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

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

EFFECTIVE
January 1, 2017
Version 2017.1

- 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 for non-preferred agents apply in addition to the general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc. 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 that require PA. For more information visit http://www.hidesigns.com/ndmedicaid.

- 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 a preferred agent has step therapy required before approval.

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

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



| CHANGES SINCE LAST 2016 VERSION | | |
|---|---|---|
| **Category** | **Product Status Changes** | **Criteria Changes** |
| ANTIDEMENTIA | | NAMENDA XR criteria added |
| ANTIHYPERLIPIDEMICS – NIACIN | | Category no longer managed by PDL |
| ANTIHYPERLIPIDEMICS – CETP INHIBITORS | | Category no longer managed by PDL |
| ANTIHYPERTENSIVE – BETA BLOCKERS | | Category no longer managed by PDL |
| ANTIPROTOZOAL AGENTS | | Category no longer managed by PDL |
| ASTHMA – Long Acting Anticholinergics | | Category no longer managed by PDL |
| COPD – Long Acting Anticholinergics | SPRIRIVA RESPIMAT 2.5 mg moved to non-preferred | |
| COPD – Long Acting Anticholinergics | TUDORZA PRESSAIR moved to non-preferred | |
| COPD – Long Acting Combination | STIOLTO RESPIMAT moved to preferred | Group PA criteria removed |
| COPD | | Category PA criteria updated |
| CYTOKINE MODULATORS | Otezla moved to preferred | |
| CYTOKINE MODULATORS | Xeljanz moved to preferred | |
| CYTOKINE MODULATORS | Xeljanz XR moved to preferred | |
| CYTOKINE MODULATORS | | Cosentyx criteria removed |
| DIABETES – DPP4 INHIBITORS | KAZANO moved to non-preferred | Category PA criteria added |
| DIABETES – DPP4 INHIBITORS | KOMBIGLYZE XR moved to non-preferred | |
| DIABETES – DPP4 INHIBITORS | NESINA moved to non-preferred | |
| DIABETES – DPP4 INHIBITORS | ONGLYZA moved to non-preferred | |
| DIABETES – DPP4 INHIBITORS | OSENI moved to non-preferred | |
| DIABETES – INSULIN | | Category no longer managed by PDL |

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

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

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

**EFFECTIVE**
**January 1, 2017**
**Version 2017.1**

| CHANGES SINCE LAST 2016 VERSION | | |
|---|---|---|
| **Category** | **Product Status Changes** | **Criteria Changes** |
| DIABETES – SGLT2 INHIBITORS | FARXIGA moved to non-preferred | DIABETES – SGLT2 INHIBITORS COMBINATIONS category merged into category |
| DIABETES – SGLT2 INHIBITORS | SYNJARDY moved to preferred | Category PA criteria updated |
| DIARRHEA – IRRITABLE BOWEL SYNDROME | | Category now managed by PDL |
| DRY EYE DISEASE | | Category no longer managed by PDL |
| EPINEPHRINE PENS | | Category no longer managed by PDL |
| GOUT – COLCHICINE | | Category now managed by PDL |
| GROWTH HORMONE | OMNITROPE moved to non-preferred | |
| HEMATOPOIETIC, GROWTH FACTOR | MIRCERA moved to non-preferred | Category PA criteria added |
| HEMATOPOIETIC, GROWTH FACTOR | EPOGEN moved to non-preferred | |
| IMMUNOGLOBULINS | | Category now managed by PDL |
| IRRITABLE BOWEL SYNDROME – CONSTIPATION | | Renamed: Constipation – Irritable Bowel Syndrome/Opioid Induced |
| IRRITABLE BOWEL SYNDROME – CONSTIPATION | MOVANTIK added to non-preferred | Category PA criteria updated |
| IRRITABLE BOWEL SYNDROME – CONSTIPATION | RELISTOR TABLET added to non-preferred | |
| IRRITABLE BOWEL SYNDROME – CONSTIPATION | RELISTOR VIAL added to non-preferred | RELISTOR VIAL criteria added |
| IRRITABLE BOWEL SYNDROME – CONSTIPATION | RELISTOR SYRINGE added to non-preferred | RELISTOR SYRINGE criteria added |
| LICE | SLICE added to preferred | Category PA criteria updated |
| MULTIPLE SCLEROSIS – Interferons | EXTAVIA moved to non-preferred | |
| MULTIPLE SCLEROSIS – Oral Non-interferons | AUBAGIO moved to preferred | Category PA criteria updated |
| OPHTHALMIC ANTIHISTAMINES | EMADINE 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 available covered drugs requiring 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 prior authorization for medications not found in this list.**

**EFFECTIVE**
**January 1, 2017**
**Version 2017.1**

| CHANGES SINCE LAST 2016 VERSION | | |
|---|---|---|
| **Category** | **Product Status Changes** | **Criteria Changes** |
| OPHTHALMIC ANTIHISTAMINES | PATADAY moved to non-preferred | PATADAY criteria updated; PATANOL criteria removed |
| OPHTHALMIC ANTI-INFECTIVES | OCUFLOX (ofloxacin) DROPS moved to non-preferred | |
| OPHTHALMIC ANTI-INFECTIVES | Ofloxacin drops moved to non-preferred | |
| OPHTHALMIC ANTI-INFLAMMATORIES | ACULAR LS moved to non-preferred | Category PA criteria updated |
| OPHTHALMIC ANTI-INFLAMMATORIES | Bromfenac sodium moved to preferred | |
| OPHTHALMIC ANTI-INFLAMMATORIES | Prednisolone acetate moved to non-preferred | |
| OPHTHALMIC ANTI-INFLAMMATORIES | Prednisolone sodium phosphate moved to non-preferred | |
| OPHTHALMIC GLAUCOMA PROSTAGLANDINS | | Category no longer managed by PDL |
| PLATELET AGGREGATION INHIBITORS | AGGRENOX moved to non-preferred | Category PA criteria updated |
| PULMONARY HYPERTENSION | LETAIRIS moved to non-preferred | Category PA criteria updated |
| PULMONARY HYPERTENSION | OPSUMIT moved to non-preferred | |
| STEROID INHALERS | ALVESCO moved to non-preferred | |
| STEROID TOPICAL SOLUTIONS | | Category no longer managed by PDL |
| ULCER ANTI-INFECTIVES | | Category no longer managed by PDL |
| URINARY ANTISPASMODICS | ENABLEX moved to non-preferred | Category PA criteria updated |
| URINARY ANTISPASMODICS | Darifenacin ER added to non-preferred | DETROL LA criteria updated |
| URINARY ANTISPASMODICS | | SANCTURA ER criteria updated |

