WYOMING MEDICAID
Preferred Drug List (PDL) - OCTOBER 12, 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.

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

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

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 for a non- Spiriva 5 day STARTER 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 for a non- Advair 7 and 14-day STARTER 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
	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 PROVENTIL HFA VENTOLIN HFA XOPENEX 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
	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	Client must have a diagnosis of opioid dependence or abuse. This is not to be used to for the treatment of chronic pain. Only one (1) narcotic prescription will be allowed between fills. Subutex will be approved for clients pregnant or nursing or with a documented allergy to naloxone. Dosage limits apply (Max Dose: 24mg/day).	SUBUTEX

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ANALGESICS *Continued*	**LONG-ACTING**		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 with the exception of Butrans (generic substitution is mandatory). **Butrans requires a trial of morphine sulfate or low dose trial of fentanyl patch. ***Embeda requires trial of preferred and client must have diagnosis of drug/ substance abuse.	AVINZA BUTRANS** EMBEDA*** KADIAN NUCYNTA ER OPANA ER oxymorphone ER (7.5mg/15mg) 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(max 8 tabs/day).	CONZIP 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 EDARBI 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 levofloxacin NOROXIN ofloxacin			

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ANTICOAGULANTS	**LOW MOLECULAR WEIGHT HEPARIN (LMWH)**			enoxaparin (BRAND IS PREFERRED) ***LOVENOX 300MG/3ML (USE PREFERRED)***
	ARIXTRA FRAGMIN **LOVENOX***			
ANTICONVULSANTS	**DIAZEPAM RECTAL GEL**			diazepam gel (BRAND IS PREFERRED)
	DIASTAT*			
ANTIDEPRESSANTS	**ANTIDEPRESSANTS**		Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks will be required before approval can be given for a non-preferred agent. Trazodone, buspirone, fluvoxamine, MAO inhibitors, TCA's, bupropion IR and venlafaxine IR do not require prior authorization but **will not count** towards meeting preferred therapy requirements. *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.	***fluoxetine 20mg tablets (use preferred)*** ***mirtazapine 7.5mg and mirtazapine rapid-dissolve tablets (use preferred)*** APLENZIN CYMBALTA* LEXAPRO** PRISTIQ VIIBRYD ***Effective 1/1/12, venlafaxine ER tablets will be non-preferred .***
	bupropion ER/SR/XL citalopram fluoxetine mirtazapine 15, 30, and 45mg paroxetine IR/CR sertraline venlafaxine ER			
ANTIPSYCHOTICS	**ATYPICAL ANTIPSYCHOTICS**		Non-preferred agents (Fanapt, Latuda, and Saphris) require a trial of ALL preferred agents at max doses. Dosage limits apply: ABILIFY <13 years of age: 23mg/day ABILIFY ≥13 years of age: 45mg/day GEODON ≤ 17 years of age: 180mg/day GEODON > 17 years of age: 300mg/day INVEGA all ages: 18mg/day Risperidone ≤ 17 years of age: 5mg/day Risperidone > 17 years of age: 24mg/day SEROQUEL <13 years of age: 600mg/day SEROQUEL 13-17 years of age: 900mg/day SEROQUEL > 17 years of age: 1200mg/day ZYPREXA < 13 years of age: 15mg/day ZYPREXA ≥ 13 years of age: 15mg/day	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		Dosage limits apply (Max Dose:1350mg/day).	
		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			

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CHOLESTEROL ***Continued***	**BILE ACID SEQUESTRANT** cholestyramine/light colestipol		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
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** **BIGUANIDES** metformin/ER			FORTAMET GLUMETZA RIOMET
	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) TRADJENTA
	INCRETIN MIMETICS (GLP-1 RECEPTOR AGONISTS)	BYETTA	Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a **preferred agent**. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	VICTOZA
	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		Quantity limit applies (1 meter/365days).	ALL OTHER METERS AND TEST STRIPS
EAR	**ANTIBIOTIC/STEROID COMBINATION SUSPENSIONS** CETRAXAL CIPRODEX CIPRO HC COLY-MYCIN S CORTISPORIN-TC Neomycin/Polymyxin B Sulfates/Hydrocortisone			
ERYTHROPOIETICS	**EPOEITIN** ARANESP PROCRIT			EPOGEN

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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**		Prior authorization required.	PANCREAZE TRI-PASE
	CREON 3000, 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 tablets (use preferred) omeprazole/bicarbonate pantoprazole VIMOVO (use separate agents)
	DEXILANT/KAPIDEX omeprazole **capsules**			
	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 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. Dosage limits apply: zaleplon: 30mg/day zolpidem: 15mg/day	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: MAXALT MLT 5mg: 27tabs/34days MAXALT MLT 10mg: 14tabs/34days naratriptan 1mg: 25tabs/34days naratriptan 2.5mg: 10tabs/34days sumatriptan kit: 3kits/34days sumatriptan vials: 2vials/34days sumatriptan nasal: 6bottles/34days sumatriptan 25mg: 41tabs/34days sumatriptan 50mg: 20tabs/34days sumatriptan 100mg: 10tabs/34days	AXERT FROVA MAXALT RELPAX TREXIMET ZOMIG
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 GILENYA TYSABRI (additional criteria applies)
	AVONEX BETASERON COPAXONE REBIF			
NSAIDS	**NSAIDs**		Trial and failure of two (2) preferred agents each greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Dosing limits apply for ketorolac (limit 5days/34 days).	CALDOLOR CAMBIA POWDER CELEBREX FLECTOR (additional criteria applies) NAPRELAN NEOPROFEN PENNSAID (additional criteria applies) SOLARAZE (additional criteria applies) SPRIX (additional criteria applies) VOLTAREN (additional criteria applies) ZIPSOR
	diclofenac etodolac fenoprofen flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate meloxicam nabumetone naproxen oxaprozin sulindac tolmetin			

