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

This is NOT an all-inclusive list of covered medications or medications that require prior authorization. Only PDL managed categories are included. Refer to cover page for complete list of rules governing this PDL.

Visit http://www.hidesigns.com/ndmedicaid for more information on medications not found in this list.

EFFECTIVE
April 1st, 2017
Version 2017.2

- 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 criteria applies 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. Refer to http://www.hidesigns.com/ndmedicaid for applicable quantity limits and therapeutic duplication edits.

- 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.

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

- This is NOT an all-inclusive list of medications covered by ND Medicaid. Please use the NDC Drug Lookup tool at http://nddruglookup.hidinc.com/ to view coverage status, quantity limits, copay, and prior authorization information for all medications.

- This is NOT an all-inclusive list of medications that require prior authorization. Please visit http://www.hidesigns.com/ndmedicaid/pa-criteria.html for PA criteria for medications not found on the PDL.

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

- Acronyms
  PA – Indicates preferred agents that require clinical prior authorization.
  *** - Indicates that additional PA criteria applies as indicated in the sidebar

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CHANGES SINCE LAST VERSION		
Please see COVER PAGE - Rules governing this PDL have been updated.		
Category	**Product Status Changes**	**Criteria Changes**
ADHD	VYVANSE (lisdexamfetamine) chew tablet added to preferred	
ANTICONVULSANTS - BENZODIAZEPINES - RECTAL		Not managed by PDL
ANTIHEMOPHILIC FACTORS	COAGADEX added to preferred	
ANTIHEMOPHILIC FACTORS	KOVALTRY added to preferred	
CONSTIPATION - IRRITABLE BOWEL SYNDROME/OPIOID INDUCED	TRULANCE (plecanatide) added to non-preferred	Category Criteria updated
CYSTIC FIBROSIS ANTIINFECTIVES	TOBI (Tobramycin) moved to non-preferred	
CYTOKINE MODULATORS	KINERET (anakinra) moved to non-preferred	
CYTOKINE MODULATORS	OTEZLA (apremilast) moved to non-preferred	Criteria Removed
CYTOKINE MODULATORS	REMICADE (infliximab) moved to non-preferred	
CYTOKINE MODULATORS	SILIQ (brodalumab) added to non-preferred	
CYTOKINE MODULATORS	XELJANZ (tofacitinib) moved to non-preferred	
CYTOKINE MODULATORS	XELJANZ XR (tofacitinib) moved to non-preferred	
DIABETES - GLP1 AGONISTS	ADLYXIN (lixisenatide) added to non-preferred	
DIABETES - GLP1 AGONISTS	SOLIQUA (insulin glargine/lixisenatide) added to non-preferred	
DIABETES - GLP1 AGONISTS	XULTOPHY (insulin glargine/liraglutide) added to non-preferred	

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Category	**Product Status Changes**	**Criteria Changes**
DIABETES - SGLT2 INHIBITORS	SYNJARDY XR (empagliflozin/metformin) added to non-preferred	
GROWTH HORMONE		Category Criteria updated
HEPATITIS C TREATMENTS		Category Criteria updated
IMMUNOGLOBULINS		Not managed by PDL
MULTIPLE SCLEROSIS - Injectable Non-Interferons	LEMTRADA (alemtuzumab) removed from PDL - medical billing only	
MULTIPLE SCLEROSIS - Injectable Non-Interferons	TYSABRI (natalizumab) removed from PDL - medical billing only	
OPHTHALMIC ANTIINFLAMMATORIES	ACULAR LS (ketorolac) moved to preferred	
OPHTHALMIC ANTIINFLAMMATORIES	Bromfenac sodium moved to preferred	
OPHTHALMIC ANTIINFLAMMATORIES	BROMSITE (bromfenac sodium) moved to preferred	
OPHTHALMIC ANTIINFLAMMATORIES	PROLENSA (bromfenac) moved to preferred	
OPIOID ANALGESIC - LONG ACTING	ARYMO ER (oxycodone) added to non-preferred	Arymo ER criteria added
OPIOID ANALGESIC - LONG ACTING		Category Criteria updated
OPIOID PARTIAL ANTAGONIST - OPIOID DEPENDENCE		Category Criteria updated
STEROID/LONG ACTING BETA AGONIST (LABA) COMBINATION INHALERS	AIRDUO RESPICLICK (fluticasone/salmeterol added to non-preferred	
STEROID/LONG ACTING BETA AGONIST (LABA) COMBINATION INHALERS	fluticasone/salmeterol added to non-preferred	

