

**WYOMING MEDICAID  
Preferred Drug List (PDL) April 15, 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/dosage 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 <small>THIS LIST IS NOT ALL-INCLUSIVE PLEASE CONTACT OptumRx WITH ANY QUESTIONS</small>
ADDICTION	<b>BUPRENORPHINE COMBINATIONS</b>		Client must have a diagnosis of opioid dependence or abuse. This is not to be used for the treatment of chronic pain. Prior authorization will be required before any narcotic, benzodiazepine, or carisoprodol prescription will be allowed between fills. Prior authorization will be required before any short-acting stimulant prescription from any doctor other than the prescriber of buprenorphine or Suboxone, will be allowed between fills.  Oral buprenorphine will be approved for clients with a documented allergy to naloxone.  Please submit PA requests on the "Oral Buprenorphine/Naloxone or Oral Buprenorphine" PA form available at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> .  Dosage limits apply Prior authorization will be required for doses >24mg	buprenorphine (oral) buprenorphine/naloxone film <b>BRAND IS PREFERRED</b> ZUSOLV
		buprenorphine/naloxone tablets SUBLOCADE SUBOXONE FILM*		
	<b>NALOXONE</b>			
	KLOXXADO naloxone nasal spray NARCAN		Kloxxado, naloxone products, and Narcan nasal spray will be limited to one fill per 180 days without prior authorization.  Naloxone formulations available in quantities of 10ml will require prior authorization.	OPVEE REXTOVY
	<b>NALTREXONE</b>		Client must have a diagnosis of alcohol or opioid dependence.  Prior authorization will be required before any narcotic, carisoprodol, or benzodiazepine prescription will be allowed between fills. Prior authorization will be required before a short-acting stimulant prescription from any doctor other than the prescriber of naltrexone or Vivitrol will be allowed between fills.  *Topiramate requires 4 week trial and failure of naltrexone or acamprosate in AUD	topiramate*
	VIVITROL	naltrexone		
ALLERGY / ASTHMA / COPD	<b>ANTIHISTAMINES, MINIMALLY SEDATING</b>		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	desloratadine levocetirizine
		cetirizine fexofenadine loratadine		
	<b>ANTIHISTAMINE/DECONGESTANT COMBINATIONS</b>		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	
		cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine		
	<b>ANTICHOLINERGIC BRONCHODILATORS</b>		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.  Spiriva 5 day STARTER package will be allowed one (1) time per recipient.	TIOTROPIUM BROM (use brand) TUDORZA YUPELRI
		ATROVENT HFA INCRUSE ELLIPTA ipratropium SPIRIVA HANDHALER* SPIRIVA RESPIMAT		
	<b>ANTICHOLINERGIC COMBINATION AGENTS</b>		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.  **Will also require the diagnosis of COPD.	BEVESPI DUAKLIR
		ANORO ELLIPTA** BREZTRI COMBIVENT STIOLTO TRELEGY		
	<b>LEUKOTRIENE MODIFIERS</b>		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	zafirlukast
		montelukast		
	<b>LONG ACTING BRONCHODILATORS</b>		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	BROVANA
		arformoterol SEREVENT STRIVERDI		
	<b>NASAL ANTIHISTAMINES</b>		Trial and failure of preferred agent greater than or equal to 90 days in the last 12 months will be required before approval can be given for a non-preferred agent.	DYMISTA (use separate agents) olopatadine 0.6% RYALTRIS
		azelastine 0.1%		
	<b>NASAL STEROIDS</b>		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.  Budesonide will be approved for pregnancy.	DYMISTA (use separate agents) OMNARIS QNASL XHANCE
		budesonide flunisolide fluticasone mometasone		
	<b>SHORT ACTING BRONCHODILATORS - INHALERS</b>		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Prior authorization will be required after a total of 12 albuterol inhalers are dispensed within 365 days.  Minimum day supply of 16 days is required.	AIRSUPRA fevalbuterol (BRAND IS PREFERRED)
		albuterol HFA PROAIR RESPICLICK VENTOLIN HFA XOPENEX HFA		
	<b>STEROID INHALANTS</b>		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.  *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 DIGHALER ALVESCO ASMANEX HFA* fluticasone HFA* QVAR REDIHALER
		ARNUITY ELLIPTA ASMANEX TWISTHALER budesonide suspension		
	<b>STEROID COMBINATION AGENTS</b>		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.  **Will also require the diagnosis of COPD or uncontrolled asthma. Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.	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) BRED ELLIPTA** DULERA SYMBICORT* TRELEGY		
	<b>EPINEPHRINE</b>		Approval for these agents will require additional clinical criteria which can be found on the Additional Therapeutic Criteria Chart.	NEFFY
	AUVI-Q (use preferred agent) epinephrine auto-injector pen EPI-PEN			
<b>EOSINOPHILIC ASTHMA AGENTS</b>		Approval for these agents will require additional clinical criteria which can be found on the Additional Therapeutic Criteria Chart.	FAENRA 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 <small>THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT ODHSM WITH ANY QUESTIONS</small>
ARTHRITIS	<b>IMMUNOMODULATORS</b>		Client must have diagnosis of AS prior to approval of a preferred agent. To receive a non-preferred agent, client must have 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 <b>Quantity Limits apply for all diagnoses:</b> Enbrel 25mg - limited to 10 per month Enbrel 50mg - limited to 5 per month Humira 20mg - limited to 10 per month Humira 40mg - limited to 5 per month	CIMZIA** COSENTYX REMICADE SIMPONI XELIANZ/XR
	<b>ANKYLOSING SPONDYLITIS (AS)</b>			
		adalimumab-fkjp ENBREL HADLIMA HUMIRA RINVOQ TALTZ		
	<b>JUVENILE IDIOPATHIC ARTHRITIS (JIA)</b>			
		adalimumab-fkjp ENBREL HADLIMA HUMIRA		
ARTHRITIS	<b>PSORIATIC ARTHRITIS (PA)</b>		Client must have diagnosis of PA prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of PA and a 56-day trial and failure of two preferred agents.  *Otezla starter pack is non-preferred **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** COSENTYX ORENCIA REMICADE SIMPONI SKYRIZI STELARA TREMIFYA XELIANZ/XR
		adalimumab-fkjp HADLIMA HUMIRA OTEZLA* RINVOQ TALTZ ZORYVE		
	<b>RHEUMATOID ARTHRITIS (RA)</b>			
		adalimumab-fkjp HADLIMA ENBREL HUMIRA RINVOQ		
SEIZURES	<b>INTERMITTENT, STEREOTYPIC SEIZURE EPISODES</b>		*Nayzilam will be allowed for patients 12 years of age and older	
		diazepam gel NAYZILAM* VALTOCO		
SEIZURES	<b>ORAL ANTICONVULSANTS</b>		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 <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> .  *Pregabalin will also be allowed for diagnoses of restless leg syndrome or anxiety **Please refer to the Additional Therapeutic Criteria chart at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> for specific requirements.	APTIOM BRIVIACT clobazam** DIACOMIT** FINTEPLA** levetiracetam ER OXTELLAR TROCENDI XR XCOPRI VIMPAT (tablets) zonisamide oral susp.
