WYOMING MEDICAID
Preferred Drug List (PDL) - February 26, 2020

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 Change Healthcare 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 THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT CHANGE HEALTHCARE WITH ANY QUESTIONS
ADDICTION	**BUPRENORPHINE COMBINATIONS**	buprenorphine/naloxone tablets **SUBOXONE FILM***	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, benzodiazepine, or carisoprodol prescription will be allowed between fills. Prior authorization will be required before any short-acting stimulant prescription from any doctor other than the prescriber of buprenorphine or Suboxone, will be allowed between fills. Oral buprenorphine will be approved for clients with a documented allergy to naloxone. Please submit PA requests on the "Oral Buprenorphine/Naloxone or Oral Buprenorphine" PA form available at www.wymedicaid.org. Dosage limits apply During first two years of treatment: 16mg After two years of treatment: 8mg	BUNAVAIL buprenorphine (oral) buprenorphine/naloxone film (BRAND IS PREFERRED) ZUBSOLV
	NALTREXONE	naltrexone VIVITROL	Client must have a diagnosis of alcohol or opioid dependance. Prior authorization will be required before any narcotic, carisoprodol, or benzodiazepine prescription will be allowed between fills. Prior authorization will be required before a short-acting stimulant prescription from any doctor other than the prescriber of naltrexone or Vivitrol will be allowed between fills.	
ALLERGY / ASTHMA **continued**	**ANTIHISTAMINES, MINIMALLY SEDATING**	cetirizine fexofenadine loratadine	Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	desloratadine CLARINEX RDT/SYRUP levocetirizine
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS	cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine	Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	CLARINEX-D
	ANTICHOLINERGIC BRONCHODILATORS	ipratropium SPIRIVA HANDIHALER SPIRIVA RESPIMAT	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. **Lonhala will be allowed for clients that have difficulty using an inhaler Spiriva 5 day STARTER package will be allowed one (1) time per recipient	ATROVENT HFA INCRUSE ELLIPTA **LONHALA SEEBRI TUDORZA YUPELRI
	ANTICHOLINERGIC COMBINATION AGENTS	ANORO ELLIPTA** BEVESPI COMBIVENT UTIBRON	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.	STIOLTO TRELEGY
	LEUKOTRIENE MODIFIERS	montelukast	Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	zafirlukast ZYFLO
	LONG ACTING BRONCHODILATORS	BROVANA FORADIL SEREVENT	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. **Arcapta will require a diagnosis of COPD and the client must be older than 40 years of age	ARCAPTA** PERFOROMIST STRIVERDI
	NASAL ANTIHISTAMINES	azelastine 0.1%	Trial and failure of preferred agent greater than or equal to 90 days in the last 12 months will be required before approval can be given for a non-preferred agent.	azelastine 0.15% AZENASE *(use separate agents)* DYMISTA *(use separate agents)* olopatadine 0.6%

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ALLERGY / ASTHMA continued	**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.	AZENASE *(use separate agents)* budesonide DYMISTA *(use separate agents)* OMNARIS QNASL TICANASE *(use separate agents)* VERAMYST XHANCE ZETONNA
	BECONASE AQ flunisolide fluticasone mometasone			
	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. Minimum day supply of at 16 days is required	levoalbuterol (BRAND IS PREFERRED) PROAIR DIGIHALER VENTOLIN HFA
	albuterol HFA PROAIR HFA PROAIR RESPICLICK PROVENTIL HFA **XOPENEX HFA***			
	STEROID INHALANTS		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. Alvesco will be approved for a history of oral thrush with steroid inhalants.	AEROBID/AEROBID-M AEROSPAN ALVESCO ARMONAIR ARNUITY ASMANEX HFA QVAR/REDIHALER
	ASMANEX FLOVENT HFA/DISK budesonide suspension PULMICORT FLEXHALER			
	STEROID COMBINATION AGENTS		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 or uncontrolled asthma. Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.	BREO ELLIPTA** fluticasone/salmeterol 55-14/113-14/232-14 fluticasone/salmeterol 100-50/250-50/500-50 (BRAND IS PREFERRED) WIXELA
	ADVAIR DISK* ADVAIR HFA DULERA SYMBICORT			
	EPINEPHRINE			ADRENACLICK *(use preferred agent)* AUVI-Q *(use preferred agent)* EPI-PEN *(use preferred agent)*
	epinephrine auto-injector pen			
ARTHRITIS	**IMMUNOMODULATORS**		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. **Cimzia will be allowed for clients that are pregnant or breast-feeding 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** COSENTYX REMICADE *(additional criteria applies)* SIMPONI TALTZ
	ANKYLOSING SPONDYLITIS (AS)			
		ENBREL 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.	ACTEMRA ORENCIA
		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. **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** COSENTYX ORENCIA OTEZLA REMICADE *(additional criteria applies)* SIMPONI STELARA TALTZ XELJANZ/XR
		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 will be allowed for clients that are pregnant or breast-feeding	ACTEMRA CIMZIA** KEVZARA KINERET OLUMIANT ORENCIA REMICADE *(additional criteria applies)* RINVOQ RITUXAN SIMPONI XELJANZ/XR
		ENBREL HUMIRA		
CONVULSIONS	**DIAZEPAM RECTAL GEL**			
	diazepam gel			
	ORAL ANTICONVULSANTS		Preferred agents will be limited to FDA approved indications related to seizures and epilepsy. For indications not related to seizures and epilepsy, please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org. **Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	APTIOM *(use preferred agent)* BRIVIACT *(use preferred agent)* clobazam** DIACOMIT** EPIDIOLEX** NAYZILAM** OXTELLAR *(use preferred agent)* TROKENDI XR *(use preferred agent)*
		carbamazepine clonazepam divalproex FELBAMATE fosphenytoin FYCOMPA gabapentin lamotrigrine/XR levetiracetam pregabalin oxcarbazepine phenytoin subvenite topiramate/ER sprinkle caps valproate/valproic acid VIMPAT zonisamide		

