



Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

For the most up to date list of covered drugs consult the Drug Lookup on the Nebraska Medicaid Website at <https://druglookup.fhsc.com/druglookupweb/?client=nestate>

- **Opioids**- The maximum opioid dose covered will decrease from 120 Morphine Milligram Equivalents (MME) per day to 90 Morphine Milligram Equivalents (MME) per day. (beginning December 1, 2020)

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>

- [Asthma Immunomodulator PA Form](#)
- [Buprenorphine Products PA Form](#)
- [Buprenorphine Products 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](#)

For a complete list of Claims Limitations visit:

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ACNE AGENTS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>benzoyl peroxide (BPO) WASH, LOTION</p> <p>clindamycin/BPO (generic Duac)</p> <p>clindamycin phosphate PLEDGET</p> <p>clindamycin phosphate SOLUTION</p> <p>DIFFERIN LOTION, CREAM, Rx-GEL (adapalene)</p> <p>DIFFERIN GEL (adapalene) OTC</p> <p>erythromycin GEL</p> <p>erythromycin SOLUTION</p> <p>erythromycin-BPO (generic for Benzamycin)</p> <p>RETIN-A (tretinoin)^{AL} CREAM, GEL</p>	<p>adapalene (generic differin)</p> <p>adapalene/BPO (generic Epiduo)</p> <p>adapalene/BPO (generic Epiduo Forte)^{NR}</p> <p><i>AKLIEF (trifarotene)</i>^{AL}</p> <p>ALTRENO (tretinoin)^{AL}</p> <p><i>AMZEEQ (minocycline)</i></p> <p><i>ARAZLO (tazarotene)</i>^{AL}</p> <p>ATRALIN (tretinoin)</p> <p>AVAR (sulfacetamide sodium/sulfur)</p> <p>AVITA (tretinoin)</p> <p>AZELEX (azelaic acid)</p> <p>BENZAACLIN PUMP (clindamycin/BPO)</p> <p>BENZEFOAM (benzoyl peroxide)^{NR}</p> <p>benzoyl peroxide CLEANSER, CLEANSING BAR OTC</p> <p>benzoyl peroxide FOAM (generic Benzepro)</p> <p>benzoyl peroxide GEL OTC</p> <p>benzoyl peroxide GEL Rx</p> <p><i>benzoyl peroxide TOWELETTE</i> OTC</p> <p>clindamycin FOAM, LOTION</p> <p>clindamycin GEL</p> <p>clindamycin phosphate (generic for Clindagel)^{NR} GEL</p> <p>clindamycin/BPO (generic Acanya, Benzaclin) GEL</p> <p>clindamycin/tretinoin (generic Veltin, Ziana)</p> <p>dapsone (generic Aczone)</p> <p>EPIDUO FORTE GEL PUMP (adapalene/BPO)</p> <p>erythromycin GEL, PLEDGET</p> <p>erythromycin-BPO (generic for Benzamycin)</p> <p>EVOCLIN (clindamycin)</p> <p>FABIOR (tazarotene foam)</p> <p>NEUAC (clindamycin/BPO)</p> <p>ONEXTON (clindamycin/BPO)</p> <p>OVACE PLUS (sulfacetamide sodium)</p> <p>PLIXDA (adapalene) SWAB</p> <p><i>RETIN-A GEL, CREAM</i>^{AL} (tretinoin)</p> <p>sulfacetamide</p> <p>sulfacetamide/sulfur</p> <p>SUMADAN (sulfacetamide/sulfur)</p> <p>tazarotene CREAM (generic Tazorac)</p> <p><i>tazarotene FOAM (generic Fabior)</i>^{NR}</p> <p>TRETIN-X (tretinoin)</p> <p>tretinoin CREAM, GELAL (generic Avita, Retin-A)</p> <p>tretinoin microspheres (generic for Retin-A Micro)^{AL}</p>	<ul style="list-style-type: none"> • Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class

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CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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ALZHEIMER'S AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHOLINESTERASE INHIBITORS		<ul style="list-style-type: none"> • 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
donepezil (generic for Aricept) donepezil ODT (generic for Aricept ODT) EXELON Transdermal (rivastigmine)	donepezil 23 (generic for Aricept 23) galantamine (generic for Razadyne) SOLUTION, TABLET galantamine ER (generic for Razadyne ER) rivastigmine (generic for Exelon)	
NMDA RECEPTOR ANTAGONIST		Drug-specific criteria: <ul style="list-style-type: none"> • 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)
memantine (generic for Namenda)	memantine ER (generic for Namenda XR) memantine SOLUTION (generic for Namenda) NAMENDA (memantine) NAMZARIC (memantine/donepezil)	

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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}	ARYMO ER (morphine sulfate) ^{QL} BELBUCA (buprenorphine) ^{QL} BUCCAL buprenorphine BUCCAL (generic for Belbuca) ^{AL,NR,QL} buprenorphine PATCH (generic Butrans) ^{QL} <i>EMBEDA (morphine sulfate/ naltrexone)</i> DURAGESIC MATRIX (fentanyl) ^{QL} fentanyl 37.5, 62.5, 87.5 mcg PATCH ^{QL} <i>hydrocodone ER (generic for Hysingla ER)</i> ^{NR, QL} hydrocodone bitartrate ER (generic for Zohydro ER) hydromorphone ER (generic for Exalgo) ^{CL} HYSINGLA ER (hydrocodone ER) KADIAN (morphine ER) methadone TABLET, ORAL SYR ^{NR,CL} MORPHABOND ER (morphine sulfate) morphine ER (generic for Avinza, Kadian) CAPSULE 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. <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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

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ANALGESICS, OPIOID SHORT-ACTING^{QL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ORAL	
acetaminophen/codeine ELIXIR, TABLET codeine TABLET hydrocodone/APAP SOLUTION, TABLET hydrocodone/ibuprofen hydromorphone TABLET morphine CONC SOLUTION, SOLUTION, TABLET oxycodone TABLET, SOLUTION oxycodone/APAP Tramadol 50 TABLET^{AL} (generic Ultram) tramadol/APAP (generic Ultracet)	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 FIORINAL/CODEINE (butalbital/ASA/codeine/caffeine) hydromorphone LIQUID, SUPPOSITORY (generic Dilaudid) IBUDONE (hydrocodone/ibuprofen) levorphanol meperidine (generic Demerol) morphine SUPPOSITORIES NALOCET (oxycodone/APAP) NUCYNTA (tapentadol) ^{CL} OXAYDO (oxycodone) ^{CL} oxycodone CAPSULE oxycodone/APAP SOLUTION oxycodone/APAP TABLET (generic Prolate) oxycodone/aspirin oxycodone CONCENTRATE oxycodone/ibuprofen oxymorphone IR (generic Opana) pentazocine/naloxone PROLATE SUSP (oxycodone/acetaminophen) ^{NR} ROXICODONE TABLET (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol)^{AL,NR} tramadol 100mg TABLET (generic Ultram) ^{AL} tramadol (generic Qdolo)^{AL,NR,QL} SOLN ZAMICET (hydrocodone/APAP)	<ul style="list-style-type: none"> 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. Beginning Oct. 11, 2018: Opiate limits for opiate naïve patients will consist of <ul style="list-style-type: none"> -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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Apadaz: Approval for 14 days or less Nucynta®: Approved only for diagnosis of acute pain, for 30 days or less

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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 (fentanyl) ^{CL} fentanyl TRANSMUCOSAL (generic Actiq) ^{CL} FENTORA (fentanyl) ^{CL}	<ul style="list-style-type: none"> Abstral®/Actiq®/Fentora®/Onsolis (fentanyl): Approved only for diagnosis of cancer AND current use of long-acting opiate

ANDROGENIC AGENTS (Topical)^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<i>ANDROGEL (testosterone) PUMP</i> ^{CL}	ANDRODERM (testosterone) ^{CL} NATESTO (testosterone) ^{CL} testosterone PACKET (generic Androgel) ^{CL} <i>testosterone PUMP (generic Androgel)</i> ^{CL} <i>testosterone GEL, PACKET, PUMP (generic Vogelxo)</i> testosterone (generic Axiron) testosterone (generic Fortesta) testosterone (generic Testim)	<ul style="list-style-type: none"> 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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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)

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ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ACE INHIBITORS		<ul style="list-style-type: none"> • Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 12 months • Non-preferred combination products may be covered as individual prescriptions without prior authorization <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> • Epaned® and Qbrelis® Oral Solution: Clinical reason why oral tablet is not appropriate
benazepril (generic Lotensin) enalapril (generic Vasotec) <i>fosinopril (generic Monopril)</i> lisinopril (generic Prinivil, Zestril) quinapril (generic Accupril) ramipril (generic Altace)	captopril (generic Capoten) EPANED (enalapril) ^{CL} ORAL SOLUTION enalapril (generic for Epaned) ^{CL} ORAL SOLUTION moexepiril (generic Univasc) perindopril (generic Aceon) QBRELIS (lisinopril) ^{CL} ORAL SOLUTION trandolapril (generic Mavik)	
ACE INHIBITOR/DIURETIC COMBINATIONS		
benazepril/HCTZ (generic Lotensin HCT) enalapril/HCTZ (generic Vaseretic) fosinopril/HCTZ (generic Monopril HCT) lisinopril/HCTZ (generic Prinzide, Zestoretic) quinapril/HCTZ (generic Accuretic)	captopril/HCTZ (generic Capozide) 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)	

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ANGIOTENSIN MODULATORS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		<ul style="list-style-type: none"> 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)	candesartan/HCTZ (generic Atacand-HCT)	
losartan/HCTZ (generic Hyzaar)	EDARBYCLOR (azilsartan/chlorthalidone)	
olmesartan/HCTZ (generic Benicar-HCT) valsartan/HCTZ (generic Diovan-HCT)	telmisartan/HCTZ (generic Micardis-HCT)	
ANGIOTENSIN MODULATOR/ CALCIUM CHANNEL BLOCKER COMBINATIONS		<ul style="list-style-type: none"> Angiotensin Modulator/Calcium Channel Blocker Combinations: Combination agents may be approved if there has been a trial and failure of preferred agent
amlodipine/benazepril (generic Lotrel)	amlodipine/olmesartan/HCTZ (generic Tribenzor)	
amlodipine/olmesartan (generic Azor)	amlodipine/telmisartan (generic Twynsta)	
amlodipine/valsartan (generic Exforge)	<i>amlodipine/valsartan/HCTZ (generic Exforge HCT)</i> PRESTALIA (perindopril/amlodipine) trandolapril/verapamil (generic Tarka)	
DIRECT RENIN INHIBITORS		<ul style="list-style-type: none"> Direct Renin Inhibitors/Direct Renin Inhibitor Combinations: May be approved with history of TWO preferred ACE Inhibitors or Angiotensin Receptor Blockers within the last 12 months
	aliskiren (generic Tekturna) ^{QL}	
DIRECT RENIN INHIBITOR COMBINATIONS		<p>Drug Specific Criteria</p> <ul style="list-style-type: none"> Entresto: May be approved with a diagnosis of heart failure AND ≥ 18 years old
	TEKTURNA/HCT (aliskiren/HCTZ)	
NEPRILYSIN INHIBITOR COMBINATION		
ENTRESTO (sacubitril/valsartan) ^{AL,QL}		
ANGIOTENSIN RECEPTOR BLOCKER/BETA-BLOCKER COMBINATIONS		
	BYVALSON (nebolol/valsartan)	

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ANTHELMINTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
albendazole (generic for Albenza) BILTRICIDE (praziquantel) ivermectin (generic for Stromectol)	ALBENZA (albendazole) EMVERM (mebendazole) ^{CL} praziquantel (generic for Biltricide) STROMECTOL (ivermectin)	<ul style="list-style-type: none"> 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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Emverm: Approval will be considered for indications not covered by preferred agents

ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ORALAIR (sweet vernal/orchard/rye/ timothy/kentucky blue grass mixed pollen allergen extract) PALFORZIA ^{AL,CL} (<i>peanut allergen powder-dnfp</i>)	<p>Drug-specific criteria:</p> <p>ORALAIR</p> <ul style="list-style-type: none"> 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 10 through 65 years of age. <p>PALFORZIA</p> <ul style="list-style-type: none"> <i>Confirmed diagnosis of peanut allergy by allergist</i> <i>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</i> <i>Initial dose and increase titration doses should be given in a healthcare setting</i> <i>Should not be used in patients with uncontrolled asthma or concurrently on a NSAID</i>

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ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FIRVANQ (vancomycin) SOLUTION metronidazole TABLET neomycin tinidazole (generic Tindamax) ^{CL}	DIFICID (fidaxomicin) ^{CL} TABLET, SUSP^{NR} FLAGYL ER (metronidazole) ^{CL} Metronidazole ^{CL} CAPSULE <i>nitazoxanide (generic Alinia)</i> TABLET^{AL, CL, QL} paromomycin SOLOSEC (secnidazole) vancomycin CAPSULE (generic Vancocin) ^{CL} XIFAXAN (rifaximin) ^{CL}	<ul style="list-style-type: none"> • Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization Drug-specific criteria: <ul style="list-style-type: none"> • Alinia[®]: Trial and failure with metronidazole is required for a diagnosis of giardiasis • Dificid[®]: Trial and failure with oral vancomycin is required for a diagnosis of C. difficile diarrhea (pseudomembranous colitis) • Flagyl ER[®]: Trial and failure with metronidazole is required • Flagyl[®]/Metronidazole 375mg capsules and Flagyl ER[®]/ 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[®]

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ANTIBIOTICS, INHALED

Preferred Agents ^{CL}	Non-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin) ^{CL} KITABIS PAK (tobramycin) ^{CL} TOBI-PODHALER (tobramycin) ^{CL,QL}	ARIKAYCE (amikacin liposomal inh) ^{CL} SUSPENSION CAYSTON (aztreonam lysine) ^{QL,CL} <i>tobramycin (generic for Bethkis)</i> tobramycin (generic Tobii) ^{CL}	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 OINTMENT bacitracin/polymyxin (generic Polysporin) mupirocin OINTMENT (generic Bactroban) neomycin/polymyxin/bacitracin (generic Neosporin, Triple AB) neomycin/polymyxin/pramoxine neomycin/polymyxin/bacitracin/pramoxine	CENTANY (mupirocin) gentamicin OINTMENT, CREAM mupirocin CREAM (generic Bactroban) ^{CL}	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Mupirocin® Cream: Clinical reason the ointment cannot be used

