WYOMING EQUALITYCARE (MEDICAID)
Preferred Drug List (PDL) - January 1, 2011

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 levocetirizine
	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 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 Spiriva 5 day package will be allowed one (1) time per recipient.	ATROVENT HFA
	CORTICOSTEROID / BRONCHODILATOR COMBO'S ADVAIR/HFA DULERA 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 Advair 7 and 14-day package will be allowed one (1) time per recipient.	
	LEUKOTRIENE MODIFIERS SINGULAIR		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months will be	SINGULAIR GRANULES (use preferred) zafirlukast 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 azelastine		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.	ASTEPRO PATANASE
	NASAL STEROIDS fluticasone NASACORT AQ NASONEX		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 OMNARIS RHINOCORT VERAMYST
	SHORT ACTING BRONCHODILATORS - INHALERS 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 budesonide FLOVENT HFA/DISK 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 ASMANEX STARTER PACK (use preferred) AZMACORT PULMICORT
ALZHEIMERS	**ALZHEIMER AGENTS**	**ARICEPT*** EXELON PATCH/SOLUTION galantamine/ER NAMENDA rivastigmine capsules	Client must have a diagnosis of dementia.	ARICEPT 23MG (use preferred) ARICEPT ODT (use preferred) donepezil (BRAND IS PREFERRED)
ANALGESICS	**BUPRENORPHINE COMBINATIONS**	SUBOXONE/FILM	Only one (1) narcotic prescription will be allowed between fills. Subutex will be approved for pregnancy. Dosage limits apply.	SUBUTEX

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ANALGESICS *Continued*	**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 oxymorphone 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 and dosage 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 PUMP (use preferred)
		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 TEVETEN
		AVAPRO BENICAR DIOVAN losartan MICARDIS		
	ARBs AND DIURETICS			ATACAND HCT TEVETEN HCT
		AVALIDE BENICAR HCT DIOVAN HCT losartan HCT MICARDIS HCT		
	ARB COMBINATIONS			TWYNSTA (use separate agents)
		AZOR EXFORGE/EXFORGE-HCT		
ANTIBIOTICS	**QUINOLONES**			AVELOX ABC PROQUIN
	AVELOX ciprofloxacin/ER FACTIVE LEVAQUIN NOROXIN ofloxacin			
ANTICOAGULANTS	**LOW MOLECULAR WEIGHT HEPARIN (LMWH)**			enoxaparin (BRAND IS PREFERRED) ***LOVENOX 300MG/3ML (USE PREFERRED)***
	ARIXTRA FRAGMIN **LOVENOX***			

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ANTICONVULSANTS	**DIAZEPAM RECTAL GEL**			diazepam gel (BRAND IS PREFERRED)
	DIASTAT*			
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 and osteoarthritis of the knee. **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, Latuda, and Saphris) require a trial of ALL preferred agents at max doses. Dosing limits apply.	ABILIFY ODT (USE PREFERRED) FANAPT LATUDA SAPHRIS SEROQUEL XR (USE PREFERRED; CURRENT USERS WILL BE GRANDFATHERED)
		ABILIFY GEODON INVEGA INVEGA SUSTENNA RISPERDAL CONSTA risperidone SEROQUEL ZYPREXA ZYPREXA RELPREVV		
	SPECIAL ATYPICAL ANTIPSYCHOTICS			
		clozapine		
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. 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.	ALTOPREV
	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. 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.	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.	ADVICOR (use separate agents) CHOLESTIN PRAVIGARD VYTORIN (use separate agents)
	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 TRILIPIX
	fenofibrate gemfibrozil TRICOR			
	INTESTINAL CHOLESTEROL ABSORPTION INHIBITOR			
	ZETIA			
	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			
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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COUGH AND COLD	DEXTROMETHORPHAN POLISTIREX			
	DELSYM			
DIABETES	DIABETES AGENTS			FORTAMET GLUMETZA RIOMET
	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.	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.	*ACTOS 30MG, 45MG (use ACTOS 15mg)* ACTOSPLUS MET (use separate agents) AVANDIA AVANDAMET (use separate agents)
	ACTOS 15MG			
	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			
	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.	KOMBIGLYZE (use separate agents)
		JANUMET JANUVIA ONGLYZA		
	LONG-ACTING INSULIN			
	LANTUS LEVEMIR			
	RAPID-ACTING INSULIN			
	APIDRA HUMALOG NOVALOG			
	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			
	CETRAXAL CIPRODEX CIPRO HC COLY-MYCIN S CORTISPORIN-TC Neomycin/Polymyxin B Sulfates/Hydrocortisone			
ERYTHROPOIETICS	EPOEITIN			EPOGEN
	ARANESP PROCRIT			
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		

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GASTROINTESTINAL	**DIGESTIVE ENZYMES**		Prior authorization required.	PANCREAZE TRI-PASE
	CREON 6000, 12000, 24000 UNIT 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. Lansoprazole solutabs will be approved for children less than or equal to 8 years of age. Lansoprazole capsules will be approved for children less than 1 year 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 (use preferred) CANASA LIALDA *PENTASA 500MG (use Pentasa 250mg)* ROWASA
	APRISO ASACOL PENTASA 250MG ONLY			
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.	HUMATROPE NORDITROPIN FLEXPRO PEN (use preferred) OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE
		GENOTROPIN NORDITROPIN NUTROPIN/AQ		
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.	PEG-INTRON
	PEGASYS			

