

**WYOMING MEDICAID
Preferred Drug List (PDL) - January 8, 2014**

Drug classes not included on this list are not managed through a Preferred Drug List (PDL).
HOWEVER, THIS EXCLUSION IS NOT A GUARANTEE OF PAYMENT OR COVERAGE. Dosage limits and other requirements may apply.
Drugs new to market are non-preferred until a clinical review has been completed. PA criteria will apply to both the pediatric population,
as well as the adult population for those plans where PA/PDL limits are allowed.

Unless otherwise noted on the PDL, generic substitution is mandatory.

Yellow highlighted items below indicate new changes to the PDL. Red font indicates quantity/dosage limits apply. *Indicates BRAND is Preferred. May Use DAW 5.
Contact the GHS PA Helpdesk @ 877-207-1126 for prior authorization if client has primary insurance that will not cover the brand name medication.

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dosage limits apply), Epocrates, 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 us for questions</small>
ADDITION AGENTS	BUPRENORPHINE COMBINATIONS		Client must have a diagnosis of opioid dependence or abuse. This is not to be used to for the treatment of chronic pain. Only one (1) narcotic prescription will be allowed between fills. Prescriber must have a XDEA number. Subutex will be approved for clients pregnant or nursing or with a documented allergy to naloxone. Dosage limits apply (Max Dose: 24mg/day). Client is limited to two (2) years of Suboxone or buprenorphine use. Please submit PA requests on the Suboxone and buprenorphine PA form available at wyequalitycare.org .	buprenorphine/naloxone tablets (use preferred) SUBUTEX
		SUBOXONE FILM ZUBSOLV		
ALLERGY / ASTHMA	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. Spiriva 5 day STARTER package will be allowed one (1) time per recipient.	ATROVENT HFA TUDORZA
	COMBIVENT ipratropium SPIRIVA			
	CORTICOSTEROID / BRONCHODILATOR COMBO'S		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. *Breo Ellipta will also require the diagnosis of COPD. Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.	BREO ELLIPTA*
	ADVAIR/HFA DULERA SYMBICORT			
	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 ZVFO
	montelukast			
	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.	ASTEPRO 0.15% azelastine (BRAND IS PREFERRED) DYMISTA (use separate agents) PATANASE
	ASTELIN*			
	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. Rhinocort will be approved for pregnancy.	DYMISTA (use separate agents) OMNARIS QNASL RHINOCORT triamcinolone VERAMYST ZETONNA
BECONASE AQ flunisolide fluticasone NASONEX				
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.	XOPENEX HFA	
PROAIR HFA PROVENTIL HFA VENTOLIN HFA				
SHORT ACTING BRONCHODILATORS - NEBULIZERS		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.	levalbuterol (BRAND IS PREFERRED)	
albuterol neb XOPENEX neb*				
STEROID INHALANTS		Trial and failure of three (3) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Alvesco will be approved for a history of oral thrush with steroid inhalants.	AEROBID/AEROBID-M ALVESCO ASMANEX PULMICORT SUSPENSION	
budesonide FLOVENT HFA/DISK PULMICORT FLEXHALER QVAR				
EPINEPHRINE			ADRENACLICK (use preferred) AUVI-Q (use preferred) epinephrine (use preferred)	
EPI-PEN				
ALZHEIMERS	ALZHEIMER AGENTS		Client must have a diagnosis of dementia.	donepezil 23mg (use preferred) donepezil ODT (use preferred) NAMENDA XR
		donepezil EXELON PATCH/SOLUTION galantamine/ER NAMENDA rivastigmine capsules		

