

# WYOMING MEDICAID

## Preferred Drug List (PDL) January 20, 2023

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 <small>THIS LIST IS NOT ALL INCLUSIVE! PLEASE CONTACT CHANGE HEALTHCARE WITH ANY QUESTIONS</small>	
<b>ADDICTION</b>	<b>BUPRENORPHINE COMBINATIONS</b>		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 <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> .  Dosage limits apply Prior authorization will be required for doses >16mg	BUNAVAIL buprenorphine (oral) buprenorphine/naloxone film (BRAND IS PREFERRED) ZUBSOLV	
		buprenorphine/naloxone tablets SUBOXONE FILM*			
		<b>NALOXONE</b>		Kloxado, 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.	naloxone nasal spray
	KLOXXADO naloxone NARCAN NASAL SPRAY				
	<b>NALTREXONE</b>		Client must have a diagnosis of alcohol or opioid dependence.  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.		
	naltrexone VIVITROL				
<b>ALLERGY / ASTHMA continued</b>	<b>ANTIHISTAMINES, MINIMALLY SEDATING</b>		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	desloratadine CLARINEX RDT/SYRUP levocetirizine	
	cetirizine fexofenadine loratadine				
	<b>ANTIHISTAMINE/DECONGESTANT COMBINATIONS</b>		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	CLARINEX-D	
	cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine				
	<b>ANTICHOLINERGIC BRONCHODILATORS</b>		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	
	ATROVENT HFA INCRUSE ELLIPTA Ipratropium SPIRIVA HANDIHALER SPIRIVA RESPIMAT				
	<b>ANTICHOLINERGIC COMBINATION AGENTS</b>		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 TREGLEY LUTIBRON	
	ANORO ELLIPTA** COMBIVENT STIOLTO				
<b>LEUKOTRIENE MODIFIERS</b>		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	zafirlukast ZYFLO		
montelukast					
<b>LONG ACTING BRONCHODILATORS</b>		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	PERFORMIST STRIVERDI		
BROVANA* FORADIL SEREVENT					
<b>NASAL ANTIHISTAMINES</b>		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%		
azelastine 0.1%					

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ALLERGY / ASTHMA continued	<b>NASAL STEROIDS</b>		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 RYALTRIS TICANASE (use separate agents) VERAMYST XHANCE ZETONNA
	BECONASE AQ flunisolide fluticasone mometasone			
	<b>SHORT ACTING BRONCHODILATORS - INHALERS</b>		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.  <b>Minimum day supply of 16 days is required</b>	levoalbuterol (BRAND IS PREFERRED) PROAIR DIGIHALER PROVENTIL HFA
	albuterol HFA PROAIR HFA PROAIR RESPICLICK VENTOLIN HFA XOPENEX HFA*			
	<b>STEROID INHALANTS</b>		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 fluticasone HFA (use preferred agent) QVAR/REDIHALER
	ASMANEX TWISTHALER budesonide suspension FLOVENT HFA/DISK PULMICORT FLEXHALER			
	<b>STEROID COMBINATION AGENTS</b>		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.  <b>Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.</b>	fluticasone/vilanterol (use preferred agent) fluticasone/salmeterol 55-14/113-14/232-14 fluticasone/salmeterol 100-50/250-50/500-50 (BRAND IS PREFERRED) TRELLEY WIXELA
	ADVAIR DISK* ADVAIR HFA BREQ ELLIPTA** DULERA SYMBICORT*			
	<b>EPINEPHRINE</b>		epinephrine auto-injector pen	ADRENACLICK (use preferred agent) AUVI-Q (use preferred agent) EPI-PEN (use preferred agent)
<b>EOSINOPHILIC ASTHMA AGENTS</b>		*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*	
	FASENRA* XOLAIR*			
ARTHRITIS	<b>IMMUNOMODULATORS</b>		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  <b>Quantity Limits apply for all diagnoses:</b> 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 SIMPONI TALTZ
	<b>ANKYLOSING SPONDYLITIS (AS)</b>			
		ENBREL HUMIRA		
	<b>JUVENILE IDIOPATHIC ARTHRITIS (JIA)</b>		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		
	<b>PSORIATIC ARTHRITIS (PA)</b>		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 SIMPONI STELARA TALTZ TREMIFYA XELJANZ/XR
		ENBREL HUMIRA OTEZLA		
<b>RHEUMATOID ARTHRITIS (RA)</b>		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 RINVOQ** RITUXAN SIMPONI XELJANZ/XR	
	ENBREL HUMIRA			
CONVULSIONS	<b>INTERMITTENT, STEREOTYPIC SEIZURE EPISODES</b>		*Nayzilam will be allowed for patients 12 years of age and older	
	diazepam gel NAYZILAM* VALTOCO			
	<b>ORAL ANTICONVULSANTS</b>		Preferred agents will be limited to FDA approved indications related to seizures and epilepsy. Non-preferred agents require 30 day trial and failure of two preferred agents prior to approval.  For indications not related to seizures and epilepsy, please refer to the Additional Therapeutic Criteria chart at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> .  **Please refer to the Additional Therapeutic Criteria chart at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> for specific requirements.	APTIOM (use preferred agent) BRIVIACT (use preferred agent) clobazam** DIACOMIT** FINTEPLA** OXTELLAR (use preferred agent) TROKENDI XR (use preferred agent) XCOPRI VIMPAT (tablets) zonisamide oral susp. (use preferred agent)
	BANZEL* carbamazepine clonazepam divalproex EPIDIOLEX FELBAMATE fosphenytoin FYCOMPA gabapentin lacosamide (tablets) lamotrigine/XR levetiracetam pregabalin oxcarbazepine phenytoin subvenite topiramate/ER sprinkle caps valproate/valproic acid VIMPAT (suspension) zonisamide			

