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.**

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- This is NOT an all-inclusive list of medications covered by ND Medicaid. Please use the NDC Drug Lookup tool at 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 for PA criteria for medications not found on the PDL.

- Prior authorization criteria applies in addition to the general Drug Utilization Review policy that is in effect for the entire pharmacy program. Refer to http://www.hidesigns.com/ndmedicaid for applicable drug utilization management and coverage rules and therapeutic duplication edits.

- Prior authorization for a non-preferred agent with a preferred brand/generic equivalent in any category will be given only if an authorized generic is not available and all other criteria is met, including all DAW criteria, clinical criteria, and step therapy specific to that category.

- 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.

- 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.

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

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

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CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
ANTIDEMENTIA	Memantine ER added to preferred with criteria	
ANTIDEMENTIA	NAMENDA XR added to non-preferred	
ANTIRETROVIRALS - NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	CIMDUO (lamivudine/tenofovir) added to preferred	
ANTIRETROVIRALS - NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	SYMFI (efavirenz/lamivudine/tenofovir) added to preferred	Category PA criteria added
ANTIRETROVIRALS - PROTEASE INHIBITORS		Category PA criteria added
COPD - Long Acting Anticholinergics	LONHALA MAGNAIR (glycopyrrolate) added to non-preferred	
DIABETES - DPP4 INHIBITORS	JUVISYNC (sitagliptin/simvastatin) added to non-preferred	
DIABETES - DPP4 INHIBITORS		Category PA criteria updated
DIABETES - DPP4 INHIBITORS/SGLT2 INHIBITOR COMBINATIONS		Category PA criteria updated
DIABETES - GLP1 AGONISTS		Category PA criteria updated
DIABETES - INSULIN	Correction - HUMALOG U-200 (insulin lispro) KWIKPEN added to non-preferred	
DIABETES - INSULIN	TOUJEO MAX SOLOSTAR (insulin glargine) added to non-preferred	
DIABETES - INSULIN/GLP1 AGONISTS		Category PA criteria updated

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CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
DIABETES - SGLT2 INHIBITORS		Category PA criteria updated
MULTIPLE SCLEROSIS - Injectable Non-Interferons	ZINBRYTA (daclizumab) removed from PDL	
OPIOID ANALGESIC - LONG ACTING	CONZIP added to non-preferred	
OPIOID PARTIAL ANTAGONIST - OPIOID DEPENDENCE		Category PA Criteria & Bunavail/Suboxone Film Criteria updated
PROGESTERONES	new category added	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ADHD AGENTS		
Category PA Criteria: Branded non-preferred agents: A 10-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. Generic non-preferred agents: A 10-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized. 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)	*** Clonidine ER will require a 1-month trial of immediate release clonidine.
ADZENYS XR - ODT (amphetamine)	CONCERTA (methylphenidate)	
ADZENYS XR (amphetamine) SOLUTION	DEXEDRINE (dextroamphetamine)	
APTENSIO XR (methylphenidate)	Dexmethylphenidate ER	
Atomoxetine	Dextroamphetamine 5 mg/5 ml	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
Clonidine	Dextroamphetamine/amphetamine ER - Labelers 00115, 00228, 00555, 66993	
Clonidine ER[PA***]	FOCALIN (dexmethylphenidate)	
COTEMPLA XR - ODT (methylphenidate)	INTUNIV (guanfacine ER)	
DAYTRANA (methylphenidate)	KAPVAY (clonidine)	
DESOXYN (methamphetamine)	METADATE ER (methylphenidate)	
Dexmethylphenidate	METHYLIN (methylphenidate) chew tablets	
Dextroamphetamine	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		
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		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANGINA		
RANEXA (ranolazine)		
ANALGESICS - NSAIDS - TOPICAL		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. A medical reason must be provided why preferred agents do not work.		
diclofenac gel	DERMACINRX LEXITRAL (diclofenac/capsicum)	***Solaraze: Patient must have a diagnosis of actinic keratosis and have had a 6 month trial of imiquimod, as evidenced by paid claims or pharmacy print outs
FLECTOR (diclofenac) PATCH	VOLTAREN (diclofenac) GEL	
PENNSAID (diclofenac)	VOPAC MDS (diclofenac)	
SOLARAZE (diclofenac) GEL[PA***]	XRYLIX (diclofenac)	
ANDROGENS		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All agents require an FDA-approved indication.		
ANDROGEL (testosterone) PACKET 1%	AXIRON (testosterone) TOPICAL SOLUTION	
ANDROGEL (testosterone) PACKET 1.62%	FORTESTA (testosterone)	
ANDRODERM (testosterone)	NATESTO (testosterone)	
	TESTIM (testosterone)	
	TESTOPEL (testosterone)	
	Testosterone gel	
	Testosterone Gel MD PMP	
	Testosterone topical solution	
	VOGELXO (testosterone) GEL MD PMP	
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.		
BEVYXXA (Betrixaban)	SAVAYSA (edoxaban)	
ELIQUIS (Apixaban)		
PRADAXA (dabigatran)		
XARELTO (rivaroxaban)		
ANTICONVULSANTS		

