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
11/15/2017
Version 2017.6

- 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

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
11/15/2017
Version 2017.6

CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
ADHD		Category PA Criteria Updated
ANTICONVULSANTS		Category PA Criteria Updated
ANTIDEPRESSANTS - NEW GENERATION		Category PA Criteria Updated
ATYPICAL ANTIPSYCHOTICS		Category PA Criteria Updated
STEROID/LONG ACTING BETA AGONIST (LABA) COMBINATION INHALERS		Category Criteria updated
ADHD AGENTS	Atomoxetine - Labelers 00093, 64980, 68462 moved to preferred	
ADHD AGENTS	ZENZEDI (dextroamphetamine) moved to non-preferred	
ALLERGENIC EXTRACTS		removed as a PDL category
TESTOSTERONE TOPICAL	ANDROGEL (testosterone) GEL MD PMP removed from PDL	
ANTIDEPRESSANTS - NEW GENERATION	desvenlafaxine ER, desvenlafaxine fumarate ER - all labelers moved to preferred	
ANTIDEPRESSANTS - NEW GENERATION	Desvenlafaxine succinate ER - labelers 00591, 51991, 68180 moved to non-preferred	
ANTIDEPRESSANTS - NEW GENERATION	PROZAC WEEKLY (fluoxetine) removed from PDL	
ANTIDEPRESSANTS - NEW GENERATION	Fluoxetine DR moved to preferred	
ANTIDEPRESSANTS - NEW GENERATION	KHEDEZLA ER (desvenlafaxine) moved to non-preferred	
ANTIDEPRESSANTS - NEW GENERATION	PRISTIQ ER (desvenlafaxine) moved to non-preferred	
ANTIDEPRESSANTS - NEW GENERATION	venlafaxine ER tablets moved to non-preferred	

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
11/15/2017
Version 2017.6

CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
ANTIRETROVIRALS - NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	Abacavir/lamivudine added to preferred	
ANTIRETROVIRALS - NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	Brand name drugs (EPIVIR, EPZICOM, TRIZIVIR, VIDEX EC, VIREAD, ZERIT, ZIAGEN) with generics moved to non-preferred	
ANTIRETROVIRALS - PROTEASE INHIBITORS	Brand name drugs (KALETRA) with generics moved to non-preferred	
ANTIRETROVIRALS - PROTEASE INHIBITORS	lopinavir/ritonavir added to preferred	
ATYPICAL ANTIPSYCHOTICS	quetiapine ER - labelers 00406, 16729, 49884, 52817 moved to non-preferred	
CONSTIPATION - IRRITABLE BOWEL SYNDROME/OPIOID INDUCED	SYMPROIC (naldemedine) added to non-preferred	
COPD - Long Acting Anticholinergics	SEEBRI NEOHALER (Glycopyrrolate) removed from PDL	
COPD - Long Acting Beta Agonists	Foradil removed from PDL	
COPD -Combination Steroid/Anticholinergics/Long Acting Beta Agonists	TRELEGY ELLIPTA (Fluticasone Furoate/Umeclidinium/Vilanterol) added to non-preferred	Group PA Criteria added
COPD - PDE4 - Inhibitor		Group PA Criteria updated
DIABETES - INSULIN/GLP1 AGONISTS		New PDL Category
MIGRAINE PROPHYLAXIS - 5HT(1) AGONISTS	Frovatriptan added to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	LOTEMAX (loteprednol) GEL DROPS added to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	VEXOL (Rimexolone) removed from PDL	
OPIOID ANALGESIC - LONG ACTING	butorphanol added to preferred	

