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- Prior authorization for a non-preferred agent in any category will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient at a therapeutic dose that resulted in a partial response with a documented intolerance.

- Prior authorization of a non-preferred isomer, pro-drug, or metabolite will be considered with a trial of a preferred parent drug of the same chemical entity at a therapeutic dose that resulted in a partial response with documented intolerance or a previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. (The required trial may be overridden when documented evidence is provided that the use of these preferred agent[s] would be medically contraindicated.)

- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC drugs are not covered unless specified.

- PA criteria for non-preferred agents apply in addition to the general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to appropriate dosing, duplication of therapy, etc.

- The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

- Quantity limits may apply. Refer to the Max Units List at http://www.hidesigns.com/ndmedicaid

- This is not an all-inclusive list of medications that require PA. For more information visit.

- Acronyms
  PA – Indicates preferred agents that require clinical prior authorization.

- This PDL is subject to change. Preferred positions and criteria will go into effect when an SRA is executed.

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CHANGES SINCE LAST UPDATE		
Category	**Product Status Changes**	**Criteria Changes**
Antihemophilic Factors	Adynovate and Eloctate were moved to Non-Preferred	Group PA criteria updated
Diabetes - Insulin	Apidra and Apidra Solostar moved to Preferred	N/A
Hepatitis C Treatments	Epclusa moved to preferred for genotype 2 and 3	Group PA criteria updated, Epclusa criteria updated
Injectable Non-Interferons – Multiple Sclerosis	N/A	Group PA criteria updated, Tysabri and Zinbryta criteria updated. Copaxone 40mg/mL criteria removed.
Interferons – Multiple Sclerosis	Extavia moved to Preferred	N/A
Interferons – Multiple Sclerosis	Avonex product dosage forms clarified	N/A
Opioid Analgesics	Tramadol ER and Butrans moved to Preferred	Group PA criteria updated, Individual drug criteria all updated with exception of Fentanyl 12mcg/hr
Otic Anti-infectives - Fluoroquinolones	Otovel was added to Preferred	N/A

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ADHD		
Category PA Criteria: Branded non-preferred agents: A 14 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30 day trial of 2 preferred generics of the same medication will satisfy this requirement. Generic non-preferred agents: A 30 day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
ADDERALL XR (dextroamphetamine/amphetamine)	ADDERALL (dextroamphetamine/amphetamine)	*** Kapvay will require a 1-month trial of immediate release clonidine.
ADZENYS XR - ODT (amphetamine)	clonidine ER	
clonidine	CONCERTA	
DAYTRANA (methylphenidate)	DEXEDRINE (dextroamphetamine)	
DESOXYN (methamphetamine)	dexmethylphenidate ER	
dexmethylphenidate	dextroamphetamine/amphetamine ER	
dextroamphetamine	FOCALIN (dexmethylphenidate)	
dextroamphetamine 5mg/5ml	INTUNIV (guanfacine ER)	
dextroamphetamine ER	METHYLIN (methylphenidate) chew tablets	
dextroamphetamine/amphetamine	METHYLIN (methylphenidate) solution	
DYANAVEL XR (amphetamine)	methylphenidate CD 30-70	
EVEKEO (amphetamine)	methylphenidate ER capsules 50-50	
FOCALIN XR (dexmethylphenidate)	methylphenidate LA capsules - 50-50	
guanfacine ER	RITALIN (methylphenidate)	
KAPVAY (clonidine)[PA]		
METADATE CD (methylphenidate CD)		
METADATE ER (methylphenidate)		
methamphetamine		
methylphenidate chew tablet		
methylphenidate ER tablet		
methylphenidate solution		
methylphenidate tablet		
PROCENTRA (dextroamphetamine)		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
QUILLIVANT XR (methylphenidate)		
RITALIN LA (methylphenidate LA capsules - 50-50)		
STRATTERA (atomoxetine)		
VYVANSE (lisdexamfetamine)		
ZENZEDI (dextroamphetamine)		
ALLERGENIC EXTRACTS		
Category PA Criteria: 1. Patient must not have severe, unstable, or uncontrolled asthma 2. Patient must be an FDA approved age 3. Patient must have an FDA approved diagnosis of allergic rhinitis due to a pollen contained in the requested product 4. Patient's diagnosis must be confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies contained in the requested product. Non-preferred agents: 1. Must have failed a trial of 2 of the following: oral antihistamines, intranasal antihistamines, intranasal corticosteroids, or leukotriene inhibitors. 2. Must have failed a trial or have intolerance to subcutaneous allergen immunotherapy (allergy shots).		
GRASTEK (GRASS POLLEN-TIMOTHY, STD)[PA]	ORALAIR (GR POL-ORC/SW VER/RYE/KENT/TIM)	
RAGWITEK (WEED POLLEN-SHORT RAGWEED)[PA]		
ANTIANGINAL		
RANEXA (ranolazine)		
ANTICOAGULANTS - ORAL		
Category PA Criteria: A 30 day trial of all preferred agents will be required before a non-preferred agent will be authorized. All agents will require an FDA indication.		
