WYOMING MEDICAID
Preferred Drug List (PDL) - October 15, 2014

Drug classes not included on this list are not managed through a Preferred Drug List (PDL).
HOWEVER, THIS EXCLUSION IS NOT A GUARANTEE OF PAYMENT OR COVERAGE. Dosage limits and other requirements may apply.
Drugs new to market are non-preferred until a clinical review has been completed. PA criteria will apply to both the pediatric population, as well as the adult population for those plans where PA/PDL limits are allowed.
Unless otherwise noted on the PDL, generic substitution is mandatory.
Yellow highlighted items below indicate new changes to the PDL. Red font indicates quantity/dosage limits apply. *Indicates BRAND is Preferred. May Use DAW 5.
Contact the GHS PA Helpdesk @ 877-207-1126 for prior authorization if client has primary insurance that will not cover the brand name medication.

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dosage limits apply), Epocrates, and the Wyoming Medicaid Provider Manual at http://wymedicaid.org for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES (THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT GHS FOR QUESTIONS)
ADDICTION AGENTS	**BUPRENORPHINE COMBINATIONS**	SUBOXONE FILM ZUBSOLV	Client must have a diagnosis of opioid dependence or abuse. This is not to be used 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. Dosage limits apply (Max Dose: 24mg/day). Client is limited to two (2) years of buprenorphine/naloxone or oral buprenorphine use. Please submit PA requests on the "Oral Buprenorphine/Naloxone or Oral Buprenorphine" PA form available at www.wymedicaid.org.	BUNAVAIL buprenorphine (oral) buprenorphine/naloxone tablets *(use preferred)*
	NALTREXONE	naltrexone VIVITROL	Client must have a diagnosis of alcohol or opioid dependance.	
ALLERGY / ASTHMA	**ANTIHISTAMINES, MINIMALLY SEDATING** cetirizine fexofenadine loratadine		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	desloratadine CLARINEX RDT/SYRUP levocetirizine
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	CLARINEX-D
	ANTICHOLINERGIC BRONCHODILATORS COMBIVENT ipratropium SPIRIVA		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Spiriva 5 day STARTER package will be allowed one (1) time per recipient.	ATROVENT HFA TUDORZA
	CORTICOSTEROID / BRONCHODILATOR COMBO'S ADVAIR/HFA DULERA SYMBICORT		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. *Will also require the diagnosis of COPD. Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.	ANORO ELLIPTA* BREO ELLIPTA*
	LEUKOTRIENE MODIFIERS montelukast		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	zafirlukast ZYFLO
	NASAL ANTIHISTAMINES **ASTELIN** azelastine 0.1%		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
	NASAL STEROIDS BECONASE AQ flunisolide fluticasone NASONEX		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Budesonide will be approved for pregnancy.	budesonide DYMISTA *(use separate agents)* OMNARIS QNASL triamcinolone VERAMYST ZETONNA
	SHORT ACTING BRONCHODILATORS - INHALERS PROAIR HFA PROVENTIL HFA VENTOLIN HFA		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	XOPENEX HFA
	SHORT ACTING BRONCHODILATORS - NEBULIZERS albuterol neb **XOPENEX neb***		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	levalbuterol (BRAND IS PREFERRED)
	STEROID INHALANTS AEROSPAN budesonide FLOVENT HFA/DISK PULMICORT FLEXHALER QVAR		Trial and failure of three (3) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Alvesco will be approved for a history of oral thrush with steroid inhalants.	AEROBID/AEROBID-M ALVESCO ASMANEX PULMICORT SUSPENSION 1mg/2ml
	EPINEPHRINE EPI-PEN			ADRENACLICK *(use preferred)* AUVI-Q *(use preferred)* epinephrine *(use preferred)*
ALZHEIMERS	**ALZHEIMER AGENTS**	donepezil EXELON PATCH/SOLUTION galantamine/ER NAMENDA/XR rivastigmine capsules	Client must have a diagnosis of dementia.	donepezil 23mg *(use preferred)* donepezil ODT *(use preferred)*

