

**WYOMING MEDICAID  
Preferred Drug List (PDL) - October 15, 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), 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>PLEASE CONTACT US FOR QUESTIONS</small>	
ADDICTION AGENTS	<b>BUPRENORPHINE COMBINATIONS</b>		<p>Client must have a diagnosis of opioid dependence or abuse. This is not to be used for the treatment of chronic pain. Prescriber must have a XDEA number. Prior authorization will be required before any narcotic or carisoprodol prescription will be allowed between fills. Prior authorization will be required before any benzodiazepine or short-acting stimulant prescription from any doctor other than the prescriber of buprenorphine or Suboxone, will be allowed between fills.</p> <p>Oral buprenorphine will be approved for clients that are pregnant or nursing or with a documented allergy to naloxone.</p> <p><b>Dosage limits apply (Max Dose: 24mg/day). Client is limited to two (2) years of buprenorphine/naloxone or oral buprenorphine use.</b></p> <p>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>.</p>	<p>buprenorphine (oral) buprenorphine/naloxone tablets (use preferred) ZUBSOLV</p>	
		<p>BUNAVAIL SUBOXONE FILM</p>			
	<b>NALTREXONE</b>		<p>Client must have a diagnosis of alcohol or opioid dependence.</p> <p>Prior authorization will be required before any narcotic or carisoprodol prescription will be allowed between fills. Prior authorization will be required before any benzodiazepine or short-acting stimulant prescription from any doctor other than the prescriber of buprenorphine or Suboxone, will be allowed between fills.</p>		
		<p>naltrexone VIVITROL</p>			
ALLERGY / ASTHMA	<b>ANTIHISTAMINES, MINIMALLY SEDATING</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>desloratadine CLARINEX RDT/SYRUP levocetirizine</p>	
		<p>cetirizine fexofenadine loratadine</p>			
		<b>ANTIHISTAMINE/DECONGESTANT COMBINATIONS</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>CLARINEX-D</p>
		<p>cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine</p>			
		<b>ANTICHOLINERGIC BRONCHODILATORS</b>		<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>Spiriva 5 day STARTER package will be allowed one (1) time per recipient.</p>	<p>ATROVENT HFA INCRUSE ELLIPTA SPIRIVA RESPIMAT TUDORZA</p>
		<p>COMBIVENT ipratropium SPIRIVA</p>			
		<b>CORTICOSTEROID / BRONCHODILATOR COMBO'S</b>		<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>***Will also require the diagnosis of COPD.</p> <p>**Advair HFA will be approved for clients 6 years of age and younger</p> <p>Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.</p>	<p>ADVAIR HFA** ANORO ELLIPTA*** BREQ ELLIPTA*** STIOLTO</p>
		<p>ADVAIR DISK DULERA SYMBICORT</p>			
		<b>LEUKOTRIENE MODIFIERS</b>		<p>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.</p>	<p>zafirlukast ZYFLO</p>
		<p>montelukast</p>			
		<b>LONG ACTING BRONCHODILATORS</b>		<p>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.</p>	<p>PERFOROMIST STRIVERDI</p>
		<p>BROVANA FORADIL SEREVENT</p>			
		<b>NASAL ANTIHISTAMINES</b>		<p>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.</p>	<p>azelastine 0.15% DYMISTA (use separate agents) olopatadine 0.6%</p>
		<p>ASTELIN azelastine 0.1%</p>			
		<b>NASAL STEROIDS</b>		<p>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.</p> <p>Budesonide will be approved for pregnancy.</p>	<p>budesonide DYMISTA (use separate agents) OMNARIS QNASL triamcinolone VERAMYST ZETONNA</p>
