WYOMING MEDICAID
Preferred Drug List - Effective 06/01/10

Listed drugs are preferred. Drugs in the PDL classes that are not listed are non-preferred and require a PA.
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.

*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.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA
ALLERGY / ASTHMA	**ANTIHISTAMINES, MINIMALLY SEDATING**		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.
	cetirizine fexofenadine loratadine		
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		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.
	cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine		
	ANTICHOLINERGIC BRONCHODILATORS		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. Spiriva 5-day package will be allowed one (1) time per recipient.
	ATROVENT HFA ipratropium SPIRIVA		
	CORTICOSTEROID / BRONCHODILATOR COMBO'S		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. Advair 7 and 14-day package will be allowed one (1) time per recipient.
	ADVAIR ADVAIR HFA SYMBICORT		
	LEUKOTRIENE MODIFIERS		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 .
	SINGULAIR		
	LONG ACTING BRONCHODILATORS		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months Serevent 14-day package will be allowed one (1) time per recipient.
	SEREVENT		
	NASAL ANTIHISTAMINES		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.
	ASTELIN		
	NASAL STEROIDS		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. Rhinocort will be approved for pregnancy.
	fluticasone NASACORT AQ NASONEX VERAMYST		
	SHORT ACTING BRONCHODILATORS - INHALERS		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.
	MAXAIR PROAIR HFA VENTOLIN HFA		
	SHORT ACTING BRONCHODILATORS - NEBULIZERS		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.
	albuterol neb		
	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.
	ASMANEX AZMACORT budesonide FLOVENT HFA FLOVENTDISK PULMICORT QVAR		

WYOMING MEDICAID
Preferred Drug List - Effective 06/01/10

Listed drugs are preferred. Drugs in the PDL classes that are not listed are non-preferred and require a PA.
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.

*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.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA
ALZHEIMERS	**ALZHEIMER AGENTS**		
	ARICEPT COGNEX EXELON galantamine/ER NAMENDA		
ANDROGENS	**TESTOSTERONE TOPICAL GELS**		Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient testosterone production.
		ANDROGEL TESTIM GEL	
ANTIBIOTICS	**QUINOLONES**		
	AVELOX ciprofloxacin/ER FACTIVE LEVAQUIN NOROXIN ofloxacin		
ANALGESICS	**LONG-ACTING C-IIs**		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. Fentanyl patches are limited to one patch every 72 hours. C-IIIs and C-IVs are not included and are available without prior authorization (generic substitution is mandatory).
	fentanyl patch morphine sulfate		
	SHORT-ACTING C-IIs		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.
	codeine sulfate hydromorphone morphine sulfate oxycodone oxycodone/APAP oxycodone/ASA		
	TRAMADOL PRODUCTS		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. Quantity/dosage limits apply.
		tramadol	
ANGIOTENSIN MODULATORS	**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		

WYOMING MEDICAID
Preferred Drug List - Effective 06/01/10

Listed drugs are preferred. Drugs in the PDL classes that are not listed are non-preferred and require a PA.
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.

*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.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA
ANGIOTENSIN MODULATORS *Continued*	**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.
		AVAPRO BENICAR **COZAAR*** DIOVAN MICARDIS	
	ARBs AND DIURETICS		
		AVALIDE BENICAR-HCT DIOVAN-HCT **HYZAAR*** MICARDIS-HCT	
	ARB COMBINATIONS		
		AZOR EXFORGE/EXFORGE-HCT TWYNSTA	
ANTICOAGULANTS	**INJECTABLE ANTICOAGULANTS**		
	ARIXTRA FRAGMIN LOVENOX		
ANTIDEPRESSANTS	**STEP 1**		**Step 2** agents require a trial and failure of a *Step 1* agent greater than or equal to six (6) weeks prior to approval. **Step 3** agents require a trial and failure of a *Step 1* AND *Step 2* agent greater than or equal to six (6) weeks **EACH** prior to approval. **Aplenzin, Cymbalta*, Effexor XR, Lexapro, and Pristiq are Step 3 agents (non-preferred agents).** Trazodone, buspirone, fluvoxamine, MAO inhibitors, TCA's, bupropion IR and venlafaxine IR do not require prior authorization but will not count towards meeting Step Therapy requirements. Mirtazapine 7.5mg and mirtazapine rapid-dissolve tablets are non-preferred. *Cymbalta will be approved for a diagnosis of peripheral neuropathy. **Lexapro will be approved for adolescents between the ages of 12 - 17.
	bupropion ER/SR citalopram fluoxetine mirtazapine 15mg, 30mg, and 45mg paroxetine IR sertraline		
	STEP 2		
		bupropion XL paroxetine CR venlafaxine ER	
ANTIPSYCHOTICS	**ATYPICAL ANTIPSYCHOTICS**		All antipsychotic agents are limited to labeled maximum dose limits. Non-preferred agents (Fanapt and Saphris) require a trial of ALL preferred agents at max doses with the exception of clozapine.
	ABILIFY clozapine GEODON INVEGA INVEGA SUSTENNA RISPERDAL CONSTA risperidone SEROQUEL/XR ZYPREXA ZYPREXA RELPREVV		
ANTIVIRALS, ORAL	**HERPES AGENTS**		
	acyclovir famciclovir **VALTREX***		

WYOMING MEDICAID
Preferred Drug List - Effective 06/01/10

Listed drugs are preferred. Drugs in the PDL classes that are not listed are non-preferred and require a PA.
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.

