

**WYOMING MEDICAID
Preferred Drug List (PDL) May 5, 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>
ADDICTION	BUPRENORPHINE COMBINATIONS		Client must have a diagnosis of opioid dependence or abuse. This is not to be used for the treatment of chronic pain. Prior authorization will be required before any narcotic, 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
		buprenorphine/naloxone tablets SUBOXONE FILM*		
	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.	naloxone nasal spray
		NALTREXONE	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		
ALLERGY / ASTHMA / COPD	ANTIHISTAMINES, MINIMALLY SEDATING		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	desloratadine CLARINEX RDT/SYRUP levocetirizine
	cetirizine fexofenadine loratadine			
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	CLARINEX-D
	cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine			
	ANTICHOLINERGIC BRONCHODILATORS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. **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			
	ANTICHOLINERGIC COMBINATION AGENTS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. **Will also require the diagnosis of COPD.	BEVESPI BREZTRI DUAKLIR TRELLEGY LUTIBRON
	ANORO ELLIPTA** COMBIVENT STIOLTO			
LEUKOTRIENE MODIFIERS		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	zafirlukast	
montelukast				
LONG ACTING BRONCHODILATORS		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.	STRIVERDI	
BROVANA* SEREVENT				
NASAL ANTIHISTAMINES		Trial and failure of preferred agent greater than or equal to 90 days in the last 12 months will be required before approval can be given for a non-preferred agent.	azelastine 0.15% DYMISTA (use separate agents) olopatadine 0.6%	
azelastine 0.1%				

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ALLERGY / ASTHMA / COPD continued	NASAL STEROIDS		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Budesonide will be approved for pregnancy.	budesonide DYMISTA (use separate agents) OMNARIS QNASL XHANCE ZETONNA		
	SHORT ACTING BRONCHODILATORS - INHALERS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. 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	levalbuterol (BRAND IS PREFERRED) PROAIR DIGIHALER PROVENTIL HFA		
	STEROID INHALANTS		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Alvesco will be approved for a history of oral thrush with steroid inhalants.	ALVESCO ARMONAIR ARNUITY ASMANEX HFA fluticasone HFA (use preferred agent) QVAR/REDIHALER		
	STEROID COMBINATION AGENTS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. **Will also require the diagnosis of COPD or uncontrolled asthma. Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.	fluticasone/vilanterol (use preferred agent) fluticasone/salmeterol 55-14/113-14/232-14 fluticasone/salmeterol 100-50/250-50/500-50 (BRAND IS PREFERRED) TRELGEY 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.		
	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 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 SIMPONI STELARA TALTZ TREMIFYA 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 RINVOQ** RITUXAN SIMPONI XELJANZ/XR		
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 EPIDIOLEX FELBAMATE fosphenytoin FYCOMPA gabapentin lacosamide (tablets) lamotrigine/XR levetiracetam pregabalin oxcarbazepine phenytoin subvenite topiramate/ER sprinkle caps valproate/valproic acid VIMPAT (suspension) zonisamide	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 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** FINTEPLA** OXTELLAR (use preferred agent) TROKENDI XR (use preferred agent) XCOPRI VIMPAT (tablets) zonisamide oral susp. (use preferred agent)		

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CROHN'S	IMMUNOMODULATORS		Client must have diagnosis of Crohn's prior to approval of the preferred agent. To receive a non-preferred agent, client must have a diagnosis of Crohn's and a 56-day trial and failure of the preferred agent. * 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	BENZOYL PEROXIDE/CLINDAMYCIN COMBOS		Clients must be 12 to 20 years of age. Requires prior authorization for clients less than 12 years of age. Acne combinations are limited to clients under the age of 21.	ACANYA (use preferred agent) ONEXTON (use preferred agent)
		clindamycin/benzoyl peroxide 1-5% clindamycin/benzoyl peroxide 1.2-5% (Refrig)		
	ISOTRETINOIN			ABSORICA (use preferred agents)
	AMNESTEEM CLARAVIS isotretinoin MYORISAN ZENATANE			
	CORTICOSTEROIDS - STEP 1 AGENTS C=CREAM; G=GEL; L=LOTION; O=OINTMENT		Trial and failure of 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)
	LOW POTENCY			
	alclometasone desonide DESOWEN 0.05% (L) flucinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) SYNALAR 0.01%			
	MEDIUM POTENCY		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%			
	HIGH POTENCY		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 TOPICORT 0.25% (C) triamcinolone 0.5% ULTRAVATE 0.05%				
IMMUNOMODULATORS - STEP 2 AGENTS		To receive a step 2 agent : Trial and failure of a preferred medium potency topical corticosteroid greater than or equal to a 21 day trial and a trial and failure of a preferred high potency topical corticosteroid greater than or equal to a 21 day trial in the last 90 days. 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			
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		*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*			
PLAQUE PSORIASIS (PP)		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*			
SCABICIDES/PEDICULICIDES		Trial and failure of a preferred agent in the last 12 months.	LINDANE malathion lotion NATROBA spinosad (BRAND IS PREFERRED)	
	permethrin VANALICE			