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CROHN'S	**IMMUNOMODULATORS**		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. **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** REMICADE *(additional criteria applies)* STELARA TYSABRI *(additional criteria applies)*
		HUMIRA		
DERMATOLOGY	**BENZOYL PEROXIDE/CLINDAMYCIN COMBOs**		Clients must be 12 to 20 years of age. Requires prior authorization for clients less than 12 years of age. Acne combinations are limited to clients under the age of 21.	ACANYA *(use preferred agent)* ONEXTON *(use preferred agent)*
		clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig)		
	ISOTRETINOIN			ABSORICA *(use preferred agents)*
	AMNESTEEM CLARAVIS isotretinoin MYORISAN ZENATANE			
	CORTICOSTEROIDS - STEP 1 AGENTS **C=CREAM; G=GEL; L=LOTION; O=OINTMENT**		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	PANDEL 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		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	Clocortolone Pivalate flurandrenol fluticasone 0.05% (L) hydrocortisone butyrate 0.1% (O) triamcinolone 0.05% (O)
	betamethasone valerate CUTIVATE 0.05% (C) DERMATOP 0.1% (C) desoximetasone 0.05%, 0.25% (C) ELOCON 0.1% fluocinolone 0.025% fluticasone 0.05% (C) hydrocortisone probutate 0.1% (C) mometasone SYNALAR 0.025% TOPICORT 0.05% (C) triamcinolone 0.025%, 0.1%			
	HIGH POTENCY		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	APEXICON 0.05% (C) amcinonide 0.1% (C,L,O) augmented betamethasone 0.05% (G,L,O) clobetasol 0.05% (L) desoximetasone 0.05%, 0.25% (G,O) diflorasone 0.05% (O) fluocinonide 0.1% (C) halcinonide 0.1% (C) HALOG 0.1% (O)
	betamethasone dipropionate clobetasol/E 0.05% (C,G,O,S) diflorasone fluocinonide flurandrenolide fluticasone 0.005% (O) halobetasol TEMOVATE/E TOPICORT 0.25% (C) triamcinolone 0.5% ULTRAVATE 0.05%			
	IMMUNOMODULATORS - STEP 2 AGENTS		**To receive a step 2 agent:** Trial and failure of a preferred medium potency topical corticosteroid greater than or equal to a 21 day trial and a trial and failure of a preferred high potency topical corticosteroid greater than or equal to a 21 day trial in the last 90 days. For clients less than two (2) years of age, a trial and failure of a preferred low potency corticosteroid greater than or equal to a 21 day trial and a trial and failure of a preferred medium potency topical cortiscosteroid greater than or equal to a 21 day trial in the last 90 days.	pimecrolimus (BRAND IS PREFERRED) tacrolimus (BRAND IS PREFERRED)
		ELIDEL* **PROTOPIC***		
	PHOSPHODIESTERASE 4 INHIBITOR - STEP 3 AGENT		**To receive a step 3 agent:** Trial and failure of a preferred step 2 agent (immunomodulator) greater than or equal to a 21 day trial within the last 30 days. *Refer to the Additional Therapeutic Criteria Chart for required criteria for the diagnosis of asthma	DUPIXENT* EUCRISA
	PLAQUE PSORIASIS (PP)		Client must have diagnosis of PP prior to approval of a preferred agent (Enbrel or Humira). To receive a non-preferred agent, client must have a diagnosis of PP and a 56-day trial and failure of both preferred agents. **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** COSENTYX ILUMYA OTEZLA REMICADE *(additional criteria applies)* SILIQ SKYRIZI STELARA TALTZ TREMFYA
		ENBREL HUMIRA		
	SALICYLIC ACID			All other topical salicylic acid formulations.
	salicylic acid cream 6% salicylic acid lotion 6% salicylic acid shampoo 6%			
	SCABICIDES/PEDICULICIDES		Trial and failure of a preferred agent in the last 12 months.	LINDANE malathion lotion SKLICE spinosad (BRAND IS PREFERRED)
	NATROBA* permethrin VANALICE			
	UREA			All other topical urea formulations.
	ALUVEA CREAM 33% UMECTA EMULSION umecta mousse aerosal 40% urea lotion 40% urea lotion 45%			