		carbamazepine divalproex FELBAMATE fosphenytoin lacosamide (tablets) lamotrigine/XR levetiracetam oxcarbazepine phenytoin subvenite valproate/valproic acid VIMPAT (suspension) zonisamide		
CROHN'S	<b>IMMUNOMODULATORS</b>		Client must have diagnosis of Crohn's prior to approval of the preferred agent. To receive a non-preferred agent, client must have a diagnosis of Crohn's and a 56-day trial and failure 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 TREMIFYA TYSABRI (additional criteria applies)
		adalimumab-fkjp HADLIMA HUMIRA RINVOQ		
DERMATOLOGY	<b>BENZOYL PEROXIDE/CLINDAMYCIN COMBOS</b>		Clients must be 12 to 20 years of age. Requires prior authorization for clients less than 12 years of age. Acne combinations are limited to clients under the age of 21.	
		clindamycin/benzoyl peroxide 1-5% clindamycin/benzoyl peroxide 1.2-5% (Refrig)		
	<b>ISOTRETINOIN</b>		Clients must be 12 to 20 years of age.	ABSORICA
		AMNESTEEM CLARAVIS isotretinoin ZENATANE		
	<b>CORTICOSTEROIDS - STEP 1 AGENTS</b> C=CREAM; G=GEL; L=LOTION; O=OINTMENT; S=SOLUTION		Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	TEXACORT 2.5% (S)
	<b>LOW POTENCY</b>			
		alclometasone desonide* fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O)	*Cream, ointment, and lotion formulations of desonide are preferred.	
	<b>MEDIUM POTENCY</b>		Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	Clocortolone Pivalate fluticasone 0.05% (L) hydrocortisone butyrate 0.1% (O)
		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%		
	<b>HIGH POTENCY</b>		Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	aminonide 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)
	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)			
<b>IMMUNOMODULATORS - STEP 2 AGENTS</b>		To receive a <b>step 2 agent</b> : 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.  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.	HYFTOR pimecrolimus	
	tacrolimus			
<b>PHOSPHODIESTERASE 4 INHIBITOR - STEP 3 AGENT</b>		To receive a <b>step 3 agent</b> : Trial and failure of a preferred step 2 agent (immunomodulator) greater than or equal to a 21 day trial within the last 30 days.	EUCRISA	
	ZORYVE			

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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%.	LITFULO OLLUMIANT	
	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** NEMLUVIO OPZELURA**	
	EBGLYSS DUPIXENT* RINVOQ ZORYVE		**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.		
	CHRONIC SPONTANEOUS URTICARIA		Client must have diagnosis of chronic spontaneous urticaria whose hives are not controlled by H1 antihistamine therapy.	RHAPSIDO	
	DUPIXENT* XOLAIR		Approval for a non-preferred agent requires a 56-day trial and failure of a preferred agent.		
	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-fkjp ENBREL HADLIMA HUMIRA OTEZLA SOTYKTU* TALTZ ZORYVE***		**Sotyktu requires diagnosis of moderate to severe PP and 56 day trial and failure of Humira. **Cimzia will be allowed for clients that are pregnant or breast-feeding ***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	DIABETES AGENTS			metformin SR 24H osm (use preferred agent) metformin SR 24H mod (use preferred agent)
		BIGUANIDES			
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.			
glimpiride/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) STEGLIJUAN (use separate preferred agents)		
JANUVIA ONGLYZA TRAJENTA					
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)		
JANUMET/XR JENTADUETO					
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.	liraglutide (use brand) MOUNJARO OZEMPIC* SOLIQUA XULTOPHY (use separate preferred agents)		
exenatide RYBELSUS TRULICITY VICIENZA*					
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 SEGLUROMET (use separate preferred agents) STEGLATRO STEGLIJUAN (use separate preferred agents) SYNJARDO XR (use separate preferred agents) TRILARDY XR (use separate preferred agents)		
FARXIGA JARDIANCE SYNJARDO 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 NOVOLOG MIX					
LONG-ACTING INSULIN		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently.	BASAGLAR (use preferred agent) Insulin Glargine (use preferred agent) Insulin Degludec SOLIQUA TOUJEO (use preferred agent) TRESIBA* (use preferred agent) XULTOPHY (use separate preferred agents)		
LANTUS SOLOSTAR* LANTUS vial					
DIABETIC METERS/TEST STRIPS		Quantity limits apply: Insulin Dependent Clients: 10 strips/day Non-Insulin Dependent Clients: 4 strips/day  Clients are limited to 1 meter/365 days	ALL OTHER METERS AND TEST STRIPS 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		
ACCU-CHEK GUIDE/STRIPS ACCU-CHEK GUIDE ME FREESTYLE (strips only) FREESTYLE FREEDOM FREESTYLE FREEDOM LITE FREESTYLE INSULINX FREESTYLE PRECISION NEO B FREESTYLE SIDEKICK II PRECISION XTRA					
EXTERNAL DIABETIC DEVICES			OMNIPOD GO		
OMNIPOD DASH OMNIPOD 5 OMNIPOD G5 FSL 2 PLUS G6					
CONTINUOUS BLOOD GLUCOSE MONITORS		Prior authorization will be required to verify if the client is injecting insulin daily. Monitors will also be limited to the labeled age.	GUARDIAN MINIMED		
DEXCOM G6 DEXCOM G7 FREESTYLE LIBRE FREESTYLE LIBRE 2 FREESTYLE LIBRE 3/PLUS					

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<b>DIABETES</b> (continued)	<b>ACUTE HYPOGLYCEMIA AGENTS</b>			GVOKE (use preferred agent)
	BAOSIMI ZEGALOGUE (autoinjector)			
<b>FIBROMYALGIA</b>	<b>FIBROMYALGIA</b>		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	pregabalin SAVELLA tablets (savella titration pak will not be covered)
	amitriptyline cyclobenzaprine duloxetine	gabapentin	Clients will not be allowed to take gabapentin and pregabalin concurrently	
<b>GASTROINTESTINAL</b>	<b>BOWEL EVACUANTS</b>			SUTAB
	CLENPIQ GAVILYTE G, N PEG 3350 SOLUTION SUFLAVE SUPREP			
	<b>CHRONIC IDIOPATHIC CONSTIPATION</b>		Client must have a diagnosis of chronic idiopathic constipation to receive a preferred agent. To receive a non-preferred agent, the client must have a diagnosis of chronic idiopathic constipation and a 30-day trial and failure of a preferred agent within the last 12 months.	MOTEGRITY
		LINZESS lubiprostone		
	<b>DIGESTIVE ENZYMES</b>		Prior authorization required.	VIOKACE
	CREON ZENPEP	PERTZYE*	*Pertzye will be preferred for members diagnosed with cystic fibrosis.	
