Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2019
Highlights indicated change from previous posting.

ALZHEIMER'S DRUGS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Cholinesterase Inhibitors [CL]		
donepezil [CL] – except 23 mg tablet donepezil ODT [CL] EXELON (rivastigmine) transdermal [CL] rivastigmine capsule [CL]	*donepezil 23 mg tablet [CL]* *galantamine tablets, solution [CL]* *galantamine ER [CL]* *rivastigmine transdermal [CL]*	▪ Link to PA Form for Alzheimer's Agents (required for all drugs in class) ▪ Donepezil 5 and 10 mg will be approved for patients with mild to severe Alzheimer's dementia ▪ Other preferred cholinesterase inhibitors will be approved for patients with mild to moderate dementia except for Exelon 13.3mg patches which will only be approved for patients with severe dementia. ▪ The other non-preferred cholinesterase inhibitors will be approved for patients with mild to moderate dementia except for Aricept 23mg which will only be approved for patients with severe Alzheimer's dementia. ▪ Aricept 23 mg will be approved for patients who have received donepezil 10 mg/day for at least three months ▪ Non-preferred agents will be approved for patients who have failed a preferred agent within the last 6 months
NMDA Receptor Antagonist [CL]		
memantine tablet [CL]	*memantine ER [CL]* *memantine solution [CL]* *NAMENDA XR (memantine) [CL]*	▪ Link to PA Form for Alzheimer's Agents (required for all drugs in class) ▪ Memantine will be approved for patients with moderate to severe Alzheimer's dementia. ▪ Namenda XR will only be approved for patients who have tried and failed memantine immediate release
Combination Products [CL]		
	NAMZARIC (donepezil/memantine) [CL]	▪ Link to PA Form for Alzheimer's Agents (required for all drugs in class) ▪ Please use prescriptions for individual agents

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ANALGESICS, NARCOTIC – LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
morphine ER tablets [CL]	*ARYMO ER (morphine ER)* [CL] *BELBUCA (buprenorphine) buccal film* [CL] *buprenorphine transdermal* [CL] *BUTRANS (buprenorphine transdermal)* [CL] *CONZIP (tramadol ER)* [CL] *EMBEDA (morphine/naloxone)* [CL] *EXALGO (hydromorphone)* [CL] *hydromorphone ER* [CL] *HYSINGLA ER (hydrocodone ER)* [CL] *fentanyl transdermal* [CL] *methadone* [CL] *MORPHABOND ER (morphine)* [CL] *morphine ER* [CL] *capsules* *NUCYNTA ER (tapentadol ER)* [CL] *oxycodone ER* [CL] *OXYCONTIN (oxycodone ER)*[CL] *oxymorphone ER* [CL] *tramadol ER* [CL] *XTAMPZA ER (oxycodone)* [CL] *ZOHYDRO ER (hydrocodone ER)*[CL]	▪ Link to PA Form for Methadone, Initial Request ▪ Link to PA Form for Methadone, Reauthorization ▪ Link to PA Form for Narcotic Analgesics, Long-Acting (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients who have received the same non-preferred agent in the last 60 days with a day supply greater than 3 days. ▪ Link to PA Form for Topical Narcotic Analgesics, Long-Acting ▪ Buprenorphine transdermal will not be approved for patients requiring greater than 80mg morphine equivalents daily. It will only be approved for patients with pain severe enough to require daily, around-the-clock, long-term opioid treatment who have tried and failed or have a contra-indication to a preferred long acting opioid and who have an inability to swallow tablets or capsules (documentation required). ▪ Fentanyl transdermal will be approved for patients meeting one of the following criteria: ▪ Diagnosis of malignant pain (ICD-9 = 140-208, 99.25 or chemotherapy administration related CPT code) ▪ Inability to swallow tablets or capsules. (Documentation required). ▪ History of 30 days or more of a preferred agent in the last 180 days and fentanyl dose requested is equivalent to the dose of preferred agent tried or documentation supporting an increase or decrease in the morphine equivalent dose provides justification. ▪ Fentanyl transdermal 37.5mcg/hr, 62.5 mcg/hr and 87.5 mcg/hr will not be approved unless adequate documentation is provided that the required pain dose cannot be achieved with a combination of 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr or 100 mcg/hr strength patches. ▪ Link to PA Form for OxyContin (oxycodone ER)

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ANALGESICS, NARCOTIC – LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		▪ OxyContin (oxycodone ER) will be approved for patients meeting one the following criteria: ▪ Diagnosis of malignant pain (ICD-9 = 140-208, 99.25 or chemotherapy administration related CPT code) ▪ History of 30 days or more of a preferred agent in the last 180 days ▪ Oxycodone dose requested is equivalent or less than the dose of the preferred agent tried or documentation supporting an increase in the morphine equivalent dose provides justification. ▪ Adequate documentation supporting the use over other long-acting opioids ▪ Tramadol ER or ConZip will be approved with adequate documentation providing therapeutic justification for why generic immediate release tramadol cannot be used. ▪ Zohydro ER will only be approved after an adequate trial of at least one preparation of **each** of the available long-acting opioids including morphine, fentanyl, oxycodone, hydromorphone and oxymorphone **plus** either documented failure of **all** of these agents and/or a documented serious adverse effect to **all** of these agents. ▪ Belbuca will be approved for treatment of severe pain for whom alternative treatment options are inadequate (includes non-opioid analgesics and immediate release opioids). Also requires trial and failure of a preferred long acting opioid. ▪ New prescriptions for the other non-preferred agents will be approved for patients meeting one of the following criteria: ▪ Documented failure of at least a 30 day trial of a preferred agent within the previous 6 months. ▪ Diagnosis of malignant pain (ICD-9 = 140-208, 99.25 or chemotherapy administration related CPT code).

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ANALGESICS, NARCOTIC – SHORT-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral/Rectal/Nasal		
hydrocodone/acetaminophen morphine IR tablet, solution and concentrate solution oxycodone/acetaminophen tablets tramadol IR tramadol/acetaminophen	*APADAZ (acetaminophen/benzhydrocodone)* *butalbital/acetaminophen/caffeine/ codeine* *butalbital/aspirin/caffeine/ codeine* *butorphanol nasal spray* *capital and codeine suspension (codeine/acetaminophen)* *carisoprodol compound w/codeine (carisoprodol/aspirin/codeine)* *codeine* *codeine/acetaminophen* *dihydrocodeine/ acetaminophen/caffeine* *dihydrocodeine/ aspirin/caffeine* *hydrocodone/ibuprofen* *hydromorphone tablets, liquid and suppositories* *IBUDONE (hydrocodone/ibuprofen)* *levorphanol* *meperidine* *morphine suppositories* *NUCYNTA (tapentadol)* *oxycodone tablets, capsules, solution, concentrate and oral syringe* *oxycodone/acetaminophen solution* *oxycodone/aspirin* *oxycodone/ibuprofen* *oxymorphone* *pentazocine/naloxone* *PRIMLEV (oxycodone/acetaminophen)* *NALOCET (oxycodone/acetaminophen)* *ROXICET solution (oxycodone/acetaminophen)* *ROXYBOND (oxycodone)*	▪ Link to PA Form for Narcotic Analgesics, Short-acting (required for Non-Preferred drugs) ▪ 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 ▪ For carisoprodol: ▪ Use will be limited to no more than 34 days ▪ Additional authorization will not be granted for at least six months following the last day of the previous course of therapy ▪ Approval will not be granted for patients with a history of meprobamate use in the previous two years ▪ Approval will not be granted for patients concurrently using opioids
Buccal/Sublingual/Transmucosal Fentanyl		
	ABSTRAL (fentanyl)[CL] *ACTIQ (fentanyl transmucosal)* [CL] *DSUVIA (sufentanil) sublingual* [CL] *fentanyl OTFC* [CL] *FENTORA (fentanyl)* [CL] *LAZANDA (fentanyl) nasal spray* [CL] *SUBSYS (fentanyl)* [CL]	▪ Link to PA Form for Fentanyl (transmucosal) (required for all buccal/sublingual/ transmucosal/nasal drugs) ▪ Fentanyl buccal/sublingual /transmucosal/nasal will only be approved for breakthrough cancer pain in patients already receiving, and tolerant to, opioid therapy.

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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 CL gabapentin capsules, tablets lidocaine transdermal LYRICA (pregabalin) CL capsule	*duloxetine 40 mg capsule (for Irenka)* *gabapentin solution* *GRALISE (gabapentin) CL* *HORIZANT (gabapentin) CL* *LYRICA (pregabalin) solution CL* *LYRICA (pregabalin) CR capsule CL* *pregabalin capsule NR* *SAVELLA (milnacipran) CL*	▪ Link to Universal PA Form ▪ Gabapentin solution will be approved for patients unable to swallow capsules or tablets. ▪ Gralise will be approved for a diagnosis of post-herpetic neuralgia ICD-10 = B02.29 or seizure disorder ICD-10 = G40 in patients who have failed use of gabapentin capsules or tablets within the last 60 days. ▪ Horizant will be approved for a diagnosis of post-herpetic neuralgia ICD-10 = B02.29 who have failed use of gabapentin capsules or tablets or for restless leg syndrome ICD-10= G25.81. ▪ Lyrica will be approved for the following diagnoses. ▪ Epilepsy ▪ Diabetic peripheral neuropathy ▪ Fibromyalgia ▪ Neuropathic pain ▪ Post-herpetic neuralgia ▪ Link to PA form for Analgesics, Topical ▪ Lidocaine transdermal will be approved for patients with pain associated with postherpetic neuralgia ▪ Link to PA Form for Fibromyalgia Agents ▪ Duloxetine, Lyrica and Savella will be approved for patients with a diagnosis of fibromyalgia ▪ Dual therapy with duloxetine and Savella will not be authorized for payment

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ANDROGENIC DRUGS (TOPICAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
testosterone gel (generic VOGELXO) *testosterone gel pump (generic VOGELXO)*	*ANDRODERM (testosterone)*[CL] *ANDROGEL (testosterone)* [CL] *packet, pump* *testosterone gel (generic ANDROGEL, FORTESTA, TESTIM)*[CL] *testosterone gel pump (generic ANDROGEL, AXIRON)*[CL]	▪ Link to PA Form for Androgenic Agents (required for all drugs in the class) ▪ Preferred androgenic drugs will be approved for male patients with a documented diagnosis of hypogonadism with: ▪ At least one non-sexual dysfunction symptom ▪ Serum testosterone level below the lower limit of normal range for testing laboratory ▪ Baseline hematocrit, hemoglobin, LDL, total cholesterol, bilirubin and hepatic transaminases within normal limits. ▪ Renewals require: -Testosterone level within normal limits -Hematocrit < or = 54% -LDL, Total cholesterol, bilirubin and hepatic transaminases within normal limits ▪ 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

ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ACE Inhibitors		
benazepril enalapril lisinopril ramipril	*captopril* *EPANED (enalapril solution)* *fosinopril* *moexipril* *perindopril* *QBRELIS (lisinopril solution)* *quinapril* *trandolapril*	▪ Link to PA Form for ACE Inhibitors (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months. ▪ EPANED will only be approved for patients who have documented inability to swallow tablets
ACE Inhibitor / Diuretic Combinations		
benazepril/hydrochlorothiazide enalapril/hydrochlorothiazide lisinopril/hydrochlorothiazide	*captopril/hydrochlorothiazide* *fosinopril/hydrochlorothiazide* *moexipril/hydrochlorothiazide* *quinapril/hydrochlorothiazide*	▪ Link to PA Form for ACE Inhibitors (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.

