

# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020  
Highlights indicated change from previous posting.

## ALZHEIMER'S DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Cholinesterase Inhibitors</b>		
donepezil – except 23 mg tablet donepezil ODT EXELON (rivastigmine) transdermal rivastigmine capsule	<i>donepezil 23 mg tablet</i> <i>galantamine tablets, solution</i> <i>galantamine ER</i> <i>rivastigmine transdermal</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Alzheimer's Agents</a> (required for non-preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients with a documented trial and failure to at least one preferred agent.</li> </ul>
<b>NMDA Receptor Antagonist</b>		
memantine tablet	<i>memantine ER</i> <i>memantine solution</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Alzheimer's Agents</a> (required for non-preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients with a documented trial and failure to at least one preferred agent.</li> </ul>
<b>Combination Products</b>		
	<i>NAMZARIC (donepezil/memantine)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Alzheimer's Agents</a> (required for non-preferred drugs)</li> <li>■ Please use prescriptions for individual agents</li> </ul>

## ANALGESICS, OPIOID – LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BUTRANS (buprenorphine transdermal) <sup>CL</sup> morphine ER <sup>CL</sup> tablets tramadol ER (ULTRAM ER) <sup>CL</sup>	<i>ARYMO ER (morphine ER)<sup>CL</sup></i> <i>BELBUCA (buprenorphine) buccal film<sup>CL</sup></i> <i>buprenorphine transdermal<sup>CL</sup></i> <i>hydrocodone ER (ZOHYDRO ER)<sup>CL</sup></i> <i>hydromorphone ER<sup>CL</sup></i> <i>HYSINGLA ER (hydrocodone ER)<sup>CL</sup></i> <i>fentanyl transdermal<sup>CL</sup></i> <i>methadone<sup>CL</sup></i> <i>MORPHABOND ER (morphine)<sup>CL</sup></i> <i>morphine ER<sup>CL</sup> capsules</i> <i>NUCYNTA ER (tapentadol ER)<sup>CL</sup></i> <i>oxycodone ER<sup>CL</sup></i> <i>OXYCONTIN (oxycodone ER)<sup>CL</sup></i> <i>oxymorphone ER<sup>CL</sup></i> <i>tramadol ER (CONZIP, RYZOLT)<sup>CL</sup></i> <i>XTAMPZA ER (oxycodone)<sup>CL</sup></i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Methadone, Initial Request</a></li> <li>■ <a href="#">Link to PA Form for Methadone, Reauthorization</a></li> <li>■ <a href="#">Link to PA Form for Opioid Analgesics</a>, (required for Non-Preferred drugs and/or combined opioid therapy &gt; 90 MME/day)</li> <li>■ Use of long acting opioids is reserved for treatment of persistent pain which has responded inadequately with around-the-clock short acting opioids for &gt; 3 months or pain due to active cancer.</li> <li>■ Use of long acting opioids is limited to one long acting agent at a time</li> <li>■ Non preferred agents will be approved for patients with a               <ul style="list-style-type: none"> <li>❖ paid claims history in the last 45 days demonstrating chronic use of the requested non-preferred agent OR</li> <li>❖ documented trial and failure of at least 30 days of a preferred long acting opioid agent within the last 180 days</li> </ul> </li> <li>■ Belbuca approval requires trial and failure of Butrans transdermal</li> </ul>

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

<sup>CL</sup> – Prior Authorization / Class Criteria apply

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## ANALGESICS, OPIOID – SHORT-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Oral/Rectal/Nasal/Transmucosal</b>		
hydrocodone/acetaminophen morphine IR tablet, solution and concentrate solution oxycodone/acetaminophen tablets tramadol IR tramadol/acetaminophen	<i>ABSTRAL (fentanyl)<sup>CL</sup></i> <i>ACTIQ (fentanyl transmucosal)<sup>CL</sup></i> <i>benzhydrocodone/acetaminophen</i> <i>butalbital/acetaminophen/caffeine/codeine</i> <i>butalbital/aspirin/caffeine/codeine</i> <i>butorphanol nasal spray</i> <i>carisoprodol compound w/codeine (carisoprodol/aspirin/codeine)</i> <i>codeine</i> <i>codeine/acetaminophen</i> <i>dihydrocodeine/ aspirin/caffeine</i> <i>DSUVIA (sufentanil) sublingual<sup>CL</sup></i> <i>fentanyl OTFC<sup>CL</sup></i> <i>FENTORA (fentanyl)<sup>CL</sup></i> <i>hydrocodone/ibuprofen</i> <i>hydromorphone tablets, liquid and suppositories</i> <i>LAZANDA (fentanyl ) nasal spray<sup>CL</sup></i> <i>levorphanol</i> <i>meperidine</i> <i>morphine suppositories</i> <i>NALOCET (oxycodone/acetaminophen)</i> <i>NUCYNTA (tapentadol)</i> <i>OXYDO (oxycodone)</i> <i>oxycodone tablets, capsules, solution, concentrate and oral syringe</i> <i>oxycodone/aspirin</i> <i>oxycodone/ibuprofen</i> <i>oxymorphone</i> <i>pentazocine/naloxone</i> <i>PRIMLEV (oxycodone/acetaminophen)</i> <i>ROXICET solution (oxycodone/acetaminophen)</i> <i>ROXYBOND (oxycodone)</i> <i>SUBSYS (fentanyl)<sup>CL</sup></i>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Opioid Analgesics.</a> (required for Non-Preferred drugs or combined opioid doses of &gt; 90 MME/day)</li> <li>▪ Non-preferred agents will be approved only after documented failure of 3 preferred agents with at least a 7 day trial of each in the past 180 days</li> <li>▪ Butalbital combinations:                             <ul style="list-style-type: none"> <li>❖ requires trial and failure of preferred medications appropriate to diagnosis (e.g. Triptans and NSAIDs for migraine)</li> <li>❖ Use will be limited to no more than 12 tablets per 30 days</li> </ul> </li> <li>▪ Carisoprodol containing combinations:                             <ul style="list-style-type: none"> <li>▪ Use will be limited to no more than 21 days</li> <li>▪ Additional authorization will not be granted for at least six months following the last day of the previous course of therapy</li> <li>▪ Approval will not be granted for patients with a history of meprobamate use in the previous two years</li> <li>▪ Approval will not be granted for patients concurrently using opioids</li> </ul> </li> <li>▪ Fentanyl buccal/sublingual /transmucosal/nasal will only be approved for breakthrough cancer pain in patients already receiving, and tolerant to, opioid therapy.</li> </ul>

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## ANALGESICS, PAIN – OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
duloxetine 20 mg, 30 mg and 60 mg capsule <sup>CL</sup> gabapentin capsules, tablets pregabalin capsule ZTLIDO (lidocaine)	duloxetine 40 mg capsule (for Irenka) DRIZALMA (duloxetine) SPRINKLE <sup>NR</sup> gabapentin solution GRALISE (gabapentin) <sup>CL</sup> HORIZANT (gabapentin) <sup>CL</sup> lidocaine transdermal LYRICA (pregabalin) CR capsule pregabalin solution SAVELLA (milnacipran) <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Non-preferred agents will be approved for patients with a documented trial and failure to at least one preferred agent.</li> </ul>

## ANDROGENIC DRUGS (TOPICAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
testosterone gel packet (generic VOGELXO) testosterone gel pump (generic VOGELXO)	ANDRODERM (testosterone) <sup>CL</sup> ANDROGEL (testosterone) <sup>CL</sup> packet, pump testosterone gel (generic ANDROGEL, FORTESTA, TESTIM, VOGELXO) <sup>CL</sup> testosterone gel pump (generic ANDROGEL, AXIRON) <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Androgenic Agents</a> (required for all drugs in the class)</li> <li>■ Preferred androgenic drugs will be approved for male patients with a documented diagnosis of hypogonadism with:                             <ul style="list-style-type: none"> <li>■ At least one non-sexual dysfunction symptom</li> <li>■ Serum testosterone level below the lower limit of normal range for testing laboratory</li> <li>■ Baseline hematocrit, hemoglobin, LDL, total cholesterol, bilirubin and hepatic transaminases within normal limits.</li> <li>■ Renewals require:                                     <ul style="list-style-type: none"> <li>-Testosterone level within normal limits</li> <li>-Hematocrit &lt; or = 54%</li> <li>-LDL, Total cholesterol, bilirubin and hepatic transaminases within normal limits</li> </ul> </li> </ul> </li> <li>■ Non-preferred agents will be approved for male patients meeting the above criteria with documented failure of a preferred agent within the last 6 months</li> </ul>

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## ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ACE Inhibitors</b>		
benazepril enalapril lisinopril ramipril	<i>captopril</i> <i>EPANED (enalapril solution)</i> <i>fosinopril</i> <i>moexipril</i> <i>perindopril</i> <i>QBRELIS (lisinopril solution)</i> <i>quinapril</i> <i>trandolapril</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for ACE Inhibitors</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.</li> <li>■ EPANED will only be approved for patients who have documented inability to swallow tablets</li> </ul>
<b>ACE Inhibitor / Diuretic Combinations</b>		
benazepril/hydrochlorothiazide enalapril/hydrochlorothiazide lisinopril/hydrochlorothiazide	<i>captopril/hydrochlorothiazide</i> <i>fosinopril/hydrochlorothiazide</i> <i>moexipril/hydrochlorothiazide</i> <i>quinapril/hydrochlorothiazide</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for ACE Inhibitors</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.</li> </ul>
<b>Angiotensin Receptor Blockers</b>		
irbesartan losartan <b>olmesartan</b> valsartan	<i>candesartan</i> <i>EDARBI (azilsartan)</i> <i>eprosartan</i> <i>MICARDIS (telmisartan)</i> <i>telmisartan</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for ARB-Angiotensin II Receptor Antagonists</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.</li> </ul>
<b>Angiotensin Receptor Blocker / Diuretic Combinations</b>		
irbesartan/hydrochlorothiazide losartan/hydrochlorothiazide <b>olmesartan/hydrochlorothiazide</b> valsartan/hydrochlorothiazide	<i>candesartan/hydrochlorothiazide</i> <i>EDARBYCLOR (azilsartan/chlorthalidone)</i> <i>MICARDIS HCT (telmisartan/hydrochlorothiazide)</i> <i>telmisartan/hydrochlorothiazide</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for ARB-Angiotensin II Receptor Antagonists</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.</li> </ul>
<b>Angiotensin Modulator / Calcium Chanel Blocker and Beta Blocker Combinations</b>		
benazepril/amlodipine valsartan/amlodipine	<i>olmesartan/amlodipine</i> <i>olmesartan/amlodipine/hydrochlorothiazide</i> <i>PRESTALIA (perindopril/amlodipine)</i> <i>TARKA (trandolapril/verapamil ER)</i> <i>telmisartan/amlodipine</i> <i>trandolapril/verapamil ER</i> <i>valsartan/amlodipine/hydrochlorothiazide</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Angiotensin Modulators-Calcium Channel Blockers</a> (required for Non-preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.</li> </ul>
<b>Direct Renin Inhibitors</b>		
	<b>aliskiren</b>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Direct Renin Inhibitors</a> (required for all drugs in the class)</li> </ul>

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## ANGIOTENSIN MODULATORS

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		<ul style="list-style-type: none"> <li>■ Tekturna will only be authorized if there is a documented trial and failure of a preferred ACEI or ARB</li> <li>■ Tekturna will not be approved for concomitant use with ACEI or ARB in diabetic or kidney disease patients</li> </ul>
<b>Direct Renin Inhibitor Combinations</b>		
	<i>TEKTURNA/HCT (aliskiren/hydrochlorothiazide)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Direct Renin Inhibitors</a> (required for all drugs in the class)</li> <li>■ Tekturna/HCT will only be authorized if there is a documented trial and failure of a preferred ACEI or ARB</li> <li>■ Tekturna/HCT will not be approved for concomitant use with ACEI or ARB in diabetic or kidney disease patients</li> </ul>
<b>Neprilysin Inhibitor Combination</b>		
ENTRESTO (sacubitril/valsartan) <sup>CL</sup>		<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Neprilysin Inhibitor Combination</a></li> <li>■ Sacubitril-valsartan (Entresto) will be approved for patients meeting the following criteria:                             <ul style="list-style-type: none"> <li>■ Chronic heart failure NYHA Class II-IV with left ventricular ejection fraction &lt; 40%</li> <li>■ Cardiologist prescribed or consulted</li> <li>■ <b>Entresto should not be administered within 36 hours of switching from or to an ACE inhibitor because of a high risk of development of angioedema.</b></li> <li>■ Not receiving concurrent aliskiren with a diagnosis of diabetes or renal failure</li> </ul> </li> </ul>

## ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
No agents are recommended to be preferred at this time.	<i>ORALAIR (grass pollen extract – Cocksfoot, Sweet Vernal Grass, Rye Grass, Meadow Grass, Timothy)</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Oral Allergy-Specific Immunotherapy agents will be approved for participants who have had an inadequate response, intolerance or contraindication to intranasal corticosteroids, leukotriene inhibitors and antihistamines. The participant must have a positive test for the specific allergen(s) covered by the specific agent and first dose must be 12 weeks before estimated actual start of the specific pollen season.</li> </ul>

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## ANTIBIOTICS, GI

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metronidazole tablet neomycin tinidazole vancomycin capsules	<i>AEMCOLO (rifamycin)</i> <sup>NR</sup> <i>ALINIA (nitazoxanide) tablets, suspension</i> <i>DIFICID (fidaxomicin)</i> <sup>CL</sup> <i>FIRVANQ (vancomycin)</i> <i>metronidazole capsule</i> <i>paromomycin</i> <i>XIFAXAN (rifaximin)</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to Universal PA Form</a></li> <li>▪ Difucid will only be approved with documentation of a clostridium difficile infection. Treatment will be limited to 10 days.</li> <li>▪ <a href="#">Link to PA Form for Xifaxan</a></li> <li>▪ Xifaxan 200 mg will only be approved for documented traveler's diarrhea and is limited to one prescription with a 3 day supply.</li> <li>▪ Xifaxan 550 mg will be approved for patients with irritable bowel syndrome with diarrhea, or documented hepatic encephalopathy who have received lactulose at least 90 ml per day for 72 of the last 90 days and are continuing on lactulose concurrently.</li> <li>▪ Other non-preferred agents will only be approved after documented failure of a preferred agent.</li> </ul>

## ANTIBIOTICS, INHALED <sup>CL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin) <sup>CL</sup> CAYSTON (aztreonam) <sup>CL</sup> KITABIS PAK (tobramycin) <sup>CL</sup>	<i>ARIKAYCE (amikacin)</i> <sup>CL</sup> <i>TOBI (tobramycin)</i> <sup>CL</sup> <i>TOBI Podhaler (tobramycin inhaled)</i> <sup>CL</sup> <i>tobramycin solution (inhalation)</i> <sup>CL</sup> <i>tobramycin pak (KITABIS PAK)</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Inhaled Antibiotics</a> (required for all agents in class)</li> <li>▪ Preferred agents will be approved for patients with a diagnosis of cystic fibrosis.</li> <li>▪ Non-preferred agents will only be approved for patients with cystic fibrosis that have a documented failure of a preferred agent</li> </ul>

## ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
mupirocin ointment	<i>gentamicin ointment and cream</i> <i>mupirocin cream</i>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Antibiotics, Topical</a> (required for Non-Preferred drugs)</li> <li>▪ Non-preferred agents will only be approved after documented failure of a preferred agent</li> </ul>

## ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CLEOCIN OVULES (clindamycin) CLINDESSE (clindamycin) NUVESSA 1.3% gel (metronidazole) <b>VANDAZOLE (metronidazole)</b>	<i>clindamycin cream</i> <b><i>metronidazole</i></b>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to Universal PA Form</a></li> <li>▪ Non-preferred agents will only be approved after documented failure of a preferred agent</li> </ul>