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DIABETES	**DIABETES AGENTS**			metformin SR 24HR osmotic release *(use preferred agent)* metformin SR 24HR modified release *(use preferred agent)* RIOMET *(use preferred agent)*
	BIGUANIDES			
	metformin/ER			
	α–GLUCOSIDASE INHIBITORS		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	miglitol
	acarbose			
	MEGLITINIDES		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	repaglinide
	nateglinide			
	THIAZOLIDINEDIONES		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ACTOSPLUS MET *(use separate agents)* AVANDIA AVANDAMET *(use separate agents)*
	pioglitazone			
	SULFONYLUREAS		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	
	glimepiride/ER glipizide/ER glyburide/ER			
	DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITORS		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	alogliptin GLYXAMBI *(use separate preferred agents)* ONGLYZA QTERN *(use separate preferred agents)* STEGLUJAN *(use separate preferred agents)* TRADJENTA
		JANUVIA		
	DPP-4 INHIBITOR COMBO AGENTS		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	alogliptin/metformin alogliptin/pioglitazone *(use separate preferred agents)* JENTADUETO JUVISYNC *(use separate preferred agents)* KOMBIGLYZE
		JANUMET/XR		
	INCRETIN MIMETICS (GLP-1 RECEPTOR AGONISTS)		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent. Dosage Limits Apply: Victoza: 1.8mg/day	ADLYXIN BYDUREON BCISE OZEMPIC SOLIQUA *(use separate preferred agents)* TANZEUM TRULICITY XULTOPHY *(use separate preferred agents)*
		BYDUREON BYETTA VICTOZA		
	SGLT2 INHIBITORS		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	GLYXAMBI *(use separate preferred agents)* INVOKAMET/XR*(use separate preferred agents)* INVOKANA QTERN *(use separate preferred agents)* SEGLUROMET *(use separate preferred agents)* STEGLATRO STEGLUJAN *(use separate preferred agents)* SYNJARDY/XR *(use separate preferred agents)* XIGDUO XR *(use separate preferred agents)*
		FARXIGA JARDIANCE		
	FAST-ACTING INSULIN		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently	ADMELOG *(use preferred agent)* insulin lispro *(use preferred agent)*
	HUMALOG			
	LONG-ACTING INSULIN		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently	BASAGLAR *(use preferred agent)* LANTUS OPTICLIK *(use preferred agent)* SOLIQUA *(use separate preferred agents)* TOUJEO *(use preferred agent)* TRESIBA *(use preferred agent)* XULTOPHY *(use separate preferred agents)*
	LANTUS SOLOSTAR LANTUS vial LEVEMIR			
	DIABETIC METERS/TEST STRIPS		Quantity limits apply: Insulin Dependent Clients: 10 strips/day Non-Insulin Dependent Clients: 4 strips/day Clients are limited to 1 meter/365 days	ALL OTHER METERS AND TEST STRIPS
	FREESTYLE FREESTYLE FREEDOM FREESTYLE FREEDOM LITE FREESTYLE INSULINX FREESTYLE PRECISION NEO B ONE TOUCH II ONE TOUCH ULTRA MINI ONE TOUCH ULTRA BLUE ONE TOUCH VERIO ONE TOUCH VERIO FLEX ONE TOUCH VERIO IQ PRECISION XTRA			
	CONTINUOUS BLOOD GLUCOSE MONITORS		Prior authorization will be required to verify if the client is on three or more insulin injections per day. Monitors will also be limited to the labeled age.	GUARDIAN MINIMED
		DEXCOM FREESTYLE LIBRE		
FIBROMYALGIA	**FIBROMYALGIA**		Trial and failure of a preferred agent greater than or equal to six (6) weeks in the last 12 months is required prior to approval of a non-preferred agent Clients will not be allowed to take gabapentin and pregabalin concurrently	pregabalin SAVELLA tablets *(savella titration pak will not be covered)*
	amitriptyline cyclobenzaprine duloxetine			

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GASTROINTESTINAL	**BOWEL EVACUANTS**			CLENPIQ *(use preferred agents)* GAVILYTE H *(use preferred agents)* POLY-PREP *(usse preferred agents)* PREPOPIK *(use preferred agents)*
	COLYTE GAVILYTE C, G, N GOLYTELY MOVIPREP NULYTELY PEG 3350 SOLUTION SUCLEAR SUPREP TRILYTE			
	CHRONIC IDIOPATHIC CONSTIPATION		Client must have a diagnosis of chronic idiopathic constipation to receive a preferred agent. To receive a non-preferred agent, the client must have a diagnosis of chronic idiopathic constipation and a 30-day trial and failure of a preferred agent within the last 12 months.	MOTEGRITY TRULANCE
		AMITIZA LINZESS		
	DIGESTIVE ENZYMES		Prior authorization required.	PANCREAZE pancrelipase PERTZYE TRI-PASE ULTRESA VIOKASE
	CREON ZENPEP			
	IRRITABLE BOWEL SYNDROME WITH CONSTIPATION		Client must have a diagnosis of Irritable Bowel Syndrome (IBS) with constipation.	TRULANCE
		AMITIZA LINZESS		
	IRRITABLE BOWEL SYNDROME WITH DIARRHEA		Client must have a diagnosis of Irritable Bowel Syndrome (IBS) with diarrhea.	
		VIBERZI		
	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.	GIAZO mesalamine DR tab 800mg (BRAND IS PREFERRED) mesalamine DR tab 1.2gm (BRAND IS PREFERRED) mesalamine ER cap 0.375gm (BRAND IS PREFERRED) mesalamine sup 1000mg SFROWASA
	APRISO* **ASACOL HD*** **LIALDA*** mesalamine 400mg DR capsule mesalamine enema PENTASA			
	OPIOID-INDUCED CONSTIPATION AGENTS		Client must have a diagnosis of opioid-induced constipation and a three (3) month trial and failure of a stool softner to receive the preferred agent. To receive the non-preferred agent, the client must have a diagnosis of opioid-induced constipation, a three (3) month trial and failure of a secretory agent, and a three (3) month trial and failure of the preferred agent. *Movantik will be approved for a diagnosis of cancer or for clients in hospice or palliative care.	MOVANTIK* RELISTOR SYMPROIC
		AMITIZA		
	PREGNANCY INDUCED NAUSEA/VOMITING			BONJESTA *(use preferred agent)*
	DICLEGIS			
	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. PREVACID 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 omeprazole 20.6mg capsules *(use preferred agent)* omeprazole tablets *(use preferred agent)* omeprazole/sodium bicarbonate OMECLAMOX *(use separate agents)* **PREVACID solutabs*** rabeprazole TALICIA *(use separate agents)* VIMOVO *(use separate agents)*
	lansoprazole capsules omeprazole capsules pantoprazole			
GOUT	**COLCHICINE**			COLCRYS *(use preferred agent)* MITIGARE *(use preferred agent)*
	colchicine			
	XANTHINE OXIDASE AND URAT1 INHIBITORS		Trial and failure of the preferred agent greater than or equal to a 60 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. *Concurrent use of the preferred agent will be required with Zurampic.	**ULORIC***
	allopurinol			ZURAMPIC*
HEMATOLOGY	**LOW MOLECULAR WEIGHT HEPARIN (LMWH)**		Prior authorization will be required for the 300mg/3ml strength.	FRAGMIN *(use preferred agent)* enoxaparin 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.	
		PRADAXA		
	FACTOR XA INHIBITOR		Limited to being used for the prophylaxis of venous thromboembolism (VTE) in adult patients hospitalized for an acute medical illness who are at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE	
		BEVYXXA		
	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. *To receive Xarelto 2.5mg, client must have a diagnosis of chronic coronary artery disease or peripheral artery disease with the need to reduce risk of major cardiovascular events	SAVAYSA *(use preferred agent)* XARELTO 2.5mg* *(use preferred agent)*
	ELIQUIS/STARTER PACK XARELTO 10mg, 15mg, 20mg, and starter pack			