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ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Angiotensin Receptor Blockers		
irbesartan losartan valsartan	*BENICAR (olmesartan)* *candesartan* *EDARBI (azilsartan)* *eprosartan* *MICARDIS (telmisartan)* *olmesartan* *telmisartan*	▪ Link to PA Form for ARB-Angiotensin II Receptor Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.
Angiotensin Receptor Blocker / Diuretic Combinations		
irbesartan/hydrochlorothiazide losartan/hydrochlorothiazide valsartan/hydrochlorothiazide	*candesartan/hydrochlorothiazide* *EDARBYCLOR (azilsartan/chlorthalidone)* *MICARDIS HCT (telmisartan/hydrochlorothiazide)* *olmesartan/hydrochlorothiazide* *telmisartan/hydrochlorothiazide*	▪ Link to PA Form for ARB-Angiotensin II Receptor Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.
Angiotensin Modulator / Calcium Channel Blocker and Beta Blocker Combinations		
benazepril/amlodipine valsartan/amlodipine	*BYVALSON (valsartan/nebivolol)* *olmesartan/amlodipine* *olmesartan/amlodipine/ hydrochlorothiazide* *PRESTALIA (perindopril/amlodipine)* *TARKA (trandolapril/verapamil ER)* *telmisartan/amlodipine* *trandolapril/verapamil ER* *valsartan/amlodipine/hydrochlorothiazide*	▪ Link to PA Form for Angiotensin Modulators-Calcium Channel Blockers (required for Non-preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.
Direct Renin Inhibitors		
	TEKTURNA (aliskiren)	▪ Link to PA Form for Direct Renin Inhibitors (required for all drugs in the class) ▪ Tekturna will only be authorized if there is a documented trial and failure of a preferred ACEI or ARB ▪ Tekturna will not be approved for concomitant use with ACEI or ARB in diabetic or kidney disease patients

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ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Direct Renin Inhibitor Combinations		
	TEKTURNA/HCT (aliskiren/hydrochlorothiazide)	▪ Link to PA Form for Direct Renin Inhibitors (required for all drugs in the class) ▪ Tekturna/HCT will only be authorized if there is a documented trial and failure of a preferred ACEI or ARB ▪ Tekturna/HCT will not be approved for concomitant use with ACEI or ARB in diabetic or kidney disease patients
Neprilysin Inhibitor Combination		
ENTRESTO (sacubitril/valsartan) CL		▪ Link to PA Form for Neprilysin Inhibitor Combination ▪ Sacubitril-valsartan (Entresto) will be approved for patients meeting the following criteria: ▪ Chronic heart failure NYHA Class II-IV with left ventricular ejection fraction < 40% ▪ Cardiologist prescribed or consulted ▪ ***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.*** ▪ Not receiving concurrent aliskiren with a diagnosis of diabetes or renal failure

ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	GRASTEK (Timothy grass pollen allergen extract) CL *ODACTRA (House dust mite - Dermatophagoides farinae and Dermatophagoides pteronyssinus)* CL *ORALAIR (grass pollen extract – Cocksfoot, Sweet Vernal Grass, Rye Grass, Meadow Grass, Timothy)* CL *RAGWITEK (Short Ragweed pollen allergen extract)* CL	▪ Link to Universal PA Form ▪ 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.

ANTIBIOTICS, GI

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metronidazole tablet neomycin	*AEMCOLO (rifamycin)* NR *ALINIA (nitazoxanide) tablets, suspension*	▪ Link to Universal PA Form

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ANTIBIOTICS, GI

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
tinidazole vancomycin capsules	*DIFICID (fidaxomicin)* CL *FIRVANQ (vancomycin)* *FLAGYL ER (metronidazole)* *metronidazole capsule* *paromomycin* *XIFAXAN (rifaximin)* CL	▪ Dificid will only be approved with documentation of a clostridium difficile infection. Treatment will be limited to 10 days. ▪ Link to PA Form for Xifaxan ▪ Xifaxan 200 mg will only be approved for documented traveler's diarrhea and is limited to one prescription with a 3 day supply. ▪ 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. ▪ Other non-preferred agents will only be approved after documented failure of a preferred agent.

ANTIBIOTICS, INHALED CL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin) CL CAYSTON (aztreonam) CL KITABIS PAK (tobramycin) CL	*ARIKAYCE (amikacin)* CL *TOBI (tobramycin)* CL *TOBI Podhaler (tobramycin inhaled)* CL *tobramycin solution (inhalation)* CL *tobramycin pak (KITABIS PAK)* CL	▪ Link to PA Form for Inhaled Antibiotics (required for all agents in class) ▪ Preferred agents will be approved for patients with a diagnosis of cystic fibrosis. ▪ Non-preferred agents will only be approved for patients with cystic fibrosis that have a documented failure of a preferred agent

ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
mupirocin ointment	*ALTABAX (retapamulin)* *gentamicin ointment and cream* *mupirocin cream*	▪ Link to PA Form for Antibiotics, Topical (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved after documented failure of a preferred agent

ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CLEOCIN OVULES (clindamycin) CLINDESSE (clindamycin) metronidazole 0.75% gel NUVESSA 1.3% gel (metronidazole)	*clindamycin cream* *VANDAZOLE (metronidazole)*	▪ Link to Universal PA Form ▪ Non-preferred agents will only be approved after documented failure of a preferred agent

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ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral		
ELIQUIS (apixaban) CL warfarin XARELTO (rivaroxaban) 10 mg, 15 mg and 20 mg tablets CL	*ELIQUIS (apixaban) dose pack* CL *PRADAXA (dabigatran)* CL *SAVAYSA (edoxaban)* CL *XARELTO (rivaroxaban) 2.5 mg tablets* CL *XARELTO (rivaroxaban) Starter Pack* CL	▪ Link to PA Form for Anticoagulants, Oral ▪ Eliquis and Xarelto (except 2.5 mg) will be approved for non-valvular atrial fibrillation, for prophylaxis of DVT or PE following hip or knee replacement surgery, for treatment of DVT or PE or to reduce the risk of recurrence of DVT or PE. ▪ Xarelto 2.5 mg will only be approved in combination with aspirin 75-100 mg in patients with documented coronary artery disease or peripheral artery disease. ▪ Pradaxa will be approved for non-valvular atrial fibrillation; for treatment of DVT or PE in patients who have been treated with a parenteral anticoagulant for 5-10 days to reduce the risk of or recurrence of DVT or PE; or for the prophylaxis of DVT and PE in patients who have undergone hip replacement surgery. Patients meeting these criteria must also have a documented failure of a preferred oral agent other than warfarin within the most recent 31 days. ▪ Savaysa will be approved for non-valvular atrial fibrillation or for treatment of DVT or PE in patients who have been treated with a parenteral anticoagulant for 5-10 days **and if** they have a documented failure of a preferred oral agent other than warfarin within the most recent 30 days.
Injectable		
enoxaparin syringe LOVENOX vial (enoxaparin)	*enoxaparin vial* *fondaparinux* *FRAGMIN (dalteparin) syringe, vial*	▪ Link to PA Form for Anticoagulants, Injectable ▪ Non-preferred agents will be approved after a trial and failure of a preferred agent within the last 30 days.

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ANTICONVULSANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Barbiturates		
phenobarbital tablets, suspension primidone		▪ Link to PA Form for Anticonvulsants for Seizure Disorder ▪ The non-preferred agents will be approved only after documented failure of a preferred agent.
Benzodiazepines		
clonazepam tablet diazepam rectal ONFI (clobazam) tablets CL	*clonazepam ODT* CL *clobazam tablets* NR *ONFI (clobazam) suspension* CL *SYMPAZAN (clobazam)* NR	▪ Link to PA Form for Anticonvulsants for Seizure Disorder ▪ Non-preferred agents without additional clinical criteria will be approved only after documented failure of a preferred agent. ▪ 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. ▪ Onfi suspension will be approved for patients meeting Onfi clinical criteria who have a documented inability to swallow tablets. ▪ Link to PA Form for Clonazepam ODT Form. ▪ 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.
Hydantoins		
DILANTIN (phenytoin) capsules DILANTIN INFATAB (phenytoin) phenytoin capsules, chewable tablets, suspension phenytoin sodium extended (generic PHENYTEK)	*PEGANONE (ethotoin)*	▪ Link to PA Form for Anticonvulsants for Seizure Disorder ▪ The non-preferred agents will be approved only after documented failure of a preferred agent.
Succinimides		
ethosuximide capsules ethosuximide syrup	*CELONTIN (methsuximide)*	▪ Link to PA Form for Anticonvulsants for Seizure Disorder
Other		
	DIACOMIT (stiripentol) NR *EPIDIOLEX (cannabidiol)* CL	▪ Link to Universal PA Form

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ANTICONVULSANTS

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Adjuvants, Epilepsy		
APTIOM (eslicarbazepine) CL divalproex sprinkle CL GABITRIL (tiagabine) CL levetiracetam solution, tablets CL oxcarbazepine suspension CL oxcarbazepine tablets CL topiramate sprinkle CL VIMPAT (lacosamide) CL zonisamide CL	*BANZEL (rufinamide) tablets, suspension* CL *BRIVIACT (brivaracetam) tablets, solution* CL *felbamate tablet, suspension* CL *FYCOMPA (perampanel) tablets, suspension* CL *lamotrigine XR* CL *levetiracetam ER* CL *OXTELLAR XR (oxcarbazepine)* CL *SABRIL (vigabatrin)* CL *SPRITAM (levetiracetam) suspension* CL *tiagabine* CL *vigabatrin powder pack* CL	▪ Link to PA Form for Anticonvulsants for Seizure Disorder ▪ (required for Non-Preferred drugs) ▪ All agents require a seizure diagnosis (ICD-9=345 or 780.39 or ICD-10= G40 or R56) within the last 2 years. ▪ Preferred agents will be approved within the approved dosage quantities and age limits for eligible participants with a seizure diagnosis. ▪ 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. ▪ Other non-preferred agents will be approved for patients with a documented failure of a preferred agent in the past 180 days.

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Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2019
Highlights indicated change from previous posting.

ANTICONVULSANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Adjuvants, Pain and Mood Disorders		
carbamazepine ER (generic for CARBATROL) carbamazepine chewable tablet carbamazepine IR carbamazepine XR (generic for TEGRETOL XR) divalproex ER divalproex tablets gabapentin capsules, tablets lamotrigine chewable, tablets CL TEGRETOL (carbamazepine) suspension topiramate ER (generic QUDEXY XR) capsules CL topiramate tablets CL valproic acid	*carbamazepine suspension* *EQUETRO (carbamazepine ER)* *LAMICTAL ODT (lamotrigine oral disintegrating tablet)* CL *lamotrigine ODT (oral disintegrating tablet)* CL *TROKENDI XR (topiramate ER) capsules* CL	▪ Link to PA Form for Anticonvulsants for Pain and Mood Disorders ▪ Preferred agents with no clinical criteria will be approved for eligible participants within the approved dosage quantities and age limits. ▪ 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. ▪ 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. ▪ Lamotrigine or lamotrigine ODT will be approved for patients with one of the following diagnoses within the previous 2 years. ▪ Seizure disorder (ICD-9=345 or 780.39 or ICD-10= G40 or R56) ▪ Bipolar disorder (ICD-9 – 296 or ICD-10 = F31) ▪ 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: ▪ Seizure disorder (ICD-9=345 or 780.39 or ICD-10= G40 or R56) ▪ Migraine headache (ICD-9 -346 or ICD-10 = G43) ▪ Non-preferred agents meeting the above clinical criteria will be approved after trial and failure of a preferred agent.