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## ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Oral</b>		
ELIQUIS (apixaban) <sup>CL</sup> <b>ELIQUIS (apixaban) Starter Pack</b> <sup>CL</sup> warfarin <sup>CL</sup> XARELTO (rivaroxaban) 10 mg, 15 mg and 20 mg tablets <sup>CL</sup> <b>XARELTO (rivaroxaban) Starter Pack</b> <sup>CL</sup>	<i>PRADAXA (dabigatran)</i> <sup>CL</sup> <i>SAVAYSA (edoxaban)</i> <sup>CL</sup> <i>XARELTO (rivaroxaban) 2.5 mg tablets</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Anticoagulants, Oral</a></li> <li>■ Non-preferred agents will be approved after a trial and failure of a preferred agent within the last 30 days</li> </ul>
<b>Injectable</b>		
enoxaparin syringe <b>enoxaparin vial</b>	<i>fondaparinux</i> <i>FRAGMIN (dalteparin) syringe, vial</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Anticoagulants, Injectable</a></li> <li>■ Non-preferred agents will be approved after a trial and failure of a preferred agent within the last 30 days.</li> </ul>

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## ANTICONVULSANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Barbiturates</b>		
phenobarbital tablets, suspension primidone		<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Anticonvulsants for Seizure Disorder</a></li> <li>▪ The non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Benzodiazepines</b>		
clobazam tablets clonazepam tablet diazepam rectal	<i>clonazepam ODT</i> <sup>CL</sup> <i>NAYZILAM (midazolam) nasal spray</i> <sup>CL</sup> <i>ONFI (clobazam) suspension</i> <sup>CL</sup> <i>SYMPAZAN (clobazam)</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Anticonvulsants for Seizure Disorder</a></li> <li>▪ Non-preferred agents without additional clinical criteria will be approved only after documented failure of a preferred agent.</li> <li>▪ Onfi will be approved for patients with a diagnosis of seizure disorder (ICD-9 = 345 or ICD-10= G40 or R56) within the previous 2 years.</li> <li>▪ Onfi suspension will be approved for patients meeting Onfi clinical criteria who have a documented inability to swallow tablets.</li> <li>▪ <a href="#">Link to PA Form for Clonazepam ODT Form.</a></li> <li>▪ Clonazepam orally disintegrating tablets (ODT) will be approved for patients that have a diagnosis of panic disorder with or without agoraphobia whose clonazepam dose is being titrated up or down or who have a documented inability to swallow other oral medication dosage forms.</li> </ul>
<b>Hydantoins</b>		
phenytoin capsules, chewable tablets, suspension phenytoin sodium extended (generic PHENYTEK)	<i>DILANTIN (phenytoin) capsules</i> <i>DILANTIN INFATAB (phenytoin)</i> <i>PEGANONE (ethotoin)</i>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Anticonvulsants for Seizure Disorder</a></li> <li>▪ The non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Succinimides</b>		
ethosuximide capsules, syrup	<i>CELONTIN (methsuximide)</i>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Anticonvulsants for Seizure Disorder</a></li> </ul>
<b>Other</b>		
	<i>DIACOMIT (stiripentol)</i> <sup>CL</sup> <i>EPIDIOLEX (cannabidiol)</i> <sup>CL</sup> <i>FINTEPLA (fenfluramine)</i> <sup>NR</sup>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Anticonvulsants for Seizure Disorder</a></li> <li>▪ <a href="#">Link to PA Form for Cannabidiols (Epidiolex)</a></li> </ul>

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Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Adjuvants, Epilepsy</b>		
<p>                     APTIOM (eslicarbazepine)<sup>CL</sup>                      DEPAKOTE (divalproex) sprinkle<sup>CL</sup>                      GABTRIL (tiagabine)<sup>CL</sup>                      levetiracetam ER<sup>CL</sup>                      levetiracetam solution, tablets<sup>CL</sup>                      oxcarbazepine suspension<sup>CL</sup>                      oxcarbazepine tablets<sup>CL</sup>                      topiramate sprinkle<sup>CL</sup>                      VIMPAT (lacosamide)<sup>CL</sup>                      zonisamide<sup>CL</sup> </p>	<p> <i>BANZEL (rufinamide) tablets, suspension<sup>CL</sup></i>  <i>BRIVIACT (brivaracetam) tablets, solution<sup>CL</sup></i>  <i>divalproex sprinkle<sup>CL</sup></i>  <i>felbamate tablet, suspension<sup>CL</sup></i>  <i>FYCOMPA (perampanel) tablets, suspension<sup>CL</sup></i>  <i>lamotrigine XR<sup>CL</sup></i>  <i>OXTELLAR XR (oxcarbazepine)<sup>CL</sup></i>  <i>SABRIL (vigabatrin) tablets, powder pack<sup>CL</sup></i>  <i>SPRITAM (levetiracetam) suspension<sup>CL</sup></i>  <i>tiagabine<sup>CL</sup></i>  <i>vigabatrin powder pack, tablet<sup>CL</sup></i>  <i>XCOPRI (cenobamate)<sup>NR</sup></i> </p>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Anticonvulsants for Seizure Disorder</a></li> <li>■ (required for Non-Preferred drugs)</li> <li>■ All agents require a seizure diagnosis (ICD-9=345 or 780.39 or ICD-10= G40 or R56) within the last 2 years.</li> <li>■ Preferred agents will be approved within the approved dosage quantities and age limits for eligible participants with a seizure diagnosis.</li> <li>■ Non-preferred brand agents will be approved for patients with a diagnosis of seizure disorder who have been receiving the brand drug for 90 days and are compliant with therapy (72 days out of the past 90) or who have documented failure of at least two different generic formulations from different manufacturers. Generic failures must also include a copy of the FDA MedWatch form documenting reason for failure.</li> <li>■ Other non-preferred agents will be approved for patients with a documented failure of a preferred agent in the past 180 days.</li> </ul>

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<sup>CL</sup> – Prior Authorization / Class Criteria apply

<sup>NR</sup> – New drug that has not been reviewed by P & T Committee

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020

Highlights indicated change from previous posting.

## ANTICONVULSANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Adjuvants, Pain and Mood Disorders</b>		
<p>carbamazepine ER (generic for CARBATROL)</p> <p>carbamazepine chewable tablet</p> <p>carbamazepine IR</p> <p>carbamazepine XR (generic for TEGRETOL XR)</p> <p>divalproex ER</p> <p>divalproex tablets</p> <p>gabapentin capsules, tablets</p> <p>lamotrigine chewable, tablets <sup>CL</sup></p> <p>TEGRETOL (carbamazepine) suspension</p> <p>topiramate ER (generic QUDEXY XR) capsules <sup>CL</sup></p> <p>topiramate tablets <sup>CL</sup></p> <p>valproic acid capsules, solution</p>	<p><i>carbamazepine suspension</i></p> <p><i>EQUETRO (carbamazepine ER)</i></p> <p><i>LAMICTAL ODT (lamotrigine) <sup>CL</sup></i></p> <p><i>lamotrigine ODT <sup>CL</sup></i></p> <p><i>TROKENDI XR (topiramate ER) capsules <sup>CL</sup></i></p>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Anticonvulsants for Pain and Mood Disorders</a></li> <li>■ Preferred agents with no clinical criteria will be approved for eligible participants within the approved dosage quantities and age limits.</li> <li>■ Non-preferred brand agents will be approved for patients with a diagnosis of seizure disorder (ICD-9=345 or 780.39 or ICD-10= G40 or R56) who have been receiving the brand drug for at least 90 days and are compliant with therapy (72 days out of the past 90 days) or who have a documented failure of at least two different generic formulations from different manufacturers. Generic failures must also include a copy of the FDA MedWatch form documenting the reason for failure.</li> <li>■ Non-preferred generic agents with no additional clinical criteria will be approved after trial and failure of a preferred agent within the approved dosage quantities and age limits.</li> <li>■ Lamotrigine or lamotrigine ODT will be approved for patients with one of the following diagnoses within the previous 2 years.             <ul style="list-style-type: none"> <li>■ Seizure disorder (ICD-9=345 or 780.39 or ICD-10= G40 or R56)</li> <li>■ Bipolar disorder (ICD-9 – 296 or ICD-10 = F31)</li> </ul> </li> <li>■ Topiramate IR, Qudexy XR or its generic equivalent topiramate ER and Trokendi XR will be approved for patients with one of the following diagnoses within the past 2 years:             <ul style="list-style-type: none"> <li>■ Seizure disorder (ICD-9=345 or 780.39 or ICD-10= G40 or R56)</li> <li>■ Migraine headache (ICD-9 -346 or ICD-10 = G43)</li> </ul> </li> <li>■ Non-preferred agents meeting the above clinical criteria will be approved after trial and failure of a preferred agent.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020

Highlights indicated change from previous posting.

## ANTIDEPRESSANTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bupropion IR bupropion SR bupropion XL duloxetine mirtazapine tablets trazodone venlafaxine IR venlafaxine ER capsules	<i>APLENZIN (bupropion HBr)</i> <i>bupropion XL (generic for FORFIVO XL)</i> <i>desvenlafaxine ER</i> <i>desvenlafaxine succinate (generic PRISTIQ)</i> <i>EMSAM (selegiline transdermal)<sup>CL</sup></i> <i>FETZIMA (levomilnacipran)</i> <i>desvenlafaxine (generic for IRENKA)</i> <i>MARPLAN (isocarboxazid)</i> <i>mirtazapine ODT</i> <i>nefazodone</i> <i>phenelzine</i> <i>SPRAVATO (esketamine) nasal spray<sup>CL</sup></i> <i>tranylcypromine</i> <i>TRINTELLIX (vortioxetine)</i> <i>venlafaxine ER tablets</i> <i>VIIBRYD (vilazodone)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Antidepressants, Other</a> (required for Non-Preferred Drugs - except duloxetine and Emsam - see below)</li> <li>■ Trintellix, Fetzima and Viibryd require trial and failure of two preferred antidepressants, including one from the Antidepressants, Other class.</li> <li>■ Other non-preferred agents will be approved for payment only after documented failure of at least one preferred agent</li> <li>■ <a href="#">Link to PA Form for duloxetine</a></li> <li>■ Duloxetine will be approved for patients meeting one of the following criteria:                         <ul style="list-style-type: none"> <li>■ Diagnosis of major depressive disorder (MDD) or generalized anxiety disorder (GAD) who have tried and failed treatment with a preferred antidepressant</li> <li>■ Diagnosis of diabetic peripheral neuropathy (DPN) who have tried and failed gabapentin therapy in the past 6 months</li> <li>■ Diagnosis of fibromyalgia</li> <li>■ Diagnosis of chronic musculoskeletal pain.</li> </ul> </li> <li>■ <a href="#">Link to PA Form for Emsam</a></li> <li>■ Emsam will be approved for adult patients meeting all of the following criteria:                         <ul style="list-style-type: none"> <li>■ Diagnosis of major depressive disorder (MDD)</li> <li>■ Failure of trials of an SSRI, an SNRI and at one least one other antidepressant from another therapeutic class</li> <li>■ Not currently receiving any contraindicated medications</li> <li>■ No diagnosis of pheochromocytoma</li> </ul> </li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020  
Highlights indicated change from previous posting.

## ANTIDEPRESSANTS, SSRIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
citalopram tablet, solution escitalopram tablets, solution fluoxetine capsules (except for 60 mg), tablets, solution fluvoxamine IR sertraline tablets, concentrate	<i>BRISDELLE (paroxetine)</i> <sup>CL</sup> <i>fluoxetine 60 mg capsule</i> <i>fluvoxamine ER</i> <i>paroxetine CR</i> <i>paroxetine tablet</i> <i>paroxetine (generic for BRISDELLE)</i> <i>PAXIL (paroxetine) Suspension</i> <i>PEXEVA (paroxetine)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Antidepressants, SSRIs</a> (required for Non-Preferred drugs – including fluoxetine weekly)</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months.</li> <li>■ Fluoxetine weekly will be approved for patients with a diagnosis of depression who are not receiving other medications at least daily.</li> <li>■ Brisdelle will be approved for treatment of vasomotor symptoms associated with menopause only and not depression.</li> </ul>

## ANTIEMETIC/ANTIVERTIGO AGENTS (ORAL/TRANSDERMAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Cannabinoids</b>		
	<i>CESAMET (nabilone)</i> <sup>CL</sup> <i>dronabinol capsules</i> <sup>CL</sup> <i>SYNDROS (dronabinol solution)</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Cannabinoids</a></li> <li>■ Dronabinol will be approved for patients who have received chemotherapy in the last 12 months or have a history of HIV associated cachexia.</li> </ul>
<b>5HT<sub>3</sub> Receptor Blockers</b>		
ondansetron ondansetron ODT	<i>granisetron</i> <sup>CL</sup> <i>SANCUSO (granisetron) transdermal</i> <sup>CL</sup> <i>ZUPLENZ (ondansetron)</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Antiemetics, Oral - 5HT<sub>3</sub> Antagonists</a> (required for non-preferred drugs)</li> <li>■ Non-preferred agents will be approved only after documented trial and failure of any preferred antiemetic agent within the last 6 months.</li> </ul>
<b>NK1 Receptor Antagonist</b>		
EMEND (aprepitant) capsules	<i>aprepitant capsules, pack</i> <i>AKYNZEO (netapitant/palonosetron)</i> <i>EMEND (aprepitant) powder pack</i> <i>VARUBI (rolapitant)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Non-preferred agents will be approved only after documented trial and failure of any preferred antiemetic agent within the last 6 months.</li> </ul>
<b>Other</b>		
dimenhydrinate OTC meclizine metoclopramide tablet prochlorperazine (oral, rectal) promethazine (oral, rectal 12.5 & 25 mg) TRANSDERM-SCOP (scopolamine)	<i>BONJESTA (doxylamine/pyridoxine)</i> <sup>CL</sup> <i>COMPRO (prochlorperazine) rectal</i> <b><i>doxylamine/pyridoxine (DICLEGIS)</i> <sup>CL</sup></b> <i>metoclopramide ODT</i> <i>promethazine 50 mg suppositories</i> <i>scopolamine (TRANSDERM-SCOP)</i> <i>trimethobenzamide (oral)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ A prescription is required for all drugs</li> <li>■ Bonjesta and Diclegis require failure of an adequate trial of OTC doxylamine and pyridoxine for nausea due to pregnancy.</li> <li>■ The other non-preferred agents will be approved after failure of at least one preferred agent in the most recent 60 days.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020

Highlights indicated change from previous posting.

## ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole fluconazole suspension, tablets griseofulvin suspension, tablets nystatin suspension terbinafine	CRESEMBA (isavuconazonium) flucytosine itraconazole 100 mg itraconazole solution ketoconazole <sup>CL</sup> nystatin tablets ONMEL (itraconazole) 200 mg ORAVIG (miconazole) posaconazole suspension, tablets SPORANOX (itraconazole solution) TOLSURA (itraconazole) voriconazole	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Antifungals, Oral</a></li> <li>■ Ketoconazole will be approved for blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis or paracoccidioidomycosis in patients who have failed or cannot tolerate other oral antifungal agents.                             <ul style="list-style-type: none"> <li>■ Ketoconazole will not be approved for fungal infections of the skin or nails or for fungal meningitis.</li> <li>■ Ketoconazole will not be approved for patients with liver disease, adrenal problems, or those who have undergone recent major surgery, or who are receiving interacting medications. ( see product PI for list of interacting medications)</li> </ul> </li> <li>■ Non-preferred agents will be approved after failure of at least one preferred agent in the most recent 60 days.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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Highlights indicated change from previous posting.

## ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Antifungals</b>		
clotrimazole OTC and RX (except RX solution) ketoconazole cream, shampoo 2% miconazole cream, powder nystatin cream, ointment, powder terbinafine OTC tolnaftate OTC cream, powder, solution	<i>ALEVAZOL (clotrimazole)</i> <i>butenafine OTC</i> <i>ciclopirox cream, gel, shampoo, suspension</i> <i>ciclopirox solution nail lacquer<sup>CL</sup></i> clotrimazole RX solution <i>clotrimazole/betamethasone lotion</i> <i>econazole</i> <i>ECOZA (econazole)</i> <i>ERTACZO (sertaconazole)</i> <i>EXELDERM (sulconazole)</i> <i>EXTINA (ketoconazole foam)</i> <i>JUBLIA (efinaconazole)</i> <i>KERYDIN (tavaborole)</i> <i>ketoconazole foam</i> <i>LAMISIL (terbinafine) cream, gel, spray</i> <i>LOPROX (ciclopirox)</i> <i>luliconazole</i> <i>miconazole nitrate/zinc oxide/petrolatum</i> <i>miconazole nitrate ointment, spray OTC</i> <i>naftifine</i> <i>NIZORAL AD shampoo OTC 1% (ketoconazole)</i> <i>oxiconazole</i> <i>OXISTAT (oxiconazole)</i> <i>tolnaftate spray</i> <i>VUSION (miconazole/petrolatum/ zinc oxide)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Antifungals, Topical</a> (required for Non-Preferred drugs -except antifungal nail lacquers - see below)</li> <li>■ Non-preferred agents will be approved only after documented failure of the preferred agents within the previous six months</li> <li>■ <a href="#">Link to PA Form for Topical Antifungal Nail Lacquer</a> (required for ciclopirox solution, Jublia (efinaconazole) and Kerydin (tavaborole))</li> <li>■ Antifungal nail preparations will only be approved for patients meeting all of the following criteria:                             <ul style="list-style-type: none"> <li>■ Diagnosis of onychomycosis within the last year</li> <li>■ Contraindication to oral itraconazole and terbinafine as defined by presence of heart failure, hepatic impairment or viral hepatitis</li> <li>■ Proof from prescriber that therapy is not for cosmetic purposes</li> </ul> </li> </ul>
<b>Antifungal/Steroid Combinations</b>		
clotrimazole/betamethasone	nystatin/triamcinolone cream, ointment	

## ANTI-HISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine solution, tablets levocetirizine tablets loratadine ODT, solution, tablets	<i>cetirizine capsules</i> <i>cetirizine chewable</i> <i>desloratadine</i> <i>desloratadine ODT</i> <i>fexofenadine</i> <i>levocetirizine solution</i> <i>loratadine capsules, chew tablets</i>	<ul style="list-style-type: none"> <li>■ A prescription is required for all drugs.</li> <li>■ <a href="#">Link to PA Form for Antihistamines, Minimally Sedating</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be authorized if a patient has failed a preferred agent within the most recent six months.</li> <li>■ Cetirizine solution is available for patients ≤ 12 years</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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## ANTIHYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CATAPRES TTS (clonidine transdermal) clonidine guanfacine methyldopa	<i>clonidine transdermal</i> <i>methyldopa-hydrochlorothiazide</i>	<ul style="list-style-type: none"> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

## ANTIHYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Allopurinol colchicine capsules probenecid	<i>colchicine<sup>CL</sup> tablets</i> <i>febuxostat<sup>CL</sup></i> <i>GLOPERBA (colchicine)<sup>NR</sup></i> <i>KRYSTEXXA (pegloticase)<sup>CL</sup></i> <i>MITIGARE (colchicine) capsules<sup>CL</sup></i> <i>probenecid/colchicine<sup>CL</sup></i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Antihyperuricemics, Oral</a> (required for Non-Preferred drugs)</li> <li>■ Colchicine:               <ul style="list-style-type: none"> <li>■ A prescription for three tablets does not require prior authorization if processed by the pharmacy as an Emergency Override.</li> <li>■ For acute gout, colchicine will be approved if there is a failure of or contraindication to NSAIDS or corticosteroids.</li> <li>■ For chronic gout, colchicine will be approved for patients on concomitant allopurinol who have failed or have documented intolerance to NSAIDS.</li> </ul> </li> <li>■ Uloric will be approved for continuation of gout attacks with serum urate levels &gt;6 mg/dl after at least three months of allopurinol at a therapeutic dose or with documented intolerance to allopurinol.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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## ANTIMIGRAINE AGENTS, CALCITONIN GENE-RELATED PEPTIDE (CGRP) ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p><b>Preventative Treatment</b></p> <p>AJOVY pen and autoinjector (fremanezumab-vfrm)<sup>CL</sup></p> <p>EMGALITY 120 mg/mL (galcanezumab-gnlm) syringe and pen<sup>CL</sup></p> <p><b>Acute Treatment</b></p> <p>NURTEC ODT (rimegepant)<sup>CL</sup></p>	<p>AIMOVIG (erenumab-aooe)<sup>CL</sup></p> <p>EMGALITY 100 mg/mL (galcanezumab-gnlm)<sup>CL</sup></p> <p>REYVOW (lasmiditan)<sup>CL</sup></p> <p>UBRELVY (uprogepant)<sup>CL</sup></p>	<p><u>Preventative Treatment</u></p> <ul style="list-style-type: none"> <li>■ CGRP inhibitors designated for preventative treatment will be approved for patients at least 18 years of age with episodic or chronic migraines that meet the following criteria. Patients with episodic cluster headaches will be evaluated on a case-by-case basis (Emgality only).</li> <li>❖ Patient meets the international Classification Headache Disorders (ICHD-3) diagnosis for episodic migraine with or without aura with 4-7 monthly headache days with moderate disability, episodic migraine with or without aura with 8-14 monthly headache days or chronic migraine defined as episodic migraine on &gt; 15 days/month for &gt; 3 months.</li> <li>❖ For episodic migraine, inability to tolerate side-effects or inadequate response to a 6-week trial each of at least 2 of the following oral prophylactic agents at recommended doses: <ul style="list-style-type: none"> <li>■ Topiramate</li> <li>■ Divalproex sodium/valproate sodium</li> <li>■ Beta-blocker: <ul style="list-style-type: none"> <li>■ -metoprolol</li> <li>■ -propranolol</li> <li>■ -timolol</li> <li>■ -atenolol</li> <li>■ -nadolol</li> </ul> </li> <li>■ Tricyclic antidepressant: <ul style="list-style-type: none"> <li>■ -amitriptyline</li> <li>■ -nortriptyline</li> </ul> </li> <li>■ Serotonin-norepinephrine reuptake inhibitor: <ul style="list-style-type: none"> <li>■ -venlafaxine</li> <li>■ -duloxetine</li> </ul> </li> </ul> </li> <li>❖ For chronic migraine, inability to tolerate side-effects or inadequate response to a 6-week trial each of at least 2 of the above oral prophylactic agents at recommended doses or have an inadequate response to a minimum of 2 quarterly injections (6 months) of onabotulinumtoxin A.</li> <li>❖ Requested drug is preferred agent or patient has an inadequate response to the preferred agent for a minimum</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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		<p>of 3 months for monthly injections or 6 months for quarterly injections (Ajoovy) OR has a documented inability to tolerate side effects.</p> <ul style="list-style-type: none"><li>■ Initial approval will be for 3 months for monthly injections or 6 months for quarterly injections.</li><li>■ Renewals will be approved for documented clinically meaningful improvement based on MIDAS, HIT-6 or Migraine Physical Function Impact Diary (MPFID) scores.</li><li>■ CGRP inhibitors will not be approved for headaches that meet the definition of Medication Overuse headaches as evidenced by use of Ergot derivatives, triptans or opioids for 10 or more days/month for &gt; 3 months OR nonopioid analgesics, acetaminophen, NSAIDS or aspirin for 15 or more days/month.</li></ul> <p><u>Acute Treatment</u></p> <ul style="list-style-type: none"><li>● CGRP inhibitors designated for acute migraine treatment will be approved for patients at least 18 years of age with episodic or chronic migraine headaches that meet the following criteria.<ul style="list-style-type: none"><li>○ Contraindication to the use of triptans or who failed to respond to or tolerate at least two oral triptans.</li><li>○ Requested drug is a preferred agent or patient has had an inadequate response to a preferred agent.</li></ul></li><li>■ Initial approval will be for 3 months. Continuation of coverage will be based on clinical assessment of improvement by the healthcare provider validating a decrease in frequency of migraine attacks.</li></ul>
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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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## ANTIMIGRAINE AGENTS, TRIPTANS<sup>CL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Oral</b>		
rizatriptan oral tablets, MLT <i>sumatriptan</i>	<i>almotriptan</i> <i>eletriptan</i> <i>frovatriptan</i> <i>naratriptan</i> <i>sumatriptan/naproxen</i> <i>TREXIMET (sumatriptan/naproxen)</i> <sup>CL</sup> <i>zolmitriptan</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Triptans</a> (required for all drugs)</li> <li>■ Triptans will be approved for migraine treatment in patients ≥ 12 years. Exception: Rizatriptan MLT may be approved for patients ≥ 6 years old.</li> <li>■ Treximet will be approved if patient has tried and failed therapy with separate prescriptions for sumatriptan and naproxen.</li> <li>■ Non-preferred agents will be approved only if the patient has tried and failed therapy with at least two preferred agents (different chemical entities) within the last 6 months.</li> </ul>
<b>Nasal</b>		
sumatriptan	<i>ONZETRA XSAIL (sumatriptan)</i> <b><i>TOSYMRA (sumatriptan)</i></b> <i>ZOMIG (zolmitriptan)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Triptans</a> (required for all drugs)</li> <li>■ Triptans will only be approved for patients with no history of ischemic heart disease, angina pectoris, silent ischemia, ischemic bowel disease, cerebrovascular disease, peripheral vascular disease or malignant or uncontrolled hypertension.</li> <li>■ Non-preferred agents will be approved only if patient has tried and failed therapy with a preferred agent within the last 6 months.</li> </ul>
<b>Injectable</b>		
sumatriptan vial, syringe	<i>SUMAVEL DOSEPRO (sumatriptan)</i> <i>ZEMBRACE SYMTOUCH (sumatriptan)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Triptans</a> (required for all drugs)</li> <li>■ Triptans will only be approved for patients with no history of ischemic heart disease, angina pectoris, silent ischemia, ischemic bowel disease, cerebrovascular disease, peripheral vascular disease or malignant or uncontrolled hypertension.</li> <li>■ Non-preferred agents will be approved only if patient has tried and failed therapy with a preferred agent within the last 6 months.</li> </ul>

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<sup>CL</sup> – Prior Authorization / Class Criteria apply

<sup>NR</sup> – New drug that has not been reviewed by P & T Committee

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020

Highlights indicated change from previous posting.

## ANTIPARASITICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NATROBA (spinosad) permethrin OTC and Rx piperonyl butoxide/pyrethrins shampoo OTC	CROTAN ( <i>crotamiton</i> ) EURAX ( <i>crotamiton</i> ) lotion & cream lindane malathion <b>SKLICE (<i>ivermectin</i>)</b> spinosad ULESFIA ( <i>benzyl alcohol</i> ) VANALICE ( <i>piperonyl butoxide/pyrethrins</i> )	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Antiparasitics, Topical</a> (required for Non-Preferred drugs)</li> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

## ANTIPARKINSON'S DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Anticholinergics</b>		
benztropine trihexyphenidyl tablets, solution		<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Antiparkinson Agents</a></li> <li>▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.</li> </ul>
<b>COMT Inhibitors</b>		
	entacapone tolcapone	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Antiparkinson Agents</a></li> <li>▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.</li> </ul>
<b>Dopamine Agonists</b>		
pramipexole IR ropinirole IR	bromocriptine KYNMOBI ( <i>apomorphine</i> ) <sup>NR</sup> MIRAPEX ER ( <i>pramipexole</i> ) NEUPRO transdermal patch ( <i>rotigotine</i> ) pramipexole ER ropinirole ER	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Antiparkinson Agents</a></li> <li>▪ <a href="#">Link to PA Form for Restless Leg Syndrome</a></li> <li>▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.</li> </ul>
<b>MAO-B Inhibitors</b>		
selegiline capsules, tablets	AZILECT ( <i>rasagiline</i> ) rasagiline XADAGO ( <i>safinamide</i> ) ZELAPAR ( <i>selegiline disintegrating tablets</i> )	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Antiparkinson Agents</a></li> <li>▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.</li> </ul>
<b>Other Antiparkinson's Drugs</b>		
amantadine capsule, syrup, tablets carbidopa/levodopa IR tablets carbidopa/levodopa ER carbidopa/levodopa/entacapone	carbidopa carbidopa/levodopa ODT GOCOVRI ( <i>amantadine</i> ) INBRIJA ( <i>levodopa</i> ) inhalation <sup>CL</sup> NOURIANZ ( <i>istradefylline</i> ) <sup>NR</sup> OSMOLEX ER ( <i>amantadine</i> ) RYTARY ( <i>carbidopa/levodopa ER</i> )	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Antiparkinson Agents</a></li> <li>▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.</li> </ul>

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## ANTIPSYCHOTICS, FIRST GENERATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Oral/Intranasal</b>		
chlorpromazine fluphenazine tablets, solution loxapine perphenazine perphenazine/amitriptyline thiothixene trifluoperazine	<i>haloperidol</i> <i>molindone</i> <i>pimozide</i> <i>thioridazine</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Antipsychotics, Oral</a></li> <li>■ A non-preferred agent will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Injectable (Acute Treatment)</b>		
haloperidol lactate		
<b>Injectable (Maintenance Treatment)</b>		
fluphenazine decanoate	<i>haloperidol decanoate</i>	

## ANTIPSYCHOTICS, SECOND GENERATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Oral/Transdermal</b>		
aripiprazole tablets clozapine tablets LATUDA (lurasidone) olanzapine tablets olanzapine ODT quetiapine tablets quetiapine ER risperidone solution, tablets, ODT ziprasidone capsules	<i>aripiprazole disintegrating tablet</i> <i>ABILIFY MYCITE (aripiprazole) <sup>CL</sup></i> <i>aripiprazole solution</i> <i>CAPLYTA (lumateperone) <sup>NR</sup></i> <i>clozapine ODT</i> <i>FANAPT (iloperidone)</i> <i>FAZACLO (clozapine ODT)</i> <i>NUPLAZID (pimavanserin) <sup>CL</sup></i> <i>olanzapine/fluoxetine (must use individual agents)</i> <i>paliperidone ER</i> <i>REXULTI (brexpiprazole)</i> <i>SAPHRIS (asenapine)</i> <i>SECUADO (asenapine) patch <sup>NR</sup></i> <i>VERSACLOZ (clozapine)</i> <i>VRAYLAR (cariprazine)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Antipsychotics, Oral</a></li> <li>■ A non-preferred agent will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Injectable (Acute Treatment)</b>		
GEODON (ziprasidone) olanzapine		
<b>Injectable (Maintenance Treatment)</b>		
ABILIFY MAINTENA (aripiprazole) <sup>CL</sup> ARISTADA (aripiprazole) <sup>CL</sup> ARISTADA INITIO (aripiprazole) <sup>CL</sup> INVEGA SUSTENNA (paliperidone) <sup>CL</sup> INVEGA TRINZA (paliperidone) <sup>CL</sup> RISPERDAL CONSTA (risperidone) <sup>CL</sup>	<i>PERSERIS (risperidone) <sup>CL</sup></i> <i>ZYPREXA RELPREVV (olanzapine) <sup>CL</sup></i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Injectable Long Acting Antipsychotics 2<sup>nd</sup> Generation</a></li> <li>■ Preferred injectable antipsychotics will be approved within FDA approved age, dosing, and diagnosis parameters in patients who have demonstrated tolerability to oral antipsychotic therapy. Non-preferred agents require</li> </ul>

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		<ul style="list-style-type: none"> <li>trial and failure or contra-indication to a preferred injectable antipsychotic.</li> <li>Zyprexa Relprevv (olanzapine) is reimbursed as a medical benefit only and not dispensed through the outpatient pharmacy program.</li> </ul>
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## ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Antiherpetic Drugs</b>		
acyclovir capsules and tablets valacyclovir	acyclovir <b>suspension</b> famciclovir SITAVIG (acyclovir) buccal	<ul style="list-style-type: none"> <li><a href="#">Link to Universal PA Form</a></li> <li>Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Antiinfluenza Drugs</b>		
oseltamivir <b>capsules</b> , suspension	RELENZA (zanamivir) rimantadine XOFLUZA (baloxavir marboxil)	<ul style="list-style-type: none"> <li><a href="#">Link to Universal PA Form</a></li> <li>Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

## ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	acyclovir cream, ointment <sup>CL</sup> DENA VIR (penciclovir) <sup>CL</sup> XERESE (acyclovir/hydrocortisone) <sup>CL</sup> ZOVIRAX (acyclovir) cream <sup>CL</sup> ZOVIRAX (acyclovir) ointment <sup>CL</sup>	<ul style="list-style-type: none"> <li><a href="#">Link to Form for Antivirals, Topical</a></li> <li>The CDC discourages the use of topical therapy for the treatment of genital herpes.</li> <li>Topical agents will not be approved unless substantial documentation of clinical benefit over oral therapy is provided.</li> </ul>

## ANXIOLYTICS/BENZODIAZEPINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bupirone clonazepam tablets diazepam tablets, solution lorazepam tablet	alprazolam alprazolam ER alprazolam intensol, ODT chlordiazepoxide clonazepam ODT clorazepate diazepam syringe, vial diazepam intensol lorazepam intensol meprobamate oxazepam	<ul style="list-style-type: none"> <li><a href="#">Link to Universal PA Form</a></li> <li>Non-preferred agents will be approved only after documented failure of a preferred agent.</li> <li><a href="#">Link to PA Form for Clonazepam ODT Form.</a></li> <li>Clonazepam orally disintegrating tablets (ODT) will be approved for patients that have a diagnosis of panic disorder with or without agoraphobia whose clonazepam dose is being titrated up or down or who have a documented inability to swallow other oral medication dosage forms.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020  
Highlights indicated change from previous posting.

