

**North Dakota Medicaid**

# **Preferred Drug List (PDL)**

## **& Prior Authorization Criteria**



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## Guiding Rules of the Preferred Drug List (PDL):

- 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. Visit <http://www.hidesigns.com/ndmedicaid> for more information on medications not found in this list.
- 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 apply 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.
- A trial will be considered a failure if a product was not effective at maximum tolerated dose with good compliance, as evidenced by paid claims or pharmacy print outs or patient has a documented intolerance or adverse reaction to an ingredient.
- Length of prior authorizations is a year unless otherwise specified.
- Rational of inability to swallow a solid dosage form must be provided after age 9 for all non-solid oral dosage forms.
- Acronyms  
PA – Indicates preferred agents that require clinical prior authorization.  
\*\*\* - Indicates that additional PA criteria applies as indicated in the Product PA Criteria

## Changes Since Last Version:

Category	Product Status Changes	Criteria Changes
ADHD Agents	Kapvay removed from PDL	
Antiretroviral Integrase Strand Transfer Inhibitors	DOVATO (Dolutegravir/Lamivudine) added to preferred	
Atopic Dermatitis		Dupixent Criteria updated
Atopic Dermatitis	Elidel moved to non-preferred, Pimecrolimus – Labeler 68682 moved to preferred	
Cytokine Modulators	SKYRIZI (risankizumab-rzaa) added to non-preferred	Criteria updated
Epinephrine Autoinjectors	Removed from PDL	
GLP-1 Agonists	Tanzeum removed from PDL	
Hematopoietic, Colony Stimulating Factors	FULPHILA (Pegfilgrastim-JMDB) and UDENYCA (pegflgrastim-CBQV) moved to preferred	
Hepatitis C		Criteria updated
Insulin	HUMALOG (insulin lispro) CARTRIDGE and NOVOLIN N (insulin NPH human isophane) VIAL moved to preferred	
Lice	CROTAN (Crotamiton) added to non-preferred	
Ophthalmic – Anti-infectives	Moxifloxacin drops moved to preferred	
Ophthalmic – Anti-inflammatories	LOTEMAX (loteprednol) OINTMENT moved to preferred, LOTE MAX (loteprednol) GEL DROPS moved to preferred.	
Ophthalmic – Dry Eye Syndrome	CEQUA (Cyclosporine) added to non-preferred	
Ophthalmic Glaucoma - Other	ROCKLATAN (Netarsudil/Latanoprost) added to preferred	
Opioid Analgesics – Long Acting	Butrans 20mcg/hr moved to preferred	
Otic Anti-infectives – Fluoroquinolones	Ciprofloxacin drops removed from PDL	
PCSK9 Inhibitors		Criteria updated
Pulmonary Hypertension Endothelin Receptor Antagonists	Ambrisentan generic added to preferred. Letairis moved to non-preferred.	

### North Dakota Medicaid Preferred Drug List

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Phosphate Binder	Eliphos (calcium acetate) removed from PDL. Sevelamer HCl added to non-preferred	
Pulmonary Hypertension - PDE-5 Inhibitors	Adcirca (tadalafil) moved to non-preferred, tadalafil moved to preferred	

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## 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.

### Product PA Criteria:

\*\*\* Clonidine ER: require a 1-month trial of immediate release clonidine.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ADZENYS XR - ODT (amphetamine)	ADDERALL (dextroamphetamine/amphetamine)
ADZENYS ER (amphetamine) SOLUTION	ADDERALL XR (dextroamphetamine/amphetamine)
APTENSIO XR (methylphenidate)	amphetamine
Atomoxetine	Clonidine ER <sup>PA***</sup>
Clonidine	DEXEDRINE (dextroamphetamine)
CONCERTA (methylphenidate)	Dexmethylphenidate ER
COTEMPLA XR - ODT (methylphenidate)	Dextroamphetamine
DAYTRANA (methylphenidate)	Dextroamphetamine 5 mg/5 ml
DESOXYN (methamphetamine)	FOCALIN (dexmethylphenidate)
Dexmethylphenidate	INTUNIV (guanfacine ER)
Dextroamphetamine ER	METADATE ER (methylphenidate)
Dextroamphetamine/amphetamine	METHYLIN (methylphenidate) chew tablets
Dextroamphetamine/amphetamine ER	Methamphetamine
DYANAVEL XR (amphetamine)	Methylphenidate ER 72 mg
EVEKEO (amphetamine)	Methylphenidate ER tablet
FOCALIN XR (dexmethylphenidate)	METHYLIN (methylphenidate) solution
Guanfacine ER	RELEXXII (methylphenidate)
Methamphetamine	RITALIN (methylphenidate)
Methylphenidate solution	RITALIN LA (methylphenidate LA capsules - 50-50)
Methylphenidate CD 30-70	STRATTERA (atomoxetine)
Methylphenidate chew tablet	
Methylphenidate ER capsules 50-50	
Methylphenidate LA capsules - 50-50	
Methylphenidate tablet	
MYDAYIS (amphetamine/dextroamphetamine)	
PROCENTRA (dextroamphetamine)	
QUILLICHEW ER (methylphenidate)	
QUILLIVANT XR (methylphenidate)	
VYVANSE (lisdexamfetamine)	
VYVANSE (lisdexamfetamine) CHEW TABLET	
ZENZEDI (dextroamphetamine)	

## Angina:

PREFERRED AGENTS	NON-PREFERRED AGENTS
RANEXA (ranolazine)	Ranolazine ER



## 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
FLECTOR (diclofenac) PATCH	diclofenac gel
PENNSAID (diclofenac)	
VOLTAREN (diclofenac) GEL	

## 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. Medical justification must be provided why patient can't use a preferred product (subject to clinical review).

### Injectable/Implantable

PREFERRED AGENTS	NON-PREFERRED AGENTS
Testosterone cypionate injection	AVEED (testosterone undecanoate)
Testosterone enanthate injection	TESTOPEL (testosterone)
	XYOSTED (testosterone enanthate)

### Oral

PREFERRED AGENTS	NON-PREFERRED AGENTS
	ANDROID (methyltestosterone)
	Methyltestosterone
	METHITEST (methyltestosterone)
	STRIANT (testosterone)
	TESTRED (methyltestosterone)

### Topical/Nasal

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANDROGEL (testosterone)	AXIRON (testosterone) TOPICAL SOLUTION
ANDRODERM (testosterone)	FORTESTA (testosterone)
	TESTIM (testosterone)
	NATESTO (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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
BEVYXXA (Betrixaban)	SAVAYSA (edoxaban)
ELIQUIS (Apixaban)	
PRADAXA (dabigatran)	
XARELTO (rivaroxaban)	

## Anticonvulsants:

### Category PA Criteria:

Branded non-preferred agents: A 30-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.

Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.

