

WYOMING MEDICAID
Preferred Drug List (PDL) January 1, 2026

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/dose limits apply. *Indicates BRAND is Preferred. May Use DAW 5.

Contact the OptumRx 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/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS
				GENERIC MANDATORY POLICY APPLIES
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.	buprenorphine (oral) buprenorphine/naloxone film BRAND IS PREFERRED ZUBSOLV
		buprenorphine/naloxone tablets SUBLOCATE SUBOXONE FILM*	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 .	
	NALOXONE		Kloxxado, naloxone nasal spray 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.	OPVEE REXTOVY
	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. *Topiramate requires 4 week trial and failure of naltrexone or acamprosate in AUD	topiramate*
	VIVITROL	naltrexone		
	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 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.	
	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. <i>Spiriva 5 day STARTER package will be allowed one (1) time per recipient.</i>	TIOTROPIUM BROM (use brand) TUDORZA YUPERI
ALLERGY / ASTHMA / COPD	ATROVENT HFA INCURSE 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 DUAKLIR
	ANORO ELLIPTA** BREZTRI COMBIVENT STILOTO TRELEGY			
	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.	BROVANA
	arformoterol SEREVENT STRIVERDI			
	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.	DYMISTA (use separate agents) olopatadine 0.6% RYATRIS
	azelastine 0.1%			
	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.	DYMISTA (use separate agents) OMNARIS QNASL XHANCE
	budesonide flunisolide fluticasone mometasone			
	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.	AIRSUPRA levalbuterol (BRAND IS PREFERRED)
	albuterol HFA PROAIR RESPICLICK VENTOLIN HFA XOPENEX 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. *Fluticasone HFA and Asmanex HFA will be approved for pediatric clients 8 years of age or younger. Alvesco will be approved for a history of oral thrush with steroid inhalants.	AIRDUO DIGIHALER ALVESCO ASMANEX HFA* fluticasone HFA* QVAR REDIHALER
	ARNUITY ELLIPTA ASMANEX TWISTHALER budesonide suspension PULMICORT FLEXHALER			
	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. <i>Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.</i>	BREYNA fluticasone/vilanterol (use preferred agent) fluticasone/salmeterol 55-14/113-14/232-14 fluticasone/salmeterol 100-50/250-50/500-50 (BRAND IS PREFERRED) WIXELA
	ADVAIR (HFA, Diskus) BREO ELLIPTA** DULERA SYMBICORT* TRELEGY			
	EPINEPHRINE			NEFFY
	AUVI-Q (use preferred agent) epinephrine auto-injector pen EPI-PEN			
	EOSINOPHILIC ASTHMA AGENTS		Approval for these agents will require additional clinical criteria which can be found on the Additional Therapeutic Criteria Chart.	FASENRA NUCALA TEZSPIRE
	DUPIXENT XOLAIR			

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS		
				GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT OptumRx WITH ANY QUESTIONS		
ARTHRITIS	IMMUNOMODULATORS					
	ANKYLOSING SPONDYLITIS (AS)					
		adalimumab-fkjp ENBREL HADLIMA HUMIRA RINVOQ TALTZ	Client must have diagnosis of AS prior to approval of a preferred agent. To receive a non-preferred agent, client must have diagnosis of AS and 56-day trial and failure of two 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 XELIANZ/XR		
	JUVENILE IDIOPATHIC ARTHRITIS (JIA)					
		adalimumab-fkjp ENBREL HADLIMA 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 ILARIS ORENCIA XELIANZ/XR		
	PSORIATIC ARTHRITIS (PA)					
		adalimumab-fkjp HADLIMA HUMIRA OTEZLA* RINVOQ TALTZ ZORYVE	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 preferred agents.	CIMZIA** COSENTYX ORENCIA REMICADE SIMPONI SKYRIZI STELARA TREMFYA XELIANZ/XR		
	RHEUMATOID ARTHRITIS (RA)					
		adalimumab-fkjp HADLIMA ENBREL HUMIRA RINVOQ	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 two preferred agents.	ACTEMRA CIMZIA* KEVZARA KINERET OLUMIANT ORENCIA REMICADE RITUXAN SIMPONI XELIANZ/XR		
	*OTEZLA					
			*Otezla starter pack is non-preferred **Cimzia will be allowed for clients that are pregnant or breast-feeding			
	**See Dermatology criteria for Atopic Dermatitis approval					
CONVULSIONS	INTERMITTENT, STEREOTYPIC SEIZURE EPISODES					
		diazepam gel NAYZILAM* VALTOCO	*Nayzilam will be allowed for patients 12 years of age and older			
CROHN'S	ORAL ANTICONVULSANTS					
		carbamazepine divalproex FELBAMATE foshenvotoin lacosamide (tablets) lamotrigine/XR levetiracetam oxcarbazepine phenytoin subvenite valproate/valproic acid VIMPAT (suspension) zonisamide	Preferred agents with clinical criteria 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 . *Pregabalin will also be allowed for diagnoses of restless leg syndrome or anxiety **Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	APTIOM BRIVIACT clobazam** DIACOMIT** FINTEPLA** levetiracetam ER OXTELLAR TROKENDI XR XCOPRI VIMPAT (tablets) zonisamide oral susp.		
