

WYOMING MEDICAID
Preferred Drug List (PDL) - January 1, 2015

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://wvmedicaid.org> for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>PLEASE CONTACT US FOR QUESTIONS</small>
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 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.wyomedicaid.org .	BUNAVAIL buprenorphine (oral) buprenorphine/naloxone tablets (use preferred) ZUBSOLV
		SUBOXONE FILM		
		NALTREXONE	Client must have a diagnosis of alcohol or opioid dependence.	
		naltrexone 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 CLARINEX RDT/SYRUP levocetirizine
	cetirizine fexofenadine loratadine			
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	CLARINEX-D
	cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine			
	ANTICHOLINERGIC BRONCHODILATORS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Spiriva 5 day STARTER package will be allowed one (1) time per recipient.	ATROVENT HFA TUDORZA
	COMBIVENT ipratropium SPIRIVA			
	CORTICOSTEROID / BRONCHODILATOR COMBO'S		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. *Will also require the diagnosis of COPD. **Advair HFA will be approved for clients 6 years of age and younger Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.	ADVAIR HFA** ANORO ELLIPTA* BREO ELLIPTA*
	ADVAIR DISK DULERA SYMBICORT			
	LEUKOTRIENE MODIFIERS		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	zafirlukast ZYFLO
	montelukast			
	NASAL ANTIHISTAMINES		Trial and failure of preferred agent greater than or equal to 90 days in the last 12 months will be required before approval can be given for a non-preferred agent.	azelastine 0.15% DYMISTA (use separate agents) olopatadine 0.6%
	ASTELIN 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. Budesonide will be approved for pregnancy.	budesonide DYMISTA (use separate agents) OMNARIS QNASL triamcinolone VERAMYST ZETONNA
	BECONASE AQ fluticasone fluticasone 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 PROVENTIL HFA 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 XOPENEX neb*				
STEROID INHALANTS		Trial and failure of three (3) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Alvesco will be approved for a history of oral thrush with steroid inhalants.	AEROBID/AEROBID-M ALVESCO ASMANEX PULMICORT SUSPENSION 1mg/2ml QVAR	
AEROSPAN budesonide FLOVENT HFA/DISK PULMICORT FLEXHALER				
EPINEPHRINE			ADRENALICK (use preferred) AUVI-Q (use preferred) epinephrine (use preferred)	
EPI-PEN			donepezil 23mg (use preferred) donepezil ODT (use preferred)	
ALZHEIMERS	ALZHEIMER AGENTS		Client must have a diagnosis of dementia.	
		donepezil EXELON PATCH/SOLUTION galantamine/ER NAMENDA/XR rivastigmine capsules		

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ANALGESICS	LONG-ACTING C-11s		<p>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.</p> <p>C-11s and C-1Vs are not included on the PDL and are available without prior authorization with the exception of Butrans (generic substitution is mandatory).</p> <p>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</p> <p>**Butrans requires a trial of morphine sulfate or low dose trial of fentanyl patch.</p> <p>***Nucynta ER will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics.</p> <p>Fentanyl patches are limited to one patch every 72 hours.</p>	<p>AVINZA BUTRANS** hydromorphone ER KADIAN (10mg/200mg) morphine sulfate ER capsules NUCYNTA ER*** OPANA ER (5mg/10mg/20mg/30mg/40mg) oxycodone ER (7.5mg/15mg) OXYCONTIN/CR</p>			
	morphine sulfate ER <u>tablets</u>				fentanyl patch		
	SHORT-ACTING C-11s				<p>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.</p> <p>**In addition to above criteria, Embeda and Oxecta require a diagnosis of drug/substance abuse.</p> <p>***Nucynta will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics.</p>	<p>EMBEDA** levorphanol NUCYNTA*** OXECTA** oxycodone oxycodone/IBU</p>	