ELIQUIS (Apixaban)[PA]	SAVAYSA (edoxaban)	
PRADAXA (dabigatran)[PA]		
XARELTO (rivaroxaban)[PA]		
ANTICONVULSANTS		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: Branded non-preferred agents: A 14 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30 day trial of 2 preferred generics of the same medication will satisfy this requirement. Generic non-preferred agents: A 30 day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
APTIOM (esucarbazepine)	carbamazepine ER capsule	
BANZEL (rufinamide) ORAL SUSPENSION	carbamazepine oral suspension	
BANZEL (rufinamide) TABLET	carbamazepine XR tablet	
BRIVIACT (brivaracetam)	CARBATROL (carbamazepine)	
carbamazepine chewable tablet	DEPAKENE (valproic acid) CAPSULE	
carbamazepine tablet	DEPAKENE (valproic acid) ORAL SOLUTION	
CELONTIN (methsuximide)	DEPAKOTE (divalproex sodium) TABLET	
divalproex ER	DEPAKOTE ER (divalproex sodium)	
divalproex sprinkle	DEPAKOTE SPRINKLE (divalproex sodium)	
divalproex tablet	DILANTIN (phenytoin) CHEWABLE TABLET	
ethosuximide capsule	DILANTIN (phenytoin) ORAL SUSPENSION	
ethosuximide oral solution	DILANTIN ER (phenytoin)	
felbamate oral suspension	EPITOL (carbamazepine)	
felbamate tablet	FELBATOL (felbamate)	
FYCOMPA (perampanel)	FELBATOL (felbamate) ORAL SUSPENSION	
FYCOMPA (perampanel) ORAL SUSPENSION	FELBITOL (felbamate) ORAL SUSPENSION	
gabapentin capsule	KEPPRA (levetiracetam)	
gabapentin oral solution	KEPPRA (levetiracetam) ORAL SOLUTION	
gabapentin tablet	KEPPRA (levetiracetam) ORAL SOLUTION	
GABITRIL (tiagabine)	KEPPRA XR (levetiracetam)	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LAMICTAL ER (lamotrigine) DOSE PACK	LAMICTAL (lamotrigine)	
LAMICTAL ODT (lamotrigine)	LAMICTAL (lamotrigine) CHEWABLE TABLET	
LAMICTAL ODT (lamotrigine) DOSE PACK	LAMICTAL (lamotrigine) DOSE PACK	
LAMICTAL XR (lamotrigine)	MYSOLINE (primidone)	
lamotrigine chewable tablet	NEURONTIN (gabapentin) CAPSULE	
lamotrigine dose pack	NEURONTIN (gabapentin) ORAL SOLUTION	
lamotrigine ER	NEURONTIN (gabapentin) TABLET	
lamotrigine ODT	QUDEXY XR (topiramate)	
lamotrigine tablet	TOPAMAX (topiramate)	
levetiracetam ER	TOPAMAX (topiramate) SPRINKLE CAPSULE	
levetiracetam oral solution	TRILEPTAL (oxcarbazepine)	
levetiracetam tablet	TRILEPTAL (oxcarbazepine) ORAL SUSPENSION	
LYRICA (pregabalin)	ZARONTIN (ethosuximide)	
LYRICA (pregabalin) ORAL SOLUTION	ZARONTIN (ethosuximide) ORAL SOLUTION	
oxcarbazepine oral solution	ZONEGRAN (zonisamide)	
oxcarbazepine tablet		
OXTELLAR XR (oxcarbazepine)		
PEGANONE (Ethotoin)		
phenobarbital elixir		
phenobarbital tablet		
PHENYTEK (pheytoin)		
phenytoin chewable tablet		
phenytoin ER capsule		
phenytoin suspension		
POTIGA (ezogabine)		
primidone		
SABRIL (vigabatrin)		
SABRIL (vigabatrin) POWDER PACK		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
TEGRETOL (carbamazepine)		
TEGRETOL XR (carbamazepine)		
TEGRETROL (carbamazepine oral suspension)		
tiagabine		
topiramate ER		
topiramate sprinkle capsule		
topiramate tablet		
TROKENDI XR (topiramate)		
valproic acid capsule		
valproic acid oral solution		
VIMPAT (lacosamide)		
VIMPAT (lacosamide) ORAL SOLUTION		
zonisamide		
ANTICONVULSANTS - BENZODIAZEPINES - RECTAL		
Category PA Criteria: A 30 day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
DIASTAT (diazepam) RECTAL KIT	diazepam rectal kit	
ANTIDEMENTIA		
Category PA Criteria: All agents will require a FDA indication for patients younger than 30 years old Branded non-preferred agents: A 14 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30 day trial of 2 preferred generics of the same medication will satisfy this requirement. Generic non-preferred agents: A 30 day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
donepezil	ARICEPT (donepezil)	
EXELON (rivastigmine)	donepezil ODT	
EXELON (rivastigmine) PATCH	NAMENDA (memantine)	
galantamine	NAMZARIC (memantine/donepezil)	
galantamine ER	RAZADYNE (galantamine)	
galantamine oral solution	RAZADYNE ER (galantamine)	
memantine	rivastigmine patch	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
NAMENDA (memantine) ORAL SOLUTION		
NAMENDA XR (memantine)		
rivastigmine		
ANTIDEPRESSANTS - NEW GENERATION		
Category PA Criteria: Branded non-preferred agents: A 14 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30 day trial of 2 preferred generics of the same medication will satisfy this requirement. Generic non-preferred agents: A 30 day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
bupropion SR tablet	APLENZIN ER (bupropion)	
bupropion tablet	CELEXA (citalopram)	
bupropion XL tablet	CYMBALTA (duloxetine)	
citalopram	EFFEXOR XR (venlafaxine)	
citalopram oral solutoin	fluoxetine DR	
clomipramine	FORFIVO XL (bupropion)	
desvenlafaxine ER	IRENKA (duloxetine)	
duloxetine	LEXAPRO (escitalopram)	
escitalopram	LEXAPRO (escitalopram) ORAL SOLUTION	
escitalopram oral solution	PAXIL (paroxetine)	
FETZIMA (levomilnacipran)	PAXIL CR (paroxetine)	
fluoxetine capsule	PROZAC (fluoxetine)	
fluoxetine solution	WELLBUTRIN (bupropion)	
fluoxetine tablet	WELLBUTRIN SR (bupropion)	
fluvoxamine	WELLBUTRIN XL (bupropion)	
fluvoxamine ER	ZOLOFT (sertraline)	
KHEDEZLA ER (desvenlafaxine)	ZOLOFT (sertraline) ORAL CONCENTRATE	
nefazodone		
OLEPTRO ER (trazodone)		
paroxetine		
paroxetine ER		

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PAXIL (paroxetine) ORAL SUSPENSION		
PEXEVA (paroxetine)		
PRISTIQ ER (desvenlafaxine)		
PROZAC WEEKLY (fluoxetine)		
sertraline		
sertraline oral concentrate		
trazodone		
TRINTELLIX (vortioxetine)		
venlafaxine capsule		
venlafaxine ER tablets		
venlafaxine tablet		
VIIBRYD (vilazodone)		
ANTIHEMOPHILIC FACTORS		
Category PA Criteria: 1. Patient must visit an accredited Hemophilia Treatment Center for yearly checkups 2. The doctor must provide the date of patient's last appointment at the treatment center 3. The doctor must include the contact information for the treatment center last visited by the patient 4. An explanation of why a preferred agent cannot be used before a non-preferred agent will be authorized		
ADVATE[PA]	ADYNOVATE[PA]	
AFSTYLA[PA]	ELOCTATE[PA]	
ALPHANATE[PA]		
ALPHANINE SD[PA]		
ALPROLIX[PA]		
BEBULIN[PA]		
BENEFIX[PA]		
FEIBA[PA]		
HELIXATE FS[PA]		
HEMOFIL M[PA]		
HUMATE-P[PA]		
IDELVION[PA]		
IXINITY[PA]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
KOATE-DVI[PA]		
KOGENATE FS BIO-SET[PA]		
KOGENATE FS[PA]		
MONOCLATE-P[PA]		
MONONINE[PA]		
NOVOEIGHT[PA]		
NOVOSEVEN[PA]		
OBIZURE[PA]		
PROFILNINE SD[PA]		
RECOMBINATE[PA]		
RIXUBIS[PA]		
WILATE[PA]		
XYNTHA[PA]		
ANTIHYPERLIPIDEMICS - CETP INHIBITORS		
VYTORIN (ezetimibe/simvastatin)		
ZETIA (ezetimibe)		
ANTIHYPERLIPIDEMICS - NIACIN		
Category PA Criteria: A 30 day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
NIASPAN ER (niacin)	niacin ER	
ANTIHYPERTENSIVE - BETA BLOCKERS		
Category PA Criteria: A 30 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30 day trial of 2 preferred generics of the same medication will satisfy this requirement.		
