NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May 2024 PDL

Noted in Red Font that Become Effective May 1, 2024

For the most up to date list of covered drugs consult the **Drug Lookup** on the Nebraska Medicaid website at https://ne.magellanrx.com/drug-lookup.

- **PDMP Check Requirements** – Nebraska Medicaid providers are required to check the prescription drug history in the statewide PDMP before prescribing CII controlled substances to certain Medicaid beneficiaries (exemption to this requirement are for beneficiaries receiving cancer treatment, hospice/palliative care, or in long-term care facilities). If not able to check the PDMP, then provider is required to document good faith effort, including reasons why unable to conduct the check and may be required to submit documentation to the State upon request.
    - PDMP check requirements are under Section 5042 of the SUPPORT for Patients and Communities Act, consistent with section 1944 of the Social Security Act [42 U.S.C. 1396w-3a].
- **Opioids** – The maximum opioid dose covered is 90 Morphine Milligram Equivalents (MME) per day.

Non-Preferred Drug Coverage

Class and drug-specific therapeutic trial and failure requirements are found within this document. Examples of non-preferred exception criteria include:

- Adverse reaction to preferred drugs
- Allergy to preferred drugs
- Contraindication to preferred drugs
- Documentation of inability to swallow solid dosage forms

Specific Class Prior Authorization forms can be found within the PDL class listings and at:
https://nebraska.fhsc.com/priorauth/paforms.asp

- Immunomodulators Self-Injectable PA Form
- Opioid Dependence Treatment PA Form
- Opioid Dependence Treatment Informed Consent
- Growth Hormone PA Form
- HAE Treatments PA Form
- Hepatitis C PA Form

For all other class medically-necessary coverage, quantity, and high dose requests use the following:
Documentation of Medical Necessity PA Form

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

ACNE AGENTS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
adapalene (generic Differin) **CREAM, GEL (OTC/Rx), GEL PUMP** benzoyl peroxide (BPO) **WASH, LOTION** clindamycin/BPO (generic BenzaClin) **PUMP** clindamycin phosphate **PLEDGET** clindamycin phosphate **SOLUTION** erythromycin **GEL** erythromycin **SOLN** erythromycin-BPO (generic for Benzamycin) RETIN-A (tretinoin)[AL] **CREAM**, **GEL**	adapalene/BPO (generic Epiduo) adapalene/BPO (generic Epiduo Forte) ALTRENO (tretinoin)[AL] AMZEEQ (minocycline) ARAZLO (tazarotene)[AL] ATRALIN (tretinoin) AVAR (sulfacetamide sodium/sulfur) AVITA (tretinoin) AZELEX (azelaic acid) BENZEFOAM (benzoyl peroxide) benzoyl peroxide **CLEANSER**, **CLEANSING BAR** OTC benzoyl peroxide **FOAM** (generic BenzePro) benzoyl peroxide **GEL** OTC benzoyl peroxide **GEL** Rx benzoyl peroxide **TOWELETTE** OTC CABTREO (clindamycin phosphate/BPO/adapalene)[AL,NR] **GEL** clindamycin **FOAM, LOTION** clindamycin **GEL** clindamycin phosphate (generic for Clindagel) **GEL** clindamycin/BPO (generic Acanya) **GEL** clindamycin/BPO (generic Duac) clindamycin/BPO **PUMP**(generic Onexton)[AL, NR] clindamycin/tretinoin (generic Veltin, Ziana) dapsone (generic Aczone) erythromycin **PLEDGET** erythromycin-BPO (generic for Benzamycin) EVOCLIN (clindamycin)	• Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class

ACNE AGENTS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	FABIOR (tazarotene) **FOAM** NEUAC (clindamycin/BPO) ONEXTON (clindamycin/BPO) OVACE PLUS (sulfacetamide sodium) RETIN-A MICRO (tretinoin) sulfacetamide sulfacetamide/sulfur SUMADAN (sulfacetamide/sulfur) tazarotene (generic Tazorac) **CREAM** tazarotene **FOAM** (generic Fabior) tazarotene **GEL** (generic Tazorac) TRETIN-X (tretinoin) tretinoin (generic Avita, Retin-A) AL **CREAM, GEL** tretinoin microspheres (generic Retin-A Micro) AL **GEL, GEL PUMP** WINLEVI (clascoterone)AL	• Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

ALZHEIMER'S AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHOLINESTERASE INHIBITORS		• Non-preferred agents will be approved for patients who have failed a 120-day trial of ONE preferred agent within this drug class within the last 6 months **OR** • Current, stabilized therapy of the non-preferred agent within the previous 45 days Drug-specific criteria: • **Donepezil 23:** Requires donepezil 10mg/day for at least 3 months AND clinical reason as to why 5mg or 10mg tablets can't be used (to deliver 20mg or 25mg)
donepezil (generic Aricept) donepezil ODT (generic Aricept ODT) rivastigmine **PATCH** (generic for Exelon Patch)	ADLARITY (donepezil) **PATCH** ARICEPT (donepezil) donepezil 23 (generic Aricept 23)CL EXELON (rivastigmine) **PATCH** galantamine (generic Razadyne) **SOLN, TAB** galantamine ER (generic Razadyne ER) rivastigmine **CAPS** (generic Exelon)	
NMDA RECEPTOR ANTAGONIST		
memantine (generic Namenda)	memantine ER (generic Namenda XR) memantine **SOLN** (generic Namenda) NAMENDA (memantine) NAMZARIC (memantine/donepezil)	

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

ANALGESICS, OPIOID LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BUTRANS (buprenorphine)[QL] **PATCH** fentanyl 25, 50, 75, 100 mcg **PATCH** [QL] morphine ER **TABLET** (generic MS Contin, Oramorph SR) OXYCONTIN [CL] (oxycodone ER) tramadol ER (generic Ultram ER)[CL] XTAMPZA (oxycodone) ER	BELBUCA (buprenorphine) [QL] **BUCCAL** buprenorphine **BUCCAL** (generic for Belbuca) [AL,QL] buprenorphine PATCH (generic Butrans)[QL] EMBEDA (morphine sulfate/ naltrexone DURAGESIC MATRIX (fentanyl)[QL] fentanyl 37.5/62.5/87.5 mcg **PATCH** [QL] hydrocodone ER (generic Hysingla ER)[QL] hydrocodone bitartrate ER (generic Zohydro ER) hydromorphone ER (generic Exalgo)[CL] HYSINGLA ER (hydrocodone ER) KADIAN (morphine ER) methadone **TABLET** [CL] methadone **ORAL SYR** [CL] MORPHABOND ER (morphine sulfate) morphine ER (generic Avinza, Kadian) **CAPS** NUCYNTA ER (tapentadol)[CL] oxycodone ER (generic Oxycontin) oxymorphone ER (generic Opana ER) tramadol ER (generic ConZip) [CL]	The Center for Disease Control (CDC) does not recommend long acting opioids when beginning opioid treatment. • Preferred agents require previous use of a long acting opioid or documentation of a trial on a short acting agent within 90 days • Non-preferred agents will be approved with failure on, or intolerance to TWO preferred agents within this drug class Drug-specific criteria: • **Methadone:** Will only be approved for use in pain control or end of life care. Trial of preferred agent not required for end of life care • **Oxycontin®:** Pain contract required for maximum quantity authorization

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

ANALGESICS, OPIOID SHORT-ACTING [QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		• Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class within the last 12 months • Note: for short acting opiate tablets and capsules there is a maximum quantity limit of #150 per 30 days. • Opiate limits for opiate naïve patients will consist of: -prescriptions limited to a 7 day supply, AND -initial opiate prescription fill limited to maximum of 50 Morphine Milligram Equivalents (MME) per day These limits may only be exceeded with patient specific documentation of medical necessity, with examples such as, cancer diagnosis, end-of-life care, palliative care, Sickle Cell Anemia, or prescriber attestation that patient is not recently opiate naive Drug-specific criteria: • **Apadaz:** Approval for 14 days or less • **Nucynta®:** Approved only for diagnosis of acute pain, for 30 days or less
acetaminophen/codeine **ELIXIR, TAB** codeine **TAB** hydrocodone/APAP **SOLN, TAB** hydrocodone/ibuprofen hydromorphone **TAB** morphine **CONC SOLN**, **SOLN, TAB** oxycodone **TAB, SOLN** oxycodone/APAP Tramadol 50 **TAB**[AL] (generic Ultram)	APADAZ (benzhydrocodone/APAP)[CL] benzhydrocodone/APAP (generic Apadaz[.CL] butalbital/caffeine/APAP/codeine butalbital compound w/codeine (butalbital/ASA/caffeine/codeine) carisoprodol compound-codeine (carisoprodol/ASA/codeine) dihydrocodeine/APAP/caffeine dihydrocodeine/aspirin/caffeine hydromorphone **LIQUID, SUPPOSITORY** (generic Dilaudid) levorphanol meperidine (generic Demerol) morphine **SUPPOSITORIES** NALOCET (oxycodone/APAP) NUCYNTA (tapentadol)[CL] oxycodone **CAPS** oxycodone/APAP **SOLN** oxycodone **CONCENTRATE** oxymorphone IR (generic Opana) pentazocine/naloxone PROLATE (oxycodone/APAP) **SOLN, TAB** ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol)[AL] tramadol 25mg[NR] tramadol 100mg (generic Ultram)[AL] tramadol (generic Qdolo)[AL,QL] **SOLN** tramadol/APAP (generic Ultracet)	

ANALGESICS, OPIOID SHORT-ACTING QL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NASAL		
	butorphanol **SPRAY**QL LAZANDA (fentanyl citrate)	
BUCCAL/TRANSMUCOSAL CL		Drug-specific criteria: • **Abstral®/Actiq®/Fentora®/ Onsolis (fentanyl):** Approved only for diagnosis of cancer AND current use of long-acting opiate
	ABSTRAL (fentanyl)CL fentanyl **TRANSMUCOSAL** (generic Actiq)CL FENTORA (fentanyl)CL	

ANDROGENIC AGENTS (TOPICAL) CL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANDROGEL (testosterone) **PUMP** CL testosterone **PUMP** (generic Androgel)CL	ANDRODERM (testosterone)CL NATESTO (testosterone)CL testosterone PACKET (generic Androgel)CL testosterone **GEL**, **PACKET, PUMP** (generic Vogelxo) testosterone (generic Axiron) testosterone (generic Fortesta) testosterone (generic Testim)	• Preferred agents approved for diagnosis of Primary hypogonadism (congenital or acquired) or Hypogonadotropic hypogonadism. Off label use for the following will be considered with documentation of necessity: female to male transsexual – gender dysphoria, weight gain, male osteoporosis, delayed puberty in males, corticosteroid-induced hypogonadism and osteoporosis, inoperable carcinoma of the breast, postpartum breast pain and engorgement, and menopause • In addition, non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: • **Androderm®/Androgel®:** Approved for Males only • **Natesto®:** Approved for Males only with diagnosis of: Primary hypogonadism (congenital or acquired) OR Hypogonadotropic hypogonadism (congenital or acquired)

ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ACE INHIBITORS		• Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class within the last 12 months • Non-preferred combination products may be covered as individual prescriptions without prior authorization Drug-specific criteria: • **Epaned® and Qbrelis® Oral Solution:** Clinical reason why oral tablet is not appropriate
benazepril (generic Lotensin) enalapril (generic Vasotec) lisinopril (generic Prinivil, Zestril) quinapril (generic Accupril) ramipril (generic Altace)	captopril (generic Capoten) EPANED (enalapril)CL **ORAL SOLN** enalapril (generic for Epaned)CL **ORAL SOLN** fosinopril (generic Monopril) moexepril (generic Univasc) perindopril (generic Aceon) QBRELIS (lisinopril)CL **ORAL SOLN** trandolapril (generic Mavik)	
ACE INHIBITOR/DIURETIC COMBINATIONS		
benazepril/HCTZ (generic Lotensin HCT) enalapril/HCTZ (generic Vaseretic) lisinopril/HCTZ (generic Prinzide, Zestoretic) quinapril/HCTZ (generic Accuretic)	captopril/HCTZ (generic Capozide) fosinopril/HCTZ (generic Monopril HCT) moexipril/HCTZ (generic Uniretic)	
ANGIOTENSIN RECEPTOR BLOCKERS		
irbesartan (generic Avapro) losartan (generic Cozaar) olmesartan (generic Benicar) valsartan (generic Diovan)	candesartan (generic Atacand) EDARBI (azilsartan) eprosartan (generic Teveten) telmisartan (generic Micardis)	

ANGIOTENSIN MODULATORS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		• Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class within the last 12 months • Non-preferred combination products may be covered as individual prescriptions without prior authorization
irbesartan/HCTZ (generic Avalide) losartan/HCTZ (generic Hyzaar) olmesartan/HCTZ (generic Benicar-HCT) valsartan/HCTZ (generic Diovan-HCT)	candesartan/HCTZ (generic Atacand-HCT) EDARBYCLOR (azilsartan/chlorthalidone) telmisartan/HCTZ (generic Micardis-HCT)	
ANGIOTENSIN MODULATOR/ CALCIUM CHANNEL BLOCKER COMBINATIONS		
amlodipine/benazepril (generic Lotrel) amlodipine/olmesartan (generic Azor) amlodipine/valsartan (generic Exforge) amlodipine/valsartan/HCTZ (generic Exforge HCT)	amlodipine/olmesartan/HCTZ (generic Tribenzor) amlodipine/telmisartan (generic Twynsta) PRESTALIA (perindopril/amlodipine) trandolapril/verapamil (generic Tarka)	
DIRECT RENIN INHIBITORS		
	aliskiren (generic Tekturna)[QL]	
DIRECT RENIN INHIBITOR COMBINATIONS		
	TEKTURNA/HCT (aliskiren/HCTZ)	• **Direct Renin Inhibitors/Direct Renin Inhibitor Combinations:** May be approved witha history of TWO preferred ACE Inhibitors or Angiotensin Receptor Blockers within the last 12 months
NEPRILYSIN INHIBITOR COMBINATION		
ENTRESTO (sacubitril/valsartan)[CL,QL]		
ANGIOTENSIN RECEPTOR BLOCKER/BETA-BLOCKER COMBINATIONS		
	BYVALSON (nevibolol/valsartan)	Drug Specific Criteria • **Entresto:** May be approved in patients ages >1 years old and with a diagnosis of heart failure

ANTHELMINTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
albendazole (generic Albenza) BILTRICIDE (praziquantel) ivermectin (generic Stromectol)	EMVERM (mebendazole)[CL] praziquantel (generic Biltricide) STROMECTOL (ivermectin)	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: • **Emverm**: Approval will be considered for indications not covered by preferred agents

ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	GRASTEK (timothy grass pollen allergen) AL,QL ODACTRA (Dermatophagoides farinae and Dermatophagoides pteronyssinus)AL,QL ORALAIR (sweet vernal/orchard/rye/ timothy/kentucky blue grass mixed pollen allergen extract)CL PALFORZIA (peanut allergen powder-dnfp) AL,CL RAGWITEK (weed pollen-short ragweed)AL,QL	**All agents require initial dose to be given in a healthcare setting** Drug-specific criteria: **GRASTEK** • Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for Timothy grass or cross-reactive grass pollens. • For use in persons 5 through 65 years of age. **ODACTRA** • Confirmed by positive skin test to licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to Dermatophagoides farinae and Dermatophagoides pteronyssinus house dust mite • For use in persons 12 through 65 years of age **ORALAIR** • Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens. • For use in patients 5 through 65 years of age. **PALFORZIA** • Confirmed diagnosis of peanut allergy by allergist • For use in patients ages 4 to 17; it may be continued in patients 18 years and older with documentation of previous use within the past 90 days • Initial dose and increase titration doses should be given in a healthcare setting • Should not be used in patients with uncontrolled asthma or concurrently on a NSAID **RAGWITEK** • Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for short ragweed pollen. • For use in patients 5 through 65 years of age.

