WYOMING MEDICAID
Preferred Drug List (PDL) - January 1, 2019

Drug classes not included on this list are not managed through a Preferred Drug List (PDL).
HOWEVER, THIS EXCLUSION IS NOT A GUARANTEE OF PAYMENT OR COVERAGE. Dosage limits and other requirements may apply.
Drugs new to market are non-preferred until a clinical review has been completed. PA criteria will apply to both the pediatric population, as well as the adult population for those plans where PA/PDL limits are allowed.
Unless otherwise noted on the PDL, generic substitution is mandatory.
Yellow highlighted items below indicate new changes to the PDL. Red font indicates quantity/dosage limits apply. *Indicates BRAND is Preferred. May Use DAW 5.
Contact the Change Healthcare PA Helpdesk @ 877-207-1126 for prior authorization if client has primary insurance that will not cover the brand name medication.

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

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES (THIS LIST IS NOT ALL INCLUSIVE. PLEASE CONTACT CHANGE HEALTHCARE WITH ANY QUESTIONS)
ADDICTION	**BUPRENORPHINE COMBINATIONS**	buprenorphine/naloxone tablets **SUBOXONE FILM***	Client must have a diagnosis of opioid dependence or abuse. This is not to be used for the treatment of chronic pain. Prescriber must have a XDEA number. Prior authorization will be required before any narcotic, benzodiazepine, or carisoprodol prescription will be allowed between fills. Prior authorization will be required before any short-acting stimulant prescription from any doctor other than the prescriber of buprenorphine or Suboxone, will be allowed between fills. Oral buprenorphine will be approved for clients with a documented allergy to naloxone. Please submit PA requests on the "Oral Buprenorphine/Naloxone or Oral Buprenorphine" PA form available at www.wymedicaid.org. Dosage limits apply During first two years of treatment: 16mg After two years of treatment: 8mg	BUNAVAIL buprenorphine (oral) buprenorphine/naloxone film (BRAND IS PREFERRED) ZUBSOLV
	NALTREXONE	naltrexone VIVITROL	Client must have a diagnosis of alcohol or opioid dependance. 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.	
ALLERGY / ASTHMA	**ANTIHISTAMINES, MINIMALLY SEDATING** cetirizine fexofenadine loratadine		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	desloratadine CLARINEX RDT/SYRUP levocetirizine
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	CLARINEX-D
	ANTICHOLINERGIC BRONCHODILATORS ipratropium SPIRIVA HANDIHALER TUDORZA		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 Respimat will be allowed for clients over the age of 5, that do not have a diagnosis of COPD, and have concurrent treatment with an inhaled corticosteroid and a long-acting bronchodilator. **Lonhala will be allowed for clients that have difficulty using an inhaler Spiriva 5 day STARTER package will be allowed one (1) time per recipient.	ATROVENT HFA INCRUSE ELLIPTA **LONHALA SEEBRI *SPIRIVA RESPIMAT (use preferred agent)
	INHALED COMBINATION AGENTS ADVAIR DISK/HFA DULERA SYMBICORT		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. ***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.	AIRDUO ANORO ELLIPTA** BEVESPI BREO ELLIPTA*** COMBIVENT fluticasone/salmeterol 232,113,55-14mcg STIOLTO TRELEGY UTIBRON
	LEUKOTRIENE MODIFIERS montelukast		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 ZYFLO
	LONG ACTING BRONCHODILATORS BROVANA FORADIL SEREVENT		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. **Arcapta will require a diagnosis of COPD and the client must be older than 40 years of age	ARCAPTA** PERFOROMIST STRIVERDI
	NASAL ANTIHISTAMINES **ASTELIN** azelastine 0.1%		Trial and failure of preferred agent greater than or equal to 90 days in the last 12 months will be required before approval can be given for a non-preferred agent.	azelastine 0.15% AZENASE *(use separate agents)* DYMISTA *(use separate agents)* olopatadine 0.6%
	NASAL STEROIDS BECONASE AQ flunisolide fluticasone **NASONEX***		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.	AZENASE *(use separate agents)* budesonide DYMISTA *(use separate agents)* mometasone (BRAND IS PREFERRED) OMNARIS QNASL TICANASE *(use separate agents)* VERAMYST ZETONNA
	SHORT ACTING BRONCHODILATORS - INHALERS PROAIR HFA PROVENTIL HFA VENTOLIN HFA **XOPENEX HFA***		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. Minimum day supply of at 16 days is required	levoalbuterol (BRAND IS PREFERRED) PROAIR RESPICLICK

