

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.

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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 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		
Category	Product Status Changes	Criteria Changes
ADHD	METADATE CD (methylphenidate CD) removed from PDL	
ADHD	ADDERALL XR (dextroamphetamine/amphetamine) moved to non-preferred	
ADHD	atomoxetine added to non-preferred	
ADHD	Dextroamphetamine/amphetamine ER - Labeler 00781 moved to preferred	
ANTIDEPRESSANTS - NEW GENERATION	Desvenlafaxine ER - labelers 00054, 00378, 00591, 51991, and 68180 moved to non-preferred	
ANTIDEPRESSANTS - NEW GENERATION	venlafaxine ER tablets - labeler 29033 and 41616 moved to non-preferred	
ATYPICAL ANTIPSYCHOTICS	quetiapine ER - except 400mg strength moved to preferred	
ATYPICAL ANTIPSYCHOTICS	quetiapine ER 50mg, 150mg, 200mg, 300mg - labeler 49884 moved to preferred	
ATYPICAL ANTIPSYCHOTICS	SEROQUEL XR (quetiapine) - except 400mg strength moved to non-preferred	
ATYPICAL ANTIPSYCHOTICS	SEROQUEL XR (quetiapine) 50mg, 150mg, 200mg, 300mg moved to non-preferred	
COPD		Category PA Criteria updated
COPD - Long Acting Anticholinergics	SEEBRI NEOHALER (glycopyrrolate) added to non-preferred	Group PA Criteria added

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Category	Product Status Changes	Criteria Changes
COPD - Long Acting Beta Agonists	BROVANA (arformoterol) moved to non-preferred	Criteria added for Arcapta Neohaler, Striverdi Respimat, and Brovana
COPD - Long Acting Combination		Group PA Criteria added, Utibron Neohaler criteria added
COPD - Short Acting Combination		Group PA Criteria added
CYTOKINE MODULATORS	KEVZARA (sarilumab) added to non-preferred	
DIARRHEA - IRRITABLE BOWEL SYNDROME	loperamide added to preferred	
DIARRHEA - IRRITABLE BOWEL SYNDROME	XIFAXIN (rifaximin) 550 mg tablet moved to preferred	Category Criteria updated
GLAUCOMA - SYMPATHOMIMETICS	ALPHAGAN P 0.15% (brimonidine) moved to preferred	
GLAUCOMA - SYMPATHOMIMETICS	brimonidine 0.15% moved to non-preferred	
INFLAMMATORY BOWEL AGENTS (ULCERATIVE COLITIS) - NONSTEROIDAL - Oral	APRISO (mesalamine) CAPSULE moved to preferred	
INFLAMMATORY BOWEL AGENTS (ULCERATIVE COLITIS) - NONSTEROIDAL - Oral	LIALDA (mesalamine) TABLET moved to preferred	
INFLAMMATORY BOWEL AGENTS (ULCERATIVE COLITIS) - NONSTEROIDAL - Rectal	ROWASA (mesalamine) ENEMA KIT added to non-preferred	
INFLAMMATORY BOWEL AGENTS (ULCERATIVE COLITIS) - NONSTEROIDAL - Rectal	SF ROWASA (mesalamine) ENEMA moved to preferred	
OPHTHALMIC ANTIHISTAMINES	Olopatadine 0.2% added to non-preferred	

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Category	Product Status Changes	Criteria Changes
OPHTHALMIC ANTIINFECTIVES	CILOXAN (ciprofloxacin) OINTMENT moved to preferred	
OPHTHALMIC ANTIINFECTIVES	Neomycin SU/bacitracin/polymyxin B drops removed from PDL	
OPHTHALMIC ANTIINFLAMMATORIES	ACULAR LS (ketorolac) moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	Dexamethasone sodium phosphate moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	Ketorolac tromethamine moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	LOTEMAX (loteprednol) DROPS added to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	Prednisolone acetate moved to preferred	
OPIOID ANALGESIC - LONG ACTING	MORPHABOND ER (morphine) added to non-preferred	oxymorphone ER removed as a step in all criteria
OPIOID ANALGESIC - LONG ACTING		ARYMO ER (oxycodone) criteria updated
OPIOID ANALGESIC - LONG ACTING		XTAMPZA ER (oxycodone) criteria updated
PLATELET AGGREGATION INHIBITORS	Clopidogrel 300mg moved to non-preferred	
URINARY ANTISPASMODICS	ENABLEX (darifenacin) moved to preferred	
URINARY ANTISPASMODICS		Trospium criteria updated
URINARY ANTISPASMODICS		Tolterodine ER criteria updated
URINARY ANTISPASMODICS		MYRBETRIQ (mirabegron) criteria updated

