

# WYOMING MEDICAID Preferred Drug List (PDL) - APRIL 18, 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 <small>THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT GHS FOR QUESTIONS</small>
ALLERGY / ASTHMA	ANTI-HISTAMINES, 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.	CLARINEX levocetirizine
	cetirizine fexofenadine loratadine			
	ANTI-HISTAMINE/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.	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  <span style="color: red;">Spiriva 5 day STARTER package will be allowed one (1) time per recipient.</span>	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  <span style="color: red;">Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.</span>	
	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	zafirlukast ZYFLO
	SINGULAIR TABS, CHEWABLES, GRANULES			
	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 0.15% 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 <span style="background-color: yellow;">QNASL</span> RHINOCORT triamcinolone (BRAND IS PREFERRED) 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 levalbuterol (BRAND IS PREFERRED) METAPROTERENOL	
albuterol neb XOPENEX 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) donepezil ODT (use preferred)
		donepezil EXELON PATCH/SOLUTION galantamine/ER NAMENDA rivastigmine capsules		
ANALGESICS	BUPRENORPHINE COMBINATIONS		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.  <span style="color: red;">Dosage limits apply (Max Dose: 24mg/day).</span>	SUBUTEX
		<span style="color: red;">SUBOXONE/FILM</span>		

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<b>ANALGESICS</b> <i>Continued</i>	<b>LONG-ACTING</b>		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.  <b>Fentanyl patches are limited to one patch every 72 hours.</b>  C-III's and C-IV's 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 and Oxecta require a diagnosis of drug/substance abuse and a 14 day trial of a preferred agent.	AVINZA BUTRANS** EMBEDA*** KADIAN (10mg/200mg) morphines sulfate ER <u>capsules</u> NUCYNTA ER OPANA ER (5mg/10mg/20mg/30mg/40mg) OXECTA*** oxymorphone ER (7.5mg/15mg) OXYCONTIN/CR				
	<b>SHORT-ACTING C-IIs</b>				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		
	<b>TRAMADOL PRODUCTS</b>						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.  <b>Quantity and dosage limits apply(max 8 tabs/day).</b>	CONZIP RYBIX ODT tramadol/apap tramadol ER
	<b>TRAMADOL</b>							
<b>ANDROGENS</b>	<b>TESTOSTERONE TOPICAL GELS</b>		Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient testosterone production. Prior authorization required for non-preferred agent.	TESTIM GEL				
	<b>ANDROGEL</b>							
<b>ANTIBIOTICS</b>	<b>QUINOLONES</b>			AVELOX FACTIVE NOROXIN PROQUIN				
	<b>DOXYCYCLINE</b>				ADOXA (use preferred) DORYX (use preferred) ORACEA (use preferred) SOLODYN (use preferred)			
	<b>MINOCYCLINE</b>							
	<b>minocycline/ER</b>							
<b>ANTICOAGULANTS</b>	<b>LOW MOLECULAR WEIGHT HEPARIN (LMWH)</b>		Client must have diagnosis of non-valvular atrial fibrillation and relative contraindication to warfarin for approval.  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.	enoxaparin (BRAND IS PREFERRED) FRAGMIN (use preferred) LOVENOX 300MG/3ML (use preferred)				
	<b>DIRECT THROMBIN INHIBITOR</b>							
	<b>PRADAXA</b>							
<b>ANTICONVULSANTS</b>	<b>SELECTIVE FACTOR XA INHIBITOR</b>							
	<b>XARELTO</b>							
<b>ANTICONVULSANTS</b>	<b>DIAZEPAM RECTAL GEL</b>			diazepam gel (BRAND IS PREFERRED)				
	<b>DIASTAT*</b>							