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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). 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 **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. Fentanyl patches are limited to one patch every 72 hours.	AVINZA BUTRANS** hydromorphone ER KADIAN (10mg/200mg) morphine sulfate ER capsules NUCYNTA ER*** OPANA ER (5mg/10mg/20mg/30mg/40mg) oxymorphone ER (7.5mg/15mg) OXYCONTIN/CR
	morphine sulfate ER tablets	fentanyl patch		
	SHORT-ACTING C-IIs		Trial and failure of three (3) preferred agents greater than or equal to a 6 day supply in the last 90 days will be required before approval can be given for a non-preferred agent. **In addition to above criteria, Embeda and Oxecta require a diagnosis of drug/substance abuse. ***Nucynta will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics.	EMBEDA** levorphanol NUCYNTA*** OXECTA** oxymorphone oxycodone/IBU
	codeine sulfate hydromorphone morphine sulfate oxycodone oxycodone/APAP oxycodone/ASA			
	C-III/C-V AGENTS		Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Quantity and dosage limits apply (max 8 tabs/day). **Butrans will require a 14 day trial and failure of tramadol IR and a 14 day trial and failure of tramadol ER prior to approval	BUTRANS** CONZIP RYBIX ODT tramadol/apap tramadol ER
	tramadol			
ANDROGENS	**TESTOSTERONE TOPICAL GELS**		Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient testosterone production. *Other testosterone dosage form products will require a diagnosis of hypogonadism or insufficient testosterone production (not outlined on PDL).*	TESTIM GEL *(use preferred)* testosterone gel 1% (BRAND IS PREFERRED) testosterone gel 2% *(use preferred)* VOGELXO GEL *(use preferred)*
		ANDROGEL*		
ANTIBIOTICS	**QUINOLONES**			FACTIVE moxifloxacin NOROXIN PROQUIN
	ciprofloxacin/ER levofloxacin ofloxacin			
	DOXYCYCLINE			ADOXA *(use preferred)* DORYX *(use preferred)* ORACEA *(use preferred)*
	doxycycline			
	MINOCYCLINE			SOLODYN *(use preferred)*
	minocycline/ER			
	INHALED TOBRAMYCIN			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, deep vein thrombosis (DVT) prophylaxis in knee or hip replacement, treatment of deep venous thrombosis (DVT) and pulmonary embolism (PE), and for the reduction in the risk for recurrent DVT and PE after initial therapy	
		ELIQUIS XARELTO		

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ANTICONVULSANTS	**DIAZEPAM RECTAL GEL**			diazepam gel (BRAND IS PREFERRED)
	DIASTAT*			
	LACOSAMIDE		Client must have a diagnosis of partial onset seizures.	
		VIMPAT		
ANTIDEPRESSANTS	**ANTIDEPRESSANTS**		Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks will be required before approval can be given for a non-preferred agent. One of the trials of preferred agents must be in the same class (NaSS, NDRI, SSRI, or SNRI) as the requested non-preferred agent. Trazodone, buspirone, fluvoxamine, MAO inhibitors, TCA's, bupropion IR and venlafaxine IR do not require prior authorization but **will not count** towards meeting preferred therapy requirements. *Duloxetine will be approved for clients with a diagnosis of osteoarthritis of the knee or chronic low back pain. **Brintellix requires trial and failure of two preferred agents in any class Clients five (5) years of age and younger will require prior authorization before approval. Dosage limits apply: bupropion ER/SR/XL: 450mg/day citalopram ≤ 60 years of age: 60mg/day citalopram > 60 years of age: 30mg/day escitalopram: 30mg/day fluoxetine ≤ 18 years of age: 90mg/day fluoxetine > 18 years of age: 120mg/day mirtazapine: 67.5mg/day paroxetine IR/CR ≤ 18 years of age: 75mg/day paroxetine IR > 18 years of age: 90mg/day paroxetine CR > 18 years of age: 112.5mg/day sertraline: 300mg/day venlafaxine ER: 337.5mg/day	
	NORADRENERGIC/SPECIFIC SEROTONERICS (NaSS)			**NaSS**
	mirtazapine 15, 30, and 45mg			mirtazapine 7.5mg and rapid dissolve tablets *(use preferred)*
	NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)			**NDRI**
	bupropion ER/SR/XL			APLENZIN FORFIVO XL
	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)			**SSRI**
	citalopram escitalopram fluoxetine capsules paroxetine IR/CR sertraline			fluoxetine tablets *(use preferred)* VIIBRYD
	SEROTONIN/NORPINEPHRINE REUPTAKE INHIBITORS (SNRI)			**SNRI**