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>ADHD</b>		
<p><b>Category PA Criteria:</b>                      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.</p> <p>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.</p> <p>Rational of inability to swallow a solid dosage form must be provided after age 9 for all non-solid dosage forms.</p>		
ADZENYS XR - ODT (amphetamine)	ADDERALL (dextroamphetamine/amphetamine)	*** Kapvay will require a 1-month trial of immediate release clonidine.
APTENSIO XR (methylphenidate)	ADDERALL XR (dextroamphetamine/amphetamine)	
Clonidine	Clonidine ER	
DAYTRANA (methylphenidate)	CONCERTA (methylphenidate)	
DESOXYN (methamphetamine)	DEXEDRINE (dextroamphetamine)	
Dexmethylphenidate	Dexmethylphenidate ER	
Dextroamphetamine	FOCALIN (dexmethylphenidate)	
Dextroamphetamine 5 mg/5 ml	INTUNIV (guanfacine ER)	
Dextroamphetamine ER	METADATE ER (methylphenidate)	
Dextroamphetamine/amphetamine	METHYLIN (methylphenidate) chew tablets	
Dextroamphetamine/amphetamine ER - Labeler 00781	METHYLIN (methylphenidate) solution	
DYANAVEL XR (amphetamine)	RITALIN (methylphenidate)	
EVEKEO (amphetamine)	RITALIN LA (methylphenidate LA capsules - 50-50)	
FOCALIN XR (dexmethylphenidate)	atomoxetine	
Guanfacine ER	Dextroamphetamine/amphetamine ER - Labelers 00115, 00228, 00555, 66993	

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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
KAPVAY (clonidine) <sup>PA***</sup>		
Methamphetamine		
Methylphenidate CD 30-70		
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		
<p><b>Category PA Criteria:</b></p> <ol style="list-style-type: none"> <li>1. Patient must not have severe, unstable, or uncontrolled asthma.</li> <li>2. Patient must be an FDA-approved age.</li> <li>3. Patient must have an FDA-approved diagnosis of allergic rhinitis due to a pollen contained in the requested product.</li> <li>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.</li> </ol> <p>Non-preferred agents:</p> <ol style="list-style-type: none"> <li>1. Must have failed a trial of 2 of the following: oral antihistamines, intranasal antihistamines, intranasal corticosteroids, or leukotriene inhibitors.</li> <li>2. Must have failed a trial or have intolerance to subcutaneous allergen immunotherapy (allergy shots).</li> </ol>		
GRASTEK (GRASS POLLEN-TIMOTHY, STD) <sup>PA</sup>	ORALAIR (GR POL-ORC/SW VER/RYE/KENT/TIM)	
RAGWITEK (WEED POLLEN-SHORT RAGWEED) <sup>PA</sup>		
ANGINA		

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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
RANEXA (ranolazine)		
<b>ANTICOAGULANTS - ORAL</b>		
<p><b>Category PA Criteria:</b> 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.</p>		
ELIQUIS (Apixaban) <sup>PA</sup>	SAVAYSA (edoxaban)	
PRADAXA (dabigatran) <sup>PA</sup>		
XARELTO (rivaroxaban) <sup>PA</sup>		
<b>ANTICONVULSANTS</b>		
<p><b>Category PA Criteria:</b>                      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.</p>		
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	

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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
Ethosuximide oral solution	KEPPRA XR (levetiracetam)	
Felbamate oral suspension	LAMICTAL (lamotrigine)	
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)		



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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PEGANONE (Ethotoin)		
Phenobarbital elixir		
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		
<p><b>Category PA Criteria:</b> 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.</p> <p>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.</p>		
Donepezil	ARICEPT (donepezil)	***Namenda XR – A 30-day trial of memantine IR will be required before

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EXELON (rivastigmine)	Donepezil ODT	Namenda XR will be authorized.
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		
<p><b>Category PA Criteria:</b></p> <p>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.</p> <p>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.</p>		
Bupropion SR tablet	APLENZIN ER (bupropion)	
Bupropion tablet	CELEXA (citalopram)	
Bupropion XL tablet	CYMBALTA (duloxetine)	
Citalopram	Desvenlafaxine ER - labelers 00054, 00378, 00591, 51991, and 68180	
Citalopram oral solution	EFFEXOR XR (venlafaxine)	
Clomipramine	Fluoxetine DR	
Desvenlafaxine ER - labeler 59762	FORFIVO XL (bupropion)	
Duloxetine	IRENKA (duloxetine)	
Escitalopram	LEXAPRO (escitalopram)	
Escitalopram oral solution	LEXAPRO (escitalopram) ORAL SOLUTION	
FETZIMA (levomilnacipran)	PAXIL (paroxetine)	
Fluoxetine capsule	PAXIL CR (paroxetine)	
Fluoxetine solution	PROZAC (fluoxetine)	

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Fluoxetine tablet	venlafaxine ER tablets - labeler 29033 and 41616	
Fluvoxamine	WELLBUTRIN (bupropion)	
Fluvoxamine ER	WELLBUTRIN SR (bupropion)	
KHEDEZLA ER (desvenlafaxine)	WELLBUTRIN XL (bupropion)	
Nefazodone	ZOLOFT (sertraline)	
OLEPTRO ER (trazodone)	ZOLOFT (sertraline) ORAL CONCENTRATE	
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 - labeler 11381 and 68025		
Venlafaxine tablet		
VIIBRYD (vilazodone)		
ANTIHEMOPHILIC FACTORS		
<b>Category PA Criteria:</b> 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 <sup>PA</sup>	ADYNOVATE	
AFSTYLA <sup>PA</sup>	ELOCTATE	
ALPHANATE <sup>PA</sup>		
ALPHANINE SD <sup>PA</sup>		