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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. Rational of inability to swallow a solid dosage form must be provided after age 9 for all non-solid dosage forms.		
ADDERALL XR (dextroamphetamine/amphetamine)	ADDERALL (dextroamphetamine/amphetamine)	*** Kapvay will require a 1-month trial of immediate release clonidine.
ADZENYS XR - ODT (amphetamine)	Clonidine ER	
APTENSIO XR (methylphenidate)	CONCERTA (methylphenidate)	
Clonidine	DEXEDRINE (dextroamphetamine)	
DAYTRANA (methylphenidate)	Dexmethylphenidate ER	
DESOXYN (methamphetamine)	Dextroamphetamine/amphetamine ER	
Dexmethylphenidate	FOCALIN (dexmethylphenidate)	
Dextroamphetamine	INTUNIV (guanfacine ER)	
Dextroamphetamine 5 mg/5 ml	METADATE CD (methylphenidate CD)	
Dextroamphetamine ER	METADATE ER (methylphenidate)	
Dextroamphetamine/amphetamine	METHYLIN (methylphenidate) chew tablets	
DYANAVEL XR (amphetamine)	METHYLIN (methylphenidate) solution	
EVEKEO (amphetamine)	RITALIN (methylphenidate)	
FOCALIN XR (dexmethylphenidate)	RITALIN LA (methylphenidate LA capsules - 50-50)	
Guanfacine ER		
KAPVAY (clonidine)PA***		
Methamphetamine		
Methylphenidate CD 30-70		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Methylphenidate chew tablet		
Methylphenidate ER capsules 50-50		
Methylphenidate ER tablet		
Methylphenidate LA capsules - 50-50		
Methylphenidate solution		
Methylphenidate tablet		
PROCENTRA (dextroamphetamine)		
QUILLICHEW ER (methylphenidate)		
QUILLIVANT XR (methylphenidate)		
STRATTERA (atomoxetine)		
VYVANSE (lisdexamfetamine)		
VYVANSE (lisdexamfetamine) chew tablet		
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		
ANGINA		
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.		

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ELIQUIS (Apixaban)PA	SAVAYSA (edoxaban)	
PRADAXA (dabigatran)PA		
XARELTO (rivaroxaban)PA		
ANTICONVULSANTS		
Category PA Criteria: Branded non-preferred agents: 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. 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 (eslicarbazepine)	CARBATROL (carbamazepine)	
BANZEL (rufinamide) ORAL SUSPENSION	DEPAKENE (valproic acid) CAPSULE	
BANZEL (rufinamide) TABLET	DEPAKENE (valproic acid) ORAL SOLUTION	
BRIVIACT (brivaracetam)	DEPAKOTE (divalproex sodium) TABLET	
Carbamazepine chewable tablet	DEPAKOTE ER (divalproex sodium)	
Carbamazepine ER capsule	DEPAKOTE SPRINKLE (divalproex sodium)	
Carbamazepine oral suspension	DILANTIN (phenytoin) CHEWABLE TABLET	
Carbamazepine tablet	DILANTIN (phenytoin) ORAL SUSPENSION	
Carbamazepine XR tablet	DILANTIN ER (phenytoin)	
CELONTIN (methsuximide)	EPITOL (carbamazepine)	
Divalproex ER	FELBATOL (felbamate)	
Divalproex sprinkle	FELBATOL (felbamate) ORAL SUSPENSION	
Divalproex tablet	KEPPRA (levetiracetam)	
Ethosuximide capsule	KEPPRA (levetiracetam) ORAL SOLUTION	
Ethosuximide oral solution	KEPPRA XR (levetiracetam)	
Felbamate oral suspension	LAMICTAL (lamotrigine)	