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CROHN'S	<b>IMMUNOMODULATORS</b>		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.  * Refer to Additional Therapeutics Clinical Criteria Chart for more information **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** ENTYVIO* REMICADE STELARA TYSABRI (additional criteria applies)
		HUMIRA		
DERMATOLOGY	<b>BENZOYL PEROXIDE/CLINDAMYCIN COMBOS</b>		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% clindamycin/benzoyl peroxide 1.2-5% (Refrig)		
	<b>ISOTRETINOIN</b>			ABSORICA (use preferred agents)
		AMNESTEEM CLARAVIS isotretinoin MYORISAN ZENATANE		
	<b>CORTICOSTEROIDS - STEP 1 AGENTS C=CREAM; G=GEL; L=LOTION; O=OINTMENT</b>		Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	PANDEL prednicarbate 0.1% (C,O) TEXACORT 2.5% (S)
	<b>LOW POTENCY</b>			
		alclometasone desonide DESOWEN 0.05% (L) flucinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) SYNALAR 0.01%		
	<b>MEDIUM POTENCY</b>		Trial and failure of two 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% flucinolone 0.025% fluticasone 0.05% (C) mometasone SYNALAR 0.025% TOPICORT 0.05% (C) triamcinolone 0.025%, 0.1%		
	<b>HIGH POTENCY</b>		Trial and failure of two 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) flucinolone 0.1% (C) halcinonide 0.1% (C) HALOG 0.1% (O)
		betamethasone dipropionate clobetasol/E 0.05% (C,G,O,S) diflorasone flucinolone flurandrenolide fluticasone 0.005% (O) halobetasol TEMOVATE/E TOPICORT 0.25% (C) triamcinolone 0.5% ULTRAVATE 0.05%		
	<b>IMMUNOMODULATORS - STEP 2 AGENTS</b>		To receive a <b>step 2 agent</b> : 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.	pimecrolimus (brand preferred)
	ELIDEL tacrolimus			
<b>PHOSPHODIESTERASE 4 INHIBITOR - STEP 3 AGENT</b>		To receive a <b>step 3 agent</b> : 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	
<b>ATOPIC DERMATITIS</b>		*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. Dupixent requires member be at least 6 months of age or older.  **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.	ADBRY** CIBINQO** OPZELURA** RINVOQ**	
	DUPIXENT*			
<b>PLAQUE PSORIASIS (PP)</b>		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.  *Sotyktu requires diagnosis of moderate to severe PP and 56 day trial and failure of Humira. **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** COSENTYX ILUMYA REMICADE SILIQ SKYRIZI STELARA TALTZ TREMIFYA	
	ENBREL HUMIRA OTEZLA SOTYKTU*			
<b>SCABICIDES/PEDICULICIDES</b>		Trial and failure of a preferred agent in the last 12 months.	LINDANE malathion lotion NATROBA SKLICE spinosad (BRAND IS PREFERRED)	
	permethrin VANALICE			
<b>UREA</b>			All other topical urea formulations.	
	ALUVEA CREAM 33% UMECTA EMULSION umecta mousse aerosol 40% urea lotion 40% urea lotion 45%			