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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)
	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 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			
	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 given for a non-preferred agent.	alogliptin/metformin alogliptin/pioglitazone (use separate preferred agents) JENTADUETO 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 unless ASCVD or risk factors are present, in which case the trial of metformin is waived. A 90 day trial of failure of the preferred agent is required before approval can be given for a non-preferred agent. *Rybelsus requires documentation of inability to use injectable agents. Dosage Limits Apply: Ozempic: 2mg/week Victoza: 1.8mg/day	BYDUREON MOUNJARO OZEMPIC* SOLIQUA RYBELSUS* (additional criteria applies) 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 ASCVD, 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) QTERN (use separate preferred agents) SEGLUROMET (use separate preferred agents) STEGLATRO STEGLUJAN (use separate preferred agents) SYNJARDY XR (use separate preferred agents) TRUJARDY 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) Insulin Glargine (use preferred agent) Insulin Degludec LANTUS OPTICLIK (use preferred agent) SOLIQUA 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 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				
EXTERNAL DIABETIC DEVICES				
OMNIPOD DASH OMNIPOD CLASSIC OMNIPOD 5				
CONTINUOUS BLOOD GLUCOSE MONITORS		Prior authorization will be required to verify if the client is injecting insulin daily. Monitors will also be limited to the labeled age.	GUARDIAN MINIMED	
	DEXCOM G6 DEXCOM G7 FREESTYLE LIBRE FREESTYLE LIBRE 2 FREESTYLE LIBRE 3			
ACUTE HYPOGLYCEMIA AGENTS				
BAQSIMI			GVOKE (use preferred agent) ZEGALOGUE	
FIBROMYALGIA	FIBROMYALGIA			
	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 will not be covered)

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GASTROINTESTINAL	BOWEL EVACUANTS			CLENPIQ (use preferred agents) GAVILYTE H (use preferred agents) POLY-PREP (use preferred agents)
	COLYTE GAVILYTE G, N GOLYTELY MOVIPREP PEG 3350 SOLUTION SUPREP			
	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
		AMITIZA LINZESS TRULANCE		
	DIGESTIVE ENZYMES		Prior authorization required.	PANCREAZE pancrelipase PERTZYE TRI-PASE ULTRESA VIOKASE
	CREON ZENPEP			
	IRRITABLE BOWEL SYNDROME WITH CONSTIPATION		Client must have a diagnosis of Irritable Bowel Syndrome (IBS) with constipation.	
		AMITIZA LINZESS TRULANCE		
	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.	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 SFRWASAA
	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 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			
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.	ULORIC*
	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		
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.	SAVAYSA (use preferred agent) XARELTO 2.5mg* (use preferred agent)	
		ELIQUIS/STARTER PACK XARELTO 10mg, 15mg, 20mg, and starter pack		
			*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	