	<p>BECONASE AQ flunisolide fluticasone NASONEX</p>				
	<b>SHORT ACTING BRONCHODILATORS - INHALERS</b>		<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>Minimum day supply of at 16 days is required</p>	<p>PROAIR RESPICLICK XOPENEX HFA</p>	
	<p>PROAIR HFA PROVENTIL HFA VENTOLIN HFA</p>				
	<b>SHORT ACTING BRONCHODILATORS - NEBULIZERS</b>		<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>levalbuterol (BRAND IS PREFERRED)</p>	
	<p>albuterol neb XOPENEX neb*</p>				
	<b>STEROID INHALANTS</b>		<p>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.</p> <p>Alvesco will be approved for a history of oral thrush with steroid inhalants.</p>	<p>AEROBID/AEROBID-M ALVESCO ARNUNITY ASMANEX budesonide suspension 1mg/2ml QVAR</p>	
	<p>AEROSPAN budesonide suspension 0.25 and 0.5mg/2ml FLOVENT HFA/DISK PULMICORT FLEXHALER</p>				
	<b>EPINEPHRINE</b>			<p>ADRENACLICK (use preferred) AUIV-Q (use preferred) epinephrine (use preferred)</p>	
	<p>EPI-PEN</p>				

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>THIS CELL IS NOT FULL INCLUSIVE PLEASE CONTACT US FOR QUESTIONS</small>		
ALZHEIMERS	ALZHEIMER AGENTS		Client must have a diagnosis of dementia.	donepezil 23mg (use preferred) donepezil ODT (use preferred) rivastigmine patches (BRAND IS PREFERRED)		
		donepezil EXELON PATCH*/SOLUTION galantamine/ER memantine NAMENDA XR rivastigmine capsules				
ANALGESICS	LONG-ACTING C-Its		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-Its and C-IVs that are not included on the PDL 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 ER 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.  ****In addition to above criteria, Embeda requires a diagnosis of drug/substance abuse.  Fentanyl patches are limited to one patch every 72 hours.	AVINZA BUTRANS** EMBEDA*** fentanyl patch 37.5, 62.5, 87.5mg (use preferreds) hydromorphone ER HYSINGLA ER (additional criteria applies) KADIAN (10mg, 200mg) morphine sulfate ER capsules NUCYNTEA ER*** oxymorphone ER OXYCONTIN* XARTEMIS XR (additional criteria applies) ZOHYDRO ER (additional criteria applies)		
	morphine sulfate ER tablets	fentanyl patch 12.5, 25, 50, 75, and 100mg				
	SHORT-ACTING C-Its				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, 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.	levorphanol NUCYNTEA*** OXAYDO** OXECTA** oxymorphone oxycodone/IBU PRIMLEV (use preferred) ZOLVIT SOLUTION (use preferred)
	codeine sulfate hydrocodone/APAP hydrocodone/IBU hydromorphone LORTAB ELIXIR 10-300MG 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).	NATESTO NASAL GEL (use preferred) TESTIM GEL (use preferred) testosterone gel 1% (BRAND IS PREFERRED) testosterone gel 2% (use preferred) VOGELXO GEL (use preferred)		
		ANDROGEL*				
ANTIBIOTICS	QUINOLONES		Minimum day supply of at 56 days is required	FACTIVE moxifloxacin NOROXIN PROQUIN  ADOKA (use preferred) DORYX (use preferred) ORACEA (use preferred) SOLODYN (use preferred)		
	ciprofloxacin/ER levofloxacin ofloxacin					
	DOXYCYCLINE					
	doxycycline					
	MINOCYCLINE					
INHALED TOBRAMYCIN						
	BETHKIS KITABIS TOBI*					
ANTICOAGULANTS	LOW MOLECULAR WEIGHT HEPARIN (LMWH)		Prior authorization will be required for the 300mg/3ml strength	FRAGMIN (use preferred) LOVENOX 300MG/3ML*		
	enoxaparin					
	DIRECT THROMBIN INHIBITOR		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.	SAVAYSA (use preferred)		
	PRADAXA					
SELECTIVE FACTOR XA INHIBITOR		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.				
