NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
NORTH DAKOTA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs requiring prior authorization. Only PDL managed categories are included. Refer to cover page for complete list of rules governing this PDL.

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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 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 PA.

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

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ADHD		
Category PA Criteria: A fourteen (14) day trial of two (2) preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. A thirty (30) day trial of two (2) preferred generics of the same medication will satisfy this requirement.		
ADDERALL XR (dextroamphetamine/amphetamine)	ADDERALL (dextroamphetamine/amphetamine)	
DAYTRANA (methylphenidate)	clonidine ER	
DESOXYN (methamphetamine)	CONCERTA	
dexmethylphenidate	DEXEDRINE (dextroamphetamine)	
dextroamphetamine	dexmethylphenidate ER	
dextroamphetamine 5mg/5ml	dextroamphetamine/amphetamine ER	
dextroamphetamine ER	FOCALIN (dexmethylphenidate)	
dextroamphetamine/amphetamine	INTUNIV (guanfacine ER)	
EVEKEO (amphetamine)	METHYLIN (methylphenidate) chew tablets	
FOCALIN XR (dexmethylphenidate)	METHYLIN (methylphenidate) solution	
guanfacine ER	methylphenidate CD 30-70	
KAPVAY (clonidine)	methylphenidate ER capsules 50-50	
METADATE CD (methylphenidate CD)	methylphenidate ER tablet - Mallinckrodt	
METADATE ER (methylphenidate)	methylphenidate LA capsules - 50-50	
methamphetamine	RITALIN (methylphenidate)	
methylphenidate chew tablet		
methylphenidate ER tablet- Actavis		
methylphenidate solution		
methylphenidate tablet		
PROCENTRA (dextroamphetamine)		
QUILLIVANT XR (methylphenidate)		
RITALIN LA (methylphenidate LA capsules - 50-50)		
STRATTERA (atomoxetine)		
VYVANSE (lisdexamfetamine)		
ZENZEDI (dextroamphetamine)		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ALLERGENIC EXTRACTS		
Category PA Criteria: 1. Patient must not have severe, unstable, or uncontrolled asthma 2. Patient must be a FDA approved age 3. Patient must have a 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 - INJECTABLE		
Category PA Criteria: A thirty (30) day trial of one (1) preferred agent will be required before a non-preferred agent will be authorized. All non-preferred agents will require a FDA indication.		
enoxaparin	ARIXTRA (fondaparinux)	
LOVENOX (enoxaparin)	fondaparinux	
	FRAGMIN (dalteparin)	
ANTICOAGULANTS - ORAL		
Category PA Criteria: A thirty (30) day trial of one (1) preffered agent will be required before a non-preferred agenet will be authorized. All agents will require a FDA indication.		
ELIQUIS (Apixaban)PA	SAVAYSA (edoxaban)	
PRADAXA (dabigatran)PA		
XARELTO (rivaroxaban)PA		
ANTICONVULSANTS		
Category PA Criteria: A thirty (30) day trial of two (2) preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions is indicated on the form. A thirty (30) day trial of two (2) preferred generics of the same medication will satisfy this requirement.		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
APTIOM (esucarbazepine)	carbamazepine ER capsule	