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ANTIBIOTICS, VAGINAL

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CLEOCIN OVULES (clindamycin) clindamycin CREAM (generic Cleocin) CLINDESSE (clindamycin) NUVESSA (metronidazole) VANDAZOLE (metronidazole)	CLEOCIN CREAM (clindamycin) METROGEL (metronidazole) <i>metronidazole, vaginal</i>	<ul style="list-style-type: none"> 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 (dabigatran) warfarin (generic Coumadin) XARELTO (rivaroxaban) 10 mg, 15 mg, 20 mg XARELTO (rivaroxaban) 2.5 mg ^{CL,QL} XARELTO DOSE PACK (rivaroxaban)	BEVYXXA (betrixaban) ^{QL} fondaparinux (generic Arixtra) FRAGMIN (dalteparin) SAVAYSA (edoxaban) ^{QL} XARELTO (rivaroxaban) ^{NR} SUSP	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 12 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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

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ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CANNABINOIDS		<ul style="list-style-type: none"> 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		<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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 ODT®: Documentation of inability to swallow or Clinical reason oral liquid cannot be used Sancuso®/Zuplenz®: Documentation of oral dosage form intolerance
ondansetron (generic Zofran/Zofran ODT) ^{QL}	ANZEMET (dolasetron) granisetron (generic Kytril) SANCUSO (granisetron) ^{CL} ZUPLENZ (ondansetron)	
NK-1 RECEPTOR ANTAGONIST		<ul style="list-style-type: none"> 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 ODT®: Documentation of inability to swallow or Clinical reason oral liquid cannot be used Sancuso®/Zuplenz®: Documentation of oral dosage form intolerance
EMEND (aprepitant) CAPSULE, CAPSULE PACK ^{QL}	aprepitant (generic Emend) ^{QL,CL} AKYNZEO (netupitant/palonosetron) ^{CL} VARUBI (rolapitant) TABLET ^{CL}	
TRADITIONAL ANTIEMETICS		<ul style="list-style-type: none"> Diclegis®/Bonjesta: Approved only for treatment of nausea and vomiting of pregnancy Metozolv ODT®: Documentation of inability to swallow or Clinical reason oral liquid cannot be used Sancuso®/Zuplenz®: Documentation of oral dosage form intolerance
DICLEGIS (doxylamine/pyridoxine) ^{CL,QL} dimenhydrinate (generic Dramamine) OTC meclizine (generic Antivert) metoclopramide (generic Reglan) phosphoric acid/dextrose/fructose SOLUTION (generic Emetrol) prochlorperazine, oral (generic Compazine) promethazine TABLET (generic Phenergan) promethazine SUPPOSITORY 12.5mg, 25mg TRANSDERM-SCOP (scopolamine)	BONJESTA (doxylamine/pyridoxine) ^{CL,QL} COMPRO (prochlorperazine) doxylamine/pyridoxine (generic Diclegis) ^{CL,QL} metoclopramide ODT (generic Metozolv ODT) prochlorperazine SUPPOSITORY (generic Compazine) promethazine SUPPOSITORY 50mg scopolamine TRANSDERMAL trimethobenzamide TABLET (generic Tigan)	

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^{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

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ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole (mucous membrane, troche) fluconazole SUSPENSION, TABLET (generic Diflucan) griseofulvin SUSPENSION griseofulvin microsize TABLET nystatin SUSPENSION, TABLET terbinafine (generic Lamisil)	BREXAFEMME (ibrexafungerp) ^{QL,NR} CRESEMBA (isavuconazonium) ^{CL} flucytosine (generic Ancobon) ^{CL} griseofulvin ultramicrosize (generic GRIS-PEG) itraconazole (generic Sporanox) ^{CL} ketoconazole (generic Nizoral) nystatin POWDER ONMEL (itraconazole) posaconazole (generic Noxafil) ^{AL,CL} TOLSURA (itraconazole) ^{CL} voriconazole (generic VFEND) ^{CL}	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Cresemba®: Approved for diagnosis of invasive aspergillosis or invasive mucormycosis • Flucytosine: Approved for diagnosis of: <ul style="list-style-type: none"> 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® Suspension: Oropharyngeal/esophageal candidiasis refractory to itraconazole and/or fluconazole • Onmel®: Requires trial and failure or contraindication to terbinafine • Sporanox®/Itraconazole: Approved for diagnosis of Aspergillosis, Blastomycosis, Histoplasmosis, Onychomycosis due to terbinafine-resistant dermatophytes, Oropharyngeal/ esophageal candidiasis refractory to fluconazole • Sporanox®: Requires trial and failure of generic itraconazole • 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, <i>S. apiospermum</i> and <i>Fusarium spp.</i>, Oropharyngeal/esophageal candidiasis refractory to fluconazole

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ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTIFUNGAL		
clotrimazole CREAM (generic Lotrimin) RX, OTC clotrimazole SOLN OTC ketoconazole CREAM, SHAMPOO (generic Nizoral) LAMISIL (terbinafine) SPRAY OTC LAMISIL AT CREAM (terbinafine) OTC miconazole CREAM, POWDER OTC nystatin terbinafine OTC (generic Lamisil AT) tolnaftate POWDER, CREAM, POWDER OTC (generic Tinactin)	ALEVAZOL (clotrimazole) OTC ciclopirox CREAM, GEL, SUSPENSION (generic Ciclodan, Loprox) ciclopirox NAIL LACQUER (generic Penlac) ciclopirox SHAMPOO (generic Loprox) clotrimazole SOLUTION RX (generic Lotrimin) DESENEXT POWDER OTC (miconazole) econazole (generic Spectazole) ERTACZO (sertaconazole) EXELDERM (sulconazole) FUNGOID OTC JUBLIA (efinaconazole) <i>tavorole SOLUTION (generic Kerydin)^{NR}</i> ketoconazole FOAM (generic Extina, Ketodan) LAMISIL AT GEL, SPRAY (terbinafine) OTC LOPROX (ciclopirox) SUSPENSION, SHAMPOO, CREAM LOTRIMIN AF CREAM OTC (clotrimazole) LOTRIMIN ULTRA (butenafine) luliconazole (generic Luzu) MENTAX (butenafine) miconazole OTC OINTMENT, SPRAY miconazole/zinc oxide/petrolatum (generic Vusion) naftifine CREAM, GEL (generic Naftin) oxiconazole (generic Oxistat) salicylic acid (generic Bensal HP) <i>tavorole SOLUTION (generic Kerydin)</i> tolnaftate SPRAY , OTC	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Extina: Requires trial and failure or contraindication to other ketoconazole forms Jublia: Approved diagnoses include Onychomycosis of the toenails due to <i>T.rubrum</i> OR <i>T. Mentagrophytes</i> ciclopirox nail lacquer: No trial required in diabetes, peripheral vascular disease (PVD), immunocompromised OR contraindication to oral terbinafine
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone CREAM (generic Lotrisone) nystatin/triamcinolone (generic Mycolog) CREAM, OINT	clotrimazole/betamethasone LOTION (generic Lotrisone)	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ANTI-HISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine TABLET, SOLUTION (Rx only) (generic for Zyrtec) loratadine TABLET, SOLUTION (generic for Claritin) levocetirizine TABLET (generic for Xyzal)	cetirizine CHEWABLE (generic for Zyrtec) cetirizine SOLUTION (OTC) desloratadine (generic for Clarinex) desloratadine ODT (generic for Clarinex Reditabs) fexofenadine (generic for Allegra) fexofenadine 180mg (generic for Allegra 180mg) ^{QL} levocetirizine (generic for Xyzal) SOLUTION loratadine CAPSULE, CHEWABLE, ODT (generic for Claritin Reditabs)	<ul style="list-style-type: none"> 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

ANTI-HYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CATAPRES-TTS (clonidine) clonidine TABLET (generic for Catapres) guanfacine (generic for Tenex) methyldopa	clonidine TRANSDERMAL methyldopa/hydrochlorothiazide	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 30-day trial with ONE preferred agent within this drug class

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ANTIHYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol (generic for Zyloprim) MITIGARE (colchicine) probenecid probenecid/colchicine (generic for Col-Probenecid)	colchicine TABLET (generic for Colcrys) ^{CL} colchicine CAPSULE (generic for Mitigare) febuxostat (generic for Uloric) ^{CL} GLOPERBA SOLN (colchicine) ^{CL, QL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class colchicine tablet®: Approved without trial for familial Mediterranean fever OR pericarditis Gloperba: <i>Approved for documented swallowing disorder</i> Uloric®: Clinical reason why allopurinol cannot be used

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>AJOVY (fremanezumab-vfrm)^{CL, QL} PEN, Autoinjector, Autoinjector 3-pack^{NR}</p> <p>EMGALITY 120 mg/mL (galcanezumab-gnlm)^{CL, QL} PEN, SYRINGE</p> <p>UBRELVY (ubrogepant)^{AL, CL, QL} TABLET</p>	<p>AIMOVIG (erenumab-aooe)^{CL, QL}</p> <p>CAFERGOT (ergotamine/caffeine)</p> <p>CAMBIA (diclofenac potassium)</p> <p>dihydroergotamine mesylate NASAL</p> <p>ELYXYB (celecoxib)^{AL, NR, QL} SOLN</p> <p>EMGALITY 100 mg (galcanezumab-gnlm)^{CL, QL} SYRINGE</p> <p>ERGOMAR SUBLINGUAL (ergotamine tartrate)</p> <p>MIGERGOT (ergotamine/caffeine) RECTAL</p> <p>MIGRANAL (dihydroergotamine) NASAL</p> <p>NURTEC ODT (rimegepant)^{AL, CL, QL}</p> <p>QULIPTA (atogepant)^{AL, NR, QL}</p> <p>REYVOW (lasmiditan)^{AL, CL, QL} TABLET</p> <p>TRUDHESA (dihydroergotamine mesylate)^{AL, NR, QL} NASAL</p>	<ul style="list-style-type: none"> All acute treatment agents will be approved for patients who have a failed trial or contraindication of a triptan. In addition, all non-preferred agents will require a failed trial or contraindication of a preferred agent of the same indication <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Cambia[®]: Requires diagnosis of migraine and documentation of why solid dosing forms not appropriate Emgality 120mg is recommended dosing for Migraine, <i>Emgality 100mg is recommended dosing for Episodic Cluster Headache</i> Aimovig, Ajoy and Emgality 120mg: 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, metoprolol, timolol, atenolol), anti-epileptics (valproate, topiramate), ACE/ARB (lisinopril, candesartan) In addition, Aimovig requires a trial of Emgality 120mg or Ajoy or clinical, patient specific reason that a preferred agent cannot be used

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ANTIMIGRAINE AGENTS, TRIPTANS^{QL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria	
ORAL			
rizatriptan (generic Maxalt) rizatriptan ODT (generic Maxalt MLT) sumatriptan	almotriptan (generic Axert) eletriptan (generic Relpax) frovatriptan (generic Frova) IMITREX (sumatriptan) naratriptan (generic Amerge) RELPA ^{QL} sumatriptan/naproxen (generic Treximet) zolmitriptan (generic Zomig/Zomig ZMT)	<ul style="list-style-type: none"> • Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> • Sumavel[®] Dosepro: Requires clinical reason sumatriptan injection cannot be used • Onzetra, Zembrace: approved for patients who have failed ALL preferred agents 	
NASAL			
IMITREX (sumatriptan)	ONZETRA XSAIL (sumatriptan) sumatriptan (generic Imitrex Nasal) TOSYMRA (sumatriptan) zolmitriptan (<i>generic for Zomig</i>) ZOMIG (zolmitriptan)		
INJECTABLE			
sumatriptan KIT, SYRINGE, VIAL	IMITREX (sumatriptan) INJECTION SUMAVEL DOSEPRO (sumatriptan) ZEMBRACE SYMTOUCH (sumatriptan)		

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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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 <i>ivermectin (generic Sklice) LOTION</i> ^{NR} lindane malathion (generic Ovide) SKLICE (ivermectin) spinosad (generic Natroba) VANALICE (piperonyl butoxide/pyrethrins)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ANTIPARKINSON'S AGENTS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ONE preferred agents within this drug class
benzotropine (generic for Cogentin) trihexyphenidyl (generic for Artane)		
COMT INHIBITORS		Drug-specific criteria: <ul style="list-style-type: none"> Carbidopa/Levodopa ODT: Approved for documented swallowing disorder COMT Inhibitors: Approved if using as add-on therapy with levodopa-containing drug
	entacapone (generic for Comtan) tolcapone (generic for Tasmar)	
DOPAMINE AGONISTS		<ul style="list-style-type: none"> 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®: <ul style="list-style-type: none"> For Parkinsons: Clinical reason required why preferred agent cannot be used For Restless Leg (RLS): Requires trial OR Contraindication to ropinirole AND pramipexole
pramipexole (generic for Mirapex) ropinirole (generic for Requip)	bromocriptine (generic for Parlodel) ropinirole ER (generic for Requip ER) ^{CL} NEUPRO (rotigotine) ^{CL} pramipexole ER (generic for Mirapex ER) ^{CL} ropinirole ER (generic for Requip XL) ^{CL}	
MAO-B INHIBITORS		<ul style="list-style-type: none"> Nourianz: Approval upon diagnosis of Parkinson's disease and concurrent treatment with carbidopa/levodopa agent
selegiline CAPSULE, TABLET (generic for Eldepryl)	rasagiline (generic for Azilect) ^{QL} XADAGO (safinamide) ZELAPAR (selegiline) ^{CL}	
OTHER ANTIPARKINSON'S DRUGS		<ul style="list-style-type: none"> 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
amantadine CAPSULE, SYRUP TABLET (generic for Symmetrel) carbidopa/levodopa (generic for Sinemet) carbidopa/levodopa ER (generic for Sinemet CR) levodopa/carbidopa/entacapone (generic for Stalevo)	APOKYN (apomorphine) SUB-Q carbidopa (generic for Lodosyn) carbidopa/levodopa ODT (generic for Parcopa) DHIVY (carbidopa/levodopa) ^{NR,QL} DUOPA (carbidopa/levodopa) GOCOVRI (amantadine) ^{QL} INBRIJA (levodopa) INHALER ^{CL,QL} KYNMOBI (apomorphine) ^{QL} KIT, SUBLINGUAL NOURIANZ (istradefylline) ^{CL,QL} OSMOLEX ER (amantadine) ^{QL} RYTARY (carbidopa/levodopa) STALEVO (ledopa/carbidopa/entacapone)	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ANTIPSORIATICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acitretin (generic for Soriatane)	methoxsalen (generic for Oxsoralen-Ultra) SORIATANE (acitretin)	<ul style="list-style-type: none"> 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, OINTMENT, SOLUTION,	calcitriol (generic for Vectical) calcipotriene/betamethasone OINTMENT (generic for Taclonex) calcipotriene/betamethasone SUSP (generic for Taclonex Scalp) CALCITRENE (calcipotriene) DOVONEX CREAM (calcipotriene) DUOBRII (halobetasol prop/tazarotene) ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTI-HERPETIC DRUGS		
acyclovir (generic Zovirax) famciclovir (generic Famvir) valacyclovir (generic Valtrex)	acyclovir (generic for Zovirax) ^{CL} SUSPENSION SITAVIG (acyclovir buccal) ^{CL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 10-day trial of ONE preferred agent within the same group
ANTI-INFLUENZA DRUGS		
oseltamivir (generic Tamiflu) ^{QL}	rimantadine (generic Flumadine) RELENZA (zanamivir) ^{QL} TAMIFLU (oseltamivir) ^{QL} XOFLUZA (baloxavir marboxil) ^{AL,CL,QL}	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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

ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acyclovir OINTMENT	acyclovir CREAM, (generic Zovirax) DENAVIR (penciclovir) XERESE (acyclovir/hydrocortisone)	<ul style="list-style-type: none"> 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, SOLUTION (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} <i>lorazepam</i> ORAL SYRINGE ^{NR} LOREEV XR (lorazepam) ^{AL,NR} meprobamate oxazepam	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with TWO preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Diazepam IntensoI®: Requires clinical reason why diazepam solution cannot be used Alprazolam IntensoI®: Requires trial of diazepam solution OR lorazepam IntensoI®

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BETA BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA BLOCKERS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Bystolic®: Only ONE trial is required with Diagnosis of Obstructive Lung Disease Coreg CR®: 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)	BYSTOLIC (nebivolol)	
bisoprolol/HCTZ (generic Ziac)	HEMANGEOL (propranolol) SOLUTION	
metoprolol (generic Lopressor)	INDERAL/INNOPRAN XL (propranolol ER)	
metoprolol ER (generic Toprol XL)	KAPSPARGO SPRINKLE (metoprolol ER)	
propranolol (generic Inderal)	LEVATOL (penbutolol)	
propranolol ER (generic Inderal LA)	metoprolol/HCTZ (generic Lopressor HCT)	
	nadolol (generic Corgard)	
	nadolol/bendroflumethiazide	
	nebivolol (generic Bystolic) ^{NR}	
	pindolol (generic Viskin)	
	propranolol/HCTZ (generic Inderide)	
	timolol (generic Blocadren)	
	TOPROL XL (metoprolol ER)	
BETA- AND ALPHA-BLOCKERS		
carvedilol (generic Coreg)	carvedilol ER (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 300mg (generic for Actigall)	BYLVAY (odevixibat) ^{NR} CAP, PELLET	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class
ursodiol 250mg TABLET (generic for URSO)	CHENODAL (chenodiol)	
ursodiol 500mg TABLET (generic for URSO FORTE)	CHOLBAM (cholic acid)	
	LIVMARLI (maralixibat) SOLN ^{AL,NR}	
	OCALIVA (obeticholic acid)	
	RELTONE (ursodiol 200mg,400mg) CAP ^{NR}	

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CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oxybutynin IR, ER (generic Ditropan/Ditropan XL) solifenacin (generic Vesicare) TOVIAZ (fesoterodine ER)	darifenacin ER (generic Enablex) GELNIQUE (oxybutynin) GEMTESA (vibegron) ^{AL,NR,QL} flavoxate MYRBETRIQ TAB, SUSP ^{AL,NR,QL} (mirabegron) OXYTROL (oxybutynin) tolterodine IR, ER (generic Detrol/ Detrol LA) trospium IR, ER (generic Sanctura/ Sanctura XR) VESICARE (solifenacin) VESICARE LS SUSP (solifenacin succinate) ^{AL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> Myrbetriq®: Covered without trial in contraindication to anticholinergic agents

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

BONE RESORPTION SUPPRESSION AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BISPHOSPHONATES		
alendronate (generic Fosamax) TABLET ibandronate (generic Boniva) ^{QL}	alendronate SOLUTION (generic Fosamax) ^{QL} ATELVIA DR (risedronate) BINOSTO (alendronate) etidronate disodium (generic Didronel) FOSAMAX PLUS D ^{QL} risedronate (generic Actonel) ^{QL}	<ul style="list-style-type: none"> • Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> • 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 heterotrophic ossification • Forteo®: Covered for high risk of fracture High risk of fracture: <ul style="list-style-type: none"> • BMD -3 or worse • Postmenopausal women with history of non-traumatic fractures • Postmenopausal women with 2 or more clinical risk factors <ul style="list-style-type: none"> ○ 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 <ul style="list-style-type: none"> ○ 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
OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS		
calcitonin-salmon NASAL raloxifene (generic Evista) teriparatide (generic Forteo) ^{CL,QL}	EVISTA (raloxifene) FORTEO (teriparatide) ^{CL,QL} TYMLOS (abaloparatide)	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALPHA BLOCKERS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
alfuzosin (generic Uroxatral) doxazosin (generic Cardura) tamsulosin (generic Flomax) terazosin (generic Hytrin)	CARDURA XL (doxazosin) silodosin (generic Rapaflo)	
5-ALPHA-REDUCTASE (5AR) INHIBITORS		Drug-specific criteria: <ul style="list-style-type: none"> Alfuzosin/dutasteride/finasteride <ul style="list-style-type: none"> 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
dutasteride (generic for Avodart) finasteride (generic for Proscar)	dutasteride/tamsulosin (generic for Jalyn)	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria	
INHALERS – Short Acting			
PROAIR HFA (albuterol) albuterol HFA (generic for ProAir HFA)	albuterol HFA (Proventil HFA, Ventolin HFA) levalbuterol HFA (generic for Xopenex HFA) <i>PROAIR DIGIHALER (albuterol)</i> PROAIR RESPICLICK (albuterol) PROVENTIL HFA (albuterol)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> Xopenex®: Covered for cardiac diagnoses or side effect of tachycardia with albuterol product 	
INHALERS – Long Acting			
SEREVENT (salmeterol)	ARCAPTA NEOHALER (indacaterol) 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 TABLET albuterol ER (generic for Vospire ER) metaproterenol (formerly generic for Alupent) terbutaline (generic for Brethine)		

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**Nebraska Medicaid
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CALCIUM CHANNEL BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SHORT-ACTING		<ul style="list-style-type: none"> • Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> • 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: May be approved with documented swallowing difficulty
Dihydropyridines		
	isradipine (generic Dynacirc) nicardipine (generic Cardene) nifedipine (generic Procardia) nimodipine (generic Nimotop) NYMALIZE (nimodipine) SOLUTION	
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 nisoldipine (generic Sular)	
Non-dihydropyridines		
diltiazem ER (generic Cardizem CD) verapamil ER TABLET	CALAN SR (verapamil) diltiazem ER (generic Cardizem LA) MATZIM LA (diltiazem ER) TIAZAC (diltiazem) verapamil ER CAPSULE verapamil 360mg CAPSULE verapamil ER (generic Verelan PM)	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		
amoxicillin/clavulanate TABLETS, SUSPENSION	amoxicillin/clavulanate CHEWABLE amoxicillin/clavulanate ER (generic Augmentin XR) AUGMENTIN (amoxicillin/clavulanate) SUSPENSION, TABLET	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within the same group
CEPHALOSPORINS – First Generation		
cefadroxil CAPSULE, SUSPENSION (generic Duricef) cephalexin CAPSULE, SUSPENSION (generic Keflex)	cefadroxil TABLET (generic Duricef) cephalexin TABLET	
CEPHALOSPORINS – Second Generation		
cefprozil (generic Cefzil) cefuroxime TABLET (generic Ceftin)	cefaclor (generic Ceclor) CEFTIN (cefuroxime) TABLET, SUSPENSION	
CEPHALOSPORINS – Third Generation		
cefdinir (generic Omnicef)	cefixime CAPSULE, SUSPENSION (generic Suprax) cefpodoxime (generic Vantin) SUPRAX CAPSULE, CHEWABLE TAB, SUSPENSION, TABLET (cefixime)	

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NEUPOGEN (filgrastim) VIAL	GRANIX (tbo-filgrastim) NEUPOGEN DISP SYR (filgrastim) NIVESTYM SYR, VIAL (filgrastim-aafi) Nyvepria (pegfilgrastim-apgf) ZARXIO (filgrastim-sndz) ZIEXTENZO SYR (pegfilgrastim-bmez)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>All reviewed agents are recommended preferred at this time <i>Only those products for review are listed.</i> Brand name products may be subject to Maximum Allowable Cost (MAC) pricing or require substitution with a generic equivalent</p> <p>Specific agents can be looked up using the Drug Look-up Tool at: https://druglookup.fhsc.com/druglookupweb/?client=nestate</p>	<p><i>DOLISHALE (ethinyl estradiol/levonorgestrel)^{NR}</i> <i>NEXTSTELLIS(drospirenone/estetrol)^{NR}</i> <i>TAYSOFY (norethindrone/ethinyl estradiol/iron)^{NR}</i> <i>TYBLUME (levonorgestrel/ ethinyl estradiol)^{NR}</i></p>	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS		<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Daliresp®: <ul style="list-style-type: none"> 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)	BEVESPI AEROSPHERE (glycopyrolate/formoterol)	
ATROVENT HFA (ipratropium)	DUAKLIR PRESSAIR (aclidinium br and formoterol fum)	
COMBIVENT RESPIMAT (albuterol/ipratropium)	INCRUSE ELIPTA (umeclidinium)	
SPIRIVA (tiotropium)	SEEBRI NEOHALER (glycopyrolate)	
STIOLTO RESPIMAT (tiotropium/olodaterol)	SPIRIVA RESPIMAT (tiotropium)	
	TUDORZA PRESSAIR (aclidinium br)	
	UTIBRON NEOHALER (indacaterol/glycopyrolate)	
INHALATION SOLUTION		
albuterol/ipratropium (generic for Duoneb)	LONHALA (glycopyrrolate inhalation soln)	
ipratropium SOLUTION (generic for Atrovent)	YUPELRI (revefenacin)	
ORAL AGENT		
	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 pseudoephedrine/codeine/ guaifenesin (generic for Lortuss EX, Tusnel C, Virtussin DAC)	<ul style="list-style-type: none"> 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 \geq 18 years of age

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**Nebraska Medicaid
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CYSTIC FIBROSIS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<p><i>BRONCHITOL (mannitol)^{AL,CL,QL}</i> KALYDECO PACKET, TABLET (ivacaftor)^{QL, AL} ORKAMBI (lumacaftor/ivacaftor) PACKET, TABLET^{QL, AL} SYMDEKO (tezacaftor/ivacaftor)^{QL, AL} TRIKAFTA (elexacaftor, tezacaftor, ivacaftor)^{AL, CL}</p>	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>ENBREL (etanercept) KIT, MINI CART, PEN, SYR, VIAL^{QL} HUMIRA (adalimumab)^{QL} OTEZLA (apremilast) ORAL^{CL,QL}</p>	<p>ACTEMRA (tocilizumab) SUB-Q ARCALYST (niloncept) CIBINQO (abrocitinib)^{AL,NR,QL} CIMZIA (certolizumab pegol)^{QL} COSENTYX (secukinumab) ENSPRYNG (satralizumab-mwge) SUB-Q ILUMYA (tildrakizumab) SUB-Q KEYZARA (sarilumab) SUB-Q, PEN, SYRINGE KINERET (anakinra) OLUMIANT (baricitinib) TAB^{CL,QL} ORENCIA (abatacept) SUB-Q RINVOQ ER (upadacitinib)^{CL,QL} SILIQ (brodalumab) SIMPONI (golimumab) SKYRIZI (risankizamab-rzaa) SYRINGE SKYRIZI PEN (risankizamab-rzaa)^{QL} STELARA (ustekinumab) SUB-Q TALTZ (ixekizumab)^{AL} TREMIFYA (guselkumab)^{QL} XELJANZ (tofacitinib) TAB, SOLN^{CL,QL} XELJANZ XR (tofacitinib) TAB^{CL,QL}</p>	<ul style="list-style-type: none"> 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 ONE preferred agent within this drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. <p>Drug-specific criteria: Otezla: Requires a trial of Humira</p> <p>Olumiant: Requires documentation of inadequate response or intolerance to a Tumor Necrosis Factor (TNF) blocker (ex., Enbrel, Humira)</p> <p>Rinvoq: Requires documentation of inadequate response or intolerance to a Tumor Necrosis Factor (TNF) blocker (ex., Enbrel, Humira)</p> <p>Xeljanz, Xeljanz XR: Requires documentation of inadequate response or intolerance to a Tumor Necrosis Factor (TNF) blocker (ex., Enbrel, Humira).</p>

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SINGLE-AGENT PRODUCTS		
amiloride TABLET bumetanide TABLET chlorothiazide TABLET chlorthalidone TABLET (generic Diuril) furosemide SOLUTION, TABLET (generic Lasix) hydrochlorothiazide CAPSULE, TABLET (generic Microzide) indapamide TABLET metolazone TABLET spironolactone TABLET (generic Aldactone) torsemide TABLET	CAROSPIR (spironolactone) SUSPENSION eplerenone TABLET (generic Inspra) ethacrynic acid CAPSULE (generic Edecrin) KERENDIA (finerenone) TABLET ^{NR,QL} methyclothiazide TABLET THALITONE (chlorthalidone) TABLET ^{NR} triamterene (generic Dyrenium)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
COMBINATION PRODUCTS		
amiloride/HCTZ TABLET spironolactone/HCTZ TABLET (generic Aldactazide) triamterene/HCTZ CAPSULE, TABLET (generic Dyazide, Maxzide)		

ENZYME REPLACEMENT, GAUCHERS DISEASE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ZAVESCA (miglustat) ^{CL}	CERDELGA (eliglustat) miglustat (generic Zavesca)	<ul style="list-style-type: none"> Non-preferred agents require clinical documentation why the preferred product within this drug class is not appropriate <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Zavesca: Approved for mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option

EPINEPHRINE, SELF-INJECTED^{QL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
epinephrine (AUTHORIZED GENERIC for Epipen/ Epipen Jr.) AUTOINJECTOR	epinephrine (generic for Adrenaclick) epinephrine (generic for Epipen/ Epipen Jr.) AUTOINJECTOR EPIPEN (epinephrine) AUTOINJ EPIPEN JR. (epinephrine) AUTOINJ SYMJEPI (epinephrine) PFS	<ul style="list-style-type: none"> Non-preferred agents require clinical documentation why the preferred product within this drug class is not appropriate <p>Brand name product may be authorized in event of documented national shortage of generic product.</p>

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ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RETACRIT (EPOETIN ALFA-EPBX)	EPOGEN (rHuEPO) PROCRIT (rHuEPO)	<ul style="list-style-type: none"> 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 TABLET (generic Cipro) levofloxacin TABLET (generic Levaquin)	BAXDELA (delafloxacin) ciprofloxacin ER ciprofloxacin SUSPENSION (generic Cipro) levofloxacin SOLUTION moxifloxacin (generic Avelox) ofloxacin	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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)

