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

Pete Ricketts, Governor

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2022 PDL

Noted in Red Font that Become Effective November 1, 2022

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

- **PDMP Check Requirements**- Nebraska Medicaid providers are required to check the prescription drug history in the statewide PDMP before prescribing CII controlled substances to certain Medicaid beneficiaries. (Exemption to this requirement are for beneficiaries receiving cancer treatment, hospice/palliative care, or in long-term care facilities). If not able to check the PDMP, then provider is required to document good faith effort, including reasons why unable to conduct the check and may be required to submit documentation to the State upon request.
    - PDMP check requirements are under Section 5042 of the SUPPORT for Patients and Communities Act, consistent with section 1944 of the Social Security Act [42 U.S.C. 1396w-3a], beginning October 1, 2021.

- **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

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For a complete list of Claims Limitations visit:
https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

ACNE AGENTS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
benzoyl peroxide (BPO) **WASH, LOTION** clindamycin/BPO (generic Benzaclin) **PUMP** clindamycin phosphate **PLEDGET** clindamycin phosphate **SOLUTION** DIFFERIN **LOTION, CREAM, Rx-GEL** (adapalene) DIFFERIN **GEL** (adapalene) OTC erythromycin **GEL** erythromycin **SOLN** erythromycin-BPO (generic for Benzamycin) RETIN-A (tretinoin)[AL] **CREAM**, **GEL**	adapalene (generic differin) adapalene/BPO (generic Epiduo) adapalene/BPO (generic Epiduo Forte) AKLIEF (trifarotene) [AL] ALTRENO (tretinoin)[AL] AMZEEQ (minocycline) ARAZLO (tazarotene)[AL] ATRALIN (tretinoin) AVAR (sulfacetamide sodium/sulfur) AVITA (tretinoin) AZELEX (azelaic acid) BENZACLIN **PUMP** (clindamycin/BPO) BENZEFOAM (benzoyl peroxide) benzoyl peroxide **CLEANSER**, **CLEANSING BAR** OTC benzoyl peroxide **FOAM** (generic Benzepro) benzoyl peroxide **GEL** OTC benzoyl peroxide **GEL** Rx benzoyl peroxide **TOWELETTE** OTC clindamycin **FOAM, LOTION** clindamycin **GEL** clindamycin phosphate (generic for Clindagel) **GEL** clindamycin/BPO (generic Acanya) **GEL** clindamycin/BPO (generic Duac) clindamycin/tretinoin (generic Veltin, Ziana) dapsone (generic Aczone) EPIDUO FORTE **GEL PUMP** (adapalene/BPO) erythromycin **GEL, PLEDGET** erythromycin-BPO (generic for Benzamycin) EVOCLIN (clindamycin) FABIOR (tazarotene foam) NEUAC (clindamycin/BPO) ONEXTON (clindamycin/BPO) OVACE PLUS (sulfacetamide sodium) PLIXDA (adapalene) SWAB RETIN-A[AL] **GEL, CREAM** (tretinoin) sulfacetamide sulfacetamide/sulfur SUMADAN (sulfacetamide/sulfur) tazarotene **CREAM,GEL**[NR] (generic Tazorac) tazarotene FOAM (generic Fabior) TRETIN-X (tretinoin) tretinoin CREAM, GELAL (generic Avita, Retin-A) tretinoin microspheres (generic for Retin-A Micro) [AL] *TWYNEO (tretinoin/BPO)[AL, NR]* ***CREAM***	• Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
CL – Prior Authorization / Class Criteria apply QL – Quantity/Duration Limit AL – Age Limit
NR – Product was not reviewed - New Drug criteria will apply

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ALZHEIMER'S AGENTS

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

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

ANALGESICS, OPIOID SHORT-ACTING[QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		
acetaminophen/codeine **ELIXIR, TABLET** codeine **TABLET** hydrocodone/APAP **SOLN, TABLET** hydrocodone/ibuprofen hydromorphone **TABLET** morphine **CONC SOLN**, **SOLN, TABLET** oxycodone **TABLET, SOLN** 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] oxycodone **CAPS** oxycodone/APAP **SOLN** oxycodone/aspirin oxycodone **CONCENTRATE** oxycodone/ibuprofen oxymorphone IR (generic Opana) pentazocine/naloxone ROXICODONE **TABLET** (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol)[AL] tramadol 100mg **TABLET**(generic Ultram)[AL] tramadol (generic Qdolo)[AL,QL] **SOLN** ZAMICET (hydrocodone/APAP)	• 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 -prescriptions limited to a 7 day supply, AND -initial opiate prescription fill limited to maximum of 50 Morphine Milligram Equivalents (MME) per day These limits may only be exceeded with patient specific documentation of medical necessity, with examples such as, cancer diagnosis, end-of-life care, palliative care, Sickle Cell Anemia, or prescriber attestation that patient is not recently opiate naive Drug-specific criteria: • **Apadaz:** Approval for 14 days or less • **Nucynta®:** Approved only for diagnosis of acute pain, for 30 days or less