BANZEL (rufinamide) ORAL SUSPENSION	carbamazepine oral suspension	
BANZEL (rufinamide) TABLET	carbamazepine XR tablet	
carbamazepine chewable tablet	CARBATROL (carbamazepine)	
carbamazepine tablet	DEPAKENE (valproic acid) CAPSULE	
CELONTIN (methsuximide)	DEPAKENE (valproic acid) ORAL SOLUTION	
divalproex ER	DEPAKOTE (divalproex sodium) TABLET	
divalproex sprinkle	DEPAKOTE ER (divalproex sodium)	
divalproex tablet	DEPAKOTE SPRINKLE (divalproex sodium)	
ethosuximide capsule	DILANTIN (phenytoin) CHEWABLE TABLET	
ethosuximide oral solution	DILANTIN (phenytoin) ORAL SUSPENSION	
felbamate oral suspension	DILANTIN ER (phenytoin)	
felbamate tablet	EPITOL (carbamazepine)	
FYCOMPA (perampanel)	FELBATOL (felbamate)	
gabapentin capsule	FELBATOL (felbamate) ORAL SUSPENSION	
gabapentin oral solution	FELBITOL (felbamate) ORAL SUSPENSION	
gabapentin tablet	KEPPRA (levetiracetam)	
GABITRIL (tiagabine)	KEPPRA (levetiracetam) ORAL SOLUTION	
LAMICTAL ER (lamotrigine) DOSE PACK	KEPPRA (levetiracetam) ORAL SOLUTION	
LAMICTAL ODT (lamotrigine)	KEPPRA XR (levetiracetam)	
LAMICTAL ODT (lamotrigine) DOSE PACK	LAMICTAL (lamotrigine)	
LAMICTAL XR (lamotrigine)	LAMICTAL (lamotrigine) CHEWABLE TABLET	
lamotrigine chewable tablet	LAMICTAL (lamotrigine) DOSE PACK	
lamotrigine dose pack	MYSOLINE (primidone)	
lamotrigine ER	NEURONTIN (gabapentin) CAPSULE	
lamotrigine ODT	NEURONTIN (gabapentin) ORAL	

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	SOLUTION	
lamotrigine tablet	NEURONTIN (gabapentin) TABLET	
levetiracetam ER	QUDEXY XR (topiramate)	
levetiracetam oral solution	TOPAMAX (topiramate)	
levetiracetam tablet	TOPAMAX (topiramate) SPRINKLE CAPSULE	
LYRICA (pregabalin)	TRILEPTAL (oxcarbazepine)	
LYRICA (pregabalin) ORAL SOLUTION	TRILEPTAL (oxcarbazepine) ORAL SUSPENSION	
oxcarbazepine oral solution	ZARONTIN (ethosuximide) ORAL SOLUTION	
oxcarbazepine tablet	ZONEGRAN (zonisamide)	
OXTELLAR XR (oxcarbazepine)	ZARONTIN (ethosuximide)	
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		
TEGRETOL (carbamazepine)		
TEGRETOL XR (carbamazepine)		
TEGRETROL (carbamazepine oral suspension)		
tiagabine		
topiramate ER		
topiramate sprinkle capsule		
topiramate tablet		
TROKENDI XR (topiramate)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
valproic acid capsule		
valproic acid oral solution		
VIMPAT (lacosamide)		
VIMPAT (lacosamide) ORAL SOLUTION		
zonisamide		
ANTICONVULSANTS - BENZODIAZEPINES - RECTAL		
Category PA Criteria: A thirty (30) day trial of one (1) preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions is indicated on the form..		
DIASTAT (diazepam) RECTAL KIT	diazepam rectal kit	
ANTIDEMENTIA		
Category PA Criteria: A thirty (30) day trial of one (1) preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions is indicated on the form.		
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	
NAMENDA (memantine) ORAL SOLUTION		
NAMENDA XR (memantine)		
rivastigmine		
ANTIDEPRESSANTS - NEW GENERATION		
Category PA Criteria: A thirty (30) day trial of two (2) preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions is indicated on the form. A thirty (30) day trial of two (2) preferred generics of the same medication will satisfy this requirement.		