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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
Felbamate tablet	LAMICTAL (lamotrigine) CHEWABLE TABLET	
FYCOMPA (perampanel)	LAMICTAL (lamotrigine) DOSE PACK	
FYCOMPA (perampanel) ORAL SUSPENSION	MYSOLINE (primidone)	
Gabapentin capsule	NEURONTIN (gabapentin) CAPSULE	
Gabapentin oral solution	NEURONTIN (gabapentin) ORAL SOLUTION	
Gabapentin tablet	NEURONTIN (gabapentin) TABLET	
GABITRIL (tiagabine)	QUDEXY XR (topiramate)	
LAMICTAL ER (lamotrigine) DOSE PACK	TEGRETOL XR (carbamazepine)	
LAMICTAL ODT (lamotrigine)	TEGRETROL (carbamazepine oral suspension)	
LAMICTAL ODT (lamotrigine) DOSE PACK	TOPAMAX (topiramate)	
LAMICTAL XR (lamotrigine)	TOPAMAX (topiramate) SPRINKLE CAPSULE	
Lamotrigine chewable tablet	TRILEPTAL (oxcarbazepine)	
Lamotrigine dose pack	TRILEPTAL (oxcarbazepine) ORAL SUSPENSION	
Lamotrigine ER	ZARONTIN (ethosuximide)	
Lamotrigine ODT	ZARONTIN (ethosuximide) ORAL SOLUTION	
Lamotrigine tablet	ZONEGRAN (zonisamide)	
Levetiracetam ER		
Levetiracetam oral solution		
Levetiracetam tablet		
LYRICA (pregabalin)		
LYRICA (pregabalin) ORAL SOLUTION		
Oxcarbazepine oral solution		
Oxcarbazepine tablet		
OXTELLAR XR (oxcarbazepine)		
PEGANONE (Ethotoin)		
Phenobarbital elixir		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Phenobarbital tablet		
PHENYTEK (phenytoin)		
Phenytoin chewable tablet		
Phenytoin ER capsule		
Phenytoin suspension		
POTIGA (ezogabine)		
Primidone		
SABRIL (vigabatrin)		
SABRIL (vigabatrin) POWDER PACK		
SPRITAM (levetiracetam)		
TEGRETOL (carbamazepine)		
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		
ANTIDEMENTIA		
Category PA Criteria: All agents will require an FDA indication for patients younger than 30 years old. Branded non-preferred agents: 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. 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)	***Namenda XR – A 30-day trial of memantine IR will be required before Namenda XR will be authorized.
EXELON (rivastigmine)	Donepezil ODT	
EXELON (rivastigmine) PATCH	NAMENDA (memantine)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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: Branded non-preferred agents: 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. 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 solution	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	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	CONCENTRATE	
Nefazodone		
OLEPTRO ER (trazodone)		
Paroxetine		
Paroxetine ER		
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.		
ADVATE[PA]	ADYNOVATE	
AFSTYLA[PA]	ELOCTATE	
ALPHANATE[PA]		
ALPHANINE SD[PA]		
ALPROLIX[PA]		
BEBULIN[PA]		
BENEFIX[PA]		
COAGADEX[PA]		
FEIBA[PA]		

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
HELIXATE FS[PA]		
HEMOFIL M[PA]		
HUMATE-P[PA]		
IDELVION[PA]		
IXINITY[PA]		
KOATE-DVI[PA]		
KOGENATE FS BIO-SET[PA]		
KOGENATE FS[PA]		
KOVALTRY[PA]		
MONOCLATE-P[PA]		
MONONINE[PA]		
NOVOEIGHT[PA]		
NOVOSEVEN[PA]		
OBIZURE[PA]		
PROFILNINE SD[PA]		
RECOMBINATE[PA]		
RIXUBIS[PA]		
VONVENDI[PA]		
WILATE[PA]		
XYNTHA[PA]		
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)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
EPIVIR (lamivudine)		
EPIVIR HBV (lamivudine)		
EPZICOM (abacavir)		
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)		
Lamivudine		
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)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
NORVIR (ritonavir)		
PREZCOBIX (darunavir/cobicistat)		
PREZISTA (darunavir)		
RAYATAZ (atazanavir)		
VIRACEPT (nelfinavir)		
ATYPICAL ANTIPSYCHOTICS		
Category PA Criteria: Branded non-preferred agents: 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. 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	quetiapine ER	
FANAPT (iloperidone)	RISPERDAL (risperidone)	
FAZACLO (clozapine) RAPDIS	RISPERDAL (risperidone) ORAL SOLUTION	
LATUDA (lurasidone)	RISPERDAL M-TAB (risperidone)	
Olanzapine	SEROQUEL (quetiapine)	
Olanzapine ODT	ZYPREXA (olanzapine)	
Olanzapine/fluoxetine	ZYPREXA ZYDIS (olanzapine)	
Paliperidone ER		
Quetiapine		
REXULTI (brexpiprazole)		
Risperidone		
Risperidone ODT		
Risperidone oral solution		
SAPHRIS (asenapine)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
SEROQUEL XR (quetiapine)		
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)		
CONSTIPATION - IRRITABLE BOWEL SYNDROME/OPIOID INDUCED		
Category PA Criteria: Patients must be 18 years old. All medications will require an FDA indication. For opioid-induced constipation, a paid claim for an opioid must be on patient's profile and a 30 day trial of Amitiza will be required before a non-preferred oral agent will be authorized. For idiopathic constipation, a 30 day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
AMITIZA (lubiprostone)	MOVANTIK (naloxegol)	***Linzess – A 30-day trial of Amitiza is required before Linzess will be authorized. ***Relistor Syringe/Vial – Documentation must be submitted to show inability to swallow a solid dosage form ***Relistor tablets - A 30 day trial of Movantik is required before Relistor tablets will be authorized
LINZESS (linaclotide)PA***	RELISTOR (methylnaltrexone) TABLET***	
	RELISTOR (methylnaltrexone) VIAL***	
	RELISTOR (methylnaltrexone) SYRINGE***	
	TRULANCE (plecanatide)	
COPD		
Category PA Criteria: A 30-day trial of all preferred agents (within the same group) 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 (umeclidinium)	
	SPIRIVA RESPIMAT 2.5 MG (tiotropium)	
	TUDORZA PRESSAIR (aclidinium)	

