WYOMING MEDICAID
Preferred Drug List (PDL) - October 1, 2010

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. Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List, Epocrates, and the Wyoming EqualityCare Provider Manual at http://wyequalitycare.org for additional criteria.

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	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT GHS FOR QUESTIONS
ALLERGY / ASTHMA	**ANTIHISTAMINES, MINIMALLY SEDATING** cetirizine fexofenadine loratadine		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.	ALAVERT CLARINEX XYZAL
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine		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.	ALAVERT D ALLEGRA-D CLARINEX-D
	ANTICHOLINERGIC BRONCHODILATORS ATROVENT HFA ipratropium SPIRIVA		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.	
	CORTICOSTEROID / BRONCHODILATOR COMBO'S ADVAIR ADVAIR HFA SYMBICORT		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.	DULERA
	LEUKOTRIENE MODIFIERS SINGULAIR		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 .	ACCOLATE ZYFLO
	LONG ACTING BRONCHODILATORS SEREVENT		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months will be Serevent 14-day package will be allowed one (1) time per recipient.	FORADIL
	NASAL ANTIHISTAMINES **ASTELIN***		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.	azelastine (BRAND IS PREFERRED) ASTEPRO PATANASE
	NASAL STEROIDS fluticasone NASACORT AQ NASONEX VERAMYST		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.	BECONASE AQ flunisolide NASALIDE NASAREL OMNARIS RHINOCORT
	SHORT ACTING BRONCHODILATORS - INHALERS MAXAIR PROAIR HFA VENTOLIN HFA		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.	ALUPENT PROVENTIL HFA XOPENEX HFA
	SHORT ACTING BRONCHODILATORS - NEBULIZERS albuterol neb		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.	ACCUNEB METAPROTERENOL PROVENTIL XOPENEX
	STEROID INHALANTS ASMANEX AZMACORT budesonide FLOVENT HFA FLOVENTDISK PULMICORT QVAR		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
ALZHEIMERS	**ALZHEIMER AGENTS** ARICEPT COGNEX **EXELON*** galantamine/ER NAMENDA			rivastigmine (BRAND IS PREFERRED)

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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). *Embeda requires trial of preferred and client must have diagnosis of drug/ substance abuse	AVINZA EMBEDA* KADIAN OPANA ER OXYCONTIN/CR
	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.	EXALGO levorphanol NUCYNTA OPANA IR oxycodone/IBU
	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 limits apply.	RYBIX ODT RYZOLT tramadol/apap tramadol ER
		tramadol		
ANDROGENS	**TESTOSTERONE TOPICAL GELS**		Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient testosterone production.	
		ANDROGEL TESTIM GEL		
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			
	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.	ATACAND losartan (BRAND IS PREFERRED) TEVETEN
		AVAPRO BENICAR **COZAAR*** DIOVAN MICARDIS		
	ARBs AND DIURETICS			ATACAND HCT losartan HCT (BRAND IS PREFERRED) TEVETEN HCT
		AVALIDE BENICAR HCT DIOVAN HCT **HYZAAR*** MICARDIS HCT		
	ARB COMBINATIONS			
		AZOR EXFORGE/EXFORGE-HCT TWYNSTA		
ANTIBIOTICS	**QUINOLONES**			PROQUIN
	AVELOX ciprofloxacin/ER FACTIVE LEVAQUIN NOROXIN ofloxacin			
ANTICOAGULANTS	**LOW MOLECULAR WEIGHT HEPARIN (LMWH)**			enoxaparin (BRAND IS PREFERRED)
	ARIXTRA FRAGMIN **LOVENOX***			