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FIRVANQ (vancomycin)[QL] **SOLN** metronidazole **TABLET** neomycin tinidazole (generic Tindamax)[CL]	DIFICID (fidaxomicin) [CL] **TAB, SUSP** LIKMEZ (metronidazole)[NR] **SUSP** metronidazole[CL] **CAPS** nitazoxanide (generic Alinia) **TAB**[AL, CL, QL] paromomycin SOLOSEC (secnidazole) vancomycin **CAPS** (generic Vancocin)[CL] vancomycin (generic Firvanq)[NR,QL] VOWST (fecal microbiota spores)[AL,NR,QL] XIFAXAN (rifaximin)[CL]	• Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization Drug-specific criteria: • **Alinia®:** Trial and failure with metronidazole is required for a diagnosis of giardiasis • **Dificid®:** For diagnosis of C. difficile diarrhea (pseudomembranous colitis), trial and failure or intolerance to oral vancomycin is required. For diagnosis of relapsed or recurrent C. difficile, an appropriate ICD-10 diagnosis code must be submitted for coverage. • **Flagyl®/Metronidazole 375mg capsules and / Metronidazole 750mg ER tabs:** Clinical reason why the generic regular release cannot be used • **tinidazole:** Approvable diagnoses include: Giardia Amebiasis intestinal or liver abscess Bacterial vaginosis or trichomoniasis • **vancomycin capsules:** Requires patient specific documentation of why the Firvanq/vancomycin solution is not appropriate for patient • **Xifaxan®:** Approvable diagnoses include: Travelers's diarrhea resistant to quinolones Hepatic encephalopathy with treatment failure of lactulose or neomycin Diarrhea-Predominant IBS (IBS-D) 550mg strength only with treatment failure of Lomotil® AND Imodium®

ANTIBIOTICS, INHALED [CL]

Preferred Agents [CL]	Non-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin) KITABIS PAK (tobramycin) tobramycin (generic Tobi) TOBI-PODHALER (tobramycin)[QL]	ARIKAYCE (amikacin liposomal inh) **SUSP** CAYSTON (aztreonam lysine)[QL] tobramycin (generic Bethkis)	• Diagnosis of Cystic Fibrosis is required for all agents ICD10 Group = E84, ICD9 = 277.00, 277.01, 277.02, 277.03, 277.09 Drug-specific criteria: • **Arikayce:** Requires diagnosis of refractory MAC lung disease defined as patients who did not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy • **Cayston®:** Trial of tobramycin via nebulizer and demonstration of TOBI® compliance required • **Tobi Podhaler®:** Requires trial of tobramycin via nebulizer or documentation why nebulized tobramycin cannot be used

ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bacitracin **OINT** bacitracin/polymyxin (generic Polysporin) mupirocin **OINT** (generic Bactroban) neomycin/polymyxin/bacitracin (generic Neosporin, Triple AB) neomycin/polymyxin/pramoxine neomycin/polymyxin/bacitracin/ pramoxine	CENTANY (mupirocin) gentamicin **OINT, CREAM** mupirocin **CREAM** (generic Bactroban)[CL]	• Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class within the last 12 months Drug-specific criteria: • **Mupirocin® Cream:** Clinical reason the ointment cannot be used

ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CLEOCIN **OVULES** (clindamycin) clindamycin **CREAM** (generic Cleocin) CLINDESSE (clindamycin) metronidazole, vaginal NUVESSA (metronidazole)	CLEOCIN **CREAM** (clindamycin) VANDAZOLE (metronidazole) XACIATO (clindamycin phosphate) **GEL** [AL]	• Non-preferred agents will be approved for patients who have failed a therapeutic trial (duration = 3 days) with ONE preferred agent within this drug class within the last 6 months

ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIQUIS (apixaban) enoxaparin (generic Lovenox) PRADAXA **CAP** (dabigatran) warfarin (generic Coumadin) XARELTO (rivaroxaban) 10 mg, 15 mg, 20 mg XARELTO (rivaroxaban) 2.5 mg[CL,QL] XARELTO DOSE PACK (rivaroxaban)	dabigatran etexilate (generic Pradaxa) fondaparinux (generic Arixtra) FRAGMIN (dalteparin) PRADAXA (dabigatran) **PELLETS** SAVAYSA (edoxaban)[CL,QL] XARELTO (rivaroxaban)[CL]**SUSP**	• Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 12 months Drug-specific criteria: • **Coumadin®:** Clinical reason generic warfarin cannot be used • **Savaysa®:** Approved diagnoses include: Stroke and systemic embolism (SE) risk reduction in nonvalvular atrial fibrillation (NVAF) OR Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) following 5-10 days of parenteral anticoagulant therapy • **Xarelto 2.5mg:** Use limited to reduction of risk of major cardiovascular events (cardiovascular death, myocardial infarction, and stroke) in patients with chronic coronary artery disease or peripheral artery disease • **Xarelto Suspension**: Approved for patients ≤12 years of age or if there is a clinical reason why a preferred solid dosage form cannot be used.

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CANNABINOIDS		• Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the same group
dronabinol (generic Marinol)[AL]	CESAMET (nabilone)	
5HT3 RECEPTOR BLOCKERS		Drug-specific criteria:
ondansetron (generic Zofran/Zofran ODT)[QL]	ANZEMET (dolasetron) granisetron (generic Kytril) SANCUSO (granisetron)[CL] ZUPLENZ (ondansetron)	• **Akynzeo®/Varubi®:** Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist • Regimens include: AC combination (Doxorubicin or Epirubicin with Cyclophosphamide), Aldesleukin, Amifostine, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carmustine, Carbplatin, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Dactinomycin, Daunorubicin, Epirubicin, Etoposide, Hexamethylmelamine, Idarubicin, Ifosfamide, Imatinib, Interferon α, Irinotecan, Mechlorethamine, Melphalan, Methotrexate, Oxaliplatin, Procarbazine, Streptozotocin, Temozolomide • **Diclegis®/Bonjesta:** Approved only for treatment of nausea and vomiting of pregnancy • **Metozolv (metoclopramide) ODT®:** Documentation of inability to swallow or Clinical reason oral liquid cannot be used • **Sancuso®/Zuplenz®:** Documentation of oral dosage form intolerance
NK-1 RECEPTOR ANTAGONIST		
aprepitant (generic Emend) **CAPS** [QL]	AKYNZEO (netupitant/palonosetron)[CL] aprepitant (generic Emend) **PACK** EMEND (aprepitant) **CAPS, PACK, POWDER** [QL] VARUBI (rolapitant) **TAB**[CL]	
TRADITIONAL ANTIEMETICS		
DICLEGIS (doxylamine/pyridoxine)[CL,QL] dimenhydrinate (generic Dramamine) **OTC** meclizine (generic Antivert) metoclopramide (generic Reglan) phosphoric acid/dextrose/fructose (generic Emetrol) **SOLN** prochlorperazine(generic Compazine) promethazine (generic Phenergan) **SYRUP**, **TAB** promethazine 12.5mg, 25mg **SUPPOSITORY** TRANSDERM-SCOP (scopolamine)	BONJESTA (doxylamine/pyridoxine)[CL,QL] COMPRO (prochlorperazine) doxylamine/pyridoxine (generic Diclegis)[CL,QL] metoclopramide **ODT** (generic Metozolv ODT) prochlorperazine **SUPPOSITOR**Y (generic Compazine) promethazine **SUPPOSITORY** 50mg scopolamine **TRANSDERMAL** trimethobenzamide **TAB** (generic Tigan)	

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole (mucous membrane, troche) fluconazole **SUSP, TAB** (generic Diflucan) griseofulvin **SUSP** griseofulvin microsized **TAB** nystatin **SUSP, TAB** terbinafine (generic Lamisil)	BREXAFEMME (ibrexafungerp)[QL] CRESEMBA (isavuconazonium)[CL] flucytosine (generic Ancobon)[CL] griseofulvin ultramicrosize (generic GRIS-PEG) itraconazole (generic Sporanox)[CL] ketoconazole (generic Nizoral) NOXAFIL (posaconazole)[AL] **SUSP, TAB** NOXAFIL (posaconazole)[AL,CL] **POWDERMIX** nystatin **POWDER** posaconazole (generic Noxafil)[AL,CL] TOLSURA (itraconazole)[CL] VIVJOA (oteseconazole) **CAPS** voriconazole (generic VFEND)[CL]	• Non-preferred agents will be approved for patients who have failed a trial of TWO diagnosis-appropriate preferred agents within this drug class Drug-specific criteria: • **Cresemba®:** Approved for diagnosis of invasive aspergillosis or invasive mucormycosis • **Flucytosine:** Approved for diagnosis of: Candida: Septicemia, endocarditis, UTIs Cryptococcus: Meningitis, pulmonary infections • **Noxafil®:** No trial for diagnosis of Neutropenia Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Neutropenic hematologic malignancies, Graft vs. Host disease(GVHD), Immunosuppression secondary to hematopoietic stem cell transplant • **Noxafil® Powdermix:** pediatric patients 2 years of age and older who weigh 40 kg or less • **Noxafil® Suspension:** Oropharyngeal/esophageal candidiasis refractory to itraconazole and/or fluconazole • **Sporanox®/Itraconazole:** Approved for diagnosis of Aspergillosis, Blastomycosis, Histoplasmosis, Onychomycosis due to terbinafine-resistant dermatophytes, Oropharyngeal/ esophageal candidiasis refractory to fluconazole • **Sporanox® Liquid:** Clinical reason solid oral cannot be used • **Tolsura:** Approved for diagnosis of Aspergillosis, Blastomycosis, and Histoplasmosis and requires a trial and failure of generic itraconazole • **Vfend®:** No trial for diagnosis of Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Graft vs. Host disease (GVHD), Candidemia (candida krusei), Esophageal Candidiasis, Blastomycosis, *S. apiospermum* and *Fusarium spp.*, Oropharyngeal/esophageal candidiasis refractory to fluconazole

ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTIFUNGAL		• Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class within the last 6 months Drug-specific criteria: • **Extina:** Requires trial and failure or contraindication to other ketoconazole forms • **Jublia and tavaborole:** Approved diagnoses include Onychomycosis of the toenails due to *T.rubrum OR T. Mentagrophytes* • **ciclopirox nail lacquer:** No trial required in diabetes, peripheral vascular disease (PVD), immunocompromised OR contraindication to oral terbinafine
clotrimazole **CREAM** (generic Lotrimin) RX, OTC clotrimazole **SOLN** OTC ketoconazole **CREAM, SHAMPOO** (generic Nizoral) LAMISIL (terbinafine) **SPRAY** OTC miconazole **CREAM, POWDER** OTC nystatin terbinafine OTC (generic Lamisil AT) tolnaftate **POWDER, CREAM, POWDER** OTC (generic Tinactin)	ALEVAZOL (clotrimazole) OTC ciclopirox **CREAM, GEL, SUSP** (generic Ciclodan, Loprox) ciclopirox **NAIL LACQUER**[CL] (generic Penlac) ciclopirox **SHAMPOO** (generic Loprox) clotrimazole **SOLN** RX (generic Lotrimin) DESENEX **POWDER OTC** (miconazole) econazole (generic Spectazole) ERTACZO (sertaconazole) EXELDERM (sulconazole) FUNGOID (miconazole) **OTC** JUBLIA (efinaconazole)[CL] ketoconazole **FOAM**[CL] (generic Extina, Ketodan) LOPROX (ciclopirox) **SUSP, SHAMPOO, CREAM** LOTRIMIN AF **CREAM** OTC (clotrimazole) LOTRIMIN ULTRA (butenafine) luliconazole (generic Luzu) MENTAX (butenafine) miconazole OTC **OINT, SPRAY, SOLN** miconazole/zinc oxide/petrolatum (generic Vusion) naftifine **CREAM, GEL** (generic Naftin) oxiconazole (generic Oxistat) salicylic acid (generic Bensal HP) tavaborole **SOLN**[CL] (generic Kerydin) tolnaftate **SPRAY, OTC** TRIPENICOL (undecylenic acid)[NR] **CREAM OTC** VOTRIZA-AL (clotrimazole)[NR] **LOTION OTC**	
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone **CREAM** (generic Lotrisone) nystatin/triamcinolone (generic Mycolog) **CREAM, OINT**	clotrimazole/betamethasone **LOTION** (generic Lotrisone)	

ANTIHISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine **TAB** (generic Zyrtec) cetirizine **SOLN** (**OTC**) (generic Zyrtec) loratadine **TAB, SOLN** (generic Claritin) levocetirizine **TAB** (generic Xyzal)	cetirizine **CHEWABLE** (generic Zyrtec) cetirizine **SOLN** (**Rx**) (generic Zyrtec) desloratadine (generic Clarinex) desloratadine ODT (generic Clarinex Reditabs) fexofenadine (generic Allegra) fexofenadine 180mg (generic Allegra 180mg)[QL] levocetirizine (generic Xyzal) **SOLN** loratadine **CAPS, CHEWABLE, ODT** (generic Claritin Reditabs)	• Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class • Combination products not covered – individual products may be covered

ANTIHYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clonidine TAB (generic Catapres) clonidine **TRANSDERMAL** guanfacine (generic Tenex) methyldopa	methyldopa/hydrochlorothiazide	• Non-preferred agents will be approved for patients who have failed a 30-day trial with ONE preferred agent within this drug class

ANTIHYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol (generic Zyloprim) colchicine **TAB** (generic Colcrys) probenecid probenecid/colchicine (generic Col-Probenecid)	allopurinol 200mg colchicine **CAPS** (generic Mitigare) febuxostat (generic Uloric)[CL] GLOPERBA **SOLN** (colchicine)[CL,QL] MITIGARE (colchicine)	• Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class • **Gloperba:** Approved for documented swallowing disorder • **Uloric/febuxostat:** Clinical reason why allopurinol cannot be used

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AJOVY (fremanezumab-vfrm) CL, QL **PEN, Autoinjector** AJOVY (fremanezumab-vfrm) **Autoinjector 3-pack** CL,QL EMGALITY 120 mg/mL (galcanezumab-gnlm) CL, QL **PEN, SYRINGE** NURTEC ODT (rimegepant) AL,CL,QL UBRELVY (ubrogepant) AL,CL, QL **TAB**	AIMOVIG (erenumab-aooe) CL,QL diclofenac (generic Cambia) **POWDER** dihydroergotamine mesylate **NASAL** ELYXYB (celecoxib) AL,QL **SOLN** EMGALITY 100 mg (galcanezumab-gnlm) CL,QL **SYR** MIGERGOT (ergotamine/caffeine) **RECTAL** MIGRANAL (dihydroergotamine) **NASAL** QULIPTA (atogepant) ALQL REYVOW (lasmiditan) AL, CL,QL **TAB** TRUDHESA (dihydroergotamine mesylate) AL,QL **NASAL** ZAVZPRET (zavegepant) AL,NR,QL **NASAL**	• In addition, all non-preferred agents will require a failed trial or contraindication of a preferred agent of the same indication • **For Acute Treatment**: agents will be approved for patients who have a failed trial or a contraindication to a triptan. • **For Prophylactic Treatment**: Require ≥ 4 migraines per month for ≥ 3 months and has tried and failed a ≥ 1 month trial of two medications listed in the 2012 American Academy of Neurology/American Headache Society guidelines (examples include: antidepressants (amitriptyline, venlafaxine), Beta blockers (propranolol, metroprolol, atenolol), anti-epileptics (valproate, topiramate), ACE (lisinopril) Drug-specific criteria: • **Emgaility 100mg** will only be approved for treatment of Episodic Cluster Headache • **Nurtec ODT:** for use in acute treatment, will be approved for patients who have a failed trial or a contraindication to a triptan. For use in preventative treatment, will be approved for patients who have a failed trial of ONE preferred injectable CGRP.

ANTIMIGRAINE AGENTS, TRIPTANS [QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		• Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class Drug-specific criteria: • **Sumavel® Dosepro:** Requires clinical reason sumatriptan injection cannot be used • **Onzetra, Zembrace:** approved for patients who have failed ALL preferred agents
rizatriptan (generic Maxalt) rizatriptan ODT (generic Maxalt MLT) sumatriptan	almotriptan (generic Axert) eletriptan (generic Relpax) frovatriptan (generic Frova) IMITREX (sumatriptan) naratriptan (generic Amerge) RELPAX (eletriptan)[QL] sumatriptan/naproxen (generic Treximet) zolmitriptan (generic Zomig)	
NASAL		
IMITREX (sumatriptan) sumatriptan (generic Imitrex Nasal)	ONZETRA XSAIL (sumatriptan) TOSYMRA (sumatriptan) zolmitriptan (generic Zomig) ZOMIG (zolmitriptan)	
INJECTABLE		
sumatriptan **KIT, SYRINGE, VIAL**	IMITREX (sumatriptan) **INJECTION** SUMAVEL DOSEPRO (sumatriptan) ZEMBRACE SYMTOUCH (sumatriptan)	

ANTIPARASITICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NATROBA (spinosad) permethrin 1% OTC (generic Nix) permethrin 5% RX (generic Elimite) pyrethrin/piperonyl butoxide (generic RID, A-200)	CROTAN (crotamiton) **LOTION** EURAX (crotamiton) **CREAM, LOTION** ivermectin (generic Sklice) **LOTION** lindane malathion (generic Ovide) spinosad (generic Natroba) VANALICE (piperonyl butoxide/pyrethrins)	• Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class within the past 6 months

ANTIPARKINSON'S AGENTS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		• Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class
benztropine (generic Cogentin) trihexyphenidyl (generic Artane)		
COMT INHIBITORS		Drug-specific criteria: • **Carbidopa/Levodopa ODT:** Approved for documented swallowing disorder • **COMT Inhibitors:** Approved if using as add-on therapy with levodopa-containing drug • **Gocovri:** Required diagnosis of Parkinson's disease and had trial of or is intolerant to amantadine AND must be used as an add-on therapy with levodopa-containing drug • **Inbrija:** Approval upon diagnosis of Parkinson's disease and concurrent treatment with carbidopa/levodopa agent • **Neupro®:** For Parkinsons: Clinical reason required why preferred agent cannot be used For Restless Leg (RLS): Requires trial OR Contraindication to ropinirole AND pramipexole • **Nourianz**: *Approval upon diagnosis of Parkinson's disease and concurrent treatment with carbidopa/levodopa agent* • **Osmolex ER:** Required diagnosis of Parkinson's disease or drug-induced extrapyramidal reactions and had trial of or is intolerant to amantadine IR • **Pramipexole ER:** Required diagnosis of Parkinson's along with preferred agent trial • **Ropinerole ER:** Required diagnosis of Parkinson's along with preferred agent trial • **Zelapar®:** Approved for documented swallowing disorder
	entacapone (generic Comtan) ONGENTYS (opicapone) tolcapone (generic Tasmar)	
DOPAMINE AGONISTS		
pramipexole (generic Mirapex) ropinirole (generic Requip)	bromocriptine (generic Parlodel) ropinirole ER (generic Requip ER)CL NEUPRO (rotigotine)CL pramipexole ER (generic Mirapex ER)CL ropinirole ER (generic Requip XL)CL	
MAO-B INHIBITORS		
selegiline **CAPS, TABLET** (generic Eldepryl)	rasagiline (generic Azilect) QL XADAGO (safinamide) ZELAPAR (selegiline)CL	
OTHER ANTIPARKINSON'S DRUGS		
amantadine **CAPS, SYRUP TABLET** (generic Symmetrel) carbidopa/levodopa (generic Sinemet) carbidopa/levodopa ER (generic Sinemet CR) levodopa/carbidopa/entacapone (generic Stalevo)	APOKYN (apomorphine) **SUB-Q** apomorphine (generic Apokyn) **SUB-Q** carbidopa (generic Lodosyn) carbidopa/levodopa ODT (generic Parcopa) DHIVY (carbidopa/levodopa)QL DUOPA (carbidopa/levodopa) GOCOVRI (amantadine)QL INBRIJA (levodopa) INHALERCL,QL KYNMOBI (apomorphine)QL, KIT, SUBLINGUAL NOURIANZ (istradefylline)CL,QL OSMOLEX ER (amantadine)QL RYTARY (carbidopa/levodopa) STALEVO (ledopa/carbidopa/entacapone)	

ANTIPSORIATICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acitretin (generic Soriatane)	methoxsalen (generic Oxsoralen-Ultra)	• Non-preferred agents will be approved for patients who have failed a trial with THE preferred agent within this drug class • Trial of acitretin (Pregnancy category X) not required in pregnancy or while attempting or planning pregnancy

ANTIPSORIATICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcipotriene **CREAM, OINT, SOLN**	calcitriol (generic Vectical)[AL] **OINT** calcipotriene/betamethasone **OINT** (generic Taclonex) calcipotriene/betamethasone **SUSP** (generic Taclonex Scalp) CALCITRENE (calcipotriene) DOVONEX **CREAM** (calcipotriene) DUOBRII (halobetasol prop/tazarotene ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene) VTAMA (tapinarof)[AL] **CREAM** ZORYVE (roflumilast)[AL] **CREAM**	• Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTI-HERPETIC DRUGS		• Non-preferred agents will be approved for patients who have failed a 10-day trial of ONE preferred agent within the same group
acyclovir (generic Zovirax) famciclovir (generic Famvir) valacyclovir (generic Valtrex)	acyclovir (generic for Zovirax)[CL] **SUSP** SITAVIG (acyclovir buccal)[CL]	
ANTI-INFLUENZA DRUGS		Drug-specific criteria: • **Acyclovir Susp:** Prior authorization NOT required for children ≤ 12 years old • **Sitavig®:** Approved for recurrent herpes labialis (cold sores) in immunocompetent adults • **Xofluza:** Requires clinical, patient specific reason that a preferred agent cannot be used
oseltamivir (generic Tamiflu)[QL] **CAPS, SUSP**	rimantadine (generic Flumadine) RELENZA (zanamivir)[QL] TAMIFLU (oseltamivir)[QL] **CAPS, SUSP** XOFLUZA (baloxavir marboxil)[AL,CL,QL]	

ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acyclovir **OINT**	acyclovir CREAM, (generic Zovirax) DENAVIR (penciclovir) penciclovir (generic Denavir) XERESE (acyclovir/hydrocortisone)	• Non-preferred agents will be approved for patients who have failed a trial with ONE preferred ORAL Antiviral agent

ANXIOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
alprazolam **TABLET** (generic for Xanax) buspirone (generic for Buspar) chlordiazepoxide diazepam **TABLET, SOLN** (generic for Valium) lorazepam **INTENSOL, TABLET** (generic for Ativan)	alprazolam ER (generic for Xanax XR) alprazolam ODT alprazolam **INTENSOL**[CL] clorazepate (generic for Tranxene-T) diazepam **INTENSOL**[CL] lorazepam **ORAL SYRINGE**[NR] LOREEV XR (lorazepam)[AL] meprobamate oxazepam	• Non-preferred agents will be approved for patients who have failed a trial with TWO preferred agents within this drug class Drug-specific criteria: • **Diazepam Intensol®:** Requires clinical reason why diazepam solution cannot be used • **Alprazolam Intensol®:** Requires trial of diazepam solution OR lorazepam Intensol®

BETA BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA BLOCKERS		• Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents within this drug class Drug-specific criteria: • **Coreg CR/carvedilol:** Requires clinical reason generic IR product cannot be used • **Hemangeol®:** Covered for diagnosis of Proliferating Infantile Hemangioma • **Sotylize®:** Covered for diagnosis of life –threatening ventricular arrhythmias OR maintenance of normal sinus rhythm in highly symptomatic atrial fibrillation/flutter (AFIB/AFL) Requires clinical reason generic sotalol cannot be used
atenolol (generic Tenormin)	acebutolol (generic Sectral)	
atenolol/chlorthalidone (generic Tenoretic)	betaxolol (generic Kerlone)	
bisoprolol (generic Zebeta)	HEMANGEOL (propranolol) **SOLN**	
bisoprolol/HCTZ (generic Ziac)	INDERAL/INNOPRAN XL (propranolol ER)	
BYSTOLIC (nebivolol)	KAPSPARGO SPRINKLE (metoprolol ER)	
metoprolol (generic Lopressor)	metoprolol/HCTZ (generic Lopressor HCT)	
metoprolol ER (generic Toprol XL)	nadolol (generic Corgard)	
nebivolol (generic Bystolic)	nadolol/bendroflumethiazide	
propranolol (generic Inderal)	pindolol (generic Viskin)	
propranolol ER (generic Inderal LA)	propranolol/HCTZ (generic Inderide)	
	timolol (generic Blocadren)	
	TOPROL XL (metoprolol ER)	
BETA- AND ALPHA-BLOCKERS		
carvedilol (generic Coreg)	carvedilol ER [CL] (generic Coreg CR)	
labetalol (generic Trandate)		
ANTIARRHYTHMIC		
sotalol (generic Betapace)	SOTYLIZE (sotalol)	

BILE SALTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ursodiol **CAPSULE** 300 mg (generic Actigall)	BYLVAY (odevixibat) **CAP, PELLET**	• Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class
ursodiol 250 mg **TABLET** (generic URSO)	CHENODAL (chenodiol)	
ursodiol 500 mg **TABLET** (generic URSO FORTE)	CHOLBAM (cholic acid)	
	LIVMARLI (maralixibat) **SOLN**[AL]	
	OCALIVA (obeticholic acid)	
	RELTONE (ursodiol 200mg,400mg) **CAP**	

BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MYRBETRIQ (mirabegron)[AL] **TAB** oxybutynin IR, ER (generic Ditropan/Ditropan XL) TOVIAZ (fesoterodine ER)	darifenacin ER (generic Enablex) fesoterodine (generic Toviaz) flavoxate HCL GELNIQUE (oxybutynin) GEMTESA (vibegron)[AL,QL] MYRBETRIQ (mirabegron) **SUSP**[AL,CL,QL] oxybutynin 2.5mg[NR] OXYTROL (oxybutynin) solifenacin (generic Vesicare) tolterodine IR, ER (generic Detrol/ Detrol LA) trospium IR, ER (generic Sanctura/ Sanctura XR) VESICARE (solifenacin) VESICARE LS **SUSP** (solifenacin) [AL]	• Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug-specific criteria: • **Myrbetriq suspension:** Covered for pediatric patients ≥ 3 years old with a diagnosis of Neurogenic Detrusor Overactivity (NDO)

BONE RESORPTION SUPPRESSION AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BISPHOSPHONATES		• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group Drug-specific criteria: • **Actonel® Combinations:** Covered as individual agents without prior authorization • **Atelvia DR®:** Requires clinical reason alendronate cannot be taken on an empty stomach • **Binosto®:** Requires clinical reason why alendronate tablets OR Fosamax® solution cannot be used • **Etidronate disodium:** Trial not required for diagnosis of hetertrophic ossification • **Forteo®:** Covered for high risk of fracture High risk of fracture: • BMD -3 or worse • Postmenopausal women with history of non-traumatic fractures • Postmenopausal women with 2 or more clinical risk factors ○ Family history of non-traumatic fractures ○ DXA BMD T-score ≤ -2.5 at any site ○ Glucocorticoid use ≥ 6 months at 7.5 dose of prednisolone equivalent ○ Rheumatoid Arthritis • Postmenopausal women with BMD T-score ≤ -2.5 at any site with any clinical risk factors ○ More than 2 units of alcohol per day ○ Current smoker • Men with primary or hypogonadal osteoporosis • Osteoporosis associated with sustained systemic glucocorticoid therapy • Trial of calcitonin-salmon not required • Maximum of 24 months treatment per lifetime
alendronate (generic Fosamax) **TAB** ibandronate (generic Boniva)QL	alendronate **SOLN** (generic Fosamax)QL ATELVIA DR (risedronate) BINOSTO (alendronate) etidronate disodium (generic Didronel) FOSAMAX PLUS DQL risedronate (generic Actonel)QL	
OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS		
calcitonin-salmon **NASAL** FORTEO (teriparatide)CL,QL raloxifene (generic Evista)	EVISTA (raloxifene) teriparatide (generic Forteo) CL,QL TYMLOS (abaloparatide)	

BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALPHA BLOCKERS		• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: • **Alfuzosin/dutasteride/finasteride** • Covered for males only • **Cardura XL®:** Requires clinical reason generic IR form cannot be used • **Flomax®:** Females covered for a 7 day supply with diagnosis of acute kidney stones • **Jalyn®:** Requires clinical reason why individual agents cannot be used
alfuzosin (generic Uroxatral) doxazosin (generic Cardura) tamsulosin (generic Flomax) terazosin (generic Hytrin)	CARDURA XL (doxazosin) silodosin (generic Rapaflo)	
5-ALPHA-REDUCTASE (5AR) INHIBITORS		
dutasteride (generic Avodart) finasteride (generic Proscar)	dutasteride/tamsulosin (generic Jalyn) ENTADFI (finasteride/tadalafil)	

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS – Short Acting		• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: • **Xopenex/levalbuterol solution:** Covered for cardiac diagnoses or side effect of tachycardia with albuterol product
albuterol HFA (generic Proventil HFA) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol HFA)	albuterol HFA (generic ProAir HFA and Ventolin HFA) levalbuterol HFA (generic Xopenex HFA) PROAIR DIGIHALER (albuterol) PROAIR RESPICLICK (albuterol)	
INHALERS – Long Acting		
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)	
INHALATION SOLUTION		
albuterol (2.5mg/3ml premix or 2.5mg/0.5ml) albuterol 100 mg/20 mL albuterol low dose (0.63mg/3ml & 1.25mg/3ml)	arformoterol tartrate (generic Brovana) BROVANA (arformoterol) formoterol fumarate (generic Perforomist) levalbuterol (generic for Xopenex) PERFOROMIST (formoterol)	
ORAL		
albuterol **SYRUP**	albuterol **TAB** albuterol ER (generic for Vospire ER) metaproterenol (formerly generic for Alupent) terbutaline (generic for Brethine)	

CALCIUM CHANNEL BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SHORT-ACTING		• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: • **Nifedipine:** May be approved without trial for diagnosis of Preterm Labor or Pregnancy Induced Hypertension (PIH) • **Nimodipine:** Covered without trial for diagnosis of subarachnoid hemorrhage • **Katerzia/ Norliqva:** May be approved with documented swallowing difficulty
Dihydropyridines		
	isradipine (generic Dynacirc) nicardipine (generic Cardene) nifedipine (generic Procardia) nimodipine (generic Nimotop) NYMALIZE (nimodipine) **SOLN**	
Non-dihydropyridines		
diltiazem (generic Cardizem) verapamil (generic Calan/Isoptin)		
LONG-ACTING		
Dihydropyridines		
amlodipine (generic Norvasc) nifedipine ER (generic Procardia XL/ Adalat CC)	felodipine ER (generic Plendil) KATERZIA (amlodipine)[QL] **SUSP** levamlodipine (generic Conjupri) nisoldipine (generic Sular) NORLIQVA (amolidipine)[AL,CL,QL] **SOLN**	
Non-dihydropyridines		
diltiazem ER (generic Cardizem CD) verapamil ER **TAB**	CALAN SR (verapamil) diltiazem ER (generic Cardizem LA) MATZIM LA (diltiazem ER) TIAZAC (diltiazem) verapamil ER **CAPS** verapamil 360mg **CAPS** verapamil ER (generic Verelan PM)	

CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		• Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within the same group Drug Specific Criteria • **Cefixime**- May be approved for a diagnosis of gonorrhea, with an appropriate ICD-10 diagnosis code without a 3-day trial of a preferred agent • **Cefpodoxime**- May be approved for a diagnosis of pyelonephritis, with an appropriate ICD-10 diagnosis code without a 3-day trial of a preferred agent
amoxicillin/clavulanate **TAB, SUSP**	amoxicillin/clavulanate **CHEWABLE** amoxicillin/clavulanate ER (generic Augmentin XR) AUGMENTIN (amoxicillin/clavulanate) **SUSP, TAB**	
CEPHALOSPORINS – First Generation		
cefadroxil **CAPS, SUSP** (generic Duricef) cephalexin **CAPS, SUSP** (generic Keflex)	cefadroxil **TAB** (generic Duricef) cephalexin **TAB**	
CEPHALOSPORINS – Second Generation		
cefprozil (generic Cefzil) cefuroxime **TAB** (generic Ceftin)	cefaclor (generic Ceclor) CEFTIN (cefuroxime) **TAB, SUSP**	
CEPHALOSPORINS – Third Generation		
cefdinir (generic Omnicef)	cefixime (generic Suprax) **CAPS**, **SUSP** cefpodoxime (generic Vantin) SUPRAX (cefixime) **CAPS, CHEWABLE TAB, SUSP, TAB**	

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FYLNETRA (pegfilgrastim-pbbk) NEUPOGEN **DISP SYR** NEUPOGEN (filgrastim) **VIAL**	FULPHILA (pegfilgrastim-jmdb) **SUB-Q** GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) **SYR** NIVESTYM (filgrastim-aafi) **SYR,VIAL** NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim-ayow) **SYR**,**VIAL** STIMUFEND (pegfilgrastim-fpgk) UDENYCA (pegfilgrastim-cbqv) **AUTOINJ** UDENYCA (pegfilgrastim-cbqv) **SUB-Q** ZARXIO (filgrastim-sndz) ZIEXTENZO **SYR** (pegfilgrastim-bmez)	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

T5CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class
All reviewed agents are recommended preferred at this time *Only those products for review are listed.* Brand name products may be subject to Maximum Allowable Cost (MAC) pricing or require substitution with a generic equivalent Specific agents can be looked up using the Drug Look-up Tool at: https://druglookup.fhsc.com/druglookupweb/?client=nestate	EMZAHH (norethindrone)[NR] JOYEAUX (levonorgestrel and ethinyl estradiol and ferrous fumarate kit)[NR] levonorgestrel and ethinyl estradiol/ iron (generic Balcoltra)[NR] TURQOZ (norgestrel and ethinyl estradiol kit)[NR]	

COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS		• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class OR Patient specific documentation of inability to use traditional inhaler device. Drug-specific criteria: • **Daliresp/roflumilast:** Covered for diagnosis of severe COPD associated with chronic bronchitis Requires trial of a bronchodilator Requires documentation of one exacerbation in last year upon initial review
ANORO ELLIPTA (umeclidinium/vilanterol) ATROVENT HFA (ipratropium) COMBIVENT RESPIMAT (albuterol/ ipratropium) SPIRIVA (tiotropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI AEROSPHERE (glycopyrolate/formoterol) DUAKLIR PRESSAIR (aclidinium br and formoterol fum) INCRUSE ELIPTA (umeclidnium) SPIRIVA RESPIMAT (tiotropium) tiotropium (generic Spiriva) TUDORZA PRESSAIR (aclidinium br)	
INHALATION SOLUTION		
albuterol/ipratropium (generic Duoneb) ipratropium **SOLN** (generic Atrovent)	LONHALA (glycopyrrolate inhalation soln) YUPELRI (revefenacin)	
ORAL AGENT		
roflumilast (generic Daliresp)[CL,QL]	DALIRESP (roflumilast)[CL, QL]	

COUGH AND COLD, OPIATE COMBINATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	guaifenesin/codeine **LIQUID** hydrocodone/homatropine SYRUP promethazine/codeine **SYRUP** promethazine/phenylephrine/codeine SYRUP	• Non-preferred agents will be approved for patients who have failed a trial of ONE dextromethorphan product • All codeine or hydrocodone containing cough and cold combinations are limited to ≥ 18 years of age

CYSTIC FIBROSIS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	BRONCHITOL (mannitol) [AL,CL,QL] KALYDECO **PACKET, TAB** (ivacaftor)[QL, AL] ORKAMBI (lumacaftor/ivacaftor) **PACKET, TAB** [QL, AL] SYMDEKO (tezacaftor/ivacaftor)[QL, AL] TRIKAFTA(elexacaftor, tezacaftor, ivacaftor)[AL, CL] **PACKET**[CL,NR]**, TAB**	Drug-specific criteria: • **Bronchitol**: Approved for diagnosis of CF and documentation that the patient has passed the BRONCHITOL Tolerance Test • **Kalydeco®:** Diagnosis of CF and documentation of the drug-specific, FDA-approved mutation of CFTR gene • **Orkambi®:** Diagnosis of CF and documentation of presence of two copies of the F580del mutation (homozygous) of CFTR gene • **Symdeko:** Diagnosis of CF and documentation of the drug specific, FDA approved mutation of CFTR gene. • **Trikafta:** Diagnosis of CF and documentation of at least one F508del mutation in the CFTR gene

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COSENTYX (secukinumab)[AL] **PEN, SYRINGE** ENBREL (etanercept) **KIT, MINI CART, PEN, SYRINGE, VIAL**[QL] HUMIRA (adalimumab)[QL] OTEZLA (apremilast) **TAB**[CL,QL]	ABRILADA **KIT** (adalimumab-afzb)[AL,NR] (CF) ABRILADA **PEN KIT** (adalimumab-afzb)[AL,NR] (CF) ACTEMRA (tocilizumab) **SUB-Q** ADALIMUMAB-AACF (CF)[AL,NR] **PEN KIT** ADALIMUMAB-AATY (CF)[AL,NR] **PEN KIT** ADALIMUMAB-ADAZ(CF)(biosim for Hyrimoz)[AL] **PEN,SYRINGE** ADALIMUMAB-ADBM(CF) **PEN CROHNS**[AL,NR] ADALIMUMAB-ADBM(CF)[AL,NR] ADALIMUMAB-FKJP (biosim for Hulio)[AL] **PEN, SYRINGE** AMJEVITA (adalimumab-atto)[AL] **AUTOINJ, SYR** AMJEVITA(adalimumab-atto)[AL,NR] **KIT** AMJEVITA(adalimumab-atto)[AL,NR] **PEN KIT** ARCALYST (nilonacept) BIMZELX (bimekizumab-bkzx)[AL,NR] **PEN, SYR** CIBINQO (abrocitinib)[AL,QL] CIMZIA (certolizumab pegol)[QL] CYLTEZO (adalimumab-adbm)[AL] **PEN SYRINGE** ENSPRYNG (satralizumab-mwge) **SUB-Q** ENTYVIO (vedolizumab)[AL,NR] **PEN** HADLIMA (adalimumab- bwwd)[AL] **PUSHTOUCH**, **SYRINGE** HADLIMA (CF) (adalimumab- bwwd)[AL] **PUSHTOUCH, SYRINGE** HULIO (adalimumab-fkjp)[AL] **PEN, SYRINGE** HYRIMOZ(CF) (adalimumab-adaz)[AL] **PEN, SYRINGE** IDACIO (adalimumab-aacf)[AL] **PE**N, **SYRINGE** ILUMYA (tildrakizumab) SUB-Q KEVZARA (sarilumab) **SUB-Q, PEN, SYRINGE** KINERET (anakinra) LITFULO (ritlecitinib)[AL,NR] **CAPS**	• Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. • Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. **JAK-Inhibitors**: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response is required. Drug-specific criteria: **Cosentyx:** Requires treatment failure of Enbrel OR Humira with the same FDA-approved indications and age limits. **Otezla**: Requires a trial of Humira