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ANALGESICS	LONG-ACTING		<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>Fentanyl patches are limited to one patch every 72 hours.</p> <p>C-IIIs and C-IVs are not included and are available without prior authorization with the exception of Butrans (generic substitution is mandatory).</p> <p>**Butrans requires a trial of morphine sulfate or low dose trial of fentanyl patch.</p> <p>***Nucynta ER will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics.</p>	<p>AVINZA BUTRANS** EXALGO KADIAN (10mg/200mg) morphines sulfate ER capsules NUCYNTA ER*** OPANA ER (5mg/10mg/20mg/30mg/40mg) oxymorphone ER (7.5mg/15mg) OXYCONTIN/CR</p>
	SHORT-ACTING C-IIIs		<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>**In addition to above criteria, Embeda and Oxecta require a diagnosis of drug/substance abuse.</p> <p>***Nucynta will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics.</p>	<p>EMBEDA** levorphanol NUCYNTA*** OXECTA** oxymorphone oxycodone/IBU</p>
	C-III/C-V AGENTS		<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>**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</p>	<p>BUTRANS** CONZIP RYBIX ODT tramadol/apap tramadol ER</p>
	fentanyl patch morphine sulfate ER tablets			
codeine sulfate hydromorphone morphine sulfate oxycodone oxycodone/APAP oxycodone/ASA				
tramadol				
ANDROGENS	TESTOSTERONE TOPICAL GELS		<p>Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient testosterone production.</p> <p><i>Other testosterone dosage form products will require a diagnosis of hypogonadism or insufficient testosterone production (not outlined on PDL).</i></p>	<p>FORTESTA (use preferred) TESTIM GEL (use preferred)</p>
		ANDROGEL		
ANTIBIOTICS	QUINOLONES			<p>AVELOX FACTIVE NOROXIN PROQUIN</p>
	DOXYCYCLINE			<p>ADOXA (use preferred) DORYX (use preferred) ORACEA (use preferred)</p>
	MINOCYCLINE			SOLODYN (use preferred)
	INHAILED TOBRAMYCIN			<p>BETHKIS (use preferred) TOBI PODHALER (use preferred) inhaled tobramycin (BRAND IS PREFERRED)</p>
	TOBI*			
ANTICOAGULANTS	LOW MOLECULAR WEIGHT HEPARIN (LMWH)			<p>enoxaparin (BRAND IS PREFERRED) FRAGMIN (use preferred) LOVENOX 300MG/3ML (use preferred)</p>
	DIRECT THROMBIN INHIBITOR		<p>Client must have diagnosis of non-valvular atrial fibrillation and relative contraindication to warfarin for approval.</p>	
	SELECTIVE FACTOR XA INHIBITOR		<p>Client must have diagnosis of non-valvular atrial fibrillation.</p>	
	XARELTO		<p>Client must have diagnosis of non-valvular atrial fibrillation, deep vein thrombosis (DVT), pulmonary embolism (PE), reduction in risk of recurrence DVT or PE, or prophylaxis of deep vein thrombosis which can lead to pulmonary embolism in clients undergoing hip or knee replacement.</p>	
ANTICONVULSANTS	DIAZEPAM RECTAL GEL			diazepam gel (BRAND IS PREFERRED)
	DIASTAT*			
	LACOSAMIDE		<p>Client must have a diagnosis of partial onset seizures.</p>	
		VIMPAT		

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ANTIDEPRESSANTS	ANTIDEPRESSANTS		<p>Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks 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.</p> <p>Trazodone, buspirone, fluvoxamine, MAO inhibitors, TCA's, bupropion IR and venlafaxine IR do not require prior authorization but will not count towards meeting preferred therapy requirements.</p> <p>*Duloxetine will be approved for clients with a diagnosis of osteoarthritis of the knee or chronic low back pain.</p> <p>**Brintellix requires trial and failure of two preferred agents in any class</p> <p>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</p>		
	NORADRENERGIC/SPECIFIC SEROTONERICS (NaSS)				NaSS
	mirtazapine 15, 30, and 45mg				mirtazapine 7.5mg and rapid dissolve tablets (use preferred)
	NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)				NDRI
	bupropion ER/SR/XL				APLENZIN FORFIVO XL
	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)				SSRI
	citalopram escitalopram fluoxetine capsules paroxetine IR/CR sertraline				fluoxetine tablets (use preferred) VIIBRYD
SEROTONIN/NORPINEPHRINE REUPTAKE INHIBITORS (SNRI)			SNRI		
venlafaxine ER capsules			duloxetine* desvenlafaxine PRISTIQ venlafaxine ER tablets (use preferred)		
			OTHER		
			BRINTELLIX**		
ANTIHYPERTENSIVES	ACE INHIBITORS		<p>Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p>		
	benazepril captopril enalapril fosinopril lisinopril moexipril perindopril quinapril ramipril trandolapril				
	ACE INHIBITORS AND DIURETICS				
	benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ moexipril/HCTZ quinapril/HCTZ				
	ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)				
		BENICAR DIOVAN irbesartan losartan			candesartan EDARBI eprosartan 600mg MICARDIS TEVETEN 400mg
	ARBs AND DIURETICS				
	BENICAR HCT DIOVAN HCT irbesartan HCTZ losartan HCT		candesartan HCTZ EDARBYCLOR MICARDIS HCTZ TEVETEN HCTZ		
ALPHA-BLOCKERS					
CATAPRES PATCHES* clonidine			clonidine patch (BRAND IS PREFERRED) NEXICLON XR (use preferred)		
ANTIVIRALS	PROTEASE INHIBITORS				
	APTIVUS CRIXIVAN INVIRASE LEXIVA NORVIR tablets PREZISTA REYATAZ VIRACEPT			NORVIR capsules (use preferred) NORVIR solution (use preferred)	

