WYOMING MEDICAID
Preferred Drug List (PDL) June 8, 2022

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 Prior authorization will be required for doses >16mg	BUNAVAIL buprenorphine (oral) buprenorphine/naloxone film (BRAND IS PREFERRED) ZUBSOLV
	NALOXONE KLOXXADO naloxone NARCAN NASAL SPRAY		Kloxxado, naloxone products, and Narcan nasal spray will be limited to one fill per 180 days without prior authorization. Naloxone formulations available in quantities of 10ml will require prior authorization.	
	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 ATROVENT HFA INCRUSE ELLIPTA 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	**LONHALA TUDORZA YUPELRI
	ANTICHOLINERGIC COMBINATION AGENTS ANORO ELLIPTA** COMBIVENT STIOLTO		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.	BEVESPI BREZTRI DUAKLIR TRELEGY UTIBRON
	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	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** BECONASE AQ flunisolide fluticasone mometasone		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
	SHORT ACTING BRONCHODILATORS - INHALERS albuterol HFA PROAIR HFA PROAIR RESPICLICK VENTOLIN HFA **XOPENEX HFA***		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Prior authorization will be required after a total of 12 albuterol inhalers are dispensed within 365 days. Minimum day supply of 16 days is required	levoalbuterol (BRAND IS PREFERRED) PROAIR DIGIHALER PROVENTIL HFA
	STEROID INHALANTS ASMANEX budesonide suspension FLOVENT HFA/DISK PULMICORT FLEXHALER		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
	STEROID COMBINATION AGENTS **ADVAIR DISK*** ADVAIR HFA DULERA SYMBICORT*		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. **Will also require the diagnosis of COPD 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) TRELEGY WIXELA
	EPINEPHRINE epinephrine auto-injector pen			ADRENACLICK *(use preferred agent)* AUVI-Q *(use preferred agent)* EPI-PEN *(use preferred agent)*
	EOSINOPHILIC ASTHMA AGENTS	FASENRA* XOLAIR*	*Approval for these agents will require additional clinical criteria which can be found on the Additional Therapeutic Criteria Chart **Trial and failure of two preferred agents greater than or equal to 56 days in last 12 months will be required for approval of a non-preferred agent. .	DUPIXENT* NUCALA*
ARTHRITIS	**IMMUNOMODULATORS** **ANKYLOSING SPONDYLITIS (AS)**	ENBREL HUMIRA	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
	JUVENILE IDIOPATHIC ARTHRITIS (JIA)	ENBREL HUMIRA	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
	PSORIATIC ARTHRITIS (PA)	ENBREL HUMIRA OTEZLA	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 two of the three preferred agents. **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** COSENTYX ORENCIA REMICADE (additional criteria applies) SIMPONI STELARA TALTZ TREMFYA XELJANZ/XR
	RHEUMATOID ARTHRITIS (RA)	ENBREL HUMIRA	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 **See Dermatology criteria for Atopic Dermatitis approval	ACTEMRA CIMZIA* KEVZARA KINERET OLUMIANT ORENCIA REMICADE *(additional criteria applies)* RINVOQ** RITUXAN SIMPONI XELJANZ/XR
CONVULSIONS	**INTERMITTENT, STEREOTYPIC SEIZURE EPISODES** diazepam gel NAYZILAM* VALTOCO		*Nayzilam will be allowed for patients 12 years of age and older	
	ORAL ANTICONVULSANTS	BANZEL* carbamazepine clonazepam divalproex FELBAMATE fosphenytoin FYCOMPA gabapentin lacosamide (tablets) lamotrigine/XR levetiracetam pregabalin oxcarbazepine phenytoin subvenite topiramate/ER sprinkle caps valproate/valproic acid zonisamide	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 FINTEPLA** OXTELLAR (use preferred agent) TROKENDI XR (use preferred agent) XCOPRI VIMPAT