	<b>IRRITABLE BOWEL SYNDROME WITH CONSTIPATION</b>		Client must have a diagnosis of Irritable Bowel Syndrome (IBS) with constipation.	
		LINZESS lubiprostone		
	<b>MESALAMINE</b>		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	mesalamine DR tab 800mg, 1.2g mesalamine ER cap 0.375gm mesalamine sup 1000mg SFROWASA
	LIALDA* mesalamine 400mg DR capsule mesalamine enema PENTASA			
	<b>OPIOID-INDUCED CONSTIPATION AGENTS</b>		Client must have a diagnosis of opioid-induced constipation and a three (3) month trial and failure of a stool softener to receive the preferred agent. To receive the non-preferred agent, the client must have a diagnosis of opioid-induced constipation, a three (3) month trial and failure of a secretory agent, and a three (3) month trial and failure of the preferred agent. *Movantik and Symproic will be approved for a diagnosis of cancer or for clients in hospice or palliative care.	MOVANTIK* SYMPROIC*
		lubiprostone		
	<b>PREGNANCY INDUCED NAUSEA/VOMITING</b>			BONJESTA DICLEGIS
	doxylamine/pyridoxine			
	<b>PROTON PUMP INHIBITORS</b>		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	amox/clarith/anso pack DEXILANT dexlansoprazole esomeprazole omeprazole 20.6mg capsules omeprazole tablets omeprazole/sodium bicarbonate PREVACID solutabs (use preferred agents) rabeprazole TALICIA (use separate agents)
	lansoprazole capsules/ODT omeprazole capsules/ODT pantoprazole			
	<b>POTASSIUM COMPETITIVE ACID REDUCERS</b>		Voquezna will require trial and failure of two proton pump inhibitors twice daily at max dose for 30 days	VOQUEZNA
<b>GOUT</b>	<b>COLCHICINE</b>			MITTIGARE (use preferred agent)
	colchicine (tablets)			
	<b>XANTHINE OXIDASE AND URATIC INHIBITORS</b>		Trial and failure of the preferred agent greater than or equal to a 60 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ULORIC*
	allopurinol			
<b>HEMATOLOGY</b>	<b>LOW MOLECULAR WEIGHT HEPARIN (LMWH)</b>		Prior authorization will be required for the 300mg/3ml strength.	FRAGMIN (use preferred agent) enoxaparin 300MG/3ML
	enoxaparin			
	<b>DIRECT THROMBIN INHIBITOR</b>		Client must have diagnosis of non-valvular atrial fibrillation and relative contraindication to warfarin for approval, treatment for deep vein thrombosis (DVT) or pulmonary embolism (PE), or for the reduction in the risk of recurrence of DVT and PE after initial therapy.	
		PRADAXA		
	<b>SELECTIVE FACTOR XA INHIBITOR</b>		*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)
	ELIQUIS (tablets) XARELTO (10/15/20mg, starter)	XARELTO 2.5mg*		
	<b>CPTP DERIVATIVES</b>		Client must have a diagnosis of acute coronary syndrome, history of myocardial infarction, or history of stroke and transient ischemic attack.	
		BRILINTA		
	<b>ANTIHEMOPHILIC FACTOR VIII</b>			ALTUVIIIO KOVALTRY
	ADVATE ADYNOVATE AFSTYLA ELOCTATE ESPEROCT HEMOFIL M HEMLIBRA JIVI KOATE/KOATE-DVI NOVOEIGHT NUWIQ OBIZUR RECOMBINATE XYNTHA/SOLOFUSE			
	<b>COAGULATION FACTOR IX</b>			
	ALHEMO ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY REBINYN RIXUBIS			
	<b>ANTIHEMOPHILIC FACTOR/VWF</b>			
	ALPHANATE HUMATE-P VORVENDI WILATE			
	<b>ERYTHROPOIESIS STIMULATING AGENTS</b>			ARANESP MIRCERA PROCRIT
	EPOGEN RETACRIT			
	<b>ADDITIONAL HEMATOLOGICAL AGENTS</b>		*Requires Sickle Cell Disease diagnosis **Additional criteria and diagnosis of beta-thalassemia required.	
	SIKLOS*	ZYNTGLO**		

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>OTHER DRUGS MAY ALSO BE COVERED PLEASE CONTACT OHSUMS WITH ANY QUESTIONS</small>	
HEPATITIS C		<b>DIRECT ACTING ANTIVIRALS</b> sofosbuvir/velbatavir MAVYRET	Limited to FDA approved indication. Prior authorization will be required prior to use of preferred agents. Please submit PA requests on the Hepatitis C PA form available at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> .	EPCLUSA (use preferred agent) HARVONI SOVALDI VOSEVI ZEPATIER	
HIDRADENITIS SUPPURATIVA		<b>IMMUNOMODULATORS</b> HUMIRA	Humira will not be covered as a first line agent for the diagnosis for hidradenitis suppurativa.	COSENTYX	
HORMONES		<b>GnRH ANTAGONISTS</b>	*Please refer to the Additional Therapeutic Criteria chart at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> for specific requirements.		
