Connecticut Clinical Criteria Prior Authorization Pilot

Frequently Asked Questions

What is the Clinical Criteria Prior Authorization Pilot?

Today in Connecticut, the Medicaid Preferred Drug List (PDL) establishes a list of prescription medications selected by the Pharmaceutical and Therapeutics (P&T) committee that provide effective and safe treatment options for Connecticut Medical Assistance Program members while also delivering cost-effective options. The PDL supports clinical quality through the expertise of our P&T Committee members and maximizes the collection of supplemental rebates by aligning prescription drug utilization to preferred products. While CT has favorable PDL adherence overall, there are areas of concern where a high percentage of non-preferred medications are being prescribed and dispensed.

To increase utilization of preferred drugs and ensure appropriate clinical use, Connecticut is introducing new clinical prior authorization criteria across 11 targeted drug classes that were identified as having low PDL compliance. These criteria are supported by current literature, manufacturer guidelines and evidence-based clinical practice guidelines developed by specialists and professional organizations in various medical fields. Adoption of this process will shift from prescriber attestation to the review of clinical documentation based on these evidence-based clinical requirements. Meeting these clinical requirements will allow members to qualify for coverage of non-preferred drugs.

What is changing, for whom, and when?

Beginning January 1, 2026, non-preferred drugs in 11 therapeutic classes will require a prior authorization where clinical criteria must be met in order to be approved. Members who obtain new prescriptions for a non-preferred drug will need their provider to complete and submit clinical information that will be reviewed. The member will either be approved for the non-preferred drug or will need to be prescribed a preferred drug.

The 11 drug classes requiring prior authorization beginning on January 1 are:

Drug Class	What Do They Treat?
Cytokine & CAM	Autoimmune conditions like rheumatoid arthritis and Crohn's disease
Anticonvulsants	Seizures and epilepsy
Bladder Relaxants	Overactive bladder and urinary incontinence
Growth Hormone	Growth disorders in children and adults
Multiple Sclerosis Agents	Multiple sclerosis (nerve and muscle problems)
Pulmonary Arterial Hypertension	High blood pressure in the lungs
Asthma Immunomodulators	Severe asthma and allergic conditions
Antimigraine (Other)	Migraine headaches
Colony Stimulating Factors	Low white blood cell counts
Antipsoriatic Topicals	Psoriasis (skin condition causing red, scaly patches)
GLP-1 Receptor Agonists	Type 2 diabetes and weight management

Why is this change occurring?

Connecticut is an outlier by not having a clinical prior authorization process in place. Nationwide, it is standard practice for Medicaid programs as well as Medicare and commercial plans to implement prior authorization clinical policies for PDL adherence, best practices, and patient safety.

DSS requested Gainwell Technologies work with the DSS Pharmacy Team members to develop and implement a plan to evaluate and manage the safe and effective utilization of preferred drug products. Alignment to best practices through use of clinical criteria provides stronger clinical oversight and adherence to appropriate prescribing guidelines. This aims to improve clinical outcomes by following evidence-based clinical criteria to ensure the right care, at the right time, and at the right cost.

What if a patient is taking a non-preferred drug in one of the identified classes? Will the prescriber need to change the patient's medication?

Members taking a medication in one of the 11 classes will be permitted to continue these medications **for 90 days** from January 1, 2026. During this time, members are encouraged to discuss with their provider next steps, including the appropriateness of switching therapy. After the 90-day grace period (i.e. April 1, 2026) the prescription will not be fillable at the pharmacy and will require submission of clinical criteria by the provider. The required one-time 14-day emergency fill may be used so that members do not go without access to medication.

What is not changing?

Providers will still be able to send a letter of medical necessity for DSS to review if coverage for medication is initially denied and the provider believes it is medically appropriate. The state will provide a determination of the prior authorization request within 24 hours once a complete form with all necessary documentation has been submitted by the provider. In the event of an adverse decision, members retain their fair hearing rights to appeal an adverse decision; that process will not change.

How will this pilot be evaluated?