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

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



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

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

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



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

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
| exceptions on the PA form is present. | | |
| APTIOM (eslicarbazepine) | CARBATROL (carbamazepine) | |
| BANZEL (rufinamide) ORAL SUSPENSION | DEPAKENE (valproic acid) CAPSULE | |
| BANZEL (rufinamide) TABLET | DEPAKENE (valproic acid) ORAL SOLUTION | |
| BRIVIACT (brivaracetam) | DEPAKOTE (divalproex sodium) TABLET | |
| Carbamazepine chewable tablet | DEPAKOTE ER (divalproex sodium) | |
| Carbamazepine ER capsule | DEPAKOTE SPRINKLE (divalproex sodium) | |
| Carbamazepine oral suspension | DILANTIN (phenytoin) CHEWABLE TABLET | |
| Carbamazepine tablet | DILANTIN (phenytoin) ORAL SUSPENSION | |
| Carbamazepine XR tablet | DILANTIN ER (phenytoin) | |
| CELONTIN (methsuximide) | EPITOL (carbamazepine) | |
| Divalproex ER | FELBATOL (felbamate) | |
| Divalproex sprinkle | FELBATOL (felbamate) ORAL SUSPENSION | |
| Divalproex tablet | KEPPRA (levetiracetam) | |
| Ethosuximide capsule | KEPPRA (levetiracetam) ORAL SOLUTION | |
| Ethosuximide oral solution | KEPPRA XR (levetiracetam) | |
| Felbamate oral suspension | LAMICTAL (lamotrigine) | |
| 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) | |

EFFECTIVE
January 1, 2017
Version 2017.1

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

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

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| LAMICTAL ER (lamotrigine) DOSE PACK | TEGRETOL XR (carbamazepine) | |
| LAMICTAL ODT (lamotrigine) | TEGRETROL (carbamazepine oral suspension) | |
| LAMICTAL ODT (lamotrigine) DOSE PACK | TOPAMAX (topiramate) | |
| LAMICTAL XR (lamotrigine) | TOPAMAX (topiramate) SPRINKLE CAPSULE | |
| Lamotrigine chewable tablet | TRILEPTAL (oxcarbazepine) | |
| Lamotrigine dose pack | TRILEPTAL (oxcarbazepine) ORAL SUSPENSION | |
| Lamotrigine ER | ZARONTIN (ethosuximide) | |
| Lamotrigine ODT | ZARONTIN (ethosuximide) ORAL SOLUTION | |
| Lamotrigine tablet | ZONEGRAN (zonisamide) | |
| Levetiracetam ER | | |
| Levetiracetam oral solution | | |
| Levetiracetam tablet | | |
| LYRICA (pregabalin) | | |
| LYRICA (pregabalin) ORAL SOLUTION | | |
| Oxcarbazepine oral solution | | |
| Oxcarbazepine tablet | | |
| OXTELLAR XR (oxcarbazepine) | | |
| PEGANONE (Ethotoin) | | |
| Phenobarbital elixir | | |
| Phenobarbital tablet | | |
| PHENYTEK (phenytoin) | | |
| Phenytoin chewable tablet | | |
| Phenytoin ER capsule | | |
| Phenytoin suspension | | |
| POTIGA (ezogabine) | | |
| Primidone | | |
| SABRIL (vigabatrin) | | |
| SABRIL (vigabatrin) POWDER PACK | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| 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 | | |
| **ANTICONVULSANTS – BENZODIAZEPINES – RECTAL** | | |
| **Category PA Criteria:** A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. | | |
| DIASTAT (diazepam) RECTAL KIT | Diazepam rectal kit | |
| **ANTIDEMENTIA** | | |
| **Category PA Criteria:** All agents will require an FDA indication for patients younger than 30 years old.<br>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.<br><br>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)*** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| Rivastigmine | | |
| **ANTIDEPRESSANTS – NEW GENERATION** | | |
| **Category PA Criteria:**<br>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.<br><br>Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. | | |
| Bupropion SR tablet | APLENZIN ER (bupropion) | |
| Bupropion tablet | CELEXA (citalopram) | |
| Bupropion XL tablet | CYMBALTA (duloxetine) | |
| Citalopram | EFFEXOR XR (venlafaxine) | |
| Citalopram oral solution | Fluoxetine DR | |
| Clomipramine | FORFIVO XL (bupropion) | |
| Desvenlafaxine ER | IRENKA (duloxetine) | |
| Duloxetine | LEXAPRO (escitalopram) | |
| Escitalopram | LEXAPRO (escitalopram) ORAL SOLUTION | |
| Escitalopram oral solution | PAXIL (paroxetine) | |
| FETZIMA (levomilnacipran) | PAXIL CR (paroxetine) | |
| Fluoxetine capsule | PROZAC (fluoxetine) | |
| Fluoxetine solution | WELLBUTRIN (bupropion) | |
| Fluoxetine tablet | WELLBUTRIN SR (bupropion) | |
| Fluvoxamine | WELLBUTRIN XL (bupropion) | |
| Fluvoxamine ER | ZOLOFT (sertraline) | |
| KHEDEZLA ER (desvenlafaxine) | ZOLOFT (sertraline) ORAL CONCENTRATE | |
| Nefazodone | | |
| OLEPTRO ER (trazodone) | | |
| Paroxetine | | |
| Paroxetine ER | | |
| PAXIL (paroxetine) ORAL SUSPENSION | | |
| PEXEVA (paroxetine) | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| PRISTIQ ER (desvenlafaxine) | | |
| PROZAC WEEKLY (fluoxetine) | | |
| Sertraline | | |
| Sertraline oral concentrate | | |
| Trazodone | | |
| TRINTELLIX (vortioxetine) | | |
| Venlafaxine capsule | | |
| Venlafaxine ER tablets | | |
| Venlafaxine tablet | | |
| VIIBRYD (vilazodone) | | |
| **ANTIHEMOPHILIC FACTORS** | | |
| **Category PA Criteria:**<br>1. Patient must visit an accredited Hemophilia Treatment Center for yearly checkups.<br>2. The doctor must provide the date of patient's last appointment at the treatment center.<br>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] | | |
| 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] | | |
| MONOCLATE-P[PA] | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
| MONONINE[PA] | | |
| NOVOEIGHT[PA] | | |
| NOVOSEVEN[PA] | | |
| OBIZURE[PA] | | |
| PROFILNINE SD[PA] | | |
| RECOMBINATE[PA] | | |
| RIXUBIS[PA] | | |
| VONVENDI[PA] | | |
| WILATE[PA] | | |
| XYNTHA[PA] | | |
| **ANTIRETROVIRALS – NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS** | | |
| Abacavir | | |
| Abacavir/lamivudine/zidovudine | | |
| ATRIPLA (efavirenz/emtricitabine/tenofovir) | | |
| COMBIVIR (lamivudine/zidovudine) | | |
| COMPLERA (emtricitabine/rilpivirine/tenofovir) | | |
| DESCOVY (emtricitabine/tenofovir) | | |
| Didanosine | | |
| Emtricitabine | | |
| EMTRIVA (emtricitabine) | | |
| EPIVIR (lamivudine) | | |
| EPIVIR HBV (lamivudine) | | |
| EPZICOM (abacavir) | | |
| GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) | | |
| Lamivudine | | |
| Lamivudine HBV | | |
| Lamivudine/zidovudine | | |
| ODEFSEY (emtricitabine/rilpivirine/tenofovir) | | |
| RETROVIR (zidovudine) | | |
| Stavudine | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) | | |
| Tenofovir | | |
| TRIUMEQ (abacavir/dolutegravir/lamivudine) | | |
| TRIZIVIR (abacavir/lamivudine) | | |
| TRUVADA (emtricitabine/tenofovir) | | |
| VIDEX (didanosine) | | |
| VIDEX EC (didanosine) | | |
| VIREAD (tenofovir) | | |
| ZERIT (stavudine) | | |
| ZIAGEN (abacavir) | | |
| Zidovudine | | |
| **ANTIRETROVIRALS – PROTEASE INHIBITORS** | | |
| APTIVUS (tipranavir) | | |
| CRIXIVAN (indinavir) | | |
| EVOTAZ (atazanavir/cobicistat) | | |
| GENVOYA (elvitegravir, cobicistat, emtricitabine and tenofovir) | | |
| INVERASE (saquinavir) | | |
| KALENTRA (lopinavir/ritonavir) | | |
| LEXIVA (fosamprenavir) | | |
| NORVIR (ritonavir) | | |
| PREZCOBIX (darunavir/cobicistat) | | |
| PREZISTA (darunavir) | | |
| RAYATAZ (atazanavir) | | |
| VIRACEPT (nelfinavir) | | |
| **ATYPICAL ANTIPSYCHOTICS** | | |
| **Category PA Criteria:**<br>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.<br><br>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. | | |