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

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

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
SABRIL (vigabatrin)		
SABRIL (vigabatrin) POWDER PACK		
SPRITAM (levetiracetam)		
TEGRETOL (carbamazepine)		
Tiagabine		
Topiramate ER		
Topiramate sprinkle capsule		
Topiramate tablet		
TROKENDI XR (topiramate)		
Valproic acid capsule		
Valproic acid oral solution		
VIMPAT (lacosamide)		
VIMPAT (lacosamide) ORAL SOLUTION		
Zonisamide		
ANTIDEMENTIA		
Category PA Criteria: All agents will require an FDA indication for patients younger than 30 years old. Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. 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.		
Donepezil	ARICEPT (donepezil)	***Namenda XR – A 30-day trial of memantine IR will be required before Namenda XR will be authorized. Patient must not reside in nursing home.
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)	
Memantine ER***		
Rivastigmine		
ANTIDEPRESSANTS - NEW GENERATION		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. 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.		
Bupropion SR tablet	APLENZIN ER (bupropion)	
Bupropion tablet	CELEXA (citalopram)	
Bupropion XL tablet	CYMBALTA (duloxetine)	
Citalopram	Desvenlafaxine ER	
Citalopram oral solution	Desvenlafaxine fumarate ER	
Clomipramine	EFFEXOR XR (venlafaxine)	
Desvenlafaxine succinate ER	FORFIVO XL (bupropion)	
Duloxetine	IRENKA (duloxetine)	
Escitalopram	KHEDEZLA ER (desvenlafaxine)	
Escitalopram oral solution	LEXAPRO (escitalopram)	
FETZIMA (levomilnacipran)	LEXAPRO (escitalopram) ORAL SOLUTION	
Fluoxetine capsule	PAXIL (paroxetine)	
Fluoxetine DR	PAXIL CR (paroxetine)	
Fluoxetine solution	PRISTIQ ER (desvenlafaxine)	
Fluoxetine tablet	PROZAC (fluoxetine)	
Fluvoxamine	venlafaxine ER tablets	
Fluvoxamine ER	WELLBUTRIN (bupropion)	
Nefazodone	WELLBUTRIN SR (bupropion)	
OLEPTRO ER (trazodone)	WELLBUTRIN XL (bupropion)	
Paroxetine	ZOLOFT (sertraline)	
Paroxetine ER	ZOLOFT (sertraline) ORAL CONCENTRATE	
PAXIL (paroxetine) ORAL SUSPENSION		
PEXEVA (paroxetine)		
Sertraline		
Sertraline oral concentrate		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Trazodone		
TRINTELLIX (vortioxetine)		
Venlafaxine ER capsules		
Venlafaxine tablet		
VIIBRYD (vilazodone)		
ANTIRETROVIRALS - INTEGRASE STRAND TRANSFER INHIBITORS		
BIKTARVY (bictegravir/Emtricitabine/Tenofovir)		
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)		
ISENTRESS (raltegravir)		
JULUCA (dolutegravir/rilpivirine)		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)		
TIVICAY (dolutegravir)		
TRIUMEQ (abacavir/dolutegravir/lamivudine)		
ANTIRETROVIRALS - NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. 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.		
Abacavir	EPIVIR (lamivudine)	
Abacavir/lamivudine	EPZICOM (abacavir)	
Abacavir/lamivudine/zidovudine	TRIZIVIR (abacavir/lamivudine)	
ATRIPLA (efavirenz/emtricitabine/tenofovir)	VIDEX EC (didanosine)	
CIMDUO (lamivudine/tenofovir)	VIREAD (tenofovir)	
COMBIVIR (lamivudine/zidovudine)	ZERIT (stavudine)	
COMPLERA (emtricitabine/rilpivirine/tenofovir)	ZIAGEN (abacavir)	
DESCOVY (emtricitabine/tenofovir)		
Didanosine		
EMTRIVA (emtricitabine)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)		
Lamivudine		
Lamivudine/zidovudine		
ODEFSEY (emtricitabine/rilpivirine/tenofovir)		
RETROVIR (zidovudine)		
SYMFI (efavirenz/lamivudine/tenofovir)		
SYMFI LO (efavirenz/lamivudine/tenofovir)		
Stavudine		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)		
Tenofovir		
TRIUMEQ (abacavir/dolutegravir/lamivudine)		
TRUVADA (emtricitabine/tenofovir)		
VIDEX (didanosine)		
Zidovudine		
ANTIRETROVIRALS - PROTEASE INHIBITORS		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. 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.		
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)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PREZISTA (darunavir)		
RAYATAZ (atazanavir)		
VIRACEPT (nelfinavir)		
ATYPICAL ANTIPSYCHOTICS		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. 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.		
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	SEROQUEL XR (quetiapine)	
Olanzapine ODT	ZYPREXA (olanzapine)	
Olanzapine/fluoxetine	ZYPREXA ZYDIS (olanzapine)	
Paliperidone ER		
Quetiapine		
quetiapine ER		
REXULTI (brexpiprazole)		
Risperidone		
Risperidone ODT		
Risperidone oral solution		
SAPHRIS (asenapine)		
SYMBYAX (olanzapine/fluoxetine)		
VRAYLAR (cariprazine)		
Ziprasidone		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ATYPICAL ANTIPSYCHOTICS - LONG ACTING		
ABILIFY MAINTENA (aripiprazole)		
ARISTADA (aripiprazole lauroxil)		
INVEGA SUSTENNA (paliperidone)		
INVEGA TRINZA (paliperidone)		
RISPERDAL CONSTA (risperidone)		
ZYPREXA RELPREVV (olanzapine)		
CONSTIPATION - IRRITABLE BOWEL SYNDROME/OPIOID INDUCED		
Category PA Criteria: Patients must be 18 years old. All medications will require an FDA indication. For opioid-induced constipation, a paid claim for an opioid must be on patient's profile and a 30 day trial of Amitiza will be required before a non-preferred oral agent will be authorized. For idiopathic constipation, a 30 day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