	codeine sulfate hydromorphone morphine sulfate oxycodone oxycodone/APAP oxycodone/ASA						
	C-11/C-1V AGENTS						<p>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.</p> <p>Quantity and dosage limits apply (max 8 tabs/day).</p> <p>**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</p>
tramadol							
HYDROCODONE AGENTS				ZOLVIT SOLUTION			
LORTAB ELIXIR 10-300MG							
ANDROGENS	TESTOSTERONE TOPICAL GELS		<p>Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient testosterone production.</p> <p><i>Other testosterone dosage form products will require a diagnosis of hypogonadism or insufficient testosterone production (not outlined on PDL).</i></p>	<p>TESTIM GEL (use preferred) testosterone gel 1% (BRAND IS PREFERRED) testosterone gel 2% (use preferred) VOGELXO GEL (use preferred)</p>			
	ANDROGEL*						
ANTIBIOTICS	QUINOLONES			<p>FACTIVE moxifloxacin NOROXIN PROQUIN</p> <p>ADOXA (use preferred) DORYX (use preferred) ORACEA (use preferred) SOLODYN (use preferred)</p> <p>inhaled tobramycin (BRAND IS PREFERRED) TOBI PODHALER (use preferred)</p>			
	ciprofloxacin/ER levofloxacin ofloxacin						
	DOXYCYCLINE						
	doxycycline						
	MINOCYCLINE						
minocycline/ER							
INHALED TOBRAMYCIN							
BETHKIS TOBI*							
ANTICOAGULANTS	LOW MOLECULAR WEIGHT HEPARIN (LMWH)		<p>Prior authorization will be required for the 300mg/3ml strength</p> <p>Client must have diagnosis of non-valvular atrial fibrillation and relative contraindication to warfarin for approval, treatment for deep vein thrombosis (DVT) or pulmonary embolism (PE), or for the reduction in the risk of recurrence of DVT and PE after initial therapy.</p> <p>Client must have diagnosis of non-valvular atrial fibrillation, treatment for deep vein thrombosis (DVT) prophylaxis in knee or hip replacement, treatment of DVT and pulmonary embolism (PE), and for the reduction in the risk of recurrent DVT and PE after initial therapy.</p>	<p>FRAGMIN (use preferred) LOVENOX 300MG/3ML*</p>			
	enoxaparin						
	DIRECT THROMBIN INHIBITOR				PRADAXA		
	SELECTIVE FACTOR XA INHIBITOR				ELIQUIS XARELTO		
ANTICONVULSANTS	DIAZEPAM RECTAL GEL		<p>Client must have a diagnosis of partial onset seizures.</p>	<p>diazepam gel (BRAND IS PREFERRED)</p>			
	DIASTAT*						
	LACOSAMIDE						
	VIMPAT						

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ANTIDEPRESSANTS	ANTIDEPRESSANTS		Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks will be required before approval can be given for a non-preferred agent. One of the trials of preferred agents must be in the same class (NaSS, NDRI, SSRI, or SNRI) as the requested non-preferred agent. Trazodone, bupropion, 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	NaSS	
	NORADRENERGIC/SPECIFIC SEROTONERICS (NaSS)			mirtazapine 7.5mg and rapid dissolve tablets (<i>use preferred</i>)	
	NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)			APLENZIN FORFIVO XL	
	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)			SSRI	
	citalopram escitalopram fluoxetine capsules paroxetine IR/CR sertraline			fluoxetine tablets (<i>use preferred</i>) VIIBRYD	
	SEROTONIN/NORPINEPHRINE REUPTAKE INHIBITORS (SNRI)			SNRI	
	venlafaxine ER capsules			duloxetine* desvenlafaxine FETZIMA PRISTIQ venlafaxine ER tablets (<i>use preferred</i>) 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.	BENICAR candesartan EDARBI eprosartan 600mg telmisartan TEVETEN 400mg valsartan (BRAND IS PREFERRED)
	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.	BENICAR HCT candesartan HCTZ EDARBYCLOR telmisartan HCTZ TEVETEN HCTZ valsartan HCTZ
	ALPHA-BLOCKERS				clonidine patch (BRAND IS PREFERRED) NEXICLON XR (<i>use preferred</i>)
CATAPRES PATCHES* clonidine					
ANTIVIRALS	PROTEASE INHIBITORS			NORVIR solution (<i>use preferred</i>)	
	APTIVUS CRIVIAN INVIRASE LEXIVA NORVIR CAPSULES NORVIR TABLETS PREZISTA REYATAZ VIRACEPT				