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

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES PLEASE CONTACT CHANGE HEALTHCARE WITH ANY QUESTIONS
ALLERGY / ASTHMA continued	**STEROID INHALANTS**		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Alvesco will be approved for a history of oral thrush with steroid inhalants.	AEROBID/AEROBID-M AEROSPAN ALVESCO ARMONAIR ARNUITY ASMANEX HFA QVAR/REDIHALER
	ASMANEX FLOVENT HFA/DISK budesonide suspension PULMICORT FLEXHALER			
	EPINEPHRINE			ADRENACLICK *(use preferred agent)* AUVI-Q *(use preferred agent)* EPI-PEN *(use preferred agent)*
	epinephrine auto-injector pen			
ARTHRITIS	**IMMUNOMODULATORS**		Client must have diagnosis of AS prior to approval of a step 1 agent (Enbrel or Humira). To receive Cosentyx, the client must have a diagnosis of AS and a 56-day trial and failure of Humira. To receive a non-preferred agent, client must have a diagnosis of AS and a 56-day trial and failure of both preferred agents (Enbrel and Humira). 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 REMICADE *(additional criteria applies)* SIMPONI
	ANKYLOSING SPONDYLITIS (AS)			
	STEP 1 AGENTS			
		ENBREL HUMIRA		
	STEP 2 AGENTS			
		COSENTYX		
	JUVENILE IDIOPATHIC ARTHRITIS (JIA)		Client must have diagnosis of JIA prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of JIA and a 56-day trial and failure of both preferred agents.	ACTEMRA ORENCIA
		ENBREL HUMIRA		
	PSORIATIC ARTHRITIS (PA)		Client must have diagnosis of PA prior to approval of a step 1 agent (Enbrel or Humira). To receive Cosentyx, the client must have a diagnosis of PA and a 56-day trial and failure of Humira. To receive a non-preferred agent, client must have a diagnosis of PA and a 56-day trial and failure of both preferred agents (Enbrel and Humira).	CIMZIA ORENCIA OTEZLA REMICADE *(additional criteria applies)* SIMPONI STELARA
	STEP 1 AGENTS			
		ENBREL HUMIRA		
	STEP 2 AGENTS			
		COSENTYX		
	RHEUMATOID ARTHRITIS (RA)		Client must have diagnosis of RA and a 56-day trial and failure of methotrexate prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of RA and a 56-day trial and failure of both preferred agents.	ACTEMRA CIMZIA KEVZARA KINERET OLUMIANT ORENCIA REMICADE *(additional criteria applies)* RITUXAN SIMPONI XELJANZ/XR
	ENBREL HUMIRA			
CONVULSIONS	**DIAZEPAM RECTAL GEL**			diazepam gel (BRAND IS PREFERRED)
	DIASTAT*			
	ORAL ANTICONVULSANTS		Limited to FDA approved indications	
		APTIOM FELBAMATE FYCOMPA VIMPAT		
CROHN'S	**IMMUNOMODULATORS**		Client must have diagnosis of Crohn's prior to approval of the preferred agent. To receive a non-preferred agent, client must have a diagnosis of Crohn's and a 56-day trial and failure of the preferred agent.	CIMZIA REMICADE *(additional criteria applies)* STELARA TYSABRI *(additional criteria applies)*
	HUMIRA			
DERMATOLOGY	**BENZOYL PEROXIDE/ADAPALENE COMBOs**			adapalene/benzoyl peroxide gel 0.1-2.5% (BRAND IS PREFERRED)
	EPIDUO*			
	BENZOYL PEROXIDE/CLINDAMYCIN COMBOs		Clients must be 12 to 20 years of age. Requires prior authorization for clients less than 12 years of age. Acne combinations are limited to clients under the age of 21.	ACANYA *(use preferred agent)* clindamycin/benzoyl peroxide 1-5% (BRAND IS PREFERRED) ONEXTON *(use preferred agent)*
		BENZACLIN* clindamycyin/benzoyl peroxide 1.2-5% (Refrig)		
	ISOTRETINOIN			ABSORICA *(use preferred agents)*
	AMNESTEEM CLARAVIS isotretinoin MYORISAN ZENATANE			
	CORTICOSTEROIDS - STEP 1 AGENTS **C=CREAM; G=GEL; L=LOTION; O=OINTMENT**		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	PANDEL prednicarbate 0.1% (C,O) TEXACORT 2.5% (S)
	LOW POTENCY			
	alclometasone desonide DESOWEN 0.05% (L) fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) SYNALAR 0.01%			
	MEDIUM POTENCY		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	Clocortolone Pivalate CORDRAN/SP fluticasone 0.05% (L) hydrocortisone butyrate 0.1% (O) TOPICORT LP TRIANEX
	betamethasone valerate CUTIVATE 0.05% (C) DERMATOP 0.1% (C) desoximetasone 0.05%, 0.25% (C) ELOCON 0.1% fluocinolone 0.025% fluticasone 0.05% (C) hydrocortisone probutate 0.1% (C) mometasone SYNALAR 0.025% TOPICORT 0.05% (C) triamcinolone 0.025%, 0.1%			

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

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES
DERMATOLOGY continued	**HIGH POTENCY**		Trial and failure of ALL preferred agents greater than or equal to 14 days in the last 90 days.	APEXICON amcinonide 0.1% (C,L,O) augmented betamethasone 0.05% (G,L,O) clobetasol 0.05% (L) desoximetasone 0.05%, 0.25% (G,O) fluocinonide 0.1% (C) HALOG
	betamethasone dipropionate clobetasol/E 0.05% (C,G,O,S) diflorasone fluocinonide flurandrenolide fluticasone 0.005% (O) halobetasol TEMOVATE/E TOPICORT 0.25% (C) triamcinolone 0.5% ULTRAVATE 0.05%			
	IMMUNOMODULATORS - STEP 2 AGENTS		**To receive a step 2 agent:** Trial and failure of a preferred medium potency topical corticosteroid greater than or equal to a 21 day trial and a trial and failure of a preferred high potency topical corticosteroid greater than or equal to a 21 day trial in the last 90 days. For clients less than two (2) years of age, a trial and failure of a preferred low potency corticosteroid greater than or equal to a 21 day trial and a trial and failure of a preferred medium potency topical cortiscosteroid greater than or equal to a 21 day trial in the last 90 days.	tacrolimus (BRAND IS PREFERRED)
		ELIDEL **PROTOPIC***		
	PHOSPHODIESTERASE 4 INHIBITOR - STEP 3 AGENT		**To receive a step 3 agent:** Trial and failure of a preferred step 2 agent (immunomodulator) greater than or equal to a 21 day trial within the last 30 days.	DUPIXENT EUCRISA
	PLAQUE PSORIASIS (PP)		Client must have diagnosis of PP prior to approval of a step 1 agent (Enbrel or Humira). To receive Cosentyx, the client must have a diagnosis of PP and a 56-day trial and failure of Humira. To receive Tremfya, the client must have a diagnosis of PP and a 56-day trial and failure of Enbrel. To receive a non-preferred agent, client must have a diagnosis of PP and a 56-day trial and failure of both preferred agents.	OTEZLA REMICADE *(additional criteria applies)* SILIQ STELARA TALTZ
	STEP 1 AGENTS			
		ENBREL HUMIRA		
	STEP 2 AGENTS			
		COSENTYX TREMFYA		
	SALICYLIC ACID			All other topical salicylic acid formulations.
	salicylic acid cream 6% salicylic acid lotion 6% salicylic acid shampoo 6%			
	SCABICIDES/PEDICULICIDES		Trial and failure of a preferred agent in the last 12 months.	LINDANE OVIDE spinosad (BRAND IS PREFERRED)
	NATROBA* permethrin SKLICE			
	UREA			All other topical urea formulations.
	ALUVEA CREAM 33% UMECTA EMULSION umecta mousse aerosal 40% urea lotion 40% urea lotion 45%			
DIABETES	**DIABETES AGENTS**			metformin SR 24HR osmotic release *(use preferred agent)* metformin SR 24HR modified release *(use preferred agent)* RIOMET *(use preferred agent)*
	BIGUANIDES			
	metformin/ER			
	α–GLUCOSIDASE INHIBITORS		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	**GLYSET***
	acarbose			
	MEGLITINIDES		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	repaglinide
	nateglinide			
	THIAZOLIDINEDIONES		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ACTOSPLUS MET *(use separate agents)* AVANDIA AVANDAMET *(use separate agents)*
	pioglitazone			
	SULFONYLUREAS		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	
	glimepiride/ER glipizide/ER glyburide/ER			
	DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITORS		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	alogliptin GLYXAMBI *(use separate preferred agents)* ONGLYZA QTERN *(use separate preferred agents)* STEGLUJAN *(use separate preferred agents)* TRADJENTA
		JANUVIA		
	DPP-4 INHIBITOR COMBO AGENTS		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	alogliptin/metformin alogliptin/pioglitazone *(use separate preferred agents)* JENTADUETO JUVISYNC *(use separate preferred agents)* KOMBIGLYZE
		JANUMET/XR		
	INCRETIN MIMETICS (GLP-1 RECEPTOR AGONISTS)		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent. Dosage Limits Apply: Victoza: 1.8mg/day	ADLYXIN BYDUREON BCISE OZEMPIC SOLIQUA TANZEUM TRULICITY
		BYDUREON BYETTA VICTOZA		