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Long Acting Beta Agonists		
BROVANA (arformoterol)	ARCAPTA NEOHALER (indacaterol)	
FORADIL (formoterol)	STRIVERDI RESPIMAT (olodaterol)	
PERFOROMIST (formoterol)		
SEREVENT (salmeterol)		
Short Acting Combination		
Albuterol/ipratropium	DUONEB (albuterol/ipratropium)	
COMBIVENT RESPIMAT (albuterol/ipratropium)		
Long Acting Combination		
STIOLTO RESPIMAT (tiotropium/olodaterol)	UTIBRON NEOHALER (glycopyrrolate/indacaterol)	
ANORO ELLIPTA (umeclidinium/vilanterol)	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 must have 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 1 second (FEV1) of less than 25% or greater than 75% predicted. ***Tobramycin/TOBI Podhaler – Patient must have a forced expiratory volume in less than 1 second (FEV1) of less than 40% or greater than 80% predicted. Patient must not have been colonized with *Burkholderia cepacia.*
KITABIS PAK (tobramycin/nebulizer)	TOBI PODHALER (Tobramycin)***	
	Tobramycin***	
	TOBI (Tobramycin)***	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CYTOKINE MODULATORS		
Category PA Criteria: A 3-month 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)	
ENBREL (etanercept)PA	CIMZIA (certolizumab)	
HUMIRA (adalimumab)PA	KINERET (anakinra)	
HUMIRA PSORIASIS (adalimumab)PA	ORENCIA (abatacept)	
	OTEZLA (apremilast)	
	SIMPONI (golimumab)	
	SILIQ (brodalumab)	
	STELARA (ustekinumab)	
	TALTZ (ixekizumab)	
	XELJANZ (tofacitinib)	
	XELJANZ XR (tofacitinib)	
DIABETES - DPP4 INHIBITORS		
Category PA Criteria: Non preferred agents will require: 1. A 30-day trial of 1 sitagliptin preferred product (Janumet, Janumet XR, or Januvia) and 1 linagliptin preferred product (Jentadueto or Tradjenta). 2. An FDA approved indication. 3. Concurrent metformin therapy. 4. A 3-month trial of metformin		
JANUMET (sitagliptin/metformin)	alogliptan/pioglitzone	***Onglyza - will require an FDA indication, a 3 month trial of metformin and concurrent metformin therapy
JANUMET XR (sitagliptin/metformin)	alogliptin/metformin	
JANUVIA (sitagliptin)	JENTADUETO XR (linagliptin/metformin)	
JENTADUETO (linagliptin/metformin)	KAZANO (alogliptin/metformin)	
KOMBIGLYZE XR (saxagliptin/metformin)	NESINA (alogliptin)	
ONGLYZA (saxagliptin)PA***	OSENI (alogliptin/pioglitazone)	
TRADJENTA (linagliptin)		
DIABETES - GLP1 AGONISTS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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)	ADLYXIN (lixisenatide)	***Victoza requires PA for an FDA-approved indication, concurrent metformin therapy, and a 3-month trial of metformin.
BYETTA (exenatide)	TRULICITY (dulaglutide)	
TANZEUM (albiglutide)		
VICTOZA (liraglutide)PA***		
DIABETES - SGLT2 INHIBITORS		
Category PA Criteria: Non-preferred agents will require: 1. An FDA indication. 2. A 3-month trial of a metformin 3. A 3-month trial of a canagliflozin and a 3-month trial of a empagliflozin agent. 4. Concurrent metformin therapy – this condition will be considered met if requested product is a metformin combination agent.		
INVOKAMET (canagliflozin)	FARXIGA (dapagliflozin)	
INVOKAMET XR (canagliflozin/metformin)	GLYXAMBI (empagliflozin/linagliptin)	
INVOKANA (canagliflozin)	XIGDUO XR (dapagliflozin/metformin)	
JARDIANCE (empagliflozin)	SYNJARDY XR (empagliflozin/metformin)	
SYNJARDY (empagliflozin/metformin)		
DIARRHEA - IRRITABLE BOWEL SYNDROME		
Category PA Criteria: Patient must be 18 years of age or older. A 30-day trial of loperamide and Viberzi will be required before a non-preferred medication will be approved.		
VIBERZI (eluxadoline)	Alosetron***	***Alosetron– Patient must be a female.
	XIFAXIN (rifaximin) 550 mg tablet	
	LOTRONEX (alosetron)***	
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)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ULTRESA (lipase/protease/amylase)	
	VIOKACE (lipase/protease/amylase)	
GOUT - COLCHICINE		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
