

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 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/en/agencies/dhs/resources/pharmacy-services/pharmacy-prior-authorization-general-requirements.html>

FFS[†] Pharmacy Prior Authorization Clinical Guidelines:
<https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/clinical-guidelines.html>

FFS[‡] Pharmacy Prior Authorization Fax Forms:
<https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/pharmacy-services-fax-forms.html>

FFS[‡] Pharmacy Quantity Limits/Daily Dose Limits:
<https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.html>

[‡]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%	Benzefoam (<i>benzoyl peroxide</i>) Foam
Benzoyl Peroxide Gel 5%	BP (<i>sodium sulfacetamide-sulfur</i>) 10-1 Wash
Benzoyl Peroxide Gel 10%	BP (<i>sodium sulfacetamide-sulfur-urea</i>) Cleansing Wash
Benzoyl Peroxide Lotion 5%	BPO (<i>benzoyl peroxide</i>) Foaming Cloths
Benzoyl Peroxide Lotion 10%	Cleocin T (<i>clindamycin</i>) Lotion
Benzoyl Peroxide Wash 5%	Clindacin ETZ (<i>clindamycin</i>) Kit
Benzoyl Peroxide Wash 10%	Clindacin ETZ (<i>clindamycin</i>) Pledget
Clindamycin 1% Gel	Clindacin (<i>clindamycin</i>) Foam
Clindamycin 1% Lotion	Clindacin P (<i>clindamycin</i>) Pledget
Clindamycin 1% Pledget/Swab	Clindacin Pac (<i>clindamycin</i>) Kit
Clindamycin 1% Solution	Clindamycin 1% Daily Gel (<i>generic Clindagel</i>)
Clindamycin-Benzoyl Peroxide 1%-5% Gel (<i>generic Benzacclin</i>)	Clindamycin Foam
Clindamycin-Benzoyl Peroxide 1.2%-5% Gel (<i>generic Duac, Neuac</i>)	Clindamycin-Benzoyl Peroxide 1%-5% Gel Pump (<i>generic Benzacclin Gel Pump</i>)
Differin (<i>adapalene</i>) 0.1% Cream ^{AR}	Clindamycin-Benzoyl Peroxide 1.2%-2.5% Gel Pump (<i>generic Acanya</i>)
Differin (<i>adapalene</i>) 0.1% Gel ^{AR}	Clindamycin-Benzoyl Peroxide 1.2%-3.75% Gel Pump (<i>generic Onexton</i>)
Ery (<i>erythromycin</i>) Pads	Clindamycin-Tretinoin Gel (<i>generic Veltin, Ziana</i>) ^{AR}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Erythromycin 2% Solution	Dapsone 5% Gel
Erythromycin-Benzoyl Peroxide Gel (<i>generic Benzamycin</i>)	Dapsone 7.5% Gel Pump
Sodium Sulfacetamide-Sulfur 8%-4% Suspension	Differin (<i>adapalene</i>) 0.1% Lotion ^{AR}
Sodium Sulfacetamide-Sulfur 9%-4.5% Wash	Differin (<i>adapalene</i>) 0.3% Gel Pump ^{AR}
Sodium Sulfacetamide-Sulfur 10%-5% Cleanser	Epiduo Forte (<i>adapalene-benzoyl peroxide</i>) Gel Pump ^{AR}
SSS (<i>sodium sulfacetamide-sulfur</i>) 10%-5% Cream	Erygel (<i>erythromycin</i>) Gel
Tretinoin Cream ^{AR}	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 8%-4% Cleanser
	Sodium Sulfacetamide-Sulfur 9%-4% Cleanser
	Sodium Sulfacetamide-Sulfur 9%-4% Wash
	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 ^{AR}
	Winlevi (<i>clascoterone</i>) Cream
	ZMA Clear (<i>sodium sulfacetamide-sodium</i>) Suspension

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 (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 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}	Namzaric Capsule ^{QL}
	Rivastigmine Patch ^{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 Solution ^{QL}
Tramadol ER (24H) Tablet (<i>generic Ultram ER</i>) ^{AR, PA, 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}
	Tramadol ER (TBMB 24HR) Tablet (<i>generic Ryzolt</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	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 ^{QL}	Codeine Tablet ^{AR, QL}
Morphine Sulfate Cup ^{QL}	Dilaudid Liquid ^{QL}
Morphine Sulfate 10 mg/0.5 ml Oral Syringe ^{QL}	Dilaudid Tablet ^{QL}
Morphine Sulfate Solution ^{QL}	Fentanyl Citrate Buccal Tablet (<i>generic Fentora</i>) ^{QL}
Morphine Sulfate Tablet ^{QL}	Fentanyl Citrate OTFC Lozenge (<i>generic Actiq</i>) ^{QL}
Oxycodone 5 mg/5 ml Solution ^{QL}	Fioricet with Codeine 50-300-30 mg Capsule ^{AR, QL}
Oxycodone Tablet ^{QL}	Hydrocodone-Acetaminophen 10-325 mg/15 mL Solution ^{QL}
Oxycodone-Acetaminophen Solution ^{QL}	
Oxycodone-Acetaminophen Tablet (<i>generic Percocet</i>) ^{QL}	

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Tramadol 50 mg, 100 mg Tablet ^{AR, QL}	Hydrocodone-Ibuprofen Tablet ^{QL}
Tramadol-Acetaminophen Tablet ^{AR, 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}	Jatenzo Capsule ^{QL}
Testosterone 1.62% (20.25 mg/1.25 gm) Gel Pump (<i>generic AndroGel 1.62%</i>) ^{PA, QL}	Methitest Tablet ^{QL}
Testosterone Cypionate Vial ^{PA, 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}
	Xyosted Auto-Injector ^{QL}

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}	

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents
Benazepril Tablet ^{QL}	Accupril Tablet ^{QL}
Benazepril-Hydrochlorothiazide Tablet ^{QL}	Accuretic Tablet ^{QL}
Captopril Tablet ^{QL}	Aliskiren Tablet ^{QL}
Enalapril Tablet ^{QL}	Altace Capsule ^{QL}
Enalapril-Hydrochlorothiazide Tablet ^{QL}	Atacand Tablet ^{QL}
Fosinopril Tablet ^{QL}	Atacand HCT Tablet ^{QL}
Fosinopril-Hydrochlorothiazide Tablet ^{QL}	Avalide Tablet ^{QL}
Irbesartan Tablet ^{QL}	Avapro Tablet ^{QL}
Irbesartan-Hydrochlorothiazide Tablet ^{QL}	Benicar Tablet ^{QL}
Lisinopril Tablet ^{QL}	Benicar HCT Tablet ^{QL}
Lisinopril-Hydrochlorothiazide Tablet ^{QL}	Candesartan Tablet ^{QL}
Losartan Tablet ^{QL}	Candesartan-Hydrochlorothiazide Tablet ^{QL}
Losartan-Hydrochlorothiazide Tablet ^{QL}	Captopril-Hydrochlorothiazide Tablet
Olmesartan Tablet ^{QL}	Cozaar Tablet ^{QL}
Olmesartan-Hydrochlorothiazide Tablet ^{QL}	Diovan Tablet ^{QL} L
Quinapril Tablet ^{QL}	Diovan HCT Tablet ^{QL}
Quinapril-Hydrochlorothiazide Tablet ^{QL}	Edarbi Tablet ^{QL}
Ramipril Capsule ^{QL}	Edarbyclor Tablet ^{QL}
Sacubitril-Valsartan Tablet ^{QL}	Enalapril Solution ^{AE<9, QL}
Telmisartan Tablet ^{QL}	Entresto Sprinkle Pellet ^{QL}
Trandolapril Tablet ^{QL}	Entresto Tablet ^{QL}
Valsartan Tablet ^{QL}	Epaned Solution ^{AE<9, QL}
Valsartan-Hydrochlorothiazide Tablet ^{QL}	Hyzaar Tablet ^{QL}
	Lotensin Tablet ^{QL}
	Lotensin HCT Tablet ^{QL}
	Micardis Tablet ^{QL}
	Micardis HCT Tablet ^{QL}
	Moexipril Tablet ^{QL}
	Perindopril Tablet ^{QL}
	Qbrelis Solution ^{AE<9, QL}
	Tekturna 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 (<i>isosorbide dinitrate-hydralazine</i>) Tablet
Isosorbide Mononitrate ER Tablet	Isosorbide Dinitrate Tablet
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}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

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
	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	
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}
Enoxaparin Syringe ^{QL}	Fragmin Syringe ^{QL}
Enoxaparin Vial ^{QL}	Fragmin Vial ^{QL}
Pradaxa Capsule ^{QL}	Lovenox Syringe ^{QL}
Warfarin Tablet	Lovenox Vial ^{QL}
Xarelto Tablet ^{QL}	Pradaxa Pellet Pack ^{QL}
	Savaysa Tablet ^{QL}
	Xarelto 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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

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}	Carbatrol ER (<i>carbamazepine ER</i>) Capsule ^{QL}
Carbamazepine ER Tablet ^{QL}	Celontin (<i>methsuximide</i>) Capsule ^{QL}
Clobazam Suspension ^{QL}	Depakote DR (<i>divalproex sodium DR</i>) Sprinkle Capsule
Clobazam Tablet ^{QL}	Depakote DR (<i>divalproex sodium DR</i>) Tablet
Clonazepam ODT ^{AR, QL}	Depakote ER (<i>divalproex sodium ER</i>) Tablet
Clonazepam Tablet ^{AR, QL}	Diacomit (<i>stiripentol</i>) Capsule
Diazepam Rectal Gel System	Diacomit (<i>stiripentol</i>) Powder Packet
Divalproex Sodium DR Sprinkle Capsule	Dilantin (<i>phenytoin</i>) 100 mg Capsule ^{QL}
Dilantin (<i>phenytoin</i>) 30 mg Capsule ^{QL}	Dilantin Infatab (<i>phenytoin</i>) Chewable Tablet ^{QL}
Divalproex Sodium DR Tablet	Dilantin (<i>phenytoin</i>) Suspension ^{QL}
Divalproex Sodium ER Tablet	Elepsia XR (<i>levetiracetam ER</i>) Tablet ^{QL}
Epidiolex (<i>cannabidiol extract</i>) Solution ^{PA}	Eprontia (<i>topiramate</i>) Solution ^{QL}
Epitol (<i>carbamazepine</i>) Tablet ^{QL}	Felbamate Suspension
Equetro (<i>carbamazepine ER</i>) Capsule ^{QL}	Felbamate Tablet
Ethosuximide Capsule ^{QL}	Felbatol (<i>felbamate</i>) Tablet
Ethosuximide Solution ^{QL}	Fintepla (<i>fenfluramine</i>) Solution ^{QL}
Lacosamide Solution ^{QL}	Fycompa (<i>perampanel</i>) Suspension ^{QL}
Lacosamide Tablet ^{QL}	Fycompa (<i>perampanel</i>) Tablet ^{QL}
Lamotrigine Tablet	Keppra (<i>levetiracetam</i>) Solution ^{QL}
Levetiracetam Solution ^{QL}	Keppra (<i>levetiracetam</i>) Tablet ^{QL}
Levetiracetam Tablet ^{QL}	Keppra XR (<i>levetiracetam ER</i>) Tablet ^{QL}
Levetiracetam ER Tablet ^{QL}	Klonopin (<i>clonazepam</i>) Tablet ^{AR, QL}
Nayzilam (<i>midazolam</i>) Nasal Spray	Lamictal (<i>lamotrigine</i>) Dispersible Tablet
Oxcarbazepine Suspension ^{QL}	Lamictal (<i>lamotrigine</i>) ODT
Oxcarbazepine Tablet ^{QL}	Lamictal (<i>lamotrigine</i>) ODT Starter Kit
Phenobarbital Elixir/Solution	Lamictal (<i>lamotrigine</i>) Tablet
Phenobarbital Tablet	Lamictal (<i>lamotrigine</i>) Tablet Starter Kit
Phenytoin Chewable Tablet ^{QL}	Lamictal XR (<i>lamotrigine ER</i>) Tablet
Phenytoin Suspension ^{QL}	Lamictal XR (<i>lamotrigine ER</i>) Tablet Starter Kit
Phenytoin ER Capsule ^{QL}	Lamotrigine Dispersible Tablet
Primidone Tablet ^{QL}	Lamotrigine ODT
Roweepra (<i>levetiracetam</i>) Tablet ^{QL}	Lamotrigine ODT Starter Kit
Subvite (<i>lamotrigine</i>) Tablet	Lamotrigine Tablet Starter Kit
Topiramate Sprinkle Capsule (<i>generic Topamax</i>) ^{QL}	Lamotrigine ER Tablet
Topiramate Tablet ^{QL}	Libervant (<i>diazepam</i>) Film ^{QL}
Topiramate ER Sprinkle Capsule (<i>generic Qudexy XR</i>) ^{QL}	Methsuximide Capsule ^{QL}
Valproic Acid Capsule ^{QL}	Motpoly XR (<i>lacosamide</i>) Capsule ^{QL}
Valproic Acid Solution ^{QL}	Onfi (<i>clobazam</i>) Suspension ^{QL}
Valtoco (<i>diazepam</i>) Nasal Spray	Onfi (<i>clobazam</i>) Tablet ^{QL}
Zonisamide Capsule ^{QL}	Oxtellar XR (<i>oxcarbazepine ER</i>) 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}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	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 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} 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} Ztalmu (<i>ganaxolone</i>) Suspension ^{QL}
--	---

