
	Levorphanol Tablet ^{QL}
	Meperidine Solution ^{QL}
	Meperidine Tablet ^{QL}
	Morphine Sulfate 20 mg/mL Oral Syringe ^{QL}
	Morphine Sulfate Rectal Suppository ^{QL}
	Nalocet Tablet ^{QL}
	Oxycodone Capsule ^{QL}
	Oxycodone Concentrate Solution ^{QL}
	Oxymorphone Tablet ^{QL}
	Pentazocine-Naloxone Tablet ^{QL}
	Percocet Tablet ^{QL}
	Prolate Solution ^{QL}
	Prolate Tablet ^{QL}
	Roxicodone Tablet ^{QL}
	Roxybond Tablet ^{QL}
	Tramadol Solution ^{AR, QL}
	Tramadol 25 mg, 75 mg Tablet ^{AR, QL}

ANDROGENIC AGENTS

Preferred Agents	Non-Preferred Agents
Depo-Testosterone Vial ^{PA, QL}	Aveed Vial ^{QL}
Testopel Implant Pellet ^{PA, QL}	Azmiro Syringe ^{QL}
Testosterone 1.62% (20.25 mg/1.25 gm) Gel Pump (<i>generic AndroGel 1.62%</i>) ^{PA, QL}	Jatenzo Capsule ^{QL}
Testosterone Cypionate Vial ^{PA, QL}	Methitest Tablet ^{QL}
	Methyltestosterone Capsule ^{QL}
	Natesto Nasal Spray ^{QL}
	Testim 1% Gel ^{QL}
	Testosterone 1% Gel Packet (<i>generic AndroGel 1% Packet</i>) ^{QL}
	Testosterone 1% Gel Pump (<i>generic AndroGel 1% Pump</i>) ^{QL}
	Testosterone 1% Gel Tube (<i>generic Testim 1%</i>) ^{QL}
	Testosterone 1.62% Gel Packet (<i>generic AndroGel 1.62%</i>) ^{QL}
	Testosterone 10 mg (2%) Gel Pump (<i>generic Fortesta</i>) ^{QL}
	Testosterone 30 mg/1.5 mL Solution Pump (<i>generic Axiron</i>) ^{QL}
	Testosterone Enanthate Vial ^{QL}
	Undecatrex Capsule ^{QL}
	Xyosted Auto-Injector ^{QL}

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

ANGIOTENSIN MODULATOR COMBINATIONS

Preferred Agents	Non-Preferred Agents
Amlodipine-Benazepril Capsule ^{QL}	Azor Tablet ^{QL}
Amlodipine-Olmesartan Tablet ^{QL}	Exforge Tablet ^{QL}
Amlodipine-Valsartan Tablet ^{QL}	Exforge HCT Tablet ^{QL}
Amlodipine-Valsartan-HCTZ Tablet ^{QL}	Lotrel Capsule ^{QL}
Olmesartan-Amlodipine-HCTZ Tablet ^{QL}	Tribenzor Tablet ^{QL}
Telmisartan-Amlodipine Tablet ^{QL}	
Trandolapril-Verapamil ER Tablet ^{QL}	

ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents
Benazepril Tablet ^{QL}	Accupril Tablet ^{QL}
Benazepril-Hydrochlorothiazide Tablet ^{QL}	Accuretic Tablet ^{QL}
Candesartan Tablet ^{QL}	Aliskiren Tablet ^{QL}
Candesartan-Hydrochlorothiazide Tablet ^{QL}	Altace Capsule ^{QL}
Captopril Tablet ^{QL}	Atacand Tablet ^{QL}
Enalapril Tablet ^{QL}	Atacand HCT Tablet ^{QL}
Enalapril-Hydrochlorothiazide Tablet ^{QL}	Avalide Tablet ^{QL}
Fosinopril Tablet ^{QL}	Avapro Tablet ^{QL}
Fosinopril-Hydrochlorothiazide Tablet ^{QL}	Benicar Tablet ^{QL}
Irbesartan Tablet ^{QL}	Benicar HCT Tablet ^{QL}
Irbesartan-Hydrochlorothiazide Tablet ^{QL}	Captopril-Hydrochlorothiazide Tablet
Lisinopril Tablet ^{QL}	Cozaar Tablet ^{QL}
Lisinopril-Hydrochlorothiazide Tablet ^{QL}	Diovan Tablet ^{QL} L
Losartan Tablet ^{QL}	Diovan HCT Tablet ^{QL}
Losartan-Hydrochlorothiazide Tablet ^{QL}	Edarbi Tablet ^{QL}
Olmesartan Tablet ^{QL}	Edarbyclor Tablet ^{QL}
Olmesartan-Hydrochlorothiazide Tablet ^{QL}	Enalapril Solution ^{AE<9, QL}
Quinapril Tablet ^{QL}	Entresto Sprinkle Pellet ^{QL}
Ramipril Capsule ^{QL}	Entresto Tablet ^{QL}
Sacubitril-Valsartan Tablet ^{QL}	Epaned Solution ^{AE<9, QL}
Telmisartan Tablet ^{QL}	Hyzaar Tablet ^{QL}
Trandolapril Tablet ^{QL}	Lotensin Tablet ^{QL}
Valsartan Tablet ^{QL}	Lotensin HCT Tablet ^{QL}
Valsartan-Hydrochlorothiazide Tablet ^{QL}	Micardis Tablet ^{QL}
	Micardis HCT Tablet ^{QL}
	Moexipril Tablet ^{QL}
	Perindopril Tablet ^{QL}
	Qbrelis Solution ^{AE<9, QL}
	Quinapril-Hydrochlorothiazide Tablet ^{QL}
	Tekturta Tablet ^{QL}
	Telmisartan-Hydrochlorothiazide Tablet ^{QL}
	Valsartan Solution ^{QL}
	Zestoretic Tablet ^{QL}
	Zestril Tablet ^{QL}

ANTIANGINAL AGENTS

Preferred Agents	Non-Preferred Agents
Isosorbide Mononitrate Tablet	BiDil (isosorbide dinitrate-hydralazine) Tablet
Isosorbide Mononitrate ER Tablet	Isosorbide Dinitrate Tablet

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Nitro-BID (<i>nitroglycerin</i>) Ointment	Isosorbide Dinitrate-Hydralazine Tablet
Nitroglycerin Patch	Nitro-DUR (<i>nitroglycerin</i>) Patch
Nitroglycerin SL Tablet	Nitroglycerin Spray
Ranolazine ER Tablet ^{QL}	Nitrolingual (<i>nitroglycerin</i>) Spray
	Nitrostat SL (<i>nitroglycerin</i>) Tablet

ANTIBIOTICS, GI AND RELATED AGENTS

Preferred Agents	Non-Preferred Agents
Metronidazole 250 mg, 500 mg Tablet	Dificid (<i>fidaxomicin</i>) Suspension ^{QL}
Neomycin Sulfate Tablet	Dificid (<i>fidaxomicin</i>) Tablet ^{QL}
Tinidazole Tablet ^{QL}	Firvanq (<i>vancomycin</i>) Solution
Vancomycin Capsule	Likmez (<i>metronidazole</i>) Suspension ^{QL}
Vancomycin Solution	Metronidazole Capsule
	Metronidazole 125 mg Tablet
	Nitazoxanide Tablet ^{QL}
	Solosec (<i>secnidazole</i>) Granule Packet
	Vancocin (<i>vancomycin</i>) Capsule

ANTIBIOTICS, INHALED

Preferred Agents	Non-Preferred Agents
Tobramycin 300 mg/5 mL Ampule (<i>generic Tobl</i>) ^{QL}	Arikayce (<i>amikacin liposomal</i>) Vial ^{QL}
	Bethkis (<i>tobramycin</i>) 300 mg/4 mL Ampule ^{QL}
	Cayston (<i>aztreonam</i>) Inhalation Solution ^{QL}
	Kitabis Pak (<i>tobramycin</i>) 300 mg/5 mL ^{QL}
	TOBI (<i>tobramycin</i>) Podhaler Inhalation Capsule ^{QL}
	TOBI (<i>tobramycin</i>) 300 mg/5 mL Solution ^{QL}
	Tobramycin 300 mg/4 mL Ampule (<i>generic Bethkis</i>) ^{QL}
	Tobramycin Pak 300 mg/5 mL (<i>generic Kitabis</i>) ^{QL}

ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred Agents
Antibiotic Plus (<i>neomycin-polymyxin B-pramoxine</i>) Cream	Mupirocin Cream
Bacitracin Ointment	Neo-Synalar (<i>neomycin-fluocinolone</i>) Cream
Bacitracin Ointment Packet	Xepi (<i>ozenoxacin</i>) Cream
Bacitracin Zinc Ointment	
Bacitracin Zinc Ointment Packet	
Double Antibiotic (<i>Bacitracin-Polymyxin</i>) Ointment	
Gentamicin Cream	
Gentamicin Ointment	
Mupirocin Ointment	
Poly Bacitracin (<i>Bacitracin-Polymyxin</i>) Ointment	
Triple Antibiotic (<i>Neomycin-Bacitracin-Polymyxin</i>) Ointment	
Triple Antibiotic (<i>Neomycin-Bacitracin-Polymyxin</i>) Ointment Packet	
Triple Antibiotic (<i>Neomycin-Bacitracin-Polymyxin-Pramoxine</i>) Plus Ointment	

ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents
Dabigatran Capsule ^{QL}	Arixtra Syringe ^{QL}
Eliquis Tablet ^{QL}	Fondaparinux Syringe ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Enoxaparin Syringe ^{QL}	Fragmin Syringe ^{QL}
Enoxaparin Vial ^{QL}	Fragmin Vial ^{QL}
Rivaroxaban 2.5 mg Tablet ^{QL}	Lovenox Syringe ^{QL}
Warfarin Tablet	Lovenox Vial ^{QL}
Xarelto Tablet (all strengths <u>except</u> 2.5 mg) ^{QL}	Pradaxa Capsule ^{QL}
	Pradaxa Pellet Pack ^{QL}
	Rivaroxaban Tablet (all strengths <u>except</u> 2.5 mg) ^{QL}
	Savaysa Tablet ^{QL}
	Xarelto Suspension ^{QL}
	Xarelto 2.5 mg Tablet ^{QL}

ANTICONVULSANTS

Preferred Agents	Non-Preferred Agents
Briviact (<i>brivaracetam</i>) Tablet ^{QL}	Aptiom (<i>eslicarbazepine</i>) Tablet ^{QL}
Carbamazepine 100 mg Chewable Tablet (<i>generic Tegretol Chewable Tablet</i>) ^{QL}	Banzel (<i>rufinamide</i>) Suspension ^{QL}
Carbamazepine Suspension ^{QL}	Banzel (<i>rufinamide</i>) Tablet ^{QL}
Carbamazepine Tablet ^{QL}	Briviact (<i>brivaracetam</i>) Solution ^{QL}
Carbamazepine ER Capsule ^{QL}	Carbamazepine 200 mg Chewable Tablet ^{QL}
Carbamazepine ER Tablet ^{QL}	Carbatrol ER (<i>carbamazepine ER</i>) Capsule ^{QL}
Clobazam Suspension ^{QL}	Celontin (<i>methsuximide</i>) Capsule ^{QL}
Clobazam Tablet ^{QL}	Depakote DR (<i>divalproex sodium DR</i>) Sprinkle Capsule
Clonazepam ODT ^{AR, QL}	Depakote DR (<i>divalproex sodium DR</i>) Tablet
Clonazepam Tablet ^{AR, QL}	Depakote ER (<i>divalproex sodium ER</i>) Tablet
Diazepam Rectal Gel System	Diacomit (<i>stiripentol</i>) Capsule
Dilantin (<i>phenytoin</i>) 30 mg Capsule ^{QL}	Diacomit (<i>stiripentol</i>) Powder Packet
Divalproex Sodium DR Sprinkle Capsule	Dilantin (<i>phenytoin</i>) 100 mg Capsule ^{QL}
Divalproex Sodium DR Tablet	Dilantin Infatab (<i>phenytoin</i>) Chewable Tablet ^{QL}
Divalproex Sodium ER Tablet	Dilantin (<i>phenytoin</i>) Suspension ^{QL}
Epidiolex (<i>cannabidiol extract</i>) Solution ^{PA}	Elepsia XR (<i>levetiracetam ER</i>) Tablet ^{QL}
Epitol (<i>carbamazepine</i>) Tablet ^{QL}	Eprontia (<i>topiramate</i>) Solution ^{QL}
Equetro (<i>carbamazepine ER</i>) Capsule ^{QL}	Eslicarbazepine Tablet ^{QL}
Ethosuximide Capsule ^{QL}	Felbamate Suspension
Ethosuximide Solution ^{QL}	Felbamate Tablet
Lacosamide Solution ^{QL}	Felbatol (<i>felbamate</i>) Tablet
Lacosamide Tablet ^{QL}	Fintepla (<i>fenfluramine</i>) Solution ^{QL}
Lamotrigine Tablet	Fycompa (<i>perampanel</i>) Suspension ^{QL}
Levetiracetam Solution ^{QL}	Fycompa (<i>perampanel</i>) Tablet ^{QL}
Levetiracetam Tablet ^{QL}	Keppra (<i>levetiracetam</i>) Solution ^{QL}
Levetiracetam ER Tablet ^{QL}	Keppra (<i>levetiracetam</i>) Tablet ^{QL}
Nayzilam (<i>midazolam</i>) Nasal Spray	Keppra XR (<i>levetiracetam ER</i>) Tablet ^{QL}
Oxcarbazepine Suspension ^{QL}	Klonopin (<i>clonazepam</i>) Tablet ^{AR, QL}
Oxcarbazepine Tablet ^{QL}	Lamictal (<i>lamotrigine</i>) Dispersible Tablet
Phenobarbital Elixir/Solution	Lamictal (<i>lamotrigine</i>) ODT
Phenobarbital Tablet	Lamictal (<i>lamotrigine</i>) ODT Starter Kit
Phenytoin Chewable Tablet ^{QL}	Lamictal (<i>lamotrigine</i>) Tablet
Phenytoin Suspension ^{QL}	Lamictal (<i>lamotrigine</i>) Tablet Starter Kit
Phenytoin ER Capsule ^{QL}	Lamictal XR (<i>lamotrigine ER</i>) Tablet
Primidone Tablet ^{QL}	Lamictal XR (<i>lamotrigine ER</i>) Tablet Starter Kit
Roweepra (<i>levetiracetam</i>) Tablet ^{QL}	Lamotrigine Dispersible Tablet
Subvenite (<i>lamotrigine</i>) Tablet	Lamotrigine ODT
Topiramate 15 mg, 25 mg Sprinkle Capsule (<i>generic Topamax</i>) ^{QL}	Lamotrigine ODT Starter Kit
	Lamotrigine Tablet Starter Kit

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Topiramate Tablet ^{QL}	Lamotrigine ER Tablet
Topiramate ER Sprinkle Capsule (<i>generic Qudexy XR</i>) ^{QL}	Levetiracetam Tablet for Suspension ^{QL}
Valproic Acid Capsule ^{QL}	Libervant (<i>diazepam</i>) Film ^{QL}
Valproic Acid Solution ^{QL}	Methsuximide Capsule ^{QL}
Valtoco (<i>diazepam</i>) Nasal Spray	Motpoly XR (<i>lacosamide</i>) Capsule ^{QL}
Zonisamide Capsule ^{QL}	Onfi (<i>clobazam</i>) Suspension ^{QL}
	Onfi (<i>clobazam</i>) Tablet ^{QL}
	Oxcarbazepine ER Tablet ^{QL}
	Oxtellar XR (<i>oxcarbazepine ER</i>) Tablet ^{QL}
	Perampanel Tablet ^{QL}
	Phenytek (<i>phenytoin ER</i>) Capsule ^{QL}
	Qudexy XR (<i>topiramate ER</i>) Capsule ^{QL}
	Rufinamide Suspension ^{QL}
	Rufinamide Tablet ^{QL}
	Sabril (<i>vigabatrin</i>) Powder Packet ^{QL}
	Sabril (<i>vigabatrin</i>) Tablet ^{QL}
	Spritam (<i>levetiracetam</i>) Tablet for Suspension ^{QL}
	Subvenite (<i>lamotrigine</i>) Starter Kit
	Sympazan (<i>clobazam</i>) Film ^{QL}
	Tegretol (<i>carbamazepine</i>) Suspension ^{QL}
	Tegretol (<i>carbamazepine</i>) Tablet ^{QL}
	Tegretol XR (<i>carbamazepine ER</i>) Tablet ^{QL}
	Tiagabine Tablet
	Topamax (<i>topiramate</i>) Sprinkle Capsule ^{QL}
	Topamax (<i>topiramate</i>) Tablet ^{QL}
	Topiramate 50 mg Sprinkle Capsule ^{QL}
	Topiramate ER Capsule (<i>generic Trokendi XR</i>) ^{QL}
	Trileptal (<i>oxcarbazepine</i>) Suspension ^{QL}
	Trileptal (<i>oxcarbazepine</i>) Tablet ^{QL}
	Trokendi XR (<i>topiramate ER</i>) Capsule ^{QL}
	Vigabatrin Powder Packet ^{QL}
	Vigabatrin Tablet ^{QL}
	Vigadrone (<i>vigabatrin</i>) Powder Packet ^{QL}
	Vigafyde (<i>vigabatrin</i>) Solution ^{QL}
	Vimpat (<i>lacosamide</i>) Solution ^{QL}
	Vimpat (<i>lacosamide</i>) Tablet ^{QL}
	Xcopri (<i>cenobamate</i>) Tablet ^{QL}
	Zarontin (<i>ethosuximide</i>) Capsule ^{QL}
	Zarontin (<i>ethosuximide</i>) Solution ^{QL}
	Zonisade (<i>zonisamide</i>) Suspension ^{QL}
	Ztalmy (<i>ganaxolone</i>) Suspension ^{QL}

ANTIDEPRESSANTS, OTHER

Preferred Agents	Non-Preferred Agents
Amitriptyline Tablet	Anafranil Capsule
Amoxapine Tablet	Auvelity ER Tablet ^{QL}
Bupropion HCl Tablet ^{QL}	Cymbalta Capsule ^{QL}
Bupropion HCl SR 100 mg, 150 mg, 200 mg Tablet (<i>generic Wellbutrin SR</i>) ^{QL}	Desipramine Tablet
Bupropion HCl XL 150 mg, 300 mg Tablet (<i>generic Wellbutrin XL</i>) ^{QL}	Desvenlafaxine ER Tablet ^{QL}
Bupropion HCl XL 450 mg Tablet (<i>generic Forfivo XL</i>) ^{QL}	Drizalma Sprinkle DR Capsule ^{QL}
Clomipramine Capsule	Duloxetine DR 40 mg Capsule (<i>generic Irenka</i>) ^{QL}
	Effexor XR Capsule ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Desvenlafaxine Succinate ER Tablet (<i>generic Pristiq</i>) ^{QL}	Emsam Patch ^{QL}
Doxepin Capsule	Fetzima ER Capsule ^{QL}
Doxepin Concentrate Solution	Forfivo XL Tablet ^{QL}
Duloxetine DR 20 mg, 30 mg, 60 mg Capsule (<i>generic Cymbalta</i>) ^{QL}	Imipramine Pamoate Capsule
Imipramine HCl Tablet	Marplan Tablet
Mirtazapine ODT ^{QL}	Nardil Tablet
Mirtazapine Tablet ^{QL}	Nefazodone Tablet
Nortriptyline Capsule	Nortriptyline Solution
Phenelzine Tablet	Pamelor Capsule
Trazodone Tablet	Pristiq ER Tablet ^{QL}
Venlafaxine Tablet ^{QL}	Protriptyline Tablet
Venlafaxine HCl ER Capsule ^{QL}	Raldesy Solution
Venlafaxine HCl ER Tablet ^{QL}	Remeron Soltab ^{QL}
Vilazodone Tablet ^{QL}	Remeron Tablet ^{QL}
	Spravato (Nasal) Dose Pack ^{QL}
	Tranlycypromine Tablet
	Trimipramine Capsule
	Trintellix Tablet ^{QL}
	Venlafaxine Besylate ER Tablet ^{QL}
	Viibryd Tablet ^{QL}
	Wellbutrin SR Tablet ^{QL}
	Zuruvae Capsule ^{QL}

ANTIDEPRESSANTS, SSRIs

Preferred Agents	Non-Preferred Agents
Citalopram 10 mg/5 mL Solution ^{QL}	Celexa Tablet ^{QL}
Citalopram Tablet ^{QL}	Citalopram Capsule ^{QL}
Escitalopram Tablet ^{QL}	Citalopram 20 mg/10 mL Solution ^{QL}
Fluoxetine Capsule ^{QL}	Escitalopram Solution ^{QL}
Fluoxetine Solution ^{QL}	Fluoxetine DR Capsule ^{QL}
Fluoxetine Tablet ^{QL}	Fluvoxamine ER Capsule ^{QL}
Fluvoxamine Tablet ^{QL}	Lexapro Tablet ^{QL}
Paroxetine Tablet ^{QL}	Paroxetine Suspension ^{QL}
Sertraline Concentrate Solution ^{QL}	Paroxetine CR/ER Tablet ^{QL}
Sertraline Tablet ^{QL}	Paroxetine Mesylate Capsule ^{QL}
	Paxil Suspension ^{QL}
	Paxil Tablet ^{QL}
	Paxil CR Tablet ^{QL}
	Prozac Capsule ^{QL}
	Sertraline Capsule ^{QL}
	Zoloft Concentrate Solution ^{QL}
	Zoloft Tablet ^{QL}