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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GI MOTILITY, CHRONIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AMITIZA (lubiprostone) ^{AL, QL} LINZESS (linaclotide) ^{QL} MOVANTIK (naloxegol oxalate) ^{QL}	alosetron (generic Lotronex) <i>lubiprostone (generic Amitiza)</i> ^{AL, QL} MOTEGRITY (prucalopride succinate) RELISTOR (methylnaltrexone) TABLET ^{QL} SYMPROIC (naldemedine) TRULANCE (plecanatide) ^{QL} VIBERZI (eluxodoline)	<ul style="list-style-type: none"> • Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> • Lotronex[®]: Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate • Relistor[®]: 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} INJECTION PROGLYCEM (diazoxide) SUSP	diazoxide SUSP (generic Proglycem) GLUCAGON EMERGENCY (glucagon) ^{QL} INJ KIT (Fresenius) GVOKE (glucagon) ^{AL, QL} KIT ^{NR} , PEN , SYRINGE, VIAL ^{NR} ZEGALOGUE (dasiglucagon) ^{AL, NR} AUTO-INJECTOR. SYRINGE	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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GLUCOCORTICIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCOCORTICIDS		<ul style="list-style-type: none"> 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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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.
ASMANEX (mometasone) ^{QL,AL} FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide)	AEROSPAN (flunisolide) ALVESCO (ciclesonide) ^{AL,CL} ARMONAIR DIGIHALER (fluticasone) ^{AL,QL} ARMONAIR RESPICLICK (fluticasone) ^{AL} ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) ^{CL,AL,QL} FLOVENT DISKUS (fluticasone) QVAR (beclomethasone) QVAR Redihaler (beclomethasone)	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol) ^{QL} ADVAIR HFA (fluticasone/salmeterol) ^{QL} DULERA (mometasone/formoterol) SYMBICORT (budesonide/ formoterol)	AIRDUO DIGIHALER (fluticasone/salmeterol) ^{AL,QL} BREO ELLIPTA (fluticasone/vilanterol) BREZTRI (budesonide/formoterol/glycopyrrolate) ^{QL} Budesonide/formoterol (generic for Symbicort) fluticasone/salmeterol (generic for Advair Diskus) ^{QL} fluticasone/salmeterol (generic for Airduo Respiclick) TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol) WIXELA INHUB (generic for Advair Diskus) ^{QL}	
INHALATION SOLUTION		
	budesonide RESPULES (generic for Pulmicort)	

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AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC CAPSULE (generic for Entocort EC) dexamethasone ELIXIR, SOLN dexamethasone TABLET hydrocortisone TABLET methylprednisolone tablet (generic for Medrol) prednisolone SOLUTION prednisolone sodium phosphate prednisone DOSE PAK prednisone TABLET	ALKINDI (hydrocortisone) GRANULES^{AL} CORTEF (hydrocortisone) cortisone TABLET dexamethasone INTENSOL DEXPAK (dexamethasone) DXEVO (dexamethasone) EMFLAZA (deflazacort) SUSPENSION, TABLET^{CL} ENTOCORT EC (budesonide) methylprednisolone 8mg, 16mg, 32mg ORTIKOS ER (budesonide)^{AL, QL} PEDIAPRED (prednisolone sodium phosphate) prednisolone sodium phosphate (generic for Millipred/Veripred) prednisolone sodium phosphate ODT prednisone SOLUTION prednisone INTENSOL RAYOS DR (prednisone) TABLET TARPEYO (budesonide)^{NR} CAPSULE TAVNEOS (avacopan)^{NR, QL} CAPSULE	<ul style="list-style-type: none"> 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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Emflaza: Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older Intensol Products: Patient specific documentation of why the less concentrated solution is not appropriate for the patient

GROWTH HORMONES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GENOTROPIN (somatropin) NORDITROPIN (somatropin)	HUMATROPE (somatropin) NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin-tcgd) ^{NR} ZOMACTON (somatropin) ZORBTIVE (somatropin)	Growth Hormone PA Form Growth Hormone Criteria

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

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}	<ul style="list-style-type: none"> 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} SUB-Q	<p style="text-align: center;">HAE Treatments PA Form</p> <ul style="list-style-type: none"> 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 <p>Drug-Specific Criteria</p> <ul style="list-style-type: none"> Cinryze, Haegarda, Orladeyo, and Takhzyro, require a history of two or more HAE attacks monthly, and trial and failure or contraindication to oral danazol

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

HEMOPHILIA TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FACTOR VIII		<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class ▪ <i>Patients receiving a hemophilia agent which moved from preferred to non-preferred status on 1-21-21 will be allowed to continue same therapy</i>
ALPHANATE HELIXATE FS HUMATE-P NOVOEIGHT NUWIQ XYNTHA KIT, SOLOFUSE	ADVATE ADYNOVATE AFSTYLA ELOCTATE ESPEROCT HEMOFIL-M JIVI ^{AL} KOATE-DVI KIT KOATE-DVI VIAL KOGENATE FS KOVALTRY 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	TRETEN	
VON WILLEBRAND PRODUCTS		
WILATE	VONVENDI	
BISPECIFIC FACTORS		
HEMLIBRA		

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

HEPATITIS B TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
entecavir TABLET	adefovir dipivoxil BARACLUDE (entecavir) SOLUTION, TABLET EPIVIR HBV (lamivudine) TABLET , SOLUTION HEPSERA (adefovir dipivoxil) lamivudine hbv TABLET VEMLIDY (tenofovir alafenamide fumarate)	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIRECT ACTING ANTI-VIRAL		Hepatitis C Treatments PA Form Hepatitis C Criteria <ul style="list-style-type: none"> ▪ 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 <p>Drug-specific criteria: Trial with with a preferred agent not required in the following:</p> <ul style="list-style-type: none"> ▪ Harvoni: <ul style="list-style-type: none"> ○ 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}	HARVONI 200/45MG, TABLET (sofosbuvir/ledipasvir) ^{CL}	
MAVYRET (glecaprevir/pibrentasvir) TABLET ^{CL} , PELLET ^{AL,CL,NR}	HARVONI (ledipasvir/sofosbuvir) ^{CL} PELLET	
VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) ^{CL}	sofosbuvir/ledipasvir (generic Harvoni) ^{CL} SOVALDI (sofosbuvir) ^{CL} PELLET SOVALDI TABLET (sofosbuvir) ^{CL} VIEKIRA PAK (ombitasvir/paritaprevir/ritonavir/dasabuvir) ^{CL} ZEPATIER (elbasvir/grazoprevir) ^{CL}	
RIBAVIRIN		
ribavirin 200mg CAPSULE, TABLET	REBETOL (ribavirin)	
INTERFERON		
PEGASYS (pegylated interferon alfa-2a) ^{CL}		
PEG-INTRON (pegylated interferon alfa-2b) ^{CL}		

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**Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria**

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

HISTAMINE II RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
famotidine TABLET (generic for Pepcid) nizatidine SOLUTION (generic for Axid)	cimetidine TABLET, SOLUTION ^{CL} (generic for Tagamet) famotidine SUSPENSION nizatidine CAP (generic for Axid) ranitidine CAPSULE , (generic for Zantac) ranitidine OTC, SYRUP, TABLET (generic for Zantac)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> Cimetidine: Approved for viral <i>M. contagiosum</i> or common wart <i>V. Vulgaris</i> treatment cimetidine solution/ famotidine suspension/ranitidine syrup: Requires clinical reason why nizatidine syrup cannot be used ***famotidine suspension is authorized during shortage of nizatidine syrup.***

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QL – Quantity/Duration Limit

AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

HIV / AIDS^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CCR5 ANTAGONISTS		<ul style="list-style-type: none"> ▪ 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 ▪ Diagnosis of HIV/AIDS required <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> ▪ Pre and Post Exposure Prophylaxis
SELZENTRY SOLN, TAB (maraviroc)	maraviroc (generic Selzentry)^{NR}	
FUSION INHIBITORS		
FUZEON SUB-Q (enfuvirtide) ^{QL}		
HIV-1 ATTACHMENT INHIBITOR		
	<i>RUKOBIA ER (fostemsavir)^{AL, QL}</i>	
INTEGRASE STRAND TRANSFER INHIBITORS (INSTIs)		
ISENTRESS (raltegravir) ^{QL} ISENTRESS HD (raltegravir) TIVICAY (dolutegravir)	TIVICAY <i>PD</i> (dolutegravir) VOCABRIA (cabotegravir) ^{NR}	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)		
efavirenz CAPSULE, TABLET (generic Sustiva) INTELENCE (etravirine) ^{QL} PIFELTRO (doravirine) ^{QL}	EDURANT (rilpivirine) ETRAVIRINE (new generic for Intelence) ^{NR, QL} nevirapine IR, ER (generic Viramune/Viramune XR) RESCRIPTOR (delavirdine) SUSTIVA CAPSULE, TABLET (efavirenz) VIRAMUNE (nevirapine) SUSP	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
abacavir SOLN, TABLET (generic Ziagen) EMTRIVA CAPSULE, SOLN (emtricitabine) lamivudine SOLN, TABLET (generic Epivir) zidovudine CAPSULE, SYRUP, TABLET (generic Retrovir)	didanosine DR (generic Videx EC) <i>emtricitabine CAPSULE (generic for Emtriva)</i> EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine CAPSULE (generic Zerit) VIDEX (didanosine) SOLN ZIAGEN (abacavir)	
NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
tenofovir TABLET (generic Viread)	VIREAD (tenofovir) POWDER	
PHARMACOKINETIC ENHANCER		
	TYBOST (cobicistat) ^{QL}	

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**Nebraska Medicaid
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PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

HIV / AIDS^{CL} (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROTEASE INHIBITORS		
atazanavir CAPSULE (generic Reyataz) LEXIVA SUSP (fosamprenavir) ritonavir TABLET (generic Norvir)	APTIVUS CAPSULE, SOLN (tipranavir) CRIXIVAN (indinavir) fosamprenavir TAB (generic Lexiva) INVIRASE (saquinavir) LEXIVA TABLET (fosamprenavir) NORVIR POWDER, SOLN (ritonavir) NORVIR (ritonavir) TAB PREZISTA (darunavir) SUSP, TABLET REYATAZ POWDER (atazanavir) VIRACEPT (nelfinavir)	<ul style="list-style-type: none"> ▪ 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 ▪ Diagnosis of HIV/AIDS required OR <ul style="list-style-type: none"> ▪ Pre and Post Exposure Prophylaxis

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

HIV / AIDS^{CL} (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PROTEASE INHIBITORS (PIs) or PIs plus PHARMACOKINETIC ENHANCER		
EVOTAZ (atazanavir/cobicistat) ^{QL} lopinavir/ritonavir SOLN (generic Kaletra)	KALETRA SOLN (lopinavir/ritonavir) KALETRA TAB (lopinavir/ritonavir) lopinavir/ritonavir TAB (generic Kaletra) ^{NR} PREZCOBIX (darunavir/cobicistat) ^{QL}	<ul style="list-style-type: none"> ▪ 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 ▪ Diagnosis of HIV/AIDS required <p>OR</p> <ul style="list-style-type: none"> ▪ Pre and Post Exposure Prophylaxis
COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir/lamivudine (generic Epzicom) CIMDUO (lamivudine/tenofovir) ^{QL} DESCOVY (emtricitabine/tenofovir) ^{QL, CL} lamivudine/zidovudine (generic Combivir) TRUVADA (emtricitabine/tenofovir)	abacavir/lamivudine/zidovudine (generic Trizivir) COMBIVIR (lamivudine/zidovudine) <i>emtricitabine/tenofovir (generic Truvada)^{CL}</i> EPZICOM (abacavir sulfate/lamivudine) TEMIXYS (lamivudine/tenofovir) ^{QL} TRIZIVIR (abacavir/lamivudine/zidovudine)	<p>Drug-Specific Criteria</p> <p>Descovy:</p> <ul style="list-style-type: none"> • <i>Approval will be granted for a diagnosis of HIV/AIDS</i> <p><i>For PrEP use: Will require prior approval with a documentation of a contraindication to Truvada.</i></p>

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

HIV / AIDS^{CL} (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PRODUCTS – MULTIPLE CLASSES		
ATRIPLA (tenofovir/emtricitabine/efavirenz) BIKTARVY (bictegravir/emtricitabine/tenofovir) ^{QL} COMPLERA (rilpivirine/emtricitabine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir) ^{QL} GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) ^{QL, AL} ODEFSEY (emtricitabine/rilpivirine/tenofovir) ^{QL} STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) ^{QL} SYMFI (efavirenz/lamivudine/tenofovir) ^{QL} SYMFI LO (efavirenz/lamivudine/tenofovir) ^{QL} TRIUMEQ (dolutegravir/abacavir/lamivudine)	DOVATO (dolutegravir/lamivudine) ^{QL} <i>efavirenz/emtricitabine/tenofovir (generic Atripla)</i> ^{CL} <i>efavirenz/lamivudine/tenofovir (generic for Symfi)</i> ^{QL} <i>efavirenz/lamivudine/tenofovir (generic for Symfi Lo)</i> ^{QL} JULUCA (dolutegravir/rilpivirine) ^{QL} SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir) ^{QL}	<ul style="list-style-type: none"> ▪ 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 ▪ Diagnosis of HIV/AIDS required OR <ul style="list-style-type: none"> ▪ Pre and Post Exposure Prophylaxis