ANTIDEPRESSANTS, OTHER

Preferred Agents	Non-Preferred Agents
Amitriptyline Tablet Amoxapine Tablet Bupropion Tablet ^{QL} Bupropion SR Tablet ^{QL} Bupropion XL Tablet ^{QL} Clomipramine Capsule Desvenlafaxine Succinate ER Tablet (<i>generic Pristiq</i>) ^{QL} Doxepin Capsule Doxepin Concentrate Solution Duloxetine DR 20 mg, 30 mg, 60 mg Capsule (<i>generic Cymbalta</i>) ^{QL} Imipramine HCl Tablet Mirtazapine ODT ^{QL} Mirtazapine Tablet ^{QL} Nortriptyline Capsule Phenelzine Tablet Trazodone Tablet Venlafaxine Tablet ^{QL} Venlafaxine HCl ER Capsule ^{QL} Venlafaxine HCl ER Tablet ^{QL} Vilazodone Tablet ^{QL}	Anafranil Capsule Auvelity ER Tablet ^{QL} Cymbalta Capsule ^{QL} Desipramine Tablet Desvenlafaxine ER Tablet ^{QL} Drizalma Sprinkle DR Capsule ^{QL} Duloxetine DR 40 mg Capsule (<i>generic Irenka</i>) ^{QL} Effexor XR Capsule ^{QL} Emsam Patch ^{QL} Fetzima ER Capsule ^{QL} Forfivo XL Tablet ^{QL} Imipramine Pamoate Capsule Marplan Tablet Nardil Tablet Nefazodone Tablet Nortriptyline Solution Pamelor Capsule Pristiq ER Tablet ^{QL} Protriptyline Tablet Remeron Soltab ^{QL} Remeron Tablet ^{QL} Spravato (Nasal) Dose Pack ^{QL} Tranlycypromine Tablet Trimipramine Capsule Trintellix Tablet ^{QL} Venlafaxine Besylate ER 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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

	Viibryd Tablet ^{QL} Wellbutrin SR Tablet ^{QL} Zuruvae Capsule ^{QL}
--	---

ANTIDEPRESSANTS, SSRIs

Preferred Agents	Non-Preferred Agents
Citalopram 10 mg/5 ml Solution ^{QL} Citalopram Tablet ^{QL} Escitalopram Tablet ^{QL} Fluoxetine Capsule ^{QL} Fluoxetine Solution ^{QL} Fluoxetine Tablet ^{QL} Fluvoxamine Tablet ^{QL} Paroxetine Tablet ^{QL} Sertraline Concentrate Solution ^{QL} Sertraline Tablet ^{QL}	Celexa Tablet ^{QL} Citalopram Capsule ^{QL} Escitalopram Solution ^{QL} Fluoxetine DR Capsule ^{QL} Fluvoxamine ER Capsule ^{QL} Lexapro Tablet ^{QL} Paroxetine Suspension ^{QL} Paroxetine CR/ER 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} Aprepitant Dose Pack ^{QL} Compro Rectal Suppository Diclegis Tablet ^{QL} Dimenhydrinate Tablet Doxylamine Succinate-Pyridoxine DR Tablet (<i>generic Diclegis</i>) ^{QL} Fosaprepitant Vial ^{QL} Granisetron Vial Meclizine Chewable Tablet Meclizine Tablet Metoclopramide Solution Metoclopramide Tablet Metoclopramide Vial Ondansetron ODT 4 mg, 8 mg ^{QL} Ondansetron Solution ^{QL} Ondansetron Syringe Ondansetron Tablet ^{QL} Ondansetron Vial ^{QL} Palonosetron Syringe Palonosetron Vial ^{QL} Phosphorated Carbohydrate Nausea Relief Solution Prochlorperazine Rectal Suppository Prochlorperazine Tablet Prochlorperazine Vial Promethazine Ampule ^{AR} Promethazine Rectal Suppository ^{AR, QL}	Akynzeo Capsule ^{QL} Akynzeo Vial ^{QL} Antivert Chewable Tablet Antivert Tablet Bonjesta Tablet ^{QL} Cinvanti Vial ^{QL} Dimenhydrinate Vial Dronabinol Capsule ^{QL} Emend Capsule ^{QL} Emend Powder Packet ^{QL} Emend Tripack ^{QL} Emend Vial ^{QL} Focinvez Vial ^{QL} Gimoti Nasal Spray ^{QL} Granisetron Tablet ^{QL} Metoclopramide ODT Phenergan Ampule ^{AR} Phenergan Vial ^{AR} Reglan Tablet Sancuso Patch ^{QL} Sustol Syringe ^{QL} Tigan Vial ^{QL} Transderm-Scop Patch ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Promethazine Solution/Syrup^{AR}
 Promethazine Tablet^{AR, QL}
 Promethazine Vial^{AR}
 Promethegan Rectal Suppository^{AR, QL}
 Scopolamine Patch^{QL}
 Trimethobenzamide Capsule^{QL}

ANTIFIBROTIC RESPIRATORY AGENTS

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

ANTIFUNGALS, ORAL

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

ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents
Alevazol (<i>clotrimazole</i>) Ointment Butenafine Cream Ciclopirox Cream Ciclopirox Solution Clotrimazole Cream Clotrimazole-Betamethasone Cream Econazole Cream Ketoconazole Cream Ketoconazole Shampoo Klayesta Powder Miconazole Cream	Ciclodan (<i>ciclopirox</i>) Solution Ciclopirox Gel Ciclopirox Shampoo Ciclopirox Suspension Ciclopirox Treatment Kit Clotrimazole Solution Clotrimazole-Betamethasone Lotion Ketoconazole Foam Ketodan (<i>ketoconazole</i>) Foam Ketodan (<i>ketoconazole + cleanser</i>) Foam Kit Micnonazole-Zinc-Petrolatum Ointment (<i>generic Vusion</i>)

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Miconazole Powder	Micomitin (<i>tolnaftate</i>) Solution
Miconazole Solution	Micotrin AC (<i>clotrimazole</i>) Cream
Nyamyc 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	Tripenicol C (<i>undecylenic acid</i>) Cream
Tolnaftate Liquid/Solution	Tritolnecide S (<i>tolnaftate</i>) Solution
Tolnaftate Liquid Spray	Vusion (<i>miconazole nitrate 0.25%-zinc oxide 15% in white petrolatum</i>) Ointment
Tolnaftate Powder	
Tolnaftate Powder Spray	

ANTIHEMOPHILIA AGENTS

Preferred Agents	Non-Preferred Agents
Advate ^{PA}	Esperoct
Adynovate ^{PA}	Idelvion
Afstyla ^{PA}	Obizur
Alphanate ^{PA}	Vonvendi
Alphanine SD ^{PA}	
Alprolix ^{PA}	
Altuviiio ^{PA}	
Benefix ^{PA}	
Eloctate ^{PA}	
Feiba NF ^{PA}	
Hemlibra ^{PA}	
Hemofil M ^{PA}	
Humate-P ^{PA}	
Ixinity ^{PA}	
Jivi ^{PA}	
Koate ^{PA}	
Kogenate FS ^{PA}	
Kovaltry ^{PA}	
Novoeight ^{PA}	
Novoseven RT ^{PA}	
Nuwiq ^{PA}	
Profilnine ^{PA}	
Rebinyon ^{PA}	
Recombinat ^{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}

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Cetirizine Solution ^{QL}	Clarinex (<i>desloratadine</i>) Tablet ^{QL}
Cetirizine Tablet ^{QL}	Clarinex-D (<i>desloratadine-pseudoephedrine</i>) 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}	

ANTIHYPERTENSIVES, SYMPATHOLYTIC

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

ANTIHYPURICEMICS

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 (<i>pegloticase</i>) Vial ^{QL}
Probenecid Tablet	Mitigare (<i>colchicine</i>) Capsule ^{QL}
Probenecid-Colchicine Tablet	Uloric (<i>febuxostat</i>) Tablet ^{QL}

ANTIMALARIALS

Preferred Agents	Non-Preferred Agents
Atovaquone-Proguanil Tablet ^{QL}	Malarone (<i>atovaquone-proguanil</i>) Tablet ^{QL}
Chloroquine Tablet	Quaalquin (<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	Sklice (<i>ivermectin</i>) Lotion
Piperonyl Butoxide-Pyrethrins 4%-0.33% Shampoo (<i>Lice Killing Shampoo, Lice Treatment Shampoo</i>)	Spinosad Topical Suspension
	Vanallice (<i>piperonyl butoxide-pyrethrins 3.5%-0.3%</i>) Gel

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Piperonyl Butoxide-Pyrethrins 4%-0.33% Shampoo + Permethrin
0.5% Spray Kit (Complete Lice Treatment Kit)

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}	Dhivy Tablet ^{QL}
Bromocriptine Tablet ^{QL}	Duopa Enteral Suspension ^{QL}
Carbidopa-Levodopa Tablet ^{QL}	Gocovri ER Capsule ^{QL}
Carbidopa-Levodopa ER Tablet ^{QL}	Inbrija Inhalation Capsule ^{QL}
Entacapone Tablet ^{QL}	Neupro Patch ^{QL}
Pramipexole Tablet ^{QL}	Nourianz Tablet ^{QL}
Ropinirole Tablet ^{QL}	Ongentys Capsule ^{QL}
Selegilene Capsule ^{QL}	Pramipexole ER Tablet ^{QL}
Selegilene Tablet ^{QL}	Rasagiline Tablet ^{QL}
Trihexyphenidyl Elixir ^{QL}	Ropinirole ER Tablet ^{QL}
Trihexyphenidyl Tablet ^{QL}	Rytary ER Capsule ^{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
Calcipotriene-Betamethasone Ointment	Sorilux Foam
Calcipotriene-Betamethasone Suspension	Taclonex Suspension
	Tazarotene Cream ^{AR}
	Tazarotene Gel ^{AR}
	Vectical Ointment
	Vtama Cream
	Zoryve 0.3% Cream