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ANTIPSYCHOTICS	ATYPICAL ANTIPSYCHOTICS		<p>**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 GHS Pharmacy Help Desk for an override.</p> <p><i>Typical antipsychotics do <u>not</u> require prior authorization.</i></p> <p>Dosage limits apply: ABILIFY <13 years of age: 23mg/day ABILIFY ≥13 years of age: 45mg/day FANAPT: 36mg/day INVEGA: 18mg/day LATUDA: 240mg/day Risperidone ≤ 17 years of age: 5mg/day Risperidone > 17 years of age: 24mg/day SAPHRIS: 30mg/day Olanzapine < 13 years of age: 15mg/day Olanzapine > 13 years of age: 30mg/day Quetiapine <13 years of age: 600mg/day Quetiapine 13-17 years of age: 900mg/day Quetiapine > 17 years of age: 1200mg/day ziprasidone < 17 years of age: 180mg/day ziprasidone > 17 years of age: 300mg/day</p>	SEROQUEL XR (use preferred)		
	SPECIAL ATYPICAL ANTIPSYCHOTICS		Dosage limits apply: 1350mg/day			
CHOLESTEROL	BILE ACID SEQUESTRANT		<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Zetia monotherapy will require PA.</p> <p>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.</p>	WELCHOL		
	clozapine					
	BILE ACID SEQUESTRANT				cholestyramine/light colestipol	
	NIACIN				NIACOR NIASPAN	
	STATINS, LOW POTENCY				lovastatin pravastatin	ALTOPREV fluvastatin/ER
	STATINS, HIGH POTENCY				atorvastatin simvastatin	CRESTOR LIVALO LIVALO
	STATIN COMBINATIONS				CADUET* VYTORIN	ADVICOR (use separate agents) amlodipine/atorvastatin (BRAND IS PREFERRED) CHOLESTIN LIPTRUZET PRAVIGARD SIMCOR ZETIA* (use preferred)
TRIGLYCERIDE LOWERING AGENTS		fenofibrate gemfibrozil TRICOR	ANTARA fenofibric FENOGLIDE LOVAZA VASCEPA			

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CONTRACEPTIVES	<p align="center">ORAL CONTRACEPTIVES</p> altavera AMETHYST apri aviane balzia BREVICON* briellyn caziant cryselle emoquette enpresse errin ESTROSTEP FE* Femcon FE gildess FE jolessa jolivet junel/junel FE kelnor kurvelo lessina levora LOESTRIN 24 FE, 1/20-21, 1/20 FE LOSEASONIQUE low-ogestrel luter microgestin MIRCETTE* mononessa NECON 10/11-28 nora-be norgestrel/ethinyl estradiol NORINYL 1/50-28 OGESTREL orsythia ORTHO TRI-CYCLEN LO* ORTHO-NOVUM 1/35-28, 7/7/7-28* portia previfem reclipsen seasonale SEASONIQUE* sprintec sronyx trinessa TRI-NORINYL* tri-previfem trivora velivet YASMIN* YAZ* zenchent ZOVIA			amethia (BRAND IS PREFERRED) aranelle (BRAND IS PREFERRED) azurette (BRAND IS PREFERRED) BEYAZ (PA required) camila (use preferred) camrese (BRAND IS PREFERRED) cesia (use preferred) cyclafem (BRAND IS PREFERRED) GENERESS FE CHW (PA required) gianvi (BRAND IS PREFERRED) heather (use preferred) introvale (use preferred) kariva (BRAND IS PREFERRED) levonorgestrel/ethinyl estrad (91-Day) (use preferred) leena (BRAND IS PREFERRED) LO LOESTRIN (PA required) lorvna (BRAND IS PREFERRED) NATAZIA (PA required) necon 0.5/35, 1/35, 7/7/7 (BRAND IS PREFERRED) NECON 1/50 (use preferred) norethindrone/ethinyl estradiol chew (PA required) norethindrone (use preferred) NORINYL 1/35 (use preferred) nortrel (BRAND IS PREFERRED) ocella (BRAND IS PREFERRED) ORTHO-NOVUM 1/50 (use preferred) quassense (use preferred) SAFYRAL (PA required) syeda (BRAND IS PREFERRED) tilia FE (BRAND IS PREFERRED) tri-legest FE (BRAND IS PREFERRED) tri-lo-sprintec (BRAND IS PREFERRED) viorele (BRAND IS PREFERRED) zarah (BRAND IS PREFERRED) zenchent FE chewable (PA required) zeosa chewable (PA required)
CORTICOSTEROIDS	<p align="center">ORAL CORTICOSTEROIDS</p> budesonide cortisone acetate dexamethasone/intensol hydrocortisone methylprednisone prednisolone prednisone			CELESTONE (use preferred)
DIABETES	<p align="center">DIABETES AGENTS</p> <p align="center">BIGUANIDES</p> metformin/ER			FORTAMET (use preferred) GLUMETZA (use preferred) RIOMET (use preferred)
	<p align="center">α-GLUCOSIDASE INHIBITORS</p> acarbose		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	GLYSET
	<p align="center">MEGLITINIDES</p> STARLIX*		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	nateglinide (BRAND IS PREFERRED) repaglinide
	<p align="center">THIAZOLIDINEDIONES</p> pioglitazone		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ACTOSPLUS MET (use separate agents) AVANDIA AVANDAMET (use separate agents)
	<p align="center">SULFONYLUREAS</p> glimepiride/ER glipizide/ER glyburide/ER		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	
	<p align="center">DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITORS</p> JANUVIA ONGLYZA		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	NESINA TRADJENTA