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ANTIDEPRESSANTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bupropion IR bupropion SR bupropion XL duloxetine [CL] mirtazapine tablets trazodone venlafaxine IR venlafaxine ER capsules	*APLENZIN (bupropion HBr)* *desvenlafaxine ER* *desvenlafaxine fumarate ER* *desvenlafaxine succinate (generic for KHEDEZLA ER)* *desvenlafaxine succinate (generic PRISTIQ)* *EMSAM (selegiline transdermal) [CL]* *FETZIMA (levomilnacipran)* *FORFIVO XL (bupropion)* *IRENKA (duloxetine) [CL]* *MARPLAN (isocarboxazid)* *mirtazapine ODT* *nefazodone* *PARNATE (tranylcypromine)* *phenelzine* *SPRAVATO (esketamine) nasal spray [NR]* *tranylcypromine* *TRINTELLIX (vortioxetine)* *venlafaxine ER tablets* *VIIBRYD (vilazodone)*	▪ Link to PA Form for Antidepressants, Other (required for Non-Preferred Drugs - except duloxetine and Emsam - see below) ▪ Trintellix, Fetzima and Viibryd require trial and failure of two preferred antidepressants, including one from the Antidepressants, Other class. ▪ Other non-preferred agents will be approved for payment only after documented failure of at least one preferred agent ▪ Link to PA Form for duloxetine ▪ Duloxetine will be approved for patients meeting one of the following criteria: ▪ Diagnosis of major depressive disorder (MDD) or generalized anxiety disorder (GAD) who have tried and failed treatment with a preferred antidepressant ▪ Diagnosis of diabetic peripheral neuropathy (DPN) who have tried and failed gabapentin therapy in the past 6 months ▪ Diagnosis of fibromyalgia ▪ Diagnosis of chronic musculoskeletal pain. ▪ Link to PA Form for Emsam ▪ Emsam will be approved for adult patients meeting all of the following criteria: ▪ Diagnosis of major depressive disorder (MDD) ▪ Failure of trials of an SSRI, an SNRI and at one least one other antidepressant from another therapeutic class ▪ Not currently receiving any contraindicated medications ▪ No diagnosis of pheochromocytoma

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ANTIDEPRESSANTS, SSRIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
citalopram tablet, solution escitalopram tablets, solution fluoxetine capsules, tablets, solution fluvoxamine sertraline tablets, concentrate	*BRISDELLE (paroxetine)* CL *fluoxetine weekly* CL *fluvoxamine ER* *paroxetine CR* *paroxetine tablet* *paroxetine (generic for BRISDELLE)* *PAXIL (paroxetine) Suspension* *PEXEVA (paroxetine)*	▪ Link to PA Form for Antidepressants, SSRIs (required for Non-Preferred drugs – including fluoxetine weekly) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months. ▪ Fluoxetine weekly will be approved for patients with a diagnosis of depression who are not receiving other medications at least daily. ▪ Brisdelle will be approved for treatment of vasomotor symptoms associated with menopause only and not depression.

ANTIEMETIC/ANTIVERTIGO AGENTS (ORAL/TRANSDERMAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Cannabinoids		
	CESAMET (nabilone) CL *dronabinol capsules* CL *SYNDROS (dronabinol solution)* CL	▪ Link to PA Form for Cannabinoids ▪ Dronabinol will be approved for patients who have received chemo-therapy in the last 12 months or have a history of HIV associated cachexia.
5HT$_3$ Receptor Blockers CL		
ondansetron CL ondansetron ODT CL	*ANZEMET (dolasetron)* CL *granisetron* CL *SANCUSO (granisetron) transdermal* CL *ZUPLENZ (ondansetron)* CL	▪ Link to PA Form for Antiemetics, Oral - 5HT3 Antagonists (required for all drugs) ▪ A PA is not required for ondansetron for the following situations: ▪ Patients 15 years and younger within the quantity limit of not more than 30 tablets monthly ▪ Adults for a one time fill of 10 tablets or less ▪ Ondansetron and ondansetron ODT will be approved for patients with: ▪ Chemotherapy or radiation-induced nausea and vomiting OR ▪ Documented clinically significant hyperemesis gravidarum OR ▪ Post-operative nausea/vomiting (limited to one fill only) ▪ Sancuso will be approved for patients with chemotherapy or radiation-induced nausea and vomiting with documentation that they cannot take oral therapy ▪ Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months

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ANTIEMETIC/ANTIVERTIGO AGENTS (ORAL/TRANSDERMAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NK1 Receptor Antagonist		
EMEND (aprepitant) capsules	*aprepitant capsules, pack* *AKYNZEO (netapitant/palonosetron)* *EMEND (aprepitant) powder pack* *VARUBI (rolapitant)*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved after failure of at least one preferred agent in the most recent 60 days
Other		
dimenhydrinate OTC meclizine metoclopramide tablet prochlorperazine (oral, rectal) promethazine (oral, rectal 12.5 & 25 mg) TRANSDERM-SCOP (scopolamine)	*COMPRO (prochlorperazine) rectal* *BONJESTA (doxylamine/pyridoxine)* CL *DICLEGIS (doxylamine/pyridoxine)* CL *metoclopramide ODT* *promethazine 50 mg suppositories* *scopolamine (TRANSDERM-SCOP)* *trimethobenzamide (oral)*	▪ Link to Universal PA Form ▪ A prescription is required for all drugs ▪ Bonjesta and Diclegis require failure of an adequate trial of OTC doxylamine and pyridoxine for nausea due to pregnancy. ▪ The other non-preferred agents will be approved after failure of at least one preferred agent in the most recent 60 days.

ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole fluconazole suspension, tablets nystatin suspension terbinafine	*CRESEMBA (isavuconazonium)* *flucytosine* *griseofulvin suspension* *griseofulvin tablets* *itraconazole 100 mg* *itraconazole solution* *ketoconazole* CL *NOXAFIL (posaconazole)* *nystatin tablets* *ONMEL (itraconazole) 200 mg* *ORAVIG (miconazole)* *SPORANOX (itraconazole solution)* *TOLSURA (itraconazole)* *voriconazole*	▪ Link to PA Form for Antifungals, Oral ▪ Ketoconazole will be approved for blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis or paracoccidioidomycosis in patients who have failed or cannot tolerate other oral antifungal agents. ▪ Ketoconazole will not be approved for fungal infections of the skin or nails or for fungal meningitis. ▪ 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) ▪ Non-preferred agents will be approved after failure of at least one preferred agent in the most recent 60 days.

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ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Antifungals		
clotrimazole OTC and RX ketoconazole cream, shampoo 2% miconazole cream, powder nystatin cream, ointment, powder terbinafine OTC tolnaftate OTC cream, powder, solution	*ALEVAZOL (clotrimazole)* *butenafine OTC* *ciclopirox cream, gel, shampoo, suspension* *ciclopirox solution nail lacquer* CL *clotrimazole/betamethasone lotion* *econazole* *ECOZA (econazole)* *ERTACZO (sertaconazole)* *EXELDERM (sulconazole)* *EXTINA (ketoconazole foam)* *JUBLIA (efinaconazole)* *KERYDIN (tavaborole)* *ketoconazole foam* *LAMISIL (terbinafine) cream, gel, spray* *LOPROX (ciclopirox)* *luliconazole* *miconazole nitrate/zinc oxide/petrolatum* *miconazole nitrate ointment, spray OTC* *naftifine* *NIZORAL AD shampoo OTC 1% (ketoconazole)* *oxiconazole* *OXISTAT (oxiconazole)* *tolnaftate spray* *VUSION (miconazole/petrolatum/ zinc oxide)*	▪ Link to PA Form for Antifungals, Topical (required for Non-Preferred drugs -except antifungal nail lacquers - see below) ▪ Non-preferred agents will be approved only after documented failure of the preferred agents within the previous six months ▪ Link to PA Form for Topical Antifungal Nail Lacquer (required for ciclopirox solution, Jublia (efinaconazole) and Kerydin (tavaborole)) ▪ Antifungal nail preparations will only be approved for patients meeting all of the following criteria: ▪ Diagnosis of onychomycosis within the last year ▪ Contraindication to oral itraconazole and terbinafine as defined by presence of heart failure, hepatic impairment or viral hepatitis ▪ Proof from prescriber that therapy is not for cosmetic purposes
Antifungal/Steroid Combinations		
clotrimazole/betamethasone	*nystatin/triamcinolone cream, ointment*	

ANTIHISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine solution, tablets levocetirizine tablets loratadine ODT, solution, tablets	*cetirizine capsule OTC* *cetirizine chewable* *desloratadine* *desloratadine ODT* *fexofenadine* *levocetirizine solution* *loratadine capsules, chew tablets* *XYZAL (levocetirizine) solution, tablets OTC*	▪ A prescription is required for all drugs. ▪ Link to PA Form for Antihistamines, Minimally Sedating (required for Non-Preferred drugs) ▪ Non-preferred agents will be authorized if a patient has failed a preferred agent within the most recent six months. ▪ Cetirizine solution is available for patients ≤ 12 years

ANTIHYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CATAPRES TTS (clonidine transdermal) clonidine guanfacine methyldopa	*clonidine transdermal* *methyldopa-hydrochlorothiazide*	▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

ANTIHYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol MITIGARE (colchicine) capsules CL probenecid	*colchicine CL capsules, tablets* *DUZALLO (allopurinol/lesinurad) CL* *KRYSTEXXA (pegloticase) CL* *probenecid/colchicine CL* *ULORIC (febuxostat) CL* *ZURAMPIC (lesinurad) CL*	▪ Link to PA Form for Antihyperuricemics, Oral (required for Non-Preferred drugs) ▪ Colchicine: ▪ A prescription for three tablets does not require prior authorization if processed by the pharmacy as an Emergency Override. ▪ For acute gout, colchicine will be approved if there is a failure of or contraindication to NSAIDS or corticosteroids. ▪ For chronic gout, colchicine will be approved for patients on concomitant allopurinol who have failed or have documented intolerance to NSAIDs. ▪ Uloric will be approved for continuation of gout attacks with serum urate levels >6 mg/dl after at least three months of allopurinol at a therapeutic dose or with documented intolerance to allopurinol. ▪ Zurampic will be approved for patients with gout who have not achieved target serum uric levels with a xanthine oxidase inhibitor alone at therapeutic doses. It will not be approved for treatment of asymptomatic hyperuricemia or as monotherapy.

ANTIMIGRAINE AGENTS, CGRP

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
EMGALITY (galcanezumab-gnlm) CL	*AIMOVIG (erenumab-aooe) CL* *AJOVY (fremanezumab-vfrm) CL*	▪

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ANTIMIGRAINE AGENTS, TRIPTANS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral		
rizatriptan oral tablets, MLT RELPAX (eletriptan) sumatriptan	*almotriptan* *eletriptan* *frovatriptan* *naratriptan* *sumatriptan/naproxen* *TREXIMET (sumatriptan/naproxen)* [CL] *zolmitriptan*	▪ Link to PA Form for Triptans (required for all drugs) ▪ Triptans will be approved for migraine treatment in patients ≥ 12 years. Exception: Rizatriptan MLT may be approved for patients ≥ 6 years old. ▪ 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 ▪ Treximet will be approved if patient has tried and failed therapy with separate prescriptions for sumatriptan and naproxen. ▪ 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.
Nasal		
sumatriptan	*ZOMIG (zolmitriptan)* *ONZETRA XSAIL (sumatriptan)*	▪ Link to PA Form for Triptans (required for all drugs) ▪ 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. ▪ Non-preferred agents will be approved only if patient has tried and failed therapy with a preferred agent within the last 6 months.
Injectable		
sumatriptan vial, syringe	*SUMAVEL DOSEPRO (sumatriptan)* *ZEMBRACE SYMTOUCH (sumatriptan)*	▪ Link to PA Form for Triptans (required for all drugs) ▪ 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. ▪ Non-preferred agents will be approved only if patient has tried and failed therapy with a preferred agent within the last 6 months.

