

**WYOMING MEDICAID
Preferred Drug List (PDL) - April 5, 2017**

Drug classes not included on this list are not managed through a Preferred Drug List (PDL).
HOWEVER, THIS EXCLUSION IS NOT A GUARANTEE OF PAYMENT OR COVERAGE. Dosage limits and other requirements may apply.
Drugs new to market are non-preferred until a clinical review has been completed. PA criteria will apply to both the pediatric population,
as well as the adult population for those plans where PA/PDL limits are allowed.

Unless otherwise noted on the PDL, generic substitution is mandatory.

Yellow highlighted items below indicate new changes to the PDL. Red font indicates quantity/dosage limits apply. *Indicates BRAND is Preferred. May Use DAW 5.
Contact the GHS PA Helpdesk @ 877-207-1126 for prior authorization if client has primary insurance that will not cover the brand name medication.

Please refer to the Additional Therapeutic Criteria Chart, **Dosage Limitation List (red font indicates quantity/dosage limits apply), and the Wyoming Medicaid Provider Manual at <http://wymedicaid.org> for additional criteria.**

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>PREPARED & NOT FOR REVISION PLEASE CONTACT GHS FOR QUESTIONS</small>
ADDICTION	BUPRENORPHINE COMBINATIONS		<p>Client must have a diagnosis of opioid dependence or abuse. This is not to be used for the treatment of chronic pain. Prescriber must have a XDEA number. Prior authorization will be required before any narcotic or carisoprodol prescription will be allowed between fills. Prior authorization will be required before any benzodiazepine or short-acting stimulant prescription from any doctor other than the prescriber of buprenorphine or Suboxone, will be allowed between fills.</p> <p>Oral buprenorphine will be approved for clients that are pregnant or nursing or with a documented allergy to naloxone.</p> <p>Please submit PA requests on the "Oral Buprenorphine/Naloxone or Oral Buprenorphine" PA form available at www.wymedicaid.org.</p> <p>Dosage limits apply During first two years of treatment: 16mg After two years of treatment: 8mg</p>	<p>BUNAVAIL buprenorphine (oral) buprenorphine/naloxone tablets (use preferred) ZUBSOLV</p>
		<p>SUBOXONE FILM</p>		
	NALTREXONE		<p>Client must have a diagnosis of alcohol or opioid dependence.</p> <p>Prior authorization will be required before any narcotic or carisoprodol prescription will be allowed between fills. Prior authorization will be required before any benzodiazepine or short-acting stimulant prescription from any doctor other than the prescriber of buprenorphine or Suboxone, will be allowed between fills.</p>	
		<p>naltrexone VIVITROL</p>		
ALLERGY / ASTHMA	ANTIHISTAMINES, MINIMALLY SEDATING		<p>Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p>	<p>desloratadine CLARINEX RDT/SYRUP levocetirizine</p>
	<p>cetirizine fexofenadine loratadine</p>			
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		<p>Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p>	<p>CLARINEX-D</p>
	<p>cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine</p>			
	ANTICHOLINERGIC BRONCHODILATORS		<p>Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>Spiriva 5 day STARTER package will be allowed one (1) time per recipient.</p>	<p>ATROVENT HFA INCRUSE ELLIPTA SPIRIVA RESPIMAT (use preferred agent) TUDORZA</p>
	<p>ipratropium SPIRIVA HANDIHALER</p>			
	INHALED COMBINATION AGENTS		<p>Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>**Will also require the diagnosis of COPD.</p> <p>***Will also require the diagnosis of COPD or uncontrolled asthma.</p> <p>Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.</p>	<p>ANORO ELLIPTA** BREO ELLIPTA*** STIOLTO</p>
	<p>ADVAIR DISK/HFA COMBIVENT DULERA SYMBICORT</p>			
	LEUKOTRIENE MODIFIERS		<p>Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p>	<p>zafirlukast ZYFLO</p>
	<p>montelukast</p>			
	LONG ACTING BRONCHODILATORS		<p>Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p>	<p>PERFOROMIST STRIVERDI</p>
	<p>BROVANA FORADIL SEREVENT</p>			
NASAL ANTIHISTAMINES		<p>Trial and failure of preferred agent greater than or equal to 90 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p>	<p>azelastine 0.15% AZENASE (use separate agents) DYMISTA (use separate agents) olopatadine 0.6%</p>	
<p>ASTELIN azelastine 0.1%</p>				
NASAL STEROIDS		<p>Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>Budesonide will be approved for pregnancy.</p>	<p>AZENASE (use separate agents) budesonide DYMISTA (use separate agents) OMNARIS QNASL TICANASE (use separate agents) triamcinolone VERAMYST ZETONNA</p>	
<p>BECONASE AQ flunisolide fluticasone NASONEX*</p>				
SHORT ACTING BRONCHODILATORS - INHALERS		<p>Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>Minimum day supply of at 16 days is required</p>	<p>PROAIR RESPICLICK XOPENEX HFA</p>	
<p>PROAIR HFA PROVENTIL HFA VENTOLIN HFA</p>				
SHORT ACTING BRONCHODILATORS - NEBULIZERS		<p>Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p>		
<p>albuterol neb levalbuterol neb</p>				