AMITIZA (lubiprostone)	MOVANTIK (naloxegol)	***Linzess – A 30-day trial of Amitiza is required before Linzess will be authorized. ***Relistor Syringe/Vial – Documentation must be submitted to show inability to swallow a solid dosage form ***Relistor tablets - A 30 day trial of Movantik is required before Relistor tablets will be authorized
LINZESS (linaclotide)[PA***]	RELISTOR (methylnaltrexone) SYRINGE***	
	RELISTOR (methylnaltrexone) TABLET***	
	RELISTOR (methylnaltrexone) VIAL***	
	SYMPROIC (naldemedine)	
	TRULANCE (plecanatide)	
COPD		
Category PA Criteria: All agents indicated only for COPD will require verification of FDA-approved indication.		
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) will require a 30 day trial of Incruse Ellipta and Tudorza Pressair in addition to Category PA Criteria
	LONHALA MAGNAIR (glycopyrrolate)	
	SEEBRI NEOHALER (glycopyrrolate)	
	SPIRIVA RESPIMAT 2.5 MG (tiotropium)***	
	TUDORZA PRESSAIR (aclidinium)	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Long Acting Beta Agonists		
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)***	
Combination Anticholinergics/Long Acting Beta Agonists		
Group PA Criteria: A 30-day trial of 2 long acting preferred products will be required before a non-preferred agent (short or long acting) will be authorized.		
Albuterol/ipratropium	COMBIVENT RESPIMAT (albuterol/ipratropium)	
ANORO ELLIPTA (umeclidinium/vilanterol)	DUONEB (albuterol/ipratropium)	
BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	STIOLTO RESPIMAT (tiotropium/olodaterol)	
	UTIBRON NEOHALER (glycopyrrolate/indacaterol)	
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. Inhaled Steroid		
	DALIRESP (roflumilast)	
CYSTIC FIBROSIS INHALED ANTIBIOTICS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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)	ACTEMRA (tocilizumab)	
ENBREL (etanercept)	CIMZIA (certolizumab)	
HUMIRA (adalimumab)	KEVZARA (sarilumab)	
HUMIRA PSORIASIS (adalimumab)	KINERET (anakinra)	
	ORENCIA (abatacept)	
	OTEZLA (apremilast)	
	SILIQ (brodalumab)	
	SIMPONI (golimumab)	
	STELARA (ustekinumab)	
	TALTZ (ixekizumab)	
	TREMFYA (guselkumab)	
	XELJANZ (tofacitinib)	
	XELJANZ XR (tofacitinib)	
DIABETES - DPP4 INHIBITORS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: Non preferred agents will require: 1. An FDA indication. 2. A trial of metformin with good compliance over for past 3 months 3. A 30 day trial of 1 sitagliptin preferred product (Janumet, Janumet XR, or Januvia) and 1 linagliptin preferred product (Jentadueto or Tradjenta). 4. Concurrent metformin therapy – this condition will be considered met if requested product is a metformin combination agent.		
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	
JANUVIA (sitagliptin)	alogliptin/metformin	
JENTADUETO (linagliptin/metformin)	JENTADUETO XR (linagliptin/metformin)	
KOMBIGLYZE XR (saxagliptin/metformin)	JUVISYNC (sitagliptin/simvastatin)	
ONGLYZA (saxagliptin)[PA***]	KAZANO (alogliptin/metformin)	
TRADJENTA (linagliptin)	NESINA (alogliptin)	
	OSENI (alogliptin/pioglitazone)	
DIABETES - DPP4 INHIBITORS/SGLT2 INHIBITOR COMBINATIONS		
Category PA Criteria: Non preferred agents will require: 1. An FDA indication. 2. A trial of metformin with good compliance over for past 3 months 3. A 30 day trial of a canagliflozin and a 3-month trial of a empagliflozin agent. 4. A 30 day trial of 1 sitagliptin preferred product (Janumet, Janumet XR, or Januvia) and 1 linagliptin preferred product (Jentadueto or Tradjenta). 5. Concurrent metformin therapy – this condition will be considered met if requested product is a metformin combination agent.		
	GLYXAMBI (empagliflozin/linagliptin)	
	STEGLUJAN (Ertugliflozin/Sitagliptin)	
	QTERN (Dapagliflozin/Saxagliptin)	
DIABETES - GLP1 AGONISTS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: All agents will require: 1. An FDA indication 2. Concurrent metformin therapy. 3. A trial of metformin with good compliance over for past 3 months Non preferred agents will require: 1. A 30-day trial of 2 preferred agents.		
BYDUREON (exenatide microspheres)	ADLYXIN (lixisenatide)	
BYETTA (exenatide)	BYDUREON BCISE (exenatide microspheres)	
VICTOZA (liraglutide)	OZEMPIC (semaglutide)	
	TANZEUM (albiglutide)	
	TRULICITY (dulaglutide)	
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 trial of metformin with good compliance over for past 3 months		
	SOLIQUA (Insulin glargine/lixisenatide)	
	XULTOPHY (insulin degludec/liraglutide)	
DIABETES - INSULIN		
Syringe/Pens: • Prescriber must provide a reason why patient needs to use a syringe/pen instead of a vial, subject to clinical review **Vials of non-preferred insulin:** • Patient must have failed a 30 day trial of a preferred insulin: Humalog, Humalox Mix 50/50, Humalog Mix 75/25, Humulin 70/30, Humulin N, Humulin R, Humulin R U-500, Lantus, Levemir, Novolin R, Novolog, or Novolog Mix 70/30, as evidenced by paid claims or pharmacy print outs.		