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HEMATOLOGY <i>continued</i>	CPTP DERIVATIVES		Client must have a diagnosis of acute coronary syndrome, history of myocardial infarction, or history of stroke and transient ischemic attack.	
		BRILINTA		
	PAR-1 ANTAGONIST		Client must have diagnosis of reduction of thrombotic cardiovascular events with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD). Must be used in conjunction with aspirin or clopidogrel.	
		ZONTIVITY		
	ANTIHEMOPHILIC FACTOR VIII			ALTUVIIIO KOVALTRY
		ADVATE ADYNOVATE AFSTYLA ELOCTATE ESPEROCT HEMOPIL M HEMLIBRA JIVI KOATE/KOATE-DVI KOGENATE FS/BIO-SET MONOCLATE-P NOVOEIGHT NUWIQ OBIZUR RECOMBINATE XYNTHA/SOLOFUSE		
	COAGULATION FACTOR IX			
		ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY REBINYN RIXUBIS		
	ANTIHEMOPHILIC FACTOR/VWF			
		ALPHANATE HUMATE-P VONVENDI WILATE		
ERYTHROPOIESIS STIMULATING AGENTS				
	EPOGEN MIRCERA RETACRIT		ARANESP PROCRIT	
SICKLE CELL ANEMIA				
	DROXIA SIKLOS			
HEPATITIS C	DIRECT ACTING ANTIVIRALS		Limited to FDA approved indication. Prior authorization will be required prior to use of preferred agents. **Positive SVR 12 will be required for consideration for retreatment Please submit PA requests on the Hepatitis C PA form available at www.wymedicaid.org .	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	IMMUNOMODULATORS		Humira will not be covered as a first line agent for the diagnosis for hidradenitis suppurativa.	
		HUMIRA		
HORMONES	GnRH ANTAGONISTS		*Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	ORILISSA
	MYFEMBREE ORIAHNN			
	GROWTH HORMONE		*Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	HUMATROPE OMNITROPE SAIZEN SEROSTIM SKYTROFA TEV-TROPIN ZORBTIVE ZOMACTON
		GENOTROPIN NORDITROPIN NUTROPIN AQ		
TESTOSTERONE TOPICAL GELS		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) TESTOPEL (use preferred agent) testosterone gel (use preferred agent) testosterone solution (use preferred agent) XYOSTED (use preferred agent)	
	ANDROGEL* TESTIM GEL			

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT CHANGE HEALTHCARE WITH ANY QUESTIONS</small>
HORMONES continued	<p style="text-align: center;">ORAL CONTRACEPTIVES</p> altavera alyacen 1-35, 7/7/7 amethyst apri aranelle aubra/EQ aviane azurette balziva blisovi 1-20 FE, 1.5-30 FE briellyn camila caziant chateal/EQ CHARLOTTE 24 FE chew cyred cryselle dasetta 1-35, 7/7/7 debiltane DESOGEN deso/ethinyl estradiol drospir/ethinyl estradiol elinest enpresse enskyce errin estanylla ethynodiol/ethinyl estradiol falmina FEMCON FE chew femynor GENERESS FE chew gildaia glidess 1-20/FE, 1.5-30/FE heather incassia introvale isibloom jencycla jolessa juleber junel 1-20/FE, 1.5-30/FE kariva kelnor kimidess kurvelo tarin 1-20/FE, 1.5-30/FE leena lessina levonest levonor/ethinyl estradiol levora lomedra 1-20 FE loryna LOSEASONIQUE* low-ogestrel lutera lyza marlissa mibelas FE chew microgestin 1-20/FE, 1.5-30/FE mili mono-linyah mononessa 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 nortrel 0.5-35, 1-35, 7/7/7 ocella ORTHO-CYCLEN philith pimtrea pirmella 1-35, 7/7/7 portia quasense reclipson SEASONIQUE* 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			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 MINASTRIN FE chew* NATAZIA noreth/ethinyl estradiol/FE chew 0.8/25 rajani rivelsa QUARTETTE SAFYRAL TAYTULLA TWIRLA tydemy