	IMMUNOMODULATORS					
		adalimumab-fkjp HADLIMA HUMIRA RINVOQ ZORYVE	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 a preferred agent. * Refer to Additional Therapeutics Clinical Criteria Chart for more info **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** ENTYVIO* REMICADE SKYRIZI STELARA TREMFYA TYSABRI (additional criteria applies)		
	BENZOYL PEROXIDE/CLINDAMYCIN COMBOS					
		clindamycin/benzoyl peroxide 1-5% clindamycin/benzoyl peroxide 1.2-5% (Refrig)	Clients must be 12 to 20 years of age. Requires prior authorization for clients less than 12 years of age. Acne combinations are limited to clients under the age of 21.			
	ISOTRETINOIN					
		AMINESTEEM CLARAVIS isotretinoin ZENATANE	Clients must be 12 to 20 years of age.	ABSORICA		
	CORTICOSTEROIDS - STEP 1 AGENTS C=CREAM; G=GEL; L=LOTION; O=OINTMENT; S=SOLUTION					
	LOW POTENCY					
		alclometasone desonide* fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O)	Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days. *Cream, ointment, and lotion formulations of desonide are preferred.	TEXACORT 2.5% (S)		
DERMATOLOGY	MEDIUM POTENCY					
		betamethasone valerate desoximetasone 0.05%, 0.25% (C) fluocinolone 0.025% flurandrenol fluticasone 0.05% (C) mometasone SYNALAR 0.025% (C, O) triamcinolone 0.025%, 0.1%, 0.05%	Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	Clocortolone Pivalate fluticasone 0.05% (L) hydrocortisone butyrate 0.1% (O)		
	HIGH POTENCY					
		betamethasone dipropionate clobetasol/E 0.05% (C,G,O,S) diflorasone 0.05% (O) fluocinonide flurandrenolide fluticasone 0.005% (O) halobetasol TOPICORT 0.025% (C) triamcinolone 0.5% ULTRAVATE 0.05% (C,O)	Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	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% (C) fluocinonide 0.1% (C) halcinonide 0.1% (C)		
	IMMUNOMODULATORS - STEP 2 AGENTS					
		tacrolimus	To receive a step 2 agent: Trial and failure of a preferred medium or high potency topical corticosteroid greater than or equal to a 21 day trial in the last 90 days.	HYFTOR pimecrolimus		
	PHOSPHODIESTERASE 4 INHIBITOR - STEP 3 AGENT					
		ZORYVE	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.			
	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		

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				GENERIC MANDATORY POLICY APPLIES	
DERMATOLOGY (continued)	ALOPECIA AREATA		Non-preferred agents require 90-day trial and failure of a high potency steroid as well as a documented SALT score of >50%.	UTFULO OLUMIANT	
	ATOPIC DERMATITIS		Dupixent requires member be at least 6 months of age or older, Adbry requires member be at least 12 years of age or older. No high-potency steroid trial will be necessary. For clients with >20% BSA, no immunomodulator trial and failure will be necessary for preferred agent(s).	ADBRY CIBINQO** NEMULIVIO OPZELURA** ZORYVE	
	EBELYS DUPIXENT* RINVOQ		**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.		
	PLAQUE PSORIASIS (PP)		Client must have diagnosis of PP prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of PP and a 56-day trial and failure of two of the preferred agents.	CIMZIA** COSENTYX ILUMYA REMICADE SKYRIZI STELARA TREMIFYA	
	adalimumab-fkip ENBREL HADUMA HUMIRA OTEZLA SOTYKTU* TALTZ ZORVYE***		*Sotykta 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 ***Zoryve will be allowed for PP after a 21-day trial and failure of a high-potency corticosteroid OR a mild-potency corticosteroid if using in intertriginous areas.		