APIDRA (insulin glulisine) VIAL	ADMELOG (insulin lispro) VIAL	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	ADMELOG SOLOSTAR (insulin lispro) INSULIN PEN	***Fiasp •Patient must have had 3 month trial with Novolog, Humalog, and Apidra ***Tresiba U-1 00 & Basaglar: •Patient must fail a 3 month trial of both Lantus and Levemir with good compliance, as evidenced by paid claims or pharmacy print outs. ***Toujeo/Toujeo Max/Tresiba U-200: •Patient must require a minimum of 100 units/day of Lantus or Levemir for a minimum of 3 months with good compliance, as evidenced by paid claims or pharmacy print outs.
HUMALOG (insulin lispro) VIAL	AFREZZA (insulin regular, human)	
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	BASAGLAR KWIKPEN U-100 (insulin glargine)***	
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	FIASP (insulin aspart) FLEXTOUCH***	
HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL	FIASP (insulin aspart) VIAL***	
HUMULIN N (insulin NPH human isophane) VIAL	HUMALOG (insulin lispro) CARTRIDGE	
HUMULIN R (insulin regular, human) VIAL	HUMALOG JUNIOR KWIKPEN (insulin lispro)	
HUMULIN R U-500 (insulin regular, human) VIAL	HUMALOG MIX 50/50 (insulin NPL/insulin lispro) KWIKPEN	
LANTUS (insulin glargine) SOLOSTAR	HUMALOG MIX 75/25 (insulin NPL/insulin lispro) KWIKPEN	
LANTUS (insulin glargine) VIAL	HUMALOG U-100 (insulin lispro) KWIKPEN	
LEVEMIR (insulin detemir) VIAL	HUMALOG U-200 (insulin lispro) KWIKPEN	
LEVEMIR (insulin detemir) FLEXTOUCH	HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN	
NOVOLIN R (insulin regular, human) VIAL	HUMULIN N (insulin NPH human isophane) KWIKPEN	
NOVOLOG (insulin aspart) CARTRIDGE	HUMULIN R (Insulin regular, human) U-500 KWIKPEN	
NOVOLOG (insulin aspart) FLEXPEN	NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL	
NOVOLOG (insulin aspart) VIAL	NOVOLIN N (insulin NPH human isophane) VIAL	
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN	TOUJEO MAX SOLOSTAR (insulin glargine)***	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL	TOUJEO SOLOSTAR (insulin glargine)***	
	TRESIBA (insulin degludec) FLEXTOUCH U-100***	
	TRESIBA (insulin degludec) FLEXTOUCH U-200***	
DIABETES - SGLT2 INHIBITORS		
Category PA Criteria: Non-preferred agents will require: 1. An FDA indication. 2. A trial of metformin with good compliance over for past 3 months 3. A 30 day trial of a canagliflozin and a 30 day 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)	
INVOKANA (canagliflozin)	INVOKAMET XR (canagliflozin/metformin)	
JARDIANCE (empagliflozin)	STEGLATRO (ertugliflozin)	
SYNJARDY (empagliflozin/metformin)	STEGLATROMET (ertugliflozin/metformin)	
SYNJARDY XR (empagliflozin/metformin)	XIGDUO XR (dapagliflozin/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.		
loperimide	alosetron***	***Alosetron– Patient must be a female.
LOTRONEX (alosetron)***		
VIBERZI (eluxadoline)		
XIFAXIN (rifaximin) 550 mg tablet		
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)	
	ULTRESA (lipase/protease/amylase)	
	VIOKACE (lipase/protease/amylase)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
EPINEPHRINE AUTOINJECTORS		
Category PA Criteria: Medical justification must be provided for why the preferred product will not work.		
epinephrine - labeler 49502	ADRENACLICK (epinephrine)	
	epinephrine - labelers 00115, 54505	
	EPIPEN (epinephrine)	
	EPIPEN JR (epinephrine)	
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)	
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, COLONY STIMULATING FACTORS		
GRANIX (TBO-Filgrastim)		
LEUKINE (Sargramostim)		
NEULASTA (Pegfilgrastim)		
NEUPOGEN (Filgrastim)		
ZARXIO (Filgrastim-SNDZ)		
HEMATOPOIETIC, ERYTHROPOIESIS STIMULATING AGENTS		
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.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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 a documented FDA-approved diagnosis. Chronic Hepatitis C must be documented by one of the following:
   a. Unknown Liver fibrosis: 2 positive HCV RNA levels at least 6 months apart
   b. Liver fibrosis F1 and below: 2 positive HCV RNA levels at least 6 months apart
   c. Liver fibrosis F2 and above: 1 positive HCV RNA test within the last 12 months
2. Patient must be an FDA-approved age.
3. Patient must be drug (illicit use of drugs by injection) and alcohol free as documented by 2 drug and alcohol tests dated at least 3 months apart and meet criteria as outlined below:
   a. If the patient has a history of alcohol use disorder, the patient must:
      i. Have completed or currently be in a treatment program from an enrolled addiction medicine/chemical dependency provider and provider attests patient has maintained sobriety from alcohol for at least 3 months
   b. If the patient has a history of illicit use of drugs by injection, the patient must:
      i. Have completed or currently be in a treatment program from an enrolled addiction medicine/chemical dependency provider (or buprenorphine waived provider) and provider attests patient has maintained sobriety from said drug use for at least 3 months
4. Patient must attest that they will continue treatment without interruption for the duration of therapy.
5. Prescriber must be, or consult with, a hepatologist, gastroenterologist, or infectious disease specialist.
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.