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ALLERGY / ASTHMA continued	STEROID INHALANTS		Trial and failure of three (3) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Alvesco will be approved for a history of oral thrush with steroid inhalants.	AEROBID/AEROBID-M ALVESCO ARNUITY ASMANEX budesonide susp 0.25mg/2ml AND 0.5mg/2ml (BRAND IS PREFERRED) budesonide susp 1mg/2ml QVAR
	AEROSPAN FLOVENT HFA/DISK PULMICORT SUSP 0.25mg/2ml AND 0.5mg/2ml* PULMICORT FLEXHALER			
	EPINEPHRINE			
	epinephrine auto-injector pen EPI-PEN			ADRENACLICK (use preferred agent) AUVI-Q (use preferred agent)
ARTHRITIS	IMMUNOMODULATORS		Client must have diagnosis of AS prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of AS and a 56-day trial and failure of both preferred agents. Quantity Limits apply for all diagnoses: Enbrel 25mg - limited to 10 per month Enbrel 50mg - limited to 5 per month Humira 20mg - limited to 10 per month Humira 40mg - limited to 5 per month	CIMZIA COSENTYX REMICADE SIMPONI
	ANKYLOSING SPONDYLITIS (AS)			
		ENBREL HUMIRA		
	JUVENILE IDIOPATHIC ARTHRITIS (JIA)			
		ENBREL HUMIRA		
	PSORIATIC ARTHRITIS (PA)		Client must have diagnosis of PA prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of PA and a 56-day trial and failure of both preferred agents.	CIMZIA COSENTYX OTEZLA REMICADE SIMPONI
	ENBREL HUMIRA			
	RHEUMATOID ARTHRITIS (RA)		Client must have diagnosis of RA and a 56-day trial and failure of methotrexate prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of RA and a 56-day trial and failure of both preferred agents.	ACTEMRA ORENCIA CIMZIA KINERET ORENCIA REMICADE RITUXAN SIMPONI XELJANZ/XR
	ENBREL HUMIRA			
CONVULSIONS	DIAZEPAM RECTAL GEL			diazepam gel (BRAND IS PREFERRED)
	DIASTAT*		Limited to FDA approved indications	
	ORAL ANTICONVULSANTS			
		APTIOM FYCOMPA VIMPAT		
CROHN'S	IMMUNOMODULATORS		Client must have diagnosis of Crohn's prior to approval of the preferred agent. To receive a non-preferred agent, client must have a diagnosis of Crohn's and a 56-day trial and failure of the preferred agent.	CIMZIA REMICADE TYSABRI (additional criteria applies)
DERMATOLOGY	IMPETIGO ANTIBIOTICS		Trial and failure of ALL preferred agents greater than or equal to 7 days in the past 90 days. Use smallest size appropriate for 7 day trial.	ALTABAX
	gentamicin mupirocin			
	BENZOYL PEROXIDE/CLINDAMYCIN COMBOs		Clients must be 12 to 20 years of age and have a diagnosis of acne vulgaris. Requires prior authorization for clients less than 12 years of age. Acne combinations are limited to clients under the age of 21.	ACANYA benzoyl peroxide/clindamycin (BRAND IS PREFERRED)
		BENZACLIN* clindamycin/benzoyl peroxide 1.2 (1)-5% (Refrig)		
	CORTICOSTEROIS		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	PANDEL prednicarbate 0.1% (C,O) TEXACORT 2.5% (S)
	LOW POTENCY			
	alclometasone desonide DESOWEN 0.05% (L) fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) SYNALAR 0.01%			
MEDIUM POTENCY		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	Clocortolone Pivalate CORDRAN/SP fluticasone 0.05% (L) hydrocortisone butyrate 0.1% (O) TOPICORT LP TRIANEX	
betamethasone valerate CUTIVATE 0.05% (C) DERMATOP 0.1% (C) desoximetasone 0.05% (C) ELOCON 0.1% fluocinolone 0.025% fluticasone 0.05% (C) hydrocortisone probutate 0.1% (C) mometasone SYNALAR 0.025% TOPICORT 0.05% (C) triamcinolone 0.025%, 0.1%				
HIGH POTENCY		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	APEXICON amcinonide 0.1% (C,L,O) augmented betamethasone 0.05% (G,L,O) clobetasol 0.05% (L) desoximetasone 0.05%, 0.25% (C,G,O) fluocinonide 0.1% (C) HALOG	
betamethasone dipropionate clobetasol/E 0.05% (C,G,O,S) diflorasone DIPROLENE 0.05% (L) fluocinonide flurandrenolide fluticasone 0.005% (O) halobetasol TEMOVATE/E TOPICORT 0.25% (C) triamcinolone 0.5% ULTRAVATE 0.05%				

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DERMATOLOGY continued	IMMUNOMODULATORS		Trial and failure of a preferred medium potency topical corticosteroid greater than or equal to a 21 day trial <u>and</u> a trial and failure of a preferred high potency topical corticosteroid greater than or equal to a 21 day trial in the last 90 days. For clients less than two (2) years of age, a trial and failure of a preferred low potency corticosteroid greater than or equal to a 21 day trial <u>and</u> a trial and failure of a preferred medium potency topical corticosteroid greater than or equal to a 21 day trial in the last 90 days.		
		ELIDEL tacrolimus ointment			
	PLAQUE PSORIASIS (PP)		Client must have diagnosis of PP prior to approval of a step 1 agent (Enbrel or Humira). To receive the step 2 agent (Cosentyx), client must have a diagnosis of PP and a 56-day trial and failure of Humira. To receive a non-preferred agent, client must have a diagnosis of PP and a 56-day trial and failure of both preferred agents.		
	STEP 1 AGENTS				
		ENBREL HUMIRA			
	STEP 2 AGENT				
		COSENTYX			
	SALICYLIC ACID				All other topical salicylic acid formulations.
		salicylic acid cream 6% salicylic acid lotion 6% salicylic acid shampoo 6%			
	SCABICIDES/PEDICULICIDES		Trial and failure of a preferred agent in the last 12 months.		LINDANE OVIDE
	NATROBA permethrin SKLICE				
UREA			All other topical urea formulations.		
	ALLVEEA CREAM 33% UMECTA EMULSION umecta mousse aerosol 40% urea lotion 40% urea lotion 45%				
DIABETES	DIABETES AGENTS			metformin SR 24HR osmotic release (<i>use preferred agent</i>) metformin SR 24HR modified release (<i>use preferred agent</i>) RIOMET (<i>use preferred agent</i>)	
	BIGUANIDES				
		metformin/ER			
	α-GLUCOSIDASE INHIBITORS		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	GLYSET*	
		acarbose			
	MEGLITINIDES		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	repaglinide	
		nateglinide			
	THIAZOLIDINEDIONES		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ACTOSPLUS MET (<i>use separate agents</i>) AVANDIA AVANDAMET (<i>use separate agents</i>)	
		pioglitazone			
	SULFONYLUREAS		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.		
		glimepiride/ER gliplizide/ER glyburide/ER			
	DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITORS		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	alogliptin GLYXAMBI (<i>use separate preferred agents</i>) ONGLYZA TRADJENTA	
		JANUVIA			
	DPP-4 INHIBITOR COMBO AGENTS		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	alogliptin/metformin alogliptin/pioglitazone (<i>use separate preferred agents</i>) JENTADUETO JUVISYNC (<i>use separate preferred agents</i>) KOMBIGLYZE	
		JANUMET/XR			
	INCRETIN MIMETICS (GLP-1 RECEPTOR AGONISTS)		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent. Dosage Limits Apply: Victoza: 1.8mg/day	ADLYXIN BYDUREON SOLIQUA TANZEUM TRULICITY	
		BYETTA VICTOZA			
SGLT2 INHIBITORS		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	FARXIGA GLYXAMBI (<i>use separate preferred agents</i>) INVOKAMET/XR (<i>use separate preferred agents</i>) INVOKANA SYNJARDY (<i>use separate preferred agents</i>) XIGDUO XR (<i>use separate preferred agents</i>)		
	JARDIANCE				
LONG-ACTING INSULIN		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently	LANTUS OPTICLIK (<i>use preferred agent</i>) TOUJEO (<i>use preferred agent</i>) TRESIBA (<i>use preferred agent</i>)		
	LANTUS SOLOSTAR LANTUS vial LEVEMIR				
DIABETIC METERS/TEST STRIPS		Quantity limits apply: Insulin Dependent Clients: 10 strips/day Non-Insulin Dependent Clients: 4 strips/day Clients are limited to 1 meter/365 days	ALL OTHER METERS AND TEST STRIPS		
	FREESTYLE INSULINX FREESTYLE LITE FREESTYLE FREEDOM LITE ONE TOUCH ULTRA ONE TOUCH ULTRA 2 ONE TOUCH ULTRA MINI ONE TOUCH ULTRASMART ONE TOUCH VERIO ONE TOUCH FLEX PRECISION XTRA				