	SCABICIDES/PEDICULICIDES		Trial and failure of a preferred agent in the last 12 months.	NATROBA spinosad (BRAND IS PREFERRED)	
	malathion lotion permethrin VANALICE				
	VITILIGO		Non-preferred agents require 90-day trial and failure of a medium or high potency steroid.	OPZELURA	
	DIABETES AGENTS			metformin SR 24H osm (use preferred agent) metformin SR 24H mod (use preferred agent)	
	BIGUANIDES				
DIABETES	metformin/ER				
	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.	ACTOPLUS MET (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 and failure of the preferred agent is required before approval can be given for a non-preferred agent.	alogliptin GLYXAMBI (use separate preferred agents) STEGLUJAN (use separate preferred agents)	
	JANUVIA ONGLYZA TRADJENTA				
	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 XR saxagliptin/metformin (BRAND IS PREFERRED) sitagliptin/metformin (BRAND IS PREFERRED)	
	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. Dosage Limits Apply: Ozempic: 2mg/week Victoza: 1.8mg/day	liraglutide (use brand) MOUNJARO OZEMPIC* SOLIQUA XULTOPHY (use separate preferred agents)	
	exenatide RYBELSUS TRULICITY 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) INVOKAMET INVOKANA SEGUROMET (use separate preferred agents) STEGLUJAN (use separate preferred agents) SYNJARDY XR (use separate preferred agents) TRIJARDY XR (use separate preferred agents)	
	FARXIGA JARDIANCE SYNJARDY XIGDUO XR				
	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) LYUMJEV	
	HUMALOG HUMALOG 75/25 HUMALOG JR. HUMALOG MIX NOVLOG 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 Glargin (use preferred agent) Insulin Degludec SOLIQUA TOUJEO (use preferred agent) TRESIBA* (use preferred agent) XULTOPHY (use separate preferred agents)	
	LANTUS SOLOSTAR* LANTUS vial				
CONTINUOUS BLOOD GLUCOSE MONITORS	DIABETIC METERS/TEST STRIPS		Quantity limits apply: Insulin Dependent Clients: 10 strips/day Non-Insulin Dependent Clients: 4 strips/day	ALL OTHER METERS AND TEST STRIPS	
	ACCU-CHEK GUIDE/STRIPS ACCU-CHEK GUIDE ME FREESTYLE (strips only) FREESTYLE FREEDOM FREESTYLE FREEDOM LITE FREESTYLE INSULINK FREESTYLE PRECISION NEO B FREESTYLE SIDEKICK II PRECISION XTRA		Clients are limited to 1 meter/365 days	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	
	EXTERNAL DIABETIC DEVICES			OMNIPOD GO	
	OMNIPOD DASH OMNIPOD 5 OMNIPOD G5 FSL 2 PLUS G6				
	DEXCOM G6 DEXCOM G7 FREESTYLE LIBRE FREESTYLE LIBRE 2 FREESTYLE LIBRE 3/PLUS				
	ACUTE HYPOGLYCEMIA AGENTS		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	
	BAGSIMI ZEGALOGUE (autoinjector)			GVOKE (use preferred agent)	

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FIBROMYALGIA	FIBROMYALGIA		Trial and failure of a preferred agent greater than or equal to six (6) weeks in the last 12 months is required prior to approval of a non-preferred agent Clients will not be allowed to take gabapentin and pregabalin concurrently	pregabalin SAVELLA tablets (savella titration pak will not be covered)
GASTROINTESTINAL	BOWEL EVACUANTS			SUTAB
	CHRONIC IDIOPATHIC CONSTIPATION	LINZESS lubiprostone	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
	DIGESTIVE ENZYMES	PERTZYE*	Prior authorization required. *Pertzye will be preferred for members diagnosed with cystic fibrosis.	VIOKACE
	IRRITABLE BOWEL SYNDROME WITH CONSTIPATION	LINZESS lubiprostone	Client must have a diagnosis of Irritable Bowel Syndrome (IBS) with constipation.	
	MESALAMINE	LIALDA* mesalamine 400mg DR capsule mesalamine enema PENTASA	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, 1.2g mesalamine ER cap 0.375gm mesalamine sup 1000mg SFROWASA
	OPIOID-INDUCED CONSTIPATION AGENTS	lubiprostone	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 will be approved for a diagnosis of cancer or for clients in hospice or palliative care.	MOVANTIK* SYMPROIC
	PREGNANCY INDUCED NAUSEA/VOMITING	doxylamine/pyridoxine		BONJESTA DICLEGIS
	PROTON PUMP INHIBITORS	lansoprazole capsules/ODT omeprazole capsules/ODT pantoprazole	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.	amox/clarity/lanso pack DEXILANT dexlansoprazole esomeprazole omeprazole 20.6mg capsules omeprazole tablets omeprazole/sodium bicarbonate PREVACID solutabs (use preferred agents) rabeprazole TALICIA (use separate agents)
	POTASSIUM COMPETITIVE ACID REDUCERS		Voquezna will require trial and failure of two proton pump inhibitors twice daily at max dose for 30 days	VOQUEZNA
GOUT	COLCHICINE	colchicine (tablets)		MITIGARE (use preferred agent)
	XANTHINE OXIDASE AND URATI INHIBITORS	allopurinol	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*
HEMATOLOGY	LOW MOLECULAR WEIGHT HEPARIN (LMWH)	enoxaparin	Prior authorization will be required for the 300mg/3ml strength.	FRAGMIN (use preferred agent) enoxaparin 300MG/3ML
	DIRECT THROMBIN INHIBITOR	PRADAXA	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.	
	SELECTIVE FACTOR XA INHIBITOR	ELIQUIS (tablets) XARELTO (10/15/20mg, starter)	*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	ELIQUIS (starter pack) SAVAYSA (use preferred agent)
	CPTP DERIVATIVES	BRILINTA	Client must have a diagnosis of acute coronary syndrome, history of myocardial infarction, or history of stroke and transient ischemic attack.	