EFFECTIVE
January 1, 2017
Version 2017.1

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

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

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| ABILIFY (aripiprazole) ORAL SOLUTION | ABILIFY (aripiprazole) | |
| ABILIFY DISCMELT (aripiprazole) | CLOZARIL (clozapine) | |
| Aripiprazole | GEODON (ziprasidone) | |
| Clozapine | INVEGA ER (paliperidone) | |
| Clozapine ODT | RISPERDAL (risperidone) | |
| FANAPT (iloperidone) | RISPERDAL (risperidone) ORAL SOLUTION | |
| FAZACLO (clozapine) RAPDIS | RISPERDAL M-TAB (risperidone) | |
| LATUDA (lurasidone) | SEROQUEL (quetiapine) | |
| Olanzapine | ZYPREXA (olanzapine) | |
| Olanzapine ODT | ZYPREXA ZYDIS (olanzapine) | |
| Olanzapine/fluoxetine | | |
| Paliperidone ER | | |
| Quetiapine | | |
| REXULTI (brexpiprazole) | | |
| Risperidone | | |
| Risperidone ODT | | |
| Risperidone oral solution | | |
| SAPHRIS (asenapine) | | |
| SEROQUEL XR (quetiapine) | | |
| SYMBYAX (olanzapine/fluoxetine) | | |
| VRAYLAR (cariprazine) | | |
| Ziprasidone | | |
| **ATYPICAL ANTIPSYCHOTICS – LONG ACTING** | | |
| ABILIFY MAINTENA (aripiprazole) | | |
| ARISTADA (aripiprazole lauroxil) | | |
| INVEGA SUSTENNA (paliperidone) | | |
| INVEGA TRINZA (paliperidone) | | |
| RISPERDAL CONSTA (risperidone) | | |
| ZYPREXA RELPREVV (olanzapine) | | |
| **CONSTIPATION – IRRITABLE BOWEL SYNDROME/OPIOID INDUCED** | | |