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ALPROLIX <sup>PA</sup>		
BEBULIN <sup>PA</sup>		
BENEFIX <sup>PA</sup>		
COAGADEX <sup>PA</sup>		
FEIBA <sup>PA</sup>		
HELIXATE FS <sup>PA</sup>		
HEMOPIL M <sup>PA</sup>		
HUMATE-P <sup>PA</sup>		
IDELVION <sup>PA</sup>		
IXINITY <sup>PA</sup>		
KOATE-DVI <sup>PA</sup>		
KOGENATE FS BIO-SET <sup>PA</sup>		
KOGENATE FS <sup>PA</sup>		
KOVALTRY <sup>PA</sup>		
MONOCLATE-P <sup>PA</sup>		
MONONINE <sup>PA</sup>		
NOVOEIGHT <sup>PA</sup>		
NOVOSEVEN <sup>PA</sup>		
OBIZURE <sup>PA</sup>		
PROFILNINE SD <sup>PA</sup>		
RECOMBINATE <sup>PA</sup>		
RIXUBIS <sup>PA</sup>		
VONVENDI <sup>PA</sup>		
WILATE <sup>PA</sup>		
XYNTHA <sup>PA</sup>		
<b>ANTIRETROVIRALS - NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS</b>		
Abacavir		
Abacavir/lamivudine/zidovudine		
ATRIPLA (efavirenz/emtricitabine/tenofovir)		

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COMBIVIR (lamivudine/zidovudine)		
COMPLERA (emtricitabine/rilpivirine/tenofovir)		
DESCOVY (emtricitabine/tenofovir)		
Didanosine		
Emtricitabine		
EMTRIVA (emtricitabine)		
EPIVIR (lamivudine)		
EPIVIR HBV (lamivudine)		
EPZICOM (abacavir)		
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)		
Lamivudine		
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)		

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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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		
<p><b>Category PA Criteria:</b>                      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.</p> <p>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.</p>		
ABILIFY (aripiprazole) ORAL SOLUTION	ABILIFY (aripiprazole)	
ABILIFY DISCMELT (aripiprazole)	CLOZARIL (clozapine)	
Aripiprazole	GEODON (ziprasidone)	
Clozapine	INVEGA ER (paliperidone)	
Clozapine ODT	quetiapine ER 400mg	
FANAPT (iloperidone)	quetiapine ER 50mg, 150mg, 200mg, 300mg -labelers 00310, 16729, 52817	
FAZACLO (clozapine) RAPDIS	RISPERDAL (risperidone)	
LATUDA (lurasidone)	RISPERDAL (risperidone) ORAL SOLUTION	
Olanzapine	RISPERDAL M-TAB (risperidone)	
Olanzapine ODT	SEROQUEL (quetiapine)	
Olanzapine/fluoxetine	SEROQUEL XR (quetiapine) 50mg, 150mg, 200mg, 300mg	

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Paliperidone ER	ZYPREXA (olanzapine)	
Quetiapine	ZYPREXA ZYDIS (olanzapine)	
quetiapine ER 50mg, 150mg, 200mg, 300mg - labeler 49884		
REXULTI (brexpiprazole)		
Risperidone		
Risperidone ODT		
Risperidone oral solution		
SAPHRIS (asenapine)		
SEROQUEL XR (quetiapine) 400mg		
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		
<p><b>Category PA Criteria:</b> 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.</p>		
AMITIZA (lubiprostone)	MOVANTIK (naloxegol)	***Linzess – A 30-day trial of Amitiza is required before Linzess will be authorized.
LINZESS (linaclotide) <sup>PA***</sup>	RELISTOR (methylnaltrexone) TABLET***	
	RELISTOR (methylnaltrexone) VIAL ***	***Relistor Syringe/Vial – Documentation must be submitted to show inability to swallow a solid dosage form
	RELISTOR (methylnaltrexone) SYRINGE***	

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	TRULANCE (plecanatide)	***Relistor tablets - A 30 day trial of Movantik is required before Relistor tablets will be authorized
<b>COPD</b>		
<b>Category PA Criteria:</b> 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.		
<b>Long Acting Anticholinergics</b>		
<b>Group PA Criteria:</b> A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
SPIRIVA (tiotropium)	INCRUSE ELLIPTA (umeclidinium)	
	SEEBRI NEOHALER (glycopyrrolate)	
	SPIRIVA RESPIMAT 2.5 MG (tiotropium)	
	TUDORZA PRESSAIR (aclidinium)	
<b>Long Acting Beta Agonists</b>		
FORADIL (formoterol)	ARCAPTA NEOHALER (indacaterol)	***Arcapta Neohaler will require a 30 day trial of Foradil and Serevent in addition to Category PA Criteria
PERFOROMIST (formoterol)	BROVANA (arformoterol)	
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)	***Striverdi Respimat will require a 30 day trial of Foradil and Serevent in addition to Category PA Criteria
		***Brovana will require a 30 day trial of Perforomist in addition to Category PA Criteria
<b>Short Acting Combination</b>		
Albuterol/ipratropium	DUONEB (albuterol/ipratropium)	
COMBIVENT RESPIMAT (albuterol/ipratropium)		
<b>Long Acting Combination</b>		
<b>Group PA Criteria:</b> A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
STIOLTO RESPIMAT (tiotropium/olodaterol)	UTIBRON NEOHALER (glycopyrrolate/indacaterol)	***Utibron Neohaler will require a 30 day trial of Bevespi Aerosphere in addition to Category PA Criteria.
ANORO ELLIPTA (umeclidinium/vilanterol)	BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	
<b>PDE4 - Inhibitor</b>		