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CROHN'S	**IMMUNOMODULATORS**	HUMIRA	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)*
DERMATOLOGY	**BENZOYL PEROXIDE/CLINDAMYCIN COMBOs**	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig)	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)*
	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) desoximetasone 0.05%, 0.25% (C) ELOCON 0.1% fluocinolone 0.025% fluticasone 0.05% (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	**PIMECROLIMUS** **PROTOPIC***	**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. Exceptions will be made for application to the face and for clients age 12 and under, a trial and failure of a preferred low potency corticosteroid greater than or equal to a 21 day trial in the last 90 days will be required.	Elidel (generic preferred) tacrolimus (BRAND IS PREFERRED)
	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.	EUCRISA
	ATOPIC DERMATITIS	ADBRY* DUPIXENT*	*Trial and failure of a preferred step 2 agent (immunomodulator) greater than or equal to a 21 day trial within the last 30 days required **Trial and failure of all criteria to receive a step 3 agent as defined above including medium/high potency topical corticosteroid, preferred step 2 immunomodulator AND 56-day trial and failure of a preferred biologic for Atopic Dermatitis in Step 3 will be required for approval of the non-preferred agents.	CIBINQO** OPZELURA** RINVOQ**
	PLAQUE PSORIASIS (PP)	ENBREL HUMIRA OTEZLA	Client must have diagnosis of PP prior to approval of a preferred agent (Enbrel, Humira, or Otezla). To receive a non-preferred agent, client must have a diagnosis of PP and a 56-day trial and failure of two of the three preferred agents. **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** COSENTYX ILUMYA REMICADE (additional criteria applies) SILIQ SKYRIZI STELARA TALTZ TREMFYA
	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**			
	BIGUANIDES			
	metformin/ER			metformin SR 24HR osmotic release *(use preferred agent)* metformin SR 24HR modified release *(use preferred agent)* RIOMET *(use preferred agent)*
	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. *Rybelsus requires documentation of inability to use injectable agents. Dosage Limits Apply: Ozempic: 1mg/week Victoza: 1.8mg/day	ADLYXIN BYDUREON OZEMPIC* SOLIQUA *(use separate preferred agents)* RYBELSUS* *(additional criteria applies)* TANZEUM TRULICITY XULTOPHY *(use separate preferred agents)*
		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 unless there is a diagnosis of CKD, in which case the trial of metformin will be waived. A 90 day trial and failure of a preferred agent is required before approval can be given 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)* TRIJARDY XR *(use separate preferred agents)* XIGDUO XR *(use separate preferred agents)*
		FARXIGA INVOKAMET INVOKANA JARDIANCE SYNJARDY		
	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)* FIASP *(use preferred agent)* insulin lispro (use preferred agents)
	HUMALOG HUMALOG 75/25 HUMALOG JR. HUMALOG MIX NOVOLOG MIX			
	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 (strips only) FREESTYLE FREEDOM FREESTYLE FREEDOM LITE FREESTYLE INSULINX FREESTYLE PRECISION NEO B ONE TOUCH ULTRA II ONE TOUCH ULTRA MINI ONE TOUCH ULTRA BLUE ONE TOUCH VERIO ONE TOUCH VERIO FLEX ONE TOUCH VERIO REFLECT 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 FREESTYLE LIBRE 2		
	ACUTE HYPOGLYCEMIA AGENTS			GVOKE *(use preferred agent)* ZEGALOGUE
	BAQSIMI			
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 gabapentin			

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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 ZENPEP
	CREON			
	IRRITABLE BOWEL SYNDROME WITH CONSTIPATION		Client must have a diagnosis of Irritable Bowel Syndrome (IBS) with constipation.	TRULANCE
		AMITIZA LINZESS		
	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 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 dexlansoprazole esomeprazole omeprazole 20.6mg capsules *(use preferred* 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**			colchicine *(use preferred agent)* MITIGARE *(use preferred agent)*
	COLCRYS*			
	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*** ZURAMPIC*
	allopurinol			
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**	BRILINTA	Client must have a diagnosis of acute coronary syndrome, history of myocardial infarction, or history of stroke and transient ischemic attack.	
	PAR-1 ANTAGONIST	ZONTIVITY	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.	
	ANTIHEMOPHILIC FACTOR VIII ADVATE ADYNOVATE AFSTYLA ELOCTATE ESPEROCT HEMOFIL M HEMLIBRA JIVI KOATE/KOATE-DVI KOGENATE FS/BIO-SET MONOCLATE-P NOVOEIGHT NUWIQ OBIZUR RECOMBINATE XYNTHA/SOLOFUSE			KOVALTRY
	COAGULATION FACTOR IX ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY MONONINE REBINYN RIXUBIS			
	ANTIHEMOPHILIC FACTOR/VWF ALPHANATE HUMATE-P VONVENDI WILATE			
	ERYTHROPOIESIS STIMULATING AGENTS EPOGEN MIRCERA RETACRIT			ARANESP PROCRIT
HEPATITIS C	**DIRECT ACTING ANTIVIRALS**	sofosbuvir/velpatasvir MAVYRET**	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)* EPCLUSA *(use preferred agent)* HARVONI *(use preferred agent)* OLYSIO (use preferred agent) SOVALDI (use preferred agent) VOSEVI** (use preferred agent) ZEPATIER (use preferred agent)
HIDRADENITIS SUPPURATIVA	**IMMUNOMODULATORS**	HUMIRA	Humira will not be covered as a first line agent for the diagnosis for hidradenitis suppurativa.	
HORMONES	**GnRH ANTAGONISTS** MYFEMBREE ORIAHNN		*Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	ORILISSA
	GROWTH HORMONE	GENOTROPIN NORDITROPIN NUTROPIN AQ		HUMATROPE OMNITROPE SAIZEN SEROSTIM SKYTROFA TEV-TROPIN ZORBTIVE ZOMACTON
	PROGESTIN	MAKENA 250mg/ml* MAKENA 275mg/1.1ml*	Prior authorization is required.	
	TESTOSTERONE TOPICAL GELS	**ANDROGEL*** TESTIM GEL	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)*

