WYOMING MEDICAID
Preferred Drug List (PDL) - November 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://wymedicaid.org for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES (brand name medications) 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.	donepezil 23mg *(use preferred)* donepezil ODT *(use preferred)* NAMENDA XR
		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	buprenorphine/naloxone tablets (use preferred) 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			
	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			
	C-III/C-V AGENTS		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). **Butrans will require a 14 day trial and failure of tramadol IR and a 14 day trial and failure of tramadol ER prior to approval	BUTRANS** CONZIP RYBIX ODT tramadol/apap tramadol ER
	tramadol			

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://wymedicaid.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 GAIL FOR QUESTIONS)
ANDROGENS	**TESTOSTERONE TOPICAL GELS**	ANDROGEL	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)*
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	PRADAXA	Client must have diagnosis of non-valvular atrial fibrillation and relative contraindication to warfarin for approval.	
	SELECTIVE FACTOR XA INHIBITOR		Client must have diagnosis of non-valvular atrial fibrillation.	
		ELIQUIS		
		XARELTO	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.	
ANTICONVULSANTS	**DIAZEPAM RECTAL GEL**			diazepam gel *(BRAND IS PREFERRED)*
	DIASTAT*			
	LACOSAMIDE	VIMPAT	Client must have a diagnosis of partial onset seizures.	
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. One of the trials of preferred agents must be in the same class (NaSS, NDRI, SSRI, or SNRI) as the requested 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 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: 337.5mg/day	
	NORADRENERGIC/SPECIFIC SEROTONERICS (NaSS)			**NaSS**
	mirtazapine 15, 30, and 45mg			mirtazapine 7.5mg and rapid dissolve tablets *(use preferred)*
	NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)			**NDRI**
	bupropion ER/SR/XL			APLENZIN FORFIVO XL
	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)			**SSRI**
	citalopram escitalopram fluoxetine capsules paroxetine IR/CR sertraline			fluoxetine tablets *(use preferred)* VIIBRYD
	SEROTONIN/NORPINEPHRINE REUPTAKE INHIBITORS (SNRI)			**SNRI**
	venlafaxine ER capsules			CYMBALTA* desvenlafaxine PRISTIQ venlafaxine ER tablets *(use preferred)*
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.	candesartan EDARBI eprosartan 600mg irbesartan *(BRAND IS PREFERRED)* MICARDIS TEVETEN 400mg
		AVAPRO* BENICAR DIOVAN losartan		
	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.	candesartan 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			

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://wymedicaid.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
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: 36mg/day INVEGA: 18mg/day LATUDA: 240mg/day Risperidone ≤ 17 years of age: 5mg/day Risperidone > 17 years of age: 24mg/day SAPHRIS: 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 VASCEPA
	fenofibrate gemfibrozil TRICOR			
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/ethiynyl 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			

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://wymedicaid.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 GAIL FOR QUESTIONS
CORTICOSTEROIDS	**ORAL CORTICOSTEROIDS**			CELESTONE *(use preferred)*
	budesonide cortisone acetate dexamethasone/intensol hydrocortisone methylprednisone prednisolone prednisone			
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)* repaglinide
	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.	NESINA 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 KAZANO OSENI
		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		
	SGLT2 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.	
		INVOKANA		
	INTERMEDIATE-ACTING INSULIN			
	HUMULIN N HUMULIN 70/30 NOVOLOG N NOVOLOG 70/30			
	LONG-ACTING INSULIN			LANTUS OPTICLIK/SOLOSTAR *(use preferred)*
	LANTUS vial			LEVEMIR (use preferred)
	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 (NEOMIX-HYDROMIX)
	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		

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://wymedicaid.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 GAIL FOR QUESTIONS
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 amox/clarith/lansoprazole pack *(use separate agents)* esomeprazole 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			
IMMUNOMODULATORS	**IMMUNOMODULATORS**		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** **56-day trial and failure of methotrexate required prior to approval of Enbrel or Humira for diagnosis of Rheumatoid Arthritis (RA) For *non-preferred agents* , 56-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)*
	ENBREL HUMIRA			
INSOMNIA	**NON-BENZODIAZEPINES**		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. Prior authorization will be required for clients under the age of 18. 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)*
	zaleplon zolpidem			