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ANTIPSYCHOTICS	ATYPICAL ANTIPSYCHOTICS		<p>**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.</p> <p>Clients five (5) years of age and younger will require prior authorization before approval.</p> <p>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</p>	SEROQUEL XR (use preferred)
	SPECIAL ATYPICAL ANTIPSYCHOTICS		Dosage limits apply: 1350mg/day	VERSACLOZ Suspension (use preferred)
	clozapine			
CHOLESTEROL	BILE ACID SEQUESTERANT		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			niacin ER (BRAND IS PREFERRED)
	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.	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
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)	
CADUET* VYTORIN		Zetia monotherapy will require PA.	CHOLESTIN LIPTRUZET PRAVIGARD SIMCOR ZETIA* (use preferred)	
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 fenofibrate 43, 50, 130, and 150mg FENOGLIDE LIPOFEN LOVAZA VASCEPA	
fenofibrate 54, 67, 134, 145, 160, and 200mg gemfibrozil				

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CONTRACEPTIVES	ORAL CONTRACEPTIVES			amethia/LO (BRAND IS PREFERRED)
	altavera			alyacen (BRAND IS PREFERRED)
	AMETHYST			aranelle (BRAND IS PREFERRED)
	azurette			BEYAZ (PA required)
	apri			camila (use preferred)
	aubra			camrese/LO (BRAND IS PREFERRED)
	aviane			cyclafem (BRAND IS PREFERRED)
	balzia			dasetta (BRAND IS PREFERRED)
	BREVICON*			daysee (BRAND IS PREFERRED)
	brlielyn			deblitane (use preferred)
	caziant			drospir/ethi (use preferred)
	chateal			GENERESS FE CHW (PA required)
	cryselle			heather (use preferred)
	delyla			introvale (use preferred)
	DESOGEN			jencycla (use preferred)
	deso/ethinyl estradiol			levonorgest/ethinyl estrad (91-Day) (use preferred)
	elinest			leena (BRAND IS PREFERRED)
	emoquette			loestrin 21, FE 1/20, FE 1.5/30 (use preferred)
	enpresse			LO LOESTRIN (PA required)
	enskyce			LO MINASTRIN FE (PA required)
	errin			loryna (use preferred)
	estarylla			MINASTRIN 24 FE CHEWABLE (PA required)
	ESTROSTEP FE*			MODICON (use preferred)
	falmina			NATAZIA (PA required)
	Femcon FE Chewable			necon 0.5/35, 1/35, 7/7/7 (BRAND IS PREFERRED)
	gianvi			NECON 1/50 (use preferred)
	gildagia			nikki (use preferred)
	gildess/FE			norethindrone (use preferred)
	jolessa			NORINYL 1/35 (use preferred)
	jolivet			norlyroc (use preferred)
	junel/FE			nor-qd (use preferred)
	kariva			nortrel (BRAND IS PREFERRED)
	kelnor			ortho micron (use preferred)
	kurvelo			pirmella (BRAND IS PREFERRED)
	lanin/FE			quasense (use preferred)
	lessina			QUARTETTE (PA required)
	levonest			SAFYRAL (PA required)
	levonor/ethi			sharobel (use preferred)
	levora			tilla FE (BRAND IS PREFERRED)
	LOESTRIN 24 FE			tri-legest FE (BRAND IS PREFERRED)
	LOMEDIA 24 FE			wera (BRAND IS PREFERRED)
	LOSEASONIQUE			wymzya FE chewable (BRAND IS PREFERRED)
	low-ogestrel			zenchent FE chewable (PA required)
	lutera			zeosa chewable (BRAND IS PREFERRED)
	lyza			
	marlissa			
	microgestin/FE			
	mono-linyah			
	mononessa			
	myzila			
	NECON 10/11-28			
	nora-be			
	norgest/ethinyl estradiol			
	noreth/ethin FE 1/20			
	NORINYL 1/50-28			
	ocella			
	OGESTREL			
	orsythia			
	ORTHO-CEPT			
	ORTHO TRI-CYCLEN LO*			
	ORTHO-NOVUM 1/35-28, 7/7/7-28*			
	philith			
	pimtrea			
	portia			
	previfem			
	reclipsen			
	SEASONIQUE*			
	sprintec			
	sronyx			
	syeda			
	tri-estaryl			
	tri-linyah			
	trinessa			
TRI-NORINYL*				
tri-previfem				
tri-sprintec				
trivora				
velivet				
vestura				
violele				
vyfemla				
zarah				
zenchent				
ZOVIA				
CORTICOSTEROIDS	ORAL CORTICOSTEROIDS			CELESTONE (use preferred)
	budesonide			
	cortisone acetate			
	dexamethasone/intensol			
	hydrocortisone			
	methylprednisone			
	prednisolone			
	prednisone			

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DIABETES	DIABETES AGENTS			FORTAMET (use preferred)
	BIGUANIDES			GLUMETZA (use preferred)
	metformin/ER			RIOMET (use preferred)
	α-GLUCOSIDASE INHIBITORS			GLYSET
	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.	