acebutolol	BETAPACE AF (sotalol)	
atenolol	CORGARD (nadolol)	
betaxolol	INDERAL LA (propranolol)	
bisoprolol	LOPRESSOR (metoprolol)	
BYSTOLIC (nebivolol)	SECTRAL (acebutolol)	
INDERAL XL (propranolol)	SORINE (sotalol)	
INNOPRAN XL (propranolol)	TENORMIN (atenolol)	
metoprolol	TOPROL XL (metoprolol)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
metoprolol ER	ZEBETA (bisoprolol)	
nadolol		
pindolol		
propranolol		
propranolol ER		
sotalol		
sotalol AF		
timolol		
ANTIPROTOZOAL AGENTS		
Category PA Criteria: A 30 day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
ALINIA (nitazoxanide)	tinidazole	
atovaquone		
MEPRON (atovaquone)		
TINDAMAX (tindazole)		
ANTIRETROVIRALS - NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir		
abacavir/lamivudine/zidovudine		
ATRIPLA (efavirenz/emtricitabine/tenofovir)		
COMBIVIR (lamivudine/zidovudine)		
COMPLERA (emtricitabine/rilpivirine/tenofovir)		
DESCOVY (emtricitabine/tenofovir)		
didanosine		
emtricitabine		
EMTRIVA (emtricitabine)		
EPIVIR (lamivudine)		
EPIVIR HBV (lamivudine)		
EPZICOM (abacavir)		
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)		
lamivudine		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
lamivudine HBV		
lamivudine/zidovudine		
ODEFSEY (emtricitabine/rilpivirine/tenofovir)		
RETROVIR (zidovudine)		
stavudine		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)		
tenofovir		
TRIUMEQ (abacavir/dolutegravir/lamivudine)		
TRIZIVIR (abacavir/lamivudine)		
TRUVADA (emtricitabine/tenofovir)		
VIDEX (didanosine)		
VIDEX EC (didanosine)		
VIREAD (tenofovir)		
ZERIT (stavudine)		
ZIAGEN (abacavir)		
zidovudine		
ANTIRETROVIRALS - PROTEASE INHIBITORS		
APTIVUS (tipranavir)		
CRIXIVAN (indinavir)		
EVOTAZ (atazanavir/cobicistat)		
GENVOYA (elvitegravir, cobicistat, emtricitabine and tenofovir)		
INVERASE (saquinavir)		
KALENTRA (lopinavir/ritonavir)		
LEXIVA (fosamprenavir)		
NORVIR (ritonavir)		
PREZCOBIX (darunavir/cobicistat)		
PREZISTA (darunavir)		
RAYATAZ (atazanavir)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
VIRACEPT (nelfinavir)		
ASTHMA - LONG ACTING ANTICHOLINERGICS		
Category PA Criteria: Patient must be 12 years old or older		
SPIRIVA RESPIMAT 1.25 MG (tiotropium)		
ATYPICAL ANTIPSYCHOTICS		
Category PA Criteria: Branded non-preferred agents: A 14 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30 day trial of 2 preferred generics of the same medication will satisfy this requirement. Generic non-preferred agents: A 30 day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
ABILIFY (aripiprazole) ORAL SOLUTION	ABILIFY (aripiprazole)	
ABILIFY DISCMELT (aripiprazole)	CLOZARIL (clozapine)	
aripiprazole	GEODON (ziprasidone)	
clozapine	INVEGA ER (paliperidone)	
clozapine ODT	RISPERDAL (risperidone)	
FANAPT (iloperidone)	RISPERDAL (risperidone) ORAL SOLUTION	
FAZACLO (clozapine) RAPDIS	RISPERDAL M-TAB (risperidone)	
LATUDA (lurasidone)	SEROQUEL (quetiapine)	
olanzapine	ZYPREXA (olanzapine)	
olanzapine ODT	ZYPREXA ZYDIS (olanzapine)	
olanzapine/fluoxetine		
paliperidone ER		
quetiapine		
REXULTI (brexipiprazole)		
risperidone		
risperidone ODT		
risperidone oral solution		
SAPHRIS (asenapine)		
SEROQUEL XR (quetiapine)		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
SYMBYAX (olanzapine/fluoxetine)		
VRAYLAR (cariprazine)		
ziprasidone		
ATYPICAL ANTIPSYCHOTICS - LONG ACTING		
ABILIFY MAINTENA (aripiprazole)		
ARISTADA (aripiprazole lauroxil)		
INVEGA SUSTENNA (paliperidone)		
INVEGA TRINZA (paliperidone)		
RISPERDAL CONSTA (risperidone)		
ZYPREXA RELPREVV (olanzapine)		
COPD		
Category PA Criteria: A 30 day trial of all preferred agents will be required before a non-preferred agent will be authorized. All preferred agents indicated only for COPD will require verification of FDA approved indication for patients who are younger than 40 years of age. All non preferred agents will require an FDA approved indication regardless of age.		
Long Acting Anticholinergics		
SPIRIVA (tiotropium)	INCRUSE ELLIPTA (umeclidium)	
SPIRIVA RESPIMAT 2.5 MG (tiotropium)		
TUDORZA PRESSAIR (aclidinium)		
Long Acting Beta Agonists		
FORADIL (formoterol)	ARCAPTA NEOHALER (indacaterol)	***Brovana/Arcapta Neohaler require a 30 day trial of Striverdi in addition to category PA criteria
SEREVENT (salmeterol)	BROVANA (arformoterol)	
PERFOROMIST (formoterol)	STRIVERDI RESPIMAT (olodaterol)	
Short Acting Combination		
albuterol/iptratopium	DUONEB (albuterol/ipratropium)	
COMBIVENT RESPIMAT (albuterol/ipratropium)		
Long Acting Combination		
Group PA Criteria: The following trials will be required before a non-preferred agent will be authorized: 1. A 30 day trial of 1 preferred agent in this class. 2. A 30 day trial of 1 preferred agent from either the Long Acting Anticholinergics group or the Long Acting Beta Agonists group		
ANORO ELLIPTA (umeclidium/vilanterol)	STIOLTO RESPIMAT (tiotropium/olodaterol)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	UTIBRON NEOHALER (indacaterol/glycopyrrolate)	
	BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	
PDE4 - Inhibitor		
Group PA Criteria: In addition to the category PA criteria, patient must have a history of exacerbations treated with corticosteroids within the last year for initial requests and had a decreased number of exacerbations treated with corticosteroids with Daliresp treatment with renewals. Patient must also have had the following 30 day trials: 1. One (1) agent in the Long Acting Anticholinergic group 2. One (1) agent in the Long Acting Beta Agonist group or 1 agent in the Steroid/Anticholinergic Combination Inhalers category 3. One (1) agent in the Steroid Inhalers category or 1 agent in the Steroid/Anticholinergic Combination Inhalers category		
	DALIRESP (roflumilast)	
CYSTIC FIBROSIS ANTIINFECTIVES		
Category PA Criteria: A 28 day trial of 1 preferred agent will be required before a non-preferred agent will be authorized. Non-preferred agents will require that the patient not have been colonized with *Burkholderia cepacia* and an FDA approved age and indication.		