ANALGESICS, OPIOID SHORT-ACTING[QL] (Continued)

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

ANDROGENIC AGENTS (Topical)[CL]

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

ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ACE INHIBITORS		• Non-preferred agents will be approved for patients who have failed 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 Drug-specific criteria: • **Epaned® and Qbrelis® Oral Solution:** Clinical reason why oral tablet is not appropriate
benazepril (generic Lotensin) enalapril (generic Vasotec) lisinopril (generic Prinivil, Zestril) quinapril (generic Accupril) ramipril (generic Altace)	captopril (generic Capoten) EPANED (enalapril)CL **ORAL SOLN** enalapril (generic for Epaned)CL **ORAL SOLN** fosinopril (generic Monopril) moexepril (generic Univasc) perindopril (generic Aceon) QBRELIS (lisinopril)CL **ORAL SOLN** trandolapril (generic Mavik)	
ACE INHIBITOR/DIURETIC COMBINATIONS		
benazepril/HCTZ (generic Lotensin HCT) enalapril/HCTZ (generic Vaseretic) lisinopril/HCTZ (generic Prinzide, Zestoretic) quinapril/HCTZ (generic Accuretic)	captopril/HCTZ (generic Capozide) fosinopril/HCTZ (generic Monopril HCT) moexipril/HCTZ (generic Uniretic)	
ANGIOTENSIN RECEPTOR BLOCKERS		
irbesartan (generic Avapro) losartan (generic Cozaar) olmesartan (generic Benicar) valsartan (generic Diovan)	candesartan (generic Atacand) EDARBI (azilsartan) eprosartan (generic Teveten) telmisartan (generic Micardis)	

ANGIOTENSIN MODULATORS (Continued)

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

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)	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: ▪ **Emverm**: Approval will be considered for indications not covered by preferred agents

ANTI-ALLERGENS, ORAL

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

ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FIRVANQ (vancomycin) **SOLN** metronidazole **TABLET** neomycin tinidazole (generic Tindamax)[CL]	DIFICID (fidaxomicin) [CL] **TABLET, SUSP** FLAGYL ER (metronidazole)[CL] metronidazole[CL] **CAPS** nitazoxanide (generic Alinia) **TABLET**[AL, CL, QL] paromomycin SOLOSEC (secnidazole) vancomycin **CAPS** (generic Vancocin)[CL] XIFAXAN (rifaximin)[CL]	• Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization Drug-specific criteria: • **Alinia®:** Trial and failure with metronidazole is required for a diagnosis of giardiasis • **Dificid®:** For diagnosis of C. difficile diarrhea (pseudomembranous colitis), **t**rial and failure or intolerance to oral vancomycin is required. For diagnosis of relapsed or recurrent C. difficile, an appropriate ICD-10 diagnosis code must be submitted for coverage. • **Flagyl 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®

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

ANTIBIOTICS, TOPICAL

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

ANTIBIOTICS, VAGINAL

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

ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CANNABINOIDS		• Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the same group
dronabinol (generic Marinol)[AL]	CESAMET (nabilone)	
5HT3 RECEPTOR BLOCKERS		Drug-specific criteria:
ondansetron (generic Zofran/Zofran ODT)[QL]	ANZEMET (dolasetron) granisetron (generic Kytril) SANCUSO (granisetron)[CL] ZUPLENZ (ondansetron)	• **Akynzeo®/Varubi®:** Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist
NK-1 RECEPTOR 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
EMEND (aprepitant) **CAPS, CAPS PACK**[QL]	aprepitant (generic Emend) [QL,CL] AKYNZEO (netupitant/palonosetron)[CL] VARUBI (rolapitant) **TABLET**[CL]	• **Diclegis®/Bonjesta:** Approved only for treatment of nausea and vomiting of pregnancy
TRADITIONAL ANTIEMETICS		• **Metozolv ODT®:** Documentation of inability to swallow or Clinical reason oral liquid cannot be used
DICLEGIS (doxylamine/pyridoxine)[CL,QL] dimenhydrinate (generic Dramamine) OTC meclizine (generic Antivert) metoclopramide (generic Reglan) phosphoric acid/dextrose/fructose **SOLN** (generic Emetrol) prochlorperazine, oral (generic Compazine) promethazine **SYRUP**, **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 **SUPPOSITOR**Y (generic Compazine) promethazine **SUPPOSITORY** 50mg scopolamine **TRANSDERMAL** trimethobenzamide **TABLET** (generic Tigan)	• **Sancuso®/Zuplenz®:** Documentation of oral dosage form intolerance

ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole (mucous membrane, troche) fluconazole **SUSP, TABLET** (generic Diflucan) griseofulvin **SUSP** griseofulvin microsized **TABLET** nystatin **SUSP, TABLET** terbinafine (generic Lamisil)	BREXAFEMME (ibrexafungerp)[QL] CRESEMBA (isavuconazonium)[CL] flucytosine (generic Ancobon)[CL] griseofulvin ultramicrosize (generic GRIS-PEG) itraconazole (generic Sporanox)[CL] ketoconazole (generic Nizoral) nystatin **POWDER** ONMEL (itraconazole) posaconazole (generic Noxafil)[AL,CL] TOLSURA (itraconazole)[CL] VIVJOA (oteseconazole) **CAPS**[NR] voriconazole (generic VFEND)[CL]	• Non-preferred agents will be approved for patients who have failed a trial of TWO diagnosis-appropriate preferred agents within this drug class Drug-specific criteria: • **Cresemba®:** Approved for diagnosis of invasive aspergillosis or invasive mucomycosis • **Flucytosine:** Approved for diagnosis of: Candida: Septicemia, endocarditis, UTIs Cryptococcus: Meningitis, pulmonary infections • **Noxafil®:** No trial for diagnosis of Neutropenia Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Neutropenic hematologic malignancies, Graft vs. Host disease(GVHD), Immunosuppression secondary to hematopoietic stem cell transplant • **Noxafil® 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, *S. apiospermum* and *Fusarium spp.*, Oropharyngeal/esophageal candidiasis refractory to fluconazole

ANTIFUNGALS, TOPICAL

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

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

ANTIHISTAMINES, MINIMALLY SEDATING

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

ANTIHYPERTENSIVES, SYMPATHOLYTICS

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

ANTIHYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol (generic for Zyloprim) MITIGARE (colchicine) probenecid probenecid/colchicine (generic for Col-Probenecid)	allopurinol[NR] 200mg colchicine **TABLET** (generic for Colcrys)[CL] colchicine **CAPS** (generic for Mitigare) febuxostat (generic for Uloric)[CL] GLOPERBA **SOLN** (colchicine)[CL,QL]	• 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:*** *Approved for documented swallowing disorder* • **Uloric®:** Clinical reason why allopurinol cannot be used

ANTIMIGRAINE AGENTS, OTHER

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

ANTIMIGRAINE AGENTS, TRIPTANS[QL]

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

ANTIPARASITICS, TOPICAL

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

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2022 PDL Highlighted in Red effective November 1, 2022

ANTIPARKINSON'S AGENTS, ORAL

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

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

ANTIPSORIATICS, ORAL

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

ANTIPSORIATICS, TOPICAL

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

ANTIVIRALS, ORAL

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

ANTIVIRALS, TOPICAL

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

ANXIOLYTICS

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

BETA BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA BLOCKERS		• Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents within this drug class Drug-specific criteria: • **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) **SOLN**	
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)	
	pindolol (generic Viskin)	
	propranolol/HCTZ (generic Inderide)	
	timolol (generic Blocadren)	
	TOPROL XL (metoprolol ER)	
BETA- AND ALPHA-BLOCKERS		
carvedilol (generic Coreg)	carvedilol ER[CL] (generic Coreg CR)	
labetalol (generic Trandate)		
ANTIARRHYTHMIC		
sotalol (generic Betapace)	SOTYLIZE (sotalol)	

BILE SALTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ursodiol **CAPSULE** 300mg (generic Actigall)	BYLVAY (odevixibat)[NR] **CAP, PELLET**	• 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 URSO)	CHENODAL (chenodiol)	
ursodiol 500mg **TABLET** (generic URSO FORTE)	CHOLBAM (cholic acid)	
	LIVMARLI (maralixibat) **SOLN**[AL,NR]	
	OCALIVA (obeticholic acid)	
	RELTONE (ursodiol 200mg,400mg) **CAP**[NR]	

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) *fesoterodine*[NR] *(generic Toviaz)* flavoxate GELNIQUE (oxybutynin) GEMTESA (vibegron)[AL,QL] MYRBETRIQ **TABLET, SUSP**[AL,CL,QL] (mirabegron) OXYTROL (oxybutynin) tolterodine IR, ER (generic Detrol/ Detrol LA) trospium IR, ER (generic Sanctura/ Sanctura XR) VESICARE (solifenacin) VESICARE LS **SUSP** (solifenacin) [AL]	• Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug-specific criteria: • **Myrbetriq®:** Covered without trial in contraindication to anticholinergic agents • **Myrbetriq suspension:** Covered for pediatric patients ≥ 3 years old with a diagnosis of Neurogenic Detrusor Overactivity (NDO)