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

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES
DIABETES continued	**SGLT2 INHIBITORS**	FARXIGA JARDIANCE	Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	GLYXAMBI *(use separate preferred agents)* INVOKAMET/XR*(use separate preferred agents)* INVOKANA QTERN *(use separate preferred agents)* SEGLUROMET *(use separate preferred agents)* STEGLATRO STEGLUJAN *(use separate preferred agents)* SYNJARDY/XR *(use separate preferred agents)* XIGDUO XR *(use separate preferred agents)*
	LONG-ACTING INSULIN		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently	LANTUS OPTICLIK *(use preferred agent)* TOUJEO *(use preferred agent)* TRESIBA *(use preferred agent)* XULTOPHY *(use preferred agent)*
	LANTUS SOLOSTAR LANTUS vial LEVEMIR			
	DIABETIC METERS/TEST STRIPS		Quantity limits apply: Insulin Dependent Clients: 10 strips/day Non-Insulin Dependent Clients: 4 strips/day Clients are limited to 1 meter/365 days	ALL OTHER METERS AND TEST STRIPS
	FREESTYLE FREESTYLE FREEDOM FREESTYLE FREEDOM LITE FREESTYLE INSULINX FREESTYLE PRECISION NEO ONE TOUCH II ONE TOUCH ULTRA MINI ONE TOUCH ULTRA BLUE ONE TOUCH VERIO ONE TOUCH VERIO FLEX ONE TOUCH VERIO IQ PRECISION XTRA			
	CONTINUOUS BLOOD GLUCOSE MONITORS	DEXCOM FREESTYLE LIBRE	Prior authorization will be required to verify if the client is on three or more insulin injections per day. Monitors will also be limited to the labeled age.	MINIMED
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	duloxetine LYRICA SAVELLA
	amitriptyline cyclobenzaprine			
GASTROINTESTINAL	**BOWEL EVACUANTS**			CLENPIQ *(use preferred agents)* GAVILYTE H *(use preferred agents)* POLY-PREP *(usse preferred agents)* PREPOPIK *(use preferred agents)*
	COLYTE GAVILYTE C, G, N GOLYTELY MOVIPREP NULYTELY PEG 3350 SOLUTION SUCLEAR SUPREP TRILYTE			
	CHRONIC IDIOPATHIC CONSTIPATION	AMITIZA LINZESS	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.	TRULANCE
	DIGESTIVE ENZYMES		Prior authorization required.	PANCREAZE pancrelipase PERTZYE TRI-PASE ULTRESA VIOKASE
	CREON ZENPEP			
	IRRITABLE BOWEL SYNDROME WITH CONSTIPATION	AMITIZA LINZESS	Client must have a diagnosis of Irritable Bowel Syndrome (IBS) with constipation.	
	IRRITABLE BOWEL SYNDROME WITH DIARRHEA	VIBERZI	Client must have a diagnosis of Irritable Bowel Syndrome (IBS) with diarrhea.	
	MESALAMINE		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ASACOL HD CANASA GIAZO mesalamine DR tab 1.2gm (BRAND IS PREFERRED) SFROWASA
	APRISO DELZICOL **LIALDA*** mesalamine enema PENTASA			
	OPIOID-INDUCED CONSTIPATION AGENTS	AMITIZA	Client must have a diagnosis of opioid-induced constipation and a three (3) month trial and failure of a secretory agent 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* RELISTOR SYMPROIC
	PREGNANCY INDUCED NAUSEA/VOMITING			BONJESTA *(use preferred agent)*
	DICLEGIS			
	PROTON PUMP INHIBITORS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. PREVACID solutabs will be approved for children less than or equal to 8 years of age.	ACIPHEX SPRINKLES amox/clarith/lanso pack *(use separate agents)* DEXILANT esomeprazole 24.65mg and 49.3mg **NEXIUM*** omeprazole 20.6mg capsules *(use preferred agent)* omeprazole tablets *(use preferred agent)* omeprazole/sodium bicarbonate OMECLAMOX *(use separate agents)* **PREVACID solutabs*** rabeprazole VIMOVO *(use separate agents)*
	lansoprazole capsules omeprazole capsules pantoprazole			
GOUT	**COLCHICINE**			COLCRYS *(use preferred agent)* MITIGARE *(use preferred agent)*
	colchicine			
	XANTHINE OXIDASE AND URAT1 INHIBITORS		Trial and failure of a 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. *Concurrent use of a preferred agent will be required with Zurampic.	ZURAMPIC*
	allopurinol ULORIC			