EFFECTIVE
January 1, 2017
Version 2017.1

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

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

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **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. All non-preferred medications require a 30-day trial of Amitiza in addition to an additional oral medication indicated for constipation. | | |
| AMITIZA (lubiprostone) | MOVANTIK (naloxegol) | ***Linzess – A 30-day trial of Amitiza is required before Linzess will be authorized.<br><br>***Relistor Syringe/Vial – Patient must be unable to tolerate oral medications. |
| LINZESS (linaclotide)PA*** | RELISTOR (methylnaltrexone) TABLET | |
| | RELISTOR (methylnaltrexone) VIAL | |
| | RELISTOR (methylnaltrexone) SYRINGE | |
| **COPD** | | |
| **Category PA Criteria:** A 30-day trial of all preferred agents (within the same group) will be required before a non-preferred agent will be authorized. All preferred agents indicated only for COPD will require verification of FDA-approved indication for patients who are younger than 40 years of age. All non-preferred agents will require an FDA-approved indication regardless of age. | | |
| **Long Acting Anticholinergics** | | |
| SPIRIVA (tiotropium) | INCRUSE ELLIPTA (umeclidinium) | |
| | SPIRIVA RESPIMAT 2.5 MG (tiotropium) | |
| | TUDORZA PRESSAIR (aclidinium) | |
| **Long Acting Beta Agonists** | | |
| FORADIL (formoterol) | ARCAPTA NEOHALER (indacaterol) | ***Brovana/Arcapta Neohaler require a 30-day trial of Striverdi in addition to category PA criteria. |
| SEREVENT (salmeterol) | BROVANA (arformoterol) | |
| PERFOROMIST (formoterol) | STRIVERDI RESPIMAT (olodaterol) | |
| **Short Acting Combination** | | |
| Albuterol/ipratropium | DUONEB (albuterol/ipratropium) | |
| COMBIVENT RESPIMAT (albuterol/ipratropium) | | |
| **Long Acting Combination** | | |
| STIOLTO RESPIMAT (tiotropium/olodaterol) | UTIBRON NEOHALER (glycopyrrolate/indacaterol) | |
| ANORO ELLIPTA (umeclidinium/vilanterol) | BEVESPI AEROSPHERE (glycopyrrolate/formoterol) | |
| **PDE4 – Inhibitor** | | |
| **Group PA Criteria:** In addition to the category PA criteria, patient must have a history of exacerbations treated with corticosteroids within the last year for initial requests and must have had a decreased number of exacerbations treated with corticosteroids with Daliresp treatment with renewals.<br><br>Patient must also have had the following 30-day trials: | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| 1. One (1) agent in the Long Acting Anticholinergic group.<br>2. One (1) agent in the Long Acting Beta Agonist group or 1 agent in the Steroid/Anticholinergic Combination Inhalers category.<br>3. One (1) agent in the Steroid Inhalers category or 1 agent in the Steroid/Anticholinergic Combination Inhalers category. | | |
| | DALIRESP (roflumilast) | |
| **CYSTIC FIBROSIS ANTI-INFECTIVES** | | |
| **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.<br>***Tobramycin/TOBI/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 (Tobramycin) | |
| | TOBI PODHALER (Tobramycin) | |
| | 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. | | |
| ENBREL (etanercept)[PA] | ACTEMRA (tocilizumab) | ***Otezla – Patient must be 18 years or older and have a rheumatology or dermatology specialist involved in therapy. Otezla must not be used in combination with other biologic therapies.<br><br>***Xeljanz/Xeljanz XR – Patient must have had an inadequate response to methotrexate, been tested for latent tuberculosis, have current lab monitoring prior to starting Xeljanz of CBC with differential, liver enzymes, and lipid panel), and not be at increased risk of gastrointestinal perforations. |
| HUMIRA (adalimumab)[PA] | CIMZIA (certolizumab) | |
| HUMIRA PSORIASIS (adalimumab)[PA] | KINERET (anakinra) | |
| COSENTYX (secukinumab)[PA] | ORENCIA (abatacept) | |
| OTEZLA (apremilast)[PA] | REMICADE (infliximab) | |
| XELJANZ (tofacitinib)[PA] | SIMPONI (golimumab) | |
| XELJANZ XR (tofacitinib)[PA] | STELARA (ustekinumab) | |
| | TALTZ (ixekizumab) | |
| | | |
| | | |
| | | |
| **DIABETES – DPP4 INHIBITORS** | | |
| **Category PA Criteria:** Non preferred agents will require:<br>1. A 30-day trial of 1 sitagliptin preferred product (Janumet, Janumet XR, or Januvia) and 1 linagliptin preferred product (Jentadueto or Tradjenta).<br>2. An FDA indication.<br>3. Concurrent metformin therapy.<br>4. A 3-month trial of metformin | | |
| JANUMET (sitagliptin/metformin) | KAZANO (alogliptin/metformin) | |

