

WYOMING MEDICAID

Preferred Drug List - Effective 12/02/09

Listed drugs are preferred. Drugs in the PDL classes that are not listed are non-preferred and require a PA. Drugs new to market are non-preferred until a clinical review has been completed. PA criteria will apply to both the pediatric population, as well as the adult population for those plans where PA/PDL limits are allowed.

Unless otherwise noted on the PDL, generic substitution is mandatory.

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA
ALLERGY / ASTHMA THERAPIES	ANTIHISTAMINES, MINIMALLY SEDATING		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.
	cetirizine fexofenadine loratadine		
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.
	cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine		
	ANTICHOLINERGIC BRONCHODILATORS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months.
	ATROVENT HFA ipratropium SPIRIVA		
	ANTICHOLINERGIC BETA-AGONIST COMBO'S		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months.
	albuterol/ipratropium COMBIVENT		
	CORTICOSTEROID / BRONCHODILATOR COMBO'S		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months.
	ADVAIR ADVAIR HFA SYMBICORT		
	NASAL STEROIDS		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months. Rhinocort will be approved for pregnancy.
	fluticasone NASACORT AQ VERAMYST		
	LEUKOTRIENE MODIFIERS		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months.
	SINGULAIR		
LONG ACTING BRONCHODILATORS		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months.	
SEREVENT			
SHORT ACTING BRONCHODILATORS - INHALERS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months.	
MAXAIR PROAIR HFA VENTOLIN HFA			
SHORT ACTING BRONCHODILATORS - NEBULIZERS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months.	
albuterol neb			
INHALED CORTICOSTEROIDS		Trial and failure of three (3) preferred agents greater than or equal to 30 days in the last 12 months. Alvesco will be approved for a history of oral thrush.	
ASMANEX AZMACORT budesonide FLOVENT HFA FLOVENTDISK PULMICORT			
ANTIBIOTICS	BETA-LACTAMS / CLAVULANATE COMBO'S		
ANALGESICS, NARCOTICS	AUGMENTIN XR		
	LONG-ACTING NARCOTICS		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.
DURAGESIC* morphine sulfate			

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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 quinapril ramipril trandolapril		
	ACE INHIBITORS AND DIURETICS		
	benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ moexipril/HCTZ quinapril/HCTZ		
	ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)		
		AVAPRO BENICAR COZAAR DIOVAN MICARDIS	
ANTIDEPRESSANTS	ARBs AND DIURETICS		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.
		AVALIDE BENICAR-HCT DIOVAN-HCT HYZAAR MICARDIS-HCT	
	ARB COMBINATIONS		
		AZOR	
ANTIVIRALS, ORAL	HERPES AGENTS		
	acyclovir famciclovir VALTREX		

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CHOLESTEROL AGENTS	STATINS, LOW POTENCY		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.
	LESCOL/LESCOL XL lovastatin pravastatin		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.
	STATINS, HIGH POTENCY		
	LIPITOR simvastatin		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.
	STATIN COMBINATIONS		
	ADVICOR CADUET SIMCOR		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.
	FIBRIC ACID DERIVATIVES		
fenofibrate gemfibrozil TRICOR		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.	
NICOTINIC ACID DERIVATIVES			
EAR	MISCELLANEOUS		
	CIPRODEX		
FIBROMYALGIA AGENTS	FIBROMYALGIA AGENTS		Trial and failure of amitriptyline or cyclobenzaprine greater than or equal to 6 weeks in the last 12 months for the diagnosis of fibromyalgia.
		SAVELLA CYMBALTA LYRICA	
GASTROINTESTINAL	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.
	KAPIDEX omeprazole PRILOSEC OTC * PROTONIX *		
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 a preferred agent within the last 12 months will be required for the following indications: Pediatric: Growth failure due to inadequate endogenous growth hormone, Prader-Willi syndrome, children born small for gestation. Turner syndrome. Adult: Replacement for those with growth hormone deficiency.
		GENOTROPIN NUTROPIN	