BRINTELLIX (vortioxetine)	APLENZIN ER (bupropion)	
bupropion SR tablet	CELEXA (citalopram)	
bupropion tablet	CYMBALTA (duloxetine)	
bupropion XL tablet	EFFEXOR XR (venlafaxine)	
citalopram	fluoxetine DR	
citalopram oral solutoin	FORFIVO XL (bupropion)	
clomipramine	IRENKA (duloxetine)	

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
desvenlafaxine ER	LEXAPRO (escitalopram)	
duloxetine	LEXAPRO (escitalopram) ORAL SOLUTION	
escitalopram	PAXIL (paroxetine)	
escitalopram oral solution	PAXIL CR (paroxetine)	
FETZIMA (levomilnacipran)	PROZAC (fluoxetine)	
fluoxetine capsule	WELLBUTRIN (bupropion)	
fluoxetine solution	WELLBUTRIN SR (bupropion)	
fluoxetine tablet	WELLBUTRIN XL (bupropion)	
fluvoxamine	ZOLOFT (sertraline)	
fluvoxamine ER	ZOLOFT (sertraline) ORAL CONCENTRATE	
KHEDEZLA ER (desvenlafaxine)		
nefazodone		
OLEPTRO ER (trazodone)		
paroxetine		
paroxetine ER		
PAXIL (paroxetine) ORAL SUSPENSION		
PEXEVA (paroxetine)		
PRISTIQ ER (desvenlafaxine)		
PROZAC WEEKLY (fluoxetine)		
sertraline		
sertraline oral concentrate		
trazodone		
venlafaxine capsule		
venlafaxine ER tablets		
venlafaxine tablet		
VIIBRYD (vilazodone)		
ANTIDIABETICS - DPP4 INHIBITORS		
JANUMET (sitagliptan/metformin)		
JANUMET XR (sitagliptan/metformin)		
JANUVIA (sitagliptan)		
JENTADUETO (linagliptin/metformin)		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
KAZANO (alogliptin/metformin)		
KOMBIGLYZE XR (sitagliptan/metformin)		
NESINA (alogliptin)		
ONGLYZA (saxagliptin)		
OSENI (alogliptin/pioglitazone)		
TRADJENTA (linagliptin)		
ANTIDIABETICS - GLP1 AGONISTS		
Category PA Criteria: Non preferred agents will require: 1. A thirty (30) day trial of two (2) preferred agents 2. A FDA indication 3. Concurrent metformin therapy 4. A 3 month trial of metformin		
BYDUREON (exenatide microspheres)	TANZEUM (albiglutide)	
BYETTA (exenatide)	TRULICITY (dulaglutide)	
VICTOZA (liraglutide)		
ANTIDIABETICS - SGLT2 INHIBITORS		
Category PA Criteria: All agents will require a 3 month trial of metformin. Non-preferred agents will require: 1. A 3 month trial of all preferred agents 2. A FDA indication 3. Concurrent metformin therapy		
FARXIGA (dapagliflozin)	JARDIANCE (empagliflozin)	
INVOKANA (canaglifozin)		
ANTIDIABETICS - SGLT2 INHIBITORS COMBINATIONS		
Category PA Criteria: Non preferred agents will require: 1. A 3 month trial of all preferred agents 2. A FDA indication 3. A 3 month trial of metformin		
INVOKAMET (canafliflozin/metformin)	GLYXAMBI (empagliflozin/linagliptan)	
	SYNJARDY (empagliflozin/metformin)	
	XIGDUO XR (dapagliflozin/metformin)	
ANTIHEMOPHILIC FACTORS		

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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		
ADVATE[PA]		
ALPHANATE[PA]		
ALPHANINE SD[PA]		
ALPROLIX[PA]		
BEBULIN[PA]		
BENEFIX[PA]		
ELOCTATE[PA]		
FEIBA[PA]		
HELIXATE FS[PA]		
HEMOFIL M[PA]		
HUMATE-P[PA]		
IXINITY[PA]		
KOATE-DVI[PA]		
KOGENATE FS[PA]		
KOGENATE FS BIO-SET[PA]		
MONOCLATE-P[PA]		
MONONINE[PA]		
NOVOEIGHT[PA]		
NOVOSEVEN[PA]		
OBIZURE[PA]		
PROFILNINE SD[PA]		
RECOMBINATE[PA]		
RIXUBIS[PA]		
WILATE[PA]		
XYNTHA[PA]		

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIHYPERLIPIDEMICS - CETP INHIBITORS		
Category PA Criteria: A thirty (30) day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
VYTORIN (ezetimibe/simvastatin)		
ZETIA (ezetimibe)		
ANTIHYPERLIPIDEMICS - NIACIN		
Category PA Criteria: A thirty (30) day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
NIASPAN ER (niacin)	niacin ER	
ANTIHYPERTENSIVE - BETA BLOCKERS		
Category PA Criteria: A thirty (30) day trial of two (2) preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. A thirty (30) day trial of two (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)	
metoprolol ER	ZEBETA (bisoprolol)	
nadolol		
pindolol		
propranolol		
propranolol ER		
sotalol		
sotalol AF		
timolol		
ANTIPROTAZOAL AGENTS		
Category PA Criteria: A thirty (30) day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
ALINIA (nitazoxanide)	tinidazole	
atovaquone		
MEPRON (atovaquone)		
TINDAMAX (tindazole)		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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)		
VIRACEPT (nelfinavir)		
ATYPICAL ANTIPSYCHOTICS		
Category PA Criteria: A thirty (30) day trial of two (2) preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. A thirty (30) day trial of two (2) preferred generics of the same medication will satisfy this requirement.		