BETHKIS (tobramycin)	CAYSTON (aztreonam)	***Cayston - Patient must have a forced expiratory volume in less than one second (FEV1) less than 25% or greater than 75% predicted. ***Tobramycin/TOBI/TOBI Podhaler - Patient must have a forced expiratory volume in less than one second (FEV1) less than 40% or greater than 80% predicted. Patient must not have been colonized with *Burkholderia Cepacia*.
KITABIS PAK (tobramycin/nebulizer)	TOBI (Tobramycin)	
	TOBI PODHALER (Tobramycin)	
	Tobramycin	
CYTOKINE MODULATORS		
Category PA Criteria: A 30 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized. All agents will require an FDA approved indication.		
COSENTYX (secukinumab)[PA]	ACTEMRA (tocilizumab)	***Cosentyx - A 3-month trial of Humira only will be required for plaque psoriasis before Cosentyx is approved. ***Otezla - Patient must be 18 years or older and have a rheumatology or dermatology specialist involved in therapy. Otezla must not be used in combination with other biologic therapies. ***Xeljanz/Xeljanz XR - Patient must have had an inadequate response to methotrexate, been tested for latent tuberculosis, have current lab monitoring prior
ENBREL (etanercept)[PA]	CIMZIA (certolizumab)	
HUMIRA (adalimumab)[PA]	KINERET (anakinra)	
HUMIRA PSORIASIS (adalimumab)[PA]	ORENCIA (abatacept)	
	OTEZLA (apremilast)	
	REMICADE (infliximab)	
	SIMPONI (golimumab)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	STELARA (ustekinumab)	to starting Xeljanz of CBC with differential, liver enzymes, and lipid panel), and not be at increased risk of gastrointestinal perforations.
	TALTZ (ixekizumab)	
	XELJANZ (tofacitanib)	
	XELJANZ XR (tofacitanib)	
DIABETES - DPP4 INHIBITORS		
JANUMET (sitagliptan/metformin)		
JANUMET XR (sitagliptan/metformin)		
JANUVIA (sitagliptan)		
JENTADUETO (linagliptin/metformin)		
JENTADUETO XR (linagliptin/metformin)		
KAZANO (alogliptin/metformin)		
KOMBIGLYZE XR (sitagliptan/metformin)		
NESINA (alogliptin)		
ONGLYZA (saxagliptin)		
OSENI (alogliptin/pioglitazone)		
TRADJENTA (linagliptin)		
DIABETES - GLP1 AGONISTS		
Category PA Criteria: Non preferred agents will require: 1. A 30 day trial of 2 preferred agents 2. An FDA indication 3. Concurrent metformin therapy 4. A 3-month trial of metformin		
BYDUREON (exenatide microspheres)	TANZEUM (albiglutide)	***Victoza requires PA for an FDA approved indication, concurrent metformin therapy, and a 3-month trial of metformin
BYETTA (exenatide)	TRULICITY (dulaglutide)	
VICTOZA (liraglutide)[PA]		
DIABETES - INSULIN		
PA Criteria: A 30 day trial of 1 preferred agent will be required in the past year before a non-preferred agent will be authorized.		
APIDRA (insulin glulisine) VIAL	AFREZZA (insulin regular, human)	
APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	HUMALOG (insulin lispro) CARTRIDGE	
HUMALOG (insulin lispro) VIAL	HUMALOG (insulin lispro) KWIKPEN	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	HUMALOG MIX 50/50 (insulin NPL/insulin lispro) KWIKPEN	
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	HUMALOG MIX 75/25 (insulin NPL/insulin lispro) KWIKPEN	
HUMULIN 70/30 (insulin NPH human/regular insulin human) INSULIN PEN	NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL	
HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN	NOVOLIN N (insulin NPH human isophane) VIAL	
HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL	NOVOLIN R (insulin regular, human) VIAL	
HUMULIN N (insulin NPH human isophane) INSULIN PEN	TOUJEO SOLOSTAR (insulin glargine)	
HUMULIN N (insulin NPH human isophane) KWIKPEN	TRESIBA (insulin degludec)	
HUMULIN N (insulin NPH human isophane) VIAL		
HUMULIN N (insulin NPH human isophane) VIAL		
HUMULIN R (insulin regular, human) VIAL		
HUMULIN R U-500 (insulin regular, human) VIAL		
LANTUS (insulin glargine) FLEXTOUCH		
LANTUS (insulin glargine) SOLOSTAR		
LANTUS (insulin glargine) VIAL		
LEVEMIR (insulin detemir) VIAL		
LEVEMIR (insulin glargine) FLEXTOUCH		
NOVOLOG (insulin aspart) CARTRIDGE		
NOVOLOG (insulin aspart) FLEXPEN		
NOVOLOG (insulin aspart) VIAL		
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) INSULIN PEN		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL		
DIABETES - SGLT2 INHIBITORS		
Category PA Criteria: All agents will require a 3 month trial of metformin.		
FARXIGA (dapagliflozin)PA		
INVOKANA (canaglifozin)PA		
JARDIANCE (empagliflozin)PA		
DIABETES - SGLT2 INHIBITORS COMBINATIONS		
Category PA Criteria: Non preferred agents will require: 1. A 3-month trial of all preferred agents 2. An FDA indication 3. A 3-month trial of metformin		
INVOKAMET (canafliflozin/metformin)	GLYXAMBI (empagliflozin/linagliptan)	
	SYNJARDY (empagliflozin/metformin)	
	XIGDUO XR (dapagliflozin/metformin)	
DIGESTIVE ENZYMES		
Category PA Criteria: A 30 day trial of all preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
CREON (lipase/protease/amylase)	PANCREAZE (lipase/protease/amylase)	
ZENPEP (lipase/protease/amylase)	PANCRELIPASE (lipase/protease/amylase)	
	PERTZYE (lipase/protease/amylase)	
	ULTRESA (lipase/protease/amylase)	
	VIOKACE (lipase/protease/amylase)	
DRY EYE DISEASE		
XIIDRA (lifitegrast)		
EPINEPHRINE PENS		
Category PA Criteria: A 30 day trial of 1 preferred agent will be required before a non-preferred agent will be authorized.		