	MEGLITINIDES			nateglinide (BRAND IS PREFERRED)
	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.	repaglinide
	THIAZOLIDINEDIONES			ACTOSPLUS MET (use separate agents)
	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.	AVANDIA AVANDAMET (use separate agents)
	SULFONYLUREAS			
	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.	
	DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITORS			NESINA TRADJENTA
		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.	
	DPP-4 INHIBITOR COMBO AGENTS			JENTADUETO JUVISYNC KAZANO OSENI
		JANUMET/XR KOMBIGLYZE	Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	
	INCRETIN MIMETICS (GLP-1 RECEPTOR AGONISTS)			BYDUREON BYETTA
		VICTOZA	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.	
SGLT2 INHIBITORS			JARDIANCE	
	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. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.		
SGLT2 INHIBITOR COMBO AGENTS			XIGDUO XR (use separate agents)	
	INVOKAMET	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.		
LONG-ACTING INSULIN			LANTUS OPTICLIK (use preferred)	
LANTUS SOLOSTAR LANTUS vial LEVEMIR		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently		
DIABETIC METERS/TEST STRIPS			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	Quantity limit applies (1 meter/365days)		
EAR	ANTIBIOTIC/STEROID COMBINATION			ciprofloxacin 0.2% (use preferred)
	CIPRODEX Neo/Poly/Hc Suspension and Solution Ofloxacin			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			PANCREAZE pancrelipase (BRAND IS PREFERRED) PERTZYE TRI-PASE ULTRESA VIOKASE
	CREON 3000, 6000, 12000, 24000, and 36000 units ZENPEP*		Prior authorization required.	
	IRRITABLE BOWEL SYNDROME AGENTS			
	CHLORIDE CHANNEL ACTIVATOR			
	AMITIZA		Client must have a diagnosis of opioid-induced constipation and a three (3) month trial and failure of a secretory agent, or a diagnosis of chronic idiopathic constipation or Irritable Bowel Syndrome (IBS) with constipation.	
	GUANYLATE CYCLASE-C AGONIST			
LINZESS		Client must have a diagnosis of chronic idiopathic constipation or Irritable Bowel Syndrome (IBS) with constipation.		
PROTON PUMP INHIBITORS				ACIPHEX SPRINKLES amox/clarith/lansoprazole oack (use searate aagents) 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)
	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.		

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GASTROINTESTINAL continued	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.	ASACOL/HD CANASA LIALDA PENTASA 500MG (<i>use preferred</i>) ROWASA	
	APRISO mesalamine enema PENTASA 250MG ONLY				
GROWTH HORMONE	GROWTH HORMONE		PA is required for use outside of FDA-approved indications. Evaluation by an endocrinologist is preferred. Clinical evidence of improved growth will be required on a yearly basis to support ongoing utilization. Clinical evidence of need for growth hormone will be required for adult growth hormone deficiency and pediatric growth failure due to inadequate endogenous growth hormone. Trial and failure of two (2) preferred agents within the last 12 months will be required for the following indications: Pediatric: Growth failure due to inadequate endogenous growth hormone, Prader-Willi syndrome, children born small for gestation, Turner syndrome. Adult: Replacement for those with growth hormone deficiency.	NUTROPIN AQ OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE	
		GENOTROPIN NORDITROPIN 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. 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. Please submit PA requests on the Hepatitis C PA form available at www.wymedicaid.org .