## BETA BLOCKERS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Beta Blockers</b>		
atenolol bisoprolol metoprolol metoprolol XL propranolol propranolol ER sotalol	<i>acebutolol</i> <i>betaxolol</i> <i>BYSTOLIC (nebivolol)</i> <i>HEMANGEOL (propranolol)</i> <sup>CL</sup> <i>INDERAL XL (propranolol)</i> <i>INNOPRAN XL (propranolol)</i> <i>KAPSPARGO (metoprolol)</i> <i>nadolol</i> <i>pindolol</i> <i>SOTYLIZE (sotalol)</i> <sup>CL</sup> <i>timolol</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Beta Adrenergic Blockers</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent within the last 6 months.</li> </ul>
<b>Beta Blocker/Diuretic Combinations</b>		
atenolol/chlorthalidone bisoprolol/hydrochlorothiazide	<i>DUTOPROL (metoprolol succinate/hydrochlorothiazide)</i> <i>metoprolol/hydrochlorothiazide</i> <i>nadolol/bendroflumethiazide</i> <i>propranolol/hydrochlorothiazide</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Beta Adrenergic Blockers</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent within the last 6 months.</li> </ul>
<b>Beta- and Alpha- Blockers</b>		
carvedilol labetalol	<i>carvedilol ER (COREG CR)</i> <i>COREG CR (carvedilol)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Beta Adrenergic Blockers</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent within the last 6 months.</li> </ul>

## BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
oxybutynin ER oxybutynin IR <b>solifenacin</b> TOVIAZ (fesoterodine)	<i>darifenacin ER</i> <i>ENABLEX (darifenacin ER)</i> <i>flavoxate</i> <i>GELNIQUE (oxybutynin)</i> <i>MYRBETRIQ (mirabegron)</i> <i>OXYTROL transdermal (oxybutynin)</i> <i>tolterodine</i> <i>tolterodine ER</i> <i>tropium</i> <i>tropium ER</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Bladder Relaxants</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020

Highlights indicated change from previous posting.

## BONE RESORPTION SUPPRESSION AND RELATED AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Bisphosphonates</b>		
alendronate tablets <b>ibandronate tablets</b>	<i>alendronate solution</i> <i>ATELVIA (risedronate)</i> <i>BINOSTO (alendronate)</i> <i>FOSAMAX Plus D (alendronate/cholecalciferol)</i> <i>risedronate</i>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Bone Resorption Suppression and Related Agents</a> (required for Non-Preferred drugs)</li> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent</li> </ul>
<b>Other Bone Resorption Suppression and Related Drugs</b>		
calcitonin-salmon	<b><i>EVENITY (romosozumab)</i></b> <i>FORTEO (teriparatide)<sup>CL</sup></i> <i>PROLIA (denosumab)</i> <i>TYMLOS (abaloparatide)</i>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Bone Resorption Suppression and Related Agents</a> for Non-Preferred drugs</li> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> <li>▪ Forteo will also be approved for patients that have a diagnosis of glucocorticoid-induced osteoporosis: ICD-10 M81.8 plus history of glucocorticoid prescription use OR documented failure of a Preferred agent</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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## BOTULINUM TOXINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>BOTOX<sup>CL</sup> (onabotulinumtoxinA) –(except for cervical dystonia)</p> <p>DYSPOORT<sup>CL</sup> (abobotulinumtoxinA)</p> <p>MYOBLOC<sup>CL</sup> (rimabotulinumtoxinB)</p> <p>XEOMIN<sup>CL</sup> (incobotulinumtoxinA)</p>	<p>BOTOX<sup>CL</sup> (onabotulinumtoxinA) – (for cervical dystonia)</p>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Botulinum toxin, Other</a></li> <li>■ <a href="#">Link to PA Form for Botox for Migraines</a></li> <li>■ Botox will be approved for the following indications:               <ul style="list-style-type: none"> <li>▪ Chronic daily headaches defined as &gt; 15 days/month lasting &gt; 4 hours/day for patients who have failed at least two oral prophylactic medications and at least two rescue medications (e.g. triptans).</li> <li>▪ Spasticity in patients who have failed at least two oral skeletal muscle relaxants.</li> <li>▪ Overactive bladder in patients who have failed at least two oral anticholinergic agents.</li> <li>▪ Urinary incontinence due to detrusor overactivity associated with a neurologic condition in patients who have failed at least two oral anticholinergic agents.</li> <li>▪ Blepharospasm and strabismus.</li> <li>▪ For cervical dystonia, trial and failure of a preferred botulinum toxin.</li> </ul> </li> <li>■ Dsyport will be approved for the following indications:               <ul style="list-style-type: none"> <li>▪ Cervical dystonia in patients who have tried and failed at least two oral skeletal muscle relaxants.</li> <li>▪ Spasticity in patients who have failed at least two oral skeletal muscle relaxants.</li> </ul> </li> <li>■ Myobloc will be approved for the following indications:               <ul style="list-style-type: none"> <li>▪ Cervical dystonia in patients who have tried and failed at least two oral skeletal muscle relaxants.</li> </ul> </li> <li>■ Xeomin will be approved for the following indications:               <ul style="list-style-type: none"> <li>▪ Blepharospasm</li> <li>▪ Cervical dystonia in patients who have tried and failed at least two oral skeletal muscle relaxants.</li> <li>▪ Spasticity in patients who have failed at least two oral skeletal muscle relaxants.</li> </ul> </li> </ul>

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## BPH TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Alpha Blockers</b>		
alfuzosin doxazosin tamsulosin terazosin	<i>CARDURA XL (doxazosin)</i> <i>RAPAFLO (silodosin)</i> <i>silodosin</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>5-Alpha-Reductase (5AR) Inhibitors</b>		
dutasteride finasteride 5 mg tablet		<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Combination Agents</b>		
	<i>dutasteride/tamsulosin</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Non-preferred agents will be approved only after documented failure of individual agents.</li> </ul>

## BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Inhalers, Short-Acting</b>		
PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	<i>albuterol HFA (generic PROAIR)</i> <i>albuterol HFA (generic PROVENTIL)</i> <i>albuterol HFA (generic for VENTOLIN)</i> <i>levalbuterol HFA</i> <i>PROAIR RESPICLICK (albuterol)</i> <i>VENTOLIN HFA (albuterol)</i> <i>XOPENEX HFA (levalbuterol)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Short-Acting Beta-2 Agonists</a> (required for Non-preferred drugs)</li> <li>■ The non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Bronchodilators, Beta Agonist Inhalers, Long-Acting</b>		
SEREVENT (salmeterol) <sup>CL</sup>	<i>STRIVERDI RESPIMAT (olodaterol)<sup>CL</sup></i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Long-Acting Beta-2 Agonists</a> (required for Non-Preferred drugs)</li> <li>■ Long-acting beta agonist inhalers will be approved for participants meeting the following criteria               <ul style="list-style-type: none"> <li>■ Concurrent (i.e., active therapy on the in-process claim date) use of a short-acting beta-2-agonist MDI or nebulizer in the last 30 days <b>PLUS</b></li> <li>■ Age &gt;17 years old <b>PLUS</b></li> <li>■ Diagnosis of chronic obstructive pulmonary disease (COPD), chronic bronchitis and emphysema (ICD-9 = 491.xx, 492.xx, 493.xx, 496.xx)</li> </ul> <p style="text-align: center;"><b>OR</b></p> <li>■ Concomitant inhaled corticosteroid use</li> </li></ul>

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## BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Inhalation Solution</b>		
albuterol	<i>levalbuterol</i> <i>BROVANA (arformoterol)</i> <i>PERFOROMIST (formoterol)</i>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Short-Acting Beta-2 Agonists</a> (required for Non-preferred drugs)</li> <li>▪ <a href="#">Link to PA Form for Long-Acting Beta-2 Agonists</a> (Brovana/Perforomist) (required for Non-preferred drugs)</li> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> <li>▪ Long-acting inhalation solution will be approved for participants meeting the following criteria                             <ul style="list-style-type: none"> <li>▪ Concurrent (i.e., active therapy on the in-process claim date) use of a short-acting beta-2-agonist MDI or nebulizer in the last 30 days <b>PLUS</b></li> <li>▪ Age &gt;17 years old <b>PLUS</b></li> <li>▪ Diagnosis of chronic obstructive pulmonary disease (COPD), chronic bronchitis and emphysema (ICD-9 = 491.xx, 492.xx, 493.xx, 496.xx)</li> </ul> <p style="text-align: center;"><b>OR</b></p> <li>▪ Concomitant inhaled corticosteroid use</li> </li></ul>
<b>Oral</b>		
	<i>albuterol tablets, solution</i> <i>albuterol ER</i> <i>metaproterenol tablets, solution</i> <i>terbutaline</i>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to Universal PA Form</a> (required for Non-Preferred drugs)</li> <li>▪ Non-preferred agents require medical justification for using an oral beta agonist rather than an inhaled beta agonist.</li> </ul>

## CALCIUM CHANNEL BLOCKERS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Short-Acting</b>		
diltiazem nifedipine verapamil	<i>isradipine</i> <i>nicardipine</i>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to Universal PA Form</a></li> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Long-Acting</b>		
amlodipine diltiazem ER capsules (generic for Cardizem CD) nifedipine ER verapamil ER tablets	<i>diltiazem ER tablets (generic for Cardizem LA)</i> <i>felodipine ER</i> <b>KATERZIA (amlodipine)</b> <i>nimodipine</i> <i>nisoldipine</i> <i>NYMALIZE (nimodipine)</i> <i>TIAZAC (diltiazem) 420 mg</i> <i>verapamil ER PM</i> <i>verapamil ER capsules</i>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to Universal PA Form</a></li> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

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CL – Prior Authorization / Class Criteria apply

NR – New drug that has not been reviewed by P & T Committee

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020

Highlights indicated change from previous posting.

## CEPHALOSPORINS AND RELATED AGENTS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Beta Lactam/Beta-Lactamase Inhibitor Combinations</b>		
amoxicillin/clavulanate IR tablets amoxicillin/clavulanate suspension except 125 mg/31.25 mg/5 mL	<i>amoxicillin/clavulanate chew tablets</i> <i>amoxicillin/clavulanate XR</i> <i>AUGMENTIN (amoxicillin/clavulanate)</i> <i>125/31.25 mg/5 ml suspension</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Cephalosporins Oral and Related Agents</a> (required for Non-preferred drugs)</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Cephalosporins – First Generation</b>		
cefadroxil capsules, suspension cephalexin capsules, suspension	<i>cefadroxil tablet</i> <i>cephalexin tablets</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Cephalosporins Oral and Related Agents</a> (required for Non-preferred drugs)</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Cephalosporins – Second Generation</b>		
cefprozil suspension, tablets cefuroxime tablets	<i>cefaclor capsules</i> <i>cefaclor ER</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Cephalosporins Oral and Related Agents</a> (required for Non-preferred drugs)</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Cephalosporins – Third Generation</b>		
cefdinir capsules, suspension	<i>cefixime <b>capsules</b>, suspension</i> <i>cefepodoxime suspension, tablets</i> <i>SUPRAX (cefixime) chew tablets</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Cephalosporins Oral and Related Agents</a> (required for Non-preferred drugs)</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

## COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GRANIX (tbo-filgrastim) NEUPOGEN (filgrastim)	<i>FULPHILA (pegfilgrastim-jmdb)</i> <i>LEUKINE (sargramostim)</i> <i>NEULASTA (pegfilgrastim)</i> <i>NIVESTYM (filgrastim-aafi)</i> <i>UDENYCA (pegfilgrastim-cbqv)</i> <i>ZARXIO (filgrastim-sndz)</i> <i>ZIEXTENZO (pegfilgrasti) <sup>NR</sup></i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

## CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<i>All agents are recommended preferred at this time</i>		

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CL – Prior Authorization / Class Criteria apply

NR – New drug that has not been reviewed by P & T Committee

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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Highlights indicated change from previous posting.

## COPD AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Anticholinergics</b>		
ATROVENT HFA (ipratropium) ipratropium nebulizer solution SPIRIVA capsules (tiotropium)	INCRUSE ELLIPTA (umeclidinium) LONHALA MAGNAIR (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) TUDORZA PRESSAIR (aclidinium) YUPELRI (revefenacin)	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for COPD Agents</a></li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Anticholinergic-Beta Agonist Combinations</b>		
albuterol/ipratropium BEVESPI AEROSPHERE (glycopyrrolate/formoterol) COMBIVENT RESPIMAT (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	ANORO ELLIPTA (umeclidinium /vilanterol) DUAKLIR PRESSAIR (aclidinium/formoterol) <sup>NR</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for COPD Agents</a></li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>PDE-4 Inhibitors</b>		
	DALIRESP (roflumilast) <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Daliresp</a></li> <li>■ Daliresp will be approved for adults with severe COPD associated with chronic bronchitis and a history of exacerbations</li> </ul>

## COUGH AND COLD AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
No agents are recommended to be preferred at this time.	<i>All products are non-preferred</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ The Idaho Medicaid Pharmacy and Therapeutics Committee has recommended not to approve cough and cold medications due to the absence of evidence establishing clinical efficacy and safety.</li> </ul>

## CYSTIC FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
KALYDECO (ivacaftor) <sup>CL</sup> SYMDEKO (ivacaftor/tezacaftor) <sup>CL</sup> TRIKAFTA (elexacaftor/tezacaftor and ivacaftor) <sup>CL</sup>	ORKAMBI (lumacaftor/ivacaftor) <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Agents will be approved for cystic fibrosis (CF) patients with documentation of the drug specific FDA approved mutation of the CFTR gene within age and quantity parameters.</li> </ul>

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<sup>CL</sup> – Prior Authorization / Class Criteria apply

<sup>NR</sup> – New drug that has not been reviewed by P & T Committee

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020

Highlights indicated change from previous posting.

## CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Anti-Tumor Necrosis Factor (TNF) Biologics</b>		
ENBREL (etanercept) ENBREL (etanercept) MINI CARTRIDGE HUMIRA (adalimumab)	<i>CIMZIA (certolizumab)</i> <i>INFLECTRA (infliximab)</i> <i>REMICADE (infliximab)</i> <i>RENFLEXIS (infliximab)</i> <i>SIMPONI ARIA (golimumab)</i> <i>SIMPONI SQ (golimumab)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Cytokine &amp; CAM Antagonists</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Other Biologic Agents</b>		
	<i>ACTEMRA (tocilizumab)</i> <i>ARCALYST (rilonacept)</i> <i>COSENTYX (secukinumab)</i> <sup>CL</sup> <i>ENTYVIO (vedolizumab)</i> <i>ILARIS (canakinumab)</i> <i>ILUMYA (tildrakizumab -asmn)</i> <i>KEVZARA (sarilumab)</i> <i>KINERET (anakinra)</i> <i>ORENCIA (abatacept)</i> <i>SILIQ (brodalumab)</i> <i>SKYRIZI (risankizumab)</i> <i>STELARA (ustekinumab)</i> <i>TALTZ (ixekizumab)</i> <i>TREMFYA (guselkumab)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Cytokine &amp; CAM Antagonists</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Non-Biologic Agents</b>		
	<i>OLUMIANT (baricitinib)</i> <i>OTEZLA (apremilast)</i> <i>RINVOQ ER (upadacitinib)</i> <i>XELJANZ (tofacitinib)</i> <i>XELJANZ XR (tofacitinib)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Cytokine &amp; CAM Antagonists</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

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<sup>CL</sup> – Prior Authorization / Class Criteria apply

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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## EPINEPHRINE, SELF-INJECTED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
epinephrine (generic EPIPEN, EPIPEN JR)	<i>epinephrine (ADRENALCLICK)</i> <i>SYMJEPI (epinephrine)</i>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

## ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ARANESP (darbepoetin) RETACRIT (epoetin alfa-epbx)	<i>EPOGEN (rHuEPO)</i> <i>PROCRIT (rHuEPO)</i> <i>REBLOZYL (luspatercept) <sup>NR</sup></i>	<ul style="list-style-type: none"> <li><a href="#">Link to PA Form for Erythropoiesis Stimulating Proteins</a></li> <li>Non-preferred agents will only be authorized if there is documented failure of one preferred agent within the past 180 days.</li> </ul>

## FLUOROQUINOLONES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ciprofloxacin tablet CIPRO Suspension (ciprofloxacin) levofloxacin tablets	<i>BAXDELA (delafloxacin)</i> <i>ciprofloxacin ER</i> <i>ciprofloxacin suspension</i> <i>levofloxacin solution</i> <i>moxifloxacin</i> <i>ofloxacin</i>	<ul style="list-style-type: none"> <li><a href="#">Link to PA Form for Fluoroquinolones</a> (required for Non-Preferred drugs)</li> <li>Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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Highlights indicated change from previous posting.

## GI MOTILITY, CHRONIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AMITIZA (lubiprostone) <sup>CL</sup> LINZESS (linaclotide) <sup>CL</sup> MOVANTIK (naloxegol) <sup>CL</sup>	alosetron <sup>CL</sup> LOTRONEX (alosetron) <sup>CL</sup> MOTEGRITY (prucalopride) <sup>CL</sup> RELISTOR (methylnaltrexone) oral, syringe, vial <sup>CL</sup> SYMPROIC (naldemedine) <sup>CL</sup> TRULANCE (plecanatide) <sup>CL</sup> VIBERZI (eluxadoline) <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for GI Motility</a></li> <li>■ Linzess or Trulance will be approved for participants with a diagnosis of chronic idiopathic constipation or irritable bowel syndrome. Trulance will also require a failure of Linzess or Amitiza 24 mg.</li> <li>■ Amitiza 8 mcg capsules will be approved for female participants with irritable bowel syndrome with constipation.</li> <li>■ Amitiza 24 mcg capsules will be approved for participants with chronic idiopathic constipation or participants with chronic constipation that have been on opioids continuously for at least four weeks.</li> <li>■ Lotronex/alosetron will be approved for female participants with diarrhea-predominant irritable bowel syndrome.</li> <li>■ Movantik will be approved for participants with chronic constipation that have been on opioids continuously for at least four weeks.</li> <li>■ Relistor will be approved for participants with chronic constipation that have been on opioids continuously for at least four weeks and have tried and failed Amitiza 24 mcg or Movantik.</li> <li>■ Trulance will be approved for participants with chronic idiopathic constipation who have failed Linzess or Amitiza 24 mg.</li> <li>■ Viberzi will be approved for participants with diarrhea-predominant irritable bowel syndrome.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020  
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## GLUCOCORTICIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Glucocorticoids</b>		
ASMANEX Twisthaler (mometasone) budesonide respules 0.25, 0.5 mg <sup>CL</sup> FLOVENT (fluticasone) HFA PULMICORT (budesonide) Respules 1 mg <sup>CL</sup>	ALVESCO ( <i>ciclesonide</i> ) ARNUITY ELLIPTA ( <i>fluticasone</i> ) ASMANEX HFA ( <i>mometasone</i> ) budesonide respules 1 mg FLOVENT ( <i>fluticasone</i> ) DISKUS PULMICORT ( <i>budesonide</i> ) FLEXHALER QVAR ( <i>beclomethasone</i> ) REDHALER	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Inhaled Glucocorticoids</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.</li> <li>■ Pulmicort/budesonide Respules are only preferred for the treatment of asthma in children 8 years and younger.</li> </ul>
<b>Glucocorticoid/Bronchodilator Combinations <sup>CL</sup></b>		
ADVAIR (fluticasone/salmeterol) <sup>CL</sup> SYMBICORT (budesonide/formoterol) <sup>CL</sup>	AIRDUO ( <i>fluticasone/salmeterol</i> ) RESPICLICK <sup>CL</sup> BREO ELLIPTA ( <i>fluticasone/vilanterol</i> ) <sup>CL</sup> DULERA ( <i>mometasone/formoterol</i> ) <sup>CL</sup> <i>fluticasone/salmeterol</i> TRELEGY ELLIPTA ( <i>fluticasone/umeclidinium/vilanterol</i> ) <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Inhaled Glucocorticoid/Bronchodilator Combinations</a> (required for all drugs)</li> <li>■ Asthma:                             <ul style="list-style-type: none"> <li>■ Advair, fluticasone/salmeterol generic or Symbicort will be approved for eligible participants with a documented diagnosis of persistent asthma (ICD-10 = J45).</li> <li>■ Dulera or Breo Ellipta will be approved for eligible participants with a documented diagnosis of persistent asthma (ICD-10 = J45) who have tried and failed Advair, fluticasone/salmeterol generic or Symbicort within the last 180 days</li> </ul> </li> <li>■ COPD:                             <ul style="list-style-type: none"> <li>■ Advair Diskus 250/50, Wixela 250/50 or Symbicort 160/4.5 will be approved for eligible participants with a diagnosis of Stage III or Stage IV COPD (ICD-10 = J44).</li> <li>■ Breo Ellipta 100/25 will be approved for eligible participants with a diagnosis of Stage III or Stage IV COPD and trial and failure of Advair Diskus 250/50, Wixela 250/50 or Symbicort 160/4.5</li> <li>■ Trelegy Ellipta will be approved for eligible participants with a diagnosis of Stage III or Stage IV COPD and trial and failure of Advair Diskus 250/50, Wixela 250/50, Symbicort 160/4.5 or Breo Ellipta 100/25.</li> </ul> </li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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Highlights indicated change from previous posting.

## GROWTH HORMONE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GENOTROPIN (somatropin) <sup>CL</sup> NORDITROPIN (somatropin) <sup>CL</sup>	<i>HUMATROPE (somatropin)<sup>CL</sup></i> <i>NUTROPIN AQ (somatropin)<sup>CL</sup></i> <i>OMNITROPE (somatropin)<sup>CL</sup></i> <i>SAIZEN (somatropin)<sup>CL</sup></i> <i>SEROSTIM (somatropin)<sup>CL</sup></i> <i>ZOMACTON (somatropin)<sup>CL</sup></i> <i>ZORBTIVE (somatropin)<sup>CL</sup></i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Growth Hormone</a> (required for all drugs)</li> <li>■ Growth hormone will be approved for patients with any of the following diagnoses and meeting the criteria defined on the PA Form:                             <ul style="list-style-type: none"> <li>■ Chronic Renal Impairment awaiting renal transplantation (ICD-10 N18.9)</li> <li>■ Growth Hormone Deficiency (ICD-10 E23.0)</li> <li>■ Prader-Willi Syndrome (ICD-10 Q87.1)</li> <li>■ Turner Syndrome (ICD-10 Q96.0)</li> <li>■ HIV plus Cachexia (ICD-10 B20)</li> </ul> </li> <li>■ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.</li> </ul>

## H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PYLERA (bismuth subcitrate potassium, metronidazole, tetracycline)	<i>lansoprazole, amoxicillin, clarithromycin</i> <i>OMECLAMOX-PAK (omeprazole, amoxicillin, clarithromycin)</i> <i>TALICIA (omeprazole, amoxicillin, rifabutin)<sup>NR</sup></i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for H. Pylori Treatment</a></li> <li>■ Non-preferred agents will only be approved after the documented trial and failure of a preferred agent.</li> <li>■ Individual agents should be used in place of combination agents of omeprazole or lansoprazole with amoxicillin and clarithromycin.</li> </ul>

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## HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Interferon</b>		
PEGASYS (pegylated interferon alfa-2a) syringe, vial PEG-INTRON (pegylated interferon alfa-2b)	PEGASYS (pegylated interferon alfa-2a) Proclick	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Hepatitis C - Interferon and Ribavirin</a> (required for Non-preferred drugs)</li> <li>■ Non-preferred agents will only be approved after the documented trial and failure of a preferred agent.</li> </ul>
<b>Ribavirin</b>		
ribavirin tablet, capsule	RIBAPAK (ribavirin) RIBASPHERE (ribavirin)	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Hepatitis C - Interferon and Ribavirin</a> (required for Non-preferred drugs)</li> <li>■ Non-preferred agents will only be approved after the documented trial and failure of a preferred agent.</li> </ul>
<b>Direct-Acting Anti-Viral Agents<sup>CL</sup></b>		
MAVYRET (glecaprevir/pibrentasvir) <sup>CL</sup> <b>sofosbuvir/velpatasvir<sup>CL</sup></b> VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) <sup>CL</sup>	ledipasvir/sofosbuvir <sup>CL</sup> SOVALDI (sofosbuvir) <sup>CL</sup> VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir) <sup>CL</sup> ZEPATIER (elbasvir/grazoprevir) <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Treatment of Hepatitis C Virus</a></li> <li>■ For complete criteria refer to the document entitled <a href="#">Hepatitis C Agents Therapeutic Criteria</a></li> </ul>

## HEREDITARY ANGIOEDEMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Acute Treatment</b>		
FIRAZYR (icatibant) <sup>CL</sup> KALBITOR (ecallantide) <sup>CL</sup>	BERINERT (C1-esterase inhibitor) <sup>CL</sup> <b>icatibant<sup>CL</sup></b> RUCONEST (recombinant C1 esterase) <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Treatment of Acute Attacks: <ul style="list-style-type: none"> <li>■ Preferred agents which require documentation of diagnosis are Firazyr and Kalbitor.</li> <li>■ Non-preferred Berinert and Ruconest require trial and failure of a preferred agent or a contra-indication to a preferred agent.</li> </ul> </li> </ul>
<b>Prophylaxis</b>		
CINRYZE (C1- esterase inhibitor) <sup>CL</sup> <b>HAEGARDA (C1-esterase inhibitor)<sup>CL</sup></b>	TAKHZYRO (lanadelumab-FLYO) <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Prophylaxis: <ul style="list-style-type: none"> <li>■ Preferred agents require documentation of diagnosis, history of 2 or more HAE attacks monthly, and trial and failure or contra-indication to oral danazol and/or oral tranexamic acid.</li> <li>■ Non-preferred Takhzyro requires trial and failure or contra-indication to a preferred agent.</li> </ul> </li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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## HIV/AIDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>CCR5 Antagonists</b>		
SELZENTRY (maraviroc) solution, tablet		
<b>Combination-Nucleos(t)ide Reverse Transcriptase Inhibitors</b>		
abacavir/lamivudine CIMDUO (lamivudine/tenofovir disoproxil fumarate) DESCOVY (emtricitabine/tenofovir alafenamide) lamivudine/zidovudine TRIZIVIR (abacavir /lamivudine/zidovudine) TRUVADA (tenofovir disoproxil fumarate/emtricitabine)	abacavir/lamivudine/zidovudine TEMIXYS (lamivudine/tenofovir disoproxil fumarate)	
<b>Combination Products – Multiple Classes</b>		
ATRIPLA (tenofovir disoproxil fumarate/emtricitabine/efavirenz) BIKTARVY (bictegravir/emtricitabine/tenofovir alafenamide) COMPLERA (tenofovir disoproxil fumarate/efavirenz) DELSTRIGO (doravirine/lamivudine/tenofovir disoproxil fumarate) GENVOYA (elvitegravir /cobicistat/emtricitabine/tenofovir alafenamide) ODEFSEY (emtricitabine/rilpivirine/tenofovir alafenamide) SYMFI (efavirenz/lamivudine/tenofovir disoproxil fumarate) SYMFI LO (efavirenz/lamivudine/tenofovir disoproxil fumarate) STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate) TRIUMEQ (dolutegravir/abacavir/lamivudine)	DOVATAO (dolutegravir/lamivudine) JULUCA (dolutegravir/rilpivirine) SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir alafenamide)	
<b>Combination Products -Protease Inhibitors or Protease Inhibitors + Pharmacokinetic Enhancer</b>		
EVOTAZ (atazanavir/cobicistat) KALETRA (lopinavir/ritonavir) PREZCOBIX (darunavir/cobicistat)	lopinavir/ritonavir solution	
<b>Fusion Inhibitor</b>		
	FUZEON (enfuvirtide) RUKOBIA (fostemsavir) <sup>NR</sup>	
<b>Integrase Strand Transfer Inhibitors (INSTI)</b>		
ISENTRESS (raltegravir) ISENTRESS HD (raltegravir) TIVICAY (dolutegravir)		
<b>Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)</b>		
EDURANT (rilpivirine) efavirenz INTELENCE (etravirine) nevirapine tablet, extended release PIFELTRO (doravirine)	nevirapine suspension RESCRIPTOR (delavirdine)	

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<sup>CL</sup> – Prior Authorization / Class Criteria apply

<sup>NR</sup> – New drug that has not been reviewed by P & T Committee

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020

Highlights indicated change from previous posting.

