

**WYOMING MEDICAID  
Preferred Drug List (PDL) - August 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 <small>This list is not all inclusive Please contact us for questions</small>
<b>ADDITION AGENTS</b>	<b>BUPRENORPHINE COMBINATIONS</b>		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.  Oral buprenorphine will be approved for clients that are pregnant or nursing or with a documented allergy to naloxone.  <b>Dosage limits apply (Max Dose: 24mg/day). Client is limited to two (2) years of buprenorphine/naloxone or oral buprenorphine use.</b>  Please submit PA requests on the "Oral Buprenorphine/Naloxone or Oral Buprenorphine" PA form available at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> .	<b>oral buprenorphine buprenorphine/naloxone tablets (use preferred)</b>
		SUBOXONE FILM ZUBSOLV		
	<b>NALTREXONE</b>		Client must have a diagnosis of alcohol or opioid dependence.	
		naltrexone VIVITROL		
<b>ALLERGY / ASTHMA</b>	<b>ANTIHISTAMINES, MINIMALLY SEDATING</b>		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	desloratadine CLARINEX RDT/SYRUP levocetirizine
	cetirizine fexofenadine loratadine			
	<b>ANTIHISTAMINE/DECONGESTANT COMBINATIONS</b>			
	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
	<b>ANTICHOLINERGIC BRONCHODILATORS</b>		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.  <b>Spiriva 5 day STARTER package will be allowed one (1) time per recipient.</b>	ATROVENT HFA TUDORZA
	COMBIVENT ipratropium SPIRIVA			
	<b>CORTICOSTEROID / BRONCHODILATOR COMBO'S</b>		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.  *Will also require the diagnosis of COPD.  <b>Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.</b>	<b>ANORO ELLIPTA*</b> BREO ELLIPTA*
	ADVAIR/HFA DULERA SYMBICORT			
	<b>LEUKOTRIENE MODIFIERS</b>		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			
	<b>NASAL ANTIHISTAMINES</b>		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% DYMISTA (use separate agents) PATANASE
	<b>ASTELIN</b> azelastine 0.1%			
	<b>NASAL STEROIDS</b>		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.  Budesonide will be approved for pregnancy.	budesonide DYMISTA (use separate agents) OMNARIS QNASL triamcinolone VERAMYST ZETONNA
	BECONASE AQ flunisolide fluticasone NASONEX			
	<b>SHORT ACTING BRONCHODILATORS - INHALERS</b>		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 PROVENTIL HFA VENTOLIN HFA				
<b>SHORT ACTING BRONCHODILATORS - NEBULIZERS</b>		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 <b>XOPENEX neb*</b>				
<b>STEROID INHALANTS</b>		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 1mg/2ml	
<b>AEROSPAN</b> budesonide FLOVENT HFA/DISK PULMICORT FLEXHALER QVAR				
<b>EPINEPHRINE</b>			ADRENACLICK (use preferred) AUVI-Q (use preferred) epinephrine (use preferred)	
EPI-PEN				
<b>ALZHEIMERS</b>	<b>ALZHEIMER AGENTS</b>		Client must have a diagnosis of dementia.	donepezil 23mg (use preferred) donepezil ODT (use preferred)
		donepezil EXELON PATCH/SOLUTION galantamine/ER NAMENDA/XR 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.  C-IIIs and C-IVs are not included and are available without prior authorization with the exception of Butrans (generic substitution is mandatory).  <b>Fentanyl patches will require a prior authorization unless a client has a cancer diagnosis or previous treatment of at least a 10 day supply within the last 45 days</b>  **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.  <b>Fentanyl patches are limited to one patch every 72 hours.</b>	AVINZA BUTRANS** <b>hydromorphone ER</b> KADIAN (10mg/200mg) morphine sulfate ER capsules NUCYNTA ER*** OPANA ER (5mg/10mg/20mg/30mg/40mg) oxymorphone ER (7.5mg/15mg) <b>OXYCONTIN/CR</b>