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<p><b>Group PA Criteria:</b> 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.</p> <p>Patient must also have had the following 30-day trials:</p> <ol style="list-style-type: none"> <li>1. One (1) agent in the Long Acting Anticholinergic group.</li> <li>2. One (1) agent in the Long Acting Beta Agonist group or 1 agent in the Steroid/Anticholinergic Combination Inhalers category.</li> <li>3. One (1) agent in the Steroid Inhalers category or 1 agent in the Steroid/Anticholinergic Combination Inhalers category.</li> </ol>		
	DALIRESP (roflumilast)	
CYSTIC FIBROSIS ANTIINFECTIVES		
<p><b>Category PA Criteria:</b> 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 <i>Burkholderia cepacia</i> and an FDA-approved age and indication.</p>		
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.
KITABIS PAK (tobramycin/nebulizer)	TOBI PODHALER (Tobramycin)***	
	Tobramycin***	***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 <i>Burkholderia cepacia</i> .
	TOBI (Tobramycin)***	
CYTOKINE MODULATORS		
<p><b>Category PA Criteria:</b> 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.</p>		
COSENTYX (secukinumab) <sup>PA</sup>	ACTEMRA (tocilizumab)	
ENBREL (etanercept) <sup>PA</sup>	CIMZIA (certolizumab)	
HUMIRA (adalimumab) <sup>PA</sup>	KEVZARA (sarilumab)	
HUMIRA PSORIASIS (adalimumab) <sup>PA</sup>	KINERET (anakinra)	
	ORENCIA (abatacept)	
	OTEZLA (apremilast)	
	SILIQ (brodalumab)	
	SIMPONI (golimumab)	
	STELARA (ustekinumab)	
	TALTZ (ixekizumab)	

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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	XELJANZ (tofacitinib)	
	XELJANZ XR (tofacitinib)	
<b>DIABETES - DPP4 INHIBITORS</b>		
<p><b>Category PA Criteria:</b> Non preferred agents will require:</p> <ol style="list-style-type: none"> <li>1. A 30-day trial of 1 sitagliptin preferred product (Janumet, Janumet XR, or Januvia) and 1 linagliptin preferred product (Jentadueto or Tradjenta).</li> <li>2. An FDA approved indication.</li> <li>3. Concurrent metformin therapy.</li> <li>4. A 3-month trial of metformin</li> </ol>		
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) <sup>PA***</sup>	OSENI (alogliptin/pioglitazone)	
TRADJENTA (linagliptin)		
<b>DIABETES - GLP1 AGONISTS</b>		
<p><b>Category PA Criteria:</b> Non preferred agents will require:</p> <ol style="list-style-type: none"> <li>1. A 30-day trial of 2 preferred agents.</li> <li>2. An FDA indication.</li> <li>3. Concurrent metformin therapy.</li> <li>4. A 3-month trial of metformin.</li> </ol>		
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) <sup>PA***</sup>		
<b>DIABETES - SGLT2 INHIBITORS</b>		
<p><b>Category PA Criteria:</b> Non-preferred agents will require:</p> <ol style="list-style-type: none"> <li>1. An FDA indication.</li> <li>2. A 3-month trial of a metformin</li> <li>3. A 3-month trial of a canagliflozin and a 3-month trial of a empagliflozin agent.</li> <li>4. Concurrent metformin therapy – this condition will be considered met if requested product is a metformin combination agent.</li> </ol>		

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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		
<b>Category PA Criteria:</b> Patient must be 18 years of age or older. A 30-day trial of all preferred agents will be required before a non-preferred medication will be approved.		
VIBERZI (eluxadoline)	LOTRONEX (alosetron)***	***Alosetron– Patient must be a female.
XIFAXIN (rifaximin) 550 mg tablet	alosetron***	
loperimide		
DIGESTIVE ENZYMES		
<b>Category PA Criteria:</b> A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
CREON (lipase/protease/amylase)	PANCREAZE (lipase/protease/amylase)	
ZENPEP (lipase/protease/amylase)	PANCRELIPASE (lipase/protease/amylase)	
	PERTZYE (lipase/protease/amylase)	
	ULTRESA (lipase/protease/amylase)	
	VIOKACE (lipase/protease/amylase)	
GOUT - COLCHICINE		
<b>Category PA Criteria:</b> 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		
<b>Category PA Criteria:</b> 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	