ANTIPSYCHOTICS

Preferred Agents	Non-Preferred Agents
<u>Injectable</u>	<u>Injectable</u>
Abilify Asimtufii (aripiprazole) ^{AR, QL}	Chlorpromazine Ampule ^{AR}
Abilify Maintena (aripiprazole) ^{AR, QL}	Chlorpromazine Vial ^{AR}
Aristada ER (aripiprazole lauroxil) ^{AR, QL}	Fluphenazine HCl Vial ^{AR}
Aristada Initio (aripiprazole lauroxil) ^{AR, QL}	Geodon (ziprasidone) Vial ^{AR, QL}
Fluphenazine Decanoate Vial ^{AR}	Haldol Decanoate (haloperidol) Ampule ^{AR}

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (years)
Non-preferred agents require prior authorization
Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Haloperidol Decanoate Ampule ^{AR}	Olanzapine Vial ^{AR, QL}
Haloperidol Decanoate Vial ^{AR}	Ziprasidone Vial ^{AR, QL}
Haloperidol Lactate Syringe ^{AR}	Zyprexa Relprevv (<i>olanzapine</i>) ^{AR, QL}
Haloperidol Lactate Vial ^{AR}	Zyprexa (<i>olanzapine</i>) Vial ^{AR, QL}
Invega Hafyera (<i>paliperidone</i>) ^{AR, QL}	
Invega Sustenna (<i>paliperidone</i>) ^{AR, QL}	
Invega Trinza (<i>paliperidone</i>) ^{AR, QL}	
Perseris ER (<i>risperidone</i>) ^{AR, QL}	
Risperdal Consta (<i>risperidone</i>) ^{AR, QL}	
Risperidone ER Vial ^{AR, QL}	
Uzedy ER (<i>risperidone</i>) ^{AR, QL}	
<u>Non-Injectable</u>	<u>Non-Injectable</u>
Aripiprazole Tablet ^{AR, QL}	Abilify (<i>aripiprazole</i>) Tablet ^{AR, QL}
Clozapine Tablet ^{AR, QL}	Adasuve (<i>loxapine</i>) Inhalation Powder ^{AR, QL}
Equetro (<i>carbamazepine</i>) Capsule ^{QL}	Aripiprazole ODT ^{AR, QL}
Fluphenazine Oral Concentrate Solution ^{AR}	Aripiprazole Solution ^{AR, QL}
Fluphenazine Tablet ^{AR}	Asenapine SL Tablet ^{AR, QL}
Haloperidol Tablet ^{AR}	Caplyta (<i>lumateperone</i>) Capsule ^{AR, QL}
Haloperidol Lactate Oral Concentrate Solution ^{AR}	Chlorpromazine Concentrate Solution ^{AR}
Loxapine Capsule ^{AR}	Chlorpromazine Tablet ^{AR}
Lurasidone Tablet ^{AR, QL}	Clozapine ODT ^{AR, QL}
Olanzapine Tablet ^{AR, QL}	Clozaril (<i>clozapine</i>) Tablet ^{AR, QL}
Paliperidone ER Tablet ^{AR, QL}	Fanapt (<i>iloperidone</i>) Tablet ^{AR, QL}
Perphenazine Tablet ^{AR}	Fluphenazine Elixir ^{AR}
Quetiapine Tablet ^{AR, QL}	Geodon (<i>ziprasidone</i>) Capsule ^{AR, QL}
Quetiapine ER Tablet ^{AR, QL}	Invega ER (<i>paliperidone</i>) Tablet ^{AR, QL}
Risperidone Solution ^{AR, QL}	Latuda (<i>lurasidone</i>) Tablet ^{AR, QL}
Risperidone Tablet ^{AR, QL}	Lybalvi (<i>olanzapine/samidorphan</i>) Tablet ^{AR, QL}
Trifluoperazine Tablet ^{AR}	Molindone Tablet ^{AR, QL}
Ziprasidone Capsule ^{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}
	Perphenazine-Amitriptyline Tablet ^{AR}
	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}

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

ANTIVIRALS, CMV

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

ANTIVIRALS, HERPES

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

ANTIVIRALS, INFLUENZA

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

ANXIOLYTICS

Preferred Agents	Non-Preferred Agents
Alprazolam Tablet ^{AR, QL}	Alprazolam ER/XR Tablet ^{AR, QL}
Buspirone Tablet ^{QL}	Alprazolam Intensol/Oral Concentrate Solution ^{AR, QL}
Chlordiazepoxide Capsule ^{AR, QL}	Alprazolam ODT ^{AR, QL}
Clonazepam ODT ^{AR, QL}	Ativan Vial ^{AR}
Clonazepam Tablet ^{AR, QL}	Clorazepate Tablet ^{AR, QL}
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	Klonopin Tablet ^{AR, QL}
Hydroxyzine HCl Tablet	Lorazepam Intensol/Concentrate Solution ^{AR, QL}
Hydroxyzine Pamoate Capsule	Loreev XR Capsule ^{AR, QL}
Lorazepam Cartridge ^{AR}	Meprobamate Tablet ^{QL}
Lorazepam Tablet ^{AR, QL}	Oxazepam Capsule ^{AR, QL}
Lorazepam Vial ^{AR}	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	Bystolic Tablet ^{QL}
Betaxolol Tablet	Carvedilol ER Capsule ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Bisoprolol 5 mg, 10 mg Tablet	Inderal LA Capsule
Bisoprolol-Hydrochlorothiazide Tablet	Inderal XL Capsule ^{QL}
Carvedilol Tablet ^{QL}	Innopran XL Capsule ^{QL}
Hemangeol Solution ^{PA}	Kaspargo Sprinkle Capsule ^{QL}
Labetalol 100 mg, 200 mg, 300 mg Tablet	Lopressor Tablet
Metoprolol Succinate ER Tablet	Metoprolol-Hydrochlorothiazide Tablet
Metoprolol Tartrate Tablet	Sotylize Solution
ONadolol Tablet	Tenoretic Tablet
Nebivolol Tablet ^{QL}	Tenormin Tablet
Pindolol Tablet	Timolol Tablet
Propranolol Solution	Toprol XL Tablet
Propranolol Tablet	
Propranolol ER Capsule	
Sorine Tablet	
Sotalol Tablet	
Sotalol AF Tablet	

BLADDER RELAXANT PREPARATIONS

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

BLOOD GLUCOSE METERS AND TEST STRIPS

Preferred Products	Non-Preferred Manufacturers
Accu-Chek Glucometers - Accu-Chek Guide^{QL} - Accu-Chek Guide Me^{QL}	All Other Blood Glucose Meters and Test Strips ^{QL}
Accu-Chek Test Strips Accu-Chek Guide^{QL}	
Trividia Glucometers - True Metrix^{QL} - True Metrix Air^{QL} - Relion True Metrix Air^{QL}	
Trividia Test Strips - True Metrix^{QL} - Relion True Metrix^{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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

BONE DENSITY REGULATORS

Preferred Agents	Non-Preferred Agents
Alendronate Tablet ^{QL}	Actonel Tablet ^{QL}
Ibandronate Tablet ^{QL}	Alendronate Solution ^{QL}
Pamidronate Vial	Atelvia DR Tablet ^{QL}
Zoledronic Acid ^{QL}	Binosto Effervescent Tablet ^{QL}
	Calcitonin Salmon Nasal Spray/Pump ^{QL}
	Calcitonin Salmon Vial ^{QL}
	Evenity Syringe ^{QL}
	Evista Tablet ^{QL}
	Forteo Pen ^{QL}
	Fosamax Tablet ^{QL}
	Fosamax Plus D Tablet ^{QL}
	Ibandronate Syringe ^{QL}
	Ibandronate Vial ^{QL}
	Miacalcin Vial ^{QL}
	Prolia Syringe ^{QL}
	Raloxifene Tablet ^{QL}
	Reclast Solution ^{QL}
	Risedronate Tablet ^{QL}
	Risedronate DR Tablet ^{QL}
	Teriparatide Pen ^{QL}
	Tymlos Pen ^{QL}
	Xgeva Vial ^{QL}

BOTULINUM TOXINS

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

BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS

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

BRONCHODILATORS, BETA AGONISTS

Preferred Agents	Non-Preferred Agents
Albuterol HFA ^{QL}	Albuterol Tablet
Albuterol Nebulizer Concentrate Solution	Arformoterol Nebulizer Vial ^{QL}
Albuterol Nebulizer Vial	Brovana Nebulizer Vial ^{QL}
Albuterol Syrup	Formoterol Nebulizer Vial ^{QL}
Levalbuterol HFA ^{QL}	Levalbuterol Nebulizer Concentrate Solution ^{QL}
Levalbuterol Nebulizer Vial ^{QL}	Perforomist Nebulizer Vial ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Proair Respiclick ^{QL} Serevent Diskus ^{QL} Striverdi Respimat ^{QL} Ventolin HFA ^{QL} Xopenex HFA ^{QL}	Terbutaline Tablet
---	--------------------

CALCIUM CHANNEL BLOCKERS

Preferred Agents	Non-Preferred Agents
Amlodipine Tablet ^{QL} Cartia XT Capsule ^{QL} Diltiazem Tablet ^{QL} Diltiazem 24HR ER (CD) Capsule (<i>generic Cardizem CD Capsule</i>) ^{QL} Diltiazem 24HR ER Capsule (<i>generic Tiazac ER Capsule</i>) ^{QL} Diltiazem 24HR ER (XR) Capsule (<i>generic Dilacor XR Capsule</i>) ^{QL} Dilt-XR Capsule ^{QL} Felodipine ER Tablet ^{QL} Nifedipine Capsule ^{QL} Nifedipine ER Tablet ^{QL} Nimodipine Capsule Taztia XT Capsule ^{QL} Tiadylt ER Capsule ^{QL} Verapamil Tablet Verapamil ER/SR Capsule (<i>generic Verelan Capsule</i>) ^{QL} Verapamil ER PM Capsule (<i>generic Verelan PM Capsule</i>) ^{QL} Verapamil ER Tablet (<i>generic Calan SR/Isoptin SR Tablet</i>) ^{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} Levamlodipine Tablet ^{QL} Matzim LA Tablet ^{QL} Nicardipine Capsule ^{QL} Nisoldipine ER Tablet ^{QL} Norliqva Solution ^{QL} Norvasc Tablet ^{QL} Nymalize Oral Syringe ^{QL} Nymalize Solution ^{QL} Procardia XL Tablet ^{QL} Sular ER Tablet ^{QL} Verelan PM Capsule ^{QL}

CEPHALOSPORINS

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

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents
Fulphila (<i>pegfilgrastim-jmdb</i>) Syringe ^{PA, QL} Granix (<i>tbo-filgrastim</i>) Syringe ^{PA} Granix (<i>tbo-filgrastim</i>) Vial ^{PA} Neupogen (<i>filgrastim</i>) Syringe ^{PA} Neupogen (<i>filgrastim</i>) Vial ^{PA} Releuko (<i>filgrastim-ayow</i>) Syringe ^{PA} Releuko (<i>filgrastim-ayow</i>) Vial ^{PA}	Fylnetra (<i>pegfilgrastim-pbbk</i>) Syringe ^{QL} Leukine (<i>sargramostim</i>) Vial Neulasta (<i>pegfilgrastim</i>) Onpro ^{QL} Neulasta (<i>pegfilgrastim</i>) Syringe ^{QL} Nivestym (<i>filgrastim-aafi</i>) Syringe Nivestym (<i>filgrastim-aafi</i>) Vial Nyvepria (<i>pegfilgrastim-apgf</i>) Syringe ^{QL} Rolvedon (<i>eflapregastim-xnst</i>) Syringe ^{QL}

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (years)
Non-preferred agents require prior authorization
Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	Stimufend (pegfilgrastim-fpgk) Syringe ^{QL}
	Udenyca (pegfilgrastim-cbvq) Autoinjector ^{QL}
	Udenyca (pegfilgrastim-cbvq) Onbody ^{QL}
	Udenyca (pegfilgrastim-cbvq) Syringe ^{QL}
	Zarxio (filgrastim-sndz) Syringe
	Ziextenzo (pegfilgrastim-bmez) Syringe ^{QL}

