# WYOMING MEDICAID
## Preferred Drug List (PDL) - July 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<br>GENERIC MANDATORY POLICY APPLIES<br>THIS LIST IS NOT ALL INCLUSIVE<br>PLEASE CONTACT GHS FOR QUESTIONS |
|---|---|---|---|---|
| **ADDICTION AGENTS** | **BUPRENORPHINE COMBINATIONS** | | Client must have a diagnosis of opioid dependence or abuse. This is not to be used for the treatment of chronic pain. Prior authorization will be required for before any narcotic prescription will be allowed between fills. Prescriber must have a XDEA number.<br><br>Oral buprenorphine will be approved for clients that are pregnant or nursing or with a documented allergy to naloxone.<br><br>Dosage limits apply (Max Dose: 24mg/day). Client is limited to two (2) years of buprenorphine/naloxone or oral buprenorphine use.<br><br>Please submit PA requests on the "Oral Buprenorphine/Naloxone or Oral Buprenorphine" PA form available at www.wymedicaid.org. | oral buprenorphine<br>buprenorphine/naloxone tablets *(use preferred)* |
| | | SUBOXONE FILM<br>ZUBSOLV | | |
| | **NALTREXONE** | | Client must have a diagnosis of alcohol or opioid dependance. | |
| | | naltrexone<br>VIVITROL | | |
| **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<br>CLARINEX RDT/SYRUP<br>levocetirizine |
| | cetirizine<br>fexofenadine<br>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<br>fexofenadine/pseudoephedrine<br>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.<br><br>Spiriva 5 day STARTER package will be allowed one (1) time per recipient. | ATROVENT HFA<br>TUDORZA |
| | COMBIVENT<br>ipratropium<br>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.<br><br>*Breo Ellipta will also require the diagnosis of COPD.<br><br>Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient. | BREO ELLIPTA* |
| | ADVAIR/HFA<br>DULERA<br>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<br>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. | azelastine 0.15%<br>DYMISTA *(use separate agents)*<br>PATANASE |
| | **ASTELIN**<br>azelastine 0.1% | | | |
| | **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.<br><br>Budesonide will be approved for pregnancy. | budesonide<br>DYMISTA *(use separate agents)*<br>OMNARIS<br>QNASL<br>triamcinolone<br>VERAMYST<br>ZETONNA |
| | BECONASE AQ<br>flunisolide<br>fluticasone<br>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. | XOPENEX HFA |
| | PROAIR HFA<br>PROVENTIL HFA<br>VENTOLIN 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<br>**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.<br><br>Alvesco will be approved for a history of oral thrush with steroid inhalants. | AEROBID/AEROBID-M<br>ALVESCO<br>ASMANEX<br>PULMICORT SUSPENSION 1mg/2ml |
| | budesonide<br>FLOVENT HFA/DISK<br>PULMICORT FLEXHALER<br>QVAR | | | |
| | **EPINEPHRINE** | | | ADRENACLICK *(use preferred)*<br>AUVI-Q *(use preferred)*<br>epinephrine *(use preferred)* |
| | EPI-PEN | | | |
| **ALZHEIMERS** | **ALZHEIMER AGENTS** | | Client must have a diagnosis of dementia. | donepezil 23mg *(use preferred)*<br>donepezil ODT *(use preferred)* |
| | | donepezil<br>EXELON PATCH/SOLUTION<br>galantamine/ER<br>NAMENDA/XR<br>rivastigmine capsules | | |

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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.<br><br>Fentanyl patches are limited to one patch every 72 hours.<br><br>C-IIIs and C-IVs are not included and are available without prior authorization with the exception of Butrans (generic substitution is mandatory).<br><br>**Butrans requires a trial of morphine sulfate or low dose trial of fentanyl patch.<br><br>***Nucynta ER will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics. | AVINZA<br>BUTRANS**<br>hydromorphone ER<br>KADIAN (10mg/200mg)<br>morphine sulfate ER capsules<br>NUCYNTA ER***<br>OPANA ER (5mg/10mg/20mg/30mg/40mg)<br>oxymorphone ER (7.5mg/15mg)<br>OXYCONTIN/CR |