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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LYRICA (pregabalin)		
LYRICA (pregabalin) ORAL SOLUTION		
SAVELLA (milnacipran)		
GLAUCOMA - SYMPATHOMIMETICS		
<b>Category PA Criteria:</b> 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)	brimonidine 0.15%	
ALPHAGAN P 0.15% (brimonidine)	IOPIDINE (apraclonidine)	
Apraclonidine		
brimonidine 0.2%		
COMBIGAN (brimonidine/timolol)		
SIMBRINZA (brinzolamide/brimonidine)		
GROWTH HORMONE		
<b>Category PA Criteria:</b> 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 <a href="http://hidesigns.com/assets/files/ndmedicaid/2017/Criteria/growth_hormone_criteria.pdf">http://hidesigns.com/assets/files/ndmedicaid/2017/Criteria/growth_hormone_criteria.pdf</a>		
GENOTROPIN (somatropin) <sup>PA</sup>	HUMATROPE (somatropin)	
GENOTROPIN MINIQUICK (somatropin) <sup>PA</sup>	NUTROPIN AQ (somatropin)	
NORDITROPIN FLEXPRO (somatropin) <sup>PA</sup>	OMNITROPE (somatropin)	
	SAIZEN (somatropin)	
	ZOMACTON (somatropin)	
HEART FAILURE - NEPRILYSIN INHIBITOR/ANGIOTENSIN RECEPTOR BLOCKER		
<b>Category PA Criteria:</b> 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		
<b>Category PA Criteria:</b> 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) <sup>PA</sup>	EPOGEN (epoetin alfa)	

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PROCRIT (epoetin alfa) <sup>PA</sup>	MIRCERA (methoxy polyethylene glycol-epoetin beta)	
HEPATITIS C TREATMENTS		
<p><b>Category PA Criteria:</b> Non-preferred agents will require a failed trial of all preferred treatment options indicated for the patient's genotype.</p> <ol style="list-style-type: none"> <li>1. Patient must have an FDA-approved diagnosis.</li> <li>2. Patient must be an FDA-approved age.</li> <li>3. Patient must attest that they will continue treatment without interruption for the duration of therapy.</li> <li>4. Prescriber must be, or consult with, a hepatologist, gastroenterologist, or infectious disease specialist.</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>8. Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment.</li> <li>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.</li> <li>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.</li> <li>11. Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions.</li> <li>12. PA approval duration will be based on label recommendation.</li> </ol>		
EPCLUSA (sofosbuvir/velpatasvir) <sup>PA***</sup>	DAKLINZA (Daclatasvir)	<p>***Epclusa:</p> <ul style="list-style-type: none"> <li>• Must be used with ribavirin for patients with decompensated cirrhosis (Child-Pugh B or Child-Pugh C).</li> <li>• Is ONLY preferred for genotype 2 and 3; for all other genotypes Epclusa is non-preferred.</li> </ul> <p>***Harvoni:</p> <ul style="list-style-type: none"> <li>• Patient must have eGFR &gt; 30 mL/min/1.73m<sup>2</sup>.</li> </ul> <p>***Technivie:</p> <ul style="list-style-type: none"> <li>• Patients must not have moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment.</li> <li>• Patients must not have cirrhosis.</li> <li>• Technivie must be used with ribavirin in treatment experienced patients.</li> </ul>
HARVONI (ledipasvir/sofosbuvir) <sup>PA***</sup>	OLYSIO (simeprevir) <sup>***</sup>	
SOVALDI (sofosbuvir) <sup>PA</sup>		
TECHNIVIE (ombitasvir/paritaprevir/ritonavir) <sup>PA***</sup>		
VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir) <sup>PA***</sup>		
VIEKIRA PAK XR (dasabuvir/ombitasvir/paritaprevir/ritonavir) <sup>PA***</sup>		
ZEPATIER (elbasvir/grazoprevir) <sup>PA***</sup>		

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		<p>***Olysio:</p> <ul style="list-style-type: none"> <li>• Must be taken in conjunction with pegylated interferon and ribavirin.</li> </ul> <p>***Viekira Pak/Viekira Pak XR:</p> <ul style="list-style-type: none"> <li>• Patients must have hepatic laboratory tests before treatment and 4 weeks after treatment begins.</li> <li>• Patients must not have moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment.</li> <li>• Viekira Pak must be used with ribavirin except for genotype 1b without cirrhosis or mild (Child-Pugh A) hepatic impairment.</li> </ul> <p>***Zepatier:</p> <ul style="list-style-type: none"> <li>• Patients must not have moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment.</li> <li>• Genotype 1a: Patient must be tested for baseline NS5A polymorphisms.</li> <li>• Zepatier must be used with ribavirin in patients with baseline NS5A polymorphisms.</li> <li>• Zepatier must be used with ribavirin in patients who have failed HCV NS3/4A protease inhibitor (PI) + RBV + PegIFN treatment.</li> <li>• Patients who have failed HCV NS3/4A protease inhibitor (PI) + RBV + PegIFN treatment must not have baseline NS5A polymorphisms.</li> </ul>
<b>INFLAMMATORY BOWEL AGENTS (ULCERATIVE COLITIS) - NONSTEROIDAL</b>		
<p><b>Category PA Criteria:</b> 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.</p>		
<b>Oral</b>		
APRISO (mesalamine) CAPSULE	ASACOL HD (mesalamine)	***Giazo - Patient must be a male.
Balsalazide capsule	AZULFIDINE (sulfasalazine)	
DELZICOL (mesalamine) CAPSULE	AZULFIDINE DR (sulfasalazine)	
DIPENTUM (olsalazine)	COLAZAL (balsalazide)	
LIALDA (mesalamine) TABLET	GIAZO (balsalazide)	
PENTASA (mesalamine)	Mesalamine DR	
Sulfasalazine DR tablet	SULFAZINE (sulfasalazine)	