CONTINUOUS GLUCOSE MONITORING PRODUCTS

Preferred Products	Non-Preferred Products
Dexcom G6 Receiver ^{PA, QL}	Eversense E3 Sensor-Holder ^{QL}
Dexcom G6 Sensor ^{PA, QL}	Eversense E3 Smart Transmitter ^{QL}
Dexcom G6 Transmitter ^{PA, QL}	Guardian 4 Glucose Sensor ^{QL}
Dexcom G7 Receiver ^{PA, QL}	Guardian 4 Transmitter ^{QL}
Dexcom G7 Sensor ^{PA, QL}	Guardian Connect Transmitter ^{QL}
Dexcom G7 15 Day Sensor ^{PA, QL}	Guardian Link 3 Transmitter ^{QL}
Freestyle Libre 2 Plus Sensor ^{PA, QL}	Guardian Sensor 3 ^{QL}
Freestyle Libre 2 Reader ^{PA, QL}	
Freestyle Libre 2 Sensor Kit ^{PA, QL}	
Freestyle Libre 3 Plus Sensor ^{PA, QL}	
Freestyle Libre 3 Reader ^{PA, QL}	
Freestyle Libre 3 Sensor ^{PA, QL}	
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 (generic Safyral)
Alyacen-28 1-35	Joyeaux
Apri	Levonorgestrel-Ethinyl Estradiol-Ferrous Bisglycinate 0.1-0.02-36 (generic Balcoltra)
Aubra	Loestrin-21
Aubra EQ	Loestrin Fe-28
Aurovela-21	Safyral
Aurovela Fe-28	Tydem
Aviane	
Ayuna	
Balziva	
Blisovi Fe-28	
Briellyn	
Chateal	
Chateal EQ	
Cryselle	
Cyred	
Cyred EQ	
Dasetta-28 1-35	
Drospirenone-Ethinyl Estradiol 3-0.03 mg (generic Yasmin)	
Elinest	
Enskyce	
Estarylla	
Ethinodiol-Ethinyl Estradiol	

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

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 (*generic
 Alesse, Levlite*)
 Levonorgestrel-Ethinyl Estradiol-28 0.15 mg-30 mcg (*generic
 Nordette, Levlen*)
 Levora
 Low-Ogestrel
 Luizza-21
 Luteria
 Marlissa
 Microgestin-21
 Microgestin Fe-28
 Mili
 Mono-Linyah
 Necon-28
 Norethindrone-Ethinyl Estradiol-21 (*generic Loestrin-21*)
 Norethindrone-Ethinyl Estradiol Fe-28 (*generic Loestrin Fe-28*)
 Norethindrone-Ethinyl Estradiol Fe 0.4-0.035 (21)-75 Chewable
 (*generic Femcon Fe, Ovcon Fe*)
 Norgestimate-Ethinyl Estradiol-28 0.25-0.35 mg (*generic Ortho-
 Cyclen*)
 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
 Valtia

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Vienna 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 Viorele Volnea	Mircette
<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
<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	Beyaz

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Charlotte 24 Fe Chewable	Drospirenone-Ethinyl Estradiol-Levomefolate 3-0.02-0.451 mg (<i>generic Beyaz</i>)
Drospirenone-Ethinyl Estradiol 3-0.02 mg (<i>generic Yaz</i>)	Gemmily Capsule
Finzala Chewable	Kaitlib Fe Chewable
Hailey 24 Fe	Layolis Fe Chewable
Jasmiel	Merzee Capsule
Junel Fe 24	Nextstellis
Larin 24 Fe	Noethindrone-Ethinyl Estradiol-Fe 0.8-0.025(24) Chewable (<i>generic Generess Fe Chewable</i>)
Lo Loestrin Fe	Noethindrone-Ethinyl Estradiol-Fe 1-0.02(24)-75 Capsule (<i>generic Taytulla Capsule</i>)
Loryna	Taysofy Capsule
Lo-Zumandimine	Taytulla Capsule
Mibelas 24 Fe Chewable	Yaz
Microgestin 24 Fe	
Nikki	
Noethindrone-Ethinyl Estradiol-Fe 1-0.02(24)-75 Chewable (<i>generic Minastrin 24 Fe</i>)	
Tarina 24 Fe	
Vestura	

28-Day Continuous Cycle

Amethyst
Dolishale
Levonorgestrel-Ethinyl Estradiol-28 0.09-0.02 mg

28-Day Continuous Cycle

3-Month Extended Cycle

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) (*generic Seasonale-91*)
Levonorgestrel-Ethinyl Estradiol + EE 0.10-0.02 mg + 0.01 mg (3-month) (*generic LoSeasonique-91*)
Levonorgestrel-Ethinyl Estradiol + EE 0.15-0.03 mg + 0.01 mg (3-month) (*generic Seasonique-91*)
Lojaimiess (3-month)
Setlakin (3-month)
Simpesse (3-month)

3-Month Extended Cycle

Levonorgestrel 0.15 mg-Ethinyl Estradiol + EE 20-25-30 mcg + 10 mcg (3-month) (*generic Quartette-91*)
Loseasonique (3-month)
Quartette (3-month)
Rivelsa (3-month)
Seasonique (3-month)

Progestin Only

Camila
Deblitane
Emzahh
Errin
Heather
Incassia
Jencycla
Lyleq

Progestin Only

Slynd

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Lyza	
Meleya	
Nora-Be	
Norethindrone-28 0.35 mg	
Opill	
Sharobel	
Tulana	

CONTRACEPTIVES, OTHER

Preferred Agents	Non-Preferred Agents
Depo-Provera 150 mg/ml Vial ^{QL}	Annovera Vaginal Ring ^{QL}
Depo-SubQ Provera 104 Syringe ^{QL}	Depo-Provera 150 mg/ml Syringe ^{QL}
Eluryng Vaginal Ring ^{QL}	Norelgestromin-Ethinyl Estradiol Patch ^{QL}
Enilloring Vaginal Ring ^{QL}	Twirla Patch ^{QL}
Etonogestrel-Ethinyl Estradiol Vaginal Ring ^{QL}	Zafemy Patch ^{QL}
Haloette Vaginal Ring ^{QL}	
Kyleena System ^{QL}	
Liletta System ^{QL}	
Medroxyprogesterone Acetate Syringe ^{QL}	
Medroxyprogesterone Acetate Vial ^{QL}	
Mirena System ^{QL}	
Nexplanon Implant ^{QL}	
Paragard T 380-A IUD ^{QL}	
Skylla 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}	Roflumilast Tablet ^{QL}
Incruse Ellipta ^{QL}	Tiotropium Capsule-Inhaler ^{QL}
Ipratropium Nebulizer Vial	Tudorza Pressair ^{QL}
Ipratropium-Albuterol Nebulizer Vial ^{QL}	Yupelri Nebulizer Vial ^{QL}
Spiriva Handihaler ^{QL}	
Spiriva Respimat ^{QL}	
Stiolto Respimat ^{QL}	
Trelegy Ellipta ^{QL}	