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HEMATOLOGY continued	**CPTP DERIVATIVES**		Client must have a diagnosis of acute coronary syndrome or a history of myocardial infarction	
		BRILINTA		
	PAR-1 ANTAGONIST		Client must have diagnosis of 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		
	ANTIHEMOPHILIC FACTOR VIII			
	ADVATE			
	ADYNOVATE			
	AFSTYLA			
	ELOCTATE			
	ESPEROCT			
	HEMOFIL M			
	HEMLIBRA			
	JIVI			
	KOATE/KOATE-DVI			
	KOGENATE FS/BIO-SET			
	KOVALTRY			
	MONOCLATE-P			
	NOVOEIGHT			
	NUWIQ			
	OBIZUR			
	RECOMBINATE			
	XYNTHA/SOLOFUSE			
	COAGULATION FACTOR IX			
	ALPHANINE SD			
	ALPROLIX			
	BENEFIX			
	IDELVION			
	IXINITY			
	MONONINE			
	REBINYN			
	RIXUBIS			
	ANTIHEMOPHILIC FACTOR/VWF			
	ALPHANATE			
	HUMATE-P			
	VONVENDI			
	WILATE			
	ERYTHROPOIESIS STIMULATING AGENTS			ARANESP PROCRIT
	EPOGEN			
	MIRCERA			
	RETACRIT			
HEPATITIS C	**DIRECT ACTING ANTIVIRALS**		Limited to FDA approved indication. Prior authorization will be required prior to use of preferred agents. **Positive SVR 12 will be required for consideration for retreatment Please submit PA requests on the Hepatitis C PA form available at www.wymedicaid.org.	DAKLINZA *(use preferred agent)* HARVONI *(use preferred agent)* OLYSIO (use preferred agent) SOVALDI (use preferred agent) VOSEVI** (use preferred agent) ZEPATIER (use preferred agent)
		EPCLUSA		
		MAVYRET**		
HIDRADENITIS SUPPURATIVA	**IMMUNOMODULATORS**		Humira will not be covered as a first line agent for the diagnosis for hidradenitis suppurativa.	
		HUMIRA		
HORMONES	**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.	HUMATROPE OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE
		GENOTROPIN		
		NORDITROPIN		
		NUTROPIN AQ		
	PROGESTIN		Prior authorization is required.	
		MAKENA 250mg/ml		
		MAKENA 275mg/1.1ml		
	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).*	ANDRODERM *(use preferred agent)* FORTESTA *(use preferred agent)* JATENZO *(use preferred agent)* STRIANT *(use preferred agent)* TESTOPEL *(use preferred agent)* testosterone gel *(use preferred agent)* testosterone solution *(use preferred agent)* XYOSTED *(use preferred agent)*
		ANDROGEL*		
		TESTIM GEL		

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT CHANGE HEALTHCARE WITH ANY QUESTIONS
HORMONES continued	**ORAL CONTRACEPTIVES**			amethia/LO (BRAND IS PREFERRED) ashlyna (BRAND IS PREFERRED) BALCOLTRA BEYAZ camrese/LO (BRAND IS PREFERRED) daysee (BRAND IS PREFERRED) drospir/ethinyl estradiol/levomefolate FALESSA KIT fayosim kaitlib FE chew layolis FE chew levonorgest/ethinyl estradiol/LO (84-7) (BRAND IS PREFERRED) levonorgest/ethinyl estradiol 0.15-0.02/0.025/0.03 and ethinyl estradiol 0.01 LO LOESTRIN melodetta FE chew (BRAND IS PREFERRED) mibelas FE chew (BRAND IS PREFERRED) NATAZIA noreth/ethinyl estradiol/FE chew 0.8/25, 1/20 rajani rivelsa QUARTETTE SAFYRAL TAYTULLA tydemy
	altavera alyacen 1-35, 7/7/7 amethyst apri aranelle aubra/EQ aviane azurette balziva bekyree blisovi 1-20 FE, 1.5-30 FE briellyn camila caziant chateal/EQ cyclafem 1-35, 7/7/7 cyred cryselle dasetta 1-35, 7/7/7 deblitane DESOGEN deso/ethinyl estradiol drospir/ethinyl estradiol elinest emoquette enpresse enskyce errin estarylla ESTROSTEP FE ethynodiol/ethinyl estradiol falmina FEMCON FE chew femynor GENERESS FE chew gianvi gildagia gildess 1-20/FE, 1.5-30/FE heather incassia introvale isibloom jencycla jolessa jolivette juleber junel 1-20/FE, 1.5-30/FE kariva kelnor kimidess kurvelo larin 1-20/FE, 1.5-30/FE larissia leena lessina levonest levonor/ethinyl estradiol levora lillow lomedia 1-20 FE loryna **LOSEASONIQUE*** low-ogestrel lutera lyza marlissa microgestin 1-20/FE, 1.5-30/FE mili **MINASTRIN FE chew*** mono-linyah mononessa myzilra NECON 0.5/35, 1/35, 1/50, 7/7/7, 10/11 nikki nora-be noreth/ethinyl estradiol/FE chew 0.4/35 noreth/ethinyl estradiol 1-20/FE norgest/ethinyl estradiol/LO norethindrone norlyda nortrel 0.5-35, 1-35, 7/7/7 ocella OGESTREL orsythia ORTHO-CYCLEN ORTHO-NOVUM 1/35, 7/7/7 philith pimtrea pirmella 1-35, 7/7/7 portia previfem quasense reclipsen			