PA approval duration will be based on label recommendation.

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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**
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-Pugh C)
MAVYRET (glecaprevir/pibrentasvir)[PA***]	HARVONI (ledipasvir/sofosbuvir)	
	OLYSIO (simeprevir)	
	SOVALDI (sofosbuvir)	
	TECHNIVIE (ombitasvir/paritaprevir/ritonavir)	
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)	
	VIEKIRA PAK XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)	
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)	
	ZEPATIER (elbasvir/grazoprevir)	
LICE		
Category PA Criteria: A 28-day/2-application trial of each of the preferred agents will be required before a non-preferred agent will be authorized. This requirement will be waived in the presence of a documented community breakout of a resistant strain that is only susceptible to a non-preferred agent.		
EURAX (crotamiton) CREAM	ELIMITE (permethrin) CREAM	
LICE SOLUTION (piperonyl butoxide/pyrethrins)	EURAX (crotamiton) LOTION	
NATROBA (spinosad)	Malathion	
Permethrin cream	OVIDE (malathion)	
SKLICE (ivermectin)	Spinosad	
ULESFIA (benzyl alcohol)		
MIGRAINE PROPHYLAXIS - 5HT(1) AGONISTS		

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

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EFFECTIVE
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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: Patients able to take oral medications: **-**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 mg in the past 24 months will be required before a non-preferred agent will be authorized. Patients not able to take oral medications (as evidenced by swallow study documentation): -A 30-day trial of rizatriptan ODT in the past 24 months will be required before a non-preferred agent will be authorized.		
RELPAX (eletriptan)	Almotriptan	***Sumatriptan Nasal Spray: - Patient must fail a 30 day trial of all of the following within the past 24 months, as evidenced by paid claims or pharmacy print outs: o Zolmitriptan Nasal Spray 5mg o Onzetra Xsail 22mg ***Zolmitriptan tablet: - Patient must fail a 30 day trial of naratriptan 2.5mg within the past 24 months, as evidenced by paid claims or pharmacy print outs ***Sumatriptan syringe/cartridge, Frovatriptan, Almotriptan, Treximet: - Medical justification must be provided as to why another triptans won't work - Patient must fail a 30 day trial of all other available triptans within the past 24 months, as evidenced by paid claims or pharmacy print outs
Rizatriptan	ALSUMA (sumatriptan) PEN INJCTR***	
Rizatriptan ODT	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***	
	Sumatriptan spray***	
	Sumatriptan syringe***	
	Sumatriptan vial	
	SUMAVEL DOSEPRO (sumatriptan)	
	TREXIMET (sumatriptan/naproxen)***	
	Zolmitriptan***	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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***	***Copaxone 40mg/ml/Glatopa/glatiramir: • A reason must be indicated why Copaxone 20 mg/mL will not work.
	glatiramer 20mg/ml***	
	glatiramer 40mg/ml***	
	Glatopa (glatiramer)***	
Oral Non-Interferons		