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<b>DIABETES</b>	<b>DIABETES AGENTS</b>			
	<b>BIGUANIDES</b>			
	metformin/ER			metformin SR 24HR osmotic release (use preferred agent) metformin SR 24HR modified release (use preferred agent) RiOMET (use preferred agent)
	<b>α-GLUCOSIDASE INHIBITORS</b>		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			
	<b>MEGLITINIDES</b>		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			
	<b>THIAZOLIDINEDIONES</b>		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			
	<b>SULFONYLUREAS</b>		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.	
	glimpiride/ER glipizide/ER glyburide/ER			
	<b>DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITORS</b>		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 given for a non-preferred agent.	alogliptin GLYXAMBI (use separate preferred agents) ONGLYZA QTERN (use separate preferred agents) STEGLUJAN (use separate preferred agents) TRADJENTA
		JANUVIA		
	<b>DPP-4 INHIBITOR COMBO AGENTS</b>		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 given for a non-preferred agent.	alogliptin/metformin alogliptin/pioglitazone (use separate preferred agents) JENTADUETO JUVISYNC (use separate preferred agents) KOMBIGLYZE
		JANUMET/XR		
	<b>INCRETIN MIMETICS (GLP-1 RECEPTOR AGONISTS)</b>		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 given for a non-preferred agent.	BYDUREON MOUJIARO OZEMPIC* SOLIQUA RYBELSUS* (additional criteria applies) TANZEUM TRULICITY XULTOPHY (use separate preferred agents)
		BYETTA VICTOZA		
	<b>SGLT2 INHIBITORS</b>		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 or heart failure, 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		
	<b>FAST-ACTING INSULIN</b>		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				
<b>LONG-ACTING INSULIN</b>		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently.	BASAGLAR (use preferred agent) Insulin Glargine (use preferred agent) Insulin Degludec 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				
<b>DIABETIC METERS/TEST STRIPS</b>		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 FREESTYLE SIDEKICK II 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				
<b>EXTERNAL DIABETIC DEVICES</b>				
OMNIPOD DASH				
<b>CONTINUOUS BLOOD GLUCOSE MONITORS</b>		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 G6 DEXCOM G7 FREESTYLE LIBRE FREESTYLE LIBRE 2 FREESTYLE LIBRE 3			
<b>ACUTE HYPOGLYCEMIA AGENTS</b>				
BAQSIMI			GVOKE (use preferred agent) ZEGALOGUE	
<b>FIBROMYALGIA</b>	<b>FIBROMYALGIA</b>			
amitriptyline cyclobenzaprine duloxetine gabapentin		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 not be covered)	