ANTIEMETICS-ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents
Aprepitant Capsule ^{QL}	Akynzeo Capsule ^{QL}
Aprepitant Dose Pack ^{QL}	Akynzeo Vial ^{QL}
Compro Rectal Suppository	Antivert Chewable Tablet
Dimenhydrinate Tablet	Antivert Tablet
Doxylamine Succinate-Pyridoxine DR Tablet (<i>generic Diclegis</i>) ^{QL}	Bonjesta Tablet ^{QL}
Fosaprepitant Vial ^{QL}	Cinvanti Vial ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Granisetron Vial	Diclegis Tablet ^{QL}
Meclizine Chewable Tablet	Dimenhydrinate Vial
Meclizine 12.5 mg, 25 mg Tablet	Dronabinol Capsule ^{QL}
Metoclopramide Solution	Emend Capsule ^{QL}
Metoclopramide Tablet	Emend Powder Packet ^{QL}
Metoclopramide Vial	Emend Tripack ^{QL}
Ondansetron ODT 4 mg, 8 mg ^{QL}	Emend Vial ^{QL}
Ondansetron Solution ^{QL}	Focinvez Vial ^{QL}
Ondansetron Syringe	Gimoti Nasal Spray ^{QL}
Ondansetron Tablet ^{QL}	Granisetron Tablet ^{QL}
Ondansetron Vial ^{QL}	Meclizine 50 mg Tablet
Palonosetron Syringe	Metoclopramide ODT
Palonosetron Vial ^{QL}	Ondansetron ODT 16 mg ^{QL}
Phosphorated Carbohydrate Nausea Relief Solution	Phenergan Ampule ^{AR}
Prochlorperazine Rectal Suppository	Phenergan Vial ^{AR}
Prochlorperazine Tablet	Posfrea Vial ^{QL}
Prochlorperazine Vial	Reglan Tablet
Promethazine Ampule ^{AR}	Sancuso Patch ^{QL}
Promethazine Rectal Suppository ^{AR, QL}	Sustol Syringe ^{QL}
Promethazine Solution/Syrup ^{AR}	Tigan Vial ^{QL}
Promethazine Tablet ^{AR, QL}	Transderm-Scop Patch ^{QL}
Promethazine Vial ^{AR}	Trimethobenzamide Capsule ^{QL}
Promethegan Rectal Suppository ^{AR, QL}	
Scopolamine Patch ^{QL}	

ANTIFIBROTIC RESPIRATORY AGENTS

Preferred Agents	Non-Preferred Agents
Ofev (<i>nintedanib</i>) Capsule ^{PA, QL}	Esbriet (<i>pirfenidone</i>) Capsule ^{QL}
Pirfenidone Capsule ^{PA, QL}	Esbriet (<i>pirfenidone</i>) Tablet ^{QL}
Pirfenidone Tablet ^{PA, QL}	

ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents
Clotrimazole Troche ^{QL}	Brexafemme Tablet ^{QL}
Fluconazole Suspension ^{QL}	Cresemba Capsule ^{QL}
Fluconazole Tablet ^{QL}	Diflucan Suspension ^{QL}
Griseofulvin Suspension	Diflucan Tablet ^{QL}
Nystatin Suspension	Flucytosine Capsule
Nystatin Tablet	Griseofulvin Microsize Tablet
Posaconazole DR Tablet ^{QL}	Griseofulvin Ultramicrosize Tablet
Terbinafine Tablet ^{QL}	Itraconazole Capsule ^{QL}
Voriconazole Tablet	Itraconazole Solution ^{QL}
	Ketoconazole Tablet ^{QL}
	Noxafil Powdermix Suspension ^{QL}
	Noxafil Suspension ^{QL}
	Noxafil DR Tablet ^{QL}
	Posaconazole Suspension ^{QL}
	Sporanox Capsule ^{QL}
	Sporanox Solution ^{QL}
	Tolsura Capsule ^{QL}
	Vfend Suspension

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	Vfend Tablet Vivjoa Capsule Voriconazole Suspension
--	---

ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents
Alevazol (<i>clotrimazole</i>) Ointment	Ciclodan (<i>ciclopirox</i>) Solution
Butenafine Cream	Ciclopirox Gel
Ciclopirox Cream	Ciclopirox Shampoo
Ciclopirox Solution	Ciclopirox Suspension
Clotrimazole Cream	Ciclopirox Treatment Kit
Clotrimazole-Betamethasone Cream	Clotrimazole Solution
Econazole Cream	Clotrimazole-Betamethasone Lotion
Ketoconazole Cream	Ketoconazole Foam
Ketoconazole Shampoo	Ketodan (<i>ketoconazole</i>) Foam
Klayesta Powder	Ketodan (<i>ketoconazole</i> + <i>cleanser</i>) Foam Kit
Miconazole Cream	Miconazole-Zinc-Petrolatum Ointment (<i>generic Vusion</i>)
Miconazole Powder	Micomitin (<i>tolnaftate</i>) Solution
Miconazole Solution	Micotrin AC (<i>clotrimazole</i>) Cream
Nyamyx Powder	Micotrin AL (<i>tolnaftate</i>) Solution
Nystatin Cream	Mycozyl AC 1% Cream
Nystatin Ointment	Naftifine Cream
Nystatin Powder	Naftifine Gel
Nystatin-Triamcinolone Cream	Naftin (<i>naftifine</i>) Gel
Nystatin-Triamcinolone Ointment	Oxiconazole Cream
Nystop Powder	Oxistat (<i>oxiconazole</i>) Lotion
Terbinafine Cream	Tavaborole Solution
Tolnaftate Cream	Trimazole (<i>clotrimazole</i>) Cream
Tolnaftate Liquid/Solution	Tripenicol C (<i>undecylenic acid</i>) Cream
Tolnaftate Liquid Spray	Tritolnecide S (<i>tolnaftate</i>) Solution
Tolnaftate Powder	Vusion (<i>miconazole nitrate 0.25%-zinc oxide 15% in white petrolatum</i>) Ointment
Tolnaftate Powder Spray	

ANTIHEMOPHILIA AGENTS

Preferred Agents	Non-Preferred Agents
Advate ^{PA}	Alhemo
Adynovate ^{PA}	Esperoct
Afstyla ^{PA}	Hypavzi ^{QL}
Alphanate ^{PA}	Idelvion
Alphanine SD ^{PA}	Obizur
Alprolix ^{PA}	Qfitlia ^{QL}
Altuviiio ^{PA}	Vonvendi
Benefix ^{PA}	
Eloctate ^{PA}	
Feiba NF ^{PA}	
Hemlibra ^{PA}	
Hemofil M ^{PA}	
Humate-P ^{PA}	
Ixinity ^{PA}	
Jivi ^{PA}	
Koate ^{PA}	

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Kogenate FS^{PA}
 Kovaltry^{PA}
 Novoeight^{PA}
 Novoseven RT^{PA}
 Nuwiq^{PA}
 Profilnine^{PA}
 Rebiny^{PA}
 Recombinate^{PA}
 Rixubis^{PA}
 Sevenfact^{PA}
 Wilate^{PA}
 Xyntha^{PA}
 Xyntha Solofuse^{PA}

ANTI-HISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents
Cetirizine Capsule ^{QL}	Cetirizine Chewable Tablet ^{QL}
Cetirizine Solution ^{QL}	Clarinet (desloratadine) Tablet ^{QL}
Cetirizine Tablet ^{QL}	Clarinet-D (desloratadine-pseudoephedrine) Tablet ^{QL}
Cetirizine-Pseudoephedrine Tablet ^{QL}	Desloratadine ODT ^{QL}
Desloratadine Tablet ^{QL}	
Fexofenadine Suspension ^{QL}	
Fexofenadine Tablet ^{QL}	
Fexofenadine-Pseudoephedrine Tablet ^{QL}	
Levocetirizine Solution ^{QL}	
Levocetirizine Tablet ^{QL}	
Loratadine Chewable Tablet ^{QL}	
Loratadine ODT ^{QL}	
Loratadine Solution ^{QL}	
Loratadine Tablet ^{QL}	
Loratadine-Pseudoephedrine Tablet ^{QL}	

ANTI-HYPERTENSIVES, SYMPATHOLYTIC

Preferred Agents	Non-Preferred Agents
Clonidine Patch ^{QL}	Clonidine ER 0.17 mg Tablet ^{QL}
Clonidine 0.1 mg, 0.2 mg, 0.3 mg Tablet	Nexiclon XR Tablet ^{QL}
Guanfacine Tablet ^{QL}	
Methyldopa Tablet	
Prazosin Capsule	

ANTI-HYPERURICEMICS

Preferred Agents	Non-Preferred Agents
Allopurinol 100 mg, 300 mg Tablet	Allopurinol 200 mg Tablet
Colchicine 0.6 mg Tablet ^{QL}	Colchicine Capsule ^{QL}
Febuxostat Tablet ^{QL}	Krystexxa (pegloticase) Vial ^{QL}
Probenecid Tablet	Mitigare (colchicine) Capsule ^{QL}
Probenecid-Colchicine Tablet	Uloric (febuxostat) Tablet ^{QL}

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

ANTIMALARIALS

Preferred Agents	Non-Preferred Agents
Atovaquone-Proguanil Tablet ^{QL}	Malarone (<i>atovaquone-proguanil</i>) Tablet ^{QL}
Chloroquine Tablet	Qualaquin (<i>quinine sulfate</i>) Capsule
Coartem (<i>artemether-lumefantrine</i>) Tablet	Quinine Sulfate Capsule
Hydroxychloroquine Tablet	Sovuna (<i>hydroxychloroquine</i>) Tablet
Krintafel (<i>tafenoquine</i>) Tablet	
Mefloquine Tablet	
Primaquine Tablet	

ANTIPARASITICS, TOPICAL

Preferred Agents	Non-Preferred Agents
Natroba (<i>spinosad</i>) Topical Suspension	Elimite Cream
Permethrin 1% Creme Rinse (<i>Lice Killing 1% Crème Rinse, Lice Treatment 1% Creme Rinse</i>)	Malathion Lotion
Permethrin 5% Cream	Pruradik (<i>crotamiton</i>) Lotion
Piperonyl Butoxide-Pyrethrins 4%-0.33% Shampoo (<i>Lice Killing Shampoo</i>)	Sklice (<i>ivermectin</i>) Lotion
Spinosad Topical Suspension	Vanallice (<i>piperonyl butoxide-pyrethrins 3.5%-0.3%</i>) Gel

ANTIPARKINSON'S AGENTS

Preferred Agents	Non-Preferred Agents
Amantadine Capsule	Azilect Tablet ^{QL}
Amantadine Solution	Carbidopa Tablet ^{QL}
Amantadine Tablet	Carbidopa-Levodopa ODT ^{QL}
Benzotropine Tablet ^{QL}	Carbidopa-Levodopa-Entacapone Tablet ^{QL}
Bromocriptine Capsule ^{QL}	Crexont ER Capsule ^{QL}
Bromocriptine Tablet ^{QL}	Dhivy Tablet ^{QL}
Carbidopa-Levodopa Tablet ^{QL}	Duopa Enteral Suspension ^{QL}
Carbidopa-Levodopa ER Tablet ^{QL}	Gocovri ER Capsule ^{QL}
Entacapone Tablet ^{QL}	Inbrija Inhalation Capsule ^{QL}
Pramipexole Tablet ^{QL}	Neupro Patch ^{QL}
Rasagiline Tablet ^{QL}	Nourianz Tablet ^{QL}
Ropinirole Tablet ^{QL}	Ongentys Capsule ^{QL}
Selegiline Capsule ^{QL}	Pramipexole ER Tablet ^{QL}
Selegiline Tablet ^{QL}	Ropinirole ER Tablet ^{QL}
Trihexyphenidyl Elixir ^{QL}	Rytary ER Capsule ^{QL}
Trihexyphenidyl Tablet ^{QL}	Sinemet Tablet ^{QL}
	Tolcapone Tablet ^{QL}
	Xadago Tablet ^{QL}

ANTIPSORIATICS, ORAL

Preferred Agents	Non-Preferred Agents
Acitretin Capsule ^{QL}	

ANTIPSORIATICS, TOPICAL

Preferred Agents	Non-Preferred Agents
Calcipotriene Cream	Calcipotriene Foam
Calcipotriene Ointment	Calcitriol Ointment
Calcipotriene Solution	Enstilar Foam

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Calcipotriene-Betamethasone Ointment
 Calcipotriene-Betamethasone Suspension
 Zoryve 0.3% Cream^{PA}
 Zoryve Foam^{PA}

Sorilux Foam
 Taclonex Suspension
 Tazarotene Cream^{AR}
 Tazarotene Gel^{AR}
 Vectical Ointment
 Vtama Cream

ANTIPSYCHOTICS

Preferred Agents	Non-Preferred Agents
<u>Injectable</u> Abilify Asimtufii (<i>aripiprazole</i>)^{AR, QL} Abilify Maintena (<i>aripiprazole</i>)^{AR, QL} Aristada ER (<i>aripiprazole lauroxil</i>)^{AR, QL} Aristada Initio (<i>aripiprazole lauroxil</i>)^{AR, QL} Fluphenazine Decanoate Vial^{AR} Haloperidol Decanoate Ampule^{AR} Haloperidol Decanoate Vial^{AR} Haloperidol Lactate Syringe^{AR} Haloperidol Lactate Vial^{AR} Invega Hafyera (<i>paliperidone palmitate</i>)^{AR, QL} Invega Sustenna (<i>paliperidone palmitate</i>)^{AR, QL} Invega Trinza (<i>paliperidone palmitate</i>)^{AR, QL} Risperdal Consta (<i>risperidone</i>)^{AR, QL} Risperidone ER Vial^{AR, QL} Uzedy ER (<i>risperidone</i>)^{AR, QL}	<u>Injectable</u> Chlorpromazine Ampule^{AR} Chlorpromazine Vial^{AR} Erzofri (<i>paliperidone palmitate</i>)^{AR, QL} Fluphenazine HCl Vial^{AR} Geodon (<i>ziprasidone</i>) Vial^{AR, QL} Haldol Decanoate (<i>haloperidol</i>) Ampule^{AR} Olanzapine Vial^{AR, QL} Ziprasidone Vial^{AR, QL} Zyprexa Relprevv (<i>olanzapine</i>)^{AR, QL} Zyprexa (<i>olanzapine</i>) Vial^{AR, QL}
<u>Non-Injectable</u> Aripiprazole Tablet^{AR, QL} Clozapine Tablet^{AR, QL} Equetro (<i>carbamazepine ER</i>) Capsule^{QL} Fluphenazine Oral Concentrate Solution^{AR} Fluphenazine Tablet^{AR} Haloperidol Tablet^{AR} Haloperidol Lactate Oral Concentrate Solution^{AR} Loxapine Capsule^{AR} Lurasidone Tablet^{AR, QL} Olanzapine Tablet^{AR, QL} Paliperidone ER Tablet^{AR, QL} Perphenazine Tablet^{AR} Quetiapine Tablet^{AR, QL} Quetiapine ER Tablet^{AR, QL} Risperidone Solution^{AR, QL} Risperidone Tablet^{AR, QL} Trifluoperazine Tablet^{AR} Ziprasidone Capsule^{AR, QL}	<u>Non-Injectable</u> Abilify (<i>aripiprazole</i>) Tablet^{AR, QL} Adasuve (<i>loxapine</i>) Inhalation Powder^{AR, QL} Aripiprazole ODT^{AR, QL} Aripiprazole Solution^{AR, QL} Asenapine SL Tablet^{AR, QL} Caplyta (<i>lumateperone</i>) Capsule^{AR, QL} Chlorpromazine Concentrate Solution^{AR} Chlorpromazine Tablet^{AR} Clozapine ODT^{AR, QL} Clozaril (<i>clozapine</i>) Tablet^{AR, QL} Cobenfy (<i>xanomeline-trospium</i>) Capsule^{AR, QL} Fanapt (<i>iloperidone</i>) Tablet^{AR, QL} Fluphenazine Elixir^{AR} Geodon (<i>ziprasidone</i>) Capsule^{AR, QL} Invega ER (<i>paliperidone</i>) Tablet^{AR, QL} Latuda (<i>lurasidone</i>) Tablet^{AR, QL} Lybalvi (<i>olanzapine/samidorphan</i>) Tablet^{AR, QL} Molindone Tablet^{AR, QL} Nuplazid (<i>pimavanserin</i>) Capsule^{AR, QL} Nuplazid (<i>pimavanserin</i>) Tablet^{AR, QL} Olanzapine ODT^{AR, QL} Olanzapine-Fluoxetine Capsule^{AR, QL} Opipza (<i>aripiprazole</i>) Film^{AR, QL} Perphenazine-Amitriptyline Tablet^{AR}

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	Pimozide Tablet ^{AR} Rexulti (<i>brexpiprazole</i>) Tablet ^{AR, QL} Risperdal (<i>risperidone</i>) Solution ^{AR, QL} Risperdal (<i>risperidone</i>) Tablet ^{AR, QL} Risperidone ODT ^{AR, QL} Saphris SL (<i>asenapine</i>) Tablet ^{AR, QL} Secuado (<i>asenapine</i>) Patch ^{AR, QL} Seroquel (<i>quetiapine</i>) Tablet ^{AR, QL} Seroquel XR (<i>quetiapine</i>) Tablet ^{AR, QL} Thioridazine Tablet ^{AR} Thiothixene Capsule ^{AR} Versacloz (<i>clozapine</i>) Suspension ^{AR} Vraylar (<i>cariprazine</i>) Capsule ^{AR, QL} Zyprexa (<i>olanzapine</i>) Tablet ^{AR, QL} Zyprexa (<i>olanzapine</i>) Zydis ^{AR, QL}
--	--

ANTIVIRALS, CMV

Preferred Agents	Non-Preferred Agents
Prevymis (<i>letermovir</i>) Tablet ^{PA, QL} Valganciclovir Solution Valganciclovir Tablet	Livtency (<i>maribavir</i>) Tablet ^{QL} Prevymis (<i>letermovir</i>) Pellet Packet ^{QL} Valcyte (<i>valganciclovir</i>) Solution Valcyte (<i>valganciclovir</i>) Tablet

ANTIVIRALS, HERPES

Preferred Agents	Non-Preferred Agents
Acyclovir Capsule ^{QL} Acyclovir Ointment ^{QL} Acyclovir Suspension ^{QL} Acyclovir Tablet ^{QL} Docosanol Cream ^{QL} Famciclovir Tablet ^{QL} Valacyclovir Tablet ^{QL}	Acyclovir Cream ^{QL} Denavir Cream ^{QL} Penciclovir Cream ^{QL} Valtrex Tablet ^{QL}

ANTIVIRALS, INFLUENZA

Preferred Agents	Non-Preferred Agents
Oseltamivir Capsule ^{QL} Oseltamivir Suspension ^{QL}	Rapivab Vial Relenza Inhalation ^{QL} Rimantadine Tablet Tamiflu Capsule ^{QL} Tamiflu Suspension ^{QL} Xofluza Tablet ^{QL}

ANXIOLYTICS

Preferred Agents	Non-Preferred Agents
Alprazolam Tablet ^{AR, QL} Buspirone 5 mg, 7.5 mg, 10 mg, 15 mg, 30 mg Tablet (generic Buspar) ^{QL} Chlordiazepoxide Capsule ^{AR, QL} Clonazepam ODT ^{AR, QL} Clonazepam Tablet ^{AR, QL}	Alprazolam ER/XR Tablet ^{AR, QL} Alprazolam Intensol/Oral Concentrate Solution ^{AR, QL} Alprazolam ODT ^{AR, QL} Ativan Vial ^{AR} Bucapsol Capsule Clorazepate Tablet ^{AR, QL}

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (in years)
Non-preferred agents require prior authorization
Effective January 2026 v10

PA = clinical prior authorization required
QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Diazepam Solution ^{AR, QL}	Diazepam Cartridge ^{AR}
Diazepam Tablet ^{AR, QL}	Diazepam Concentrate Solution ^{AR, QL}
Diazepam Vial ^{AR}	Diazepam Syringe ^{AR}
Hydroxyzine HCl 10 mg/5 mL Solution/Syrup	Hydroxyzine HCl 50 mg/25 mL Solution
Hydroxyzine HCl Tablet	Klonopin Tablet ^{AR, QL}
Hydroxyzine Pamoate Capsule	Lorazepam Intensol/Concentrate Solution ^{AR, QL}
Lorazepam Cartridge ^{AR}	Loreev XR Capsule ^{AR, QL}
Lorazepam Tablet ^{AR, QL}	Meprobamate Tablet ^{QL}
Lorazepam Vial ^{AR}	Oxazepam Capsule ^{AR, QL}
	Xanax Tablet ^{AR, QL}
	Xanax XR Tablet ^{AR, QL}

BETA BLOCKERS

Preferred Agents	Non-Preferred Agents
Acebutolol Capsule	Betapace Tablet
Atenolol Tablet	Betapace AF Tablet
Atenolol-Chlorthalidone Tablet	Bisoprolol 2.5 mg Tablet
Betaxolol Tablet	Bystolic Tablet ^{QL}
Bisoprolol 5 mg, 10 mg Tablet	Carvedilol ER Capsule ^{QL}
Bisoprolol-Hydrochlorothiazide Tablet	Inderal LA Capsule
Carvedilol Tablet ^{QL}	Inderal XL Capsule ^{QL}
Hemangeol Solution ^{PA}	Innopran XL Capsule ^{QL}
Labetalol 100 mg, 200 mg, 300 mg Tablet	Kaspargo Sprinkle Capsule ^{QL}
Metoprolol Succinate ER Tablet	Labetolol 400 mg Tablet
Metoprolol Tartrate 25 mg, 37.5 mg, 50 mg, 75 mg, 100 mg Tablet	Lopressor Tablet
Nadolol Tablet	Metoprolol-Hydrochlorothiazide Tablet
Nebivolol Tablet ^{QL}	Metoprolol Tartrate 12.5 mg Tablet
Pindolol Tablet	Sotyize Solution
Propranolol Solution	Tenoretic Tablet
Propranolol Tablet	Tenormin Tablet
Propranolol ER Capsule	Timolol Tablet
Sorine Tablet	Toprol XL Tablet
Sotalol Tablet	
Sotalol AF Tablet	

BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents
Darifenacin ER Tablet ^{QL}	Fesoteridine ER Tablet ^{QL}
Myrbetriq ER Tablet ^{QL}	Flavoxate Tablet
Oxybutynin Syrup ^{QL}	Gemtesa Tablet ^{QL}
Oxybutynin 5 mg Tablet ^{QL}	Mirabegron ER Tablet ^{QL}
Oxybutynin ER Tablet ^{QL}	Myrbetriq ER Suspension ^{QL}
Oxytrol for Women Patch (OTC) ^{QL}	Oxybutynin 2.5 mg Tablet ^{QL}
Solifenacin Tablet ^{QL}	Oxytrol Patch ^{QL}
Tolterodine Tablet ^{QL}	Toviaz ER Tablet ^{QL}
Tolterodine ER Capsule ^{QL}	Trospium ER Capsule ^{QL}
Trospium Tablet ^{QL}	Vesicare Tablet ^{QL}
	Vesicare LS Suspension ^{QL}

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

BLOOD GLUCOSE METERS AND TEST STRIPS

Preferred Products	Non-Preferred Manufacturers
Accu-Chek Glucometers Accu-Chek Guide^{QL}	All Other Blood Glucose Meters and Test Strips ^{QL}
Accu-Chek Test Strips Accu-Chek Guide^{QL}	
Trividia Glucometers Trueness (NDC 56151-2121-01 only)^{QL}	
Trividia Test Strips Trueness (NDC 56151-2122-05 only)^{QL}	