ABILIFY (aripiprazole)	aripiprazole	
ABILIFY (aripiprazole) ORAL SOLUTION	CLOZARIL (clozapine)	
ABILIFY DISCMELT (aripiprazole)	GEODON (ziprasidone)	
clozapine	RISPERDAL (risperidone)	
clozapine ODT	RISPERDAL (risperidone) ORAL SOLUTION	
FANAPT (iloperidone)	RISPERDAL M-TAB (risperidone)	
FAZACLO (clozapine) RAPDIS	SEROQUEL (quetiapine)	
INVEGA (paliperidone)	ZYPREXA (olanzapine)	
LATUDA (lurasidone)	ZYPREXA ZYDIS (olanzapine)	
olanzapine		
olanzapine ODT		
olanzapine/fluoxetine		
quetiapine		
REXULTI (brexipiprazole)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
risperidone		
risperidone ODT		
risperidone oral solution		
SAPHRIS (asenapine)		
SEROQUEL XR (quetiapine)		
SYMBYAX (olanzapine/fluoxetine)		
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 thirty (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 less than 40 years of age. All non preferred agents will require 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 trail 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		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Group PA Criteria: A thirty (30) day trial of one (1) preferred agent in either the Long Acting Beta Agonist or Long Acting anticholinergic group will be required in addition to category PA criteria before a non-preferred agent will be authorized.		
ANORO ELLIPTA (umeclidium/vilanterol)	STIOLTO RESPIMAT (tiotropium/olodaterol)	
PDE4 - Inhibitor		
Group PA Criteria: In addition to the Category PA Criteria, patient must not have a hisotry of exacerbations treated with corticosteroids within the last year and have had the following thirty (30) day trials: 1. one (1) preferred agent in the Long Acting anticholinergic group 2. one (1) preferred agent in the Long Acting Beta Agonist group 2. concurrent therapy consisting of one (1) preferred agent in the STEROID/ANTICHOLINERGIC COMBINATION INHALERS CATEGORY and one (1) preferred agent in the Long Acting anticholinergic group		
	DALIRESP (roflumilast)	
CYSTIC FIBROSIS		
Category PA Criteria: A twenty eight (28) day trial of all preferred agents 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 a 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 thirty (30) day trial of two (2) preferred agents will be required before a non-preferred agent will be authorized. All agents will require a FDA approved indication.		
COSENTYX (secukinumab)PA	ACTEMRA (tocilizumab)	***Cosentyx - A 3 month trial of Humira will be required for plaque psoriasis before Cosyntyx is approved.
ENBREL (etanercept)PA	CIMZIA (certolizumab)	
HUMIRA (adalimumab)PA	KINERET (anakinra)	
HUMIRA PSORIASIS (adalimumab)PA	ORENCIA (abatacept)	
	OTEZLA (apremilast)	
	SIMPONI (golimumab)	
	STELARA (ustekinumab)	
	XELJANZ (tofacitanib)	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
DIGESTIVE ENZYMES		
Category PA Criteria: A thirty (30) day trial of all preferred agents will be required before a non-preferred agent will be authorized unless one (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)	
	PERTYZE (lipase/protease/amylase)	
	ULTRESA (lipase/protease/amylase)	
	VIOKACE (lipase/protease/amylase)	
EPINEPHRINE PENS		
Category PA Criteria: A thirty (30) day trial of one (1) preferred agent will be required before a non-preferred agent will be authorized.		