	ELIQUIS XARELTO					
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>BASED ON 2014 PDL FULL INCULCATED FUTURE CONTRACTS MAY VARY SIGHTLY</small>	
ANTIDEPRESSANTS	<b>ANTIDEPRESSANTS</b>		<p>Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks <b>WITHIN THE LAST 2 YEARS</b> 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, buspirone, 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>Clients will not be allowed to be on more than one antidepressant, including fluvoxamine, bupropion IR, and venlafaxine IR, at one time with the exception of mirtazapine or bupropion with a SSRI.</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>Clients five (5) years of age and younger will require prior authorization before approval.</p> <p>Dosage limits apply:  bupropion ER/SR/XL: 450mg/day  citalopram &lt; 60 years of age: 60mg/day  citalopram &gt; 60 years of age: 30mg/day  escitalopram: 30mg/day  fluoxetine &lt; 18 years of age: 90mg/day  fluoxetine &gt; 18 years of age: 120mg/day  mirtazapine: 67.5mg/day  paroxetine IR/CR &lt; 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>		
	<b>NORADRENERGIC/SPECIFIC SEROTONERICS (NaSS)</b>				NaSS
	mirtazapine 15, 30, and 45mg				mirtazapine 7.5mg and rapid dissolve tablets (use preferred)
	<b>NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)</b>				NDRI
	bupropion ER/SR/XL				APLENZIN FORFIVO XL
	<b>SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)</b>				SSRI
	citalopram escitalopram fluoxetine capsules paroxetine IR/CR sertraline				fluoxetine tablets (use preferred) VIIBRYD
	<b>SEROTONIN/NORPINEPHRINE REUPTAKE INHIBITORS (SNRI)</b>				SNRI
	venlafaxine ER capsules				duloxetine** desvenlafaxine FETZIMA PRISTIQ venlafaxine ER tablets (use preferred)
	<b>OTHER</b>				Brintellix***
ANTHYPERTENSIVES	<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> <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>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> <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>		
	<b>ACE INHIBITORS AND DIURETICS</b>				
	benazepril captopril enalapril fosinopril lisinopril moexipril perindopril quinapril ramipril trandolapril				
	benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ moexipril/HCTZ quinapril/HCTZ				
	<b>ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)</b>				BENICAR candesartan EDARBI eprosartan 600mg telmisartan TEVETEN 400mg valsartan (BRAND IS PREFERRED)
	<b>ARBs AND DIURETICS</b>				BENICAR HCT candesartan HCTZ EDARBYCLOR telmisartan HCTZ TEVETEN HCTZ valsartan HCTZ
		DIOVAN* irbesartan losartan			
<b>ALPHA-BLOCKERS</b>			clonidine patch (BRAND IS PREFERRED) NEXICLON XR (use preferred)		
ANTIVIRALS	<b>PROTEASE INHIBITORS</b>		<p>NORVIR solution (use preferred)</p>		
	APTIVUS CRIXIVAN INVIRASE LEXIVA NORVIR CAPSULES NORVIR TABLETS PREZISTA REYATAZ VIRACEPT				

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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>
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 &lt;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 &gt; 17 years of age: 24mg/day            SAPHRIS: 30mg/day            Olanzapine &lt; 13 years of age: 15mg/day            Olanzapine ≥ 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 ≤ 17 years of age: 180mg/day            ziprasidone &gt; 17 years of age: 300mg/day</p>	aripiprazole tablets SEROQUEL XR (use preferred)
	SPECIAL ATYPICAL ANTIPSYCHOTICS		Dosage limits apply: 1350mg/day	VERSACLOZ Suspension (use preferred)
	clozapine/ODT			
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) 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 fenofibrate 43, 50, 120, 130, and 150mg LIPOFEN LOVAZA VASCEPA	
fenofibrate 54, 67, 134, 145, 160, and 200mg gemfibrozil				