BONE DENSITY REGULATORS

Preferred Agents	Non-Preferred Agents
Alendronate Tablet ^{QL} Ibandronate Tablet ^{QL} Jubbonti (<i>denosumab-bbdz</i>) Syringe ^{PA, QL} Pamidronate Vial Wyost (<i>denosumab-bbdz</i>) Vial ^{PA, QL} Zoledronic Acid ^{QL}	Actonel (<i>risedronate</i>) Tablet ^{QL} Alendronate Solution ^{QL} Atelvia DR (<i>risedronate</i>) Tablet ^{QL} Binosto (<i>alendronate</i>) Effervescent Tablet ^{QL} Bonsity (<i>teriparatide</i>) Pen ^{QL} Calcitonin Salmon Nasal Spray/Pump ^{QL} Calcitonin Salmon Vial ^{QL} Evenity (<i>romosozumab-aqqg</i>) Syringe ^{QL} Evista (<i>raloxifene</i>) Tablet ^{QL} Forteo (<i>teriparatide</i>) Pen ^{QL} Fosamax (<i>alendronate</i>) Tablet ^{QL} Fosamax Plus D (<i>alendronate-vitamin D3</i>) Tablet ^{QL} Ibandronate Syringe ^{QL} Ibandronate Vial ^{QL} Miacalcin (<i>calcitonin salmon</i>) Vial ^{QL} Osenvelt (<i>denosumab-bmwo</i>) Vial ^{QL} Prolia (<i>denosumab</i>) Syringe ^{QL} Raloxifene Tablet ^{QL} Reclast Solution ^{QL} Risedronate Tablet ^{QL} Risedronate DR Tablet ^{QL} Stoboclo (<i>denosumab-bmwo</i>) Syringe ^{QL} Teriparatide Pen ^{QL} Tymlos Pen ^{QL} Xgeva Vial ^{QL}

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

BOTULINUM TOXINS

Preferred Agents	Non-Preferred Agents
Botox ^{PA, QL} Dysport ^{PA, QL}	Daxxify ^{QL} Myobloc ^{QL} Xeomin ^{QL}

BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS

Preferred Agents	Non-Preferred Agents
Alfuzosin ER Tablet ^{QL} Doxazosin Tablet ^{QL} Dutasteride Capsule ^{QL} Finasteride Tablet ^{QL} Tamsulosin Capsule ^{QL} Terazosin Capsule ^{QL}	Cardura Tablet ^{QL} Cardura XL Tablet ^{QL} Cialis Tablet ^{QL} Dutasteride-Tamsulosin Capsule ^{QL} Flomax Capsule ^{QL} Proscar Tablet ^{QL} Rapaflo Capsule ^{QL} Silodosin Capsule ^{QL} Tadalafil Tablet (<i>generic Cialis</i>) ^{QL} Tezruy Solution ^{QL}

BRONCHODILATORS, BETA AGONISTS

Preferred Agents	Non-Preferred Agents
Albuterol HFA ^{QL} Albuterol Nebulizer Concentrate Solution Albuterol Nebulizer Vial Albuterol Syrup Levalbuterol HFA ^{QL} Levalbuterol Nebulizer Vial ^{QL} Proair Respiclick ^{QL} Serevent Diskus ^{QL} Striverdi Respimat ^{QL} Ventolin HFA ^{QL} Xopenex HFA ^{QL}	Albuterol Tablet Arformoterol Nebulizer Vial ^{QL} Brovana Nebulizer Vial ^{QL} Formoterol Nebulizer Vial ^{QL} Levalbuterol Nebulizer Concentrate Solution ^{QL} Perforomist Nebulizer Vial ^{QL} Terbutaline Tablet

CALCIUM CHANNEL BLOCKERS

Preferred Agents	Non-Preferred Agents
Amlodipine Tablet ^{QL} Cartia XT (<i>diltiazem ER 24H</i>) Capsule ^{QL} Diltiazem Tablet ^{QL} Diltiazem 24HR ER(CD) (ER24H) Capsule (<i>generic Cardizem CD Capsule</i>) ^{QL} Diltiazem 24HR ER (SA 24H) Capsule (<i>generic Tiazac ER Capsule</i>) ^{QL} Diltiazem 24HR ER(XR) (ER DEG) Capsule (<i>generic Dilacor XR Capsule</i>) ^{QL} Dilt-XR (<i>diltiazem ER DEG</i>) Capsule ^{QL} Felodipine ER Tablet ^{QL} Nifedipine Capsule ^{QL} Nifedipine ER Tablet ^{QL} Nimodipine Capsule Tiadylt ER (<i>diltiazem CAP SA 24H</i>) Capsule ^{QL}	Amlodipine-Atorvastatin Tablet ^{QL} Caduet Tablet ^{QL} Diltiazem 12HR ER Capsule (<i>generic Cardizem SR Capsule</i>) ^{QL} Diltiazem 24HR ER(LA) Tablet (<i>generic Cardizem LA Tablet</i>) ^{QL} Isradipine Capsule ^{QL} Katerzia Suspension ^{QL} Matzim LA (<i>diltiazem ER 24H</i>) Tablet ^{QL} Nicardipine Capsule ^{QL} Nimodipine Solution ^{QL} Nisoldipine ER Tablet ^{QL} Norliqva Solution ^{QL} Norvasc Tablet ^{QL} Nymalize Oral Syringe ^{QL} Nymalize Solution ^{QL} Procardia XL Tablet ^{QL}

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (in years)
Non-preferred agents require prior authorization
Effective January 2026 v10

PA = clinical prior authorization required
QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Verapamil Tablet	Sular ER Tablet ^{QL}
Verapamil ER/SR (CAP24H PEL) Capsule (<i>generic Verelan Capsule</i>) ^{QL}	Verelan PM (CAP24H PCT) Capsule ^{QL}
Verapamil ER PM (CAP24H PCT) Capsule (<i>generic Verelan PM Capsule</i>) ^{QL}	
Verapamil ER Tablet (<i>generic Calan SR/Isoptin SR Tablet</i>) ^{QL}	

CEPHALOSPORINS

Preferred Agents	Non-Preferred Agents
Cefadroxil Capsule	Cefaclor Capsule
Cefdinir Capsule	Cefaclor Suspension
Cefdinir Suspension	Cefaclor ER Tablet
Cefixime Capsule	Cefadroxil Suspension
Cefpodoxime Tablet	Cefadroxil Tablet
Cefprozil Suspension	Cefixime Suspension
Cefprozil Tablet	Cefixime Tablet
Cefuroxime Tablet	Cefpodoxime Suspension
Cephalexin 250 mg, 500 mg Capsule	Cephalexin 750 mg Capsule
Cephalexin Suspension	Cephalexin Tablet

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents
Fulphila (<i>pegfilgrastim-jmdb</i>) Syringe ^{PA, QL}	Leukine (<i>sargramostim</i>) Vial
Fylmetra (<i>pegfilgrastim-pbbk</i>) Syringe ^{PA, QL}	Neulasta (<i>pegfilgrastim</i>) Onpro ^{QL}
Granix (<i>tbo-filgrastim</i>) Syringe ^{PA}	Neulasta (<i>pegfilgrastim</i>) Syringe ^{QL}
Granix (<i>tbo-filgrastim</i>) Vial ^{PA}	Nivestym (<i>filgrastim-aafi</i>) Syringe
Neupogen (<i>filgrastim</i>) Syringe ^{PA}	Nivestym (<i>filgrastim-aafi</i>) Vial
Neupogen (<i>filgrastim</i>) Vial ^{PA}	Nyvepria (<i>pegfilgrastim-apgf</i>) Syringe ^{QL}
Releuko (<i>filgrastim-ayow</i>) Syringe ^{PA}	Rolvedon (<i>eflapegrastim-xnst</i>) Syringe ^{QL}
Releuko (<i>filgrastim-ayow</i>) Vial ^{PA}	Ryzneuta (<i>efbemaenogragstim alfa-vuxw</i>) Syringe ^{QL}
	Stimufend (<i>pegfilgrastim-fpgk</i>) Syringe ^{QL}
	Udenyca (<i>pegfilgrastim-cbvq</i>) Autoinjector ^{QL}
	Udenyca (<i>pegfilgrastim-cbvq</i>) Onbody ^{QL}
	Udenyca (<i>pegfilgrastim-cbvq</i>) Syringe ^{QL}
	Zarxio (<i>filgrastim-sndz</i>) Syringe
	Ziextenzo (<i>pegfilgrastim-bmez</i>) Syringe ^{QL}

CONTINUOUS GLUCOSE MONITORING PRODUCTS

Preferred Products	Non-Preferred Products
Dexcom G6 Receiver ^{PA, QL}	Eversense 365 Sensor ^{QL}
Dexcom G6 Sensor ^{PA, QL}	Eversense 365 Transmitter ^{QL}
Dexcom G6 Transmitter ^{PA, QL}	Eversense E3 Sensor-Holder ^{QL}
Dexcom G7 Receiver ^{PA, QL}	Eversense E3 Smart Transmitter ^{QL}
Dexcom G7 Sensor ^{PA, QL}	Guardian 4 Glucose Sensor ^{QL}
Dexcom G7 15 Day Sensor ^{PA, QL}	Guardian 4 Transmitter ^{QL}
Freestyle Libre 2 Plus Sensor ^{PA, QL}	Guardian Connect Transmitter ^{QL}
Freestyle Libre 2 Reader ^{PA, QL}	Guardian Link 3 Transmitter ^{QL}
Freestyle Libre 2 Sensor Kit ^{PA, QL}	Guardian Sensor 3 ^{QL}
Freestyle Libre 3 Plus Sensor ^{PA, QL}	Simplera Sensor ^{QL}
Freestyle Libre 3 Reader ^{PA, QL}	Simplera Sync Sensor ^{QL}
Freestyle Libre 3 Sensor ^{PA, QL}	

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Freestyle Libre 14-Day Reader^{PA, QL}
 Freestyle Libre 14-Day Sensor Kit^{PA, QL}

CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents
<u>Monophasic</u>	<u>Monophasic</u>
Afirmelle	Balcoltra
Altavera	Drospirenone-Ethinyl Estradiol-Levomefolate 3-0.03-0.451 mg (<i>generic Safyral</i>)
Alyacen-28 1-35	Femlyv 1 mg-0.02 mg ODT
Apri	Joyeaux
Aubra	Minzoya-28
Aubra EQ	Levonorgestrel-Ethinyl Estradiol-Ferrous Bisglycinate 0.1-0.02-36 (<i>generic Balcoltra</i>)
Aurovela-21	Loestrin-21
Aurovela Fe-28	Loestrin Fe-28
Aviane	Safyral
Ayuna	Tydemy
Balziva	
Blisovi Fe-28	
Briellyn	
Chateal	
Chateal EQ	
Cryselle	
Cyred	
Cyred EQ	
Dasetta-28 1-35	
Drospirenone-Ethinyl Estradiol 3-0.03 mg (<i>generic Yasmin</i>)	
Elinest	
Enskyce	
Estarylla	
Ethinodiol-Ethinyl Estradiol	
Falmina	
Feirza-28	
Hailey-21	
Hailey Fe-28	
Isibloom	
Juleber	
Junel-21	
Junel Fe-28	
Kalliga	
Kelnor-28 1-35	
Kelnor-28 1-50	
Kurvelo	
Larin-21	
Larin Fe-28	
Lessina	
Levonorgestrel-Ethinyl Estradiol-28 0.1 mg-20 mcg (<i>generic Alesse, Levlite</i>)	
Levonorgestrel-Ethinyl Estradiol-28 0.15 mg-30 mcg (<i>generic Nordette, Levlen</i>)	
Levora	
Low-Ogestrel	

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Luizza-21 Lutera Marlissa Microgestin-21 Microgestin Fe-28 Mili Mono-Linyah Necon-28 Norethindrone-Ethinyl Estradiol-21 (<i>generic Loestrin-21</i>) Norethindrone-Ethinyl Estradiol Fe-28 (<i>generic Loestrin Fe-28</i>) Norethindrone-Ethinyl Estradiol Fe 0.4-0.035 (21)-75 Chewable (<i>generic Femcon Fe, Ovcon Fe</i>) Norgestimate-Ethinyl Estradiol-28 0.25-0.35 mg (<i>generic Ortho-Cyclen</i>) Nortrel-21 1-35 Nortrel-28 0.5-35 Nortrel-28 1-35 Nylia-28 1-35 Nymyo Ocella Philith Pirmella-28 1-35 Portia Reclipsen Sprintec Sronyx Syeda Tarina Fe Tarina Fe EQ Turqoz Tyblume Chewable Valtya Vienva Vyfemla Vylibra Wera Wymzya Fe Chewable Xelria Fe Chewable Yasmin Zovia 1-35 Zumandimine	
<u>Biphasic</u>	<u>Biphasic</u>
Azurette Desogestrel-Ethinyl Estradiol 21-2-5 (<i>generic Mircette</i>) Kariva Pimtrea Simliya Violele Volnea	Mircette

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

<u>Triphasic</u>	<u>Triphasic</u>
Alyacen 7-7-7 Aranelle Dasetta 7-7-7 Enpresse Leena Levonest Levonorgestrel-Ethinyl Estradiol Triphasic (<i>generic TriPhasil, Tri-Levlen</i>) Norgestimate-Ethinyl Estradiol Triphasic (<i>generic Ortho Tri-Cyclen</i>) Nortrel 7-7-7 Nylia 7-7-7 Pirmella 7-7-7 Tri-Estarylla Tri-Linyah Tri-Lo-Estarylla Tri-Lo-Marzia Tri-Lo-Mili Tri-Lo-Sprintec Tri-Mili Tri-Nymyo Tri-Sprintec Trivora Tri-Vylibra Tri-Vylibra Lo Velivet	Norethindrone-Ethinyl Estradiol-Fe 1 mg/20-30-35 mcg (5-7-9-5) Tilia Fe Tri-Legest Fe Xarah Fe 1 mg/20-30-25 mcg
<u>Four-Phasic</u>	<u>Four-Phasic</u>
	Natazia
<u>28-Day Extended Cycle</u>	<u>28-Day Extended Cycle</u>
Aurovela 24 Fe Blisovi 24 Fe Charlotte 24 Fe Chewable Drospirenone-Ethinyl Estradiol 3-0.02 mg (<i>generic Yaz</i>) Finzala Chewable Hailey 24 Fe Jasmiel Junel Fe 24 Larin 24 Fe Lo Loestrin Fe Loryna Lo-Zumandimine Mibelas 24 Fe Chewable Microgestin 24 Fe Nikki Noethindrone-Ethinyl Estradiol-Fe 1-0.02(24)-75 Chewable (<i>generic Minastrin 24 Fe</i>) Tarina 24 Fe Vestura	Beyaz Drospirenone-Ethinyl Estradiol-Levomefolate 3-0.02-0.451 mg (<i>generic Beyaz</i>) Galbriela 0.8-0.025 mg Chewable Gemmily Capsule Kaitlib Fe Chewable Layolis Fe Chewable Merzee Capsule Nextstellis Noethindrone-Ethinyl Estradiol-Fe 0.8-0.025(24) Chewable (<i>generic Generess Fe Chewable</i>) Noethindrone-Ethinyl Estradiol-Fe 1-0.02(24)-75 Capsule (<i>generic Taytulla Capsule</i>) Taysofy Capsule Taytulla Capsule Yaz

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

<u>28-Day Continuous Cycle</u>	<u>28-Day Continuous Cycle</u>
Amethyst Dolishale Levonorgestrel-Ethinyl Estradiol-28 0.09-0.02 mg	
<u>3-Month Extended Cycle</u>	<u>3-Month Extended Cycle</u>
Amethia (3-month) Ashlyna (3-month) Camrese (3-month) Camrese Lo (3-month) Daysee (3-month) Iclevia (3-month) Introvale (3-month) Jaimiess (3-month) Jolessa (3-month) Levonorgestrel-Ethinyl Estradiol 0.15-0.03 mg (3-month) (<i>generic Seasonale-91</i>) Levonorgestrel-Ethinyl Estradiol + EE 0.10-0.02 mg + 0.01 mg (3-month) (<i>generic LoSeasonique-91</i>) Levonorgestrel-Ethinyl Estradiol + EE 0.15-0.03 mg + 0.01 mg (3-month) (<i>generic Seasonique-91</i>) Lojaimiess (3-month) Setlakin (3-month) Simpesse (3-month)	Levonorgestrel 0.15 mg-Ethinyl Estradiol + EE 20-25-30 mcg + 10 mcg (3-month) (<i>generic Quartette-91</i>) Loseasonique (3-month) Quartette (3-month) Rivelsa (3-month) Seasonique (3-month)
<u>Progestin Only</u>	<u>Progestin Only</u>
Camila Deblitane Emzahh Errin Heather Incassia Jencycla Lyleq Meleya Nora-Be Norethindrone-28 0.35 mg Opill Orquidea Sharobel	Slynd

CONTRACEPTIVES, OTHER

Preferred Agents	Non-Preferred Agents
Depo-Provera 150 mg/mL Vial ^{QL} Depo-SubQ Provera 104 Syringe ^{QL} Eluryng Vaginal Ring ^{QL} Enilloring Vaginal Ring ^{QL} Etonogestrel-Ethinyl Estradiol Vaginal Ring ^{QL} Haloette Vaginal Ring ^{QL} Kyleena System ^{QL} Liletta System ^{QL}	Annovera Vaginal Ring ^{QL} Depo-Provera 150 mg/mL Syringe ^{QL} Norelgestromin-Ethinyl Estradiol Patch ^{QL} Twirla Patch ^{QL} Zafemy Patch ^{QL}

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Medroxyprogesterone Acetate Syringe^{QL}
 Medroxyprogesterone Acetate Vial^{QL}
 Mirena System^{QL}
 Nexplanon Implant^{QL}
 Paragard T 380-A IUD^{QL}
 Skyla System^{QL}
 Xulane Patch^{QL}

COPD AGENTS

Preferred Agents	Non-Preferred Agents
Anoro Ellipta ^{QL}	Breztri Aerosphere ^{QL}
Atrovent HFA ^{QL}	Daliresp Tablet ^{QL}
Bevespi Aerosphere ^{QL}	Duaklir Pressair ^{QL}
Combivent RespiMat ^{QL}	Ohtuvayre Inhalation Suspension ^{QL}
Incruse Ellipta ^{QL}	Roflumilast Tablet ^{QL}
Ipratropium Nebulizer Vial	Tiotropium Capsule-Inhaler ^{QL}
Ipratropium-Albuterol Nebulizer Vial ^{QL}	Tudorza Pressair ^{QL}
Spiriva Handihaler ^{QL}	Umeclidinium-Vilanterol Blister w/ Device (<i>generic Anoro Ellipta</i>) ^{QL}
Spiriva RespiMat ^{QL}	Yupelri Nebulizer Vial ^{QL}
Stiolto RespiMat ^{QL}	
Trelegy Ellipta ^{QL}	

CYTOKINE AND CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents
Adalimumab-aaty(CF) 100 mg/mL Autoinjector ^{PA, QL}	Abrilada(CF) (<i>adalimumab-afzb</i>) 50 mg/mL Pen ^{QL}
Adalimumab-aaty(CF) 100 mg/mL Syringe ^{PA, QL}	Abrilada(CF) (<i>adalimumab-afzb</i>) 50 mg/mL Syringe ^{QL}
Adalimumab-fkjp(CF) 50 mg/mL Pen ^{PA, QL}	Actemra (<i>tocilizumab</i>) Actpen ^{QL}
Adalimumab-fkjp(CF) 50 mg/mL Syringe ^{PA, QL}	Actemra (<i>tocilizumab</i>) Syringe ^{QL}
Avsola (<i>infliximab-axxq</i>) Vial ^{PA}	Actemra (<i>tocilizumab</i>) Vial ^{QL}
Enbrel (<i>etanercept</i>) Mini Cartridge ^{PA, QL}	Adalimumab-aacf(CF) 50 mg/mL Pen ^{QL}
Enbrel (<i>etanercept</i>) Sureclick Pen ^{PA, QL}	Adalimumab-aacf(CF) 50 mg/mL Syringe ^{QL}
Enbrel (<i>etanercept</i>) Syringe ^{PA, QL}	Adalimumab-adaz(CF) 100 mg/mL Pen ^{QL}
Enbrel (<i>etanercept</i>) Vial ^{PA, QL}	Adalimumab-adaz(CF) 100 mg/mL Syringe ^{QL}
Hadlima (<i>adalimumab-bwwd</i>) 50 mg/mL Pushtouch ^{PA, QL}	Adalimumab-adbm(CF) 50 mg/mL Pen ^{QL}
Hadlima (<i>adalimumab-bwwd</i>) 50 mg/mL Syringe ^{PA, QL}	Adalimumab-adbm(CF) 50 mg/mL Syringe ^{QL}
Infliximab Vial (<i>Janssen's unbranded infliximab</i>) ^{PA}	Adalimumab-adbm(CF) 100 mg/mL Pen ^{QL}
Kineret (<i>anakinra</i>) Syringe ^{PA}	Adalimumab-adbm(CF) 100 mg/mL Syringe ^{QL}
Orencia (<i>abatacept</i>) Clickjet ^{PA, QL}	Adalimumab-ryvk(CF) 100 mg/mL Autoinjector ^{QL}
Orencia (<i>abatacept</i>) Vial ^{PA, QL}	Adalimumab-ryvk(CF) 100 mg/mL Syringe
Otezla (<i>apremilast</i>) Tablet ^{PA, QL}	Amjevita(CF) (<i>adalimumab-atto</i>) 50 mg/mL Autoinjector ^{QL}
Pyzchiva (<i>ustekinumab-ttwe</i>) Syringe ^{PA, QL}	Amjevita(CF) (<i>adalimumab-atto</i>) 50 mg/mL Syringe ^{QL}
Pyzchiva (<i>ustekinumab-ttwe</i>) Vial ^{PA, QL}	Amjevita(CF) (<i>adalimumab-atto</i>) 100 mg/mL Autoinjector ^{QL}
Simlandi(CF) (<i>adalimumab-ryvk</i>) 100 mg/mL Autoinjector ^{PA, QL}	Amjevita(CF) (<i>adalimumab-atto</i>) 100 mg/mL Syringe ^{QL}
Simlandi(CF) (<i>adalimumab-ryvk</i>) 100 mg/mL Syringe ^{PA, QL}	Arcalyst (<i>rilonacept</i>) Vial ^{QL}
Simponi (<i>golimumab</i>) Pen ^{PA, QL}	Bimzelx (<i>bimekizumab-bkzx</i>) Autoinjector ^{QL}
Simponi (<i>golimumab</i>) Syringe ^{PA, QL}	Bimzelx (<i>bimekizumab-bkzx</i>) Syringe ^{QL}
Skyrizi (<i>risankizumab-rzaa</i>) On-Body Injector ^{PA, QL}	Cimzia (<i>certolizumab pegol</i>) Syringe ^{QL}
Skyrizi (<i>risankizumab-rzaa</i>) Pen ^{PA, QL}	Cosentyx (<i>secukinumab</i>) Sensoready Pen ^{QL}
Skyrizi (<i>risankizumab-rzaa</i>) Syringe ^{PA, QL}	Cosentyx (<i>secukinumab</i>) Syringe ^{QL}
Skyrizi (<i>risankizumab-rzaa</i>) Vial ^{PA, QL}	Cosentyx (<i>secukinumab</i>) Unoready Pen ^{QL}
Taltz (<i>ixekizumab</i>) Autoinjector ^{PA, QL}	Cosentyx (<i>secukinumab</i>) Vial