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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
	atorvastatin			
	rosuvastatin			
	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/ CARDIOLOGY	**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			
	COMBINATION PRODUCTS		Client must be greater than one year of age and have a diagnosis of Congestive Heart Failure (CHF) NYHA Class II-IV. Angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) will not be allowed in combination with Entresto.	
		ENTRESTO		
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 TOBI PODHALER (use preferred agent)
	BETHKIS KITABIS			
	ANTI-RETROVIRALS		*Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements. **Rukobia aproval requires documentation of multi-drug resistance defined as failure of two medications from different classes.	DOVATO ritonavir tablets (BRAND IS PREFERRED) RUKOBIA** STRIBILD (use separate agents) SYMTUZA (use separate preferred agents)
	BIKTARVY CIMDUO DELSTRIGO EVOTAZ GENVOYA JULUCA **NORVIR*** ODEFSEY PIFELTRO 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)* diclofenac 1.3% patch (BRAND IS PREFERRED) diclofenac 1.5% soln. diclofenac 3% gel 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)*
	celecoxib 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)* DAYVIGO 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			citalopram capsules fluoxetine tablets 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 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. ***Rexulti approval for MDD treatment requires concurrent antidepressant therapy as well as a trial and failure of aripiprazole or other preferred atypical antipsychotic indicated for the adjunct treatment of MDD. 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. Prior authorization will be required for any client five (5) years of age or younger, or for any cleint 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 441/662/882mg: 1 injection per 28 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	ABILIFY MYCITE (use preferred agent) CAPLYTA GEODON 20MG INJ (use preferred agent) LYBALVI NUPLAZID olanzapine 10mg Inj (use preferred agent) quetiapine XR (use preferred agent) SECUADO REXULTI*** ZYPREXXA RELPREVV
	ABILIFY MAINTENA aripiprazole tab/solution/ODT ARISTADA FANAPT** paliperidone INVEGA SUSTENNA/TRINZA LATUDA** olanzapine PERSERIS quetiapine* RISPERDAL CONSTA risperidone SAPHRIS** VRAYLAR ziprasidone			
	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).	**AMPHETAMINES**
	LONG ACTING 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
		ADDERALL XR amphetamine salts combo XR dextroamphetamine CR caps VYVANSE CAPSULES**		
	IMMEDIATE RELEASE AMPHETAMINES		For clients over the age of 17, they must meet the DSM-5 criteria for diagnosis of ADHD. These criteria include:	
		amphetamine salts combo dextroamphetamine tablets	• 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.	
	METHYLPHENIDATES			**METHYLPHENIDATES**
	LONG ACTING 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, APTENSIO XR) QUILLICHEW ER QUILLIVANT
		CONCERTA* **FOCALIN XR*** methylin ER methylphenidate ER tablets		
	IMMEDIATE RELEASE METHYLPHENIDATES			
		dexmethylphenidate methylphenidate tablets		
			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	
	SELECTIVE ALPHA-ADRENERGIC AGONIST		To obtain the **non-preferred agent**, client must meet the following criteria:	clonidine ER
	clonidine		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.	