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CONTRACEPTIVES	ORAL CONTRACEPTIVES			amethia/LO (BRAND IS PREFERRED) alyacen (BRAND IS PREFERRED) aranelle (BRAND IS PREFERRED) BEYAZ (PA required) camila (use preferred) camrese/LO (BRAND IS PREFERRED) cyclafem (BRAND IS PREFERRED) dasetta (BRAND IS PREFERRED) daysee (BRAND IS PREFERRED) deblitane (use preferred) drospir/ethi (use preferred) GENERESS FE CHW (PA required) heather (use preferred) introvale (use preferred) jencycla (use preferred) levonorgest/ethinyl estrad (91-Day) (use preferred) levonorgest/ethinyl estradiol (Continuous) 90-20 (use preferred) leena (BRAND IS PREFERRED) loestrin 21, FE 1/20, FE 1.5/30 (use preferred) LO LOESTRIN (PA required) LO MINASTRIN FE (PA required) loryna (use preferred) MINASTRIN 24 FE CHEWABLE (PA required) MODICON (use preferred) NATAZIA (PA required) necon 0.5/35, 1/35, 7/7/7 (BRAND IS PREFERRED) NECON 1/50 (use preferred) nikki (use preferred) norethindrone (use preferred) NORINYL 1/35 (use preferred) norlyroc (use preferred) nor-qd (use preferred) nortrel (BRAND IS PREFERRED) ortho micron (use preferred) pirmella (BRAND IS PREFERRED) quasense (use preferred) QUARTETTE (PA required) SAFYRAL (PA required) sharobel (use preferred) wera (BRAND IS PREFERRED) wymzya FE chewable (BRAND IS PREFERRED) zenchent FE chewable (PA required) zeosa chewable (BRAND IS PREFERRED)
	altavera amethyst azurette apri aubra aviane balzia <b>BREVICON*</b> briellyn caziant chateal crysselle delyla DESOGEN deso/ethinyl estradiol elinest emoquette enpresse enskyce errin estarylla falmina Femcon FE Chewable gianvi gildagia gildess/FE jolessa jolivette junel/FE kariva kelnor kurvelo larin/FE lessina levonest levonor/ethi levora LOESTRIN 24 FE LOMEDIA 24 FE LOSEASONIQUE low-ogestrel lutera 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 <b>ORTHO TRI-CYCLEN LO*</b> <b>ORTHO-NOVUM 1/35-28, 7/7/7-28*</b> philith pimtrea portia previfem reclipsen <b>SEASONIQUE*</b> sprintec sronyx syeda tilia FE tri-estaryl tri-legest FE tri-linyah trinessa <b>TRI-NORINYL*</b> tri-previfem tri-sprintec trivora velivet vestura viorele vyfemla zarah zenchent ZOVIA			
CORTICOSTEROIDS	ORAL CORTICOSTEROIDS			CELESTONE (use preferred)
	budesonide cortisone acetate dexamethasone/intensol hydrocortisone methylprednisone prednisolone prednisone			

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DIABETES	<b>DIABETES AGENTS</b>			FORTAMET (use preferred)
	<b>BIGUANIDES</b>			GLUMETZA (use preferred)
	metformin/ER			RIOMET (use preferred)
	<b>α-GLUCOSIDASE INHIBITORS</b>			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.	
	<b>MEGLITINIDES</b>			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
	<b>THIAZOLIDINEDIONES</b>			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)
	<b>SULFONYLUREAS</b>			
	glimpiride/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>			GLYXAMBI (use separate preferred agents)
		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
	<b>DPP-4 INHIBITOR COMBO AGENTS</b>			JENTADUETO
		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.	JUVISYNC KAZANO OSENI
	<b>INCRETIN MIMETICS (GLP-1 RECEPTOR AGONISTS)</b>			BYDUREON
		TANZELUM 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.	BYETTA TRULICITY
<b>SGLT2 INHIBITORS</b>			GLYXAMBI (use separate preferred agents)	
	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.	JARDIANCE	
<b>SGLT2 INHIBITOR COMBO AGENTS</b>			SYNJARDY	
	INVOKAMET XIGDUO XR	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.		
<b>LONG-ACTING INSULIN</b>			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	TOUJEO (use preferred)	
<b>DIABETIC METERS/TEST STRIPS</b>			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 ONE TOUCH VERIO PRECISION XTRA	Quantity limits apply: Insulin Dependent Clients: 10 strips/day Non-Insulin Dependent Clients: 4 strips/day Clients are limited to 1 meter/365 days		
EAR	<b>ANTIBIOTIC/STEROID COMBINATION</b>			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	<b>FIBROMYALGIA STEP 1</b>			
	amitriptyline cyclobenzaprine			
	<b>FIBROMYALGIA STEP 2</b>			
	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.		
<b>FIBROMYALGIA STEP 3</b>				
	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	<b>DIGESTIVE ENZYMES</b>			PANCREAZE
	CREON 3000, 6000, 12000, 24000, and 36000 units ZENPEP*		Prior authorization required.	pancreliase (BRAND IS PREFERRED) PERTZYE TRI-PASE ULTRESA VIKASE
	<b>IRRITABLE BOWEL SYNDROME AGENTS</b>			
		AMITIZA LINZESS	Client must have a diagnosis of chronic idiopathic constipation or Irritable Bowel Syndrome (IBS) with constipation.	