	venlafaxine ER capsules			duloxetine* desvenlafaxine FETZIMA PRISTIQ venlafaxine ER tablets *(use preferred)*
				OTHER
				BRINTELLIX**
ANTIHYPERTENSIVES	**ACE INHIBITORS**		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	
	benazepril captopril enalapril fosinopril lisinopril moexipril perindopril quinapril ramipril trandolapril			
	ACE INHIBITORS AND DIURETICS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	
	benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ moexipril/HCTZ quinapril/HCTZ			
	ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)		Trial and failure of an ACE Inhibitor greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for preferred ARB. Non-preferred ARBs and ARB/diuretic combinations also require a history of ALL preferred ARBs before approval can be given.	candesartan EDARBI eprosartan 600mg telmisartan TEVETEN 400mg valsartan (BRAND IS PREFERRED)
		BENICAR **DIOVAN*** irbesartan losartan		
	ARBs AND DIURETICS		Trial and failure of an ACE Inhibitor greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for preferred ARB. Non-preferred ARBs and ARB/diuretic combinations also require a history of ALL preferred ARBs before approval can be given.	candesartan HCTZ EDARBYCLOR telmisartan HCTZ TEVETEN HCTZ
		BENICAR HCT DIOVAN HCT irbesartan HCTZ losartan HCT		
	ALPHA-BLOCKERS			clonidine patch (BRAND IS PREFERRED) NEXICLON XR *(use preferred)*
	CATAPRES PATCHES*			
	clonidine			
ANTIVIRALS	**PROTEASE INHIBITORS**			NORVIR capsules *(use preferred)* NORVIR solution *(use preferred)*
	APTIVUS CRIXIVAN INVIRASE LEXIVA NORVIR tablets PREZISTA REYATAZ VIRACEPT			

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ANTIPSYCHOTICS	**ATYPICAL ANTIPSYCHOTICS**		**Quetiapine doses less than 100mg will require prior authorization without a diagnosis of mood disorder or major depressive disorder. For titration doses, contact the GHS Pharmacy Help Desk for an override. Clients five (5) years of age and younger will require prior authorization before approval. Dosage limits apply: ABILIFY <13 years of age: 23mg/day ABILIFY ≥13 years of age: 45mg/day FANAPT: 36mg/day INVEGA: 18mg/day LATUDA: 240mg/day Risperidone ≤ 17 years of age: 5mg/day Risperidone > 17 years of age: 24mg/day SAPHRIS: 30mg/day Olanzapine < 13 years of age: 15mg/day Olanzapine > 13 years of age: 30mg/day Quetiapine <13 years of age: 600mg/day Quetiapine 13-17 years of age: 900mg/day Quetiapine > 17 years of age: 1200mg/day ziprasidone < 17 years of age: 180mg/day ziprasidone > 17 years of age: 300mg/day	SEROQUEL XR *(use preferred)*
	ABILIFY/ODT ABILIFY MAINTENA FANAPT INVEGA INVEGA SUSTENNA LATUDA olanzapine quetiapine RISPERDAL CONSTA risperidone SAPHRIS ziprasidone 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 colestipol			
	NIACIN			
	NIACOR NIASPAN			
	STATINS, LOW POTENCY		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization.	ALTOPREV fluvastatin/ER
	lovastatin pravastatin			
	STATINS, HIGH POTENCY		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization.	CRESTOR LIVALO
	atorvastatin simvastatin			
	STATIN COMBINATIONS		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Zetia monotherapy will require PA.	ADVICOR *(use separate agents)* amlodopine/atorvastatin (BRAND IS PREFERRED) CHOLESTIN LIPTRUZET PRAVIGARD SIMCOR ZETIA* (*use preferred*)
	CADUET* VYTORIN			
	TRIGLYCERIDE LOWERING AGENTS		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ANTARA fenofibric FENOGLIDE LOVAZA VASCEPA
	fenofibrate gemfibrozil TRICOR			

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CONTRACEPTIVES	**ORAL CONTRACEPTIVES**			