PREFERRED AGENTS	NON-PREFERRED AGENTS
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 tablet	LAMICTAL (lamotrigine)
Felbamate oral suspension	LAMICTAL (lamotrigine) CHEWABLE TABLET
FYCOMPA (perampanel)	LAMICTAL (lamotrigine) DOSE PACK
FYCOMPA (perampanel) ORAL SUSPENSION	MYSOLINE (primidone)
Gabapentin capsule	NEURONTIN (gabapentin) CAPSULE
Gabapentin oral solution	NEURONTIN (gabapentin) ORAL SOLUTION
Gabapentin tablet	NEURONTIN (gabapentin) TABLET
GABITRIL (tiagabine)	QUDEXY XR (topiramate)
LAMICTAL ER (lamotrigine) DOSE PACK	TEGRETOL XR (carbamazepine)
LAMICTAL ODT (lamotrigine)	TEGRETROL (carbamazepine oral suspension)
LAMICTAL ODT (lamotrigine) DOSE PACK	tiagabine
LAMICTAL XR (lamotrigine)	TOPAMAX (topiramate)
Lamotrigine chewable tablet	TOPAMAX (topiramate) SPRINKLE CAPSULE
Lamotrigine dose pack	TRILEPTAL (oxcarbazepine)
Lamotrigine ER	TRILEPTAL (oxcarbazepine) ORAL SUSPENSION

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Lamotrigine ODT	vigabatrin
Lamotrigine tablet	vigabatrin powder pack
Levetiracetam ER	VIGADRONE (vigabatrin)
Levetiracetam oral solution	ZARONTIN (ethosuximide)
Levetiracetam tablet	ZARONTIN (ethosuximide) ORAL SOLUTION
LYRICA (pregabalin)	ZONEGRAN (zonisamide)
LYRICA (pregabalin) ORAL SOLUTION	
Oxcarbazepine oral solution	
Oxcarbazepine tablet	
OXTELLAR XR (oxcarbazepine)	
PEGANONE (Ethoin)	
Phenobarbital elixir	
Phenobarbital tablet	
PHENYTEK (phenytoin)	
Phenytoin chewable tablet	
Phenytoin ER capsule	
Phenytoin suspension	
Primidone	
SABRIL (vigabatrin)	
SABRIL (vigabatrin) POWDER PACK	
SPRITAM (levetiracetam)	
TEGRETOL (carbamazepine)	
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.

### Product PA Criteria:

\*\*\*Memantine ER: A 30-day trial of memantine IR will be required before Namenda XR will be authorized. Patient must not reside in nursing home.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Donepezil 5mg, 10mg	ARICEPT (donepezil)
Donepezil ODT	Donepezil 23mg
EXELON (rivastigmine) PATCH	Memantine oral solution
Galantamine	Memantine ER

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Galantamine ER	NAMENDA (memantine)
Galantamine oral solution	NAMZARIC (memantine/donepezil)
Memantine	RAZADYNE (galantamine)
Rivastigmine	RAZADYNE ER (galantamine)
	Rivastigmine patch
	NAMENDA XR (memantine)

## Antiretrovirals

### Integrase Strand Transfer Inhibitors

PREFERRED AGENTS	NON-PREFERRED AGENTS
BIKTARVY (bictegravir/Emtricitabine/Tenofovir)	
DOVATO (Dolutegravir/Lamivudine)	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)	
ISENTRESS (raltegravir)	
JULUCA (dolutegravir/rilpivirine)	
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)	
TIVICAY (dolutegravir)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	

### 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Abacavir	COMBIVIR (lamivudine/zidovudine)
Abacavir/lamivudine	EPIVIR (lamivudine)
Abacavir/lamivudine/zidovudine	EPZICOM (abacavir)
ATRIPLA (efavirenz/emtricitabine/tenofovir)	RETROVIR (zidovudine)
BIKTARVY (bictegravir/Emtricitabine/Tenofovir)	TRIZIVIR (abacavir/lamivudine)
CIMDUO (lamivudine/tenofovir)	VIDEX EC (didanosine)
COMPLERA (emtricitabine/rilpivirine/tenofovir)	VIREAD (tenofovir)
DELSTRIGO (doravirine/lamivudine/tenofovir)	ZERIT (stavudine) CAPSULE
DESCOVY (emtricitabine/tenofovir)	ZIAGEN (abacavir)
Didanosine	
EMTRIVA (emtricitabine)	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)	
Lamivudine	
Lamivudine/zidovudine	
ODEFSEY (emtricitabine/rilpivirine/tenofovir)	
SYMFI (efavirenz/lamivudine/tenofovir)	
SYMFI LO (efavirenz/lamivudine/tenofovir)	
Stavudine	
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)	

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SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir)	
Tenofovir	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	
TRUVADA (emtricitabine/tenofovir)	
VIDEX (didanosine)	
ZERIT (stavudine) SOLUTION	
Zidovudine	

## Protease Inhibitor

### 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
APTIVUS (tipranavir)	KALETRA (lopinavir/ritonavir) SOLUTION
atazanavir	LEXIVA (Fosamprenavir)
CRIXIVAN (indinavir)	REYATAZ (atazanavir) CAPSULE
EVOTAZ (atazanavir/cobicistat)	ritonavir
Fosamprenavir	
INVIRASE (saquinavir)	
KALETRA (lopinavir/ritonavir) TABLET	
lopinavir/ritonavir solution	
NORVIR (ritonavir)	
PREZCOBIX (darunavir/cobicistat)	
PREZISTA (darunavir)	
REYATAZ (atazanavir) POWDER PACK	
SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir)	
VIRACEPT (nelfinavir)	

## Atopic Dermatitis

### Category PA Criteria:

Patient must have a FDA approved indication and age.

A complete preferred drug list of topical corticosteroids may be found at:

[http://www.hidesigns.com/assets/files/ndmedicaid/2018/Criteria/PA\\_Criteria.pdf](http://www.hidesigns.com/assets/files/ndmedicaid/2018/Criteria/PA_Criteria.pdf)

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.

### Product PA Criteria:

\*\*\*Eucrisa: Patient must have had a 30 day trial within the past 180 days of either a topical calcineurin inhibitor (tacrolimus or pimecrolimus) or corticosteroid

\*\*\*Dupixent: Initial Approval: 3 months; Subsequent Approval: 12 months

Initial Criteria:

- Patient must have a diagnosis of an FDA-approved indication for use
- Patient must be 12 years of age or older
- Patient must have had a 6-week trial of at least one of the following, as evidenced by paid claims or pharmacy print-outs:
  - Tacrolimus or Pimecrolimus
- One of the following must be met (A or B):
  - A. Patient must have had two 2-week trials of topical corticosteroids of medium or higher potency, as evidenced by paid claims or pharmacy print-outs.
  - B. Patient must meet both of the following (1 and 2):
    1. Affected area is on face, groin, axilla, or under occlusion
    2. Patient must have had two 2-week trials of topical corticosteroids of low or higher potency, as evidenced by paid claims or pharmacy print-outs.

Renewal Criteria:

- Documentation from the prescriber must be provided showing that the patient has achieved a significant reduction in severity of atopic dermatitis.