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IMMUNOMODULATORS	IMMUNOMODULATORS (DIAGNOSIS REQUIRED)	ENBREL HUMIRA	Client must have ***diagnosis prior to approval*** for ***preferred agents*** *(outlined below)* : ***Enbrel*** : 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 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.	EDLUAR (additional criteria applies) LUNESTA ROZEREM zolpidem ER ZOLPIMIST (additional criteria applies)
MIGRAINE	TRIPTANS	MAXALT MLT naratriptan sumatriptan	Trial and failure of a preferred agent will be required before approval can be given for a non-preferred agent. Quantity limits apply.	AXERT FROVA MAXALT RELPAX TREXIMET ZOMIG
MULTIPLE SCLEROSIS	MULTIPLE SCLEROSIS AGENTS AVONEX BETASERON COPAXONE REBIF		Trial and failure of one (1) interferon agent AND failure of Copaxone. For Gilenya, in addition to the above criteria, a trial and failure of Tysabri is required. For Tysabri, in addition to the above criteria, additional prior authorization criteria applies.	EXTAVIA GILENYA TYSABRI (additional criteria applies)
NSAIDS	NSAIDs diclofenac etodolac fenoprofen flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate meloxicam nabumetone naproxen oxaprozin sulindac tolmetin		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 CELEBREX FLECTOR (additional criteria applies) NAPRELAN NEOPROFEN PENNSAID (additional criteria applies) SOLARAZE (additional criteria applies) VOLTAREN (additional criteria applies) ZIPSOR

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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 levofloxacin 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.	ACULAR/LS/PF (USE PREFERRED) ACUVAIL BROMDAY NEVANAC XIBROM
	flurbiprofen diclofenac ketorolac			
	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 BEPREVE CLARITIN OTC ELESTAT EMADINE LASTACAFT ZYRTEC ITCHY EYE
	azelastine cromolyn ketotifen 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 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.	ACTONEL ATELVIA BONIVA FOSAMAX-D
	alendronate			
	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 GELNIQUE GEL 10% OXYTROL DIS SANCTURA XR
	oxybutynin /ER TOVIAZ trospium 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.	JALYN (use separate agents)
	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.	JALYN (use separate agents) UROXATRAL
	doxazosin tamsulosin terazosin			
PULMONARY ANTIHYPERTENSIVES	**ENDOTHELIN RECEPTOR ANTAGONISTS**			
	LETAIRIS TRACLEER			

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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.	AMRIX carisoprodol chlorzoxazone metaxalone methocarbamol orphenadrine
	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.	**AMPHETAMINES:** amphetamine salts combo ER (BRAND IS PREFERRED) *ADDERALL XR WILL **ONLY** BE PREFFERRED FOR THOSE CLIENTS CURRENTLY ON THE MEDICATION.* **METHYLPHENIDATES:** dexmethylphenidate/ER (BRAND IS PREFERRED) METADATE CD RITALIN LA
	LONG ACTING AMPHETAMINES			
		***ADDERALL XR** ** VYVANSE dextroamphetamine CR		
	IMMEDIATE RELEASE AMPHETAMINES			
		amphetamine salts combo dextroamphetamine		
	STIMULANT LIKE			
		STRATTERA		
	METHYLPHENIDATES			
	LONG ACTING METHYLPHENIDATES			
		CONCERTA DAYTRANA FOCALIN XR methylin ER methylphenidate ER/CR/SR		
	IMMEDIATE RELEASE METHYLPHENIDATES			
		FOCALIN* methylin (tabs) methylphenidate		
	SELECTIVE ALPHA-ADRENERGIC AGONIST		To obtain the **non-preferred agent**, client must meet the following criteria: Client must have a diagnosis of ADHD or ADD. Prior authorization will be required for clients under the age of 5. Client must have a trial and failure of a stimulant greater than or equal to a 14 OR a trial and failure of Strattera greater than or equal to a 30 day supply **AND** trial and benefit of guanfacine (Tenex) in the previous 12 months OR a contraindication to ADHD medications (including stimulant and non-stimulant) OR a TIC disorder associated with stimulants (trial of stimulant required).	INTUNIV
	guanfacine			

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
TOPICAL AGENTS	**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		Acne combinations are limited to clients under the age of 21.	ACANYA
		benzoyl peroxide/clindamycin		
	CORTICOSTEROIS C=CREAM; G=GEL; L=LOTION; O=OINTMENT		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	PANDEL
	LOW POTENCY			
	alclometasone desonide fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) prednicarbate			
	MEDIUM POTENCY		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	CLODERM CORDRAN/SP
	betamethasone valerate desoximetasone 0.05% (C) fluocinolone 0.025% fluticasone 0.05% (C) hydrocortisone butyrate 0.1% (O) hydrocortisone probutate 0.1% (C) mometasone 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.	HALOG
	amcinonide betamethasone dipropionate clobetasol desoximetasone 0.25%, 0.05% (G) diflorasone fluocinonide flurandrenolide fluticasone 0.005% (O) halobetasol triamcinolone 0.5%			
	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		