*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.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA
CHOLESTEROL	**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.
	LESCOL/LESCOL XL 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.
	LIPITOR 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.
	ADVICOR CADUET SIMCOR		
	FIBRIC ACID DERIVATIVES		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.
	fenofibrate gemfibrozil TRICOR TRILIPIX		
	NICOTINIC ACID DERIVATIVES		Slo-Niacin is an over-the-counter product and is not covered.
	niacin NIACOR NIASPAN		
	INTESTINAL CHOLESTEROL ABSORPTION INHIBITOR		
	ZETIA		
CONTRACEPTIVES	**BIPHASIC ORAL CONTRACEPTIVES**		Monophasic and triphasic oral contraceptives are not included and are available without prior authorization. (generic substitution is mandatory)
	KARIVA LO-SEASONIQUE NECON 10/11 SEASONIQUE		
DIABETES	**DIABETES AGENTS**		
	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.
	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.
	STARLIX*		
	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.
	ACTOS		
	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 glipizide/ER glyburide/ER		

WYOMING MEDICAID
Preferred Drug List - Effective 06/01/10

Listed drugs are preferred. Drugs in the PDL classes that are not listed are non-preferred and require a PA.
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.

*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.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA
DIABETES Continued	**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**. Trial and failure of 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**. No concomitant use of insulin.
		ONGLYZA	
	DIABETIC METERS/TEST STRIPS		
	FREESTYLE LITE FREESTYLE FREEDOM LITE ONE TOUCH ULTRA ONE TOUCH ULTRA 2 ONE TOUCH ULTRA MINI ONE TOUCH ULTRASMART PRECISION XTRA		
EAR	**ANTIBIOTIC/STEROID COMBINATION SUSPENSIONS**		
	CIPRODEX CIPRO HC COLY-MYCIN S CORTISPORIN-TC Neomycin/Polymyxin B Sulfates/Hydrocortisone		
FIBROMYALGIA	**STEP 1**		
	amitriptyline cyclobenzaprine		
	STEP 2		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.
		SAVELLA	
	STEP 3		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.
		CYMBALTA LYRICA	
GASTROINTESTINAL	**DIGESTIVE ENZYMES**		
	ZENPEP		
	MESALAMINE		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 PENTASA 250MG ONLY		
	PROTON PUMP 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. Prevacid Solutabs will be approved for children less than or equal to 8 years of age. Pantoprazole will be allowed for clients on concurrent Plavix therapy.
	DEXILANT/KAPIDEX omeprazole		

WYOMING MEDICAID
Preferred Drug List - Effective 06/01/10

Listed drugs are preferred. Drugs in the PDL classes that are not listed are non-preferred and require a PA.
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.

*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.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA
GROWTH HORMONE	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.
		GENOTROPIN NUTROPIN OMNITROPE	
HEPATITIS C	INTERFERON		Trial and failure of preferred agent greater than or equal to 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Peg-Intron will be approved for pediatric patients (aged 18 and under), for retreatment, and for dosage adjustments that cannot be achieved with Pegasys.
	PEGASYS		
IMMUNOMODULATORS	IMMUNOMODULATORS		
	ALFERON N CIMZIA ENBREL 25MG ONLY HUMIRA INFERGEN INTRON A ILARIS KINERET ORENCIA REMICADE SIMPONI		
INSOMNIA	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. Rozerem is non-preferred without a history of substance abuse. Dosage limits apply.
		zaleplon zolpidem	
MIGRAINE	TRIPTANS		Trial and failure of ALL preferred agents each greater than or equal to 14 days in the last 12 months will be required before approval can be given for a non-preferred agent. Quantity limits apply.
		MAXALT MLT sumatriptan	

WYOMING MEDICAID
Preferred Drug List - Effective 06/01/10

Listed drugs are preferred. Drugs in the PDL classes that are not listed are non-preferred and require a PA.
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.