MITIGARE (colchicine)	Colchicine capsule	
	Colchicine tablet	
	COLCRYS (colchicine) TABLET	
FIBROMYALGIA		
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 (milnacipran)		
GLAUCOMA - SYMPATHOMIMETICS		
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.		
ALPHAGAN P 0.1% (brimonidine)	ALPHAGAN P 0.15% (brimonidine)	
Apraclonidine	IOPIDINE (apraclonidine)	
brimonidine 0.15%		
brimonidine 0.2%		
COMBIGAN (brimonidine/timolol)		
SIMBRINZA (brinzolamide/brimonidine)		
GROWTH HORMONE		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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. Additional criteria applies. For details, see http://hidesigns.com/assets/files/ndmedicaid/2017/Criteria/growth_hormone_criteria.pdf		
GENOTROPIN (somatropin)PA	HUMATROPE (somatropin)	
GENOTROPIN MINIQUICK (somatropin)PA	NUTROPIN AQ (somatropin)	
NORDITROPIN FLEXPRO (somatropin)PA	OMNITROPE (somatropin)	
	SAIZEN (somatropin)	
	ZOMACTON (somatropin)	
HEART FAILURE - NEPRILYSIN INHIBITOR/ANGIOTENSIN RECEPTOR BLOCKER		
Category PA Criteria: 1. Patient must have symptomatic chronic heart failure (NYHA class II-IV). 2. Patient must have systolic dysfunction (left ventricular ejection fraction ≤ 40%).		
ENTRESTO (sacubitril/valsartan)		
HEMATOPOIETIC, GROWTH FACTOR		
Category PA Criteria: All agents will require an FDA indication. A 4-week trial of all preferred products will be required before non-preferred agents will be authorized.		
ARANESP (darbepoetin alfa)PA	EPOGEN (epoetin alfa)	
PROCRIT (epoetin alfa)PA	MIRCERA (methoxy polyethylene glycol-epoetin beta)	
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 failed trial of all preferred treatment options indicated for the patient's genotype. 1. Patient must have an 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. Documentation includes at least 2 drug and alcohol tests dated at least 3 months apart and chart notes addressing patient's alcohol and drug free status throughout the past year. 6. Patient must provide documentation of liver biopsy or non-invasive test that shows a Metavir score of 1 or greater, Ishak score of 2 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. Patient must have established compliant behavior including attending scheduled provider visits (defined as 1 or less no-shows) and filling maintenance medications on time as shown in the prescription medication history for the past 12 months. 10. Patient must be tested for hepatitis B, and if the test is positive, hepatitis B must either be treated or closely monitored if patient does not need treatment. 11. Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions. 12. PA approval duration will be based on label recommendation.		
EPCLUSA (sofosbuvir/velpatasvir)PA***	DAKLINZA (Daclatasvir)	***Epclusa: • Must must be used with ribavirin for patients with decompensated cirrhosis (Child-Pugh B or Child-Pugh C). • 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.
HARVONI (ledipasvir/sofosbuvir)PA***	OLYSIO (simeprevir)***	
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/Viekira Pak XR: • 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 who have failed HCV NS3/4A protease inhibitor (PI) + RBV + PegIFN treatment. • Patients who 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		
Balsalazide capsule	APRISO (mesalamine) CAPSULE	
DELZICOL (mesalamine) CAPSULE	ASACOL HD (mesalamine)	
DIPENTUM (olsalazine)	AZULFIDINE (sulfasalazine)	
PENTASA (mesalamine)	AZULFIDINE DR (sulfasalazine)	
Sulfasalazine DR tablet	COLAZAL (balsalazide)	
Sulfasalazine tablet	GIAZO (balsalazide)	
	LIALDA (mesalamine) TABLET	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	Mesalamine DR	
	SULFAZINE (sulfasalazine)	
Rectal		
CANASA (mesalamine) RECTAL SUPPOSITORY	Mesalamine enema kit	
Mesalamine enema	SF ROWASA (mesalamine) ENEMA	
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.		
EURAX (crotamiton) CREAM	ELIMITE (permethrin) CREAM	