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HORMONES continued	ORAL CONTRACEPTIVES (cont.)				
	tri-previfem tri-sprintec/LO trivora tri-vylibra velivet vestura vienna viorele vyfemla vylibra wera 0.5-35 wyzmya FE chew zenchent/FE chew				
HYPERLIPIDEMIA	BILE ACID SEQUESTERANT		Trial and failure of ALL preferred agents greater than or equal to six (6) months in the last 12 months will be required before approval can be given for a non-preferred agent.	WELCHOL	
	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	
	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 ZYPITAMAG	
	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)	
	PCSK9-RELATED AGENTS		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
	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) icosapent 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) EDARBI irbesartan losartan olmesartan telmisartan valsartan		Non-preferred ARBs will require a history of ALL preferred ARBs before approval	candesartan eprosartan 600mg TEVETEN 400mg	
	ARBs AND DIURETICS EDARBYCLOR irbesartan HCTZ losartan HCT olmesartan HCTZ valsartan HCTZ		Non-preferred ARB/diuretic combinations will require a history of ALL preferred	candesartan HCTZ telmisartan HCTZ TEVETEN HCTZ	
	ALPHA-BLOCKERS clonidine clonidine TD patches			NEXICLON XR (use preferred agent)	
	COMBINATION PRODUCTS	ENTRESTO	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.		
INFECTIOUS DISEASE	QUINOLONES ciprofloxacin/ER levofloxacin ofloxacin		Please refer to the Additional Therapeutic Criteria Chart located at http://www.wymedicaid.org/additional-therapeutic-criteria for Baxdela criteria.	maxifloxacin (use preferred agents) NOROXIN (use preferred agents) PROQUIN (use preferred agents)	
	DOXYCYCLINE doxycycline			ADOXA (use preferred agent) DORYX (use preferred agent) ORACEA (use preferred agent)	
	MINOCYCLINE minocycline/ER			minocycline 65mg and 115mg ER (use preferred agent) SOLODYN (use preferred agent)	
	INHALED TOBRAMYCIN KITABIS		*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	BETHKIS inhaled tobramycin TOBI PODHALER (use preferred agent)	
	ANTI-RETROVIRALS APRETUDE BIKTARVY CIMDUO DELSTRIGO DOVATO EVOTAZ GENVOYA JULUCA ODEFSEY PIFELTRO PREZCOBIX ritonavir tablets SYMFI/LO TRIUMEQ TROGARZO	CABENUVA* DESCOVY* TRUVADA*		*Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements. **Rukobia approval requires documentation of multi-drug resistance defined as failure of two medications from different classes.	NORVIR RUKOBIA** STRIBILD (use separate agents) SUNLENCA SYMITUZA (use separate preferred agents)
	INFLAMMATION	NSAIDs celecoxib diclofenac tablets etodolac FLECTOR* flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate meloxicam nabumetone naproxen oxaprozin piroxicam sulindac		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) SPRIX (additional criteria applies) ZIPSOR (use preferred agent) ZORVOLEX (use preferred agent)
ORAL CORTICOSTEROIDS budesonide cortisone acetate dexamethasone/intensol hydrocortisone methylprednisone prednisolone prednisone				CELESTONE (use preferred agent)	
INSOMNIA	NON-BENZODIAZEPINES BELSOMRA eszopiclone zaleplon zolpidem zolpidem ER		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. Dosage limits apply: zaleplon: 30mg/day zolpidem: 15mg/day	EDLUAR (additional criteria applies) DAYVIGO QUVIVIQ ROZEREM* zolpidem sublingual (additional criteria applies) ZOLPIMIST (additional criteria applies)	

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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. One of the trials of preferred agents must be in the same class (NaSS, NDRI, SSRI, or SNRI) as the requested non-preferred agent.	NaSS
	NORADRENERGIC/SPECIFIC SEROTONERGICS (NaSS)			mirtazapine rapid dissolve tablets (use preferred agent)
	NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)			NDRI
	bupropion ER/SR/XL			APLENZIN AUVELITY FORFIVO XL*
	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)		Trazodone, bupirone, fluvoxamine, MAO inhibitors, TCA's, bupropion IR, and venlafaxine IR do not require prior authorization but will not count 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				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			*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. **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.	
SPECIAL ATYPICAL ANTIPSYCHOTICS			Dosage limits apply: 900mg/day	VERSACLOZ Suspension (use preferred agent)
clozapine/ODT				

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MENTAL HEALTH continued	AMPHETAMINES		<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"> • Five or more symptoms of inattention, present for at least 6 months, inappropriate for developmental level. <li style="text-align: center;">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. <li style="text-align: center;">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. <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>**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.</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. Two or more long-acting agents will not be allowed concurrently.</p> <p>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 JORNAY PM: 100mg/day methylin/methylphenidate/ER: 90mg/day VYVANSE: 105mg/day</p>	AMPHETAMINES	
		LONG ACTING AMPHETAMINES		ADDERALL XR amphetamine salts combo XR dextroamphetamine CR caps VYVANSE CAPSULES**	ADZENYS XR ODT amphetamine ER suspension 1.25mg/ml DYANAVEL XR EVEKEO/ODT MYDAYIS PROCENTRA VYVANSE CHEWABLES ZENZEDI 2.5 AND 7.5MG TABLETS
		IMMEDIATE RELEASE AMPHETAMINES		amphetamine salts combo dextroamphetamine tablets	
		METHYLPHENIDATES		CONCERTA* dexmethylphenidate ER methylin ER methylphenidate ER tablets	METHYLPHENIDATES
		LONG ACTING METHYLPHENIDATES			ADHANSIA XR 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
		IMMEDIATE RELEASE METHYLPHENIDATES		dexmethylphenidate methylphenidate chewables methylphenidate solution methylphenidate tablets	
		SELECTIVE ALPHA-ADRENERGIC AGONIST			
		clonidine			clonidine ER
					To obtain the non-preferred agent , client must meet the following criteria: Client must have a diagnosis of ADD or ADHD Prior authorization will be required for clients under the age of 4. To receive clonidine ER, clients must have completed a 14 day trial of clonidine IR with benefit in the previous 12 months.