	morphine sulfate ER <u>tablets</u>	<b>fentanyl patch</b>		
	SHORT-ACTING C-IIIs			
	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.  <b>Quantity and dosage limits apply (max 8 tabs/day).</b>  **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** <b>CONZIP</b> <b>RYBIX ODT</b> <b>tramadol/apap</b> <b>tramadol ER</b>
	tramadol			
ANDROGENS	TESTOSTERONE TOPICAL GELS		Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient testosterone production.  <i>Other testosterone dosage form products will require a diagnosis of hypogonadism or insufficient testosterone production (not outlined on PDL).</i>	FORTESTA GEL (use preferred) TESTIM GEL (use preferred) <b>testosterone gel (BRAND IS PREFERRED)</b> <b>VOGELXO GEL (use preferred)</b>
		ANDROGEL*		
ANTIBIOTICS	QUINOLONES			FACTIVE moxifloxacin NOROXIN PROQUIN
	ciprofloxacin/ER levofloxacin ofloxacin			
	DOXYCYCLINE			ADOXA (use preferred) DORYX (use preferred) ORACEA (use preferred)
	doxycycline			SOLODYN (use preferred)
	MINOCYCLINE			
minocycline/ER				
	INHALED TOBRAMYCIN			inhaled tobramycin (BRAND IS PREFERRED) TOBI PODHALER (use preferred)
	BETHKIS 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 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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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>(EPICRATES IS NOT TO BE USED) PLEASE CONTACT WMS FOR QUESTIONS</small>	
ANTIDEPRESSANTS	<b>ANTIDEPRESSANTS</b>		<p>Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks will be required before approval can be given for a non-preferred agent. <b>One of the trials of preferred agents must be in the same class (NaSS, NDRI, SSRI, or SNRI) as the requested non-preferred agent.</b></p> <p>Trazodone, bupropion, fluvoxamine, MAO inhibitors, TCA's, bupropion IR and venlafaxine IR do not require prior authorization but <b>will not count</b> towards meeting preferred therapy requirements.</p> <p>*Duloxetine will be approved for clients with a diagnosis of osteoarthritis of the knee or chronic low back pain.</p> <p>**Brintellix requires trial and failure of two preferred agents in any class</p> <p>Dosage limits apply:                      bupropion ER/SR/XL: 450mg/day                      citalopram ≤ 60 years of age: 60mg/day                      citalopram &gt; 60 years of age: 30mg/day                      escitalopram: 30mg/day                      fluoxetine ≤ 18 years of age: 90mg/day                      fluoxetine &gt; 18 years of age: 120mg/day                      mirtazapine: 67.5mg/day                      paroxetine IR/CR ≤ 18 years of age: 75mg/day                      paroxetine IR &gt; 18 years of age: 90mg/day                      paroxetine CR &gt; 18 years of age: 112.5mg/day                      sertraline: 300mg/day                      venlafaxine ER: 337.5mg/day</p>		
	NORADRENERGIC/SPECIFIC SEROTONERICS (NaSS)				
	mirtazapine 15, 30, and 45mg				NaSS mirtazapine 7.5mg and rapid dissolve tablets (use preferred)
	NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)				NDRI APLENZIN FORFIVO XL
	bupropion ER/SR/XL				SSRI fluoxetine <u>tablets</u> (use preferred) VIIBRYD
	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)				SNRI duloxetine* desvenlafaxine FETZIMA PRISTIQ venlafaxine ER <u>tablets</u> (use preferred)
	citalopram escitalopram fluoxetine <u>capsules</u> paroxetine IR/CR sertraline				OTHER BRINTELLIX**
SEROTONIN/NORPINEPHRINE REUPTAKE INHIBITORS (SNRI)					