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

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES PLEASE CONTACT CHANGE HEALTHCARE WITH ANY QUESTIONS
HEMATOLOGY	**LOW MOLECULAR WEIGHT HEPARIN (LMWH)**		Prior authorization will be required for the 300mg/3ml strength.	FRAGMIN *(use preferred agent)* **LOVENOX 300MG/3ML***
	enoxaparin			
		DIRECT THROMBIN INHIBITOR	Client must have diagnosis of non-valvular atrial fibrillation and relative contraindication to warfarin for approval, treatment for deep vein thrombosis (DVT) or pulmonary embolism (PE), or for the reduction in the risk of recurrence of DVT and PE after initial therapy.	
		PRADAXA		
		FACTOR XA INHIBITOR	Limited to being used for the prophylaxis of venous thromboembolism (VTE) in adult patients hospitalized for an acute medical illness who are at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE	
		BEVYXXA		
		SELECTIVE FACTOR XA INHIBITOR	Client must have diagnosis of non-valvular atrial fibrillation, treatment for deep vein thrombosis (DVT) prophylaxis in knee or hip replacement, treatment of DVT and pulmonary embolism (PE), and for the reduction in the risk of recurrent DVT and PE after initial therapy.	SAVAYSA *(use preferred agent)*
		ELIQUIS/STARTER PACK XARELTO/STARTER PACK		
		THIENOPYRIDINE DERIVATIVES	Prior authorization required for clients on antiplatelet therapy greater than one (1) year.	
	clopidogrel prasugrel ticlopidine			
		CPTP DERIVATIVES	Client must have a diagnosis of acute coronary syndrome or a history of myocardial infarction	
		BRILINTA		
		PAR-1 ANTAGONIST	Client must have diagnosis of reduction of thrombotic cardiovascular events with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD). Must be used in conjunction with aspirin or clopidogrel.	
		ZONTIVITY		
	ANTIHEMOPHILIC FACTOR VIII			
	ADVATE ADYNOVATE AFSTYLA ELOCTATE HELIXATE FS HEMOFIL M KOATE/KOATE-DVI KOGENATE FS/BIO-SET KOVALTRY MONOCLATE-P NUWIQ NOVOEIGHT OBIZUR RECOMBINATE XYNTHA/SOLOFUSE			
	ANTIHEMOPHILIC FACTOR/VWF			
	ALPHANATE HUMATE-P WILATE			
HEPATITIS C		**DIRECT ACTING ANTIVIRALS**	Limited to FDA approved indication. Prior authorization will be required prior to use of preferred agents. **Positive SVR 12 will be required for consideration for retreatment Please submit PA requests on the Hepatitis C PA form available at www.wymedicaid.org.	DAKLINZA *(use preferred agent)* OLYSIO *(use preferred agent)* SOVALDI *(use preferred agent)* VOSEVI *(use preferred agent)* ZEPATIER *(use preferred agent)*
		EPCLUSA HARVONI MAVYRET**		
HIDRADENITIS SUPPURATIVA		**IMMUNOMODULATORS**	Humira will not be covered as a first line agent for the diagnosis for hidradenitis suppurativa.	
		HUMIRA		
HORMONES		**GROWTH HORMONE**	PA is required for use outside of FDA-approved indications. Evaluation by an endocrinologist is preferred. Clinical evidence of improved growth will be required on a yearly basis to support ongoing utilization. Clinical evidence of need for growth hormone will be required for adult growth hormone deficiency and pediatric growth failure due to inadequate endogenous growth hormone. Trial and failure of two (2) preferred agents within the last 12 months will be required for the following indications: Pediatric: Growth failure due to inadequate endogenous growth hormone, Prader-Willi syndrome, children born small for gestation. Turner syndrome. Adult: Replacement for those with growth hormone deficiency.	HUMATROPE OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE
		GENOTROPIN NORDITROPIN NUTROPIN AQ		
		PROGESTIN	Prior authorization is required.	
		MAKENA 250mg/ml MAKENA 275mg/1.1ml		
		TESTOSTERONE TOPICAL GELS	Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient testosterone production. *Other testosterone dosage form products will require a diagnosis of hypogonadism or insufficient testosterone production (not outlined on PDL).*	NATESTO NASAL GEL *(use preferred agent)* TESTIM GEL *(use preferred agent)* testosterone gel 1% (BRAND IS PREFERRED) testosterone gel 2% *(use preferred agent)* VOGELXO GEL *(use preferred agent)*
		ANDROGEL*		

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

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES PLEASE CONTACT CHANGE HEALTHCARE WITH ANY QUESTIONS
HORMONES continued	**ORAL CONTRACEPTIVES**			amethia/LO (BRAND IS PREFERRED) aranelle *(use preferred agent)* ashlyna (BRAND IS PREFERRED) BEYAZ *(PA required)* BREVICON *(use preferred agent)* camrese/LO (BRAND IS PREFERRED) daysee (BRAND IS PREFERRED) drospir/ethi *(use preferred agent)* estarylla tri-lo (BRAND IS PREFERRED) FALESSA KIT *(use preferred agent)* introvale *(use preferred agent)* layolis FE chewable *(PA required)* levonorgest/ethinyl estrad (91-Day) levonorgest/ethinyl estradiol (Continuous) *(use preferred agent)* levonorgest/ethinyl estradiol/LO (84-7) (BRAND IS PREFERRED) LO LOESTRIN *(PA required)* LO MINASTRIN FE *(PA required)* loryna *(use preferred agent)* MINASTRIN 24 FE CHEWABLE *(PA required)* NATAZIA *(PA required)* norgest/ethi estradiol lo (BRAND IS PREFERRED) NATAZIA *(PA required)* NECON 1/50-28 *(use preferred agent)* nikki *(use preferred agent)* noreth/ethin FE chewable *(PA required)* NORINYL 1/35 *(use preferred agent)* quasense *(use preferred agent)* QUARTETTE *(PA required)* SAFYRAL *(PA required)* tri-lo sprintec (BRAND IS PREFERRED) trinessa lo (BRAND IS PREFERRED) wymzya FE chewable (BRAND IS PREFERRED) zenchent FE chewable (BRAND IS PREFERRED)
	altavera alyacen 1-35, 7/7/7 amethyst azurette apri aubra aviane balziva bekyree blisovi 1-20 FE/24, 1.5-30 FE briellyn camila caziant chateal cyclafem 1-35, 7/7/7 cyred cryselle dasetta 1-35, 7/7/7 deblitane delyla DESOGEN deso/ethinyl estradiol elinest emoquette enpresse enskyce errin estarylla falmina FEMCON FE CHEWABLE gianvi gildagia gildess 1-20/FE/24, 1.5-30/FE heather jencycla jolessa jolivette juleber junel 1-20/FE/24, 1.5-30/FE kariva kelnor kimidess kurvelo larin 1-20/FE/24, 1.5-30/FE leena lessina levonest levonor/ethi levora lomedia 24 FE **LOSEASONIQUE*** low-ogestrel lutera lyza marlissa microgestin 1-20/FE/24, 1.5-30/FE MODICON mono-linyah mononessa myzilra NECON 0.5-35, 1-35, 7/7/7, 10/11-28 nora-be norgest/ethinyl estradiol norethindrone norlyroc noreth/ethin 1-20/FE/24 NORINYL 1/50-28 nortrel 0.5-35, 1-35, 7/7/7 ocella OGESTREL orsythia **ORTHO TRI-CYCLEN LO*** **ORTHO-NOVUM 1/35, 7/7/7*** philith pimtrea pirmella 1-35, 7/7/7 portia previfem reclipsen **SEASONIQUE*** setlakin sprintec sharobel sronyx syeda tilia FE tri-estaryll tri-legest FE tri-linyah trinessa **TRI-NORINYL*** tri-previfem tri-sprintec trivora velivet vestura vienva viorele vyfemla wera 0.5-35 YAZ zarah zenchent ZOVIA			

