Missouri Pharmacy Program – Preferred Drug List

Pancreatic Enzyme Agents

Effective 06/23/2011
Revised 07/11/2019

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Creon®</td>
<td>• Pancreaze®</td>
</tr>
<tr>
<td>• Zenpep®</td>
<td>• Pertzye®</td>
</tr>
<tr>
<td></td>
<td>• Viokace®</td>
</tr>
</tbody>
</table>

Approval Criteria

- Failure to achieve desired therapeutic outcomes with trial on 2 or more preferred agents
  - Documented trial period of preferred agents
  - Documented ADE/ADR to preferred agents
- Documented compliance on current therapy regimen

Denial Criteria

- Lack of adequate trial on required preferred agents
- Therapy will be denied if no approval criteria are met
- Drug Prior Authorization Hotline: (800) 392-8030