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INSOMNIA AGENTS	NON-BENZODIAZEPINES		Non-preferred products require a 14 day history of a preferred product in the last 365 days prior to approval for a non-preferred product. Rozerem is non-preferred without a history of substance abuse.
	LUNESTA zaleplon zolpidem		
MIGRAINE AGENTS	TRIPTANS		Trial and failure of ALL preferred agents each greater than or equal to 14 days is required for PA approval of non-preferred agents in the last 12 months. Quantity limits apply.
	MAXALT/MAXALT MLT RELPAX sumatriptan		
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 NSAID.
	diclofenac etodolac fenoprofen flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate mefenamic acid 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 required prior to PA approval.	
OPHTHALMICS	OP. -ANTIBIOTICS- QUINOLONES		Trial and failure of a preferred agent greater than or equal to 5 days in the last 12 months. Azasite will be approved for pregnancy.
	ciprofloxacin ofloxacin VIGAMOX ZYMAR		
	OP. -ANTI-INFLAMMATORY- NSAIDS		Trial of each preferred agent greater than or equal to 5 days in the last 12 months.
	ACULAR/LS/PF flurbiprofen diclofenac		
	OP. -BETA-BLOCKERS		Trial and failure of three (3) different preferred agents each greater than or equal to 30 days in the last 12 months. Betoptic S will be approved for those with heart and lung conditions.
	betaxolol carteolol levobunolol metipranolol timolol		
	OP. -CARBONIC ANHYDRASE INHIBITOR		Trial of a preferred agent greater than or equal to 30 days in the last 12 months.
	dorzolamide		Trial of a preferred agent greater than or equal to 30 days in the last 12 months.
	OP. -CARBONIC ANHYDRASE INHIBITOR COMBO		
	dorzolamide/timolol		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months. Emadine, Alomide, and Alocril will be approved for pregnancy. Alomide will be approved for children under the age of 3.
	OP. -MAST CELL STABILIZERS		
	cromolyn ketotifen OPTIVAR PATADAY PATANOL		
OP. -PROSTAGLANDINS			
LUMIGAN TRAVATAN/TRAVATAN Z		Trial of each preferred agent greater than or equal to 30 days in the last 12 months.	
OP. -SYMPATHOMIMETICS		Trial of a preferred agent greater than or equal to 30 days in the last 12 months.	
ALPHAGAN P brimonidine dipivefrin			

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OVERACTIVE BLADDER AGENTS	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. The patch will only be allowed if the patient has the inability to swallow.
	DETROL LA ENABLEX oxybutynin /ER SANCTURA / XR VESICARE		
PROSTATE AGENTS	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.
	AVODART finasteride		
	ALPHA BLOCKERS		
doxazosin terazosin			
SKELETAL MUSCLE RELAXANTS	MUSCLE RELAXANTS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months, along with a medical diagnosis of muscle spasticity will be required before approval can be given for a non-preferred agent.
	baclofen cyclobenzaprine tizanidine		
SMOKING CESSATION	NICOTINE REPLACEMENT		Quantity limits apply. Generic bupropion SR needs to be an AB rated generic of Zyban.
	nicotine gum, lozenges, and patches		
	OTHER		
bupropion SR CHANTIX			
STIMULANTS	AMPHETAMINES		Clients must have a diagnosis for ADD or ADHD.
	LONG ACTING AMPHETAMINES		
	ADDERALL XR* VYVANSE		Prior Authorization will be required for clients under the age of 5.
	IMMEDIATE RELEASE AMPHETAMINES		
	amphetamine salts combo dextroamphetamine		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.
	STIMULANT LIKE		
	STRATTERA		
	METHYLPHENIDATES		Dosing limits will apply (150% of labeled max).
	LONG ACTING METHYLPHENIDATES		
	CONCERTA FOCALIN XR methylin ER methylphenidate ER/CR/SR		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.
IMMEDIATE RELEASE METHYLPHENIDATES			
dexmethylphenidate methylin (tabs) methylphenidate			
TOPICAL AGENTS	IMMUNOMODULATORS		
	ELIDEL PROTOPIC		