	altavera AMETHYST apri aviane balzia **BREVICON*** briellyn caziant cryselle emoquette enpresse errin **ESTROSTEP FE*** Femcon FE gildess FE jolessa jolivette junel/junel FE kelnor kurvelo lessina levora LOESTRIN 24 FE, 1/20-21, 1/20 FE LOSEASONIQUE low-ogestrel lutera microgestin **MIRCETTE*** mononessa NECON 10/11-28 nora-be norgestrel/ethinyl estradiol NORINYL 1/50-28 OGESTREL orsythia **ORTHO TRI-CYCLEN LO*** **ORTHO-NOVUM 1/35-28, 7/7/7-28*** portia previfem reclipsen seasonale **SEASONIQUE*** sprintec sronyx trinessa **TRI-NORINYL*** tri-previfem trivora velivet **YASMIN*** **YAZ*** zenchent ZOVIA			amethia (BRAND IS PREFERRED) aranelle (BRAND IS PREFERRED) azurette (BRAND IS PREFERRED) BEYAZ *(PA required)* camila *(use preferred)* camrese (BRAND IS PREFERRED) cesia *(use preferred)* cyclafem (BRAND IS PREFERRED) GENERESS FE CHW *(PA required)* gianvi (BRAND IS PREFERRED) heather *(use preferred)* introvale *(use preferred)* kariva (BRAND IS PREFERRED) levonorgestrel /ethinyl estrad (91-Day) *(use preferred)* leena (BRAND IS PREFERRED) LO LOESTRIN *(PA required)* loryna (BRAND IS PREFERRED) NATAZIA (PA required) necon 0.5/35, 1/35, 7/7/7 (BRAND IS PREFERRED) NECON 1/50 *(use preferred)* norethindrone/ethyinyl estchew *(PA required)* norethindrone *(use preferred)* NORINYL 1/35 *(use preferred)* nortrel (BRAND IS PREFERRED) ocella (BRAND IS PREFERRED) ORTHO-NOVUM 1/50 *(use preferred)* quasense *(use preferred)* SAFYRAL *(PA required)* syeda (BRAND IS PREFERRED) tilia FE (BRAND IS PREFERRED) tri-legest FE (BRAND IS PREFERRED) tri-lo-sprintec (BRAND IS PREFERRED) viorele (BRAND IS PREFERRED) zarah (BRAND IS PREFERRED) zenchent FE chewable *(PA required)* zeosa chewable *(PA required)*
CORTICOSTEROIDS	**ORAL CORTICOSTEROIDS**			CELESTONE *(use preferred)*
	budesonide cortisone acetate dexamethasone/intensol hydrocortisone methylprednisone prednisolone prednisone			
DIABETES	**DIABETES AGENTS** **BIGUANIDES**			FORTAMET *(use preferred)* GLUMETZA *(use preferred)* RIOMET *(use preferred)*
	metformin/ER			
	α–GLUCOSIDASE INHIBITORS		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	GLYSET
	acarbose			
	MEGLITINIDES		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	nateglinide (BRAND IS PREFERRED) repaglinide
	STARLIX*			
	THIAZOLIDINEDIONES		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ACTOSPLUS MET *(use separate agents)* AVANDIA AVANDAMET *(use separate agents)*
	pioglitazone			
	SULFONYLUREAS		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	
	glimepiride/ER glipizide/ER glyburide/ER			
	DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITORS		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	NESINA TRADJENTA
		JANUVIA ONGLYZA		
	DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITOR COMBO AGENTS		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a **preferred agent**. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	JANUMET XR JENTADUETO KAZANO OSENI
		JANUMET JUVISYNC KOMBIGLYZE		

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DIABETES continued	INCRETIN MIMETICS (GLP-1 RECEPTOR AGONISTS)	BYETTA	Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a **preferred agent**. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	BYDUREON TANZEUM VICTOZA
	SGLT2 INHIBITORS	FARXIGA INVOKANA	Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent.	INVOKAMET *(use separate agents)*
	INTERMEDIATE-ACTING INSULIN HUMULIN N HUMULIN 70/30 NOVOLIN N NOVOLIN 70/30		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently	
	LONG-ACTING INSULIN LANTUS SOLOSTAR LANTUS vial		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently	LANTUS OPTICLIK *(use preferred)* LEVEMIR (*use preferred*)
	RAPID-ACTING INSULIN APIDRA HUMALOG NOVOLOG		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently	
	SHORT-ACTING INSULIN HUMULIN R NOVOLIN R		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently	
	DIABETIC METERS/TEST STRIPS FREESTYLE INSULINX FREESTYLE LITE FREESTYLE FREEDOM LITE ONE TOUCH ULTRA ONE TOUCH ULTRA 2 ONE TOUCH ULTRA MINI ONE TOUCH ULTRASMART PRECISION XTRA		Quantity limit applies (1 meter/365days).	ALL OTHER METERS AND TEST STRIPS
EAR	ANTIBIOTIC/STEROID COMBINATION Neo/Poly/HC Suspension and Solution Ofloxacin			CIPRODEX *(use preferred)* ciprofloxacin 0.2% *(use preferred)* CIPRO HC *(use preferred)* COLY-MYCIN S *(use preferred)* CORTISPORIN-TC *(use preferred)* FLUOCINOLONE ACET OIL 0.01% *(use preferred)*
FIBROMYALGIA	FIBROMYALGIA STEP 1 amitriptyline cyclobenzaprine			
	FIBROMYALGIA STEP 2	SAVELLA	Trial and failure of a Step 1 agent greater than or equal to six (6) weeks in the last 12 months is required for approval of a Step 2 agent.	