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

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



| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| JANUMET XR (sitagliptin/metformin) | KOMBIGLYZE XR (sitagliptin/metformin) | |
| JANUVIA (sitagliptin) | NESINA (alogliptin) | |
| JENTADUETO (linagliptin/metformin) | ONGLYZA (saxagliptin) | |
| TRADJENTA (linagliptin) | OSENI (alogliptin/pioglitazone) | |
| **DIABETES – GLP1 AGONISTS** | | |
| **Category PA Criteria:** Non preferred agents will require:<br>1. A 30-day trial of 2 preferred agents.<br>2. An FDA indication.<br>3. Concurrent metformin therapy.<br>4. A 3-month trial of metformin. | | |
| BYDUREON (exenatide microspheres) | TRULICITY (dulaglutide) | ***Victoza requires PA for an FDA-approved indication, concurrent metformin therapy, and a 3-month trial of metformin. |
| BYETTA (exenatide) | | |
| TANZEUM (albiglutide) | | |
| VICTOZA (liraglutide)PA*** | | |
| **DIABETES – SGLT2 INHIBITORS** | | |
| **Category PA Criteria:** Non-preferred agents will require:<br>1. A 3-month trial of a canagliflozin and a 3-month trial of a empagliflozin agent.<br>2. An FDA indication.<br>3. Concurrent metformin therapy – this condition will be considered met if requested product is a metformin combination agent. | | |
| INVOKAMET (canagliflozin/metformin) | FARXIGA (dapagliflozin) | |
| INVOKAMET XR (canagliflozin/metformin) | GLYXAMBI (empagliflozin/linagliptin) | |
| INVOKANA (canagliflozin) | XIGDUO XR (dapagliflozin/metformin) | |
| JARDIANCE (empagliflozin) | | |
| SYNJARDY (empagliflozin/metformin) | | |
| **DIARRHEA – IRRITABLE BOWEL SYNDROME** | | |
| **Category PA Criteria:** Patient must be 18 years of age or older. A 30-day trial of loperamide and Viberzi will be required before a non-preferred medication will be approved. | | |
| VIBERZI (eluxadoline) | Alosetron | ***Lotronex – Patient must be a female. |
| | XIFAXIN (rifaximin) 550 mg tablet | |
| | LOTRONEX (alosetron) | |
| **DIGESTIVE ENZYMES** | | |
| **Category PA Criteria:** A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. | | |
| CREON (lipase/protease/amylase) | PANCREAZE (lipase/protease/amylase) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| ZENPEP (lipase/protease/amylase) | PANCRELIPASE (lipase/protease/amylase) | |
| | PERTZYE (lipase/protease/amylase) | |
| | ULTRESA (lipase/protease/amylase) | |
| | VIOKACE (lipase/protease/amylase) | |
| **GOUT – COLCHICINE** | | |
| **Category PA Criteria:** A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. | | |
| MITIGARE (colchicine) | Colchicine capsule | |
| | Colchicine tablet | |
| | COLCRYS (colchicine) TABLET | |
| **FIBROMYALGIA** | | |
| **Category PA Criteria:** A 30-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized. A 30-day trial of 2 preferred generics of the same medication will satisfy this requirement. | | |
| Duloxetine | CYMBALTA (duloxetine) | |
| Gabapentin capsule | NEURONTIN (gabapentin) CAPSULE | |
| Gabapentin oral solution | NEURONTIN (gabapentin) TABLET | |
| Gabapentin tablet | NEURONTIN (gabapentin) ORAL SOLUTION | |
| LYRICA (pregabalin) | | |
| LYRICA (pregabalin) ORAL SOLUTION | | |
| SAVELLA (milnacipran) | | |
| **GLAUCOMA – SYMPATHOMIMETICS** | | |
| **Category PA Criteria:** A 30-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30-day trial of 2 preferred generics of the same medication will satisfy this requirement. | | |
| ALPHAGAN P 0.1% (brimonidine) | ALPHAGAN P 0.15% (brimonidine) | |
| Apraclonidine | IOPIDINE (apraclonidine) | |
| brimonidine 0.15% | | |
| brimonidine 0.2% | | |
| COMBIGAN (brimonidine/timolol) | | |
| SIMBRINZA (brinzolamide/brimonidine) | | |
| **GROWTH HORMONE** | | |
| **Category PA Criteria:** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| 1. Patients new to GH therapy must meet the criteria below and be started on a preferred growth hormone.<br>2. Patients continuing GH therapy and having met the criteria listed below must be switched to a preferred growth hormone.<br>3. Patients must not have an active malignancy.<br><br>Additional criteria applies. For details, see http://www.hidesigns.com/assets/files/ndmedicaid/Criteria/2016/growth_hormone_criteria.pdf. | | |
| GENOTROPIN (somatropin)PA | HUMATROPE (somatropin) | |
| GENOTROPIN MINIQUICK (somatropin)PA | NUTROPIN AQ (somatropin) | |
| NORDITROPIN FLEXPRO (somatropin)PA | OMNITROPE (somatropin) | |
| | SAIZEN (somatropin) | |
| | ZOMACTON (somatropin) | |
| **HEART FAILURE – NEPRILYSIN INHIBITOR/ANGIOTENSIN RECEPTOR BLOCKER** | | |
| **Category PA Criteria:**<br>1. Patient must have symptomatic chronic heart failure (NYHA class II-IV).<br>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.<br>1. Patient must have an FDA-approved diagnosis.<br>2. Patient must be an FDA-approved age.<br>3. Patient must attest that they will continue treatment without interruption for the duration of therapy.<br>4. Prescriber must be, or consult with, a hepatologist, gastroenterologist, or infectious disease specialist.<br>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.<br>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.<br>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.<br>8. Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment.<br>9. Patient must have established compliant behavior including attending scheduled provider visits and filling maintenance medications on time as shown in the prescription medication history.<br>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.<br>11. Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| 12. PA approval duration will be based on label recommendation. | | |
| EPCLUSA (sofosbuvir/velpatasvir)[PA] | DAKLINZA (Daclatasvir) | ***Epclusa:<br>• Must must be used with ribavirin for patients with decompensated cirrhosis (Child-Pugh B or Child-Pugh C).<br>• Is ONLY preferred for genotype 2 and 3; for all other genotypes Epclusa is non-preferred.<br>***Harvoni:<br>• Patient must have eGFR > 30 mL/min/1.73m2.<br>***Technivie:<br>• Patients must not have moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment.<br>• Patients must not have cirrhosis.<br>• Technivie must be used with ribavirin in treatment experienced patients.<br>***Olysio:<br>• Must be taken in conjunction with pegylated interferon and ribavirin.<br>***Viekira Pak/Viekira Pak XR:<br>• Patients must have hepatic laboratory tests before treatment and 4 weeks after treatment begins.<br>• Patients must not have moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment.<br>• Viekira Pak must be used with ribavirin except for genotype 1b without cirrhosis or mild (Child-Pugh A) hepatic impairment.<br>***Zepatier:<br>• Patients must not have moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment.<br>• Genotype 1a: Patient must be tested for baseline NS5A polymorphisms.<br>• Zepatier must be used with ribavirin in patients with baseline NS5A polymorphisms.<br>• Zepatier must be used with ribavirin in patients who have failed HCV NS3/4A protease inhibitor (PI) + RBV + PegIFN treatment.<br>• Patients who have failed HCV NS3/4A protease inhibitor (PI) + RBV + PegIFN treatment must not have baseline NS5A polymorphisms. |
| HARVONI (ledipasvir/sofosbuvir)[PA] | OLYSIO (simeprevir) | |
| SOVALDI (sofosbuvir)[PA] | | |
| TECHNIVIE (ombitasvir/paritaprevir/ritonavir)[PA] | | |
| VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)[PA] | | |
| VIEKIRA PAK XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)[PA] | | |
| ZEPATIER (elbasvir/grazoprevir)[PA] | | |