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EAR	ANTIBIOTIC/STEROID COMBINATION			ciprofloxacin 0.2% (use preferred agent) CIPRO HC (use preferred agent) COLY-MYCIN S (use preferred agent) CORTISPORIN-TC (use preferred agent) FLUOCINOLONE ACET OIL 0.01% (use preferred agent) ofloxacin (use preferred agent)			
	CIPRODEX Neo/Poly/HC Suspension and Solution						
FIBROMYALGIA	FIBROMYALGIA STEP 1						
	amitriptyline cyclobenzaprine						
	FIBROMYALGIA STEP 2		SAVELLA	Trial and failure of a Step 1 agent greater than or equal to six (6) weeks in the last 12 months is required for approval of a Step 2 agent.			
	FIBROMYALGIA STEP 3		duloxetine LYRICA	Trial and failure of a Step 1 agent and a Step 2 agent greater than or equal to six (6) weeks in the last 12 months is required for approval of a Step 3 agent. Dosage Limits Apply: Lyrica: 600mg/day			
GASTROINTESTINAL	DIGESTIVE ENZYMES		CREON ZENPEP	Prior authorization required.	PANCREAZE pancrelipase PERTZYE TRI-PASE ULTRESA VIOKASE		
	IRRITABLE BOWEL SYNDROME AGENTS			AMITIZA LINZESS	Client must have a diagnosis of chronic idiopathic constipation or Irritable Bowel Syndrome (IBS) with constipation.		
	PREGNANCY INDUCED NAUSEA/VOMITING			DICLEGIS			
	OPIOID-INDUCED CONSTIPATION AGENTS			AMITIZA	Client must have a diagnosis of opioid-induced constipation and a three (3) month trial and failure of a secretory agent to receive the preferred agent. To receive the non-preferred agent, client must have a diagnosis of opioid-induced constipation, a three (3) month trial and failure of a secretory agent, and a three (3) month trial and failure of the preferred agent. Movantik will be approved with a diagnosis of cancer or for clients in hospice or palliative care.	MOVANTIK*	
	PROTON PUMP INHIBITORS			lansoprazole capsules omeprazole capsules pantoprazole	Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Lansoprazole solutabs will be approved for children less than or equal to 8 years of age.	ACIPHEX SPRINKLES amox/clarith/lanso pack (use separate agents) DEXILANT esomeprazole 24.65mg and 49.3mg lansoprazole solutabs NEXIUM* omeprazole 20.6mg capsules (use preferred agent) omeprazole tablets (use preferred agent) omeprazole/sodium bicarbonate OMECLAMOX (use separate agents) rabeprazole VIMOVO (use separate agents)	
	MESALAMINE			mesalamine enema PENTASA	Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	APRISO ASACOL/HD CANASA DELZICOL GIAZO LIALDA ROWASA	
	GOUT	COLCHICINE			MITIGARE	colchicine (use preferred agent) COLCRYS (use preferred agent)	
XANTHINE OXIDASE AND URAT1 INHIBITORS			allopurinol ULORIC	Trial and failure of a preferred agent greater than or equal to a 60 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. *Concurrent use of a preferred agent will be required with Zurampic.	ZURAMPIC*		
HEMATOLOGY	LOW MOLECULAR WEIGHT HEPARIN (LMWH)			enoxaparin	Prior authorization will be required for the 300mg/3ml strength.	FRAGMIN (use preferred agent) LOVENOX 300MG/3ML*	
	DIRECT THROMBIN INHIBITOR				PRADAXA	Client must have diagnosis of non-valvular atrial fibrillation and relative contraindication to warfarin for approval, treatment for deep vein thrombosis (DVT) or pulmonary embolism (PE), or for the reduction in the risk of recurrence of DVT and PE after initial therapy.	
	SELECTIVE FACTOR XA INHIBITOR				ELIQUIS XARELTO	Client must have diagnosis of non-valvular atrial fibrillation, treatment for deep vein thrombosis (DVT) prophylaxis in knee or hip replacement, treatment of DVT and pulmonary embolism (PE), and for the reduction in the risk of recurrent DVT and PE after initial therapy.	SAVAYSA (use preferred agent)
	THIENOPYRIDINE DERIVATIVES				clopidogrel EFFIENT ticlopidine	Prior authorization required for clients on antiplatelet therapy greater than one (1) year.	
	CPTP DERIVATIVES					Prior authorization is required.	BRILINTA
	PAR-1 ANTAGONIST					Client must have diagnosis of reduction of thrombotic cardiovascular events with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD). Must be used in conjunction with aspirin or clopidogrel.	
					ZONTIVITY		