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ANTIPARASITICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NATROBA (spinosad) permethrin OTC and Rx piperonyl butoxide/pyrethrins shampoo OTC SKLICE (ivermectin)	*CROTAN (crotamiton)* *EURAX (crotamiton) lotion & cream* *lindane* *malathion* *spinosad* *ULESFIA (benzyl alcohol)* *VANALICE (piperonyl butoxide/pyrethrins)*	▪ Link to PA Form for Antiparasitics, Topical (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

ANTIPARKINSON'S DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Anticholinergics		
benztropine trihexyphenidyl tablets, solution		▪ Link to PA Form for Antiparkinson Agents ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.
COMT Inhibitors		
	entacapone *tolcapone*	▪ Link to PA Form for Antiparkinson Agents ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.
Dopamine Agonists		
bromocriptine pramipexole IR ropinirole IR	*MIRAPEX ER (pramipexole)* *NEUPRO transdermal patch (rotigotine)* *pramipexole ER* *ropinirole ER*	▪ Link to PA Form for Antiparkinson Agents ▪ Link to PA Form for Restless Leg Syndrome ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.
MAO-B Inhibitors		
selegiline capsules, tablets	*AZILECT (rasagiline)* *rasagiline* *XADAGO (safinamide)* *ZELAPAR (selegiline disintegrating tablets)*	▪ Link to PA Form for Antiparkinson Agents ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.
Other Antiparkinson's Drugs		
amantadine capsule, syrup carbidopa/levodopa IR tablets carbidopa/levodopa ER carbidopa/levodopa/entacapone	*amantadine tablet* *carbidopa* *carbidopa/levodopa ODT* *GOCOVRI (amantadine)* *INBRIJA (levodopa) inhalation* NR *OSMOLEX ER (amantadine)* *RYTARY (carbidopa/levodopa ER)*	▪ Link to PA Form for Antiparkinson Agents ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.

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ANTIPSYCHOTICS, FIRST GENERATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral/Intranasal		
chlorpromazine fluphenazine loxapine ORAP (pimozide) perphenazine perphenazine/amitriptyline thiothixene trifluoperazine	*haloperidol* *pimozide* *thioridazine*	▪ Link to PA Form for Antipsychotics, Oral ▪ A non-preferred agent will be approved only after documented failure of a preferred agent.
Injectable (Acute Treatment)		
haloperidol lactate		
Injectable (Maintenance Treatment)		
fluphenazine decanoate	*haloperidol decanoate*	

ANTIPSYCHOTICS, SECOND GENERATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral		
aripiprazole tablets clozapine FAZACLO (clozapine ODT) LATUDA (lurasidone) olanzapine olanzapine ODT quetiapine quetiapine XR risperidone solution, tablets, ODT ziprasidone	*aripiprazole disintegrating tablet* *aripiprazole solution* *clozapine ODT* *FANAPT (iloperidone)* *NUPLAZID (pimavanserin)* CL *olanzapine/fluoxetine (must use individual agents)* *paliperidone ER* *REXULTI (brexpiprazole)* *SAPHRIS (asenapine)* *VERSACLOZ (clozapine)* *VRAYLAR (cariprazine)*	▪ Link to PA Form for Antipsychotics, Oral ▪ A non-preferred agent will be approved only after documented failure of a preferred agent.
Injectable (Acute Treatment)		
GEODON (ziprasidone) olanzapine		
Injectable (Maintenance Treatment)		
ABILIFY MAINTENA (aripiprazole) CL ARISTADA (aripiprazole) CL ARISTADA INITIO (aripiprazole) CL INVEGA SUSTENNA (paliperidone) CL INVEGA TRINZA (paliperidone) CL RISPERDAL CONSTA (risperidone) CL	*ABILIFY MYCITE (aripiprazole)* NR *PERSERIS (risperidone)* CL *ZYPREXA RELPREVV (olanzapine)* CL	▪ Link to PA Form for Injectable Long Acting Antipsychotics 2nd Generation ▪ Preferred injectable antipsychotics will be approved within FDA approved age, dosing, and diagnosis parameters in patients who have failed oral therapy. Non-preferred agents require trial and failure or contra-indication to a preferred injectable antipsychotic. ▪ Zyprexa Relprevv (olanzapine) is reimbursed as a medical benefit only and not dispensed through the outpatient pharmacy program.

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ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Antiherpetic Drugs		
acyclovir capsules, tablets, suspension valacyclovir	*famciclovir* *SITAVIG (acyclovir) buccal*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Antiinfluenza Drugs		
oseltamivir suspension TAMIFLU (oseltamivir) capsule	*oseltamivir capsule* *RELENZA (zanamivir)* *rimantadine* *XOFLUZA (baloxavir marboxil)*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	acyclovir cream, ointment CL *DENAVIR (penciclovir)* CL *XERESE (acyclovir/hydrocortisone)* CL *ZOVIRAX (acyclovir) cream* CL *ZOVIRAX (acyclovir) ointment* CL	▪ Link to Form for Antivirals, Topical ▪ The CDC discourages the use of topical therapy for the treatment of genital herpes. ▪ Topical agents will not be approved unless substantial documentation of clinical benefit over oral therapy is provided.

ANXIOLYTICS/BENZODIAZEPINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
alprazolam alprazolam ER buspirone clonazepam tablets diazepam tablets, solution lorazepam tablet	*alprazolam intensol, ODT* *chlordiazepoxide* *clonazepam ODT* *clorazepate* *diazepam syringe, vial* *diazepam intensol* *lorazepam intensol* *meprobamate* *oxazepam*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent. ▪ Link to PA Form for Clonazepam ODT Form. ▪ 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.

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BETA BLOCKERS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Beta Blockers		
atenolol bisoprolol metoprolol metoprolol XL propranolol propranolol ER sotalol	*acebutolol* *betaxolol* *BYSTOLIC (nebivolol)* *HEMANGEOL(propranolol)* CL *INDERAL XL (propranolol)* *INNOPRAN XL (propranolol)* *KAPSPARGO (metoprolol)* *nadolol* *pindolol* *SOTYLIZE (sotalol)* CL *timolol*	▪ Link to PA Form for Beta Adrenergic Blockers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent within the last 6 months.
Beta Blocker/Diuretic Combinations		
atenolol/chlorthalidone bisoprolol/hydrochlorothiazide	*DUTOPROL (metoprolol succinate/hydrochlorothiazide)* *metoprolol/hydrochlorothiazide* *nadolol/bendroflumethiazide* *propranolol/hydrochlorothiazide*	▪ Link to PA Form for Beta Adrenergic Blockers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent within the last 6 months.
Beta- and Alpha- Blockers		
carvedilol labetalol	*carvedilol ER (COREG CR)* *COREG CR (carvedilol)*	▪ Link to PA Form for Beta Adrenergic Blockers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent within the last 6 months.

BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
oxybutynin ER oxybutynin IR TOVIAZ (fesoterodine) VESICARE (solifenacin)	*darifenacin ER* *ENABLEX (darifenacin ER)* *flavoxate* *GELNIQUE (oxybutynin)* *MYRBETRIQ (mirabegron)* *OXYTROL transdermal (oxybutynin)* *solifenacin* NR *tolterodine* *tolterodine ER* *trospium* *trospium ER*	▪ Link to PA Form for Bladder Relaxants (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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BONE RESORPTION SUPPRESSION AND RELATED AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Bisphosphonates		
alendronate tablets	*alendronate solution* *ATELVIA (risedronate)* *BINOSTO (alendronate)* *etidronate* *FOSAMAX Plus D (alendronate/cholecalciferol)* *ibandronate* *risedronate*	▪ Link to PA Form for Bone Resorption Suppression and Related Agents (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent
Other Bone Resorption Suppression and Related Drugs		
calcitonin-salmon	*EVENITY (romosozumab)* [NR] *FORTEO (teriparatide)* [CL] *PROLIA (denosumab)* *TYMLOS (abaloparatide)*	▪ Link to PA Form for Bone Resorption Suppression and Related Agents for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent. ▪ 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

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Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2019
Highlights indicated change from previous posting.

BOTULINUM TOXINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BOTOX [CL] (onabotulinumtoxinA) –(except for cervical dystonia) DYSPORT [CL] (abobotulinumtoxinA) MYOBLOC [CL] (rimabotulinumtoxinB) XEOMIN [CL] (incobotulinumtoxinA)	*BOTOX [CL] (onabotulinumtoxinA) – (for cervical dystonia)*	▪ Link to PA Form for Botulinum toxin, Other ▪ Link to PA Form for Botox for Migraines ▪ Botox will be approved for the following indications: ▪ Chronic daily headaches defined as > 15 days/month lasting > 4 hours/day for patients who have failed at least two oral prophylactic medications and at least two rescue medications (e.g. triptans). ▪ Spasticity in patients who have failed at least two oral skeletal muscle relaxants. ▪ Overactive bladder in patients who have failed at least two oral anticholinergic agents. ▪ Urinary incontinence due to detrusor overactivity associated with a neurologic condition in patients who have failed at least two oral anticholinergic agents. ▪ Blepharospasm and strabismus. ▪ For cervical dystonia, trial and failure of a preferred botulinum toxin. ▪ Dsyport will be approved for the following indications: ▪ Cervical dystonia in patients who have tried and failed at least two oral skeletal muscle relaxants. ▪ Spasticity in patients who have failed at least two oral skeletal muscle relaxants. ▪ Myobloc will be approved for the following indications: ▪ Cervical dystonia in patients who have tried and failed at least two oral skeletal muscle relaxants. ▪ Xeomin will be approved for the following indications: ▪ Blepharospasm ▪ Cervical dystonia in patients who have tried and failed at least two oral skeletal muscle relaxants. ▪ Spasticity in patients who have failed at least two oral skeletal muscle relaxants.

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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).

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BPH TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Alpha Blockers		
alfuzosin doxazosin tamsulosin terazosin	*CARDURA XL (doxazosin)* *RAPAFLO (silodosin)* *silodosin*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
5-Alpha-Reductase (5AR) Inhibitors		
dutasteride finasteride 5 mg tablet		▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Combination Agents		
	dutasteride/tamsulosin	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of individual agents.

BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Inhalers, Short-Acting		
PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	*albuterol HFA (generic PROAIR)* NR *albuterol HFA (generic PROVENTIL)* NR *levalbuterol HFA* *PROAIR RESPICLICK (albuterol)* *VENTOLIN HFA (albuterol)* *XOPENEX HFA (levalbuterol)*	▪ Link to PA Form for Short-Acting Beta-2 Agonists (required for Non-preferred drugs) ▪ The non-preferred agents will be approved only after documented failure of a preferred agent.
Bronchodilators, Beta Agonist Inhalers, Long-Acting		
SEREVENT (salmeterol) CL	*ARCAPTA (indacaterol)* CL *STRIVERDI RESPIMAT (olodaterol)* CL	▪ Link to PA Form for Long-Acting Beta-2 Agonists (required for Non-Preferred drugs) ▪ Long-acting beta agonist inhalers will be approved for participants meeting the following criteria ▪ 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 **PLUS** ▪ Age >17 years old **PLUS** ▪ Diagnosis of chronic obstructive pulmonary disease (COPD) ,chronic bronchitis and emphysema (ICD-9 = 491.xx, 492.xx, 493.xx, 496.xx) ***OR*** ▪ Concomitant inhaled corticosteroid use

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BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Inhalation Solution		
albuterol	*levalbuterol* *BROVANA (arformoterol)* *PERFOROMIST (formoterol)*	▪ Link to PA Form for Short-Acting Beta-2 Agonists (required for Non-preferred drugs) ▪ Link to PA Form for Long-Acting Beta-2 Agonists (Brovana/Perforomist) (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent. ▪ Long-acting inhalation solution will be approved for participants meeting the following criteria ▪ 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 **PLUS** ▪ Age >17 years old **PLUS** ▪ Diagnosis of chronic obstructive pulmonary disease (COPD) ,chronic bronchitis and emphysema (ICD-9 = 491.xx, 492.xx, 493.xx, 496.xx) ***OR*** ▪ Concomitant inhaled corticosteroid use
Oral		
terbutaline	*albuterol* *albuterol ER* *metaproterenol*	▪ Link to Universal PA Form (required for Non-Preferred drugs) ▪ Non-preferred agents require medical justification for using an oral beta agonist rather than an inhaled beta agonist.