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GASTROINTESTINAL	<b>BOWEL EVACUANTS</b>			CLENPIQ (use preferred agents) GAVILYTE H (use preferred agents) NULYTELY (use preferred agents) POLY-PREP (use preferred agents) PREPOPIK (use preferred agents)
	COLYTE GAVILYTE C, G, N GOLYTELY MOVIPREP PEG 3350 SOLUTION SUCLEAR SUPREP TRILYTE			
	<b>CHRONIC IDIOPATHIC CONSTIPATION</b>		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.	MOTTEGRITY
		AMITIZA LINZESS TRULANCE		
	<b>DIGESTIVE ENZYMES</b>		Prior authorization required.	PANCREAZE pancrelipase PERTZYE TRI-PASE ULTRESA VIOKASE
	CREON ZENPEP			
	<b>IRRITABLE BOWEL SYNDROME WITH CONSTIPATION</b>		Client must have a diagnosis of Irritable Bowel Syndrome (IBS) with constipation.	
		AMITIZA LINZESS TRULANCE		
	<b>MESALAMINE</b>		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 SROWASA
	APRISO* ASACOL HD* LIALDA* mesalamine 400mg DR capsule mesalamine enema PENTASA			
<b>OPIOID-INDUCED CONSTIPATION AGENTS</b>		Client must have a diagnosis of opioid-induced constipation and a three (3) month trial and failure of a stool softener 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* RELISTOR SYMPROIC	
	AMITIZA			
<b>PREGNANCY INDUCED NAUSEA/VOMITING</b>				
BONJESTA DICLEGIS				
<b>PROTON PUMP INHIBITORS</b>		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	<b>COLCHICINE</b>			colchicine (use preferred agent) MITIGARE (use preferred agent)
	COLCRYS*			
	<b>XANTHINE OXIDASE AND URAT1 INHIBITORS</b>		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	<b>LOW MOLECULAR WEIGHT HEPARIN (LMWH)</b>		Prior authorization will be required for the 300mg/3ml strength.	FRAGMIN (use preferred agent) enoxaparin 300MG/3ML
	enoxaparin			
	<b>DIRECT THROMBIN INHIBITOR</b>		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		
	<b>FACTOR XA INHIBITOR</b>		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			
<b>SELECTIVE FACTOR XA INHIBITOR</b>		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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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>THIS LIST IS NOT ALL INCLUSIVE. PLEASE CONTACT CHANGE HEALTHCARE WITH ANY QUESTIONS.</small>
HEMATOLOGY continued	<b>CPTP DERIVATIVES</b>		Client must have a diagnosis of acute coronary syndrome, history of myocardial infarction, or history of stroke and transient ischemic attack.	
		BRILINTA		
	<b>PAR-1 ANTAGONIST</b>		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		
	<b>ANTIHEMOPHILIC FACTOR VIII</b>			KOVALTRY
		ADVATE ADYNOVATE AFSTYLA ELOCTATE ESPEROCT HEMOFIL M HEMLIBRA JIVI KOATE/KOATE-DVI KOGENATE FS/BIO-SET MONOCLATE-P NOVOEIGHT NUWIQ OBIZUR RECOMBINATE XYNTHA/SOLOFUSE		
	<b>COAGULATION FACTOR IX</b>			
		ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY MONONINE REBINYN RIXUBIS		
	<b>ANTIHEMOPHILIC FACTOR/VWF</b>			
		ALPHANATE HUMATE-P VONVENDI WILATE		
<b>ERYTHROPOIESIS STIMULATING AGENTS</b>			ARANESP PROCRIT	
	EPOGEN MIRCERA RETACRIT			
<b>SICKLE CELL ANEMIA</b>				
	DROXIA SIKLOS			
HEPATITIS C	<b>DIRECT ACTING ANTIVIRALS</b>		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 <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> .	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)
		sofosbuvir/velpatasvir MAVYRET**		
HIDRADENITIS SUPPURATIVA	<b>IMMUNOMODULATORS</b>		Humira will not be covered as a first line agent for the diagnosis of hidradenitis suppurativa.	
		HUMIRA		
HORMONES	<b>GnRH ANTAGONISTS</b>		*Please refer to the Additional Therapeutic Criteria chart at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> for specific requirements.	ORILISSA
	MYFEMBREE ORIAHNN			
	<b>GROWTH HORMONE</b>			HUMATROPE OMNITROPE SAIZEN SEROSTIM SKYTROFA TEV-TROPIN ZORBTIVE ZOMACTON
		GENOTROPIN NORDITROPIN NUTROPIN AQ		
	<b>PROGESTIN</b>		Prior authorization is required.	
	MAKENA 250mg/ml* MAKENA 275mg/1.1ml*			
<b>TESTOSTERONE TOPICAL GELS</b>		Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient testosterone production.  <i>Other testosterone dosage form products will require a diagnosis of hypogonadism or insufficient testosterone production (not outlined on PDL).</i>	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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<b>HORMONES</b> continued	<p style="text-align: center;"><b>ORAL CONTRACEPTIVES</b></p> 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 CHARLOTTE 24 FE chew cyclofem 1-35, 7/7/7 cyred cryselle dasetta 1-35, 7/7/7 debiltane DESOGEN deso/ethinyl estradiol drospir/ethinyl estradiol elinest emoquette enpresse enskyce errin estarylla ESTROSTEP FE ethinodiol/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 jollessa jolivette juleber junel 1-20/FE, 1.5-30/FE kariva keinor kimidess kurvelo larin 1-20/FE, 1.5-30/FE larissia leena lessina levonest levonor/ethinyl estradiol levora lillow lomedia 1-20 FE loryna <b>LOSEASONIQUE*</b> low-ogestrel lutera lyza marlissa melodetta FE chew mibelas FE chew microgestin 1-20/FE, 1.5-30/FE mili mono-linyah mononessa myzilra NECON 0.5/35, 1/35, 1/50, 7/7/7, 10/11 nikki nora-be noreth/ethinyl estradiol/FE chw 0.4/35, 1/20 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 pimtreea pirmella 1-35, 7/7/7 portia previfem quasense reclipsen			amethia/LO (BRAND IS PREFERRED) ashlyna (BRAND IS PREFERRED) BALCOLTRA BEVAZ camrese/LO (BRAND IS PREFERRED) daysee (BRAND IS PREFERRED) drospir/ethinyl estradiol/levomefolate FALESSA KIT fayosim FINZALA FE chew 1/20 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 <b>MINASTRIN FE chew*</b> NATAZIA noreth/ethinyl estradiol/FE chew 0.8/25 rajani rivelsa QUARTETTE SAFYRAL TAYTULLA TWIRLA tydemy