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://wymedicaid.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 GAIL FOR QUESTIONS
MIGRAINE	**TRIPTANS**		Trial and failure of all preferred agents will be required for approval of a non-preferred agent. Quantity limits apply: naratriptan 1mg: 25 tabs/34 days naratriptan 2.5mg: 10 tabs/34 days sumatriptan kit: 3 kits/34 days sumatriptan vials: 2 vials/34 days sumatriptan nasal: 6 bottles/34 days sumatriptan 25mg: 41 tabs/34 days sumatriptan 50mg: 20 tabs/34 days sumatriptan 100mg: 10 tabs/34 days	AXERT FROVA RELPAX rizatriptan TREXIMET zolmitriptan
	naratriptan sumatriptan			
MULTIPLE SCLEROSIS	**IMMUNOMODULATOR (GLATIRAMER INJECTION)**		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 TECFIDERA TYSABRI (additional criteria applies)
	COPAXONE			
	INTERFERON			
	AVONEX			
NEUROPATHIC PAIN	**TRICYCLIC ANTIDEPRESSANTS**		For the diagnosis of neuropathic pain, trial and failure of a tricyclic antidepressant greater than or equal to a 12 week supply AND trial and failure of gabapentin at a dose of 3600mg per day for greater than or equal to a 12 week supply in the last 12 months will be required before approval can be given for a non-preferred agent.	CYMBALTA LYRICA
		amitriptyline imipramine nortriptyline		
	GABAPENTIN			
		gabapentin		
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 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
	diclofenac etodolac fenoprofen flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate meloxicam nabumetone naproxen oxaprozin sulindac tolmetin			
OPHTHALMICS	**OP. -ANTI-ALLERGICS**		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
	azelastine cromolyn PATADAY PATANOL			
	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 gatifloxacin IQUIX levofloxacin ZYMAR
	ciprofloxacin ofloxacin MOXEZA 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			
	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			

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://wymedicaid.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 GAIS FOR QUESTIONS
PLATELET AGGREGATE INHIBITORS	**THIENOPYRIDINE DERIVATIVES**		Prior authorization reuquired for clients on antiplatelet therapy greater than one (1) year.	
	clopidogrel EFFIENT ticlopidine			
	CYCLOPENTYLTRIAZOLOPYRIMIDINE (CPTP) Derivatives		Client must have diagnosis of acute coronary syndrome to reduce thrombotic cardiovascular events.	
		BRILINTA		
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		
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			
STIMULANT	**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 4. 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	**AMPHETAMINES:** ZENZEDI 2.5 AND 7.5MG TABLETS **METHYLPHENIDATES:** methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA) QUILLIVANT XR SUSPENSION
	LONG ACTING AMPHETAMINES			
		amphetamine salts combo 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 tablets		
	IMMEDIATE RELEASE METHYLPHENIDATES			
		FOCALIN methylin tablets methylphenidate		

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://wymedicaid.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 GAIL FOR QUESTIONS)
STIMULANT-LIKE AGENTS	**SELECTIVE ALPHA-ADRENERGIC AGONIST**		To obtain the **non-preferred agent**, client must meet the following criteria: Client must have diagnosis of ADD or ADHD. Prior authorization will be required for clients under the age of 4. Clients must have completed a 14 day trial of clonidine IR with benefit in the previous 12 months.	KAPVAY
	CLONIDINE AGENTS clonidine			
	GUANFACINE AGENTS guanfacine		To obtain the **non-preferred agent**, client must meet the following criteria: Client must have diagnosis of ADD or ADHD. Prior authorization will be required for clients under the age of 4. Clients must have trial and failure of a stimulant greater than or equal to a 14 day supply **OR** a trial and failure of Strattera greater than or equal to a 30 day supply **AND** a 14 day trial of guanfacine with benefit 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
	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	
TOPICAL AGENTS	**IMPETIGO ANTIBIOTICS** gentamicin mupirocin		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
	BENZOYL PEROXIDE/CLINDAMYCIN COMBOs	**BENZACLIN®** clindamycyin/benzoyl peroxide 1.2 (1)-5% (Refrig)	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)
	CORTICOSTEROIS C=CREAM; G=GEL; L=LOTION; O=OINTMENT **LOW POTENCY** alclometasone desonide fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) prednicarbate		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	PANDEL
	MEDIUM POTENCY 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%		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
	HIGH POTENCY amcinonide betamethasone dipropionate clobetasol desoximetasone 0.25%, 0.05% (G) diflorasone fluocinonide flurandrenolide fluticasone 0.005% (O) halobetasol triamcinolone 0.5%		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	APEXICON HALOG
	IMMUNOMODULATORS	ELIDEL PROTOPIC	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.	
	SALICYLIC ACID aliclen shampoo 6% salacyn cream/lotion 6% Salicylic Acid Shampoo 6%			All other topical salicylic acid formulations.
	SCABICIDES/PEDICULICIDES permethrin LINDANE		Trial and failure of a preferred agent in the last 12 months.	NATROBA OVIDE SKLICE ULESFIA
	UREA Kerafoam Aerosol 30% Remeven Cream 50% urea hydration aerosol 35% urea emulsion 50% urea nail suspension 40% urea suspension 50% X-Viate Cream 40%			All other topical urea formulations.