| | | fentanyl patch<br>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.<br><br>**In addition to above criteria, Embeda and Oxecta require a diagnosis of drug/substance abuse.<br><br>***Nucynta will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics. | EMBEDA**<br>levorphanol<br>NUCYNTA***<br>OXECTA**<br>oxymorphone<br>oxycodone/IBU |
| | codeine sulfate<br>hydromorphone<br>morphine sulfate<br>oxycodone<br>oxycodone/APAP<br>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.<br><br>Quantity and dosage limits apply (max 8 tabs/day).<br><br>**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**<br>CONZIP<br>RYBIX ODT<br>tramadol/apap<br>tramadol ER |
| | tramadol | | | |
| **ANDROGENS** | **TESTOSTERONE TOPICAL GELS** | | Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient testosterone production.<br><br>*Other testosterone dosage form products will require a diagnosis of hypogonadism or insufficient testosterone production (not outlined on PDL).* | FORTESTA *(use preferred)*<br>TESTIM GEL *(use preferred)* |
| | | ANDROGEL | | |
| **ANTIBIOTICS** | **QUINOLONES** | | | FACTIVE<br>moxifloxacin<br>NOROXIN<br>PROQUIN |
| | ciprofloxacin/ER<br>levofloxacin<br>ofloxacin | | | |
| | **DOXYCYCLINE** | | | ADOXA *(use preferred)*<br>DORYX *(use preferred)*<br>ORACEA *(use preferred)* |
| | doxycycline | | | |
| | **MINOCYCLINE** | | | SOLODYN *(use preferred)* |
| | minocycline/ER | | | |
| | **INHALED TOBRAMYCIN** | | | inhaled tobramycin (BRAND IS PREFERRED)<br>TOBI PODHALER *(use preferred)* |
| | **BETHKIS**<br>**TOBI*** | | | |
| **ANTICOAGULANTS** | **LOW MOLECULAR WEIGHT HEPARIN (LMWH)** | | | enoxaparin (BRAND IS PREFERRED)<br>FRAGMIN *(use preferred)*<br>LOVENOX 300MG/3ML *(use preferred)* |
| | **LOVENOX*** | | | |
| | **DIRECT THROMBIN INHIBITOR** | | Client must have diagnosis of non-valvular atrial fibrillation and relative contraindication to warfarin for approval. | |
| | | PRADAXA | | |
| | **SELECTIVE FACTOR XA INHIBITOR** | | Client must have diagnosis of non-valvular atrial fibrillation or deep vein thrombosis (DVT) prophylaxis in knee or hip replacement. | |
| | | 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 DVT 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.<br><br>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.<br><br>*Duloxetine will be approved for clients with a diagnosis of osteoarthritis of the knee or chronic low back pain.<br><br>**Brintellix requires trial and failure of two preferred agents in any class<br><br>Dosage limits apply:<br>bupropion ER/SR/XL: 450mg/day<br>citalopram ≤ 60 years of age: 60mg/day<br>citalopram > 60 years of age: 30mg/day<br>escitalopram: 30mg/day<br>fluoxetine ≤ 18 years of age: 90mg/day<br>fluoxetine > 18 years of age: 120mg/day<br>mirtazapine: 67.5mg/day<br>paroxetine IR/CR ≤ 18 years of age: 75mg/day<br>paroxetine IR > 18 years of age: 90mg/day<br>paroxetine CR > 18 years of age: 112.5mg/day<br>sertraline: 300mg/day<br>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<br>FORFIVO XL |
| | **SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)** | | | **SSRI** |
| | citalopram<br>escitalopram<br>fluoxetine capsules<br>paroxetine IR/CR<br>sertraline | | | fluoxetine tablets *(use preferred)*<br>VIIBRYD |
| | **SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS (SNRI)** | | | **SNRI** |