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

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES
HYPERLIPIDEMIA	**BILE ACID SEQUESTRANT**		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
	cholestyramine/light colestipol			
	PCSK9 INHIBITOR		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.	REPATHA *(use preferred agent)*
		PRALUENT		
	STATINS, LOW POTENCY		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization. Prior authorization will be required for clients under the age of 10.	fluvastatin/ER ZYPITAMAG
	lovastatin pravastatin			
	STATINS, HIGH POTENCY		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization. Prior authorization will be required for clients under the age of 10.	LIVALO rosuvastatin
	atorvastatin simvastatin			
	STATIN COMBINATIONS		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Prior authorization will be required for clients under the age of 10.	amlodopine/atorvastatin (BRAND IS PREFERRED) ezetimibe/simvastatin (BRAND IS PREFERRED)
	CADUET* **VYTORIN***			
	TRIGLYCERIDE LOWERING AGENTS		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ANTARA fenofibric fenofibrate 43, 50, 120, 130, and 150mg LIPOFEN omega-3-acid VASCEPA
	fenofibrate 48, 54, 67, 134, 145, 160, and 200mg gemfibrozil			
HYPERTENSION	**ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)**		Non-preferred ARBs will require a history of ALL preferred ARBs before approval can be given.	candesartan eprosartan 600mg TEVETEN 400mg
	EDARBI irbesartan losartan olmesartan telmisartan valsartan			
	ARBs AND DIURETICS		Non-preferred ARB/diuretic combinations will require a history of ALL preferred ARBs before approval can be given.	candesartan HCTZ telmisartan HCTZ TEVETEN HCTZ
	EDARBYCLOR irbesartan HCTZ losartan HCT olmesartan HCTZ valsartan HCTZ			
	ALPHA-BLOCKERS			clonidine patch (BRAND IS PREFERRED) NEXICLON XR *(use preferred agent)*
	CATAPRES PATCHES* clonidine			
INFECTIOUS DISEASE	**QUINOLONES**			FACTIVE moxifloxacin NOROXIN PROQUIN
	ciprofloxacin/ER levofloxacin ofloxacin			
	DOXYCYCLINE			ADOXA *(use preferred agent)* DORYX *(use preferred agent)* ORACEA *(use preferred agent)*
	doxycycline			
	MINOCYCLINE			*minocycline 65mg and 115mg ER (use preferred agent)* SOLODYN *(use preferred agent)*
	minocycline/ER			
	INHALED TOBRAMYCIN		*Tobi Podhaler requires a 28 day trial of a preferred agent, as well as 28 days off of that same preferred agent prior to approval. Minimum day supply of at 56 days is required	inhaled tobramycin *(use preferred agent)* TOBI PODHALER *(use preferred agent)*
	BETHKIS KITABIS			
	KEFLEX			cephalexin 750mg (BRAND IS PREFERRED)
	KEFLEX 750mg*			
	ANTI-RETROVIRALS			STRIBILD (use separate agents) SYMTUZA (use separate preferred agents) TRIUMEQ (use separate agents)
	BIKTARVY CIMDUO DESCOVY EVOTAZ GENVOYA NORVIR ODEFSEY PREZCOBIX SYMFI/LO TROGARZO			