CYTOKINE AND CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents
Adalimumab-aacf(CF) 50 mg/ml Pen ^{PA, QL}	Abrilada(CF) (<i>adalimumab-afzb</i>) 50 mg/ml Pen ^{QL}
Adalimumab-aacf(CF) 50 mg/ml Syringe ^{PA, QL}	Abrilada(CF) (<i>adalimumab-afzb</i>) 50 mg/ml Syringe ^{QL}
Adalimumab-adaz(CF) 100 mg/ml Pen ^{PA, QL}	Actemra (<i>tocilizumab</i>) Actpen ^{QL}
Adalimumab-adaz(CF) 100 mg/ml Syringe ^{PA, QL}	Actemra (<i>tocilizumab</i>) Syringe ^{QL}
Adalimumab-adbm(CF) 50 mg/ml Pen (Boehringer Ingelheim [00597] labeler only) ^{PA, QL}	Actemra (<i>tocilizumab</i>) Vial ^{QL}
Adalimumab-adbm(CF) 50 mg/ml Syringe (Boehringer Ingelheim [00597] labeler only) ^{PA, QL}	Adalimumab-aaty(CF) 100 mg/ml Autoinjector ^{QL}
	Adalimumab-aaty(CF) 100 mg/ml Syringe ^{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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Adalimumab-adbm(CF) 100 mg/ml Pen (Boehringer Ingelheim [00597] labeler only) ^{PA, QL}	Adalimumab-adbm(CF) 50 mg/ml Pen (all labelers <u>except</u> Boehringer Ingelheim [00597]) ^{QL}
Adalimumab-adbm(CF) 100 mg/ml Syringe (Boehringer Ingelheim [00597] labeler only) ^{PA, QL}	Adalimumab-adbm(CF) 50 mg/ml Syringe (all labelers <u>except</u> Boehringer Ingelheim [00597]) ^{QL}
Adalimumab-fkjp(CF) 50 mg/ml Pen ^{PA, QL}	Adalimumab-adbm(CF) 100 mg/ml Pen (all labelers <u>except</u> Boehringer Ingelheim [00597]) ^{QL}
Adalimumab-fkjp(CF) 50 mg/ml Syringe ^{PA, QL}	Adalimumab-adbm(CF) 100 mg/ml Syringe (all labelers <u>except</u> Boehringer Ingelheim [00597]) ^{QL}
Amjevita(CF) (<i>adalimumab-atto</i>) 100 mg/ml Autoinjector ^{PA, QL}	Adalimumab-ryvk(CF) 100 mg/ml Autoinjector ^{QL}
Amjevita(CF) (<i>adalimumab-atto</i>) 100 mg/ml Syringe ^{PA, QL}	Adalimumab-ryvk(CF) 100 mg/ml Syringe
Avsola (<i>infliximab-axxq</i>) Vial ^{PA}	Amjevita(CF) (<i>adalimumab-atto</i>) 50 mg/ml Autoinjector ^{QL}
Enbrel (<i>etanercept</i>) Mini Cartridge ^{PA, QL}	Amjevita(CF) (<i>adalimumab-atto</i>) 50 mg/ml Syringe ^{QL}
Enbrel (<i>etanercept</i>) Sureclick Pen ^{PA, QL}	Arcalyst (<i>rilonacept</i>) Vial ^{QL}
Enbrel (<i>etanercept</i>) Syringe ^{PA, QL}	Bimzelx (<i>bimekizumab-bkzx</i>) Autoinjector ^{QL}
Enbrel (<i>etanercept</i>) Vial ^{PA, QL}	Bimzelx (<i>bimekizumab-bkzx</i>) Syringe ^{QL}
Hadlima (<i>adalimumab-bwwd</i>) 50 mg/ml Pushtouch ^{PA, QL}	Cimzia (<i>certolizumab pegol</i>) Syringe ^{QL}
Hadlima (<i>adalimumab-bwwd</i>) 50 mg/ml Syringe ^{PA, QL}	Cosentyx (<i>secukinumab</i>) Sensoready Pen ^{QL}
Hadlima(CF) (<i>adalimumab-bwwd</i>) 100 mg/ml Pushtouch ^{PA, QL}	Cosentyx (<i>secukinumab</i>) Syringe ^{QL}
Hadlima(CF) (<i>adalimumab-bwwd</i>) 100 mg/ml Syringe ^{PA, QL}	Cosentyx (<i>secukinumab</i>) Unoready Pen ^{QL}
Humira (<i>adalimumab</i>) 50 mg/ml Pen ^{PA, QL}	Cosentyx (<i>secukinumab</i>) Vial
Humira (<i>adalimumab</i>) 50 mg/ml Syringe ^{PA, QL}	Cyltezo(CF) (<i>adalimumab-adbm</i>) 50 mg/ml Pen ^{QL}
Humira(CF) (<i>adalimumab</i>) 100 mg/ml Pen ^{PA, QL}	Cyltezo(CF) (<i>adalimumab-adbm</i>) 50 mg/ml Syringe ^{QL}
Humira(CF) (<i>adalimumab</i>) 100 mg/ml Syringe ^{PA, QL}	Cyltezo(CF) (<i>adalimumab-adbm</i>) 100 mg/ml Pen ^{QL}
Infliximab Vial (<i>Janssen's unbranded infliximab</i>) ^{PA}	Cyltezo(CF) (<i>adalimumab-adbm</i>) 100 mg/ml Syringe ^{QL}
Kineret (<i>anakinra</i>) Syringe ^{PA}	Entyvio (<i>vedolizumab</i>) Pen ^{QL}
Orencia (<i>abatacept</i>) Clickjet ^{PA, QL}	Entyvio (<i>vedolizumab</i>) Vial ^{QL}
Orencia (<i>abatacept</i>) Vial ^{PA, QL}	Hulio(CF) (<i>adalimumab-fkjp</i>) 50 mg/ml Pen ^{QL}
Otezla (<i>apremilast</i>) Tablet ^{PA, QL}	Hulio(CF) (<i>adalimumab-fkjp</i>) 50 mg/ml Syringe ^{QL}
Otulfli (<i>ustekinumab-aauz</i>) Syringe ^{PA}	Hyrimoz(CF) (<i>adalimumab-adaz</i>) 100 mg/ml Pen ^{QL}
Otulfli (<i>ustekinumab-aauz</i>) Vial ^{PA}	Hyrimoz(CF) (<i>adalimumab-adaz</i>) 100 mg/ml Syringe ^{QL}
Pyzchiva (<i>ustekinumab-ttwe</i>) Syringe ^{PA}	Idacio(CF) (<i>adalimumab-aacf</i>) 50 mg/ml Pen ^{QL}
Pyzchiva (<i>ustekinumab-ttwe</i>) Vial ^{PA}	Idacio(CF) (<i>adalimumab-aacf</i>) 50 mg/ml Syringe ^{QL}
Selarsdi (<i>ustekinumab-aekn</i>) Syringe ^{PA}	Ilaris (<i>canakinumab</i>) Vial ^{QL}
Selarsdi (<i>ustekinumab-aekn</i>) Vial ^{PA}	Ilumya (<i>tildrakizumab</i>) Syringe ^{QL}
Simlandi(CF) (<i>adalimumab-ryvk</i>) 100 mg/ml Autoinjector ^{PA, QL}	Inflectra (<i>infliximab-dyyb</i>) Vial
Simlandi(CF) (<i>adalimumab-ryvk</i>) 100 mg/ml Syringe ^{PA, QL}	Kevzara (<i>sarilumab</i>) Pen ^{QL}
Simponi (<i>golimumab</i>) Pen ^{PA, QL}	Kevzara (<i>sarilumab</i>) Syringe ^{QL}
Simponi (<i>golimumab</i>) Syringe ^{PA, QL}	Litfulo (<i>ritilecitinib</i>) Capsule ^{QL}
Skyrizi (<i>risankizumab-rzaa</i>) On-Body Injector ^{PA, QL}	Olumiant (<i>baricitinib</i>) Tablet ^{QL}
Skyrizi (<i>risankizumab-rzaa</i>) Pen ^{PA, QL}	Omvoh (<i>mirikizumab-mrkz</i>) Pen ^{QL}
Skyrizi (<i>risankizumab-rzaa</i>) Syringe ^{PA, QL}	Omvoh (<i>mirikizumab-mrkz</i>) Syringe ^{QL}
Skyrizi (<i>risankizumab-rzaa</i>) Vial ^{PA, QL}	Omvoh (<i>mirikizumab-mrkz</i>) Vial ^{QL}
Steqeyma (<i>ustekinumab-stba</i>) Syringe ^{PA}	Orencia (<i>abatacept</i>) Syringe ^{QL}
Steqeyma (<i>ustekinumab-stba</i>) Vial ^{PA}	Remicade (<i>infliximab</i>) Vial
Taltz (<i>ixekizumab</i>) Autoinjector ^{PA, QL}	Renflexis (<i>infliximab-abda</i>) Vial
Taltz (<i>ixekizumab</i>) Syringe ^{PA, QL}	Rinvoq ER (<i>upadacitinib</i>) Tablet ^{QL}
Tyenne (<i>tocilizumab-aazg</i>) Autoinjector ^{PA, QL}	Rinvoq LQ (<i>upadacitinib</i>) Solution ^{QL}
Tyenne (<i>tocilizumab-aazg</i>) Syringe ^{PA, QL}	Simponi Aria (<i>golimumab</i>) Vial
Tyenne (<i>tocilizumab-aazg</i>) Vial ^{PA, QL}	Sotyktu (<i>deucravacitinib</i>) Tablet ^{QL}
Xeljanz (<i>tofacitinib</i>) Solution ^{PA, QL}	Spevigo (<i>spesolimab-sbzo</i>) Syringe ^{QL}
Xeljanz (<i>tofacitinib</i>) Tablet ^{PA, QL}	Spevigo (<i>spesolimab-sbzo</i>) Vial ^{QL}
Xeljanz XR (<i>tofacitinib</i>) Tablet ^{PA, QL}	Stelara (<i>ustekinumab</i>) Syringe ^{QL}
Yesintek (<i>ustekinumab-kfce</i>) Syringe ^{PA}	Stelara (<i>ustekinumab</i>) Vial ^{QL}
Yesintek (<i>ustekinumab-kfce</i>) Vial ^{PA}	
Yusimry(CF) (<i>adalimumab-aqvh</i>) 50 mg/ml Pen ^{PA, QL}	

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

	Tofidence (tocilizumab-bavi) Vial ^{QL} Tremfya (guselkumab) Autoinjector ^{QL} Tremfya (guselkumab) Syringe ^{QL} Ustekinumab Syringe (Janssen's unbranded ustekinumab) Ustekinumab Vial (Janssen's unbranded ustekinumab) Ustekinumab-aekn Syringe Ustekinumab-aekn Vial Ustekinumab-ttwe Syringe Ustekinumab-ttwe Vial Yuflyma(CF) (adalimumab-aaty) 100 mg/ml Autoinjector ^{QL} Yuflyma(CF) (adalimumab-aaty) 100 mg/ml Syringe ^{QL} Zymfentra (infliximab-dyyb) Pen Zymfentra (infliximab-dyyb) Syringe
--	--

DRY EYE TREATMENTS (formerly OPHTHALMICS, IMMUNOMODULATORS)

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

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
Epinephrine Autoinjector (Mylan [49502] labeler only)	Auvi-Q Autoinjector Epinephrine Auto-Injector (all labelers <u>except</u> Mylan [49502]) EpiPen Autoinjector EpiPen Jr. Autoinjector

ERYTHROPOIESIS STIMULATING AGENTS

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

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

ESTROGENS

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

FLUOROQUINOLONES, ORAL

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

GI MOTILITY, CHRONIC AGENTS

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

GLUCOCORTICOIDS, INHALED

Preferred Agents	Non-Preferred Agents
<u>Single-Ingredient ICS</u>	<u>Single-Ingredient ICS</u>
Arnuita Ellipta ^{QL}	Alvesco HFA ^{QL}
Asmanex HFA ^{QL}	Budesonide 1 mg/ml Respule ^{QL}
Asmanex Twisthaler ^{QL}	Fluticasone Propionate Diskus ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Budesonide 0.25 mg/2 ml, 0.5 mg/2 ml Respule ^{QL} Pulmicort Flexhaler ^{QL} Qvar Redihaler ^{QL}	Fluticasone Propionate HFA ^{AE<19, QL} Pulmicort Respule ^{QL}
<u>ICS + LABA Combinations</u>	<u>ICS + LABA Combinations</u>
Advair Diskus ^{QL} Advair HFA ^{QL} Dulera ^{QL} Fluticasone-Salmeterol Aerosol Powder (<i>generic Airduo Respclick</i>) ^{QL} Fluticasone-Salmeterol Blister w/ Device (<i>generic Advair Diskus</i>) ^{QL} Symbicort ^{QL}	Airduo Respclick ^{QL} Breo Ellipta ^{QL} Breyna 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>	<u>ICS + LABA + LAMA Combinations</u>
Trelegy Ellipta ^{QL}	Breztri Aerosphere ^{QL}

GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents
Budesonide DR/EC Capsule ^{QL} Budesonide ER Tablet ^{QL} Dexamethasone Elixir Dexamethasone Intensol Drops Dexamethasone Solution Dexamethasone Tablet Fludrocortisone Tablet Hydrocortisone Tablet Methylprednisolone Dose Pack Methylprednisolone Tablet Prednisolone Solution Prednisolone Sodium Phosphate Solution Prednisone Dose Pack Prednisone Intensol/Concentrate Solution Prednisone Solution Prednisone 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} Hemady Tablet Medrol Dose Pack Medrol Tablet Ortikos ER Capsule ^{QL} Prednisolone Tablet Prednisolone Sodium Phosphate ODT Rayos DR Tablet Taperdex Dose Pack Tarpeyo DR Capsule ^{QL}

GROWTH HORMONES

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

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

	Serostim Vial ^{QL} Sogroya Pen ^{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 Talcia IR-DR Capsule Voquezna Dual Pak ^{QL} Voquezna Triple Pak ^{QL}

HEMATOPOIETIC MIXTURES

Preferred Agents	Non-Preferred Agents
Ferrex 150 Forte Capsule Folivane-F Capsule Ifrex 150 Forte Capsule Iron Folate-F Capsule Trigels-F Forte Capsule	Active Fe Tablet Bentivite Bx Tablet Centratex Capsule Chromagen Capsule Corvita 150 Tablet Corvite 150 Tablet Corvite FE Tablet Dermacinrx Foliflex Tablet Dermacinrx Folitín-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 Hemocyte Plus Capsule Integra F Capsule Integra Plus Capsule Iron Folate Plus Capsule Irospan Tablet Nephron FA Tablet Niferex Tablet Nufera Tablet Purevit Dualfe Plus Capsule SE-Tan Plus Capsule Tandem Plus Capsule Taron Forte Capsule Tulivite 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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

HEPATIC AND BILIARY AGENTS (formerly BILE SALTS)

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} 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} Epivir HBV Solution ^{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} Epivir HBV 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} Haegarda (<i>C1 esterase inhibitor</i>) Vial ^{PA, QL} Icatibant Syringe ^{PA, QL} Kalbitor (<i>ecallantide</i>) Vial ^{PA, QL} Orladeyo (<i>berotralstat</i>) Capsule ^{PA, QL} Ruconest (<i>C1 esterase inhibitor, recombinant</i>) Vial ^{PA, QL} Sajazir (<i>icatibant</i>) Syringe ^{PA, QL} Takhzyro (<i>lanadelumab-flyo</i>) Syringe ^{PA, QL} Takhzyro (<i>lanadelumab-flyo</i>) Vial ^{PA, QL}	Firazyr (<i>icatibant</i>) Syringe ^{QL}

HISTAMINE 2 RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents
Acid Reducer Complete (<i>famotidine-calcium carbonate-magnesium hydroxide chewable</i>) Tablet Chew	Cimetidine Solution

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (years)
Non-preferred agents require prior authorization
Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Cimetidine Tablet
Famotidine Piggyback
Famotidine Suspension
Famotidine Tablet^{QL}
Famotidine Vial
Nizatidine Capsule

HIV/AIDS ANTIRETROVIRALS

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

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Zidovudine Syrup ^{QL} Zidovudine Tablet ^{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} Symfi Lo (<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} 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	

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

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

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents
<u>Amylin Analogs</u>	<u>Amylin Analogs</u>
	Symlin Pen ^{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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