Data on utilization of preferred vs non-preferred drugs in these 11 classes will be collected prior to implementation (4th quarter of 2025). Subsequent data will be collected in each quarter of 2026 to compare utilization of preferred vs non-preferred drugs in these classes. In addition, DSS pharmacy staff will provide ongoing oversight and monitoring as Gainwell implements review of these new prior authorizations to ensure patient access to medication is not compromised and clinical criteria are adhered to.

How are drugs selected to be preferred or non-preferred?

The Pharmaceutical and Therapeutics Committee ("P&T Committee") for the Connecticut Medical Assistance Program is established under the authority of section 17b-274d of the Connecticut General Statutes. The purpose of the P&T Committee is to adopt one or more PDLs for use in the Connecticut Medical Assistance Program. As necessary and appropriate, the P&T Committee reviews and evaluates medical criteria, standards, and educational intervention methods concerning the establishment of one or more PDLs and make recommendations to the DSS. The P&T Committee may also make recommendations to the DSS regarding prior authorization of any prescribed drug covered by the Connecticut Medical Assistance Program.

Where can I find information on the clinical criteria for these 11 classes, the prior authorization forms and the Preferred Drug List?

All of this information can be found on the Connecticut Medical Assistance Program website under the **Pharmacy Information** page. This page will be updated prior to Jan 1, 2026, to include the new information. The 11 drug classes with the current preferred drugs in each class are listed at the end of this document.

https://www.ctdssmap.com/CTPortal/Pharmacy-Information

How often are drugs, or drug classes, reviewed and changes made to the Preferred Drug List?

The P&T Committee meets twice a year in May and November via teleconference. Each therapeutic class is reviewed annually- half of the drug classes are reviewed in May and the other half are reviewed in November.

How can I provide comments to the P&T Committee?

The public may provide comment during the P&T Committee meeting or attend by emailing connecticutpdlquestions@gainwelltechnologies.com. A link and login information to attend the meeting will be provided.

Where can I find more information about the Therapeutics Committee and DUR Board meetings?

The schedule for review of therapeutic classes and meeting information can be found at Pharmacy Information.

Do preferred drugs require a prior authorization?

No, preferred drugs do not require prior authorization in general, with some exceptions as listed on the **Pharmacy Information** page.

How are drugs new to the market being handled?

New drugs are reviewed during the P&T Committee meeting in which the class is scheduled for review. Until approved by the Committee, they will be designated as non-preferred.

Will the process to obtain a prior authorization change?

No, the process is not changing. The provider may submit a prior authorization form and supporting documentation via fax to 1-866-759-4110 or call Gainwell Technologies at 1-866-409-8386.

Therapeutic Class List (as of Dec 1, 2025)