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

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



| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **IMMUNOGLOBULINS** | | |
| **Category PA Criteria:**<br>1. Indication must be provided.<br>2. If patient's BMI is > 30, patient's adjusted body weight must be provided and a calculated dose based on adjusted body weight must be provided. | | |
| BIVIGAM (human immunoglobulin gamma) | HIZENTRA (human immunoglobulin gamma) | ***Gammagard S/D: Patient must be intolerant to IgA (i.e., treatment of an autoimmune process in a patient with undetectable levels of IgA).<br><br>***Hizentra, Cuvitru, or Hyqvia: Patient must not be able to tolerate IV administration. Patient must fail a trial of 2 of the following products: Gamunex-C, Gammaked, or Gammagard. |
| CARIMUNE NF (human immunoglobulin gamma) | CUVITRU (human immunoglobulin gamma) | |
| FLEBOFAMMA DIF (human immunoglobulin gamma) | GAMMAGARD S-D (human immunoglobulin gamma) | |
| GAMANEX-C (human immunoglobulin gamma) | HYQVIA (human immune globulin G and hyaluronidase | |
| GAMASTAN S-D | | |
| GAMMAGARD LIQUID (human immunoglobulin gamma) | | |
| GAMMAKED (human immunoglobulin gamma) | | |
| GAMMAPLEX (human immunoglobulin gamma) | | |
| OCTAGAM (human immunoglobulin gamma) | | |
| PRIVIGEN (human immunoglobulin gamma) | | |
| **INFLAMMATORY BOWEL AGENTS (ULCERATIVE COLITIS) – NONSTEROIDAL** | | |
| **Category PA Criteria:** A 30-day trial of each of the preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents will require an FDA indication. | | |
| **Oral** | | |
| Balsalazide capsule | APRISO (mesalamine) CAPSULE | |
| DELZICOL (mesalamine) CAPSULE | ASACOL HD (mesalamine) | |
| PENTASA (mesalamine) 250 MG CAPSULE | AZULFIDINE (sulfasalazine) | |
| Sulfasalazine DR tablet | AZULFIDINE DR (sulfasalazine) | |
| Sulfasalazine tablet | COLAZAL (balsalazide) | |
| | DIPENTUM (olsalazine) | |
| | GIAZO (balsalazide) | |
| | LIALDA (mesalamine) TABLET | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | Mesalamine DR | |
| | PENTASA (mesalamine) 500 MG CAPSULE | |
| | SULFAZINE (sulfasalazine) | |
| **Rectal** | | |
| CANASA (mesalamine) RECTAL SUPPOSITORY | Mesalamine enema kit | |
| Mesalamine enema | SF ROWASA (mesalamine) ENEMA | |
| **LICE** | | |
| **Category PA Criteria:** A 28-day/2-application trial of each of the preferred agents will be required before a non-preferred agent will be authorized. This requirement will be waived in the presence of a documented community breakout of a resistant strain that is only susceptible to a non-preferred agent. | | |
| LICE SOLUTION (piperonyl butoxide/pyrethrins) | ELIMITE (permethrin) CREAM | |
| Lindane shampoo | EURAX (crotamiton) CREAM | |
| NATROBA (spinosad) | EURAX (crotamiton) LOTION | |
| Permethrin cream | Malathion | |
| Permethrin liquid | OVIDE (malathion) | |
| SKLICE (ivermectin) | Spinosad | |
| ULESFIA (benzyl alcohol) | | |
| **MIGRAINE PROPHYLAXIS – 5HT(1) AGONISTS** | | |
| **Category PA Criteria:**<br>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.<br>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.<br><br>***Frova – A 30-day trial of naratriptan 2.5 mg within the past 24 months will be required in addition to the class criteria. The patient's migraine headaches must either menstrual, long in duration, and/or recurring.<br><br>***Axert – A 30-day trial of Zolmitriptan 5 mg 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 | FROVA (frovatriptan) | |
| | IMITREX (sumatriptan) CARTRIDGE | |
| | IMITREX (sumatriptan) PEN INJCTR | |
| | IMITREX (sumatriptan) SPRAY | |
| | IMITREX (sumatriptan) TABLET | |
| | IMITREX (sumatriptan) VIAL | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | MAXALT (rizatriptan) | ***Zecuity/Sumavel DosePro/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. |
| | MAXALT MLT (rizatriptan) | |
| | Naratriptan | |
| | ONSETRA XSAIL (sumatriptan) | |
| | Sumatriptan cartridge | |
| | Sumatriptan pen injctr | |
| | Sumatriptan spray | |
| | Sumatriptan syringe | |
| | Sumatriptan vial | |
| | SUMAVEL DOSEPRO (sumatriptan) | |
| | TREXIMET (sumatriptan/naproxen) | |
| | ZECUITY (sumatriptan) PATCH | |
| | Zolmitriptan | |
| | Zolmitriptan ODT | |
| | ZOMIG (zolmitriptan) | |
| | ZOMIG (zolmitriptan) SPRAY | |
| | ZOMIG ODT (zolmitriptan) | |
| **MULTIPLE SCLEROSIS** | | |
| **Interferons** | | |
| **Category PA Criteria:** A 3-month long trial of a preferred agent will be required before a non-preferred agent will be authorized. An FDA indication is required. | | |
| AVONEX (interferon beta-1A) VIAL | AVONEX (interferon beta-1A) SYRINGE | |
| BETASERON (interferon beta-1B) | AVONEX (interferon beta-1A) PEN | |
| 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** | | |
| **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 | ***Lemtrada:<br>• If patient has early aggressive disease defined as ≥ 2 relapses in the year |
| | Glatopa (glatiramer) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | LEMTRADA (alemtuzumab) | and ≥ 1 Gadolinium (Gd)+ lesion, the trials of oral non-interferons will not be required.<br>• If patient has not been vaccinated or have a history of varicella zoster virus (VZV), patient must have an VZV antibody titer.<br>• Patient must have had a urinalysis with urine cell counts.<br>• Patient must have had a thyroid function test.<br>• Patient must be screened for TB and have been treated if TB positive.<br>• - Patient must have SCr levels.<br>***Tysabri:<br>• 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.<br>• Patient must have Anti-JC virus antibodies taken.<br>• Patient must have had an MRI scan.<br>***Zinbryta:<br>• Transaminase and bilirubin levels must have been obtained within 6 months of request.<br>• Patient must not have hepatitis B or C.<br>• Patient must be screened for TB and have been treated if TB positive.<br>• 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.<br>• Patient must have Anti-JC virus antibodies taken.<br>***Copaxone/Glatopa:<br>• A reason must be indicated why Copaxone 20 mg/mL will not work. |
| | TYSABRI (natalizumab) | |
| | ZINBRYTA (daclizumab) | |
| **Oral Non-interferons** | | |
| **Category PA Criteria:** A 3-month long trial of all preferred agents and Copaxone will be required before a non-preferred agent will be authorized. If patient has a documented intolerance, hypersensitivity, or labeled contraindication to Copaxone, a 3-month trial of interferon beta-1 is required for non-preferred agents. An FDA indication is required. Prescriber must be a neurologist. | | |
| AUBAGIO (teriflunomide) | TECFIDERA (dimethyl fumarate) | *** Tecfidera:<br>• Patient must have had a CBC with lymphocyte count within 6 months of request. |
| GILENYA (fingolimod) | | |
| | | |