<b>OPIOID-INDUCED CONSTIPATION AGENTS</b>				
	AMITIZA	Client must have a diagnosis of opioid-induced constipation and a three (3) month trial and failure of a secretary agent to receive the preferred agent. To receive the non-preferred agent, client must have a diagnosis of opioid-induced constipation, a three (3) month trial and failure of a secretary agent, and a three (3) month trial and failure of the preferred agent.	MOVANTIK	

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GASTROINTESTINAL continued	PROTON PUMP INHIBITORS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.  Lansoprazole solutabs will be approved for children less than or equal to 8 years of age.	ACIPHEX SPRINKLES amox/clarith/lanso pack (use separate agents) DEXILANT esomeprazole 24.65mg and 49.3mg 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				
	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 DELZICOL LIALDA PENTASA 500MG (use preferred) 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				
	NSSA INHIBITOR				Prior authorization is required prior to use of Daklinza.
		DAKLINZA			Please submit PA requests on the Hepatitis C PA form available at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> .
	NUCLEOTIDE ANALOG POLYMERASE INHIBITOR				Prior authorization is required prior to use of Sovaldi.
		SOVALDI			Please submit PA requests on the Hepatitis C PA form available at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> .
	PROTEASE INHIBITOR		Prior authorization is required prior to use of Olysio.		
		OLYSIO	Please submit PA requests on the Hepatitis C PA form available at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> .		
	HEP C COMBO AGENTS		Prior authorization is required prior to use of Harvoni, Technivie, or Viekira Pak.		
		HARVONI TECHNIVIE VIEKIRA PAK	Please submit PA requests on the Hepatitis C PA form available at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> .		
IMMUNOMODULATORS	ANKYLOSING SPONDYLITIS (AS)		Client must have diagnosis of AS prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of AS and a 56-day trial and failure of both preferred agents.  Quantity Limits apply for all diagnoses: Enbrel 25mg - limited to 10 per month Enbrel 50mg - limited to 5 per month Humira 20mg - limited to 10 per month Humira 40mg - limited to 5 per month	CIMZIA REMICADE SIMPONI	
		ENBREL HUMIRA			
	CROHN'S				Client must have diagnosis of Crohn's prior to approval of the preferred agent. To receive a non-preferred agent, client must have a diagnosis of Crohn's and a 56-day trial and failure of the preferred agent.
		HUMIRA			
	JUVENILE IDIOPATHIC ARTHRITIS (JIA)				Client must have diagnosis of JIA prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of JIA and a 56-day trial and failure of both preferred agents.
		ENBREL HUMIRA			
	PSORIATIC ARTHRITIS (PA)				Client must have diagnosis of PA prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of PA and a 56-day trial and failure of both preferred agents.