EPIPEN (epinephrine)	ADRENACLICK (epinephrine)	
EPIPEN JR (epinephrine)	epinephrine	
FIBROMYALGIA		
Category PA Criteria: A thirty (30) day trial of two (2) preferred agents will be required before a non-preferred agent will be authorized. A thirty (30) day trial of two (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 criteria below and be started on a preferred growth hormone 2. Patients continuing GH therapy and having met criteria listed below must be switched to a preferred growth hormone 3. Patients must not have an active malignancy Additional criteria applies. See for details: http://www.hidesigns.com/assets/files/ndmedicaid/Criteria/2016/growth_hormone_criteria.pdf		
GENOTROPIN (somatropin)[PA]	HUMATROPE (somatropin)	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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)		
PROCRIT (epoetin alfa)		
HEPATITIS C TREATMENTS		
Category PA Criteria: Non-preferred agents will require a failed trial of all preferred treatment options indicated for the patient's genotype. 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.		
HARVONI (ledipasvir/sofosbuvir)PA	DAKLINZA (Daclatasvir)	***Harvoni: - Patient must have eGFR > 30 mL/min/1.73m2 - Genotypes 4, 5 and 6: Patient must be treatment naïve ***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
SOVALDI (sofosbuvir)PA	OLYSIO (simeprevir)	
TECHNIVIE (Ombitasvir/Paritaprevir/ Ritonavir)PA		
VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)PA		
ZEPATIER (elbasvir/grazoprevir)PA		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		***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. ***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 protrase inhibitor (PI) + RBV + PegIFN treatment - Patients that have failed HCV NS3/4A protrase inhibitor (PI) + RBV + PegIFN treatment must not have baseline NS5A polymorphisms
IMMUNE GLOBULINS INTRAVENOUS (IVIG)		
BIVIGAM (human immunoglobulin gamma)		
CARIMUNE NF (human immunoglobulin gamma)		
FLEBOGAMMA DIF (human immunoglobulin gamma)		
GAMMAGARD LIQUID (human immunoglobulin gamma)		
GAMMAGARD S-D (human immunoglobulin gamma		
GAMMAKED (human immunoglobulin gamma)		
GAMMAPLEX (human immunoglobulin gamma)		
GAMUNEX-C (human immunoglobulin gamma)		
OCTAGAM (human immunoglobulin gamma)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PRIVIGEN (human immunoglobulin gamma)		
INFLAMMATORY BOWEL AGENTS (ULCERATIVE COLIATIS) - NONSTEROIDAL		
Category PA Criteria: A thirty (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		
CANASA (mesalamine) RECTAL SUPPOSITORY	mesalamine enema kit	
mesalamine enema	SF ROWASA (mesalamine) ENEMA	
INSULIN - ANTIDIABETES		
PA Criteria: A thirty (30) day trial of one (1) preferred agent will be required in the past year before a non-preferred agent will be authorized.		
HUMALOG (insulin lispro) VIAL	AFREZZA (insulin regular, human)	
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	APIDRA (insulin glulisine) VIAL	
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	
HUMULIN 70/30 (insulin NPH human/regular insulin human) INSULIN PEN	HUMALOG (insulin lispro) CARTRIDGE	
HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN	HUMALOG (insulin lispro) KWIKPEN	
HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL	HUMALOG MIX 50/50 (insulin NPL/insulin lispro) KWIKPEN	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
HUMULIN N (insulin NPH human isophane) INSULIN PEN	HUMALOG MIX 75/25 (insulin NPL/insulin lispro) KWIKPEN	
HUMULIN N (insulin NPH human isophane) KWIKPEN	NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL	
HUMULIN N (insulin NPH human isophane) VIAL	NOVOLIN N (insulin NPH human isophane) VIAL	
HUMULIN N (insulin NPH human isophane) VIAL	NOVOLIN R (insulin regular, human) VIAL	
HUMULIN R (insulin regular, human) VIAL	TOUJEO SOLOSTAR (insulin glargine)	
HUMULIN R U-500 (insulin regular, human) VIAL	TRESIBA (insulin degludec)	
LANTUS (insulin glargine) FLEXTOUCH		
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		
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL		
IRRITABLE BOWEL SYNDROME - CONSTIPATION		
Category PA Criteria: Patients must be 18 years old. All medications will require an FDA indication		
AMITIZA (lubiprostone)PA		*** Linzess - A 30 day trial of Amitiza is required before Linzess will be authorized.