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ANTIDEPRESSANTS	**STEP 1**		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.	***fluoxetine 20mg tablets*** *(USE PREFERRED)* ***mirtazapine 7.5mg and mirtazapine rapid-dissolve tablets*** *(USE PREFERRED)*
	bupropion ER/SR citalopram fluoxetine mirtazapine 15, 30, and 45mg paroxetine IR sertraline			
	STEP 2		**Step 2** agents require a trial and failure of a Step 1 agent greater than or equal to six (6) weeks prior to approval.	
		bupropion XL paroxetine CR venlafaxine ER *tablets*		
	STEP 3		**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. *Cymbalta will be approved for a diagnosis of peripheral neuropathy. **Lexapro will be approved for adolescents between the ages of 12 - 17.	
		Aplenzin Cymbalta* Lexapro** Pristiq Venlafaxine ER *capsules*		
ANTIPSYCHOTICS	**ATYPICAL ANTIPSYCHOTICS**		Non-preferred agents (Fanapt and Saphris) require a trial of ALL preferred agents at max doses with the exception of clozapine. Dosing limits apply.	FANAPT SAPHRIS
		ABILIFY clozapine GEODON INVEGA INVEGA SUSTENNA RISPERDAL CONSTA risperidone SEROQUEL/XR ZYPREXA ZYPREXA RELPREVV		
ANTIVIRALS, ORAL	**HERPES AGENTS**			valacyclovir (BRAND IS PREFERRED)
	acyclovir famciclovir **VALTREX***			
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.	ALTOPREV
	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.	CRESTOR LIVALO
	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.	CHOLESTIN PRAVIGARD VYTORIN (use separate agents)
	ADVICOR CADUET SIMCOR			
	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 FENOGLIDE LOVAZA
	fenofibrate gemfibrozil TRICOR TRILIPIX			
	NICOTINIC ACID DERIVATIVES		*Slo-Niacin is an over-the-counter product and is not covered.	Slo-Niacin*
	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			

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DIABETES	**DIABETES AGENTS**			
	BIGUANIDES			
	metformin/ER			FORTAMET GLUMETZA RIOMET
	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.	nateglinide (BRAND IS PREFERRED) PRANDIN
	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.	AVANDIA
	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.	glibenclamide
	glimepiride/ER glipizide/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**. 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.	JANUVIA
		ONGLYZA		
	DIABETIC METERS/TEST STRIPS			ALL OTHER METERS AND 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**			
	CREON 6000, 12000, 24000 UNIT PANCREAZE TRI-PASE ZENPEP			
	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.	ACIPHEX lansoprazole NEXIUM omeprazole/bicarbonate pantoprazole PRILOSEC OTC VIMOVO (use separate agents)
	DEXILANT/KAPIDEX omeprazole			
	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.	ASACOL HD CANASA LIALDA *PENTASA 500MG (use Pentasa 250mg)* ROWASA
	APRISO ASACOL PENTASA 250MG ONLY			

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GROWTH HORMONE	**GROWTH HORMONE**	GENOTROPIN NUTROPIN OMNITROPE	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 NORDITROPIN SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE
HEPATITIS C	**INTERFERON** PEGASYS		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.	PEG-INTRON
IMMUNOMODULATORS	**IMMUNOMODULATORS (DIAGNOSIS REQUIRED)**	ENBREL 25MG/ML HUMIRA	Client must have ***diagnosis prior to approval*** for ***preferred agents*** *(outlined below)* : ***Enbrel 25mg/ml*** : Ankylosing Spondylitis (AS), Juvenile Idiopathic Arthritis (JIA), Plaque Psoriasis (PP), Psoriatic Arthritis (PA), Rheumatoid Arthritis (RA)** ***Humira*** : AS, Crohn's, JIA, PP, PA, RA** **60-day trial and failure of methotrexate required prior to approval of Enbrel or Humira for diagnosis of Rheumatoid Arthritis (RA) For *non-preferred agents* , 60-day trial and failure of a preferred agent is required and client must have diagnosis prior to approval (outlined below): *Actemra* : RA (60-day trial of methotrexate is required) *Amevive* : PP *Cimzia* : Crohn's***, RA *Kineret* : RA *Orencia* : JIA, RA *Remicade* : AS, Crohn's, PP, PA, RA, Ulcerative Colitis**** *Rituxan* : RA *Simponi* : AS, PA, RA *Stelara* : PP *Tysabri* : Crohn's *(additional PA criteria applies)* ****Cimzia will be allowed without a preferred trial for diagnosis of Crohn's* *****Remicade will be allowed without a preferred trial for diagnosis of Ulcerative Colitis*	ACTEMRA AMEVIVE CIMZIA *ENBREL 25MG/0.5ML (use Enbrel 25mg/mL)* *ENBREL 50MG (use Enbrel 25mg/mL)* KINERET ORENCIA RAPTIVA REMICADE RITUXAN SIMPONI STELARA TYSABRI (additional criteria applies)
INSOMNIA	**NON-BENZODIAZEPINES**	zaleplon zolpidem	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. Dosing limits apply.	AMBIEN CR EDLUAR LUNESTA ROZEREM
MIGRAINE	**TRIPTANS**	MAXALT MLT sumatriptan	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.	AXERT FROVA MAXALT naratriptan RELPAX TREXIMET ZOMIG