	FIBROMYALGIA STEP 3	duloxetine LYRICA	Trial and failure of a Step 1 agent and a Step 2 agent greater than or equal to six (6) weeks in the last 12 months is required for approval of a Step 3 agent.	
GASTROINTESTINAL	DIGESTIVE ENZYMES CREON 3000, 6000, 12000, 24000, and 36000 units **ZENPEP***		Prior authorization required.	PANCREAZE pancrelipase (BRAND IS PREFERRED) PERTZYE TRI-PASE ULTRESA VIOKASE
	PROTON PUMP INHIBITORS lansoprazole capsules omeprazole capsules pantoprazole		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Lansoprazole solutabs will be approved for children less than or equal to 8 years of age.	ACIPHEX SPRINKLES amox/clarith/lansopra pack *(use separate agents)* DEXILANT esomeprazole lansoprazole solutabs NEXIUM omeprazole 20.6mg capsules *(use preferred)* omeprazole tablets *(use preferred)* omeprazole/sodium bicarbonate OMECLAMOX *(use separate agents)* rabeprazole VIMOVO *(use separate agents)*
	MESALAMINE mesalamine enema PENTASA 250MG ONLY		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	APRISO ASACOL/HD CANASA LIALDA PENTASA 500MG *(use preferred)* ROWASA
GROWTH HORMONE	GROWTH HORMONE	GENOTROPIN NORDITROPIN HUMATROPE	PA is required for use outside of FDA-approved indications. Evaluation by an endocrinologist is preferred. Clinical evidence of improved growth will be required on a yearly basis to support ongoing utilization. Clinical evidence of need for growth hormone will be required for adult growth hormone deficiency and pediatric growth failure due to inadequate endogenous growth hormone. Trial and failure of two (2) preferred agents within the last 12 months will be required for the following indications: Pediatric: Growth failure due to inadequate endogenous growth hormone, Prader-Willi syndrome, children born small for gestation. Turner syndrome. Adult: Replacement for those with growth hormone deficiency.	NUTROPIN AQ OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES (THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT GHS FOR QUESTIONS)
HEPATITIS C	**INTERFERON**		Trial and failure of preferred agent greater than or equal to 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Peg-Intron will be approved for pediatric patients (aged 18 and under), for retreatment, and for dosage adjustments that cannot be achieved with Pegasys.	PEG-INTRON
	PEGASYS			
	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			
		OLYSIO		
IMMUNOMODULATORS	**IMMUNOMODULATORS**		Client must have ***diagnosis prior to approval*** for ***preferred agents*** (outlined below): ***Enbrel*** : Ankylosing Spondylitis (AS), Juvenile Idiopathic Arthritis (JIA), Plaque Psoriasis (PP), Psoriatic Arthritis (PA), Rheumatoid Arthritis (RA)** ***Humira*** : AS, Crohn's, JIA, PP, PA, Ulcerative Colitis (UC), RA** ***Simponi*** : AS, PA, RA** **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). For *non-preferred agents* , 56-day trial and failure of a preferred agent is required and client must have diagnosis prior to approval (outlined below): *Actemra* : RA** *Amevive* : PP *Cimzia* : AS, PA, Crohn's, RA** *Kineret* : RA *Orencia* : JIA, RA** *Otezla* : PA *Remicade* : AS, Crohn's, PP, PA, RA**, UC *Rituxan* : RA** *Stelara* : PP *Tysabri* : Crohn's (additional PA criteria applies)	ACTEMRA AMEVIVE CIMZIA KINERET ORENCIA OTEZLA RAPTIVA REMICADE RITUXAN STELARA TYSABRI *(additional criteria applies)*
		ENBREL HUMIRA 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. Prior authorization will be required for clients under the age of 18. Rozerem is non-preferred without a history of substance abuse Prior authorization will be required when a client is taking more than one insomnia agent concurrently. Dosage limits apply: zaleplon: 30mg/day zolpidem: 15mg/day	EDLUAR *(additional criteria applies)* eszopiclone INTERMEZZO *(additional criteria applies)* ROZEREM zolpidem ER ZOLPIMIST *(additional criteria applies)*
	zaleplon zolpidem			