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HEPATITIS C	NSSA INHIBITOR		Limited to FDA approved indication. Prior authorization will be required prior to use of Daklinza. Please submit PA requests on the Hepatitis CPA form available at www.wymedicaid.org .	
		DAKLINZA		
	NUCLEOTIDE ANALOG POLYMERASE INHIBITOR		Limited to FDA approved indication. Prior authorization will be required prior to use of Sovaldi. Please submit PA requests on the Hepatitis C PA form available at www.wymedicaid.org .	
		SOVALDI		
	PROTEASE INHIBITOR		Limited to FDA approved indication. Prior authorization will be required prior to use of Olysio. Please submit PA requests on the Hepatitis C PA form available at www.wymedicaid.org .	
	OLYSIO			
HEP C COMBO AGENTS		Limited to FDA approved indication. Prior authorization will be required prior to use of Harvoni, Technivie, Viekira Pak, or Zepatier. *Testing for the presence of virus with NSSA resistance-associated polymorphisms will be required prior to Zepatier being approved. Ribavirin will be required for any client that is positive for the above mentioned polymorphism. Please submit PA requests on the Hepatitis CPA form available at www.wymedicaid.org .		
		EPCLUSA HARVONI TECHNIVIE VIEKIRA PAK/XR ZEPATIER*		
HIDRADENITIS SUPPURATIVA	IMMUNOMODULATORS		Humira will not be covered as a first line agent for the diagnosis for hidradenitis suppurativa.	
		HUMIRA		
HORMONES	GROWTH HORMONE		PA is required for use outside of FDA-approved indications. Evaluation by an endocrinologist is preferred. Clinical evidence of improved growth will be required on a yearly basis to support ongoing utilization. Clinical evidence of need for growth hormone will be required for adult growth hormone deficiency and pediatric growth failure due to inadequate endogenous growth hormone. Trial and failure of two (2) preferred agents within the last 12 months will be required for the following indications: Pediatric: Growth failure due to inadequate endogenous growth hormone, Prader-Willi syndrome, children born small for gestation, Turner syndrome. Adult: Replacement for those with growth hormone deficiency.	HUMATROPE OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBIVIE
		GENOTROPIN NORDITROPIN NUTROPIN AQ		
	PROGESTIN		Prior authorization is required.	
		MAKENA		
	TESTOSTERONE TOPICAL GELS		Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient testosterone production. <i>Other testosterone dosage form products will require a diagnosis of hypogonadism or insufficient testosterone production (not outlined on PDL).</i>	NATESTO NASAL GEL (use preferred agent) TESTIM GEL (use preferred agent) testosterone gel 1% (BRAND IS PREFERRED) testosterone gel 2% (use preferred agent) VOGELXO GEL (use preferred agent)
	ANDROGEL*			
ORAL CONTRACEPTIVES				amethia/LO (BRAND IS PREFERRED) aranelle (use preferred agent) ashlyna (BRAND IS PREFERRED) BEYAZ (PA required) BREVICON (use preferred agent) camrese/LO (BRAND IS PREFERRED) daysee (BRAND IS PREFERRED) drospir/ethi (use preferred agent) estarylla tri-lo (BRAND IS PREFERRED) FALESSA KIT (use preferred agent) introvale (use preferred agent) layolis FE chewable (PA required) levonorgest/ethinyl estrad (91-Day) levonorgest/ethinyl estradiol (Continuous) (use preferred agent) levonorgest/ethinyl estradiol/LO (84-7) (BRAND IS PREFERRED) LO LOESTRIN (PA required) LO MINASTRIN FE (PA required) loryna (use preferred agent) MINASTRIN 24 FE CHEWABLE (PA required) NATAZIA (PA required) norgest/ethi estradiol lo (BRAND IS PREFERRED) NATAZIA (PA required) NECON 1/50-28 (use preferred agent) nikki (use preferred agent) noreth/ethin FE chewable (PA required) NORINYL 1/35 (use preferred agent) quasense (use preferred agent) QUARTETTE (PA required) SAFYRAL (PA required) tri-lo sprintec (BRAND IS PREFERRED) trinessa lo (BRAND IS PREFERRED) wymzya FE chewable (BRAND IS PREFERRED) zenchent FE chewable (BRAND IS PREFERRED)
	altavera alyacen 1-35, 7/7/7 amethyst azurette apri aubra aviane balziva bekyree blisovi 1-20 FE/24, 1.5-30 FE briellyn camila caziant chateal cyclafem 1-35, 7/7/7 cyred cryselle dasetta 1-35, 7/7/7 deblitane delyla DESOGEN deso/ethinyl estradiol elinest emoquette enpresse enskyce errin estarylla falmina FEMCON FE CHEWABLE gianvi gildagla gildess 1-20/FE/24, 1.5-30/FE heather			

WYOMING MEDICAID
Preferred Drug List (PDL) - April 5, 2017

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>PLEASE CONTACT US FOR QUESTIONS</small>
HORMONES continued	jencycla jolessa jolivette juleber junel 1-20/FE/24, 1.5-30/FE kariva kelnor kimidess kurvelo larin 1-20/FE/24, 1.5-30/FE leena lessina levonest levonor/ethi levora lomedica 24 FE LOSEASONIQUE* low-ogestrel lutera lyza marlissa microgestin 1-20/FE/24, 1.5-30/FE MODICON mono-linyah mononessa myzila NECON 0.5-35, 1-35, 7/7/7, 10/11-28 nora-be norgest/ethinyl estradiol norethindrone norlyroc noreth/ethin 1-20/FE/24 NORINYL 1/50-28 nortrel 0.5-35, 1-35, 7/7/7 ocella OGESTREL orsythia ORTHO TRI-CYCLEN LO* ORTHO-NOVUM 1/35, 7/7/7* phlith pimtrea pirmella 1-35, 7/7/7 portia previfem reclipfen SEASONIQUE* setlakin sprintec sharobel sronyx syeda tilia FE tri-estanyl tri-legest FE tri-linyah trinessa TRI-NORINYL* tri-previfem tri-sprintec trivora velivet vestura vienna viorele vyfemla wera 0.5-35 YAZ zarah zenchent ZOVIA			