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

CL – Prior Authorization / Class Criteria apply **QL – Quantity/Duration Limit**
AL– Age Limit **NR – Product was not reviewed - New Drug criteria will apply**

CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	OLUMIANT (baricitinib) **TAB**[CL,QL] OMVOH (mirikizumab-mrkz)[AL,NR] **PEN** ORENCIA (abatacept**) SUB-Q** RINVOQ ER (upadacitinib)[CL,QL] SILIQ (brodalumab) SIMLANDI (CF) (adalimumab-ryvk)[AL,NR] **KIT** SIMPONI (golimumab) SKYRIZI (risankizamab-rzaa) **SYR** SKYRIZI **ON-BODY** (risankizamab-rzaa)[QL] SKYRIZI **PEN** (risankizamab-rzaa)[QL] SOTYKTU (deucravacitinib) **TAB** SPEVIGO (spesolimab-sbzo)[AL,NR] **SYR** STELARA (ustekinumab) **SUB-Q** TALTZ (ixekizumab)[AL] TREMFYA (guselkumab)[QL] VELSIPITY (etrasimod)[NR,QL] **TAB** XELJANZ (tofacitinib) **TAB, SOLN**[CL,QL] XELJANZ XR (tofacitinib) **TAB**[CL,QL] YUFLYMA 100mg/mL (CF) (adalimumab-aaty)[AL] **KIT,PEN KIT** YUFLYMA 80mg/mL (CF) (adalimumab-aaty)[AL,NR] **AUTOINJ, PEN, KIT** YUSIMRY (CF) (adalimumab-aqvh)[AL] **PEN KIT** ZYMFENTRA **PEN, SYR** (infliximab-dyyb)[NR]	• Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. • Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. **JAK-Inhibitors**: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response is required. Drug-specific criteria: **Cosentyx:** Requires treatment failure of Enbrel OR Humira with the same FDA-approved indications and age limits. **Otezla**: Requires a trial of Humira

DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SINGLE-AGENT PRODUCTS		• Non-preferred agents will be approved for patients who have failed a trial of **TWO** preferred agents within this drug class • **Eplerenone**: Will be approved with a failed trial or intolerance to spironolactone, a trial with two preferred agents is not required. • **Kerendia**: For diagnosis of chronic kidney disease associated with Type-II diabetes in adults, trial of a preferred agent not required.
amiloride **TAB** bumetanide **TAB** chlorothiazide **TAB** chlorthalidone **TAB** (generic Diuril) furosemide **SOLN, TAB** (generic Lasix) hydrochlorothiazide **CAPS, TAB** (generic Microzide) indapamide **TAB** metolazone **TAB** spironolactone **TAB** (generic Aldactone) torsemide **TAB**	CAROSPIR (spironolactone) **SUSP** eplerenone **TAB** (generic Inspra)[CL] ethacrynic acid **CAPS** (generic Edecrin) KERENDIA (finerenone) **TAB** [CL,QL] spironolactone (generic Carospir)[NR] **SUSP** THALITONE (chlorthalidone) **TAB** triamterene (generic Dyrenium)	
COMBINATION PRODUCTS		
amiloride/HCTZ **TAB** spironolactone/HCTZ **TAB** (generic Aldactazide) triamterene/HCTZ **CAPS, TAB** (generic Dyazide, Maxzide)		

ENZYME REPLACEMENT, GAUCHER'S DISEASE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ZAVESCA (miglustat)[CL]	CERDELGA (eliglustat) miglustat (generic Zavesca)	• Non-preferred agents require clinical documentation why the preferred product within this drug class is not appropriate Drug-specific criteria: • **Zavesca/miglustat:** Approved for mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

EPINEPHRINE, SELF-INJECTED QL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUVI-Q 0.1mg (epinephrine) epinephrine (AUTHORIZED GENERIC Epipen/ Epipen Jr.) **AUTOINJ** EPIPEN (epinephrine) **AUTOINJ** EPIPEN JR. (epinephrine) **AUTOINJ**	AUVI-Q 0.15mg (epinephrine) AUVI-Q 0.3mg (epinephrine) epinephrine (generic for Adrenaclick) epinephrine (generic for Epipen/ Epipen Jr.) **AUTOINJ** SYMJEPI (epinephrine) **PFS**	• Non-preferred agents require clinical documentation why the preferred product within this drug class is not appropriate

ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ARANESP (darbopoetine alfa) **DISP SYR, VIAL** EPOGEN (rHuEPO) RETACRIT (epoetin alfa-epbx) *Pfizer manufacturer only*	JESDUVROQ (daprodustat)NR **TAB** PROCRIT (rHuEPO) RETACRIT (epoetin alfa-epbx) *Vifor manufacturer only*	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

FLUOROQUINOLONES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ciprofloxacin **TAB** (generic Cipro) levofloxacin **TAB** (generic Levaquin)	BAXDELA (delafloxacin) ciprofloxacin ER ciprofloxacin **SUSP** (generic Cipro) levofloxacin **SOLN** moxifloxacin (generic Avelox) ofloxacin	• Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class Drug-specific criteria: • **Baxdela:** Coverable with documented intolerance or failure of preferred MRSA agents (clindamycin, doxycycline, linezolid, sulfamethoxazole/trimethoprim) • **Ciprofloxacin/Levofloxacin Suspension:** Coverable with documented swallowing disorders • **Ofloxacin:** Trial of preferred not required for diagnoses of Pelvic Inflammatory Disease OR Acute Epididymitis (non-gonorrhea)

GI MOTILITY, CHRONIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AMITIZA (lubiprostone)[AL, QL] LINZESS (linaclotide)[AL,QL] MOVANTIK (naloxegol oxalate)[QL] RELISTOR (methylnaltrexone) **SYR**	alosetron (generic Lotronex) IBSRELA (tenapanor)[AL,QL] lubiprostone (generic Amitiza)[AL,QL] MOTEGRITY (prucalopride succinate) RELISTOR (methylnaltrexone) **TAB**[QL] SYMPROIC (naldemedine) TRULANCE (plecanatide)[QL] VIBERZI (eluxodoline)	• Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class with the same indication Drug-specific criteria: • **Ibsrela**: May be approved for diagnosis of IBS with constipation after trial of at least TWO OTC laxatives (senna, bisacodyl, etc.) • **Lotronex®:** Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate • **Relistor® TAB**: Covered for diagnosis of opioid-induced constipation in adults with chronic, non-cancer pain after trial of at least TWO OTC laxatives (senna, bisacodyl, etc.) and failure of Movantik • **Symproic**: Covered for diagnosis of opioid-induced constipation in adult patients with chronic non-cancer pain after trial on at least TWO OTC laxatives and failure of Movantik • **Trulance®:** Covered for diagnosis of either chronic idiopathic constipation or IBS with constipation after trial of at least TWO OTC laxatives (senna, bisacodyl, etc.) • **Viberzi®:** Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate

GLUCAGON AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BAQSIMI (glucagon)[AL,QL] **NASAL** GLUCAGON EMERGENCY (glucagon)[QL] **INJ KIT** (Lilly) glucagon[QL] **INJ** PROGLYCEM (diazoxide) **SUSP** ZEGALOGUE (dasiglucagon)[AL, QL] **AUTO-INJ**	diazoxide **SUSP** (generic Proglycem) GLUCAGON EMERGENCY (glucagon)[QL] **INJ KIT** (Fresenius) GVOKE (glucagon)[AL,QL] **KIT**, **PEN**, **SYR, VIAL** ZEGALOGUE (dasiglucagon)[AL, QL] **SYR**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

GLUCOCORTICOIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCOCORTICOIDS		• Non-preferred agents within the Glucocorticoids and Glucocorticoid/Bronchodilator Combo groups will be approved for patients who have failed a trial of TWO preferred agents within this drug class within the last 6 months Drug-specific criteria: • **budesonide respules:** Covered without PA for age ≤ 8 years OR for diagnosis of eosinophilic esophagitis in patients ≥ 9 years, by GI biopsy or upper endoscopy. For other indications, must have failed a trial of two preferred agents within this drug class, within the last 6 months. • **fluticasone HFA:** Covered without PA for age ≤ 8 years
ARNUITY ELLIPTA (fluticasone)	ALVESCO (ciclesonide)[AL,CL]	
ASMANEX (mometasone)[QL,AL]	ARMONAIR DIGIHALER (fluticasone)[AL,QL]	
ASMANEX HFA (mometasone)[QL]	ARMONAIR RESPICLICK (fluticasone)[AL]	
FLOVENT HFA (fluticasone)	FLOVENT DISKUS (fluticasone)	
PULMICORT FLEXHALER (budesonide)	fluticasone (generic Flovent Diskus)[NR]	
	fluticasone HFA (generic Flovent HFA)[CL]	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/ salmeterol)[QL]	AIRDUO DIGIHALER (fluticasone/salmeterol)[AL,QL]	
ADVAIR HFA (fluticasone/salmeterol)[QL]	AIRSUPRA HFA (albuterol and budesonide)[AL]	
DULERA (mometasone/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)	
SYMBICORT (budesonide/ formoterol)	BREZTRI (budesonide/formoterol/ glycopyrrolate)[QL]	
TRELEGY ELLIPTA (fluticasone/ umeclidinium/vilanterol)	budesonide/formoterol (generic for Symbicort)	
	fluticasone/salmeterol (generic for Advair Diskus)[QL]	
	fluticasone/salmeterol (generic for Advair HFA)[QL]	
	fluticasone/salmeterol (generic for Airduo Respiclick)	
	fluticasone/vilanterol (Breo Ellipta)	
	WIXELA INHUB (generic for Advair Diskus)[QL]	
INHALATION SOLUTION		
	budesonide **RESPULES** (generic for Pulmicort)	

GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC **CAPS** (generic Entocort EC) dexamethasone **ELIXIR, SOLN** dexamethasone **TAB** hydrocortisone **TAB** methylprednisolone tablet (generic Medrol) prednisolone **SOLN** prednisolone sodium phosphate prednisone **DOSE PAK** prednisone **TAB**	ALKINDI (hydrocortisone) **GRANULES**[AL] CORTEF (hydrocortisone) cortisone **TAB** dexamethasone **INTENSOL** ENTOCORT EC (budesonide) EOHILIA (budesonide)[AL,NR,QL] **SUSP** HEMADY (dexamethasone) methylprednisolone 8mg, 16mg, 32mg ORTIKOS ER (budesonide)[AL,QL] prednisolone sodium phosphate (generic Millipred/Veripred) prednisolone sodium phosphate **ODT** prednisone **SOLN** prednisone **INTENSOL** RAYOS DR (prednisone) **TAB** TARPEYO (budesonide) **CAPS**	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: • **Intensol Products:** Patient specific documentation of why the less concentrated solution is not appropriate for the patient • Tarpeyo: Indicated for the treatment of primary immunoglobulin A nephropathy (IgAN)

GROWTH HORMONES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GENOTROPIN (somatropin) NUTROPIN AQ (somatropin) NORDITROPIN (somatropin)	HUMATROPE (somatropin) NGENLA (somatrogon-ghla)[AL,NR] OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin-tcgd) SOGROYA (somapacitan-beco)[NR] ZOMACTON (somatropin) ZORBTIVE (somatropin)	Growth Hormone PA Form Growth Hormone Criteria

H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PYLERA (bismuth, metronidazole, tetracycline)[QL]	lansoprazole/amoxicillin/clarithromycin (generic Prevpac)[QL] OMECLAMOX-PAK (omeprazole, clarithromycin, amoxicillin)[QL] bismuth,metronidazole,tetracycline (generic Pylera)[NR,QL] TALICIA (omeprazole/amoxicillin/rifabutin) VOQUEZNA (vonoprazan)[NR, QL]	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

HAE TREATMENTS [CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BERINERT (C1 esterase inhibitor, human) **INTRAVENOUS** HAEGARDA (C1 esterase inhibitor, human)[AL,CL] **SUB-Q** icatibant acetate (generic for FIRAZYR)[AL] **SUB-Q**	CINRYZE (C1 esterase inhibitor, human)[AL,CL] **INTRAVENOUS** FIRAZYR (icatibant acetate)[AL]**SUB-Q** ORLADEYO (berotralstat) **CAP**[AL,QL] RUCONEST (recombinant human C1 inhibitor)[AL] **INTRAVENOUS** TAKHZYRO (lanadelumab-flyo)[AL,CL] **VIAL** TAKHZYRO (lanadelumab-flyo)[AL,CL] **SYRINGE**	HAE Treatments PA Form • All agents require documentation of diagnosis of Type I or Type II HAE and deficient or dysfunctional C1 esterase inhibitor enzyme. Concomitant use with ACE inhibitors, NSAIDs, or estrogen-containing products is contraindicated • Non-preferred agents will be approved for patients who have a failed trial or a contraindication to ONE preferred agent within this drug class with the same indication. Drug-Specific Criteria • **Cinryze, Haegarda, Orladeyo, and Takhzyro,** require a history of two or more HAE attacks monthly

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

HEMOPHILIA TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FACTOR VIII		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
ALPHANATE HUMATE-P KOVALTRY NOVOEIGHT NUWIQ XYNTHA **KIT, SOLOFUSE**	ADVATE ADYNOVATE AFSTYLA ALTUVIIIO ELOCTATE ESPEROCT HEMOFIL-M JIVI[AL] KOATE-DVI **KIT** KOATE-DVI **VIAL** KOGENATE FS OBIZUR RECOMBINATE	
FACTOR IX		
ALPROLIX BENEFIX	ALPHANINE SD IDELVION IXINITY MONONINE PROFILNINE SD REBINYN RIXUBIS	
FACTOR VIIa AND PROTHROMBIN COMPLEX-PLASMA DERIVED		
NOVOSEVEN RT	FEIBA NF SEVENFACT[AL]	
FACTOR X AND XIII PRODUCTS		
COAGADEX CORIFACT	TRETTEN	
VON WILLEBRAND PRODUCTS		
WILATE	VONVENDI	
BISPECIFIC FACTORS		
HEMLIBRA		

HEPATITIS B TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
entecavir **TAB**	adefovir dipivoxil BARACLUDE (entecavir) **SOLN, TAB** EPIVIR HBV (lamivudine) **TAB, SOLN** lamivudine hbv **TAB** VEMLIDY (tenofovir alafenamide fumarate)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug Specific Criteria ▪ **tenofovir disoproxil fumarate (generic Viread) tablet**: Diagnosis for use required. May be indicated for chronic hepatitis B or HIV-1 infection. ○ See HIV/AIDS class for drug listing and placement

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIRECT ACTING ANTI-VIRAL		Hepatitis C Treatments PA Form Hepatitis C Criteria ▪ Non-preferred products require trial of preferred agents within the same group and/or will only be considered with documentation of why the preferred product within this drug class is not appropriate for patient ▪ Patients newly eligible for Medicaid will be allowed to complete treatment with the original that treatment was initially authorized by another payor Drug-specific criteria: Trial with with a preferred agent not required in the following: ▪ **Harvoni**: ○ Post liver transplant for genotype 1 or 4 ▪ **Vosevi:** Requires documentation of non-response after previous treatment course of Direct Acting Anti-viral agent (DAA) for genotype 1-6 without cirrhosis or with compensated cirrhosis
sofosbuvir/velpatasvir (generic Epclusa)[CL] MAVYRET (glecaprevir/pibrentasvir) **TAB**[CL], **PELLET**[AL,CL] VOSEVI (sofosbuvir/velpatasvir/ voxilaprevir)[CL]	HARVONI 200/45MG, **TAB** (sofosbuvir/ledipasvir)[CL] HARVONI (ledipasvir/sofosbuvir)[CL] **PELLET** sofosbuvir/ledipasvir (generic Harvoni)[CL] SOVALDI (sofosbuvir)[CL] **PELLET** SOVALDI **TAB** (sofosbuvir)[CL] VIEKIRA **PAK** (ombitasvir/ paritaprevir/ritonavir/dasabuvir)[CL] ZEPATIER (elbasvir/grazoprevir)[CL]	
RIBAVIRIN		
ribavirin 200mg **CAPSULE, TAB**		
INTERFERON		
PEGASYS (pegylated interferon alfa-2a) [CL]		

HISTAMINE II RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
famotidine **TAB** (generic for Pepcid) famotidine **SUSP**	cimetidine **TAB, SOLN**[CL] (generic Tagamet) famotidine[NR] **CHEW-TAB** nizatidine **CAPS** (generic for Axid)	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: • **Cimetidine:** Approved for viral M. contagiosum or common wart V. Vulgaris treatment

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

HIV / AIDS [CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CAPSID INHIBITOR		▪ All agents require: ○ Diagnosis of HIV/AIDS required, OR ○ Diagnosis of Pre and Post Exposure Prophylaxis ▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	SUNLENCA (lenacapavir)[QL]	
CCR5 ANTAGONISTS		
SELZENTRY **SOLN, TAB** (maraviroc)	maraviroc (generic Selzentry)	
FUSION INHIBITORS		
FUZEON **SUB-Q** (enfuvirtide)[QL]		
HIV-1 ATTACHMENT INHIBITOR		
	RUKOBIA ER (fostemsavir)[AL,QL]	
INTEGRASE STRAND TRANSFER INHIBITORS (INSTIs)		
ISENTRESS (raltegravir)[QL] ISENTRESS HD (raltegravir) TIVICAY (dolutegravir)	TIVICAY PD (dolutegravir)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)		
EDURANT (rilpivirine) efavirenz **CAPS, TABLET** (generic Sustiva) INTELENCE (etravirine)[QL] PIFELTRO (doravirine)[QL]	etravirine (generic Intelence)[QL] nevirapine IR, ER (generic Viramune/Viramune XR) basglaSUSTIVA **CAPS, TABLET** (efavirenz) VIRAMUNE (nevirapine) **SUSP**	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
abacavir **SOLN, TABLET** (generic Ziagen) EMTRIVA **CAPS, SOLN** (emtricitabine) lamivudine **SOLN, TABLET** (generic Epivir) zidovudine **CAPS, SYRUP, TABLET** (generic Retrovir)	didanosine DR (generic Videx EC) emtricitabine **CAPS** (generic for Emtriva) EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine **CAPS** (generic Zerit) ZIAGEN (abacavir)	
NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
tenofovir **TABLET** (generic Viread)	VIREAD (tenofovir) **POWDER**	
PHARMACOKINETIC ENHANCER		
	TYBOST (cobicistat)[QL]	

