WYOMING MEDICAID
Preferred Drug List (PDL) - January 1, 2014

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 THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT GHS FOR QUESTIONS
ADDICTION AGENTS	**BUPRENORPHINE COMBINATIONS**	SUBOXONE FILM ZUBSOLV	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
ALLERGY / ASTHMA	**ANTIHISTAMINES, MINIMALLY SEDATING**	cetirizine fexofenadine loratadine	Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	desloratadine CLARINEX RDT/SYRUP levocetirizine
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS	cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine	Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	CLARINEX-D
	ANTICHOLINERGIC BRONCHODILATORS	COMBIVENT ipratropium SPIRIVA	Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Spiriva 5 day STARTER package will be allowed one (1) time per recipient.	ATROVENT HFA TUDORZA
	CORTICOSTEROID / BRONCHODILATOR COMBO'S	ADVAIR/HFA DULERA SYMBICORT	Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. *Breo Ellipta will also require the diagnosis of COPD. Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.	BREO ELLIPTA*
	LEUKOTRIENE MODIFIERS	montelukast	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
	NASAL ANTIHISTAMINES	**ASTELIN***	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% azelastine (BRAND IS PREFERRED) DYMISTA *(use separate agents)* PATANASE
	NASAL STEROIDS	BECONASE AQ flunisolide fluticasone NASONEX	Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Rhinocort will be approved for pregnancy.	DYMISTA *(use separate agents)* OMNARIS QNASL RHINOCORT triamcinolone VERAMYST ZETONNA
	SHORT ACTING BRONCHODILATORS - INHALERS	PROAIR HFA PROVENTIL HFA VENTOLIN HFA	Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	XOPENEX HFA
	SHORT ACTING BRONCHODILATORS - NEBULIZERS	albuterol neb **XOPENEX neb***	Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	levalbuterol (BRAND IS PREFERRED)
	STEROID INHALANTS	budesonide FLOVENT HFA/DISK PULMICORT FLEXHALER QVAR	Trial and failure of three (3) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Alvesco will be approved for a history of oral thrush with steroid inhalants.	AEROBID/AEROBID-M ALVESCO ASMANEX PULMICORT SUSPENSION
	EPINEPHRINE	EPI-PEN		ADRENACLICK *(use preferred)* AUVI-Q *(use preferred)* epinephrine *(use preferred)*
ALZHEIMERS	**ALZHEIMER AGENTS**	donepezil EXELON PATCH/SOLUTION galantamine/ER NAMENDA rivastigmine capsules	Client must have a diagnosis of dementia.	donepezil 23mg *(use preferred)* donepezil ODT *(use preferred)* NAMENDA XR

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ANALGESICS	**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 clients with significant gastrointestinal concerns with other CII narcotics.	AVINZA EXALGO KADIAN (10mg/200mg) morphines sulfate ER capsules NUCYNTA ER*** OPANA ER (5mg/10mg/20mg/30mg/40mg) oxymorphone ER (7.5mg/15mg) OXYCONTIN/CR
	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			
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			
	INHALED TOBRAMYCIN			BETHKIS *(use preferred)* TOBI PODHALER *(use preferred)* inhaled tobramycin (BRAND IS PREFERRED)
	TOBI*			
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.	
		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		Client must have a diagnosis of partial onset seizures.	
		VIMPAT		

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ANTIDEPRESSANTS	**ANTIDEPRESSANTS**		Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks will be required before approval can be given for a non-preferred agent. 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. **Brintellix requires trial and failure of two preferred agents in any class 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)*
				OTHER
				BRINTELLIX**
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 MICARDIS TEVETEN 400mg
		BENICAR DIOVAN irbesartan 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 MICARDIS HCTZ TEVETEN HCTZ
		BENICAR HCT DIOVAN HCT irbesartan HCTZ losartan HCT		
	ALPHA-BLOCKERS			clonidine patch (BRAND IS PREFERRED) NEXICLON XR *(use preferred)*
	CATAPRES PATCHES*			
	clonidine			
ANTIVIRALS	**PROTEASE INHIBITORS**			NORVIR capsules *(use preferred)* NORVIR solution *(use preferred)*
	APTIVUS CRIXIVAN INVIRASE LEXIVA NORVIR tablets PREZISTA REYATAZ VIRACEPT			

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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			
	NIACIN			
	NIACOR NIASPAN			
	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 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 LIPTRUZET 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			