EPIPEN (epinephrine)	ADRENACLICK (epinephrine)	
EPIPEN JR (epinephrine)	epinephrine	
FIBROMYALGIA		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: A 30 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized. A 30 day trial of 2 preferred generics of the same medication will satisfy this requirement.		
duloxetine	CYMBALTA (duloxetine)	
gabapentin capsule	NEURONTIN (gabapentin) CAPSULE	
gabapentin oral solution	NEURONTIN (gabapentin) TABLET	
gabapentin tablet	NEURONTIN (gabapentin) ORAL SOLUTION	
LYRICA (pregabalin)		
LYRICA (pregabalin) ORAL SOLUTION		
SAVELLA (milnacapran)		
GROWTH HORMONE		
Category PA Criteria: 1. Patients new to GH therapy must meet the criteria below and be started on a preferred growth hormone 2. Patients continuing GH therapy and having met the criteria listed below must be switched to a preferred growth hormone 3. Patients must not have an active malignancy Additional criteria applies. For details, see http://www.hidesigns.com/assets/files/ndmedicaid/Criteria/2016/growth_hormone_criteria.pdf		
GENOTROPIN (somatropin)[PA]	HUMATROPE (somatropin)	
GENOTROPIN MINIQUICK (somatropin)[PA]	NUTROPIN AQ (somatropin)	
NORDITROPIN FLEXPRO (somatropin)[PA]	SAIZEN (somatropin)	
OMNITROPE (somatropin)[PA]	ZOMACTON (somatropin)	
HEMATOPOIETIC, GROWTH FACTOR		
ARANESP (darbopoetin alfa)		
EPOGEN (epoetin alfa)		
MIRCERA (methoxy polyethylene glycol-epoetin beta)		
PROCRIT (epoetin alfa)		
HEPATITIS C TREATMENTS		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: Non-preferred agents will require a reason why none of the preferred treatment options that are indicated are treatment options for the patient. 1. Patient must have FDA approved diagnosis 2. Patient must be an FDA approved age 3. Patient must attest that they will continue treatment without interruption for the duration of therapy 4. Prescriber must be or consult with a hepatologist, gastroenterologist, or infectious disease specialist 5. Prescriber must provide documentation that the patient has been drug and alcohol free for the past 12 months 6. Patient must have liver biopsy Metavir score of 2 or greater, or Ishak score of 3 or greater 7. HCV RNA level must be taken on week 4 and sent with a renewal request for any duration of treatment 12 weeks or longer 8. Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment 9. PA approval duration will be based on label recommendation.		
DAKLINZA (Daclatasvir)PA	OLYSIO (simeprevir)	***Epclusa -Epclusa must be used with ribavirin for patients with decompensated cirrhosis (Child-Pugh B or Child-Pugh C). -Epclusa is ONLY preferred for genotype 2 and 3, for all other genotypes Epclusa is non-preferred. ***Harvoni: - Patient must have eGFR > 30 mL/min/1.73m2 ***Technivie: - Patients must not have moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment - Patients must not have cirrhosis -Technivie must be used with ribavirin in treatment experienced patients ***Olysio:
EPCLUSA (sofosbuvir/velpatasvir)PA		
HARVONI (ledipasvir/sofosbuvir)PA		
SOVALDI (sofosbuvir)PA		
TECHNIVIE (ombitasvir/paritaprevir/ritonavir)PA		
VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)PA		
VIEKIRA PAK XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)PA		
ZEPATIER (elbasvir/grazoprevir)PA		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		- Olysio must be taken in conjunction with pegylated interferon and ribavirin ***Viekira Pak: - Patients must have hepatic laboratory tests before treatment and 4 weeks after treatment begins - Patients must not have moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment - Viekira Pak must be used with ribavirin except for genotype 1b without cirrhosis or mild (Child-Pugh A) hepatic impairment. ***Zepatier: - Patients must not have moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment - Genotype 1a: Patient must be tested for baseline NS5A polymorphisms - Zepatier must be used with ribavirin in patients with baseline NS5A polymorphisms - Zepatier must be used with ribavirin in patients that have failed HCV NS3/4A protease inhibitor (PI) + RBV + PegIFN treatment - Patients that have failed HCV NS3/4A protease inhibitor (PI) + RBV + PegIFN treatment must not have baseline NS5A polymorphisms
INFLAMMATORY BOWEL AGENTS (ULCERATIVE COLITIS) - NONSTEROIDAL		
Category PA Criteria: A 30 day trial of each of the preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents will require an FDA indication.		
Oral		
APRISO (mesalamine) CAPSULE	ASACOL HD (mesalamine)	
balsalazide capsule	AZULFIDINE (sulfasalazine)	
DELZICOL (mesalamine) CAPSULE	AZULFIDINE DR (sulfasalazine)	
LIALDA (mesalamine) TABLET	COLAZAL (balsalazide)	
PENTASA (mesalamine) CAPSULE	DIPENTUM (olsalazine)	
sulfasalazine DR tablet	GIAZO (balsalazide)	
sulfasalazine tablet	SULFAZINE (sulfasalazine)	
Rectal		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CANASA (mesalamine) RECTAL SUPPOSITORY	mesalamine enema kit	
mesalamine enema	SF ROWASA (mesalamine) ENEMA	
IRRITABLE BOWEL SYNDROME - CONSTIPATION		
Category PA Criteria: Patients must be 18 years old. All medications will require an FDA indication.		
AMITIZA (lubiprostone)		*** Linzess - A 30 day trial of Amitiza is required before Linzess will be authorized.
LINZESS (linaclotide)PA		
LICE		
Category PA Criteria: A 28 day/2 application trial of each of the preferred agents will be required before a non-preferred agent will be authorized. This requirement will be waived in the presence of a documented community breakout of a resistant strain that is only susceptible to a non-preferred agent.		
LICE SOLUTION (piperonyl butoxide/pyrethrins)	ELIMITE (permethrin) CREAM	
lindane lotion	EURAX (crotamiton) CREAM	
lindane shampoo	EURAX (crotamiton) LOTION	
NATROBA (spinosad)	malathion	
permethrin cream	OVIDE (malathion)	
permethrin liquid	spinosad	
ULESFIA (benzyl alcohol)		
MIGRAINE PROPHYLAXIS - 5HT(1) AGONISTS		
Category PA Criteria: Patients 18 years old or older: A 30 day trial of all preferred agents in the past 24 months will be required before a non-preferred agent will be authorized. Patients 6 to 17 years of age: A 30 day trial of rizatriptan in the past 24 months will be required before a non-preferred agent will be authorized.		
RELPAX (eletriptan)	almotriptan	***Treximet - For patients 18 years or older, the patient must be stable on the combination product and have had a 30 day trial of naproxen in addition to sumatriptan to be approved. This criteria is in addition to the class criteria. ***Frova - A 30-day trial of naratriptan 2.5 mg within the past 24 months will be required in addition to the class criteria. The patient's migraine headaches must either mentrual migraine, be long in duration, and/or recur.
rizatriptan	ALSUMA (sumatriptan) PEN INJCTR	
rizatriptan tab rapdis	AMERGE (naratriptan)	
sumatriptan tablet	FROVA (frovatriptan)	
	IMITREX (sumatriptan) CARTRIDGE	
	IMITREX (sumatriptan) PEN INJCTR	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	IMITREX (sumatriptan) SPRAY	***Axert - A 30-day trial of Zomitriptan 5 mg in the past 24 months will be required in addition to the class criteria. ***Zecuity/Sumavel DosePro/Sumatriptan Injection - A 30-day trial of Naratriptan 2.5 mg, Sumatriptan Nasal Spray 20 mg, Zomig Nasal Spray 5 mg, Zomitriptan 5 mg, Axert 12.5 mg, Treximet, and Frova in the past 24 months will be required in addition to the class criteria.