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**PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA**

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
Sulfasalazine tablet		
<b>Rectal</b>		
CANASA (mesalamine) RECTAL SUPPOSITORY	Mesalamine enema kit	
Mesalamine enema	ROWASA (mesalamine) ENEMA KIT	
SF ROWASA (mesalamine) ENEMA		
<b>LICE</b>		
<p><b>Category PA Criteria:</b> 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.</p>		
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)		
<b>MIGRAINE PROPHYLAXIS - 5HT(1) AGONISTS</b>		
<p><b>Category PA Criteria:</b>                      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.</p>		
RELPAK (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.
Rizatriptan	ALSUMA (sumatriptan) PEN INJCTR***	
Rizatriptan tab rap. dis.	AMERGE (naratriptan)	***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.
Sumatriptan tablet	FROVA (frovatriptan)***	
	IMITREX (sumatriptan) CARTRIDGE***	***Almotriptan – A 30-day trial of Zolmitriptan 5 mg in the past 24 months will be
	IMITREX (sumatriptan) PEN INJCTR***	

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	IMITREX (sumatriptan) SPRAY	required in addition to the class criteria.
	IMITREX (sumatriptan) TABLET	**Zembrace 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) 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		
<b>Category PA Criteria:</b> 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		



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<p><b>Category PA Criteria:</b> 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</p>		
COPAXONE (glatiramer) 20 MG/ML	COPAXONE (glatiramer) 40 MG/ML ***	<p>***Zinbryta:</p> <ul style="list-style-type: none"> <li>Transaminase and bilirubin levels must have been obtained within 6 months of request.</li> <li>Patient must not have hepatitis B or C.</li> <li>Patient must be screened for TB and have been treated if TB positive.</li> <li>If patient has early aggressive disease defined as <math>\geq 2</math> relapses in the year and <math>\geq 1</math> Gadolinium (Gd)+ lesion, the trials of oral non-interferons will not be required.</li> <li>Patient must have Anti-JC virus antibodies taken.</li> </ul> <p>***Copaxone/Glatopa:</p> <ul style="list-style-type: none"> <li>A reason must be indicated why Copaxone 20 mg/mL will not work.</li> </ul>
	Glatopa (glatiramer)***	
	ZINBRYTA (daclizumab)***	
<p><b>Oral Non-Interferons</b></p> <p><b>Category PA Criteria:</b> 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.</p>		
AUBAGIO (teriflunomide)	TECFIDERA (dimethyl fumarate)***	<p>*** Tecfidera: Patient must have had a CBC with lymphocyte count within 6 months of request.</p>
GILENYA (fingolimod)		
OPHTHALMIC ANTIHISTAMINES		
<p><b>Category PA Criteria:</b> A 30-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized.</p>		
ALOCRIIL (nedocromil)	ELESTAT (epinastine)	
ALOMIDE (lodoxamide)	Epinastine	
Azelastine	Olopatadine 0.2%	
BEPREVE (bepotastine)	PATADAY 0.2% (olopatadine)	
Cromolyn	PATANOL 0.1% (olopatadine)	
EMADINE (emedastine)		

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LASTACAFT (alcaftadine)		
Olopatadine 0.1%		
PAZEO (olopatadine)		
OPHTHALMIC ANTIINFECTIVES		
<b>Category PA Criteria:</b> 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	Gatifloxacin drops	
CILOXAN (ciprofloxacin) OINTMENT	GENTAK (gentamicin sulfate) OINTMENT	
Ciprofloxacin drops	ILOTYCIN (erythromycin) OINTMENT	
Erythromycin ointment	Levofloxacin drops	
Gentamicin sulfate drops	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) OINTMENT	
Gentamicin sulfate ointment	NEOSPORIN (neomycin SU/polymyxin B/gramicidin) DROPS	
MOXEZA (moxifloxacin) DROPS	OCUFLOX (ofloxacin) DROPS	
Neomycin SU/bacitracin/polymyxin B ointment	POLYCIN (bacitracin/polymyxin) OINTMENT	
Neomycin SU/polymyxin B/gramicidin drops	POLYTRIM (polymyxin B/trimethoprim) DROPS	
Ofloxacin drops	TOBEX (tobramycin) DROPS	
Polymyxin B/trimethoprim drops	ZYMAXID (gatifloxacin) DROPS	
Sulfacetamide drops		
Sulfacetamide ointment		
Tobramycin drops		
TOBEX (tobramycin) OINTMENT		
VIGAMOX (moxifloxacin) DROPS		
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES		