WYOMING MEDICAID
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HYPERLIPIDEMIA	BILE ACID SEQUESTRANT		Trial and failure of ALL preferred agents greater than or equal to six (6) months in the last 12 months will be required before approval can be given for a non-preferred agent.	WELCHOL
	cholestyramine/light colestipol			
	STATINS, LOW POTENCY		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization. Prior authorization will be required for clients under the age of 10.	fluvastatin/ER
	lovastatin pravastatin			
	STATINS, HIGH POTENCY		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization. Prior authorization will be required for clients under the age of 10.	LIVALO rosuvastatin
	atorvastatin simvastatin			
STATIN COMBINATIONS		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Prior authorization will be required for clients under the age of 10.	amlodopine/atorvastatin (BRAND IS PREFERRED)	
CADUET* VYTORIN				
TRIGLYCERIDE LOWERING AGENTS		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ANTARA fenofibric fenofibrate 43, 50, 120, 130, and 150mg LIPOFEN omega-3-acid VASCEPA	
fenofibrate 48, 54, 67, 134, 145, 160, and 200mg gemfibrozil				
HYPERTENSION	ACE INHIBITORS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	
	benazepril captopril enalapril fosinopril lisinopril moexipril perindopril quinapril ramipril trandolapril			
	ACE INHIBITORS AND DIURETICS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	
	benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ moexipril/HCTZ quinapril/HCTZ			
	ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)		Trial and failure of an ACE Inhibitor greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for preferred ARB. Non-preferred ARBs and ARB/diuretic combinations also require a history of ALL preferred ARBs before approval can be given.	BENICAR candesartan EDARBI eprosartan 600mg telmisartan TEVETEN 400mg
	irbesartan losartan valsartan			
	ARBs AND DIURETICS		Trial and failure of an ACE Inhibitor greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for preferred ARB. Non-preferred ARBs and ARB/diuretic combinations also require a history of ALL preferred ARBs before approval can be given.	BENICAR HCT candesartan HCTZ EDARBYCLOR telmisartan HCTZ TEVETEN HCTZ valsartan HCTZ
irbesartan HCTZ losartan HCT				
ALPHA-BLOCKERS			clonidine patch (BRAND IS PREFERRED) NEXICLON XR (use preferred agent)	
CATAPRES PATCHES* clonidine				
INFECTIOUS DISEASE	QUINOLONES			FACTIVE moxifloxacin NOROXIN PROQUIN
	ciprofloxacin/ER levofloxacin ofloxacin			
	DOXYCYCLINE			ADOXA (use preferred agent) DORYX (use preferred agent) ORACEA (use preferred agent) SOLODYN (use preferred agent)
	doxycycline			
	MINOCYCLINE			
	minocycline/ER			
	INHALED TOBRAMYCIN		*Tobi Podhaler requires a 28 day trial of a preferred agent, as well as 28 days off of that same preferred agent prior to approval. Minimum day supply of at 56 days is required	inhaled tobramycin (use preferred agent)
BETHKIS KITABIS	TOBI PODHALER*			
ANTI-RETROVIRALS			NORVIR solution (use preferred agent)	
	DESCOVY EVOTAZ GENVOYA NORVIR tablets/capsules ODEFSEY PREZCOBIX			

WYOMING MEDICAID
Preferred Drug List (PDL) - April 5, 2017

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INFLAMMATION	NSAIDs		Trial and failure of two (2) preferred agents each greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Dosing and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets).	CALDOLOR (use preferred agent) CAMBIA POWDER (use preferred agent) celecoxib diclofenac 1.5% solution (additional criteria applies) diclofenac 3% gel (additional criteria applies) fenoprofen FLECTOR (additional criteria applies) mefenamic acid NEOPROFEN (use preferred agent) SPRIX (additional criteria applies) TIVORBEX (use preferred agent) VIVLODEX (use preferred agent) VOLTAREN (additional criteria applies) ZIPSOR (use preferred agent) ZORVOLEX (use preferred agent)		
	ORAL CORTICOSTEROIDS			CELESTONE (use preferred agent)		
INNSOMNIA	NON-BENZODIAZEPINES		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Prior authorization will be required for clients under the age of 18. Rozerem is non-preferred without a history of substance abuse Prior authorization will be required when a client is taking more than one insomnia agent concurrently. Dosage limits apply: zaleplon: 30mg/day zolpidem: 15mg/day	BELSOMRA (additional criteria applies) EDLUAR (additional criteria applies) eszopiclone INTERMEZZO (additional criteria applies) ROZEREM zolpidem ER ZOLPIMIST (additional criteria applies)		
	ALZHEIMER AGENTS		Client must have a diagnosis of dementia.	donepezil 23mg (use preferred agent) rivastigmine patches (BRAND IS PREFERRED) NAMENDA XR NAMZARIC (use separate agents)		
MENTAL HEALTH	ANTIDEPRESSANTS		Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks WITHIN THE LAST 2 YEARS will be required before approval can be given for a non-preferred agent. One of the trials of preferred agents must be in the same class (NaSS, NDRI, SSRI, or SNRI) as the requested non-preferred agent. Trazodone, bupropion, fluvoxamine, MAO inhibitors, TCA's, bupropion IR, and venlafaxine IR do not require prior authorization but will not count towards meeting preferred therapy requirements. Clients will not be allowed to be on more than one antidepressant, including fluvoxamine, bupropion IR, and venlafaxine IR, at one time with the exception of mirtazapine or bupropion with a SSRI or SNRI. **Duloxetine will be approved for clients with a diagnosis of osteoarthritis of the knee or chronic low back pain. ***Trintellix requires trial and failure of two preferred agents in any class Clients five (5) years of age and younger will require prior authorization before approval. Dosage limits apply: bupropion ER/SR/XL: 450mg/day citalopram < 60 years of age: 60mg/day citalopram > 60 years of age: 30mg/day escitalopram: 30mg/day fluoxetine < 18 years of age: 90mg/day fluoxetine > 18 years of age: 120mg/day mirtazapine: 67.5mg/day paroxetine IR/CR < 18 years of age: 75mg/day paroxetine IR > 18 years of age: 90mg/day paroxetine CR > 18 years of age: 112.5mg/day sertraline: 300mg/day venlafaxine ER: 337.5mg/day	donepezil 23mg (use preferred agent) rivastigmine patches (BRAND IS PREFERRED) NAMENDA XR NAMZARIC (use separate agents)		
	NORADRENERGIC/SPECIFIC SEROTONERICS (NaSS)					NaSS mirtazapine 7.5mg and rapid dissolve tablets (use preferred agent)
	NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)					NDRI APLENZIN FORFIVO XL
	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)					SSRI fluoxetine tablets (use preferred agent) VIIBRYD
	SEROTONIN/NORPINEPHRINE REUPTAKE INHIBITORS (SNRI)					SNRI duloxetine** desvenlafaxine FETZIMA PRISTIQ venlafaxine ER Tablets (use preferred agent)
						OTHER TRINTELLIX***