BONE RESORPTION SUPRESSION AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BISPHOSPHONATES		• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group

alendronate (generic Fosamax) **TABLET**
ibandronate (generic Boniva)[QL]
	alendronate **SOLN** (generic Fosamax)[QL]
	ATELVIA DR (risedronate)
	BINOSTO (alendronate)
	etidronate disodium (generic Didronel)
	FOSAMAX PLUS D[QL]
	risedronate (generic Actonel)[QL]
		Drug-specific criteria:
		• **Actonel® Combinations:** Covered as individual agents without prior authorization
		• **Atelvia DR®:** Requires clinical reason alendronate cannot be taken on an empty stomach
		• **Binosto®:** Requires clinical reason why alendronate tablets OR Fosamax® solution cannot be used
		• **Etidronate disodium:** Trial not required for diagnosis of hetertrophic ossification
		• **Forteo®:** Covered for high risk of fracture
		High risk of fracture:
		  ○ BMD -3 or worse
		  ○ Postmenopausal women with history of non-traumatic fractures
		  ○ Postmenopausal women with 2 or more clinical risk factors
		  ○ Family history of non-traumatic fractures
		  ○ DXA BMD T-score ≤ -2.5 at any site
		  ○ Glucocorticoid use ≥ 6 months at 7.5 dose of prednisolone equivalent
		  ○ Rheumatoid Arthritis
		  ○ Postmenopausal women with BMD T-score ≤ -2.5 at any site with any clinical risk factors
		  ○ More than 2 units of alcohol per day
		  ○ Current smoker
		  ○ Men with primary or hypogonadal osteoporosis
		  ○ Osteoporosis associated with sustained systemic glucocorticoid therapy
		  ○ Trial of calcitonin-salmon not required
		  ○ Maximum of 24 months treatment per lifetime

OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS		
calcitonin-salmon **NASAL** FORTEO (teriparatide)[CL,QL] raloxifene (generic Evista)	EVISTA (raloxifene) teriparatide (generic Forteo) [CL,QL] TYMLOS (abaloparatide)	

BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS

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

BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS – Short Acting		• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: • **Xopenex®:** Covered for cardiac diagnoses or side effect of tachycardia with albuterol product • **Ventolin HFA** is temporarily authorized due to ProAir HFA discontinuation
albuterol HFA (generic for ProAir HFA)	albuterol HFA (Proventil HFA, Ventolin HFA) levalbuterol HFA (generic for Xopenex HFA) *PROAIR DIGIHALER (albuterol)* PROAIR RESPICLICK (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	
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)	

CALCIUM CHANNEL BLOCKERS, ORAL

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

CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		• Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within the same group
amoxicillin/clavulanate **TABLETS, SUSP**	amoxicillin/clavulanate **CHEWABLE** amoxicillin/clavulanate ER (generic Augmentin XR) AUGMENTIN (amoxicillin/clavulanate) **SUSP TABLET**	
CEPHALOSPORINS – First Generation		
cefadroxil **CAPS, SUSP** (generic Duricef) cephalexin **CAPS, SUSP** (generic Keflex)	cefadroxil **TABLET** (generic Duricef) cephalexin **TABLET**	
CEPHALOSPORINS – Second Generation		
cefprozil (generic Cefzil) cefuroxime **TABLET** (generic Ceftin)	cefaclor (generic Ceclor) CEFTIN (cefuroxime) **TABLET, SUSP**	
CEPHALOSPORINS – Third Generation		
cefdinir (generic Omnicef)	Cefixime (generic Suprax) **CAPS, SUSP** cefpodoxime (generic Vantin) SUPRAX (cefixime) **CAPS, CHEWABLE TABLET, SUSP, TABLET**	

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NEUPOGEN (filgrastim) **VIAL**	FYLNETRA (pegfilgrastim-pbbk)^{NR} GRANIX (tbo-filgrastim) NEUPOGEN **DISP SYR** (filgrastim) NIVESTYM **SYR,VIAL** (filgrastim-aafi) NYVEPRIA (pegfilgrastim-apgf) *RELEUKO (filgrastim-ayow)*^{NR} ***SYR,VIAL*** ZARXIO (filgrastim-sndz) ZIEXTENZO **SYR** (pegfilgrastim-bmez)	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
All reviewed agents are recommended preferred at this time *Only those products for review are listed.* Brand name products may be subject to Maximum Allowable Cost (MAC) pricing or require substitution with a generic equivalent Specific agents can be looked up using the Drug Look-up Tool at: https://druglookup.fhsc.com/druglookupweb/?client=nestate	FINZALA (ethinyl estradiol/norethindrone acetate) **CHEW** NR norethindrone/ethinyl estradiol FE estrophasic (generic EstropFE)NR	

COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS		• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class OR Patient specific documentation of inability to use traditional inhaler device. Drug-specific criteria: • **Daliresp®:** Covered for diagnosis of severe COPD associated with chronic bronchitis Requires trial of a bronchodilator Requires documentation of one exacerbation in last year upon initial review
ANORO ELLIPTA (umeclidinium/vilanterol) ATROVENT HFA (ipratropium) COMBIVENT RESPIMAT (albuterol/ ipratropium) SPIRIVA (tiotropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI AEROSPHERE (glycopyrolate/formoterol) DUAKLIR PRESSAIR (aclidinium br and formoterol fum) INCRUSE ELIPTA (umeclidnium) SEEBRI NEOHALER (glycopyrolate) SPIRIVA RESPIMAT (tiotropium) TUDORZA PRESSAIR (aclidinium br) UTIBRON NEOHALER (indacaterol/glycopyrolate)	
INHALATION SOLUTION		
albuterol/ipratropium (generic for Duoneb) ipratropium **SOLN** (generic for Atrovent)	LONHALA (glycopyrrolate inhalation soln) YUPELRI (revefenacin)	
ORAL AGENT		
	DALIRESP (roflumilast)[CL, QL] roflumilast (generic Daliresp)[CL,NR,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)	• Non-preferred agents will be approved for patients who have failed a trial of ONE dextromethorphan product • All codeine or hydrocodone containing cough and cold combinations are limited to ≥ 18 years of age

CYSTIC FIBROSIS, ORAL

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

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2022 PDL Highlighted in Red effective November 1, 2022

CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ENBREL (etanercept) **KIT, MINI CART, PEN, SYR, VIAL**[QL] HUMIRA (adalimumab)[QL] OTEZLA (apremilast) **ORAL**[CL,QL]	ACTEMRA (tocilizumab) **SUB-Q** ARCALYST (nilonacept) CIBINQO (abrocitinib)[AL,NR,QL] CIMZIA (certolizumab pegol)[QL] COSENTYX (secukinumab) ENSPRYNG (satralizumab-mwge) **SUB-Q** ILUMYA (tildrakizumab) SUB-Q KEVZARA (sarilumab) **SUB-Q, PEN, SYRINGE** KINERET (anakinra) OLUMIANT (baricitinib) **TABLET**[CL,QL] ORENCIA (abatacept**) SUB-Q** RINVOQ ER (upadacitinib)[CL,QL] SILIQ (brodalumab) SIMPONI (golimumab) SKYRIZI (risankizamab-rzaa) **SYRINGE** SKYRIZI **ON-BODY** (risankizamab-rzaa)[NR,QL] SKYRIZI **PEN** (risankizamab-rzaa)[QL] SOTYKTU (deucravacitinib)[NR] **TABLET** STELARA (ustekinumab) **SUB-Q** TALTZ (ixekizumab)[AL] TREMFYA (guselkumab)[QL] XELJANZ (tofacitinib) **TABLET, SOLN**[CL,QL] XELJANZ XR (tofacitinib) **TABLET**[CL,QL]	• 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. Drug-specific criteria: **Otezla**: Requires a trial of Humira **Olumiant:** Requires documentation of inadequate response or intolerance to a Tumor Necrosis Factor (TNF) blocker (ex., Enbrel, Humira) **Rinvoq:** Requires documentation of inadequate response or intolerance to a Tumor Necrosis Factor (TNF) blocker (ex., Enbrel, Humira) **Xeljanz, Xeljanz XR**: Requires documentation of inadequate response or intolerance to a Tumor Necrosis Factor (TNF) blocker (ex., Enbrel, Humira).

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2022 PDL Highlighted in Red effective November 1, 2022

DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SINGLE-AGENT PRODUCTS		• Non-preferred agents will be approved for patients who have failed a trial of **TWO** preferred agents within this drug class • **Eplerenone**: Will be approved with a failed trial or intolerance to spironolactone, a trial with two preferred agents is not required. • **Kerendia**: For diagnosis of chronic kidney disease associated with Type-II diabetes in adults, trial of a preferred agent not required.
amiloride **TABLET** bumetanide **TABLET** chlorothiazide **TABLET** chlorthalidone **TABLET** (generic Diuril) furosemide **SOLN, TABLET** (generic Lasix) hydrochlorothiazide **CAPS, TABLET** (generic Microzide) indapamide **TABLET** metolazone **TABLET** spironolactone **TABLET** (generic Aldactone) torsemide **TABLET**	CAROSPIR (spironolactone) **SUSP** eplerenone **TABLET** (generic Inspra)[CL] ethacrynic acid **CAPS** (generic Edecrin) KERENDIA (finerenone) **TABLET** [CL,QL] methyclothiazide **TABLET** THALITONE (chlorthalidone) **TABLET** triamterene (generic Dyrenium)	
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)	• Non-preferred agents require clinical documentation why the preferred product within this drug class is not appropriate Drug-specific criteria: • **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**	• Non-preferred agents require clinical documentation why the preferred product within this drug class is not appropriate Brand name product may be authorized in event of documented national shortage of generic product.

