WYOMING MEDICAID
Preferred Drug List (PDL) - JANUARY 1, 2012

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.

Yellow highlighted items below indicate new changes to the PDL. Red font indicates quantity/dosage limits apply. *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.

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.	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.	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 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 Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.	
	LEUKOTRIENE MODIFIERS SINGULAIR TABS,CHEWABLES, GRANULES		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months will be	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 0.15% 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 triamcinolone (BRAND IS PREFERRED) 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 **XOPENEX 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 levalbuterol (BRAND IS PREFERRED) METAPROTERENOL
	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**	donepezil EXELON PATCH/SOLUTION galantamine/ER NAMENDA rivastigmine capsules	Client must have a diagnosis of dementia.	ARICEPT 23MG (use preferred) donepezil ODT (use 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 (10mg/200mg) morphines sulfate ER capsules NUCYNTA ER OPANA ER (5mg/10mg/20mg/30mg/40mg) oxymorphone ER (7.5mg/15mg) OXYCONTIN/CR
	fentanyl patch morphine sulfate ER tablets			
	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 tramadol/apap tramadol ER
	tramadol			
ANDROGENS	**TESTOSTERONE TOPICAL GELS**		Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient testosterone production. Prior authorization required for non-preferred agent.	TESTIM GEL
		ANDROGEL		
ANTIBIOTICS	**QUINOLONES**			AVELOX FACTIVE NOROXIN PROQUIN
	ciprofloxacin/ER levofloxacin ofloxacin			
	DOXYCYCLINE			ADOXA (use preferred) DORYX (use preferred) ORACEA (use preferred)
	doxycycline			
	MINOCYCLINE			SOLODYN (use preferred)
	minocycline/ER			
ANTICOAGULANTS	**LOW MOLECULAR WEIGHT HEPARIN (LMWH)**			enoxaparin (BRAND IS PREFERRED) FRAGMIN (use preferred) ***LOVENOX 300MG/3ML (USE PREFERRED)***
	LOVENOX*			
	DIRECT THROMBIN INHIBITOR		Client must have diagnosis of non-valvular atrial fibrillation and relative contraindication to warfarin for approval.	
		PRADAXA		
	SELECTIVE FACTOR XA INHIBITOR		Client must have diagnosis of non-valvular atrial fibrillation or prophylaxis of deep vein thrombosis which can lead to pulmonary embolism in clients undergoing hip or knee replacement.	
		XARELTO		
ANTICONVULSANTS	**DIAZEPAM RECTAL GEL**			diazepam gel (BRAND IS PREFERRED)
	DIASTAT*			

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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 tablets** (use preferred)* ***mirtazapine 7.5mg and mirtazapine rapid-dissolve tablets** (use preferred)* ***venlafaxine ER tablets** (use preferred)* APLENZIN CYMBALTA* LEXAPRO** PRISTIQ VIIBRYD
	bupropion ER/SR/XL citalopram fluoxetine capsules mirtazapine 15, 30, and 45mg paroxetine IR/CR sertraline venlafaxine ER capsules			
ANTIHYPERTENSIVES	**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 eprosartan 600mg TEVETEN 400mg
		AVAPRO BENICAR DIOVAN losartan MICARDIS		
	ARBs AND DIURETICS			ATACAND HCT TEVETEN HCT
		AVALIDE BENICAR HCT DIOVAN HCT losartan HCT MICARDIS HCT		
	ARB COMBINATIONS			AZOR
		EXFORGE/EXFORGE-HCT		TWYNSTA (use separate agents) TRIBENZOR (use separate agents)
	ALPHA-BLOCKERS			clonidine patch (BRAND IS PREFERRED) NEXICLON XR (use preferred)
	CATAPRES PATCHES* clonidine			