<u>DPP-4 Inhibitors</u>	<u>DPP-4 Inhibitors</u>
Janumet Tablet ^{QL} Janumet XR Tablet ^{QL} Januvia Tablet ^{QL} Jentadueto Tablet ^{QL} Jentadueto XR Tablet ^{QL} Tadjenta Tablet ^{QL}	Alogliptin Tablet ^{QL} Alogliptin-Metformin Tablet ^{QL} Alogliptin-Pioglitazone Tablet ^{QL} Glyxambi Tablet ^{QL} Qtern Tablet ^{QL} Saxagliptin Tablet ^{QL} Saxagliptin-Metformin ER Tablet ^{QL} Sitagliptin Tablet ^{QL} Sitagliptin-Metformin Tablet Steglujan Tablet ^{QL} Trijardy XR Tablet ^{QL} Zituvio Tablet ^{QL}
<u>Drugs Containing a GLP-1 Receptor Agonist</u>	<u>Drugs Containing a GLP-1 Receptor Agonist</u>
Ozempic (<i>semaglutide</i>) Pen ^{PA, QL} Trulicity (<i>dulaglutide</i>) Pen ^{PA, QL} Victoza (<i>liraglutide</i>) Pen ^{PA, QL}	Bydureon BCise (<i>exenatide microspheres</i>) Autoinjector ^{QL} Liraglutide Pen ^{QL} Mounjaro (<i>tirzepatide</i>) Pen ^{QL} Rybelsus (<i>semaglutide</i>) Tablet ^{QL}

HYPOGLYCEMICS, INSULIN AND RELATED AGENTS

<u>Preferred Agents</u>	<u>Non-Preferred Agents</u>
<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 Insulin Glargine Max 300 units/ml Solostar Lantus (<i>insulin glargine</i>) 100 units/ml Solostar Lantus (<i>insulin glargine</i>) 100 units/ml Vial Toujeo (<i>insulin glargine</i>) 300 units/ml Solostar Toujeo Max (<i>insulin glargine</i>) 300 units/ml Solostar	Basaglar (<i>insulin glargine</i>) 100 units/ml Kwikpen Basaglar (<i>insulin glargine</i>) 100 units/ml Tempo Pen Insulin Degludec 100 units/ml Pen Insulin Degludec 100 units/ml Vial Insulin Degludec 200 units/ml Pen 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
<u>Mixed Insulins</u>	<u>Mixed Insulins</u>

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

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 Aspart Protamine-Insulin Aspart 70-30 Pen	Novolin 70-30 Vial
Insulin Aspart Protamine-Insulin Aspart 70-30 Vial	NovoLog Mix (<i>insulin aspart protamine-insulin aspart</i>) 70-30 Flexpen
Insulin Lispro Protamine Mix 75-25 Pen	NovoLog Mix (<i>insulin aspart protamine-insulin aspart</i>) 70-30 Vial

Rapid-Acting

Apidra (*insulin glulisine*) Solostar
Apidra (*insulin glulisine*) Vial
Insulin Aspart Penfill Cartridge
Insulin Aspart Pen
Insulin Aspart Vial
Insulin Lispro 100 units/ml Kwikpen
Insulin Lispro 100 units/ml Vial
Insulin Lispro Jr Kwikpen

Rapid-Acting

Admelog (*insulin lispro*) Solostar
Admelog (*insulin lispro*) Vial
Fiasp (*insulin aspart*) Flextouch
Fiasp (*insulin aspart*) Penfill Cartridge
Fiasp (*insulin aspart*) Pumpcart Cartridge
Fiasp (*insulin aspart*) Vial
Humalog (*insulin lispro*) 100 units/ml Cartridge
Humalog (*insulin lispro*) 100 units/ml Kwikpen
Humalog (*insulin lispro*) 100 units/ml Vial
Humalog (*insulin lispro*) 200 units/ml Kwikpen
Humalog (*insulin lispro*) 100 units/ml Tempo Pen
Humalog Jr (*insulin lispro*) Kwikpen
Lyumjev (*insulin lispro*) 100 units/ml Kwikpen
Lyumjev (*insulin lispro*) 200 units/ml Kwikpen
Lyumjev (*insulin lispro*) 100 units/ml Tempo Pen
Lyumjev (*insulin lispro*) 100 units/ml Vial
Novolog (*insulin aspart*) Flexpen
Novolog (*insulin aspart*) Penfill Cartridge
Novolog (*insulin aspart*) Vial

Short-Acting

Humulin R 100 units/ml Vial
Humulin R 500 units/ml Kwikpen
Humulin R 500 units/ml Vial
Novolin R Flexpen
Novolin R Vial

Short-Acting

HYPOGLYCEMICS, MEGLITINIDES

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

HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents
Glipizide-Metformin Tablet ^{QL} Glyburide-Metformin Tablet ^{QL} Metformin 500 mg, 850 mg, 1000 mg Tablet ^{QL} Metformin ER 500 mg, 750 mg Tablet (<i>generic Glucophage XR Tablet</i>) ^{QL}	Metformin Solution ^{QL} Metformin 625 mg Tablet ^{QL} Metformin ER (Gastric) Tablet (<i>generic Glumetza ER</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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

HYPOGLYCEMICS, SGLT2 INHIBITORS

Preferred Agents	Non-Preferred Agents
Farxiga Tablet ^{QL}	Dapagliflozin Tablet ^{QL}
Invokamet Tablet ^{QL}	Dapagliflozin-Metformin ER Tablet ^{QL}
Invokana Tablet ^{QL}	Glyxambi Tablet ^{QL}
Jardiance Tablet ^{QL}	Inpefa Tablet ^{QL}
Synjardy Tablet ^{QL}	Invokamet XR Tablet ^{QL}
Xigduo XR Tablet ^{QL}	Qtern Tablet ^{QL}
	Segluromet Tablet ^{QL}
	Steglatro Tablet ^{QL}
	Steglujan Tablet ^{QL}
	Synjardy XR Tablet ^{QL}
	Trijardy XR Tablet ^{QL}

HYPOGLYCEMICS, SULFONYLUREAS

Preferred Agents	Non-Preferred Agents
Glimepiride 1 mg, 2 mg, 4 mg Tablet ^{QL}	Glipizide 2.5 mg Tablet ^{QL}
Glipizide 5 mg, 10 mg Tablet ^{QL}	Glucotrol XL Tablet ^{QL}
Glipizide ER/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}	Opzelura (<i>ruxolitinib</i>) Cream ^{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 Cream
Ebglyss (<i>lebrikizumab-lbkz</i>) Pen ^{PA, QL}	
Ebglyss (<i>lebrikizumab-lbkz</i>) Syringe ^{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

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>)

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

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}
	Synjoynt Syringe ^{QL}
	Synvisc Syringe ^{QL}
	Synvisc-One Syringe ^{QL}
	Trilon 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 Nasal Spray ^{QL}
	Ryaltris Nasal Spray ^{QL}
	Sinuva Implant
	Triamcinolone Acetonide Nasal Spray ^{AE<4, QL}
	Xhance Nasal Spray ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Zetonna Nasal Spray^{QL}

IRON CHELATING AGENTS

Preferred Agents	Non-Preferred Agents
Deferasirox Granule Packet ^{PA}	Deferiprone Tablet
Deferasirox Tablet ^{PA}	Exjade (<i>deferasirox</i>) Tablet for Oral Suspension
Deferasirox Tablet for Oral Suspension ^{PA}	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
Ferlecit (<i>sodium ferric gluconate complex</i>) Vial	Feraheme (<i>ferumoxytol</i>) Vial ^{QL}
Infed (<i>iron dextran, LMW</i>) Vial	Ferumoxytol Vial ^{QL}
Injectafer (<i>ferric carboxymaltose</i>) Vial	Monoferic (<i>ferric derisomaltose</i>) Vial ^{QL}
Sodium Ferric Gluconate Complex in Sucrose Vial	
Venofer (<i>iron sucrose</i>) Vial ^{QL}	

LEUKOTRIENE MODIFIERS

Preferred Agents	Non-Preferred Agents
Montelukast Chewable Tablet ^{QL}	Accolate (<i>zafirlukast</i>) Tablet ^{QL}
Montelukast 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	Colesevelam Powder Packet ^{QL}
Cholestyramine Powder Packet	Colesevelam Tablet ^{QL}
Cholestyramine Light Powder	Colestid Granule
Cholestyramine Light Powder Packet	Colestid Tablet ^{QL}
Colestipol Tablet ^{QL}	Colestipol Granule
Ezetimibe Tablet ^{QL}	Colestipol Granule Packet
Fenofibrate 54 mg, 160 mg Tablet (<i>generic Lofibra Tablet</i>) ^{QL}	Evkeeza Vial
Fenofibrate Micronized 43 mg, 130 mg Capsule (<i>generic Antara</i>) ^{QL}	Fenofibrate 50 mg, 150 mg Capsule (<i>generic Lipofen</i>) ^{QL}
Fenofibrate Micronized 67 mg, 134 mg, 200 mg Capsule (<i>generic Lofibra Capsule</i>) ^{QL}	Fenofibrate 40 mg, 120 mg Tablet (<i>generic Fenoglide</i>) ^{QL}
Fenofibrate Nanocrystalized 48 mg, 145 mg Tablet (<i>generic Tricor</i>) ^{QL}	Fenofibrate (Micronized) 90 mg Capsule (<i>generic Antara</i>) ^{QL}
Fenofibric Acid (Choline) DR 45 mg, 135 mg Capsule (<i>generic Trilipix</i>) ^{QL}	Fenofibric Acid 35 mg, 105 mg Tablet (<i>generic Fibracor</i>) ^{QL}
Gemfibrozil Tablet ^{QL}	Icosapent Ethyl Capsule ^{QL}
Nexletol Tablet ^{PA, QL}	Juxtapid Capsule ^{QL}
Nexlizet Tablet ^{PA, QL}	Leqvio Syringe ^{QL}
Omega-3 Ethyl Esters Capsule ^{QL}	Lipofen Capsule ^{QL}
	Lopid Tablet ^{QL}
	Niacin ER Tablet (<i>generic Niaspan</i>)
	Questran Powder

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Praluent Pen ^{PA, QL}	Questran Powder Packet
Prevalite Powder	Questran Light Powder
Prevalite Powder Packet	Tricor Tablet ^{QL}
Repatha Pushtronex ^{PA, QL}	Welchol Powder Packet ^{QL}
Repatha Sureclick ^{PA, QL}	Welchol Tablet ^{QL}
Repatha Syringe ^{PA, 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}
	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
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

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	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} Eylea (<i>aflibercept</i>) Syringe ^{PA, QL} Eylea (<i>aflibercept</i>) Vial ^{PA, QL} Lucentis (<i>ranibizumab</i>) Syringe ^{PA, QL} Syfovre (<i>pegcetacoplan</i>) Vial ^{PA, QL} Vabysmo (<i>faricimab-svoa</i>) Syringe ^{PA} Vabysmo (<i>faricimab-svoa</i>) Vial ^{PA, QL}	Beovu (<i>brolucizumab-dbll</i>) Syringe ^{QL} Byooviz (<i>ranibizumab-nuna</i>) Vial ^{QL} Eylea HD (<i>aflibercept</i>) Vial ^{QL} Izervay (<i>avacincaptad pegol sodium</i>) Vial ^{QL} Susvimo (<i>ranibizumab</i>) Vial