LICE SOLUTION (piperonyl butoxide/pyrethrins)	EURAX (crotamiton) LOTION	
NATROBA (spinosad)	Malathion	
Permethrin cream	OVIDE (malathion)	
Permethrin liquid	Spinosad	
SKLICE (ivermectin)		
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. ***Frovatriptan – 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 menstrual, long in duration, and/or recurring. ***Almotriptan – A 30-day trial of Zolmitriptan 5 mg in the past 24 months will be
Rizatriptan	ALSUMA (sumatriptan) PEN INJCTR***	
Rizatriptan tab rap. dis.	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	required in addition to the class criteria. **Zembrance Symtouch/Sumatriptan Injection – A 30-day trial of Naratriptan 2.5 mg, Sumatriptan Nasal Spray 20 mg, Zomig Nasal Spray 5 mg, Zolmitriptan 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)***	
	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	
REBIF (interferon beta-1A)	EXTAVIA (interferon beta-1B)	
REBIF REBIDOSE (interferon beta-1A)	PLEGRIDY (peginterferon beta-1A) SYRINGE	
	PLEGRIDY (peginterferon beta-1A) PEN	
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	COPAXONE (glatiramer) 40 MG/ML***	***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 if TB positive. • If patient has early aggressive disease defined as ≥ 2 relapses in the year and ≥ 1 Gadolinium (Gd)+ lesion, the trials of oral non-interferons will not be required. • Patient must have Anti-JC virus antibodies taken. ***Copaxone/Glatopa: • A reason must be indicated why Copaxone 20 mg/mL will not work.
	Glatopa (glatiramer)***	
	ZINBRYTA (daclizumab)***	
Oral Non-Interferons		
Category PA Criteria: A 3-month long trial of all preferred agents and Copaxone 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 for non-preferred agents. An FDA indication is required. Prescriber must be a neurologist.		
AUBAGIO (teriflunomide)	TECFIDERA (dimethyl fumarate)***	*** Tecfidera: Patient must have had a CBC with lymphocyte count within 6 months of request.
GILENYA (fingolimod)		
OPHTHALMIC ANTIHISTAMINES		
Category PA Criteria: A 30-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized.		
ALOCRIL (nedocromil)	ELESTAT (epinastine)	
ALOMIDE (lodoxamide)	Epinastine	
Azelastine	PATADAY (olopatadine)	
BEPREVE (bepotastine)	PATANOL (olopatadine)	
Cromolyn		
EMADINE (emedastine)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LASTACAFT (alcaftadine)		
Olopatadine		
PAZEO (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.		
AZASITE (azithromycin) DROPS	AK-POLY-BAC (bacitracin/polymyxin) OINTMENT	
Bacitracin ointment	BLEPH-10 (sulfacetamide) DROPS	
Bacitracin/polymyxin ointment	CILOXAN (ciprofloxacin) DROPS	
BESIVANCE (besifloxacin) DROPS	CILOXAN (ciprofloxacin) OINTMENT	
Ciprofloxacin drops	Gatifloxacin drops	
Erythromycin ointment	GENTAK (gentamicin sulfate) OINTMENT	
Gentamicin sulfate drops	ILOTYCIN (erythromycin) OINTMENT	
Gentamicin sulfate ointment	Levofloxacin drops	
MOXEZA (moxifloxacin) DROPS	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) DROPS	
Neomycin SU/bacitracin/polymyxin B drops	NEOSPORIN (neomycin SU/polymyxin B/gramicidin) DROPS	
Neomycin SU/bacitracin/polymyxin B ointment	OCUFLOX (ofloxacin) DROPS	
Neomycin SU/polymyxin B/gramicidin drops	POLYCIN (bacitracin/polymyxin) OINTMENT	
Ofloxacin drops	POLYTRIM (polymyxin B/trimethoprim) DROPS	
Polymyxin B/trimethoprim drops	TOBREX (tobramycin) DROPS	
Sulfacetamide drops	ZYMAXID (gatifloxacin) DROPS	
Sulfacetamide ointment		
Tobramycin drops		
TOBREX (tobramycin) OINTMENT		
VIGAMOX (moxifloxacin) DROPS		
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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.		
MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS	BLEPHAMIDE (sulfacetamide/prednisolone) DROPS	
Neomycin/bacitracin/polymyxin b/hydrocortisone ointment	BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone) ointment	
Neomycin/polymyxin b/dexamethasone drops	MAXITROL (neomycin/polymyxin b/dexamethasone) OINTMENT	