	MYFEMBREE ORIAHN ORILISSA				
		<b>GROWTH HORMONE</b> GENOTROPIN NORDITROPIN SKYTROFA		HUMATROPE NGENLA SEROSTIM SOGROYA ZOMACTON	
		<b>TESTOSTERONE TOPICAL GELS</b> 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 (use preferred agent) TESTOPEL (use preferred agent) testosterone gel (use preferred agent) testosterone solution (use preferred agent) XYOSTED (use preferred agent)	
	ARMOUR THYROID LEVOXYL levothyroxine (tablets) LEVO-T liothyronine SYNTHROID UNITHROID			Ermeza will be covered with confirmed diagnosis of dysphagia.	THYQUIDITY
		<b>CONTRACEPTIVES</b>			alyacen 1-35, 7/7/7 aranelle BALCOLTRA balziva briellyn drospir/ethinyl estradiol/levomefolate enpresse FEMLYV kaitlib FE chew levonest levonorgest/ethinyl estradiol/LO (84-7) levonorgest/ethinyl estradiol 0.15- NEXTSTELLIS noreth/ethinyl estradiol/FE chew 0.8/25 nortrel OPILL philit rivelsa SAFYRAL SLYND TAYSOFY TAYTULLA tilia FE tri-legest FE TWIRLA TYBLUME tydemy vyfemla wera wymzya FE chew

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HORMONES; CONTRACEPTIVES <i>(continued)</i>	sprintec sronyx syeda tri-estarylla/LO tri-linyah tri-marzia LO tri-mili/LO tri-sprintec/LO tri-vylibra velivet vestura vienva viorele volnea vylibra yasmin-28 XULANE YAZ ZAFEMY zumandimine			
HYPERLIPIDEMIA	<b>BILE ACID SEQUESTRANT</b>		Trial and failure of ALL preferred agents greater than or equal to six (6) months in the last 12 months will be required before approval can be given for a non- preferred agent.	WELCHOL
	<b>STATINS, LOW POTENCY</b>		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.  If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization.  Prior authorization will be required for clients under the age of 10.	fluvastatin/ER
	<b>STATINS, HIGH POTENCY</b>		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.  If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization.  Prior authorization will be required for clients under the age of 10.	LIVALO ZYPITAMAG
	<b>STATIN COMBINATIONS</b>		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.  Prior authorization will be required for clients under the age of 10.	ezetimibe/simvastatin (BRAND IS PREFERRED)
	<b>PCSK9-RELATED AGENTS</b>		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
	<b>TRIGLYCERIDE LOWERING AGENTS</b>		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	fenofibric acid fenofibrate (43/50/120/130/150mg) icosapent LIPOFEN
	<b>ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)</b>		Non-preferred ARBs will require a history of ALL preferred ARBs before approval	candesartan
	<b>ARBs AND DIURETICS</b>		Non-preferred ARB/diuretic combinations will require a history of ALL preferred	candesartan HCTZ telmisartan HCTZ
HYPERTENSION/ CARDIOLOGY	<b>ALPHA-BLOCKERS</b>			
	<b>COMBINATION PRODUCTS</b>		Client must be greater than one year of age and have a diagnosis of Congestive Heart Failure (CHF) NYHA Class II-IV. Angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) will not be allowed in combination with Entresto.	ENTRESTO SPRINKLES VERQUVO
	<b>ANTI-VIRALS</b>		Paxlovid requires COVID diagnosis. Product is limited to 1 dosepak per 30 days.	
	<b>QUINOLONES</b>			moxifloxacin ( <i>use preferred agents</i> )
INFECTIOUS DISEASE	<b>DOXYCYCLINE</b>			DORYX ( <i>use preferred agent</i> )
	<b>MINOCYCLINE</b>			minocycline 65mg and 115mg ER ( <i>use preferred agent</i> )
	<b>INHALED TOBRAMYCIN</b>		*Tobi Podhaler requires a 28 day trial of a preferred agent, as well as 28 days off of that same preferred agent prior to approval. <b>Minimum day supply of 56 days is required</b>	BETHKIS inhaled tobramycin TOBI PODHALER ( <i>use preferred agent</i> )

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<b>INFECTIOUS DISEASE</b> (continued)	<b>ANTI-RETROVIRALS</b>	DESCOVY* TRUVADA*	*Please refer to the Additional Therapeutic Criteria chart at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> for specific requirements.  **Rukobia approval requires documentation of multi-drug resistance defined as failure of two medications from different classes.	CABENUVA EMCITRABINE/RILPIVIRINE/TENOFOVIR JULUCA NORVIR RUKOBYA** STRIBILD (use separate agents) SUNLENCA SYM TUZA (use separate preferred agents)
<b>INFLAMMATION</b>	<b>NSAIDs</b>		Trial and failure of two (2) preferred agents each greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non- preferred agent. <b>Dosing and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets).</b> *Diclofenac 3% requires diagnosis of actinic keratosis	CALDOLOR (use preferred agent) diclofenac 1.3% patch diclofenac 1.5% soln. diclofenac 3% gel* fenoprofen mefenamic acid NEOPROFEN (use preferred agent)
	<b>ORAL CORTICOSTEROIDS</b>			CELESTONE (use preferred agent) EMFLAZA