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.**

CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
OPIOID ANALGESIC - LONG ACTING	levorphanol added to preferred	
OPIOID ANALGESIC - LONG ACTING	pentazocine-naloxone added to preferred	
PHOSPHATE BINDERS	Lanthanum added to non-preferred	
PHOSPHATE BINDERS	PHOSLO (calcium acetate) removed from PDL	
PULMONARY HYPERTENSION -PDE-5 Inhibitors		Sildenafil criteria removed. Group Criteria updated
PULMONARY HYPERTENSION-Prostacyclins	Epoprostenol removed from PDL	
PULMONARY HYPERTENSION-Prostacyclins	FLOLAN (epoprostenol) removed from PDL	
PULMONARY HYPERTENSION-Prostacyclins	VELETRI (epoprostenol) removed from PDL	
STEROIDs - INHALED	QVAR REDIHALER (beclomethasone) added to non-preferred	

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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ADHD		
Category PA Criteria: Branded non-preferred agents: A 10-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. Generic non-preferred agents: A 10-day trial of a pharmaceutically equivalent preferred agents 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)	
Atomoxetine	DEXEDRINE (dextroamphetamine)	
Clonidine	Dexmethylphenidate ER	
COTEMPLA XR - ODT (methylphenidate)	Dextroamphetamine/amphetamine ER - Labelers 00115, 00228, 00555, 66993	
DAYTRANA (methylphenidate)	FOCALIN (dexmethylphenidate)	
DESOXYN (methamphetamine)	INTUNIV (guanfacine ER)	
Dexmethylphenidate	METADATE ER (methylphenidate)	
Dextroamphetamine	METHYLIN (methylphenidate) chew tablets	
Dextroamphetamine 5 mg/5 ml	METHYLIN (methylphenidate) solution	
Dextroamphetamine ER	RITALIN (methylphenidate)	
Dextroamphetamine/amphetamine	RITALIN LA (methylphenidate LA capsules - 50-50)	
Dextroamphetamine/amphetamine ER - Labeler 00781	STRATTERA (atomoxetine)	
DYANAVEL XR (amphetamine)	ZENZEDI (dextroamphetamine)	
EVEKEO (amphetamine)		
FOCALIN XR (dexmethylphenidate)		
Guanfacine ER		

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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
KAPVAY (clonidine)[PA***]		
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		
MYDAYIS (amphetamine/dextroamphetamine)		
PROCENTRA (dextroamphetamine)		
QUILLICHEW ER (methylphenidate)		
QUILLIVANT XR (methylphenidate)		
VYVANSE (lisdexamfetamine)		
VYVANSE (lisdexamfetamine) chew tablet		
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.		
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 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. 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	

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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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)	
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)	

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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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		
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		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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)	
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 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. 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)	