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CONTRACEPTIVES	**ORAL CONTRACEPTIVES**			
	altavera AMETHYST apri aviane balzia **BREVICON*** briellyn caziant cryselle emoquette enpresse errin **ESTROSTEP FE*** Femcon FE gildess FE jolessa jolivette junel/junel FE kelnor kurvelo lessina levora LOESTRIN 24 FE, 1/20-21, 1/20 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			amethia (BRAND IS PREFERRED) aranelle (BRAND IS PREFERRED) azurette (BRAND IS PREFERRED) BEYAZ *(PA required)* camila *(use preferred)* camrese (BRAND IS PREFERRED) cesia *(use preferred)* cyclafem (BRAND IS PREFERRED) GENERESS FE CHW *(PA required)* gianvi (BRAND IS PREFERRED) heather *(use preferred)* introvale *(use preferred)* kariva (BRAND IS PREFERRED) levonorgestrel /ethinyl estrad (91-Day) *(use preferred)* leena (BRAND IS PREFERRED) LO LOESTRIN *(PA required)* loryna (BRAND IS PREFERRED) NATAZIA (PA required) necon 0.5/35, 1/35, 7/7/7 (BRAND IS PREFERRED) NECON 1/50 *(use preferred)* norethindrone/ethyinyl estradiol chew *(PA required)* norethindrone *(use preferred)* NORINYL 1/35 *(use preferred)* nortrel (BRAND IS PREFERRED) ocella (BRAND IS PREFERRED) ORTHO-NOVUM 1/50 *(use preferred)* quasense *(use preferred)* SAFYRAL *(PA required)* syeda (BRAND IS PREFERRED) tilia FE (BRAND IS PREFERRED) tri-legest FE (BRAND IS PREFERRED) tri-lo-sprintec (BRAND IS PREFERRED) viorele (BRAND IS PREFERRED) zarah (BRAND IS PREFERRED) zenchent FE chewable *(PA required)* zeosa chewable *(PA required)*
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) 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		

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DIABETES *cont.*	**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 KAZANO OSENI
	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
	SGLT2 INHIBITORS	INVOKANA	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.	
	INTERMEDIATE-ACTING INSULIN HUMULIN N HUMULIN 70/30 NOVOLIN N NOVOLIN 70/30			
	LONG-ACTING INSULIN LANTUS SOLOSTAR LANTUS vial			LANTUS OPTICLIK *(use preferred)* LEVEMIR *(use preferred)*
	RAPID-ACTING INSULIN APIDRA HUMALOG NOVOLOG			
	SHORT-ACTING INSULIN HUMULIN R NOVOLIN R			
	DIABETIC METERS/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		Quantity limit applies (1 meter/365days).	ALL OTHER METERS AND TEST STRIPS
EAR	**ANTIBIOTIC/STEROID COMBINATION** Neo/Poly/HC Suspension and Solution Ofloxacin			CIPRODEX *(use preferred)* ciprofloxacin 0.2% *(use preferred)* CIPRO HC *(use preferred)* COLY-MYCIN S *(use preferred)* CORTISPORIN-TC *(use preferred)* FLUOCINOLONE ACET OIL 0.01% *(use preferred)*
FIBROMYALGIA	**FIBROMYALGIA STEP 1** amitriptyline cyclobenzaprine			
	FIBROMYALGIA STEP 2	SAVELLA	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.	
	FIBROMYALGIA STEP 3	CYMBALTA LYRICA	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.	
GASTROINTESTINAL	**DIGESTIVE ENZYMES** CREON 3000, 6000, 12000, 24000, and 36000 units **ZENPEP***		Prior authorization required.	PANCREAZE pancrelipase (BRAND IS PREFERRED) PERTZYE TRI-PASE ULTRESA VIOKASE
	PROTON PUMP INHIBITORS lansoprazole capsules omeprazole capsules pantoprazole		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.	ACIPHEX SPRINKLES amox/clarith/lansoprazole pack *(use separate agents)* DEXILANT esomeprazole lansoprazole solutabs NEXIUM omeprazole tablets *(use preferred)* omeprazole/sodium bicarbonate OMECLAMOX *(use separate agents)* rabeprazole VIMOVO *(use separate agents)*
	MESALAMINE mesalamine enema PENTASA 250MG ONLY		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

