Wyoming
Department
of Health

Division of Healthcare Financing

Medicaid Pharmacy News

Dear Providers: December 19, 2019

PREFERRED DRUG LIST (PDL) CHANGES (Effective 01/01/2020)

Please refer to www.wymedicaid.org for the complete PDL.

THERAPEUTIC CATEGORY	PREFERRED DRUG LIST CHANGES
ALLERGY/ASTHMA Anticholinergic Bronchodilators	Spiriva Respimat will be preferred ***Tudorza will be non-preferred**
ALLERGY/ASTHMA Anticholinergic Combination Agents	Anoro Ellipta, Bevespi, Combivent and Utibron will be preferred ***Stiolto and Trelegy will be non-preferred**
ALLERGY/ASTHMA Short-Acting Bronchodilators – Inhalers	ProAir Respiclick will be preferred ***ProAir Digihaler and Ventolin HFA will be non-preferred**
ALLERGY/ASTHMA Steroid Combination Agents	Advair Disk, Advair HFA, Dulera and Symbicort will be preferred ***Breo Ellipta, fluticasone/salmeterol 55-14/113-14/232-14, fluticasone salmeterol 100-50/250-50/500-50 and Wixela will be non-preferred**
ARTHRITIS Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis	***All non-preferred agents will require trial and failure of both preferred agents**
CONVULSIONS	Diazepam gel will be preferred Preferred agents are limited to FDA approved indications ***Aptiom, Briviact, clobazam, Diacomit, Epidiolex, Oxtellar, and Trokendi XR are non-preferred- see Additional Therapeutic Criteria chart for further information**
DERMATOLOGY Plaque Psoriasis	***All non-preferred agents will require trial and failure of both preferred agents**
DERMATOLOGY Scabicides/Pediculocides	Vanalice will be preferred
DIABETES Incretin Mimetics & Long-Acting Insulin	***Soliqua and Xultophy are non-preferred (use separate preferred agents)**
FIBROMYALGIA	***Pregabalin will be non-preferred**
GASTROINTESTINAL Chronic Idiopathic Constipation	***Motegrity will be non-preferred**

THERAPEUTIC CATEGORY	PREFERRED DRUG LIST CHANGES
GASTROINTESTINAL Mesalamine	Apriso, Asacol HD and mesalamine 400 mg DR capsule will be preferred ***Mesalamine DR 800 mg tablets and ER 0.375 capsules will be non-preferred (brand is preferred)**
GASTROINTESTINAL Irritable Bowel Syndrome with Constipation	***Trulance will be non-preferred**
HEMATOLOGY Antihemophilic Factor VIII	Hemlibra and Jivi will be preferred
HEMATOLOGY Coagulation Factor IX	Alphanine SD, Alprolix, Benefix, Idelvion, Ixinity, Mononine, Rebinyn, and Rixubis will be preferred
HEMATOLOGY Antihemophilic Factory/VWF	Vonvendi will be preferred
HEMATOLOGY Erythropoiesis Stimulating Agents	Epogen, Mircera and Retacrit will be preferred ***Aranesp and Procrit will be non-preferred**
HEPATITIS C	***Harvoni will be non-preferred**
HORMONES Testosterone Topical Agents	Testim Gel will require prior authorization, but will be preferred ***Androderm, Fortesta, Striant, Testorel and testosterone solution will be non-preferred**
INFECTIOUS DISEASE Anti-retrovirals	Delstrigo, Dovato, Juluca, Tivicay and Triumeq will be preferred Desocvy and Truvada will be preferred, but require clinical criteria (see Additional Therapeutic Criteria Chart for specific requirements)
MENTAL HEALTH Alzheimer Agents	***Rivastigmine capsules/patches will be non-preferred**
MENTAL HEALTH Serotonin/Norepinephrine Reuptake Inhibitors	***Drizalma will be non-preferred**
MENTAL HEALTH Atypical Antipsychotics	Dosage limits apply- please see Preferred Drug List for details ***Abilify Maintena and Nuplazid will be non-preferred**
MENTAL HEALTH Long Acting Methylphenidates	Quillichew ER and Quillivant XR will be preferred for clients under the age of 17 years ***Daytrana will be non-preferred**
MIGRAINE Step 2 Agents	Emgality will be preferred, but will require step therapy ***Ajovy will be non-preferred**
MIGRAINE Triptans	***Tosymra will be non-preferred**
MULTIPLE SCLEROSIS Immunomodulator and Interferon	Aubagio will be preferred ***Glotopa and Mayzent will be non-preferred**
NEUROPATHIC PAIN	***Pregabalin will be non-preferred**
OPHTHALMICS Quinolones	Moxifloxacin 0.5% will be preferred
OPHTHALMICS Anti-inflammatory Agents	Nevanac will be preferred
OSTEOPOROSIS Bisphosphonates	***Risedronate/DR will be non-preferred**
PULMONARY ANTIHYPERTENSIVES 5-Alpha-Reductase Inhibitors	Alyq and tadalafil will be preferred and will require diagnosis verification prior to being allowed

ADDITIONAL THERAPEUTIC CRITERIA CHART (ATCC) CHANGES (Effective 01/01/2020)

- Descovy will be covered for a diagnosis of HIV/AIDS. For prophylaxis treatment, additional criteria must be met.
- Katerzia will be limited to clients between the ages of 6 and 18 years.
- Praluent and Repatha will require a diagnosis of homozygous familial hypercholesterolemia, heterozygous familial hypercholesterolemia or atherosclerotic cardiovascular disease AND not at goal with a maximum dose statin or intolerant to statin therapy.
- All anti-psychotic agents will now be limited to 100% of the FDA maximum dose including injectables.
- Savella will be limited to 200mg per day.

NUTRITIONAL PRODUCTS AND INCONTINENCE PRODUCTS

Effective January 1, 2020, nutritional products such as Ensure and Pediasure, as well incontinence supplies such as diapers, pads, and inserts, will no longer be covered through the Wyoming Medicaid Pharmacy point-of-sale. **These products will continue to be covered, in accordance with Wyoming Medicaid DME policy, when billed by DME providers through the medical billing system.** Infant formula claims submitted through the Medicaid Pharmacy point-of-sale system will continue to be covered for members eligible for infant formula coverage. For questions regarding this new policy, please contact the Change Healthcare pharmacy help desk at 877-209-1264.