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MULTIPLE SCLEROSIS	**MULTIPLE SCLEROSIS AGENTS**		Trial and failure of one (1) interferon agent AND failure of Copaxone. For Tysabri, in addition to the above criteria, additional prior authorization criteria applies.	EXTAVIA TYSABRI (additional 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. Dosing limits apply for ketorolac.	CALDOLOR CAMBIA POWDER FLECTOR (additional criteria applies) NAPRELAN NEOPROFEN PENNSAID (additional criteria applies) SOLARAZE (additional criteria applies) VOLTAREN (additional criteria applies) ZIPSOR
	diclofenac etodolac fenoprofen flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate meloxicam nabumetone naproxen oxaprozin sulindac tolmetin			
	COX 2 INHIBITORS	CELEBREX	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.	
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.	AZASITE BESIVANCE IQUIX QUIXIN ZYMAXID
	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.	ACUVAIL ketorolac (BRAND IS PREFERRED) NEVANAC XIBROM
	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.	BETIMOL BETOPTIC S ISTALOL
	betaxolol carteolol levobunolol metipranolol timolol			
	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.	AZOPT
	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.	ALAMAST alaway ALOCRIL ALOMIDE ALREX azelastine (BRAND IS PREFERRED) BEPREVE claritin otc ELESTAT EMADINE zyrtec otc
	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.	XALATAN
	LUMIGAN TRAVATAN/TRAVATAN Z			

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OPHTHALMICS	**OP. -SYMPATHOMIMETICS** ALPHAGAN P brimonidine dipivefrin		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.	
	OP. -SYMPATHOMIMETIC COMBO COMBIGAN		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.	
OSTEOPOROSIS	**BISPHOSPHONATES** alendronate BONIVA		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.	ACTONEL FOSAMAX-D
	NASAL CALCITONIN calcitonin-salmon fortical			
OVERACTIVE BLADDER	**OVERACTIVE BLADDER AGENTS** DETROL LA ENABLEX oxybutynin /ER SANCTURA XR TOVIAZ trospium VESICARE		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 flavoxate GELNIQUE GEL 10% hyoscyamine OXYTROL DIS
PROSTATE	**5-ALPHA-REDUCTASE INHIBITORS** AVODART finasteride		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.	JALYN (use separate agents)
	ALPHA BLOCKERS doxazosin terazosin UROXATRAL		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.	JALYN (use separate agents) tamsulosin
PULMONARY ANTIHYPERTENSIVES	**ENDOTHELIN RECEPTOR ANTAGONISTS** LETAIRIS TRACLEER			
SKELETAL MUSCLE RELAXANTS	**MUSCLE RELAXANTS** baclofen cyclobenzaprine tizanidine		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.	AMRIX carisoprodol chlorzoxazone LIORESAL metaxalone methocarbamol orphenadrine
SMOKING CESSATION	**NICOTINE REPLACEMENT**	nicotine gum, lozenges, and patches	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.	
	OTHER	bupropion SR CHANTIX		

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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.	**AMPHETAMINES:** amphetamine salts combo ER (BRAND IS PREFERRED) DEXEDRINE DEXTROSTA **METHYLPHENIDATES:** DAYTRANA dexmethylphenidate/ER (BRAND IS PREFERRED) METADATE CD RITALIN/RITALIN LA
	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.	benzoyl peroxide/clindamycin (BRAND IS PREFERRED)
		ACANYA		
		BENZACLIN*		
	IMIQUIMODS		Trial and failure of a preferred agent greater than or equal to 28 days in the last 12 months will be required before approval can be given for a non-preferred agent.	imiquimod (BRAND IS PREFERRED) ZYCLARA
	ALDARA*			
	IMMUNOMODULATORS			
	ELIDEL			
	PROTOPIC			
	MISC TOPICAL		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.	
		TAZORAC		