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Taltz (<i>ixekizumab</i>) Syringe ^{PA, QL}	Cyltezo(CF) (<i>adalimumab-adbm</i>) 50 mg/mL Pen ^{QL}
Tofacitinib Solution (Novadoz [72205] labeler only) ^{PA, QL}	Cyltezo(CF) (<i>adalimumab-adbm</i>) 50 mg/mL Syringe ^{QL}
Tofacitinib Tablet (all labelers <u>except</u> Apotex [60505]) ^{PA, QL}	Cyltezo(CF) (<i>adalimumab-adbm</i>) 100 mg/mL Pen ^{QL}
Tofacitinib ER Tablet (all labelers <u>except</u> Apotex [60505], Edenbridge [42799], and Exelan [76282]) ^{PA, QL}	Cyltezo(CF) (<i>adalimumab-adbm</i>) 100 mg/mL Syringe ^{QL}
Tyenne (<i>tocilizumab-aazg</i>) Autoinjector ^{PA, QL}	Entyvio (<i>vedolizumab</i>) Pen ^{QL}
Tyenne (<i>tocilizumab-aazg</i>) Syringe ^{PA, QL}	Entyvio (<i>vedolizumab</i>) Vial ^{QL}
Tyenne (<i>tocilizumab-aazg</i>) Vial ^{PA, QL}	Hadlima(CF) (<i>adalimumab-bwwd</i>) 100 mg/mL Pushtouch ^{QL}
Xeljanz (<i>tofacitinib</i>) Solution ^{PA, QL}	Hadlima(CF) (<i>adalimumab-bwwd</i>) 100 mg/mL Syringe ^{QL}
Xeljanz (<i>tofacitinib</i>) Tablet ^{PA, QL}	Hulio(CF) (<i>adalimumab-fkjp</i>) 50 mg/mL Pen ^{QL}
Xeljanz XR (<i>tofacitinib</i>) Tablet ^{PA, QL}	Hulio(CF) (<i>adalimumab-fkjp</i>) 50 mg/mL Syringe ^{QL}
	Humira (<i>adalimumab</i>) 50 mg/mL Pen ^{QL}
	Humira (<i>adalimumab</i>) 50 mg/mL Syringe ^{QL}
	Humira(CF) (<i>adalimumab</i>) 100 mg/mL Pen ^{QL}
	Humira(CF) (<i>adalimumab</i>) 100 mg/mL Syringe ^{QL}
	Hyrimoz(CF) (<i>adalimumab-adaz</i>) 100 mg/mL Pen ^{QL}
	Hyrimoz(CF) (<i>adalimumab-adaz</i>) 100 mg/mL Syringe ^{QL}
	Idacio(CF) (<i>adalimumab-aacf</i>) 50 mg/mL Pen ^{QL}
	Idacio(CF) (<i>adalimumab-aacf</i>) 50 mg/mL Syringe ^{QL}
	Ilaris (<i>canakinumab</i>) Vial ^{QL}
	Ilumya (<i>tildrakizumab</i>) Syringe ^{QL}
	Inflectra (<i>infliximab-dyyb</i>) Vial
	Imuldosa (<i>ustekinumab-srlf</i>) Syringe ^{QL}
	Imuldosa (<i>ustekinumab-srlf</i>) Vial ^{QL}
	Kevzara (<i>sarilumab</i>) Pen ^{QL}
	Kevzara (<i>sarilumab</i>) Syringe ^{QL}
	Leqselvi (<i>deuruxolitinib</i>) Tablet ^{QL}
	Litfulo (<i>ritlecitinib</i>) Capsule ^{QL}
	Olumiant (<i>baricitinib</i>) Tablet ^{QL}
	Omvo (<i>mirikizumab-mrkz</i>) Pen ^{QL}
	Omvo (<i>mirikizumab-mrkz</i>) Syringe ^{QL}
	Omvo (<i>mirikizumab-mrkz</i>) Vial ^{QL}
	Orencia (<i>abatacept</i>) Syringe ^{QL}
	Otulf (<i>ustekinumab-aauz</i>) Syringe ^{QL}
	Otulf (<i>ustekinumab-aauz</i>) Vial ^{QL}
	Remicade (<i>infliximab</i>) Vial
	Renflexis (<i>infliximab-abda</i>) Vial
	Rinvoq ER (<i>upadacitinib</i>) Tablet ^{QL}
	Rinvoq LQ (<i>upadacitinib</i>) Solution ^{QL}
	Selarsdi (<i>ustekinumab-aekn</i>) Syringe ^{QL}
	Selarsdi (<i>ustekinumab-aekn</i>) Vial ^{QL}
	Simponi Aria (<i>golimumab</i>) Vial
	Sotyktu (<i>deucravacitinib</i>) Tablet ^{QL}
	Spevigo (<i>spesolimab-sbzo</i>) Syringe ^{QL}
	Spevigo (<i>spesolimab-sbzo</i>) Vial ^{QL}
	Stelara (<i>ustekinumab</i>) Syringe ^{QL}
	Stelara (<i>ustekinumab</i>) Vial ^{QL}
	Steqeyma (<i>ustekinumab-stba</i>) Syringe ^{QL}
	Steqeyma (<i>ustekinumab-stba</i>) Vial ^{QL}
	Tofacitinib Solution (all labelers <u>except</u> Novadoz [72205]) ^{QL}
	Tofacitinib Tablet (Apotex [60505] labeler only) ^{QL}
	Tofacitinib ER Tablet (Apotex [60505], Edenbridge [42799], and Exelan [76282] labelers only) ^{QL}
	Tofidence (<i>tocilizumab-bavi</i>) Vial ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	Tremfya (<i>guselkumab</i>) One-Press Autoinjector ^{QL} Tremfya (<i>guselkumab</i>) Pen ^{QL} Tremfya (<i>guselkumab</i>) Syringe ^{QL} Tremfya (<i>guselkumab</i>) Vial ^{QL} Ustekinumab Syringe (<i>Janssen's unbranded ustekinumab</i>) ^{QL} Ustekinumab Vial (<i>Janssen's unbranded ustekinumab</i>) ^{QL} Ustekinumab-aaaz Syringe ^{QL} Ustekinumab-aekn Syringe ^{QL} Ustekinumab-ttwe Syringe ^{QL} Ustekinumab-ttwe Vial ^{QL} Yesintek (<i>ustekinumab-kfce</i>) Syringe ^{QL} Yesintek (<i>ustekinumab-kfce</i>) Vial ^{QL} Yuflyma(CF) (<i>adalimumab-aaty</i>) 100 mg/mL Autoinjector ^{QL} Yuflyma(CF) (<i>adalimumab-aaty</i>) 100 mg/mL Syringe ^{QL} Yusimry(CF) (<i>adalimumab-aqv</i>) 50 mg/mL Pen ^{QL} Zymfentra (<i>infliximab-dyyb</i>) Pen Zymfentra (<i>infliximab-dyyb</i>) Syringe
--	--

DRY EYE TREATMENTS

Preferred Agents	Non-Preferred Agents
Eysuvis Drop Restasis Droperette ^{QL} Xiidra Droperette ^{QL}	Cequa Droperette ^{QL} Cyclosporine Emulsion Droperette ^{QL} Lacrisert Insert Miebo Drop Restasis Multidose Drop ^{QL} Tyrvaya Nasal Spray ^{QL} Vevye Drop

ENZYME REPLACEMENTS, GAUCHER DISEASE

Preferred Agents	Non-Preferred Agents
Cerdelga Capsule ^{PA, QL} Cerezyme Vial ^{PA} Elelyso Vial ^{PA} Miglustat Capsule ^{PA, QL} Vpriv Vial ^{PA} Yargesa Capsule ^{PA, QL} Zavesca Capsule ^{PA, QL}	

EPINEPHRINE, SELF-ADMINISTERED

Preferred Agents	Non-Preferred Agents
Auvi-Q 0.1 mg/0.1 mL Autoinjector Epinephrine Autoinjector (Mylan [49502] labeler only)	Auvi-Q Autoinjector (all strengths <u>except</u> 0.1 mg/0.1 mL) Epinephrine Auto-Injector (all labelers <u>except</u> Mylan [49502]) EpiPen Autoinjector EpiPen Jr. Autoinjector Neffy Nasal Spray

ERYTHROPOIESIS STIMULATING AGENTS

Preferred Agents	Non-Preferred Agents
Epogen Vial ^{PA} Retacrit Vial ^{PA}	Aranesp Syringe Aranesp Vial

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (in years)
Non-preferred agents require prior authorization
Effective January 2026 v10

PA = clinical prior authorization required
QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	Mircera Syringe Procrit Vial
--	---------------------------------

ESTROGENS

Preferred Agents	Non-Preferred Agents
<u>Systemic Estrogens</u> Angeliq Tablet ^{QL} Climara Pro Patch ^{QL} Combipatch ^{QL} Delestrogen Vial Depo-Estradiol Vial Elestrin Gel Estradiol Gel Packet ^{QL} Estradiol Patch (Once-Weekly) ^{QL} Estradiol Patch (Twice-Weekly) ^{QL} Estradiol Tablet Estradiol Valerate Vial Evamist Spray ^{QL} Femring Vaginal Ring Fyavolv Tablet ^{QL} Jinteli Tablet ^{QL} Norethindrone-Ethinyl Estradiol Tablet (<i>generic Femhrt Tablet</i>) ^{QL} Premarin Tablet Premphase Tablet ^{QL} Prempro Tablet ^{QL}	<u>Systemic Estrogens</u> Activella Tablet ^{QL} Bijuva Capsule ^{QL} Climara Patch ^{QL} Divigel Packet ^{QL} Dotti Patch Duavee Tablet ^{QL} Estradiol Gel Pump Estradiol-Norethindrone Tablet (<i>generic Activella Tablet</i>) ^{QL} Estrogen-Methyltestosterone Tablet Lyllana Patch ^{QL} Menest Tablet Menostar Patch ^{QL} Mimvey Tablet ^{QL} Minivelle Patch ^{QL} Premarin Vial Vivelle-Dot Patch ^{QL}
<u>Vaginal Estrogens</u> Estradiol Vaginal Cream Estradiol Vaginal Tablet Estring Vaginal Ring Premarin Vaginal Cream Vagifem Vaginal Tablet Yuvaferm Vaginal Insert	<u>Vaginal Estrogens</u> Estrace Vaginal Cream

FLUOROQUINOLONES, ORAL

Preferred Agents	Non-Preferred Agents
Cipro Suspension Ciprofloxacin Tablet Levofloxacin Tablet Moxifloxacin Tablet	Baxdela Tablet Cipro Tablet Levofloxacin Solution ^{AE<12} Ofloxacin Tablet

GI MOTILITY, CHRONIC AGENTS

Preferred Agents	Non-Preferred Agents
Linzess Capsule ^{PA, QL} Lubiprostone Capsule ^{PA, QL} Movantik Tablet ^{PA, QL}	Alosetron Tablet ^{QL} Amitiza Capsule ^{QL} Ibsrela Tablet ^{QL} Lotronex Tablet ^{QL} Motegrity Tablet ^{QL}

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	Prucalopride Tablet ^{QL} Symproic Tablet ^{QL} Viberzi Tablet ^{QL}
--	--

GLP-1 RECEPTOR AGONISTS

Preferred Agents	Non-Preferred Agents
Ozempic (<i>semaglutide</i>) Pen ^{PA, QL} Rybelsus (R1 formulation) (<i>semaglutide</i>) 3 mg, 7 mg, 14 mg Tablet ^{PA, QL} Trulicity (<i>dulaglutide</i>) Pen ^{PA, QL} Victoza (<i>liraglutide</i>) Pen ^{PA, QL}	Exenatide Pen ^{QL} Liraglutide 2-Pak, 3-Pak Pen (<i>generic Victoza</i>) ^{QL} Mounjaro (<i>tirzepatide</i>) Pen ^{QL} Wegovy (<i>semaglutide</i>) Pen ^{QL} Zepbound (<i>tirzepatide</i>) Pen ^{QL}

GLUCOCORTICOIDS, INHALED

Preferred Agents	Non-Preferred Agents
<u>Single-Ingredient ICS</u> Arnuity Ellipta ^{QL} Asmanex HFA ^{QL} Asmanex Twisthaler ^{QL} Budesonide 0.25 mg/2 mL, 0.5 mg/2 mL Respule ^{QL} Qvar Redihaler ^{QL}	<u>Single-Ingredient ICS</u> Alvesco HFA ^{QL} Budesonide 1 mg/mL Respule ^{QL} Fluticasone Propionate Diskus ^{QL} Fluticasone Propionate HFA ^{AE<19, QL} Pulmicort Respule ^{QL}
<u>ICS + LABA Combinations</u> Advair Diskus ^{QL} Advair HFA ^{QL} Dulera ^{QL} Fluticasone-Salmeterol Aerosol Powder (<i>generic Airduo Respiclick</i>) ^{QL} Fluticasone-Salmeterol Blister w/ Device (<i>generic Advair Diskus</i>) ^{QL} Symbicort ^{QL}	<u>ICS + LABA Combinations</u> Airduo Respiclick ^{QL} Breo Ellipta ^{QL} Breyndra HFA ^{QL} Budesonide-Formoterol Fumarate HFA (<i>generic Symbicort</i>) ^{QL} Fluticasone-Salmeterol HFA (<i>generic Advair HFA</i>) ^{QL} Fluticasone-Vilanterol (<i>generic Breo Ellipta</i>) ^{QL} Wixela Inhub ^{QL}
<u>ICS + SABA Combinations</u>	<u>ICS + SABA Combinations</u> Airsupra HFA ^{QL}
<u>ICS + LABA + LAMA Combinations</u> Trelegy Ellipta ^{QL}	<u>ICS + LABA + LAMA Combinations</u> Breztri Aerosphere ^{QL}

GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents
Budesonide DR/EC Capsule ^{QL} Budesonide ER Tablet ^{QL} Dexamethasone Elixir Dexamethasone Intensol Drop Dexamethasone Solution Dexamethasone Tablet Fludrocortisone Tablet Hydrocortisone Tablet Methylprednisolone Dose Pack Methylprednisolone Tablet	Agamree Suspension ^{QL} Alkindi Sprinkle Capsule Cortef Tablet Cortisone Tablet Deflazacort Suspension ^{QL} Deflazacort Tablet ^{QL} Dexamethasone Dose Pack Emflaza Suspension ^{QL} Emflaza Tablet ^{QL} Eohilia Suspension Packet ^{QL}

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (in years)
Non-preferred agents require prior authorization
Effective January 2026 v10

PA = clinical prior authorization required
QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Prednisolone Solution	Hemady Tablet
Prednisolone Sodium Phosphate Solution	Khindivi Solution
Prednisone Dose Pack	Medrol Dose Pack
Prednisone Intensol/Concentrate Solution	Medrol Tablet
Prednisone Solution	Ortikos ER Capsule ^{QL}
Prednisone Tablet	Prednisolone Tablet
	Prednisolone Sodium Phosphate ODT
	Tarpeyo DR Capsule ^{QL}

GROWTH HORMONES

Preferred Agents	Non-Preferred Agents
Genotropin Cartridge ^{PA}	Humatrope Cartridge
Genotropin Miniquick Syringe ^{PA}	Ngenla Pen ^{QL}
Norditropin Flexpro ^{PA}	Nutropin AQ Nuspin Pen
Skytrofa Cartridge ^{PA}	Omnitrope Cartridge
Sogroya Pen ^{PA, QL}	Omnitrope Vial
	Saizen Vial
	Saizen Saizenprep Cartridge
	Serostim Vial ^{QL}
	Zomacton Vial
	Zorbtive Vial

H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents
	Bismuth-Metronidazole-Tetracycline Capsule
	Lansoprazole-Amoxicillin-Clarithromycin Combo Pack ^{QL}
	Omeclamox-Pak Combo Pack
	Pylera Capsule
	Talicia IR-DR Capsule
	Voquezna Dual Pak ^{QL}
	Voquezna Triple Pak ^{QL}

HEMATOPOIETIC MIXTURES

Preferred Agents	Non-Preferred Agents
Ferrex 150 Forte Capsule	Bentivite Bx Tablet
Folivane-F Capsule	Centratex Capsule
Ifrex 150 Forte Capsule	Chromagen Capsule
Iron Folate-F Capsule	Corvita 150 Tablet
Trigels-F Forte Capsule	Corvite 150 Tablet
	Corvite FE Tablet
	Dermacinrx Foliflex Tablet
	Dermacinrx Folitin-Z Tablet
	Dermacinrx Ribotin-E Tablet
	Dermacinrx Venexa Fe Tablet
	Dermacinrx Vitranol Fe Tablet
	Dermacinrx Vitrexate Fe Tablet
	Dermacinrx Zinetrexyl-C Tablet
	Feriva 21-7 Tablet
	Feriva FA Capsule
	Fusion Plus Capsule

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	Hemocyte Plus Capsule Integra F Capsule Integra Plus Capsule Iron Folate Plus Capsule Irospan Tablet Nephron FA Tablet Niferex Tablet Purevit Dualfe Plus Capsule SE-Tan Plus Capsule Tandem Plus Capsule Taron Forte Capsule Tulivite Tablet
--	--

HEPATIC AND BILIARY AGENTS

Preferred Agents	Non-Preferred Agents
Cholbam (<i>cholic acid</i>) Capsule ^{PA} Ursodiol 300 mg Capsule ^{QL} Ursodiol Tablet ^{QL}	Chenodal (<i>chenodiol</i>) Tablet ^{QL} Ctexli (<i>chenodiol</i>) Tablet ^{QL} Iqirvo (<i>elafibranor</i>) Tablet ^{QL} Livdelzi (<i>seladelpar</i>) Capsule ^{QL} Reltone (<i>ursodiol</i>) Capsule Urso Forte (<i>ursodiol</i>) Tablet ^{QL}

HEPATITIS B AGENTS

Preferred Agents	Non-Preferred Agents
Adefovir Dipivoxil Tablet ^{QL} Baraclude Solution ^{QL} Entecavir Tablet ^{QL} Lamivudine HBV Tablet ^{QL} Tenofovir Disoproxil Fumarate 300 mg Tablet ^{QL} Viread Powder ^{QL} Viread Tablet (all strengths <u>except</u> 300 mg) ^{QL}	Baraclude Tablet ^{QL} Vemlidy Tablet ^{QL} Viread 300 mg Tablet ^{QL}

HEPATITIS C AGENTS

Preferred Agents	Non-Preferred Agents
Mavyret Pelet Pack ^{QL} Mavyret Tablet ^{QL} Ribavirin Capsule Ribavirin Tablet Sofosbuvir-Velpatasvir Tablet ^{QL}	Epclusa Pelet Pack ^{QL} Epclusa Tablet ^{QL} Harvoni Pelet Pack ^{QL} Harvoni Tablet ^{QL} Ledipasvir-Sofosbuvir Tablet ^{QL} Pegasys Syringe ^{QL} Pegasys Vial ^{QL} Sovaldi Pelet Pack ^{QL} Sovaldi Tablet ^{QL} Vosevi Tablet ^{QL} Zepatier Tablet ^{QL}

HEREDITARY ANGIOEDEMA (HAE) AGENTS

Preferred Agents	Non-Preferred Agents
Berinert (<i>C1 esterase inhibitor</i>) Kit ^{PA} Cinryze (<i>C1 esterase inhibitor</i>) Vial ^{PA, QL}	Firazyr (<i>icatibant</i>) Syringe ^{QL} Sajazyr (<i>icatibant</i>) Syringe ^{QL}

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (in years)
Non-preferred agents require prior authorization
Effective January 2026 v10

PA = clinical prior authorization required
QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Haegarda (C1 esterase inhibitor) Vial ^{PA, QL}	
Icatibant Syringe ^{PA, QL}	
Kalbitor (ecallantide) Vial ^{PA, QL}	
Orladeyo (berotralstat) Capsule ^{PA, QL}	
Orladeyo (berotralstat) Pellet Packet ^{PA, QL}	
Ruconest (C1 esterase inhibitor, recombinant) Vial ^{PA, QL}	
Takhzyro (lanadelumab-flyo) Syringe ^{PA, QL}	

HISTAMINE 2 RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents
Acid Reducer Complete (famotidine-calcium carbonate-magnesium hydroxide chewable) Tablet Chew	Cimetidine Solution
Cimetidine Tablet	Nizatidine Capsule
Famotidine Piggyback	
Famotidine Suspension	
Famotidine Tablet ^{QL}	
Famotidine Vial	

HIV/AIDS ANTIRETROVIRALS

Preferred Agents	Non-Preferred Agents
<u>INSTIs</u>	<u>INSTIs</u>
Apretude ER (cabotegravir ER) Vial ^{QL}	Isentress HD (raltegravir) Tablet ^{QL}
Isentress (raltegravir) Chewable Tablet ^{QL}	
Isentress (raltegravir) Powder Pack ^{QL}	
Isentress (raltegravir) Tablet ^{QL}	
Tivicay (dolutegravir) Tablet ^{QL}	
Tivicay PD (dolutegravir) Tablet for Suspension ^{QL}	
<u>Miscellaneous</u>	<u>Miscellaneous</u>
Yeztugo (lenacapavir) Tablet ^{QL}	Maraviroc Tablet ^{QL}
Yeztugo (lenacapavir) Vial ^{QL}	Rukobia ER (fostemsavir ER) Tablet ^{QL}
	Selzentry (maraviroc) Solution ^{QL}
	Selzentry (maraviroc) Tablet ^{QL}
	Sunlenca (lenacapavir) Tablet ^{QL}
	Sunlenca (lenacapavir) Vial ^{QL}
	Trogarzo (ibalizumab-uiyk) Vial ^{QL}
	Tyboost (cobicistat) Tablet ^{QL}
<u>NNRTIs</u>	<u>NNRTIs</u>
Edurant (rilpivirine) Tablet ^{QL}	Edurant Ped (rilpivirine) Tablet for Suspension
Efavirenz Capsule ^{QL}	Etravirine Tablet ^{QL}
Efavirenz Tablet ^{QL}	Intelence (etravirine) Tablet ^{QL}
Nevirapine Tablet ^{QL}	Nevirapine Suspension ^{QL}
	Nevirapine ER Tablet ^{QL}
	Pifeltro (doramivirine) Tablet ^{QL}
<u>NRTIs</u>	<u>NRTIs</u>
Abacavir Solution ^{QL}	Emtriva (emtricitabine) Capsule ^{QL}
Abacavir Tablet ^{QL}	Epivir (lamivudine) Solution ^{QL}
Abacavir-Lamivudine Tablet ^{QL}	Epivir (lamivudine) Tablet ^{QL}