venlafaxine ER <u>capsules</u>					
ANTIHYPERTENSIVES	<b>ACE INHIBITORS</b>		<p>Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p>		
	benazepril captopril enalapril fosinopril lisinopril moexipril perindopril quinapril ramipril trandolapril				
	<b>ACE INHIBITORS AND DIURETICS</b>				
	benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ moexipril/HCTZ quinapril/HCTZ				
	<b>ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)</b>			<p>Trial and failure of an ACE Inhibitor greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for preferred ARB. Non-preferred ARBs and ARB/diuretic combinations also require a history of ALL preferred ARBs before approval can be given.</p>	candesartan EDARBI eprosartan 600mg telmisartan TEVETEN 400mg valsartan (BRAND IS PREFERRED)
		BENICAR DIOVAN* irbesartan losartan			
	<b>ARBs AND DIURETICS</b>			<p>Trial and failure of an ACE Inhibitor greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for preferred ARB. Non-preferred ARBs and ARB/diuretic combinations also require a history of ALL preferred ARBs before approval can be given.</p>	candesartan HCTZ EDARBYCLOR telmisartan HCTZ TEVETEN HCTZ
	BENICAR HCT DIOVAN HCT irbesartan HCTZ losartan HCT				
<b>ALPHA-BLOCKERS</b>			clonidine patch (BRAND IS PREFERRED) NEXICLON XR (use preferred)		
CATAPRES PATCHES* clonidine					
ANTIVIRALS	<b>PROTEASE INHIBITORS</b>		<p>NORVIR capsules (use preferred) NORVIR solution (use preferred)</p>		
	APTIVUS CRIXIVAN INVIRASE LEXIVA NORVIR tablets PREZISTA REYATAZ VIRACEPT				

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ANTIPSYCHOTICS	ATYPICAL ANTIPSYCHOTICS		<p>**Quetiapine doses less than 100mg will require prior authorization <u>without</u> a diagnosis of mood disorder or major depressive disorder. For titration doses, contact the GHS Pharmacy Help Desk for an override.</p> <p><i>Typical antipsychotics do <u>not</u> required prior authorization.</i></p> <p>Dosage limits apply:            ABILIFY &lt;13 years of age: 23mg/day            ABILIFY ≥13 years of age: 45mg/day            FANAPT: 36mg/day            INVEGA: 18mg/day            LATUDA: 240mg/day            Risperidone &lt; 17 years of age: 5mg/day            Risperidone &gt; 17 years of age: 24mg/day            SAPHRIS: 30mg/day            Olanzapine &lt; 13 years of age: 15mg/day            Olanzapine &gt; 13 years of age: 30mg/day            Quetiapine &lt;13 years of age: 600mg/day            Quetiapine 13-17 years of age: 900mg/day            Quetiapine &gt; 17 years of age: 1200mg/day            ziprasidone &lt; 17 years of age: 180mg/day            ziprasidone &gt; 17 years of age: 300mg/day</p>	SEROQUEL XR (use preferred)
	SPECIAL ATYPICAL ANTIPSYCHOTICS		Dosage limits apply: 1350mg/day	VERSACLOZ Suspension (use preferred)
	ABILIFY/ODT ABILIFY MAINTENA FANAPT INVEGA INVEGA SUSTENNA LATUDA olanzapine quetiapine RISPERDAL CONSTA risperidone SAPHRIS ziprasidone ZYPREXA RELPREVV			
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
	clozapine			
	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.	ALTOPREV fluvastatin/ER
	lovastatin pravastatin		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.	
	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.	CRESTOR LIVALO LIVALO
atorvastatin simvastatin		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.		
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.	ADVICOR (use separate agents) amlodopine/atorvastatin (BRAND IS PREFERRED) CHOLESTIN LIPTRUZET PRAVIGARD SIMCOR ZETIA* (use preferred)	
CADUET* VYTORIN		Zetia monotherapy will require PA.		