Drug Class	Preferred Products (preferred brands are BOLD when generic is available but non-preferred)	Non-preferred products
Anticonvulsants	CARBAMAZEPINE TAB CHEW, IR TABLET (not ER) **CARBATROL ER CAPSULE** CLOBAZAM SUSPENSION CLOBAZAM TABLET CLONAZEPAM IR TABLET (not ODT or ER) **DEPAKOTE SPRINKLE CAPSULE (not TABLET)** DIAZEPAM RECTAL GEL SYSTEM DIVALPROEX SOD DR TABLET (not SPRINKLE) DIVALPROEX SOD ER TABLET EPIDIOLEX SOLUTION EPITOL TABLET ETHOSUXIMIDE CAPSULE, SOLUTION LACOSAMIDE TABLET, SOLUTION LAMOTRIGINE CHEW DISPERS TAB (not ODT) LAMOTRIGINE TABLET (not ER) LEVETIRACETAM SOLUTION, IR TABLET (not ER) NAYZILAM NASAL SPRAY OXCARBAZEPINE TABLET PHENOBARBITAL ELIXIR, SOLUTION, TABLET PHENYTOIN CHEW TABLET, SUSPENSION PHENYTOIN SOD EXT 100 MG CAPS (not 200MG, 300MG) PRIMIDONE TABLET ROWEEPRA TABLET **SABRIL 500 MG POWDER PACK** **SABRIL 500 MG TABLET** SUBVENITE TABLET (not START KIT) **TEGRETOL 100 MG/5 ML SUSPENSION** TEGRETOL XR TABLET (ORAL) TIAGABINE TABLET TOPIRAMATE SPRINKLE CAPSULE TOPIRAMATE TABLET (not ER) **TRILEPTAL 300 MG/5 ML SUSPENSION** VALPROIC ACID CAPSULE, SOLUTION VALTOCO NASAL SPRAY ZONISAMIDE CAPSULE	APTIOM TABLET BANZEL SUSPENSION, TABLET BRIVIACT SOLUTION, TABLET CARBAMAZEPINE SUSPENSION CELONTIN CAPSULE CLONAZEPAM ODT DEPAKOTE DR, ER TABLET DIACOMIT CAPS, POWDER PACK DILANTIN CAPSULE, SUSPENSION DILANTIN INFATAB DIVALPROEX SPRINKLE CAPSULE ELEPSIA XR TABLET EPRONTIA SOLUTION EQUETRO CAPSULE ESLICARBAZEPINE TABLET FELBAMATE SUSPENSION, TAB FELBATOL SUSPENSION, TAB FINTEPLA SOLUTION FYCOMPA SUSPENSION, TABLET KEPPRA SOLUTION, TABLET KEPPRA XR TABLET KLONOPIN TABLET LAMICTAL TABLET LAMICTAL ODT, ODT START KIT LAMICTAL XR START KIT LAMICTAL XR TABLET LAMOTRIGINE ER TABLET LAMOTRIGINE ODT TABLET LAMOTRIGINE TAB START KIT LIBERVANT FILM METHSUXIMIDE CAPSULE MOTPOLY XR CAPSULE MYSOLINE TABLET ONFI SUSPENSION, TABLET OXCARBAZEPINE SUSPENSION OXTELLAR XR TABLET PHENYTEK CAPSULE PHENYTOIN SOD EXT CAP (200MG, 300MG)

		RUFINAMIDE SUSP, TABLET SEZABY VIAL SPRITAM TABLET SUBVENITE SUSPENSION SUBVENITE TAB START KIT SYMPAZAN FILM TEGRETOL TABLET TOPAMAX SPRINKLE CAPSULE TOPAMAX TABLET TOPIRAMATE ER CAPSULE TOPIRAMATE ER SPRINK CAP TRILEPTAL TABLET TROKENDI XR CAPSULE VIGABATRIN POWDER PACKET VIGABATRIN TABLET VIGADRONE POWDER PACKET VIGADRONE TABLET VIGAFYDE SOLUTION VIGPODER POWDER PACKET VIMPAT SOLUTION, TABLET VIMPAT STARTER KIT XCOPRI TAB, TITRATION PAK
Bladder Relaxant Preparations	FESOTERODINE ER TABLET (ORAL) **MYRBETRIQ ER TABLET (ORAL)** OXYBUTYNIN ER TABLET (ORAL) OXYBUTYNIN SOLUTION, TABLET (not 2.5MG) (ORAL) SOLIFENACIN TABLET (ORAL)	DARIFENACIN ER TABLET DETROL TABLET DETROL LA CAPSULE FLAVOXATE TABLET GEMTESA TABLET MIRABEGRON ER TABLET MYRBETRIQ ER SUSPENSION OXYBUTYNIN 2.5 MG TABLET OXYTROL PATCH (RX) OXYTROL FOR WOMEN OTC TOLTERODINE ER CAPSULE TOLTERODINE TABLET TOVIAZ ER TABLET TROSPIUM TABLET TROSPIUM ER CAPSULE VESICARE TABLET VESICARE LS SUSPENSION
Cytokine and CAM Antagonists	ADALIMUMAB-ADAZ PEN, SYRINGE ENBREL DISP SYRINGE, KIT, PEN ENBREL MINI CARTRIDGE ENBREL VIAL HADLIMA PUSHTOUCH, SYRINGE HUMIRA KIT, PEN INJ KIT INFLIXIMAB VIAL ORENCIA CLICKJET, SYRINGE	ABRILADA PEN, SYRINGE ACTEMRA PEN, VIAL ADALIMUMAB-AACF ADALIMUMAB-AATY ADALIMUMAB-ADBM ADALIMUMAB-FKJP ADALIMUMAB-RYVK