| | venlafaxine ER capsules | | | duloxetine*<br>desvenlafaxine<br>FETZIMA<br>PRISTIQ<br>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<br>captopril<br>enalapril<br>fosinopril<br>lisinopril<br>moexipril<br>perindopril<br>quinapril<br>ramipril<br>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<br>captopril/HCTZ<br>enalapril/HCTZ<br>fosinopril/HCTZ<br>lisinopril/HCTZ<br>moexipril/HCTZ<br>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<br>EDARBI<br>eprosartan 600mg<br>telmisartan<br>TEVETEN 400mg |
| | | BENICAR<br>DIOVAN<br>irbesartan<br>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<br>EDARBYCLOR<br>telmisartan HCTZ<br>TEVETEN HCTZ |
| | | BENICAR HCT<br>DIOVAN HCT<br>irbesartan HCTZ<br>losartan HCT | | |
| | **ALPHA-BLOCKERS** | | | clonidine patch (BRAND IS PREFERRED)<br>NEXICLON XR *(use preferred)* |
| | **CATAPRES PATCHES***<br>clonidine | | | |
| **ANTIVIRALS** | **PROTEASE INHIBITORS** | | | NORVIR capsules *(use preferred)*<br>NORVIR solution *(use preferred)* |
| | APTIVUS<br>CRIXIVAN<br>INVIRASE<br>LEXIVA<br>NORVIR tablets<br>PREZISTA<br>REYATAZ<br>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.<br><br>*Typical antipsychotics do not required prior authorization.*<br><br>Dosage limits apply:<br>ABILIFY <13 years of age: 23mg/day<br>ABILIFY ≥13 years of age: 45mg/day<br>FANAPT: 36mg/day<br>INVEGA: 18mg/day<br>LATUDA: 240mg/day<br>Risperidone ≤ 17 years of age: 5mg/day<br>Risperidone > 17 years of age: 24mg/day<br>SAPHRIS: 30mg/day<br>Olanzapine < 13 years of age: 15mg/day<br>Olanzapine > 13 years of age: 30mg/day<br>Quetiapine <13 years of age: 600mg/day<br>Quetiapine 13-17 years of age: 900mg/day<br>Quetiapine > 17 years of age: 1200mg/day<br>ziprasidone < 17 years of age: 180mg/day<br>ziprasidone > 17 years of age: 300mg/day | SEROQUEL XR *(use preferred)* |
| | ABILIFY/ODT<br>ABILIFY MAINTENA<br>FANAPT<br>INVEGA<br>INVEGA SUSTENNA<br>LATUDA<br>olanzapine<br>quetiapine<br>RISPERDAL CONSTA<br>risperidone<br>SAPHRIS<br>ziprasidone<br>ZYPREXA RELPREVV | | | |
| | **SPECIAL ATYPICAL ANTIPSYCHOTICS** | | Dosage limits apply: 1350mg/day | VERSACLOZ Suspension *(use preferred)* |
| | 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<br>colestipol | | | |
| | **NIACIN** | | | |
| | NIACOR<br>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.<br><br>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<br>fluvastatin/ER |
| | lovastatin<br>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.<br><br>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<br>LIVALO<br>LIVALO |
| | atorvastatin<br>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.<br><br>Zetia monotherapy will require PA. | ADVICOR *(use separate agents)*<br>amlodopine/atorvastatin (BRAND IS PREFERRED)<br>CHOLESTIN<br>LIPTRUZET<br>PRAVIGARD<br>SIMCOR<br>ZETIA* *(use preferred )* |
| | **CADUET***<br>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<br>fenofibric<br>FENOGLIDE<br>LOVAZA<br>VASCEPA |
| | fenofibrate<br>gemfibrozil<br>TRICOR | | | |

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| **CONTRACEPTIVES** | **ORAL CONTRACEPTIVES** | | | amethia (BRAND IS PREFERRED)<br>aranelle (BRAND IS PREFERRED)<br>azurette (BRAND IS PREFERRED)<br>BEYAZ *(PA required)*<br>camila *(use preferred)*<br>camrese (BRAND IS PREFERRED)<br>cesia *(use preferred)*<br>cyclafem (BRAND IS PREFERRED)<br>GENERESS FE CHW *(PA required)*<br>gianvi (BRAND IS PREFERRED)<br>heather *(use preferred)*<br>introvale *(use preferred)*<br>kariva (BRAND IS PREFERRED)<br>levonorgestrel /ethinyl estrad (91-Day) *(use preferred)*<br>leena (BRAND IS PREFERRED)<br>LO LOESTRIN *(PA required)*<br>loryna (BRAND IS PREFERRED)<br>NATAZIA (PA required)<br>necon 0.5/35, 1/35, 7/7/7 (BRAND IS PREFERRED)<br>NECON 1/50 *(use preferred)*<br>norethindrone/ethyinyl estradiol chew *(PA required)*<br>norethindrone *(use preferred)*<br>NORINYL 1/35 *(use preferred)*<br>nortrel (BRAND IS PREFERRED)<br>ocella (BRAND IS PREFERRED)<br>ORTHO-NOVUM 1/50 *(use preferred)*<br>quasense *(use preferred)*<br>SAFYRAL *(PA required)*<br>syeda (BRAND IS PREFERRED)<br>tilia FE (BRAND IS PREFERRED)<br>tri-legest FE (BRAND IS PREFERRED)<br>tri-lo-sprintec (BRAND IS PREFERRED)<br>viorele (BRAND IS PREFERRED)<br>zarah (BRAND IS PREFERRED)<br>zenchent FE chewable *(PA required)*<br>zeosa chewable *(PA required)* |