		SOVALDI			
PROTEASE INHIBITOR		Prior authorization is required prior to use of Olysio. Please submit PA requests on the Hepatitis C PA form available at www.wymedicaid.org .			
	OLYSIO				
HEP C COMBO AGENTS		Prior authorization is required prior to use of Harvoni. Please submit PA requests on the Hepatitis C PA form available at www.wymedicaid.org .			
	HARVONI				
IMMUNOMODULATORS	IMMUNOMODULATORS		Client must have one of the diagnoses prior to approval for preferred agents (outlined below): Enbrel: Ankylosing Spondylitis (AS), Juvenile Idiopathic Arthritis (JIA), Psoriatic Arthritis (PA), Plaque Psoriasis (PP), and Rheumatoid Arthritis (RA)** Humira: AS, Crohn's, JIA, PA, PP, Ulcerative Colitis (UC), RA** **56-day trial and failure of methotrexate required prior to approval of a preferred agent (Enbrel or Humira) for diagnosis of Rheumatoid Arthritis (RA). For non-preferred agents with a diagnosis of AS, JIA, PP, PA, and RA, a 56-day trial and failure of both preferred agents is required. For non-preferred agents with a diagnosis of Crohn's or UC, a 56-day trial and failure of Humira is required. The approved diagnoses for the non-preferred agents are outlined below: Actemra: RA** Amevive: PP Cimzia: AS, Crohn's, PA, RA** Kineret: RA Orencia: JIA, RA** Otezla: PA, PP Remicade: AS, Crohn's, PA, PP, RA**, UC Rituxan: RA** Simponi: AS, PA, RA** Stelara: PP Tysabri: Crohn's (additional PA criteria applies) Xeljanz: RA**	ACTEMRA AMEVIVE CIMZIA KINERET ORENCIA OTEZLA RAPTIVA REMICADE RITUXAN SIMPONI STELARA TYSABRI (<i>additional criteria applies</i>) XELJANZ	
		ENBREL HUMIRA			
INSOMNIA	NON-BENZODIAZEPINES		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Prior authorization will be required for clients under the age of 18. Rozerem is non-preferred without a history of substance abuse 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 (<i>additional criteria applies</i>) eszopiclone INTERMEZZO (<i>additional criteria applies</i>) ROZEREM zolpidem ER ZOLPIMIST (<i>additional criteria applies</i>)	
	zaleplon zolpidem				

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MIGRAINE	<p>TRIPTANS</p> <p>naratriptan sumatriptan</p>		<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 RELPAX rizatriptan TREMIMET zolmitriptan</p>
MULTIPLE SCLEROSIS	<p>STEP 1 MS AGENTS</p> <p>IMMUNOMODULATOR (GLATIRAMER INJECTION)</p> <p>COPAXONE 20MG/ML</p> <p>INTERFERON</p> <p>AVONEX BETASERON</p> <p>STEP 2 MS AGENTS</p> <p>GILENYA</p>		<p>Trial and failure of one preferred agent will be required before approval can be given for the step 2 MS agent (Gilenya).</p> <p>Trial and failure of a preferred step 1 interferon agent AND trial and failure of Copaxone 20mg/ml will be required before approval can be given for a non-preferred agent.</p> <p>For Tysabri, in addition to the above criteria, additional prior authorization criteria applies.</p>	<p>AUBAGIO COPAXONE 40MG/ML (use preferred) EXTAVIA REBIF TECIDERA TYSABRI (additional criteria applies)</p>
NEUROPATHIC PAIN	<p>TRICYCLIC ANTIDEPRESSANTS</p> <p>amitriptyline imipramine</p> <p>GABAPENTIN</p> <p>gabapentin</p>		<p>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.</p>	<p>duloxetine LYRICA</p>
NSAIDS	<p>NSAIDs</p> <p>diclofenac tablets etodolac flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate meloxicam nabumetone naproxen oxaprozin piroxicam sulindac tolmetin</p>		<p>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.</p> <p>Dosing and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets).</p>	<p>CALDOLOR (use preferred) CAMBIA POWDER (use preferred) CELEBREX diclofenac 1.5% solution (additional criteria applies) diclofenac 3% gel (additional criteria applies) fenoprofen FLECTOR (additional criteria applies) mefenamic acid NEOPROFEN (use preferred) SPRIX (additional criteria applies) VOLTAREN (additional criteria applies) ZIPSOR (use preferred) ZORVOLEX (use preferred)</p>