	ANTIHEMOPHILIC FACTOR VIII	ADVATE ADYNONATE AFSTYLA ELOCTATE ESPEROCT HEMOFIL M HEMLIBRA JIVI KOATE/KOATE-DVI NOVOEIGHT NUWIQ OBIZUR RECOMBINATE XYNTHA/SOLOFUSE		ALTUVIIO KOVALTRY
	COAGULATION FACTOR IX	ALHEMO ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY REBINYN RIXUBIS		
	ANTIHEMOPHILIC FACTOR/VWF	ALPHANATE HUMATE-P VONVENDI WILATE		
	ERYTHROPOEISIS STIMULATING AGENTS	EPOGEN RETACRIT		ARANESP MIRCERA PROCRIT
	ADDITIONAL HEMATOLOGICAL AGENTS	SIKLOS*	*Requires Sickle Cell Disease diagnosis **Additional criteria and diagnosis of beta-thalassemia required.	

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				GENERIC MANDATORY POLICY APPLIES
HEPATITIS C		DIRECT ACTING ANTIVIRALS sofosbuvir/velpatasvir MAVYRET	Limited to FDA approved indication. Prior authorization will be required prior to use of preferred agents. <i>Please submit PA requests on the Hepatitis C PA form available at www.wymedicaid.org.</i>	EPCLUSA (<i>use preferred agent</i>) HARVONI SOVALDI VOSEVI** ZEPATIER
HIDRADENITIS SUPPURATIVA		IMMUNOMODULATORS HUMIRA	Humira will not be covered as a first line agent for the diagnosis for hidradenitis suppurativa.	COSENTYX
HORMONES		GnRH ANTAGONISTS MYFEMBREE ORIAHN ORILISSA	*Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	HUMATROPE NGENLA SEROSTIM SOGROYA ZOMACTON
		GROWTH HORMONE GENOTROPIN NORDITROPIN SKYTROFA		
		TESTOSTERONE TOPICAL GELS TESTIM GEL	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>	JATENZO (<i>use preferred agent</i>) TESTOPEL (<i>use preferred agent</i>) testosterone gel (<i>use preferred agent</i>) testosterone solution (<i>use preferred agent</i>) XYOSTED (<i>use preferred agent</i>)
		THYROID HORMONES ARMOUR THYROID LEVOXYL levothyroxine (tablets) LEVO-T liothyronine SYNTHROID UNITHROID	Ermeza will be covered with confirmed diagnosis of dysphagia.	THYQUIDITY
		CONTRACEPTIVES		alyacen 1-35, 7/7/7 aranelle BALCOLTRA balziva briellyn drospirenone/ethynodiol/levomefolate enpresse FEMLYV kaitlib FE chew levonest levonorgestrel/ethynodiol/LO (84-7) levonorgestrel/ethynodiol 0.15- NEXTSTELLIS noreth/ethynodiol/FE chew 0.8/25 nortrel OPILL philith rivilsa SAFRAL SLYND SLYND TAYSOFY TAYTULLA tilia FE tri-legest FE TWIRLA TYBLUME tydemry vyfemla wera wymzya FE chew
	altavera amethyst apri ashlyna apri ashlyna aurovela 1-20/FE 1-20, 1-35 aviane ayuna azurette bilsivo 1-20 FE, 1.5-30 FE beyaz camila camrese/LO chateal/EQ CHARLOTTE 24 FE chew cyred dasetta 1-35, 7/7/7 daysee debitane deso/ethynodiol drospirenone/ethynodiol elinest emzahh enskyce errin estarylla estarylla falmina finzala FE chew halley FE 1/20, 1/35 heather iclevia incassia introvale isibloom jaimeess jencycla jolessa juleber juned 1-20/FE, 1.5-30/FE kalliga kariva kelnor kurvelo larin 1-20/FE, 1.5-30/FE lessina levora lo loestrin loestrin FE loryna low-ogestrel luteria marilisa mibelas FE chew microgestin 1-20/FE, 1.5-30/FE mili mono-linyah natazia NECON 0.5/35 nikki nora-be noreth/ethynodiol/FE chw noreth/ethynodiol 1-20/FE norgestrel/ethynodiol/LO norethindrone nylia pimtrea portia reclipsen setakin sharobel similiya simpesse			

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				GENERIC MANDATORY POLICY APPLIES
HORMONES; CONTRACEPTIVES (continued)	sprintec sronyx sveda tri-estarrylla/LO tri-linah tri-marzia LO tri-mill/LO tri-sprintec/LO tri-vylibra velvet vestura vienna viorele volnea vylibra yasmim-28 XULANE YAZ ZAFEMY zumandimine			<small>THIS LIST IS NOT ALL-INCLUSIVE. PLEASE CONTACT Dynamic with ANY QUESTIONS.</small>
HYPERLIPIDEMIA				
	BILE ACID SEQUESTRANT	cholestyramine/light colestipol	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	lovastatin pravastatin	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.	fluvastatin/ER
	STATINS, HIGH POTENCY	atorvastatin rosuvastatin simvastatin	Prior authorization will be required for clients under the age of 10. 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.	LIVALO ZYPITAMAG
	STATIN COMBINATIONS	amlodipine/atorvastatin VYTORIN*	Prior authorization will be required for clients under the age of 10. 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.	ezetimibe/simvastatin (BRAND IS PREFERRED)