ERYTHROPOIESIS STIMULATING PROTEINS

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

GI MOTILITY, CHRONIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AMITIZA (lubiprostone)[AL, QL] LINZESS (linaclotide)[QL] MOVANTIK (naloxegol oxalate)[QL]	alosetron (generic Lotronex) *IBSRELA (tenapanor)*[AL,NR,QL] lubiprostone (generic Amitiza)[AL,QL] MOTEGRITY (prucalopride succinate) RELISTOR (methylnaltrexone) **TABLET**[QL] SYMPROIC (naldemedine) TRULANCE (plecanatide)[QL] VIBERZI (eluxodoline)	• Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class Drug-specific criteria: • **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**, **PEN**, **SYRINGE, VIAL** ZEGALOGUE (dasiglucagon)[AL, QL] **AUTO-INJECTOR, SYRINGE**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

GLUCOCORTICOIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCOCORTICOIDS		• Non-preferred agents within the Glucocorticoids and Glucocorticoid/Bronchodilator Combo groups will be approved for patients who have failed a trial of TWO preferred agents within this drug class within the last 6 months Drug-specific criteria: • **budesonide respules:** Covered without PA for age ≤ 8 years OR for diagnosis of eosinophilic esophagitis in patients ≥ 9 years, by GI biopsy or upper endoscopy. For other indications, must have failed a trial of two preferred agents within this drug class, within the last 6 months.
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) *fluticasone HFA (generic Flovent HFA)[NR]* 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) *fluticasone/vilanterol[NR] (Breo Ellipta)* TRELEGY ELLIPTA (fluticasone/ umeclidinium/vilanterol) WIXELA INHUB (generic for Advair Diskus)[QL]	
INHALATION SOLUTION		
	budesonide **RESPULES** (generic for Pulmicort)	

GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC **CAPS** (generic for Entocort EC) dexamethasone **ELIXIR, SOLN** dexamethasone **TABLET** hydrocortisone **TABLET** methylprednisolone tablet (generic for Medrol) prednisolone **SOLN** prednisolone sodium phosphate prednisone **DOSE PAK** prednisone **TABLET**	ALKINDI (hydrocortisone) **GRANULES**[AL] CORTEF (hydrocortisone) cortisone **TABLET** dexamethasone **INTENSOL** DEXPAK (dexamethasone) DXEVO (dexamethasone) EMFLAZA (deflazacort) **SUSP, 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 **SOLN** prednisone **INTENSOL** RAYOS DR (prednisone) **TABLET** TARPEYO (budesonide)[NR] **CAPS**	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: • **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) NUTROPIN AQ (somatropin) NORDITROPIN (somatropin)	HUMATROPE (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin-tcgd) ZOMACTON (somatropin) ZORBTIVE (somatropin)	Growth Hormone PA Form Growth Hormone Criteria

H. PYLORI TREATMENTS

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

HAE TREATMENTS[CL]

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

HEMOPHILIA TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FACTOR VIII		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class ▪ *Patients receiving a hemophilia agent which moved from preferred to non-preferred status on 1-21-21 will be allowed to continue same therapy*
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	TRETTEN	
VON WILLEBRAND PRODUCTS		
WILATE	VONVENDI	
BISPECIFIC FACTORS		
HEMLIBRA		

HEPATITIS B TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
entecavir **TABLET**	adefovir dipivoxil BARACLUDE (entecavir) **SOLN, TABLET** EPIVIR HBV (lamivudine) **TABLET, SOLN** lamivudine hbv **TABLET** VEMLIDY (tenofovir alafenamide fumarate)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIRECT ACTING ANTI-VIRAL		Hepatitis C Treatments PA Form Hepatitis C Criteria ▪ Non-preferred products require trial of preferred agents within the same group and/or will only be considered with documentation of why the preferred product within this drug class is not appropriate for patient ▪ Patients newly eligible for Medicaid will be allowed to complete treatment with the original that treatment was initially authorized by another payor Drug-specific criteria: Trial with with a preferred agent not required in the following: ▪ **Harvoni**: o 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]		