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**Nebraska Medicaid
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HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acarbose (generic for Precose)	miglitol (generic for Glyset) GLYSET (miglitol)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST (GLP-1 RA)^{CL}		<p>Preferred agents require metformin trial and diagnosis of diabetes</p> <p>Non-preferred agents will be approved for patients who have:</p> <ul style="list-style-type: none"> ▪ Failed a trial of TWO preferred agents within GLP-1 RA <p>AND</p> <ul style="list-style-type: none"> ▪ Diagnosis of diabetes with HbA1C ≥ 7 AND ▪ Trial of metformin, or contraindication or intolerance to metformin
BYDUREON (exenatide ER) BYDUREON PEN (exenatide ER) subcutaneous BYETTA (exenatide) subcutaneous TRULICITY (dulaglutide) VICTOZA (liraglutide) subcutaneous	ADLYXIN (lixisenatide) BYDUREON BCISE PEN (exenatide) ^{QL} OZEMPIC (semaglutide) RYBELSUS (semaglutide) TANZEUM (albiglutide)	
INSULIN/GLP-1 RA COMBINATIONS		<p>ALL criteria must be met</p> <ul style="list-style-type: none"> ▪ Concurrent use of short-acting mealtime insulin ▪ Current therapy compliance ▪ No diagnosis of gastroparesis ▪ HbA1C ≤ 9% within last 90 days ▪ Fingerstick monitoring of glucose during <u>initiation</u> of therapy
	SOLIQUA (insulin glargine/lixisenatide) XULTOPHY (insulin degludec/liraglutide)	
AMYLIN ANALOG		<p>ALL criteria must be met</p> <ul style="list-style-type: none"> ▪ Concurrent use of short-acting mealtime insulin ▪ Current therapy compliance ▪ No diagnosis of gastroparesis ▪ HbA1C ≤ 9% within last 90 days ▪ Fingerstick monitoring of glucose during <u>initiation</u> of therapy
	SYMLIN (pramlintide) subcutaneous	
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR^{QL}		<p>Non-preferred DPP-4s will be approved for patients who have failed a trial of ONE preferred agent within DPP-4</p>
GLYXAMBI (empagliflozin/linagliptin) JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin (generic for Nesina) alogliptin/metformin (generic for Kazano) JENTADUETO XR (linagliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) ONGLYZA (saxagliptin) alogliptin/pioglitazone (generic for Oseni) QTERN (dapagliflozin/saxagliptin) STEGLUJAN (ertugliflozin/sitagliptin) TRIJARDY XR (empagliflozin/linagliptin/metformin) ^{AL}	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>HUMALOG (insulin lispro) U-100 CARTRIDGE, PEN, VIAL</p> <p>HUMALOG JR. (insulin lispro) U-100 KWIKPEN</p> <p>HUMALOG MIX VIAL (insulin lispro/lispro protamine)</p> <p>HUMALOG MIX KWIKPEN (insulin lispro/lispro protamine)</p> <p>HUMULIN (insulin) VIAL</p> <p>HUMULIN 70/30 VIAL</p> <p>HUMULIN U-500 VIAL</p> <p>HUMULIN R U-500 KWIKPEN^{CL}</p> <p>HUMULIN OTC PEN</p> <p>HUMULIN 70/30 OTC PEN</p> <p>insulin aspart (generic for Novolog)</p> <p>insulin aspart/insulin aspart protamine PEN, VIAL(generic for Novolog Mix)</p> <p>insulin lispro (generic for Humalog) PEN, VIAL, JR KWIKPEN</p> <p>insulin lispro/lispro protamine KWIKPEN (Humalog Mix Kwikpen)</p> <p>LANTUS SOLOSTAR PEN (insulin glargine)</p> <p>LANTUS (insulin glargine) VIAL</p> <p>LEVEMIR (insulin detemir) PEN, VIAL</p> <p>NOVOLOG (insulin aspart) CARTRIDGE, FLEXPEN, VIAL</p> <p>NOVOLOG MIX FLEXPEN, VIAL (insulin aspart/aspart protamine)</p>	<p>ADMELOG (insulin lispro) PEN, VIAL</p> <p>AFREZZA (regular insulin) INHALATION</p> <p>APIDRA (insulin glulisine)</p> <p>BASAGLAR (insulin glargine, rec) PEN</p> <p>FIASP (insulin aspart) CARTRIDGE, PEN, VIAL</p> <p>HUMALOG (insulin lispro) U-200 KWIKPEN</p> <p>insulin Glargine-YFGN PEN, VIAL (generic for Semglee-YFGN)^{NR}</p> <p>LYUMJEV KWIKPEN, VIAL(insulin lispro-aabc)</p> <p>NOVOLIN (insulin)</p> <p>NOVOLIN 70/30 VIAL(insulin)</p> <p>TOUJEO SOLOSTAR (insulin glargine)</p> <p>SEMGLEE (insulin glargine) PEN, VIAL</p> <p>SEMGLEE YFGN (insulin glargine) PEN, VIAL^{NR}</p> <p>TRESIBA (insulin degludec)</p>	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Afrezza[®]: Approved for T1DM on long-acting insulin with no current history of smoking or chronic lung disease Humulin[®] R U-500 Kwikpen: Approved for physical reasons – such as dexterity problems and vision impairment <ul style="list-style-type: none"> Usage must be for self-administration, not only convenience Patient requires >200 units/day Safety reason patient can't use vial/syringe

HYPOGLYCEMICS, MEGLITINIDES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>repaglinide (generic for Prandin)</p>	<p>nateglinide (generic for Starlix)^{CL}</p> <p>repaglinide/metformin (generic for Prandimet)^{CL}</p>	<ul style="list-style-type: none"> 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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metformin IR & ER (generic Glucophage/Glucophage XR)	metformin ER (generic Fortamet/Glumetza) metformin SOLUTION (generic Riomet) RIOMET ER (metformin ER) ^{AL}	<ul style="list-style-type: none"> • 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

HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin) ^{QL,CL} INVOKAMET (canagliflozin/metformin) ^{QL, CL} INVOKANA (canagliflozin) ^{CL} JARDIANCE (empagliflozin) ^{QL, CL} SYNJARDY (empagliflozin/metformin) ^{AL,CL,QL} XIGDUO XR (dapagliflozin/metformin) ^{QL,CL}	INVOKAMET XR (canagliflozin/metformin) ^{QL} SEGLUROMET (ertugliflozin/metformin) ^{QL} STEGLATRO (ertugliflozin) ^{QL} SYNJARDY XR (empagliflozin/ metformin) ^{AL,QL}	<ul style="list-style-type: none"> • Preferred agents are Approved for diagnosis of diabetes AND a trial of metformin • Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class <p>Drug Specific Criteria:</p> <p>Farxiga and Jardiance:</p> <ul style="list-style-type: none"> - Approved for a diagnosis of heart failure with reduced ejection fraction (NYHA class II-IV)

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	<ul style="list-style-type: none"> • 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)		

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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

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

HYPOGLYCEMICS, TZD

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
THIAZOLIDINEDIONES (TZDs)		<ul style="list-style-type: none"> ▪ 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)	AVANDIA (rosiglitazone)	
TZD COMBINATIONS		<ul style="list-style-type: none"> ▪ Combination products: Require clinical reason why individual ingredients cannot be used
	pioglitazone/glimepiride (generic for Duetact) pioglitazone/metformin (generic for Actoplus Met)	

IDIOPATHIC PULMONARY FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
OFEV (nintedanib esylate) ^{CL}	ESBRIET (pirfenidone)	<ul style="list-style-type: none"> • Non-preferred agent requires trial of preferred agent within this drug class • FDA approved indication required – ICD-10 diagnosis code

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PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

IMMUNOMODULATORS, ASTHMA^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p><i>FASENRA (benralizumab)^{AL} PEN</i> <i>XOLAIR (omalizumab) SYR^{AL,QL}</i></p>	<p><i>NUCALA (mepolizumab)^{AL}</i> AUTO-INJ, SYR,</p>	<p>Asthma Immunomodulator PA Form</p> <ul style="list-style-type: none"> Non-preferred agents require a trial of a preferred agent within this drug class with the same indication <p>Drug Specific Criteria:</p> <p>Dupixent: is indicated for</p> <ul style="list-style-type: none"> Patients 6 years and older as an add-on maintenance treatment in patients with moderate-to-severe asthma with an eosinophilic phenotype or with oral corticosteroid dependent asthma For other indications, see Immunomodulators, Atopic Dermatitis <p>Fasenra: is indicated for</p> <ul style="list-style-type: none"> Patient 12 years and older for add on maintenance treatment of severe asthma, and with an eosinophilic phenotype <p>Nucala: is indicated for</p> <ul style="list-style-type: none"> Patients 6 years and older for add on maintenance treatment of severe asthma, and with an eosinophilic phenotype Patients 12 years and older with hypereosinophilic syndrome (HES) for ≥ 6 months without identifiable non-hematologic secondary cause Patients 18 years and older for add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRWSwNP) with inadequate response to nasal corticosteroids. Adult patients with eosinophilic granulomatosis with polyangiitis <p>Xolair Syringe- is indicated for</p> <ul style="list-style-type: none"> Patients 6 years and older for moderate to severe persistent asthma with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids Patients 12 years and older with Chronic spontaneous urticaria (CSU) who remain symptomatic despite H1 antihistamine treatment Patients 18 years and older with Nasal Polyps with inadequate response to nasal corticosteroids. As add-on maintenance treatment

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^{CL} – Prior Authorization / Class Criteria apply

^{QL} – Quantity/Duration Limit

^{AL} – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

IMMUNOMODULATORS, ATOPIC DERMATITIS^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIDEL (pimecrolimus) EUKRISA (crisaborole) ^{CL,QL}	ADBRY (tralokinumab-ldrm) SUB-Q ^{AL,NR,QL} DUPIXENT (dupilumab) ^{AL,CL} DUPIXENT PEN ^{AL} Opzelura (ruxolitinib phosphate) CREAM ^{AL,NR,QL} pimecrolimus (generic for Elidel) tacrolimus (generic for Protopic) ^{CL}	<ul style="list-style-type: none"> ▪ Non-preferred agents require: Trial of a topical steroid AND Trial of one preferred product within this drug class Drug-specific criteria: Dupixent: Indicated for the treatment of patients aged 6 years and older with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. DUPIXENT can be used with or without topical corticosteroids. -as an add-on maintenance treatment of patients aged 6 years and older with moderate-to-severe asthma characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma. - as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) <ul style="list-style-type: none"> • Eucrisa: Requires use and failure of 1 topical steroid or Elidel.

IMMUNOMODULATORS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
imiquimod (generic for Aldara)	ALDARA (imiquimod) imiquimod (generic for Zyclara) podofilox (generic for Condyllox) VEREGEN (sinecatechins) ZYCLARA (imiquimod)	<ul style="list-style-type: none"> • Non-preferred agents require clinical reason why preferred agent within this drug class cannot be used

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^{QL} – Quantity/Duration Limit

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**Nebraska Medicaid
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IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathioprine (generic Imuran) cyclosporine, modified CAPSULE (generic Neoral) mycophenolate CAPSULE, TABLET (generic Cellcept) RAPAMUNE (sirolimus) SOLUTION RAPAMUNE (sirolimus) TABLET tacrolimus ZORTRESS (everolimus) ^{AL}	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) azathioprine (generic Azasan, Imuran 75 mg and 100 mg) ^{NR} cyclosporine CAPSULE, SOFTGEL cyclosporine, modified SOLUTION (generic Neoral) ENVARUSUS XR (tacrolimus) GENGRAF (cyclosporine, modified) CAPSULE, SOLUTION mycophenolate SUSPENSION (generic Cellcept) mycophenolic acid MYFORTIC (mycophenolate sodium) PROGRAF (tacrolimus) CAPSULE, PACKET SANDIMMUNE (cyclosporine) CAPSULE, SOLUTION sirolimus SOLUTION, TABLET (generic Rapamune) everolimus (generic for Zortress) ^{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

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**Nebraska Medicaid
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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
ipratropium (generic for Atrovent)		
ANTIHISTAMINES		Drug-specific criteria: <ul style="list-style-type: none"> ▪ mometasone: Prior authorization NOT required for children ≤ 12 years ▪ budesonide: Approved for use in Pregnancy (Pregnancy Category B) ▪ Veramyst®: Prior authorization NOT required for children ≤ 12 years ▪ Xhance: Indicated for treatment of nasal polyps in ≥ 18 years only
azelastine 0.1% (generic for Astelin)	azelastine 0.15% (generic for Astepro) <i>azelastine/fluticasone (generic for Dymista)</i> olopatadine (generic for Patanase)	
CORTICOSTEROIDS		
fluticasone (generic for Flonase)	BECONASE AQ (beclomethasone) budesonide Rx (generic for Rhinocort) flunisolide (generic for Nasalide) mometasone (generic for Nasonex) OMNARIS (ciclesonide) QNASL 40 & 80 (beclomethasone) TICANASE (fluticasone) VERAMYST (fluticasone) XHANCE (fluticasone) ZETONNA (ciclesonide)	

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**Nebraska Medicaid
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LEUKOTRIENE MODIFIERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
montelukast TABLET/CHEWABLE (generic for Singulair) ^{AL}	montelukast GRANULES (generic for Singulair) ^{CL, AL} zafirlukast (generic for Accolate) zileuton ER (generic for Zyflo CR) ZYFLO (zileuton)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 30-day trial of THE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> montelukast granules: PA not required for age < 2 years

LINCOSAMIDES / OXAZOLIDINONES / STREPTOGRAMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clindamycin CAPSULE clindamycin palmitate SOLUTION linezolid TABLET	CLEOCIN (clindamycin) CAPSULE CLEOCIN PALMITATE (clindamycin) linezolid SUSPENSION SIVEXTRO (tedizolid phosphate) ZYVOX (linezolid) SUSPENSION, TABLET	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> ▪ Colesevelam: Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate ▪ Juxtapid®/ Kynamro®: <ul style="list-style-type: none"> ○ 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 ▪ Vascepa®: Approved for TG ≥ 500
cholestyramine (generic Questran) colestipol TABLETS (generic Colestid)	colesevelam (generic Welchol) TABLET, 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 Fibracor/Trilipix) fenofibrate (generic Antara/Fenoglide/ Lipofen/Triglide)	
NIACIN		
niacin ER (generic for Niaspan)	NIACOR (niacin IR) NIASPAN (niacin ER)	
OMEGA-3 FATTY ACIDS		
omega-3 fatty acids (generic for Lovaza)	icosapent (generic for Vascepa) ^{CL} omega-3 OTC VASCEPA (icosapent) ^{CL}	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe (generic for Zetia)	<i>NEXLIZET (bempedoic acid/ ezetimibe)</i> ^{QL}	

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LIPOTROPICS, OTHER (continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		
	PRALUENT (alorocumab) ^{CL} REPATHA (evolocumab) ^{CL}	<ul style="list-style-type: none"> ▪ Praluent®: Approved for diagnoses of: <ul style="list-style-type: none"> • atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) • Homozygous familial hypercholesterolemia (HoFH) as an adjunct to other LDL-C lowering therapies • AND <ul style="list-style-type: none"> • Maximized high-intensity statin WITH ezetimibe for at 3 continuous months • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL ▪ Repatha®: Approved for: <ul style="list-style-type: none"> • adult diagnoses of atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) • homozygous familial hypercholesterolemia (HoFH) in age ≥ 13 • statin-induced rhabdomyolysis AND <ul style="list-style-type: none"> • 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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
STATINS		<ul style="list-style-type: none"> ▪ 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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ 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} EZALLOR SPRINKLE (rosuvastatin) ^{QL} fluvastatin IR/ER (generic Lescol/ Lescol XL) LIVALO (pitavastatin) 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		<ul style="list-style-type: none"> • 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 TABLET, SUSPENSION (generic Biaxin) erythromycin ethylsuccinate SUSPENSION	clarithromycin ER (generic Biaxin XL) E.E.S. SUSPENSION (erythromycin ethylsuccinate) E.E.S. TABLET (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYPED SUSPENSION (erythromycin) ERYTHROCIN (erythromycin) erythromycin base TABLET, CAPSULE	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

METHOTREXATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
methotrexate PF VIAL, TABLET, VIAL	OTREXUP (methotrexate) SUB-Q RASUVO (methotrexate) SUB-Q REDITREX (methotrexate) SUB-Q ^{AL} TREXALL (methotrexate) TABLET XATMEP (methotrexate) SOLUTION	<ul style="list-style-type: none"> Non-preferred agents will be approved for FDA-approved indications <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Xatmep™: Indicated for pediatric patients only

MOVEMENT DISORDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUSTEDO (deutetrabenazine) ^{CL} INGREZZA (valbenazine) ^{AL,CL,QL} CAP tetrabenazine (generic for Xenazine) ^{CL}	INGREZZA (valbenazine) ^{CL} INITIATION PACK XENAZINE (tetrabenazine) ^{CL}	Non-preferred agent requires trial of Austedo All drugs require an FDA approved indication – ICD-10 diagnosis code required. Drug-specific criteria: <ul style="list-style-type: none"> Austedo: 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 Ingrezza: Diagnosis of Tardive Dyskinesia in adults tetrabenazine: Diagnosis of chorea with Huntington's Disease

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

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} KESIMPTA (<i>Ofatumumab</i>) ^{CL, QL} TECFIDERA (dimethyl fumarate)	AUBAGIO (teriflunomide) BAFIERTAM (<i>monomethyl fumarate</i>) ^{QL} dalfampridine (generic Ampyra) ^{QL} dimethyl fumarate (generic for Tecfidera) EXTAVIA (interferon beta-1b) ^{QL} GILENYA (fingolimod) ^{QL} glatiramer (generic Copaxone) ^{QL} MAVENCLAD (cladribine) MAYZENT (siponimod) ^{QL} PLEGRIDY (peginterferon beta-1a) ^{QL} PONVORY (ponesimod) ^{NR} REBIF (interferon beta-1a) ^{QL} VUMERITY (diroximel) ^{QL} ZEPOSIA (<i>ozanimod</i>) ^{AL, QL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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

NITROFURAN DERIVATIVES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
nitrofurantoin macrocrystals CAPSULE (generic for Macrochantin) nitrofurantoin monohydrate-macrocrystals CAPSULE (generic for Macrobid)	nitrofurantoin SUSPENSION (generic for Furadantin)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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NSAIDs, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE		<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ▪ Arthrotec®: Requires clinical reason why individual ingredients cannot be used ▪ Duexis®/Vimovo®: Requires clinical reason why individual agents cannot be used ▪ meclofenamate: Approvable without trial of preferred agents for menorrhagia
diclofenac sodium (generic for Voltaren)	diclofenac potassium (generic for Cataflam, Zipsor)	
ibuprofen OTC, Rx (generic for Advil, Motrin) CHEW, DROPS, SUSPENSION, TABLET	diclofenac SR (generic for Voltaren-XR) diflunisal (generic for Dolobid)	
indomethacin CAPSULE (generic for Indocin)	etodolac & SR (generic for Lodine/XL)	
ketorolac (generic for Toradol)	fenoprofen (generic for Nalfon)	
meloxicam TABLET (generic for Mobic)	flurbiprofen (generic for Ansaid)	
nabumetone (generic for Relafen)	ibuprofen OTC (generic for Advil, Motrin) CAPSULE	
naproxen Rx, OTC (generic for Naprosyn)	indomethacin ER (generic for Indocin) INDOCIN RECTAL, SUSPENSION	
naproxen enteric coated	ketoprofen & ER (generic for Orudis)	
sulindac (generic for Clinoril)	meclofenamate (generic for Meclomen)	
	mefenamic acid (generic for Ponstel)	
	meloxicam CAP (generic Vivlodex) ^{CL, QL}	
	naproxen CR (generic for Naprelan)	
	naproxen SUSPENSION (generic for Naprosyn)	
	naproxen sodium (generic for Anaprox)	
	<i>naproxen-esomeprazole (generic for Vimovo)</i>	
	oxaprozin (generic for Daypro)	
	piroxicam (generic for Feldene)	
	RELAFEN DS (nabumetone)	
	tolmetin (generic for Tolectin)	
	Ketorolac Nasal ^{QL} (generic for Sprix)	

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^{QL} – Quantity/Duration Limit

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NSAIDs, ORAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE (continued)		
	ALL BRAND NAME NSAIDs including: CAMBIA (diclofenac oral solution) DUEXIS (ibuprofen/famotidine) ^{CL} ibuprofen/famotidine (generic Duexis) ^{CL} SPRIX (ketorolac nasal spray) NASAL ^{QL, CL} TIVORBEX (indomethacin) VIVLODEX (meloxicam submicronized) ZIPSOR (diclofenac) ZORVOLEX (diclofenac)	Drug-specific criteria: <ul style="list-style-type: none"> ▪ Sprix[®]: Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs ▪ Tivorbex[®]: Requires clinical reason why indomethacin capsules cannot be used ▪ Zorvolex[®]: Requires trial of oral diclofenac OR clinical reason why diclofenac potassium/sodium cannot be used
NSAID/GI PROTECTANT COMBINATIONS		
	diclofenac/misoprostol (generic for Arthrotec)	
COX-II SELECTIVE		
celecoxib (generic for Celebrex)		

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NSAIDs, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
diclofenac sodium GEL (OTC only)	diclofenac (generic for Pennsaid Solution) ^{CL} FLECTOR PATCH (diclofenac) ^{CL} LICART PATCH (diclofenac) ^{CL} PENNSAID PACKET, PUMP (diclofenac) ^{CL} VOLTAREN GEL (diclofenac) ^{CL}	Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class Drug Specific Criteria <ul style="list-style-type: none"> • Flector®/Licart: Approved for diagnosis of acute pain due to sprain/strain/contusion AND trial of oral diclofenac OR clinical reason patient cannot use oral dosage form • Pennsaid®: Approved for osteoarthritis of the knees AND trial of oral diclofenac OR clinical reason patient cannot use oral dosage form • Pennsaid® Pump: Requires clinical reason why 1.5% solution cannot be used • Voltaren®: Approved for diagnosis of osteoarthritis AND trial of oral diclofenac OR clinical reason patient cannot use oral dosage form

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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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		<ul style="list-style-type: none"> • 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
IBRANCE (palbociclib)	KISQALI (ribociclib) KISQALI FEMARA CO-PACK VERZENIO (abemaciclib)	
CHEMOTHERAPY		
cyclophosphamide XELODA (capecitabine)	capecitabine (generic for Xeloda) ^{CL}	
HORMONE BLOCKADE		<p>Drug-specific criteria</p> <ul style="list-style-type: none"> ▪ anastrozole: May be approved for malignant neoplasm of male breast (male breast cancer) ▪ capecitabine: Requires trial of Xeloda or clinical reason Xeloda cannot be used ▪ Fareston®: 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
anastrozole (generic for Arimidex) exemestane (generic for Aromasin) letrozole (generic for Femara) tamoxifen citrate (generic for Nolvadex)	SOLTAMOX SOLN (tamoxifen) ^{CL} toremifene (generic for Fareston) ^{CL}	
OTHER		
	NERLYNX (neratinib) PIQRAY (alpelisib) lapatinib (generic Tykerb) ^{CL} TALZENNA (talazoparib tosylate) ^{QL} TUKYSA(tucatinib) ^{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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

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ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALL		<ul style="list-style-type: none"> ▪ 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 Drug-specific criteria <ul style="list-style-type: none"> ▪ Hydrea®: Requires clinical reason why generic cannot be used ▪ Melphalan: Requires trial of Alkeran or clinical reason Alkeran cannot be used ▪ Purixan: Prior authorization not required for age ≤12 or for documented swallowing disorder ▪ Tabloid: Prior authorization not required for age <19 ▪ Tasigna: Patients receiving Tasigna, which changed from preferred to non-preferred on 1-17-19 will be allowed to continue therapy ▪ Xpovio: Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone
mercaptopurine	PURIXAN (mercaptopurine) ^{AL}	
AML		
	DAURISMO (glasdegib maleate) ^{QL} IDHIFA (enasidenib) RYDAPT (midostaurin) TIBSOVO (ivosidenib) ^{QL} XOSPATA (gilteritinib) ^{QL}	
CLL		
IMBRUVICA (ibrutinib) LEUKERAN (chlorambucil) VENCLEXTA (venetoclax)	COPIKTRA (duvelisib) ^{QL} ZYDELIG (idelalisib)	
CML		
hydroxyurea (generic for Hydrea) imatinib (generic for Gleevec) MYLERAN (busulfan) SPRYCEL (dasatinib)	BOSULIF (bosutinib) GLEEVEC (imatinib) HYDREA (hydroxyurea) ICLUSIG (ponatinib) SCEMBLIX (asciminib) ^{NR} TASIGNA (nilotinib) ^{CL}	
MPN		
JAKAFI (ruxolitinib)		
MYELOMA		
ALKERAN (melphalan) REVLIMID (lenalidomide)	FARYDAK (panobinostat) melphalan (generic for Alkeran) NINLARO (ixazomib) POMALYST (pomalidomide) THALOMID (thalidomide) XPOVIO (selinexor) ^{CL}	
OTHER		
MATULANE (procarbazine) TABLOID (thioguanine) tretinoin (generic for Vesanoïd)	BRUKINSA (zanubrutinib) ^{QL} CALQUENCE (acalabrutinib) ^{QL} INREBIC (fedratinib dihydrochloride) ^{QL} INQOVI (decitabine/cedazuridine) UKONIQ (umbralisib) ^{NR} ZOLINZA (vorinostat)	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ONCOLOGY AGENTS, ORAL, LUNG

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALK		
ALECENSA (alectinib)	ALUNBRIG (brigatinib) ^{QL} LORBRENA (lorlatinib) ^{QL} ZYKADIA (ceritinib) CAPSULE, TABLET	<ul style="list-style-type: none"> ▪ 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 Drug-Specific Criteria <ul style="list-style-type: none"> ▪ Iressa/ Xalkori: Patients receiving Iressa or Xalkori prior to 1/21/21 (which changed from preferred to non-preferred) will be allowed to continue current treatment
ALK / ROS1 / NTRK		
	ROZLYTREK (entrectinib) ^{AL,QL} XALKORI (crizotinib)	
EGFR		
TAGRISSO (osimertinib)	erlotinib (generic for Tarceva) EXKIVITY (mobocertinib) ^{NR,QL} GILOTRIF (afatinib) IRESSA (gefitinib) TARCEVA (erlotinib) VIZIMPRO (dacomitinib) ^{QL}	
OTHER		
	GAVRETO (<i>pralsetinib</i>) ^{QL} HYCAMTIN (topotecan) LUMAKRAS (<i>sotrasib</i>) ^{QL} RETEVMO (<i>selpercatinib</i>) ^{AL} TABRECTA (<i>capmatinib</i>) ^{QL} TEPMETKO (<i>tepotinib</i>) ^{QL}	

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QL – Quantity/Duration Limit

AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ONCOLOGY AGENTS, ORAL, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CAPRELSA (vandetanib) GLEOSTINE (lomustine) LYNPARZA (olaparib) temozolomide (generic for Temodar) ZEJULA (niraparib)	AYVAKIT (avapritinib) ^{AL,NR,QL} BALVERSA (erdafitinib) COMETRIQ (cabozantinib) HEXALEN (altretamine) KOSELUGO (selumetinib) ^{AL} LONSURF (trifluridine/tipiracil) PEMAZYRE (pemigatinib) ^{QL} RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat) ^{AL} TURALIO (pexidartinib) ^{QL} TRUSELTIQ (infigratinib) CAPSULE VITRAKVI (larotrectinib) CAPSULE, SOLUTION ^{QL}	<ul style="list-style-type: none"> 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

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QL – Quantity/Duration Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ONCOLOGY AGENTS, ORAL, PROSTATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
abiraterone (generic for Zytiga) ^{AL,QL} bicalutamide (generic for Casodex) flutamide XTANDI (enzalutamide) ^{AL,QL} ZYTIGA (abiraterone) ^{AL,QL}	EMCYT (estramustine) ERLEADA (apalutamide) ^{QL} nilutamide (generic for Nilandron) NUBEQA (darolutamide) ^{QL} YONSA (abiraterone acetone, submicronized)	<ul style="list-style-type: none"> 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

ONCOLOGY AGENTS, ORAL, RENAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INLYTA (axitinib) LENVIMA (lenvatinib) SUTENT (sunitinib) VOTRIENT (pazopanib)	AFINITOR DISPERZ (everolimus) ^{CL} CABOMETYX (cabozantinib) everolimus (generic for Afinitor) everolimus SUSP (generic for Afinitor Disperz) ^{NR} FOTIVDA (tivozanib) ^{NR} NEXAVAR (sorafenib) sunitinib malate (generic for Sutent) WELIREG (belzutifan) ^{NR,QL}	<ul style="list-style-type: none"> 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 <p>Drug-specific criteria</p> <ul style="list-style-type: none"> Afinitor: Patients receiving Afinitor, which changed from preferred to non-preferred on 1-17-19 will be allowed to continue therapy

ONCOLOGY AGENTS, ORAL, SKIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BASAL CELL		<ul style="list-style-type: none"> 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
ERIVEDGE (vismodegib)	ODOMZO (sonidegib) ^{CL}	
BRAF MUTATION		<p>Drug-specific criteria</p> <ul style="list-style-type: none"> Odomzo: Patients receiving Odomzo, which changed from preferred to non-preferred on 1-17-19 will be allowed to continue therapy
MEKINIST (trametinib) TAFINLAR (dabrafenib)	BRAFTOVI (encorafenib) COTELLIC (cobimetinib) MEKTOVI (binimetinib) ZELBORAF (vemurafenib)	

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^{AL} – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALREX (loteprednol 0.2%) cromolyn (generic for Opticrom) ketotifen OTC (generic for Zaditor) olopatadine 0.1% (generic for Patanol) olopatadine 0.2% (generic for Pataday once daily, Pataday twice daily)	ALOCRIL (nedocromil) ALOMIDE (Iodoxamide) azelastine (generic for Optivar) BEPREVE (bepotastine besilate) bepotastine besilate (generic for Bepreve) EMADINE (emedastine) epinastine (generic for Elestat) LASTACAFT (alcaftadine) PATADAY XS (olopatadine 0.7%) PATADAY OTC (olopatadine 0.2%) PAZEO (olopatadine 0.7%) ZERVIAE (certirizine) ^{AL}	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