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DIABETES <i>cont.</i>	DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITOR COMBO AGENTS		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent . A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	JANUMET XR JENTADUETO KAZANO OSENI	
		JANUMET JUVISYNC KOMBIGLYZE			
		INCRETIN MIMETICS (GLP-1 RECEPTOR AGONISTS)		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent . A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	BYDUREON VICTOZA
		BYETTA			
		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.	
		INVOKANA			
		INTERMEDIATE-ACTING INSULIN			
		HUMULIN N HUMULIN 70/30 NOVOLIN N NOVOLIN 70/30			
		LONG-ACTING INSULIN			LANTUS OPTICLIK (<i>use preferred</i>) LEVEMIR (<i>use preferred</i>)
		LANTUS SOLOSTAR LANTUS <u>via</u>			
		RAPID-ACTING INSULIN			
	APIDRA HUMALOG NOVOLOG				
	SHORT-ACTING INSULIN				
	HUMULIN R NOVOLIN R				
	DIABETIC METERS/TEST STRIPS		Quantity limit applies (1 meter/365days).	ALL OTHER METERS AND TEST STRIPS	
	FREESTYLE INSULINX FREESTYLE LITE FREESTYLE FREEDOM LITE ONE TOUCH ULTRA ONE TOUCH ULTRA 2 ONE TOUCH ULTRA MINI ONE TOUCH ULTRASMART PRECISION XTRA				
EAR	ANTIBIOTIC/STEROID COMBINATION			CIPRODEX (<i>use preferred</i>) ciprofloxacin 0.2% (<i>use preferred</i>) CIPRO HC (<i>use preferred</i>) COLY-MYCIN S (<i>use preferred</i>) CORTISPORIN-TC (<i>use preferred</i>) FLUOCINOLONE ACET OIL 0.01% (<i>use preferred</i>)	
		Neo/Poly/Hc Suspension and Solution Ofloxacin			
FIBROMYALGIA	FIBROMYALGIA STEP 1		Trial and failure of a Step 1 agent greater than or equal to six (6) weeks in the last 12 months is required for approval of a Step 2 agent.		
	amitriptyline cyclobenzaprine				
		SAVELLA			
	FIBROMYALGIA STEP 3		Trial and failure of a Step 1 agent and a Step 2 agent greater than or equal to six (6) weeks in the last 12 months is required for approval of a Step 3 agent.		
		duloxetine LYRICA			
GASTROINTESTINAL	DIGESTIVE ENZYMES		Prior authorization required.	PANCREAZE pancrelipase (BRAND IS PREFERRED) PERTZYE TRI-PASE ULTRESA VIOKASE	
	CREON 3000, 6000, 12000, 24000, and 36000 units ZENPEP*				
		PROTON PUMP INHIBITORS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Lansoprazole solutabs will be approved for children less than or equal to 8 years of age.	ACIPHEX SPRINKLES amox/clarith/lansoprazole pack (<i>use separate agents</i>) DEXILANT esomeprazole lansoprazole solutabs NEXIUM omeprazole 20.6mg capsules (<i>use preferred</i>) omeprazole tablets (<i>use preferred</i>) omeprazole/sodium bicarbonate OMECLAMOX (<i>use separate agents</i>) rabeprazole VIMOVO (<i>use separate agents</i>)
	lansoprazole capsules omeprazole capsules pantoprazole				
	MESALAMINE		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	APRISO ASACOL/HD CANASA LIALDA PENTASA 500MG (<i>use preferred</i>) ROWASA	
	mesalamine enema PENTASA 250MG ONLY				