## HIV/AIDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Nucleos(t)ide Reverse Transcriptase Inhibitors (NRTI)</b>		
abacavir EMTRIVA (emtricitabine) lamivudine tenofovir zidovudine	didanosine stavudine	
<b>Pharmacokinetic Enhancer</b>		
	TYBOST (cobicistat)	
<b>Protease Inhibitors</b>		
atazanavir LEXIVA (fosamprenavir) PREZISTA (darunavir) ritonavir	APTIVUS (tipranavir) CRIXIVAN (indinavir) fosamprenavir INVIRASE (saquinavir) VIRACEPT (nelfinavir)	
<b>Recombinant Monoclonal Antibody</b>		
	TROGARZO (ibalizumab-uiyk) IV	

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020

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## HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>INCRETIN ENHANCERS</b>		
GLYXAMBI (empagliflozin/linagliptin) JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	<i>alogliptin</i> <i>alogliptin/metformin</i> <i>alogliptin/pioglitazone</i> <i>JENTADUETO XR (linagliptin/metformin)</i> <i>KOMBIGLYZE XR (saxagliptin/metformin)</i> <i>ONGLYZA (saxagliptin)</i> <i>QTERN (dapagliflozin/saxagliptin)</i> <i>STEGLUJAN (ertugliflozin/sitagliptin)</i> <i>TRIJARDY XR</i> <i>(empagliflozin/linagliptin/metformin)<sup>NR</sup></i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Hypoglycemics – Incretin Enhancers</a></li> <li>■ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.</li> </ul>
<b>INCRETIN MIMETICS</b>		
<b>OZEMPIC (semaglutide)<sup>CL</sup></b> SYMLIN (pramlintide) <sup>CL</sup> VICTOZA (liraglutide) <sup>CL</sup>	<i>ADLYXIN (lixisenatide)<sup>CL</sup></i> <b><i>BYDUREON (exenatide ER)<sup>CL</sup> pens</i></b> <i>BYDUREON BCISE (exenatide)<sup>CL</sup></i> <b><i>BYETTA (exenatide)<sup>CL</sup></i></b> <b><i>RYBELSUS (semaglutide)<sup>CL</sup></i></b> <i>SOLIQUA (Insulin glargine/lixisenatide)<sup>CL</sup></i> <i>TRULICITY (dulaglutide)<sup>CL</sup></i> <i>XULTOPHY (Insulin degludec/liraglutide)<sup>CL</sup></i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Hypoglycemics, Incretin Mimetics</a> (for all products except Symlin)</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> <li>■ <a href="#">Link to PA Form for Symlin</a></li> <li>■ Symlin will be approved for patients with diabetes who are currently on insulin therapy.</li> <li>■ Symlin will not be approved for pediatric patients &lt;6 years of age or for patients with a diagnosis of gastroparesis or who require the use of medication to stimulate gastric motility.</li> </ul>

## HYPOGLYCEMICS, INSULIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HUMALOG (insulin lispro) except 200 U/ml <b>HUMALOG JUNIOR KWIKPEN (insulin lispro)</b> HUMALOG MIX (insulin lispro/lispro protamine) HUMULIN (insulin) <b>HUMULIN (insulin) 70/30</b> <b>HUMULIN (insulin) 500 U/ml</b> LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	<i>ADMELOG (insulin lispro)</i> <i>AFREZZA (insulin, inhaled)<sup>CL</sup></i> <i>APIDRA (insulin glulisine)</i> <i>BASAGLAR KWIKPEN (insulin glargine)</i> <i>FIASP (insulin aspart)</i> <i>HUMALOG (insulin lispro) 200 U/ml</i> <b><i>insulin aspart</i></b> <b><i>insulin aspart/aspart protamine</i></b> <i>insulin lispro</i> <i>LYUMJEV (insulin lispro-aabc)<sup>NR</sup></i> <i>NOVOLIN (insulin)</i> <b><i>NOVOLIN (insulin) 70/30</i></b> <i>TOUJEO (insulin glargine)</i> <i>TOUJEO MAX SOLOSTAR (insulin glargine)</i> <i>TRESIBA (insulin degludec) Flextouch, vial</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Insulin</a> (required for non-preferred drugs)</li> <li>■ Apidra will be approved for participants with documented hypoglycemia with Humalog or NovoLog.</li> <li>■ Afrezza requires medical necessity documentation for why injectable insulin cannot be used.</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

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<sup>NR</sup> – New drug that has not been reviewed by P & T Committee

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020

Highlights indicated change from previous posting.

## HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
glyburide-metformin metformin metformin ER (GLUCOPHAGE XR)	<i>FORTAMET (metformin ER)</i> <i>glipizide-metformin</i> <i>metformin ER (FORTAMET)</i> <i>metformin ER (GLUMETZA)</i> <i>RIOMET (metformin) oral solution</i> <b><i>RIOMET ER (metformin) oral solution</i></b>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

## HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin) <sup>CL</sup> INVOKANA (canagliflozin) <sup>CL</sup> <b>INVOKAMET (canagliflozin/metformin) <sup>CL</sup></b> JARDIANCE (empagliflozin) <sup>CL</sup> SYNJARDY (empagliflozin/metformin) <sup>CL</sup> <b>XIGDUO XR (dapagliflozin/metformin XR) <sup>CL</sup></b>	<i>INVOKAMET XR (canagliflozin/metformin) <sup>CL</sup></i> <i>SEGLUOMET (ertugliflozin/metformin) <sup>CL</sup></i> <i>STEGLATRO (ertugliflozin) <sup>CL</sup></i> <i>SYNJARDY XR (empagliflozin/metformin) <sup>CL</sup></i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for SGLT2 Inhibitors</a> (required for non-preferred drugs)</li> <li>■ Preferred sodium Glucose Co-transporter Inhibitors will be approved after a trial of metformin within the previous 30 days.</li> <li>■ Non-preferred agents will be approved after a trial of any agent in the following drug classes within the previous 30 days <u>and</u> a failure of a preferred SGLT2 Inhibitor: <ul style="list-style-type: none"> <li>■ Metformins</li> <li>■ Incretin mimetic/enhancers</li> <li>■ Insulins</li> </ul> </li> <li>■ Jardiance (empagliflozin) will be approved for patients with both Type 2 diabetes mellitus and atherosclerotic cardiovascular disease defined as a documented history of coronary artery disease, stroke, or peripheral artery disease <u>OR</u> after a trial of any agent in the following drug classes within the previous 30 days and a failure of a preferred SGLT2 Inhibitor: <ul style="list-style-type: none"> <li>■ Metformins</li> <li>■ Incretin mimetic/enhancers</li> <li>■ Insulins</li> </ul> </li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020  
Highlights indicated change from previous posting.

## HYPOGLYCEMICS, TZDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Thiazolidinediones</b>		
pioglitazone	<i>AVANDIA (rosiglitazone)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Thiazolidinedione Combinations</b>		
	<i>pioglitazone/glimepiride<sup>CL</sup></i> <i>pioglitazone/metformin<sup>CL</sup></i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

## IMMUNE GLOBULINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Primary Immunodeficiency Products</b>		
BIVIGAM intravenous solution <sup>CL</sup> CUTAQUIG subcutaneous solution <sup>CL</sup> CUVITRU subcutaneous solution <sup>CL</sup> CYTOGAM (cytomegalovirus immune globulin) intravenous solution <sup>CL</sup> FLEBOGAMMA DIF intravenous solution <sup>CL</sup> GAMASTAN S/D intramuscular <sup>CL</sup> GAMMAGARD LIQUID injection solution <sup>CL</sup> GAMMAGARD S/D powder for intravenous solution <sup>CL</sup> GAMMAKED injection solution <sup>CL</sup> GAMMAPLEX intravenous solution <sup>CL</sup> GAMUNEX-C injection solution <sup>CL</sup> HIZENTRA subcutaneous solution <sup>CL</sup> HYQVIA subcutaneous solution <sup>CL</sup> OCTAGAM intravenous solution <sup>CL</sup> PANZYGA intravenous solution <sup>CL</sup> PRIVIGEN intravenous solution <sup>CL</sup>	<i>ASCENIV intravenous solution<sup>NR</sup></i> <i>XEMBIFY subcutaneous solution<sup>NR</sup></i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Immune Globulin PA Form</a></li> <li>■ Preferred immune globulin products will be approved for FDA indications or for diagnoses that have evidence-based documentation to support their usage for which there are no therapeutic alternatives. Usual age, dosage, and frequency limitations apply as well as reasonable dosage rounding (+/- 10%) to utilize whole vials to minimize wastage.</li> <li>■ Non-preferred agents require either trial and failure of a preferred agent or documentation of medical necessity.</li> </ul>
<b>Virus Products</b>		
HYPERHEP B S-D injection solution VARIZIG (Varicella-Zoster immune globulin) intramuscular <sup>CL</sup>	<i>HEPAGAM B (hepatitis B immune globulin) intramuscular<sup>CL</sup></i> <i>HYPER RAB<sup>CL</sup></i> <i>KED RAB<sup>CL</sup></i>	

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020

Highlights indicated change from previous posting.

## IMMUNOMODULATORS FOR ATOPIC DERMATITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIDEL (pimecrolimus)	<i>DUPIXENT (dupilumab)</i> <sup>CL</sup> <i>EUCRISA (crisaborole)</i> <sup>CL</sup> <i>pimecrolimus</i> <i>PROTOPIC (tacrolimus)</i> <i>tacrolimus</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Dupixent will be approved for adult participants with moderate-to-severe atopic dermatitis who have not achieved adequate control with topical therapy including at least two prior treatments with topical corticosteroids within a 6 month period.</li> <li>■ Eucrisa will be approved for participants 2 years or older with a diagnosis of mild to moderate atopic dermatitis who have failed a preferred agent.</li> <li>■ Black box warning – Not FDA approved for use in children less than 2 years of age (Elidel 1% and Protopic 0.03%) or &lt;16 years old (Protopic 0.1%).</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

## IMMUNOMODULATORS, ASTHMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FASENRA (benralizumab) <sup>CL</sup>	<i>CINQUAIR (reslizumab)</i> <sup>CL</sup> <i>DUPIXENT (dupilumab)</i> <sup>CL</sup> <i>NUCALA (mepolizumab)</i> <sup>CL</sup> vial, auto-injector, syringe <i>XOLAIR (omalizumab)</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Immunomodulators, Asthma</a></li> <li>■ Please refer to the PA form for the criteria for each drug.</li> </ul>

## IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathioprine cyclosporine, modified mycophenolate mofetil capsules, tablets RAPAMUNE (sirolimus) solution tacrolimus	<i>ASTAGRAF (tacrolimus XL)</i> <i>AZASAN (azathioprine)</i> <i>cyclosporine capsule</i> <i>cyclosporine softgel</i> <i>ENVARUS XR (tacrolimus)</i> <i>mycophenolate mofetil suspension</i> <i>mycophenolic acid</i> <b><i>PROGRAF granules (tacrolimus)</i></b> <i>sirolimus solution, tablets</i> <i>ZORTRESS (everolimus)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Immunosuppressives, Oral</a></li> <li>■ Non-preferred agents will be approved for payment only after documented failure of at least one preferred agent within the last 6 months.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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Highlights indicated change from previous posting.

## INTRANASAL RHINITIS AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Anticholinergics</b>		
ipratropium		<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Intranasal Rhinitis Agents</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Antihistamines</b>		
azelastine (for ASTELIN)	<i>azelastine (for ASTEPRO)</i> <i>olopatadine</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Intranasal Rhinitis Agents</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Corticosteroids</b>		
fluticasone	<i>BECONASE AQ (beclomethasone)</i> <i>flunisolide</i> <i>mometasone</i> <i>OMNARIS (ciclesonide)</i> <i>QNASL (beclomethasone)</i> <i>TICANASE (fluticasone)</i> <i>ZETONNA (ciclesonide)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Intranasal Rhinitis Agents</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Antihistamine / Corticosteroid Combinations</b>		
	<i>DYMISTA (azelastine/fluticasone)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Intranasal Rhinitis Agents</a> (required for Non-Preferred drugs)</li> <li>■ Dymista will be approved only after documented failure of any preferred intranasal rhinitis agent.</li> </ul>

## LEUKOTRIENE MODIFIERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
montelukast tablets, chewable tablets	<i>montelukast granules</i> <i>zafirlukast</i> <i>zileuton ER</i> <i>ZYFLO (zileuton)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Leukotriene Modifiers</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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## LIPOTROPICS, OTHER (NON-STATINS)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors</b>		
	NEXLETOL ( <i>bempedoic acid</i> ) <sup>NR</sup> NEXLIZENT ( <i>bempedoic acid/ezetimibe</i> ) <sup>NR</sup>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to Universal PA Form</a></li> </ul>
<b>Apolipoprotein B Synthesis Inhibitors</b>		
	JUXTAPID ( <i>lomitapide mesylate</i> ) <sup>CL</sup> KYNAMRO ( <i>mipomersen</i> ) <sup>CL</sup>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to Universal PA Form</a></li> <li>▪ Juxtapid and Kynamro may be approved for patients with homozygous familial hypercholesterolemia.</li> </ul>
<b>Bile Acid Sequestrants</b>		
cholestyramine colestipol granules, tablets	colesevelam WELCHOL ( <i>colesevelam</i> )	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Non-Statin Lipotropics</a> (required for Non-Preferred drugs - except for ezetimibe - see below)</li> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Fibric Acid Derivatives</b>		
fenofibrate (generic TRICOR) gemfibrozil 600 mg	fenofibrate ( <i>generic ANTARA , FENOGLIDE, LIPOFEN, LOFIBRA, TRIGLIDE</i> ) fenofibric acid ( <i>generic FIBRICOR, TRILIPIX</i> ) FENOGLIDE ( <i>fenofibrate</i> ) TRIGLIDE ( <i>fenofibrate</i> )	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Non-Statin Lipotropics</a> (required for Non-Preferred drugs - except for ezetimibe - see below)</li> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent</li> </ul>
<b>Niacin</b>		
	niacin niacin ER NIACOR ( <i>niacin</i> )	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Non-Statin Lipotropics</a> (required for Non-Preferred drugs -except for ezetimibe - see below)</li> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Omega-3 Fatty Acids</b>		
	omega-3 fatty ethyl esters ( <i>generic for LOVAZA</i> ) VASCEPA ( <i>icosapent ethyl</i> )	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Non-Statin Lipotropics</a> (required for Non-Preferred drugs - except for ezetimibe - see below)</li> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>
<b>Cholesterol Absorption Inhibitors</b>		
ezetimibe		<ul style="list-style-type: none"> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

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## LIPOTROPICS, OTHER (NON-STATINS)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>PCSK9 Inhibitors</b>		
	<p><i>PRALUENT (alirocumab)</i> <sup>CL</sup> <i>REPATHA (evolocumab)</i> <sup>CL</sup></p>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Praluent and Repatha will be approved for patients meeting the following criteria.               <ul style="list-style-type: none"> <li>■ Diagnosis of atherosclerotic cardiovascular disease or heterozygous familial hypercholesterolemia (HeFH). Repatha may also be approved for homozygous familial hypercholesterolemia (HoFH).</li> <li>■ Age &gt; 18 years unless treatment is for HoFH then &gt; 13 years.</li> <li>■ Prescribed in consultation with a cardiologist, lipidologist or endocrinologist.</li> <li>■ Failure to reach LDL-C goal of &lt; 70 mg/dl in clinically significant ASCVD or &lt; 100 mg/dl in HeFH or HoFH with either the highest available dose or maximally tolerated dose of a high intensity statin (rosuvastatin or atorvastatin) in combination with ezetimibe for at least three continuous months.</li> </ul> </li> </ul>

## LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>STATINS</b>		
<p>atorvastatin lovastatin pravastatin rosuvastatin</p>	<p><i>ALTOPREV (lovastatin)</i> <i>EZALLOR SPRINKLE (rosuvastatin)</i> <i>FLOLIPID (simvastatin suspension)</i> <i>fluvastatin</i> <i>fluvastatin ER</i> <i>LESCOL XL (fluvastatin)</i> <i>LIVALO (pitavastatin)</i> <i>simvastatin</i> <i>ZYPITAMAG (pitavastatin)</i></p>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Statins</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent within the last 6 months.</li> <li>■ Simvastatin 80 mg will only be approved for patients who have been on this dose for more than one year without muscle toxicity.</li> </ul>
<b>Statin Combinations</b>		
	<p><i>atorvastatin/amlodipine</i> <i>simvastatin/ezetimibe (VYTORIN)</i> <i>VYTORIN (simvastatin/ezetimibe)</i></p>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Statins</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one single entity agent within the last 6 months.</li> <li>■ Please use individual prescriptions for atorvastatin/amlodipine.</li> </ul>

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<sup>CL</sup> – Prior Authorization / Class Criteria apply

<sup>NR</sup> – New drug that has not been reviewed by P & T Committee

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020

Highlights indicated change from previous posting.