	PCSK9-RELATED AGENTS	PRALUENT REPATHA	Prior authorization will be required for clients under the age of 10. 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
	TRIGLYCERIDE LOWERING AGENTS	fenofibrate gemfibrozil omega-3-acid	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.	fenofibric acid fenofibrate (43/50/120/130/150mg) icosapent LIPOFEN
HYPERTENSION/ CARDIOLOGY				
	ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)	EDARBII irbesartan losartan olmesartan telmisartan valsartan	Non-preferred ARBs will require a history of ALL preferred ARBs before approval	candesartan
	ARBs AND DIURETICS	EDARBYCLOL irbesartan HCTZ losartan HCT olmesartan HCTZ valsartan HCTZ	Non-preferred ARB/diuretic combinations will require a history of ALL preferred	candesartan HCTZ telmisartan HCTZ
	ALPHA-BLOCKERS	clonidine clonidine TD patches		
	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.	ENTRESTO SPRINKLES VERQUVO
INFECTIOUS DISEASE				
	ANTI-VIRALS	PAXLOVID	Paxlovid requires COVID diagnosis. Product is limited to 1 dose/pk per 30 days.	
	QUINOLONES	ciprofloxacin levofloxacin ofloxacin		moxifloxacin (use preferred agents)
	DOXYCYCLINE	doxycycline		DORYX (use preferred agent)
	MINOCYCLINE	minocycline/ER		minocycline 65mg and 115mg ER (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 56 days is required	BETHKIS inhaled tobramycin TOBI PODHALER (use preferred agent)

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				GENERIC MANDATORY POLICY APPLIES
INFECTIOUS DISEASE (continued)		ANTI-RETROVIRALS	<p>*Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.</p> <p>**Rukobia approval requires documentation of multi-drug resistance defined as failure of two medications from different classes.</p>	CABENUVA EMCITRABINE/RILPIVIRINE/TENOFOVIR JULUCA NORVIR RUKOBIA** STRIBILD (use separate agents) SUNLENCA SYMTUZA (use separate preferred agents)
INFLAMMATION		NSAIDs	<p>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.</p> <p>Dosing and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets).</p>	CALDOLOR (use preferred agent) diclofenac 1.3% patch diclofenac 1.5% soln. diclofenac 3% gel fenoprofen mefenamic acid NEOPROFEN (use preferred agent)
		ORAL CORTICOSTEROIDS		CELESTONE (use preferred agent) EMFLAZA
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. Prior Authorization will be required for clients under the age of 18</p> <p>*Quviviq requires trial and failure of two preferred agents with different mechanisms of action</p> <p>**Rozerem is non-preferred without a history of substance abuse</p> <p>Prior authorization will be required when a client is taking more than one insomnia agent concurrently.</p> <p>Dosage limits apply: zaleplon: 30mg/day zolpidem: 15mg/day</p>	EOLUAR (additional criteria applies) DAYVIGO QUVIVIQ* ROZEREM** zolpidem sublingual (additional criteria applies)
MASH (Metabolic-Associated Steatohepatitis)		APPROVED AGENTS	<p>*Wegovy will require diagnosis of MASH. Please consult the Additional Therapeutics Clinical Criteria chart for more information regarding cardiovascular disease criteria.</p>	REZDIFRA
MENTAL HEALTH		ALZHEIMER'S AGENTS	Client must have a diagnosis of dementia.	donepezil 23mg (<i>use preferred agent</i>) memantine ER NAMZARIC (use separate agents) rivastigmine capsules/patches
		ANTIDEPRESSANTS		NaSS
		NORADRENERGIC/SPECIFIC SEROTONERGICS (NaSS)		mirtazapine rapid dissolve tablets (<i>use preferred agent</i>)
		mirtazapine tablets		NDRI
		NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)		AUVELITY FORFIVO XL*
		bupropion ER/SR/XL		SSRI
		SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)	Trazodone, bupropine, fluvoxamine, MAO inhibitors, TCA's, bupropion IR, and venlafaxine IR do not require prior authorization but will not count towards meeting preferred therapy requirements.	BUCAPSOL citalopram capsules fluoxetine tablets VIBRYD
		SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS (SNRI)	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. ***Trintellix requires trial and failure of two preferred agents in any class	SNRI desvenlafaxine FETZIMA venlafaxine ER tablets (<i>use preferred agent</i>)