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<b>ANTIDEPRESSANTS</b>	<b>ANTIDEPRESSANTS</b>		<p>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.</p> <p>Trazodone, buspirone, fluvoxamine, MAO inhibitors, TCA's, bupropion IR and venlafaxine IR do not require prior authorization but <b>will not count</b> towards meeting preferred therapy requirements.</p> <p>*Cymbalta will be approved for a diagnosis of peripheral neuropathy and osteoarthritis of the knee.</p> <p>**Lexapro will be approved for adolescents between the ages of 12 - 17.</p>	<p><i>fluoxetine tablets (use preferred)</i> <i>mirtazapine 7.5mg and mirtazapine rapid-dissolve tablets (use preferred)</i> <i>venlafaxine ER tablets (use preferred)</i></p> <p>APLENZIN CYMBALTA* LEXAPRO** (use brand) PRISTIQ VIIBRYD</p>
<b>ANTIHYPERTENSIVES</b>	<b>ACE INHIBITORS</b>		<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>	
	<b>ACE INHIBITORS AND DIURETICS</b>		<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>	
	<b>ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)</b>		<p>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.</p>	<p>ATACAND EDARBI eprosartan 600mg <i>irbesartan (BRAND IS PREFERRED)</i> TEVETEN 400mg</p>
	<b>ARBs AND DIURETICS</b>			<p>ATACAND HCTZ <i>EDARBYCLOR</i> <i>irbesartan HCTZ (BRAND IS PREFERRED)</i> TEVETEN HCTZ</p>
	<b>ARB COMBINATIONS</b>			<p>AZOR TWINSTA (use separate agents) TRIBENZOR (use separate agents)</p>
	<b>ALPHA-BLOCKERS</b>			<p>clonidine patch (BRAND IS PREFERRED) <i>NEXICLON XR (use preferred)</i></p>
	<b>CATAPRES PATCHES*</b>			
	clonidine			

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ANTIPSYCHOTICS	<b>ATYPICAL ANTIPSYCHOTICS</b>		<p>**Seroquel doses less than 100mg will require prior authorization <u>without</u> a diagnosis of mood disorder or major depressive disorder. For titration doses, contact the GHS Pharmacy Help Desk for an override.</p> <p>Non-preferred agents (Fanapt, Latuda, and Saphris) require a trial of ALL preferred agents at max doses.</p> <p><i>Typical antipsychotics do <u>not</u> require prior authorization.</i></p> <p><b>Dosage limits apply:</b></p> <p>ABILIFY &lt;13 years of age: 23mg/day            ABILIFY ≥13 years of age: 45mg/day            GEODON ≤ 17 years of age: 180mg/day            GEODON &gt; 17 years of age: 300mg/day            INVEGA all ages: 18mg/day            Risperidone ≤ 17 years of age: 5mg/day            Risperidone &gt; 17 years of age: 24mg/day            Olanzapine &lt; 13 years of age: 15mg/day            Olanzapine &gt; 13 years of age: 30mg/day            SEROQUEL &lt;13 years of age: 600mg/day            SEROQUEL 13-17 years of age: 900mg/day            SEROQUEL &gt; 17 years of age: 1200mg/day</p> <p>***Latuda will be approved for female clients of child-bearing age.</p>	<p>FANAPT            LATUDA***            SAPHRIS            SEROQUEL XR (<i>use preferred</i>)            ziprasidone (<b>BRAND IS PREFERRED</b>)</p>
	<b>SPECIAL ATYPICAL ANTIPSYCHOTICS</b>		Dosage limits apply: 1350mg/day	
ANTIVIRALS, ORAL	<b>HERPES AGENTS</b>			valacyclovir ( <b>BRAND IS PREFERRED</b> )
CHOLESTEROL	<b>BILE ACID SEQUESTRANT</b>		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
	<b>INTESTINAL CHOLESTEROL ABSORPTION INHIBITOR</b>			
	<b>STATINS, LOW POTENCY</b>		<p>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.</p> <p>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.</p>	ALTOPREV LESCOL/XL
	<b>STATINS, HIGH POTENCY</b>		<p>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.</p> <p>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.</p>	CRESTOR LIVALO
	<b>STATIN COMBINATIONS</b>		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 ( <i>use separate agents</i> ) amlodopine/atorvastatin ( <b>BRAND IS PREFERRED</b> ) CHOLESTIN PRAVIGARD SIMCOR VYTORIN ( <i>use separate agents</i> )
	<b>TRIGLYCERIDE LOWERING AGENTS</b>		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