LINZESS (linaclotide)PA		
LICE		
Category PA Criteria: A thirty (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.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
EURAX (crotamiton) CREAM	ELIMITE (permethrin) CREAM	
EURAX (crotamiton) LOTION	OVIDE (malathion)	
LICE SOLUTION (piperonyl butoxide/pyrethrins)		
lindane lotion		
lindane shampoo		
malathion		
NATROBA (spinosad)		
permethrin cream		
permethrin liquid		
SKLICE (ivermectin)		
spinosad		
ULESFIA (benzyl alcohol)		
MIGRAINE PROPHYLAXIS - 5HT(1) AGONISTS		
Category PA Criteria: Patients 18 years old or greater: A thirty (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 18 years of age: A thirty (30) day trial rizatriptan in the past 24 months will be required before a non-preferred agent will be authorized.		
RELPAX (eletriptan)	almotriptan	***Zomig Nasal Spray - a 30 day trial of zolmitriptan 5mg within the past 24 months will be required in addition to class criteria ***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 be long in duration and or recur. ***Axert/Sumatriptan Nasal Spray - a 30 day trial of Naratriptan 2.5mg, Zomig Nasal Spray 5 mg, Zomitriptan 5 mg, Treximet, and Frova in the past 24 months will be required in addition to the class criteria. ***Zecuity/Sumavel DosePro - a 30 day trial of Naratriptan 2.5mg, Sumatriptan Nasal Spray 20 mg, Zomig Nasal Spray 5 mg, Zomitriptan 5 mg, Axert 12.5mg, Treximet, and Frova in the past 24 months will be required in addition to the class
rizatriptan	ALSUMA (sumatriptan) PEN INJCTR	
sumatriptan tablet	AMERGE (naratriptan)	
	FROVA (frovatriptan)	
	IMITREX (sumatriptan) CARTRIDGE	
	IMITREX (sumatriptan) PEN INJCTR	
	IMITREX (sumatriptan) SPRAY	
	IMITREX (sumatriptan) TABLET	
	IMITREX (sumatriptan) VIAL	
	MAXALT (rizatriptan)	
	MAXALT MLT (rizatriptan)	
	naratriptan	
	rizatriptan tab rapdis	
	sumatriptan cartridge	
	sumatriptan pen injctr	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	sumatriptan spray	criteria.
	sumatriptan syringe	
	sumatriptan vial	
	SUMAVEL DOSEPRO (sumatriptan)	
	TREXIMET (sumatriptan/naproxen)	
	ZECUITY (sumatriptan) PATCH	
	zolmitriptan	
	zolmitriptan ODT	
	ZOMIG (zolmitriptan)	
	ZOMIG (zolmitriptan) SPRAY	
	ZOMIG ODT (zolmitriptan)	
MS AGENTS		
Non-Interferons		
Category PA Criteria: A three (3) month long trial of a preferred agent will be required before a non-preferred agent will be authorized. A three (3) month trial of Copaxone is required. If patient has a documented intolerance, hypersensitivity, or labeled contraindication to Copaxone, a 3 month trial of interferon beta-1 is required. A FDA indication is required.		
GILENYA (fingolimod)PA	AUBAGIO (teriflunomide)	***Aubagio - Prescriber must be a neurologist - Transaminase and bilirubin levels must have been obtained within 6 months of request - Patient must not be pregnant and if patient is of childbearing potential, reliable contraception must be used - Must not be coadministered with leflunomide ***Copaxone 40 mg/mL/glatopa (glatiramer)
COPAXONE (glatiramer) 20 MG/ML	LEMTRADA (alemtuzumab)	
	TECFIDERA (dimethyl fumarate)	
	COPAXONE (glatiramer) 40 MG/ML	
	glatopa (glatiramer)	
	TYSABRI (natalizumab)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		- These agents will require three (3) month trials of Aubagio and Tecfidera in addition to category criteria ***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), prescriber must take VZV antibioties - Appointment date for first dose must be supplied ***Lemtrada - Unless patient has early aggressive disease defined as >= 2 relapses in the year and >=1 Cadollmium (Cd)+ lesion, three (3) month trials of Tecfidera, Aubagio, and Tysabri will be required in addition to category criteria. - If patient has not been vaccinated or have a history of Varicella Zoster Virus (VZV), prescriber must take VZV antibioties - Patient must have had a urinalysis with urine cell counts - Patient must have had a thyroid function test - Patient must have had a TB test - Patient must have SCr levels *** Tecfidera - Patient must have had a CBC with lymphocyte count within 6 months of request - Patient must have a three (3) month trials with Aubagio in addition to category criteria ***Tysabri - Unless patient has early aggressive disease defined as >= 2 relapses in the year and >=1 Cadollmium (Cd)+ lesion, three (3) month trials of Tecfidera and Aubagio and will be required in addition to category criteria.