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.**

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
Bupropion tablet	CELEXA (citalopram)	
Bupropion XL tablet	CYMBALTA (duloxetine)	
Citalopram	Desvenlafaxine ER	
Citalopram oral solution	Desvenlafaxine fumarate ER	
Clomipramine	Desvenlafaxine succinate ER - labelers 00591, 51991, 68180	
Desvenlafaxine succinate ER - labeler 59762	EFFEXOR XR (venlafaxine)	
Duloxetine	FORFIVO XL (bupropion)	
Escitalopram	IRENKA (duloxetine)	
Escitalopram oral solution	KHEDEZLA ER (desvenlafaxine)	
FETZIMA (levomilnacipran)	LEXAPRO (escitalopram)	
Fluoxetine capsule	LEXAPRO (escitalopram) ORAL SOLUTION	
Fluoxetine DR	PAXIL (paroxetine)	
Fluoxetine solution	PAXIL CR (paroxetine)	
Fluoxetine tablet	PRISTIQ ER (desvenlafaxine)	
Fluvoxamine	PROZAC (fluoxetine)	
Fluvoxamine ER	venlafaxine ER tablets	
Nefazodone	WELLBUTRIN (bupropion)	
OLEPTRO ER (trazodone)	WELLBUTRIN SR (bupropion)	
Paroxetine	WELLBUTRIN XL (bupropion)	
Paroxetine ER	ZOLOFT (sertraline)	
PAXIL (paroxetine) ORAL SUSPENSION	ZOLOFT (sertraline) ORAL CONCENTRATE	
PEXEVA (paroxetine)		
Sertraline		
Sertraline oral concentrate		
Trazodone		
TRINTELLIX (vortioxetine)		
Venlafaxine capsule		
Venlafaxine ER capsules		
Venlafaxine tablet		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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]		
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]		
NUWIQ[PA]		
OBIZURE[PA]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PROFILNINE SD[PA]		
RECOMBINATE[PA]		
RIXUBIS[PA]		
VONVENDI[PA]		
WILATE[PA]		
XYNTHA[PA]		
ANTIRETROVIRALS - NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS		
Abacavir	EPIVIR (lamivudine)	
Abacavir/lamivudine	EPZICOM (abacavir)	
Abacavir/lamivudine/zidovudine	TRIZIVIR (abacavir/lamivudine)	
ATRIPLA (efavirenz/emtricitabine/tenofovir)	VIDEX EC (didanosine)	
COMBIVIR (lamivudine/zidovudine)	VIREAD (tenofovir)	
COMPLERA (emtricitabine/rilpivirine/tenofovir)	ZERIT (stavudine)	
DESCOVY (emtricitabine/tenofovir)	ZIAGEN (abacavir)	
Didanosine		
EMTRIVA (emtricitabine)		
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)		
Lamivudine		
Lamivudine/zidovudine		
ODEFSEY (emtricitabine/rilpivirine/tenofovir)		
RETROVIR (zidovudine)		
Stavudine		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)		
Tenofovir		
TRIUMEQ (abacavir/dolutegravir/lamivudine)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
TRUVADA (emtricitabine/tenofovir)		
VIDEX (didanosine)		
Zidovudine		
ANTIRETROVIRALS - PROTEASE INHIBITORS		
APTIVUS (tipranavir)	KALETRA (lopinavir/ritonavir)	
CRIXIVAN (indinavir)		
EVOTAZ (atazanavir/cobicistat)		
GENVOYA (elvitegravir, cobicistat, emtricitabine and tenofovir)		
INVERASE (saquinavir)		
LEXIVA (fosamprenavir)		
lopinavir/ritonavir		
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 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. 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 - labelers 00406, 16729, 49884, 52817	
FANAPT (iloperidone)	RISPERDAL (risperidone)	
FAZACLO (clozapine) RAPDIS	RISPERDAL (risperidone) ORAL SOLUTION	