<b>INSOMNIA</b>	<b>NON-BENZODIAZEPINES</b>		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Prior Authorization will be required for clients under the age of 18  *Quviviq requires trial and failure of two preferred agents with different mechanisms of action  **Rozerem is non-preferred without a history of substance abuse Prior authorization will be required when a client is taking more than one insomnia agent concurrently.  Dosage limits apply: zaleplon: 30mg/day zolpidem: 15mg/day	EDLUAR (additional criteria applies) DAYVIGO QUVIVIQ* ROZEREM** zolpidem sublingual (additional criteria applies)
<b>MASH (Metabolic-Associated Steatohepatitis)</b>	<b>APPROVED AGENTS</b>	WEGOVY (INJECTABLE)*	*Wegovy injectables will require diagnosis of MASH. Please consult the Additional Therapeutics Clinical Criteria chart for more information regarding cardiovascular disease criteria.	REZDIFRA
<b>MENTAL HEALTH</b>	<b>ALZHEIMER'S AGENTS</b>	donepezil/ODT galantamine/ER memantine tablets/solution	Client must have a diagnosis of dementia.	donepezil 23mg (use preferred agent) memantine ER NAMZARIC (use separate agents) rivastigmine capsules/patches
	<b>ANTIDEPRESSANTS</b>		Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks <b>WITHIN THE LAST 2 YEARS</b> will be required before approval can be given for a non-preferred agent. <b>One of the trials of preferred agents must be in the same class (NaSS, NDRI, SSRI, or SNRI) as the requested non-preferred agent.</b>	<b>NaSS</b>
	<b>NORADRENERGIC/SPECIFIC SEROTONERGICS (NaSS)</b>	mirtazapine tablets		mirtazapine rapid dissolve tablets (use preferred agent)
	<b>NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)</b>	bupropion ER/SR/XL		<b>NDRI</b>
	<b>SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)</b>	citalopram escitalopram fluoxetine capsules paroxetine IR/CR sertraline		AUVELITY FORFIVO XL*
	<b>SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS (SNRI)</b>	duloxetine venlafaxine ER capsules		<b>SSRI</b>
			Trazodone, buspirone, fluvoxamine, MAO inhibitors, TCA's, bupropion IR, and venlafaxine IR do not require prior authorization but <b>will not count</b> towards meeting preferred therapy requirements.  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  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	<b>SNRI</b>
				<b>OTHER</b>
				TRINTELLIX***

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<b>MENTAL HEALTH</b> (continued)	<b>ATYPICAL ANTIPSYCHOTICS</b> ABILIFY MAINTENA ABILIFY ASINTUFIL aripiprazole 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 <u>without</u> 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 or Capiyta 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:            aripiprazole &lt;13 years of age: 15mg/day; ≥13 years of age: 30mg/day            asenapine: 20mg/day            ABILIFY 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; &gt;17 years of age: 160mg/day            olanzapine &lt;13 years of age: 10mg/day; ≥13 years of age: 20mg/day            paliperidone: 12mg/day            PERSERIS: 1 injection per 28 days            quetiapine &lt;13 years of age: 400mg/day; 13-17 years of age: 600mg/day; &gt;17 years of age: 800mg/day            risperidone &lt;10 years of age: 3mg/day; 10-17 years of age: 6mg/day; &gt;17 years of age: 16mg/day            RISPERDAL CONSTA: 2 injections per 28 days            ziprasidone ≤17 years of age: 120mg/day; &gt;17 years of age: 200mg/day</p>	ABILIFY MYCITE (use preferred agent) CAPLYTA*** COBENFY GEODON 20MG INJ LYBALVI (additional criteria applies) NUPLAZID olanzapine 10mg Inj SAPHRIS (use preferred agent) SECUADO REXULTI*** RYKINDO ZYPREXA RELPREVV
	<b>SPECIAL ATYPICAL ANTIPSYCHOTICS</b> clozapine/ODT		Dosage limits apply: 900mg/day	VERSACLOZ Suspension (use preferred agent)
	<b>AMPHETAMINES</b> <b>LONG ACTING AMPHETAMINES</b>	ADDERALL XR* amphetamine salts combo XR dextroamphetamine CR caps VYVANSE 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).	<b>AMPHETAMINES</b> ADZENYS XR ODT DYANAVEL XR MYDAYIS PROCENTRA VYVANSE CHEWABLES ZENZEDI
	<b>IMMEDIATE RELEASE AMPHETAMINES</b>	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.	
	<b>METHYLPHENIDATES</b> <b>LONG ACTING METHYLPHENIDATES</b>	CONCERTA* dexamethylphenidate ER methylphenidate ER tablets	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.	<b>METHYLPHENIDATES</b> APTENSIO XR AZSTARYS COTEMPLA XR DAYTRANA FOCALIN XR JORNAY PM methylphenidate ER osmotic release (BRAND IS PREFERRED) methylphenidate ER/CR/SR capsules (RITALIN LA, APTENSIO XR) RELEXII QUILLICHEW ER QUILLIVANT
	<b>IMMEDIATE RELEASE METHYLPHENIDATES</b>	dexamethylphenidate methylphenidate chewables methylphenidate solution methylphenidate tablets	**Vyvanse will be approved for the diagnosis of binge-eating disorder for clients 18 years of age and older. Authorizations will be approved for 12 weeks. After initiation a one-year prior authorization of Vyvanse for this diagnosis will require additional documentation prior to approval.  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.  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.	