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<b>HORMONES</b> continued	<b>ORAL CONTRACEPTIVES (cont.)</b>			
	<b>SEASONIQUE*</b> setlakin sprintec sharobel sronyx syeda tarina 1/20 FE tilia FE tri-estaryl/LO tri-femynor tri-legest FE tri-linyah tri-marzia LO tri-mili trinessa/LO tri-previfem tri-sprintec/LO trivora tri-vyibra tulana velivet vestura vienwa viorele vyfemla vyibra wera 0.5-35 wymzya FE chew zarah zenchent/FE chew zovia			
<b>HYPERLIPIDEMIA</b>	<b>BILE ACID SEQUESTRANT</b>		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
	<b>STATINS, LOW POTENCY</b>		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			
	<b>STATINS, HIGH POTENCY</b>		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			
	<b>STATIN COMBINATIONS</b>		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 <b>VYTORIN*</b>			
<b>PCSK9-RELATED AGENTS</b>		PRALUENT	Client must have a diagnosis of homozygous familial hypercholesterolemia; have a diagnosis of heterozygous familial hypercholesterolemia or atherosclerotic cardiovascular disease AND not at goal with a maximum dose statin; or be intolerant to statin therapy. Approval for a non-preferred agent requires trial and failure of a preferred agent.	LEQVIO REPATHA
<b>TRIGLYCERIDE LOWERING AGENTS</b>			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) icosapent LIPOFEN omega-3-acid VASCEPA
	fenofibrate 48, 54, 67, 134, 145, 160, and 200mg gemfibrozil			



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HYPERTENSION/ CARDIOLOGY	<b>ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)</b>		Non-preferred ARBs will require a history of ALL preferred ARBs before approval	candesartan eprosartan 600mg TEVETEN 400mg
	EDARBI irbesartan losartan olmesartan telmisartan valsartan			
	<b>ARBs AND DIURETICS</b>		Non-preferred ARB/diuretic combinations will require a history of ALL preferred	candesartan HCTZ telmisartan HCTZ TEVETEN HCTZ
	EDARBYCLOR irbesartan HCTZ losartan HCT olmesartan HCTZ valsartan HCTZ			
	<b>ALPHA-BLOCKERS</b>			NEXICLON XR (use preferred agent)
	clonidine clonidine TD patches			
	<b>COMBINATION PRODUCTS</b>		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	<b>QUINOLONES</b>		Please refer to the Additional Therapeutic Criteria Chart located at <a href="http://www.wymedicaid.org/additional-therapeutic-criteria">http://www.wymedicaid.org/additional-therapeutic-criteria</a> for Baxdela criteria.	FACTIVE (use preferred agents) moxifloxacin (use preferred agents) NOROXIN (use preferred agents) PROQUIN (use preferred agents)
	ciprofloxacin/ER levofloxacin ofloxacin			
	<b>DOXYCYCLINE</b>			ADOXA (use preferred agent) DORYX (use preferred agent) ORACEA (use preferred agent)
	doxycycline			
	<b>MINOCYCLINE</b>			minocycline 65mg and 115mg ER (use preferred agent) SOLODYN (use preferred agent)
	minocycline/ER			
	<b>INHALED TOBRAMYCIN</b>		*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.  <b>Minimum day supply of at 56 days is required</b>	BETHKIS inhaled tobramycin TOBI PODHALER (use preferred agent)
	KITABIS			
	<b>ANTI-RETROVIRALS</b>		*Please refer to the Additional Therapeutic Criteria chart at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> for specific requirements.  **Rukobia approval requires documentation of multi-drug resistance defined as failure of two medications from different classes.	DOVATO NORVIR RUKOBIA** STRIBILD (use separate agents) SYM TUZA (use separate preferred agents)
	APRETUDE BIKTARVY CIMDUO DELSTRIGO EVOTAZ GENVOYA JULUCA ODEFSEY PIFELTRO PREZCOBIX ritonavir tablets SYMFI/LO TIVICAY TRIUMEQ TROGARZO	CABENUVA* DESCOVY* TRUVADA*		
INFLAMMATION	<b>NSAIDs</b>		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.  <b>Dosing and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets).</b>	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 <b>FLECTOR*</b> flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate meloxicam nabumetone naproxen oxaprozin piroxicam sulindac tolmetin			
	<b>ORAL CORTICOSTEROIDS</b>			CELESTONE (use preferred agent)
	budesonide cortisone acetate dexamethasone/intensol hydrocortisone methylprednisone prednisolone prednisone			
INSOMNIA	<b>NON-BENZODIAZEPINES</b>		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  *Quiviviq requires trial and failure of two preferred agents with different mechanisms of action  **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.  <b>Dosage limits apply:</b> zaleplon: 30mg/day zolpidem: 15mg/day	EDLUAR (additional criteria applies) DAYVIGO QUVIVIQ <b>ROZEREM*</b> zolpidem sublingual (additional criteria applies) ZOLPIMIST (additional criteria applies)
	BELSOMRA eszopiclone zaleplon zolpidem zolpidem ER			