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<b>CONTRACEPTIVES</b>	<p align="center"><b>ORAL CONTRACEPTIVES</b></p> altavera apri aviane azurette balzia <b>BREVICON*</b> briellyn cryselle emoquette enpresse errin <b>ESTROSTEP FE*</b> gildess FE jolessa jolivette junel/junel FE kariva kelnor lessina levora LOESTRIN 24 FE LOSEASONIQUE low-ogestrel luteru LYBREL microgestin mononessa NECON 10/11-28 nora-be norgestrel/ethinyl estradiol NORINYL 1/50-28 OGESTREL orsythia <b>ORTHO TRI-CYCLEN LO*</b> <b>ORTHO-NOVUM 1/35-28, 7/7/7-28*</b> OVCON 50 portia previfem reclipen seasonale <b>SEASONIQUE*</b> solia sprintec sronyx trinessa <b>TRI-NORINYL*</b> tri-previfem trivora velivet <b>YASMIN*</b> <b>YAZ*</b> zenchent ZOVIA			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) cyclofem (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) neon 0.5/35, 1/35, 7/7/7 (BRAND IS PREFERRED) NECON 1/50 (use preferred) norethindrone/ethinyl 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)
<b>CORTICOSTEROIDS</b>	<p align="center"><b>ORAL CORTICOSTEROIDS</b></p> budesonide cortisone acetate dexamethasone/intensol hydrocortisone methylprednisone prednisolone prednisone			CELESTONE (use preferred)
<b>COUGH AND COLD</b>	<p align="center"><b>COMBINATION AGENTS</b></p> BROMFED DM <p align="center"><b>DEXTROMETHORPHAN AGENTS</b></p> DELSYM <p align="center"><b>GUAIFENESIN AGENTS</b></p> guaifenesin MUCINEX TAB 1200MG MUCINEX TAB 600MG ER MUCINEX CGH LIQ 5-100MG MUCINEX/KIDS GRA 100MG		Refer to the Over the Counter Drug Coverage at <a href="http://www.wyequalitycare.org">www.wyequalitycare.org</a> for a list of covered products.	

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<b>DIABETES</b>	<b>DIABETES AGENTS</b>			
	BIGUANIDES			
	metformin/ER			FORTAMET (use preferred) GLUMETZA (use preferred) RIOMET (use preferred)
	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		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)
	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			
		JANUVIA ONGLYZA TRADJENTA	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.	
	DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITOR COMBO AGENTS			
		JANUMET JUVISYNC KOMBIGLYZE	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.	JANUMET XR JENTADUETO
	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.	BYDUREON VICTOZA
	INTERMEDIATE-ACTING INSULIN			
	HUMULIN N HUMULIN 70/30 NOVOLOG N NOVOLOG 70/30			
	LONG-ACTING INSULIN			
LANTUS <u>via</u>			LANTUS OPTICLIK/SOLOSTAR (use preferred) LEVEMIR (use preferred)	
RAPID-ACTING INSULIN				
APIDRA HUMALOG NOVOLOG				
DIABETIC METERS/TEST STRIPS				
FREESTYLE INSULINX		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				
<b>EAR</b>	<b>ANTIBIOTIC/STEROID COMBINATION</b>			
CORTISPORIN SOL 1% OTIC* <small>Neomycin/Polymyxin B Sulfates/Hydrocortisone suspension</small>			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) <small>Neomycin/Polymyxin B Sulfates/Hydrocortisone solution (BRAND IS PREFERRED)</small>	
ofloxacin				