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	<b>ORAL CONTRACEPTIVES</b>			
	altavera AMETHYST apri aviane balzia <b>BREVICON*</b> briellyn caziant cryselle emoquette enpresse errin <b>ESTROSTEP FE*</b> Femcon FE gildess FE jolessa jolivet junel/junel FE kelnor kurvelo lessina levora LOESTRIN 24 FE, 1/20-21, 1/20 FE LOSEASONIQUE low-ogestrel luter microgestin <b>MIRCETTE*</b> mononessa NECON 10/11-28 nora-be norgestrel/ethinyl estradiol NORINYL 1/50-28 OGESTREL orsythia <b>ORTHO TRI-CYCLEN LO*</b> <b>ORTHO-NOVUM 1/35-28, 7/7/7-28*</b> portia previfem reclipsen seasonale <b>SEASONIQUE*</b> sprintec sronyx trinessa <b>TRI-NORINYL*</b> tri-previfem trivora velivet <b>YASMIN*</b> <b>YAZ*</b> 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) lorvna (BRAND IS PREFERRED) NATAZIA (PA required) necon 0.5/35, 1/35, 7/7/7 (BRAND IS PREFERRED) NECON 1/50 (use preferred) norethindrone/ethinyl estradiol chew (PA required) norethindrone (use preferred) NORINYL 1/35 (use preferred) nortrel (BRAND IS PREFERRED) ocella (BRAND IS PREFERRED) ORTHO-NOVUM 1/50 (use preferred) quasense (use preferred) SAFYRAL (PA required) syeda (BRAND IS PREFERRED) tilia FE (BRAND IS PREFERRED) tri-legest FE (BRAND IS PREFERRED) tri-lo-sprintec (BRAND IS PREFERRED) viorele (BRAND IS PREFERRED) zarah (BRAND IS PREFERRED) zenchent FE chewable (PA required) zeosa chewable (PA required)
CORTICOSTEROIDS	<b>ORAL CORTICOSTEROIDS</b>			
	budesonide cortisone acetate dexamethasone/intensol hydrocortisone methylprednisone prednisolone prednisone			CELESTONE (use preferred)
DIABETES	<b>DIABETES AGENTS</b>			
	<b>BIGUANIDES</b>			
	metformin/ER			FORTAMET (use preferred) GLUMETZA (use preferred) RIOMET (use preferred)
	<b>α-GLUCOSIDASE INHIBITORS</b>			
	acarbose		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	GLYSET
	<b>MEGLITINIDES</b>			
	STARLIX*		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	nateglinide (BRAND IS PREFERRED) repaglinide
	<b>THIAZOLIDINEDIONES</b>			
pioglitazone		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)	
<b>SULFONYLUREAS</b>				
glimepiride/ER glipizide/ER glyburide/ER		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.		
<b>DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITORS</b>				
	JANUVIA ONGLYZA	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	

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DIABETES <i>cont.</i>	<b>DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITOR COMBO AGENTS</b>		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 <b>preferred agent</b> . 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		
	<b>INCRETIN MIMETICS (GLP-1 RECEPTOR AGONISTS)</b>		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 <b>preferred agent</b> . A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	BYDUREON <b>TANZEUM</b> VICTOZA
		BYETTA		
	<b>SGLT2 INHIBITORS</b>		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 INVOKANA		
	<b>INTERMEDIATE-ACTING INSULIN</b>		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently	
	HUMULIN N HUMULIN 70/30 NOVOLIN N NOVOLIN 70/30			
	<b>LONG-ACTING INSULIN</b>		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently	LANTUS OPTICLIK ( <i>use preferred</i> ) LEVEMIR ( <i>use preferred</i> )
	LANTUS SOLOSTAR LANTUS <i>via</i>			
	<b>RAPID-ACTING INSULIN</b>		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently	
	APIDRA HUMALOG NOVOLOG			
<b>SHORT-ACTING INSULIN</b>		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently		
HUMULIN R NOVOLIN R				
<b>DIABETIC METERS/TEST STRIPS</b>		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	<b>ANTIBIOTIC/STEROID COMBINATION</b>			CIPRODEX ( <i>use preferred</i> ) ciprofloxacin 0.2% ( <i>use preferred</i> ) CIPRO HC ( <i>use preferred</i> ) COLY-MYCIN S ( <i>use preferred</i> ) CORTISPORIN-TC ( <i>use preferred</i> ) FLUOCINOLONE ACET OIL 0.01% ( <i>use preferred</i> )
		Neo/Poly/Hc Suspension and Solution Ofloxacin		
FIBROMYALGIA	<b>FIBROMYALGIA STEP 1</b>		Trial and failure of a Step 1 agent greater than or equal to six (6) weeks in the last 12 months is required for approval of a Step 2 agent.	
		amitriptyline cyclobenzaprine		
	<b>FIBROMYALGIA STEP 2</b>		Trial and failure of a Step 1 agent and a Step 2 agent greater than or equal to six (6) weeks in the last 12 months is required for approval of a Step 3 agent.	