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

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



| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **OPHTHALMIC ANTIHISTAMINES** | | |
| **Category PA Criteria:** A 30-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized. | | |
| BEPREVE (bepotastine) | ALOCRIL (nedocromil) | ***Pataday and epinastine will require a 30-day trial of azelastine in addition to the category PA criteria. |
| Cromolyn | ALOMIDE (lodoxamide) | |
| Olopatadine | Azelastine | |
| PAZEO (olopatadine) | ELESTAT (epinastine) | |
| | EMADINE (emedastine) | |
| | Epinastine | |
| | LASTACAFT (alcaftadine) | |
| | PATADAY (olopatadine) | |
| | PATANOL (olopatadine) | |
| **OPHTHALMIC ANTI-INFECTIVES** | | |
| **Category PA Criteria:** A 3-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. | | |
| Bacitracin ointment | AK-POLY-BAC (bacitracin/polymyxin) OINTMENT | |
| Bacitracin/polymyxin ointment | AZASITE (azithromycin) DROPS | |
| Ciprofloxacin drops | BESIVANCE (besifloxacin) DROPS | |
| Erythromycin ointment | BLEPH-10 (sulfacetamide) DROPS | |
| Gentamicin sulfate drops | CILOXAN (ciprofloxacin) DROPS | |
| Gentamicin sulfate ointment | CILOXAN (ciprofloxacin) OINTMENT | |
| MOXEZA (moxifloxacin) DROPS | Gatifloxacin drops | |
| Neomycin SU/bacitracin/polymyxin B drops | GENTAK (gentamicin sulfate) OINTMENT | |
| Neomycin SU/bacitracin/polymyxin B ointment | ILOTYCIN (erythromycin) OINTMENT | |
| Neomycin SU/polymyxin B/gramicidin drops | Levofloxacin drops | |
| Polymyxin B/trimethoprim drops | NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) DROPS | |
| Sulfacetamide drops | NEOSPORIN (neomycin SU/polymyxin B/gramicidin) DROPS | |
| Sulfacetamide ointment | OCUFLOX (ofloxacin) DROPS | |
| Tobramycin drops | Ofloxacin drops | |
| TOBREX (tobramycin) OINTMENT | POLYCIN (bacitracin/polymyxin) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | OINTMENT | |
| VIGAMOX (moxifloxacin) DROPS | POLYTRIM (polymyxin B/trimethoprim) DROPS | |
| | TOBREX (tobramycin) DROPS | |
| | ZYMAXID (gatifloxacin) DROPS | |
| **OPHTHALMIC ANTI-INFECTIVES/ANTI-INFLAMMATORIES** | | |
| **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. | | |
| Neomycin/bacitracin/polymyxin b/hydrocortisone ointment | BLEPHAMIDE (sulfacetamide/prednisolone) DROPS | |
| Neomycin/polymyxin b/dexamethasone drops | MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS | |
| Neomycin/polymyxin b/dexamethasone ointment | MAXITROL (neomycin/polymyxin b/dexamethasone) OINTMENT | |
| Neomycin/polymyxin b/hydrocortisone drops | Tobramycin/dexamethasone | |
| PRED-G (gentamicin/prednisol ac) DROPS | BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone) ointment | |
| PRED-G (gentamicin/prednisol ac) OINTMENT | | |
| Sulfacetamide/prednisolone drops | | |
| TOBRADEX (tobramycin/dexamethasone) DROPS | | |
| TOBRADEX (tobramycin/dexamethasone) OINTMENT | | |
| TOBRADEX ST (tobramycin/dexamethasone) DROPS | | |
| ZYLET (tobramycin/lotepred etab) DROPS | | |
| **OPHTHALMIC ANTI-INFLAMMATORIES** | | |
| **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) | |
| Dexamethasone sodium phosphate | Bromfenac sodium | |
| Diclofenac sodium | FML (fluorometholone) | |
| DUREZOL (difluprednate) | OCUFEN (flurbiprofen) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| FLAREX (fluorometholone) | OMNIPRED (prednisolone acetate) | |
| Fluorometholone | PRED FORTE (prednisolone acetate) | |
| Flurbiprofen sodium | Prednisolone acetate | |
| FML FORTE (fluorometholone) | Prednisolone sodium phosphate | |
| FML S.O.P. (fluorometholone) | | |
| ILEVRO (nepafenac) | | |
| ILUVIEN (fluocinolone) | | |
| Ketorolac tromethamine | | |
| LOTEMAX (loteprednol) | | |
| MAXIDEX (dexamethasone) | | |
| NEVANAC (nepafenac) | | |
| OZURDEX (dexamethasone) | | |
| PRED MILD (prednisolone) | | |
| PROLENSA (bromfenac) | | |
| RETISERT (fluocinolone) | | |
| TRIESENCE (triamcinolone) | | |
| VEXOL (rimexolone) | | |
| **OPHTHALMIC GLAUCOMA COMBINATION AGENTS** | | |
| **Category PA Criteria:** A 30-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions is indicated on the form. A 30-day trial of 2 preferred generics of the same medication will satisfy this requirement. | | |
| COMBIGAN (brimonidine/timolol) | COSOPT (dorzolamide/timolol) | |
| COSOPT PF (dorzolamide/timolol) | | |
| Dorzolamide/timolol | | |
| SIMBRINZA (brinzolamide/brimonidine) | | |
| **OPIOID ANALGESIC – LONG ACTING** | | |
| **Category PA Criteria:** A 30-day trial of a product containing fentanyl and one containing morphine will be required before a non-preferred agent will be authorized. For non-preferred agents to be authorized, patient must have required around-the-clock pain relief for the past 90 days and 3 months of the PDMP report must be reviewed and attached. | | |
| BUTRANS (buprenorphine) | BELBUCA (buprenorphine) | *** 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) | DURAGESIC (fentanyl) | |
| Fentanyl 12 mcg/hr[PA] | EXALGO (hydromorphone) | |
| Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr | Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | 87.5 mcg/hr | *** Belbuca, Hysingla, Fentanyl Patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr require a 30-day failed trial of Opana ER and Oxycontin in addition to category PA criteria.<br><br>***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 Opana ER and Oxycontin is required in addition to category PA criteria.<br>.<br>***Oxycodone ER, Zohydro ER – A 30-day failed trial of Opana ER will be required in addition to category PA criteria.<br><br>***Methadone requires a 30-day failed trial of Opana ER, Oxycontin, Butrans, tramadol ER, Nucynta ER in addition to category PA criteria. |
| Morphine ER tablets | Hydromorphone ER tablets | |
| NUCYNTA ER (tapentadol) | HYSINGLA ER (hydrocodone) | |
| Tramadol ER | KADIAN (morphine) | |
| | Methadone | |
| | Morphine ER capsules | |
| | MS CONTIN (morphine) | |
| | OPANA ER (oxymorphone) | |
| | oxycodone ER | |
| | OXYCONTIN (oxycodone) | |
| | oxymorphone ER tablets | |
| | ULTRAM ER (tramadol ER) | |
| | XARTEMIS XR (oxycodone/acetaminophen) | |
| | 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.<br>1. Patient must be 16 years of age or older.<br>2. Patient must not be taking other opioids, tramadol, or carisoprodol concurrently.<br>3. The prescriber must be registered to prescribe under the Substance Abuse and Mental Health Services Administration (SAMHSA) and provide his/her DEA number.<br>4. The prescriber and patient must have a contract or the prescriber must have developed a treatment plan.<br>5. The prescriber must perform routine drug screens.<br>6. The prescriber must routinely check the PDMP and attach the last 3 months of PDMP reports that have been reviewed.<br>7. The prescriber must be enrolled with ND Medicaid. | | |
| ZUBSOLV (buprenorphine/naloxone)[PA] | BUNAVAIL FILM (buprenorphine/naloxone) | *** Bunavail/Suboxone Film/buprenorphine will require a 30-day trial of buprenorphine/naloxone tablets in addition to the category PA criteria. |
| | Buprenorphine tablets | |
| | Buprenorphine-naloxone tablets | |
| | SUBOXONE FILM (buprenorphine/naloxone) | |