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

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES
INFLAMMATION	**NSAIDs**		Trial and failure of two (2) preferred agents each greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Dosing and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets).	CALDOLOR *(use preferred agent)* CAMBIA POWDER *(use preferred agent)* celecoxib diclofenac 1.5% solution *(additional criteria applies)* diclofenac 3% gel *(additional criteria applies)* fenoprofen mefenamic acid NEOPROFEN *(use preferred agent)* SPRIX *(additional criteria applies)* TIVORBEX *(use preferred agent)* VIVLODEX *(use preferred agent)* **VOLTAREN*** *(additional criteria applies)* ZIPSOR *(use preferred agent)* ZORVOLEX *(use preferred agent)*
	diclofenac *tablets* etodolac FLECTOR flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate meloxicam nabumetone naproxen oxaprozin piroxicam sulindac tolmetin			
	ORAL CORTICOSTEROIDS			CELESTONE *(use preferred agent)*
	budesonide cortisone acetate dexamethasone/intensol hydrocortisone methylprednisone prednisolone prednisone			
INSOMNIA	**NON-BENZODIAZEPINES**		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. 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	BELSOMRA EDLUAR *(additional criteria applies)* eszopiclone INTERMEZZO *(additional criteria applies)* ROZEREM zolpidem ER ZOLPIMIST *(additional criteria applies)*
	zaleplon zolpidem			
MENTAL HEALTH	**ALZHEIMER AGENTS**		Client must have a diagnosis of dementia.	donepezil 23mg *(use preferred agent)* rivastigmine patches (BRAND IS PREFERRED) memantine ER NAMZARIC *(use separate agents)*
		donepezil/ODT **EXELON PATCH*** galantamine/ER memantine tablets/solution rivastigmine capsules		
	ANTIDEPRESSANTS		Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks WITHIN THE LAST 2 YEARS will be required before approval can be given for a non-preferred agent. One of the trials of preferred agents must be in the same class (NaSS, NDRI, SSRI, or SNRI) as the requested non-preferred agent. Trazodone, buspirone, fluvoxamine, MAO inhibitors, TCA's, bupropion IR, and venlafaxine IR do not require prior authorization but **will not count** towards meeting preferred therapy requirements. 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. **Duloxetine will be approved for clients with a diagnosis of osteoarthritis of the knee or chronic low back pain. ***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	
	NORADRENERGIC/SPECIFIC SEROTONERGICS (NaSS)			**NaSS**
	mirtazapine 15, 30, and 45mg			mirtazapine 7.5mg and rapid dissolve tablets *(use preferred agent)*
	NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)			**NDRI**
	bupropion ER/SR/XL			APLENZIN FORFIVO XL
	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)			**SSRI**
	citalopram escitalopram fluoxetine capsules paroxetine IR/CR sertraline			fluoxetine tablets *(use preferred agent)* VIIBRYD
	SEROTONIN/NORPINEPHRINE REUPTAKE INHIBITORS (SNRI)			**SNRI**
	venlafaxine ER capsules			duloxetine** desvenlafaxine FETZIMA venlafaxine ER tablets *(use preferred agent)*
				OTHER
				TRINTELLIX***

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

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES PLEASE CONTACT CHANGE HEALTHCARE WITH ANY QUESTIONS
MENTAL HEALTH continued	**ATYPICAL ANTIPSYCHOTICS**		**Quetiapine doses less than 100mg will require prior authorization without a diagnosis of mood disorder or major depressive disorder. For titration doses, contact the Change Healthcare Pharmacy Help Desk for an override. Clients five (5) years of age and younger will require prior authorization before approval. 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 ***Clients nine (9) years of age and younger will require a prior authorization to receive approval of Latuda. Dosage limits apply: aripiprazole <13 years of age: 23mg/day aripiprazole ≥13 years of age: 45mg/day FANAPT: 36mg/day INVEGA: 18mg/day LATUDA 10-17 years of age: 120mg/day LATUDA >17 years of age: 240mg/day olanzapine <13 years of age: 15mg/day olanzapine ≥13 years of age: 30mg/day quetiapine <13 years of age: 600mg/day quetiapine 13-17 years of age: 900mg/day quetiapine >17 years of age: 1200mg/day risperidone ≤ 17 years of age: 5mg/day risperidone >17 years of age: 24mg/day SAPHRIS: 30mg/day ziprasidone ≤17 years of age: 180mg/day ziprasidone >17 years of age: 300mg/day	aripiprazole ODT (BRAND IS PREFERRED) NUPLAZID PERSERIS REXULTI quetiapine XR *(use preferred agent)* VRAYLAR
	ABILIFY MAINTENA **ABILIFY ODT*** aripiprazole tab/solution ARISTADA FANAPT paliperidone INVEGA SUSTENNA/TRINZA LATUDA*** olanzapine PERSERIS quetiapine** RISPERDAL CONSTA risperidone SAPHRIS ziprasidone ZYPREXA RELPREVV			
	SPECIAL ATYPICAL ANTIPSYCHOTICS		Dosage limits apply: 1350mg/day	VERSACLOZ Suspension *(use preferred agent)*
	clozapine/ODT			
	AMPHETAMINES		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). 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. • Symptoms must be present in two or more settings (home, school or work); and • There must be clear evidence that the symptoms interfere or reduce the quality of social, school or work functioning; and • The symptoms must not be better explained by another mental disorder. Diagnosis of MS fatigue will require a fatigue severity scale score of 5.0, a 60-day trial of amantadine and discontinuation of medications that may contribute to drowsiness and fatigue. Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant. Prior Authorization will be required for clients under the age of 4. **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, and further use of Vyvanse for this diagnosis will require additional documentation prior to approval. Claims will require Prior Authorization if clients have a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use. Trial and failure of two (2) preferred agents (each from a different class: methylphenidate and amphetamine) greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Dosage limits apply: 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 methylin/methylphenidate/ER: 90mg/day VYVANSE: 105mg/day	**AMPHETAMINES** ADZENYS XR ODT/ER SUSP DYANAVEL XR EVEKEO PROCENTRA VYVANSE CHEWABLES ZENZEDI 2.5 AND 7.5MG TABLETS **METHYLPHENIDATES** APTENSIO XR COTEMPLA XR dexmethylphenidate ER (BRAND IS PREFERRED) methylphenidate ER osmotic release (BRAND IS PREFERRED) methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA) QUILLICHEW QUILLIVANT XR SUSPENSION
	LONG ACTING AMPHETAMINES			
		amphetamine salts combo XR dextroamphetamine CR caps VYVANSE CAPSULES**		
	IMMEDIATE RELEASE AMPHETAMINES			
		amphetamine salts combo dextroamphetamine tablets		
	METHYLPHENIDATES			
	LONG ACTING METHYLPHENIDATES			
		DAYTRANA **CONCERTA*** **FOCALIN XR*** methylin ER methylphenidate ER tablets		
	IMMEDIATE RELEASE METHYLPHENIDATES			
		dexmethylphenidate methylphenidate tablets		
	SELECTIVE ALPHA-ADRENERGIC AGONIST		To obtain the **non-preferred agent**, client must meet the following criteria: Client must have a diagnosis of ADD or ADHD Prior authorization will be required for clients under the age of 4. To receive Kapvay, clients must have completed a 14 day trial of clonidine IR with benefit in the previous 12 months.	**KAPVAY***
	clonidine			