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Cimduo (<i>lamivudine-tenofovir DF</i>) Tablet ^{QL} Descovy (<i>emtricitabine-tenofovir alafenamide</i>) Tablet ^{QL} Emtricitabine Capsule ^{QL} Emtricitabine-Tenofovir Disoproxil Fumarate Tablet ^{QL} Emtriva (<i>emtricitabine</i>) Solution ^{QL} Lamivudine Solution ^{QL} Lamivudine Tablet ^{QL} Lamivudine-Zidovudine Tablet ^{QL} Tenofovir Disoproxil Fumarate 300 mg Tablet ^{QL} Viread (<i>tenofovir DF</i>) Powder ^{QL} Viread (<i>tenofovir DF</i>) Tablet (all strengths <u>except</u> 300 mg) ^{QL} Zidovudine Capsule ^{QL} Zidovudine Syrup ^{QL} Zidovudine Tablet ^{QL}	Retrovir (<i>zidovudine</i>) Capsule ^{QL} Retrovir (<i>zidovudine</i>) Syrup ^{QL} Truvada (<i>emtricitabine-tenofovir DF</i>) Tablet ^{QL} Viread (<i>tenofovir DF</i>) 300 mg Tablet ^{QL} Ziagen (<i>abacavir</i>) Solution ^{QL}
<u>PIs</u>	<u>PIs</u>
Atazanavir Capsule ^{QL} Darunavir Tablet ^{QL} Evotaz (<i>atazanavir-cobicistat</i>) Tablet ^{QL} Kaletra (<i>lopinavir-ritonavir</i>) Solution ^{QL} Lopinavir-Ritonavir Tablet ^{QL} Norvir (<i>ritonavir</i>) Powder Packet ^{QL} Prezcobix (<i>darunavir-cobicistat</i>) Tablet ^{QL} Prezista (<i>darunavir</i>) Suspension ^{QL} Reyataz (<i>atazanavir</i>) Powder Packet ^{QL} Ritonavir Tablet ^{QL}	Aptivus (<i>tipranavir</i>) Capsule ^{QL} Fosamprenavir Tablet ^{QL} Kaletra (<i>lopinavir-ritonavir</i>) Tablet ^{QL} Norvir (<i>ritonavir</i>) Tablet ^{QL} Prezista (<i>darunavir</i>) Tablet ^{QL} Reyataz (<i>atazanavir</i>) Capsule ^{QL} Viracept (<i>nelfinavir</i>) Tablet ^{QL}
<u>Single Product Regimens</u>	<u>Single Product Regimens</u>
Biktarvy (<i>bictegravir-emtricitabine-tenofovir alafenamide</i>) Tablet ^{QL} Cabenuva (<i>cabotegravir-rilpivirine</i>) Vial ^{QL} Complera (<i>emtricitabine-rilpivirine-tenofovir DF</i>) Tablet ^{QL} Delstrigo (<i>doravirine-lamivudine-tenofovir DF</i>) Tablet ^{QL} Dovato (<i>dolutegravir-lamivudine</i>) Tablet ^{QL} Efavirenz-Emtricitabine-Tenofovir Disoproxil Fumarate Tablet ^{QL} Genvoya (<i>elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide</i>) Tablet ^{QL} Juluca (<i>dolutegravir-rilpivirine</i>) Tablet ^{QL} Odefsey (<i>emtricitabine-rilpivirine-tenofovir alafenamide</i>) Tablet ^{QL} Symfi (<i>efavirenz-lamivudine-tenofovir DF</i>) Tablet ^{QL} Triumeq (<i>abacavir-dolutegravir-lamivudine</i>) Tablet ^{QL}	Atripla (<i>efavirenz-emtricitabine-tenofovir DF</i>) Tablet ^{QL} Efavirenz-Lamivudine-Tenofovir Disoproxil Fumarate Tablet ^{QL} Emtricitabine-Rilpivirine-Tenofovir Disoproxil Fumarate Tablet ^{QL} Stribild (<i>elvitegravir-cobicistat-emtricitabine-tenofovir DF</i>) Tablet ^{QL} Symtuza (<i>darunavir-cobicistat-emtricitabine-tenofovir alafenamide</i>) Tablet ^{QL} Triumeq PD (<i>abacavir-dolutegravir-lamivudine</i>) Tablet for Suspension ^{QL}

HYPOGLYCEMIA TREATMENTS

Preferred Agents	Non-Preferred Agents
Baqsimi Spray Glucagon Emergency Kit Gvoke Hypopen Gvoke PFS Syringe Gvoke Vial Zegalogue Autoinjector Zegalogue Syringe	

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

Preferred Agents	Non-Preferred Agents
Acarbose Tablet ^{QL}	Miglitol Tablet ^{QL}

HYPOGLYCEMICS, DPP-4 INHIBITORS (formerly HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS)

Preferred Agents	Non-Preferred Agents
Janumet Tablet ^{PA, QL}	Alogliptin Tablet ^{QL}
Janumet XR Tablet ^{PA, QL}	Alogliptin-Metformin Tablet ^{QL}
Januvia Tablet ^{PA, QL}	Alogliptin-Pioglitazone Tablet ^{QL}
Jentadueto Tablet ^{PA, QL}	Glyxambi Tablet ^{QL}
Jentadueto XR Tablet ^{PA, QL}	Qtern Tablet ^{QL}
Tradjenta Tablet ^{PA, QL}	Saxagliptin Tablet ^{QL}
	Saxagliptin-Metformin ER Tablet ^{QL}
	Sitagliptin Tablet ^{QL}
	Sitagliptin-Metformin Tablet ^{QL}
	Sitagliptin-Metformin ER Tablet ^{QL}
	Steglujan Tablet ^{QL}
	Trijardy XR Tablet ^{QL}
	Zituvimet Tablet ^{QL}
	Zituvimet XR Tablet ^{QL}
	Zituvio Tablet ^{QL}

HYPOGLYCEMICS, INSULIN AND RELATED AGENTS

Preferred Agents	Non-Preferred Agents
<u>Alternate Formulations</u>	<u>Alternate Formulations</u>
	Afrezza Cartridge
	Soliqua (<i>insulin glargine-lixisenatide</i>) Pen ^{QL}
	Xultophy (<i>insulin degludec-liraglutide</i>) Pen ^{QL}
<u>Intermediate-Acting</u>	<u>Intermediate-Acting</u>
Humulin N Kwikpen	
Humulin N Vial	
Novolin N Flexpen	
Novolin N Vial	
<u>Long-Acting</u>	<u>Long-Acting</u>
Insulin Glargine 300 units/mL Solostar	Basaglar (<i>insulin glargine</i>) 100 units/mL Kwikpen
Insulin Glargine Max 300 units/mL Solostar	Basaglar (<i>insulin glargine</i>) 100 units/mL Tempo Pen
Lantus (<i>insulin glargine</i>) 100 units/mL Solostar	Insulin Degludec 100 units/mL Pen
Lantus (<i>insulin glargine</i>) 100 units/mL Vial	Insulin Degludec 100 units/mL Vial
Toujeo (<i>insulin glargine</i>) 300 units/mL Solostar	Insulin Degludec 200 units/mL Pen
Toujeo Max (<i>insulin glargine</i>) 300 units/mL Solostar	Insulin Glargine-yfgn 100 units/mL Pen
	Insulin Glargine-yfgn 100 units/mL Vial
	Rezvoglar (<i>insulin glargine-aqlr</i>) 100 units/mL Kwikpen
	Semglee (yfgn) (<i>insulin glargine-yfgn</i>) 100 units/mL Pen
	Semglee (yfgn) (<i>insulin glargine-yfgn</i>) 100 units/mL Vial
	Tresiba (<i>insulin degludec</i>) 100 units/mL Flextouch
	Tresiba (<i>insulin degludec</i>) 100 units/mL Vial
	Tresiba (<i>insulin degludec</i>) 200 units/mL Flextouch

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

<u>Mixed Insulins</u>		<u>Mixed Insulins</u>	
Humalog Mix (<i>insulin lispro protamine-insulin lispro</i>) 50-50 Kwikpen		Humalog Mix (<i>insulin lispro protamine-insulin lispro</i>) 75-25 Kwikpen	
Humalog Mix (<i>insulin lispro protamine-insulin lispro</i>) 75-25 Vial		Humulin 70-30 Kwikpen	
Humulin 70-30 Vial		Novolin 70-30 Flexpen	
Insulin Lispro Protamine Mix 75-25 Pen		Novolin 70-30 Vial	
NovoLog Mix (<i>insulin aspart protamine-insulin aspart</i>) 70-30 Flexpen			
NovoLog Mix (<i>insulin aspart protamine-insulin aspart</i>) 70-30 Vial			
<u>Rapid-Acting</u>		<u>Rapid-Acting</u>	
Apidra (<i>insulin glulisine</i>) Solostar		Admelog (<i>insulin lispro</i>) Solostar	
Apidra (<i>insulin glulisine</i>) Vial		Admelog (<i>insulin lispro</i>) Vial	
Insulin Lispro 100 units/mL Kwikpen		Fiasp (<i>insulin aspart</i>) Flextouch	
Insulin Lispro 100 units/mL Vial		Fiasp (<i>insulin aspart</i>) Penfill Cartridge	
Insulin Lispro Jr Kwikpen		Fiasp (<i>insulin aspart</i>) Pumpcart Cartridge	
Novolog (<i>insulin aspart</i>) Flexpen		Fiasp (<i>insulin aspart</i>) Vial	
Novolog (<i>insulin aspart</i>) Penfill Cartridge		Humalog (<i>insulin lispro</i>) 100 units/mL Cartridge	
Novolog (<i>insulin aspart</i>) Vial		Humalog (<i>insulin lispro</i>) 100 units/mL Kwikpen	
		Humalog (<i>insulin lispro</i>) 100 units/mL Vial	
		Humalog (<i>insulin lispro</i>) 200 units/mL Kwikpen	
		Humalog (<i>insulin lispro</i>) 100 units/mL Tempo Pen	
		Humalog Jr (<i>insulin lispro</i>) Kwikpen	
		Lyumjev (<i>insulin lispro</i>) 100 units/mL Kwikpen	
		Lyumjev (<i>insulin lispro</i>) 200 units/mL Kwikpen	
		Lyumjev (<i>insulin lispro</i>) 100 units/mL Tempo Pen	
		Lyumjev (<i>insulin lispro</i>) 100 units/mL Vial	
		Merilog (<i>insulin aspart-szjj</i>) 100 units/mL Solostar	
		Merilog (<i>insulin aspart-szjj</i>) 100 units/mL Vial	
<u>Short-Acting</u>		<u>Short-Acting</u>	
Humulin R 100 units/mL Vial			
Humulin R 500 units/mL Kwikpen			
Novolin R Flexpen			
Novolin R Vial			

HYPOGLYCEMICS, MEGLITINIDES

Preferred Agents	Non-Preferred Agents
Nateglinide Tablet ^{QL}	
Repaglinide Tablet ^{QL}	

HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents
Glipizide-Metformin Tablet ^{QL}	Metformin Solution ^{QL}
Glyburide-Metformin Tablet ^{QL}	Metformin 625 mg, 750 mg Tablet ^{QL}
Metformin 500 mg, 850 mg, 1000 mg Tablet ^{QL}	Metformin ER (Gastric) Tablet (<i>generic Glumetza ER</i>) ^{QL}
Metformin ER 500 mg, 750 mg Tablet (<i>generic Glucophage XR Tablet</i>) ^{QL}	Metformin ER (Osmotic) Tablet (<i>generic Fortamet ER</i>) ^{QL}
	Riomet Solution ^{QL}

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

HYPOGLYCEMICS, SGLT2 INHIBITORS

Preferred Agents	Non-Preferred Agents
Dapagliflozin Tablet ^{QL}	Dapagliflozin-Metformin ER Tablet (Ohm/Sun [63304] and Prasco [66993] labelers only) ^{QL}
Dapagliflozin-Metformin ER Tablet (all labelers <u>except</u> Ohm/Sun [63304] and Prasco [66993]) ^{QL}	Farxiga Tablet ^{QL}
Jardiance Tablet ^{QL}	Glyxambi Tablet ^{QL}
Synjardy Tablet ^{QL}	Inpefa Tablet ^{QL}
Synjardy XR Tablet ^{QL}	Invokamet Tablet ^{QL}
	Invokamet XR Tablet ^{QL}
	Invokana Tablet ^{QL}
	Qtern Tablet ^{QL}
	Segluromet Tablet ^{QL}
	Steglatro Tablet ^{QL}
	Steglujan Tablet ^{QL}
	Trijardy XR Tablet ^{QL}
	Xigduo XR Tablet ^{QL}

HYPOGLYCEMICS, SULFONYLUREAS

Preferred Agents	Non-Preferred Agents
Glimepiride 1 mg, 2 mg, 4 mg Tablet ^{QL}	Glimepiride 3 mg Tablet ^{QL}
Glipizide 5 mg, 10 mg Tablet ^{QL}	Glipizide 2.5 mg Tablet ^{QL}
Glipizide ER/XL Tablet ^{QL}	Glucotrol XL Tablet ^{QL}
Glyburide Tablet ^{QL}	
Glyburide Micronized Tablet ^{QL}	

HYPOGLYCEMICS, TZDs

Preferred Agents	Non-Preferred Agents
Pioglitazone Tablet ^{QL}	Alogliptin-Pioglitazone Tablet ^{QL}
	Duetact Tablet ^{QL}
	Pioglitazone-Glimepiride Tablet ^{QL}
	Pioglitazone-Metformin Tablet ^{QL}

IMMUNOMODULATORS, DERMATOLOGICS

Preferred Agents	Non-Preferred Agents
Adbry (<i>tralokinumab-ldrm</i>) Autoinjector ^{PA, QL}	Eucrisa (<i>crisaborole</i>) Ointment
Adbry (<i>tralokinumab-ldrm</i>) Syringe ^{PA, QL}	Nemluvio (<i>nemolizumab-ilto</i>) Pen ^{QL}
Cibinqo (<i>abrocitinib</i>) Tablet ^{PA, QL}	Pimecrolimus Cream
Dupixent (<i>dupilumab</i>) Pen ^{PA, QL}	Rinvoq ER (<i>upadacitinib</i>) Tablet ^{QL}
Dupixent (<i>dupilumab</i>) Syringe ^{PA, QL}	Vtama (<i>tapinarof</i>) Cream
Ebglyss (<i>lebrikizumab-lbkz</i>) Pen ^{PA, QL}	Zoryve (<i>roflumilast</i>) 0.15% Cream
Ebglyss (<i>lebrikizumab-lbkz</i>) Syringe ^{PA, QL}	
Opzelura (<i>ruxolitinib</i>) Cream ^{PA, QL}	
Tacrolimus Ointment	

IMMUNOMODULATORS, TOPICAL

Preferred Agents	Non-Preferred Agents
Imiquimod Cream 5% Packet	Imiquimod Cream 3.75% Packet
	Imiquimod Cream 3.75% Pump

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents
Azathioprine 50 mg Tablet (<i>generic Imuran</i>)	Astagraf XL (<i>tacrolimus extended-release</i>) Capsule
Cyclosporine Capsule	Azathioprine 75 mg, 100 mg Tablet (<i>generic Azasan</i>)
Cyclosporine (Modified) Capsule/Softgel	Cellcept (<i>mycophenolate mofetil</i>) Capsule
Cyclosporine (Modified) Solution	Cellcept (<i>mycophenolate mofetil</i>) Suspension
Mycophenolate Mofetil Capsule	Cellcept (<i>mycophenolate mofetil</i>) Tablet
Mycophenolate Mofetil Suspension	Envarsus XR (<i>tacrolimus extended-release</i>) Tablet
Mycophenolate Mofetil Tablet	Everolimus Tablet
Mycophenolic Acid DR Tablet	Gengraf (<i>cyclosporine, modified</i>) Capsule
Sandimmune (<i>cyclosporine</i>) Solution	Gengraf (<i>cyclosporine, modified</i>) Solution
Sirolimus Solution	Imuran (<i>azathioprine</i>) Tablet
Sirolimus Tablet	Lupkynis (<i>voclosporin</i>) Capsule ^{QL}
Tacrolimus Capsule	Myfortic DR (<i>mycophenolic acid delayed-release</i>) Tablet
	Myhibbin (<i>mycophenolate mofetil</i>) Suspension
	Neoral (<i>cyclosporine, modified</i>) Capsule
	Neoral (<i>cyclosporine, modified</i>) Solution
	Prograf (<i>tacrolimus</i>) Capsule
	Prograf (<i>tacrolimus</i>) Granule Packet
	Rezurock (<i>belumosudil</i>) Tablet ^{QL}
	Sandimmune (<i>cyclosporine</i>) Capsule
	Zortress (<i>everolimus</i>) Tablet

INTRA-ARTICULAR HYALURONATES

Preferred Agents	Non-Preferred Agents
Durolane Syringe ^{PA, QL}	Gel-One Syringe ^{QL}
Euflexxa Syringe ^{PA, QL}	Genvisc 850 Syringe ^{QL}
Gelsyn-3 Syringe ^{PA, QL}	Hymovis Syringe ^{QL}
Hyalgan Syringe ^{PA, QL}	Monovisc Syringe ^{QL}
Hyalgan Vial ^{PA, QL}	Orthovisc Syringe ^{QL}
Visco-3 Syringe ^{PA, QL}	Supartz FX Syringe ^{QL}
	Synojoint Syringe ^{QL}
	Synvisc Syringe ^{QL}
	Synvisc-One Syringe ^{QL}
	Triluron Syringe ^{QL}
	Trivisc Syringe ^{QL}

INTRANASAL RHINITIS AGENTS

Preferred Agents	Non-Preferred Agents
Azelastine 0.1% (137 mcg) Nasal Spray (<i>generic Astelin</i>) ^{QL}	Azelastine 0.15% (205.5 mcg) Nasal Spray (<i>generic Astepro</i>) ^{QL}
Fluticasone Propionate Nasal Spray (Rx) ^{QL}	Azelastine-Fluticasone Nasal Spray ^{QL}
Ipratropium Nasal Spray ^{QL}	Budesonide Nasal Spray ^{QL}
	Dymista Nasal Spray ^{QL}
	Flunisolide Nasal Spray ^{QL}
	Fluticasone Propionate Nasal Spray (OTC) ^{QL}
	Mometasone Furoate Nasal Spray ^{QL}
	Nasonex Nasal Spray
	Olopatadine Nasal Spray ^{QL}
	Omnaris Nasal Spray ^{QL}
	Qnasl Nasal Spray ^{QL}
	Qnasl Children's Nasal Spray ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	Ryaltris Nasal Spray ^{QL} Sinuva Implant Triamcinolone Acetonide Nasal Spray ^{AE<4, QL} Xhance Nasal Spray ^{QL} Zetonna Nasal Spray ^{QL}
--	---

IRON CHELATING AGENTS

Preferred Agents	Non-Preferred Agents
Deferasirox Granule Packet ^{PA} Deferasirox Tablet ^{PA} Deferasirox Tablet for Oral Suspension ^{PA}	Deferiprone Tablet Exjade (<i>deferasirox</i>) Tablet for Oral Suspension Ferriprox (<i>deferiprone</i>) Solution Ferriprox (<i>deferiprone</i>) Tablet Jadenu (<i>deferasirox</i>) Sprinkle Granule Packet Jadenu (<i>deferasirox</i>) Tablet

IRON, PARENTERAL

Preferred Agents	Non-Preferred Agents
Ferrelecit (<i>sodium ferric gluconate complex</i>) Vial Infed (<i>iron dextran, LMW</i>) Vial Injectafer (<i>ferric carboxymaltose</i>) Vial Sodium Ferric Gluconate Complex in Sucrose Vial Venofer (<i>iron sucrose</i>) Vial ^{QL}	Feraheme (<i>ferumoxytol</i>) Vial ^{QL} Ferumoxytol Vial ^{QL} Monoferric (<i>ferric derisomaltose</i>) Vial ^{QL}

LEUKOTRIENE MODIFIERS

Preferred Agents	Non-Preferred Agents
Montelukast Chewable Tablet ^{QL} Montelukast Tablet ^{QL}	Accolate (<i>zafirlukast</i>) Tablet ^{QL} Montelukast Granule Packet ^{AE<2, QL} Singulair (<i>montelukast</i>) Chewable Tablet ^{QL} Singulair (<i>montelukast</i>) Granule Packet ^{QL} Singulair (<i>montelukast</i>) Tablet ^{QL} Zafirlukast Tablet ^{QL} Zileuton ER Tablet ^{QL} Zyflo (<i>zileuton</i>) Tablet ^{QL}

LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents
Cholestyramine Powder Cholestyramine Powder Packet Cholestyramine Light Powder Cholestyramine Light Powder Packet Colestipol Tablet ^{QL} Ezetimibe Tablet ^{QL} Fenofibrate 54 mg, 160 mg Tablet (<i>generic Lofibra Tablet</i>) ^{QL} Fenofibrate Micronized 43 mg, 130 mg Capsule (<i>generic Antara</i>) ^{QL} Fenofibrate Micronized 67 mg, 134 mg, 200 mg Capsule (<i>generic Lofibra Capsule</i>) ^{QL} Fenofibrate Nanocrystalized 48 mg, 145 mg Tablet (<i>generic Tricor</i>) ^{QL} Fenofibric Acid (Choline) DR 45 mg, 135 mg Capsule (<i>generic Trilipix</i>) ^{QL}	Colesevelam Powder Packet ^{QL} Colesevelam Tablet ^{QL} Colestid Granule Colestid Tablet ^{QL} Colestipol Granule Colestipol Granule Packet Evkeeza Vial Fenofibrate 50 mg, 150 mg Capsule (<i>generic Lipofen</i>) ^{QL} Fenofibrate 40 mg, 120 mg Tablet (<i>generic Fenoglide</i>) ^{QL} Fenofibrate (Micronized) 90 mg Capsule (<i>generic Antara</i>) ^{QL} Fenofibric Acid 35 mg, 105 mg Tablet (<i>generic Fibracor</i>) ^{QL} Icosapent Ethyl Capsule ^{QL} Juxtapid Capsule ^{QL} Leqvio Syringe ^{QL}