Neomycin/polymyxin b/dexamethasone ointment	Neomycin/polymyxin b/hydrocortisone drops	
PRED-G (gentamicin/prednisol ac) DROPS	NEO-POLYCIN HC (neomycin SU/bacitracin/polymyxin B/hydrocortisone) OINTMENT	
PRED-G (gentamicin/prednisol ac) OINTMENT	TOBRADEX ST (tobramycin/dexamethasone) DROPS	
Sulfacetamide/prednisolone drops	Tobramycin/dexamethasone	
TOBRADEX (tobramycin/dexamethasone) DROPS		
TOBRADEX (tobramycin/dexamethasone) OINTMENT		
ZYLET (tobramycin/lotepred etab) DROPS		
OPHTHALMIC ANTIINFLAMMATORIES		
Category PA Criteria: A 5-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.		
ACULAR LS (ketorolac)	ACULAR (ketorolac)	
ACUVAIL (ketorolac)	FML (fluorometholone)	
ALREX (loteprednol)	OCUFEN (flurbiprofen)	
Bromfenac sodium	OMNIPRED (prednisolone acetate)	
BROMSITE (bromfenac sodium)	PRED FORTE (prednisolone acetate)	
Dexamethasone sodium phosphate	Prednisolone acetate	
Diclofenac sodium	Prednisolone sodium phosphate	
DUREZOL (difluprednate)		
FLAREX (fluorometholone)		
Fluorometholone		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Flurbiprofen sodium		
FML FORTE (fluorometholone)		
FML S.O.P. (fluorometholone)		
ILEVRO (nepafenac)		
Ketorolac tromethamine		
LOTEMAX (loteprednol)		
MAXIDEX (dexamethasone)		
NEVANAC (nepafenac)		
PRED MILD (prednisolone)		
PROLENSA (bromfenac)		
VEXOL (rimexolone)		
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 attach the last 3 months of North Dakota PDMP reports that have been reviewed.		
BUTRANS (buprenorphine)	ARYMO ER (oxycodone)***	*** Fentanyl 12 mcg/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. *** Zohydro ER, Xtampza ER, and Arymo ER require a 30-day failed trial of oxymorphone ER in addition to category PA criteria. ***Belbuca, Oxycodone ER, Hysingla ER, and Morphine ER Cap – A 30-day failed trial of oxymorphone ER and a long acting oxycodone will be required 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 60 mg oral morphine daily, 25 mcg transdermal fentanyl/hour, 30 mg oxycodone daily, 8 mg of oral hydromorphone daily, or another opioid daily. A 30-day failed trial of oxymorphone ER and a long acting oxycodone is required in addition to category PA criteria. ***Methadone, and Fentanyl Patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr requires a 30-day failed trial of oxymorphone ER, a long acting oxycodone,
EMBEDA (morphine/naltrexone)	BELBUCA (buprenorphine)***	
Fentanyl 12 mcg/hr[PA***]	DURAGESIC (fentanyl)	
Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	EXALGO (hydromorphone)***	
Morphine ER tablets	Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr***	
NUCYNTA ER (tapentadol)	Hydromorphone ER tablets***	
Tramadol ER	HYSINGLA ER (hydrocodone)***	
	KADIAN (morphine)***	
	Methadone***	
	Morphine ER capsules***	
	MS CONTIN (morphine)	
	OPANA ER (oxymorphone)	
	Oxycodone ER***	
	OXYCONTIN (oxycodone)***	
	Oxymorphone ER tablets	
	ULTRAM ER (tramadol ER)	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	XARTEMIS XR (oxycodone/acetaminophen)	Butrans, tramadol ER, Nucynta ER in addition to category PA criteria.
	XTAMPZA ER (oxycodone)***	
	ZOHYDRO ER (hydrocodone)***	
OPIOID ANTAGONIST - OPIOID AND ALCOHOL DEPENDENCE		
VIVITROL (Naltrexone Microspheres)		
OPIOID PARTIAL ANTAGONIST - OPIOID DEPENDENCE		
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 North Dakota 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 will be allowed during a period that a patient is pregnant or breastfeeding.
	Buprenorphine tablets***	
	Buprenorphine-naloxone tablets	
	SUBOXONE FILM (buprenorphine/naloxone)***	
OTIC ANTI-INFECTIVES - FLUOROQUINOLONES		
Category PA Criteria: A 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)	FLOXIN (ofloxacin)	
CIPRODEX (ciprofloxacin/dexamethasone)	Ofloxacin	
	OTOVEL (ciprofloxacin/fluocinolone)	