			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 dexamethylphenidate: 30mg/day FOCALIN XR < 13 years of age: 45mg/day FOCALIN XR > 13 years of age: 60mg/day JORNAY PM: 100mg/day methylin/methylphenidate/ER: 90mg/day VYVANSE: 70mg/day	

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MENTAL HEALTH continued	SELECTIVE ALPHA-ADRENERGIC AGONIST		Client must have a diagnosis of ADD or ADHD. Prior authorization will be required for clients under the age of 4.	ONYDA XR
	clonidine, clonidine ER guanfacine, guanfacine ER			
	SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR		Atomoxetine: Clients must have a diagnosis for ADD, ADHD, narcolepsy, obstructive sleep apnea, shift work sleep disturbance, or refractory depression (see refractory depression criteria below).  Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant.  Prior Authorization required for clients under the age of 4.  Claims will require Prior Authorization if clients have a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use.  Qelbree: Clients must have a 30-day trial and failure of a preferred non-stimulant 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. <b>Dosage limits apply: atomoxetine: 100mg/day</b>	
		atomoxetine QELBREE		
MIGRAINE	MIGRAINE PROPHYLAXIS		Trial and failure of both an anticonvulsant and a beta blocker (Step 1 agents) greater than or equal to three (3) months will be required before approval can be given for the step 2 agents. Concurrent use of Botox will not be approved. <b>Nurtec will be limited to 16 tabs/30 days.</b>	NURTEC
	STEP 1 AGENTS			
	beta blockers	divalproex topiramate		
	STEP 2 AGENTS		*Starting dose will be limited to 70mg **Approval for non-preferred agents requires trial and failure of a preferred agent along with the trial and failures described with Step 1 Agents' criteria above.	QULIPTA**
	ACUTE MIGRAINE TREATMENT			
	STEP 1 AGENTS		Trial and failure of two preferred agents will be required for approval of a non-preferred agent.	almotriptan ELYXB Sumatriptan-Naproxen Sodium TOSYMRA (use preferred agent) ZEMBRACE (use preferred agent) ZAVZPRET zolmitriptan
	frovatriptan naratriptan RELPAX* sumatriptan rizatriptan		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	
	STEP 2 AGENTS		Trial and failure of two triptan agents required for Step 2 Agent approval Trial and failure of two preferred triptan agents AND Nurtec OR Ubrelyv will be required for approval of a non-preferred agent. Quantity limits apply: NURTEC 75mg: limited to 8 tabs/30 days	
		NURTEC UBRELVY		
MOVEMENT DISORDERS	VMAT 2 INHIBITORS		Quantity limits apply: AUSTEDO: limited to 4 tabs/day INGREZZA: limited to 4 tabs/day *Please refer to the Additional Therapeutic Criteria chart at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a>	INGREZZA (sprinkles)
	AUSTEDO/XR* INGREZZA* TETRABENAZINE			
MULTIPLE SCLEROSIS	MS AGENTS		Gilenya, Kesimpta, Lemtrada, Ocrevus, and Tysabri will be approved for highly active disease, please refer to the ATCC for additional information.	AUBAGIO AVONEX BAFIERTAM BRIUMVI glatramer (BRAND IS PREFERRED) GLATOPA (use preferred agent) MAVENCLAD MAYZENT PLEGRIDY PONVORY TECFIDERA VUMERITY ZEPOSIA
	BETASERON COPAXONE 20MG/ML* dimethyl fumarate REBIF teriflunomide	GILENYA KESIMPTA** LEMTRADA OCREVUS TYSABRI	Trial and failure of two preferred agents for at least 56 days (each from a separate class) will be required before approval can be given for a non-preferred agent.  For Mavenclad, in addition to the above criteria, approval will be granted on a case-by-case basis.	
NARCOLEPSY	STIMULANTS		Modafinil and Nuvigil: Client must be > 16 years of age. Client must have a diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, Multiple Sclerosis (MS) Fatigue, or ADD/ADHD with a concurrent diagnosis of substance abuse.	
		modafinil NUVIGIL*	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.  Clients will not be allowed to take two or more agents in this class concurrently	SUNOSI WAKIX XYREM
NEUROPATHIC PAIN	GABAPENTIN		Clients will not be allowed to take gabapentin and pregabalin concurrently Prior authorizations for perioperative pain will be approved for gabapentin OR pregabalin for less than or equal to 14 day supplies	
		gabapentin pregabalin		
	TOPICAL LIDOCAINE			ZTLIDO
	Lidocaine Patches			
	ADDITIONAL AGENTS		Trial and failure of a tricyclic antidepressant greater than or equal to a 12 week supply AND trial and failure of gabapentin at a dose of 3600mg per day OR pregabalin for greater than or equal to a 12 week supply in the last 12 months will be required before approval can be given for a non-preferred agent.	imipramine (capsules) oxcarbazepine valproic acid
	amitriptyline desipramine imipramine (tablets) nortriptyline			
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.	
		ZEPBOUND		

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT DORAMIE WITH ANY QUESTIONS</small>					
<b>OPHTHALMICS</b>	<b>OP. -ANTI-ALLERGENICS</b>		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Alomide and Alocril will be approved for pregnancy. Alomide will be approved for children under the age of 3.	bepotastine epinastine ZERVATIE					
	ALREX azelastine BEPREVE* cromolyn 0.4%			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.	gatifloxacin				
	<b>OP. -ANTIBIOTICS- QUINOLONES</b>								
	ciprofloxacin BESIVANCE gentamicin moxifloxacin 0.5% ofloxacin tobramycin								
	<b>OP. -ANTI-INFLAMMATORY</b>				Trial and failure of ALL preferred agents each greater than or equal to 5 day supply in the last 12 months will be required before approval can be given for a non- preferred agent.	ACULAR/LS/PF (use preferred agent) ACUVAIL bromfenac 0.9% BROMSITE DUREZOL ILEVRO INVELTYS LOTEMAX SM loteprednol 0.5% (BRAND IS PREFERRED) PROLENSA			
	flurbiprofen diclofenac LOTEMAX* ketorolac NEVANAC								
	<b>OP. -BETA-BLOCKERS</b>					Trial and failure of three (3) preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non- preferred agent. *Betoptic S will be approved for those with heart and lung conditions.	BETIMOL BETOPIC S*		
	betaxolol carteolol levobunolol timolol								
	<b>OP. -CARBONIC ANHYDRASE INHIBITOR</b>						Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	brinzolamide (BRAND IS PREFERRED)	
	AZOPT* dorzolamide								
	<b>OP. -COMBO PRODUCTS</b>								dorzolamide/timolol (BRAND IS PREFERRED)
	COMBIGAN* COSOPT ROCKLATAN SIMBRINZA								
	<b>OP. -DRY EYE AGENTS</b>							Trial and failure of the preferred agent greater than or equal to 12 weeks will be required before approval can be given for the non-preferred agent.	CEQUA cyclosporine (BRAND IS PREFERRED) EYSUVIS MIEBO RESTASIS MULTIDOSE (see preferred) TYRVAYA
	RESTASIS* XIIDRA								
	<b>OP. -PROSTAGLANDINS</b>								Trial and failure of ALL preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non- preferred agent.