		ENBREL HUMIRA			
	PLAQUE PSORIASIS (PP)				Client must have diagnosis of PP prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of PP and a 56-day trial and failure of both preferred agents.  **Cosentyx will only require a 56-day trial and failure of Humira
		ENBREL HUMIRA**			
	RHEUMATOID ARTHRITIS (RA)		Client must have diagnosis of RA and a 56-day trial and failure of methotrexate prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of RA and a 56-day trial and failure of both preferred agents.	CIMZIA CIMZIA KINERET ORENCIA REMICADE RITUXAN SIMPONI XELJANZ	
	ENBREL HUMIRA				
	ULCERATIVE COLITIS (UC)		Client must have diagnosis of UC prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of UC and a 56-day trial and failure of the preferred agent.	REMICADE	
		HUMIRA			

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INSOMNIA	NON-BENZODIAZEPINES		<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>Rozerem 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><b>Dosage limits apply:</b> zaleplon: 30mg/day zolpidem: 15mg/day</p>	<p>BELSOMRA EDLUAR (<i>additional criteria applies</i>) eszopiclone INTERMEZZO (<i>additional criteria applies</i>) ROZEREM zolpidem ER ZOLPIMIST (<i>additional criteria applies</i>)</p>
	zaleplon zolpidem			
MIGRAINE	TRIPTANS		<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><b>Quantity limits apply:</b> 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>almotriptan FROVA RELPAK rizatriptan TREMIMET ZECUITY PAD (<i>use preferreds</i>) zolmitriptan</p>
	naratriptan sumatriptan			
MULTIPLE SCLEROSIS	STEP 1 MS AGENTS IMMUNOMODULATOR (GLATIRAMER INJECTION)		<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>AUBAGIO COPAXONE 40MG/ML (<i>use preferred</i>) EXTAVIA LEMTRADA PLEGRIDY REBIF TECFIDERA TYSABRI (<i>additional criteria applies</i>)</p>
	COPAXONE 20MG/ML			
	INTERFERON		<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>	
	AVONEX BETASERON			
	STEP 2 MS AGENTS			
GILENYA				
NEUROPATHIC PAIN	TRICYCLIC ANTIDEPRESSANTS		<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>
	amitriptyline desipramine imipramine nortriptyline			
	GABAPENTIN gabapentin			
NSAIDS	NSAIDs		<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><b>Dosing and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets).</b></p>	<p>CALDOLOR (<i>use preferred</i>) CAMBIA POWDER (<i>use preferred</i>) celecoxib diclofenac 1.5% solution (<i>additional criteria applies</i>) diclofenac 3% gel (<i>additional criteria applies</i>) fenoprofen FLECTOR (<i>additional criteria applies</i>) mefenamic acid NEOPROFEN (<i>use preferred</i>) SPRIX (<i>additional criteria applies</i>) TIVORBEX (<i>use preferred</i>) VOLTAREN (<i>additional criteria applies</i>) ZIPSOR (<i>use preferred</i>) ZORVOLEX (<i>use preferred</i>)</p>
	diclofenac tablets etodolac flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclizolam meloxicam nabumetone naproxen oxaprozin piroxicam sulindac tolmetin			
OPHTHALMICS	OP. -ANTI-ALLERGICS		<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>ALAMAST ALOCRIL ALOMIDE ALREX azelastine BEPREVE EMADINE epinastine ketotifen LASTACAFT PAZEO</p>
	cromolyn PATADAY PATANOL			
	OP. -ANTIBIOTICS- QUINOLONES		<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>AZASITE BESIVANCE gatifloxacin IQIUX levofloxacin ZYMAR</p>
	ciprofloxacin ofloxacin MOXEZA VIGAMOX			
	OP. -ANTI-INFLAMMATORY- NSAIDS		<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>ACULAR/LS/PF (<i>use preferred</i>) ACUVAIL bromfenac 0.9% ILEVRO NEVANAC PROLENSA</p>
	flurbiprofen diclofenac ketorolac			
	OP. -BETA-BLOCKERS		<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>BETIMOL BETOPTIC S ISTALOL</p>
	betaxolol carteolol levobunolol metipranolol timolol			
	OP. -CARBONIC ANHYDRASE INHIBITOR		<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>AZOPT</p>
	dorzolamide			
OP. - COMBO PRODUCTS		<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>		
COMBIGAN dorzolamide/timolol SIMBRINZA				
OP. -PROSTAGLANDINS		<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>bimatoprost LUMIGAN 0.1% ZIOPTAN</p>	
latanoprost TRAVATAN Z				



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OPHTHALMICS continued	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)		
	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		
PHOSPHATE BINDERS	PHOSPHATE BINDERS		Prior authorization required for non-preferred agents.	AURYXIA FOSRENOL sevelamer VELPHORO		
	calcium acetate PHOSLYRA RENAGEL					
PLATELET AGGREGATE INHIBITORS	THIENOPYRIDINE DERIVATIVES		Prior authorization required for clients on antiplatelet therapy greater than one (1) year.			
	clopidogrel EFFIENT ticlopidine					
	CPTP DERIVATIVES				Prior authorization is required.	BRILINTA
	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.			