CALCIUM CHANNEL BLOCKERS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Short-Acting		
diltiazem nifedipine verapamil	*isradipine* *nicardipine*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Long-Acting		
amlodipine diltiazem ER capsules (generic for Cardizem CD) nifedipine ER verapamil ER tablets	*diltiazem ER tablets (generic for Cardizem LA)* *felodipine ER* *nimodipine* *nisoldipine* *KATERZIA (amlodipine)* [NR] *NYMALIZE (nimodipine)* *TIAZAC (diltiazem) 420 mg* *verapamil ER PM* *verapamil ER capsules*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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CEPHALOSPORINS AND RELATED AGENTS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Beta Lactam/Beta-Lactamase Inhibitor Combinations		
amoxicillin/clavulanate IR tablets amoxicillin/clavulanate suspension except 125 mg/31.25 mg/5 mL	*amoxicillin/clavulanate chew tablets* *amoxicillin/clavulanate XR* *AUGMENTIN (amoxicillin/clavulanate) 125/31.25 mg/5 ml suspension*	▪ Link to PA Form for Cephalosporins Oral and Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Cephalosporins – First Generation		
cefadroxil capsules, suspension cephalexin capsules, suspension	*cefadroxil tablet* *cephalexin tablets* *DAXBIA (cephalexin)*	▪ Link to PA Form for Cephalosporins Oral and Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Cephalosporins – Second Generation		
cefprozil suspension, tablets cefuroxime tablets	*cefaclor capsules* *cefaclor ER*	▪ Link to PA Form for Cephalosporins Oral and Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Cephalosporins – Third Generation		
cefdinir capsules, suspension	*cefixime suspension* *cefpodoxime suspension, tablets* *SUPRAX (cefixime) capsules, chew tablets,*	▪ Link to PA Form for Cephalosporins Oral and Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GRANIX (tbo-filgrastim) NEUPOGEN (filgrastim)	*FULPHILA (pegfilgrastim-jmdb)* *LEUKINE (sargramostim)* *NEULASTA (pegfilgrastim)* *NIVESTYM (filgrastim–aafi)* *ZARXIO (filgrastim-sndz)*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

CONTRACEPTIVES, ORAL

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

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Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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COPD AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Anticholinergics		
ATROVENT HFA (ipratropium) ipratropium nebulizer solution SPIRIVA capsules (tiotropium)	*INCRUSE ELLIPTA (umeclidinium)* *LONHALA MAGNAIR (glycopyrrolate)* *SEEBRI NEOHALER (glycopyrrolate)* *SPIRIVA RESPIMAT (tiotropium)* *TUDORZA PRESSAIR (aclidinium)* *YUPELRI (revefenacin)*[NR]	▪ Link to PA Form for COPD Agents ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Anticholinergic-Beta Agonist Combinations		
albuterol/ipratropium BEVESPI AEROSPHERE (glycopyrrolate/formoterol) COMBIVENT RESPIMAT (albuterol/ipratropium) STIOLTO RESPIMAT(tiotropium/olodaterol)	*ANORO ELLIPTA (umeclidinium /vilanterol)* *UTIBRON NEOHALER(glycopyrrolate/indacaterol)*	▪ Link to PA Form for COPD Agents ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
PDE-4 Inhibitors		
	DALIRESP (roflumilast)[CL]	▪ Link to PA Form for Daliresp ▪ Daliresp will be approved for adults with severe COPD associated with chronic bronchitis and a history of exacerbations

COUGH AND COLD AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
No agents are recommended to be preferred at this time.	*All products are non-preferred*	▪ Link to Universal PA Form ▪ 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.

CYSTIC FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
KALYDECO (ivacaftor) [CL] SYMDEKO(ivacaftor/tezacaftor) [CL]	*ORKAMBI (lumacaftor/ivacaftor)* [CL]	▪ Link to Universal PA Form ▪ 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.

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Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Anti-Tumor Necrosis Factor (TNF) Biologics		
ENBREL (etanercept) ENBREL (etanercept) MINI CARTRIDGE HUMIRA (adalimumab)	*CIMZIA (certolizumab)* *INFLECTRA (infliximab)* *REMICADE (infliximab)* *RENFLEXIS (infliximab)* *SIMPONI ARIA (golimumab)* *SIMPONI SQ (golimumab)*	▪ Link to PA Form for Cytokine & CAM Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Other Biologic Agents		
COSENTYX (secukinumab) CL	*ACTEMRA (tocilizumab)* *ARCALYST (rilonacept)* *ENTYVIO (vedolizumab)* *ILARIS (canakinumab)* *ILUMYA (tildrakizumab -asmn)* *KEVZARA (sarilumab)* *KINERET (anakinra)* *ORENCIA (abatacept)* *SILIQ (brodalumab)* *SKYRIZI (risankizumab)* NR *STELARA (ustekinumab)* *TALTZ (ixekizumab)* *TREMFYA (guselkumab)*	▪ Link to PA Form for Cytokine & CAM Antagonists (required for Non-Preferred drugs) ▪ Cosentyx (seculkinumab) will be approved after a documented failure of Humira (adlimumab) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Non-Biologic Agents		
	OLUMIANT (baricitinib) *OTEZLA (apremilast)* *XELJANZ (tofacitinib)* *XELJANZ XR (tofacitinib)*	▪ Link to PA Form for Cytokine & CAM Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

EPINEPHRINE, SELF-INJECTED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
epinephrine (generic EPIPEN, EPIPEN JR)	epinephrine (ADRENACLICK)	▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ARANESP (darbepoetin) PROCRIT (rHuEPO)	*EPOGEN (rHuEPO)* *RETACRIT (epoetin alfa-epbx)*	▪ Link to PA Form for Erythropoiesis Stimulating Proteins ▪ Non-preferred agents will only be authorized if there is documented failure of one preferred agent within the past 180 days.

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FLUOROQUINOLONES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ciprofloxacin tablet CIPRO Suspension (ciprofloxacin) levofloxacin tablets	*BAXDELA (delafloxacin)* *ciprofloxacin ER* *ciprofloxacin suspension* *levofloxacin solution* *moxifloxacin* *ofloxacin*	▪ Link to PA Form for Fluoroquinolones (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

GI MOTILITY, CHRONIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AMITIZA (lubiprostone) CL LINZESS (linaclotide) CL MOVANTIK (naloxegol) CL	*alosetron* CL *LOTRONEX (alosetron)* CL *MOTEGRITY (prucalopride)* CL *RELISTOR (methylnaltrexone) oral, syringe, vial* CL *SYMPROIC (naldemedine)* CL *TRULANCE (plecanatide)* CL *VIBERZI (eluxadoline)* CL	▪ Link to PA Form for GI Motility ▪ 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. ▪ Amitiza 8 mcg capsules will be approved for female participants with irritable bowel syndrome with constipation. ▪ 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. ▪ Lotronex/alosetron will be approved for female participants with diarrhea-predominant irritable bowel syndrome. ▪ Movantik will be approved for participants with chronic constipation that have been on opioids continuously for at least four weeks. ▪ 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. ▪ Trulance will be approved for participants with chronic idiopathic constipation who have failed Linzess or Amitiza 24 mg. ▪ Viberzi will be approved for participants with diarrhea-predominant irritable bowel syndrome.

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GLUCOCORTICOIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Glucocorticoids		
ASMANEX Twisthaler (mometasone) budesonide respules 0.25, 0.5 mg CL FLOVENT (fluticasone) HFA PULMICORT (budesonide) Respules 1 mg CL	*AEROSPAN (flunisolide)* *ALVESCO (ciclesonide)* *ARMONAIR RESPICLICK (fluticasone)* *ARNUITY ELLIPTA (fluticasone)* *ASMANEX HFA (mometasone)* *budesonide respules 1 mg* *FLOVENT (fluticasone) DISKUS* *PULMICORT (budesonide) FLEXHALER* *QVAR (beclomethasone)* *QVAR (beclomethasone) REDIHALER*	▪ Link to PA Form for Inhaled Glucocorticoids (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months. ▪ Pulmicort/budesonide Respules are only preferred for the treatment of asthma in children 8 years and younger.
Glucocorticoid/Bronchodilator Combinations CL		
ADVAIR (fluticasone/salmeterol) CL SYMBICORT (budesonide/formoterol) CL	*AIRDUO (fluticasone/salmeterol) RESPICLICK CL* *BREO ELLIPTA (fluticasone/vilanterol) CL* *DULERA (mometasone/formoterol) CL* *fluticasone/salmeterol* *TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol) CL* *WIXELA INHUB (fluticasone/salmeterol) NR*	▪ Link to PA Form for Inhaled Glucocorticoid/Bronchodilator Combinations (required for all drugs) ▪ Asthma: ▪ Advair, fluticasone/salmeterol generic or Symbicort will be approved for eligible participants with a documented diagnosis of persistent asthma (ICD-10 = J45). ▪ 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 ▪ COPD: ▪ 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). ▪ 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 ▪ 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.

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GROWTH HORMONE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GENOTROPIN (somatropin) CL NORDITROPIN (somatropin) CL	*HUMATROPE (somatropin)* CL *NUTROPIN AQ (somatropin)* CL *OMNITROPE (somatropin)* CL *SAIZEN (somatropin)* CL *SEROSTIM (somatropin)* CL *ZOMACTON (somatropin)* CL *ZORBTIVE (somatropin)* CL	▪ Link to PA Form for Growth Hormone (required for all drugs) ▪ Growth hormone will be approved for patients with any of the following diagnoses and meeting the criteria defined on the PA Form: ▪ Chronic Renal Impairment awaiting renal transplantation (ICD-10 N18.9) ▪ Growth Hormone Deficiency (ICD-10 E23.0) ▪ Prader-Willi Syndrome (ICD-10 Q87.1) ▪ Turner Syndrome (ICD-10 Q96.0) ▪ HIV plus Cachexia (ICD-10 B20) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.

H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PYLERA (bismuth subcitrate potassium, metronidazole, tetracycline)	*lansoprazole, amoxicillin, clarithromycin* *OMECLAMOX-PAK (omeprazole, amoxicillin, clarithromycin)*	▪ Link to PA Form for H. Pylori Treatment ▪ Non-preferred agents will only be approved after the documented trial and failure of a preferred agent. ▪ Individual agents should be used in place of combination agents of omeprazole or lansoprazole with amoxicillin and clarithromycin.