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MENTAL HEALTH	ALZHEIMER AGENTS		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. <b>One of the trials of preferred agents must be in the same class (NaSS, NDRI, SSRI, or SNRI) as the requested non-preferred agent.</b>	NaSS
	NORADRENERGIC/SPECIFIC SEROTONERGICS (NaSS)			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, bupropion, fluvoxamine, MAO inhibitors, TCA's, bupropion IR, and venlafaxine IR do not require prior authorization but <b>will not count</b> towards meeting preferred therapy requirements.	SSRI
	citalopram escitalopram fluoxetine capsules paroxetine IR/CR sertraline		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.	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	desvenlafaxine DRIZALMA FETZIMA venlafaxine ER tablets (use preferred agent)
			Clients five (5) years of age and younger will require prior authorization before approval.	OTHER
		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	TRINTELLIX***	
ATYPICAL ANTIPSYCHOTICS		*Quetiapine doses less than 100mg will require prior authorization <u>without</u> a diagnosis of mood disorder or major depressive disorder. For titration doses, contact the Change Healthcare Pharmacy Help Desk for an override.	ABILIFY MYCITE (use preferred agent) CAPLYTA GEODON 20MG INJ (use preferred agent) LYBALVI (additional criteria applies) NUPLAZID olanzapine 10mg Inj (use preferred agent) SECUADO REXULTI*** ZYPREXA RELPREVV	
ABILIFY MAINTENA aripiprazole tab/solution/ODT ARISTADA FANAPT** paliperidone INVEGA HAFYERA/SUSTENNA/TRINZA LATUDA** olanzapine PERSERIS quetiapine* quetiapine ER RISPERDAL CONSTA risperidone SAPHRIS** VRAYLAR ziprasidone		**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 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 441/662/882mg: 1 injection per 28 days ARISTADA 1064mg: 1 injection per 56 days ARISTADA INITIO: 1 injection per 365 days FANAPT: 24mg/day INVEGA HAFYERA: 1 injection per 6 months 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		
SPECIAL ATYPICAL ANTIPSYCHOTICS		Dosage limits apply: 1350mg/day	VERSACLOZ Suspension (use preferred agent)	
clozapine/ODT				

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MENTAL HEALTH continued	<b>AMPHETAMINES</b>		<p>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).</p> <p>For clients over the age of 17, they must meet the DSM-5 criteria for diagnosis of ADHD. These criteria include:</p> <ul style="list-style-type: none"> <li>• Five or more symptoms of inattention, present for at least 6 months, inappropriate for developmental level.</li> <li style="text-align: center;">OR</li> <li>• 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.</li> <li style="text-align: center;">AND</li> <li>• Symptoms must be present in two or more settings (home, school or work); and</li> <li>• There must be clear evidence that the symptoms interfere or reduce the quality of social, school or work functioning; and</li> <li>• The symptoms must not be better explained by another mental disorder.</li> </ul> <p>Diagnosis of MS fatigue will require a fatigue severity scale score of 5.0, a 60-day trial of amantadine and discontinuation of medications that may contribute to drowsiness and fatigue.</p> <p>Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant.</p> <p>Prior Authorization will be required for clients under the age of 4.</p> <p><b>**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.</b></p> <p>Claims will require Prior Authorization if clients have a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use.</p> <p>Trial and failure of two (2) preferred agents (each from a different class: methylphenidate and amphetamine) greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p><b>Dosage limits apply:</b>            amphetamine salts combo XR: 60mg/day            amphetamine salts combo: 60mg/day            amphetamine salts combo (narcolepsy): 90mg/day            DAYTRANA: 45mg/9 hour patch/day            dextroamphetamine: 90mg/day            dextroamphetamine CR: 90mg/day            dexmethylphenidate: 30mg/day            FOCALIN XR &lt; 13 years of age: 45mg/day            FOCALIN XR &gt; 13 years of age: 60mg/day            PM: 100mg/day            methylin/methylphenidate/ER: 90mg/day            VYVANSE: 105mg/day</p>	<b>AMPHETAMINES</b>	
	<b>LONG ACTING AMPHETAMINES</b>			<b>ADDERALL XR</b> amphetamine salts combo XR dextroamphetamine CR caps VYVANSE CAPSULES**	<b>ADZENYS XR ODT</b> amphetamine ER suspension 1.25mg/ml DYANAVEL XR EVEKEO/ODT MYDAYIS PROCENTRA VYVANSE CHEWABLES ZENZEDI 2.5 AND 7.5MG TABLETS
	<b>IMMEDIATE RELEASE AMPHETAMINES</b>			amphetamine salts combo dextroamphetamine tablets	<b>METHYLPHENIDATES</b>
	<b>METHYLPHENIDATES</b>			<b>CONCERTA*</b> dexmethylphenidate ER methylin ER methylphenidate ER tablets	<b>ADHANSIA XR</b> APTENSIO XR AZSTARYS COTEMPLA XR DAYTRANA FOCALIN XR JORNAY PM methylphenidate ER osmotic release (BRAND IS PREFERRED) methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA, APTENSIO XR) QUILLICHEW ER QUILLIVANT
	<b>LONG ACTING METHYLPHENIDATES</b>			<b>CONCERTA*</b> dexmethylphenidate ER methylin ER methylphenidate ER tablets	
	<b>IMMEDIATE RELEASE METHYLPHENIDATES</b>			dexmethylphenidate methylphenidate tablets	
	<b>SELECTIVE ALPHA-ADRENERGIC AGONIST</b>				
	clonidine				clonidine ER
				To obtain the <b>non-preferred agent</b> , client must meet the following criteria:	
				Client must have a diagnosis of ADD or ADHD	
			Prior authorization will be required for clients under the age of 4.		
			To receive clonidine ER, clients must have completed a 14 day trial of clonidine IR with <b>benefit</b> in the previous 12 months.		