## MACROLIDES (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azithromycin clarithromycin IR tablets erythromycin base capsules erythromycin ethylsuccinate 200 mg suspension	<i>clarithromycin ER</i> <i>clarithromycin suspension</i> <i>E.E.S. 400 mg tablets (erythromycin ethylsuccinate)</i> <i>ERYPED suspension (erythromycin ethylsuccinate)</i> <i>ERY-TAB (erythromycin)</i> <i>erythromycin base tablets</i> erythromycin ethylsuccinate 400 mg suspension	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Macrolides</a> (required for Non-Preferred drugs)</li> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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## MOVEMENT DISORDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUSTEDO (deutetrabenazine) <sup>CL</sup> tetrabenazine <sup>CL</sup>	<i>INGREZZA (valbenazine)</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Movement Disorders PA Form</a></li> <li>■ Austedo will be approved for the following indications and associated criteria:               <ul style="list-style-type: none"> <li>■ Huntington’s Chorea:                   <ul style="list-style-type: none"> <li>-Genetic documentation of diagnosis</li> <li>-Clinically significant chorea document in chart note</li> <li>-Unified Huntington’s Disease Rating Scale (or equivalent test) documenting chorea</li> </ul> </li> <li>■ Tardive Dyskinesia:                   <ul style="list-style-type: none"> <li>- Documentation of diagnosis of clinically significant tardive dyskinesia with drug(s) that are suspected to have caused the disease state.</li> <li>- Documentation of steps that have been taken to reduce the risk for tardive dyskinesia such as discontinuing drug, changing drug therapy, reducing drug dosage unless clinically inappropriate.</li> <li>- AIMS (or equivalent test) documenting tardive dyskinesia</li> </ul> </li> </ul> </li> <li>■ Ingrezza will be approved for participants with a diagnosis of Tardive Dyskinesia that meet the following criteria:               <ul style="list-style-type: none"> <li>■ Documentation of diagnosis of clinically significant tardive dyskinesia with drug(s) that are suspected to have caused the disease state.</li> <li>■ Documentation of steps that have been taken to reduce the risk for tardive dyskinesia such as discontinuing drug, changing drug therapy, reducing drug dosage, unless clinically inappropriate.</li> <li>■ AIMS (or equivalent test) documenting tardive dyskinesia</li> </ul> </li> <li>■ Xenazine/tetrabenazine will be approved for participants with a diagnosis of Huntington’s Chorea that meet the following criteria:               <ul style="list-style-type: none"> <li>■ Genetic documentation of diagnosis</li> <li>■ Clinically significant chorea documented in chart note</li> <li>■ Unified Huntington’s Disease Rating Scale (or equivalent test) documenting chorea</li> </ul> </li> </ul>

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## MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Injectable Disease Modifying Therapies</b>		
<p>AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE 20 mg syringe (glatiramer)</p>	<p>COPAXONE 40 mg syringe (glatiramer) <sup>CL</sup> EXTAVIA (interferon beta-1b) glatiramer 20 mg, 40 mg syringe LEMTRADA (alemtuzumab) IV <sup>CL</sup> OCREVUS (ocrelizumab) <sup>CL</sup> PLEGRIDY (peginterferon beta-1 a) IV <b>REBIF (interferon beta-1a)</b> <b>REBIF REBIDOSE (interferon beta-1a)</b> TYSABRI (natalizumab)</p>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Non-preferred injectable agents (except Lemtrada and Tysabri) will be approved only after documented failure (e.g. inadequate response, adverse reaction) of a preferred injectable agent.</li> <li>■ Glatopa (glatiramer) will be approved only after documented failure of Copaxone (glatiramer) 20 mg.</li> <li>■ Copaxone (glatiramer) 40 will be approved only after documented inability to use Copaxone or Glatopa 20 mg.</li> <li>■ Lemtrada (alemtuzumab) will be approved as a clinician administered drug for patients with relapsing forms of multiple sclerosis who have a documented inadequate response to 2 or more previous treatments for MS. Lemtrada is only available through the health care professional who administers the drug. Idaho Medicaid does not pay for this drug to be dispensed through a retail pharmacy.</li> <li>■ Tysabri (natalizumab) is a clinician administered infusion drug for treatment of patients with relapsing forms of multiple sclerosis who do not have anti-JCV antibodies. It is also FDA approved for treatment of Crohn's disease. Tysabri is only available through the TOUCH Prescribing Program to prescribers and infusion centers. Idaho Medicaid does not pay for this drug to be dispensed through a retail pharmacy.</li> <li>■ All other non-preferred injectable agents will be approved only after documented failure of a preferred agent.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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## MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Oral Disease Modifying Therapies</b>		
TECFIDERA (dimethyl fumarate) <sup>CL</sup>	AUBAGIO (teriflunomide) <sup>CL</sup> GILENYA (fingolimod) <sup>CL</sup> MAVENCLAD (cladribine) <sup>CL</sup> MAYZENT (siponimod) <sup>CL</sup> VUMERITY (diroximel fumarate) <sup>CL</sup> ZEPOSIA (ozanimod hydrochloride) <sup>NR</sup>	<ul style="list-style-type: none"> <li>■ Aubagio (teriflunomide) will be approved for patients with a relapsing form of multiple sclerosis who have a documented contraindication or history of intolerance to any preferred multiple sclerosis agent.</li> <li>■ Tecfidera (dimethyl fumarate) will be approved for patients with a relapsing form of multiple sclerosis who have a documented contraindication or history of intolerance to any preferred multiple sclerosis agent.</li> <li>■ Gilenya (fingolimod) will be approved for patients with a relapsing form of multiple sclerosis <u>and</u> an EKG within the most recent 3 months that shows no evidence of heart block or bradycardia.</li> </ul>
<b>Other</b>		
	AMPYRA (dalfampridine) <sup>CL</sup> dalfampridine ER	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA form for Ampyra</a></li> <li>■ Ampyra will be approved for patients with multiple sclerosis who are ambulatory, have a creatinine clearance of greater than 50 ml/min and no history of seizure disorder.</li> <li>■ Chart note documentation of the medical necessity is required.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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## NSAIDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Nonselective</b>		
ibuprofen* indomethacin IR capsules nabumetone naproxen* sulindac	<i>diclofenac IR</i> <i>diclofenac SR</i> <i>diflunisal</i> <i>etodolac IR</i> <i>etodolac SR</i> <i>fenoprofen</i> <i>flurbiprofen</i> <i>INDOCIN (indomethacin) rectal</i> <i>INDOCIN (indomethacin) suspension</i> <i>indomethacin ER</i> <i>ketoprofen ER</i> <i>ketoprofen IR</i> <i>ketorolac</i> <i>meclofenamate</i> <i>mefenamic acid</i> <i>NAPRELAN (naproxen CR 750 mg)</i> <i>naproxen CR 375 and 500 mg</i> <i>naproxen EC</i> <i>naproxen sodium</i> <i>naproxen suspension*</i> <i>oxaprozin</i> <i>piroxicam</i> <i>RELAFEN DS (nabumetone) <sup>NR</sup></i> <i>SPRIX nasal (ketorolac)</i> <i>TIVORBEX (indomethacin)</i> <i>tolmetin</i> <i>ZIPSOR (diclofenac)</i> <i>ZORVOLEX (diclofenac)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for NSAIDs</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved only after documented failure of a non-selective or COX-II selective preferred agent.</li> <li>■ If the non-preferred agent ketorolac is approved, it will be for a maximum of 5 days of treatment per FDA warnings that longer courses of therapy are associated with increased frequency and severity of adverse reactions including bleeding.</li> <li>■ * Prescription strength only; OTC ibuprofen and OTC naproxen are not covered by Idaho Medicaid.</li> </ul>
<b>NSAID/GI Protectant Combinations</b>		
	<i>diclofenac/misoprostol <sup>CL</sup></i> <i>DUEXIS (ibuprofen/famotidine) <sup>CL</sup></i> <i>VIMOVO (naproxen/esomeprazole) <sup>CL</sup></i>	<ul style="list-style-type: none"> <li>■ Please use prescriptions for individual agents.</li> </ul>
<b>COX-II Selective</b>		
celecoxib meloxicam tablets	<i>meloxicam suspension</i> <i>QMIIZ (meloxicam) ODT</i> <i>VIVLODEX (meloxicam)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for NSAIDs</a></li> <li>■ Non-preferred agents will be approved only after documented failure of a non-selective or COX-II selective preferred agent.</li> </ul>
<b>NSAIDS, TOPICAL</b>		
diclofenac gel 1%	<i>diclofenac solution 1.5%</i> <i>FLECTOR PATCH (diclofenac 1.3%)</i> <i>LICART PATCH (diclofenac 1.3%) <sup>AN</sup></i> <i>PENNSAID PUMP (diclofenac 2%)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA form for Analgesics, Topical</a> (required for non-preferred agents)</li> <li>■ Non-preferred agents will be approved if the patient has a history of at least one preferred agent in the last 6 months.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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## OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX (tobramycin/dexamethasone) ointment and suspension	<i>BLEPHAMIDE (prednisolone/sulfacetamide)</i> <i>BLEPHAMIDE S.O.P. ointment (prednisolone/sulfacetamide)</i> <i>neomycin/bacitracin/polymyxin/hydrocortisone</i> <i>neomycin/polymyxin/ hydrocortisone</i> <i>PRED-G (gentamicin/prednisolone)</i> <i>TOBRADEX ST (tobramycin/dexamethasone)</i> <i>tobramycin/dexamethasone</i> <i>ZYLET (loteprednol/tobramycin)</i>	<ul style="list-style-type: none"> <li>• <a href="#">Link to PA Form for Ophthalmic Antibiotic-Steroid Combinations</a> (required for Non-preferred drugs).</li> <li>• Non-preferred agents will be approved for participants failing to respond to a preferred agent.</li> </ul>

## OPHTHALMIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bacitracin/polymyxin CILOXAN (ciprofloxacin) ointment ciprofloxacin erythromycin gentamicin MOXEZA (moxifloxacin) polymyxin/trimethoprim tobramycin solution TOBREX Ointment (tobramycin)	<i>AZASITE (azithromycin)</i> <i>bacitracin</i> <i>BESIVANCE (besifloxacin)</i> <i>CILOXAN (ciprofloxacin) solution</i> <i>gatifloxacin</i> <i>levofloxacin</i> <i>moxifloxacin</i> <i>NATACYN (natamycin)</i> <i>neomycin/bacitracin/polymyxin</i> <i>neomycin/polymyxin/gramicidin</i> <i>ofloxacin</i> <i>sulfacetamide ointment</i> <i>sulfacetamide solution</i> <i>ZYMAXID (gatifloxacin)</i>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Ophthalmic Antibiotics</a> (required for Non-Preferred drugs)</li> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

## OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cromolyn olopatadine 0.1% (generic PATANOL) PAZEO (olopatadine 0.7%)	<i>ALOCRIL (nedocromil)</i> <i>ALOMIDE (lodoxamide)</i> <i>ALREX (loteprednol)</i> <i>azelastine</i> <i>BEPREVE (bepotastine)</i> <i>epinastine</i> <i>LASTACRAFT (alcaftadine)</i> <i>olopatadine 0.2% (generic PATADAY)</i>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Ophthalmics for Allergic Conjunctivitis</a> (required for Non-Preferred drugs)</li> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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## OPHTHALMIC ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
dexamethasone diclofenac DUREZOL (difluprednate) fluorometholone flurbiprofen ketorolac 0.5 % ketorolac LS 0.4% LOTEMAX drops (loteprednol) MAXIDEX (dexamethasone) PRED MILD (prednisolone acetate) prednisolone acetate	ACUVAIL (ketorolac 0.45%) bromfenac 0.09% BROMSITE (bromfenac 0.075%) <sup>NR</sup> FLAREX (fluorometholone) FML FORTE (fluorometholone) FML S.O.P. (fluorometholone) ILEVRO (nepafenac 0.3%) INVELTYS (loteprednol) <sup>NR</sup> LOTEMAX gel and ointment (loteprednol) NEVANAC (nepafenac 0.1%) PRED FORTE (prednisolone acetate) prednisolone sodium phosphate PROLENSA (bromfenac 0.07%) VEXOL (rimexolone)	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Ophthalmic Anti-Inflammatories</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients failing to respond to a preferred agent.</li> </ul>

## OPHTHALMICS, ANTI-INFLAMMATORY/IMMUNOMODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RESTASIS (cyclosporine) <sup>CL</sup>	CEQUA (cyclosporin) <sup>CL</sup> XIIDRA (lifitegrast) <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA form for Ophthalmics, Anti-Inflammatory/Immunomodulators</a></li> <li>■ All agents require a diagnosis of suppressed tear production due to ocular inflammation associated with keratoconjunctivitis sicca (dry eye disease) ICD-10 = H16.221</li> <li>■ Preferred agents will be approved for patients with the diagnosis who have tried and failed at least two different OTC ophthalmic lubricants.</li> <li>■ Non-preferred agents will be approved after trial and failure of a preferred agent.</li> <li>■ Restasis and Xiidra will be approved for participants with suppressed tear production due to ocular inflammation associated with Keratoconjunctivitis sicca (dry eye disease) ICD-9 = 370.33 or ICD-10 =H16.221</li> <li>■ Xiidra will also require a trial and failure of Restasis for approval.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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## OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CIPRODEX (ciprofloxacin/dexamethasone) ciprofloxacin CIPRO HC (ciprofloxacin/hydrocortisone) COLY-MYCIN S (colistin/neomycin/hydrocortisone) CORTISPORIN – TC (colistin/hydrocortisone/neomycin/thonzonium) neomycin/polymyxin/hydrocortisone	<i>ofloxacin</i> <i>OTOVEL (ciprofloxacin/fluocinolone)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Otic Antibiotics</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients failing to respond to a preferred agent.</li> </ul>

## PANCREATIC ENZYMES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CREON ZENPEP	<i>PANCREAZE</i> <i>PERTZYE</i> <i>VIOKACE</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Pancreatic Enzymes</a></li> <li>■ Non-preferred agents will be approved for patients failing to respond to a preferred agent within the last 6 months</li> </ul>

## PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate capsule (generic for PhosLo) <b>RENAGEL (sevelamer HCl)</b> <b>sevelamer HCL (generic for RENVELAI)</b>	<i>AURYXIA (ferric citrate)</i> <i>calcium acetate tablet</i> <i>FOSRENOL (lanthanum)</i> <i>lanthanum</i> <i>PHOSLYRA (calcium acetate)</i> <i>sevelamer carbonate</i> <i>sevelamer HCL (generic for RENAGEL)</i> <i>VELPHORO (sucroferric oxyhydroxide)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Phosphate Binders</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients failing to respond to a preferred agent.</li> </ul>

## PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clopidogrel dipyridamole prasugrel	<i>AGGRENOLX (aspirin/ dipyridamole)</i> <i>aspirin/dipyridamole</i> <i>BRILINTA (ticagrelor)</i> <i>ZONTIVITY (vorapaxar)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Platelet Aggregation Inhibitors</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients failing to respond to a preferred agent.</li> </ul>

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## PROTON PUMP INHIBITORS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
lansoprazole capsules Rx NEXIUM suspension (esomeprazole) omeprazole Rx pantoprazole	<i>DEXILANT (dexlansoprazole)</i> <i>esomeprazole magnesium</i> <i>esomeprazole strontium</i> <i>lansoprazole capsules OTC</i> <i>lansoprazole solutab</i> <i>omeprazole OTC</i> <i>omeprazole magnesium OTC</i> <i>omeprazole/sodium bicarbonate</i> <i>PREVACID SOLUTAB (lansoprazole)</i> <i>PRIOSEC Suspension (omeprazole)</i> <i>PROTONIX suspension (pantoprazole)</i> <i>rabeprazole</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for PPIs</a> (required for Non-Preferred drugs)</li> <li>■ Prevacid SoluTabs will be approved for patients who cannot swallow tablets or capsules and are not a candidate for a preferred liquid preparation.</li> <li>■ Other non-preferred agents will only be approved if patient has tried and failed therapy with two preferred agents within the last six months.</li> <li>■ Quantity limits of one dose per day apply to this class</li> </ul>