| | altavera<br>AMETHYST<br>apri<br>aviane<br>balzia<br>**BREVICON***<br>briellyn<br>caziant<br>cryselle<br>emoquette<br>enpresse<br>errin<br>**ESTROSTEP FE***<br>Femcon FE<br>gildess FE<br>jolessa<br>jolivette<br>junel/junel FE<br>kelnor<br>kurvelo<br>lessina<br>levora<br>LOESTRIN 24 FE, 1/20-21, 1/20 FE<br>LOSEASONIQUE<br>low-ogestrel<br>lutera<br>microgestin<br>**MIRCETTE***<br>mononessa<br>NECON 10/11-28<br>nora-be<br>norgestrel/ethinyl estradiol<br>NORINYL 1/50-28<br>OGESTREL<br>orsythia<br>**ORTHO TRI-CYCLEN LO***<br>**ORTHO-NOVUM 1/35-28, 7/7/7-28***<br>portia<br>previfem<br>reclipsen<br>seasonale<br>**SEASONIQUE***<br>sprintec<br>sronyx<br>trinessa<br>**TRI-NORINYL***<br>tri-previfem<br>trivora<br>velivet<br>**YASMIN***<br>**YAZ***<br>zenchent<br>ZOVIA | | | |
| **CORTICOSTEROIDS** | **ORAL CORTICOSTEROIDS** | | | CELESTONE *(use preferred)* |
| | budesonide<br>cortisone acetate<br>dexamethasone/intensol<br>hydrocortisone<br>methylprednisone<br>prednisolone<br>prednisone | | | |
| **DIABETES** | **DIABETES AGENTS** | | | FORTAMET *(use preferred)*<br>GLUMETZA *(use preferred)*<br>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)<br>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)*<br>AVANDIA<br>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<br>glipizide/ER<br>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<br>TRADJENTA |
| | | JANUVIA<br>ONGLYZA | | |

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|---|---|---|---|---|
| **DIABETES**<br>***cont.*** | **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<br>JENTADUETO<br>KAZANO<br>OSENI |
| | | JANUMET<br>JUVISYNC<br>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<br>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. | |
| | | FARXIGA<br>INVOKANA | | |
| | **INTERMEDIATE-ACTING INSULIN** | | Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently | |
| | HUMULIN N<br>HUMULIN 70/30<br>NOVOLIN N<br>NOVOLIN 70/30 | | | |
| | **LONG-ACTING INSULIN** | | Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently | LANTUS OPTICLIK *(use preferred)*<br>LEVEMIR *(use preferred )* |
| | LANTUS SOLOSTAR<br>LANTUS vial | | | |
| | **RAPID-ACTING INSULIN** | | Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently | |
| | APIDRA<br>HUMALOG<br>NOVOLOG | | | |
| | **SHORT-ACTING INSULIN** | | Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently | |
| | HUMULIN R<br>NOVOLIN R | | | |
| | **DIABETIC METERS/TEST STRIPS** | | Quantity limit applies (1 meter/365days). | ALL OTHER METERS AND TEST STRIPS |
| | FREESTYLE INSULINX<br>FREESTYLE LITE<br>FREESTYLE FREEDOM LITE<br>ONE TOUCH ULTRA<br>ONE TOUCH ULTRA 2<br>ONE TOUCH ULTRA MINI<br>ONE TOUCH ULTRASMART<br>PRECISION XTRA | | | |
| **EAR** | **ANTIBIOTIC/STEROID COMBINATION** | | | CIPRODEX *(use preferred)*<br>ciprofloxacin 0.2% *(use preferred)*<br>CIPRO HC *(use preferred)*<br>COLY-MYCIN S *(use preferred)*<br>CORTISPORIN-TC *(use preferred)*<br>FLUOCINOLONE ACET OIL 0.01% *(use preferred)* |
| | Neo/Poly/HC Suspension and Solution<br>Ofloxacin | | | |
| **FIBROMYALGIA** | **FIBROMYALGIA STEP 1** | | | |
| | amitriptyline<br>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. | |