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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LATUDA (lurasidone)	RISPERDAL M-TAB (risperidone)	
Olanzapine	SEROQUEL (quetiapine)	
Olanzapine ODT	SEROQUEL XR (quetiapine)	
Olanzapine/fluoxetine	ZYPREXA (olanzapine)	
Paliperidone ER	ZYPREXA ZYDIS (olanzapine)	
Quetiapine		
quetiapine ER - labeler 00310		
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		
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.
LINZESS (linaclotide)PA***	RELISTOR (methylnaltrexone) TABLET***	
	RELISTOR (methylnaltrexone) VIAL***	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	RELISTOR (methylnaltrexone) SYRINGE***	***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
	SYMPROIC (naldemedine)	
	TRULANCE (plecanatide)	
COPD		
Category PA Criteria: All non-preferred agents will require an FDA-approved indication regardless of age.		
Long Acting Anticholinergics		
Group PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
SPIRIVA (tiotropium)	INCRUSE ELLIPTA (umeclidinium)	
	SPIRIVA RESPIMAT 2.5 MG (tiotropium)	
	TUDORZA PRESSAIR (aclidinium)	
Long Acting Beta Agonists		
Group PA Criteria: All preferred agents indicated only for COPD will require verification of FDA-approved indication for patients who are younger than 40 years of age.		
PERFOROMIST (formoterol)	ARCAPTA NEOHALER (indacaterol)***	***Arcapta Neohaler/Striverdi Respimat will require a 30 day trial of Serevent in addition to Category PA Criteria ***Brovana will require a 30 day trial of Perforomist in addition to Category PA Criteria
SEREVENT (salmeterol)	BROVANA (arformoterol)***	
	STRIVERDI RESPIMAT (olodaterol)***	
Short Acting Combination		
Group 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. All preferred agents indicated only for COPD will require verification of FDA-approved indication for patients who are younger than 40 years of age.		
Albuterol/ipratropium	DUONEB (albuterol/ipratropium)	
COMBIVENT RESPIMAT (albuterol/ipratropium)		
Long Acting Combination		
Group PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All preferred agents indicated only for COPD will require verification of FDA-approved indication for patients who are younger than 40 years of age.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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)	
Combination Steroid/Anticholinergics/Long Acting Beta Agonists		
Group PA Criteria: In addition to the category PA criteria, patient must a 30 day trial of all preferred agents in the following combinations: 1. Steroid/Long Acting Beta Agonist (LABA) Combination Inhalers + Long Acting Anticholinergics 2. Combination Anticholinergics/Long Acting Beta Agonist + Inhaled Steriod		
	TRELEGY ELLIPTA (Fluticasone Furoate/Umeclidinium/Vilanterol)	
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 a 30 day trial with a medication in each of the following therapeutic classes from either single ingredient or combination products: 1. Long acting anticholinergic 2. Long acting beta agonist 3. Steroid		
	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)***	
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)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
HUMIRA (adalimumab)PA	KEVZARA (sarilumab)	
HUMIRA PSORIASIS (adalimumab)PA	KINERET (anakinra)	
	ORENCIA (abatacept)	
	OTEZLA (apremilast)	
	SILIQ (brodalumab)	
	SIMPONI (golimumab)	
	STELARA (ustekinumab)	
	TALTZ (ixekizumab)	
	TREMFYA (guselkumab)	
	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		
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)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
VICTOZA (liraglutide)PA***		
DIABETES - INSULIN/GLP1 AGONISTS		
Category PA Criteria: 1. A 30-day trial of exenatide and liraglutide GLP-1 agonists in combination with each of insulin glargine and insulin detemir insulins 2. An FDA indication. 3. Concurrent metformin therapy. 4. A 3-month trial of metformin		
	SOLIQUA (Insulin glargine/lixisenatide)	
	XULTOPHY (insulin degludec/liraglutide)	
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 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		
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)	brimonidine 0.15%	
ALPHAGAN P 0.15% (brimonidine)	IOPIDINE (apraclonidine)	
Apraclonidine		
brimonidine 0.2%		
COMBIGAN (brimonidine/timolol)		
SIMBRINZA (brinzolamide/brimonidine)		
GROWTH HORMONE		
Category PA Criteria: 1. Patients new to GH therapy must meet the criteria below and be started on a preferred growth hormone. 2. Patients continuing GH therapy and having met the criteria listed below must be switched to a preferred growth hormone. Additional criteria applies. For details, see http://hidesigns.com/assets/files/ndmedicaid/2017/Criteria/growth_hormone_criteria.pdf		
GENOTROPIN (somatropin)[PA]	HUMATROPE (somatropin)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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		
Category PA Criteria: Non-preferred agents will require a failed trial of all preferred treatment options indicated for the patient's genotype and be labeled for failure of previous treatment. 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. HCV RNA level must be taken on week 4 and sent with a renewal request for any duration of treatment 12 weeks or longer. 7. Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment. 8. 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. 9. 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. 10. Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions. 11. PA approval duration will be based on label recommendation.		
EPCLUSA (sofosbuvir/velpatasvir)[PA***]	DAKLINZA (Daclatasvir)	***Epclusa: • Must be used with ribavirin for patients with decompensated cirrhosis (Child-Pugh B or Child-Pugh C). ***Mavyret/Vosevi: • Patient must not have decompensated cirrhosis (Child-Pugh B or Child-
MAVYRET (glecaprevir/pibrentasvir)[PA***]	HARVONI (ledipasvir/sofosbuvir)	
	OLYSIO (simeprevir)	
	SOVALDI (sofosbuvir)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	TECHNIVIE (ombitasvir/paritaprevir/ritonavir)	Pugh C)
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)	
	VIEKIRA PAK XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)	
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)	
	ZEPATIER (elbasvir/grazoprevir)	
INFLAMMATORY BOWEL AGENTS (ULCERATIVE COLITIS) - NONSTEROIDAL		
Category PA Criteria: A 30-day trial of each of the preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents will require an FDA indication.		
Oral		
APRISO (mesalamine) CAPSULE	ASACOL HD (mesalamine)	***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)	
Sulfasalazine tablet		
Rectal		
CANASA (mesalamine) RECTAL SUPPOSITORY	Mesalamine enema kit	
Mesalamine enema	ROWASA (mesalamine) ENEMA KIT	
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		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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 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.
Rizatriptan	ALSUMA (sumatriptan) PEN INJCTR***	
Rizatriptan tab rap. dis.	AMERGE (naratriptan)	
Sumatriptan tablet	Eletriptan	
	FROVA (frovatriptan)***	
	Frovatriptan	
	IMITREX (sumatriptan) CARTRIDGE***	
	IMITREX (sumatriptan) PEN INJCTR***	
	IMITREX (sumatriptan) SPRAY	
	IMITREX (sumatriptan) TABLET	
	IMITREX (sumatriptan) VIAL***	
	MAXALT (rizatriptan)	
	MAXALT MLT (rizatriptan)	
	Naratriptan	
	ONSETRA XSAIL (sumatriptan)***	
	Sumatriptan cartridge***	
	Sumatriptan pen injctr***	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	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) PEN	EXTAVIA (interferon beta-1B)	
AVONEX (interferon beta-1A) SYRINGE	PLEGRIDY (peginterferon beta-1A) PEN	
AVONEX (interferon beta-1A) VIAL	PLEGRIDY (peginterferon beta-1A) SYRINGE	
BETASERON (interferon beta-1B)		
REBIF (interferon beta-1A)		
REBIF REBIDOSE (interferon beta-1A)		
Injectable Non-Interferons		
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.
	Glatopa (glatiramer)***	
	ZINBRYTA (daclizumab)***	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		***Copaxone/Glatopa: • A reason must be indicated why Copaxone 20 mg/mL will not work.
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	Olopatadine 0.2%	
BEPREVE (bepotastine)	PATADAY 0.2% (olopatadine)	
Cromolyn	PATANOL 0.1% (olopatadine)	
EMADINE (emedastine)		
LASTACAFT (alcaftadine)		
Olopatadine 0.1%		
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	Gatifloxacin drops	
CILOXAN (ciprofloxacin) OINTMENT	GENTAK (gentamicin sulfate) OINTMENT	
Ciprofloxacin drops	ILOTYCIN (erythromycin) OINTMENT	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Erythromycin ointment	Levofloxacin drops	
Gentamicin sulfate drops	moxifloxacin drops	
Gentamicin sulfate ointment	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) OINTMENT	
MOXEZA (moxifloxacin) 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		
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	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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.		
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)	LOTEMAX (loteprednol) GEL DROPS	
Fluorometholone	OCUFEN (flurbiprofen)	
Flurbiprofen sodium	OMNIPRED 1% (prednisolone acetate)	
FML FORTE (fluorometholone)	PRED FORTE 1% (prednisolone acetate)	
FML S.O.P. (fluorometholone)	Prednisolone sodium phosphate 1%	
ILEVRO (nepafenac)		
LOTEMAX (loteprednol) OINTMENT		
MAXIDEX (dexamethasone)		
NEVANAC (nepafenac)		
PRED MILD 0.12% (prednisolone acetate)		
Prednisolone acetate 1%		
PROLENSA (bromfenac)		
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.		