	IMITREX (sumatriptan) TABLET	
	IMITREX (sumatriptan) VIAL	
	MAXALT (rizatriptan)	
	MAXALT MLT (rizatriptan)	
	naratriptan	
	ONSETRA XSAIL (sumatriptan)	
	sumatriptan cartridge	
	sumatriptan pen injctr	
	sumatriptan spray	
	sumatriptan syringe	
	sumatriptan vial	
	SUMAVEL DOSEPRO (sumatriptan)	
	TREXIMET (sumatriptan/naproxen)	
	ZECUITY (sumatriptan) PATCH	
	zolmitriptan	
	zolmitriptan ODT	
	ZOMIG (zolmitriptan)	
	ZOMIG (zolmitriptan) SPRAY	
	ZOMIG ODT (zolmitriptan)	
MULTIPLE SCLEROSIS		
Interferons		
Category PA Criteria: A 3 month long trial of a preferred agent will be required before a non-preferred agent will be authorized. An FDA indication is required.		
AVONEX (interferon beta-1A) VIAL	AVONEX (interferon beta-1A) SYRINGE	
BETASERON (interferon beta-1B)	AVONEX (interferon beta-1A) PEN	
EXTAVIA (interferon beta-1B)	PLEGRIDY (peginterferon beta-1A)	
REBIF (interferon beta-1A)	PLEGRIDY PEN (peginterferon beta-1A)	
REBIF REBIDOSE (interferon beta-1A)		
Injectable Non-Interferons		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: A 3 month long trial of all preferred agents and 3 month trials of Aubagio, Tecfidera, and Gilenya will be required before a non-preferred agent will be authorized. If patient has a documented intolerance, hypersensitivity, or labeled contraindication to Copaxone, a 3-month trial of interferon beta-1 is required. An FDA indication is required. Prescriber must be a neurologist		
COPAXONE (glatiramer) 20 MG/ML	LEMTRADA (alemtuzumab)	***Lemtrada - If patient has early aggressive disease defined as ≥ 2 relapses in the year and ≥ 1 Cadollmium (Cd)+ lesion, the trials of oral non-interferons will not be required. - If patient has not been vaccinated or have a history of varicella zoster virus (VZV), patient must have an VZV antibody titer - Patient must have had a urinalysis with urine cell counts - Patient must have had a thyroid function test - Patient must be screened for TB and have been treated in TB positive - Patient must have SCr levels ***Tysabri - If patient has early aggressive disease defined as ≥ 2 relapses in the year and ≥ 1 Cadollmium (Cd)+ lesion, the trials of oral non-interferons will not be required. - Patient must have Anti-JC virus antiboties taken - Patient must have had a MRI scan ***Zinbryta - Transaminase and bilirubin levels must have been obtained within 6 months of request - Patient must not have hepatitis B or C - Patient must be screened for TB and have been treated in TB positive
	COPAXONE (glatiramer) 40 MG/ML	
	glatopa (glatiramer)	
	TYSABRI (natalizumab)	
	ZINBRYTA (daclizumab)	
Oral Non-Interferons		
Category PA Criteria: A 3 month long trial of all preferred agents will be required before a non-preferred agent will be authorized. A 3 month trial of Copaxone is required for Gilenya and all non-preferred agents. If patient has a documented intolerance, hypersensitivity, or labeled contraindication to Copaxone, a 3-month trial of interferon beta-1 is required. An FDA indication is required. Prescriber must be a neurologist		
GILENYA (fingolimod)[PA]	AUBAGIO (teriflunomide)	***Aubagio - Transaminase and bilirubin levels must have been obtained within 6 months of
	TECFIDERA (dimethyl fumarate)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		request - Patient must not be pregnant and if patient is of childbearing potential, reliable contraception must be used ***Gilenya - Patient must have had within 6 months of request: 1. CBC with differential 2. Electrocardiogram 3. Transaminase and bilirubin levels - Patient must have an opthalmologic evaluation at baseline - If patient has not been vaccinated or have a history of varicella zoster virus (VZV), patient must have an VZV antibody titer - Appointment date for first dose must be supplied *** Tecfidera - Patient must have had a CBC with lymphocyte count within 6 months of request
OPHTHALMIC ANTIHISTAMINES		
Category PA Criteria: A 30 day trial of 3 preferred agents will be required before a non-preferred agent will be authorized.		
BEPREVE (bepotastine)	ALOCRIL (nedocromil)	***Patanol, epinastine, and Lastacaft will require a 30 day trial of azelastine and Elestat in addition to the category PA criteria
cromolyn	ALOMIDE (lodoxamide)	
EMADINE (emedastine)	azelastine	
olopatadine	ELESTAT (epinastine)	
PATADAY (olopatadine)	epinastine	
PAZEO (olopatadine)	LASTACAFT (alcaftadine)	
	PATANOL (olopatadine)	
OPHTHALMIC ANTIINFECTIVES		
Category PA Criteria: A 3 day trial of 3 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
bacitracin ointment	AK-POLY-BAC (bacitracin/polymixin) OINTMENT	
bacitracin/polymixin ointment	AZASITE (arithromycin) DROPS	
ciprofloxacin drops	BESIVANCE (besifloxacin) DROPS	
erythromycin ointment	CILOXAN (ciprofloxacin) DROPS	
gentamicin sulfate drops	CILOXAN (ciprofloxacin) OINTMENT	
gentamicin sulfate ointment	gatifloxacin drops	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
MOXEZA (moxifloxacin) DROPS	GENTAK (gentamicin sulfate) OINTMENT	
neomycin SU/bacitracin/polymixin B drops	ILOTYCIN (erythromycin) OINTMENT	
neomycin SU/polymixin B/gramicidin drops	levofloxacin drops	
OCUFLOX (ofloxacin) DROPS	NEO-POLYCIN (neomycin SU/bacitracin/polymixin B) DROPS	
ofloxacin drops	NEOSPORIN (neomycin SU/polymixin B/gramicidin) DROPS	
polymixin B/trimethoprim drops	POLYCIN (bacitracin/polymixin) OINTMENT	
tobramycin drops	POLYTRIM (polymixin B/trimethoprim) DROPS	
TOBREX (tobramycin) OINTMENT	TOBREX (tobramycin) DROPS	
VIGAMOX (moxifloxacin) DROPS	ZYMAXID (gatifloxacin) DROPS	
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES		
Category PA Criteria: A 7 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30 day trial of 2 preferred generics of the same medication will satisfy this requirement.		
neomycin/polymyxin b/dexamethasone	tobramycin/dexamethasone	
neomycin/bacitracin/polymyxin b/hydrocortisone	MAXITROL (neomycin/polymyxin b/dexamethasone)	
neomycin/polymyxin b/hydrocortisone		
PRED-G (gentamicin/prednisol ac)		
TOBRADEX (tobramycin/dexamethasone)		
TOBRADEX ST (tobramycin/dexamethasone)		
ZYLET (tobramycin/lotepred etab)		
OPHTHALMIC ANTIINFLAMMATORIES		
Category PA Criteria: A 30 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions is indicated on the form. A 30 day trial of 2 preferred generics of the same medication will satisfy this requirement.		