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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 bromfenac NEVANAC
	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			
OPHTHALMICS *Continued*	**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.	latanoprost
	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			

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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
PRENATAL VITAMINS	**PRENATAL VITAMINS**			ALL OTHER PRENATAL VITAMINS INCLUDING OVER-THE-COUNTER FORMULATIONS
	BP MULTINATL TAB PLUS COMPLETE-RF CO-NATAL FA ELITE-OB FOLIVANE-OB INATAL ULTRA LACTOCAL-F MARNATAL-F MAXINATE NATAFORT O-CAL PRENAFIRST PRENAPLUS PRENATABS RX PRENATAL 19/CHEWABLE PRENATAL LOW IRON PRENATAL PLUS/FE SE-CARE/CHEWABLE SELECT-OB CHEWABLE SE-NATAL 19/CHEWABLE SE-NATAL 90 SE-NATAL ONE TARON-BC TARON-EC CAL TRIMESIS RX TRINATAL RX TRINATE TRI RX TRIVEEN-U VINATE II VINATE AZ VINATE C VINATE CAL VINATE IC VINATE M VINATE ONE VINATE ULTRA VITASPIRE VOL-TAB RX VOL-PLUS			
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.	alfuzosin JALYN (use separate agents)
	doxazosin tamsulosin terazosin			
PULMONARY ANTIHYPERTENSIVES	**ENDOTHELIN RECEPTOR ANTAGONISTS**			
	LETAIRIS TRACLEER			
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.	carisoprodol chlorzoxazone cyclobenzaprine ER 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: 735pcs &/or 84 days/365days NICOTINE LOZ: 735 pcs &/or 84 days/365days NICOTINE PATCH 5mg: 14 PATCH &/or 14 days/365days NICOTINE PATCH 7mg: 14 PATCH &/or 14 days/365days NICOTINE PATCH 10mg: 14 PATCH &/or 14 days/365days NICOTINE PATCH 14mg: 14 PATCH &/or 14 days/365days NICOTINE PATCH 15mg: 84 PATCH &/or 84 days/365days NICOTINE PATCH 21mg: 42 PATCH &/or 42 days/365days bupropion SR: 168 tabs &/or 84 days/365days CHANTIX: 168 tabs &/or 84 days/365days	
		nicotine gum, lozenges, and patches		
	OTHER			
		bupropion SR CHANTIX		

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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
STIMULANTS	**AMPHETAMINES** LONG ACTING AMPHETAMINES	***ADDERALL XR* *** VYVANSE dextroamphetamine CR	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. 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. ***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.*** **Quantity limits apply:** **ADDERALL XR: 60mg/day** **amphetamine salts combo: 60mg/day** **amphetamine salts combo (narcolepsy): 90mg/day** **CONCERTA: 135mg/day** **DAYTRANA: 45mg/9 hour patch** **dextroamphetamine: 90mg/day** **dextroamphetamine CR: 90mg/day** **FOCALIN: 30mg/day** **FOCALIN XR ≤ 13 years of age: 45mg/day** **FOCALIN XR > 13 years of age: 60mg/day** **methylin/methylphenidate: 135mg/day** **methylin/methylphenidate ER/CR/SR: 135mg/day** **VYVANSE: 105mg/day**	**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 methylphenidate ER 18,27,36mg (BRAND IS PREFERRED) RITALIN LA
	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		
	SELECTIVE ALPHA-ADRENERGIC AGONIST GUANFACINE AGENTS		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			
	CLONIDINE AGENTS		Trial and benefit of clonidine IR will be required prior to approval of the non-preferred agent.	KAPVAY
	clonidine			

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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		Clients must be 12 to 20 years of age and have a diagnosis of acne vulgaris. Requires prior authorization for clients less than 12 years of age. Acne combinations are limited to clients under the age of 21.	ACANYA
		benzoyl peroxide/clindamycin		
	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 TOPICORT LP TRIANEX
	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		
	SALICYLIC ACID			All other topical salicylic acid formulations.
	aliclen shampoo 6% salacyn cream/lotion 6% Salicylic Acid Shampoo 6%			
	UREA			All other topical urea formulations.
	Kerafoam Aerosol 30% Remeven Cream 50% urea hydration aerosol 35% urea emulsion 50% urea nail suspension 40% urea suspension 50% X-Viate Cream 40%			