| | | duloxetine<br>LYRICA | | |
| **GASTROINTESTINAL** | **DIGESTIVE ENZYMES** | | Prior authorization required. | PANCREAZE<br>pancrelipase (BRAND IS PREFERRED)<br>PERTZYE<br>TRI-PASE<br>ULTRESA<br>VIOKASE |
| | CREON 3000, 6000, 12000, 24000, and 36000 units<br>**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.<br><br>Lansoprazole solutabs will be approved for children less than or equal to 8 years of age. | ACIPHEX SPRINKLES<br>amox/clarith/lansoprazole pack *(use separate agents)*<br>DEXILANT<br>esomeprazole<br>lansoprazole solutabs<br>NEXIUM<br>omeprazole 20.6mg capsules *(use preferred)*<br>omeprazole tablets *(use preferred)*<br>omeprazole/sodium bicarbonate<br>OMECLAMOX *(use separate agents)*<br>rabeprazole<br>VIMOVO *(use separate agents)* |
| | lansoprazole capsules<br>omeprazole capsules<br>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<br>ASACOL/HD<br>CANASA<br>LIALDA<br>PENTASA 500MG *(use preferred)*<br>ROWASA |
| | mesalamine enema<br>PENTASA 250MG ONLY | | | |

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| **GROWTH HORMONE** | **GROWTH HORMONE** | | PA is required for use outside of FDA-approved indications. Evaluation by an endocrinologist is preferred.<br><br>Clinical evidence of improved growth will be required on a yearly basis to support ongoing utilization.<br><br>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.<br><br>Trial and failure of two (2) preferred agents within the last 12 months will be required for the following indications:<br><br>Pediatric: Growth failure due to inadequate endogenous growth hormone, Prader-Willi syndrome, children born small for gestation. Turner syndrome.<br><br>Adult: Replacement for those with growth hormone deficiency. | NUTROPIN AQ<br>OMNITROPE<br>SAIZEN<br>SEROSTIM<br>TEV-TROPIN<br>ZORBTIVE |
| | | GENOTROPIN<br>NORDITROPIN<br>HUMATROPE | | |
| **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.<br><br>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 | | | |
| | **NUCLEOTIDE ANALOG POLYMERASE INHIBITOR** | | Prior authorization is required prior to use of Sovaldi. | |
| | | SOVALDI | | |
| | **PROTEASE INHIBITOR** | | Prior authorization is required prior to use of Olysio. | |
| | INCIVEK<br>VICTRELIS | OLYSIO | | |
| **IMMUNOMODULATORS** | **IMMUNOMODULATORS** | | Client must have ***diagnosis prior to approval*** for ***preferred agents*** (outlined below):<br>***Enbrel*** : Ankylosing Spondylitis (AS), Juvenile Idiopathic Arthritis (JIA), Plaque Psoriasis (PP), Psoriatic Arthritis (PA), Rheumatoid Arthritis (RA)**<br>***Humira*** : AS, Crohn's, JIA, PP, PA, Ulcerative Colitis (UC), RA**<br>***Simponi*** : AS, PA, RA**<br><br>**56-day trial and failure of methotrexate required prior to approval of a preferred agent (Enbrel, Humira, or Simponi) for diagnosis of Rheumatoid Arthritis (RA).<br><br>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):<br>*Actemra* : RA**<br>*Amevive* : PP<br>*Cimzia* : AS, PA, Crohn's, RA**<br>*Kineret* : RA<br>*Orencia* : JIA, RA**<br>*Otezla* : PA<br>*Remicade* : AS, Crohn's, PP, PA, RA**, UC<br>*Rituxan* : RA**<br>*Stelara* : PP<br>*Tysabri* : Crohn's (additional PA criteria applies) | ACTEMRA<br>AMEVIVE<br>CIMZIA<br>KINERET<br>ORENCIA<br>OTEZLA<br>RAPTIVA<br>REMICADE<br>RITUXAN<br>STELARA<br>TYSABRI *(additional criteria applies)* |
| | | ENBREL<br>HUMIRA<br>SIMPONI | | |
| **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.<br><br>Prior authorization will be required for clients under the age of 18.<br><br>Rozerem is non-preferred without a history of substance abuse<br><br>Prior authorization will be required when a client is taking more than one insomnia agent concurrently.<br><br>Dosage limits apply:<br>zaleplon: 30mg/day<br>zolpidem: 15mg/day | EDLUAR *(additional criteria applies)*<br>eszopiclone<br>INTERMEZZO *(additional criteria applies)*<br>ROZEREM<br>zolpidem ER<br>ZOLPIMIST *(additional criteria applies)* |