ACULAR LS (ketorolac)	ACULAR (ketorolac)	
ACUVAIL (ketorolac)	FML (fluorometholone)	
ALREX (loteprednol)	OCUFEN (flurbiprofen)	
bromfenac sodium	OMNIPRED (prednisolone acetate)	
dexamethasone sodium phosphate	PRED FORTE (prednisolone acetate)	

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
diclofenac sodium		
DUREZOL (difluprednate)		
FLAREX (fluorometholone)		
fluorometholone		
flurbiprofen sodium		
FML FORTE (fluorometholone)		
FML S.O.P. (fluorometholone)		
ILEVRO (nepafenac)		
ILUVIEN (fluocinolone)		
ketorolac tromethamine		
LOTEMAX (loteprednol)		
MAXIDEX (dexamethasone)		
NEVANAC (nepafenac)		
OZURDEX (dexamethasone)		
PRED MILD (prednisolone)		
prednisolone acetate		
prednisolone sodium phosphate		
PROLENSA (bromfenac)		
RETISERT (fluocinolone)		
TRIESENCE (triamcinolone)		
VEXOL (rimexolone)		
OPHTHALMIC GLAUCOMA COMBINATION AGENTS		
Category PA Criteria: A 30 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions is indicated on the form. A 30 day trial of 2 preferred generics of the same medication will satisfy this requirement.		
COMBIGAN (brimonidine/timolol)	COSOPT (dorzolamide/timolol)	
COSOPT PF (dorzolamide/timolol)		
dorzolamide/timolol		
SIMBRINZA (brinzolamide/brimonidine)		
OPHTHALMIC GLAUCOMA PROSTAGLANDINS		
Category PA Criteria: A 30 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions is indicated on the form. A 30 day trial of 2 preferred generics of the same medication will satisfy this requirement.		
bimatoprost	XALATAN (latanoprost)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
latanoprost		
LUMIGAN (bimatoprost)		
TRAVATAN Z (travoprost)		
travoprost		
ZIOPTAN (tafluprost)		
OPIOID ANALGESIC - LONG ACTING		
Category PA Criteria: A 30 day trial of a product containing fentanyl and one containing morphine will be required before a non-preferred agent will be authorized. For non-preferred agents to be authorized, patient must have required around the clock pain relief for the past 90 days and 3 months of the PDMP report must be reviewed and attached.		
BUTRANS (buprenorphine)	DURAGESIC (fentanyl)	*** Fentanyl 12mcg/hr - The total daily opioid dose must be less than 60 Morphine Equivalent Dose (MED) and 3 months of the PDMP report must be reviewed and attached *** Belbuca, Hysingla, Fentanyl Patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr require a 30 day failed trial of Opana ER and Oxycontin in addition to category PA criteria. ***Hydromorphone ER and Exalgo - The 90 day around the clock pain relief requirement must be met by an equianalgesic dose of 60mg oral morphine daily, 25 mcg transdermal fentanyl/hour, 30mg oxycodone daily, 8 mg of oral hydromorphone daily or another opioid daily. A 30 day failed trial of Opana ER and Oxycontin is required in addition to category PA criteria. . ***Oxycontin, Zohydro ER - A 30 day failed trial of Opana ER will be required in addition to category PA criteria ***methadone - requires a 30 day failed trial of Opana ER, Oxycontin, Butrans, tramadol ER, Nucynta ER in addition to category PA criteria.
EMBEDA (morphine/naltrexone)	DURAGESIC PATCH (fentanyl)	
fentanyl 12 mcg/hr[PA]	EXALGO (hydromorphone)	
fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr	
morphine ER tablets	hydromorphine ER tablets	
NUCYNTA ER (tapentadol)	HYSINGLA ER (hydrocodone)	
tramadol ER	KADIAN (morphine)	
	methadone	
	morphine ER capsules	
	MS CONTIN (morphine)	
	OPANA ER (oxymorphone)	
	oxycodone ER	
	OXYCONTIN (oxycodone)	
	oxymorphone ER tablets	
	ULTRAM ER (tramadol ER)	
	XARTEMIS XR (oxycodone/acetaminophen)	
	ZOHYDRO ER (hydrocodone)	
OPIOID ANTAGONIST - OPIOID AND ALCOHOL DEPENDENCE		
VIVITROL (Naltrexone Microspheres)		
OPIOID PARTIAL ANTAGONIST - OPIOID DEPENDENCE		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: A 30 day trial of 1 preferred agent will be required before a non-preferred agent will be authorized. 1. Patient must be 16 years of age or older 2. Patient must not be taking other opioids, tramadol, or carisoprodol concurrently 3. The prescriber must be registered to prescribe under the Substance Abuse and Mental Health Services Administration (SAMHSA) and provide his/her DEA number 4. The prescriber and patient must have a contract or the prescriber must have developed a treatment plan 5. The prescriber must perform routine drug screens 6. The prescriber must routinely check the PDMP, and attach the last 3 months of PDMP reports that have been reviewed 7. The prescriber must be enrolled with ND Medicaid		
ZUBSOLV (buprenorphine/naloxone)[PA]	BUNAVAIL FILM (buprenorphine/naloxone)	*** Bunavail/Suboxone Film/buprenorphine - will require a 30-day trial of buprenorphine/naloxone tablets in addition to the category PA Criteria
	buprenorphine tablets	
	buprenorphine-naloxone tablets	
	SUBOXONE FILM (buprenorphine/naloxone)	
OTIC ANTI-INFECTIVES - FLUOROQUINOLONES		
Category PA Criteria: A seven (7) day trial of 1 preferred product in the past 3 months is required before a non-preferred product will be approved.		
CIPRO HC (ciprofloxacin/hydrocortisone)	OCUFLOX (ofloxacin)	
CIPRODEX (ciprofloxacin/dexamethasone)	ofloxacin	
OTOVEL (ciprofloxacin/fluocinolone)		
PHOSPHATE BINDERS		
Category PA Criteria: The following criteria will be required before a non-preferred agent will be authorized. 1. Patient must have had a 3 month trial of 3 preferred different chemical entities. 2. Patient must have end stage renal disease or chronic kidney disease 3. Patients with chronic kidney disease stage 5 must have a phosphate level greater than 5.5 mg/dL 4. All other patients must have a phosphate level greater than 4.6 mg/dL		
calcium acetate capsule	AURYXIA (ferric citrate) TABLET	*** Fosrenol Powder Pack - A 3 month trial of Renvela Powder Pack will be required in addition to category PA criteria *** Velphoro - A 3 month trial of Auryxia will be required in addition to category PA criteria
calcium acetate tablet	FOSRENOL (lanthanum) POWDER PACK	
ELIPHOS (calcium acetate) TABLET	RENVELA (sevelamer) POWDER PACK	
FOSRENOL (lanthanum) CHEWABLE TABLET	VELPHORO (sucroferric oxyhydroxide) CHEWABLE TABLET	
PHOSLO (calcium acetate) CAPSULE		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PHOSLYRA (calcium acetate) ORAL solution		
RENAGEL (sevelamer) TABLET		
RENVELA (sevelamer) TABLET		
PLATELET AGGREGATION INHIBITORS		
Category PA Criteria: A 30 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions is indicated on the form. A 30 day trial of 2 preferred generics of the same medication will satisfy this requirement.		