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
THERAPEUTIC DRUG CLASS		
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 ALPHA ADRENERGICS - GLAUCOMA		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. 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.		
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)		
OPHTHALMIC ANTIHISTAMINES		
Category PA Criteria: A 30-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized.		
ALOMIDE (lodoxamide)	ALOCRIL (nedocromil)	
Azelastine	ELESTAT (epinastine)	
BEPREVE (bepotastine)	EMADINE (emedastine)	
Cromolyn	Epinastine	
LASTACAFT (alcaftadine)	Olopatadine 0.2%	
Olopatadine 0.1%	PATANOL 0.1% (olopatadine)	
PATADAY 0.2% (olopatadine)		
PAZEO (olopatadine)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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.		
Bacitracin/polymyxin ointment	Bacitracin ointment	
BESIVANCE (besifloxacin) DROPS	BLEPH-10 (sulfacetamide) DROPS	
CILOXAN (ciprofloxacin) OINTMENT	CILOXAN (ciprofloxacin) DROPS	
Ciprofloxacin drops	Gatifloxacin drops	
Erythromycin ointment	GENTAK (gentamicin sulfate) OINTMENT	
Gentamicin sulfate drops	Levofloxacin drops	
Gentamicin sulfate ointment	moxifloxacin drops	
MOXEZA (moxifloxacin) DROPS	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) OINTMENT	
Neomycin SU/bacitracin/polymyxin B ointment	NEOSPORIN (neomycin SU/polymyxin B/gramicidin) DROPS	
Neomycin SU/polymyxin B/gramicidin drops	OCUFLOX (ofloxacin) DROPS	
Ofloxacin drops	POLYCIN (bacitracin/polymyxin) OINTMENT	
Polymyxin B/trimethoprim drops	POLYTRIM (polymyxin B/trimethoprim) DROPS	
Sulfacetamide drops	Sulfacetamide ointment	
Tobramycin drops	TOBREX (tobramycin) DROPS	
TOBREX (tobramycin) OINTMENT	VIGAMOX (moxifloxacin) DROPS	
	ZYMAXID (gatifloxacin) 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.		
Neomycin/bacitracin/polymyxin b/hydrocortisone ointment	BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone) ointment	
BLEPHAMIDE (sulfacetamide/prednisolone) DROPS	MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS	
Neomycin/polymyxin b/dexamethasone drops	MAXITROL (neomycin/polymyxin b/dexamethasone) OINTMENT	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Neomycin/polymyxin b/dexamethasone ointment	Neomycin/polymyxin b/hydrocortisone drops	
PRED-G (gentamicin/prednisol ac) DROPS	NEO-POLYCIN HC (neomycin SU/bacitracin/polymyxin B/hydrocortisone) OINTMENT	
PRED-G (gentamicin/prednisol ac) OINTMENT	TOBRADEX ST (tobramycin/dexamethasone) DROPS	
Sulfacetamide/prednisolone drops	Tobramycin/dexamethasone	
TOBRADEX (tobramycin/dexamethasone) DROPS		
TOBRADEX (tobramycin/dexamethasone) OINTMENT		
ZYLET (tobramycin/lotepred etab) DROPS		
OPHTHALMIC ANTIINFLAMMATORIES		
Category PA Criteria: A 5-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
ACUVAIL (ketorolac)	ACULAR (ketorolac)	
ALREX (loteprednol)	ACULAR LS (ketorolac)	
Diclofenac sodium	Bromfenac sodium	
DUREZOL (difluprednate)	BROMSITE (bromfenac sodium)	
FLAREX (fluorometholone)	Dexamethasone sodium phosphate	
Fluorometholone	FML (fluorometholone)	
Flurbiprofen sodium	LOTEMAX (loteprednol) GEL DROPS	
FML FORTE (fluorometholone)	LOTEMAX (loteprednol) OINTMENT	
FML S.O.P. (fluorometholone)	OCUFEN (flurbiprofen)	
ILEVRO (nepafenac)	OMNIPRED 1% (prednisolone acetate)	
ketorolac tromethamine 0.4%	PRED FORTE 1% (prednisolone acetate)	
Ketorolac tromethamine 0.5%	Prednisolone acetate 1%	
LOTEMAX (loteprednol) DROPS	PROLENSA (bromfenac)	
MAXIDEX (dexamethasone)		
NEVANAC (nepafenac)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PRED MILD 0.12% (prednisolone acetate)		
Prednisolone sodium phosphate 1%		
OPHTHALMIC IMMUNOMODULATORS - DRY EYE SYNDROME		
Restasis (cyclosporine)		
Restasis multidose (cyclosporine)		
Xiidra (lifitegrast)		
OPIOID ANALGESIC - LONG ACTING		
Category PA Criteria: For non-preferred agents to be authorized: 1. Patient must have required around-the-clock pain relief for the past 90 days 2. The past 3 months of North Dakota PDMP reports must have been reviewed by the prescriber.		