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

CL – Prior Authorization / Class Criteria apply **QL – Quantity/Duration Limit**
AL– Age Limit **NR – Product was not reviewed - New Drug criteria will apply**

HIV / AIDS [CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROTEASE INHIBITORS		▪ All agents require: ○ Diagnosis of HIV/AIDS required, OR ○ Diagnosis of Pre and Post Exposure Prophylaxis ▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
atazanavir **CAPS** (generic Reyataz) NORVIR (ritonavir) **TAB**	APTIVUS **CAPS, SOLN** (tipranavir) CRIXIVAN (indinavir) DARUNAVIR PROPYLENE GLYCOLATE[AL,NR] **TAB** darunavir ethanolate (generic Prezista)[AL,NR] **TAB** fosamprenavir **TAB** (generic Lexiva) LEXIVA **SUSP** (fosamprenavir) LEXIVA **TAB** (fosamprenavir) NORVIR **POWDER, SOLN** (ritonavir) PREZISTA (darunavir) **SUSP, TAB** REYATAZ **POWDER** (atazanavir) ritonavir **TAB** (generic Norvir) VIRACEPT (nelfinavir)	
COMBINATION PROTEASE INHIBITORS (PIs) or PIs plus PHARMACOKINETIC ENHANCER		▪ All agents require: ○ Diagnosis of HIV/AIDS required; OR ○ Diagnosis of Pre and Post Exposure Prophylaxis ▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
EVOTAZ (atazanavir/cobicistat)[QL] lopinavir/ritonavir **SOLN, TAB** (generic Kaletra)	KALETRA **SOLN** (lopinavir/ritonavir) KALETRA **TAB** (lopinavir/ritonavir) PREZCOBIX (darunavir/cobicistat)[QL]	
COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir/lamivudine (generic Epzicom) CIMDUO (lamivudine/tenofovir)[QL] DESCOVY (emtricitabine/tenofovir)[QL] emtricitabine/tenofovir (generic Truvada) lamivudine/zidovudine (generic Combivir)	abacavir/lamivudine/zidovudine (generic Trizivir) COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir sulfate/lamivudine) TRIZIVIR (abacavir/lamivudine/zidovudine) TRUVADA (emtricitabine/tenofovir)	

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

CL – Prior Authorization / Class Criteria apply **QL – Quantity/Duration Limit**
AL– Age Limit **NR – Product was not reviewed - New Drug criteria will apply**

HIV / AIDS [CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PRODUCTS – MULTIPLE CLASSES		▪ All agents require: ○ Diagnosis of HIV/AIDS required, OR ○ Diagnosis of Pre and Post Exposure Prophylaxis ▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
BIKTARVY (bictegravir/emtricitabine/ tenofovir)[QL] COMPLERA (rilpivirine/emtricitabine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir)[QL] DOVATO (dolutegravir/lamivudine)[QL] efavirenz/emtricitabine/tenofovir (generic Atripla)[CL] GENVOYA (elvitegravier/cobicistat/ emtricitabine/tenofovir)[QL, AL] JULUCA (dolutegravir/rilpivirine)[QL] ODEFSEY (emtricitabine/rilpivirine/ tenofovir)[QL] STRIBILD (elvitegravir/cobicistat/ emtricitabine/tenofovir)[QL] SYMFI (efavirenz/lamivudine/ tenofovir)[QL] SYMFI LO (efavirenz/lamivudine/ tenofovir)[QL] SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir)[QL] TRIUMEQ (dolutegravir/abacavir/ lamivudine)	ATRIPLA (efavirenz/emtricitabine/tenofovir) efavirenz/lamivudine/tenofovir (generic for Symfi)[QL] efavirenz/lamivudine/tenofovir (generic for Symfi Lo)[QL] TRIUMEQ PD (abacavir, dolutegravir, and lamivudine) **SUSP**	

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acarbose (generic for Precose)	miglitol (generic for Glyset) GLYSET (miglitol)	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST (GLP-1 RA)[CL]		**GLP-1 RA Criteria**
OZEMPIC (semaglutide)[QL] TRULICITY (dulaglutide) VICTOZA (liraglutide) subcutaneous	ADLYXIN (lixisenatide) BYDUREON BCISE **PEN** (exenatide)[QL] BYETTA (exenatide) subcutaneous MOUNJARO (tirazepatide) **PEN** RYBELSUS (semaglutide)	Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin **OR** A diagnosis of ASCVD associated with a diagnosis of Type II diabetes (no metformin trial required) Non-preferred agents will be approved for patients who have: • Failed a trial of TWO preferred agents within GLP-1 RA AND • Diagnosis of diabetes with HbA1C ≥ 7 AND • Trial of metformin, or contraindication or intolerance to metformin
INSULIN/GLP-1 RA COMBINATIONS		
	SOLIQUA (insulin glargine/lixisenatide) XULTOPHY (insulin degludec/liraglutide)	
AMYLIN ANALOG		**Amylin Analog Criteria**
	SYMLIN (pramlintide) subcutaneous	ALL criteria must be met ▪ Concurrent use of short-acting mealtime insulin ▪ Current therapy compliance ▪ No diagnosis of gastroparesis ▪ HbA1C ≤ 9% within last 90 days ▪ Monitoring of glucose during initiation of therapy
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR[AL,QL]		**DPP-4 Inhibitor Criteria**
JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin (generic Nesina) alogliptin/metformin (generic Kazano) alogliptin/pioglitazone (generic Oseni) GLYXAMBI (empagliflozin/linagliptin) JENTADUETO XR (linagliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) ONGLYZA (saxagliptin) QTERN (dapagliflozin/saxagliptin) saxagliptin (generic Onglyza)[NR] saxagliptin/metformin ER[NR] (generic Kombiglyze ER) sitagliptin (generic Zituvio)[NR] STEGLUJAN (ertugliflozin/sitagliptin) TRIJARDY XR (empagliflozin/linagliptin/metformin) ZITUVIO (sitagliptin)[NR]	Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin. Non-preferred DPP-4s will be approved for patients who have failed a trial of ONE preferred agent within the DPP-4 inhibitor class

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

CL – Prior Authorization / Class Criteria apply **QL – Quantity/Duration Limit**
AL– Age Limit **NR – Product was not reviewed - New Drug criteria will apply**

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
APIDRA (insulin glulisine) **SOLOSTAR, VIAL** HUMALOG (insulin lispro) U-100 **CARTRIDGE, PEN, VIAL** HUMALOG JR. (insulin lispro) U-100 **KWIKPEN** HUMALOG MIX **VIAL** (insulin lispro/lispro protamine) HUMALOG MIX **KWIKPEN** (insulin lispro/lispro protamine) HUMULIN (insulin) **VIAL** HUMULIN 70/30 **VIAL** HUMULIN U-500 **VIAL** HUMULIN R U-500 **KWIKPEN**CL HUMULIN OTC **PEN** HUMULIN 70/30 OTC **PEN** insulin aspart (generic for Novolog) insulin aspart/insulin aspart protamine **PEN, VIAL**(generic for Novolog Mix) insulin glargine **PEN, VIAL** insulin lispro (generic for Humalog) **PEN, VIAL, JR KWIKPEN** LANTUS SOLOSTAR **PEN** (insulin glargine) LANTUS (insulin glargine) **VIAL** LEVEMIR (insulin detemir) **PEN, VIAL** NOVOLIN (insulin) **PEN** NOVOLOG (insulin aspart) **CARTRIDGE, FLEXPEN, VIAL** NOVOLOG MIX **FLEXPEN** (insulin aspart/aspart protamine)	ADMELOG (insulin lispro) **PEN, VIAL** AFREZZA (regular insulin) **INHALATION** BASAGLAR (insulin glargine, rec) **PEN, TEMPO PEN**NR FIASP (insulin aspart) **CARTRIDGE, PEN, VIAL** HUMALOG U-100 **TEMPO PEN**NR HUMALOG (insulin lispro)CL U-200 **KWIKPEN** insulin degludec (generic Tresiba) 100U/mL **PEN**, **VIAL** insulin degludec (generic Tresiba) 200U/mL **PEN** insulin glargine (Toujeo)NR insulin glargine max (Toujeo Max)NR insulin glargine-YFGN **PEN, VIAL** (generic for Semglee-YFGN) insulin lispro/lispro protamine **KWIKPEN** (Humalog Mix Kwikpen) LYUMJEV **KWIKPEN, VIAL**(insulin lispro-aabc) LYUMJEV (insulin lispro-aabc) **TEMPO PEN** NOVOLIN (insulin) NOVOLIN 70/30 **VIAL**(insulin) NOVOLOG MIX (insulin aspart/aspart protamine) **VIAL** REZVOGLAR (insulin glargine-aglr)NR **KWIKPEN** SEMGLEE (insulin glargine) **PEN, VIAL** SEMGLEE YFGN (insulin glargine) **PEN, VIAL** TOUJEO SOLOSTAR (insulin glargine) TRESIBA (insulin degludec)	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: • **Afrezza®:** Approved for T1DM on long-acting insulin with no current history of smoking or chronic lung disease • **Humulin® R U-500 Kwikpen:** May be approved for patients who require >200 units/day • **Humalog U-200 Pen:** May be approved for patients who require > 100 units/day AND using an insulin pump

HYPOGLYCEMICS, MEGLITINIDES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
repaglinide (generic for Prandin)	nateglinide (generic for Starlix)[CL]	• Non-preferred agents will be approved for patients with: Failure of a trial of ONE preferred agent in another Hypoglycemic class OR T2DM and inadequate glycemic control

HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metformin IR & ER (generic Glucophage/Glucophage XR)	metformin ER (generic Fortamet/Glumetza) metformin **SOLN** (generic Riomet) RIOMET ER (metformin ER)[AL]	• **Metformin ER (generic Fortamet®)/Glumetza®:** Requires clinical reason why generic Glucophage XR® cannot be used • **Metformin solution:** Prior authorization not required for age <7 years

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin) CL.QL INVOKAMET (canagliflozin/ metformin) CL.QL INVOKANA (canagliflozin)CL JARDIANCE (empagliflozin) CL.QL SYNJARDY (empagliflozin/metformin)AL,CL,QL XIGDUO XR (dapagliflozin/metformin)CL.QL	dapagliflozinCL.NR,QL (generic Farxiga) dapagliflozin/metforminCL.NR.QL (generic Xigduo) INPEFA (sotagliflozin)NR,QL **TAB** INVOKAMET XR (canagliflozin/metformin)QL SEGLUROMET (ertugliflozin/metformin) QL STEGLATRO (ertugliflozin)QL SYNJARDY XR (empagliflozin/ metformin)AL,QL	Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin, **OR** A diagnosis of ASCVD or Heart Failure, or Chronic Kidney Disease associated with a diagnosis of Type II diabetes (no metformin trial required) • Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug Specific Criteria: • **Farxiga/ dapagliflozin:** May be approved for a diagnosis of Heart Failure without a diagnosis of diabetes • May be approved for a diagnosis of chronic kidney disease at risk of progression without a diagnosis of diabetes • **Jardiance:** May be approved for a diagnosis of Heart Failure without a diagnosis of diabetes

HYPOGLYCEMICS, SULFONYLUREAS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
glimepiride (generic Amaryl) glipizide IR & ER (generic Glucotrol/ Glucotrol XL) glyburide (generic Diabeta/Glynase)	chlorpropamide tolazamide tolbutamide	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
SULFONYLUREA COMBINATIONS		
glipizide/metformin glyburide/metformin (generic Glucovance)		

HYPOGLYCEMICS, TZD

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
THIZAOLIDINEDIONES (TZDs)		▪ Non-preferred agents will be approved for patients who have failed a trial of THE preferred agent within this drug class
pioglitazone (generic for Actos)		
TZD COMBINATIONS		
	pioglitazone/glimepiride (generic for Duetact) pioglitazone/metformin (generic for Actoplus Met)	▪ **Combination products:** Require clinical reason why individual ingredients cannot be used

IDIOPATHIC PULMONARY FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
OFEV (nintedanib esylate)[CL] pirfenidone (generic Esbriet)[QL]	ESBRIET (pirfenidone)[QL]	• Non-preferred agent requires trial of preferred agent within this drug class • FDA approved indication required – ICD-10 diagnosis code

IMMUNOMODULATORS, ASTHMA [CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FASENRA (benralizumab)[AL] **PEN** XOLAIR (omalizumab) **SYR**[AL,QL]	NUCALA (mepolizumab)[AL] **AUTO-INJ, SYR** TEZSPIRE (tezepelumab-ekko)[AL] **PEN** XOLAIR (omalizumab)[AL,NR,QL] **AUTO-INJ**	Immunomodulators Self-Injectable PA Form • All agents require prior authorization AND an FDA-approved diagnosis for approval • Non-preferred agents require a trial of a preferred agent within this drug class with the same indication • For asthma indications: All agents must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist • Agents listed may have other FDA approved indications, and will be subject to prior authorization **Drug Specific Criteria:** • **Dupixent**: (For other indications, see Immunomodulators, Atopic Dermatitis therapeutic class) • **For Eosinophilic Asthma or Corticosteroid Dependent Asthma**: Patients must be ages 6 and older. Documentation of moderate to severe asthma with either eosinophils >/= 150 + 1 exacerbation OR oral corticosteroid dependency AND prior drug therapy of med-high or max-tolerated inhaled corticosteroid + controller OR max-tolerated inhaled corticosteroid / long acting beta agonist combo

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

IMMUNOMODULATORS, ATOPIC DERMATITIS [AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ADBRY (tralokinumab-ldrm) [AL,CL,QL] **SUB-Q** DUPIXENT (dupilumab)[AL,CL] **PEN,SYR** ELIDEL (pimecrolimus) EUCRISA (crisaborole)[CL,QL] tacrolimus (generic for Protopic)	OPZELURA (ruxolitinib phosphate) **CREAM**[AL,CL,QL] pimecrolimus (generic for Elidel) PROTOPIC (tacrolimus) ZORYVE (roflumilast)[AL,NR] **FOAM**	Immunomodulators Self-Injectable PA Form (For Adbry and Dupixent only) ▪ Non-preferred agents require: Trial of a topical steroid AND Trial of one preferred product within this drug class Drug-specific criteria: • **ADBRY:** May be approved after a trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor • **Dupixent**: 1. **Atopic Dermatitis**: May be approved after a maximum of a 90-day trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor 2. **Eosinophilic Esophagitis**: Trial, failure, or technique difficulty to a swallowed topical corticosteroid or treatment failure of a proton pump inhibitor. Prescribed by, or in consultation with an allergist, gastroenterologist, or immunologist. Documentation that the Patient has a confirmed diagnosis of eosinophilic esophagitis with ≥ 15 eosinophils/high-power field. 3. **Nasal Polyps**: May be approved with documentation of treatment failure or contraindication within the previous year to an intranasal corticosteroid OR systemic corticosteroid therapy OR prior nasal surgery. Prescribed by, or in consultation with an allergist, pulmonologist, or otolaryngologist [ENT]. 4. **Prurigo Nodularis**: Patient must have a diagnosis of Prurigo Nodularis with provider attestation of > 20 nodular lesions. Trial and failure of a topical corticosteroid. Prescribed by, or in consultation with an allergist, dermatologist, or immunologist. • **Eucrisa**: May be approved after a 30 day trial failure of a preferred topical corticosteroid (TCS) or topical calcineurin inhibitor (TCI) within the past 180 days; Maximum of 300 grams per year • **Opzelura**: May be approved for a diagnosis of Atopic Dermatitis and after a trial/failure of a topical steroid and trial of a preferred agent

IMMUNOMODULATORS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
imiquimod (generic for Aldara)	HYFTOR (sirolimus)[AL] **GEL** imiquimod (generic Zyclara) podofilox (generic Condylox) **GEL**[NR], **SOLN** VEREGEN (sinecatechins) ZYCLARA (imiquimod)	• Non-preferred agents require clinical reason why preferred agent within this drug class cannot be used

IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathioprine (generic Imuran) azathioprine (generic Azasan)[NR] cyclosporine, modified (generic Neoral) **CAPS** everolimus (generic for Zortress)[AL] mycophenolate (generic Cellcept) **CAPS, TAB** RAPAMUNE (sirolimus) **SOLN** RAPAMUNE (sirolimus) **TAB** tacrolimus sirolimus (generic Rapamune) **SOLN, TAB**	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) cyclosporine **CAP**, **SOFTGEL** cyclosporine, modified (generic Neoral) **SOLN** ENVARSUS XR (tacrolimus) GENGRAF (cyclosporine, modified) **CAP, SOLN** mycophenolate (generic Cellcept) **SUSP** mycophenolic acid MYFORTIC (mycophenolate sodium) PROGRAF (tacrolimus) **CAPS, PACKET** REZUROCK (belumosudil)[AL,QL] **TAB** SANDIMMUNE (cyclosporine) **CAPS, SOLN** TAVNEOS (avacopan)[QL] **CAPS** ZORTRESS (everolimus) [AL]	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class ▪ Patients established on existing therapy will be allowed to continue Drug Specific Criteria ▪ **Tavneos** (avacopan) ▪ No trial of a preferred agent required with appropriate FDA indications with concurrent use of standard therapy, including glucocorticoids