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HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Interferon		
PEGASYS (pegylated interferon alfa-2a) syringe, vial PEG-INTRON (pegylated interferon alfa-2b)	*PEGASYS (pegylated interferon alfa-2a) Proclick*	▪ Link to PA Form for Hepatitis C - Interferon and Ribavirin (required for Non-preferred drugs) ▪ Non-preferred agents will only be approved after the documented trial and failure of a preferred agent.
Ribavirin		
ribavirin tablet, capsule	*RIBAPAK (ribavirin)* *RIBASPHERE (ribavirin)* *ribavirin dose pack*	▪ Link to PA Form for Hepatitis C - Interferon and Ribavirin (required for Non-preferred drugs) ▪ Non-preferred agents will only be approved after the documented trial and failure of a preferred agent.
Direct-Acting Anti-Viral Agents CL		
EPCLUSA (sofosbuvir/velpatasvir) CL MAVYRET (glecaprevir/pibrentasvir) CL VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) CL	*HARVONI (ledipasvir/sofosbuvir) CL* *ledipasvir/sofosbuvir CL* *sofosbuvir/velpatasvir CL* *SOVALDI (sofosbuvir) CL* *VIEKIRA PAK (dasabuvir/ombitasvir/ paritaprevir/ritonavir) CL* *ZEPATIER (elbasvir/grazoprevir) CL*	▪ Link to PA Form for Treatment of Hepatitis C Virus ▪ For complete criteria refer to the document entitled Hepatitis C Agents Therapeutic Criteria

HEREDITARY ANGIOEDEMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CINRYZE (C1- esterase inhibitor) CL FIRAZYR (icatibant) CL KALBITOR (ecallantide) CL	*BERINERT (C1-esterase inhibitor) CL* *HAEGARDA (C1-esterase inhibitor) CL* *RUCONEST (recombinant C1 esterase) CL* *TAKHZYRO (lanadelumab-FLYO) CL*	▪ Link to Universal PA Form ▪ Treatment of Acute Attacks: Preferred agents which require documentation of diagnosis are Firazyr and Kalbitor. Non-preferred Berinert and Ruconest require trial and failure of a preferred agent or a contra-indication to a preferred agent. ▪ Prophylaxis: The preferred agent Cinryze requires 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.

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HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INCRETIN ENHANCERS		
GLYXAMBI (empagliflozin/linagliptin) JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	*alogliptin* *alogliptin/metformin* *alogliptin/pioglitazone* *JENTADUETO XR (linagliptin/metformin)* *KOMBIGLYZE XR (saxagliptin/metformin)* *ONGLYZA (saxagliptin)* *QTERN (dapagliflozin/saxagliptin)* *STEGLUJAN (ertugliflozin/sitagliptin)*	▪ Link to PA Form for Hypoglycemics – Incretin Enhancers ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.
INCRETIN MIMETICS		
BYDUREON (exenatide ER) CL pens BYETTA (exenatide) CL SYMLIN (pramlintide) CL VICTOZA (liraglutide) CL	*ADLYXIN (lixisenatide)* *BYDUREON (exenatide ER) CL subcutaneous* *BYDUREON BCISE (exenatide) CL* *SOLIQUA (Insulin glargine/lixisenatide) CL* *OZEMPIC (semaglutide) CL* *TRULICITY (dulaglutide) CL* *XULTOPHY (Insulin degludec/liraglutide) CL*	▪ Link to PA Form for Hypoglycemics, Incretin Mimetics (for all products except Symlin) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent. ▪ Link to PA Form for Symlin ▪ Symlin will be approved for patients with diabetes who are currently on insulin therapy. ▪ Symlin will not be approved for pediatric patients <6 years of age or for patients with a diagnosis of gastroparesis or who require the use of medication to stimulate gastric motility.

HYPOGLYCEMICS, INSULIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HUMALOG (insulin lispro) except 200 U/ml HUMALOG MIX (insulin lispro/lispro protamine) HUMULIN (insulin) vials (except 500 U/ml) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	*ADMELOG (insulin lispro)* *AFREZZA (insulin, inhaled) CL* *APIDRA (insulin glulisine)* *BASAGLAR KWIKPEN (insulin glargine)* *FIASP (insulin aspart)* *HUMALOG (insulin lispro) 200 U/ml* *HUMALOG JUNIOR KWIKPEN (insulin lispro)* *HUMULIN (insulin) pens* *HUMULIN (insulin) vials 500 U/ml* *insulin lispro* *NOVOLIN (insulin)* *TOUJEO (insulin glargine)* *TOUJEO MAX SOLOSTAR (insulin glargine)* *TRESIBA (insulin degludec) Flextouch, vial*	▪ Link to PA Form for Insulin (required for non-preferred drugs) ▪ Apidra will be approved for participants with documented hypoglycemia with Humalog or NovoLog. ▪ Afrezza requires medical necessity documentation for why injectable insulin cannot be used. ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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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, 2019
Highlights indicated change from previous posting.

HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
glyburide-metformin metformin metformin ER (GLUCOPHAGE XR)	*FORTAMET (metformin ER)* *glipizide-metformin* *metformin ER (FORTAMET)* *metformin ER (GLUMETZA)* *RIOMET (metformin) oral solution*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin) CL INVOKANA (canagliflozin) CL JARDIANCE (empagliflozin) CL SYNJARDY (empagliflozin/metformin) CL	*INVOKAMET (canagliflozin/metformin) CL* *INVOKAMET XR (canagliflozin/metformin CL* *SEGLUROMET (ertugliflozin/metformin) CL* *STEGLATRO (ertugliflozin) CL* *SYNJARDY XR (empagliflozin/metformin) CL* *XIGDUO XR (dapagliflozin/metformin XR) CL*	▪ Link to PA Form for SGLT2 Inhibitors (required for non-preferred drugs) ▪ Preferred sodium Glucose Co-transporter Inhibitors will be approved after a trial of metformin within the previous 30 days. ▪ Non-preferred agents will be approved after a trial of any agent in the following drug classes within the previous 30 days and a failure of a preferred SGLT2 Inhibitor: ▪ Metformins ▪ Incretin mimetic/enhancers ▪ Insulins ▪ 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 OR after a trial of any agent in the following drug classes within the previous 30 days and a failure of a preferred SGLT2 Inhibitor: ▪ Metformins ▪ Incretin mimetic/enhancers ▪ Insulins

HYPOGLYCEMICS, TZDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Thiazolidinediones		
pioglitazone	*AVANDIA (rosiglitazone)*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Thiazolidinedione Combinations		
	pioglitazone/glimepiride CL *pioglitazone/metformin CL*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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IMMUNE GLOBULINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Primary Immunodeficiency Products		
CARIMUNE NF nano filtered powder for intravenous solution CL CYTOGAM (cytomegalovirus immune globulin) intravenous solution CL FLEBOGAMMA DIF intravenous solution CL GAMASTAN S/D intramuscular CL GAMMAGARD LIQUID injection solution CL GAMMAGARD S/D powder for intravenous solution CL GAMUNEX-C injection solution CL HIZENTRA subcutaneous solution CL PRIVIGEN intravenous solution CL	*BIVIGAM intravenous solution* CL *CUTAQUIG subcutaneous solution* NR *CUVITRU subcutaneous solution* *GAMMAKED injection solution* CL *GAMMAPLEX intravenous solution* CL *HYQVIA subcutaneous solution* CL *OCTAGAM intravenous solution* CL	▪ Link to Immune Globulin PA Form ▪ 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. ▪ Non-preferred agents require either trial and failure of a preferred agent or documentation of medical necessity.
Virus Products		
HYPERHEP B S-D injection solution VARIZIG (Varicella-Zoster immune globulin) intramuscular CL	*HEPAGAM B (hepatitis B immune globulin) intramuscular* CL *HYPER RAB* CL *IMOGAM RABIES-HT intramuscular* CL *KED RAB* CL	

IMMUNOMODULATORS FOR ATOPIC DERMATITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIDEL (pimecrolimus)	*DUPIXENT (dupilumab)* CL *EUCRISA (crisaborole)* CL *pimecrolimus* NR *PROTOPIC (tacrolimus)* *tacrolimus*	▪ Link to Universal PA Form ▪ 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. ▪ 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. ▪ Black box warning – Not FDA approved for use in children less than 2 years of age (Elidel 1% and Protopic 0.03%) or <16 years old (Protopic 0.1%). ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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IMMUNOMODULATORS, ASTHMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
No agents are recommended to be preferred at this time.	*CINQUAIR (reslizumab)* CL *FASENRA (benralizumab)* CL *NUCALA (mepolizumab)* CL *XOLAIR (omalizumab)* CL	▪ Link to PA Form for Immunomodulators, Asthma ▪ Please refer to the PA form for the criteria for each drug.

IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathioprine cyclosporine, modified mycophenolate mofetil capsules, tablets RAPAMUNE (sirolimus) solution tacrolimus	*ASTAGRAF (tacrolimus XL)* *AZASAN (azathioprine)* *cyclosporine capsule* *cyclosporine softgel* *ENVARSUS XR (tacrolimus)* *mycophenolate mofetil suspension* *mycophenolic acid* *sirolimus solution, tablets* *ZORTRESS (everolimus)*	▪ Link to PA Form for Immunosuppressives, Oral ▪ Non-preferred agents will be approved for payment only after documented failure of at least one preferred agent within the last 6 months.

INTRANASAL RHINITIS AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Anticholinergics		
ipratropium		▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Antihistamines		
azelastine (for ASTELIN)	*azelastine (for ASTEPRO)* *olopatadine*	▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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INTRANASAL RHINITIS AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Corticosteroids		
fluticasone	*BECONASE AQ (beclomethasone)* *flunisolide* *mometasone* *OMNARIS (ciclesonide)* *QNASL (beclomethasone)* *SINUVA (mometasone furoate) sinus implant* CL *TICANASE (fluticasone)* *VERAMYST (fluticasone)* *XHANCE (fluticasone propionate) nasal spray* CL *ZETONNA (ciclesonide)*	▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Antihistamine / Corticosteroid Combinations		
	DYMISTA (azelastine/fluticasone)	▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ Dymista will be approved only after documented failure of any preferred intranasal rhinitis agent.

LEUKOTRIENE MODIFIERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
montelukast tablets, chewable tablets	*montelukast granules* *zafirlukast* *zileuton ER* *ZYFLO (zileuton)* *ZYFLO CR (zileuton)*	▪ Link to PA Form for Leukotriene Modifiers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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LIPOTROPICS, OTHER (NON-STATINS)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Apolipoprotein B Synthesis Inhibitors		
	JUXTAPID (lomitapide mesylate) CL *KYNAMRO (mipomersen)* CL	▪ Link to Universal PA Form (required for Non-Preferred drugs - except for ezetimibe - see below) ▪ Juxtapid and Kynamro may be approved for patients with homozygous familial hypercholesterolemia.
Bile Acid Sequestrants		
cholestyramine colestipol granules, tablets	*colesevelam* *WELCHOL (colesevelam)*	▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs - except for ezetimibe - see below) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Fibric Acid Derivatives		
fenofibrate (generic TRICOR) gemfibrozil 600 mg	*fenofibrate (generic ANTARA , FENOGLIDE, LIPOFEN, LOFIBRA, TRIGLIDE)* *fenofibric acid (generic FIBRICOR, TRILIPIX)* *FENOGLIDE (fenofibrate)* *TRIGLIDE (fenofibrate)*	▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs - except for ezetimibe - see below) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent
Niacin		
	niacin *niacin ER* *NIACOR (niacin)*	▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs -except for ezetimibe - see below) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Omega-3 Fatty Acids		
	omega-3 fatty ethyl esters (generic for LOVAZA) *VASCEPA (icosapent ethyl)*	▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs - except for ezetimibe - see below) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Cholesterol Absorption InhibitorsCL		
ezetimibe CL		▪ Link to PA form to ezetimibe (Zetia) ▪ Ezetimibe is approved for patients who have a diagnosis of hypercholesterolemia and who have either failed statin monotherapy or who have a documented intolerance to statin therapy.

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CL – Prior Authorization / Class Criteria apply

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LIPOTROPICS, OTHER (NON-STATINS)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PCSK9 Inhibitors		
	PRALUENT (alirocumab) [CL] *REPATHA (evolocumab)* [CL]	▪ Link to Universal PA Form ▪ Praluent and Repatha will be approved for patients meeting the following criteria. ▪ Diagnosis of atherosclerotic cardiovascular disease or heterozygous familial hypercholesterolemia (HeFH). Repatha may also be approved for homozygous familial hypercholesterolemia (HoFH). ▪ Age > 18 years unless treatment is for HoFH then > 13 years. ▪ Prescribed in consultation with a cardiologist, lipidologist or endocrinologist. ▪ Failure to reach LDL-C goal of < 70 mg/dl in clinically significant ASCVD or < 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.

LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
STATINS		
atorvastatin lovastatin pravastatin rosuvastatin	*ALTOPREV (lovastatin)* *EZALLOR SPRINKLE (rosuvastatin)* [NR] *FLOLIPID (simvastatin suspension)* *fluvastatin* *fluvastatin ER* *LESCOL XL (fluvastatin)* *LIVALO (pitavastatin)* *simvastatin* *ZYPITAMAG (pitavastatin)*	▪ Link to PA Form for Statins (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent within the last 6 months. ▪ Simvastatin 80 mg will only be approved for patients who have been on this dose for more than one year without muscle toxicity.
Statin Combinations		
	atorvastatin/amlodipine *simvastatin/ezetimibe (VYTORIN)* *VYTORIN (simvastatin/ezetimibe)*	▪ Link to PA Form for Statins (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one single entity agent within the last 6 months. ▪ Please use individual prescriptions for atorvastatin/amlodipine.

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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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MACROLIDES (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azithromycin clarithromycin IR tablets erythromycin base capsules erythromycin ethylsuccinate 200 mg suspension	*clarithromycin ER* *clarithromycin suspension* *E.E.S. 400 mg tablets (erythromycin ethylsuccinate)* *ERYPED suspension (erythromycin ethylsuccinate)* *ERY-TAB (erythromycin)* *erythromycin base tablets* *erythromycin ethylsuccinate 400 mg suspension*	▪ Link to PA Form for Macrolides (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated July 1, 2019
Highlights indicated change from previous posting.

MOVEMENT DISORDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
No agents are recommended to be preferred at this time.	*AUSTEDO (deutetrabenazine)* [CL] *INGREZZA (valbenazine)* [CL] *tetrabenazine* [CL] *XENAZINE (tetrabenazine)* [CL]	▪ Link to Movement Disorders PA Form ▪ Austedo will be approved for the following indications and associated criteria: ▪ Huntington's Chorea: -Genetic documentation of diagnosis -Clinically significant chorea document in chart note -Unified Huntington's Disease Rating Scale (or equivalent test) documenting chorea ▪ Tardive Dyskinesia: - Documentation of diagnosis of clinically significant tardive dyskinesia with drug(s) that are suspected to have caused the disease state. - Documentation of steps that have been taken to reduce the risk for tardive dyskinesia such as discontinuing drug, changing drug therapy, reducing drug dosage. - AIMS (or equivalent test) documenting tardive dyskinesia ▪ Ingrezza will be approved for participants with a diagnosis of Tardive Dyskinesia that meet the following criteria: ▪ Documentation of diagnosis of clinically significant tardive dyskinesia with drug(s) that are suspected to have caused the disease state. ▪ Documentation of steps that have been taken to reduce the risk for tardive dyskinesia such as discontinuing drug, changing drug therapy, reducing drug dosage. ▪ AIMS (or equivalent test) documenting tardive dyskinesia ▪ Xenazine/tetrabenazine will be approved for participants with a diagnosis of Huntington's Chorea that meet the following criteria: ▪ Genetic documentation of diagnosis ▪ Clinically significant chorea documented in chart note ▪ Unified Huntington's Disease Rating Scale (or equivalent test) documenting chorea

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MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Injectable Disease Modifying Therapies		
AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE 20 mg syringe (glatiramer) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a)	*COPAXONE 40 mg syringe (glatiramer)* [CL] *EXTAVIA (interferon beta-1b)* *glatiramer 20 mg, 40 mg syringe* *LEMTRADA (alemtuzamab) IV* [CL] *OCREVUS (ocrelizumab)* [CL] *PLEGRIDY (peginterferon beta-1 a) IV* *TYSABRI (natalizumab)*	▪ Link to Universal PA Form ▪ 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. ▪ Glatopa (glatiramer) will be approved only after documented failure of Copaxone (glatiramer) 20 mg. ▪ Copaxone (glatiramer) 40 will be approved only after documented inability to use Copaxone or Glatopa 20 mg. ▪ 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. ▪ 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. ▪ All other non-preferred injectable agents will be approved only after documented failure of a preferred agent.

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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).

MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral Disease Modifying Therapies		
TECFIDERA (dimethyl fumarate) CL	*AUBAGIO (teriflunomide)* CL *GILENYA (fingolimod)* CL *MAVENCLAD (cladribine)* NR *MAYZENT (siponimod)* NR	▪ 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. ▪ 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. ▪ Gilenya (fingolimod) will be approved for patients with a relapsing form of multiple sclerosis and an EKG within the most recent 3 months that shows no evidence of heart block or bradycardia.
Other		
	AMPYRA (dalfampridine) CL *dalfampridine ER*	▪ Link to PA form for Ampyra ▪ 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. ▪ Chart note documentation of the medical necessity is required.

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NSAIDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Nonselective		
diclofenac SR flurbiprofen ibuprofen* indomethacin IR capsules nabumetone naproxen* naproxen EC sulindac	*diclofenac IR* *diflunisal* *etodolac IR* *etodolac SR* *fenoprofen* *INDOCIN (indomethacin) rectal* *INDOCIN (indomethacin) suspension* *indomethacin ER* *ketoprofen ER* *ketoprofen IR* *ketorolac* *meclofenamate* *mefenamic acid* *NAPRELAN (naproxen CR 750 mg)* *naproxen suspension** *naproxen CR 375 and 500 mg* *naproxen sodium* *oxaprozin* *piroxicam* *SPRIX nasal (ketorolac)* *TIVORBEX (indomethacin)* *tolmetin* *ZIPSOR (diclofenac)* *ZORVOLEX (diclofenac)*	▪ Link to PA Form for NSAIDs (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent. ▪ 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. ▪ * Prescription strength only; OTC ibuprofen and OTC naproxen are not covered by Idaho Medicaid.
NSAID/GI Protectant Combinations		
	diclofenac/misoprostol [CL] *DUEXIS (ibuprofen/famotidine)* [CL] *VIMOVO (naproxen/esomeprazole)* [CL]	▪ Please use prescriptions for individual agents.
COX-II Selective		
meloxicam tablets	*celecoxib* *meloxicam suspension* *QMIIZ (meloxicam) ODT* [NR] *VIVLODEX (meloxicam)*	▪ Link to PA Form for NSAIDs ▪ Celecoxib will be approved after documented failure of two preferred NSAIDs (non-selective or COX- II Selective) ▪ Other non-preferred agents will be approved after documented failure of a preferred agent (non-selective or COX-II Selective)
NSAIDS, TOPICAL		
VOLTAREN GEL (diclofenac 1% or 1.5%)	*diclofenac gel 1% or 1.5%* *diclofenac solution 1.5%* *FLECTOR PATCH (diclofenac 1.3%)* *PENNSAID PUMP (diclofenac 2%)*	▪ Link to PA form for Analgesics, Topical (required for non-preferred agents) ▪ Non-preferred agents will be approved if the patient has a history of at least one preferred agent in the last 6 months.

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OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
sulfacetamide/prednisolone TOBRADEX (tobramycin/dexamethasone) ointment and suspension	*BLEPHAMIDE (prednisolone/sulfacetamide)* *BLEPHAMIDE S.O.P. ointment (prednisolone/sulfacetamide)* *neomycin/bacitracin/polymyxin/ hydrocortisone* *neomycin/polymyxin/dexamethasone* *neomycin/polymyxin/ hydrocortisone* *PRED-G (gentamicin/prednisolone)* *TOBRADEX ST (tobramycin/dexamethasone)* *tobramycin/dexamethasone* *ZYLET (loteprednol/tobramycin)*	• Link to PA Form for Ophthalmic Antibiotic-Steroid Combinations (required for Non-preferred drugs). • Non-preferred agents will be approved for participants failing to respond to a preferred agent.

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)	*AZASITE (azithromycin)* *bacitracin* *BESIVANCE (besifloxacin)* *CILOXAN (ciprofloxacin) solution* *gatifloxacin* *levofloxacin* *moxifloxacin* *NATACYN (natamycin)* *neomycin/bacitracin/polymyxin* *neomycin/polymyxin/gramicidin* *ofloxacin* *sulfacetamide ointment* *sulfacetamide solution* *ZYMAXID (gatifloxacin)*	▪ Link to PA Form for Ophthalmic Antibiotics (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cromolyn PAZEO (olopatadine 0.7%)	*ALOCRIL (nedocromil)* *ALOMIDE (lodoxamide)* *ALREX (loteprednol)* *azelastine* *BEPREVE (bepotastine)* *EMADINE (emedastine)* *epinastine* *LASTACAFT (alcaftadine)* *olopatadine 0.1% (generic PATANOL)* *olopatadine 0.2% (generic PATADAY)*	▪ Link to PA Form for Ophthalmics for Allergic Conjunctivitis (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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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%)* NR *FLAREX (fluorometholone)* *FML FORTE (fluorometholone)* *FML S.O.P. (fluorometholone)* *ILEVRO (nepafenac 0.3%)* *INVELTYS (loteprednol)* NR *LOTEMAX gel and ointment (loteprednol)* *NEVANAC (nepafenac 0.1%)* *PRED FORTE (prednisolone acetate)* *prednisolone sodium phosphate* *PROLENSA (bromfenac 0.07%)* *VEXOL (rimexolone)*	▪ Link to PA Form for Ophthalmic Anti-Inflammatories (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

OPHTHALMICS, ANTI-INFLAMMATORY/IMMUNOMODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RESTASIS (cyclosporine) CL	*CEQUA (cyclosporin)* NR *XIIDRA (lifitegrast)* CL	▪ Link to PA form for Ophthalmics, Anti-Inflammatory/Immunomodulators ▪ All agents require a diagnosis of suppressed tear production due to ocular inflammation associated with keratoconjunctivitis sicca (dry eye disease) ICD-10 = H16.221 ▪ Preferred agents will be approved for patients with the diagnosis who have tried and failed at least two different OTC ophthalmic lubricants. ▪ Non-preferred agents will be approved after trial and failure of a preferred agent. ▪ Restasis and Xiidra will be approved for participants with suppressed tear production due to ocular inflammation associated with Keratoconjuntivitis sicca (dry eye disease) ICD-9 = 370.33 or ICD-10 =H16.221 ▪ Xiidra will also require a trial and failure of Restasis for approval.

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SUBSTANCE USE DISORDER TREATMENT

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Alcohol Treatment		
	naltrexone oral CL *VIVITROL (naltrexone) injection* CL	▪ Vivitrol (naltrexone) injectable or naltrexone oral will be approved for patients with alcohol dependence (ICD-10 = F10) with adequate clinical documentation for need.
Opiate Dependence Treatments		
buprenorphine/naloxone SL tablets SUBOXONE film (buprenorphine/naloxone)	*BUNAVAIL(buprenorphine/naloxone) buccal* *buprenorphine* *buprenorphine/naloxone SL film* *LUCEMYRA (lofexidine)* CL *PROBUPHINE (buprenorphine) implant* CL *SUBLOCADE (buprenorphine) injection* CL *VIVITROL (naltrexone) injection* CL *ZUBSOLV (buprenorphine/naloxone tablet)*	▪ Link to PA Form for Opiate Dependence Treatments ▪ 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. ▪ Non-preferred oral buprenorphine-based agents will be approved after documented failure of a preferred agent. ▪ Total daily doses of buprenorphine cannot exceed 24 mg. ▪ LUCEMYRA will be approved for opioid withdrawal syndrome in patients who have received initial treatment with Lucemyra in an acute care setting. ▪ 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 < 8 mg/day. ▪ SUBLOCADE (buprenorphine) injection will be approved for patients who are stable on transmucosal buprenorphine at doses between 8-24 mg daily for at least 30 days with the following documentation: ▪ Evidence that the patient has had their cravings and withdrawal symptoms clinically controlled while on transmucosal buprenorphine. ▪ A clinically valid evidence-based reason to switch from transmucosal buprenorphine to injectable Sublocade. ▪ 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

SUBSTANCE USE DISORDER TREATMENT

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		rationale for receiving non-buprenorphine based treatment or have a documented inadequate response to prior treatment with buprenorphine-based treatment.
Opioid Reversal Agents		
naloxone vial, syringe NARCAN (naloxone) nasal		▪ No prior authorization required for naloxone. ▪ 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.