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<b>FIBROMYALGIA</b>	<b>FIBROMYALGIA STEP 1</b>			
	amitriptyline cyclobenzaprine			
	<b>FIBROMYALGIA STEP 2</b>		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		
	<b>FIBROMYALGIA STEP 3</b>		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		
	<b>DIGESTIVE ENZYMES</b>		Prior authorization required.	PANCREAZE pancrelipase ( <i>BRAND IS PREFERRED</i> ) TRI-PASE
	CREON 3000, 6000, 12000, 24000 UNIT ZENPEP*			
<b>GASTROINTESTINAL</b>	<b>PROTON PUMP INHIBITORS</b>		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.	ACIPHEX lansoprazole NEXIUM omeprazole <u>tablets</u> ( <i>use preferred</i> ) omeprazole bicarbonate VIMOVO ( <i>use separate agents</i> )
	DEXILANT omeprazole <u>capsules</u> pantoprazole		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.	
	<b>MESALAMINE</b>		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 ( <i>use preferred</i> ) ROWASA
	mesalamine enema PENTASA 250MG ONLY			
<b>GROWTH HORMONE</b>	<b>GROWTH HORMONE</b>		PA is required for use outside of FDA-approved indications. Evaluation by an endocrinologist is preferred.	HUMATROPE OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE
		GENOTROPIN NORDITROPIN NUTROPIN AQ	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.	
<b>HEPATITIS C</b>	<b>INTERFERON</b>		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
	PEGASYS		Peg-Intron will be approved for pediatric patients (aged 18 and under), for retreatment, and for dosage adjustments that cannot be achieved with Pegasys.	
	<b>PROTEASE INHIBITOR</b>		Prior authorization required for non-preferred agent.	INCIVEK
	VICTRELIS			

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>(THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT GHS FOR QUESTIONS)</small>
<b>IMMUNOMODULATORS</b>	<b>IMMUNOMODULATORS</b>		<p>Client must have <b>diagnosis prior to approval</b> for <b>preferred agents</b> (outlined below):</p> <p><b>Enbrel</b>: Ankylosing Spondylitis (AS), Juvenile Idiopathic Arthritis (JIA), Plaque Psoriasis (PP), Psoriatic Arthritis (PA), Rheumatoid Arthritis (RA)**</p> <p><b>Humira</b>: 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 <b>non-preferred agents</b>, 60-day trial and failure of a preferred agent is required and client must have diagnosis prior to approval (outlined below):</p> <p><b>Actemra</b>: RA (60-day trial of methotrexate is required)</p> <p><b>Amevive</b>: PP</p> <p><b>Cimzia</b>: Crohn's***, RA</p> <p><b>Kineret</b>: RA</p> <p><b>Orencia</b>: JIA, RA</p> <p><b>Remicade</b>: AS, Crohn's, PP, PA, RA, Ulcerative Colitis****</p> <p><b>Rituxan</b>: RA</p> <p><b>Simponi</b>: AS, PA, RA</p> <p><b>Stelara</b>: PP</p> <p><b>Tysabri</b>: 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>
<b>INSOMNIA</b>	<b>NON-BENZODIAZEPINES</b>		<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>**Eduar, Intermezzo, and Zolpimist will be approved for clients with an inability to swallow zolpidem tablets.</p> <p>***Rozerem is non-preferred without a history of substance abuse.</p> <p>Dosage limits apply: zaleplon: 30mg/day zolpidem: 15mg/day</p>	<p>EDLUAR** (additional criteria applies) INTERMEZZO** (additional criteria applies) ROZEREM** zolpidem ER ZOLPIMIST** (additional criteria applies)</p>
<b>MIGRAINE</b>	<b>TRIPTAN STEP 1</b>		<p>Quantity limits apply:</p> <p>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</p>	<p>AXERT FROVA MAXALT RELPAX TREMIMET ZOMIG</p>
	<b>TRIPTAN STEP 2</b>		<p>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.</p> <p>Quantity limits apply: MAXALT MLT 5mg: 27tabs/34days MAXALT MLT 10mg: 14tabs/34days</p>	
<b>MULTIPLE SCLEROSIS</b>	<b>IMMUNOMODULATOR (GLATIRAMER INJECTION)</b>		<p>Trial and failure of one (1) interferon agent AND failure of Copaxone before approval can be give for a non-preferre agent.</p> <p>For Tysabri, in addition to the above criteria, additional prior authorization criteria applies.</p>	<p>EXTAVIA GILENYA TYSABRI (additional criteria applies)</p>
	COPAXONE			
	<b>INTERFERON BETA-1A</b>			
	AVONEX			
	REBIF			
	<b>INTERFERON BETA-1B</b>			
	BETASERON			