	OTEZLA STARTER PACK, TABLET PYZCHIVA SYRINGE, VIAL (SUBCUTANEOUS) SELARSDI SYRINGE STEQEYMA SYRINGE, VIAL TYENNE AUTOINJECT, SYRINGE TYENNE VIAL XELJANZ IR TABLET (not XR or SOLUTION)	AMJEVITA AUTOINJECT, SYRINGE ARCALYST VIAL AVASOLA VIAL AVTOZMA VIAL BIMZELX AUTOINJECTOR, SYRINGE CIBINQO TABLET CIMZIA SYRINGE, VIAL COSENTYX SENSOREADY PEN, SYRINGE CYLTEZO PEN, SYRINGE ENSPRYNG SYRINGE ENTYVIO PEN, VIAL HULIO PEN, SYRINGE HYRIMOZ PEN, SYRINGE IDACIO PEN SYRINGE INFLECTRA VIAL ILARIS VIAL ILUMYA IMULDOSA KEVZARA PEN, SYRINGE KINERET SYRINGE LEQSELVI TABLET LITFULO CAPSULE OLUMIANT TABLET OMVOH ORENCIA VIAL OTEZLA XR TABLET OTULFI PYZCHIVA VIALS (IV) REMICADE VIAL RENFLEXIS VIAL RINVOQ ER TABLET RINVOQ LQ SOLUTION SIMLANDI AUTOINJECT, PEN SIMPONI PEN, SYRINGE SIMPONI ARIA VIAL SILIQ SYRINGE SKYRIZI SOTYKTU TABLET SPEVIGO SYRINGE, VIAL STARJEMZA STELARA TALTZ AUTOINJECTOR, SYRINGE TOFIDENCE VIAL TREMFYA UPLIZNA VIAL USTEKINUMAB USTEKINUMAB-AEKN USTEKINUMAB-TTWE

		VELSIPITY TABLET XELJANZ SOLUTION XELJANZ XR TABLET YESINTEK YUFLYMA PEN YUSIMRY PEN ZYMFENTRA PEN, SYRINGE
Growth Hormone	GENOTROPIN CARTRIDGE GENOTROPIN MINIQUICK NORDITROPIN FLEXPRO	HUMATROPE CARTRIDGE NGENLA PEN NUTROPIN AQ NUSPIN PEN OMNITROPE CARTRIDGE OMNITROPE VIAL SEROSTIM VIAL SKYTROFA CARTRIDGE SOGROYA PEN ZOMACTON VIAL
Multiple Sclerosis Agents	AVONEX PEN, PREFILLED SYRINGE BETASERON 0.3 MG KIT **COPAXONE 20 MG/ML SYRINGE (not 40 MG/ML)** DALFAMPRIDINE ER TABLET DIMETHYL FUMARATE DR CAPSULE DIMETHYL FUMARATE DR STARTER PACK FINGOLIMOD CAPSULE KESIMPTA PEN TERIFLUNOMIDE TABLET	AMPYRA ER TABLET AUBAGIO TABLET BAFIERTAM DR CAPSULE BETASERON VIAL BRIUMVI VIAL COPAXONE 40 MG/ML SYRINGE GILENYA CAPSULE GLATIRAMER SYRINGE GLATOPA SYRINGE LEMTRADA VIAL MAVENCLAD TABLET PK MAYZENT TABLET OCREVUS VIAL OCREVUS ZUNOVO VIAL PLEGRIDY PEN PONVORY STARTER PACK PONVORY TABLET REBIF SYRINGE REBIF REBIDOSE REBIF TITRATION PACK TASCENSO ODT TABLET TECFIDERA DR CAPSULE TECFIDERA STARTER PACK TYRUKO VIAL TYSABRI VIAL VUMERITY DR CAPSULE ZEPOSIA CAPSULE ZEPOSIA STARTER PACK
Pulmonary Arterial Hypertension Agents	ALYQ 20 MG TABLET *(DX CODE REQ.)* AMBRISENTAN TABLET SILDENAFIL 20 MG TABLET (DX CODE REQ.) TADALAFIL 20 MG TABLET (ADCIRCA) *(DX CODE REQ.)* **TRACLEER 62.5 MG & 125 MG TABLET**	ADCIRCA TABLET ADEMPAS TABLET BOSENTAN TABLET LETAIRIS TABLET OPSUMIT TABLET OPSYNVI TABLET ORENITRAM ER TABLET