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<b>Category PA Criteria:</b> 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		
<b>Category PA Criteria:</b> 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.		
ACUVAIL (ketorolac)	ACULAR (ketorolac)	
ALREX (loteprednol)	ACULAR LS (ketorolac)	
Bromfenac sodium	Dexamethasone sodium phosphate	
BROMSITE (bromfenac sodium)	FML (fluorometholone)	
Diclofenac sodium	Ketorolac tromethamine	
DUREZOL (difluprednate)	LOTEMAX (loteprednol) DROPS	
FLAREX (fluorometholone)	OCUFEN (flurbiprofen)	
Fluorometholone	OMNIPRED (prednisolone acetate)	
Flurbiprofen sodium	PRED FORTE (prednisolone acetate)	
FML FORTE (fluorometholone)	Prednisolone sodium phosphate	

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FML S.O.P. (fluorometholone)		
ILEVRO (nepafenac)		
LOTEMAX (loteprednol) OINTMENT		
MAXIDEX (dexamethasone)		
NEVANAC (nepafenac)		
PRED MILD (prednisolone)		
Prednisolone acetate		
PROLENSA (bromfenac)		
VEXOL (rimexolone)		
OPIOID ANALGESIC - LONG ACTING		
<b>Category PA Criteria:</b> 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.
EMBEDA (morphine/naltrexone)	BELBUCA (buprenorphine)***	
Fentanyl 12 mcg/hr <sup>PA</sup> ***	DURAGESIC (fentanyl)	***Belbuca, Oxycodone ER, Hysingla ER, Morphine ER Cap, Morphabond ER and Arymo ER – A 30-day failed trial of a long acting oxycodone will be required in addition to category PA criteria.
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***	***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 a long acting oxycodone, Butrans, tramadol ER, Nucynta ER in addition to category PA criteria.
NUCYNTA ER (tapentadol)	Hydromorphone ER tablets***	
Tramadol ER	HYSINGLA ER (hydrocodone)***	
	KADIAN (morphine)***	
	Methadone***	
	Morphine ER capsules***	
	MORPHABOND ER (morphine)***	
	MS CONTIN (morphine)	
	OPANA ER (oxymorphone)	
	Oxycodone ER***	
	OXYCONTIN (oxycodone)***	
	Oxymorphone ER tablets	
	ULTRAM ER (tramadol ER)	

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	XARTEMIS XR (oxycodone/acetaminophen)	
	XTAMPZA ER (oxycodone)	
	ZOHYDRO ER (hydrocodone)***	
<b>OPIOID ANTAGONIST - OPIOID AND ALCOHOL DEPENDENCE</b>		
VIVITROL (Naltrexone Microspheres)		
<b>OPIOID PARTIAL ANTAGONIST - OPIOID DEPENDENCE</b>		
<p><b>Category PA Criteria:</b> A 30-day trial of 1 preferred agent will be required before a non-preferred agent will be authorized.</p> <ol style="list-style-type: none"> <li>1. Patient must be 16 years of age or older.</li> <li>2. Patient must not be taking other opioids, tramadol, or carisoprodol concurrently.</li> <li>3. The prescriber must be registered to prescribe under the Substance Abuse and Mental Health Services Administration (SAMHSA) and provide his/her DEA number.</li> <li>4. The prescriber and patient must have a contract or the prescriber must have developed a treatment plan.</li> <li>5. The prescriber must perform routine drug screens.</li> <li>6. The prescriber must routinely check the PDMP and attach the last 3 months of North Dakota PDMP reports that have been reviewed.</li> <li>7. The prescriber must be enrolled with ND Medicaid.</li> </ol>		
ZUBSOLV (buprenorphine/naloxone) <sup>PA</sup>	BUNAVAIL FILM (buprenorphine/naloxone)***	<p>*** Bunavail/Suboxone Film/buprenorphine will require a 30-day trial of buprenorphine/naloxone tablets in addition to the category PA criteria.</p> <p>***Buprenorphine tablets will be allowed during a period that a patient is pregnant or breastfeeding.</p>
	Buprenorphine tablets***	
	Buprenorphine-naloxone tablets	
	SUBOXONE FILM (buprenorphine/naloxone)***	
<b>OTIC ANTI-INFECTIVES - FLUOROQUINOLONES</b>		
<p><b>Category PA Criteria:</b> A 7-day trial of 1 preferred product in the past 3 months is required before a non-preferred product will be approved.</p>		
CIPRO HC (ciprofloxacin/hydrocortisone)	FLOXIN (ofloxacin)	
CIPRODEX (ciprofloxacin/dexamethasone)	Ofloxacin	
	OTOVEL (ciprofloxacin/fluocinolone)	
<b>PHOSPHATE BINDERS</b>		