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

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES
MENTAL HEALTH continued	**GUANFACINE AGENTS**		To obtain the **non-preferred agent**, client must meet the following criteria:	guanfacine ER
	guanfacine		Client must have a diagnosis of ADD or ADHD Prior authorization will be required for clients under the age of 4. To receive guanfacine ER, clients in the previous 12 months must have: A) a trial and failure of a stimulant greater than or equal to a 14 day supply, or B) a trial and failure of Strattera greater than or equal to a 30 day supply, or C) a contraindication to ADHD medications (including stimulant and non-stimulant), or D) a diagnosis of a TIC disorder, **AND** E) a 14 day trial of guanfacine **with benefit**	
	SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR		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 will be required for clients under the age of 4. Claims will require Prior Authorization if clients have a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use. Dosage limits apply: atomoxetine: 150mg/day	
		atomoxetine		
MIGRAINE	**MIGRAINE PROPHYLAXIS**		Trial and failure of three (3) preferred agent within the generic preferred drug classes greater than or equal to three (3) months will be required before approval can be given for the non-preferred agent.	AIMOVIG
	beta blockers divalproex tricyclic antidepressants topiramate			
	TRIPTANS		Trial and failure of two preferred agents will be required for approval of a non-preferred agent. Rizatriptan will be approved for clients between 6 and 17 years of age 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 sumatriptan vials: 2 vials/34 days sumatriptan nasal: 6 bottles/34 days sumatriptan 25mg: 41 tabs/34 days sumatriptan 50mg: 20 tabs/34 days sumatriptan 100mg: 10 tabs/34 days	almotriptan frovatriptan ONZETRA *(use preferred agent)* rizatriptan TREXIMET ZEMBRACE *(use preferred agent)* zolmitriptan
	naratriptan RELPAX sumatriptan			
MULTIPLE SCLEROSIS	**STEP 1 MS AGENTS**		Trial and failure of one injectable preferred agent will be required before approval can be given for the step 2 MS agent (Gilenya). Trial and failure of a two preferred agents (each from a separate class) will be required before approval can be given for a non-preferred agent. *Ocrevus will be approved for a diagnosis of primary progressive multiple sclerosis. For relapsing forms of multiple sclerosis, the requirements listed above will need to be followed For Tysabri, in addition to the above criteria, additional prior authorization criteria applies.	AUBAGIO COPAXONE 40MG/ML (use preferred agent) EXTAVIA LEMTRADA OCREVUS* PLEGRIDY TECFIDERA TYSABRI (additional criteria applies)
	IMMUNOMODULATOR (GLATIRAMER INJECTION)			
	COPAXONE 20MG/ML			
	INTERFERON			
	AVONEX BETASERON REBIF			
	STEP 2 MS AGENTS			
		GILENYA		
NEUROPATHIC PAIN	**TRICYCLIC ANTIDEPRESSANTS**		For the diagnosis of neuropathic pain, trial and failure of a tricyclic antidepressant greater than or equal to a 12 week supply AND trial and failure of gabapentin at a dose of 3600mg per day for greater than or equal to a 12 week supply in the last 12 months will be required before approval can be given for a non-preferred agent.	duloxetine LYRICA
		amitriptyline desipramine imipramine nortriptyline		
	GABAPENTIN			
		gabapentin		

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

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES
OPHTHALMICS	**OP. -ANTI-ALLERGICS**		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Emadine, Alomide, and Alocril will be approved for pregnancy. Alomide will be approved for children under the age of 3.	ALAMAST ALOCRIL ALOMIDE ALREX azelastine BEPREVE EMADINE epinastine ketotifen LASTACAFT olopatadine 0.1% and 0.2%
	cromolyn PAZEO			
	OP. -ANTIBIOTICS- QUINOLONES		Trial and failure of a preferred agent greater than or equal to 5 days in the last 12 months will be required before approval can be given for a non-preferred agent. Azasite will be approved for pregnancy.	AZASITE BESIVANCE gatifloxacin IQUIX levofloxacin moxifloxacin 0.5% (BRAND IS PREFERRED) ZYMAR
	ciprofloxacin ofloxacin MOXEZA **VIGAMOX***			
	OP. -ANTI-INFLAMMATORY		Trial and failure of ALL preferred agents each greater than or equal to 5 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ACULAR/LS/PF *(use preferred)* ACUVAIL bromfenac 0.9% BROMSITE DUREZOL NEVENAC PROLENSA
	flurbiprofen diclofenac LOTEMAX ketorolac ILEVRO			
	OP. -BETA-BLOCKERS		Trial and failure of three (3) preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. *Betoptic S will be approved for those with heart and lung conditions.	BETIMOL BETOPTIC S*
	betaxolol carteolol levobunolol metipranolol timolol			
	OP. -CARBONIC ANHYDRASE INHIBITOR		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	AZOPT
	dorzolamide			
	OP. -COMBO PRODUCTS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	
	COMBIGAN dorzolamide/timolol SIMBRINZA			
	OP. -DRY EYE AGENTS		Trial and failure of the preferred agent greater than or equal to 12 weeks will be required before approval can be given for the non-preferred agent.	CYCLOSPORINE IN KLARITY RESTASIS MULTIDOSE (use preferred) XIIDRA
	RESTASIS			
	OP. -PROSTAGLANDINS		Trial and failure of ALL preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	bimatoprost LUMIGAN 0.1% ZIOPTAN
	latanoprost TRAVATAN Z			
	OP. -RHO KINASE INHIBITOR			
	RHOPRESSA			
	OP. -SYMPATHOMIMETICS		Trial of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	brimonidine 0.15% (BRAND IS PREFERRED)
	ALPHAGAN P 0.1% **ALPHAGAN P 0.15%*** brimonidine 0.2%			
OSTEOPOROSIS	**BISPHOSPHONATES**		Trial and failure of a preferred agent greater than or equal to 12 months will be required before approval can be given for a non-preferred agent. Fosamax liquid will be approved for clients that have difficulty swallowing.	risedronate ATELVIA FOSAMAX-D ibandronate TYMLOS
	alendronate			
	NASAL CALCITONIN			
	calcitonin-salmon fortical			
OTIC	**ANTIBIOTIC/STEROID COMBINATION**			ciprofloxacin 0.2% *(use preferred agent)* CIPRO HC *(use preferred agent)* COLY-MYCIN S *(use preferred agent)* CORTISPORIN-TC *(use preferred agent)* FLUOCINOLONE ACET OIL 0.01% *(use preferred agent)* ofloxacin *(use preferred agent)*
	CIPRODEX Neo/Poly/HC Suspension and Solution			
OVERACTIVE BLADDER	**OVERACTIVE BLADDER AGENTS**		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Oxytrol will be approved for clients that have an inability to swallow.	darifenacin GELNIQUE GEL 10% MYRBETRIQ OXYTROL DIS SANCTURA XR tolterodine/ER trospium
	oxybutynin /ER TOVIAZ VESICARE			