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ANTIPSYCHOTICS	**ATYPICAL ANTIPSYCHOTICS**		**Seroquel doses less than 100mg will require prior authorization without a diagnosis of mood disorder or major depressive disorder. For titration doses, contact the GHS Pharmacy Help Desk for an override. Non-preferred agents (Fanapt, Latuda, and Saphris) require a trial of ALL preferred agents at max doses. *Typical antipsychotics do not required prior authorization.* 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 Olanzapine < 13 years of age: 15mg/day Olanzapine > 13 years of age: 30mg/day SEROQUEL <13 years of age: 600mg/day SEROQUEL 13-17 years of age: 900mg/day SEROQUEL > 17 years of age: 1200mg/day ***Latuda will be approved for female clients of child-bearing age.**	FANAPT LATUDA*** SAPHRIS SEROQUEL XR (use preferred)
	ABILIFY/ODT GEODON INVEGA INVEGA SUSTENNA olanzapine RISPERDAL CONSTA risperidone SEROQUEL** ZYPREXA RELPREVV			
	SPECIAL ATYPICAL ANTIPSYCHOTICS		Dosage limits apply: 1350mg/day	
	clozapine			
ANTIVIRALS, ORAL	**HERPES AGENTS**			valacyclovir (BRAND IS PREFERRED)
	acyclovir famciclovir **VALTREX***			
CHOLESTEROL	**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			
	INTESTINAL CHOLESTEROL ABSORPTION INHIBITOR			
	ZETIA			
	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
	atorvastatin 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) amlodopine/atorvastatin (BRAND IS PREFERRED) CHOLESTIN PRAVIGARD SIMCOR VYTORIN (use separate agents)
	CADUET*			
	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			

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CONTRACEPTIVES	**ORAL CONTRACEPTIVES**			amethia (BRAND IS PREFERRED) amethyst (BRAND IS PREFERRED) aranelle (BRAND IS PREFERRED) BEYAZ (PA required) camila (use preferred) camrese (BRAND IS PREFERRED) caziant (use preferred) cesia (use preferred) cyclafem (BRAND IS PREFERRED) FEMCON FE (PA required) GENERESS FE CHW (PA required) gianvi (BRAND IS PREFERRED) heather (use preferred) introvale (use preferred) leena (BRAND IS PREFERRED) LO LOESTRIN (PA required) loryna (BRAND IS PREFERRED) NATAZIA (PA required) necon 0.5/35, 1/35, 7/7/7 (BRAND IS PREFERRED) NECON 1/50 (use preferred) norethindrone/ethyinyl estradiol chew (PA required) norethindrone (use preferred) NORINYL 1/35 (use preferred) nortrel (BRAND IS PREFERRED) ocella (BRAND IS PREFERRED) ORTHO-NOVUM 1/50 (use preferred) quasense (use preferred) SAFYRAL (PA required) syeda (BRAND IS PREFERRED) tilia FE (BRAND IS PREFERRED) tri-legest FE (BRAND IS PREFERRED) tri-lo-sprintec (BRAND IS PREFERRED) zarah (BRAND IS PREFERRED) zenchent FE chewable (PA required) zeosa chewable (PA required)
	altavera apri aviane azurette balzia **BREVICON*** briellyn cryselle emoquette enpresse errin **ESTROSTEP FE*** gildess FE jolessa jolivette junel/junel FE kariva kelnor lessina LOESTRIN 24 FE LOSEASONIQUE low-ogestrel lutera LYBREL microgestin mononessa NECON 10/11-28 nora-be norgestrel/ethinyl estradiol NORINYL 1/50-28 OGESTREL orsythia **ORTHO TRI-CYCLEN LO*** **ORTHO-NOVUM 1/35-28, 7/7/7-28*** OVCON 50 portia previfem reclipsen seasonale **SEASONIQUE*** solia sprintec sronyx trinessa **TRI-NORINYL*** tri-previfem trivora velivet **YASMIN*** **YAZ*** zenchent ZOVIA			
CORTICOSTEROIDS	**ORAL CORTICOSTEROIDS**			CELESTONE (use preferred)
	budesonide cortisone acetate dexamethasone/intensol hydrocortisone methylprednisone prednisolone prednisone			
COUGH AND COLD	**COMBINATION AGENTS**		Refer to the Over the Counter Drug Coverage at www.wyequalitycare.org for a list of covered products.	
	BROMFED DM			
	DEXTROMETHORPHAN AGENTS			
	DELSYM			
	GUAIFENESIN AGENTS			
	guaifenesin MUCINEX TAB 1200MG MUCINEX TAB 600MG ER MUCINEX CGH LIQ 5-100MG MUCINEX/KIDS GRA 100MG			