METHOTREXATE

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

MIGRAINE ACUTE TREATMENT AGENTS

Preferred Agents	Non-Preferred Agents
Eletriptan Tablet ^{QL} Naratriptan Tablet ^{QL} Nurtec (<i>rimegepant</i>) ODT ^{PA, QL} Rizatriptan ODT ^{QL} Rizatriptan Tablet ^{QL} Sumatriptan Cartridge ^{QL} Sumatriptan Nasal Spray ^{QL} Sumatriptan Pen Injector ^{QL} Sumatriptan Tablet ^{QL} Sumatriptan Vial ^{QL} Ubrovelvy Tablet ^{PA, QL} Zolmitriptan ODT ^{QL} Zolmitriptan Tablet ^{QL}	Almotriptan Tablet ^{QL} Diclofenac Potassium Powder Packet ^{QL} Dihydroergotamine Mesylate Ampule Dihydroergotamine Mesylate Nasal Spray ^{QL} Elyxib Solution ^{QL} Ergomar SL Tablet Frova Tablet ^{QL} Frovatriptan Tablet ^{QL} Imitrex Cartridge ^{QL} Imitrex Pen Injector ^{QL} Imitrex Tablet ^{QL} Maxalt Tablet ^{QL} Maxalt MLT ^{QL} Relpax Tablet ^{QL} Reyvow Tablet ^{QL} Sumatriptan-Naproxen Tablet ^{QL} Tosymra Nasal Spray ^{QL} Zavzpret Nasal Spray ^{QL} Zembrace Symtouch ^{QL} Zolmitriptan Nasal Spray ^{QL} Zomig Nasal Spray ^{QL} Zomig 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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

MIGRAINE PREVENTION AGENTS (PREVIOUSLY ANTIMIGRAINE AGENTS, OTHER)

Preferred Agents	Non-Preferred Agents
Aimovig (<i>erenumab-aooe</i>) Autoinjector ^{PA, QL}	Qulipta (<i>atogepant</i>) Tablet ^{QL}
Ajovy (<i>fremanezumab-vfrm</i>) Autoinjector ^{PA, QL}	Vyepti (<i>eptinezumab-jjmr</i>) Vial ^{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}	

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

Preferred Agents	Non-Preferred Agents
Dupixent (<i>dupilumab</i>) Pen ^{PA, QL}	Cinqair (<i>reslizumab</i>) Vial
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}	

MULTIPLE SCLEROSIS AGENTS

Preferred Agents	Non-Preferred Agents
Avonex (<i>interferon beta-1a</i>) Pen Kit ^{QL}	Ampyra ER (<i>dalfampridine ER</i>) Tablet ^{QL}
Avonex (<i>interferon beta-1a</i>) Syringe Kit ^{QL}	Aubagio (<i>teriflunomide</i>) Tablet ^{QL}
Betaseron (<i>interferon beta-1b</i>) Kit ^{QL}	Bafiertam DR (<i>monomethyl fumarate DR</i>) Capsule ^{QL}
Briumvi (<i>ublituximab-xiiy</i>) Vial ^{PA, QL}	Copaxone (<i>glatiramer</i>) Syringe ^{QL}
Dalfampridine ER Tablet ^{PA, QL}	Gilenya (<i> fingolimod HCl</i>) Capsule ^{QL}
Dimethyl Fumarate DR Capsule ^{PA, QL}	Lemtrada (<i>alemtuzumab</i>) Vial ^{QL}
Fingolimod Capsule ^{PA, QL}	Mavenclad (<i>cladribine</i>) Tablet ^{QL}
Glatiramer Syringe ^{QL}	Mayzent (<i>siponimod</i>) Tablet ^{QL}
Glatopa (<i>glatiramer</i>) Syringe ^{QL}	Plegridy (<i>peginterferon beta-1a</i>) Pen ^{QL}
Kesimpta (<i>ofatumumab</i>) Pen ^{PA, QL}	Plegridy (<i>peginterferon beta-1a</i>) Syringe ^{QL}
Ocrevus (<i>ocrelizumab</i>) Vial ^{PA, QL}	Ponvory (<i>ponesimod</i>) Tablet ^{QL}
Rebif (<i>interferon beta-1a</i>) Rebidose Autoinjector ^{QL}	Tascenso (<i>fingolimod lauryl sulfate</i>) ODT ^{QL}
Rebif (<i>interferon beta-1a</i>) Syringe ^{QL}	Tecfidera DR (<i>dimethyl fumarate DR</i>) Capsule ^{QL}
Teriflunomide Tablet ^{PA, QL}	Vumerity DR (<i>diroxime fumarate DR</i>) Capsule ^{QL}
Tysabri (<i>natalizumab</i>) Vial ^{PA, QL}	Zeposia (<i>ozanimod</i>) Capsule ^{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 Capsule ^{QL}	Duloxetine DR 40 mg Capsule (<i>generic Irenka</i>) ^{QL}
Gabapentin Solution ^{QL}	Gabapentin ER Tablet (<i>generic Gralise ER</i>) ^{QL}
Gabapentin Tablet ^{QL}	Gralise ER Tablet ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Lidocaine 4% Patch	Horizant ER Tablet ^{QL}
Lidocaine 5% Patch (<i>generic Lidoderm Patch</i>) ^{QL}	Lidaflex Patch ^{QL}
Pregabalin Capsule ^{QL}	Lyrica Capsule ^{QL}
Pregabalin Solution ^{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}
	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 Drops ^{QL}	Diclofenac Epolamine 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 Drops ^{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 Suspension ^{QL}	Indomethacin Rectal Suppository ^{QL}
Naproxen 250 mg, 375 mg, 500 mg Tablet (<i>generic Naprosyn Tablet</i>) ^{QL}	Indomethacin Suspension ^{QL}
Naproxen DR 375 mg, 500 mg Tablet (<i>generic Naprosyn EC Tablet</i>) ^{QL}	Ketoprofen ER Capsule ^{QL}
Naproxen Sodium 220 mg Capsule (<i>generic Aleve Liquid Gel Cap</i>) ^{QL}	Kiprofen Capsule ^{QL}
Naproxen Sodium 220 mg Tablet (<i>generic Aleve Caplet/Tablet</i>) ^{QL}	Lofena Tablet ^{QL}
Naproxen Sodium 275 mg Tablet (<i>generic Anaprox Tablet</i>) ^{QL}	Meclofenamate Capsule ^{QL}
Naproxen Sodium DS 550 mg Tablet (<i>generic Anaprox DS Tablet</i>) ^{QL}	Mefenamic Acid Capsule ^{QL}
Piroxicam Capsule ^{QL}	Meloxicam Capsule ^{QL}
Sulindac Tablet ^{QL}	Nalfon Capsule ^{QL}
	Nalfon Tablet ^{QL}
	Naprelan CR Tablet ^{QL}
	Naprosyn 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}
	Tolmetin Sodium Capsule ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

Tolmetin Sodium Tablet^{QL}

OBESITY TREATMENT AGENTS

Preferred Agents	Non-Preferred Agents
<u>Drugs Containing a GLP-1 Receptor Agonist</u>	<u>Drugs Containing a GLP-1 Receptor Agonist</u>
Saxenda (<i>liraglutide</i>) Pen ^{PA, QL} Wegovy (<i>semaglutide</i>) Pen ^{PA, QL} Zepbound (<i>tirzepatide</i>) Pen ^{PA, QL}	
<u>Miscellaneous</u>	<u>Miscellaneous</u>
Phentermine Capsule ^{PA, QL} Phentermine Tablet ^{PA, QL}	Adipex-P (<i>phentermine</i>) Capsule ^{QL} Adipex-P (<i>phentermine</i>) Tablet ^{QL} Amphetamine 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} Xenical (<i>orlistat</i>) Capsule ^{QL}

ONCOLOGY AGENTS, BREAST CANCER

Preferred Agents	Non-Preferred Agents
Anastrozole Tablet ^{QL} Exemestane Tablet ^{QL} Letrozole Tablet ^{PA, QL} Tamoxifen Tablet ^{QL}	Arimidex Tablet ^{QL} Aromasin Tablet ^{QL} Fareston 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} Abitrega Tablet ^{PA, QL} Afinitor Disperz Tablet ^{PA, QL} Akeega Tablet ^{PA, QL} Alecensa Capsule ^{PA, QL} Alunbrig Tablet ^{PA, QL} Augtyro Capsule ^{PA, QL} Ayvakit Tablet ^{PA, QL} Balversa Tablet ^{PA, QL} Bicalutamide Tablet ^{PA, QL} Bosulif Capsule ^{PA, QL} Bosulif Tablet ^{PA, QL} Braftovi Capsule ^{PA, QL} Brukinsa Capsule ^{PA, QL}	Abiraterone Acetate 500 mg Tablet ^{QL} Afinitor Tablet ^{QL} Casodex Tablet ^{QL} Everolimus Tablet for Suspension ^{QL} Gefitinib Tablet ^{QL} Gleevec Tablet ^{QL} Iclusig 30 mg Tablet ^{QL} Imbruvica Suspension ^{QL} Imbruvica Tablet ^{QL} Lapatinib Tablet ^{QL} Pazopanib Tablet ^{QL} Qinlock Tablet ^{QL} Sorafenib Tablet ^{QL} Sunitinib Capsule ^{QL}

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (years)
Non-preferred agents require prior authorization
Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Brukinsa Tablet ^{PA}	Tafinlar Tablet for Suspension ^{QL}
Cabometyx Tablet ^{PA, QL}	Tarceva Tablet ^{QL}
Calquence Tablet ^{PA, QL}	Xeloda Tablet
Capecitabine Tablet ^{PA}	Yonsa Tablet ^{QL}
Caprelsa Tablet ^{PA, QL}	Zytiga Tablet ^{QL}
Cometriq Capsule ^{PA, QL}	
Copiktra Capsule ^{PA, QL}	
Cotellic Tablet ^{PA, 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}	
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}	
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}	
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}	
Mekinist Tablet ^{PA, QL}	
Mektovi Tablet ^{PA, QL}	
Nerlynx Tablet ^{PA, QL}	
Nexavar Tablet ^{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}	

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Retevmo Capsule^{PA, QL}
 Retevmo Tablet^{PA, QL}
 Rezlidhia Capsule^{PA, QL}
 Rozlytrek Capsule^{PA, QL}
 Rozlytrek Pellet Packet^{PA, QL}
 Rubraca Tablet^{PA, QL}
 Rydapt Capsule^{PA, QL}
 Scemblix Tablet^{PA, QL}
 Sprycel Tablet^{PA, QL}
 Stivarga Tablet^{PA, QL}
 Sutent Capsule^{PA, QL}
 Tabrecta Tablet^{PA, QL}
 Tafenlar Capsule^{PA, QL}
 Tagrisso Tablet^{PA, QL}
 Talzenna Capsule^{PA, QL}
 Tassigna Capsule^{PA, QL}
 Tazverik Tablet^{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}
 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}
 Xtandi Tablet^{PA, QL}
 Zejula Tablet^{PA, QL}
 Zelboraf Tablet^{PA, QL}
 Zolanza Capsule^{PA, QL}
 Zydelig Tablet^{PA, QL}
 Zykadia Tablet^{PA, QL}

OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents
Alaway Drops	Alocril Drops
Azelastine Drops	Alomide Drops
Cromolyn Sodium Drops	Alrex Drops
Ketotifen Drops	Bepotastine Drops

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Naphcon-A Drops	Bepreve Drops
Olopatadine Drops	Epinastine Drops
Zaditor Drops	Lastacaft Drops
	Loteprednol 0.2% Drops (<i>generic Alrex</i>)
	Pataday Eye Drops
	Zerviate Dropperette

OPHTHALMICS, ANTIBIOTICS

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

OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

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

OPHTHALMICS, ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents
Dexamethasone Sodium Phosphate Drops	Acular Drops
Diffprednate Drops	Acular LS Drops
Flarex Drops	Acuvail Dropperette
Fluorometholone Drops	Alrex Drops
Flurbiprofen Drops	Bromfenac 0.07% Drops (<i>generic Prolensa</i>)
FML Forte Drops	Bromfenac 0.075% Drops (<i>generic Bromsite</i>)
Ilevro Drops	Bromfenac 0.09% Drops (<i>generic Bromday</i>)
Ketorolac Drops	Bromsite Drops
Lotemax Ointment	Dextenza Insert
Maxidex Drops	Diclofenac Drops
Nevanac Drops	Durezol Drops
Pred Mild Drops	FML Liquifilm Drops
Prednisolone Acetate Drops	Iluvien Implant
Prednisolone Sodium Phosphate Drops	Inveltys Drops
	Lotemax Drops