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<b>Category PA Criteria:</b> The following criteria will be required before a non-preferred agent will be authorized:		
<ol style="list-style-type: none"> <li>1. Patient must have had a 3-month trial of 3 preferred different chemical entities.</li> <li>2. Patient must have end stage renal disease or chronic kidney disease.</li> <li>3. Patients with chronic kidney disease stage 5 must have a phosphate level greater than 5.5 mg/dL.</li> <li>4. All other patients must have a phosphate level greater than 4.6 mg/dL.</li> </ol>		
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		
REVELA (sevelamer) POWDER PACK		
REVELA (sevelamer) TABLET		
PLATELET AGGREGATION INHIBITORS		
<b>Category PA Criteria:</b> 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.
BRILINTA (ticagrelor)	Clopidogrel 300mg	
Clopidogrel 75 mg	DURLAZA (aspirin ER)***	***Durlaza/Yosprala DR – Patient must have a reason that immediate release aspirin is not an option.
Dipyridamole	PERSANTINE (dipyridamole)	
EFFIENT (prasugrel)	PLAVIX (clopidogrel)	
Ticlopidine	YOSPRALA DR (aspirin/omeprazole)***	
	ZONTIVITY (vorapaxar)***	
PULMONARY HYPERTENSION		
PDE-5 Inhibitors		
<b>Category PA Criteria:</b> 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) <sup>PA</sup>	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 <sup>PA***</sup>	REVATIO (sildenafil) TABLET	

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		***Sildenafil – A 30-day trial of Adcirca will be required for all patients younger than 18 years old.
<b>Soluble Guanylate Cyclase Stimulators</b>		
<b>Category PA Criteria:</b> 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) <sup>PA</sup>		
<b>Endothelin Receptor Antagonist</b>		
<b>Category PA Criteria:</b> 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) <sup>PA***</sup>	LETAIRIS (ambrisentan)	***Tracleer – LFTs must be measured at baseline and monthly during therapy.
	OPSUMIT (macitentan) <sup>***</sup>	***Opsumit - A 30 day trial of Letairis will be required in addition to category PA criteria
<b>Prostacyclins</b>		
<b>Category PA Criteria:</b> A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
Epoprostenol <sup>PA</sup>	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) <sup>PA</sup>	TYVASO (treprostinil)	
ORENITRAM ER (treprostinil) <sup>PA</sup>	UPTRAVI (selexipag)	
VELETRI (epoprostenol) <sup>PA</sup>	VENTAVIS (iloprost) 20 mcg/mL ***	
VENTAVIS (iloprost) 10 mcg/mL <sup>PA</sup>		
<b>STEROID/LONG ACTING BETA AGONIST (LABA) COMBINATION INHALERS</b>		
<b>Category PA Criteria:</b> 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.		
<p>For COPD diagnosis, the following will be required in addition to the category PA criteria:</p> <ol style="list-style-type: none"> <li>1. A 30-day trial of Tudorza Pressair, Spiriva, Spiriva Respimat, Incruse Ellipta, Anoro Ellipta, or Stiolto Respimat.</li> <li>2. A 30-day trial of Anoro Ellipta, Stiolto Respimat, Foradil, Brovana, Arcapta Neohaler, Striverdi Respimat, Perforomist, or Serevent.</li> </ol> <p>For asthma diagnosis, patient must have been reviewed for step down therapy for all renewal requests.</p>		
ADVAIR DISKUS (fluticasone/salmeterol)	ADVAIR HFA (fluticasone/salmeterol)	
DULERA (mometasone/formoterol)	AIRDUO RESPICLICK (fluticasone/salmeterol)	

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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
SYMBICORT (budesonide/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)	
	fluticasone/salmeterol	
STEROID INHALERS		
<b>Category PA Criteria:</b> 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		
<b>Category PA Criteria:</b> 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 <sup>PA</sup>	ANDRODERM (testosterone)	
ANDROGEL (testosterone) PACKET 1% <sup>PA</sup>	FORTESTA (testosterone)	
ANDROGEL (testosterone) PACKET 1.62% <sup>PA</sup>	NATESTO (testosterone)	
AXIRON (testosterone) <sup>PA</sup>	TESTIM (testosterone)	
	TESTOPEL (testosterone)	
	Testosterone gel	
	Testosterone Gel MD PMP	
	VOGELXO (testosterone) GEL MD PMP	
URINARY ANTISPASMODICS		
<b>Category PA Criteria:</b> 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.		
ENABLEX (darifenacin)	Darifenacin ER	***SANCTURA ER/Trospium ER and will require a 1-month trial of Myrbetriq, trospium, and tolterodine in addition to the category PA criteria.
Flavoxate	DETROL (tolterodine)	
GELNIQUE (oxybutynin)	DETROL LA (tolterodine)	
Oxybutynin ER	DITROPAN XL (oxybutynin)	
Oxybutynin syrup	MYRBETRIQ (mirabegron)	
Oxybutynin tablet	SANCTURA (trospium)	
OXYTROL (oxybutynin) PATCH	SANCTURA ER (trospium)***	
TOVIAZ (fesoterodine)	Tolterodine	



**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.

<p><b>EFFECTIVE</b> <b>July 1st, 2017</b> <b>Version 2017.3</b></p>
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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
VESICARE (solifenacin)	Tolterodine ER	
	Trospium	
	Trospium ER***	