WYOMING MEDICAID
Preferred Drug List (PDL) - April 5, 2017

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MENTAL HEALTH continued	ATYPICAL ANTIPSYCHOTICS		<p>**Quetiapine doses less than 100mg will require prior authorization <u>without</u> a diagnosis of mood disorder or major depressive disorder. For titration doses, contact the GHS Pharmacy Help Desk for an override.</p> <p>Clients five (5) years of age and younger will require prior authorization before approval.</p> <p>*Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for REXULTI or VRAYLAR.</p> <p>Dosage limits apply: aripiprazole <13 years of age: 23mg/day aripiprazole ≥13 years of age: 45mg/day FANAPT: 36mg/day INVEGA: 18mg/day LATUDA: 240mg/day olanzapine <13 years of age: 15mg/day olanzapine ≥13 years of age: 30mg/day quetiapine <13 years of age: 600mg/day quetiapine 13-17 years of age: 900mg/day quetiapine >17 years of age: 1200mg/day risperidone ≤ 17 years of age: 5mg/day risperidone >17 years of age: 24mg/day SAPHRIS: 30mg/day ziprasidone ≤17 years of age: 180mg/day ziprasidone >17 years of age: 300mg/day</p>	aripiprazole ODT (BRAND IS PREFERRED) paliperidone (BRAND IS PREFERRED) REXULTI* SEROQUEL XR (use preferred agent) VRAYLAR*
	SPECIAL ATYPICAL ANTIPSYCHOTICS		Dosage limits apply: 1350mg/day	VERSACLOZ Suspension (use preferred agent)
	clozapine/ODT			
AMPHETAMINES				
LONG ACTING AMPHETAMINES		ADDERALL XR* ADZENYS XR ODT DEXEDRINE CAPSULES* VYVANSE**	Clients over the age of 17 must have a diagnosis for ADD, ADHD, narcolepsy, obstructive sleep apnea, shift work sleep disturbance, MS fatigue (see MS Fatigue criteria below), or refractory depression (see refractory depression criteria below).	AMPHETAMINES
IMMEDIATE RELEASE AMPHETAMINES		amphetamine salts combo* dextroamphetamine tablets	Diagnosis of MS fatigue will require a fatigue severity scale score of 5.0, a 60-day trial of amantadine and discontinuation of medications that may contribute to drowsiness and fatigue.	amphetamine salts combo XR (BRAND IS PREFERRED) dextroamphetamine CR capsules (BRAND IS PREFERRED) DYNAVEL ZENZEDI 2.5 AND 7.5MG TABLETS
METHYLPHENIDATES				
LONG ACTING METHYLPHENIDATES		DAYTRANA FOCALIN XR* methylin ER methylphenidate ER/CR/SA/SR tablets***	Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant.	METHYLPHENIDATES
IMMEDIATE RELEASE METHYLPHENIDATES		dexmethylphenidate methylin tablets methylphenidate tablets	Prior Authorization will be required for clients under the age of 4.	APTENSIO XR dexmethylphenidate ER (BRAND IS PREFERRED) methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA) QUILLICHEW QUILLIVANT XR SUSPENSION
			<p>**Vyvanse will be approved for the diagnosis of binge-eating disorder for clients 18 years of age and older. Authorizations will be approved for 12 weeks, and further use of Vyvanse for this diagnosis will require additional documentation prior to approval.</p> <p>***Only authorized generics for Concerta will be covered.</p> <p>Claims will require Prior Authorization if clients have a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use.</p> <p>Trial and failure of two (2) preferred agents (each from a different class: methylphenidate and amphetamine) greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>Dosage limits apply: amphetamine salts combo XR: 60mg/day amphetamine salts combo: 60mg/day amphetamine salts combo (narcolepsy): 90mg/day DAYTRANA: 45mg/9 hour patch/day dextroamphetamine: 90mg/day dextroamphetamine CR: 90mg/day dexmethylphenidate: 30mg/day FOCALIN XR < 13 years of age: 45mg/day FOCALIN XR > 13 years of age: 60mg/day methylin/methylphenidate/ER: 90mg/day VYVANSE: 105mg/day</p>	