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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
butorphanol	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. ***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. ***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.
BUTRANS (buprenorphine) PATCHES	BELBUCA (buprenorphine)***	
EMBEDA (morphine/naltrexone)	buprenorphine patches***	
Fentanyl 12 mcg/hr[PA***]	DURAGESIC (fentanyl)	
Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	EXALGO (hydromorphone)***	
levorphanol	Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr***	
Morphine ER tablets	Hydromorphone ER tablets***	
NUCYNTA ER (tapentadol)	HYSINGLA ER (hydrocodone)***	
pentazocine-naloxone	KADIAN (morphine)***	
	Methadone***	
	MORPHABOND ER (morphine)***	
	Morphine ER capsules***	
	MS CONTIN (morphine)	
	OPANA ER (oxymorphone)	
	Oxycodone ER***	
	OXYCONTIN (oxycodone)***	
	Oxymorphone ER tablets	
	ULTRAM ER (tramadol ER)	
	XARTEMIS XR (oxycodone/acetaminophen)	
	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.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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		
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	
PHOSLYRA (calcium acetate) ORAL solution	sevelamer powder pack	
RENAGEL (sevelamer) TABLET	Lanthanum	
RENVELA (sevelamer carbonate) TABLET		
RENVELA (sevelamer) POWDER PACK		
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