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GROWTH HORMONE	GROWTH HORMONE		<p>PA is required for use outside of FDA-approved indications. Evaluation by an endocrinologist is preferred.</p> <p>Clinical evidence of improved growth will be required on a yearly basis to support ongoing utilization.</p> <p>Clinical evidence of need for growth hormone will be required for adult growth hormone deficiency and pediatric growth failure due to inadequate endogenous growth hormone.</p> <p>Trial and failure of two (2) preferred agents within the last 12 months will be required for the following indications:</p> <p>Pediatric: Growth failure due to inadequate endogenous growth hormone, Prader-Willi syndrome, children born small for gestation. Turner syndrome.</p> <p>Adult: Replacement for those with growth hormone deficiency.</p>	<p>NUTROPIN AQ OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE</p>
		<p>GENOTROPIN NORDITROPIN HUMATROPE</p>		
HEPATITIS C	INTERFERON		<p>Trial and failure of preferred agent greater than or equal to 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>Peg-Intron will be approved for pediatric patients (aged 18 and under), for retreatment, and for dosage adjustments that cannot be achieved with Pegasys.</p>	PEG-INTRON
	PEGASYS			
	PROTEASE INHIBITOR			
	INCIVEK VICTRELIS			
IMMUNOMODULATORS	IMMUNOMODULATORS		<p>Client must have diagnosis prior to approval for preferred agents (outlined below):</p> <p>Enbrel: Ankylosing Spondylitis (AS), Juvenile Idiopathic Arthritis (JIA), Plaque Psoriasis (PP), Psoriatic Arthritis (PA), Rheumatoid Arthritis (RA)**</p> <p>Humira: AS, Crohn's, JIA, PP, PA, Ulcerative Colitis (UC), RA**</p> <p>Simponi: AS, PA, RA**</p> <p>**56-day trial and failure of methotrexate required prior to approval of Enbrel, Humira, or Simponi for diagnosis of Rheumatoid Arthritis (RA)</p> <p>For non-preferred agents, 56-day trial and failure of a preferred agent is required and client must have diagnosis prior to approval (outlined below):</p> <p>Actemra: RA (60-day trial of methotrexate is required)</p> <p>Amevive: PP</p> <p>Cimzia: AS, PA, Crohn's, RA</p> <p>Kineret: RA</p> <p>Orenzia: JIA, RA</p> <p>Remicade: AS, Crohn's, PP, PA, RA, UC</p> <p>Rituxan: RA</p> <p>Stelara: PP</p> <p>Tysabri: Crohn's (additional PA criteria applies)</p>	<p>ACTEMRA AMEVIVE CIMZIA KINERET ORENCIA RAPTIVA REMICADE RITUXAN STELARA TYSABRI (additional criteria applies)</p>
		<p>ENBREL HUMIRA SIMPONI</p>		
INSOMNIA	NON-BENZODIAZEPINES		<p>Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.</p> <p>Prior authorization will be required for clients under the age of 18.</p> <p>Rozerem is non-preferred without a history of substance abuse</p> <p>Dosage limits apply: zaleplon: 30mg/day zolpidem: 15mg/day</p>	<p>EDLUAR (additional criteria applies) INTERMEZZO (additional criteria applies) ROZEREM zolpidem ER ZOLPIMIST (additional criteria applies)</p>
	zaleplon zolpidem			
MIGRAINE	TRIPTANS		<p>Trial and failure of all preferred agents will be required for approval of a non-preferred agent.</p> <p>Quantity limits apply: naratriptan 1mg: 25 tabs/34 days naratriptan 2.5mg: 10 tabs/34 days sumatriptan kit: 3 kits/34 days sumatriptan vials: 2 vials/34 days sumatriptan nasal: 6 bottles/34 days sumatriptan 25mg: 41 tabs/34 days sumatriptan 50mg: 20 tabs/34 days sumatriptan 100mg: 10 tabs/34 days</p>	<p>AXERT FROVA RELPAX rizatriptan TREMIMET zolmitriptan</p>
	naratriptan sumatriptan			
MULTIPLE SCLEROSIS	IMMUNOMODULATOR (GLATIRAMER INJECTION)		<p>Trial and failure of a preferred interferon agent AND failure of Copaxone before approval can be give for a non-preferred agent.</p> <p>For Tysabri, in addition to the above criteria, additional prior authorization criteria applies.</p>	<p>AUBAGIO EXTAVIA BETASERON GILENYA TECFIDERA TYSABRI (additional criteria applies)</p>
	COPAXONE			
	INTERFERON			
	AVONEX REBIF			