MIGRAINE	**TRIPTANS**		Trial and failure of all preferred agents will be required for approval of a non-preferred agent. Rizatriptan will be approved for clients between 6 and 17 years of age 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	AXERT FROVA RELPAX rizatriptan TREXIMET zolmitriptan
	naratriptan sumatriptan			
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. For Tysabri, in addition to the above criteria, additional prior authorization criteria applies.	AUBAGIO BETASERONE COPAXONE 40MG/ML EXTAVIA GILENYA TECFIDERA TYSABRI (additional criteria applies)
	COPAXONE 20MG/ML			
	INTERFERON			
	AVONEX 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 LYRICA
		amitriptyline imipramine nortriptyline		
	GABAPENTIN			
		gabapentin		

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NSAIDS	**NSAIDs**		Trial and failure of two (2) preferred agents each greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Dosing and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets).	CALDOLOR CAMBIA POWDER CELEBREX 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 meclofenamate meloxicam nabumetone naproxen oxaprozin piroxicam sulindac tolmetin			
OPHTHALMICS	**OP. -ANTI-ALLERGICS**		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Emadine, Alomide, and Alocril will be approved for pregnancy. Alomide will be approved for children under the age of 3.	ALAMAST ALOCRIL ALOMIDE ALREX azelastine (BRAND IS PREFERRED) BEPREVE ELESTAT EMADINE ketotifen LASTACAFT
	cromolyn **OPTIVAR*** PATADAY PATANOL			
	OP. -ANTIBIOTICS- QUINOLONES		Trial and failure of a preferred agent greater than or equal to 5 days in the last 12 months will be required before approval can be given for a non-preferred agent. Azasite will be approved for pregnancy.	AZASITE BESIVANCE gatifloxacin IQUIX levofloxacin ZYMAR
	ciprofloxacin ofloxacin MOXEZA VIGAMOX			
	OP. -ANTI-INFLAMMATORY- NSAIDS		Trial and failure of ALL preferred agents each greater than or equal to 5 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ACULAR/LS/PF *(use preferred)* ACUVAIL BROMDAY bromfenac ILEVRO NEVANAC
	flurbiprofen diclofenac ketorolac			
	OP. -BETA-BLOCKERS		Trial and failure of three (3) preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Betoptic S will be approved for those with heart and lung conditions.	BETIMOL BETOPTIC S ISTALOL
	betaxolol carteolol levobunolol metipranolol timolol			
	OP. -CARBONIC ANHYDRASE INHIBITOR		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	AZOPT
	dorzolamide			
	OP. - 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 dorzolamide/timolol 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 ZIOPTAN
	latanoprost TRAVATAN Z			
	OP. -SYMPATHOMIMETICS		Trial of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	ALPHAGAN P 0.1% brimonidine 0.15% (BRAND IS PREFERRED) COMBIGAN (use separate agents)
	ALPHAGAN P 0.15%* brimonidine 0.2%			
OSTEOPOROSIS	**BISPHOSPHONATES**		Trial and failure of a preferred agent greater than or equal to 12 months will be required before approval can be given for a non-preferred agent. Fosamax liquid will be approved for clients that have difficulty swallowing.	risedronate ATELVIA FOSAMAX-D ibandronate
	alendronate			
	NASAL CALCITONIN			
	calcitonin-salmon fortical			
OVERACTIVE BLADDER	**OVERACTIVE BLADDER AGENTS**		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Oxytrol will be approved for clients that have an inability to swallow.	ENABLEX GELNIQUE GEL 10% MYRBETRIQ OXYTROL DIS SANCTURA XR tolterodine/ER trospium
	oxybutynin /ER TOVIAZ VESICARE			
PHOSPHATE BINDERS	**PHOSPHATE BINDERS**		Prior authorization required for non-preferred agents.	calcium acetate tabs (BRAND IS PREFERRED) FOSRENOL sevelamer VELPHORO
	calcium acetate capsules **ELIPHOS*** PHOSLYRA RENAGEL			
PLATELET AGGREGATE INHIBITORS	**THIENOPYRIDINE DERIVATIVES**		Prior authorization reuquired for clients on antiplatelet therapy greater than one (1) year.	
	clopidogrel EFFIENT ticlopidine			
	CYCLOPENTYLTRIAZOLOPYRIMIDINE (CPTP) DERIVATIVES		Client must have diagnosis of acute coronary syndrome to reduce thrombotic cardiovascular events.	