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (in years)
Non-preferred agents require prior authorization
Effective January 2026 v10

PA = clinical prior authorization required
QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Gemfibrozil Tablet ^{QL}	Lipofen Capsule ^{QL}
Nexletol Tablet ^{PA, QL}	Lopid Tablet ^{QL}
Nexlizet Tablet ^{PA, QL}	Niacin ER Tablet (<i>generic Niaspan</i>)
Omega-3 Ethyl Esters Capsule ^{QL}	Questran Powder
Praluent Pen ^{PA, QL}	Questran Powder Packet
Prevalite Powder	Questran Light Powder
Prevalite Powder Packet	Tricor Tablet ^{QL}
Repatha Pushtronex ^{PA, QL}	Tryngolza Autoinjector ^{QL}
Repatha Sureclick ^{PA, QL}	Welchol Powder Packet ^{QL}
Repatha Syringe ^{PA, QL}	Welchol Tablet ^{QL}
	Zetia Tablet ^{QL}

LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents
Atorvastatin Tablet ^{QL}	Altoprev ER Tablet ^{QL}
Lovastatin Tablet ^{QL}	Amlodipine-Atorvastatin Tablet ^{QL}
Pravastatin Tablet ^{QL}	Atorvaliq Suspension ^{QL}
Rosuvastatin Tablet ^{QL}	Caduet Tablet ^{QL}
Simvastatin Tablet ^{QL}	Crestor Tablet ^{QL}
	Ezallor Sprinkle Capsule ^{QL}
	Ezetimibe-Simvastatin Tablet ^{QL}
	Flolipid Suspension ^{QL}
	Fluvastatin Capsule ^{QL}
	Fluvastatin ER Tablet ^{QL}
	Lescol XL Tablet ^{QL}
	Lipitor Tablet ^{QL}
	Livalo Tablet ^{QL}
	Pitavastatin Tablet ^{QL}
	Vytorin Tablet ^{QL}
	Zocor Tablet ^{QL}
	Zypitamag Tablet ^{QL}

LOCAL ANESTHETICS, TOPICAL

Preferred Agents	Non-Preferred Agents
Glydo Jelly (mucous membrane) Syringe ^{AR}	Dermacinrx Lidocan Patch ^{QL}
Lidocaine Cream	Dermacinrx Lidogel Gel
Lidocaine Jelly ^{AR}	Dermacinrx Lidorex Gel
Lidocaine Ointment	Lidaflex Patch ^{QL}
Lidocaine 4% Patch ^{QL}	Lidocaine + Dressing Kit
Lidocaine 5% Patch (<i>generic Lidoderm Patch</i>) ^{QL}	Lidocaine-Prilocaine Kit
Lidocaine (mucous membrane) Solution ^{AR}	Lidocan Patch ^{QL}
Lidocaine (topical) Solution	Lidoderm Patch ^{QL}
Lidocaine Viscous Solution ^{AR}	Lidotral Cream
Lidocaine-Prilocaine Cream	Tetri-AG Ointment
	Tridacaine Patch ^{QL}
	Ztlido Patch ^{QL}

MACROLIDES

Preferred Agents	Non-Preferred Agents
Azithromycin Packet	Clarithromycin ER Tablet
Azithromycin Suspension	E.E.S. 400 Filmtab

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Azithromycin Tablet	E.E.S. 200 Suspension
Clarithromycin Suspension	EryPed Suspension
Clarithromycin Tablet	Ery-Tab DR Tablet
	Erythrocin (Stearate) Filmtab
	Erythromycin Base DR Capsule
	Erythromycin Base DR Tablet
	Erythromycin Base Filmtab
	Erythromycin Ethylsuccinate Suspension
	Erythromycin Ethylsuccinate Tablet
	Zithromax Packet
	Zithromax Suspension
	Zithromax Tablet
	Zithromax Tri-Pak

MACULAR DEGENERATION AGENTS

Preferred Agents	Non-Preferred Agents
Cimerli (<i>ranibizumab-eqrn</i>) Vial ^{PA, QL}	Beovu (<i>brolucizumab-dbl</i>) Syringe ^{QL}
Eylea (<i>aflibercept</i>) Syringe ^{PA, QL}	Byooviz (<i>ranibizumab-nuna</i>) Vial ^{QL}
Eylea (<i>aflibercept</i>) Vial ^{PA, QL}	Eylea HD (<i>aflibercept</i>) Vial ^{QL}
Lucentis (<i>ranibizumab</i>) Syringe ^{PA, QL}	Izervay (<i>avacincaptad pegol sodium</i>) Vial ^{QL}
Syfovre (<i>pegcetacoplan</i>) Vial ^{PA, QL}	Pavblu (<i>aflibercept-ayyh</i>) Syringe ^{QL}
Syfovre (<i>pegcetacoplan</i>) Vial Kit ^{PA, QL}	Pavblu (<i>aflibercept-ayyh</i>) Vial ^{QL}
Vabysmo (<i>faricimab-svoa</i>) Syringe ^{PA, QL}	Susvimo (<i>ranibizumab</i>) Vial
Vabysmo (<i>faricimab-svoa</i>) Vial ^{PA, QL}	
Visudyne (<i>verteporfin</i>) Vial ^{PA}	

METHOTREXATE

Preferred Agents	Non-Preferred Agents
Methotrexate Tablet	Jylamvo Solution
Methotrexate Vial	Otrexup Autoinjector ^{QL}
Methotrexate Preservative-Free Vial	Rasuvo Autoinjector ^{QL}
	Trexall Tablet
	Xatmep Solution

MIGRAINE ACUTE TREATMENT AGENTS

Preferred Agents	Non-Preferred Agents
Eletriptan Tablet ^{QL}	Almotriptan Tablet ^{QL}
Naratriptan Tablet ^{QL}	Cafergot Tablet
Nurtec (<i>rimegepant</i>) ODT ^{PA, QL}	Diclofenac Potassium Powder Packet ^{QL}
Rizatriptan ODT ^{QL}	Dihydroergotamine Mesylate Ampule
Rizatriptan Tablet ^{QL}	Dihydroergotamine Mesylate Nasal Spray ^{QL}
Sumatriptan Cartridge ^{QL}	Elyxib Solution ^{QL}
Sumatriptan Nasal Spray ^{QL}	Ergomar SL Tablet
Sumatriptan Pen Injector ^{QL}	Frova Tablet ^{QL}
Sumatriptan Tablet ^{QL}	Frovatriptan Tablet ^{QL}
Sumatriptan Vial ^{QL}	Imitrex Cartridge ^{QL}
Ubrovelvy Tablet ^{PA, QL}	Imitrex Pen Injector ^{QL}
Zolmitriptan ODT ^{QL}	Imitrex Tablet ^{QL}
Zolmitriptan Tablet ^{QL}	Maxalt Tablet ^{QL}
	Maxalt MLT ^{QL}
	Relpax Tablet ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	Reyvow Tablet ^{QL} Sumatriptan-Naproxen Tablet ^{QL} Symbravo Tablet ^{QL} Tosymra Nasal Spray ^{QL} Zavzpret Nasal Spray ^{QL} Zembrace Symtouch ^{QL} Zolmitriptan Nasal Spray ^{QL} Zomig Nasal Spray ^{QL} Zomig Tablet ^{QL}
--	--

MIGRAINE PREVENTION AGENTS

Preferred Agents	Non-Preferred Agents
Aimovig (<i>erenumab-aooe</i>) Autoinjector ^{PA, QL} Ajovy (<i>fremanezumab-vfrm</i>) Autoinjector ^{PA, QL} Ajovy (<i>fremanezumab-vfrm</i>) Syringe ^{PA, QL} Emgality (<i>galcanezumab-gnlm</i>) Pen ^{PA, QL} Emgality (<i>galcanezumab-gnlm</i>) Syringe ^{PA, QL} Nurtec (<i>rimegepant</i>) ODT ^{PA, QL}	Qulipta (<i>atogepant</i>) Tablet ^{QL} Vyepi (<i>eptinezumab-jjmr</i>) Vial ^{QL}

MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IGE, ANTI-TSLP

Preferred Agents	Non-Preferred Agents
Dupixent (<i>dupilumab</i>) Pen ^{PA, QL} Dupixent (<i>dupilumab</i>) Syringe ^{PA, QL} Fasenra (<i>benralizumab</i>) Pen ^{PA, QL} Fasenra (<i>benralizumab</i>) Syringe ^{PA, QL} Nucala (<i>mepolizumab</i>) Autoinjector ^{PA, QL} Nucala (<i>mepolizumab</i>) Syringe ^{PA, QL} Nucala (<i>mepolizumab</i>) Vial ^{PA, QL} Tezspire (<i>tezepelumab</i>) Pen ^{PA, QL} Tezspire (<i>tezepelumab</i>) Syringe ^{PA, QL} Xolair (<i>omalizumab</i>) Autoinjector ^{PA, QL} Xolair (<i>omalizumab</i>) Syringe ^{PA, QL} Xolair (<i>omalizumab</i>) Vial ^{PA, QL}	Cinqair (<i>reslizumab</i>) Vial

MULTIPLE SCLEROSIS AGENTS

Preferred Agents	Non-Preferred Agents
Avonex (<i>interferon beta-1a</i>) Pen Kit ^{QL} Avonex (<i>interferon beta-1a</i>) Syringe Kit ^{QL} Betaseron (<i>interferon beta-1b</i>) Kit ^{QL} Briumvi (<i>ublituximab-xiiv</i>) Vial ^{PA, QL} Dalfampridine ER Tablet ^{PA, QL} Dimethyl Fumarate DR Capsule ^{PA, QL} Fingolimod Capsule ^{PA, QL} Glatiramer Syringe ^{QL} Glatopa (<i>glatiramer</i>) Syringe ^{QL} Kesimpta (<i>ofatumumab</i>) Pen ^{PA, QL} Ocrevus (<i>ocrelizumab</i>) Vial ^{PA, QL} Ocrevus Zunovo (<i>ocrelizumab</i>) Vial ^{PA, QL} Rebif (<i>interferon beta-1a</i>) Rebifose Autoinjector ^{QL} Rebif (<i>interferon beta-1a</i>) Syringe ^{QL} Teriflunomide Tablet ^{PA, QL}	Ampyra ER (<i>dalfampridine ER</i>) Tablet ^{QL} Aubagio (<i>teriflunomide</i>) Tablet ^{QL} Bafiertam DR (<i>monomethyl fumarate DR</i>) Capsule ^{QL} Copaxone (<i>glatiramer</i>) Syringe ^{QL} Gilenya (<i>fingolimod HCl</i>) Capsule ^{QL} Lemtrada (<i>alemtuzumab</i>) Vial ^{QL} Mavenclad (<i>cladribine</i>) Tablet ^{QL} Mayzent (<i>siponimod</i>) Tablet ^{QL} Plegridy (<i>peginterferon beta-1a</i>) Pen ^{QL} Plegridy (<i>peginterferon beta-1a</i>) Syringe ^{QL} Ponvory (<i>ponesimod</i>) Tablet ^{QL} Tascenso (<i>fingolimod lauryl sulfate</i>) ODT ^{QL} Tecfidera DR (<i>dimethyl fumarate DR</i>) Capsule ^{QL} Vumerity DR (<i>diroxime fumarate DR</i>) Capsule ^{QL} Zeposia (<i>ozanimod</i>) Capsule ^{QL}

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (in years)
Non-preferred agents require prior authorization
Effective January 2026 v10

PA = clinical prior authorization required
QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Tysabri (natalizumab) Vial^{PA, QL}

NEUROPATHIC PAIN AGENTS

Preferred Agents	Non-Preferred Agents
Capsaicin Cream (<i>generic Zostrix, Zostrix HP</i>)	Cymbalta Capsule ^{QL}
Duloxetine DR 20 mg, 30 mg, 60 mg Capsule (<i>generic Cymbalta</i>) ^{QL}	Drizalma Sprinkle Capsule ^{QL}
Gabapentin 100 mg, 300 mg, 400 mg Capsule (<i>generic Neurontin</i>) ^{QL}	Duloxetine DR 40 mg Capsule (<i>generic Irenka</i>) ^{QL}
Gabapentin Solution (<i>generic Neurontin</i>) ^{QL}	Gabapentin ER Tablet (<i>generic Gralise ER</i>) ^{QL}
Gabapentin 600 mg, 800 mg Tablet (<i>generic Neurontin</i>) ^{QL}	Gabarone Tablet ^{QL}
Lidocaine 4% Patch	Gralise ER Tablet ^{QL}
Lidocaine 5% Patch (<i>generic Lidoderm Patch</i>) ^{QL}	Horizant ER Tablet ^{QL}
Pregabalin Capsule ^{QL}	Lidaflex Patch ^{QL}
Pregabalin Solution ^{QL}	Lyrica Capsule ^{QL}
	Lyrica Solution ^{QL}
	Lyrica CR Tablet ^{QL}
	Neurontin Capsule ^{QL}
	Neurontin Solution ^{QL}
	Neurontin Tablet ^{QL}
	Pregabalin ER Tablet ^{QL}
	Qutenza Patch ^{QL}
	Savella Tablet ^{QL}
	Tonmya SL Tablet ^{QL}
	Ztildo Patch ^{QL}

NSAIDs

Preferred Agents	Non-Preferred Agents
Celecoxib Capsule ^{QL}	Arthrotec Tablet ^{QL}
Diclofenac Sodium 1% Gel ^{QL}	Celebrex Capsule ^{QL}
Diclofenac Sodium 1.5% Topical Solution Drop ^{QL}	Diclofenac Epalamine Patch ^{QL}
Diclofenac Sodium DR/EC 25 mg, 50 mg, 75 mg Tablet (<i>generic Voltaren EC Tablet</i>) ^{QL}	Diclofenac Potassium Capsule ^{QL}
Diclofenac Sodium-Misoprostol Tablet ^{QL}	Diclofenac Potassium Powder Packet ^{QL}
EC-Naproxen 375 mg, 500 mg Tablet (<i>generic Naprosyn EC Tablet</i>) ^{QL}	Diclofenac Potassium Tablet ^{QL}
Flurbiprofen Tablet ^{QL}	Diclofenac Sodium 2% Topical Solution Pump ^{QL}
Ibuprofen Capsule ^{QL}	Diclofenac Sodium ER 24HR 100 mg Tablet (<i>generic Voltaren-XR Tablet</i>) ^{QL}
Ibuprofen Chewable Tablet ^{QL}	Diflunisal Tablet ^{QL}
Ibuprofen Suspension ^{QL}	Dolobid Tablet ^{QL}
Ibuprofen Suspension Drop ^{QL}	Elyxyb Solution ^{QL}
Ibuprofen 200 mg, 400 mg, 600 mg, 800 mg Tablet ^{QL}	Etodolac Capsule ^{QL}
Indomethacin Capsule ^{QL}	Etodolac Tablet ^{QL}
Indomethacin ER Capsule ^{QL}	Etodolac ER Tablet ^{QL}
Ketorolac Tablet ^{QL}	Fenoprofen Capsule ^{QL}
Meloxicam Tablet ^{QL}	Fenopron Capsule
Nabumetone Tablet ^{QL}	Ibuprofen-Famotidine Tablet ^{QL}
Naproxen 250 mg, 375 mg, 500 mg Tablet (<i>generic Naprosyn Tablet</i>) ^{QL}	Indomethacin Rectal Suppository ^{QL}
Naproxen DR 375 mg, 500 mg Tablet (<i>generic Naprosyn EC Tablet</i>) ^{QL}	Indomethacin Suspension ^{QL}
Naproxen Sodium 220 mg Capsule (<i>generic Aleve Liquid Gel Cap</i>) ^{QL}	Ketoprofen Capsule ^{QL}
	Ketoprofen ER Capsule ^{QL}
	Kiprofen Capsule ^{QL}
	Lofena Tablet ^{QL}
	Meclofenamate Capsule ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Naproxen Sodium 220 mg Tablet (<i>generic Aleve Caplet/Tablet</i>) ^{QL}	Mefenamic Acid Capsule ^{QL}
Naproxen Sodium 275 mg Tablet (<i>generic Anaprox Tablet</i>) ^{QL}	Meloxicam Capsule ^{QL}
Naproxen Sodium DS 550 mg Tablet (<i>generic Anaprox DS Tablet</i>) ^{QL}	Nalfon Capsule ^{QL}
Piroxicam Capsule ^{QL}	Nalfon Tablet ^{QL}
Sulindac Tablet ^{QL}	Naprelan CR Tablet ^{QL}
	Naprosyn Suspension ^{QL}
	Naproxen Suspension ^{QL}
	Naproxen-Esomeprazole DR Tablet ^{QL}
	Naproxen Sodium CR/ER Tablet (<i>generic Naprelan CR Tablet</i>) ^{QL}
	Oxaprozin Tablet ^{QL}
	Pennsaid Pump ^{QL}
	Relafen DS Tablet ^{QL}
	Tolectin Tablet ^{QL}
	Tolectin DS Capsule ^{QL}
	Tolmetin Sodium Capsule ^{QL}
	Tolmetin Sodium Tablet ^{QL}

OBESITY TREATMENT AGENTS

Preferred Agents	Non-Preferred Agents
Phentermine Capsule ^{QL}	Amphetamine Tablet ^{QL}
Phentermine Tablet ^{QL}	Benzphetamine Tablet ^{QL}
	Diethylpropion Tablet ^{QL}
	Diethylpropion ER Tablet ^{QL}
	Evekeo (<i>amphetamine</i>) Tablet ^{QL}
	Lomaira (<i>phentermine</i>) Tablet ^{QL}
	Orlistat Capsule ^{QL}
	Phendimetrazine Tablet ^{QL}
	Phendimetrazine ER Capsule ^{QL}
	Phentermine-Topiramate ER (<i>CPMP 24HR</i>) Capsule ^{QL}
	Xenical (<i>orlistat</i>) Capsule ^{QL}

ONCOLOGY AGENTS, BREAST CANCER

Preferred Agents	Non-Preferred Agents
Anastrozole Tablet ^{QL}	Arimidex Tablet ^{QL}
Exemestane Tablet ^{QL}	Aromasin Tablet ^{QL}
Letrozole Tablet ^{PA, QL}	Fareston Tablet ^{QL}
Tamoxifen Tablet ^{QL}	Femara Tablet ^{QL}
	Orserdu Tablet ^{QL}
	Soltamox Solution ^{QL}
	Toremifene Tablet ^{QL}

ONCOLOGY AGENTS, ORAL

Preferred Agents	Non-Preferred Agents
Abiraterone Acetate 250 mg Tablet ^{PA, QL}	Abiraterone Acetate 500 mg Tablet ^{QL}
Abirtega Tablet ^{PA, QL}	Afinitor Tablet ^{QL}
Afinitor Disperz Tablet ^{PA, QL}	Casodex Tablet ^{QL}
Akeega Tablet ^{PA, QL}	Dantizen Tablet ^{QL}
Alecensa Capsule ^{PA, QL}	Everolimus Tablet for Suspension ^{QL}
Alunbrig Tablet ^{PA, QL}	Gefitinib Tablet ^{QL}
Augtyro Capsule ^{PA, QL}	Gleevec Tablet ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Avmapi-Fakzynja Combo Package ^{PA, QL}	Iclusig 30 mg Tablet ^{QL}
Ayvakit Tablet ^{PA, QL}	Imbruvica Suspension ^{QL}
Balversa Tablet ^{PA, QL}	Imbruvica Tablet ^{QL}
Bicalutamide Tablet ^{PA, QL}	Imkeldi Solution ^{QL}
Bosulif Capsule ^{PA, QL}	Lapatinib Tablet ^{QL}
Bosulif Tablet ^{PA, QL}	Nexavar Tablet ^{QL}
Braftovi Capsule ^{PA, QL}	Nilotinib D-Tartrate Capsule ^{QL}
Brukina Capsule ^{PA, QL}	Pazopanib Tablet ^{QL}
Brukina Tablet ^{PA, QL}	Qinlock Tablet ^{QL}
Cabometyx Tablet ^{PA, QL}	Sprycel Tablet ^{QL}
Calquence Tablet ^{PA, QL}	Sunitinib Capsule ^{QL}
Capecitabine Tablet ^{PA}	Tafinlar Tablet for Suspension ^{QL}
Caprelsa Tablet ^{PA, QL}	Tarceva Tablet ^{QL}
Cometriq Capsule ^{PA, QL}	Tasigna Capsule ^{QL}
Copiktra Capsule ^{PA, QL}	Xeloda Tablet
Cotellic Tablet ^{PA, QL}	Yonsa Tablet ^{QL}
Dasatinib Tablet ^{PA, QL}	Zytiga Tablet ^{QL}
Daurismo Tablet ^{PA, QL}	
Erivedge Capsule ^{PA, QL}	
Erleada Tablet ^{PA, QL}	
Erlotinib Tablet ^{PA, QL}	
Everolimus Tablet ^{PA, QL}	
Fotivda Capsule ^{PA, QL}	
Fruzaqla Capsule ^{PA, QL}	
Gavreto Capsule ^{PA, QL}	
Gilotrif Tablet ^{PA, QL}	
Gomelki Capsule ^{PA, QL}	
Gomelki Tablet for Suspension ^{PA, QL}	
Ibrance Capsule ^{PA, QL}	
Ibrance Tablet ^{PA, QL}	
Iclusig 10 mg, 15 mg, 45 mg Tablet ^{PA, QL}	
Idhifa Tablet ^{PA, QL}	
Imatinib Tablet ^{PA, QL}	
Imbruvica Capsule ^{PA, QL}	
Inlyta Tablet ^{PA, QL}	
Inrebic Capsule ^{PA, QL}	
Iressa Tablet ^{PA, QL}	
Itovebi Tablet ^{PA, QL}	
Iwifin Tablet ^{PA, QL}	
Jakafi Tablet ^{PA, QL}	
Jaypirca Tablet ^{PA, QL}	
Kisqali Tablet ^{PA, QL}	
Kisqali Femara Co-Pack ^{PA, QL}	
Koselugo Capsule ^{PA, QL}	
Krazati Tablet ^{PA, QL}	
Lazcluze Tablet ^{PA, QL}	
Lenvima Capsule ^{PA, QL}	
Lonsurf Tablet ^{PA, QL}	
Lorbrena Tablet ^{PA, QL}	
Lumakras Tablet ^{PA, QL}	
Lynparza Tablet ^{PA, QL}	
Lytgobi Tablet ^{PA, QL}	
Mekinist Solution ^{PA, QL}	