AGGRENOX (aspirin/dipyridamole)	PLAVIX (clopidogrel)	***Zontivity - Patient must be 18 years of age or older. Zontivity must be taken with aspirin and/or clopidogrel. Patient must not have a history of stroke, transient ischemic attack, or intracranial hemorrhage.
aspirin/dipyridamole ER	ZONTIVITY (vorapaxar)	
BRILINTA (ticagrelor)	PERSANTINE (dipyridamole)	
clopidogrel		
dipyridamole		
EFFIENT (prasugrel)		
ticlopidine		
PULMONARY HYPERTENSION		
PDE-5 Inhibitors		
Category PA Criteria: A 30 day trial of all preferred agents will be required before a non-preferred agent will be authorized. All medications require an FDA approved indication.		
ADCIRCA (tadalafil)PA	REVATIO (sildenafil) SUSPENSION	***Revatio Suspension - Patients 7 years and older will be required to submit documentation of their inability to ingest a solid dosage form ***Sildenafil - A 30 day trial of Adcirca will be required for all patients younger than 18 years old
sildenafilPA	REVATIO (sildenafil) TABLET	
Soluble Guanylate Cyclase Stimulators		
Category PA Criteria: Patients of childbearing potential must not be pregnant, be taking a reliable form of birth control, and have a pregnancy test before initiation and monthly during therapy. All medications require an FDA approved indication. Patients must be at least 18 years of age.		
ADEMPAS (riociguat)PA		
Endothelin Receptor Antagonist		
Category PA Criteria: Patients of childbearing potential must not be pregnant, be taking a reliable form of birth control, and have a pregnancy test before initiation and monthly during therapy. All medications require an FDA approved indication. Patients must be at least 18 years of age.		
LETAIRIS (ambrisentan)PA		***Tracleer - LFTs must be measured at baseline and monthly during therapy
OPSUMIT (macitentan)PA		

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
TRACLEER (bosentan)PA		
Prostacyclins		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. Patients must be at least 18 years of age.		
eproprostenolPA	REMODULIN (treprostinil)	***Ventavis 20 mcg/mL - A patient must be maintained at a 5 mcg dose and repeatedly experiencing incomplete dosing due to extended treatment time to be approved
FLOLAN (epoprostenol)PA	TYVASO (treprostinil)	
ORENITRAM ER (treprostinil)PA	UPTRAVI (selexipag)	
VELETRI (epoprostenol)PA	VENTAVIS (iloprost) 20 mcg/mL	
VENTAVIS (iloprost) 10 mcg/mLPA		
STEROID/LONG ACTING BETA AGONIST (LABA) COMBINATION INHALERS		
Category PA Criteria: A 30 day trial of all preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents must have FDA approved indication. For COPD diagnosis, the following will be required in addition to the category PA criteria. 1. A 30 day trial of Tudorza Pressair, Spiriva, Incruse Ellipta, Anoro Ellipta, or Stiolto Respimat. 2. A 30 day trial of Anoro Ellipta, Stiolto Respimat, Foradil, Brovana, Arcapta, or Sevevent. For asthma diagnosis, patient must have been reviewed for step down therapy for all renewal requests.		
ADVAIR DISKUS (fluticasone/salmeterol)	ADVAIR HFA (fluticasone/salmeterol)	
DULERA (mometasone/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)	
SYMBICORT (budesonide/formoterol)		
STEROID INHALERS		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
AEROSPAN (flunisolide)	ASMANEX HFA (mometasone)	
ALVESCO (ciclesonide)	ARNUITY ELLIPTA (fluticasone)	
ASMANEX (mometasone) TWISTHALER		
FLOVENT DISKUS (fluticasone)		
FLOVENT HFA (fluticasone)		
PULMICORT FLEXHALER (budesonide)		
QVAR (beclomethasone)		
STEROID TOPICAL SOLUTIONS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
clobetasol solution		
ELOCON (mometasone) solution		
fluocinolone solution		
hydrocortisone solution		
mometasone solution		
SYNALAR (fluocinolone) SOLUTION		
TEXACORT (hydrocortisone SOLUTION		
TESTOSTERONE TOPICAL		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All medications require a FDA approved indication.		
ANDROGEL (testosterone) PACKET[PA]	ANDRODERM (testosterone)	
ANDROGEL (testosterone) GEL MD PMP[PA]	FORTESTA (testosterone)	
AXIRON (testosterone)[PA]	NATESTO (testosterone)	
	TESTIM (testosterone)	
	TESTOPEL (testosterone)	
	testosterone gel	
	testosterone Gel MD PMP	
	VOGELXO (testosterone) GEL MD PMP	
ULCER ANTI-INFECTIVES		
Category PA Criteria: A 10 day trial in the past 3 months of all preferred agents will be required before a non-preferred agent will be authorized.		
PYLERA (bismuth/methronidazole/tegracycline)	PREVPAC (lansoprazole/amoxicillin/clarithromycin)	
	lansoprazole/amoxicillin/clarithromycin	
	OMECLAMOX-PAK (omeprazole/clarithromycin/amoxicillin)	
URINARY ANTISPASMODICS		
Category PA Criteria: A 30 day trial of 4 preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents require an FDA approved indication.		
ENABLEX (darifenacin)	DETROL (tolterodine)	***Tolterodine ER will require a 1 month trial of Sanctura XR, Myrbetriq, trospium, and tolterodine in addition to the category PA criteria. ***Trospium ER will require a 1 month trial of Myrbetriq, trospium, and tolterodine
flavoxate	DETROL LA (tolterodine)	
oxybutynin ER	DITROPAN XL (oxybutynin)	
oxybutynin syrup	GELNIQUE (oxybutynin)	

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
oxybutynin tablet	MYRBETRIQ (mirabegron)	in addition to the category PA criteria. ***Myrbetriq will require a 1 month trial of trospium and tolterodine in addition to the category PA criteria. ***Trospium will require a 1 month trial of tolterodine in addition to the category PA criteria.
TOVIAZ (fesoterodine)	OXYTROL (oxybutynin) PATCH	
VESICARE (solifenacin)	SANCTURA (trospium)	
	SANCTURA ER (trospium)	
	tolterodine	
	tolterodine ER	
	trospium	
	trospium ER	