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DIABETES	**DIABETES AGENTS**			FORTAMET (use preferred) GLUMETZA (use preferred) RIOMET (use preferred)
	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.	ACTOSPLUS MET (use separate agents) AVANDIA AVANDAMET (use separate agents)
	ACTOS			
	SULFONYLUREAS		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	
	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.	
		JANUVIA ONGLYZA TRADJENTA		
	DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITOR COMBO AGENTS		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.	
		JANUMET JUVISYNC KOMBIGLYZE		
	INCRETIN MIMETICS (GLP-1 RECEPTOR AGONISTS)		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
		BYETTA		
	INTERMEDIATE-ACTING INSULIN			
	HUMULIN N HUMULIN 70/30 NOVOLOG N NOVOLOG 70/30			
	LONG-ACTING INSULIN			LANTUS OPTICLIK/SOLOSTAR (use preferred) LEVEMIR (use preferred)
	LANTUS vial			
	RAPID-ACTING INSULIN			
	APIDRA HUMALOG NOVOLOG			
	DIABETIC METERS/TEST STRIPS		Quantity limit applies (1 meter/365days).	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**			CETRAXAL (use preferred) CIPRODEX (use preferred) CIPRO HC (use preferred) COLY-MYCIN S (use preferred) CORTISPORIN-TC (use preferred) dexamethasone sodium phosphate (use preferred) FLUOCINOLONE ACET OIL 0.01% (use preferred) Neomycin/Polymyxin B Sulfates/Hydrocortisone solution (BRAND IS PREFERRED)
	CORTISPORIN SOL 1% OTIC*			
	Neomycin/Polymyxin B Sulfates/Hydrocortisone suspension			
	ofloxacin			
FIBROMYALGIA	**FIBROMYALGIA STEP 1**			
	amitriptyline cyclobenzaprine			
	FIBROMYALGIA 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		
	FIBROMYALGIA 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
	CREON 3000, 6000, 12000, 24000 UNIT			pancrelipase (BRAND IS PREFERRED)
	ZENPEP*			TRI-PASE
	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.	ACIPHEX lansoprazole NEXIUM omeprazole tablets (use preferred) omeprazole bicarbonate VIMOVO (use separate agents)
	DEXILANT omeprazole capsules pantoprazole			
	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.	APRISO ASACOL/HD CANASA LIALDA PENTASA 500MG (use preferred) ROWASA
	mesalamine enema 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			
	PROTEASE INHIBITOR		Prior authorization required for non-preferred agent.	INCIVEK
	VICTRELIS			

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IMMUNOMODULATORS	**IMMUNOMODULATORS**	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	**TRIPTAN STEP 1** naratriptan sumatriptan		Quantity limits apply: 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
	TRIPTAN STEP 2	MAXALT MLT	Trial and failure of a Step 1 agent greater will be required for approval of a Step 2 agent. Trial and failure of a Step 1 agent and a Step 2 agent will be required for approval of a non-preferred agent. Quantity limits apply: MAXALT MLT 5mg: 27tabs/34days MAXALT MLT 10mg: 14tabs/34days	
MULTIPLE SCLEROSIS	**IMMUNOMODULATOR (GLATIRAMER INJECTION)** COPAXONE **INTERFERON BETA-1A** AVONEX REBIF **INTERFERON BETA-1B** BETASERON		Trial and failure of one (1) interferon agent AND failure of Copaxone before approval can be give for a non-preferre agent. For Tysabri, in addition to the above criteria, additional prior authorization criteria applies.	EXTAVIA GILENYA TYSABRI (additional criteria applies)