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Mekinist Tablet^{PA, QL}
 Mektovi Tablet^{PA, QL}
 Nerlynx Tablet^{PA, QL}
 Nilotinib HCl Capsule^{PA, QL}
 Ninlaro Capsule^{PA, QL}
 Nubeqa Tablet^{PA, QL}
 Odomzo Tablet^{PA, QL}
 Ogsiveo Tablet^{PA, QL}
 Ojemda Suspension^{PA, QL}
 Ojemda Tablet^{PA, QL}
 Ojjaara Tablet^{PA, QL}
 Pemazyre Tablet^{PA, QL}
 Piqray Tablet^{PA, QL}
 Retevmo Capsule^{PA, QL}
 Retevmo Tablet^{PA, QL}
 Revuforj Tablet^{PA, QL}
 Rezlidhia Capsule^{PA, QL}
 Romvimza Capsule^{PA, QL}
 Rozlytrek Capsule^{PA, QL}
 Rozlytrek Pellet Packet^{PA, QL}
 Rubraca Tablet^{PA, QL}
 Rydapt Capsule^{PA, QL}
 Scemblix Tablet^{PA, QL}
 Sorafenib Tablet^{PA, QL}
 Stivarga Tablet^{PA, QL}
 Sutent Capsule^{PA, QL}
 Tabrecta Tablet^{PA, QL}
 Tafenlar Capsule^{PA, QL}
 Tagrisso Tablet^{PA, QL}
 Talzena Capsule^{PA, QL}
 Temozolomide Capsule^{PA}
 Tepmetko Tablet^{PA, QL}
 Tibsovo Tablet^{PA, QL}
 Torpenz Tablet^{PA}
 Truqap Tablet^{PA, QL}
 Tukysa Tablet^{PA, QL}
 Turalio Capsule^{PA, QL}
 Tykerb Tablet^{PA, QL}
 Vanflyta Tablet^{PA, QL}
 Venclexta Tablet^{PA, QL}
 Verzenio Tablet^{PA, QL}
 Vitrakvi Capsule^{PA, QL}
 Vitrakvi Solution^{PA, QL}
 Vizimpro Tablet^{PA, QL}
 Vonjo Tablet^{PA, QL}
 Voranigo Tablet^{PA, QL}
 Votrient Tablet^{PA, QL}
 Welireg Tablet^{PA, QL}
 Xalkori Capsule^{PA, QL}
 Xalkori Pellet^{PA, QL}
 Xospata Tablet^{PA, QL}
 Xpovio Tablet^{PA, QL}
 Xtandi Capsule^{PA, QL}

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Xtandi Tablet^{PA, QL}
 Zejula Tablet^{PA, QL}
 Zelboraf Tablet^{PA, QL}
 Zolinza Capsule^{PA, QL}
 Zydelig Tablet^{PA, QL}
 Zykadia Tablet^{PA, QL}

OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents
Alaway Drop	Alrex Drop
Azelastine Drop	Bepotastine Drop
Cromolyn Sodium Drop	Bepreve Drop
Ketotifen Drop	Epinastine Drop
Naphcon-A Drop	Lastacaft Drop
Olopatadine 0.1% Drop	Loteprednol 0.2% Drop (<i>generic Alrex</i>)
Olopatadine 0.2% Drop	Pataday Eye Drop
Olopatadine 0.7% Drop	Zerviate Droperette
Zaditor Drop	

OPHTHALMICS, ANTIBIOTICS

Preferred Agents	Non-Preferred Agents
Bacitracin-Polymyxin Ointment	Azasite (<i>azithromycin</i>) Drop
Ciprofloxacin Drop	Bacitracin Ointment
Erythromycin Ointment	Besivance (<i>besifloxacin</i>) Drop
Gatifloxacin Drop	Ciloxan (<i>ciprofloxacin</i>) Ointment
Gentamicin Drop	Levofloxacin 0.5% Drop
Moxifloxacin Drop	Moxifloxacin Viscous Drop
Ofloxacin Drop	Neomycin-Bacitracin-Polymyxin Ointment
Polycin (<i>bacitracin-polymyxin B</i>) Ointment	Neomycin-Polymyxin-Gramicidin Drop
Polymyxin B-Trimethoprim Drop	Neo-Polycin (<i>neomycin-bacitracin-polymyxin B</i>) Ointment
Tobramycin Drop	Ocuflox (<i>ofloxacin</i>) Drop
	Sulfacetamide Sodium Drop
	Tobrex (<i>tobramycin</i>) Ointment
	Vigamox (<i>moxifloxacin</i>) Drop

OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred Agents
Neomycin-Bacitracin-Polymyxin-HC Ointment	Maxitrol (<i>neomycin-polymyxin B-dexamethasone</i>) Drop
Neomycin-Polymyxin-Dexamethasone Drop	Maxitrol (<i>neomycin-polymyxin B-dexamethasone</i>) Ointment
Neomycin-Polymyxin-Dexamethasone Ointment	Neomycin-Polymyxin-HC Drop
Neo-Polycin HC (<i>neomycin-bacitracin-polymyxin B-hydrocortisone</i>) Ointment	Tobradex ST (<i>tobramycin-dexamethasone</i>) Drop
Sulfacetamide-Prednisolone Drop	Tobramycin-Dexamethasone Drop
Tobradex (<i>tobramycin-dexamethasone</i>) Ointment	Zylet (<i>tobramycin-loteprednol</i>) Drop

OPHTHALMICS, ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents
Bromfenac 0.09% Drop (<i>generic Bromday</i>)	Acular Drop
Dexamethasone Sodium Phosphate Drop	Acular LS Drop
Diffuprednate Drop	Acuvail Droperette

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Flarex Drop	Alrex Drop
Fluorometholone Drop	Bromfenac 0.07% Drop (<i>generic Prolensa</i>)
Flurbiprofen Drop	Bromfenac 0.075% Drop (<i>generic Bromsite</i>)
FML Forte Drop	Bromsite Drop
Ketorolac 0.4% Drop (<i>generic Acular LS</i>)	Dextenza Insert
Ketorolac 0.5% Drop (<i>generic Acular</i>)	Diclofenac Drop
Lotemax Ointment	Durezol Drop
Maxidex Drop	FML Liquifilm Drop
Pred Mild Drop	Ilevro Drop
Prednisolone Acetate Drop	Iluvien Implant
Prednisolone Sodium Phosphate Drop	Inveltys Drop
	Lotemax Drop
	Lotemax Gel Drop
	Lotemax SM Gel Drop
	Loteprednol 0.2% Drop (<i>generic Alrex</i>)
	Loteprednol 0.5% Drop (<i>generic Lotemax</i>)
	Loteprednol Gel Drop
	Nevanac Drop
	Ozurdex Implant
	Pred Forte Drop
	Prolensa Drop
	Retisert Implant
	Triesence Vial ^{QL}
	Xipere Vial

OPHTHALMICS, GLAUCOMA

Preferred Agents	Non-Preferred Agents
Alphagan P 0.1% Drop	Apraclonidine Drop
Alphagan P 0.15% Drop	Azopt Drop
Brimonidine 0.2% Drop	Betaxolol Drop
Carteolol Drop	Betimol Drop
Combigan Drop	Betoptic S 0.25% Drop
Dorzolamide Drop	Bimatoprost 0.03% Drop
Dorzolamide-Timolol Drop (<i>generic Cosopt</i>)	Brimonidine 0.1% Drop
Latanoprost 0.005% Drop	Brimonidine 0.15% Drop
Levobunolol Drop	Brimonidine-Timolol Drop
Simbrinza Drop	Brinzolamide Drop
Timolol Maleate Drop (<i>generic Timoptic</i>)	Cosopt Drop
	Cosopt PF Dropperette
	Dorzolamide-Timolol Dropperette (<i>generic Cosopt PF</i>)
	Durysta Implant
	Idose TR Implant
	Iopidine Dropperette
	Iyuzeh Dropperette
	Lumigan 0.01% Drop
	Pilocarpine Drop
	Rhopressa Drop
	Rocklatan Drop
	Tafluprost Dropperette
	Timolol Maleate Dropperette (<i>generic Timolol Ocudose</i>)
	Timolol Maleate (Daily) Drop (<i>generic Istalol</i>)
	Timolol Gel-Solution

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

	Timoptic Drop Timoptic Ocudose Dropperette Timoptic-XE GFS Travatan Z Drop Travoprost Drop Vyzulta Drop Xalatan Drop Xelpros Drop Zioptan Dropperette
--	---

OPIOID OVERDOSE AGENTS

Preferred Agents	Non-Preferred Agents
Kloxxado Nasal Spray Naloxone Cartridge Naloxone Nasal Spray Naloxone Syringe Naloxone Vial Narcan Nasal Spray Opvee Nasal Spray Rextovy Nasal Spray Zimhi Syringe Zurnai Autoinjector	

OPIOID USE DISORDER TREATMENTS

Preferred Agents	Non-Preferred Agents
Brixadi Monthly Syringe ^{QL} Brixadi Weekly Syringe ^{QL} Buprenorphine SL Tablet ^{QL} Buprenorphine-Naloxone SL Film ^{QL} Buprenorphine-Naloxone SL Tablet ^{QL} Clonidine Tablet Naltrexone Tablet Sublocade Syringe ^{QL} Vivitrol Vial ^{QL}	Lofexidine Tablet ^{QL} Lucemyra Tablet ^{QL} Suboxone SL Film ^{QL} Zubsolv SL Tablet ^{QL}

OTIC ANTIBIOTIC PREPARATIONS

Preferred Agents	Non-Preferred Agents
Cipro HC Otic Suspension Neomycin-Polymyxin-Hydrocortisone Otic Solution Neomycin-Polymyxin-Hydrocortisone Otic Suspension Ofloxacin Otic Drop	Ciprofloxacin Otic Solution Dropperette Ciprofloxacin-Dexamethasone Drop Cortisporin-TC Otic Suspension

PANCREATIC ENZYMES

Preferred Agents	Non-Preferred Agents
Creon DR Capsule Zenpep DR Capsule	Pertzye DR Capsule Viokace Tablet

PENICILLINS

Preferred Agents	Non-Preferred Agents
Amoxicillin Capsule	Amoxicillin-Clavulanate Chewable Tablet

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (in years)
Non-preferred agents require prior authorization
Effective January 2026 v10

PA = clinical prior authorization required
QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Amoxicillin Chewable Tablet	Amoxicillin-Clavulanate 250-62.5 mg/5 mL Suspension
Amoxicillin Suspension	Amoxicillin-Clavulanate ER Tablet
Amoxicillin Tablet	Augmentin Suspension
Amoxicillin-Clavulanate 200-28.5 mg/5 mL Suspension	Augmentin ES-600 Suspension
Amoxicillin-Clavulanate 400-57 mg/5 mL Suspension	
Amoxicillin-Clavulanate 600-42.9 mg/5 mL Suspension	
Amoxicillin-Clavulanate Tablet	
Ampicillin Capsule	
Dicloxacillin Capsule	
Penicillin VK Solution	
Penicillin VK Tablet	

PHOSPHATE LOWERING AGENTS

Preferred Agents	Non-Preferred Agents
Calcium Acetate Capsule ^{QL}	Auryxia (<i>ferric citrate</i>) Tablet ^{QL}
Calcium Acetate Tablet ^{QL}	Ferric Citrate Tablet ^{QL}
Calphron (<i>calcium acetate</i>) Tablet ^{QL}	Fosrenol (<i>lanthanum carbonate</i>) Chewable Tablet ^{QL}
Sevelamer Carbonate Tablet ^{QL}	Fosrenol (<i>lanthanum carbonate</i>) Powder Packet ^{QL}
	Lanthanum Carbonate Chewable Tablet ^{QL}
	Renagel (<i>sevelamer hydrochloride</i>) Tablet ^{QL}
	Renvela (<i>sevelamer carbonate</i>) Powder Packet ^{QL}
	Renvela (<i>sevelamer carbonate</i>) Tablet ^{QL}
	Sevelamer Carbonate Powder Packet ^{QL}
	Sevelamer HCl Tablet ^{QL}
	Velphoro (<i>sucroferric oxyhydroxide</i>) Chewable Tablet ^{QL}
	Xphozah (<i>tenapanor</i>) Tablet ^{QL}

PITUITARY SUPPRESSIVE AGENTS, LHRH

Preferred Agents	Non-Preferred Agents
Eligard (<i>leuprolide acetate</i>) Kit ^{PA, QL}	Camcevi (<i>leuprolide mesylate</i>) Syringe ^{QL}
Fensolvi (<i>leuprolide acetate</i>) Kit ^{PA, QL}	Orgovyx (<i>relugolix</i>) Tablet ^{QL}
Firmagon (<i>degarelix acetate</i>) Kit ^{PA, QL}	Oriahnn (<i>elagolix-estradiol-norethindrone + elagolix</i>) Capsule ^{QL}
Leuprolide Acetate Kit ^{PA}	Supprelin LA (<i>histrelin</i>) Kit ^{QL}
Leuprolide Acetate Vial ^{PA}	Synarel (<i>nafarelin acetate</i>) Nasal Spray ^{QL}
Leuprolide Depot Vial ^{PA, QL}	Trelstar (<i>triptorelin pamoate</i>) Vial ^{QL}
Lupron Depot (<i>leuprolide acetate</i>) Kit ^{PA, QL}	
Lupron Depot-Ped (<i>leuprolide acetate</i>) Kit ^{PA, QL}	
Lutrate Depot (<i>leuprolide acetate</i>) Vial ^{PA, QL}	
Myfembree (<i>relugolix-estradiol-norethindrone</i>) Tablet ^{PA, QL}	
Orilissa (<i>elagolix</i>) Tablet ^{PA, QL}	
Triptodur (<i>triptorelin pamoate</i>) Kit ^{PA, QL}	

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents
Aspirin-Dipyridamole ER Capsule ^{QL}	Effient (<i>prasugrel</i>) Tablet ^{QL}
Brilinta (<i>ticagrelor</i>) Tablet ^{QL}	Plavix (<i>clopidogrel</i>) Tablet ^{QL}
Clopidogrel Tablet ^{QL}	Ticagrelor 60 mg Tablet ^{QL}
Dipyridamole Tablet ^{QL}	
Prasugrel Tablet ^{QL}	
Ticagrelor 90 mg Tablet ^{QL}	

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

POTASSIUM REMOVING AGENTS

Preferred Agents	Non-Preferred Agents
Lokelma (<i>sodium zirconium cyclosilicate</i>) Powder Packet (NDCs 00310111030, 00310110530, 00310110539, 00310111039 only) ^{PA} , QL	Lokelma (<i>sodium zirconium cyclosilicate</i>) Powder Packet (NDCs 00310110501, 00310111001) ^{QL}
Veltassa (<i>patiomer</i>) Powder Packet (NDCs 53436001060, 53436001001, 53436016830, 53436016801, 53436008430, 53436008401 only) ^{PA} , QL	Veltassa (<i>patiomer</i>) Powder Packet (NDCs 53436025230, 53436025201, 53436008404) ^{QL}

PRENATAL VITAMINS

Preferred Agents	Non-Preferred Agents
Complete Natal DHA Combo Pack	Citranatal B-Calm Combo Pack
M-Natal Plus Tablet	C-Nate DHA Capsule
Prenatal Plus Vitamin-Mineral Tablet	Completenate Chewable Tablet
Prenatal Vitamin Plus Low Iron Tablet	Concept DHA Capsule
Thrivite Rx Tablet	Concept OB Capsule
Trinatal RX 1 Tablet	Dermacinrx Prenatrix Tablet
Westab Plus Tablet	Dermacinrx Prenatryl Tablet
	Dermacinrx Pretrate Tablet
	Elite-OB Tablet
	Enbrace HR Capsule
	Folivane-OB Capsule
	Natal PNV Tablet
	Nestabs Tablet
	Nestabs DHA Combo Pack
	Nestabs One Capsule
	OB Complete Tablet
	OB Complete One Capsule
	OB Complete Petite Capsule
	OB Complete Premier Tablet
	OB Complete with DHA Capsule
	PNV-DHA Capsule
	PNV-Omega Capsule
	PNV-Select Tablet
	Prenate AM Tablet
	Prenate Chewable Tablet
	Prenate DHA Capsule
	Prenate Elite Tablet
	Prenate Enhance Capsule
	Prenate Essential Capsule
	Prenate Mini Capsule
	Prenate Pixie Capsule
	Prenate Restore Capsule
	Primacare Capsule
	Provida OB Capsule
	Select-OB Chewable Tablet
	Select-OB + DHA Combo Pack
	Taron-C DHA Capsule
	Tricare Tablet
	Tristart DHA Capsule

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

	Virt-Nate DHA Capsule Virt-PN DHA Capsule Vitafof Fe Plus Capsule Vitafof Gummies Vitafof Nano Tablet Vitafof Ultra Capsule Vitafof-OB Tablet Vitafof-OB+DHA Combo Pack Vitafof-One Capsule Vitamedmd One Rx Capsule Vitapearl Capsule Wescap-C DHA Capsule Wescap-PN DHA Capsule Wesnate DHA Capsule Westgel DHA Capsule Zatean-PN DHA Capsule Zatean-PN Plus Capsule
--	--

PROGESTATIONAL AGENTS

Preferred Agents	Non-Preferred Agents
Gallifrey Tablet ^{QL} Medroxyprogesterone Tablet ^{QL} Norethindrone Tablet ^{QL} Progesterone Capsule ^{QL} Progesterone Vial	Crinone Gel Provera Tablet ^{QL}

PROTON PUMP INHIBITORS

Preferred Agents	Non-Preferred Agents
Esomeprazole Magnesium DR Capsule ^{AR, QL} Esomeprazole DR (Suspension) Packet ^{AR, QL} Lansoprazole DR Capsule ^{AR, QL} Lansoprazole ODT ^{AR, QL} Nexium DR (Suspension) Packet ^{AR, QL} Omeprazole DR Capsule (Rx) ^{AR, QL} Pantoprazole DR Suspension Packet ^{AR, QL} Pantoprazole DR Tablet ^{AR, QL} Rabeprazole DR Tablet ^{AR, QL}	Aciphex DR Tablet ^{AR, QL} Dexilant DR Capsule ^{AR, QL} Dexlansoprazole DR Capsule ^{AR, QL} Konvomep Suspension ^{AR, QL} Nexium DR Capsule ^{AR, QL} Omeprazole DR ODT ^{AR, QL} Omeprazole DR Tablet ^{AR, QL} Omeprazole Magnesium DR Capsule ^{AR, QL} Omeprazole Magnesium DR Tablet ^{AR, QL} Omeprazole-Sodium Bicarbonate Capsule ^{AR, QL} Omeprazole-Sodium Bicarbonate Packet ^{AR, QL} Prevacid 24HR DR Capsule ^{AR, QL} Prevacid DR Capsule ^{AR, QL} Prevacid Solutab ^{AR, QL} Prilosec DR Suspension (Packet) ^{AR, QL} Protonix DR Tablet ^{AR, QL} Protonix Suspension (Packet) ^{AR, QL} Voquezna Tablet ^{QL}

PULMONARY HYPERTENSION AGENTS, ORAL AND INHALED

Preferred Agents	Non-Preferred Agents
Ambrisentan Tablet ^{PA, QL} Bosentan Tablet ^{PA, QL}	Adcirca (<i>tadalafil</i>) Tablet ^{QL} Adempas (<i>riociguat</i>) Tablet ^{QL}

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (in years)
Non-preferred agents require prior authorization
Effective January 2026 v10

PA = clinical prior authorization required
QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Sildenafil Suspension (<i>generic Revatio</i>) ^{PA, QL}	Alyq (<i>tadalafil</i>) Tablet ^{QL}
Sildenafil Tablet (<i>generic Revatio</i>) ^{PA, QL}	Letairis (<i>ambrisentan</i>) Tablet ^{QL}
Tadalafil Tablet (<i>generic Adcirca</i>) ^{PA, QL}	Opsumit (<i>macitentan</i>) Tablet ^{QL}
Tyvaso (<i>treprostinil</i>) Inhalation Solution ^{PA, QL}	Opsynvi (<i>macitentan/tadalafil</i>) Tablet ^{QL}
Tyvaso (<i>treprostinil</i>) Refill Kit ^{PA, QL}	Orenitram ER (<i>treprostinil</i>) Tablet
Tyvaso (<i>treprostinil</i>) Starter Kit ^{PA, QL}	Revatio (<i>sildenafil</i>) Tablet ^{QL}
Tyvaso (<i>treprostinil</i>) DPI Cartridge ^{PA}	Tadliq (<i>tadalafil</i>) Suspension ^{QL}
Tyvaso (<i>treprostinil</i>) DPI Maintenance Kit ^{PA}	Tracleer (<i>bosentan</i>) Tablet ^{QL}
Tyvaso (<i>treprostinil</i>) DPI Titration Kit ^{PA}	Tracleer (<i>bosentan</i>) Tablet for Suspension ^{QL}
	Upravi (<i>selexipag</i>) Tablet ^{QL}

SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents
Doxepin Capsule	Ambien Tablet ^{QL}
Doxepin Concentrate Solution	Ambien CR Tablet ^{QL}
Eszopiclone Tablet ^{QL}	Belsomra Tablet ^{QL}
Temazepam 15 mg, 30 mg Capsule ^{AR, QL}	Dayvigo Tablet ^{QL}
Zaleplon Capsule ^{QL}	Doxepin Tablet ^{QL}
Zolpidem 5 mg, 10 mg Tablet ^{QL}	Edluar SL Tablet ^{QL}
	Estazolam Tablet ^{AR, QL}
	Flurazepam Capsule ^{AR, QL}
	Halcion Tablet ^{AR, QL}
	Hetlioz Capsule ^{QL}
	Hetlioz LQ Suspension ^{QL}
	Igalmi Film ^{QL}
	Midazolam Syrup ^{AR}
	Quviviq Tablet ^{QL}
	Ramelteon Tablet ^{QL}
	Restoril Capsule ^{AR, QL}
	Rozerem Tablet ^{QL}
	Tasimelteon Capsule ^{QL}
	Temazepam 7.5 mg, 22.5 mg Capsule ^{AR, QL}
	Triazolam Tablet ^{AR, QL}
	Zolpidem Capsule ^{QL}
	Zolpidem ER Tablet ^{QL}
	Zolpidem SL Tablet ^{QL}

SICKLE CELL ANEMIA AGENTS

Preferred Agents	Non-Preferred Agents
Hydroxyurea Capsule	Adakveo Vial
Siklos Tablet ^{AR}	Endari Powder Packet ^{QL}
Xromi Solution	L-Glutamine Powder Packet ^{QL}

SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred Agents
Baclofen 5 mg, 10 mg, 20 mg Tablet ^{QL}	Amrix ER Capsule ^{QL}
Cyclobenzaprine Tablet ^{QL}	Baclofen Solution ^{QL}
Dantrolene Capsule ^{QL}	Baclofen Suspension ^{QL}
Methocarbamol Tablet ^{QL}	Baclofen 15 mg Tablet ^{QL}
Tizanidine Tablet ^{QL}	Carisoprodol Tablet ^{QL}
	Chlorzoxazone Tablet ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	Cyclobenzaprine ER Capsule ^{QL} Dantrium Capsule ^{QL} Fexmid Tablet ^{QL} Fleqsuvy Suspension ^{QL} Lorzone Tablet ^{QL} Lyvispah Granule Packet ^{QL} Metaxalone Tablet ^{QL} Norgesic Tablet ^{QL} Norgesic Forte Tablet ^{QL} Orphenadrine-Aspirin-Caffeine Tablet ^{QL} Orphenadrine ER Tablet ^{QL} Orphengesic Forte Tablet ^{QL} Ozobax Solution ^{QL} Ozobax DS Solution ^{QL} Soma Tablet ^{QL} Tanlor Tablet ^{QL} Tizanidine Capsule ^{QL} Tonmya SL Tablet ^{QL} Zanaflex Capsule ^{QL} Zanaflex Tablet ^{QL}
--	--

SMOKING CESSATION

Preferred Agents	Non-Preferred Agents
Bupropion HCl SR 150 mg Tablet (<i>generic Zyban SR</i>) ^{QL} Chantix Tablet ^{QL} Nicotine Gum ^{QL} Nicotine Lozenge ^{QL} Nicotine Mini Lozenge ^{QL} Nicotine Patch ^{QL} Varenicline Tablet ^{QL}	Nicotine Transdermal System (Steps 1, 2, 3) ^{QL} Nicotrol NS Spray ^{QL}

STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents
<u>Low Potency</u> Fluocinolone Body Oil Fluocinolone Scalp Oil Hydrocortisone 0.5% Cream Hydrocortisone 1% Cream Hydrocortisone 2.5% Cream Hydrocortisone 2.5% Lotion Hydrocortisone Ointment Hydrocortisone-Aloe Cream	<u>Low Potency</u> Alclometasone Cream Alclometasone Ointment Capex (<i>fluocinolone</i>) Shampoo Derma-Smoothe-FS (<i>fluocinolone</i>) Oil Desonide Cream Desonide Lotion Desonide Ointment Hydrocortisone 2.5% Solution Hydroxym (<i>hydrocortisone</i>) Gel Texacort (<i>hydrocortisone</i>) Solution
<u>Medium Potency</u> Fluticasone Cream Fluticasone Ointment Mometasone Cream Mometasone Ointment	<u>Medium Potency</u> Betamethasone Valerate Foam Clocortolone Cream Fluocinolone Cream Fluocinolone Ointment

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (in years)
Non-preferred agents require prior authorization
Effective January 2026 v10

PA = clinical prior authorization required
QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Mometasone Solution	Fluocinolone Solution Flurandrenolide Cream Flurandrenolide Lotion Fluticasone Lotion Hydrocortisone Butyrate Cream Hydrocortisone Butyrate Lotion Hydrocortisone Butyrate Ointment Hydrocortisone Butyrate Solution Hydrocortisone Valerate Cream Hydrocortisone Valerate Ointment Locoid (<i>hydrocortisone butyrate</i>) Lotion Locoid (<i>hydrocortisone butyrate/emollient</i>) Lipocream Luxiq (<i>betamethasone valerate</i>) Foam Pandel (<i>hydrocortisone probutate</i>) Cream Prednicarbate Cream Prednicarbate Ointment Synalar (<i>fluocinolone</i>) Cream Synalar (<i>fluocinolone/emollient</i>) Cream Kit Synalar (<i>fluocinolone</i>) Ointment Synalar (<i>fluocinolone/emollient</i>) Ointment Kit Synalar (<i>fluocinolone</i>) Solution Synalar (<i>fluocinolone/cleanser</i>) TS Kit
<u>High Potency</u>	<u>High Potency</u>
Betamethasone Dipropionate Cream Betamethasone Dipropionate Lotion Betamethasone Dipropionate Augmented Cream Betamethasone Valerate Cream Betamethasone Valerate Lotion Betamethasone Valerate Ointment Fluocinonide Cream Fluocinonide Gel Fluocinonide Ointment Fluocinonide Solution Triamcinolone Acetonide Cream Triamcinolone Acetonide Lotion Triamcinolone Acetonide Ointment	Amcinonide Cream Betamethasone Dipropionate Ointment Betamethasone Dipropionate Augmented Gel Betamethasone Dipropionate Augmented Lotion Betamethasone Dipropionate Augmented Ointment Desoximetasone Cream Desoximetasone Gel Desoximetasone Ointment Desoximetasone Spray Diflorasone Cream Diflorasone Ointment Diprolene (<i>betamethasone dipropionate augmented</i>) Ointment Fluocinonide-E Cream Kenalog (<i>triamcinolone</i>) Spray Topicort (<i>desoximetasone</i>) Cream Topicort (<i>desoximetasone</i>) Gel Topicort (<i>desoximetasone</i>) Ointment Topicort (<i>desoximetasone</i>) Spray Triamcinolone Spray
<u>Very High Potency</u>	<u>Very High Potency</u>
Clobetasol 0.05% Cream (<i>generic Temovate</i>) Clobetasol 0.05% Ointment (<i>generic Temovate</i>) Clobetasol Solution Clodan (<i>clobetasol</i>) Shampoo	Apexicon E (<i>diflorasone/emollient</i>) Cream Clobetasol 0.25% Cream Clobetasol Foam Clobetasol Gel Clobetasol Lotion Clobetasol Shampoo Clobetasol Spray

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	Clobetasol Emollient Cream Clobetasol Emollient Foam Clobetasol Emulsion Foam Clobex (<i>clobetasol</i>) Shampoo Clobex (<i>clobetasol</i>) Spray Clodan (<i>clobetasol/cleanser</i>) Kit Halcinonide Cream Halcinonide Solution Halobetasol Cream Halobetasol Foam Halobetasol Ointment Halog (<i>halcinonide</i>) Cream Halog (<i>halcinonide</i>) Ointment Halog (<i>halcinonide</i>) Solution Impeklo (<i>clobetasol</i>) Lotion Lexette (<i>halobetasol</i>) Foam Olux (<i>clobetasol</i>) Foam Olux-E (<i>clobetasol/emollient</i>) Foam Tovet (<i>clobetasol/emollient</i>) Emollient Foam Tovet (<i>clobetasol/emollient</i>) Foam Kit Ultravate (<i>halobetasol</i>) Lotion
--	--

STIMULANTS AND RELATED AGENTS

Preferred Agents	Non-Preferred Agents
Armodafinil Tablet ^{PA, QL} Atomoxetine Capsule ^{AR, QL} Clonidine ER 0.1 mg Tablet (<i>generic Kapvay ER</i>) ^{AR, QL} Concerta (<i>methylphenidate ER 24HR</i>) Tablet ^{AR, QL} Dexmethylphenidate Tablet ^{AR, QL} Dexmethylphenidate ER (CPBP 50-50) Capsule (<i>generic Focalin XR</i>) ^{AR, QL} Dextroamphetamine Tablet ^{AR, QL} Dextroamphetamine ER Capsule ^{AR, QL} Dextroamphetamine-Amphetamine Tablet (<i>generic Adderall</i>) ^{AR, QL} Dextroamphetamine-Amphetamine ER (24HR) Capsule (<i>generic Adderall XR</i>) ^{AR, QL} Dyanavel XR (<i>amphetamine SUS BP 24HR</i>) Suspension ^{AR, QL} Guanfacine ER Tablet ^{AR, QL} Lisdexamfetamine Capsule ^{AR, QL} Methylphenidate Solution ^{AR, QL} Methylphenidate Tablet ^{AR, QL} Methylphenidate ER/CD (CPBP 30-70) Capsule (<i>generic Metadate CD</i>) ^{AR, QL} Methylphenidate ER Tablet (<i>generic Ritalin SR</i>) ^{AR, QL} Methylphenidate ER (24HR) 18 mg, 27 mg, 36 mg, 54 mg Tablet (<i>generic Concerta ER</i>) ^{AR, QL} Methylphenidate ER/LA (CPBP 50-50) Capsule (<i>generic Ritalin LA</i>) ^{AR, QL} Modafinil Tablet ^{PA, QL} Procentra (<i>dextroamphetamine</i>) Solution ^{AR, QL} Qelbree ER (<i>viloxazine</i>) Capsule ^{AR, QL}	Adderall (<i>dextroamphetamine-amphetamine</i>) Tablet ^{AR, QL} Adderall XR (<i>dextroamphetamine-amphetamine ER 24HR</i>) Capsule ^{AR, QL} Adzenys XR-ODT (<i>amphetamine RAP BP tablet</i>) ^{AR, QL} Amphetamine Tablet (<i>generic Evekeo</i>) ^{AR, QL} Aptensio XR (<i>methylphenidate CSBP 40-60</i>) Capsule ^{AR, QL} Azstarys (<i>serdexmethylphenidate-dexmethylphen</i>) Capsule ^{AR, QL} Cotempla XR-ODT (<i>methylphenidate RAP BP tablet</i>) ^{AR, QL} Daytrana (<i>methylphenidate</i>) Patch ^{AR, QL} Dexedrine ER (<i>dextroamphetamine ER</i>) Capsule ^{AR, QL} Dextroamphetamine Solution ^{AR, QL} Dextroamphetamine-Amphetamine ER (CPTP 24HR) Capsule (<i>generic Mydayis ER</i>) ^{AR, QL} Dyanavel XR (<i>amphetamine TB BP 24HR</i>) Tablet ^{AR, QL} Evekeo (<i>amphetamine</i>) Tablet ^{AR, QL} Focalin (<i>dexmethylphenidate</i>) Tablet ^{AR, QL} Focalin XR (<i>dexmethylphenidate CPBP 50-50</i>) Capsule ^{AR, QL} Intuniv ER (<i>guanfacine ER 24HR</i>) Tablet ^{AR, QL} Jornay PM (<i>methylphenidate CPDR ER SP</i>) Capsule ^{AR, QL} Lisdexamfetamine Chewable Tablet ^{AR, QL} Methamphetamine Tablet ^{AR, QL} Methylin (<i>methylphenidate</i>) Solution ^{AR, QL} Methylphenidate Chewable Tablet ^{AR, QL} Methylphenidate Patch ^{AR, QL} Methylphenidate ER (CSBP 40-60) Capsule (<i>generic Aptensio XR</i>) ^{AR, QL} Methylphenidate ER (24HR) Tablet (all strengths <u>except</u> 18 mg, 27 mg, 36 mg, 54 mg) (<i>generic Relexxii ER [24HR]</i>) ^{AR, QL}

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (in years)
Non-preferred agents require prior authorization
Effective January 2026 v10

PA = clinical prior authorization required
QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Quillichew ER (methylphenidate TAB CBP24H) Chewable Tablet ^{AR, QL}	Mydayis ER (dextroamphetamine-amphetamine CPTP 24HR) Capsule ^{AR, QL}
Quillivant XR (methylphenidate SU ER RC24) Suspension ^{AR, QL}	Nuvigil (armodafinil) Tablet ^{QL}
	Onyda XR (clonidine ER 24H) Suspension ^{AR, QL}
	Provigil (modafinil) Tablet ^{QL}
	Relexxii ER (methylphenidate ER 24HR) Tablet ^{AR, QL}
	Ritalin (methylphenidate) Tablet ^{AR, QL}
	Ritalin LA (methylphenidate CPBP 50-50) Capsule ^{AR, QL}
	Strattera (atomoxetine) Capsule ^{AR, QL}
	Sunosi (solriamfetol) Tablet ^{QL}
	Vyvanse (lisdexamfetamine) Capsule ^{AR, QL}
	Vyvanse (lisdexamfetamine) Chewable Tablet ^{AR, QL}
	Wakix (pitolisant) Tablet ^{QL}
	Xelstryl (dextroamphetamine) Patch ^{AR, QL}
	Zenzedi (dextroamphetamine) Tablet ^{AR, QL}

TETRACYCLINES

Preferred Agents	Non-Preferred Agents
Doxycycline Hyclate 50 mg, 100 mg Capsule (generic Vibramycin Capsule)	Demeclocycline Tablet
Doxycycline Hyclate 20 mg Tablet (generic Periostat Tablet)	Doryx MPC DR Tablet ^{QL}
Doxycycline Hyclate 100 mg Tablet (generic Vibra-Tabs Tablet)	Doxycycline Hyclate 50 mg Tablet (generic Targadox)
Doxycycline Monohydrate 50 mg, 100 mg Capsule (generic Monodox Capsule)	Doxycycline Hyclate 75 mg, 150 mg Tablet (generic Acticlate Tablet)
Doxycycline Monohydrate Suspension (generic Vibramycin Suspension)	Doxycycline Hyclate DR Tablet (generic Doryx DR Tablet) ^{QL}
Doxycycline Monohydrate 50 mg, 75 mg, 100 mg Tablet (generic Adoxa Tablet)	Doxycycline IR-DR 40 mg Capsule (generic Oracea Capsule) ^{QL}
Minocycline Capsule	Doxycycline Monohydrate 75 mg Capsule (generic Monodox Capsule)
Tetracycline Capsule	Doxycycline Monohydrate 150 mg Capsule (generic Adoxa Capsule)
	Doxycycline Monohydrate 150 mg Tablet (generic Adoxa Pak Tablet)
	Minocycline Tablet (generic Dynacin Tablet)
	Minocycline ER Tablet (generic Solodyn ER Tablet) ^{QL}
	Nuzyra Tablet ^{QL}
	Oracea Capsule ^{QL}
	Tetracycline Tablet

THALIDOMIDE AND DERIVATIVES

Preferred Agents	Non-Preferred Agents
Revlimid (lenalidomide) Capsule ^{PA, QL}	Lenalidomide Capsule ^{QL}
Thalomid (thalidomide) Capsule ^{PA, QL}	Pomalyst (pomalidomide) Capsule ^{QL}

THROMBOPOIETICS

Preferred Agents	Non-Preferred Agents
Nplate (romiplostim) Vial ^{PA}	Alvaiz (eltrombopag choline) Tablet ^{QL}
Promacta (eltrombopag olamine) Suspension Packet ^{PA, QL}	Doptelet (avatrombopag) Tablet ^{QL}
Promacta (eltrombopag olamine) Tablet ^{PA, QL}	Eltrombopag Olamine Suspension Packet ^{QL}
	Eltrombopag Olamine Tablet ^{QL}
	Mulpleta (lusutrombopag) Tablet ^{QL}
	Tavalisse (fostatinib) Tablet ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

THYROID HORMONES

Preferred Agents	Non-Preferred Agents
Armour Thyroid (<i>thyroid, pork</i>) Tablet	Adthyza (<i>thyroid, pork</i>) Tablet
Cytomel (<i>liothyronine</i>) Tablet ^{QL}	Levothyroxine Vial
Levo-T (<i>levothyroxine</i>) Tablet	Liothyronine Vial
Levothyroxine Tablet	Synthroid (<i>levothyroxine</i>) Tablet
Levoxyl (<i>levothyroxine</i>) Tablet	Thyquidity (<i>levothyroxine</i>) Solution
Liothyronine Tablet ^{QL}	Unithroid (<i>levothyroxine</i>) Tablet
Niva Thyroid (<i>thyroid, pork</i>) Tablet	
NP Thyroid (<i>thyroid, pork</i>) Tablet	
Renthroid (<i>thyroid, pork</i>) Tablet	

TUBELESS INSULIN DELIVERY DEVICES

Preferred Products	Non-Preferred Products
CeQur Simplicity Insert ^{QL}	
CeQur Simplicity Patch ^{QL}	
Omnipod 5 (G6/Libre 2 Plus) Intro Kit ^{QL}	
Omnipod 5 (G6/Libre 2 Plus) Pods ^{QL}	
Omnipod 5 Dex G6-G7 Intro Kit ^{QL}	
Omnipod 5 Dex G6-G7 Pods ^{QL}	
Omnipod Dash Intro Kit ^{QL}	
Omnipod Dash PDM Kit ^{QL}	
Omnipod Dash Pods ^{QL}	
V-Go Disposable Insulin Device ^{QL}	

ULCERATIVE COLITIS AGENTS

Preferred Agents	Non-Preferred Agents
Balsalazide Capsule ^{QL}	Azulfidine (<i>sulfasalazine</i>) Tablet ^{QL}
Mesalamine DR 400 mg Capsule (<i>generic Delzicol</i>) ^{QL}	Azulfidine (<i>sulfasalazine</i>) EN-Tab ^{QL}
Mesalamine DR 1.2 g Tablet (<i>generic Lialda</i>) ^{QL}	Budesonide Rectal Foam ^{QL}
Mesalamine Enema ^{QL}	Canasa (<i>mesalamine</i>) Rectal Suppository ^{QL}
Mesalamine ER 0.375 g Capsule (<i>generic Apriso ER</i>) ^{QL}	Dipentum (<i>olsalazine</i>) Capsule ^{QL}
Mesalamine Rectal Suppository ^{QL}	Lialda DR (<i>mesalamine</i>) Tablet ^{QL}
Pentasa (<i>mesalamine</i>) Capsule ^{QL}	Mesalamine DR 800 mg Tablet (<i>generic Asacol HD</i>) ^{QL}
Sulfasalazine Tablet ^{QL}	Mesalamine Enema Kit
Sulfasalazine DR Tablet ^{QL}	Mesalamine ER Capsule (<i>generic Pentasa</i>) ^{QL}
	Rowasa (<i>mesalamine</i>) Enema Kit
	Velsipity (<i>etrasimod</i>) Tablet ^{QL}
	Zeposia (<i>ozanimod</i>) Capsule ^{QL}

UREA CYCLE DISORDER AGENTS

Preferred Agents	Non-Preferred Agents
Buphenyl (<i>sodium phenylbutyrate</i>) Powder	Olpruva (<i>sodium phenylbutyrate</i>) Kit
Buphenyl (<i>sodium phenylbutyrate</i>) Tablet	Pheburane (<i>sodium phenylbutyrate</i>) Pellet ^{QL}
Sodium Phenylbutyrate Powder	Ravicti (<i>glycerol phenylbutyrate</i>) Liquid ^{QL}
Sodium Phenylbutyrate Tablet	

Pennsylvania Department of Human Services

Statewide Preferred Drug List (PDL)*

*The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

URINARY ANTI-INFECTIVES

Preferred Agents	Non-Preferred Agents
Methenamine Hippurate Tablet ^{QL}	Fosfomycin Sachet ^{QL}
Nitrofurantoin Capsule (<i>generic Macrochantin</i>) ^{QL}	Macrobid (<i>nitrofurantoin monohydrate-macrocrystals</i>) Capsule ^{QL}
Nitrofurantoin Monohydrate-Macro Capsule (<i>generic Macrobid</i>) ^{QL}	Macrochantin (<i>nitrofurantoin macrocrystals</i>) Capsule ^{QL}
	MB Caps (<i>methenamine-methylene blue-sodium phosphate monobasic-phenyl salicylate-hyoscyamine</i>) ^{QL}
	ME-NaPhos-MB-Hyo 1 (<i>methenamine-monobasic sodium phosphate-methylene blue-hyoscyamine</i>) Tablet
	Methenamine Mandelate Tablet
	Nitrofurantoin Suspension ^{AE<9, QL}
	Urelle (<i>hyoscyamine-methenamine-methylene blue-phenyl salicylate-sodium phosphate monobasic</i>) Tablet ^{QL}
	Urimar-T (<i>methenamine-methylene blue-sodium phosphate monobasic-phenyl salicylate-hyoscyamine</i>) Capsule ^{QL}
	Urogesic-Blue (<i>methenamine-monobasic sodium phosphate-methylene blue-hyoscyamine</i>) Tablet ^{QL}
	Uro-MP (<i>methenamine-methylene blue-sodium phosphate-phenyl salicylate-hyoscyamine</i>) Capsule

VAGINAL ANTI-INFECTIVES

Preferred Agents	Non-Preferred Agents
Cleocin (<i>clindamycin</i>) Ovules	Cleocin (<i>clindamycin</i>) Vaginal Cream
Clindamycin 2% Vaginal Cream	Gynazole 1 (<i>butoconazole</i>) Vaginal Cream
Clindesse (<i>clindamycin</i> 2%) Vaginal Cream	Metronidazole 1.3% Vaginal Gel (<i>generic Nuversa</i>)
Clotrimazole 3 (2%) Vaginal Cream	Miconazole 3 (200 mg) Vaginal Suppository
Clotrimazole 7 (1%) Vaginal Cream	Nuversa (<i>metronidazole</i> 1.3%) Vaginal Gel
Metronidazole 250 mg, 500 mg Tablet	Solosec (<i>secnidazole</i>) Granule Packet
Metronidazole 0.75% Vaginal Gel (<i>generic MetroGel</i>)	Terconazole Vaginal Cream
Miconazole 1 (1200 mg-2%) Combination Pack	Terconazole Vaginal Suppository
Miconazole 3 (200 mg-2%) Combination Pack	Vandazole (<i>metronidazole</i> 0.75%) Vaginal Gel
Miconazole 3 (4%-2%) Combination Pack	Xaciato (<i>clindamycin</i>) Vaginal Gel
Miconazole 3 (4%) Vaginal Cream	
Miconazole 7 (2%) Vaginal Cream	
Miconazole 7 (100 mg) Vaginal Suppository	
Tinidazole Tablet ^{QL}	
Tioconazole-1 (6.5%) Vaginal Ointment	

VITAMIN D ANALOGS

Preferred Agents	Non-Preferred Agents
Calcitriol Capsule	Calcitriol Solution
Calcitriol Vial	Doxercalciferol Capsule
Doxercalciferol Vial	Paricalcitol Capsule
Paricalcitol Vial	Rayaldee (<i>calcifediol</i>) ER Capsule ^{QL}
	Zemplar (<i>paricalcitol</i>) Capsule
	Zemplar (<i>paricalcitol</i>) Vial

VMAT2 INHIBITORS

Preferred Agents	Non-Preferred Agents
Austedo (<i>deutetrabenazine</i>) Tablet ^{PA, QL}	Xenazine (<i>tetrabenazine</i>) Tablet ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (in years)
 Non-preferred agents require prior authorization
 Effective January 2026 v10

PA = clinical prior authorization required
 QL = quantity limit applies to FFS claims

Pennsylvania Department of Human Services
Statewide Preferred Drug List (PDL)*

**The Statewide PDL is not an all-inclusive list of drugs covered by Medical Assistance. Drugs in Statewide PDL classes that are new to the market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Austedo XR (deutetrabenazine) Tablet ^{PA, QL}	
Ingrezza (valbenazine) Capsule ^{PA, QL}	
Ingrezza (valbenazine) Sprinkle Capsule ^{PA, QL}	
Tetrabenazine Tablet ^{PA, QL}	