INTRANASAL RHINITIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **mometasone:** Prior authorization NOT required for children ≤ 12 years ▪ **budesonide:** Approved for use in Pregnancy (Pregnancy Category B) ▪ **Xhance:** Indicated for treatment of nasal polyps in ≥ 18 years only
ipratropium (generic for Atrovent)		
ANTIHISTAMINES		
azelastine 0.1% (generic for Astelin)	azelastine 0.15% (generic for Astepro) azelastine/fluticasone (generic for Dymista) olopatadine (generic for Patanase) RYALTRIS (olopatadine/mometasone)[AL]	
CORTICOSTEROIDS		
fluticasone **Rx** (generic Flonase)	BECONASE AQ (beclomethasone) budesonide Rx (generic for Rhinocort) flunisolide (generic for Nasalide) fluticasone OTC (generic Flonase OTC) mometasone (generic for Nasonex) **RX, OTC**[NR] OMNARIS (ciclesonide) QNASL 40 & 80 (beclomethasone) XHANCE (fluticasone) ZETONNA (ciclesonide)	

LEUKOTRIENE MODIFIERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
montelukast (generic for Singulair) **TAB**[QL]**/CHEWABLE**[AL]	montelukast **GRANULES** (generic Singulair)[CL, AL] zafirlukast (generic Accolate) zileuton ER (generic Zyflo CR) ZYFLO (zileuton)	• Non-preferred agents will be approved for patients who have failed a 30-day trial of THE preferred agent within this drug class Drug-specific criteria: • **montelukast granules:** PA not required for age < 2 years

LINCOSAMIDES / OXAZOLIDINONES / STREPTOGRAMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clindamycin **CAPS** clindamycin palmitate **SOLN** linezolid **TAB**	CLEOCIN (clindamycin) **CAPS** CLEOCIN PALMITATE (clindamycin) linezolid **SUSP** SIVEXTRO (tedizolid phosphate) ZYVOX (linezolid) **SUSP, TAB**	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Colesevelam**: Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate ▪ **Juxtapid®/ Kynamro®:** ○ Approved for diagnosis of homozygous familial hypercholesterolemia (HoFH) OR ○ Treatment failure/maximized dosing/contraindication to ALL the following: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, bile acid sequestrants ○ Require faxed copy of REMS PA form
cholestyramine (generic Questran) colestipol **TAB** (generic Colestid)	colesevelam (generic Welchol) **TAB, PACKET** colestipol **GRANULES** (generic Colestid) QUESTRAN LIGHT (cholestyramine)	
TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA		
	JUXTAPID (lomitapide)CL KYNAMRO (mipomersen)CL	
FIBRIC ACID DERIVATIVES		
fenofibrate (generic Tricor) fenofibrate (generic Lofibra) gemfibrozil (generic Lopid)	fenofibric acid (generic Fibricor/Trilipix) fenofibrate (generic Antara/Fenoglide/ Lipofen/Triglide)	
NIACIN		
niacin ER (generic Niaspan)	NIACOR (niacin IR)	
OMEGA-3 FATTY ACIDS		
omega-3 fatty acids (generic Lovaza) VASCEPA (icosapent)	icosapent (generic Vascepa)CL omega-3 OTC	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe (generic Zetia)	NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ ezetimibe)QL	

LIPOTROPICS, OTHER (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		▪ **Praluent®:** Approved for diagnoses of: • atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) • Homozygous familial hypercholesterolemia (HoFH) as an adjunct to other LDL-C lowering therapies • AND • Trial and failure or intolerance to a statin for 8 continuous weeks • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL ▪ **Repatha®:** May be approved for: • adult diagnoses of atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) in adults and pediatric patients aged 10 years and older • homozygous familial hypercholesterolemia (HoFH) in adults and pediatric patients aged 10 years and older AND • Maximized high-intensity statin WITH ezetimibe for 3+ continuous months • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL • Concurrent use of maximally-tolerated statin must continue, except for statin-induced rhabdomyolysis or a contraindication to a statin
PRALUENT (alorocumab)CL	REPATHA (evolocumab)CL	

LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
STATINS		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agent within this drug class, within the last 12 months Drug-specific criteria: ▪ **Altoprev®:** One of the TWO trials must be IR lovastatin ▪ **Combination products:** Require clinical reason why individual ingredients cannot be used ▪ **fluvastatin ER:** Requires trial of TWO preferred agents AND trial of IR fluvastatin OR clinical reason IR cannot be used ▪ **simvastatin/ezetimibe:** Approved for 3-month continuous trial of ONE standard dose statin
atorvastatin (generic Lipitor)[QL] lovastatin (generic Mevacor) pravastatin (generic Pravachol) rosuvastatin (generic Crestor) simvastatin (generic Zocor)	ALTOPREV (lovastatin ER)[CL] ATORVALIQ (atorvastatin)[NR,QL] **SUSP** EZALLOR SPRINKLE (rosuvastatin)[QL] fluvastatin IR/ER (generic Lescol/ Lescol XL) LIVALO (pitavastatin)[AL,QL] pitavastatin (generic Livalo)[AL,NR.QL] ZYPITAMAG (pitavastatin)	
STATIN COMBINATIONS		
	atorvastatin/amlodipine (generic Caduet) simvastatin/ezetimibe (generic Vytorin)	

MACROLIDES AND KETOLIDES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MACROLIDES		• Non-preferred agents require clinical reason why preferred products within this drug class cannot be used AND ≥ 3-day trial on a preferred product
azithromycin (generic Zithromax) clarithromycin **TAB, SUSP** (generic Biaxin) E.E.S. **SUSP** (erythromycin ethylsuccinate)	clarithromycin ER (generic Biaxin XL) E.E.S. **TAB** (erythromycin ethylsuccinate) ERY-TAB (erythromycin) erythromycin ethylsuccinate **SUSP** ERYPED **SUSP** (erythromycin) ERYTHROCIN (erythromycin) erythromycin base **TAB, CAPS**	

METHOTREXATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
methotrexate **PF VIAL, TABLET, VIAL**	JYLAMVO (methotrexate)[NR] **SOLN** OTREXUP (methotrexate) **SUB-Q** RASUVO (methotrexate) **SUB-Q** REDITREX (methotrexate) **SUB-Q** TREXALL (methotrexate) **TABLET** XATMEP (methotrexate) **SOLN**	Non-preferred agents require a trial of the preferred agent AND will be approved for an FDA-approved indication Drug-specific criteria: • **Xatmep™**:Indicated for pediatric patients only

MOVEMENT DISORDERS

FPreferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUSTEDO (deutetrabenazine)[CL] AUSTEDO XR (deutetrabenazine)[CL] AUSTEDO XR Titration Pack (deutetrabenazine)[CL] INGREZZA (valbenazine)[AL,CLQL] **CAPS** tetrabenazine (generic for Xenazine)[CL]	INGREZZA (valbenazine)[CL] **INITIATION PACK** XENAZINE (tetrabenazine)[CL]	All drugs require an FDA approved indication – ICD-10 diagnosis code required. Non-preferred agents require a trial and failure of a preferred agent with the same indication or a clinical reason why a preferred agent in this class cannot be used. Drug-specific criteria: • **Austedo/Austedo XR/Ingrezza:** Diagnosis of Tardive Dyskinesia or chorea associated with Huntington's Disease; Requires a Step through tetrabenazine with the diagnosis of chorea associated with Huntington's Disease • **tetrabenazine:** Diagnosis of chorea with Huntington's Disease

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AVONEX (interferon beta-1a)[QL] BETASERON (interferon beta-1b)[QL] COPAXONE 20mg (glatiramer)[QL] dimethyl fumarate (generic for Tecfidera) fingolimod (generic Gilenya)[QL] KESIMPTA (Ofatumumab)[CL,QL] teriflunomide (generic Aubagio)[QL]	AUBAGIO (teriflunomide)[QL] BAFIERTAM (monomethyl fumarate)[QL] dalfampridine (generic Ampyra)[QL] EXTAVIA (interferon beta-1b)[QL] GILENYA (fingolimod)[QL] glatiramer (generic Copaxone)[QL] MAVENCLAD (cladribine) MAYZENT (siponimod)[QL] PLEGRIDY (peginterferon beta-1a)[QL] PONVORY (ponesimod) REBIF (interferon beta-1a)[QL] TASCENSO ODT (fingolimod) **TAB**[AL] TECFIDERA (dimethyl fumarate) VUMERITY (diroximel)[QL] ZEPOSIA (ozanimod)[AL,CL,QL]	• Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agent within this drug class Drug-specific criteria: • **Ampyra®:** Approved for diagnosis of gait disorder associated with MS AND EDSS score ≤ 7 • **Plegridy:** Approved for diagnosis of relapsing MS • **Kesimpta:** Approved for patients who have failed a trial of a preferred injectable agent within this class • **Zeposia:** Approved for a diagnosis of relapsing forms of multiple sclerosis (MS) with trial of ONE preferred agent OR a diagnosis of moderately to severely active ulcerative colitis and treatment failure of Humira.

NITROFURAN DERIVATIVES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
nitrofurantoin macrocrystals **CAPSULE** (generic Macrodantin) nitrofurantoin monohydrate-macrocrystals **CAPS** (generic Macrobid)	nitrofurantoin **SUSPENSION** (genericFuradantin)	• Non-preferred agents will be approved for patients who have failed a trial of **ONE** preferred agent within this drug class

NSAIDs, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE		• Non-preferred agents within COX-1 SELECTIVE group will be approved for patients who have failed no less than 30-day trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **meclofenamate**: Approvable without trial of preferred agents for menorrhagia ▪ **Sprix/ketoralac Nasal:** Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs
diclofenac sodium (generic Voltaren) ibuprofen OTC, Rx (generic Advil, Motrin) **CHEW, DROPS, SUSP**, **TAB** ibuprofen OTC (generic Advil, Motrin) **CAPS** indomethacin (generic Indocin) **CAPS** ketorolac (generic Toradol) meloxicam (generic Mobic) **TAB** nabumetone (generic Relafen) naproxen Rx, OTC (generic Naprosyn) naproxen enteric coated sulindac (generic Clinoril)	diclofenac potassium (generic Cataflam, Zipsor) diclofenac SR (generic Voltaren-XR) diflunisal (generic Dolobid) etodolac & SR (generic Lodine/XL) fenoprofen (generic Nalfon) flurbiprofen (generic Ansaid) ibuprofen/famotidine (generic Duexis)[CL] indomethacin ER (generic Indocin) ketoprofen & ER (generic Orudis) meclofenamate (generic Meclomen) mefenamic acid (generic Ponstel) meloxicam (generic Vivlodex)[CL, QL] **CAP** meloxicam (generic Mobic) **SUSP** naproxen CR (generic Naprelan) naproxen (generic Naprosyn) **SUSP** naproxen sodium (generic Anaprox) naproxen-esomeprazole (generic Vimovo) oxaprozin (generic Daypro) piroxicam (generic Feldene) tolmetin (generic Tolectin) ketorolac (generic Sprix Nasal) [QL] **NASAL**	

NSAIDs, ORAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE (continued)		• All combination agents require a clinical reason why individual agents can't be used separately
	ALL BRAND NAME NSAIDs including: DUEXIS (ibuprofen/famotidine)CL NALFON (fenoprofen) RELAFEN DS (nabumetone)	
NSAID/GI PROTECTANT COMBINATIONS		
	diclofenac/misoprostol (generic Arthrotec)	
COX-II SELECTIVE		
celecoxib (generic Celebrex)		

NSAIDs, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
diclofenac sodium **GEL (OTC only)** PENNSAID **PUMP** (diclofenac)	diclofenac **PUMP** (generic Pennsaid)CL diclofenac **SOLN** (generic Pennsaid) FLECTOR **PATCH** (diclofenac)CL LICART **PATCH** (diclofenac)CL PENNSAID **PACKET** (diclofenac)CL VOLTAREN **GEL** (diclofenac)CL	• Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class AND a clinical reason why patient cannot use oral dosage form.

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

NOTE: Other oral oncology agents not listed here may also be available. See https://nebraska.fhsc.com/default.asp for coverage information and prior authorization status for products not listed.

ONCOLOGY AGENTS, ORAL, BREAST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CDK 4/6 INHIBITOR		• Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines • Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy Drug-specific critera ▪ **anastrozole:** May be approved for malignant neoplasm of male breast (male breast cancer) ▪ **Fareston/toremifene:** Require clinical reason why tamoxifen cannot be used ▪ **letrozole:** Approved for diagnosis of breast cancer with day supply greater than 12 – NOT approved for short term use ▪ **Soltamox:** May be approved with documented swallowing difficulty
	IBRANCE (palbociclib) KISQALI (ribociclib) KISQALI FEMARA **CO-PACK** VERZENIO (abemaciclib)	
CHEMOTHERAPY		
capecitabine (generic Xeloda) cyclophosphamide	XELODA (capecitabine)	
HORMONE BLOCKADE		
anastrozole (generic Arimidex) exemestane (generic Aromasin) letrozole (generic Femara) tamoxifen citrate (generic Nolvadex)	ORSERDU (elacestrant) SOLTAMOX **SOLN** (tamoxifen)[CL] toremifene (generic Fareston)[CL]	
OTHER		
	NERLYNX (neratinib) PIQRAY (alpelisib) lapatinib (generic Tykerb) TALZENNA (talazoparib tosylate) [QL] TUKYSA(tucatinib)[QL] TRUQAP (capivasertib)[NR]	

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

NOTE: Other oral oncology agents not listed here may also be available. See https://nebraska.fhsc.com/default.asp for coverage information and prior authorization status for products not listed.

ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALL		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy Drug-specific critera ▪ **Hydrea®:** Requires clinical reason why generic cannot be used ▪ **Purixan:** Prior authorization not required for age ≤12 or for documented swallowing disorder ▪ **Tabloid:** Prior authorization not required for age <19 ▪ **Xpovio:** Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone
mercaptopurine	PURIXAN (mercaptopurine)[AL]	
AML		
	DAURISMO (glasdegib maleate)[QL] IDHIFA (enasidenib) REZLIDHIA (olutasidenib)[QL] RYDAPT (midostaurin) TIBSOVO (ivosidenib)[QL] VANFLYTA (quizartinib) XOSPATA (gilteritinib) [QL]	
CLL		
LEUKERAN (chlorambucil)	COPIKTRA (duvelisib) [QL] IMBRUVICA (ibrutinib) VENCLEXTA (venetoclax) ZYDELIG (idelalisib)	
CML		
hydroxyurea (generic for Hydrea) imatinib (generic for Gleevec) MYLERAN (busulfan)	BOSULIF (bosutinib) **TAB** GLEEVEC (imatinib) HYDREA (hydroxyurea) ICLUSIG (ponatinib) SCEMBLIX (asciminib) SPRYCEL (dasatinib) TASIGNA (nilotinib)[CL]	
MPN		
	JAKAFI (ruxolitinib)	
MYELOMA		
melphalan (generic Alkeran) REVLIMID[QL] (lenalidomide)	lenalidomide[QL] (generic Revlimid) NINLARO (ixazomib) POMALYST (pomalidomide) THALOMID (thalidomide) XPOVIO (selinexor) [CL]	
OTHER		
MATULANE (procarbazine) TABLOID (thioguanine) tretinoin (generic for Vesanoid)[AL]	BRUKINSA (zanubrutinib[QL] CALQUENCE (acalabrutinib)[QL] INREBIC (fedratinib dihydrochloride)[QL] INQOVI (decitabine/cedazuridine) OJJAARA (momelotinib)[NR] VONJO (pacritinib)[QL] ZOLINZA (vorinostat)	

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

CL – Prior Authorization / Class Criteria apply **QL – Quantity/Duration Limit**
AL– Age Limit **NR – Product was not reviewed - New Drug criteria will apply**

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

NOTE: Other oral oncology agents not listed here may also be available. See https://nebraska.fhsc.com/default.asp for coverage information and prior authorization status for products not listed.

ONCOLOGY AGENTS, ORAL, LUNG

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALK		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	ALECENSA (alectinib) ALUNBRIG (brigatinib)[QL] LORBRENA (lorlatinib) [QL] ZYKADIA (ceritinib) **CAPS, TAB**	
ALK / ROS1 / NTRK		
	AUGTYRO (repotrectinib)[NR] ROZLYTREK (entrectinib)[QL] **CAPS, PELLETS**[NR] XALKORI (crizotinib) **CAPS, PELLETS**[NR]	
EGFR		
erlotinib (generic for Tarceva)	EXKIVITY (mobocertinib)[QL] gefitinib (generic Iressa) GILOTRIF (afatinib) IRESSA (gefitinib) TAGRISSO (osimertinib) TARCEVA (erlotinib) VIZIMPRO (dacomitinib)[QL]	
OTHER		
	GAVRETO (pralsetinib)[QL] HYCAMTIN (topotecan) KRAZATI (adagrasib) LUMAKRAS (sotrasib)[QL] RETEVMO (selpercatinib)[AL] TABRECTA (capmatinib)[QL] TEPMETKO (tepotinib) [QL]	

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

NOTE: Other oral oncology agents not listed here may also be available. See https://nebraska.fhsc.com/default.asp for coverage information and prior authorization status for products not listed.

ONCOLOGY AGENTS, ORAL, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
temozolomide (generic Temodar)	AYVAKIT (avapritinib)[AL,QL] BALVERSA (erdafitinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) FRUZAQLA (fruquintinib)[NR] **CAPS** HEXALEN (altretamine) IWILFIN (eflornithine)[NR] JAYPIRCA (pirtobrutinib) KOSELUGO (selumetinib)[AL] LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) LYTGOBI (futibatinib) OGSIVEO (nirogacestat)[NR] **TAB** PEMAZYRE (pemigatinib)[QL] QINLOCK (ripretinib) RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat)[AL] TURALIO (pexidartinib)[QL] TRUSELTIQ (infigratinib) **CAPS** VITRAKVI (larotrectinib) **CAPS, SOLN** ZEJULA (niraparib) **CAPS, TABS**	• Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines • Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

ONCOLOGY AGENTS, ORAL, PROSTATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
abiraterone (generic Zytiga)[AL,QL] bicalutamide (generic Casodex) flutamide XTANDI (enzalutamide)[AL,QL]	AKEEGA (niraparib/abiraterone) EMCYT (estramustine) ERLEADA (apalutamide)[QL] nilutamide (generic Nilandron) NUBEQA (darolutamide) [QL] ORGOVYX (relugolix)[AL] YONSA (abiraterone acetonide, submicronized) ZYTIGA (abiraterone)[AL,QL]	• Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines • Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

NOTE: Other oral oncology agents not listed here may also be available. See https://nebraska.fhsc.com/default.asp for coverage information and prior authorization status for products not listed.