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) neomycin/polymyxin/hydrocortisone	*ofloxacin* *OTOVEL (ciprofloxacin/fluocinolone)*	▪ Link to PA Form for Otic Antibiotics (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

PANCREATIC ENZYMES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CREON ZENPEP	*PANCREAZE* *PERTZYE* *VIOKACE*	▪ Link to PA Form for Pancreatic Enzymes ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent within the last 6 months

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate capsule (generic for PhosLo) RENAGEL (sevelamer HCl)	*AURYXIA (ferric citrate)* *calcium acetate tablet* *FOSRENOL (lanthanum)* *lanthanum* *PHOSLYRA (calcium acetate)* *sevelamer carbonate* *sevelamer HCL (generic for Renagel)* *VELPHORO (sucroferric oxyhydroxide)*	▪ Link to PA Form for Phosphate Binders (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

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PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clopidogrel dipyridamole prasugrel	*AGGRENOX (aspirin/ dipyridamole)* *aspirin/dipyridamole* *BRILINTA (ticagrelor)* *ticlopidine* *ZONTIVITY (vorapaxar)*	▪ Link to PA Form for Platelet Aggregation Inhibitors (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

PROTON PUMP INHIBITORS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
lansoprazole capsules Rx NEXIUM suspension (esomeprazole) omeprazole Rx pantoprazole	*DEXILANT (dexlansoprazole)* *esomeprazole magnesium* *esomeprazole strontium* *lansoprazole solutab* *omeprazole OTC* *omeprazole magnesium OTC* *omeprazole/sodium bicarbonate* *PREVACID SOLUTAB (lansoprazole)* *PRILOSEC Suspension (omeprazole)* *PROTONIX suspension (pantoprazole)* *rabeprazole*	▪ Link to PA Form for PPIs (required for Non-Preferred drugs) ▪ Prevacid SoluTabs will be approved for patients who cannot swallow tablets or capsules and are not a candidate for a preferred liquid preparation. ▪ Other non-preferred agents will only be approved if patient has tried and failed therapy with two preferred agents within the last six months. ▪ Quantity limits of one dose per day apply to this class

PULMONARY ARTERIAL HYPERTENSION AGENTS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Endothelin Receptor Antagonists		
LETAIRIS (ambrisentan) TRACLEER (bosentan) tablets	*ambrisentan* [NR] *bosentan* [NR] *OPSUMIT (macitentan)* *TRACLEER (bosentan) suspension*	▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months. ▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)
Prostacyclin Receptor Agonist		
	UPTRAVI (selexipag)	▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months. ▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)
Prostanoids		
	ORENITRAM ER (treprostinil)) *TYVASO (treprostinil)* *VENTAVIS (iloprost)*	▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months. ▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)

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PULMONARY ARTERIAL HYPERTENSION AGENTS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PDE-5 Inhibitors		
sildenafil [CL]	*ADCIRCA (tadalafil)* *REVATIO (sildenafil) suspension* [CL] *tadalafil* [CL]	▪ Adcirca and sildenafil will only be approved for diagnosis of pulmonary artery hypertension (ICD-9 416xx) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months. ▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)
Soluble Guanylate Cyclase Stimulators		
	ADEMPAS (riociguat)	▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months. ▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)

SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Benzodiazepines		
	estazolam *flurazepam* *temazepam* *triazolam*	▪ Link to PA Form for Sedative Hypnotics (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.
Others		
doxepin 10 mg ROZEREM (ramelteon) zolpidem IR	*BELSOMRA (suvorexant)* *EDLUAR (zolpidem)* *eszopiclone* *HETLIOZ (tasimelteon)* [CL] *INTERMEZZO SL (zolpidem)* *ramelteon* [NR] *SILENOR (doxepin)* *zaleplon* *zolpidem ER* *zolpidem SL* *ZOLPIMIST (zolpidem)*	▪ Link to PA Form for Sedative Hypnotics (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months. ▪ Link to PA Form for Hetlioz ▪ 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.

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SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
baclofen 10, 20 mg tablets cyclobenzaprine IR 5, 10 mg tablets methocarbamol tizanidine tablets	*AMRIX (cyclobenzaprine ER)* *baclofen 5 mg* *carisoprodol* CL *carisoprodol compound* CL *chlorzoxazone* *cyclobenzaprine IR 7.5 mg tablets* *dantrolene* *LORZONE (chlorzoxazone)* *metaxalone* *orphenadrine* *tizanidine capsules*	▪ Link to PA Form for Skeletal Muscle Relaxants (required for Non-Preferred drugs) ▪ The non-preferred agents will be approved for patients with documented failure of at least a one week trial each of two preferred agents. ▪ For carisoprodol: ▪ Use will be limited to no more than 34 days ▪ Additional authorization will not be granted for at least six months following the last day of the previous course of therapy ▪ Approval will not be granted for patients with a history of meprobamate use in the previous two years ▪ Approval will not be granted for patients concurrently using opioids

STIMULANTS AND RELATED DRUGS CL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
amphetamine salt combination ER CL amphetamine salt combination IR CL APTENSIO XR (methylphenidate) CL FOCALIN XR (dexmethylphenidate) CL methylphenidate ER (generic Concerta) CL methylphenidate IR Tablets QUILLICHEW ER (methylphenidate) CL QUILLIVANT XR (methylphenidate) solution CL VYVANSE (lisdexamfetamine) CL	*ADHANSIA XR (methylphenidate)* NR *ADZENYS ER suspension (amphetamine)* CL *ADZENYS XR ODT (amphetamine)* CL *CONTEMPLA XR-ODT (methylphenidate)* CL *DAYTRANA (methylphenidate)* CL *dexmethylphenidate* CL *dexmethylphenidate XR* CL *dextroamphetamine IR, ER* CL *dextroamphetamine solution* CL *DYANAVEL XR (amphetamine)* CL *EVEKEO (amphetamine)* CL *EVEKEO ODT (amphetamine)* NR *methylphenidate CD* *methylphenidate chewable tablets* CL *methylphenidate ER (generic for MEDADATE)* CL *methylphenidate ER (generic Ritalin LA)* CL *methylphenidate solution* CL *JORNAY PM (methylphenidate)* NR *MYDAYIS (amphetamine salt combination ER)* CL *ZENZEDI (dextroamphetamine)* CL	▪ Link to PA Form for Stimulants - ADD/ADHD Drugs (required for Non-Preferred drugs) ▪ Stimulants for adults (> or = to 18 years) will be approved for patients with a diagnosis of ADHD (ICD-9 = 314 or ICD-10 F90) in the previous two years without any of the following contraindications: ▪ opiate abuse ▪ drug dependence, including to opioids, cocaine, amphetamine, hallucinogens ▪ hypertension ▪ hyperthyroidism ▪ glaucoma ▪ Daytrana will only be approved for patients who are unable to take oral therapy. ▪ Non-preferred agents will be approved for payment only after documented failure of at least one preferred agent.

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STIMULANTS AND RELATED DRUGS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Non-Stimulants		
atomoxetine clonidine IR guanfacine ER guanfacine IR	*clonidine ER* [CL]	▪ Link to PA Form for Non-Stimulant Therapy for ADHD ▪ Guanfacine, clonidine, guanfacine ER will be approved for patients with a diagnosis of ADHD (ICD-9 = 314.xx or ICD-10 = F90) ▪ Clonidine long-acting will be approved after documented failure of clonidine IR within the past 60 days. ▪ Strattera will be approved for patients with a documented diagnosis of ADHD (ICD-9 = 314.xx or ICD-10 = F90)
Narcolepsy-Specific Agents		
	armodafinil [CL] *modafinil* [CL] *NUVIGIL (armodafinil)* [CL] *SUNOSI (solriamfetol)* [NR]	▪ Link to PA Form for Nuvigil & Provigil ▪ Modafinil and Nuvigil will be approved for patient > 16 years of age with documented need in the following diagnoses ▪ Narcolepsy (ICD-9=347, ICD-10=G47.1) ▪ Obstructive sleep apnea (ICD-9=780.51, 780.53, ICD-10=G47.33) ▪ Shift work sleep disorder (ICD-9=307.45, ICD-10=G47.26)

TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR: 20mg, 50mg, 100 mg minocycline capsules	*ACTICLATE (doxycycline)* [NR] *demeclocycline* *DORYX (doxycycline hyclate)* *doxycycline hyclate DR* *doxycycline hyclate IR: 75mg, 150mg* *doxycycline monohydrate* *minocycline ER* *minocycline tablets* *MORGIDOX (doxycycline)* *NUZYRA (omadacycline)* *ORACEA (doxycycline)* *SEYSARA (sarecycline)* [NR] *SOLODYN (minocycline)* *TARGADOX (doxycycline)* [CL] *tetracycline* *VIBRAMYCIN suspension, syrup (doxycycline)* *XIMINO (minocycline)*	▪ Link to PA Form for Oral Antibiotics for Acne ▪ Non-preferred agents will be approved only after documented failure of a preferred agent ▪ An age override is required for patients less than 9 years of age

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TOBACCO CESSATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bupropion SR 150 MG CHANTIX (varenicline) CL nicotine gum OTC buccal (nicotine polacrilex) nicotine lozenge OTC buccal (nicotine polacrilex) nicotine patch OTC (nicotine)	*NICOTROL inhalation (nicotine)* *NICOTROL NS nasal (nicotine)*	▪ Link to PA Form Tobacco Cessation: Nicotine Replacement or Bupropion SR ▪ Nicotine replacement agents or bupropion SR will be approved for participants over the age of 18 years. Up to two (2) 90 days treatments will be approved over any 12 month period. ▪ Non-preferred agents will be considered if there is failure of an adequate trial of a preferred agent. ▪ Chantix (varenicline) (link to PA for Chantix (varenicline)) will be considered for approval for participants 18 years or older who have been provided with appropriate educational materials and counseling to support quit attempt. Documentation of risk vs benefits must be noted on the prior authorization form and a follow-up appointment scheduled for evaluation for adverse effects.

ULCERATIVE COLITIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral		
APRISO (mesalamine) sulfasalazine DR sulfasalazine IR	*ASACOL HD (mesalamine)* *azulfadine tablets* *azulfadine DR tablets* *balsalazide* *budesonide DR* *DELZICOL (mesalamine)* *DIPENTUM (olsalazine)* *GIAZO (balsalazide)* *LIALDA (mesalamine)* *mesalamine (generic for ASACOL HD, LIALDA)* *PENTASA (mesalamine)*	▪ Link to PA Form for Ulcerative Colitis Drugs (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent
Rectal		
CANASA (mesalamine) mesalamine (generic for ROWASA)	*mesalamine (generic for CANASA)* *SFROWASA (mesalamine)* *UCERIS (budesonide)*	▪ Link to PA Form for Ulcerative Colitis Drugs (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent

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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)	*BIDIL (isosorbide dinitrate/hydralazine)* *GONITRO (nitroglycerin)* *isosorbide dinitrate ER capsules* *nitroglycerin translingual spray* *NITROSTAT (nitroglycerin sublingual tablets)*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent. ▪ Individual agents must be used prior to use of isosorbide dinitrate/hydralazine (BiDil).

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