		duloxetine		OTHER
		venlafaxine ER capsules	Clients five (5) years of age and younger will require prior authorization before approval. Dosage limits apply: bupropion ER/SR/XL: 450mg/day citalopram < 60 years of age: 60mg/day citalopram > 60 years of age: 30mg/day escitalopram: 30mg/day fluoxetine < 18 years of age: 90mg/day fluoxetine > 18 years of age: 120mg/day mirtazapine: 67.5mg/day paroxetine IR/CR < 18 years of age: 75mg/day paroxetine IR > 18 years of age: 90mg/day paroxetine CR > 18 years of age: 112.5mg/day sertraline: 300mg/day venlafaxine ER: 337.5mg/day	TRINTELLIX***

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MENTAL HEALTH (continued)	ATYPICAL ANTIPSYCHOTICS ABILITY MAINTENA ABILITY ASIMTOFII ariprazole tab/solution/ODT ARISTADA asenapine FANAPT** paliperidone INVEGA HAFYERA INVEGA SUSTENNA INVEGA TRINZA lurasidone** olanzapine PERSERIS quetiapine* quetiapine ER RISPERDAL CONSTA risperidone UZEDY VRAYLAR ziprasidone ziprasidone		<p>*Quetiapine doses less than 100mg will require prior authorization without a diagnosis of mood disorder or major depressive disorder. For titration doses, contact the OptumRx Pharmacy Help Desk for an override.</p> <p>**Clients nine (9) years of age and younger will require a prior authorization to receive approval of lurasidone and asenapine. Clients eighteen (18) years of age and younger will require a prior authorization to receive approval of Fanapt.</p> <p>***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 adjunct MDD treatment.</p> <p>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.</p> <p>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.</p> <p>Dosage limits apply: ariprazole <13 years of age: 15mg/day; ≥13 years of age: 30mg/day asenapine: 20mg/day ABILITY MAINTENA: 400mg per 26 days ARISTADA 441/662/882mg: 1 injection per 28 days; 1064mg: 1 injection per 56 days ARISTADA INITIO: 1 injection per 365 days FANAPT: 24mg/day INVEGA HAFYERA: 1 injection per 6 months INVEGA SUSTENNA: 1 injection per 28 days INVEGA TRINZA: 1 injection per 84 days lurasidone 10-17 years of age: 80mg/day; >17 years of age: 160mg/day olanzapine <13 years of age: 10mg/day; ≥13 years of age: 20mg/day paliperidone: 12mg/day PERSERIS: 1 injection per 28 days quetiapine <13 years of age: 400mg/day; 13-17 years of age: 600mg/day; >17 years of age: 800mg/day risperidone <10 years of age: 3mg/day; 10-17 years of age: 6mg/day; >17 years of age: 16mg/day RISPERDAL CONSTA: 2 injections per 28 days ziprasidone ≤17 years of age: 120mg/day; >17 years of age: 200mg/day</p>	ABILITY MYCITE (use preferred agent) CAPLYTA GEDON 20MG INJ LYBALVI (additional criteria applies) NUPLAZID olanzapine 10mg Inj SAPHRIS (use preferred agent) SECUDO REXULTI** RYKINDO ZYPREXA RELPREVV
	SPECIAL ATYPICAL ANTIPSYCHOTICS clozapine/ODT		Dosage limits apply: 900mg/day	VERSACLOZ Suspension (use preferred agent)
	AMPHETAMINES LONG ACTING AMPHETAMINES ADDERALL XR* amphetamine salts combo XR dextroamphetamine CR caps VIVANSE CAPSULES**		Clients over the age of 17 must have a diagnosis for ADD, ADHD (see ADD/ADHD criteria below), narcolepsy, obstructive sleep apnea, shift work sleep disturbance, MS fatigue (see MS Fatigue criteria below), or refractory depression (see refractory depression criteria below).	AMPHETAMINES ADZENYS XR ODT DYANAVEL XR MYDAYIS PROCENTRA VIVANSE CHEWABLES ZENZEDI
	IMMEDIATE RELEASE AMPHETAMINES amphetamine salts combo dextroamphetamine tablets		For clients over the age of 17, they must meet the DSM-5 criteria for diagnosis of ADHD. These criteria include: • Five or more symptoms of inattention, present for at least 6 months, inappropriate for developmental level. OR • Five or more symptoms of hyperactivity and impulsivity, present for at least 6 months, to an extent that is disruptive and inappropriate for developmental level. AND • Symptoms must be present in two or more settings (home, school or work); • There must be clear evidence that the symptoms interfere or reduce the quality of social, school or work functioning; and • The symptoms must not be better explained by another mental disorder.	