## PULMONARY ARTERIAL HYPERTENSION AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Endothelin Receptor Antagonists</b>		
<b>ambrisentan</b> <sup>CL</sup> TRACLEER (bosentan) tablets <sup>CL</sup>	<b>bosentan tablets</b> <sup>CL</sup> <i>OPSUMIT (macitentan)</i> <sup>CL</sup> <i>TRACLEER (bosentan) suspension</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.</li> <li>■ <a href="#">Link to PA Form for Pulmonary Arterial Hypertension Agents</a> (required for Non-Preferred drugs)</li> </ul>
<b>Prostacyclin Receptor Agonist</b>		
	<i>UPTRAVI (selexipag)</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.</li> <li>■ <a href="#">Link to PA Form for Pulmonary Arterial Hypertension Agents</a> (required for Non-Preferred drugs)</li> </ul>
<b>Prostanoids</b>		
	<i>ORENITRAM ER (treprostinil)</i> <sup>CL</sup> <i>TYVASO (treprostinil)</i> <sup>CL</sup> <i>VENTAVIS (iloprost)</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.</li> <li>■ <a href="#">Link to PA Form for Pulmonary Arterial Hypertension Agents</a> (required for Non-Preferred drugs)</li> </ul>

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## PULMONARY ARTERIAL HYPERTENSION AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>PDE-5 Inhibitors</b>		
REVATIO (sildenafil) suspension <sup>CL</sup> sildenafil tablet <sup>CL</sup>	<i>sildenafil suspension</i> <sup>CL</sup> <i>tadalafil</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ Adcirca and sildenafil will only be approved for diagnosis of pulmonary artery hypertension (ICD-9 416xx)</li> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.</li> <li>■ <a href="#">Link to PA Form for Pulmonary Arterial Hypertension Agents</a> (required for Non-Preferred drugs)</li> </ul>
<b>Soluble Guanylate Cyclase Stimulators</b>		
	<i>ADEMPAS (riociguat)</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.</li> <li>■ <a href="#">Link to PA Form for Pulmonary Arterial Hypertension Agents</a> (required for Non-Preferred drugs)</li> </ul>

## SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Benzodiazepines</b>		
	<i>estazolam</i> <i>flurazepam</i> <i>temazepam</i> <i>triazolam</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Sedative Hypnotics</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.</li> </ul>
<b>Others</b>		
doxepin 10 mg ROZEREM (ramelteon) zolpidem IR	<i>BELSOMRA (suvorexant)</i> <i>DAYVIGO (lemborexant)</i> <sup>NR</sup> <i>EDLUAR (zolpidem)</i> <i>eszopiclone</i> <i>HETLIOZ (tasimelteon)</i> <sup>CL</sup> <i>INTERMEZZO SL (zolpidem)</i> <i>ramelteon</i> <i>SILENOR (doxepin)</i> <i>zaleplon</i> <i>zolpidem ER</i> <i>zolpidem SL</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Sedative Hypnotics</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.</li> <li>■ <a href="#">Link to PA Form for Hetlioz</a></li> <li>■ Hetlioz will be approved for patients 18 years or older with a documented non-24 sleep-wake disorder diagnosis who have tried and failed at least 6 months of other melatonin receptor agonists. Hetlioz must be prescribed by or in consultation with a sleep specialist and other sleep, neurological, or behavioral disorder diagnoses must have been ruled out.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020

Highlights indicated change from previous posting.

## SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
baclofen cyclobenzaprine IR 5, 10 mg tablets methocarbamol tizanidine tablets	<i>AMRIX (cyclobenzaprine ER)</i> <i>carisoprodol</i> <sup>CL</sup> <i>carisoprodol compound</i> <sup>CL</sup> <i>chlorzoxazone</i> <b><i>cyclobenzaprine ER</i></b> <i>cyclobenzaprine IR 7.5 mg tablets</i> <i>dantrolene</i> <i>LORZONE (chlorzoxazone)</i> <i>metaxalone</i> <i>orphenadrine</i> <i>tizanidine capsules</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Skeletal Muscle Relaxants</a> (required for Non-Preferred drugs)</li> <li>■ The non-preferred agents will be approved for patients with documented failure of at least a one week trial each of two preferred agents.</li> <li>■ For carisoprodol:                             <ul style="list-style-type: none"> <li>■ Use will be limited to no more than 34 days</li> <li>■ Additional authorization will not be granted for at least six months following the last day of the previous course of therapy</li> <li>■ Approval will not be granted for patients with a history of meprobamate use in the previous two years</li> <li>■ Approval will not be granted for patients concurrently using opioids</li> </ul> </li> </ul>

## STIMULANTS AND RELATED DRUGS<sup>CL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
amphetamine salt combination ER <sup>CL</sup> amphetamine salt combination IR <sup>CL</sup> dexamethylphenidate <sup>CL</sup> FOCALIN XR (dexamethylphenidate) <sup>CL</sup> methylphenidate CD <sup>CL</sup> methylphenidate ER (generic Concerta) <sup>CL</sup> methylphenidate ER (generic for MEDADATE) <sup>CL</sup> methylphenidate IR Tablets <sup>CL</sup> methylphenidate solution <sup>CL</sup> VYVANSE (lisdexamfetamine) <sup>CL</sup>	<i>ADHANSIA XR (methylphenidate)</i> <sup>CL</sup> <i>ADZENYS ER suspension (amphetamine)</i> <sup>CL</sup> <i>ADZENYS XR ODT (amphetamine)</i> <sup>CL</sup> <i>APTENSIO XR (methylphenidate)</i> <sup>CL</sup> <i>CONTEMPLA XR-ODT (methylphenidate)</i> <sup>CL</sup> <i>DAYTRANA (methylphenidate)</i> <sup>CL</sup> <i>dexamethylphenidate XR</i> <sup>CL</sup> <i>dextroamphetamine IR, ER</i> <sup>CL</sup> <i>dextroamphetamine solution</i> <sup>CL</sup> <i>DYANAVEL XR (amphetamine)</i> <sup>CL</sup> <i>EVEKEO (amphetamine)</i> <sup>CL</sup> <i>EVEKEO ODT (amphetamine)</i> <sup>CL</sup> <i>JORNAY PM (methylphenidate)</i> <sup>CL</sup> <i>methylphenidate chewable tablets</i> <sup>CL</sup> <i>methylphenidate ER (generic Ritalin LA)</i> <sup>CL</sup> <i>MYDAYIS (amphetamine salt combination ER)</i> <sup>CL</sup> <i>QUILLICHEW ER (methylphenidate)</i> <sup>CL</sup> <i>QUILLIVANT XR (methylphenidate)</i> <i>solution</i> <sup>CL</sup> <i>ZENZEDI (dextroamphetamine)</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Stimulants - ADD/ADHD Drugs</a> (required for Non-Preferred drugs)</li> <li>■ Stimulants for adults (&gt; or = to 18 years) will be approved for patients with a diagnosis of ADHD (ICD-10 = F90) in the previous two years.</li> <li>■ Daytrana will only be approved for patients who are unable to take oral therapy.</li> <li>■ Non-preferred agents will be approved for payment only after documented failure of at least one preferred agent.</li> </ul>

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# Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2020

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## STIMULANTS AND RELATED DRUGS<sup>CL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Non-Stimulants</b>		
atomoxetine clonidine IR guanfacine ER guanfacine IR	<i>clonidine ER</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Non-Stimulant Therapy for ADHD</a> <ul style="list-style-type: none"> <li>▪ Guanfacine, clonidine, guanfacine ER will be approved for patients with a diagnosis of ADHD (ICD-9 = 314.xx or ICD-10 = F90)</li> <li>▪ Clonidine long-acting will be approved after documented failure of clonidine IR within the past 60 days.</li> <li>▪ Strattera will be approved for patients with a documented diagnosis of ADHD (ICD-9 = 314.xx or ICD-10 = F90)</li> </ul> </li> </ul>
<b>Narcolepsy-Specific Agents</b>		
	<i>armodafinil</i> <sup>CL</sup> <i>modafinil</i> <sup>CL</sup> <i>NUVIGIL (armodafinil)</i> <sup>CL</sup> <i>SUNOSI (solriamfetol)</i> <i>WAKIX (pitolisant)</i> <sup>NR</sup>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Nuvigil &amp; Provigil</a></li> <li>▪ Modafinil and Nuvigil will be approved for patient &gt; 16 years of age with documented need in the following diagnoses               <ul style="list-style-type: none"> <li>▪ Narcolepsy (ICD-9=347, ICD-10=G47.1)</li> <li>▪ Obstructive sleep apnea (ICD-9=780.51, 780.53, ICD-10=G47.33)</li> <li>▪ Shift work sleep disorder (ICD-9=307.45, ICD-10=G47.26)</li> </ul> </li> </ul>

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## SUBSTANCE USE DISORDER TREATMENT

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Alcohol Treatment</b>		
naltrexone oral <sup>CL</sup>	<i>VIVITROL (naltrexone) injection</i> <sup>CL</sup>	<ul style="list-style-type: none"> <li>■ Vivitrol (naltrexone) injectable or naltrexone oral will be approved for patients with alcohol dependence (ICD-10 = F10) with adequate clinical documentation for need.</li> </ul>
<b>Opiate Use Disorder Treatments</b>		
buprenorphine/naloxone SL tablets naloxone vial, syringe NARCAN (naloxone) nasal SUBOXONE film (buprenorphine/naloxone)	<i>BUNAVAIL (buprenorphine/naloxone) buccal buprenorphine</i> <i>buprenorphine/naloxone SL film</i> <i>LUCEMYRA (lofexidine)</i> <sup>CL</sup> <i>PROBUPHINE (buprenorphine) implant</i> <sup>CL</sup> <i>SUBLOCADE (buprenorphine) injection</i> <sup>CL</sup> <i>VIVITROL (naltrexone) injection</i> <sup>CL</sup> <i>ZUBSOLV (buprenorphine/naloxone tablet)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Opiate Dependence Treatments</a></li> <li>■ Oral buprenorphine/naloxone combination products are preferred except in pregnant women to minimize the possibility of diversion of buprenorphine single entity via the injection route.</li> <li>■ Non-preferred oral buprenorphine - based agents will be approved for patients with opioid-use disorder (ICD-10= F11) who are currently stable on requested agent, or have a documented clinical rational for receiving the requested agent.</li> <li>■ Total daily doses of buprenorphine cannot exceed 24 mg.</li> <li>■ LUCEMYRA will be approved for opioid withdrawal syndrome in patients who have received initial treatment with Lucemyra in an acute care setting.</li> <li>■ <a href="#">Link to PA Form for Opioid Use Disorder Treatment – Physician Administered Drugs</a></li> <li>■ The following drugs are physician administered drugs and are payable as a medical claim only:               <ul style="list-style-type: none"> <li>■ PROBUPHINE (buprenorphine) Intradermal will be approved for patients with documented clinical justification and prolonged clinical stability on low to moderate doses of a transmucosal buprenorphine product. Ex. Suboxone film &lt; 8 mg/day.</li> <li>■ SUBLOCADE (buprenorphine) injection will be approved for patients who are stable on sublingual buprenorphine at doses between 8-24 mg daily for at least 30 days with the following documentation:                   <ul style="list-style-type: none"> <li>- Evidence that the patient has had their cravings and withdrawal</li> </ul> </li> </ul> </li> </ul>

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		<p>symptoms clinically controlled while on sublingual buprenorphine.</p> <p>- A clinically valid evidence-based reason to switch from sublingual buprenorphine to injectable Sublocade.</p> <ul style="list-style-type: none"> <li>▪ VIVITROL (naltrexone) injectable will be approved for patients with a diagnosis of opioid dependence/abuse (ICD-10 = F11) who are currently stable on Vivitrol, have a documented rationale for receiving non-buprenorphine based treatment or have a documented inadequate response to prior treatment with buprenorphine-based treatment.</li> </ul>
<b>Opioid Reversal Agents</b>		
<p>naloxone vial, syringe NARCAN (naloxone) nasal</p>		<ul style="list-style-type: none"> <li>▪ No prior authorization required for naloxone.</li> <li>▪ Naloxone may be prescribed and dispensed by an authorized pharmacist using the pharmacist's individual NPI (not the pharmacy NPI) as prescriber. Reimbursement will be to the pharmacy.</li> </ul>

## TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>doxycycline hyclate IR: 20mg, 50mg, 100 mg minocycline capsules</p>	<p><i>demeclocycline</i> <i>DORYX (doxycycline hyclate)</i> <i>doxycycline hyclate DR</i> <i>doxycycline hyclate IR: 75mg, 150mg</i> <i>doxycycline monohydrate</i> <i>minocycline ER</i> <i>minocycline tablets</i> <b><i>MINOLIRA ER (minocycline)</i></b> <i>MORGIDOX (doxycycline)</i> <i>NUZYRA (omadacycline)</i> <i>ORACEA (doxycycline)</i> <i>SOLODYN (minocycline)</i> <i>TARGADOX (doxycycline)</i> <i>tetracycline</i> <i>VIBRAMYCIN suspension, syrup (doxycycline)</i> <i>XIMINO (minocycline)</i></p>	<ul style="list-style-type: none"> <li>▪ <a href="#">Link to PA Form for Oral Antibiotics for Acne</a></li> <li>▪ Non-preferred agents will be approved only after documented failure of a preferred agent</li> <li>▪ An age override is required for patients less than 9 years of age</li> </ul>

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## TOBACCO CESSATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bupropion SR 150 MG CHANTIX (varenicline) nicotine gum OTC buccal (nicotine polacrilex) nicotine lozenge OTC buccal (nicotine polacrilex) nicotine patch OTC (nicotine)	<i>NICOTROL inhalation (nicotine)</i> <i>NICOTROL NS nasal (nicotine)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Non-preferred agents will be approved for patients failing to respond to a preferred agent.</li> </ul>

## ULCERATIVE COLITIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Oral</b>		
APRISO (mesalamine) sulfasalazine DR sulfasalazine IR	<i>azulfadine tablets</i> <i>azulfadine DR tablets</i> <i>balsalazide</i> <i>budesonide DR</i> <i>DIPENTUM (olsalazine)</i> <i>mesalamine (ASACOL HD, DELZICOL, LIALDA)</i> <i>mesalamine ER (APRISO)</i> <i>PENTASA (mesalamine)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Ulcerative Colitis Drugs</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients failing to respond to a preferred agent</li> </ul>
<b>Rectal</b>		
mesalamine (generic for SFROWASA)	<i>mesalamine (generic for CANASA)</i> <i>UCERIS (budesonide)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to PA Form for Ulcerative Colitis Drugs</a> (required for Non-Preferred drugs)</li> <li>■ Non-preferred agents will be approved for patients failing to respond to a preferred agent</li> </ul>

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## VASODILATORS, CORONARY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
isosorbide dinitrate tablets isosorbide mononitrate tablets isosorbide mononitrate SR tablets NITRO-BID (nitroglycerin) transdermal ointment nitroglycerin ER oral capsules nitroglycerin sublingual nitroglycerin transdermal patch NITROLINGUAL spray (nitroglycerin lingual spray)	<i>BIDIL (isosorbide dinitrate/hydralazine)</i> <i>GONITRO (nitroglycerin)</i> <i>isosorbide dinitrate ER capsules</i> <i>nitroglycerin translingual spray</i> <i>NITROSTAT (nitroglycerin sublingual tablets)</i>	<ul style="list-style-type: none"> <li>■ <a href="#">Link to Universal PA Form</a></li> <li>■ Non-preferred agents will be approved for patients failing to respond to a preferred agent.</li> <li>■ Individual agents must be used prior to use of isosorbide dinitrate/hydralazine (BiDil).</li> </ul>

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