\*\*\*Protopic: 0.1% strength is covered for adults only

PREFERRED AGENTS	NON-PREFERRED AGENTS
DERMA-SMOOTH-FS (Fluocinolone Acetonide) OIL 0.01%	Fluocinolone Acetonide Oil 0.01%
DUPIXENT (dupilumab) <sup>PA***</sup>	Tacrolimus 0.03%
Pimecrolimus – Labeler 68682	Tacrolimus 0.1%
EUCRISA (crisaborole) OINTMENT <sup>PA***</sup>	ELIDEL (pimecrolimus) CREAM
PROTOPIC (tacrolimus) OINTMENT 0.03%	Pimecrolimus – Labeler 00591
PROTOPIC (tacrolimus) OINTMENT 0.1% <sup>***</sup>	

## Atypical Antipsychotics

### Oral

#### 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.

#### Product PA Criteria:

\*\*\*Olanzapine/fluoxetine: Plan prefers individual drugs prescribed separate

PREFERRED AGENTS	NON-PREFERRED AGENTS
aripiprazole solution	ABILIFY (aripiprazole)
Aripiprazole	ABILIFY DISCMELT (aripiprazole)
Aripiprazole ODT	CLOZARIL (clozapine)
Clozapine	FAZACLO (clozapine) RAPDIS
Clozapine ODT	GEODON (ziprasidone)
FANAPT (iloperidone)	INVEGA ER (paliperidone)
LATUDA (lurasidone)	Olanzapine/Fluoxetine***
Olanzapine	RISPERDAL (risperidone)
Olanzapine ODT	RISPERDAL (risperidone) ORAL SOLUTION
Paliperidone ER	RISPERDAL M-TAB (risperidone)
Quetiapine	SEROQUEL (quetiapine)
Quetiapine ER	SEROQUEL XR (quetiapine)
REXULTI (brexipiprazole)	SYMBYAX (olanzapine/fluoxetine) ***
Risperidone	ZYPREXA (olanzapine)
Risperidone ODT	ZYPREXA ZYDIS (olanzapine)
Risperidone oral solution	
SAPHRIS (asenapine)	
VRAYLAR (cariprazine)	
Ziprasidone	

### Long Acting Injectable

PREFERRED AGENTS	NON-PREFERRED AGENTS
ABILIFY MAINTENA (aripiprazole)	
ARISTADA (aripiprazole lauroxil)	
ARISTADA INITIO (aripiprazole lauroxil)	
INVEGA SUSTENNA (paliperidone)	
INVEGA TRINZA (paliperidone)	
PERSERIS (risperidone)	
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 idiopathic constipation:

- A 30 day trial of both Amitiza and Linzess will be required before a non-preferred agent will be authorized.

For opioid-induced constipation:

- A paid claim for an opioid must be on patient's profile
- A 30 day trial of Amitiza and Movantik will be required before a non-preferred oral agent will be authorized.

PREFERRED AGENTS	NON-PREFERRED AGENTS
AMITIZA (lubiprostone)	LINZESS (linaclotide) 72 mcg
LINZESS (linaclotide) 145 mcg, 290 mcg	MOTEGRITY (prucalopride)
MOVANTIK (naloxegol)	RELISTOR (methylnaltrexone) TABLET
RELISTOR (methylnaltrexone) SYRINGE	SYMPROIC (naldemedine)
RELISTOR (methylnaltrexone) VIAL	TRULANCE (plecanatide)

## COPD (Chronic Obstructive Pulmonary Disease)

### Long Acting Anticholinergics

#### Group PA Criteria:

A 30-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized.

Either single ingredient or combination products will count toward trials. All non-preferred agents indicated only for COPD will require verification of FDA-approved indication.

#### Product PA Criteria:

\*\*\*Lonhala Magnair - Patients must have both of the following:

- A failure of a 30 day trial of Yupelri will be required before Lonhala Magnair will be authorized.
- Clinical justification must be given for why another product will not work in addition to Category PA Criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
INCRUSE ELLIPTA (umeclidinium)	LONHALA MAGNAIR (glycopyrrolate)***
SEEBRI NEOHALER (glycopyrrolate)	YUPELRI (revefenacin)
SPIRIVA HANDHALER (tiotropium)	
SPIRIVA RESPIMAT 2.5 MG (tiotropium)	
TUDORZA PRESSAIR (aclidinium)	



COPD continued:

### Long Acting Beta Agonists

#### Group PA Criteria:

All agents indicated only for COPD will require verification of FDA-approved indication.

#### Product PA Criteria:

\*\*\*Brovana will require a 30 day trial of Perforomist in addition to Category PA Criteria

PREFERRED AGENTS	NON-PREFERRED AGENTS
ARCAPTA NEOHALER (indacaterol)	BROVANA (arformoterol)***
PERFOROMIST (formoterol)	
SEREVENT DISKUS (salmeterol)	
STRIVERDI RESPIMAT (olodaterol)	

### Combination Anticholinergics/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. All agents indicated only for COPD will require verification of FDA-approved indication.

PREFERRED AGENTS	NON-PREFERRED AGENTS
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 have an FDA approved indication and a 30 day trial of the following combinations:

1. Steroid/Long Acting Beta Agonist (LABA) Combination Inhalers + Long Acting Anticholinergics
2. Combination Anticholinergics/Long Acting Beta Agonist + Inhaled Steroid

PREFERRED AGENTS	NON-PREFERRED AGENTS
	TRELEGY ELLIPTA (Fluticasone Furoate/Umeclidinium/Vilanterol)

## COPD Continued:

### PDE4-Inhibitor

#### Group PA Criteria:

Patient must have an FDA approved indication.

Patient must also be concurrently taking a long acting anticholinergic with good compliance.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	DALIRESP (roflumilast)

## Corticosteroids – Inhaled

#### Category PA Criteria:

Patient must have failed a 30-day trial of all preferred inhalers will be required before a non-preferred agent will be authorized.

Preferred	Non-Preferred
ASMANEX (mometasone) TWISTHALER	ALVESCO (ciclesonide)
budesonide suspension	ARMONAIR RESPICLICK (fluticasone)
FLOVENT DISKUS (fluticasone)	ARNUITY ELLIPTA (fluticasone)
FLOVENT HFA (fluticasone)	ASMANEX HFA (mometasone)
PULMICORT FLEXHALER (budesonide)	PULMICORT RESPULES (budesonide)
QVAR REDHALER (beclomethasone)	

## Cystic Fibrosis Inhaled Antibiotics

#### 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.

#### Product PA Criteria:

\*\*\*Tobi Podhaler - Patient must have a 28 day trial of preferred nebulized product. All agents will require an FDA-approved indication

\*\*\*Cayston – Patient must also have had 28 day trial of TOBI Podhaler in addition to Category PA Criteria. Patient must be colonized with *Pseudomonas aeruginosa*.

\*\*\*Arikayce – Patient must be colonized with *Mycrobacterium avium* complex (MAC). Patient must have not achieved negative sputum cultures after a minimum duration of 6 consecutive months of background treatment with a macrolide, a rifamycin, and ethambutol.

PREFERRED AGENTS	NON-PREFERRED AGENTS
BETHKIS (Tobramycin)	ARIKAYCE (Amikacin/Nebulizer) ***
KITABIS PAK (Tobramycin/Nebulizer)	CAYSTON (Aztreonam)***
TOBI PODHALER (Tobramycin) <sup>PA***</sup>	TOBI (Tobramycin)
Tobramycin	Tobramycin/Nebulizer

## 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.

### Product PA Criteria:

\*\*\*Stelara - For the diagnosis of Chron's disease, Category PA Criteria must be met. Remicade can be given and billed on the medical side. For all other indications, patient must fail a 3-month trial of one non-preferred agent in addition to Category PA Criteria.