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>EPICRATES IS NOT FOR MEDICATIONS PLEASE CONTACT WMS FOR QUESTIONS</small>
NEUROPATHIC PAIN	TRICYCLIC ANTIDEPRESSANTS		For the diagnosis of neuropathic pain, trial and failure of a tricyclic antidepressant greater than or equal to a 12 week supply AND trial and failure of gabapentin at a dose of 3600mg per day for greater than or equal to a 12 week supply in the last 12 months will be required before approval can be given for a non-preferred agent.	duloxetine
		amitriptyline imipramine nortriptyline		LYRICA
	GABAPENTIN			
		gabapentin		
NSAIDS	NSAIDs		Trial and failure of two (2) preferred agents each greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Dosing and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets).	CALDOLOR CAMBIA POWDER CELEBREX diclofenac 3% gel (additional criteria applies) FLECTOR (additional criteria applies) mefenamic acid NAPRELAN NEOPROFEN PENNSAID (additional criteria applies) SPRIX (additional criteria applies) VOLTAREN (additional criteria applies) ZIPSOR ZORVOLEX
	diclofenac etodolac fenoprofen flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclizolam meloxicam nabumetone naproxen oxaprozin sulindac tolmetin			
OPHTHALMICS	OP. -ANTI-ALLERGICS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Emadine, Alomide, and Alocril will be approved for pregnancy. Alomide will be approved for children under the age of 3.	ALAMAST ALOCRIL ALOMIDE ALREX azelastine (BRAND IS PREFERRED) BEPREVE ELESTAT EMADINE ketotifen LASTACAPT
	cromolyn OPTIVAR* PATADAY PATANOL			
	OP. -ANTIBIOTICS- QUINOLONES		Trial and failure of a preferred agent greater than or equal to 5 days in the last 12 months will be required before approval can be given for a non-preferred agent. Azasite will be approved for pregnancy.	AZASITE BESIVANCE gatifloxacin IQUIX levofloxacin ZYMAR
	ciprofloxacin ofloxacin MOXEZA VIGAMOX			
	OP. -ANTI-INFLAMMATORY- NSAIDS		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) ACUVAIL BROMDAY bromfenac NEVANAC
	flurbiprofen diclofenac ketorolac			
	OP. -BETA-BLOCKERS		Trial and failure of three (3) preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Betoptic S will be approved for those with heart and lung conditions.	BETIMOL BETOPTIC S ISTALOL
	betaxolol carteolol levobunolol metipranolol timolol			
	OP. -CARBONIC ANHYDRASE INHIBITOR		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	AZOPT
	dorzolamide			
OP. - COMBO PRODUCTS		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.		
COMBIGAN dorzolamide/timolol SIMBRINZA				
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.	LUMIGAN ZIOPTAN	
latanoprost TRAVATAN Z				
OP. -SYMPATHOMIMETICS		Trial of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	ALPHAGAN P 0.1% brimonidine 0.15% (BRAND IS PREFERRED) COMBIGAN (use separate agents)	
ALPHAGAN P 0.15%* brimonidine 0.2%				
OSTEOPOROSIS	BISPHOSPHONATES		Trial and failure of a preferred agent greater than or equal to 12 months will be required before approval can be given for a non-preferred agent. Fosamax liquid will be approved for clients that have difficulty swallowing.	ACTONEL ATELVIA FOSAMAX-D ibandronate
	alendronate			
	NASAL CALCITONIN			
	calcitonin-salmon fortical			
OVERACTIVE BLADDER	OVERACTIVE BLADDER AGENTS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Oxytrol will be approved for clients that have an inability to swallow.	DETROL LA ENABLEX GELNIQUE GEL 10% MYRBETRIQ OXYTROL DIS SANCTURA XR tolterodine trospium
	oxybutynin /ER TOVIAZ VESICARE			
PHOSPHATE BINDERS	PHOSPHATE BINDERS		Prior authorization required for non-preferred agents.	calcium acetate <u>caps</u> (BRAND IS PREFERRED) FOSRENOL RENVELA
	calcium acetate <u>capsules</u> ELIPHOS* PHOSLYRA RENAGEL			