ONCOLOGY AGENTS, ORAL, RENAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SUTENT (sunitinib) VOTRIENT (pazopanib)	AFINITOR DISPERZ (everolimus)[CL] CABOMETYX (cabozantinib) everolimus (generic Afinitor) everolimus **SUSP** (generic Afinitor Disperz) FOTIVDA (tivozanib) INLYTA (axitinib) LENVIMA (lenvatinib) NEXAVAR (sorafenib) PAZOPANIB (generic Votrient)[NR] **TAB** sorafenib (generic Nexavar) sunitinib malate (generic Sutent) WELIREG (belzutifan)[QL]	• Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines • Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

ONCOLOGY AGENTS, ORAL, SKIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BASAL CELL		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
ERIVEDGE (vismodegib)	ODOMZO (sonidegib)[CL]	
BRAF MUTATION		
MEKINIST (trametinib) TAFINLAR (dabrafenib)	BRAFTOVI (encorafenib) COTELLIC (cobimetinib) MEKINIST (trametinib) **SOLN** MEKTOVI (binimetinib) TAFINLAR (dabrafenib) **SUSP** ZELBORAF (vemurafenib)	

OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALREX (loteprednol 0.2%) cromolyn (generic Opticrom) ketotifen **OTC** (generic Zaditor) olopatadine **OTC** (Pataday once daily) olopatadine **OTC** (Pataday twice daily)	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) azelastine (generic Optivar) BEPREVE (bepotastine besilate) bepotastine besilate (generic Bepreve) epinastine (generic Elestat) LASTACAFT (alcaftadine) LASTACAFT (alcaftadine) **OTC** loteprednol[NR] 0.2% (generic Alrex) olopatadine **DROPS** (generic Pataday) olopatadine 0.1% (generic Patanol) PATADAY XS (olopatadine 0.7%) PATADAY OTC (olopatadine 0.2%) ZERVIATE (certirizine)[AL]	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

OPHTHALMICS, ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FLUOROQUINOLONES		▪ Non-preferred agents will be approved for patients who have failed a one-month trial of TWO preferred agent within this drug class ▪ **Azasite®:** Approval only requires trial of erythromycin Drug-specific criteria: ▪ **Natacyn®:** Approved for documented fungal infection
ciprofloxacin **SOLN** (generic Ciloxan) ofloxacin (generic Ocuflox)	BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) gatifloxacin 0.5% (generic Zymaxid) levofloxacin MOXEZA (moxifloxacin) moxifloxacin (generic Vigamox) moxifloxacin (generic Moxeza) VIGAMOX (moxifloxacin)	
MACROLIDES		
erythromycin	AZASITE (azithromycin)[CL]	
AMINOGLYCOSIDES		
gentamicin **SOLN** tobramycin (generic Tobrex drops)	TOBREX **OINT** (tobramycin)	
OTHER OPHTHALMIC AGENTS		
bacitracin/polymyxin B (generic Polysporin) polymyxin B/trimethoprim (generic Polytrim)	bacitracin NATACYN (natamycin)[CL] neomycin/bacitracin/polymyxin B **OINT** neomycin/polymyxin B/gramicidin NEOSPORIN (neomycin/polymyxin B/gramcidin) sulfacetamide **SOLN** (generic Bleph-10) sulfacetamide **OINT**	

OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
neomycin/polymyxin/dexamethasone (generic Maxitrol) sulfacetamide/prednisolone TOBRADEX **SUSP, OINT** (tobramycin and dexamethasone) tobramycin/dexamethasone **SUSP** (generic TobraDex) *all other manufacturers only*	BLEPHAMIDE (prednisolone and sulfacetamide) BLEPHAMIDE S.O.P. neomycin/polymyxin/HC neomycin/bacitracin/poly/HC PRED-G **SUSP, OINT** (prednisolone/gentamicin) tobramycin/dexamethasone **SUSP** (generic TobraDex) *Falcon manufacturer* TOBRADEX S.T. (tobramycin and dexamethasone) ZYLET (loteprednol, tobramycin)	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

OPHTHALMICS, ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CORTICOSTEROIDS		▪ ALL sub-classes unless listed below: Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class ▪ **NSAID class:** Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same sub-class
fluorometholone 0.1% (generic FML) **OINT** LOTEMAX **SOLN** (loteprednol 0.5%) MAXIDEX (dexamethasone) PRED MILD (prednisolone 0.12%)	dexamethasone (generic Maxidex) difluprednate (generic Durezol) DUREZOL (difluprednate) FLAREX (fluorometholone) FML (fluorometholone 0.1% **SOLN**) FML FORTE (fluorometholone 0.25%) FML S.O.P. (fluorometholone 0.1%) INVELTYS (loteprednol etabonate) LOTEMAX **OINT, GEL** (loteprednol) loteprednol **GEL** (generic Lotemax Gel) loteprednol 0.5% **SOLN** (generic Lotemax SOLN) prednisolone acetate 1% (generic Omnipred, Pred Forte) prednisolone sodium phosphate prednisolone sodium phosphate 1%	
NSAID		
diclofenac (generic Voltaren) ketorolac 0.5% (generic Acular)	ACUVAIL (ketorolac 0.45%) bromfenac 0.09% (generic Bromday) bromfenac (generic Bromsite)[NR] bromfenac 0.07% (generic Prolensa)[NR] BROMSITE (bromfenac) flurbiprofen (generic Ocufen) ILEVRO (nepafenac 0.3%) ketorolac LS 0.4% (generic Acular LS) NEVANAC (nepafenac) PROLENSA (bromfenac 0.07%)	

OPHTHALMICS, ANTI-INFLAMMATORY / IMMUNOMODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RESTASIS (cyclosporine) RESTASIS MULTIDOSE (cyclosporine) XIIDRA (lifitegrast)	CEQUA (cyclosporine) QL cyclosporine (generic Restasis) EYSUVIS (loteprednol etabonate)QL MIEBO (perfluorohexyloctane) TYRVAYA (varenicline tartrate)QL VERKAZIA (cyclosporine emulsion) VEVYE (cyclosporine)NR	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

OPHTHALMICS, GLAUCOMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MIOTICS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Rhopressa and Rocklatan:** Electronically approved for patients who have a trial of ONE generic agent, within ophthalmics - glaucoma within 60 days
pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide) VUITY (pilocarpine)	
SYMPATHOMIMETICS		
ALPHAGAN P (brimonidine 0.15%) brimonidine 0.2% (generic for Alphagan)	ALPHAGAN P (brimonidine 0.1%) apraclonidine (generic Iopidine) brimonidine P 0.15% (generic Alphagan P 0.15%) brimonidine 0.1% (generic Alphagan P 0.1%)	
BETA BLOCKERS		
levobunolol (generic for Betagan) timolol (generic for Timoptic)	betaxolol (generic Betoptic) BETIMOL (timolol) BETOPTIC S (betaxolol) carteolol (generic Ocupress) timolol (generic Istalol) timolol (generic Timoptic Ocudose) TIMOPTIC OCUDOSE TIMOPTIC XE (timolol gel forming solution)	
CARBONIC ANHYDRASE INHIBITORS		
dorzolamide (generic for Trusopt)	AZOPT (brinzolamide) brinzolamide (generic Azopt)	
PROSTAGLANDIN ANALOGS		
latanoprost (generic for Xalatan) TRAVATAN Z (travoprost)	bimatoprost (generic Lumigan) IYUZEH (latanoprost) tafluprost (generic Zioptan) travoprost (generic Travatan Z) VYZULTA (latanoprostene) XALATAN (latanoprost) ZIOPTAN (tafluprost)	
COMBINATION DRUGS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol (generic Cosopt)	brimonidine/timolol (generic Combigan) COSOPT (dorzolamide/timolol) dorzolamide/timolol PF (generic Cosopt PF) SIMBRINZA (brinzolamide/brimonidine)	

OPHTHALMICS, GLAUCOMA (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
OTHER		
RHOPRESSA (netarsudil)[CL] ROCKLATAN (netarsudil and latanoprost) [CL]		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Rhopressa and Rocklatan:** Electronically approved for patients who have a trial of ONE generic agent, within ophthalmics - glaucoma within 60 days

OPIOID DEPENDENCE TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
buprenorphine **SL** buprenorphine/naloxone **TAB (SL)** SUBOXONE **FILM** (buprenorphine/ naloxone)	buprenorphine/naloxone **FILM** LUCEMYRA (lofexidine)[CL,QL] ZUBSOLV (buprenorphine/naloxone)	Opioid Dependence Treatment PA Form Opioid Dependence Treatment Informed Consent ▪ Non-preferred agents require a treatment failure of a preferred drug or patient-specific documentation of why a preferred product is not appropriate for the patient. Drug-specific criteria: ▪ **Lucemyra**: Approved for FDA approved indication and dosing per label. Trial of preferred product not required.

OPIOID-REVERSAL TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
naloxone **NASAL(Rx), SYR, VIAL** naltrexone **TAB**	KLOXXADO (naloxone) **NASAL** naloxone (generic Narcan) **OTC NASAL** NARCAN (naloxone) **NASAL** NARCAN (naloxone) **NASAL OTC** OPVEE (nalmefene)[AL] **NASAL** ZIMHI (naloxone) **SYR**	▪ Non-preferred agents will be approved with documentation of why preferred products within this drug class are not appropriate for the patient

OTIC ANTI-INFECTIVES & ANESTHETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acetic acid (generic for Vosol)	acetic acid/hydrocortisone (generic for Vosol HC)	▪ Non-preferred agents will be approved for patients who have failed a trial of the preferred agent within this drug class

OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CIPRO HC (ciprofloxacin/ hydrocortisone) CIPRODEX (ciprofloxacin/dexamethasone) ciprofloxacin/dexamethasone (generic CIPRODEX) neomycin/polymyxin/hydrocortisone (generic Cortisporin) ofloxacin (generic Floxin)	ciprofloxacin ciprofloxacin/fluocinolone (generic Otovel) CORTISPORIN TC (colistin/neomycin thonzonium/hydrocortisone OTOVEL (ciprofloxacin/fluocinolone)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

PAH (PULMONARY ARTERIAL HYPERTENSION AGENTS), ORAL AND INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ambrisentan (generic Letairis) REVATIO (sildenafil)[CL] **SUSP, TAB**[QL] tadalafil (generic for Adcirca)[CL] TRACLEER (bosentan) **TAB** TYVASO (treprostinil) **INHALATION** VENTAVIS (iloprost) **INHALATION**	ADEMPAS (riociguat)[CL] ADCIRCA (tadalafil)[CL] bosentan (generic Tracleer) **TAB** LETAIRIS (ambrisentan) LIQREV (sildenafil)[NR] **SUSP** OPSUMIT (macitentan) OPSYNVI (macitentan and tadalafil)[NR] **TAB** ORENITRAM ER (treprostinil) sildenafil (generic Revatio)[CL] **SUSP, TAB** TADLIQ (tadalafil) **SUSP** TRACLEER (bosentan) **TAB FOR SUSPENSION** TYVASO DPI (treprostinil) **INHALATION POWDER** UPTRAVI (selexipag)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: ▪ **Adcirca®/Revatio®:** Approved for diagnosis of Pulmonary Arterial Hypertension (PAH) ▪ **Adempas®:** PAH: Requires clinical reason preferred agent cannot be used CTEPH: Approved for persistent/recurrent diagnosis after surgical treatment or inoperable CTEPH NOT for use in Pregnancy ▪ **sildenafil suspension (Liqrev, generic Revatio):** Requires clinical reason why preferred Revatio® suspension cannot be used

PANCREATIC ENZYMES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CREON ZENPEP (pancrelipase)	PERTZYE (pancrelipase) VIOKACE (pancrelipase)	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHILD MVI (mvi, ped mvi no. 19/FA, ped mvi no. 17) **OTC CHEW** CHILDREN'S MVI-IRON **OTC CHEW** (ped mvi no. 91/iron fum) CHILDREN'S CHEWABLES **OTC** (ped mvi no. 25/FA, ped mvi no. 31 /iron/FA, ped mvi no.17/iron sulf) CHILDREN'S VITAMINS W/ IRON **CHEW OTC** (mvi with iron) FLUORIDE/VITAMINS A,C,AND D **DROPS** (ped mvi A,C,D3 no.21/ fluoride) MULTIVITAMINS W/ FLUORIDE (PEDI MVI NO.2 W-FLUORIDE) **DROPS** MULTIVITS W/ IRON & FLUORIDE **DROPS** (ped mvi no. 45/fluoride/iron) PED MVI NO. 16 w/ FLUORIDE **CHEW** PED MVI NO.17 W/ FLUORIDE **CHEW** POLY-VITAMIN (ped mvi no. 212) **DROPS OTC** POLY-VITAMIN W/ IRON (ped mvi no. 207 w/ferrous sulf) **DROPS OTC** TRI-VI-SOL (vit A palmitate/vit C/vit D3) TRI-VITAMIN W/ FLUORIDE (ped mvi A,C, D3 no. 21/fluoride)	DEKAs PLUS[AL] FLORIVA (ped mvi no.85/fluoride) **CHEW** FLORIVA PLUS (ped mvi no.161/fluoride) **OTC DROP** MULTI-VIT-FLOR (ped mvi no.205/fluoride) **CHEW** PEDI MVI NO.242/FLUORIDE CHEW[NR] **OTC** POLY-VI-FLOR (ped mvi no.217/fluoride, ped mvi no. 205/fluoride) **CHEW** POLY-VI-FLOR (ped mvi no.213 w/fluoride) **DROPS** POLY-VI-FLOR W/ IRON (ped mvi no. 205/fluoride/iron) **CHEW** POLY-VI-FLOR W/ IRON (ped mvi no. 214/fluoride/iron) **DROP** QUFLORA (ped mvi no.84/fluoride, ped mvi no. 63/fluoride, ped mvi no. 83/fluoride) QUFLORA FE (ped mvi 142/iron/fluoride, ped mvi no. 151/iron/fluoride) **CHEW** QUFLORA (ped mvi no.157/ fluoride) **OTC** TRI-VI-FLOR (ped mvi A,C,D3 no.38/fluoride) **DROPS**	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class Drug specific criteria: ▪ **DEKAs Plus**: Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent

PENICILLINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
amoxicillin **CAPS, CHEWABLE TAB, SUSP, TAB** ampicillin **CAPS** dicloxacillin penicillin VK		▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate **TAB** CALPHRON OTC (calcium acetate) RENVELA (sevelamer carbonate) **PWD PACK, TAB**	AURYXIA (ferric citrate) calcium acetate **CAPS** lanthanum (generic FOSRENOL) PHOSLYRA (calcium acetate) RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate) PWD PACK sevelamer HCl (generic Renagel) sevelamer carbonate (generic Renvela) VELPHORO (sucroferric oxyhydroxide) XPHOZAH (tenapanor)^{NR} **TAB**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
aspirin BRILINTA (ticagrelor) clopidogrel (generic Plavix) dipyridamole (generic Persantine) prasugrel (generic Effient)	aspirin/dipyridamole (generic Aggrenox) ticlopidine (generic Ticlid) YOSPRALA (aspirin/omeprazole)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class OR documented clopidogrel resistance

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

Additional covered agents can be looked up using the Drug Look-up Tool at:
https://druglookup.fhsc.com/druglookupweb/?client=nestate

PRENATAL VITAMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMPLETENATE **CHEW TAB** EXPECTA PRENATAL **OTC** FE C/FA FE C/VIT C/VIT B12/FA **OTC** MARNATAL-F O-CAL FA PNV2/IRON B-G SUC-P/FA/OMEGA-3 PNV 11-IRON FUM-FOLIC ACID-OM3 PNV NO.118/IRON FUMARATE/FA **CHEW TAB** PNV NO.15/IRON FUM & PS CMP/FA PNV W-CA NO.40/IRON FUM/FA CMB NO.1 PNV WITH CA,NO.72/IRON/FA PNV#16/IRON FUM & PS/FA/OM-3 PNV2/IRON B-G SUC-P/FA/OMEGA-3 PRENATAL VIT #76/IRON,CARB/FA PRENATAL VIT NO.78/IRON/FA PRENATAL VIT/FE FUMARATE/FA **OTC** PUREFE OB PLUS PUREFE PLUS STUART ONE **OTC** TRINATAL RX 1 VITAFOL **CHEW TAB** VITAFOL ULTRA	CITRANATAL B-CALM DERMACINRX PRENATRIX **OTC** DERMACINRX PRETRATE **TAB OTC** ENBRACE HR MULTI-MAC **OTC** NATAL PNV (pnv no.164/iron/folate no.6)[NR] NESTABS NESTABS ABC NESTABS DHA NESTABS ONE OB COMPLETE ONE OB COMPLETE PETITE OB COMPLETE PREMIER OB COMPLETE **TAB** OB COMPLETE WITH DHA PNV COMBO#47/IRON/FA #1/DHA PNV WITH CA NO.68/IRON/FA NO.1/DHA PNV WITH CA,NO.72/IRON/FA PNV WITH CA,NO.74/IRON/FA **OTC** PNV119/IRON FUMARATE/FA/DSS PRENATAL + DHA **OTC** PRENATAL MULTI **OTC** PRENATE AM PRENATE **CHEW TAB** PRENATE DHA PRENATE ELITE PRENATE ENHANCE PRENATE ESSENTIAL PRENATE MINI PRENATE PIXIE PRENATE RESTORE PRENATE STAR PRIMACARE SELECT-OB + DHA SELECT-OB **CHEW TAB** TENDERA-OB **OTC** TRICARE TRINATAL RX 1 TRISTART DHA VITAFOL FE+ VITAFOL NANO VITAFOL-OB VITAFOL-OB+DHA VITAFOL-ONE WESTGEL DHA	▪ Non-preferred agents will be approved for patients who have failed a trial of or are intolerant to TWO preferred agents within this drug class

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

CL – Prior Authorization / Class Criteria apply **QL – Quantity/Duration Limit**
AL– Age Limit **NR – Product was not reviewed - New Drug criteria will apply**