HISTAMINE II RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
famotidine **TABLET** (generic for Pepcid) nizatidine **SOLN** (generic for Axid)	cimetidine **TABLET, SOLN**[CL] (generic for Tagamet) famotidine **SUSP** nizatidine **CAPS** (generic for Axid) ranitidine **CAPS,** (generic for Zantac) ranitidine OTC, SYRUP, TABLET (generic for Zantac)	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: • **Cimetidine:** Approved for viral M. contagiosum or common wart V. Vulgaris treatment • **cimetidine solution/ famotidine suspension/ranitidine syrup:** Requires clinical reason why nizatidine syrup cannot be used ******famotidine suspension is authorized during shortage of nizatidine syrup.*****

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2022 PDL Highlighted in Red effective November 1, 2022

HIV / AIDS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CCR5 ANTAGONISTS		▪ 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 ▪ Pre and Post Exposure Prophylaxis
SELZENTRY **SOLN, TAB** (maraviroc)	maraviroc (generic Selzentry)	
FUSION INHIBITORS		
FUZEON **SUB-Q** (enfuvirtide)[QL]		
HIV-1 ATTACHMENT INHIBITOR		
	RUKOBIA ER (fostemsavir)[AL,QL]	
INTEGRASE STRAND TRANSFER INHIBITORS (INSTIs)		
ISENTRESS (raltegravir)[QL] ISENTRESS HD (raltegravir) TIVICAY (dolutegravir)	TIVICAY PD (dolutegravir)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)		
efavirenz **CAPS, TABLET** (generic Sustiva) INTELENCE (etravirine)[QL] PIFELTRO (doravirine)[QL]	EDURANT (rilpivirine) etravirine (generic Intelence)[QL] nevirapine IR, ER (generic Viramune/Viramune XR) RESCRIPTOR (delavirdine) SUSTIVA **CAPS, TABLET** (efavirenz) VIRAMUNE (nevirapine) **SUSP**	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
abacavir **SOLN, TABLET** (generic Ziagen) EMTRIVA **CAPS, SOLN** (emtricitabine) lamivudine **SOLN, TABLET** (generic Epivir) zidovudine **CAPS, SYRUP, TABLET** (generic Retrovir)	didanosine DR (generic Videx EC) emtricitabine **CAPS** (generic for Emtriva) EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine **CAPS** (generic Zerit) VIDEX (didanosine) **SOLN** ZIAGEN (abacavir)	
NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
tenofovir **TABLET** (generic Viread)	VIREAD (tenofovir) **POWDER**	
PHARMACOKINETIC ENHANCER		
	TYBOST (cobicistat)[QL]	

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

CL – Prior Authorization / Class Criteria apply QL – Quantity/Duration Limit AL – Age Limit

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

HIV / AIDS[CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROTEASE INHIBITORS		
atazanavir **CAPS** (generic Reyataz) ritonavir **TABLET** (generic Norvir)	APTIVUS **CAPS, SOLN** (tipranavir) CRIXIVAN (indinavir) fosamprenavir **TAB** (generic Lexiva) INVIRASE (saquinavir) LEXIVA **SUSP** (fosamprenavir) LEXIVA **TABLET** (fosamprenavir) NORVIR **POWDER, SOLN** (ritonavir) NORVIR (ritonavir) **TAB** PREZISTA (darunavir) **SUSP, TABLET** REYATAZ **POWDER** (atazanavir) VIRACEPT (nelfinavir)	▪ 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 ▪ Pre and Post Exposure Prophylaxis

HIV / AIDS[CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PROTEASE INHIBITORS (PIs) or PIs plus PHARMACOKINETIC ENHANCER		▪ 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 ▪ Pre and Post Exposure Prophylaxis
EVOTAZ (atazanavir/cobicistat)[QL] lopinavir/ritonavir **SOLN** (generic Kaletra)	KALETRA **SOLN** (lopinavir/ritonavir) KALETRA **TAB** (lopinavir/ritonavir) lopinavir/ritonavir **TAB** (generic Kaletra) PREZCOBIX (darunavir/cobicistat)[QL]	
COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir/lamivudine (generic Epzicom) CIMDUO (lamivudine/tenofovir)[QL] DESCOVY (emtricitabine/tenofovir)[QL, CL] emtricitabine/tenofovir (generic Truvada)[CL] lamivudine/zidovudine (generic Combivir)	abacavir/lamivudine/zidovudine (generic Trizivir) COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir sulfate/lamivudine) TEMIXYS (lamivudine/tenofovir)[QL] TRIZIVIR (abacavir/lamivudine/zidovudine) TRUVADA (emtricitabine/tenofovir)	Drug-Specific Criteria **Descovy**: • Approval will be granted for a diagnosis of HIV/AIDS • For PrEP use: Will require prior approval with a documentation of a contraindication to Truvada cannot be used.