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HORMONES continued	**ORAL CONTRACEPTIVES (cont.)**			
	SEASONIQUE*			
	setlakin			
	sprintec			
	sharobel			
	sronyx			
	syeda			
	tarina 1/20 FE			
	tilia FE			
	tri-estaryll/LO			
	tri-femynor			
	tri-legest FE			
	tri-linyah			
	tri-marzia LO			
	tri-mili			
	trinessa/LO			
	tri-previfem			
	tri-sprintec/LO			
	trivora			
	tri-vylibra			
	tulana			
	velivet			
	vestura			
	vienva			
	viorele			
	vyfemla			
	vylibra			
	wera 0.5-35			
	wymzya FE chew			
	zarah			
	zenchent/'FE chew			
	zovia			
HYPERLIPIDEMIA	**BILE ACID SEQUESTRANT**		Trial and failure of ALL preferred agents greater than or equal to six (6) months in the last 12 months will be required before approval can be given for a non-preferred agent.	WELCHOL
	cholestyramine/light			
	colestipol			
	STATINS, LOW POTENCY		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization. Prior authorization will be required for clients under the age of 10.	fluvastatin/ER ZYPITAMAG
	lovastatin			
	pravastatin			
	STATINS, HIGH POTENCY		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization. Prior authorization will be required for clients under the age of 10.	EZALLOR LIVALO rosuvastatin
	atorvastatin			
	simvastatin			
	STATIN COMBINATIONS		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Prior authorization will be required for clients under the age of 10.	ezetimibe/simvastatin (BRAND IS PREFERRED)
	amlodopine/atorvastatin			
	VYTORIN*			
	TRIGLYCERIDE LOWERING AGENTS		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ANTARA fenofibric fenofibrate 43, 50, 120, 130, and 150mg LIPOFEN omega-3-acid VASCEPA
	fenofibrate 48, 54, 67, 134, 145, 160, and 200mg			
	gemfibrozil			

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HYPERTENSION	**ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)**		Non-preferred ARBs will require a history of ALL preferred ARBs before approval can be given.	candesartan eprosartan 600mg TEVETEN 400mg
	EDARBI irbesartan losartan olmesartan telmisartan valsartan			
	ARBs AND DIURETICS		Non-preferred ARB/diuretic combinations will require a history of ALL preferred ARBs before approval can be given.	candesartan HCTZ telmisartan HCTZ TEVETEN HCTZ
	EDARBYCLOR irbesartan HCTZ losartan HCT olmesartan HCTZ valsartan HCTZ			
	ALPHA-BLOCKERS			clonidine patch (BRAND IS PREFERRED) NEXICLON XR *(use preferred agent)*
	CATAPRES PATCHES* clonidine			
INFECTIOUS DISEASE	**QUINOLONES**		Please refer to the Additional Therapeutic Criteria Chart located at http://www.wymedicaid.org/additional-therapeutic-criteria for Baxdela criteria.	FACTIVE *(use preferred agents)* moxifloxacin *(use preferred agents)* NOROXIN *(use preferred agents)* PROQUIN *(use preferred agents)*
	ciprofloxacin/ER levofloxacin ofloxacin			
	DOXYCYCLINE			ADOXA *(use preferred agent)* DORYX *(use preferred agent)* ORACEA *(use preferred agent)*
	doxycycline			
	MINOCYCLINE			*minocycline 65mg and 115mg ER (use preferred agent)* SOLODYN *(use preferred agent)*
	minocycline/ER			
	INHALED TOBRAMYCIN		*Tobi Podhaler requires a 28 day trial of a preferred agent, as well as 28 days off of that same preferred agent prior to approval. Minimum day supply of at 56 days is required	inhaled tobramycin *(use preferred agent)* TOBI PODHALER *(use preferred agent)*
	BETHKIS KITABIS			
	ANTI-RETROVIRALS		*Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	ritonavir tablets (BRAND IS PREFERRED) STRIBILD (use separate agents) SYMTUZA (use separate preferred agents)
	BIKTARVY CIMDUO DELSTRIGO DESCOVY DOVATO EVOTAZ GENVOYA JULUCA **NORVIR*** ODEFSEY PREZCOBIX SYMFI/LO TIVICAY TRIUMEQ TROGARZO	DESCOVY* TRUVADA*		
INFLAMMATION	**NSAIDs**		Trial and failure of two (2) preferred agents each greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Dosing and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets).	CALDOLOR *(use preferred agent)* CAMBIA POWDER *(use preferred agent)* celecoxib diclofenac 1% gel *(additional criteria applies)* diclofenac 1.3% patch (BRAND IS PREFERRED) diclofenac 1.5% solution *(additional criteria applies)* diclofenac 3% gel *(additional criteria applies)* fenoprofen mefenamic acid NEOPROFEN *(use preferred agent)* QMIIZ *(use preferred agent)* SPRIX *(additional criteria applies)* TIVORBEX *(use preferred agent)* VIVLODEX *(use preferred agent)* ZIPSOR *(use preferred agent)* ZORVOLEX *(use preferred agent)*
	diclofenac *tablets* etodolac **FLECTOR*** flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate meloxicam nabumetone naproxen oxaprozin piroxicam sulindac tolmetin			
	ORAL CORTICOSTEROIDS			CELESTONE *(use preferred agent)*
	budesonide cortisone acetate dexamethasone/intensol hydrocortisone methylprednisone prednisolone prednisone			
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	BELSOMRA EDLUAR *(additional criteria applies)* eszopiclone **ROZEREM*** zolpidem ER zolpidem sublingual *(additional criteria applies)* ZOLPIMIST *(additional criteria applies)*
	zaleplon zolpidem			