		BRILINTA		
	PROTEASE-ACTIVATED RECEPTOR (PAR-1) ANTAGONIST		Client must have diagnosis reduction of thrombotic cardiovascular events with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD). Must be used in conjunction with aspirin or clopidogrel.	
		ZONTIVITY		

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PROGESTIN	**PROGESTIN**	MAKENA	Prior authorization is required.	
PROSTATE	**5-ALPHA-REDUCTASE INHIBITORS** finasteride		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)*
	ALPHA BLOCKERS doxazosin tamsulosin terazosin		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
PULMONARY ANTIHYPERTENSIVES	**5-ALPHA-REDUCTASE INHIBITORS**	ADCIRCA REVATIO SUSPENSION sildenafil (Revatio A/B rated generic)	Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
	ENDOTHELIN RECEPTOR ANTAGONISTS	LETAIRIS TRACLEER	Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	OPSUMIT
	SOLUBLE GUANYLATE CYCLASE STIMULATORS	ADEMPAS	Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
	PROSTACYCLINE VASODILATOR	ORENITRAM	Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
RESTLESS LEG SYNDROME	**RESTLESS LEG SYNDROME**	gabapentin pramipexole ropinirole	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*
SKELETAL MUSCLE RELAXANTS	**MUSCLE RELAXANTS** baclofen cyclobenzaprine tizanidine tablets		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months, along with a medical diagnosis of muscle spasticity will be required before approval can be given for a non-preferred agent. Cyclobenzaprine will require a prior authorization for clients concurrently taking a tricylic antidepressant.	carisoprodol chlorzoxazone cyclobenzaprine ER metaxalone methocarbamol orphenadrine tizanidine capsules *(use preferred)* Carisoprodol is limited to 84 tabs/365 days.
STIMULANT	**AMPHETAMINES** **LONG ACTING AMPHETAMINES**	amphetamine salts combo XR **DEXEDRINE CAPSULES*** VYVANSE	Clients must have a diagnosis for ADD, ADHD, narcolepsy, obstructive sleep apnea, shift work sleep disturbance, MS fatigue (see MS Fatigue criteria below), or refractory depression (see refractory depression criteria below). Diagnosis of MS fatigue will require a fatigue severity scale score of 5.0, a 60-day trial of amantadine and discontinuation of medications that may contribute to drowsiness and fatigue. Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant. Prior Authorization will be required for clients under the age of 4. Claims will require Prior Authorization if clients have a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use. Trial and failure of two (2) preferred agents (each from a different class: methylphenidate and amphetamine) greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Dosage limits apply: ADDERALL XR: 60mg/day amphetamine salts combo: 60mg/day amphetamine salts combo (narcolepsy): 90mg/day CONCERTA: 135mg/day DAYTRANA: 45mg/9 hour patch dextroamphetamine: 90mg/day dextroamphetamine CR: 90mg/day dexmethylphenidate: 30mg/day FOCALIN XR < 13 years of age: 45mg/day FOCALIN XR > 13 years of age: 60mg/day methylin/methylphenidate: 135mg/day methylin/methylphenidate ER/CR/SR: 135mg/day VYVANSE: 105mg/day	**AMPHETAMINES:** dextroamphetamine CR capsules (BRAND IS PREFERRED) ZENZEDI 2.5 AND 7.5MG TABLETS **METHYLPHENIDATES:** methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA) QUILLIVANT XR SUSPENSION
	IMMEDIATE RELEASE AMPHETAMINES	amphetamine salts combo* dextroamphetamine tablets		
	METHYLPHENIDATES **LONG ACTING METHYLPHENIDATES**	DAYTRANA FOCALIN XR methylin ER methylphenidate ER/CR/SA/SR tablets		
	IMMEDIATE RELEASE METHYLPHENIDATES	dexmethylphenidate methylin tablets methylphenidate		

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STIMULANT-LIKE AGENTS	**SELECTIVE ALPHA-ADRENERGIC AGONIST**		To obtain the **non-preferred agent**, client must meet the following criteria: Client must have a diagnosis of ADD or ADHD Prior authorization will be required for clients under the age of 4. Clients must have completed a 14 day trial of clonidine IR with benefit in the previous 12 months.	**KAPVAY***
	CLONIDINE AGENTS			