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AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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OPHTHALMICS, ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FLUOROQUINOLONES		<ul style="list-style-type: none"> ▪ 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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Natacyn®: Approved for documented fungal infection
ciprofloxacin SOLUTION (generic for Ciloxan) ofloxacin (generic for Ocuflax)	BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) gatifloxacin 0.5% (generic for Zymaxid) levofloxacin MOXEZA (moxifloxacin) moxifloxacin (generic for Vigamox) moxifloxacin (generic for Moxeza) VIGAMOX (moxifloxacin)	
MACROLIDES		
erythromycin	AZASITE (azithromycin) ^{CL}	
AMINOGLYCOSIDES		
gentamicin OINTMENT gentamicin SOLUTION tobramycin (generic for Tobrex drops)	TOBREX OINTMENT (tobramycin)	
OTHER OPHTHALMIC AGENTS		
bacitracin/polymyxin B (generic Polysporin) polymyxin B/trimethoprim (generic for Polytrim)	bacitracin NATACYN (natamycin) ^{CL} neomycin/bacitracin/polymyxin B OINTMENT neomycin/polymyxin B/gramicidin NEOSPORIN (neomycin/polymyxin B/gramicidin) sulfacetamide SOLUTION (generic for Bleph-10) sulfacetamide OINTMENT	

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^{QL} – Quantity/Duration Limit

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**Nebraska Medicaid
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with Prior Authorization Criteria**

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OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
neomycin/polymyxin/dexamethasone (generic for Maxitrol) sulfacetamide/prednisolone TOBRADEX SUSPENSION, OINTMENT (tobramycin and dexamethasone)	BLEPHAMIDE (prednisolone and sulfacetamide) BLEPHAMIDE S.O.P. neomycin/polymyxin/HC neomycin/bacitracin/poly/HC PRED-G SUSPENSION, OINTMENT (prednisolone/gentamicin) tobramycin/dexamethasone SUSPENSION (generic for Tobradex) TOBRADEX S.T. (tobramycin and dexamethasone) ZYLET (loteprednol, tobramycin)	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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OPHTHALMICS, ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CORTICOSTEROIDS		<ul style="list-style-type: none"> ▪ 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
fluorometholone 0.1% (generic for FML) OINTMENT LOTEMAX SOLUTION (loteprednol 0.5%) MAXIDEX (dexamethasone) PRED MILD (prednisolone 0.12%)	dexamethasone (generic for Maxidex) difluprednate (generic Durezol) ^{NR} DUREZOL (difluprednate) FLAREX (fluorometholone) FML (fluorometholone 0.1% SOLUT.) FML FORTE (fluorometholone 0.25%) FML S.O.P. (fluorometholone 0.1%) INVELTYS (loteprednol etabonate) LOTEMAX OINTMENT, GEL (loteprednol) <i>loteprednol GEL (generic for Lotemax Gel)</i> loteprednol 0.5% SOLUTION (generic for Lotemax SOLUTION) prednisolone acetate 1% (gen. for Omnipred, Pred Forte) prednisolone sodium phosphate prednisolone sodium phosphate 1%	
NSAID		
diclofenac (generic for Voltaren) ketorolac 0.5% (generic for Acular)	ACUVAIL (ketorolac 0.45%) BROMSITE (bromfenac) bromfenac 0.09% (generic for Bromday) flurbiprofen (generic for Ocufer) ILEVRO (nepafenac 0.3%) ketorolac LS 0.4% (generic for 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)	<i>CEQUA (cyclosporine)^{QL}</i> cyclosporine (generic Restasis)^{NR} EYSUVIS (loteprednol etabonate) ^{QL} TYRVAYA (varenicline tartrate) ^{NR, QL}	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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OPHTHALMICS, GLAUCOMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MIOTICS		<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide) VUIITY (pilocarpine) ^{NR}	
SYMPATHOMIMETICS		
Alphagan P (brimonidine 0.15%) brimonidine 0.2% (generic for Alphagan)	Alphagan P (brimonidine 0.1%) apraclonidine (generic for Iopidine) brimonidine P 0.15%	
BETA BLOCKERS		
levobunolol (generic for Betagan) timolol (generic for Timoptic)	betaxolol (generic for Betoptic) BETIMOL (timolol) BETOPTIC S (betaxolol) carteolol (generic for Ocupress) timolol (generic for Istalol) <i>timolol (generic for Timoptic Ocudose)</i> TIMOPTIC OCUDOSE TIMOPTIC XE (timolol gel forming solution)	
CARBONIC ANHYDRASE INHIBITORS		
dorzolamide (generic for Trusopt)	AZOPT (brinzolamide) <i>brinzolamide (generic for Azopt)</i>	
PROSTAGLANDIN ANALOGS		
latanoprost (generic for Xalatan) TRAVATAN Z (travoprost)	bimatoprost (generic for Lumigan) travoprost (generic for Travatan Z) VYZULTA (latanoprostene) XALATAN (latanoprost) ZIOPTAN (tafluprost)	
COMBINATION DRUGS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol (generic for Cosopt)	brimonidine/timolol (generic Combigan) ^{NR} dorzolamide/timolol PF (generic for Cosopt PF) SIMBRINZA (brinzolamide/brimonidine)	
OTHER		
RHOPRESSA (netarsudil) ^{CL} ROCKLATAN (netarsudil and latanoprost) ^{CL}		<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Rhopressa and Rocklatan: Electronically approved for patients who have a trial of ONE generic agent, within ophthalmics- glaucoma within 60 days

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OPIOID DEPENDENCE TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
buprenorphine SL buprenorphine/naloxone TAB (SL) SUBOXONE FILM (buprenorphine/ naloxone)	BUNAVAIL (buprenorphine/naloxone) buprenorphine/naloxone FILM LUCEMYRA (lofexidine) ^{CL,QL} ZUBSOLV (buprenorphine/naloxone)	<p style="text-align: center;">Buprenorphine PA Form Buprenorphine Informed Consent</p> Non-Preferred buprenorphine and buprenorphine /naloxone agents: <ul style="list-style-type: none"> ▪ Diagnosis of Opioid Use Disorder, NOT approved for pain management ▪ Verification of "X" DEA license number of prescriber ▪ No concomitant opioids ▪ Failed trial of preferred drug or patient-specific documentation of why preferred product not appropriate for patient Drug-specific criteria: <ul style="list-style-type: none"> ▪ 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 SYRINGE, VIAL naltrexone TABLET NARCAN (naloxone) SPRAY	KLOXXADO (naloxone) ^{NR} NASAL naloxone SPRAY (generic for Narcan) ^{NR} ZIMHI (naloxone) ^{AL,NR} SYRINGE	<ul style="list-style-type: none"> ▪ 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)	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of the preferred agent within this drug class

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OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CIPRODEX (ciprofloxacin/dexamethasone) neomycin/polymyxin/hydrocortisone (generic for Cortisporin) ofloxacin (generic for Floxin)	CIPRO HC (ciprofloxacin/ hydrocortisone) ciprofloxacin ciprofloxacin/dexamethasone (generic for CIPRODEX) COLY-MYCIN S(neomycin/ hydrocortisone/colistin) OTOVEL (ciprofloxacin/fluocinolone)	<ul style="list-style-type: none"> 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) sildenafil TABLET (generic Revatio) ^{CL} tadalafil (generic for Adcirca) ^{CL} TRACLEER TABLET (bosentan) TYVASO INHALATION (treprostinil) VENTAVIS INHALATION (iloprost)	ADEMPAS (riociguat) ^{CL} ADCIRCA (tadalafil) ^{CL} bosentan TABLET (generic Tracleer) LETAIRIS (ambrisentan) OPSUMIT (macitentan) ORENITRAM ER (treprostinil) sildenafil SUSPENSION (generic Revatio) ^{CL} TRACLEER TABLETS FOR SUSPENSION (bosentan) UPTRAVI (selexipag)	<ul style="list-style-type: none"> 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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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: Requires clinical reason why sildenafil tablets cannot be used

PANCREATIC ENZYMES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CREON ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PERTZYE (pancrelipase) VIOKACE (pancrelipase)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

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PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>CHILD LITTLE ANIMALS VITAMINS CHEW OTC (pedi multivit 91/iron fum) CHEW</p> <p>child multivitamins chew otc (pedi multivit 19/folic acid) CHEW</p> <p>CHILDREN'S CHEW MULTIVIT-IRON OTC (pedi multivit 91/iron fum) CHEW</p> <p>children's chewables otc (pedi multivit 23/folic acid) CHEW</p> <p>children's vitamins with iron otc (pedi multivit/iron)</p> <p>fluoride/vitamins A,C,AND D (pedi multivit A,C,D3, 21/fluoride) DROPS</p> <p>infant-toddler multivit drop OTC (pediatric multivit no. 165 drops)</p> <p>infant-toddler multivit-iron OTC (pedi mv no.164/ferrous sulfate drops)</p> <p>infant-toddler tri-vit drop (vit a palmitate/vit c/vit d3 drops)</p> <p>multivitamins with fluoride (pedi multivit 2/fluoride) DROPS</p> <p>multivits with iron and fluoride (pedi multivit 45/fluoride/iron) DROPS</p> <p>MVC-FLUORIDE (pedi multivit 12/fluoride) CHEW TAB</p> <p>ped mvi A,C,D3,No 21/fluoride DROPS</p> <p>pedi mvi no. 16 with fluoride CHEW</p> <p>pedi mvi 17 with fluoride CHEW</p> <p>POLY-VI-SOL OTC (pedi multivit 81) DROPS</p> <p>POLY-VI-SOL WITH IRON (pedi multivit 80/ferrous sulfate) DROPS</p> <p>TRI-VI-SOL OTC (vit A palmitate/vit C/Vit D3) DROPS</p> <p>tri-vite-fluoride 0.25 mg/ml, and 0.5 mg/ml</p> <p>VITALETS OTC (pedi multivit 36/iron) CHEW</p>	<p>DEKAs PLUS (ped multivitamin no.128/vitamin K)^{NR}</p> <p>ESCAVITE (pedi multivit 47/iron/fluoride)</p> <p>ESCAVITE D (pedi multivit 78/iron/fluoride) CHEW</p> <p>ESCAVITE LQ (pedi multivit 86/iron/fluoride)</p> <p>FLORIVA (pedi multivit 85/fluoride) CHEW</p> <p>FLORIVA PLUS OTC and Rx (pedi multivit 130/fluoride) DROPS</p> <p>multivit A, B, D, E, K, ZN (pediatric multivit 153/D3/K)</p> <p>POLY-VI-FLOR (pedi multivit 33/fluoride) CHEW</p> <p>POLY-VI-FLOR (pedi multivit 37/fluoride) DROPS</p> <p>POLY-VI-FLOR w/IRON (pedi multivit 33/fluoride/iron) CHEW</p> <p>POLY-VI-FLOR w/IRON (pedi multivit 37/fluoride/iron) DROPS</p> <p>QUFLORA OTC and Rx (pedi multivit 84/fluoride)</p> <p>QUFLORA FE (pedi multivit 142/iron/fluoride)</p> <p>TRI-VI-FLORO (ped multivit A, C, D3, 38/fluoride)</p>	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class <p>Drug specific criteria:</p> <ul style="list-style-type: none"> ▪ DEKAs Plus: Approved for diagnosis of Cystic Fibrosis

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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PENICILLINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
amoxicillin CAPSULE, CHEWABLE TABLET, SUSP, TABLET ampicillin CAPSULE dicloxacillin penicillin VK		<ul style="list-style-type: none"> 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 TABLET, CAPSULE CALPHRON OTC (calcium acetate) RENVELA (sevelamer carbonate)	AURYXIA (ferric citrate) ELIPHOS (calcium acetate) lanthanum (generic FOSRENOL) PHOSLO (calcium acetate) PHOSLYRA (calcium acetate) RENAGEL (sevelamer HCl) sevelamer HCl (generic Renagel) sevelamer carbonate (generic Renvela) VELPHORO (sucroferric oxyhydroxide)	<ul style="list-style-type: none"> 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
AGGRENOX (dipyridamole/aspirin) aspirin BRILINTA (ticagrelor) clopidogrel (generic Plavix) dipyridamole (generic Persantine) prasugrel (generic Effient)	aspirin/dipyridamole (generic Aggrenox) ticlopidine (generic Ticlid) YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar) ^{CL}	<ul style="list-style-type: none"> 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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Zontivity®: Approved for reduction of thrombotic cardiovascular events in history of MI or with peripheral artery disease (PAD) Use with aspirin and/or clopidogrel

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PRENATAL VITAMINS

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
c-nate dha SOFTGEL complete natal dha (pnv2/iron b-g suc-p/fa/omega-3) classic prenatal TABLET (prenatal vit/fe fum/fa) COMPLETENATE CHEWABLE pnv with ca, #72/iron/fa prenatal vitamin TABLET (pnv#124/iron/fa) prenatal no.137/iron/fa OTC pretab 29mg-1 TABLET (pnv#78/iron/fa) PUREFE PLUS PUREFE OB PLUS TRINATAL RX 1 virt-nate dha SOFTGEL (pnv 11-iron fum-fa-om3) zatean-pn plus SOFTGEL (pnv/ca no.68/iron/fa1/dha)	DERMACINRX PRENATRIX CAPLET (prenatal vit no. 170/fe/fa) DERMACINRX PRENATRYL CAPLET (prenatal vit no.170/fe/fa) DERMACINRX PRETRATE CAPLET (prenatal vit no. 170/fe/fa) ^{NR} folivane-ob CAPSULE (pnv#15/iron fum & ps cmp/fa) niva-plus TABLET (pnv with ca,no.74/iron/fa) pnv-dha SOFTGEL (pnv combo#47/iron/fa #1/dha) taron-c dha CAPSULE (pnv#16/iron fum &ps/fa/om-3) virt-c dha SOFTGEL (pnv#16/iron fum &ps/fa/om-3) virt-pm dha SOFTGEL (pnv combo#47/iron/fa #1/dha) WESTGEL DHA (prenatal 93/iron/folate 9/dha) zatean-pn dha CAPSULE (pnv #47/iron/fa #1/dha)	<ul style="list-style-type: none"> ▪ 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

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PROGESTERONE (hydroxyprogesterone caproate)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MAKENA AUTO INJECTOR (hydroxyprogesterone caproate)	hydroxyprogesterone caproate (generic Makena) MAKENA (hydroxyprogesterone caproate) SDV	<ul style="list-style-type: none"> ▪ When filled as outpatient prescription, use limited to: <ul style="list-style-type: none"> ▪ Singleton pregnancy AND ▪ Previous Pre-term delivery AND ▪ No more than 20 doses (administered between 16 -36 weeks gestation) ▪ Maximum of 30 days per dispensing