| | zaleplon<br>zolpidem | | | |
| **MIGRAINE** | **TRIPTANS** | | Trial and failure of all preferred agents will be required for approval of a non-preferred agent.<br><br>Rizatriptan will be approved for clients between 6 and 17 years of age<br><br>Quantity limits apply:<br>naratriptan 1mg: 25 tabs/34 days<br>naratriptan 2.5mg: 10 tabs/34 days<br>sumatriptan vials: 2 vials/34 days<br>sumatriptan nasal: 6 bottles/34 days<br>sumatriptan 25mg: 41 tabs/34 days<br>sumatriptan 50mg: 20 tabs/34 days<br>sumatriptan 100mg: 10 tabs/34 days | AXERT<br>FROVA<br>RELPAX<br>rizatriptan<br>TREXIMET<br>zolmitriptan |
| | naratriptan<br>sumatriptan | | | |

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| **MULTIPLE SCLEROSIS** | **IMMUNOMODULATOR (GLATIRAMER INJECTION)** | | Trial and failure of a preferred interferon agent AND failure of Copaxone 20mg/ml will be required before approval can be give for a non-preferred agent.<br><br>For Tysabri, in addition to the above criteria, additional prior authorization criteria applies. | AUBAGIO<br>BETASERONE<br>COPAXONE 40MG/ML<br>EXTAVIA<br>GILENYA<br>TECFIDERA<br>TYSABRI (additional criteria applies) |
| | COPAXONE 20MG/ML | | | |
| | **INTERFERON** | | | |
| | AVONEX<br>REBIF | | | |
| **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. | duloxetine<br>LYRICA |
| | | amitriptyline<br>imipramine<br>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.<br><br>Dosing and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets). | CALDOLOR<br>CAMBIA POWDER<br>CELEBREX<br>diclofenac 3% gel *(additional criteria applies)*<br>FLECTOR *(additional criteria applies)*<br>mefenamic acid<br>NAPRELAN<br>NEOPROFEN<br>PENNSAID *(additional criteria applies)*<br>SPRIX *(additional criteria applies)*<br>VOLTAREN *(additional criteria applies)*<br>ZIPSOR<br>ZORVOLEX |
| | diclofenac *tablets*<br>etodolac<br>fenoprofen<br>flurbiprofen<br>ibuprofen<br>indomethacin<br>ketoprofen<br>ketorolac<br>meclofenamate<br>meloxicam<br>nabumetone<br>naproxen<br>oxaprozin<br>piroxicam<br>sulindac<br>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.<br><br>Emadine, Alomide, and Alocril will be approved for pregnancy.<br><br>Alomide will be approved for children under the age of 3. | ALAMAST<br>ALOCRIL<br>ALOMIDE<br>ALREX<br>azelastine (BRAND IS PREFERRED)<br>BEPREVE<br>ELESTAT<br>EMADINE<br>ketotifen<br>LASTACAFT |
| | cromolyn<br>**OPTIVAR***<br>PATADAY<br>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.<br><br>Azasite will be approved for pregnancy. | AZASITE<br>BESIVANCE<br>gatifloxacin<br>IQUIX<br>levofloxacin<br>ZYMAR |
| | ciprofloxacin<br>ofloxacin<br>MOXEZA<br>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)*<br>ACUVAIL<br>BROMDAY<br>bromfenac<br>NEVANAC |
| | flurbiprofen<br>diclofenac<br>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.<br><br>Betoptic S will be approved for those with heart and lung conditions. | BETIMOL<br>BETOPTIC S<br>ISTALOL |
| | betaxolol<br>carteolol<br>levobunolol<br>metipranolol<br>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. - COMBO PRODUCTS** | | 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. | |
| | COMBIGAN<br>dorzolamide/timolol<br>SIMBRINZA | | | |
| | **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<br>ZIOPTAN |
| | latanoprost<br>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%<br>brimonidine 0.15% (BRAND IS PREFERRED)<br>COMBIGAN (use separate agents) |