Interferons		
Category PA Criteria: A three (3) month long trial of a preferred agent will be required before a non-preferred agent will be authorized. A FDA indication is required.		
BETASERON (interferon beta-1B)	AVONEX (interferon beta-1A)	
REBIF (interferon beta-1A)	AVONEX (interferon beta-1A) PEN	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
REBIF REBIDOSE (interferon beta-1A)	AVONEX (interferon beta-1A) ADMINISTRATION PACK	
	EXTAVIA (interferon beta-1B)	
	PLEGRIDY (peginterferon beta-1A)	
	PLEGRIDY PEN (peginterferon beta-1A)	
OPHTHALMIC ANTIHISTAMINES		
Category PA Criteria: A thirty (30) day trial of three (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 trail 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 three (3) day trial of three (3) preferred agents will be required before a non-preferred agent will be authorized unless one (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	
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	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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 seven (7) day trial of two (2) preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. A thirty (30) day trial of two (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 thirty (30) day trial of two (2) preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions is indicated on the form. A thirty (30) day trial of two (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)	
diclofenac sodium		
DUREZOL (difluprednate)		
FLAREX (fluorometholone)		
fluorometholone		
flurbiprofen sodium		
FML FORTE (fluorometholone)		
FML S.O.P. (fluorometholone)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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 thirty (30) day trial of two (2) preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions is indicated on the form. A thirty (30) day trial of two (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 thirty (30) day trial of two (2) preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions is indicated on the form. A thirty (30) day trial of two (2) preferred generics of the same medication will satisfy this requirement.		
bimatoprost	XALATAN (latanoprost)	
latanoprost		
LUMIGAN (bimatoprost)		
TRAVATAN Z (travoprost)		
travoprost		
ZIOPTAN (tafluprost)		
OPIOID ANALGESIC - LONG ACTING		

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: A thirty (30) day trial of two (2) preferred agents will be required before a non-preferred agent will be authorized. Patient must have required around the clock pain relief for at least 90 days. 3 months of the PDMP report must be reviewed and attached.		
EMBEDA (morphine/naltrexone)	BUTRANS (buprenorphine)	*** Oxycontin, morphine ER capsules, oxymorphone ER, Zohydro ER require a 30 day failed trial of Opana ER in addition to Category PA criteria. *** Hysingla, Fentanyl Patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr, and methadone require a 30 day failed trial of Opana ER, Oxycontin, and Zohydro ER in addition to Category PA criteria. ***Hydromorphone ER and Exalgo - the 90 day around the clock pain relief requirement must be met by an eqaianalgesic 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, Oxycontin, and Zohydro ER is required in addition to Category PA criteria.
fentanyl 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	DURAGESIC (fentanyl)	
KADIAN (morphine) 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 80 MG, 100 MG	DURAGESIC PATCH (fentanyl)	
morphine ER tablets 15mg, 30mg, 60mg	EXALGO (hydromorphone)	
NUCYNTA ER (tapentadol)	fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr	
	hydromorphine ER tablets	
	HYSINGLA ER (hydrocodone)	
	KADIAN (morphine) 200 mg	
	methadone	
	morphine ER capsules	
	morphine ER tablets 100mg, 200mg	
	MS CONTIN (morphine)	
	OPANA ER (oxymorphone)	
	oxycodone ER	
	OXYCONTIN (oxycodone)	
	oxymorphone ER tablets	
	tramadol ER	
	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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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: A thirty (30) day trial of one (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 registred 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 thre 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 buphrenorphine/naloxone tablets in addition to the Category PA Criteria
	buprenorphine tablets	
	buprenorphine-naloxone tablets	
	SUBOXONE FILM (buprenorphine/naloxone)	
OTIC ANTINFECTIVES - FLOROQUINOLONES		
Category PA Criteria: A thirty (30) day trial of two (2) preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions is indicated on the form. A thirty (30) day trial of two (2) preferred generics of the same medication will satisfy this requirement.		
