

**WYOMING EQUALITYCARE (MEDICAID)
Preferred Drug List (PDL) - MAY 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		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
	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.	ALAVERT ALLEGRA-D CLARINEX-D
	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- 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- Advair 7 and 14-day package will be allowed one (1) time per recipient.	
	ADVAIR/HFA DULERA SYMBICORT			
	LEUKOTRIENE MODIFIERS		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
	SINGULAIR			
	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.	ASTEPRO PATANASE
	azelastine			
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.	BECONASE AQ flunisolide OMNARIS RHINOCORT VERAMYST	
fluticasone NASACORT AQ NASONEX				
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.	ALUPENT	
PROAIR HFA PROVENTIL HFA VENTOLIN HFA XOPENEX 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.	ACCUNEB METAPROTERENOL PROVENTIL XOPENEX	
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.	AEROBID/AEROBID-M ALVESCO ASMANEX STARTER PACK (use preferred) AZMACORT PULMICORT	
ASMANEX budesonide FLOVENT HFA/DISK QVAR				
ALZHEIMERS	ALZHEIMER AGENTS		Client must have a diagnosis of dementia.	ARICEPT 23MG (use preferred) ARICEPT ODT (use preferred) donepezil (BRAND IS PREFERRED)
		ARICEPT* EXELON PATCH/SOLUTION galantamine/ER NAMENDA rivastigmine <u>capsules</u>		
ANALGESICS	BUPRENORPHINE COMBINATIONS		Only one (1) narcotic prescription will be allowed between fills. Subutex will be approved for pregnancy. Dosage limits apply.	SUBUTEX
		SUBOXONE/FILM		

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ANALGESICS <i>Continued</i>	LONG-ACTING C-Is		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-III's and C-IV's 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 BUTRANS EMBEDA** KADIAN OPANA ER OXYCONTIN/CR
	SHORT-ACTING C-Is		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
	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
	fentanyl patch morphine sulfate			
ANDROGENS	TESTOSTERONE TOPICAL GELS		Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient testosterone production.	
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.	
	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.	
	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 EDARBI TEVETEN
	ARBs AND DIURETICS			
	ARB COMBINATIONS			TWYNSTA (use separate agents)
	benazepril captopril enalapril fosinopril lisinopril moexipril perindopril quinapril ramipril trandolapril	ANDROGEL TESTIM GEL		
ANTIBIOTICS	QUINOLONES			AVELOX ABC PROQUIN
	AVELOX ciprofloxacin/ER FACTIVE LEVAQUIN NOROXIN ofloxacin			

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ANTICOAGULANTS	LOW MOLECULAR WEIGHT HEPARIN (LMWH)			enoxaparin (BRAND IS PREFERRED) LOVENOX 300MG/3ML (USE PREFERRED)
	ARIXTRA FRAGMIN LOVENOX*			
ANTICONSULSANTS	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 <u>tablets</u>		
	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.	
		Aplenzin Cymbalta* Lexapro** Pristiq Venlafaxine ER <u>capsules</u>	*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.	
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				

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CONTRACEPTIVES	BIPHASIC ORAL CONTRACEPTIVES KARIVA LO-SEASONIQUE NECON 10/11 SEASONIQUE		Monophasic and triphasic oral contraceptives are not included and are available without prior authorization. (generic substitution is mandatory)	
COUGH AND COLD	DEXTROMETHORPHAN POLISTIREX DELSYM			
DIABETES	DIABETES AGENTS			FORTAMET GLUMETZA RIOMET
	BIGUANIDES metformin/ER			
	α-GLUCOSIDASE INHIBITORS acarbose		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
	MEGLITINIDES STARLIX*		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
	THIAZOLIDINEDIONES ACTOS 15MG		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)
	SULFONYLUREAS glimepiride/ER glipizide/ER glyburide/ER		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.	
	DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITORS JANUMET JANUVIA ONGLYZA		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)
	LONG-ACTING INSULIN LANTUS LEVEMIR			
	RAPID-ACTING INSULIN APIDRA HUMALOG NOVALOG			
	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			ALL OTHER METERS AND TEST STRIPS
EAR	ANTIBIOTIC/STEROID COMBINATION SUSPENSIONS CETRAXAL CIPRODEX CIPRO HC COLY-MYCIN S CORTISPORIN-TC <small>Neomycin/Polymyxin B Sulfates/Hydrocortisone</small>			
ERYTHROPOIETICS	EPOEITIN ARANESP PROCRIT			EPOGEN
FIBROMYALGIA	STEP 1 amitriptyline cyclobenzaprine			
	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.	
	STEP 3 CYMBALTA 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.	

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GASTROINTESTINAL	DIGESTIVE ENZYMES		Prior authorization required.	PANCREAZE TRI-PASE
	CREON 6000, 12000, 24000 UNIT ZENPEP		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)
	PROTON PUMP INHIBITORS			
	DEXILANT/KAPIDEX omeprazole			
	MESALAMINE			
	APRISO ASACOL PENTASA 250MG ONLY		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
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 OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE
	INTERFERON			
HEPATITIS C	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