	clonidine			
	GUANFACINE AGENTS		To obtain the **non-preferred agent**, client must meet the following criteria: Client must have a diagnosis of ADD or ADHD Prior authorization will be require for clients under the age of 4. Clients must have a trial and failure of a stimulant greater than or equal to a 14 day supply OR a trial and failure of Strattera greater than or equal to a 30 day supply **AND** a 14 day trial of guanfacine with benefit in the previous 12 months, OR a contraindication to ADHD medications (including stimulant and non-stimulant), OR a TIC disorder associated with stimulants (trial of stimulant required).	INTUNIV
	guanfacine			
	SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR		Clients must have a diagnosis for ADD, ADHD, narcolepsy, obstructive sleep apnea, shift work sleep disturbance, MS fatigue (see MS Fatigue criteria below), or refractory depression (see refractory depression criteria below). Diagnosis of MS fatigue will require a fatigue severity scale score of 5.0, a 60-day trial of amantadine and discontinuation of medications that may contribute to drowsiness and fatigue. Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant. Prior Authorization will be required for clients under the age of 5. Claims will require Prior Authorization if clients have a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use. Strattera is limited to 1 tablet/day; unless the dose is greater than 40mg/day or unable to achieve a prescribed dose with 1 tablet. Dosage limits apply: STRATTERA: 150mg/day	
		STRATTERA		

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TOPICAL AGENTS	**IMPETIGO ANTIBIOTICS**		Trial and failure of ALL preferred agents greater than or equal to 7 days in the past 90 days. Use smallest size appropriate for 7 day trial.	ALTABAX
	gentamicin mupirocin			
	BENZOYL PEROXIDE/CLINDAMYCIN COMBOs		Clients must be 12 to 20 years of age and have a diagnosis of acne vulgaris. Requires prior authorization for clients less than 12 years of age. Acne combinations are limited to clients under the age of 21.	ACANYA benzoyl perox/clinda (BRAND IS PREFERRED)
		BENZACLIN* clindamycyin/benzoyl peroxide 1.2 (1)-5% (Refrig)		
	CORTICOSTEROIS **C=CREAM; G=GEL; L=LOTION; O=OINTMENT**		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	PANDEL
	LOW POTENCY			
	alclometasone desonide fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) prednicarbate			
	MEDIUM POTENCY		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	Clocortolone Pivalate CORDRAN/SP TOPICORT LP TRIANEX
	betamethasone valerate desoximetasone 0.05% (C) fluocinolone 0.025% fluticasone 0.05% (C) hydrocortisone butyrate 0.1% (O) hydrocortisone probutate 0.1% (C) mometasone triamcinolone 0.025%, 0.1%			
	HIGH POTENCY		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	APEXICON HALOG
	amcinonide betamethasone dipropionate clobetasol desoximetasone 0.25%, 0.05% (G) diflorasone fluocinonide flurandrenolide fluticasone 0.005% (O) halobetasol triamcinolone 0.5%			
	IMMUNOMODULATORS		Trial and failure of a preferred medium potency topical corticosteroid greater than or equal to a 21 day trial and a trial and failure of a preferred high potency topical corticosteroid greater than or equal to a 21 day trial in the last 90 days. For clients less than two (2) years of age, a trial and failure of a preferred low potency corticosteroid greater than or equal to a 21 day trial and a trial and failure of a preferred medium potency topical cortiscosteroid greater than or equal to a 21 day trial in the last 90 days.	
		ELIDEL PROTOPIC		
	SALICYLIC ACID			All other topical salicylic acid formulations.
	aliclen shampoo 6% salacyn cream/lotion 6% Salicylic Acid Shampoo 6%			
	SCABICIDES/PEDICULICIDES		Trial and failure of a preferred agent in the last 12 months.	OVIDE permethrin cream SKLICE ULESFIA
	LINDANE NATROBA permethrin solution			
	UREA			All other topical urea formulations.
	Kerafoam Aerosol 30% Remeven Cream 50% urea hydration aerosol 35% urea emulsion 50% urea nail suspension 40% urea suspension 50% X-Viate Cream 40%			