PROTON PUMP INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DEXILANT (dexlansoprazole) omeprazole (generic Prilosec) **RX** pantoprazole (generic Protonix)[QL] PROTONIX **SUSP** (pantoprazole)	dexlansoprazole (generic Dexilant) esomeprazole magnesium (generic Nexium) **RX**[QL] esomeprazole magnesium (generic Nexium) **OTC**[QL] esomeprazole strontium KONVOMEP (omeprazole/sodium bicarb)[NR] **SUSP** lansoprazole (generic Prevacid)[QL] NEXIUM **SUSP** (esomeprazole) omeprazole/sodium bicarbonate (generic Zegerid RX) pantoprazole **GRANULES** [QL] rabeprazole (generic Aciphex)	▪ Non-preferred agents will be approved for patients who have failed an 8-week trial of preferred Dexilant (dexlansoprazole), omeprazole Rx, AND pantoprazole OR Protonix SUSP. **Pediatric Patients:** Patients ≤ 4 years of age – No PA required for Prevacid 30mg/ lansoprazole 30mg capsules (used to compound suspensions). Drug-specific criteria: ▪ **Prilosec®OTC/Omeprazole OTC:** EXCLUDED from coverage Acceptable as trial instead of Omeprazole 20mg ▪ **Prevacid (lansoprazole) Solutab**: may be approved after trial of compounded suspension. Patients ≥ 5 years of age- Only approve non-preferred for GI diagnosis if: ▪ Child can not swallow whole generic omeprazole capsules OR, ▪ Documentation that contents of capsule may not be sprinkled in applesauce

SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BENZODIAZEPINES		**Benzodiazepines Criteria** ▪ Non-preferred agents require a trial of the preferred benzodiazepine agent ▪ temazepam 7.5/22.5 mg: Requires clinical reason why 15 mg/30 mg cannot be used
temazepam 15 mg, 30 mg (generic for Restoril)	estazolam (generic for ProSom) temazepam (generic for Restoril) 7.5 mg, 22.5 mg triazolam (generic for Halcion)	
OTHERS		**Others Criteria** ▪ Non-preferred agents require a trial of TWO preferred agents in the OTHERS sub-category ▪ **Silenor/doxepin Tablet**: Must meet ONE of the following: ○ Contraindication to all of the preferred oral sedative hypnotics agents in the OTHERS sub-category ○ Medical necessity for doxepin dose < 10 mg ○ Age greater than 65 years old or hepatic impairment (3 mg dose will be approved if this criterion is met) ▪ **zolpidem/zolpidem ER**: Maximum daily dose for females: zolpidem 5 mg; zolpidem ER 6.25 mg ▪ **zolpidem SL**: Requires clinical reason why half of zolpidem tablet cannot be used or documented swallowing disorder
zaleplon (generic for Sonata) zolpidem (generic for Ambien)	BELSOMRA (suvorexant) AL,QL DAYVIGO (lemborexant) AL,QL doxepin (generic for Silenor) EDLUAR (zolpidem sublingual) eszopiclone (generic for Lunesta) HETLIOZ (tasimelteon)CL HETLIOZ LQ (tasimelteon) **SUSP** AL,QL QUVIVIQ (daridorexant)QL ramelteon (generic for Rozerem) tasimelteon (generic for Hetlioz) CL zolpidemQL **CAP** zolpidem ER (generic for Ambien CR) zolpidem SL (generic for Intermezzo)	

SICKLE CELL ANEMIA TREATMENT [AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DROXIA (hydroxyurea) ENDARI (L-glutamine)[CL]	OXBRYTA (voxelotor)[CL] SIKLOS (hydroxyurea)	Drug-Specific Criteria ▪ **Endari:** Patient must have documented two or more hospital admissions per year due to sickle cell crisis despite maximum hydroxyurea dosage. ▪ **Oxbryta**: Not inidcated for sickle cell crisis. Patient must have had at least one sickle cell-related vaso-occlusive event within the past 12 months; AND baseline hemoglobin is 5.5 g/dL ≤ 10.5 g/dL; AND patient is not receiving concomitant, prophylactic blood tranfusion therapy ▪ **Siklos**: May be approved for use in patients ages 2 to 17 years old without a trial of Droxia

SINUS NODE INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	CORLANOR **SOLN, TAB** (ivabradine)	▪ Diagnosis of Chronic Heart Failure with left ventricular ejection fraction less than or equal to 35%, AND ▪ Sinus rhythm with resting heart rate greater than or equal to 70 beats per minute, AND ▪ On maximally tolerated doses of beta-blockers OR have a contraindication to beta-blocker use

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
baclofen (generic Lioresal) chlorzoxazone (generic Parafon Forte) cyclobenzaprine (generic Flexeril)[QL] methocarbamol (generic Robaxin) tizanidine **TAB** (generic Zanaflex)	baclofen (generic Fleqsuvy)[NR,QL] **SUSP** baclofen (generic Ozobax)[QL] **SOLN** baclofen (generic Ozobax DS)[NR] **SOLN** carisoprodol (generic Soma)[CL,QL] carisoprodol compound cyclobenzaprine ER (generic Amrix)[CL] dantrolene (generic Dantrium) FEXMID (cyclobenzaprine ER) FLEQSUVY (baclofen)[QL] **SUSP** LORZONE (chlorzoxazone)[CL] LYVISPAH (baclofen)[QL] **GRANULES** metaxalone (generic Skelaxin) NORGESIC FORTE (orphenadrine/ASA/caffeine) orphenadrine ER PARAFON FORTE (chlorzoxazone) tizanidine **CAPS** ZANAFLEX (tizanidine) **CAPS, TAB**	▪ Non-preferred agents will be approved for patients who have failed a 1-week trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **cyclobenzaprine ER:** ○ Requires clinical reason why IR cannot be used ○ Approved only for acute muscle spasms ○ NOT approved for chronic use ▪ **carisoprodol:** ○ Approved for Acute, musculoskeletal pain - NOT for chronic pain ○ Use is limited to no more than 30 days ○ Additional authorizations will not be granted for at least 6 months following the last dayy of previous course of therapy ▪ **Dantrolene:** Trial NOT required for treatment of spasticity from spinal cord injury ▪ **Lorzone®:** Requires clinical reason why chlorzoxazone cannot be used ▪ **Soma® 250 mg:** Requires clinical reason why 350 mg generic strength cannot be used ▪ **Zanaflex® Capsules:** Requires clinical reason generic cannot be used

STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
LOW POTENCY		▪ Low Potency Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
DERMA-SMOOTHE FS (fluocinolone) hydrocortisone OTC & RX **CREAM, LOTION, OINT (Rx only)** hydrocortisone/aloe **OINT**	alclometasone dipropionate (generic for Aclovate) DESONATE (desonide) **GEL** desonide **LOTION** (generic for Desowen) desonide **CREAM, OINT** (generic Desowen, Tridesilon) fluocinolone 0.01% **OIL** (generic DERMA-SMOOTHE-FS) hydrocortisone/aloe **CREAM** hydrocortisone **OTC OINT** HYDROXYM (hydrocortisone) **GEL** TEXACORT (hydrocortisone)	
MEDIUM POTENCY		▪ Medium Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
fluticasone propionate **CREAM, OINT** (generic for Cutivate) mometasone furoate **CREAM, OINT, SOLN** (generic for Elocon)	betamethasone valerate (generic for Luxiq) clocortolone (generic for Cloderm) fluocinolone acetonide (generic for Synalar) flurandrenolide (generic for Cordran) fluticasone propionate **LOTION** (generic for Cutivate) hydrocortisone butyrate (generic for Locoid) hydrocortisone butyrate/emoll (generic for Locoid Lipocream) hydrocortisone valerate (generic for Westcort) PANDEL (hydrocortisone probutate 0.1%) prednicarbate (generic for Dermatop)	

STEROIDS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HIGH POTENCY		▪ High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
triamcinolone acetonide **OINTMENT, CREAM** triamcinolone **LOTION**	amcinonide **CREAM, LOTION, OINTMENT** betamethasone dipropionate betamethasone / propylene glycol betamethasone valerate desoximetasone diflorasone diacetate fluocinonide **SOLN** fluocinonide **CREAM, GEL, OINT** fluocinonide emollient halcinonide **CREAM** (generic for Halog) HALOG (halcinonide) **CREAM**, **OINT, SOLN** KENALOG AEROSOL (triamcinolone) SERNIVO (betamethasone dipropionate) triamcinolone **SPRAY** (generic for Kenalog spray) VANOS (fluocinonide)	
VERY HIGH POTENCY		▪ Very High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
clobetasol emollient (generic Temovate-E) clobetasol propionate **CREAM**, **OINT, SOLN** halobetasol propionate (generic Ultravate)	APEXICON-E (diflorasone) BRYHALI (halobetasol prop) **LOTION** clobetasol **SHAMPOO, LOTION** clobetasol propionate **GEL**, **FOAM, SPRAY** halobetasol propionate **FOAM** (generic for Lexette) AL,QL IMPEKLO (clobetasol) **LOTION**AL LEXETTE(halobetasol propionate) AL,QL OLUX-E /OLUX/OLUX-E CP (clobetasol)	

STIMULANTS AND RELATED AGENTS [AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CNS STIMULANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Procentra/ dextroamphetamine soln:** May be approved with documentation of swallowing disorder ▪ **Zenzedi®:** Requires clinical reason generic dextroamphetamine IR cannot be used
Amphetamine type		
ADDERALL XR (amphetamine salt combo) amphetamine salt combination IR DYANAVEL XR (amphetamine)[QL] VYVANSE (lisdexamfetamine)[QL] **CAPS, CHEWABLE**	ADZENYS XR (amphetamine) amphetamine ER (generic Adzenys ER) **SUSP** amphetamine salt combination ER (generic for Adderall XR) amphetamine salt combination ER (generic Mydayis)[AL, NR] **CAP** amphetamine sulfate (generic for Evekeo) dextroamphetamine (generic for Dexedrine) dextroamphetamine **SOLN** (generic Procentra) dextroamphetamine ER (generic for Dexedrine ER) EVEKEO ODT (amphetamine sulfate) lisdexamfetamine (generic Vyvanse Chew)[AL,QL] **CHEW** lisdexamfetamine (generic Vyvanse)[AL,QL] **CAP** methamphetamine (generic for Desoxyn) MYDAYIS (amphetamine salt combo)[QL] XELSTRYM (detroamphetamine)[AL,QL] **PATCH** ZENZEDI (dextroamphetamine)	

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Methylphenidate type		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class ▪ Maximum accumulated dose of 108mg per day for ages < 18 ▪ Maximum accumulated dose of 72mg per day for ages > 19 Drug-specific criteria: ▪ **Daytrana/methylphenidate patch:** May be approved in history of substance use disorder by parent, caregiver, or patient. May be approved with documentation of difficulty swallowing ▪ **QuilliChew ER**: May be approved for children ≤ 12 years of age OR with documentation of difficulty swallowing
CONCERTA (methylphenidate ER)[QL] 18 mg, 27 mg, 36 mg, 54 mg DAYTRANA **PATCH** (methylphenidate)[QL] dexmethylphenidate (generic for Focalin IR) dexmethylphenidate (generic Focalin XR) METHYLIN **SOLN** (methylphenidate) methylphenidate (generic Ritalin) methylphenidate **SOLN** (generic Methylin) QUILLICHEW ER **CHEWTAB** (methylphenidate) QUILLIVANT XR (methylphenidate)**SUSP**	ADHANSIA XR (methylphenidate) [QL] APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphenidate and dexmethylphenidate)[QL] COTEMPLA XR-ODT (methylphenidate)[QL] FOCALIN IR (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) JORNAY PM (methylphenidate) [QL] methylphenidate CHEW methylphenidate ER (45 mg and 63 mg)[QL] methylphenidate 50/50 (generic Ritalin LA) methylphenidate 30/70 (generic Metadate CD) methylphenidate ER 18 mg, 27 mg, 36 mg, 54 mg (generic Concerta)[QL] methylphenidate ER **CAP** (generic Aptensio XR)[QL] methylphenidate ER (generic Metadate ER) methylphenidate ER 72 mg (generic RELEXXII)[QL] methylphenidate ER (generic Ritalin SR) methylphenidate TD24[AL] **PATCH** (generic Daytrana) RELEXXII ER (methylphenidate 45mg and 63mg)[AL,QL] **TAB** RITALIN (methylphenidate)	

STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MISCELLANEOUS		**Note:** generic guanfacine IR and clonidine IR are available without prior authorization • Non-preferred agents will be approve for patients who have failed a trial of ONE preferred agent within this class
atomoxetine (generic Strattera)[QL] guanfacine ER (generic Intuniv)[QL] QELBREE (viloxazine)[QL]	clonidine ER (generic Kapvay)[QL] STRATTERA (atomoxetine)	
ANALEPTICS		Drug-specific criteria: ▪ **armodafinil and *Sunosi*:** Require trial of modafinil ▪ **armodafinil and modafinil:** approved only for: ○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed ○ Narcolepsy with documentation of diagnosis via sleep study ○ Shift Work Sleep Disorder (only approvable for 6 months) with work schedule verified and documented. Shift work is defined as working the all night shift ▪ **Sunosi** approved only for: ○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed ○ Narcolepsy with documentation of diagnosis via sleep study ▪ **Wakix**: approved only for excessive daytime sleepiness in adults with narcolepsy with documentation of narcolepsy diagnosis via sleep study
	armodafinil (generic Nuvigil)[CL] modafanil (generic Provigil)[CL] SUNOSI (solriamfetol) [CL,QL] WAKIX (pitolisant)[CL,QL]	

TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR (generic Vibramycin) doxycycline monohydrate **50MG, 100MG CAPS** doxycycline monohydrate **SUSP, TAB** (generic Vibramycin) minocycline HCl **CAPS** (generic Dynacin/ Minocin/Myrac)	demeclocycline (generic Declomycin)[CL] DORYX MPC DR (doxycycline pelletized) doxycycline hyclate DR (generic Doryx) doxycycline monohydrate 40MG, 75MG and 150MG **CAP** (generic Adoxa/Monodox/ Oracea) minocycline HCl **TAB** (generic Dynacin/Myrac) minocycline HCl ER (generic Solodyn) NUZYRA (omadacycline) tetracycline VIBRAMYCIN **SUSP** (doxycycline) XIMINO (minocycline ER)[QL]	▪ Non-preferred agents will be approved for patients who have failed a sequential 3-day trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **Demeclocycline:** Approved for diagnosis of SIADH ▪ **doxycycline suspension:** May be approved with documented swallowing difficulty

THROMBOPOIESIS STIMULATING PROTEINS [CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROMACTA (eltrombopag) **TAB**	ALVAIZ (eltrombopag choline)[AL,NR] DOPTELET (avatrombopag) MULPLETA (lusutrombopag) PROMACTA (eltrombopag) **SUSP** TAVALISSE (fostamatinib)	▪ All agents will be approved with FDA-approved indication, ICD-10 code is required. ▪ Non-preferred agents require a trial of a preferred agent with the same indication or a contraindication. Drug-Specific Criteria ▪ **Doptelet/Mulpleta**: Approved for one course of therapy for a scheduled procedure with a risk of bleeding for treatment of thrombocytopenia in adult patients with chronic liver disease

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

THYROID HORMONES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
levothyroxine **TAB** (generic Synthroid) liothyronine **TAB** (generic Cytomel) thyroid, pork **TAB** UNITHROID (levothyroxine)	ADTHYZA (thyroid, pork)[NR] ERMEZA (levothyroxine) **SOLN** EUTHYROX (levothyroxine) LEVO-T (levothyroxine) levothyroxine **CAPS** (generic Tirosint) THYQUIDITY (levothyroxine) **SOLN** TIROSINT **CAPS** (levothyroxine) TIROSINT-SOL **LIQUID** (levothyroxine)[CL]	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Tirosint-Sol**: May be approved with documented swallowing difficulty

ULCERATIVE COLITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Asacol HD®/Delzicol DR®/ Pentasa®:** Requires clinical reason why preferred mesalamine products cannot be used
APRISO (mesalamine) Sulfasalazine IR, DR (generic Azulfidine) LIALDA (mesalamine)	balsalazide (generic Colazal) budesonide DR (generic Uceris) DIPENTUM (olsalazine) mesalamine ER (generic Apriso) mesalamine ER (generic Pentasa) mesalamine (generic Asacol HD/ Delzicol/Lialda) PENTASA (mesalamine)	
RECTAL		
Sulfite-Free ROWASA (mesalamine) mesalamine **SUPPOSITORY** (generic Canasa)	CANASA (mesalamine) mesalamine **ENEMA** (generic Rowasa) ROWASA (mesalamine) UCERIS (budesonide)	

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May PDL Highlighted in Red indicates changes that become effective May 1, 2024

https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

UTERINE DISORDER TREATMENT

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MYFEMBREE (relugolix/ estradiol/ norethindrone acetate)[AL, CL,QL] ORIAHNN (elagolix/ estradiol/ norethindrone)[AL,CL] ORILISSA (elagolix sodium)[QL,CL]		Drug-specific criteria: • **Myfembree, Orilissa, and Oriahnn:** Requires an FDA approved indication, must follow FDA dosing guidelines, and have had a trial and failure of an NSAID and oral contraceptive ○ Total duration of treatment is max of 24 months

VASODILATORS, CORONARY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BIDIL (isosorbide dinitrate/ hydralazine)[CL] isosorbide dinitrate **TAB** isosorbide dinitrate ER, SA **TAB (generic Dilatrate-SR/Isordil)** isosorbide mono IR/SR **TAB** nitroglycerin **SUBLINGUAL, TRANSDERMAL** nitroglycerin ER **TAB**	GONITRO (nitroglycerin) isosorbide dinitrate **TAB (Oceanside Pharm MFR only)** isosorbide dinitrate/hydralazine (Bidil)[CL] NITRO-BID **OINT** (nitroglycerin) NITRO-DUR (nitroglycerin) nitroglycerin **TRANSLINGUAL** (generic Nitrolingual) VERQUVO (vericiguat)[AL,CL,QL]	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **BiDil:** Approved for the treatment of heart failure as an adjunct therapy to standard therapy in self-identified black patients ▪ **Verquvo:** Approved for use in patients following a recent hospitalization for HF within the past 6 months OR need for outpatient IV diuretics, in adults with symptomatic chronic HF and EF less than 45%