WYOMING MEDICAID
Preferred Drug List (PDL) - JANUARY 1, 2013

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**		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.	desloratadine CLARINEX RDT/SYRUP levocetirizine
	cetirizine fexofenadine loratadine			
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	CLARINEX-D
	cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine			
	ANTICHOLINERGIC BRONCHODILATORS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Spiriva 5 day STARTER package will be allowed one (1) time per recipient.	ATROVENT HFA TUDORZA
	ipratropium SPIRIVA			
	CORTICOSTEROID / BRONCHODILATOR COMBO'S		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.	
	ADVAIR/HFA DULERA SYMBICORT			
	LEUKOTRIENE MODIFIERS		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	zafirlukast ZYFLO
	montelukast			
	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% DYMISTA *(use separate agents)* 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 DYMISTA *(use separate agents)* flunisolide OMNARIS QNASL RHINOCORT triamcinolone *(BRAND IS PREFERRED)* VERAMYST ZETONNA
	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.	VENTOLIN HFA XOPENEX HFA
	PROAIR HFA PROVENTIL 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.	levalbuterol *(BRAND IS PREFERRED)*
	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 PULMICORT SUSPENSION
	budesonide FLOVENT HFA/DISK PULMICORT FLEXHALER 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. Prescriber must have a XDEA number. Subutex will be approved for clients pregnant or nursing or with a documented allergy to naloxone. Dosage limits apply (Max Dose: 24mg/day). Client is limited to two (2) years of Suboxone or buprenorphine use. Please submit PA requests on the Suboxone and buprenorphine PA form available at wyequalitycare.org.	SUBUTEX
		SUBOXONE/FILM		
	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. ***Nucynta ER will be allowed for diabetic peripheral neuropathy or slients with significant gastrointestinal concerns with other CII narcotics.	AVINZA BUTRANS** EXALGO 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			

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ANALGESICS *CONTINUED*	**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. **In addition to above criteria, Embeda and Oxecta require a diagnosis of drug/substance abuse. ***Nucynta will be allowed for diabetic peripheral neuropathy or slients with significant gastrointestinal concerns with other CII narcotics.	EMBEDA** levorphanol NUCYNTA*** OXECTA** 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. *Other testosterone dosage form products will require a diagnosis of hypogonadism or insufficient testosterone production (not outlined on PDL).*	FORTESTA *(use preferred)* TESTIM GEL *(use preferred)*
		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, deep vein thrombosis (DVT), pulmonary embolism (PE), reduction in risk of recurrence DVT or PE, 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*			
	LACOSAMIDE		Client must have a diagnosis of partial onset seizures.	
		VIMPAT		
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 clients with a diagnosis of peripheral neuropathy, osteoarthritis of the knee, or chronic low back pain. Dosage limits apply: bupropion ER/SR/XL: 450mg/day citalopram ≤ 60 years of age: 60mg/day citalopram > 60 years of age: 30mg/day escitalopram: 30mg/day fluoxetine ≤ 18 years of age: 90mg/day fluoxetine > 18 years of age: 120mg/day mirtazapine: 67.5mg/day paroxetine IR/CR ≤ 18 years of age: 75mg/day paroxetine IR > 18 years of age: 90mg/day paroxetine CR > 18 years of age: 112.5mg/day sertraline: 300mg/day venlafaxine ER ≤ 18 years of age: 450mg/day venlafaxine ER > 18 years of age: 337.5mg/day	***fluoxetine tablets*** *(use preferred)* ***mirtazapine 7.5mg and mirtazapine rapid-dissolve tablets*** *(use preferred)* ***venlafaxine ER tablets*** *(use preferred)* APLENZIN CYMBALTA* FORFIVO XL PRISTIQ VIIBRYD
	bupropion ER/SR/XL citalopram escitalopram 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 irbesartan *(BRAND IS PREFERRED)* MICARDIS TEVETEN 400mg
		AVAPRO*		
		BENICAR		
		DIOVAN		
		losartan		