\*\*\*Ilumya, Siliq, Skyrizi, Taltz, Tremfya - Patient must fail a 3-month trial of one non-preferred agent in addition to Category PA Criteria

PREFERRED AGENTS	NON-PREFERRED AGENTS
COSENTYX (secukinumab)	ACTEMRA (tocilizumab)
ENBREL (etanercept)	CIMZIA (certolizumab)
HUMIRA (adalimumab)	KEVZARA (sarilumab)
	KINERET (anakinra)
	OLUMIANT (baricitinib)
	ORENCIA (abatacept)
	OTEZLA (apremilast)
	SILIQ (brodalumab)***
	SIMPONI (golimumab)
	SKYRIZI (risankizumab-rzaa)***
	STELARA (ustekinumab)***
	TALTZ (ixekizumab)***
	TREMFYA (guselkumab)***
	XELJANZ (tofacitinib)
	XELJANZ XR (tofacitinib)

## Diabetes

### DPP4-Inhibitors

#### Category PA Criteria:

All agents will require:

1. A diagnosis of an FDA-approved indication for use
2. One of the following:
  - A: The requested agent is a combination product containing metformin
  - B: Metformin use with good compliance in the past 3 months before and concurrently with requested agent (patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER)

In addition, non-preferred agents will require a failed trial of each of the following:

1. 30 days of 1 sitagliptin preferred product (Janumet, Janumet XR, or Januvia)
2. 30 days of 1 linagliptin preferred product (Jentadueto or Tradjenta)
3. 30 days of Victoza

PREFERRED AGENTS	NON-PREFERRED AGENTS
JANUMET (sitagliptin/metformin)	alogliptan/pioglitazone
JANUMET XR (sitagliptin/metformin)	alogliptin
JANUVIA (sitagliptin)	alogliptin/metformin
JENTADUETO (linagliptin/metformin)	JENTADUETO XR (linagliptin/metformin)
TRADJENTA (linagliptin)	JUVISYNC (sitagliptin/simvastatin)
	KAZANO (alogliptin/metformin)
	KOMBIGLYZE XR (saxagliptin/metformin)
	NESINA (alogliptin)
	ONGLYZA (saxagliptin)
	OSENI (alogliptin/pioglitazone)

### DPP4-Inhibitors/SGLT2 Inhibitors Combination

**Category PA Criteria:** The prescriber must provide medical justification explaining why the patient cannot use individual preferred products separately

PREFERRED AGENTS	NON-PREFERRED AGENTS
	GLYXAMBI (Empagliflozin/linagliptin)
	STEGLUJAN (Ertugliflozin/Sitagliptin)
	QTERN (Dapagliflozin/Saxagliptin)

## GLP-1 Agonists

### Category PA Criteria:

All agents will require:

1. A diagnosis of an FDA-approved indication for use
2. Metformin use with good compliance in the past 3 months before and concurrently with requested agent (patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER)

Non-preferred agents will require:

1. A 30-day trial of 2 preferred agents.

PREFERRED AGENTS	NON-PREFERRED AGENTS
VICTOZA (liraglutide)	ADLYXIN (lixisenatide)
BYDUREON (exenatide microspheres)	BYDUREON BCISE (exenatide microspheres)
BYETTA (exenatide)	OZEMPIC (semaglutide)
	TRULICITY (dulaglutide)

## Insulin/GLP-1 Agonist Combination

**Category PA Criteria:** The prescriber must provide medical justification explaining why the patient cannot use individual preferred products separately

PREFERRED AGENTS	NON-PREFERRED AGENTS
	SOLIQUA (Insulin glargine/lixisenatide)
	XULTOPHY (insulin degludec/liraglutide)

## Insulin

### Category PA Criteria:

Non-preferred insulin:

- The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review).

Syringe/Pens:

- Prescriber must provide a reason why patient needs to use a syringe/pen instead of a vial, subject to clinical review

### Product PA Criteria:

\*\*\*Fiasp

- Patient must have had 3 month trial with Novolog, Humalog, and Apidra

\*\*\*Basaglar:

- The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review).

\*\*\*Toujeo/Tresiba -

Initial Criteria: Approval 6 months

1. Patient must have one of the following:

- a. Recurrent episodes of hypoglycemia on Insulin glargine U100, insulin detemir U100, or U-500R despite adjustments to current regimen (prandial insulin, interacting drugs, meal and exercise timing)
- b. Inconsistent blood sugars with a basal insulin requirement of a minimum of 100 units/day for a minimum of 3 months with good compliance, as evidenced by paid claims or pharmacy print outs.

2. Must be prescribed by or in consultation with a endocrinologist or diabetes specialist

3. Patient must provide clinical explanation for the following:

- a. If dose is greater than 200 units of insulin per day, why patient is not a candidate for U-500R (Toujeo and Tresiba are not intended as replacements for U500 insulin)
- b. Need for smaller volume of insulin (max is 80 units/injection for both Insulin glargine 300 units/mL and 100 units/mL. Patients using Insulin glargine 300 unit/mL may require more basal insulin than those receiving 100 units/mL)

Renewal Criteria: Approval 12 months

One of the following, evidenced by clinical notes or labs:

1. Improvement in frequency and/or severity of hypoglycemia
2. Improved glycemic control (A1C)

## Insulin Continued:

PREFERRED AGENTS	NON-PREFERRED AGENTS
APIDRA (insulin glulisine) VIAL	ADMELOG (insulin lispro) VIAL
APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	ADMELOG SOLOSTAR (insulin lispro) INSULIN PEN
HUMALOG (insulin lispro) VIAL	AFREZZA (insulin regular, human)
HUMALOG (insulin lispro) CARTRIDGE	BASAGLAR KWIKPEN U-100 (insulin glargine)***
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	FIASP (insulin aspart) FLEXTOUCH***
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	FIASP (insulin aspart) VIAL ***
HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL	Insulin lispro vial
HUMULIN N (insulin NPH human isophane) VIAL	Insulin lispro syringe
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
NOVOLIN N (insulin NPH human isophane) VIAL	HUMULIN R (Insulin regular, human) U-500 KWIKPEN
NOVOLOG (insulin aspart) CARTRIDGE	NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL
NOVOLOG (insulin aspart) FLEXPEN	NOVOLIN 70-30 (insulin NPH human/regular insulin human) FLEXPEN
NOVOLOG (insulin aspart) VIAL	TOUJEO MAX SOLOSTAR (insulin glargine)***
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN	TOUJEO SOLOSTAR (insulin glargine)***
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL	TRESIBA (insulin degludec) FLEXTOUCH U-100***
	TRESIBA (insulin degludec) FLEXTOUCH U-200***
	TRESIBA (insulin degludec) VIAL***

## SGLT2 Inhibitors

### Category PA Criteria:

All agents will require:

1. A diagnosis of an FDA-approved indication for use
2. One of the following:
  - A: The requested agent is a combination product containing metformin
  - B: Metformin use with good compliance in the past 3 months before and concurrently with requested agent (patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER)

In addition, non-preferred agents will require:

3. A 30 day trial of a empagliflozin agent, as evidenced by paid claims or pharmacy print-outs

### Product PA Criteria:

\*\*\*Steglatro/Steglatromet - Patient must have a 30 day trial of a dapagliflozin and canagliflozin agent in addition to Category PA Criteria

PREFERRED AGENTS	NON-PREFERRED AGENTS
JARDIANCE (empagliflozin)	FARXIGA (dapagliflozin)
SYNJARDY (empagliflozin/metformin)	INVOKAMET (canagliflozin)
SYNJARDY XR (empagliflozin/metformin)	INVOKAMET XR (canagliflozin/metformin)
	INVOKANA (canagliflozin)
	STEGLATRO (ertugliflozin)***
	STEGLATROMET (ertugliflozin/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.