		SAVELLA		
<b>FIBROMYALGIA STEP 3</b>				
		duloxetine LYRICA		
GASTROINTESTINAL	<b>DIGESTIVE ENZYMES</b>		Prior authorization required.	PANCREAZE pancrelipase (BRAND IS PREFERRED) PERTZYE TRI-PASE ULTRESA VIOKASE
		CREON 3000, 6000, 12000, 24000, and 36000 units ZENPEP*		
	<b>PROTON PUMP INHIBITORS</b>		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.  Lansoprazole solutabs will be approved for children less than or equal to 8 years of age.	ACIPHEX SPRINKLES amox/clarith/lansoprazole pack ( <i>use separate agents</i> ) DEXILANT esomeprazole lansoprazole solutabs NEXIUM omeprazole 20.6mg capsules ( <i>use preferred</i> ) omeprazole <u>tablets</u> ( <i>use preferred</i> ) omeprazole/sodium bicarbonate OMECLAMOX ( <i>use separate agents</i> ) rabeprazole VIMOVO ( <i>use separate agents</i> )
		lansoprazole <u>capsules</u> omeprazole <u>capsules</u> pantoprazole		
<b>MESALAMINE</b>		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	APRISO ASACOL/HD CANASA LIALDA PENTASA 500MG ( <i>use preferred</i> ) ROWASA	
	mesalamine enema PENTASA 250MG ONLY			

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

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>PLEASE CONTACT WMS FOR QUESTIONS</small>
<b>GROWTH HORMONE</b>	<b>GROWTH HORMONE</b>		<p>PA is required for use outside of FDA-approved indications. Evaluation by an endocrinologist is preferred.</p> <p>Clinical evidence of improved growth will be required on a yearly basis to support ongoing utilization.</p> <p>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.</p> <p>Trial and failure of two (2) preferred agents within the last 12 months will be required for the following indications:</p> <p>Pediatric: Growth failure due to inadequate endogenous growth hormone, Prader-Willi syndrome, children born small for gestation. Turner syndrome.</p> <p>Adult: Replacement for those with growth hormone deficiency.</p>	<p>NUTROPIN AQ OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE</p>
<b>HEPATITIS C</b>	PEGASYS	<b>INTERFERON</b>	<p>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.</p> <p>Peg-Intron will be approved for pediatric patients (aged 18 and under), for retreatment, and for dosage adjustments that cannot be achieved with Pegasys.</p>	PEG-INTRON
	<b>NUCLEOTIDE ANALOG POLYMERASE INHIBITOR</b>		Prior authorization is required prior to use of Sovaldi.	
	SOVALDI			
	<b>PROTEASE INHIBITOR</b>		Prior authorization is required prior to use of Olysio.	
	INCIVEK	OLYSIO		
	VICTRELIS			
<b>IMMUNOMODULATORS</b>	<b>IMMUNOMODULATORS</b>		<p>Client must have <b>diagnosis prior to approval</b> for <b>preferred agents</b> (outlined below):</p> <p><b>Enbrel</b>: Ankylosing Spondylitis (AS), Juvenile Idiopathic Arthritis (JIA), Plaque Psoriasis (PP), Psoriatic Arthritis (PA), Rheumatoid Arthritis (RA)**</p> <p><b>Humira</b>: AS, Crohn's, JIA, PP, PA, Ulcerative Colitis (UC), RA**</p> <p><b>Simponi</b>: AS, PA, RA**</p> <p>**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).</p> <p>For <b>non-preferred agents</b>, 56-day trial and failure of a preferred agent is required and client must have diagnosis prior to approval (outlined below):</p> <p><b>Actemra</b>: RA**</p> <p><b>Amevive</b>: PP</p> <p><b>Cimzia</b>: AS, PA, Crohn's, RA**</p> <p><b>Kineret</b>: RA</p> <p><b>Orencia</b>: JIA, RA**</p> <p><b>Otezla</b>: PA</p> <p><b>Remicade</b>: AS, Crohn's, PP, PA, RA**, UC</p> <p><b>Rituxan</b>: RA**</p> <p><b>Stelara</b>: PP</p> <p><b>Tysabri</b>: Crohn's (additional PA criteria applies)</p>	<p>ACTEMRA AMEVIVE CIMZIA KINERET ORENCIA OTEZLA RAPTIVA REMICADE RITUXAN STELARA TYSABRI (additional criteria applies)</p>
<b>INSOMNIA</b>	zaleplon zolpidem	<b>NON-BENZODIAZEPINES</b>	<p>Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>Prior authorization will be required for clients under the age of 18.</p> <p>Rozereem is non-preferred without a history of substance abuse</p> <p>Prior authorization will be required when a client is taking more than one insomnia agent concurrently.</p> <p>Dosage limits apply: zaleplon: 30mg/day zolpidem: 15mg/day</p>	<p>EDLUAR (additional criteria applies) eszopiclone INTERMEZZO (additional criteria applies) ROZEREM zolpidem ER ZOLPIMIST (additional criteria applies)</p>