latanoprost LUMIGAN TRAVATAN Z XALATAN ZIOPTAN									
<b>OP. -RHO KINASE INHIBITOR</b>									
RHOPRESSA									
<b>OP. -SYMPATHOMIMETICS</b>		Trial of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	brimonidine 0.15% (BRAND IS PREFERRED)						
ALPHAGAN P 0.1% ALPHAGAN P 0.15%* brimonidine 0.2%									
<b>OSTEOPOROSIS</b>	<b>BISPHOSPHONATES</b>		Trial and failure of a preferred agent greater than or equal to 12 months will be required before approval can be given for a non-preferred agent.  Fosamax liquid will be approved for clients that have difficulty swallowing.  **Evinity will only be allowed for a maximum of 12 months of treatment, will not be allowed with any concurrent osteoporosis treatment, and will be limited to approved indication  ***Will be limited to 2 years of use	EVENITY** FORTEO*** FOSAMAX-D TYMLOS***					
	alendronate ibandronate risedronate								
<b>NASAL CALCITONIN</b>									
calcitonin-salmon									
<b>OTIC</b>	<b>ANTIBIOTIC/STEROID COMBINATION</b>			ciprofloxacin 0.2% (use preferred agent) CIPRO HC (use preferred agent) CORTISPORIN-TC (use preferred agent) FLUOCINOLONE ACET OIL 0.01% (use preferred agent)					
	ciprofloxacin/dexamethasone Neo/Poly/HC suspension/solution ofloxacin tobramycin/dexamethasone								
<b>OVERACTIVE BLADDER</b>	<b>OVERACTIVE BLADDER AGENTS</b>		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Oxytrol will be approved for clients that have an inability to swallow.	darifenacin GEMTESA mirabegron (BRAND IS PREFERRED) OXYTROL DIS tolterodine/ER TOVIAZ trospium					
	MYRBETRIQ* oxybutynin /ER solfenacin								
<b>PAIN</b>	<b>LONG-ACTING C-III's</b>		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's and C-IV's that are not included on the PDL and are generally available without prior authorization  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: 37.5mcg, 1 strength at a time, 1 patch every 3 days Hydromorphone ER: 30mg/day Hysingla ER: 120mg/day Methadone: Limited to 3 tablets per day Morphine ER: 90mg/day Oxycontin: 60mg/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 caulsules (use preferred agents) oxymorphone ER OXYCONTIN					
	morphine ER tablets								

**WYOMING MEDICAID  
Preferred Drug List (PDL) April 15, 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 <small>THIS LIST IS NOT ALL-INCLUSIVE PLEASE CONTACT Opioids WITH ANY QUESTIONS</small>																																																																																																																	
PAIN continued	<b>SHORT-ACTING C-II's</b>		<p>Trial and failure of three (3) preferred agents greater than or equal to a 6 day supply in the last 90 days will be required before approval can be given for a non-preferred agent.</p> <p>Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid.</p> <p><b>All short-acting narcotics, long-acting narcotics, OR combinations thereof, will be limited to a total dose of 90 MME per day.</b></p> <p><b>Clients will be limited to one short-acting narcotic at a time</b></p>	levorphanol oxycodone ROXYBOND																																																																																																																	
	codeine sulfate hydrocodone/APAP hydrocodone/IBU hydromorphone meperidine morphine oxycodone oxycodone/APAP					<b>C-III/C-IV AGENTS</b>		<p>Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. <b>Quantity and dosage limits apply (max 8 tabs/day).</b></p> <p>Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid.</p>	BELBUCA tramadol/apap tramadol ER capsules/tablets		BUTRANS* tramadol		PARKINSON'S DISEASE	<b>SHORT-ACTING AGENTS</b>				amantadine benztropine tablets carbidopa/levodopa pramipexole ropinirole			<b>LONG-ACTING AGENTS</b>		<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		ropinirole ER RYTARY		PHOSPHATE BINDERS	<b>PHOSPHATE BINDERS</b>		Prior authorization required for non-preferred agents.	AURYXIA lanthanum sevelamer VELPHORO	PROSTATE	<b>5-ALPHA-REDUCTASE INHIBITORS</b>		<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)	finasteride			<b>ALPHA BLOCKERS</b>		<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>	alfuzosin dutasteride/tamsulosin (use separate agents) silodosin		doxazosin tamsulosin terazosin		PULMONARY ANTIHYPERTENSIVES	<b>5-ALPHA-REDUCTASE INHIBITORS</b>		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	OPSYNVI		ALYQ sildenafil suspension sildenafil (A/B rated generics)				<b>ENDOTHELIN RECEPTOR ANTAGONISTS</b>		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	bosentan (BRAND IS PREFERRED) OPSUMIT (use preferred agent) TRACLEER TABS FOR ORAL SUSP (use preferred agent) WINREVAIR		LETAIRIS TRACLEER TABS*					<b>GUANYLATE CYCLASE INHIBITORS</b>		Prior authorization required.	ADEMPAS (use preferred agent)		<b>PROSTACYCLINE VASODILATORS</b>		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.				ORENTRAM				<b>PROSTACYCLINE RECEPTOR AGONIST</b>		Prior authorization required.	UPTRAVI (use preferred agent)	RESTLESS LEG SYNDROME	<b>RESTLESS LEG SYNDROME</b>		<p>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.</p> <p>*Neupro will be approved for clients with difficulty swallowing or for clients with a diagnosis of Parkinson's Disease.</p> <p>Clients will not be allowed to take gabapentin and pregabalin concurrently</p>	HORIZANT NEUPRO*		pramipexole ropinirole	gabapentin pregabalin			SKELETAL MUSCLE RELAXANTS	<b>MUSCLE RELAXANTS</b>		<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>Cyclobenzaprine will require a prior authorization for clients concurrently taking a tricyclic antidepressant. <b>Carisoprodol is limited to 84 tabs/365 days</b></p>	carisoprodol chlorzoxazone cyclobenzaprine ER metaxalone methocarbamol orphenadrine tizanidine capsules (use preferred agent)	baclofen (5, 10, 20mg tablets) cyclobenzaprine tizanidine tablets		ULCERATIVE COLITIS	<b>IMMUNOMODULATORS</b>		<p>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.</p> <p>* Refer to Additional Therapeutics Clinical Criteria Chart for more information</p>	ENTYVIO* REMICADE SIMPONI SKYRIZI STELARA TREMIFYA XELJANZ/XR		adalimumab-fkjp HADUMA HUMIRA RINVOQ	UVEITIS	<b>IMMUNOMODULATORS</b>		Client must have diagnosis of non-infectious intermediate, posterior, or panuveitis			