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<b>NSAIDS</b>	<p align="center"><b>NSAIDs</b></p> diclofenac etodolac fenoprofen flurbiprofen ibuprofen indomethacin ketoprofen <b>ketorolac</b> meclufenamate meloxicam nabumetone naproxen oxaprozin sulindac tolmetin		Trial and failure of two (2) preferred agents each greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.  Dosing limits apply for ketorolac (limit 5days/34 days).	CALDOLOR CAMBIA POWDER CELEBREX FLECTOR <i>(additional criteria applies)</i> NAPRELAN NEOPROFEN PENNSAID <i>(additional criteria applies)</i> SOLARAZE <i>(additional criteria applies)</i> <b>SPRIX</b> <i>(additional criteria applies)</i> VOLTAREN <i>(additional criteria applies)</i> ZIPSOR
<b>OPHTHALMICS</b>	<p align="center"><b>OP. -ANTIBIOTICS- QUINOLONES</b></p> ciprofloxacin ofloxacin VIGAMOX		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
	<p align="center"><b>OP. -ANTI-INFLAMMATORY- NSAIDS</b></p> flurbiprofen diclofenac ketorolac		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 <i>(use preferred)</i> ACUVAIL BROMDAY bromfenac NEVANAC
	<p align="center"><b>OP. -BETA-BLOCKERS</b></p> betaxolol carteolol levobunolol metipranolol timolol		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
	<p align="center"><b>OP. -CARBONIC ANHYDRASE INHIBITOR</b></p> dorzolamide		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
	<p align="center"><b>OP. -CARBONIC ANHYDRASE INHIBITOR COMBO</b></p> dorzolamide/timolol		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.	<b>COSOPT PF</b>
	<p align="center"><b>OP. -ANTIHISTAMINE/MAST CELL STABILIZERS STEP 1</b></p> <b>azelastine</b> cromolyn		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.	ALAMAST ALOCRIIL ALOMIDE ALREX
	<p align="center"><b>OP. -ANTIHISTAMINE/MAST CELL STABILIZERS STEP 2</b></p> PATADAY PATANOL		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.  Alomide will be approved for children under the	BEPREVE ELESTAT EMADINE ketotifen LASTACAPT
	<p align="center"><b>OP. -PROSTAGLANDINS</b></p> latanoprost TRAVATAN Z		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 <b>ZIOPATAN</b>
	<p align="center"><b>OP. -SYMPATHOMIMETICS</b></p> ALPHAGAN P brimonidine dipivefrin		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 <i>(use separate agents)</i>
<b>OSTEOPOROSIS</b>	<p align="center"><b>BISPHOSPHONATES</b></p> alendronate		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 FOSAMAX-D <b>ibandronate</b>
	<p align="center"><b>NASAL CALCITONIN</b></p> calcitonin-salmon fortical			