### Product PA Criteria:

\*\*\*Alosetron– Patient must be a female.

PREFERRED AGENTS	NON-PREFERRED AGENTS
LOTROXEX (alosetron)***	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 patient stable on a pancreatic enzyme written by a gastroenterologist or pancreas disease specialist

PREFERRED AGENTS	NON-PREFERRED AGENTS
CREON (lipase/protease/amylase)	PANCREAZE (lipase/protease/amylase)
ZENPEP (lipase/protease/amylase)	PANCRELIPASE (lipase/protease/amylase)
	PERTZYE (lipase/protease/amylase)
	VIOKACE (lipase/protease/amylase)

## Growth Hormone

### 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.

### Covered Indications:

1. Multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease or its treatment (brain surgery and/or radiation)
2. Turner's syndrome
3. SHOX syndrome
4. Noonan syndrome
5. Chronic renal insufficiency
6. Prader-Willi syndrome
7. Endogenous growth hormone deficiency

### For Initial or Subsequent Authorization:

For any indication:

- Patient must not have active malignancy
- Prescriber must be an endocrinologist or nephrologist or prescriber must have at least one annual consultation about the patient with the pediatric specialty
- Patient must not have epiphyseal closure and must still be growing:
  - Exceptions:
    - Prader-Willi syndrome
    - Endogenous growth hormone deficiency - if patient is experiencing hypoglycemic episodes without growth hormone and growth hormone is needed to maintain proper blood glucose

For Chronic renal insufficiency:

- Patient must not have received a renal transplant
- Patient must consult with a dietitian to maintain a nutritious diet

For Prader-Willi syndrome:

- Sleep apnea must be ruled out by sleep study in obese patients
- Patient must consult with a dietitian to maintain a nutritious diet

### Additional Criteria for Initial Authorization

For Endogenous growth hormone deficiency:

- Must meet ONE of below criteria
  - Patients with multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease or its treatment (brain surgery and/or radiation) must have an IGF-1 or IGFBP-3 level of less than SDS 1.3.
  - Patient must have had two GH stimulation tests by insulin, levodopa, L-arginine, propranolol, clonidine, or glucagon with a maximum peak of < 10ng/mL after stimulation no more than 6 months apart

### Additional Criteria for Subsequent Authorization

For any indication:

- Patient must have been compliant with growth hormone (last 6 fills must have been on time).

For Prader-Willi:

- If patient is obese, BMI must have decreased. If patient is not obese, BMI must have maintained or decreased.

### Growth Hormone Continued:

PREFERRED AGENTS	NON-PREFERRED AGENTS
NORDITROPIN FLEXPRO (somatropin) <sup>PA</sup>	GENOTROPIN (somatropin)
	GENOTROPIN MINIQUICK (somatropin)
	HUMATROPE (somatropin)
	NUTROPIN AQ (somatropin)
	OMNITROPE (somatropin)
	SAIZEN (somatropin)
	ZOMACTON (somatropin)

## Heart Failure – Neprilysin Inhibitor/Angiotensin Receptor Blocker

### Category PA Criteria:

1. Patient must have FDA approved diagnosis
2. Patient must be 18 years or older

PREFERRED AGENTS	NON-PREFERRED AGENTS
ENTRESTO (sacubitril/valsartan) <sup>PA</sup>	

## Hematopoietic, Colony Stimulating Factors

**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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
FULPHILA (Pegfilgrastim-JMDB)	NIVESTYM (Figrastim-AAFI)
GRANIX (TBO-Filgrastim)	ZARXIO (Filgrastim-SNDZ)
LEUKINE (Sargramostim)	
NEULASTA (Pegfilgrastim)	
NEUPOGEN (Filgrastim)	
UDENYCA (pegfilgrastim-CBQV)	

## 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ARANESP (darbepoetin alfa) <sup>PA</sup>	EPOGEN (epoetin alfa)
PROCRIT (epoetin alfa) <sup>PA</sup>	MIRCERA (methoxy polyethylene glycol-epoetin beta)
	RETACRIT (epoetin alfa - EPBX)

## 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. Liver fibrosis F1 and below: 2 positive HCV RNA levels at least 6 months apart
  - b. 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 have abstained from alcohol for at least 12 months OR patient must:
    - i. have abstained from alcohol for at least 3 months AND
    - ii. be receiving treatment from an enrolled provider and agree to abstain from alcohol during treatment AND
    - iii. be under the care of an addiction medicine/chemical dependency treatment provider and the provider attests the patient has abstained from alcohol use for at least 3 months
  - b. If the patient has a history of illicit use of drugs by injection, the patient must have abstained from drug use for at least 12 months OR patient must:
    - i. have abstained from drug use for at least 3 months AND
    - ii. be receiving treatment from an enrolled provider and agree to abstain from said drug use during treatment AND
    - iii. be under the care of an addiction medicine/chemical dependency treatment (or buprenorphine waived provider) provider and the provider attests the patient agrees to abstain from drug use for at least 3 months
4. Patient must not be receiving a known recreationally used high risk combination of drugs (e.g. “the holy trinity”) for the past 6 months
5. Patient must attest that they will continue treatment without interruption for the duration of therapy.
6. Prescriber must be, or consult with, a hepatology, gastroenterology, or infectious disease specialist.
7. HCV RNA level must be taken on week 4 and sent with a renewal request for any duration of treatment 12 weeks or longer.
8. Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment.
9. Patient must have established compliant behavior including attending scheduled provider visits (defined as 1 or less no-shows) and filling maintenance medications on time as shown in the prescription medication history for the past 6 months.
10. Patient must be tested for hepatitis B, and if the test is positive, hepatitis B must either be treated or closely monitored if patient does not need treatment.
11. Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions.
12. PA approval duration will be based on label recommendation.