	VENTAVIS SOLUTION	ORENITRAM TITR KIT REVATIO SUSP & TABLET SILDENAFIL SUSPENSION TADLIQ SUSPENSION TRACLEER TABLET FOR SUSP TYVASO INHALATION TYVASO DPI INHALATION UPTRAVI TABLET YUTREPIA INHALATION
Asthma & Allergy Immunomodulators	ADBRY AUTOINJECTOR, SYRINGE (DX CODE REQ) DUPIXENT PEN, SYRINGE (DX CODE REQ) EBGLYSS PEN, SYRINGE (DX CODE REQ) FASENRA PEN, SYRINGE (DX CODE REQ) TEZSPIRE PEN, SYRINGE (DX CODE REQ) XOLAIR AUTOINJECTOR, SYRINGE, VIAL (DX CODE REQ)	CINQAIR VIAL NEMLUVIO PEN NUCALA AUTOINJECTOR, SYRINGE, VIAL
Antimigraine: other	AJOVY AUTOINJECTOR, SYRINGE EMGALITY 120 MG PEN, SYRINGE NURTEC ODT TABLET QULIPTA TABLET UBRELVY TABLET	AIMOVIG AUTOINJECTOR EMGALITY 100 MG SYRINGE REYVOW TABLET VYEPTI VIAL ZAVZPRET NASAL SPRAY
Colony Stimulating Factors	FYLNETRA SYRINGE NEUPOGEN DISP SYRINGE, VIAL	GRANIX SYRINGE, VIAL FULPHILA SYRINGE LEUKINE VIAL NEULASTA KIT, SYRINGE NIVESTYM SYRINGE, VIAL NYVEPRIA SYRINGE RELEUKO SYRINGE, VIAL ROLVEDON SYRINGE RYZNEUTA SYRINGE STIMUFEND SYRINGE UDENYCA AUTOINJECT, ONBODY, SYRINGE ZARXIO SYRINGE ZIEXTENZO SYRINGE
Antipsoriatic topical	CALCIPOTRIENE 0.005% CREAM, OINTMENT CALCIPOTRIENE 0.005% SOLUTION CALCIPOTRIENE-BETAMETH DP OINTMENT **VECTICAL 3 MCG/G OINTMENT**	CALCIPOTRIENE FOAM CALCIPOTRIENE/BETAMETHASONE SUSPENSION CALCITRIOL OINTMENT (generic Vectical) ENSTILAR FOAM SORILUX FOAM TACLONEX OINTMENT TACLONEX SCALP SUSPENSION ZORYVE 0.3% CREAM

GLP-1/GIP Agonists for Type 2 Diabetes	OZEMPIC DOSE PEN, SYRINGE *(DX CODE REQ.)* TRULICITY PEN *(DX CODE REQ.)* **VICTOZA PEN *(DX CODE REQ.)***	BYDUREON BCISE AUTOINJECT EXENATIDE PEN LIRAGLUTIDE PEN (generic VICTOZA) MOUNJARO PEN RYBELSUS TABLET SOLIQUA PEN XULTOPHY PEN