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PLATELET AGGREGATE INHIBITORS	THIENOPYRIDINE DERIVATIVES		Prior authorization required for clients on antiplatelet therapy greater than one (1) year.	
	clopidogrel EFFIENT ticlopidine			
	CYCLOPENTYLTRIAZOLOPYRIMIDINE (CPTP) Derivatives		Client must have diagnosis of acute coronary syndrome to reduce thrombotic cardiovascular events.	
		BRILINTA		
PROGESTIN	PROGESTIN		Prior authorization is required.	
		MAKENA		
PROSTATE	5-ALPHA-REDUCTASE INHIBITORS		Trial and failure of a preferred agent greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	AVODART JALYN (use separate agents)
	finasteride			
	ALPHA BLOCKERS		Trial and failure of a preferred agent greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	alfuzosin JALYN (use separate agents) RAPAFLO
doxazosin tamsulosin terazosin				
PULMONARY ANTIHYPERTENSIVES	5-ALPHA-REDUCTASE INHIBITORS		Client must have a diagnosis of pulmonary hypertension.	
		ADCIRCA 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		
SOLUBLE GUANYLATE CYCLASE STIMULATORS		Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.		
	ADEMPAS			
RESTLESS LEG SYNDROME	RESTLESS LEG SYNDROME		Client must have a diagnosis of Restless Leg Syndrome (RLS). Trial and failure of gabapentin greater than or equal to 60 days and a trial and failure of a dopamine agonist greater than or equal to 60 days in the last 12 months will be required before approval can be given for a non-preferred agent. *Neupro will be approved for clients with difficulty swallowing or for clients with a diagnosis of Parkinson's Disease.	HORIZANT NEUPRO*
		gabapentin pramipexole ropinirole		
SKELETAL MUSCLE RELAXANTS	MUSCLE RELAXANTS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months, along with a medical diagnosis of muscle spasticity will be required before approval can be given for a non-preferred agent. Cyclobenzaprine will require a prior authorization for clients concurrently taking a tricyclic antidepressant.	carisoprodol chlorzoxazone cyclobenzaprine ER metaxalone methocarbamol orphenadrine tizanidine capsules (use preferred) Carisoprodol is limited to 84 tabs/365 days.
	baclofen cyclobenzaprine tizanidine tablets			
STIMULANT	AMPHETAMINES		Clients must have a diagnosis for ADD, ADHD, narcolepsy, obstructive sleep apnea, shift work sleep disturbance, MS fatigue (see MS Fatigue criteria below), or refractory depression (see refractory depression criteria below). Diagnosis of MS fatigue will require a fatigue severity scale score of 5.0, a 60-day trial of amantadine and discontinuation of medications that may contribute to drowsiness and fatigue. Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant. Prior Authorization will be required for clients under the age of 4. Claims will require Prior Authorization if clients have a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use. Trial and failure of two (2) preferred agents (each from a different class: methylphenidate and amphetamine) greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Dosage limits apply: ADDERALL XR: 60mg/day amphetamine salts combo: 60mg/day amphetamine salts combo (narcolepsy): 90mg/day CONCERTA: 135mg/day DAYTRANA: 45mg/9 hour patch dextroamphetamine: 90mg/day dextroamphetamine CR: 90mg/day dexmethylphenidate: 30mg/day FOCALIN XR < 13 years of age: 45mg/day FOCALIN XR > 13 years of age: 60mg/day methylin/methylphenidate: 135mg/day methylin/methylphenidate ER/CR/SR: 135mg/day VYVANSE: 105mg/day	AMPHETAMINES: dextroamphetamine CR capsules (BRAND IS PREFERRED) ZENZEDI 2.5 AND 7.5MG TABLETS METHYLPHENIDATES: methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA) QUILLIVANT XR SUSPENSION
	LONG ACTING AMPHETAMINES			
		amphetamine salts combo XR DEXEDRINE CAPSULES* VYVANSE		
	IMMEDIATE RELEASE AMPHETAMINES			
		amphetamine salts combo* dextroamphetamine tablets		
	METHYLPHENIDATES			
		DAYTRANA FOCALIN XR methylin ER methylphenidate ER/CR/SA/SR tablets		
	IMMEDIATE RELEASE METHYLPHENIDATES			
		dexmethylphenidate methylin tablets methylphenidate		