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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 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 be limited to a max dose of 400mg in clients 6-17 years of age, and 600mg for clients 18 years of age or older. <b>Dosage limits apply:</b> atomoxetine: 150mg/day	QELBREE
		atomoxetine		
MIGRAINE	MIGRAINE PROPHYLAXIS		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. <b>Nurtec will be limited to 16 tabs/30 days.</b>	NURTEC
	STEP 1 AGENTS			
	beta blockers	divalproex topiramate		
	STEP 2 AGENTS		*Starting dose will be limited to 70mg	QULIPTA**
		AIMOVIG* AJOVY EMGALITY	**Approval for non-preferred agents requires trial and failure of a preferred agent along with the trial and failures described with Step 1 Agents' criteria above.	
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 limited to clients 6 years of age or older  <b>Quantity limits apply:</b> naratriptan 1mg: 25 tabs/34 days naratriptan 2.5mg: 10 tabs/34 days RELPAK 20mg: 20 tabs/34 days RELPAK 40mg: 14 tabs/34 days rizatriptan 5mg: 27 doses/34 days rizatriptan 10mg: 14 doses/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) TOSYMRA (use preferred agent) TREMIMET TROKENDI XR ZEMBRACE (use preferred agent) zolmitriptan
			Trial and failure of two triptan agents is required for approval of a Step 2 Agent.	REYVOW UBRELVY
		NURTEC	Trial and failure of two preferred triptan agents AND Nurtec will be required for approval of a non-preferred agent. <b>Quantity limits apply:</b> NURTEC 75mg: limited to 8 tabs/30 days REYVOW: 200mg/day or 1 tab/day	
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 <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> 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).	BAFIERTAM EXTAVIA glatiramer (BRAND IS PREFERRED) GLATOPA (use preferred agent) KESIMPTA LEMTRADA MAVENCLAD MAYZENT OCREVUS** PLEGRIDY PONVORY TECFIDERA TYSABRI (additional criteria applies) VUMERITY ZEPOSIA
	AUBAGIO AVONEX BETASERON COPAXONE 20MG/ML* dimethyl fumarate REBIF		Trial and failure of two preferred agents for at least 56 days (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 and Mavenclad, in addition to the above criteria, approval will be granted on a case-by-case basis.	
		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.	
		modafinil NUVIGIL*		SUNOSI WAKIX XYREM
	NON-STIMULANTS		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	
NEUROPATHIC PAIN	GABAPENTIN		Clients will not be allowed to take gabapentin and pregabalin concurrently	
		gabapentin pregabalin	Prior authorizations for perioperative pain will be approved for gabapentin OR pregabalin for less than or equal to 14 day supplies	
	TOPICAL LIDOCAINE			ZTUDO
	Lidocaine Patches			
	ADDITIONAL AGENTS			
	amitriptyline desipramine imipramine nortriptyline		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