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	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.	ATACAND HCTZ EDARBYCLOR irbesartan HCTZ *(BRAND IS PREFERRED)* MICARDIS HCTZ TEVETEN HCTZ
		AVALIDE* BENICAR HCTZ DIOVAN HCTZ losartan HCTZ		
	ARB COMBINATIONS			AZOR TWYNSTA *(use separate agents)* TRIBENZOR *(use separate agents)*
		EXFORGE/EXFORGE-HCTZ		
	ALPHA-BLOCKERS			clonidine patch (BRAND IS PREFERRED) NEXICLON XR *(use preferred)*
	CATAPRES PATCHES* clonidine			
ANTIPSYCHOTICS	**ATYPICAL ANTIPSYCHOTICS**		**Quetiapine 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. *Typical antipsychotics do not required prior authorization.* Dosage limits apply: ABILIFY <13 years of age: 23mg/day ABILIFY ≥13 years of age: 45mg/day FANAPT all ages: 36mg/day INVEGA all ages: 18mg/day LATUDA all ages: 240mg/day Risperidone ≤ 17 years of age: 5mg/day Risperidone > 17 years of age: 24mg/day SAPHRIS all ages: 30mg/day Olanzapine < 13 years of age: 15mg/day Olanzapine > 13 years of age: 30mg/day Quetiapine <13 years of age: 600mg/day Quetiapine 13-17 years of age: 900mg/day Quetiapine > 17 years of age: 1200mg/day ziprasidone < 17 years of age: 180mg/day ziprasidone > 17 years of age: 300mg/day	SEROQUEL XR *(use preferred)*
	ABILIFY/ODT FANAPT INVEGA INVEGA SUSTENNA LATUDA olanzapine quetiapine RISPERDAL CONSTA risperidone SAPHRIS ziprasidone ZYPREXA RELPREVV			
	SPECIAL ATYPICAL ANTIPSYCHOTICS		Dosage limits apply: 1350mg/day	
	clozapine			
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			
	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 fluvastatin/ER
	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. Zetia monotherapy will require PA.	ADVICOR *(use separate agents)* amlodopine/atorvastatin (BRAND IS PREFERRED) CHOLESTIN PRAVIGARD SIMCOR ZETIA* (*use preferred*)
	CADUET* VYTORIN			
	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)* aranelle *(BRAND IS PREFERRED)* azurette *(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)* kariva *(BRAND IS 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)* viorele *(BRAND IS PREFERRED)* zarah *(BRAND IS PREFERRED)* zenchent FE chewable *(PA required)* zeosa chewable *(PA required)*
	altavera AMETHYST apri aviane azurette balzia **BREVICON*** briellyn cryselle emoquette enpresse errin **ESTROSTEP FE*** gildess FE jolessa jolivette junel/junel FE kariva kelnor kurvelo lessina levora LOESTRIN 24 FE LOSEASONIQUE low-ogestrel lutera microgestin **MIRCETTE*** 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*** portia previfem reclipsen seasonale **SEASONIQUE*** 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			
DIABETES	**DIABETES AGENTS** **BIGUANIDES**			FORTAMET *(use preferred)* GLUMETZA *(use preferred)* RIOMET *(use preferred)*
	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)*
	pioglitazone			
	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. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	TRADJENTA
		JANUVIA ONGLYZA		
	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**. 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
		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.	BYDUREON VICTOZA
		BYETTA		

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DIABETES ***CONTINUED***	**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 INSULINX 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		
GASTROINTESTINAL	**DIGESTIVE ENZYMES**		Prior authorization required.	PANCREAZE pancrelipase *(BRAND IS PREFERRED)* PERTZYE TRI-PASE ULTRESA VIOKASE
	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.	ACIPHEX lansoprazole NEXIUM omeprazole tablets *(use preferred)* omeprazole bicarbonate OMECLAMOX *(use separate agents)* PREVPAC *(use separate agents)* 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, Ulcerative Colitis (UC), 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, UC *Rituxan* : RA *Simponi* : AS, PA, RA *Stelara* : PP *Tysabri* : Crohn's *(additional PA criteria applies)*	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)* INTERMEZZO *(additional criteria applies)* ROZEREM zolpidem ER ZOLPIMIST *(additional criteria applies)*
MIGRAINE	**TRIPTANS** naratriptan sumatriptan		Trial and failure of all preferred agents will be required for approval of a non-preferred agent. 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/MLT RELPAX TREXIMET ZOMIG
MULTIPLE SCLEROSIS	**IMMUNOMODULATOR (GLATIRAMER INJECTION)** COPAXONE **INTERFERON** AVONEX		Trial and failure of preferred interferon agent AND failure of Copaxone before approval can be give for a non-preferred agent. For Tysabri, in addition to the above criteria, additional prior authorization criteria applies.	AUBAGIO EXTAVIA BETASERON GILENYA REBIF TYSABRI (additional criteria applies)
NSAIDS	**NSAIDs** diclofenac etodolac fenoprofen flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate 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 and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets).	CALDOLOR CAMBIA POWDER CELEBREX FLECTOR *(additional criteria applies)* mefenamic acid NAPRELAN NEOPROFEN PENNSAID *(additional criteria applies)* SOLARAZE *(additional criteria applies)* SPRIX *(additional criteria applies)* VOLTAREN *(additional criteria applies)* ZIPSOR
OPHTHALMICS	**OP. -ANTI-ALLERGICS** azelastine cromolyn PATADAY PATANOL		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. Emadine, Alomide, and Alocril will be approved for pregnancy. Alomide will be approved for children under the age of 3.	ALAMAST ALOCRIL ALOMIDE ALREX BEPREVE ELESTAT EMADINE ketotifen LASTACAFT
	OP. -ANTIBIOTICS- QUINOLONES ciprofloxacin ofloxacin MOXEZA 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 ZYMAR ZYMAXID
	OP. -ANTI-INFLAMMATORY- NSAIDS 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 *(use preferred)* ACUVAIL BROMDAY bromfenac NEVANAC
	OP. -BETA-BLOCKERS 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
	OP. -CARBONIC ANHYDRASE INHIBITOR 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