## Hepatitis C Continued:

### Product PA Criteria:

#### \*\*\*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)

#### \*\*\*Zepatier:

- Patient must not have decompensated cirrhosis (Child-Pugh B or Child-Pugh C)
- Genotype 1a - must test for presence of virus with NS5A resistance-associated polymorphisms

PREFERRED AGENTS	NON-PREFERRED AGENTS
EPCLUSA (sofosbuvir/velpatasvir) <sup>PA***</sup>	HARVONI (ledipasvir/sofosbuvir)
MAVYRET (glecaprevir/pibrentasvir) <sup>PA***</sup>	Ledipasvir/sofosbuvir
ZEPATIER (elbasvir/grazoprevir) <sup>PA***</sup>	Sofosbuvir/velpatasvir
	SOVALDI (sofosbuvir)
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)

## 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
LICE KILLING SHAMPOO (piperonyl butoxide/pyrethrins)	CROTAN (Crotamiton)
NATROBA (spinosad)	ELIMITE (permethrin) CREAM
NIX 1% (Permethrin) CRÈME RINSE LIQUID	EURAX (crotamiton)
Permethrin 5% cream	Malathion
SKLICE (ivermectin)	OVIDE (malathion)
SM LICE TREATMENT (Permethrin) 1% CRÈME RINSE LIQUID	Spinosad
ULESFIA (benzyl alcohol)	

## Migraine

### Treatment – 5HT(1) Agonist

#### 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.

#### Product PA Criteria:

\*\*\*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 Zomig 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 pen/syringe/cartridge, Frovatriptan, Almotriptan, Sumatriptan/naproxen:

- 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

PREFERRED AGENTS	NON-PREFERRED AGENTS
RELPAX (eletriptan)	Almotriptan***
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
	ONZETRA XSAIL (sumatriptan)

North Dakota Medicaid Preferred Drug List

This is NOT an all-inclusive list of covered medications or medications that require prior authorization  
Visit <http://www.hidesigns.com/ndmedicaid> for more information on medications not found in this list.

## Migraine Treatment – 5HT(1) Agonist Continued:

PREFERRED AGENTS	NON-PREFERRED AGENTS
	Sumatriptan cartridge***
	Sumatriptan pen injctr***
	Sumatriptan spray***
	Sumatriptan syringe***
	Sumatriptan vial
	Sumatriptan/naproxen***
	ZEMBRANCE SYMTOUCH (Sumatriptan)
	Zolmitriptan***
	Zolmitriptan ODT
	ZOMIG (zolmitriptan)***
	ZOMIG (zolmitriptan) SPRAY
	ZOMIG ODT (zolmitriptan)

## Prophylaxis – CGRP Inhibitors

### Category PA Criteria:

Initial: Approval for 3 months

- Patient must experience 4 or more migraine days per month.
- Prescriber must submit documentation of treatment failure of a 2 month trial of two of the following agents from different therapeutic classes: amitriptyline, atenolol, divalproex sodium, metoprolol, nadolol, propranolol, timolol, topiramate, venlafaxine
  - Documentation must include clinical notes regarding failure to reduce migraine frequency.
- A 3 month trial of each preferred agent will be required before a non-preferred agent will be authorized, as evidenced by paid claims or pharmacy print outs.
- Renewal:
  - Patient must experience a reduction in migraines of at least 50%

PREFERRED AGENTS	NON-PREFERRED AGENTS
EMGALITY (Galcanzumab-gnlm)	AIMOVIG (Erenumab-aooe)
	AJOVY (Fremanezumab-vfrm)

## Multiple Sclerosis

### Interferons

**Group 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
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

**Group 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. An FDA indication is required. Clinical justification must be provided why preferred product will not work.

PREFERRED AGENTS	NON-PREFERRED AGENTS
COPAXONE (glatiramer) 20 MG/ML	COPAXONE (glatiramer) 40 MG/ML ***
	glatiramer 20mg/ml***
	glatiramer 40mg/ml***
	Glatopa (glatiramer)***

### Oral Non-Interferons

**Group PA Criteria:** Non-preferred agents: 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
AUBAGIO (teriflunomide)	MAVENCLAD (Cladribine)
GILENYA (fingolimod)	MAYZENT (Siponimod)
	TECFIDERA (dimethyl fumarate)



## Ophthalmic

### Dry Eye Syndrome

PREFERRED AGENTS	NON-PREFERRED AGENTS
RESTASIS (Cyclosporine)	CEQUA (Cyclosporine)
	RESTASIS MULTIDOSE (Cyclosporine)
	XIIDRA (Lifitegrast)

### Glaucoma – Alpha Adrenergic

#### Group 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ALPHAGAN P 0.1% (brimonidine)	Apraclonidine 0.5%
ALPHAGAN P 0.15% (brimonidine)	brimonidine 0.15%
IOPIDINE (apraclonidine) 1%	
IOPIDINE (apraclonidine) 0.5%	
brimonidine 0.2%	
COMBIGAN (brimonidine/timolol)	
SIMBRINZA (brinzolamide/brimonidine)	

### Glaucoma – Beta Blockers

#### Group PA Criteria:

A 30-day trial of 2 preferred ingredients will be required before a non-preferred agent will be authorized.

PREFERRED AGENTS	NON-PREFERRED AGENTS
BETOPTIC S (Betaxolol) 0.25%	Betaxolol 0.5%
Carteolol	COSOPT (Dorzolamide/Timolol)
COMBIGAN (brimonidine/timolol)	ISTALOL (Timolol) Daily
Dorzolamide/Timolol	Timolol Daily
Levobunolol	Timolol gel forming solution
Timolol Maleate	TIMOPTIC (Timolol Maleate)
TIMOPTIC OCUDOSE (timolol)	TIMOPTIC-XE (Timolol gel forming solution)

### Glaucoma - Prostaglandin

#### Group PA Criteria:

A 30-day trial of 2 preferred ingredients will be required before a non-preferred agent will be authorized.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Latanoprost	Bimatoprost 0.03%

LUMIGAN (Bimatoprost) 0.01%	VYZULTA (latanoprostene)
TRAVATAN Z (Travoprost)	XALATAN (Latanoprost)
ZIOPTAN (Tafluprost)	XELPROS (Latanoprost)

## Glaucoma - Other

### Group 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
AZOPT (Brinzolamide)	ISOPTO CARPINE (Pilocarpine)
Dorzolamide	TRUSOPT (Dorzolamide)
PHOSPHOLINE (Echothiophate Iodide)	
Pilocarpine	
RHOPRESSA (Netarsudil)	
ROCKLATAN (Netarsudil/Latanoprost)	

## Antihistamines

### Group PA Criteria:

A 30-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ALOMIDE (Iodoxamide)	ALOCRIL (nedocromil)
Azelastine	ELESTAT (epinastine)
BEPREVE (bepotastine)	Epinastine
Cromolyn	Olopatadine 0.2%
LASTACRAFT (alcaftadine)	PATANOL 0.1% (olopatadine)
Olopatadine 0.1%	PATADAY 0.2% (olopatadine)
PAZEO (olopatadine)	

## Anti-infectives

### Group 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Bacitracin/polymyxin B ointment	AZASITE (azithromycin)
BESIVANCE (besifloxacin) DROPS	Bacitracin ointment
CILOXAN (ciprofloxacin) OINTMENT	BLEPH-10 (sulfacetamide) DROPS
Ciprofloxacin drops	CILOXAN (ciprofloxacin) DROPS
Erythromycin ointment	Gatifloxacin drops
Gentamicin sulfate drops	GENTAK (gentamicin sulfate) OINTMENT
Gentamicin sulfate ointment	Levofloxacin drops
MOXEZA (moxifloxacin) DROPS	Neomycin SU/bacitracin/polymyxin B ointment
moxifloxacin drops	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) OINTMENT