<b>MIGRAINE</b>	naratriptan sumatriptan	<b>TRIPITANS</b>	<p>Trial and failure of all preferred agents will be required for approval of a non-preferred agent.</p> <p>Rizatriptan will be approved for clients between 6 and 17 years of age</p> <p>Quantity limits apply: naratriptan 1mg: 25 tabs/34 days naratriptan 2.5mg: 10 tabs/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</p>	<p>AXERT FROVA RELPAK rizatriptan TREMIMET zolmitriptan</p>

WYOMING MEDICAID  
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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>PLEASE CONTACT WMS FOR QUESTIONS</small>
MULTIPLE SCLEROSIS	<b>IMMUNOMODULATOR (GLATIRAMER INJECTION)</b>		Trial and failure of a preferred interferon agent AND failure of Copaxone 20mg/ml will be required before approval can be given for a non-preferred agent.	AUBAGIO BETASERONE COPAXONE 40MG/ML EXTAVIA GILENYA TECFIDERA TYSABRI (additional criteria applies)
	COPAXONE 20MG/ML			
	<b>INTERFERON</b>		For Tysabri, in addition to the above criteria, additional prior authorization criteria applies.	
	AVONEX REBIF			
NEUROPATHIC PAIN	<b>TRICYCLIC ANTIDEPRESSANTS</b>		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 LYRICA
	amitriptyline imipramine nortriptyline			
	<b>GABAPENTIN</b>			
	gabapentin			
NSAIDS	<b>NSAIDS</b>		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 diclofenac 1.5% solution (additional criteria applies) diclofenac 3% gel (additional criteria applies) FLECTOR (additional criteria applies) mefenamic acid NAPRELAN NEOPROFEN SPRIX (additional criteria applies) VOLTAREN (additional criteria applies) ZIPSOR ZORVOLEX
	diclofenac tablets etodolac fenoprofen flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclizolamine meloxicam nabumetone naproxen oxaprozin piroxicam sulindac tolmetin			
OPHTHALMICS	<b>OP. -ANTI-ALLERGICS</b>		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 LASTACRAFT
	cromolyn OPTIVAR* PATADAY PATANOL			
	<b>OP. -ANTIBIOTICS- QUINOLONES</b>		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			
	<b>OP. -ANTI-INFLAMMATORY- NSAIDS</b>		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 ILEVRO NEVANAC
	flurbiprofen diclofenac ketorolac			
	<b>OP. -BETA-BLOCKERS</b>		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			
	<b>OP. -CARBONIC ANHYDRASE INHIBITOR</b>		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			
<b>OP. - COMBO PRODUCTS</b>		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 dorzolamide/timolol SIMBRINZA				
<b>OP. -PROSTAGLANDINS</b>		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				
<b>OP. -SYMPATHOMIMETICS</b>		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	<b>BISPHOSPHONATES</b>		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.	risedronate ATELVIA FOSAMAX-D ibandronate
	alendronate			
	<b>NASAL CALCITONIN</b>			
	calcitonin-salmon fortical			
OVERACTIVE BLADDER	<b>OVERACTIVE BLADDER AGENTS</b>		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.  Oxytrol will be approved for clients that have an inability to swallow.	ENABLEX GELNIQUE GEL 10% MYRBETRIQ OXYTROL DIS SANCTURA XR tolterodine/ER trospium
	oxybutynin /ER TOVIAZ VESICARE			
PHOSPHATE BINDERS	<b>PHOSPHATE BINDERS</b>		Prior authorization required for non-preferred agents.	calcium acetate tabs (BRAND IS PREFERRED) FOSRENOL sevelamer VELPHORO
	calcium acetate capsules ELIPHOS* PHOSLYRA RENAGEL			



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PLATELET AGGREGATE INHIBITORS	THIENOPYRIDINE DERIVATIVES		Prior authorization required 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		Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
		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.	OPSUMIT
		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		
	PROSTACYCLINE VASODILATOR		Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
		ORENITRAM		
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 tricyclic 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 LONG ACTING 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).	AMPHETAMINES: dextroamphetamine CR capsules (BRAND IS PREFERRED) ZENZEDI 2.5 AND 7.5MG TABLETS
		amphetamine salts combo XR DEXEDRINE CAPSULES* VYVANSE		
	IMMEDIATE RELEASE AMPHETAMINES		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.	