| | **ALPHAGAN P 0.15%***<br>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.<br><br>Fosamax liquid will be approved for clients that have difficulty swallowing. | ACTONEL<br>ATELVIA<br>FOSAMAX-D<br>ibandronate |
| | alendronate | | | |
| | **NASAL CALCITONIN** | | | |
| | calcitonin-salmon<br>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.<br><br>Oxytrol will be approved for clients that have an inability to swallow. | ENABLEX<br>GELNIQUE GEL 10%<br>MYRBETRIQ<br>OXYTROL DIS<br>SANCTURA XR<br>tolterodine/ER<br>trospium |
| | oxybutynin /ER<br>TOVIAZ<br>VESICARE | | | |
| **PHOSPHATE BINDERS** | **PHOSPHATE BINDERS** | | Prior authorization required for non-preferred agents. | calcium acetate tabs (BRAND IS PREFERRED)<br>FOSRENOL<br>sevelamer |
| | calcium acetate capsules<br>**ELIPHOS***<br>PHOSLYRA<br>RENAGEL | | | |

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| **PLATELET AGGREGATE INHIBITORS** | **THIENOPYRIDINE DERIVATIVES** | | Prior authorization reuquired for clients on antiplatelet therapy greater than one (1) year. | |
| | clopidogrel<br>EFFIENT<br>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<br>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<br>JALYN *(use separate agents)*<br>RAPAFLO |
| | doxazosin<br>tamsulosin<br>terazosin | | | |
| **PULMONARY ANTIHYPERTENSIVES** | **5-ALPHA-REDUCTASE INHIBITORS** | | Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis. | |
| | | ADCIRCA<br>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. | OPSUMIT |
| | | LETAIRIS<br>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.<br><br>*Neupro will be approved for clients with difficulty swallowing or for clients with a diagnosis of Parkinson's Disease. | HORIZANT<br>NEUPRO* |
| | | gabapentin<br>pramipexole<br>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.<br><br>Cyclobenzaprine will require a prior authorization for clients concurrently taking a tricylic antidepressant. | carisoprodol<br>chlorzoxazone<br>cyclobenzaprine ER<br>metaxalone<br>methocarbamol<br>orphenadrine<br>tizanidine capsules *(use preferred)*<br><br>Carisoprodol is limited to 84 tabs/365 days. |
| | baclofen<br>cyclobenzaprine<br>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).<br><br>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.<br><br>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.<br><br>Prior Authorization will be required for clients under the age of 4.<br><br>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.<br><br>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.<br><br>Dosage limits apply:<br>ADDERALL XR: 60mg/day<br>amphetamine salts combo: 60mg/day<br>amphetamine salts combo (narcolepsy): 90mg/day<br>CONCERTA: 135mg/day<br>DAYTRANA: 45mg/9 hour patch<br>dextroamphetamine: 90mg/day<br>dextroamphetamine CR: 90mg/day<br>dexmethylphenidate: 30mg/day<br>FOCALIN XR < 13 years of age: 45mg/day<br>FOCALIN XR > 13 years of age: 60mg/day<br>methylin/methylphenidate: 135mg/day<br>methylin/methylphenidate ER/CR/SR: 135mg/day<br>VYVANSE: 105mg/day | **AMPHETAMINES:**<br>dextroamphetamine CR capsules (BRAND IS PREFERRED)<br>ZENZEDI 2.5 AND 7.5MG TABLETS<br><br>**METHYLPHENIDATES:**<br>methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA)<br>QUILLIVANT XR SUSPENSION |
| | LONG ACTING AMPHETAMINES | | | |
| | | amphetamine salts combo XR<br>**DEXEDRINE CAPSULES***<br>VYVANSE | | |
| | IMMEDIATE RELEASE AMPHETAMINES | | | |
| | | amphetamine salts combo*<br>dextroamphetamine tablets | | |
| | **METHYLPHENIDATES** | | | |
| | LONG ACTING METHYLPHENIDATES | | | |
| | | DAYTRANA<br>FOCALIN XR<br>methylin ER<br>methylphenidate ER/CR/SA/SR tablets | | |
| | IMMEDIATE RELEASE METHYLPHENIDATES | | | |
| | | dexmethylphenidate<br>methylin tablets<br>methylphenidate | | |