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IMMUNOMODULATORS	IMMUNOMODULATORS (DIAGNOSIS REQUIRED)		<p>Client must have diagnosis prior to approval for preferred agents (outlined below):</p> <p>Enbrel: Ankylosing Spondylitis (AS), Juvenile Idiopathic Arthritis (JIA), Plaque Psoriasis (PP), Psoriatic Arthritis (PA), Rheumatoid Arthritis (RA)**</p> <p>Humira: AS, Crohn's, JIA, PP, PA, RA**</p> <p>**60-day trial and failure of methotrexate required prior to approval of Enbrel or Humira for diagnosis of Rheumatoid Arthritis (RA)</p> <p>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):</p> <p>Actemra: RA (60-day trial of methotrexate is required)</p> <p>Amevive: PP</p> <p>Cimzia: Crohn's***, RA</p> <p>Kineret: RA</p> <p>Orenzia: JIA, RA</p> <p>Remicade: AS, Crohn's, PP, PA, RA, Ulcerative Colitis****</p> <p>Rituxan: RA</p> <p>Simponi: AS, PA, RA</p> <p>Stelara: PP</p> <p>Tysabri: Crohn's (additional PA criteria applies)</p> <p>***Cimzia will be allowed without a preferred trial for diagnosis of Crohn's</p> <p>****Remicade will be allowed without a preferred trial for diagnosis of Ulcerative Colitis</p>	<p>ACTEMRA AMEVIVE CIMZIA KINERET ORENCIA RAPTIVA REMICADE RITUXAN SIMPONI STELARA TYSABRI (additional criteria applies)</p>
INSOMNIA	NON-BENZODIAZEPINES		<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>Rozereem is non-preferred without a history of substance abuse.</p> <p>Dosing limits apply.</p>	<p>EDLUAR (additional criteria applies) LUNESTA ROZEREM zolpidem ER ZOLPIMIST (additional criteria applies)</p>
MIGRAINE	TRIPTANS		<p>Trial and failure of a preferred agent will be required before approval can be given for a non-preferred agent.</p> <p>Quantity limits apply.</p>	<p>AXERT FROVA MAXALT RELPAK TREMIMET ZOMIG</p>
MULTIPLE SCLEROSIS	MULTIPLE SCLEROSIS AGENTS		<p>Trial and failure of one (1) interferon agent AND failure of Copaxone.</p> <p>For Gilenya, in addition to the above criteria, a trial and failure of Tysabri is required.</p> <p>For Tysabri, in addition to the above criteria, additional prior authorization criteria applies.</p>	<p>EXTAVIA GILENYA TYSABRI (additional criteria applies)</p>
NSAIDS	NSAIDs		<p>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.</p> <p>Dosing limits apply for ketorolac.</p>	<p>CALDOLOR CAMBIA POWDER CELEBREX FLECTOR (additional criteria applies) NAPRELAN NEOPROFEN PENNSAID (additional criteria applies) SOLARAZE (additional criteria applies) VOLTAREN (additional criteria applies) ZIPSOR</p>

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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 IQIUX levofloxacin ZYMAXID	
	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	
	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	
	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	
	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.		
	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 LASTACAPT ZYRTEC ITCHY EYE	
	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.	latanoprost	
	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.		
	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.		
	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
		NASAL CALCITONIN			
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	
	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)	
PROSTATE	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	
	ENDOTHELIN RECEPTOR ANTAGONISTS				
PULMONARY ANTIHYPERTENSIVES					

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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 metaxalone methocarbamol orphenadrine
SMOKING CESSATION	NICOTINE REPLACEMENT nicotine gum, lozenges, and patches OTHER bupropion SR CHANTIX		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.	
STIMULANTS	AMPHETAMINES LONG ACTING AMPHETAMINES ADDERALL XR * VYVANSE dextroamphetamine CR IMMEDIATE RELEASE AMPHETAMINES amphetamine salts combo dextroamphetamine METHYLPHENIDATES LONG ACTING METHYLPHENIDATES CONCERTA DAYTRANA FOCALIN XR methylin ER methylphenidate ER/CR/SR IMMEDIATE RELEASE METHYLPHENIDATES FOCALIN* methylin (tabs) methylphenidate		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 <u>and</u> 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 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. <u>Strattera is limited to 1 tablet/day; unless the dose is greater than 40mg/day or unable to achieve a prescribed dose with 1 tablet.</u>	AMPHETAMINES: amphetamine salts combo ER (BRAND IS PREFERRED) <u>ADDERALL XR WILL ONLY BE PREFERRED FOR THOSE CLIENTS CURRENTLY ON THE MEDICATION.</u> METHYLPHENIDATES: dexmethylphenidate/ER (BRAND IS PREFERRED) METADATE CD RITALIN LA
	SELECTIVE ALPHA-ADRENERGIC AGONIST guanfacine		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

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

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS <small>GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT GHS FOR QUESTIONS</small>
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		Acne combinations are limited to clients under the age of 21.	ACANYA
	BENZOYL PEROXIDE/CLINDAMYCIN COMBOS			
		benzoyl peroxide/clindamycin	Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	PANDEL
	CORTICOSTEROIS			
	<small>C=CREAM; G=GEL; L=LOTION; O=OINTMENT</small>			
	LOW POTENCY		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	CLODERM CORDRAN/SP
	alclometasone desonide fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) prednicarbate		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	HALOG
	MEDIUM POTENCY			
	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%		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	ALDARA*
HIGH POTENCY				
amcinonide betamethasone dipropionate clobetasol desoximetasone 0.25%, 0.05% (G) diflorasone fluocinonide flurandrenolide fluticasone 0.005% (O) halobetasol triamcinolone 0.5%		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	
IMIQUIMODS				
ALDARA*		IMMUNOMODULATORS		
IMMUNOMODULATORS				
ELIDEL PROTOPIC		MISC TOPICAL		
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.		