butorphanol	ARYMO ER (oxycodone)***	*** Hysingla ER, oxymorphone ER, Zohydro ER require 30-day trials of fentanyl, morphine, and oxycodone products in addition to Category PA Criteria ***Belbuca- Patient must have failed 30-day trials of Butrans, Nucynta ER, and tramadol ER in additional 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. Patient must have failed 30-day trials of fentanyl, morphine, and oxycodone products in addition to Category PA Criteria ***Methadone, Fentanyl Patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr, morphine ER capsules, Arymo ER, Morphabond ER, and Oxycontin - Clinical justification must be given for why another product will not work in additional to Category PA Criteria. *** Fentanyl 12 mcg/hr – The total daily opioid dose must be less than 60 Morphine Equivalent Dose (MED) in additional to Category PA Criteria
BUTRANS (buprenorphine) PATCHES	BELBUCA (buprenorphine)***	
EMBEDA (morphine/naltrexone)	buprenorphine patches	
Fentanyl 12 mcg/hr[PA***]	CONZIP (tramadol ER)	
Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	DURAGESIC (fentanyl)	
levorphanol	EXALGO (hydromorphone)***	
Morphine ER tablets	Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr***	
NUCYNTA ER (tapentadol)	Hydromorphone ER tablets***	
pentazocine-naloxone	HYSINGLA ER (hydrocodone)***	
	KADIAN (morphine)***	
	Methadone***	
	MORPHABOND ER (morphine)***	
	Morphine ER capsules***	
	MS CONTIN (morphine)	
	Oxycodone ER***	
	OXYCONTIN (oxycodone)***	
	Oxymorphone ER tablets***	
	Tramadol ER***	
	ULTRAM ER (tramadol ER)	
	XTAMPZA ER (oxycodone)***	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ZOHYDRO ER (hydrocodone)***	***Tramadol ER - Patient must have failed two 30-day trials of preferred medications in additional to Category PA Criteria ***Xtampza ER - Patient must have failed 30-day trials of fentanyl and morphine products in addition to Category PA Criteria
OPIOID ANTAGONIST - OPIOID AND ALCOHOL DEPENDENCE		
VIVITROL (Naltrexone Microspheres)		
OPIOID PARTIAL ANTAGONIST - OPIOID DEPENDENCE		
Category PA Criteria: A 30-day trial of the preferred agent will be required before a non-preferred agent will be authorized. The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review). 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 the last 3 months of North Dakota PDMP reports must have been reviewed by the prescriber. 7. The prescriber must be enrolled with ND Medicaid.		
ZUBSOLV (buprenorphine/naloxone)[PA]	BUNAVAIL FILM (buprenorphine/naloxone)***	*** Bunavail/Suboxone Film will require a 30-day trial of buprenorphine/naloxone tablets in addition to the category PA criteria. The prescriber must submit medical justification explaining why the patient cannot use buprenorphine/naloxone tablets (subject to clinical review). ***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 drops	
Ciprofloxacin drops	OTIPRIO (ciprofloxacin)	
OTOVEL (ciprofloxacin/fluocinolone)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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	
Calcium acetate tablet	ELIPHOS (calcium acetate) TABLET	
FOSRENOL (lanthanum) CHEWABLE TABLET	FOSRENOL (lanthanum) POWDER PACK	
PHOSLYRA (calcium acetate) ORAL solution	Lanthanum	
RENAGEL (sevelamer) TABLET	RENVELA (sevelamer carbonate) TABLET	
RENVELA (sevelamer) POWDER PACK	sevelamer powder pack	
sevelamer tablets	VELPHORO (sucroferric oxyhydroxide)	
PLATELET AGGREGATION INHIBITORS		
Category PA Criteria: A 30 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions is indicated on the form.		
Aspirin/dipyridamole ER	AGGRENOX (aspirin/dipyridamole)	***Zontivity – Patient must be 18 years of age or older. Zontivity must be taken with aspirin and/or clopidogrel. Patient must not have a history of stroke, transient ischemic attack, or intracranial hemorrhage. ***Durlaza/Yosprala DR – Patient must have a reason that immediate release aspirin is not an option.