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MENTAL HEALTH	**ALZHEIMER AGENTS**	donepezil/ODT galantamine/ER memantine tablets/solution	Client must have a diagnosis of dementia.	donepezil 23mg *(use preferred agent)* memantine ER NAMZARIC (use separate agents) rivastigmine capsules/patches
	ANTIDEPRESSANTS		Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks WITHIN THE LAST 2 YEARS 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.	
	NORADRENERGIC/SPECIFIC SEROTONERGICS (NaSS)			**NaSS**
	mirtazapine tablets			mirtazapine rapid dissolve tablets *(use preferred agent)*
	NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)			**NDRI**
	bupropion ER/SR/XL			APLENZIN **FORFIVO XL***
	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)		Trazodone, buspirone, fluvoxamine, MAO inhibitors, TCA's, bupropion IR, and venlafaxine IR do not require prior authorization but **will not count** towards meeting preferred therapy requirements. 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 or SNRI.	**SSRI**
	citalopram escitalopram fluoxetine capsules paroxetine IR/CR sertraline			fluoxetine tablets *(use preferred agent)* VIIBRYD
	SEROTONIN/NORPINEPHRINE REUPTAKE INHIBITORS (SNRI)			**SNRI**
	duloxetine venlafaxine ER capsules		***Trintellix 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	desvenlafaxine DRIZALMA FETZIMA venlafaxine ER tablets (use preferred agent) **OTHER** TRINTELLIX***
	ATYPICAL ANTIPSYCHOTICS		**Quetiapine doses less than 100mg will require prior authorization without a diagnosis of mood disorder or major depressive disorder. For titration doses, contact the Change Healthcare Pharmacy Help Desk for an override. Clients five (5) years of age and younger will require prior authorization before approval. 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 unless otherwise specified. ***Clients nine (9) years of age and younger will require a prior authorization to receive approval of Latuda and Saphris. Clients eighteen (18) years of age and younger will require a prior authorization to receive approval of Fanapt. Prior authorization will be required for any client taking both an injectable and oral dosage form of the same medication concurrently. Dosage limits apply: aripiprazole <13 years of age: 15mg/day aripiprazole ≥13 years of age: 30mg/day ARISTADA 441/662mg: 1 injection per 28 days ARISTADA 882mg: 1 injection per 42 days ARISTADA 1064mg: 1 injection per 56 days ARISTADA INITIO: 1 injection per 365 days FANAPT: 24mg/day INVEGA SUSTENNA: 1 injection per 28 days INVEGA TRINZ: 1 injection per 84 days LATUDA 10-17 years of age: 80mg/day LATUDA >17 years of age: 160mg/day olanzapine <13 years of age: 10mg/day olanzapine ≥13 years of age: 20mg/day paliperidone: 12mg/day PERSERIS: 1 injection per 28 days quetiapine <13 years of age: 400mg/day quetiapine 13-17 years of age: 600mg/day quetiapine >17 years of age: 800mg/day risperidone <10 years of age: 3mg/day risperidone 10-17 years of age: 6mg/day risperidone >17 years of age: 16mg/day RISPERDAL CONSTA: 2 injections per 28 days SAPHRIS: 20mg/day ziprasidone ≤17 years of age: 120mg/day ziprasidone >17 years of age: 200mg/day ZYPREXA RELPREVV 210/300mg: 2 injections per 28 days ZYPREXA RELPREVV 405mg: 1 injection per 28 days	
	aripiprazole tab/solution/ODT ARISTADA FANAPT*** paliperidone INVEGA SUSTENNA/TRINZA LATUDA*** olanzapine PERSERIS quetiapine** RISPERDAL CONSTA risperidone SAPHRIS*** ziprasidone ZYPREXA RELPREVV			ABILIFY MAINTENA *(use preferred agent)* ABILIFY MYCITE *(use preferred agent)* GEODON 20MG INJ *(use preferred agent)* NUPLAZID olanzapine 10mg Inj *(use preferred agent)* quetiapine XR *(use preferred agent)* REXULTI VRAYLAR
	SPECIAL ATYPICAL ANTIPSYCHOTICS		Dosage limits apply: 1350mg/day	VERSACLOZ Suspension *(use preferred agent)*
	clozapine/ODT			