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STIMULANT-LIKE AGENTS	SELECTIVE ALPHA-ADRENERGIC AGONIST CLONIDINE AGENTS		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. Clients must have completed a 14 day trial of clonidine IR with <u>benefit</u> in the previous 12 months.	KAPVAY
	GUANFACINE AGENTS		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 require for clients under the age of 4. Clients must have a trial and failure of a stimulant greater than or equal to a 14 day supply OR a trial and failure of Strattera greater than or equal to a 30 day supply AND a 14 day trial of guanfacine with <u>benefit</u> in the previous 12 months, OR a contraindication to ADHD medications (including stimulant and non-stimulant), OR a TIC disorder associated with stimulants (trial of stimulant required).	INTUNIV
	SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR STRATTERA		Clients must have a diagnosis for ADD, ADHD, narcolepsy, obstructive sleep apnea, shift work sleep disturbance, MS fatigue (see MS Fatigue criteria below), or refractory depression (see refractory depression criteria below). Diagnosis of MS fatigue will require a fatigue severity scale score of 5.0, a 60-day trial of amantadine and discontinuation of medications that may contribute to drowsiness and fatigue. Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant. Prior Authorization will be required for clients under the age of 5. 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. Strattera is limited to 1 tablet/day; unless the dose is greater than 40mg/day or unable to achieve a prescribed dose with 1 tablet. <small>Dosage limits apply: - STRATTERA: 150mg/day</small>	

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TOPICAL AGENTS	IMPETIGO ANTIBIOTICS		Trial and failure of ALL preferred agents greater than or equal to 7 days in the past 90 days. Use smallest size appropriate for 7 day trial.	ALTABAX
	gentamicin mupirocin			
	BENZOYL PEROXIDE/CLINDAMYCIN COMBOS		Clients must be 12 to 20 years of age and have a diagnosis of acne vulgaris. Requires prior authorization for clients less than 12 years of age. Acne combinations are limited to clients under the age of 21.	ACANYA benzoyl peroxide/clindamycin (BRAND IS PREFERRED)
		BENZACLIN* clindamycin/benzoyl peroxide 1.2 (1)-5% (Refrig)		
	CORTICOSTEROIS <small>C-CREAM; G-GEEL; L-LOTION; O-OINTMENT</small>		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	PANDEL
	LOW POTENCY			
	alclometasone desonide fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) prednicarbate			
	MEDIUM POTENCY		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	CLODERM CORDRAN/SP TOPICORT LP TRIANEX
	betamethasone valerate desoximetasone 0.05% (C) fluocinolone 0.025% fluticasone 0.05% (C) hydrocortisone butyrate 0.1% (O) hydrocortisone probutate 0.1% (C) mometasone triamcinolone 0.025%, 0.1%			
	HIGH POTENCY		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	APEXICON HALOG
	amcinonide betamethasone dipropionate clobetasol desoximetasone 0.25%, 0.05% (G) diflorasone fluocinonide flurandrenolide fluticasone 0.005% (O) halobetasol triamcinolone 0.5%			
	IMMUNOMODULATORS		Trial and failure of a preferred medium potency topical corticosteroid greater than or equal to a 21 day trial and a trial and failure of a preferred high potency topical corticosteroid greater than or equal to a 21 day trial in the last 90 days. For clients less than two (2) years of age, a trial and failure of a preferred low potency corticosteroid greater than or equal to a 21 day trial and a trial and failure of a preferred medium potency topical corticosteroid greater than or equal to a 21 day trial in the last 90 days.	
	ELIDEL PROTOPIC			
SALICYLIC ACID			All other topical salicylic acid formulations.	
aliclen shampoo 6% salacyn cream/lotion 6% Salicylic Acid Shampoo 6%				
SCABICIDES/PEDICULICIDES		Trial and failure of a preferred agent in the last 12 months.	OVIDE permethrin cream SKLICE ULESFIA	
LINDANE NATROBA permethrin solution				
UREA			All other topical urea formulations.	
Kerafoam Aerosol 30% Remeven Cream 50% urea hydration aerosol 35% urea emulsion 50% urea nail suspension 40% urea suspension 50% X-Viate Cream 40%				