WYOMING MEDICAID
Preferred Drug List (PDL) - JANUARY 1, 2012

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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)
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			
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 MOXEZA ZYMAR ZYMAXID
	ciprofloxacin ofloxacin VIGAMOX			
	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 STEP 1**		Trial and failure of a Step 1 agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a Step 2 agent. Trial and failure of a Step 1 agent and a Step 2 agent greater than or equal to 30 days in the last 12 months will be required for approval of a non-preferred agent. Emadine, Alomide, and Alocril will be approved for pregnancy.	ALAMAST ALOCRIL ALOMIDE ALREX azelastine BEPREVE ELESTAT EMADINE ketotifen LASTACAFT
	cromolyn			
	OP. -MAST CELL STABILIZERS STEP 2			
		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.	LUMIGAN
	latanoprost 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.	COMBIGAN (use separate agents)
	ALPHAGAN P brimonidine dipivefrin			
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			

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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 trospium
	oxybutynin /ER TOVIAZ VESICARE			
PHOSPHATE BINDERS	**PHOSPHATE BINDERS**		Prior authorization required for non-preferred agents.	FOSRENOL RENVELA
	calcium acetate **ELIPHOS*** **PHOSLO*** **PHOSLYRA** RENAGEL			
PRENATAL VITAMINS	**PRENATAL VITAMINS**		Prenatal vitamins containing Omega-3 and DHA will be approved for clients at high risk for pre-term labor.	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.	AVODART JALYN (use separate agents)
	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) RAPAFLO
	doxazosin tamsulosin terazosin			
PULMONARY ANTIHYPERTENSIVES	**5-ALPHA-REDUCTASE INHIBITORS**		Client must have a diagnosis of pulmonary hypertension.	
		ADCIRCA REVATIO		
	ENDOTHELIN RECEPTOR ANTAGONISTS		Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	TRACLEER
		LETAIRIS		
RESTLESS LEG SYNDROME	**RESTLESS LEG SYNDROME**		Client must have a diagnosis of Restless Leg Syndrome (RLS). Trial and failure of gabapentin greater than or equal to 60 days and a trial and failure of a dopamine agonist greater than or equal to 60 days in the last 12 months will be required before approval can be given for a non-preferred agent.	HORIZANT
		gabapentin		

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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.	carisoprodol chlorzoxazone cyclobenzaprine ER metaxalone methocarbamol orphenadrine Carisoprodol is limited to 84 tabs/365 days.
	baclofen cyclobenzaprine tizanidine			
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. 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** **dexmethylphenidate: 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) **METHYLPHENIDATES:** METADATE CD RITALIN LA
	LONG ACTING AMPHETAMINES			
		ADDERALL XR*		
		VYVANSE		
		dextroamphetamine CR		
	IMMEDIATE RELEASE AMPHETAMINES			
		amphetamine salts combo		
		dextroamphetamine		
	METHYLPHENIDATES			
	LONG ACTING METHYLPHENIDATES			
		DAYTRANA		
		FOCALIN XR		
		methylin ER		
		methylphenidate ER/CR/SA/SR		
	IMMEDIATE RELEASE METHYLPHENIDATES			
		FOCALIN		
		methylin tablets		
		methylphenidate		
STIMULANTS *Continued*	**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 AGENTS			
	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%			
	IMMUNOMODULATORS		Trial and failure of a preferred medium potency topical corticosteroid greater than or equal to a 21 day trial and a trial and failure of a preferred high potency topical corticosteroid greater than or equal to a 21 day trial in the last 90 days.	
		ELIDEL PROTOPIC		
	SALICYLIC ACID			All other topical salicylic acid formulations.
	aliclen shampoo 6% salacyn cream/lotion 6% Salicylic Acid Shampoo 6%			
	SCABICIDES/PEDICULICIDES		Trial and failure of a preferred agent in the last 12 months.	NATROBA OVIDE ULESFIA
	permethrin LINDANE			
	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%			