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OPHTHALMICS *CONTINUED*	**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			
	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 ZIOPTAN
	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.	ALPHAGAN P 0.1% brimonidine 0.15% *(BRAND IS PREFERRED)* COMBIGAN (use separate agents)
	ALPHAGAN P 0.15%* brimonidine 0.2%			
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 FOSAMAX-D ibandronate
	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% MYRBETRIQ OXYTROL DIS SANCTURA XR tolterodine trospium
	oxybutynin /ER TOVIAZ VESICARE			
PHOSPHATE BINDERS	**PHOSPHATE BINDERS**		Prior authorization required for non-preferred agents.	calcium acetate tabs (*BRAND IS PREFERRED)* FOSRENOL PHOSLYRA RENAGEL 800MG *(use preferred)* RENVELA
	calcium acetate capsules **ELIPHOS*** RENAGEL 400MG ONLY			
PLATELET AGGREGATE INHIBITORS	**THIENOPYRIDINE DERIVATIVES**			
	clopidogrel EFFIENT ticlopidine			
	CYCLOPENTYLTRIAZOLOPYRIMIDINE (CPTP) Derivatives		Client must have diagnosis of acute coronary syndrome to reduce thrombotic cardiovascular events.	
		BRILINTA		
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
	COMPLETE-RF CO-NATAL FA ELITE-OB INATAL ULTRA LACTOCAL-F MARNATAL-F MAXINATE NATAFORT O-CAL PRENAFIRST PRENATABS RX PRENATAL 19/CHEWABLE PRENATAL LOW IRON PRENATAL PLUS/FE SE-CARE CHEWABLE SE-NATAL 19/CHEWABLE SE-NATAL 90 SE-NATAL ONE TARON-BC TRIMESIS RX TRINATAL RX TRI RX TRIVEEN-U VINATE II VINATE AZ 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		
		sildenafil (Revatio A/B rated generic)		
	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. *Neupro will be approved for clients with difficulty swallowing or for clients with a diagnosis of Parkinson's Disease.	HORIZANT NEUPRO*
		gabapentin		
		pramipexole ropinirole		

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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. Cyclobenzaprine will require a prior authorization for clients concurrently taking a tricylic antidepressant.	carisoprodol chlorzoxazone cyclobenzaprine ER metaxalone methocarbamol orphenadrine tizanidine capsules *(use preferred)* Carisoprodol is limited to 84 tabs/365 days.
	baclofen cyclobenzaprine tizanidine tablets			
STIMULANTS	**AMPHETAMINES** LONG ACTING AMPHETAMINES	amphetamine salts combo 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 with the exception of amphetamine salts combo immediate release, which will require prior authorization for clients under the age of 3. 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. **Dosage 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**	**METHYLPHENIDATES:** methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA)
		amphetamine salts combo* dextroamphetamine		
	METHYLPHENIDATES LONG ACTING METHYLPHENIDATES	DAYTRANA FOCALIN XR methylin ER methylphenidate ER/CR/SA/SR tablets		
	IMMEDIATE RELEASE METHYLPHENIDATES	FOCALIN methylin tablets methylphenidate		
STIMULANT-LIKE AGENTS	**SELECTIVE ALPHA-ADRENERGIC AGONIST** CLONIDINE AGENTS		Trial and benefit of clonidine IR will be required prior to approval of the non-preferred agent.	KAPVAY
	clonidine			
	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 days 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			
	SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR	STRATTERA	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. 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. Dosage limits apply: STRATTERA: 150mg/day	

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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 (BRAND IS PREFERRED)
		BENZACLIN* clindamycyin/benzoyl peroxide 1.2 (1)-5% (Refrig)		
TOPICAL AGENTS *Continued*	**CORTICOSTEROIS** C=CREAM; G=GEL; L=LOTION; O=OINTMENT **LOW POTENCY**		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	PANDEL
	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.	APEXICON 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. For clients less than two (2) years of age, a trial and failure of a preferred low potency corticosteroid greater than or equal to a 21 day trial and a trial and failure of a preferred medium potency topical cortiscosteroid 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%			