OPHTHALMICS	<p>OP. -ANTI-ALLERGICS</p> <p>icromolyn OPTIVAR* PATADAY PATANOL</p> <p>OP. -ANTIBIOTICS- QUINOLONES</p> <p>ciprofloxacin ofloxacin MOXEZA VIGAMOX</p> <p>OP. -ANTI-INFLAMMATORY- NSAIDS</p> <p>flurbiprofen diclofenac ketorolac</p> <p>OP. -BETA-BLOCKERS</p> <p>betaxolol carteolol levobunolol metipranolol timolol</p> <p>OP. -CARBONIC ANHYDRASE INHIBITOR</p> <p>dorzolamide</p> <p>OP. - COMBO PRODUCTS</p> <p>COMBIGAN dorzolamide/timolol SIMBRINZA</p> <p>OP. -PROSTAGLANDINS</p> <p>latanoprost TRAVATAN Z</p> <p>OP. -SYMPATHOMIMETICS</p> <p>ALPHAGAN P 0.15%* brimonidine 0.2%</p>		<p>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.</p> <p>Emadine, Alomide, and Alocril will be approved for pregnancy.</p> <p>Alomide will be approved for children under the age of 3.</p> <p>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.</p> <p>Azasite will be approved for pregnancy.</p> <p>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.</p> <p>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.</p> <p>Betoptic S will be approved for those with heart and lung conditions.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>ALAMAST ALOCRIL ALOMIDE ALREX azelastine (BRAND IS PREFERRED) BEPREVE ELESTAT EMADINE ketotfen LASTACAPT AZASITE BESIVANCE gatitofloxacin IQIUX levofloxacin ZYMAR ACULAR/LS/PF (use preferred) ACUVAIL BROMDAY bromfenac ILEVRO NEVANAC BETIMOL BETOPTIC S ISTALOL AZOPT LUMIGAN ZIOPTAN ALPHAGAN P 0.1% brimonidine 0.15% (BRAND IS PREFERRED) COMBIGAN (use separate agents)</p>

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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			
OVERACTIVE BLADDER	NASAL CALCITONIN		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
	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 <u>tabs</u> (BRAND IS PREFERRED) FOSRENOL sevelamer VELPHORO
	calcium acetate capsules ELIPHOS* PHOSLYRA RENAGEL			
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		
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			
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 (<i>use separate agents</i>)
	finasteride			
PROSTATE	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 (<i>use separate agents</i>) 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 REVATIO SUSPENSION sildenafil (Revatio A/B rated generic)		
	ENDOTHELIN RECEPTOR ANTAGONISTS		Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
		LETAIRIS TRACLEER		
	SOLUBLE GUANYLATE CYCLASE STIMULATORS		Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
		ADEMPAS		
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 <u>and</u> 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 (<i>use preferred</i>) Carisoprodol is limited to 84 tabs/365 days
	baclofen cyclobenzaprine tizanidine tablets			

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STIMULANT	AMPHETAMINES		<p>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).</p> <p>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.</p> <p>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.</p> <p>Prior Authorization will be required for clients under the age of 4.</p> <p>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.</p> <p>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.</p> <p>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/day 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 methylphenidate: 135mg/day methylphenidate ER/CR/SR: 135mg/day VYVANSE: 105mg/day</p>	<p>AMPHETAMINES: dextroamphetamine CR capsules (BRAND IS PREFERRED) ZENZEDI 2.5 AND 7.5MG TABLETS</p> <p>METHYLPHENIDATES: methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA) QUILLIVANT XR SUSPENSION</p>