	METHYLPHENIDATES LONG ACTING METHYLPHENIDATES CONCERTA* dexmethylphenidate ER methylphenidate ER tablets			METHYLPHENIDATES APTENSIO XR AZSTARYS COTEMPLA XR DAYTRANA FOCALIN XR JORNAY PM methylphenidate ER osmotic release (BRAND IS PREFERRED) methylphenidate ER/CR/SR capsules (RITALINA, APTENSIO XR) RELEXXII QUILLICHEW ER QUILLIVANT
	IMMEDIATE RELEASE METHYLPHENIDATES dexmethylphenidate methylphenidate chewables methylphenidate solution methylphenidate tablets		<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>**Vivanse 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 client is under the age of 4, or has 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 methyltin/methylphenidate/ER: 90mg/day VIVANSE: 105mg/day</p>	

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				GENERIC MANDATORY POLICY APPLIES	
MENTAL HEALTH continued	SELECTIVE ALPHA-ADRENERGIC AGONIST clonidine, clonidine ER guanfacine, guanfacine ER		Client must have a diagnosis of ADD or ADHD. Prior authorization will be required for clients under the age of 4.	ONYDA XR	
	SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR atomoxetine QELBREE		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 OR trial and failure of two preferred ADHD agents. 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	THIS LIST IS NOT ALL INCLUSIVE. PLEASE CONTACT Dynamic with ANY QUESTIONS	
MIGRAINE	MIGRAINE PROPHYLAXIS STEP 1 AGENTS beta blockers divalproex topiramate		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 2 AGENTS AIMOVIG* AJOVY EMGALITY		*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 frovatriptan naratriptan RELPAX* sumatriptan rizatriptan		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 RELPAX 20mg: 20 tabs/34 days RELPAX 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	alimiptriptan ELYXYB Sumatriptan-Naproxen Sodium TOSYMRRA (use preferred agent) ZEMBRACE (use preferred agent) ZAVZPRET zolmitriptan	
	STEP 2 AGENTS NURTEC UBRELVY		Trial and failure of two triptan agents required for Step 2 Agent approval Trial and failure of two preferred triptan agents AND Nurtec OR Ubrelvy will be required for approval of a non-preferred agent. Quantity limits apply: NURTEC 75mg: limited to 8 tabs/30 days		
MOVEMENT DISORDERS	VMAT 2 INHIBITORS AUSTEDO/XR* INGREZZA* TETRABENAZINE		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	INGREZZA (sprinkles)	
MULTIPLE SCLEROSIS	MS AGENTS BETASERON COPAXONE 20MG/ML* dimethyl fumarate REBIF teriflunomide		Gilenya, Kesimpta, Lemtrada, Ocrevus, and Tysabri will be approved for highly active disease, please refer to the ATCC for additional information. 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.	AUBAGIO AVONEX BAFIERTAM BRUMUVI glatiramer (BRAND IS PREFERRED) GLATOPA (use preferred agent) MAVENCLAD MAYZENT PLEGRIDY PONVORY TECFIDERA VUMERITY ZEPOSIA	
NARCOLEPSY	STIMULANTS modafinil NUVIGIL*		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.		
	NON-STIMULANTS		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.	SUNOSI WAKIX XYREM	
NEUROPATHIC PAIN	GABAPENTIN gabapentin pregabalin		Clients will not be allowed to take two or more agents in this class concurrently		
	TOPICAL LIDOCAINE Lidocaine Patches			ZTLLIDO	
	ADDITIONAL AGENTS amitriptyline desipramine imipramine (tablets) nortriptyline		Trial and failure of a tricyclic antidepressant greater than or equal to a 12 week supply AND trial and failure of gabapentin at a dose of 3600mg per day OR pregabalin for greater than or equal to a 12 week supply in the last 12 months will be required before approval can be given for a non-preferred agent.	carbamazepine imipramine (capsules) oxcarbazepine valproic acid	
OBSTRUCTIVE SLEEP APNEA	GLP-1 Agonists		Client must have diagnosis of moderate to severe obstructive sleep apnea. Will be approved for obese adults with an AHI (Apnea-Hypopnea Index) of greater than 15 as evidenced by sleep study within the prior 12 months. Prior authorization will be required again at 6 months to show at least 5% weight loss. Prior authorization will be required again at 12 months to demonstrate improvement in obstructive sleep apnea.		