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

	Lotemax Gel Drops Lotemax SM Gel Drops Loteprednol 0.2% Drops (<i>generic Alrex</i>) Loteprednol 0.5% Drops (<i>generic Lotemax</i>) Loteprednol Gel Drops Ozurdex Implant Prolensa Drops Retisert Implant Triesence Vial ^{QL} Xipere Vial
--	--

OPHTHALMICS, GLAUCOMA

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

OPIOID OVERDOSE AGENTS

Preferred Agents	Non-Preferred Agents
Kloxxado Nasal Spray	

AR = age restriction, clinical prior authorization required
AE = age exemption for specified ages (years)
Non-preferred agents require prior authorization
Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

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

OTIC ANTIBIOTIC PREPARATIONS

Preferred Agents	Non-Preferred Agents
Cipro HC Otic Suspension	Ciprofloxacin Otic Solution Droperette
Neomycin-Polymyxin-Hydrocortisone Ear Solution	Ciprofloxacin-Dexamethasone Drops
Neomycin-Polymyxin-Hydrocortisone Ear Suspension	Ciprofloxacin-Fluocinolone Vial
Ofloxacin Ear Drops	Cortisporin-TC Ear Suspension

PANCREATIC ENZYMES

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

PENICILLINS

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

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

PHOSPHATE LOWERING AGENTS (formerly PHOSPHATE BINDERS)

Preferred Agents	Non-Preferred Agents
Calcium Acetate Capsule ^{QL}	Auryxia (<i>ferric citrate</i>) Tablet ^{QL}
Calcium Acetate Tablet ^{QL}	Fosrenol (<i>lanthanum carbonate</i>) Chewable Tablet ^{QL}
Calphron (<i>calcium acetate</i>) Tablet ^{QL}	Fosrenol (<i>lanthanum carbonate</i>) Powder Packet ^{QL}
Sevelamer Carbonate Tablet ^{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}	
Dipyridamole Tablet ^{QL}	
Prasugrel Tablet ^{QL}	

POTASSIUM REMOVING AGENTS

Preferred Agents	Non-Preferred Agents
Lokelma (<i>sodium zirconium cyclosilicate</i>) Powder Packet ^{PA, QL}	
Veltassa (<i>patiromer</i>) Powder Packet ^{PA, QL}	

PRENATAL VITAMINS

Preferred Agents	Non-Preferred Agents
Complete Natal DHA Combo Pack	Citrnatal B-Calm Combo Pack
M-Natal Plus Tablet	C-Nate DHA Capsule
Niva-Plus Tablet	Completenate Chewable Tablet
Prenatal Plus Vitamin-Mineral Tablet	Concept DHA Capsule
Prenatal Vitamin Plus Low Iron Tablet	Concept OB Capsule
Se-Natal 19 Chewable Tablet	Dermacinrx Prenatrix Tablet

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

Se-Natal 19 Tablet	Dermacinrx Prenatryl Tablet
Thrivite Rx Tablet	Dermacinrx Pretrate Tablet
Trinatal RX 1 Tablet	Elite-OB Tablet
Wesnatal DHA Complete Combo Pack	Enbrace HR Capsule
Westab Plus Tablet	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
	Virt-Nate DHA Capsule
	Virt-PN DHA Capsule
	Vitafol Fe Plus Capsule
	Vitafol Gummies
	Vitafol Nano Tablet
	Vitafol Ultra Capsule
	Vitafol-OB Tablet
	Vitafol-OB+DHA Combo Pack
	Vitafol-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

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

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

SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents
Doxepin Capsule	Ambien Tablet ^{QL}

AR = age restriction, clinical prior authorization required
 AE = age exemption for specified ages (years)
 Non-preferred agents require prior authorization
 Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

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
Droxia Capsule	Adakveo Vial
Hydroxyurea Capsule	Endari Powder Packet ^{QL}
	Hydrea Capsule
	Siklos Tablet

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}
	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
	Orphenadrine ER Tablet ^{QL}
	Orphengesic Forte Tablet ^{QL}
	Ozobax 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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

	Ozobax DS Solution ^{QL} Soma Tablet ^{QL} Tanlor Tablet Tizanidine Capsule ^{QL} Zanaflex Capsule ^{QL} Zanaflex Tablet ^{QL}
--	---

SMOKING CESSATION

Preferred Agents	Non-Preferred Agents
Bupropion SR 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 Oil Hydrocortisone Cream Hydrocortisone 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 Lotion Complete Kit (<i>hydrocortisone/cleanser</i>) Hydroxym (<i>hydrocortisone</i>) Gel Texacort (<i>hydrocortisone</i>) Solution
<u>Medium Potency</u> Fluticasone Cream Fluticasone Ointment Mometasone Cream Mometasone Ointment Mometasone Solution	<u>Medium Potency</u> Betamethasone Valerate Foam Clocortolone Cream Fluocinolone Cream Fluocinolone Ointment 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

AR = age restriction, clinical prior authorization required

AE = age exemption for specified ages (years)

Non-preferred agents require prior authorization

Effective July 7, 2025, v6

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.*

	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 Foam Clobetasol Gel Clobetasol Lotion Clobetasol Shampoo Clobetasol Spray 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 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

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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	Olux-E (clobetasol/emollient) Foam Tovet (clobetasol/emollient) Emollient Foam Tovet (clobetasol/emollient) Foam Kit Ultravate (halobetasol) 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} Quillichew ER (<i>methylphenidate TAB CBP24H</i>) Chewable Tablet ^{AR, QL} Quillivant XR (<i>methylphenidate SU ER RC24</i>) Suspension ^{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} Mydayis ER (<i>dextroamphetamine-amphetamine CPTP 24HR</i>) Capsule ^{AR, QL} Nuvigil (<i>armodafinil</i>) Tablet ^{QL} Provigil (<i>modafinil</i>) Tablet ^{QL} Relexxii ER (<i>methylphenidate ER 24HR</i>) Tablet ^{AR, QL} Ritalin (<i>methylphenidate</i>) Tablet ^{AR, QL} Ritalin LA (<i>methylphenidate CPBP 50-50</i>) Capsule ^{AR, QL} Strattera (<i>atomoxetine</i>) Capsule ^{AR, QL} Sunosi (<i>solriamfetol</i>) Tablet ^{QL} Vyvanse (<i>lisdexamfetamine</i>) Capsule ^{AR, QL} Vyvanse (<i>lisdexamfetamine</i>) Chewable Tablet ^{AR, QL} Wakix (<i>pitolisant</i>) Tablet ^{QL} Xelstryl (<i>dextroamphetamine</i>) Patch ^{AR, QL} Zenzedi (<i>dextroamphetamine</i>) Tablet ^{AR, 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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

TETRACYCLINES

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

THALIDOMIDE AND DERIVATIVES

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

THROMBOPOIETICS

Preferred Agents	Non-Preferred Agents
Nplate (<i>romiplostim</i>) Vial ^{PA}	Alvaiz (<i>eltrombopag choline</i>) Tablet ^{QL}
Promacta (<i>eltrombopag olamine</i>) Suspension Packet ^{PA, QL}	Doptelet (<i>avatrombopag</i>) Tablet ^{QL}
Promacta (<i>eltrombopag olamine</i>) Tablet ^{PA, QL}	Mulpleta (<i>lusutrombopag</i>) Tablet ^{QL}
	Tavalisse (<i>fostratinib</i>) Tablet ^{QL}

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
Ermeza (<i>levothyroxine</i>) Solution	Liothyronine Vial
Levo-T (<i>levothyroxine</i>) Tablet	Synthroid (<i>levothyroxine</i>) Tablet
Levothyroxine Tablet	Thyquidity (<i>levothyroxine</i>) Solution
Levoxyl (<i>levothyroxine</i>) Tablet	Unithroid (<i>levothyroxine</i>) Tablet
Liothyronine Tablet ^{QL}	
Niva Thyroid (<i>thyroid, pork</i>) Tablet	
NP Thyroid (<i>thyroid, pork</i>) Tablet	
Renthroid (<i>thyroid, pork</i>) 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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

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 Classic Pods ^{QL}	
Omnipod Dash Intro Kit ^{QL}	
Omnipod Dash PDM Kit ^{QL}	
Omnipod Dash Pods ^{QL}	
Omnipod Go 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
	sfRowasa (<i>mesalamine</i>) Enema ^{QL}
	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	

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}
	ME-NaPhos-MB-Hyo 1 (<i>methenamine-monobasic sodium phosphate-methylene blue-hyoscyamine</i>) Tablet
	Methenamine Mandelate 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 market will be non-preferred until reviewed by the DHS Pharmacy and Therapeutics Committee.

	Nitrofurantoin Suspension ^{AE<9, QL} Urelle (hyoscyamine-methenamine-methylene blue-phenyl salicylate-sodium phosphate monobasic) Tablet ^{QL} Uribel (methenamine-methylene blue-phenyl salicylate-hyoscyamine) Tablet Urimar-T (methenamine-methylene blue-sodium phosphate monobasic-phenyl salicylate-hyoscyamine) Capsule ^{QL} Urogesic-Blue (methenamine-monobasic sodium phosphate-methylene blue-hyoscyamine) Tablet ^{QL} Uro-MP (methenamine-methylene blue-sodium phosphate-phenyl salicylate-hyoscyamine) Capsule
--	---

VAGINAL ANTI-INFECTIVES

Preferred Agents	Non-Preferred Agents
Cleocin (clindamycin) Ovules Clindamycin 2% Vaginal Cream Clindesse (clindamycin 2%) Vaginal Cream Clotrimazole 3 (2%) Vaginal Cream Clotrimazole 7 (1%) Vaginal Cream Metronidazole 250 mg, 500 mg Tablet Metronidazole 0.75% Vaginal Gel (generic MetroGel) Miconazole 1 (1200 mg-2%) Combination Pack Miconazole 3 (200 mg-2%) Combination Pack Miconazole 3 (4%-2%) Combination Pack 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	Cleocin (clindamycin) Vaginal Cream Gynazole 1 (butoconazole) Vaginal Cream Metronidazole 1.3% Vaginal Gel (generic Nuvessa) Miconazole 3 (200 mg) Vaginal Suppository Nuvessa (metronidazole 1.3%) Vaginal Gel Solosec (secnidazole) Granule Packet Terconazole Vaginal Cream Terconazole Vaginal Suppository Vandazole (metronidazole 0.75%) Vaginal Gel Xaciat (clindamycin) Vaginal Gel

VITAMIN D ANALOGS

Preferred Agents	Non-Preferred Agents
Calcitriol Capsule Calcitriol Vial Doxercalciferol Vial Paricalcitol Vial	Calcitriol Solution Doxercalciferol Capsule Paricalcitol Capsule Rayaldee (calcifediol) ER Capsule ^{QL} Rocaltrol (calcitriol) Capsule Rocaltrol (calcitriol) Solution Zemplar (paricalcitol) Capsule Zemplar (paricalcitol) Vial

VMAT2 INHIBITORS

Preferred Agents	Non-Preferred Agents
Austedo (deutetrabenazine) Tablet ^{PA, QL} Austedo XR (deutetrabenazine) Tablet ^{PA, QL} Ingrezza (valbenazine) Capsule ^{PA, QL} Ingrezza (valbenazine) Sprinkle Capsule ^{PA, QL} Tetrabenazine Tablet ^{PA, QL}	Xenazine (tetrabenazine) Tablet ^{QL}