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GROWTH HORMONE	**GROWTH HORMONE**	GENOTROPIN NORDITROPIN HUMATROPE	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.	NUTROPIN AQ OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE
HEPATITIS C	**INTERFERON** PEGASYS		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
	PROTEASE INHIBITOR INCIVEK VICTRELIS			
IMMUNOMODULATORS	**IMMUNOMODULATORS**	ENBREL HUMIRA SIMPONI	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** ***Simponi*** : AS, PA, RA** **56-day trial and failure of methotrexate required prior to approval of Enbrel, Humira, or Simponi 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* : AS, PA, Crohn's, RA *Kineret* : RA *Orencia* : JIA, RA *Remicade* : AS, Crohn's, PP, PA, RA, UC *Rituxan* : RA *Stelara* : PP *Tysabri : Crohn's (additional PA criteria applies)*	ACTEMRA AMEVIVE CIMZIA KINERET ORENCIA RAPTIVA REMICADE RITUXAN 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. 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)*
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: 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
MULTIPLE SCLEROSIS	**IMMUNOMODULATOR (GLATIRAMER INJECTION)** COPAXONE **INTERFERON** AVONEX REBIF		Trial and failure of a 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 TECFIDERA TYSABRI (additional criteria applies)

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES (THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT DHS FOR QUESTIONS)
NEUROPATHIC PAIN	**TRICYCLIC ANTIDEPRESSANTS**	amitriptyline imipramine nortriptyline	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
	GABAPENTIN	gabapentin		
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 ZORVOLEX
OPHTHALMICS	**OP. -ANTI-ALLERGICS** cromolyn **OPTIVAR*** 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 azelastine (BRAND IS PREFERRED) 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 gatifloxacin IQUIX levofloxacin ZYMAR
	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
	OP. - COMBO PRODUCTS COMBIGAN dorzolamide/timolol SIMBRINZA		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.	
	OP. -PROSTAGLANDINS 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 ZIOPTAN
	OP. -SYMPATHOMIMETICS **ALPHAGAN P 0.15%*** brimonidine 0.2%		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)
OSTEOPOROSIS	**BISPHOSPHONATES** 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 ibandronate
	NASAL CALCITONIN calcitonin-salmon fortical			
OVERACTIVE BLADDER	**OVERACTIVE BLADDER AGENTS** oxybutynin /ER TOVIAZ VESICARE		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
PHOSPHATE BINDERS	**PHOSPHATE BINDERS** calcium acetate capsules **ELIPHOS*** PHOSLYRA RENAGEL		Prior authorization required for non-preferred agents.	calcium acetate tabs (BRAND IS PREFERRED) FOSRENOL RENVELA

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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		
PROGESTIN	**PROGESTIN**		Prior authorization is required.	
		MAKENA		
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.	
		LETAIRIS TRACLEER		
	SOLUBLE GUANYLATE CYCLASE STIMULATORS		Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
		ADEMPAS		
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:** dextroamphetamine CR capsules (BRAND IS PREFERRED) 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 **DEXEDRINE CAPSULES*** VYVANSE		
	IMMEDIATE RELEASE AMPHETAMINES			
		amphetamine salts combo* dextroamphetamine tablets		
	METHYLPHENIDATES			
	LONG ACTING METHYLPHENIDATES			
		DAYTRANA FOCALIN XR methylin ER methylphenidate ER/CR/SA/SR tablets		
	IMMEDIATE RELEASE METHYLPHENIDATES			
		dexmethylphenidate methylin tablets methylphenidate		

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STIMULANT-LIKE AGENTS	**SELECTIVE ALPHA-ADRENERGIC AGONIST**		To obtain the **non-preferred agent**, client must meet the following criteria: Client must have a 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		To obtain the **non-preferred agent**, client must meet the following criteria: Client must have a diagnosis of ADD or ADHD Prior authorization will be require for clients under the age of 4. Clients must have a 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
	guanfacine			
	SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR		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	
		STRATTERA		

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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)		
	CORTICOSTEROIS C=CREAM; G=GEL; L=LOTION; O=OINTMENT		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	PANDEL
	LOW POTENCY			
	alclometasone desonide fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) prednicarbate			
	MEDIUM POTENCY		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	CLODERM CORDRAN/SP TOPICORT LP TRIANEX
	betamethasone valerate desoximetasone 0.05% (C) fluocinolone 0.025% fluticasone 0.05% (C) hydrocortisone butyrate 0.1% (O) hydrocortisone probutate 0.1% (C) mometasone triamcinolone 0.025%, 0.1%			
	HIGH POTENCY		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	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.	OVIDE permethrin cream SKLICE ULESFIA
	LINDANE NATROBA permethrin solution			
	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%			