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
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.	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					

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STIMULANT	<b>AMPHETAMINES</b>		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).	<b>AMPHETAMINES:</b> dextroamphetamine CR capsules (BRAND IS PREFERRED) ZENZEDI 2.5 AND 7.5MG TABLETS
	<b>LONG ACTING AMPHETAMINES</b>			
	amphetamine salts combo XR DEXEDRINE CAPSULES* VYVANSE**			
	<b>IMMEDIATE RELEASE AMPHETAMINES</b>		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			
	<b>METHYLPHENIDATES</b>		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.	
<b>LONG ACTING METHYLPHENIDATES</b>				
DAYTRANA FOCALIN XR* methylphen ER methylphenidate ER/CR/SA/SR tablets		Prior Authorization will be required for clients under the age of 4.	<b>METHYLPHENIDATES:</b> APTENSIO XR dexmethylphenidate ER (BRAND IS PREFERRED) methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA) QUILLIVANT XR SUSPENSION	
<b>IMMEDIATE RELEASE METHYLPHENIDATES</b>				
dexmethylphenidate methylphen tablets methylphenidate tablets		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.		
		<b>Dosage limits apply:</b> amphetamine salts combo XR: 60mg/day amphetamine salts combo: 60mg/day amphetamine salts combo (narcolepsy): 90mg/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 methylphen/methylphenidate/ER: 90mg/day VYVANSE: 105mg/day		
STIMULANT-LIKE AGENTS	<b>SELECTIVE ALPHA-ADRENERGIC AGONIST</b>		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			
	<b>GUANFACINE AGENTS</b>		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 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).	guanfacine ER
<b>SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR</b>		STRATTERA	Clients must have a diagnosis for ADD, ADHD, narcolepsy, obstructive sleep apnea, shift work sleep disturbance, or refractory depression (see refractory depression criteria below).  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.  <b>Dosage limits apply:</b> STRATTERA: 150mg/day	

WYOMING MEDICAID  
Preferred Drug List (PDL) - October 15, 2015

Please refer to the Additional Therapeutic Criteria Chart, <b>Dosage Limitation List</b> (red font indicates quantity/dosage limits apply), and the Wyoming Medicaid Provider Manual at <a href="http://wymedicaid.org">http://wymedicaid.org</a> 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>
TOPICAL AGENTS	<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
	gentamicin mupirocin			
	<b>BENZOYL PEROXIDE/CLINDAMYCIN COMBOS</b>		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)
		<b>BENZACLIN*</b> clindamycin/benzoyl peroxide 1.2 (1)-5% (Refrig)		
	<b>CORTICOSTEROIS</b>		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	PANDEL prednicarbate 0.1% (C,O) TEXACORT 2.5% (S)
	<b>LOW POTENCY</b>			
	alclometasone desonide DESOWEN 0.05% (L) flucinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) SYNALAR 0.01%			
	<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 fluticasone 0.05% (L) hydrocortisone butyrate 0.1% (O) TOPICORT LP TRIANEX
	betamethasone valerate CUTIVATE 0.05% (C) DERMATOP 0.1% (C) desoximetasone 0.05% ( C) ELOCON 0.1% flucinolone 0.025% fluticasone 0.05% (C) hydrocortisone probutate 0.1% (C) mometasone SYNALAR 0.025% TOPICORT 0.05% (C) triamcinolone 0.025%, 0.1%			
	<b>HIGH POTENCY</b>		Trial and failure of ALL preferred agents greater than or equal to 14 days 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) flucionide 0.1% (C) HALOG
	betamethasone dipropionate clobetasol/E 0.05% (C,G,O,S) diflorasone DIPROLENE 0.05% (L) flucionide flurandrenolide fluticasone 0.005% (O) halobetasol TEMOVATE/E TOPICORT 0.25% (C) triamcinolone 0.5% ULTRAVATE 0.05%			
	<b>IMMUNOMODULATORS</b>		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.	
	ELIDEL PROTOPIC			
<b>SALICYLIC ACID</b>			All other topical salicylic acid formulations.	
aliclen shampoo 6% salacyn cream/lotion 6% Salicylic Acid Shampoo 6%				
<b>SCABICIDES/PEDICULICIDES</b>		Trial and failure of a preferred agent in the last 12 months.	OVIDE permethrin cream SKLICE ULESFIA	
LINDANE NATROBA permethrin solution				
<b>UREA</b>			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%				