	<b>C-III/C-IV AGENTS</b>		<p>Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. <b>Quantity and dosage limits apply (max 8 tabs/day).</b></p> <p>Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid.</p>	BELBUCA tramadol/apap tramadol ER capsules/tablets																																																																																																																	
	BUTRANS* tramadol				PARKINSON'S DISEASE	<b>SHORT-ACTING AGENTS</b>				amantadine benztropine tablets carbidopa/levodopa pramipexole ropinirole			<b>LONG-ACTING AGENTS</b>		<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		ropinirole ER RYTARY		PHOSPHATE BINDERS	<b>PHOSPHATE BINDERS</b>		Prior authorization required for non-preferred agents.	AURYXIA lanthanum sevelamer VELPHORO	PROSTATE	<b>5-ALPHA-REDUCTASE INHIBITORS</b>		<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)	finasteride			<b>ALPHA BLOCKERS</b>		<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>	alfuzosin dutasteride/tamsulosin (use separate agents) silodosin		doxazosin tamsulosin terazosin		PULMONARY ANTIHYPERTENSIVES	<b>5-ALPHA-REDUCTASE INHIBITORS</b>		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	OPSYNVI		ALYQ sildenafil suspension sildenafil (A/B rated generics)					<b>ENDOTHELIN RECEPTOR ANTAGONISTS</b>		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	bosentan (BRAND IS PREFERRED) OPSUMIT (use preferred agent) TRACLEER TABS FOR ORAL SUSP (use preferred agent) WINREVAIR		LETAIRIS TRACLEER TABS*					<b>GUANYLATE CYCLASE INHIBITORS</b>		Prior authorization required.	ADEMPAS (use preferred agent)		<b>PROSTACYCLINE VASODILATORS</b>		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.				ORENTRAM				<b>PROSTACYCLINE RECEPTOR AGONIST</b>		Prior authorization required.	UPTRAVI (use preferred agent)	RESTLESS LEG SYNDROME	<b>RESTLESS LEG SYNDROME</b>		<p>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.</p> <p>*Neupro will be approved for clients with difficulty swallowing or for clients with a diagnosis of Parkinson's Disease.</p> <p>Clients will not be allowed to take gabapentin and pregabalin concurrently</p>	HORIZANT NEUPRO*		pramipexole ropinirole	gabapentin pregabalin			SKELETAL MUSCLE RELAXANTS	<b>MUSCLE RELAXANTS</b>		<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>Cyclobenzaprine will require a prior authorization for clients concurrently taking a tricyclic antidepressant. <b>Carisoprodol is limited to 84 tabs/365 days</b></p>	carisoprodol chlorzoxazone cyclobenzaprine ER metaxalone methocarbamol orphenadrine tizanidine capsules (use preferred agent)	baclofen (5, 10, 20mg tablets) cyclobenzaprine tizanidine tablets		ULCERATIVE COLITIS	<b>IMMUNOMODULATORS</b>		<p>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.</p> <p>* Refer to Additional Therapeutics Clinical Criteria Chart for more information</p>	ENTYVIO* REMICADE SIMPONI SKYRIZI STELARA TREMIFYA XELJANZ/XR		adalimumab-fkjp HADUMA HUMIRA RINVOQ	UVEITIS	<b>IMMUNOMODULATORS</b>		Client must have diagnosis of non-infectious intermediate, posterior, or panuveitis				adalimumab-fkjp HADUMA HUMIRA						
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PHOSPHATE BINDERS	<b>PHOSPHATE BINDERS</b>		Prior authorization required for non-preferred agents.	AURYXIA lanthanum sevelamer VELPHORO																																																																																																																	
PROSTATE	<b>5-ALPHA-REDUCTASE INHIBITORS</b>		<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)																																																																																																																	
	finasteride					<b>ALPHA BLOCKERS</b>		<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>	alfuzosin dutasteride/tamsulosin (use separate agents) silodosin		doxazosin tamsulosin terazosin		PULMONARY ANTIHYPERTENSIVES	<b>5-ALPHA-REDUCTASE INHIBITORS</b>		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	OPSYNVI		ALYQ sildenafil suspension sildenafil (A/B rated generics)				<b>ENDOTHELIN RECEPTOR ANTAGONISTS</b>			Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	bosentan (BRAND IS PREFERRED) OPSUMIT (use preferred agent) TRACLEER TABS FOR ORAL SUSP (use preferred agent) WINREVAIR		LETAIRIS TRACLEER TABS*						<b>GUANYLATE CYCLASE INHIBITORS</b>		Prior authorization required.	ADEMPAS (use preferred agent)		<b>PROSTACYCLINE VASODILATORS</b>		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.				ORENTRAM				<b>PROSTACYCLINE RECEPTOR AGONIST</b>		Prior authorization required.	UPTRAVI (use preferred agent)	RESTLESS LEG SYNDROME	<b>RESTLESS LEG SYNDROME</b>		<p>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.</p> <p>*Neupro will be approved for clients with difficulty swallowing or for clients with a diagnosis of Parkinson's Disease.</p> <p>Clients will not be allowed to take gabapentin and pregabalin concurrently</p>	HORIZANT NEUPRO*		pramipexole ropinirole	gabapentin pregabalin			SKELETAL MUSCLE RELAXANTS	<b>MUSCLE RELAXANTS</b>		<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>Cyclobenzaprine will require a prior authorization for clients concurrently taking a tricyclic antidepressant. <b>Carisoprodol is limited to 84 tabs/365 days</b></p>	carisoprodol chlorzoxazone cyclobenzaprine ER metaxalone methocarbamol orphenadrine tizanidine capsules (use preferred agent)	baclofen (5, 10, 20mg tablets) cyclobenzaprine tizanidine tablets		ULCERATIVE COLITIS	<b>IMMUNOMODULATORS</b>		<p>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.</p> <p>* Refer to Additional Therapeutics Clinical Criteria Chart for more information</p>	ENTYVIO* REMICADE SIMPONI SKYRIZI STELARA TREMIFYA XELJANZ/XR		adalimumab-fkjp HADUMA HUMIRA RINVOQ	UVEITIS	<b>IMMUNOMODULATORS</b>		Client must have diagnosis of non-infectious intermediate, posterior, or panuveitis				adalimumab-fkjp HADUMA HUMIRA																																
	<b>ALPHA BLOCKERS</b>		<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>	alfuzosin dutasteride/tamsulosin (use separate agents) silodosin																																																																																																																	
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