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MENTAL HEALTH continued	**AMPHETAMINES**		Clients over the age of 17 must have a diagnosis for ADD, ADHD, (see ADD/ADHD criteria below), narcolepsy, obstructive sleep apnea, shift work sleep disturbance, MS fatigue (see MS Fatigue criteria below), or refractory depression (see refractory depression criteria below). For clients over the age of 17, they must meet the DSM-5 criteria for diagnosis of ADHD. These criteria include: • Five or more symptoms of inattention, present for at least 6 months, inappropriate for developmental level. OR • Five or more symptoms of hyperactivity and impulsivity, present for at least 6 months, to an extent that is disruptive and inappropriate for developmental level. AND • Symptoms must be present in two or more settings (home, school or work); and • There must be clear evidence that the symptoms interfere or reduce the quality of social, school or work functioning; and • The symptoms must not be better explained by another mental disorder. Diagnosis of MS fatigue will require a fatigue severity scale score of 5.0, a 60-day trial of amantadine and discontinuation of medications that may contribute to drowsiness and fatigue. Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant. Prior Authorization will be required for clients under the age of 4. **Vyvanse will be approved for the diagnosis of binge-eating disorder for clients 18 years of age and older. Authorizations will be approved for 12 weeks. After initiation a one-year prior authorization of Vyvanse for this diagnosis will require additional documentation prior to approval. Claims will require Prior Authorization if clients have a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use. Trial and failure of two (2) preferred agents (each from a different class: methylphenidate and amphetamine) greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Dosage limits apply: 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 methylin/methylphenidate/ER: 90mg/day VYVANSE: 105mg/day	**AMPHETAMINES** ADZENYS XR ODT amphetamine ER suspension 1.25mg/ml DYANAVEL XR EVEKEO/ODT MYDAYIS PROCENTRA VYVANSE CHEWABLES ZENZEDI 2.5 AND 7.5MG TABLETS **METHYLPHENIDATES** ADHANSIA XR APTENSIO XR COTEMPLA XR DAYTRANA dexmethylphenidate ER (BRAND IS PREFERRED) JORNAY PM methylphenidate ER osmotic release (BRAND IS PREFERRED) methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA)
	LONG ACTING AMPHETAMINES			
		amphetamine salts combo XR dextroamphetamine CR caps VYVANSE CAPSULES**		
	IMMEDIATE RELEASE AMPHETAMINES			
		amphetamine salts combo dextroamphetamine tablets		
	METHYLPHENIDATES			
	LONG ACTING METHYLPHENIDATES			
		CONCERTA* **FOCALIN XR*** methylin ER methylphenidate ER tablets QUILLICHEW ER QUILLIVANT XR		
	IMMEDIATE RELEASE METHYLPHENIDATES			
		dexmethylphenidate methylphenidate tablets		
	SELECTIVE ALPHA-ADRENERGIC AGONIST		To obtain the **non-preferred agent**, client must meet the following criteria: Client must have a diagnosis of ADD or ADHD Prior authorization will be required for clients under the age of 4. To receive clonidine ER, clients must have completed a 14 day trial of clonidine IR with benefit in the previous 12 months.	clonidine ER
	clonidine			

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MENTAL HEALTH continued	**SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR**	atomoxetine	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. Dosage limits apply: atomoxetine: 150mg/day	
MIGRAINE	**MIGRAINE PROPHYLAXIS** **STEP 1 AGENTS** beta blockers	divalproex topiramate	Trial and failure of both an anticonvulsant and a beta blocker (Step 1 agents) greater than or equal to three (3) months will be required before approval can be given for the step 2 agents. Concurrent use of Botox will not be approved.	AJOVY *(use preferred step 2 agents)*
	STEP 2 AGENTS	AIMOVIG* EMGALITY**	*Starting dose will be limited to 70mg **The 120mg dose will be limited to treatment for migraines, the 100mg dose will be limited to treatment for episodic cluster headaches	
	TRIPTANS naratriptan RELPAX sumatriptan		Trial and failure of two preferred agents will be required for approval of a non-preferred agent. Rizatriptan will be approved for clients between 6 and 17 years of age Quantity limits apply: naratriptan 1mg: 25 tabs/34 days naratriptan 2.5mg: 10 tabs/34 days RELPAX 20mg: 20 tabs/34 days RELPAX 40mg: 14 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	almotriptan frovatriptan ONZETRA *(use preferred agent)* rizatriptan TOSYMRA *(use preferred agent)* TREXIMET ZEMBRACE *(use preferred agent)* zolmitriptan
MULTIPLE SCLEROSIS	**STEP 1 MS AGENTS** AUBAGIO AVONEX BETASERON **COPAXONE 20MG/ML*** REBIF		Trial and failure of one injectable preferred agent will be required before approval can be given for the step 2 MS agent (Gilenya). Trial and failure of a two preferred agents (each from a separate class) will be required before approval can be given for a non-preferred agent. **Ocrevus will be approved for a diagnosis of primary progressive multiple sclerosis. For relapsing forms of multiple sclerosis, the requirements listed above will need to be followed For Tysabri, in addition to the above criteria, additional prior authorization criteria applies.	EXTAVIA glatiramer *(BRAND IS PREFERRED)* GLATOPA *(use preferred agent)* LEMTRADA MAVENCLAD MAYZENT OCREVUS** PLEGRIDY TECFIDERA TYSABRI (additional criteria applies)
	STEP 2 MS AGENTS	GILENYA		
NEUROPATHIC PAIN	**TRICYCLIC ANTIDEPRESSANTS**	amitriptyline desipramine imipramine nortriptyline	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.	pregabalin
	GABAPENTIN	gabapentin	Clients will not be allowed to take gabapentin and pregabalin concurrently	