		amphetamine salts combo* dextroamphetamine tablets		
	METHYLPHENIDATES LONG ACTING METHYLPHENIDATES		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.	METHYLPHENIDATES: methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA) QUILLIVANT XR SUSPENSION
		DAYTRANA FOCALIN XR methylin ER methylphenidate ER/CR/SA/SR tablets		
	IMMEDIATE RELEASE METHYLPHENIDATES		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	
		dexmethylphenidate methylin tablets methylphenidate		

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STIMULANT-LIKE AGENTS	<b>SELECTIVE ALPHA-ADRENERGIC AGONIST</b> CLONIDINE AGENTS		To obtain the <b>non-preferred agent</b> , 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 <u>benefit</u> in the previous 12 months.	KAPVAY*	
	clonidine		To obtain the <b>non-preferred agent</b> , 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 <b>AND</b> a 14 day trial of guanfacine with <u>benefit</u> 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	
	<b>GUANFACINE AGENTS</b>		guanfacine		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.  <b>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.</b>  <small>Dosage limits apply: - STRATTERA: 150mg/day</small>

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<b>TOPICAL AGENTS</b>	gentamicin mupirocin	<b>IMPETIGO ANTIBIOTICS</b>	Trial and failure of ALL preferred agents greater than or equal to 7 days in the past 90 days.  Use smallest size appropriate for 7 day trial.	ALTABAX
		<b>BENZOYL PEROXIDE/CLINDAMYCIN COMBOS</b>  <b>BENZACLIN*</b> clindamycin/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)
	alclometasone desonide fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) prednicarbate	<b>CORTICOSTEROIS</b> <small>C-CREAM; G-GEEL; L-LOTION; O-OINTMENT</small>  <b>LOW POTENCY</b>	Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	PANDEL
	betamethasone valerate desoximetasone 0.05% (C) fluocinolone 0.025% fluticasone 0.05% (C) hydrocortisone butyrate 0.1% (O) hydrocortisone probutate 0.1% (C) mometasone triamcinolone 0.025%, 0.1%	<b>MEDIUM POTENCY</b>	Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	Clocortolone Pivalate CORDRAN/SP TOPICORT LP TRIANEX
	amcinonide betamethasone dipropionate clobetasol desoximetasone 0.25%, 0.05% (G) diflorasone fluocinonide flurandrenolide fluticasone 0.005% (O) halobetasol triamcinolone 0.5%	<b>HIGH POTENCY</b>	Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	APEXICON HALOG
		<b>IMMUNOMODULATORS</b>  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 corticosteroid greater than or equal to a 21 day trial in the last 90 days.	
	aliclen shampoo 6% salacyn cream/lotion 6% Salicylic Acid Shampoo 6%	<b>SALICYLIC ACID</b>		All other topical salicylic acid formulations.
	LINDANE NATROBA permethrin solution	<b>SCABICIDES/PEDICULICIDES</b>	Trial and failure of a preferred agent in the last 12 months.	OVIDE permethrin cream SKLICE ULESFIA
	Kerafoam Aerosol 30% Remeven Cream 50% urea hydration aerosol 35% urea emulsion 50% urea nail suspension 40% urea suspension 50% X-Viate Cream 40%	<b>UREA</b>		All other topical urea formulations.