WYOMING MEDICAID
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MENTAL HEALTH continued	SELECTIVE ALPHA-ADRENERGIC AGONIST		To obtain the non-preferred agent , client must meet the following criteria: Client must have a diagnosis of ADD or ADHD Prior authorization will be required for clients under the age of 4. To receive Kapvay, clients must have completed a 14 day trial of clonidine IR with benefit in the previous 12 months.	KAPVAY*
	clonidine			
	GUANFACINE AGENTS		To obtain the non-preferred agent , client must meet the following criteria: Client must have a diagnosis of ADD or ADHD Prior authorization will be required for clients under the age of 4. To receive Intuniv, clients must have: A) a trial and failure of a stimulant greater than or equal to a 14 day supply, or B) a trial and failure of Strattera greater than or equal to a 30 day supply, or C) a contraindication to ADHD medications (including stimulant and non-stimulant), or D) a diagnosis of a TIC disorder, AND E) a 14 day trial of guanfacine with benefit in the previous 12 months.	guanfacine ER
guanfacine				
	SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR		Clients must have a diagnosis for ADD, ADHD, narcolepsy, obstructive sleep apnea, shift work sleep disturbance, or refractory depression (see refractory depression criteria below). Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant. Prior Authorization will be required for clients under the age of 4. Claims will require Prior Authorization if clients have a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use. Dosage limits apply: STRATTERA: 150mg/day	
		STRATTERA		
MIGRAINE	TRIPTANS		Trial and failure of two preferred agents will be required for approval of a non-preferred agent. Rizatriptan will be approved for clients between 6 and 17 years of age Quantity limits apply: naratriptan 1mg: 25 tabs/34 days naratriptan 2.5mg: 10 tabs/34 days RELPAK 20mg: 20 tabs/34 days RELPAK 40mg: 14 tabs/34 days sumatriptan vials: 2 vials/34 days sumatriptan nasal: 6 bottles/34 days sumatriptan 25mg: 41 tabs/34 days sumatriptan 50mg: 20 tabs/34 days sumatriptan 100mg: 10 tabs/34 days	almotriptan frovatriptan ONZETRA (use preferred agent) rizatriptan TREXIMET ZEMBRACE (use preferred agent) zolmitriptan
	naratriptan RELPAK sumatriptan			
MULTIPLE SCLEROSIS	STEP 1 MS AGENTS		Trial and failure of one injectable preferred agent will be required before approval can be given for the step 2 MS agent (Gilenya).	COPAXONE 40MG/ML (use preferred agent) EXTAVIA LEMTRADA PLEGRIDY TECFIDERA TYSABRI (additional criteria applies) ZINBRYTA
	IMMUNOMODULATOR (GLATIRAMER INJECTION)			
	COPAXONE 20MG/ML			
	INTERFERON			
	AVONEX BETASERON REBIF			
	PYRIMIDINE SYNTHESIS INHIBITOR			
AUBAGIO		For Tysabri, in addition to the above criteria, additional prior authorization criteria applies.		
STEP 2 MS AGENTS				
GILENYA				
NEUROPATHIC PAIN	TRICYCLIC ANTIDEPRESSANTS		For the diagnosis of neuropathic pain, trial and failure of a tricyclic antidepressant greater than or equal to a 12 week supply AND trial and failure of gabapentin at a dose of 3600mg per day for greater than or equal to a 12 week supply in the last 12 months will be required before approval can be given for a non-preferred agent.	duloxetine LYRICA
	amitriptyline desipramine imipramine nortriptyline			
	GABAPENTIN			
		gabapentin		

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OPHTHALMICS	OP. -ANTI-ALLERGENICS		<p>Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>Emadine, Alomide, and Alocril will be approved for pregnancy.</p> <p>Alomide will be approved for children under the age of 3.</p>	ALAMAST ALOCRIL ALOMIDE ALREX azelastine BEPREVE EMADINE epinastine ketotifen LASTACRAFT PATADAY		
	cromolyn olopatadine PAZEO					
	OP. -ANTIBIOTICS- QUINOLONES				<p>Trial and failure of a preferred agent greater than or equal to 5 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>Azasite will be approved for pregnancy.</p>	AZASITE BESIVANCE gatifloxacin IQIUX levofloxacin ZYMAR
	ciprofloxacin ofloxacin MOXEZA VIGAMOX					
	OP. -ANTI-INFLAMMATORY				<p>Trial and failure of ALL preferred agents each greater than or equal to 5 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p>	ACULAR/LS/PF (use preferred) ACUVAIL bromfenac 0.9% BROMSITE NEVENAC PROLENSA
	flurbiprofen diclofenac DUREZOL LOTEMAX ketorolac ILEVRO					
	OP. -BETA-BLOCKERS				<p>Trial and failure of three (3) preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>Betoptic S will be approved for those with heart and lung conditions.</p>	BETIMOL BETOPTIC S ISTALOL
	betaxolol carteolol levobunolol metipranolol timolol					
	OP. -CARBONIC ANHYDRASE INHIBITOR				<p>Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p>	AZOPT
	dorzolamide					
OP. - COMBO PRODUCTS		<p>Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p>				
COMBIGAN dorzolamide/timolol SIMBRINZA						
OP. - LFA-1 ANTAGONIST						
XIIDRA						
OP. -PROSTAGLANDINS		<p>Trial and failure of ALL preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p>	bimatoprost LUMIGAN 0.1% ZIOPTAN			
latanoprost TRAVATAN Z						
OP. -SYMPATHOMIMETICS		<p>Trial of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.</p>	ALPHAGAN P 0.1% brimonidine 0.15% (BRAND IS PREFERRED)			
ALPHAGAN P 0.15%* brimonidine 0.2%						
OSTEOPOROSIS	BISPHOSPHONATES		<p>Trial and failure of a preferred agent greater than or equal to 12 months will be required before approval can be given for a non-preferred agent.</p> <p>Fosamax liquid will be approved for clients that have difficulty swallowing.</p>	risedronate ATELVIA FOSAMAX-D ibandronate		
	alendronate					
NASAL CALCITONIN						
calcitonin-salmon fortical						
OVERACTIVE BLADDER	OVERACTIVE BLADDER AGENTS		<p>Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>Oxytrol will be approved for clients that have an inability to swallow.</p>	darifenacin GELNIQUE GEL 10% MYRBETRIQ OXYTROL DIS SANCTURA XR tolterodine/ER trospium		
oxybutynin /ER TOVIAZ VESICARE						