*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.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA
MULTIPLE SCLEROSIS	**MULTIPLE SCLEROSIS AGENTS**		Failure of one (1) interferon agent AND failure of Copaxone. For Tysabri, in addition to the above criteria, additional prior authorization criteria applies.
	AVONEX BETA SERON COPAXONE REBIF		
NSAIDS	**NON-SELECTIVE**		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.
	diclofenac etodolac fenoprofen flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate meloxicam nabumetone naproxen oxaprozin sulindac tolmetin		
	COX 2 INHIBITORS		Trial and failure of two (2) preferred non-selective NSAIDs greater than or equal to a 14 days supply in the last 12 months will be required before approval can be given for a non-preferred agent.
		CELEBREX	
OPHTHALMICS	**OP. -ANTIBIOTICS- QUINOLONES**		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. Azasite will be approved for pregnancy.
	ciprofloxacin ofloxacin VIGAMOX ZYMAR		
	OP. -ANTI-INFLAMMATORY- NSAIDS		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.
	ACULAR/LS/PF* flurbiprofen diclofenac		
	OP. -BETA-BLOCKERS		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. Betoptic S will be approved for those with heart and lung conditions.
	betaxolol carteolol levobunolol metipranolol timolol		

WYOMING MEDICAID
Preferred Drug List - Effective 06/01/10

Listed drugs are preferred. Drugs in the PDL classes that are not listed are non-preferred and require a PA.
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.

*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.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA
OPHTHALMICS *Continued*	**OP. -CARBONIC ANHYDRASE INHIBITOR**		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.
	dorzolamide		
	OP. -CARBONIC ANHYDRASE INHIBITOR COMBO		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.
	dorzolamide/timolol		
	OP. -MAST CELL STABILIZERS		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. Emadine, Alomide, and Alocril will be approved for pregnancy. Alomide will be approved for children under the age of 3.
	cromolyn ketotifen **OPTIVAR*** PATADAY PATANOL		
	OP. -PROSTAGLANDINS		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.
	LUMIGAN TRAVATAN Z		
	OP. -SYMPATHOMIMETICS		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.
	ALPHAGAN P brimonidine dipivefrin		
	OP. -SYMPATHOMIMETIC COMBO		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.
	COMBIGAN		
OSTEOPOROSIS	**BISPHOSPHONATES**		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. Fosamax liquid will be approved for clients that have difficulty swallowing.
	alendronate BONIVA		
	NASAL CALCITONIN		
	calcitonin-salmon fortical		
OVERACTIVE BLADDER	**OVERACTIVE BLADDER AGENTS**		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. Oxytrol will be approved for clients that have an inability to swallow.
	DETROL LA ENABLEX oxybutynin /ER SANCTURA / XR TOVIAZ VESICARE		
PROSTATE	**5-ALPHA-REDUCTASE INHIBITORS**		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.
	AVODART finasteride		
	ALPHA BLOCKERS		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.
	doxazosin terazosin UROXATRAL		
PULMONARY ANTIHYPERTENSIVES	**ENDOTHELIN RECEPTOR ANTAGONISTS**		
	LETAIRIS TRACLEER		

WYOMING MEDICAID
Preferred Drug List - Effective 06/01/10

Listed drugs are preferred. Drugs in the PDL classes that are not listed are non-preferred and require a PA.
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.

*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.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA
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.
	baclofen cyclobenzaprine tizanidine		
SMOKING CESSATION	**NICOTINE REPLACEMENT**		Generic bupropion SR needs to be an AB rated generic of Zyban. Concomitant use of Chantix with bupropion SR or other nicotine replacement therapies will not be allowed. Quantity limits apply.
		nicotine gum, lozenges, and patches	
	OTHER		
		bupropion SR CHANTIX	
STIMULANTS	**AMPHETAMINES**		Clients 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). 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. 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 5. 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. Dosing limits apply (150% of labeled max). Trial and failure of two (2) preferred agents (each from a different class: methylphenidate, amphetamine, stimulant like) 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.
	LONG ACTING AMPHETAMINES		
		ADDERALL XR*	
		VYVANSE	
	IMMEDIATE RELEASE AMPHETAMINES		
		amphetamine salts combo dextroamphetamine	
	STIMULANT LIKE		
		STRATTERA	
	METHYLPHENIDATES		
	LONG ACTING METHYLPHENIDATES		
		CONCERTA FOCALIN XR methylin ER methylphenidate ER/CR/SR	
	IMMEDIATE RELEASE METHYLPHENIDATES		
		FOCALIN* methylin (tabs) methylphenidate	
TOPICAL AGENTS	**BENZOYL PEROXIDE/CLINDAMYCIN COMBOs**		Acne combinations are limited to clients under the age of 21.
		ACANYA **BENZACLIN***	
	GENITAL WARTS		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.
	ALDARA*		
	IMMUNOMODULATORS		
	ELIDEL PROTOPIC		

WYOMING MEDICAID
Preferred Drug List - Effective 06/01/10

Listed drugs are preferred. Drugs in the PDL classes that are not listed are non-preferred and require a PA.
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.

*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.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA
TOPICAL AGENTS *Continued*	**MISC TOPICAL**	TAZORAC	Tazorac is allowed for clients with the diagnosis of psoriasis for all ages. For the treatment of acne vulgaris, acne combinations are limited to those clients under the age of 21.