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

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



| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **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) | OCUFLOX (ofloxacin) | |
| CIPRODEX (ciprofloxacin/dexamethasone) | Ofloxacin | |
| Ciprofloxacin | | |
| OTOVEL (ciprofloxacin/fluocinolone) | | |
| **PHOSPHATE BINDERS** | | |
| **Category PA Criteria:** The following criteria will be required before a non-preferred agent will be authorized:<br>1. Patient must have had a 3-month trial of 3 preferred different chemical entities.<br>2. Patient must have end stage renal disease or chronic kidney disease.<br>3. Patients with chronic kidney disease stage 5 must have a phosphate level greater than 5.5 mg/dL.<br>4. All other patients must have a phosphate level greater than 4.6 mg/dL. | | |
| Calcium acetate capsule | AURYXIA (ferric citrate) TABLET | *** Fosrenol Powder Pack – A 3-month trial of Renvela Powder Pack will be required in addition to category PA criteria.<br><br>*** Velphoro – A 3-month trial of Auryxia will be required in addition to category PA criteria. |
| Calcium acetate tablet | FOSRENOL (lanthanum) POWDER PACK | |
| ELIPHOS (calcium acetate) TABLET | RENVELA (sevelamer) POWDER PACK | |
| FOSRENOL (lanthanum) CHEWABLE TABLET | VELPHORO (sucroferric oxyhydroxide) CHEWABLE TABLET | |
| PHOSLO (calcium acetate) CAPSULE | | |
| PHOSLYRA (calcium acetate) ORAL solution | | |
| RENAGEL (sevelamer) TABLET | | |
| RENVELA (sevelamer) TABLET | | |
| **PLATELET AGGREGATION INHIBITORS** | | |
| **Category PA Criteria:** A 30 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions is indicated on the form. | | |
| 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.<br><br>***Durlaza/Yosprala DR – Patient must have a reason that immediate release aspirin is not an option. |
| BRILINTA (ticagrelor) | DURLAZA (aspirin ER) | |
| Clopidogrel | PERSANTINE (dipyridamole) | |
| Dipyridamole | PLAVIX (clopidogrel) | |
| EFFIENT (prasugrel) | YOSPRALA DR (aspirin/omeprazole) | |
| Ticlopidine | ZONTIVITY (vorapaxar) | |
| **PULMONARY HYPERTENSION** | | |
| **PDE-5 Inhibitors** | | |

EFFECTIVE
January 1, 2017
Version 2017.1

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

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

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **Category PA Criteria:** A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All medications require an FDA-approved indication. | | |
| ADCIRCA (tadalafil)PA | REVATIO (sildenafil) SUSPENSION | ***Revatio Suspension – Patients 7 years and older will be required to submit documentation of their inability to ingest a solid dosage form.<br><br>***Sildenafil – A 30-day trial of Adcirca will be required for all patients younger than 18 years old. |
| SildenafilPA*** | REVATIO (sildenafil) TABLET | |
| | | |
| **Soluble Guanylate Cyclase Stimulators** | | |
| **Category PA Criteria:** Patients of childbearing potential must not be pregnant, be taking a reliable form of birth control, and have a pregnancy test before initiation and monthly during therapy. All medications require an FDA-approved indication. Patients must be at least 18 years of age. | | |
| ADEMPAS (riociguat)PA | | |
| **Endothelin Receptor Antagonist** | | |
| **Category PA Criteria:** Patients of childbearing potential must not be pregnant, be taking a reliable form of birth control, and have a pregnancy test before initiation and monthly during therapy. All medications require an FDA-approved indication. Patients must be at least 18 years of age. 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 (macitentan) | |
| **Prostacyclins** | | |
| **Category PA Criteria:** A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. Patients must be at least 18 years of age. | | |
| EpoprostenolPA | REMODULIN (treprostinil) | ***Ventavis 20 mcg/mL – A patient must be maintained at a 5 mcg dose and repeatedly experiencing incomplete dosing due to extended treatment time to be approved. |
| FLOLAN (epoprostenol)PA | TYVASO (treprostinil) | |
| ORENITRAM ER (treprostinil)PA | UPTRAVI (selexipag) | |
| VELETRI (epoprostenol)PA | VENTAVIS (iloprost) 20 mcg/mL | |
| VENTAVIS (iloprost) 10 mcg/mLPA | | |
| **STEROID/LONG ACTING BETA AGONIST (LABA) COMBINATION INHALERS** | | |
| **Category PA Criteria:** A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents must have an FDA-approved indication.<br><br>For COPD diagnosis, the following will be required in addition to the category PA criteria:<br>1. A 30-day trial of Tudorza Pressair, Spiriva, Incruse Ellipta, Anoro Ellipta, or Stiolto Respimat.<br>2. A 30-day trial of Anoro Ellipta, Stiolto Respimat, Foradil, Brovana, Arcapta, or Serevent.<br><br>For asthma diagnosis, patient must have been reviewed for step down therapy for all renewal requests. | | |
| ADVAIR DISKUS (fluticasone/salmeterol) | ADVAIR HFA (fluticasone/salmeterol) | |
| DULERA (mometasone/formoterol) | BREO ELLIPTA (fluticasone/vilanterol) | |

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

EFFECTIVE
January 1, 2017
Version 2017.1

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

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

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | SANCTURA ER (trospium) | |
| | Tolterodine | |
| | Tolterodine ER | |
| | Trospium | |
| | Trospium ER | |