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				GENERIC MANDATORY POLICY APPLIES
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. Alomide and Aloril will be approved for pregnancy. Alomide will be approved for children under the age of 3.	bepotastine epinastine ZERVIALE
	ciprofloxacin BESIVANCE gentamicin moxifloxacin 0.5% ofloxacin tobramycin	OP.-ANTIBIOTICS- QUINOLONES		gatifloxacin
	flurbiprofen diclofenac LOTEMAX* ketorolac NEVANAC	OP.-ANTI-INFLAMMATORY		ACULAR/LS/PF (use preferred agent) ACUVAIL bromfenac 0.9% BROMSITE DUREZOL ILEVRO INVELTYS LOTEMAX SM Ioteprednol 0.5% (BRAND IS PREFERRED) PROLENSA
	betaxolol carteolol levobunolol timolol	OP.-BETA-BLOCKERS		BETIMOL BETOPIC S*
	AZOPT dorzolamide	OP.-CARBONIC ANHYDRASE INHIBITOR		brinzolamide (BRAND IS PREFERRED)
	COMBIGAN* COSOPT ROCKLATAN SIMBRINZA	OP.-COMBO PRODUCTS		dorzolamide/timolol (BRAND IS PREFERRED)
	RESTASIS* XIIDRA	OP.-DRY EYE AGENTS		CEQUA cyclosporine (BRAND IS PREFERRED) EYESUVIS MIEBO RESTASIS MULTIDOSE (see preferred) TYRVAYA
	latanoprost LUMIGAN TRAVATAN Z XALATAN ZIOPTAN	OP.-PROSTAGLANDINS		bimatoprost IYZUEH tafluprost
	RHOPRESSA	OP.-RHO KINASE INHIBITOR		
	ALPHAGAN P 0.1% ALPHAGAN P 0.15%* brimonidine 0.2%	OP.-SYMPATHOMIMETICS		brimonidine 0.15% (BRAND IS PREFERRED)
OSTEOPOROSIS	BISPHOSPHONATES		Trial and failure of a preferred agent greater than or equal to 12 weeks will be required before approval can be given for the non-preferred agent.	EVENITY** FORTEO*** FOSAMAX-D TYMLOS***
	alendronate ibandronate risedronate	NASAL CALCITONIN		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
OTIC	ANTIBIOTIC/STEROID COMBINATION			ciprofloxacin 0.2% (use preferred agent) CIPRO HC (use preferred agent) CORTISPORIN-TC (use preferred agent) FLUOCINOLONE ACET OIL 0.01% (use preferred agent)
OVERACTIVE BLADDER	OVERACTIVE BLADDER AGENTS		Trial and failure of a preferred agent greater than or equal to 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Oxytrol will be approved for clients that have an inability to swallow.	darifenacin GEMTESA mirabegron (BRAND IS PREFERRED) OXYTROL DIS tolterodine/ER TOVIAZ trospium
PAIN	LONG-ACTING C-II		Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. C-III and C-IVs that are not included on the PDL and are available without prior authorization with the exception of Butrans (generic substitution is mandatory). Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid. Fentanyl: 50mcg, 1 strength at a time, 1 patch every 3 days Hydromorphone ER: 30mg/day Hysingla ER: 120mg/day Methodone: Limited to 3 tablets per day Morphine ER: 90mg/day Oxycontin: 80mg/day Oxymorphone: 40mg/day Clients will be limited to one long-acting narcotic at a time.	fentanyl patches hydrocodone ER hydromorphone ER HYSINGLA ER METHADONE morphine ER capsules (use preferred agents) oxymorphone ER OXYCONTIN

WYOMING MEDICAID
Preferred Drug List (PDL) January 1, 2026

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS	
				GENERIC MANDATORY POLICY APPLIES	
PAIN continued	SHORT-ACTING C-lls		<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>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>	levorphanol oxymorphone ROXYBOND	
	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>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>	BELBUCA tramadol/apap tramadol ER capsules/tablets	
PARKINSON'S DISEASE	SHORT-ACTING AGENTS				
	amantadine benztropine tablets carbidopa/levodopa pramipexole ropinirole				
PHOSPHATE BINDERS	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>*Neupro will be approved for clients with difficulty swallowing</p>	APOKYN benztropine injectables GOCOVRI INBRIJA NEUPRO* ONGENTYS pramipexole ER XADAGO	
	calcium acetate			AURYXIA lanthanum sevelamer VELPHORO	
PROSTATE	5-ALPHA-REDUCTASE INHIBITORS		<p>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.</p>	dutasteride dutasteride/tamsulosin (use separate agents)	
	doxazosin tamsulosin terazosin			alfuzosin dutasteride/tamsulosin (use separate agents) silodosin	
PULMONARY ANTIHYPERTENSIVES	5-ALPHA-REDUCTASE INHIBITORS		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	OPSYNVI	
	ALYQ sildenafil suspension sildenafil (A/B rated generics)				
	ENDOTHELIN RECEPTOR ANTAGONISTS		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	bosentan (BRAND IS PREFERRED) OPSUMIT (use preferred agent) TRACLEAR TABS FOR ORAL SUSP (use preferred agent) WINREVAIR	
	LETAIRIS TRACLEAR TABS*				
	GUANYLATE CYCLASE INHIBITORS		Prior authorization required.	ADEMPAS (use preferred agent)	
	PROSTACYCLINE VASODILATORS		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.		
	ORENITRAM				
RESTLESS LEG SYNDROME	PROSTACYCLINE RECEPTOR AGONIST		Prior authorization required.	UPTRAVI (use preferred agent)	
	pramipexole ropinirole	gabapentin pregabalin	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*	
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 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 metaxalone methocarbamol orphenadrine tizanidine capsules (use preferred agent)	
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 SKYRIZI STELARA TREMFYA XELJANZ/XR	
UVEITIS	IMMUNOMODULATORS		Client must have diagnosis of non-infectious intermediate, posterior, or panuveitis		
	adalimumab-fkjp HADLIMA HUMIRA RINVOQ ZORYVE				
	adalimumab-fkjp HADLIMA HUMIRA				