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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. Dosage limits apply: atomoxetine: 100mg/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. Nurtec will be limited to 16 tabs/30 days.	NURTEC
	STEP 1 AGENTS			
	beta blockers	divalproex topiramate		
	STEP 2 AGENTS		*Starting dose will be limited to 70mg **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.	QULIPTA**
	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 Quantity limits apply: 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 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. 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 8 tabs/30 days REYVOW: 200mg/day or 1 tab/day	REYVOW UBRELVY
	STEP 2 AGENTS			
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	MS AGENTS		Gilenya, Lemtrada, Ocrevus will be approved for highly active disease, please refer to the ATCC for additional information.	BAFIERTAM BRIUMVI
	AUBAGIO AVONEX BETASERON COPAXONE 20MG/ML* dimethyl fumarate REBIF VUMERITY	GILENYA LEMTRADA OCREVUS TYSABRI	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. For Mavenclad, in addition to the above criteria, approval will be granted on a case-by-case basis.	EXTAVIA glatiramer (BRAND IS PREFERRED) GLATOPA (use preferred agent) KESIMPTA MAVENCLAD MAYZENT PLEGRIDY PONVORY TECFIDERA ZEPOSIA
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*	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	SUNOSI WAKIX XYREM
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			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 imipramine (capsules) oxcarbazepine valproic acid
	amitriptyline desipramine imipramine (tablets) nortriptyline			

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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>
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.	ALAMAST ALOCRIL ALOMIDE bepotastine epinastine ketotifen ZERVIAE
	ALREX azelastine BEPREVE* cromolyn 0.4% olopatadine 0.1%, 0.2%		Emadine, Alomide, and Alocril will be approved for pregnancy. Alomide will be approved for children under the age of 3.	
	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 gatfloxacin IQUIX levofloxacin ZYMAXID
	ciprofloxacin BESIVANCE gentamycin moxifloxacin 0.5% ofloxacin tobramycin		Azasite will be approved for pregnancy.	
	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 loteprednol 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.	BETIMOL BETOPTIC S*
	betaxolol carteolol levobunolol metipranolol timolol		*Betoptic S will be approved for those with heart and lung conditions.	
	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* COSOPT* 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% tafluprost	
latanoprost TRAVATAN Z ZIOPTAN				
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.	EVENITY** FORTEO*** FOSAMAX-D ibandronate risedronate/DR TYMLOS***
	alendronate		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 ***Will be limited to 2 years of use	
	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.	darifenacin GELNIQUE GEL 10% GEMTESA OXYTROL DIS SANCTURA XR tolterodine/ER trospium
MYRBETRIQ oxybutynin /ER solifenacin TOVIAZ		Oxytrol will be approved for clients that have an inability to swallow.		

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PAIN	LONG-ACTING C-11s		<p>Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>C-11s and C-1Vs 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>**Nucynta ER will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CI narcotics.</p> <p>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</p> <p>Clients will be limited to one long-acting narcotic at a time</p>	<p>fentanyl patches hydrocodone ER hydromorphone ER HYSINGLA ER METHADONE morphine ER capsules (use preferred agents) NUCYNТА ER** oxymorphone ER OXYCONTIN XTAMPZA ER (additional criteria applies)</p>
	SHORT-ACTING C-11s		<p>Trial and failure of three (3) preferred agents greater than or equal to a 6 day supply in the last 90 days will be required before approval can be given for a non-preferred agent.</p> <p>*Nucynta will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CI narcotics.</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>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)</p> <p>Clients will be limited to one short-acting narcotic at a time</p>	<p>APADAZ levorphanol NUCYNТА* oxymorphone oxycodone/IBU ROXYBOND</p>
	C-III/C-V AGENTS		<p>BUTRANS 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>Quantity and dosage limits apply (max 8 tabs/day).</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	SHORT-ACTING AGENTS			
	LONG-ACTING AGENTS		<p>**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</p>	<p>APOKYN benztropine injectables GOCOVRI INBRIJA KYNMOBI ONGENTYS pramipexole ER XADAGO</p>
PHOSPHATE BINDERS	PHOSPHATE BINDERS		<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.	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.	
		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	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. Carisoprodol is limited to 84 tabs/365 days	carisoprodol chlorzoxazone cyclobenzaprine ER LYVISPAP metaxalone methocarbamol orphenadrine tizanidine capsules (<i>use preferred agent</i>)		
	baclofen (tablets) 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				