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<b>OPHTHALMICS</b>	<b>OP. -ANTI-ALLERGICS</b>		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 ZERVIAE
	ALREX azelastine BEPREVE* cromolyn 0.4% LASTACAF* olopatadine 0.1%, 0.2%			
	<b>OP. -ANTIBIOTICS- QUINOLONES</b>		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 IQIUX levofloxacin ZYMAR
	ciprofloxacin ofloxacin MOXEZA moxifloxacin 0.5%			
	<b>OP. -ANTI-INFLAMMATORY</b>		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 loteprednol 0.5% (BRAND PREFERRED) PROLENSA
	flurbiprofen diclofenac LOTEMAX* ketorolac NEVANAC			
	<b>OP. -BETA-BLOCKERS</b>		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			
	<b>OP. -CARBONIC ANHYDRASE INHIBITOR</b>		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			
	<b>OP. -COMBO PRODUCTS</b>			dorzolamide/timolol (BRAND PREFERRED)
	COMBIGAN* COSOPT* ROCKLATAN SIMBRINZA			
	<b>OP. -DRY EYE AGENTS</b>		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*				
<b>OP. -PROSTAGLANDINS</b>		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				
<b>OP. -RHO KINASE INHIBITOR</b>				
RHOPRESSA				
<b>OP. -SYMPATHOMIMETICS</b>		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%				
<b>OSTEOPOROSIS</b>	<b>BISPHOSPHONATES</b>		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  ***Forte will be limited to 2 years of use	EVINITY** FORTEO*** FOSAMAX-D ibandronate risedronate/DR TYMLOS
	alendronate			
	<b>NASAL CALCITONIN</b>			
	calcitonin-salmon fortical			
<b>OTIC</b>	<b>ANTIBIOTIC/STEROID COMBINATION</b>		Trial and failure of a preferred agent greater than or equal to 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.	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			
<b>OVERACTIVE BLADDER</b>	<b>OVERACTIVE BLADDER AGENTS</b>		Trial and failure of a preferred agent greater than or equal to 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 OXYTROL DIS SANCTURA XR tolterodine/ER trospium
	MYRBETRIQ oxybutynin /ER solifenacin TOVIAZ			

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PAIN	<b>LONG-ACTING C-Its</b>		<p>Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>C-Its and C-IVs that are not included on the PDL and are available without prior authorization with the exception of Butrans (generic substitution is mandatory).</p> <p>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.</p> <p><b>**Nucynta ER will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CI narcotics.</b></p> <p>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            Oxycotin: 80mg/day            Oxymorphone: 40mg/day            Xtampza ER: 80mg/day            Zohydro ER: 120mg/day</p> <p><b>Clients will be limited to one long-acting narcotic at a time</b></p>	<p><b>ARYMO ER (use preferred agents)</b>            BELBUCA            fentanyl patches            hydrocodone ER            hydromorphone ER            HYSINGLA ER            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)</p>
	<b>SHORT-ACTING C-Its</b>		<p>Trial and failure of three (3) preferred agents greater than or equal to a 6 day supply in the last 90 days will be required before approval can be given for a non-preferred agent.</p> <p><b>*Nucynta will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CI narcotics.</b></p> <p>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.</p> <p><b>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 <a href="http://www.wymedicaid.org">www.wymedicaid.org</a>)</b></p> <p><b>Clients will be limited to one short-acting narcotic at a time</b></p>	<p>APADAZ            levorphanol            NUCYNTA*            oxymorphone            oxycodone/IBU            ROXYBOND</p>
	<b>C-III/C-V AGENTS</b>		<p><b>BUTRANS</b>            tramadol</p>	<p>Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p><b>Quantity and dosage limits apply (max 8 tabs/day).</b></p> <p><b>**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</b></p> <p>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.</p>
PARKINSON'S DISEASE	<b>SHORT-ACTING AGENTS</b>			
	<b>LONG-ACTING AGENTS</b>		<p><b>**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</b></p>	<p>APOKYN            benzotropine injectables            GOCOVRI            INBRIJA            KYNMOBI            ONGENTYS            pramipexole ER            XADAGO</p>
PHOSPHATE BINDERS	<b>PHOSPHATE BINDERS</b>		<p>Prior authorization required for non-preferred agents.</p>	<p>AURYXIA            lanthanum            PHOSLYRA            sevelamer            VELPHORO</p>

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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 ( <i>use separate agents</i> )		
	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 ( <i>use separate agents</i> ) 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 ( <i>use preferred agent</i> ) TRACLEER TABS FOR ORAL SUSP ( <i>use preferred agent</i> )
		LETAIRIS TRACLEER TABS*				
	GUANYLATE CYCLASE INHIBITORS				Prior authorization required.	ADEMPAS ( <i>use preferred agent</i> )
	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 ( <i>use preferred agent</i> )			
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*		
	pramipexole ropinirole	gabapentin				
SKELETAL MUSCLE RELAXANTS	MUSCLE RELAXANTS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months, along with a medical diagnosis of muscle spasticity will be required before approval can be given for a non-preferred agent.  Cyclobenzaprine will require a prior authorization for clients concurrently taking a tricyclic antidepressant. <b>Carisoprodol is limited to 84 tabs/365 days</b>	carisoprodol chlorzoxazone cyclobenzaprine ER LYVISPAP metaxalone methocarbamol orphenadrine tizanidine capsules ( <i>use preferred agent</i> )		
	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.  * Refer to Additional Therapeutics Clinical Criteria Chart for more information	ENTYVIO* REMICADE SIMPONI STELARA XELJANZ/XR		
		HUMIRA				
UVEITIS	IMMUNOMODULATORS		Client must have diagnosis of non-infectious intermediate, posterior, or panuveitis in adult patients			
		HUMIRA				