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<b>OVERACTIVE BLADDER</b>	<b>OVERACTIVE BLADDER AGENTS</b>		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
<b>PHOSPHATE BINDERS</b>	<b>PHOSPHATE BINDERS</b>		Prior authorization required for non-preferred agents.	FOSRENOL RENVELA
<b>PRENATAL VITAMINS</b>	<b>PRENATAL VITAMINS</b>		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
<b>PROSTATE</b>	<b>5-ALPHA-REDUCTASE INHIBITORS</b>		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 ( <i>use separate agents</i> )
	<b>ALPHA BLOCKERS</b>		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 ( <i>use separate agents</i> ) RAPAFLO
<b>PULMONARY ANTIHYPERTENSIVES</b>	<b>5-ALPHA-REDUCTASE INHIBITORS</b>		Client must have a diagnosis of pulmonary hypertension.	
	ADCIRCA REVATIO		Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	TRACLEER
<b>RESTLESS LEG SYNDROME</b>	<b>RESTLESS LEG SYNDROME</b>		Client must have a diagnosis of Restless Leg Syndrome (RLS). Trial and failure of gabapentin greater than or equal to 60 days <u>and</u> 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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<b>SKELETAL MUSCLE RELAXANTS</b>	<b>MUSCLE RELAXANTS</b> baclofen cyclobenzaprine <b>tizanidine tablets</b>		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.	<b>carisoprodol</b> chlorzoxazone cyclobenzaprine ER metaxalone methocarbamol orphenadrine <b>tizanidine capsules (use preferred)</b>  <b>Carisoprodol is limited to 84 tabs/365 days.</b>
<b>STIMULANTS</b>	<b>AMPHETAMINES</b> <b>LONG ACTING AMPHETAMINES</b>  <b>ADDERALL XR*</b> <b>VYVANSE</b> <b>dextroamphetamine CR</b>  <b>IMMEDIATE RELEASE AMPHETAMINES</b>  <b>amphetamine salts combo</b> <b>dextroamphetamine</b>  <b>METHYLPHENIDATES</b> <b>LONG ACTING METHYLPHENIDATES</b>  <b>DAYTRANA</b> <b>FOCALIN XR</b> <b>methylin ER</b> <b>methylphenidate ER/CR/SA/SR tablets</b>  <b>IMMEDIATE RELEASE METHYLPHENIDATES</b>  <b>FOCALIN</b> <b>methylin tablets</b> <b>methylphenidate</b>		<p>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).</p> <p>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.</p> <p>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.</p> <p>Prior Authorization will be required for clients under the age of 5.</p> <p>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.</p> <p>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.</p> <p><b><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></b></p> <p><b>Quantity limits apply:</b>  <b>ADDERALL XR: 60mg/day</b>  <b>amphetamine salts combo: 60mg/day</b>  <b>amphetamine salts combo (narcolepsy): 90mg/day</b>  <b>CONCERTA: 135mg/day</b>  <b>DAYTRANA: 45mg/9 hour patch</b>  <b>dextroamphetamine: 90mg/day</b>  <b>dextroamphetamine CR: 90mg/day</b>  <b>dexmethylphenidate: 30mg/day</b>  <b>FOCALIN XR ≤ 13 years of age: 45mg/day</b>  <b>FOCALIN XR &gt; 13 years of age: 60mg/day</b>  <b>methylin/methylphenidate: 135mg/day</b>  <b>methylin/methylphenidate ER/CR/SR: 135mg/day</b>  <b>VYVANSE: 105mg/day</b></p>	<b>AMPHETAMINES:</b> <b>amphetamine salts combo ER (BRAND IS PREFERRED)</b>  <b>METHYLPHENIDATES:</b> <b>methylphenidate ER/CR/SR capsules</b> <b>(METADATE CD/RITALIN LA)</b>
	<b>SELECTIVE ALPHA-ADRENERGIC AGONIST</b> <b>GUANFACINE AGENTS</b>  <b>guanfacine</b>		<p>To obtain the <b>non-preferred agent</b>, client must meet the following criteria:</p> <p>Client must have a diagnosis of ADHD or ADD. Prior authorization will be required for clients under the age of 5.</p> <p>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 <b>AND</b>  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).</p>	<b>INTUNIV</b>

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<b>STIMULANTS</b> <i>Continued</i>	<b>CLONIDINE AGENTS</b>		Trial and benefit of clonidine IR will be required prior to approval of the non-preferred agent.	KAPVAY
	clonidine			
<b>TOPICAL AGENTS</b>	<b>IMPETIGO ANTIBIOTICS</b>		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			
	<b>BENZOYL PEROXIDE/CLINDAMYCIN COMBOS</b>		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		
	<b>CORTICOSTEROIS</b> <small>C=CREAM; G=GEL; L=LOTION; O=OINTMENT</small>		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	PANDEL
	<b>LOW POTENCY</b>			
	alclometasone desonide fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) prednicarbate			
	<b>MEDIUM POTENCY</b>		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%			
	<b>HIGH POTENCY</b>		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%			
	<b>IMMUNOMODULATORS</b>		Trial and failure of a preferred medium potency topical corticosteroid greater than or equal to a 21 day trial <u>and</u> 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		
	<b>SALICYLIC ACID</b>			All other topical salicylic acid formulations.
	aliclen shampoo 6% salacyn cream/lotion 6% Salicylic Acid Shampoo 6%			
	<b>SCABICIDES/PEDICULICIDES</b>		Trial and failure of a preferred agent in the last 12 months.	NATROBA OVIDE ULESFIA
	permethrin LINDANE			
	<b>UREA</b>			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%			