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MENTAL HEALTH continued	**SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR**	atomoxetine	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 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. Qelbree: Clients must have a 30-day trial and failure of a preferred non-stimulant. Approval will only be granted for clients 6-17 years of age. Dosage limits apply: atomoxetine: 150mg/day	QELBREE
MIGRAINE	**MIGRAINE PROPHYLAXIS** **STEP 1 AGENTS**		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.	NURTEC
	beta blockers	divalproex topiramate		
	STEP 2 AGENTS		*Starting dose will be limited to 70mg **Approval for non-preferred agents requires trial and failure of Aimovig and/or Emgality along with the trial and failures described with Step 1 Agents' criteria above.	AJOVY** QULIPTA**
		AIMOVIG* EMGALITY		
	ACUTE MIGRAINE TREATMENT **STEP 1 AGENTS**		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 20mg: 6 bottles/34 days; 5mg: 12 bottles/34 days sumatriptan 25mg: 41 tabs/34 days sumatriptan 50mg: 20 tabs/34 days sumatriptan 100mg: 10 tabs/34 days	almotriptan ELYXYB frovatriptan ONZETRA (use preferred agent) rizatriptan TOSYMRA (use preferred agent) TREXIMET TROKENDI XR ZEMBRACE *(use preferred agent)* zolmitriptan
	naratriptan RELPAX* sumatriptan			
	STEP 2 AGENTS		Trial and failure of two triptan agents is required for approval of a Step 2 Agent. Trial and failure of two preferred triptan agents AND Nurtec will be required for approval of a non-preferred agent. Quantity limits apply: NURTEC 75mg: limited to 15 tabs/30 days REYVOW: 200mg/day or 1 tab/day	REYVOW UBRELVY
		NURTEC		
MOVEMENT DISORDERS	**VMAT 2 INHIBITORS**		Quantity limits apply: AUSTEDO: limited to 4 tabs/day INGREZZA: limited to 4 tabs/day *Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	
	AUSTEDO* INGREZZA* TETRABENAZINE			
MULTIPLE SCLEROSIS	**STEP 1 MS AGENTS**		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.	BAFIERTAM EXTAVIA glatiramer (BRAND IS PREFERRED) GLATOPA (use preferred agent) KESIMPTA LEMTRADA MAVENCLAD MAYZENT OCREVUS** PLEGRIDY PONVORY TYSABRI (additional criteria applies) VUMERITY ZEPOSIA
	AUBAGIO AVONEX BETASERON **COPAXONE 20MG/ML*** REBIF TECFIDERA*			
	STEP 2 MS AGENTS			
		GILENYA		
NARCOLEPSY	**STIMULANTS**		Modafinil and Nuvigil: Client must be > 16 years of age. Client must have a diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, Multiple Sclerosis (MS) Fatigue, or ADD/ADHD with a concurrent diagnosis of substance abuse. Diagnosis of MS 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 or fatigue. Existing criteria for obstructive sleep apnea also applies, see ATCC for more information Clients will not be allowed to take two or more agents in this class concurrently	
		modafinil NUVIGIL*		
	NON-STIMULANTS			SUNOSI WAKIX XYREM
NEUROPATHIC PAIN	**GABAPENTIN**		Clients will not be allowed to take gabapentin and pregabalin concurrently Prior authorizations for perioperative pain will be approved for gabapentin OR pregabalin for less than or equal to 14 day supplies	
		gabapentin pregabalin		
	TOPICAL LIDOCAINE			ZTLIDO
	Lidocaine Patches			
	ADDITIONAL AGENTS		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 OR pregabalin 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.	carbamazepine oxcarbazepine valproic acid
		amitriptyline desipramine imipramine nortriptyline		

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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
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 bepotastine EMADINE epinastine ketotifen ZERVIATE
	ALREX azelastine BEPREVE* cromolyn 0.4% LASTACAFT olopatadine 0.1%, 0.2%			
	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 ILEVRO INVELTYS LOTEMAX SM lotepredno l 0.5% (BRAND PREFERRED) PROLENSA
	flurbiprofen diclofenac **LOTEMAX*** ketorolac 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.	brinzolamide (BRAND PREFERRED)
	AZOPT dorzolamide			
	OP. -COMBO PRODUCTS			dorzolamide/timolol (BRAND PREFERRED)
	COMBIGAN* 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 cyclosporine (BRAND PREFERRED) EYSUVIS RESTASIS MULTIDOSE (use preferred agent) TYRVAYA 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% GEMTESA MYRBETRIQ OXYTROL DIS SANCTURA XR tolterodine/ER trospium
	oxybutynin /ER solifenacin TOVIAZ			

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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
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 codeine sulfate hydrocodone/APAP hydrocodone/IBU hydromorphone LORTAB ELIXIR 10-300MG meperidine morphine oxycodone oxycodone/APAP oxycodone/ASA		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
	C-III/C-V AGENTS tramadol		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
PARKINSON'S DISEASE	**SHORT-ACTING AGENTS** amantadine benztropine tablets carbidopa/levodopa pramipexole ropinirole			
	LONG-ACTING AGENTS NEUPRO patches ropinirole ER RYTARY		**Non-preferred Parkinson's agents will require a 30 day trial and failure of 2 preferred medications including at least one short-acting agent and one long-acting agent	APOKYN benztropine injectables GOCOVRI INBRIJA KYNMOBI ONGENTYS pramipexole ER XADAGO
PHOSPHATE BINDERS	**PHOSPHATE BINDERS** calcium acetate RENAGEL*		Prior authorization required for non-preferred agents.	AURYXIA lanthanum PHOSLYRA sevelamer VELPHORO

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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***		
	GUANYLATE CYCLASE INHIBITORS		Prior authorization required.	ADEMPAS *(use preferred agent)*
	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 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 STELARA XELJANZ/XR
		HUMIRA		
UVEITIS	IMMUNOMODULATORS		Client must have diagnosis of non-infectious intermediate, posterior, and panuveitis in adult patients	
		HUMIRA		