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
BRILINTA (ticagrelor)	Clopidogrel 300mg	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.
Clopidogrel 75 mg	DURLAZA (aspirin ER)***	
Dipyridamole	PERSANTINE (dipyridamole)	
EFFIENT (prasugrel)	PLAVIX (clopidogrel)	
Ticlopidine	YOSPRALA DR (aspirin/omeprazole)***	
	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. Patient cannot be taking nitrates of any form.		
ADCIRCA (tadalafil)PA	REVATIO (sildenafil) SUSPENSION***	***Revatio Suspension – Patients 7 years and older will be required to submit documentation of their inability to ingest a solid dosage form.
Sildenafil	REVATIO (sildenafil) TABLET	
Soluble Guanylate Cyclase Stimulators		
Category PA Criteria: Patients of childbearing potential must not be pregnant, be taking a reliable form of birth control, and have a pregnancy test before initiation and monthly during therapy. All medications require an FDA-approved indication.		
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.		
ORENITRAM ER (treprostinil)PA	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.
VENTAVIS (iloprost) 10 mcg/mLPA	TYVASO (treprostinil)	
	UPTRAVI (selexipag)	
	VENTAVIS (iloprost) 20 mcg/mL***	
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-		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
approved indication. For COPD diagnosis: EITHER both of the following will be required in addition to the category PA criteria: 1. A 30-day trial of Tudorza Pressair, Spiriva, Spiriva Respimat, or Incruse Ellipta 2. A 30-day trial of Brovana, Arcapta Neohaler, Striverdi Respimat, Perforomist, or Serevent. OR A 30-day trial of Anoro Ellipta, Stiolto Respimat, Utibron NeoHaler, or Bevespi Aerosphere 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)	
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	ARMONAIR RESPICLICK (fluticasone)	
FLOVENT DISKUS (fluticasone)	QVAR RediHaler (beclomethasone)	
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) PACKET 1%PA	ANDRODERM (testosterone)	
ANDROGEL (testosterone) PACKET 1.62%PA	AXIRON (testosterone) TOPICAL SOLUTION	
	FORTESTA (testosterone)	
	NATESTO (testosterone)	
	TESTIM (testosterone)	
	TESTOPEL (testosterone)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	Testosterone gel	
	Testosterone Gel MD PMP	
	Testosterone topical solution	
	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.		
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	
VESICARE (solifenacin)	Tolterodine ER	
	Trospium	
	Trospium ER***	