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| **STIMULANT-LIKE AGENTS** | **SELECTIVE ALPHA-ADRENERGIC AGONIST**<br>**CLONIDINE AGENTS** | | | |
| | clonidine | | To obtain the **non-preferred agent**, client must meet the following criteria:<br><br>Client must have a diagnosis of ADD or ADHD<br><br>Prior authorization will be required for clients under the age of 4.<br><br>Clients must have completed a 14 day trial of clonidine IR with <u>benefit</u> in the previous 12 months. | **KAPVAY*** |
| | **GUANFACINE AGENTS** | | | |
| | guanfacine | | To obtain the **non-preferred agent**, client must meet the following criteria:<br>Client must have a diagnosis of ADD or ADHD<br>Prior authorization will be require for clients under the age of 4.<br><br>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 <u>**AND**</u> a 14 day trial of guanfacine with <u>benefit</u> in the previous 12 months,<br><br>OR a contraindication to ADHD medications (including stimulant and non-stimulant),<br><br>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).<br><br>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.<br><br>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.<br><br>Prior Authorization will be required for clients under the age of 5.<br><br>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.<br><br>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.<br><br>Dosage limits apply:<br>STRATTERA: 150mg/day | |

**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<br>GENERIC MANDATORY POLICY APPLIES<br>THIS LIST IS NOT ALL INCLUSIVE<br>PLEASE CONTACT GHS FOR QUESTIONS |
|---|---|---|---|---|
| **TOPICAL AGENTS** | **IMPETIGO ANTIBIOTICS** | | Trial and failure of ALL preferred agents greater than or equal to 7 days in the past 90 days.<br><br>Use smallest size appropriate for 7 day trial. | ALTABAX |
| | gentamicin<br>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.<br>Acne combinations are limited to clients under the age of 21. | ACANYA<br>benzoyl peroxide/clindamycin (BRAND IS PREFERRED) |
| | | **BENZACLIN***<br>clindamycyin/benzoyl peroxide 1.2 (1)-5% (Refrig) | | |
| | **CORTICOSTEROIS**<br>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<br>desonide<br>fluocinolone 0.01%<br>hydrocortisone butyrate 0.1% (C)<br>hydrocortisone 1%, 2.5% (C,L,O)<br>prednicarbate | | | |
| | **MEDIUM POTENCY** | | Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days. | Clocortolone Pivalate<br>CORDRAN/SP<br>TOPICORT LP<br>TRIANEX |
| | betamethasone valerate<br>desoximetasone 0.05% (C)<br>fluocinolone 0.025%<br>fluticasone 0.05% (C)<br>hydrocortisone butyrate 0.1% (O)<br>hydrocortisone probutate 0.1% (C)<br>mometasone<br>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<br>HALOG |
| | amcinonide<br>betamethasone dipropionate<br>clobetasol<br>desoximetasone 0.25%, 0.05% (G)<br>diflorasone<br>fluocinonide<br>flurandrenolide<br>fluticasone 0.005% (O)<br>halobetasol<br>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.<br><br>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<br>PROTOPIC | | |
| | **SALICYLIC ACID** | | | All other topical salicylic acid formulations. |
| | aliclen shampoo 6%<br>salacyn cream/lotion 6%<br>Salicylic Acid Shampoo 6% | | | |
| | **SCABICIDES/PEDICULICIDES** | | Trial and failure of a preferred agent in the last 12 months. | OVIDE<br>permethrin cream<br>SKLICE<br>ULESFIA |
| | LINDANE<br>NATROBA<br>permethrin solution | | | |
| | **UREA** | | | All other topical urea formulations. |
| | Kerafoam Aerosol 30%<br>Remeven Cream 50%<br>urea hydration aerosol 35%<br>urea emulsion 50%<br>urea nail suspension 40%<br>urea suspension 50%<br>X-Viate Cream 40% | | | |