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Neomycin SU/polymyxin B/gramicidin drops	NEOSPORIN (neomycin SU/polymyxin B/gramicidin) DROPS
Ofloxacin drop	OCUFLOX (ofloxacin) DROPS
Polymyxin B/trimethoprim drops	POLYCIN (bacitracin/polymyxin) OINTMENT
Sulfacetamide drops	POLYTRIM (polymyxin B/trimethoprim) DROPS
Tobramycin drops	Sulfacetamide ointment
TOBREX (tobramycin) OINTMENT	TOBREX (tobramycin) DROPS
	VIGAMOX (moxifloxacin) DROPS
	ZYMAXID (gatifloxacin) DROPS

## Anti-infectives/Anti-inflammatories

### Group 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
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
Neomycin/polymyxin b/dexamethasone ointment	Neomycin/polymyxin b/hydrocortisone drops
Neomycin/polymyxin b/hydrocortisone ointment	NEO-POLYCIN HC (neomycin SU/bacitracin/polymyxin B/hydrocortisone) OINTMENT
PRED-G (gentamicin/prednisol ac) DROPS	TOBRADEX ST (tobramycin/dexamethasone) DROPS
PRED-G (gentamicin/prednisol ac) OINTMENT	Tobramycin/dexamethasone
Sulfacetamide/prednisolone drops	
TOBRADEX (tobramycin/dexamethasone) DROPS	
TOBRADEX (tobramycin/dexamethasone) OINTMENT	
ZYLET (tobramycin/lotepred etab) DROPS	

## Anti-inflammatories

### Group PA Criteria:

A 5-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ACUVAIL (ketorolac)	ACULAR (ketorolac)
ALREX (loteprednol)	ACULAR LS (ketorolac)
Diclofenac sodium	Bromfenac sodium
FLAREX (fluorometholone)	BROMSITE (bromfenac sodium)
Fluorometholone	Dexamethasone sodium phosphate
Flurbiprofen sodium	DUREZOL (difluprednate)
FML FORTE (fluorometholone)	INVELTYS (Loteprednol)
FML S.O.P. (fluorometholone)	FML (fluorometholone)
ILEVRO (nepafenac)	LOTEMAX SM (Loteprednol)
ketorolac tromethamine 0.4%	Loteprednol eye drops
Ketorolac tromethamine 0.5%	OCUFEN (flurbiprofen)

LOTEMAX (loteprednol) GEL DROPS	OMNIPRED 1% (prednisolone acetate)
LOTEMAX (loteprednol) OINTMENT	PRED FORTE 1% (prednisolone acetate)
MAXIDEX (dexamethasone)	PROLENSA (bromfenac)
NEVANAC (nepafenac)	
PRED MILD 0.12% (prednisolone acetate)	
Prednisolone acetate 1%	
Prednisolone sodium phosphate 1%	

## Opioid Analgesics – Long Acting

### Category PA Criteria:

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.
3. Patient must be in consult with oncologist or pain management specialist with a pain management contract (with treatment plan including goals for pain and function, and urine and/or blood screens) if one of the following:
  - a. Cumulative daily dose of narcotics exceeds 90 MED/day
  - b. Patient is using benzodiazepine concurrently with narcotic medication
4. Patient must have not achieved therapeutic goal with non-narcotic medication (NSAIDs, TCAs, SNRIs, Corticosteroids, etc.) and non-medication alternatives (Weight Loss, Physical Therapy, Cognitive Behavioral Therapy, etc.)
5. Renewal Criteria: Documentation noting progress toward therapeutic goal must be included with request (including pain level and function).

### Abuse Deterrent Formulations/Unique Mechanisms from Full Agonist Opioids

**Group PA Criteria:** A 30 day trial of tapentadol, morphine, and oxycodone products will be required in addition to Category PA Criteria before a non-preferred agent will be authorized.

### Product PA Criteria:

\*\*\* Belbuca, Methadone, Arymo ER, Morphabond ER, and Oxycontin - Clinical justification must be given for why another product will not work in addition to Category PA Criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
butorphanol <sup>PA</sup>	ARYMO ER (morphine)***
BUTRANS (buprenorphine) PATCHES <sup>PA</sup>	BELBUCA (buprenorphine)***
EMBEDA (morphine/naltrexone) <sup>PA</sup>	buprenorphine patches
levorphanol <sup>PA</sup>	CONZIP (tramadol ER)
NUCYNTA ER (tapentadol) <sup>PA</sup>	HYSINGLA ER (hydrocodone)
pentazocine-naloxone <sup>PA</sup>	Methadone***
Tramadol ER <sup>PA</sup>	MORPHABOND ER (morphine)***
XTAMPZA ER (oxycodone) <sup>PA</sup>	OXYCONTIN (oxycodone)***
	ULTRAM ER (tramadol ER)

## Full Agonist Opioids Without Abuse Deterrent Formulations

**Group PA Criteria:** 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 before a non-preferred agent will be authorized.

### Product PA Criteria:

\*\*\* Fentanyl Patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr, morphine ER capsules, morphine ER tablets 60mg, 100mg, and 200mg and oxycodone ER - Clinical justification must be given for why another product will not work in addition 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

PREFERRED AGENTS	NON-PREFERRED AGENTS
Fentanyl 12 mcg/hr <sup>PA</sup>	EXALGO (hydromorphone)
Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr <sup>PA</sup>	Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr <sup>***</sup>
Morphine ER tablets 15mg, 30mg <sup>PA</sup>	Hydromorphone ER tablets
	KADIAN (morphine) <sup>***</sup>
	Morphine ER capsules
	Morphine ER tablets 60mg, 100mg, 200mg
	MS CONTIN (morphine)
	Oxycodone ER
	Oxymorphone ER tablets
	ZOXYDRO ER (hydrocodone)

## Opioid Antagonist – Opioid and Alcohol Dependence

PREFERRED AGENTS	NON-PREFERRED AGENTS
VIVITROL (Naltrexone Microspheres)	

## Opioid Partial Antagonist – Opioid Dependence

### Category PA Criteria:

A 30-day trial of all preferred agents 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 products (subject to clinical review). A FDA MedWatch form for the failed product must be faxed to the FDA and submitted with request for all non-preferred buprenorphine/naloxone products.

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.

## Oral Agents

### Product PA Criteria:

\*\*\* Buprenorphine tablets will be allowed during a period that a patient is pregnant or breastfeeding.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Buprenorphine-naloxone tablets <sup>PA</sup>	BUNAVAIL FILM (buprenorphine/naloxone)
ZUBSOLV (buprenorphine/naloxone) <sup>PA</sup>	Buprenorphine tablets***
	buprenorphine/naloxone film
	SUBOXONE FILM (buprenorphine/naloxone)

## Non-Oral Agents

PREFERRED AGENTS	NON-PREFERRED AGENTS
SUBLOCADE (buprenorphine) <sup>PA</sup>	
PROBUPHENE (buprenorphine) <sup>PA</sup>	

## 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
CIPRO HC (ciprofloxacin/hydrocortisone)	
CIPRODEX (ciprofloxacin/dexamethasone)	
Ofloxacin drops	
OTOVEL (ciprofloxacin/fluocinolone)	

## PCSK9 Inhibitors

### Category PA Criteria:

- Patient must have one of the following diagnosis:
  - Heterozygous or homozygous familial hypercholesterolemia
  - Clinical atherosclerotic cardiovascular disease
- Patient's LDL must have remained greater than 100 mg/DL or greater after a 3-month trial with good compliance of Rosuvastatin 20-40mg or Atorvastatin 40-80mg combined with another lipid lowering agent

For non-preferred agents, the prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review).