PROTON PUMP INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
omeprazole (generic Prilosec) RX pantoprazole (generic Protonix) ^{QL} PROTONIX SUSP (pantoprazole)	DEXILANT (dexlansoprazole) dexlansoprazole (generic Dexilant) ^{NR} esomeprazole magnesium (generic Nexium) RX, OTC ^{NR, QL} esomeprazole strontium lansoprazole (generic Prevacid) ^{QL} NEXIUM SUSPENSION (esomeprazole) omeprazole/sodium bicarbonate (generic Zegerid RX) <i>pantoprazole</i> GRANULES ^{QL} rabeprazole (generic Aciphex)	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed an 8-week trial of BOTH preferred agents within this drug class <p>Pediatric Patients: Patients ≤ 4 years of age – No PA required for Prevacid 30mg or omeprazole 20mg capsules (used to compound suspensions).</p> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Prilosec®OTC/Omeprazole OTC: EXCLUDED from coverage Acceptable as trial instead of Omeprazole 20mg ▪ Prevacid Solutab: may be approved after trial of compounded suspension. Patients ≥ 5 years if age- Only approve non-preferred for GI diagnosis if: <ul style="list-style-type: none"> ▪ Child can not swallow whole generic omeprazole capsules OR, ▪ Documentation that contents of capsule may not be sprinkled in applesauce

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SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BENZODIAZEPINES		
temazepam 15mg, 30mg (generic for Restoril)	estazolam (generic for ProSom) flurazepam (generic for Dalmane) temazepam (generic for Restoril) 7.5mg, 22.5mg triazolam (generic for Halcion)	<ul style="list-style-type: none"> ▪ Lunesta®/ Rozerem®/zolpidem ER: Requires a trial with generic zolpidem within the last 12 months AND Trial OR Clinical reason why zaleplon and preferred benzodiazepine cannot be used ▪ Edluar®: Requires a trial with generic zolpidem within the last 12 months AND Trial OR Clinical reason why zaleplon and preferred benzodiazepine cannot be used and Requires documentation of swallowing disorder ▪ flurazepam/triazolam: Requires trial of preferred benzodiazepine ▪ Hetlitz®: Requires trial with generic zolpidem within last 12 months AND clinical reason why zaleplon AND preferred benzodiazepine cannot be used ▪ Silenor®: Must meet ONE of the following: <ul style="list-style-type: none"> ○ Contraindication to preferred oral sedative hypnotics ○ Medical necessity for doxepin dose < 10mg ○ Age greater than 65 years old or hepatic impairment (3mg dose will be approved if this criteria is met) ▪ temazepam 7.5mg/22.5mg: Requires clinical reason why 15mg/30mg cannot be used ▪ zolpidem/zolpidem ER: Maximum daily dose for females: Zolpidem 5mg; Zolpidem ER® 6.25mg ▪ zolpidem SL: Requires clinical reason why half of zolpidem tablet cannot be used
OTHERS		
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} <i>HETLIOZ LQ (tasimelteon)</i> SUSP ^{AL,QL} ramelteon (generic for Rozerem) zolpidem ER (generic for Ambien CR) zolpidem SL (generic for Intermezzo)	

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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)	<p>Drug-Specific Criteria</p> <ul style="list-style-type: none"> ▪ Endari: Patient must have documented two or more hospital admissions per year due to sickle cell crisis despite maximum hydroxyurea dosage. ▪ Oxbryta: Not indicated 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 transfusion therapy ▪ Siklos: Approved for use in patients ages 2 to 17 years old

SINUS NODE INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	CORLANOR SOLUTION, TABLET (ivabradine)	<ul style="list-style-type: none"> ▪ 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

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**Nebraska Medicaid
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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 TABLET (generic Zanaflex)	carisoprodol (generic Soma) ^{CL,QL} carisoprodol compound cyclobenzaprine ER (generic Amrix) ^{CL} dantrolene (generic Dantrium) FEXMID (cyclobenzaprine ER) FLEQSUVY (baclofen)^{NR} SUSP LORZONE (chlorzoxazone) ^{CL} metaxalone (generic Skelaxin) NORGESIC FORTE (orphenadrine/ASA/caffeine) orphenadrine ER PARAFON FORTE (chlorzoxazone) tizanidine CAPSULE ZANAFLEX (tizanidine) CAPSULE, TABLET	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a 1-week trial of TWO preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ cyclobenzaprine ER: <ul style="list-style-type: none"> ○ Requires clinical reason why IR cannot be used ○ Approved only for acute muscle spasms ○ NOT approved for chronic use ▪ carisoprodol: <ul style="list-style-type: none"> ○ 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 day 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[®] 250mg: Requires clinical reason why 350mg generic strength cannot be used ▪ Zanaflex[®] Capsules: Requires clinical reason generic cannot be used

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STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
LOW POTENCY		<ul style="list-style-type: none"> ▪ Low Potency Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
hydrocortisone OTC & RX CREAM, LOTION, OINTMENT (Rx only) hydrocortisone/aloe OINTMENT SCALPICIN OTC (hydrocortisone)	ALA-CORT (hydrocortisone) CREAM ALA-SCALP HP (hydrocortisone) alclometasone dipropionate (generic for Aclovate) CAPEX SHAMPOO (fluocinolone) DESONATE (desonide) GEL desonide LOTION (generic for Desowen) desonide CREAM, OINTMENT (generic for former products Desowen, Tridesilon) fluocinolone 0.01% OIL (generic for DERMA-SMOOTHIE-FS) hydrocortisone/aloe CREAM hydrocortisone OTC OINTMENT MICORT-HC (hydrocortisone) TEXACORT (hydrocortisone)	
MEDIUM POTENCY		<ul style="list-style-type: none"> ▪ 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, OINTMENT (generic for Cutivate) mometasone furoate CREAM, OINTMENT, SOLUTION (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)	

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STEROIDS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HIGH POTENCY		<ul style="list-style-type: none"> ▪ 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 SOLUTION fluocinonide CREAM, GEL, OINTMENT fluocinonide emollient halcinonide CREAM (generic for Halog) HALOG (halcinonide) CREAM, OINT, SOLN KENALOG AEROSOL (triamcinolone) SERNIVO (betamethasone dipropionate) triamcinolone SPRAY (generic for Kenalog spray) TRIANEX OINTMENT (triamcinolone) VANOS (fluocinonide)	
VERY HIGH POTENCY		<ul style="list-style-type: none"> ▪ 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 for Temovate-E) clobetasol propionate CREAM, GEL, OINTMENT, SOLUTION halobetasol propionate (generic for Ultravate)	APEXICON-E (diflorasone) BRYHALI (halobetasol prop) LOTION clobetasol SHAMPOO, LOTION clobetasol propionate FOAM, SPRAY CLOBEX (clobetasol) halobetasol propionate FOAM (generic for Lexette) ^{AL,QL} IMPEKLO (clobetasol) LOTION ^{AL} LEXETTE(halobetasol propionate) ^{AL,QL} OLUX-E /OLUX/OLUX-E CP (clobetasol)	

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STIMULANTS AND RELATED AGENTS^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CNS STIMULANTS		<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Procentra[®]: 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 VYVANSE (lisdexamfetamine) ^{QL} CAPSULE, CHEWABLE	ADZENYS XR (amphetamine) amphetamine ER (generic for Adzenys ER) SUSPENSION amphetamine salt combination ER (generic for Adderall XR) amphetamine sulfate (generic for Evekeo) AZSTARYS (serdexmethylphenidate and dexamethylphenidate) ^{QL} dextroamphetamine (generic for Dexedrine) dextroamphetamine SOLUTION (generic for Procentra) dextroamphetamine ER (generic for Dexedrine ER) DYANAVEL XR (amphetamine) EVEKEO ODT (amphetamine sulfate) MYDAYIS (amphetamine salt combo) ^{QL} methamphetamine (generic for Desoxyn) ZENZEDI (dextroamphetamine)	

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STIMULANTS AND RELATED ADHD DRUGS (Continued)^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Methylphenidate type		<ul style="list-style-type: none"> ▪ 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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Daytrana®: May be approved in history of substance use disorder by parent, caregiver, or patient. May be approved with documentation of difficulty swallowing
<p>CONCERTA (methylphenidate ER)^{QL} 18mg, 27mg, 36mg, 54mg dexamethylphenidate (generic for Focalin IR) FOCALIN XR (dexamethylphenidate) METHYLIN SOLUTION (methylphenidate) methylphenidate (generic for Ritalin) methylphenidate SOLUTION (generic for Methylin) QUILLICHEW ER CHEWTAB (methylphenidate)</p>	<p>ADHANSIA XR (methylphenidate)^{QL} APTENSIO XR (methylphenidate) COTEMPLA XR-ODT (methylphenidate)^{QL} DAYTRANA PATCH (methylphenidate)^{QL} dexamethylphenidate XR (generic for Focalin XR) FOCALIN IR (dexamethylphenidate) JORNAY PM (methylphenidate)^{QL} <i>methylphenidate 50/50 (generic for Ritalin LA)</i> <i>methylphenidate 30/70 (generic for Metadate CD)</i> methylphenidate ER 18mg, 27mg, 36mg, 54mg (generic Concerta)^{QL} methylphenidate ER CAP (generic for Aptensio XR)^{QL} Methylphenidate ER (generic for Metadate ER) methylphenidate ER 72mg (generic for RELEXXII)^{QL} methylphenidate ER (generic for Ritalin SR) QUILLIVANT XR SUSP (methylphenidate) RITALIN (methylphenidate)</p>	

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STIMULANTS AND RELATED ADHD DRUGS (Continued)^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MISCELLANEOUS		<p>Note: generic guanfacine IR and clonidine IR are available without prior authorization</p> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ armodafinil and Sunosi: Require trial of modafinil ▪ armodafinil and modafinil: approved only for: <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed ○ Narcolepsy with documentation of diagnosis via sleep study ▪ <i>Wakix: approved only for excessive daytime sleepiness in adults with narcolepsy with documentation of narcolepsy diagnosis via sleep study</i>
atomoxetine (generic for Strattera) ^{QL} guanfacine ER (generic for Intuniv) ^{QL}	clonidine ER (generic for Kapvay) ^{QL} QELBREE (viloxazine) ^{QL} STRATTERA (atomoxetine)	
ANALEPTICS		
	armodafinil (generic for Nuvigil) ^{CL} modafanil (generic for Provigil) ^{CL} SUNOSI (solriamfetol) ^{CL,QL} WAKIX (pitolisant) ^{CL,QL}	

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TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR (generic Vibramycin) doxycycline monohydrate 50MG, 100MG CAPSULE doxycycline monohydrate SUSP, TABLET (generic Vibramycin) minocycline HCl CAPSULE, TABLET (generic Dynacin/ Minocin/Myrac)	demeclocycline (generic Declomycin) ^{CL} DORYX MPC DR (doxycycline pelletized) doxycycline hyclate DR (generic Doryx) doxycycline monohydrate 40MG, 75MG and 150MG CAPSULES (generic for Adoxa/Monodox/ Oracea) minocycline HCl ER (generic Solodyn) NUZYRA (omadacycline) tetracycline VIBRAMYCIN SUSP (doxycycline) XIMINO (minocycline ER) ^{QL}	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of TWO preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Demeclocycline: Approved for diagnosis of SIADH ▪ Doryx®/doxycycline hyclate DR/ Dynacin®/Oracea®/Solodyn®: Requires clinical reason why generic doxycycline, minocycline or tetracycline cannot be used ▪ doxycycline suspension: May be approved with documented swallowing difficulty

THROMBOPOIESIS STIMULATING PROTEINS^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROMACTA (<i>eltrombopag</i>) TABLET^{CL}	DOPTELET (<i>avatrombopag</i>) MULPLETA (<i>lusutrombopag</i>) PROMACTA (<i>eltrombopag</i>) SUSP TAVALISSE (<i>fostamatinib</i>)	<ul style="list-style-type: none"> ▪ 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. <p>Drug-Specific Criteria</p> <ul style="list-style-type: none"> ▪ 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

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

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

THYROID HORMONES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
levothyroxine TABLET (generic Synthroid) liothyronine TABLET (generic Cytomel) thyroid, pork TABLET UNITHROID (levothyroxine)	EUTHYROX (levothyroxine) LEVO-T (levothyroxine) <i>levothyroxine CAPSULE (generic for Tirosint)</i> THYROLAR TABLET (liotrix) THYQUIDITY (levothyroxine) SOLN TIROSINT CAPSULE (levothyroxine) TIROSINT-SOL LIQUID (levothyroxine) ^{CL}	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> ▪ Tirosint-Sol: May be approved with documented swallowing difficulty

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ULCERATIVE COLITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		
APRISO (mesalamine) Sulfasalazine IR, DR (generic Azulfidine) LIALDA (mesalamine)	balsalazide (generic Colazal) budesonide DR (generic Uceris) DIPENTUM (olsalazine) GIAZO (balsalazide) mesalamine ER (generic Apriso) mesalamine (generic Asacol HD/Delzicol/Lialda) PENTASA (mesalamine)	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> ▪ Asacol HD®/Delzicol DR®/Pentasa®: Requires clinical reason why preferred mesalamine products cannot be used ▪ Giazo®: Requires clinical reason why generic balsalazide cannot be used NOT covered in females
RECTAL		
CANASA (mesalamine) ROWASA (mesalamine)	mesalamine ENEMA (generic Rowasa) mesalamine SUPPOSITORY (generic Canasa) UCERIS (budesonide)	

UTERINE DISORDER TREATMENT

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORIAHNN (elagolix/ estradiol/ norethindrone) ^{AL,CL} ORILISSA (elagolix sodium) ^{QL,CL}	MYFEMBREE (relugolix/ estradiol/ norethindrone acetate) ^{AL, NR, QL}	Drug-specific criteria: <ul style="list-style-type: none"> • Orilissa/Oriahnn: Requires an FDA approved indication, must follow FDA dosing guidelines, and have had a trial and failure of an NSAID and oral contraceptive <ul style="list-style-type: none"> ○ Total duration of treatment is max of 24 months

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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**

PDL Updated March 1, 2022 **Highlights** indicated change from previous posting

VASODILATORS, CORONARY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
isosorbide dinitrate TABLET isosorbide dinitrate ER, SA TABLET (generic Dilatrate-SR/Isordil) isosorbide mono IR/SR TABLET nitroglycerin SUBLINGUAL, TRANSDERMAL nitroglycerin ER TABLET	BIDIL (isosorbide dinitrate/ hydralazine) ^{CL} GONITRO (nitroglycerin) isosorbide dinitrate TABLET (Oceanside Pharm MFR only) NITRO-BID OINTMENT (nitroglycerin) NITRO-DUR (nitroglycerin) nitroglycerin TRANSLINGUAL (generic Nitrolingual) NITROMIST (nitroglycerin) VERQUVO (<i>vericiguat</i>) ^{AL, CL, QL}	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> ▪ 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%

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CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

NR – Product was not reviewed - New Drug criteria will apply