BRILINTA (ticagrelor)	Clopidogrel 300mg	
Clopidogrel 75 mg	DURLAZA (aspirin ER)***	
Dipyridamole	EFFIENT (prasugrel)	
Ticlopidine	PERSANTINE (dipyridamole)	
	PLAVIX (clopidogrel)	
	prasugrel	
	YOSPRALA DR (aspirin/omeprazole)***	
	ZONTIVITY (vorapaxar)***	
PROGESTERONES		
Category PA Criteria: All medications require an FDA-approved indication. Non-preferred agents will require a 30-day trial of all preferred medications.		
MAKENA (hydroxyprogesterone caproate)[PA]***	hydroxyprogesterone caproate	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		***Makena auto-injector is the preferred product for subcutaneous (Sub-Q) administration of hydroxyprogesterone caproate via pharmacy point of sale billing. Intramuscular (IM) administration of hydroxyprogesterone caproate must be billed on the medical side via 837I and 837P transactions.
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.		
Sildenafil[PA]	ADCIRCA (tadalafil)	***Revatio Suspension – Patients 7 years and older will be required to submit documentation of their inability to ingest a solid dosage form.
	REVATIO (sildenafil) SUSPENSION***	
	REVATIO (sildenafil) TABLET	
Soluble Guanylate Cyclase Stimulators		
Category PA Criteria: All medications require an FDA-approved indication. 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. Patient may not be taking with nitrates of any form or specific (sildenafil or tadalafil) or non-specific (dipyridamole or theophylline) PDE-5 inhibitors.		
ADEMPAS (riociguat)		
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)	LETAIRIS (ambrisentan)***	***Opsumit - A 30 day trial of Letairis will be required in addition to category PA criteria
	OPSUMIT (macitentan)***	
Prostacyclins		
Category PA Criteria: All medications require an FDA-approved indication. A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
ORENITRAM ER (treprostinil)	TYVASO (treprostinil)	
REMODULIN (treprostinil)	UPTRAVI (selexipag)	
VENTAVIS (iloprost)		
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.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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, Incruse Ellipta, or Seebri Neohaler 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, Bevespi Aerosphere, or Trelegy Ellipta For asthma diagnosis, patient must have been reviewed for step down therapy for all renewal requests.		
ADVAIR DISKUS (fluticasone/salmeterol)	BREO ELLIPTA (fluticasone/vilanterol)	
ADVAIR HFA (fluticasone/salmeterol)	fluticasone/salmeterol	
AIRDUO RESPICLICK (fluticasone/salmeterol)		
DULERA (mometasone/formoterol)		
SYMBICORT (budesonide/formoterol)		
STEROIDs - INHALED		
Category PA Criteria: Inhalers: A 30-day trial of all preferred inhalers will be required before a non-preferred agent will be authorized. Inhaled suspensions (nebulizers): Non-preferred Brand medication: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. Non-preferred Generic medication: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized.		
ALVESCO (ciclesonide)	AEROSPAN (flunisolide)	
ASMANEX (mometasone) TWISTHALER	ARMONAIR RESPICLICK (fluticasone)	
budesonide suspension 0.25 mg/2 mL	ARNUITY ELLIPTA (fluticasone)	
budesonide suspension 0.5 mg/2 mL	ASMANEX HFA (mometasone)	
FLOVENT HFA (fluticasone)	budesonide suspension 1 mg/2 mL	
PULMICORT FLEXHALER (budesonide)	FLOVENT DISKUS (fluticasone)	
PULMICORT RESPULES (budesonide) 1 MG/2 ML	PULMICORT RESPULES (budesonide) 0.25 mg/2 mL	
QVAR (beclomethasone)	PULMICORT RESPULES (budesonide) 0.5 mg/2 mL	
	QVAR REDIHALER (beclomethasone)	

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
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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
THERAPEUTIC DRUG CLASS		
ULCERATIVE COLITIS AGENTS - 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		
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 Myrbetriq will require a 1-month trial of trospium and tolterodine/tolterodine ER 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***	