Preferred	Non-Preferred
Praluent Pen	Repatha Sureclick
Repatha Pushtronex	Repatha Syringe

## 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Calcium acetate capsule	AURYXIA (ferric citrate) TABLET
Calcium acetate tablet	FOSRENOL (lanthanum) POWDER PACK
FOSRENOL (lanthanum) CHEWABLE TABLET	Lanthanum chew tab
PHOSLYRA (calcium acetate) ORAL solution	RENVELA (sevelamer carbonate) TABLET
RENAGEL (Sevelamer HCl) TABLET	Sevelamer HCl tablet
RENVELA (sevelamer) POWDER PACK	Sevelamer Powder Pack - labeler 65862, 43598
Sevelamer Carbonate tablet	VELPHORO (Sucroferric oxyhydroxide)
Sevelamer Powder Pack - Labeler 00955	

## Pituitary Suppressants

PREFERRED AGENTS	NON-PREFERRED AGENTS
ELIGARD (leuprolide)	
LUPRON DEPOT (leuprolide)	
SUPPRELIN LA (histrelin)	
SYNAREL (nafarelin)	
TRESTAR (triptorelin)	
TRIPTODUR (triptorelin)	
VANTAS (histrelin)	
ZOLADEX (goserelin)	

## 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. Patient must have FDA indication.

**Product PA Criteria:**

\*\*\*Yosprala DR/Durlaza – The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review).

PREFERRED AGENTS	NON-PREFERRED AGENTS
AGGRENOX (aspirin/dipyridamole)	Aspirin/dipyridamole ER
Aspirin	Clopidogrel 300mg
BRILINTA (ticagrelor)	DURLAZA (aspirin ER)***
Clopidogrel 75 mg	EFFIENT (prasugrel)
Dipyridamole	PLAVIX (clopidogrel)
Prasugrel	YOSPRALA DR (aspirin/omeprazole)***
	ZONTIVITY (vorapaxar)

## Progesterone

**Category PA Criteria:** All medications require an FDA-approved indication. Non-preferred agents will require a 30-day trial of all preferred medications.

PREFERRED AGENTS	NON-PREFERRED AGENTS
MAKENA (hydroxyprogesterone caproate) <sup>PA</sup>	hydroxyprogesterone caproate

## Pulmonary Hypertension

**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.

### PDE-5 Inhibitors

**Group PA Criteria:** Patient cannot be taking nitrates of any form.

**Product PA Criteria:**

\*\*\*Revatio Suspension – Patients 7 years and older will be required to submit documentation of their inability to ingest a solid dosage form.

PREFERRED AGENTS	NON-PREFERRED AGENTS
REVATIO (sildenafil) SUSPENSION <sup>PA***</sup>	ADCIRCA (tadalafil)
Sildenafil tablet <sup>PA</sup>	REVATIO (sildenafil) TABLET
Tadalafil tablet <sup>PA</sup>	

## Soluble Guanylate Cyclase Stimulators

**Group 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. Patient may not



be taking with nitrates of any form or specific (sildenafil or tadalafil) or non-specific (dipyridamole or theophylline) PDE-5 inhibitors.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ADEMPAS (riociguat)	

## Endothelin Receptor Antagonists

**Group 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.

Tracleer - Patient must be less than 9 years of age for suspension and less than 18 years old for tablets.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Ambrisentan	LETAIRIS (ambrisentan)
TRACLEER (bosentan) SUSPENSION***	OPSUMIT (macitentan)
TRACLEER (bosentan) TABLETS***	

## Prostacyclins

PREFERRED AGENTS	NON-PREFERRED AGENTS
ORENITRAM ER (treprostinil)	REMODULIN (treprostinil)
treprostinil injection	TYVASO (treprostinil)
VENTAVIS (iloprost)	UPTRAVI (selexipag)

## Tardive Dyskinesia

### Category PA Criteria

1. Patient is 18 years of age or older
2. Patient must have a specialist (neurologist or psychiatrist) involved in therapy
3. Patient has been diagnosed with tardive dyskinesia including the following
  - a. Involuntary athetoid or choreiform movements
  - b. History of treatment with dopamine receptor blocking agent (DRBA)
  - c. Symptom duration lasting longer than 4-8 weeks
4. Patient must not be taking monoamine oxidase inhibitor (MAOI)
5. Patient is not pregnant or breastfeeding

### Product PA Criteria:

\*\*\* Austedo/tetrabenazine:

1. Patient must have chorea associated with Huntington's disease or Tardive Dyskinesia
2. Patient must not have hepatic impairment

PREFERRED AGENTS	NON-PREFERRED AGENTS
INGREZZA (valbenazine) <sup>PA</sup>	AUSTEDO (deutetrabenazine) <sup>***</sup>
tetrabenazine <sup>PA***</sup>	

## 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

PREFERRED AGENTS	NON-PREFERRED AGENTS
APRISO (mesalamine) CAPSULE	AZULFIDINE (sulfasalazine)
ASACOL HD (mesalamine)	AZULFIDINE DR (sulfasalazine)
Balsalazide capsule	COLAZAL (balsalazide)
DELZICOL (mesalamine) CAPSULE	Mesalamine DR
DIPENTUM (olsalazine)	Mesalamine HD
LIALDA (mesalamine) TABLET	SULFAZINE (sulfasalazine)
PENTASA (mesalamine)	
Sulfasalazine DR tablet	
Sulfasalazine tablet	

### Rectal

PREFERRED AGENTS	NON-PREFERRED AGENTS
Mesalamine enema	CANASA (mesalamine) RECTAL SUPPOSITORY
Mesalamine rectal suppository	Mesalamine enema kit
	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.

### Product PA Criteria:

\*\*\* Trospium ER will require two of the a 1-month trials to be with trospium and tolterodine ER.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Flavoxate	Darifenacin ER
GELNIQUE (oxybutynin)	DETROL (tolterodine)
Oxybutynin ER	DETROL LA (tolterodine)
Oxybutynin syrup	DITROPAN XL (oxybutynin)
Oxybutynin tablet	ENABLEX (darifenacin)
OXYTROL (oxybutynin) PATCH	MYRBETRIQ (mirabegron)
Tolterodine	SANCTURA (trospium)
Tolterodine ER	SANCTURA ER (trospium)***
TOVIAZ (fesoterodine)	Trospium ER***
Trospium	
VESICARE (solifenacin)	

## Vaginal Anti-Infectives

**Category PA Criteria:** A trial of 3 preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents require an FDA-approved indication.

PREFERRED AGENTS	NON-PREFERRED AGENTS
AVC (sulfanilamide)	clindamycin cream
CLEOCIN (clindamycin) SUPPOSITORY	CLEOCIN (clindamycin) CREAM
CLINDESSE (clindamycin) CREAM	GYNAZOLE 1 (butoconazole) CREAM
metronidazole gel	NUVESSA (metronidazole) GEL
terconazole cream	METROGEL-VAGINAL (metronidazole)
VANDAZOLE (metronidazole) GEL	MICONAZOLE 3 (miconazole) suppository
	terconazole suppository

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