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>PLEASE CONTACT US FOR QUESTIONS</small>
PAIN	<p align="center">LONG-ACTING C-III's</p> <p>morphine sulfate ER <u>tablets</u></p>	<p>fentanyl patch 12.5, 25, 50, 75, and</p>	<p>Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>C-III's and C-IV's that are not included on the PDL and are available without prior authorization with the exception of Butrans (generic substitution is mandatory).</p> <p>Concurrent use of a narcotic and benzodiazepine will require prior authorization</p> <p>Fentanyl patches will require a prior authorization unless a client has a cancer diagnosis or previous treatment of at least a 10 day supply within the last 45 days</p> <p>**Butrans requires a trial of morphine sulfate ER or low dose trial of fentanyl patch.</p> <p>***Nucynta ER will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics.</p> <p>****In addition to above criteria, Embeda requires a diagnosis of drug/substance abuse.</p> <p>Fentanyl patches are limited to one patch every 72 hours.</p> <p>Belbuca: 1.8mg/day (1800mcg/day) Butrans: 20mcg, 1 strength at a time, 1 patch every 7 days Fentanyl: 75mcg, 1 strength at a time, 1 patch every 3 days Hysingla ER: 180mg/day Hydromorphone ER: 32mg/day Morphine ER: 180mg/day Methadone: Limited to 3 tablets per day Nucynta ER: 490.5mg/day Oxycontin: 120mg/day Oxymorphone ER: 60mg/day Xartemis XR: 120mg/day Xtampza ER: 120mg/day Zohydro ER: 180mg/day</p> <p>Clients will be limited to one long-acting narcotic at a time</p>	<p>AVINZA BELBUCA BUTRANS** EMBEDA**** fentanyl patch 37.5, 62.5, 87.5mg hydromorphone ER HYSINGLA ER (additional criteria applies) KADIAN 200mg (use preferred agent) METHADONE morphine sulfate ER capsules (use preferred) NUCYNTA ER*** oxymorphone ER OXYCONTIN XARTEMIS XR (additional criteria applies) XTAMPZA ER (additional criteria applies) ZOHYDRO ER (additional criteria applies)</p>
	<p align="center">SHORT-ACTING C-III's</p> <p>codeine sulfate hydrocodone/APAP hydrocodone/IBU hydromorphone LORTAB ELIXIR 10-300MG meperidine morphine sulfate oxycodone oxycodone/APAP oxycodone/ASA</p>		<p>Trial and failure of three (3) preferred agents greater than or equal to a 6 day supply in the last 90 days will be required before approval can be given for a non-preferred agent.</p> <p>*Nucynta will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics.</p> <p>Concurrent use of a narcotic and benzodiazepine will require prior authorization</p> <p>All short-acting narcotics, after 42 days of consecutive use of any combination of short-acting narcotics, will be limited to 6 tablets per day (liquids have specific dosing limits per medication - please refer to dosage limitation chart at www.wymedicaid.org)</p> <p>Clients will be limited to one short-acting narcotic at a time</p>	<p>levorphanol NUCYNTA* oxymorphone oxycodone/IBU</p>
	<p align="center">C-III/C-V AGENTS</p> <p>tramadol</p>		<p>Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>Quantity and dosage limits apply (max 8 tabs/day).</p> <p>**Butrans will require a 14 day trial and failure of tramadol IR and a 14 day trial and failure of tramadol ER prior to approval</p>	<p>BUTRANS** RYBIX ODT tramadol/apap tramadol ER capsules tramadol ER tablets</p>
PHOSPHATE BINDERS	<p align="center">PHOSPHATE BINDERS</p> <p>calcium acetate PHOSLYRA RENAGEL</p>		<p>Prior authorization required for non-preferred agents.</p>	<p>AURYXIA FOSRENOL sevelamer VELPHORO</p>
PROSTATE	<p align="center">5-ALPHA-REDUCTASE INHIBITORS</p> <p>finasteride</p>		<p>Trial and failure of a preferred agent greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p>	<p>dutasteride dutasteride/tamsulosin (use separate agents)</p>
	<p align="center">ALPHA BLOCKERS</p> <p>doxazosin tamsulosin terazosin</p>		<p>Trial and failure of a preferred agent greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p>	<p>alfuzosin dutasteride/tamsulosin (use separate agents) RAPAFLO</p>

WYOMING MEDICAID
Preferred Drug List (PDL) - April 5, 2017

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dosage limits apply), and the Wyoming Medicaid Provider Manual at http://wymedicaid.org for additional criteria.				
THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>PLEASE CONTACT US FOR QUESTIONS</small>
PULMONARY ANTIHYPERTENSIVES	5-ALPHA-REDUCTASE INHIBITORS		Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
		ADCIRCA REVATIO SUSPENSION sildenafil (Revatio A/B rated generic)		
	ENDOTHELIN RECEPTOR ANTAGONISTS		Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
		LETAIRIS TRACLEER		
	PROSTACYCLINE VASODILATORS		Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
	ORENITRAM			
PROSTACYCLINE RECEPTOR AGONIST		Prior authorization required.	UPTRAVI (<i>use preferred pulmonary HTN agent</i>)	
RESTLESS LEG SYNDROME	RESTLESS LEG SYNDROME gabapentin pramipexole ropinirole		Client must have a diagnosis of Restless Leg Syndrome (RLS). Trial and failure of gabapentin greater than or equal to 60 days <u>and</u> a trial and failure of a dopamine agonist greater than or equal to 60 days in the last 12 months will be required before approval can be given for a non-preferred agent. *Neupro will be approved for clients with difficulty swallowing or for clients with a diagnosis of Parkinson's Disease.	HORIZANT NEUPRO*
SKELETAL MUSCLE RELAXANTS	MUSCLE RELAXANTS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months, along with a medical diagnosis of muscle spasticity will be required before approval can be given for a non-preferred agent. Cyclobenzaprine will require a prior authorization for clients concurrently taking a tricyclic antidepressant.	carisoprodol chlorzoxazone cyclobenzaprine ER metaxalone methocarbamol orphenadrine tizanidine capsules (<i>use preferred agent</i>) Carisoprodol is limited to 84 tabs/365 days
		baclofen cyclobenzaprine tizanidine tablets		
ULCERATIVE COLITIS	IMMUNOMODULATORS		Client must have diagnosis of UC prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of UC and a 56-day trial and failure of the preferred agent.	REMICADE
UVEITIS	IMMUNOMODULATORS		Client must have diagnosis of non-infectious intermediate, posterior, and panuveitis in adult patients	