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

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES PLEASE CONTACT CHANGE HEALTHCARE WITH ANY QUESTIONS
PAIN	**LONG-ACTING C-IIs**		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-IIIs 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 use of a narcotic and benzodiazpine will require prior authorization Fentanyl patches will require a prior authorization unless a client has a cancer diagnosis or previous treatment of at least a 10 day supply within the last 45 days **Butrans requires a trial of morphine sulfate ER or low dose trial of fentanyl patch. ***Nucynta ER will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics. ****In addition to above criteria, Embeda requires a diagnosis of drug/substance abuse. Belbuca: 1.2mg/day (1200mcg/day) Butrans: 20mcg, 1 strength at a time, 1 patch every 7 days Fentanyl: 50mcg, 1 strength at a time, 1 patch every 3 days Hysingla ER: 120mg/day Hydromorphone ER: 30mg/day Morphabond: 120mg/day Morphine ER: 120mg/day Methadone: Limited to 3 tablets per day Nucynta ER: 327mg/day Oxycontin: 80mg/day Oxymorphone ER: 40mg/day Xartemis XR: 80mg/day Xtampza ER: 80mg/day Zohydro ER: 120mg/day Clients will be limited to one long-acting narcotic at a time	AVINZA BELBUCA **BUTRANS**** EMBEDA**** fentanyl patch 37.5, 62.5, 87.5mg hydromorphone ER HYSINGLA ER *(additional criteria applies)* KADIAN 70, 130, 150, and 200mg *(use preferred agent)* METHADONE MORPHABOND morphine sulfate ER capsules *(use preferred)* NUCYNTA ER*** oxymorphone ER OXYCONTIN XARTEMIS XR *(additional criteria applies)* XTAMPZA ER *(additional criteria applies)* ZOHYDRO ER *(additional criteria applies)*
	morphine sulfate ER tablets	fentanyl patch 12.5, 25, 50, 75, and 100mg		
	SHORT-ACTING C-IIs		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. *Nucynta will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics. Concurrent use of a narcotic and benzodiazepine will require prior authorization 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) Clients will be limited to one short-acting narcotic at a time	levorphanol NUCYNTA* oxymorphone oxycodone/IBU
	codeine sulfate hydrocodone/APAP hydrocodone/IBU hydromorphone LORTAB ELIXIR 10-300MG meperidine morphine sulfate oxycodone oxycodone/APAP oxycodone/ASA			
	C-III/C-V AGENTS		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. Quantity and dosage limits apply (max 8 tabs/day). **Butrans will require a 14 day trial and failure of tramadol IR and a 14 day trial and failure of tramadol ER prior to approval	BUTRANS** RYBIX ODT tramadol/apap tramadol ER capsules tramadol ER tablets
	tramadol			
PARKINSON'S DISEASE	**AMANTADINE**			GOCOVRI *(use preferred agent)* OSMOLEX ER *(use preferred agent)*
	amantadine			
PHOSPHATE BINDERS	**PHOSPHATE BINDERS**		Prior authorization required for non-preferred agents.	AURYXIA lanthanum PHOSLYRA sevelamer VELPHORO
	calcium acetate **RENAGEL***			
PROSTATE	**5-ALPHA-REDUCTASE INHIBITORS**		Trial and failure of a preferred agent greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	dutasteride dutasteride/tamsulosin *(use separate agents)*
	finasteride			
	ALPHA BLOCKERS		Trial and failure of a preferred agent greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	alfuzosin dutasteride/tamsulosin *(use separate agents)* RAPAFLO
	doxazosin tamsulosin terazosin			

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

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES PLEASE CONTACT CHANGE HEALTHCARE WITH ANY QUESTIONS
PULMONARY ANTIHYPERTENSIVES	**5-ALPHA-REDUCTASE INHIBITORS**	ADCIRCA REVATIO SUSPENSION sildenafil (Revatio A/B rated generic)	Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
	ENDOTHELIN RECEPTOR ANTAGONISTS	LETAIRIS TRACLEER TABS	Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	OPSUMIT *(use preferred agent)* TRACLEER TABS FOR ORAL SUSP *(use preferred agent)*
	PROSTACYCLINE VASODILATORS	ORENITRAM	Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
	PROSTACYCLINE RECEPTOR AGONIST		Prior authorization required.	UPTRAVI *(use preferred pulmonary HTN agent)*
RESTLESS LEG SYNDROME	**RESTLESS LEG SYNDROME**	gabapentin pramipexole ropinirole	Client must have a diagnosis of Restless Leg Syndrome (RLS). Trial and failure of gabapentin greater than or equal to 60 days and a trial and failure of a dopamine agonist greater than or equal to 60 days in the last 12 months will be required before approval can be given for a non-preferred agent. *Neupro will be approved for clients with difficulty swallowing or for clients with a diagnosis of Parkinson's Disease.	HORIZANT NEUPRO*
SKELETAL MUSCLE RELAXANTS	**MUSCLE RELAXANTS** baclofen cyclobenzaprine tizanidine tablets		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months, along with a medical diagnosis of muscle spasticity will be required before approval can be given for a non-preferred agent. Cyclobenzaprine will require a prior authorization for clients concurrently taking a tricylic antidepressant.	carisoprodol chlorzoxazone cyclobenzaprine ER metaxalone methocarbamol orphenadrine tizanidine capsules *(use preferred agent)* Carisoprodol is limited to 84 tabs/365 days
ULCERATIVE COLITIS	**IMMUNOMODULATORS**	HUMIRA	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.	REMICADE *(additional criteria applies)*
UVEITIS	**IMMUNOMODULATORS**	HUMIRA	Client must have diagnosis of non-infectious intermediate, posterior, and panuveitis in adult patients	