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OPHTHALMICS	**OP. -ANTI-ALLERGICS**		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Emadine, Alomide, and Alocril will be approved for pregnancy. Alomide will be approved for children under the age of 3.	ALAMAST ALOCRIL ALOMIDE ALREX azelastine BEPREVE EMADINE epinastine ketotifen LASTACAFT olopatadine 0.1% and 0.2%
	cromolyn PAZEO			
	OP. -ANTIBIOTICS- QUINOLONES		Trial and failure of a preferred agent greater than or equal to 5 days in the last 12 months will be required before approval can be given for a non-preferred agent. Azasite will be approved for pregnancy.	AZASITE BESIVANCE gatifloxacin IQUIX levofloxacin ZYMAR
	ciprofloxacin ofloxacin MOXEZA moxifloxacin 0.5%			
	OP. -ANTI-INFLAMMATORY		Trial and failure of ALL preferred agents each greater than or equal to 5 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ACULAR/LS/PF *(use preferred agent)* ACUVAIL bromfenac 0.9% BROMSITE DUREZOL LOTEMAX SM loteprednol 0.5% (BRAND IS PREFERRED) PROLENSA
	flurbiprofen diclofenac **LOTEMAX*** ketorolac ILEVRO NEVANAC			
	OP. -BETA-BLOCKERS		Trial and failure of three (3) preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. *Betoptic S will be approved for those with heart and lung conditions.	BETIMOL BETOPTIC S*
	betaxolol carteolol levobunolol metipranolol timolol			
	OP. -CARBONIC ANHYDRASE INHIBITOR		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	AZOPT
	dorzolamide			
	OP. -COMBO PRODUCTS			
	COMBIGAN dorzolamide/timolol ROCKLATAN SIMBRINZA			
	OP. -DRY EYE AGENTS		Trial and failure of the preferred agent greater than or equal to 12 weeks will be required before approval can be given for the non-preferred agent.	CEQUA RESTASIS MULTIDOSE (*use preferred agent*) XIIDRA
	RESTASIS			
	OP. -PROSTAGLANDINS		Trial and failure of ALL preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	bimatoprost LUMIGAN 0.1% ZIOPTAN
	latanoprost TRAVATAN Z			
	OP. -RHO KINASE INHIBITOR			
	RHOPRESSA			
	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.	brimonidine 0.15% (BRAND IS PREFERRED)
	ALPHAGAN P 0.1% **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. **Evinity will only be allowed for a maximum of 12 months of treatment, will not be allowed with any concurrent osteoporosis treatment, and will be limited to approved indication ***Forteo will be limited to 2 years of use	EVENITY** FORTEO*** FOSAMAX-D ibandronate risedronate/DR TYMLOS
	alendronate			
	NASAL CALCITONIN			
	calcitonin-salmon fortical			
OTIC	**ANTIBIOTIC/STEROID COMBINATION**			ciprofloxacin 0.2% *(use preferred agent)* CIPRO HC *(use preferred agent)* COLY-MYCIN S *(use preferred agent)* CORTISPORIN-TC *(use preferred agent)* FLUOCINOLONE ACET OIL 0.01% *(use preferred agent)* ofloxacin *(use preferred agent)*
	CIPRODEX Neo/Poly/HC Suspension and Solution			
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.	darifenacin GELNIQUE GEL 10% MYRBETRIQ OXYTROL DIS SANCTURA XR tolterodine/ER trospium
	oxybutynin /ER solifenacin TOVIAZ			

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 THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT CHANGE HEALTHCARE WITH ANY QUESTIONS
PAIN	**LONG-ACTING C-IIs**	BUTRANS morphine ER tablets	Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. C-IIIs and C-IVs that are not included on the PDL and are available without prior authorization with the exception of Butrans (generic substitution is mandatory). Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid. **Nucynta ER will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics. Belbuca: 1.2mg/day (1200mcg/day) Butrans: 20mcg, 1 strength at a time, 1 patch every 7 days Fentanyl: 50mcg, 1 strength at a time, 1 patch every 3 days Hydromorphone ER: 30mg/day Hysingla ER: 120mg/day Methadone: Limited to 3 tablets per day Morphine ER: 120mg/day Nucynta ER: 327mg/day Oxycontin: 80mg/day Oxymorphone: 40mg/day Xtampza ER: 80mg/day Zohydro ER: 120mg/day Clients will be limited to one long-acting narcotic at a time	ARYMO ER *(use preferred agents)* BELBUCA fentanyl patches hydrocodone ER hydromorphone ER HYSINGLA ER *(additional criteria applies)* METHADONE MORPHABOND *(use preferred agents)* morphine ER capsules *(use preferred agents)* NUCYNTA ER** OPANA ER *(additional criteria applies)* oxymorphone ER OXYCONTIN XTAMPZA ER *(additional criteria applies)*
	SHORT-ACTING C-IIs		Trial and failure of three (3) preferred agents greater than or equal to a 6 day supply in the last 90 days will be required before approval can be given for a non-preferred agent. *Nucynta will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics. Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid. All short-acting narcotics, after 42 days of consecutive use of any combination of short-acting narcotics, will be limited to **4 tablets** per day (liquids have specific dosing limits per medication - please refer to dosage limitation chart at www.wymedicaid.org) Clients will be limited to one short-acting narcotic at a time	APADAZ levorphanol NUCYNTA* oxymorphone oxycodone/IBU ROXYBOND
	codeine sulfate hydrocodone/APAP hydrocodone/IBU hydromorphone LORTAB ELIXIR 10-300MG meperidine morphine 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 Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid.	BUTRANS** RYBIX ODT tramadol/apap tramadol ER capsules tramadol ER tablets
	tramadol			
PARKINSON'S DISEASE	**AMANTADINE**			GOCOVRI *(use preferred agent)* OSMOLEX ER *(use preferred agent)*
	amantadine			
PHOSPHATE BINDERS	**PHOSPHATE BINDERS**		Prior authorization required for non-preferred agents.	AURYXIA lanthanum PHOSLYRA sevelamer VELPHORO
	calcium acetate RENAGEL			

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT CHANGE HEALTHCARE WITH ANY QUESTIONS
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.	dutasteride dutasteride/tamsulosin *(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 dutasteride/tamsulosin *(use separate agents)* silodosin
	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.	sildenafil suspension (BRAND IS PREFERRED)
		ALYQ tadalafil **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.	bosentan (BRAND IS PREFERRED) OPSUMIT *(use preferred agent)* TRACLEER TABS FOR ORAL SUSP *(use preferred agent)*
		LETAIRIS **TRACLEER TABS***		
	PROSTACYCLINE VASODILATORS		Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
		ORENITRAM		
	PROSTACYCLINE RECEPTOR AGONIST		Prior authorization required.	UPTRAVI *(use preferred pulmonary HTN agent)*
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. Clients will not be allowed to take gabapentin and pregabalin concurrently	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 tricylic antidepressant.	carisoprodol chlorzoxazone cyclobenzaprine ER metaxalone methocarbamol orphenadrine tizanidine capsules *(use preferred agent)* Carisoprodol is limited to 84 tabs/365 days
	baclofen cyclobenzaprine tizanidine tablets			
ULCERATIVE COLITIS	**IMMUNOMODULATORS**		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 *(additional criteria applies)* SIMPONI XELJANZ/XR
		HUMIRA		
UVEITIS	**IMMUNOMODULATORS**		Client must have diagnosis of non-infectious intermediate, posterior, and panuveitis in adult patients	
		HUMIRA		