CIPRO HC (ciprofloxacin/hydrocortisone)	OCUFLOX (ofloxacin)	
CIPRODEX (ciprofloxacin/dexamethasone)		
ofloxacin		
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 three (3) month trial of three (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 trail of Renvela Powder Pack will be required in addition to Category PA Criteria *** Velphoro - A 3 month trail of Aryxia 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	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PHOSLO (calcium acetate) CAPSULE		
PHOSLYRA (calcium acetate) ORAL solution		
RENAGEL (sevelamer) TABLET		
RENVELA (sevelamer) TABLET		
PLATELET AGGREGATION INHIBITORS		
Category PA Criteria: A thirty (30) day trial of two (2) preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions is indicated on the form. A thirty (30) day trial of two (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 not 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 thirty (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 thirty (30) day trial of Adcirca will be required for all patients less 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

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
OPSUMIT (macitentan)PA		
TRACLEER (bosentan)PA		
Prostacyclins		
Category PA Criteria: A thirty (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.		
eprosprostenolPA	REMODULIN (treprostinil)	***Ventavis 20mcg/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/ANTICHOLINERGIC COMBINATION INHALERS		
Category PA Criteria: A thirty (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 thirty (30) day trial of Tudorza Pressair, Spiriva, Incruse Ellipta, Anoro Ellipta, or Stiolto Respimat will be required. 2. A thirty (30) day trial of Anoro Ellipta, Stiolto Respimat, Foradil, Brovana, Arcapta, or Sevevent will be required. 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 thirty (30) day trial of all preferred agents will be required before a non-preferred agent will be authorized		
AEROSPAN (flunisolide)	ASMANEX HFA (mometasone)	A thirty (30) day trial of all preferred agents will be required before a non-preferred agent will be authorized
ALVESCO (ciclesonide)	ARNUITY ELLIPTA (fluticasone)	
ASMANEX (mometasone) TWISTHALER		
FLOVENT DISKUS (fluticasone)		
FLOVENT HFA (fluticasone)		
PULMICORT FLEXHALER (budesonide)		
QVAR (beclomethasone)		
STEROID TOPICAL SOLUTIONS		
clobetasol 0.05% solution		
ELOCON (mometasone) 0.1% solution		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
fluocinolone 0.01% solution		
fluocinolone 0.05% solution		
hydrocortisone 0.1% solution		
mometasone 0.1% solution		
SYNALAR (fluocinolone 0.01%) SOLUTION		
TEXACORT (hydrocortisone) 2.5% SOLUTION		
TOPICAL TESTOSTERONE		
Category PA Criteria: A thirty (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)PA	ANDRODERM (testosterone)	
ANDROGEL (testosterone) GEL MD PMPPA	FORTESTA (testosterone)	
AXIRON (testosterone)PA	NATESTO (testosterone)	
	TESTIM (testosterone)	
	TESTOPEL (testosterone)	
	testosterone 1% gel	
	testosterone 1% Gel MD PMP	
	testosterone 2% Gel MD PMP	
	VOGELXO (testosterone) GEL MD PMP	
ULCER ANTI-INFECTIVES		
Category PA Criteria: A ten (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 thirty (30) day trial of four (4) preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents require a 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.
flavoxate	DETROL LA (tolterodine)	
oxybutynin ER	DITROPAN XL (oxybutynin)	

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
oxybutynin syrup	GELNIQUE (oxybutynin)	***trospium ER will require a 1 month trial of Myrbetriq, trospium, and tolterodine 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.
oxybutynin tablet	MYRBETRIQ (mirabegron)	
TOVIAZ (fesoterodine)	OXYTROL (oxybutynin) PATCH	
VESICARE (solifenacin)	SANCTURA (trospium)	
	SANCTURA ER (trospium)	
	tolterodine	
	tolterodine ER	
	trospium	
	trospium ER	