PHOSPHATE BINDERS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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	*** 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	VELPHORO (sucroferric oxyhydroxide)***	
FOSRENOL (lanthanum) 500 MG AND 750 MG CHEWABLE TABLET	FOSRENOL (lanthanum) 1000 MG CHEWABLE TABLET	
PHOSLO (calcium acetate) CAPSULE		
PHOSLYRA (calcium acetate) ORAL solution		
RENAGEL (sevelamer) TABLET		
RENVELA (sevelamer) POWDER PACK		
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.		
Aspirin/dipyridamole ER	AGGRENOX (aspirin/dipyridamole)	***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. ***Durlaza/Yosprala DR – Patient must have a reason that immediate release aspirin is not an option.
BRILINTA (ticagrelor)	DURLAZA (aspirin ER)***	
Clopidogrel	PERSANTINE (dipyridamole)	
Dipyridamole	PLAVIX (clopidogrel)	
EFFIENT (prasugrel)	YOSPRALA DR (aspirin/omeprazole)***	
Ticlopidine	ZONTIVITY (vorapaxar)***	
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.
SildenafilPA***	REVATIO (sildenafil) TABLET	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		***Sildenafil – A 30-day trial of Adcirca will be required for all patients younger than 18 years old.
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.		
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. Non-preferred agents will require a 30-day trial of all preferred medications.		
TRACLEER (bosentan)PA***	LETAIRIS (ambrisentan)	***Tracleer – LFTs must be measured at baseline and monthly during therapy. ***Opsumit - A 30 day trial of Letairis will be required in addition to category PA criteria
	OPSUMIT (macitentan)***	
Prostacyclins		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
EpoprostenolPA	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 an 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, Spiriva Respimat, Incruse Ellipta, Anoro Ellipta, or Stiolto Respimat. 2. A 30-day trial of Anoro Ellipta, Stiolto Respimat, Foradil, Brovana, Arcapta Neohaler, Striverdi Respimat, Perforomist, or Serevent. 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)	AIRDUO RESPICLICK (fluticasone/salmeterol)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
SYMBICORT (budesonide/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)	
	fluticasone/salmeterol	
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)	ARNUITY ELLIPTA (fluticasone)	
ALVESCO (ciclesonide)	ASMANEX HFA (mometasone)	
ASMANEX (mometasone) TWISTHALER		
FLOVENT DISKUS (fluticasone)		
FLOVENT HFA (fluticasone)		
PULMICORT FLEXHALER (budesonide)		
QVAR (beclomethasone)		
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 an FDA-approved indication.		
ANDROGEL (testosterone) GEL MD PMP PA	ANDRODERM (testosterone)	
ANDROGEL (testosterone) PACKET 1%PA	FORTESTA (testosterone)	
ANDROGEL (testosterone) PACKET 1.62%PA	NATESTO (testosterone)	
AXIRON (testosterone)PA	TESTIM (testosterone)	
	TESTOPEL (testosterone)	
	Testosterone gel	
	Testosterone Gel MD PMP	
	VOGELXO (testosterone) GEL MD PMP	
URINARY ANTISPASMODICS		
Category PA Criteria: A 30-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents require an FDA-approved indication.		
Flavoxate	Darifenacin ER***	***SANCTURA ER/Trospium ER and ENABLEX/darifenacin ER will require a 1-month trial of Myrbetriq, trospium, and tolterodine in addition to the category PA criteria. ***MYRBETRIQ and DETROL LA/Tolterodine ER will require a 1-month trial of trospium and tolterodine in addition to the category PA criteria. ***SACTURA/Trospium will require a 1-month trial of tolterodine in addition to the category PA criteria.
GELNIQUE (oxybutynin)	DETROL (tolterodine)	
Oxybutynin ER	DETROL LA (tolterodine)***	
Oxybutynin syrup	DITROPAN XL (oxybutynin)	
Oxybutynin tablet	ENABLEX (darifenacin)***	
OXYTROL (oxybutynin) PATCH	MYRBETRIQ (mirabegron)***	
TOVIAZ (fesoterodine)	SANCTURA (trospium)***	
VESICARE (solifenacin)	SANCTURA ER (trospium)***	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	Tolterodine	
	Tolterodine ER***	
	Trospium***	
	Trospium ER***	