	LONG ACTING AMPHETAMINES			
	amphetamine salts combo XR DEXDRINE CAPSULES* VYVANSE			
	IMMEDIATE RELEASE AMPHETAMINES			
	amphetamine salts combo* dextroamphetamine tablets			
	METHYLPHENIDATES			
	LONG ACTING METHYLPHENIDATES			
DAYTRANA FOCALIN XR methylphenidate ER/CR/SA/SR tablets				
IMMEDIATE RELEASE METHYLPHENIDATES				
dexmethylphenidate				
STIMULANT-LIKE AGENTS	SELECTIVE ALPHA-ADRENERGIC AGONIST		<p>To obtain the non-preferred agent, client must meet the following criteria:</p> <p>Client must have a diagnosis of ADD or ADHD</p> <p>Prior authorization will be required for clients under the age of 4.</p> <p>Clients must have completed a 14 day trial of clonidine IR with <u>benefit</u> in the previous 12 months.</p>	KAPVAY*
	clonidine			
	GUANFACINE AGENTS			
guanfacine		<p>To obtain the non-preferred agent, client must meet the following criteria:</p> <p>Client must have a diagnosis of ADD or ADHD</p> <p>Prior authorization will be required for clients under the age of 4.</p> <p>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 <u>benefit</u> in the previous 12 months,</p> <p>OR a contraindication to ADHD medications (including stimulant and non-stimulant),</p> <p>OR a TIC disorder associated with stimulants (trial of stimulant required).</p>	INTUNIV	
SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR		<p>Clients must have a diagnosis for ADD, ADHD, narcolepsy, obstructive sleep apnea, shift work sleep disturbance, or refractory depression (see refractory depression criteria below).</p> <p>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.</p> <p>Prior Authorization will be required for clients under the age of 5.</p> <p>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.</p> <p>Dosage limits apply: STRATTERA: 150mg/day</p>		
STRATTERA				

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TOPICAL AGENTS	IMPETIGO ANTIBIOTICS		Trial and failure of ALL preferred agents greater than or equal to 7 days in the past 90 days. Use smallest size appropriate for 7 day trial.	ALTABAX		
	gentamicin mupirocin					
	BENZOYL PEROXIDE/CLINDAMYCIN COMBOS		Clients must be 12 to 20 years of age and have a diagnosis of acne vulgaris. Requires prior authorization for clients less than 12 years of age. Acne combinations are limited to clients under the age of 21.	ACANYA benzoyl peroxide/clindamycin (BRAND IS PREFERRED)		
		BENZACLIN* clindamycin/benzoyl peroxide 1.2 (1)-5% (Refrig)				
	CORTICOSTEROIS		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	hc butyrate 0.1% (C) PANDEL prednicarbate 0.1% (C,O) TEXACORT 2.5% (S)		
	LOW POTENCY					
	alclometasone desonide DESOWEN 0.05% (L) fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) SYNALAR 0.01%					
	MEDIUM POTENCY					
	betamethasone valerate CUTIVATE 0.05% (C) DERMATOP 0.1% (C) desoximetasone 0.05% (C) ELOCON 0.1% fluocinolone 0.025% fluticasone 0.05% (C) hydrocortisone butyrate 0.1% (O) hydrocortisone probutate 0.1% (C) mometasone SYNALAR 0.025% TOPICORT 0.05% (C) triamcinolone 0.025%, 0.1%					
	HIGH POTENCY					
	betamethasone dipropionate clobetasol/E 0.05% (C,G,O,S) diflorasone DIPROLENE 0.05% (L) fluciclonide flurandrenolide fluticasone 0.005% (O) halobetasol TEMOVATE/E TOPICORT 0.25% (C) triamcinolone 0.5% ULTRAVATE 0.05%					
	IMMUNOMODULATORS				Trial and failure of a preferred medium potency topical corticosteroid greater than or equal to a 21 day trial <u>and</u> 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 <u>and</u> 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.	APEXICON amcinonide 0.1% (C,L,O) augmented betamethasone 0.05% (G,L,O) clobetasol 0.05% (L) desoximetasone 0.05%, 0.25% (C,G,O) fluciclonide 0.1% (C) HALOG
		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%						