HIV / AIDS[CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PRODUCTS – MULTIPLE CLASSES		
BIKTARVY (bictegravir/emtricitabine/ tenofovir)[QL] COMPLERA (rilpivirine/emtricitabine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir)[QL] DOVATO (dolutegravir/lamivudine)[QL] efavirenz/emtricitabine/tenofovir (generic Atripla)[CL] GENVOYA (elvitegravier/cobicistat/ emtricitabine/tenofovir)[QL, AL] ODEFSEY (emtricitabine/rilpivirine/ tenofovir)[QL] STRIBILD (elvitegravir/cobicistat/ emtricitabine/tenofovir)[QL] SYMFI (efavirenz/lamivudine/ tenofovir)[QL] SYMFI LO (efavirenz/lamivudine/ tenofovir)[QL] SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir)[QL] TRIUMEQ (dolutegravir/abacavir/ lamivudine)	ATRIPLA (efavirenz/emtricitabine/tenofovir) efavirenz/lamivudine/tenofovir (generic for Symfi)[QL] efavirenz/lamivudine/tenofovir (generic for Symfi Lo)[QL] JULUCA (dolutegravir/rilpivirine)[QL] TRIUMEQ PD (abacavir, dolutegravir, and lamivudine) **SUSP**[NR]	▪ 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 ▪ Pre and Post Exposure Prophylaxis

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

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

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2022 PDL Highlighted in Red effective November 1, 2022

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

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

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

CL – Prior Authorization / Class Criteria apply QL – Quantity/Duration Limit AL – Age Limit

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

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria

HUMALOG (insulin lispro) U-100 **CARTRIDGE, PEN, VIAL**
HUMALOG JR. (insulin lispro) U-100 **KWIKPEN**
HUMALOG MIX **VIAL** (insulin lispro/lispro protamine)
HUMALOG MIX **KWIKPEN** (insulin lispro/lispro protamine)
HUMULIN (insulin) **VIAL**
HUMULIN 70/30 **VIAL**
HUMULIN U-500 **VIAL**
HUMULIN R U-500 **KWIKPEN**[CL]
HUMULIN OTC **PEN**
HUMULIN 70/30 OTC **PEN**
insulin aspart (generic for Novolog)
insulin aspart/insulin aspart protamine **PEN, VIAL**(generic for Novolog Mix)
insulin lispro (generic for Humalog) **PEN, VIAL, JR KWIKPEN**
insulin lispro/lispro protamine **KWIKPEN** (Humalog Mix Kwikpen)
LANTUS SOLOSTAR **PEN** (insulin glargine)
LANTUS (insulin glargine) **VIAL**
LEVEMIR (insulin detemir) **PEN, VIAL**
NOVOLIN (insulin) **PEN**
NOVOLOG (insulin aspart) **CARTRIDGE, FLEXPEN, VIAL**
NOVOLOG MIX **FLEXPEN, VIAL** (insulin aspart/aspart protamine)
	ADMELOG (insulin lispro) **PEN, VIAL**
	AFREZZA (regular insulin) **INHALATION**
	APIDRA (insulin glulisine)
	BASAGLAR (insulin glargine, rec) **PEN**
	FIASP (insulin aspart) **CARTRIDGE, PEN, VIAL**
	HUMALOG (insulin lispro) U-200 **KWIKPEN**
	insulin degludec (generic Tresiba)[NR] 100U/mL **PEN**, 200U/mL **PEN**, **VIAL**
	insulin glargine **PEN, VIAL**
	insulin Glargine-YFGN **PEN, VIAL** (generic for Semglee-YFGN)
	LYUMJEV **KWIKPEN, VIAL**(insulin lispro-aabc)
	NOVOLIN (insulin)
	NOVOLIN 70/30 **VIAL**(insulin)
	NOVOLOG MIX (insulin aspart/aspart protamine) **VIAL**
	TOUJEO SOLOSTAR (insulin glargine)
	SEMGLEE (insulin glargine) **PEN, VIAL**
	SEMGLEE YFGN (insulin glargine) **PEN, VIAL**
	TRESIBA (insulin degludec)
		• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
		
		Drug-specific criteria:
		• **Afrezza®:** Approved for T1DM on long-acting insulin with no current history of smoking or chronic lung disease
		• **Humulin® R U-500 Kwikpen:** Approved for physical reasons – such as dexterity problems and vision impairment
		  • 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
repaglinide (generic for Prandin)	nateglinide (generic for Starlix)[CL] repaglinide/metformin (generic for Prandimet)[CL]	• Non-preferred agents will be approved for patients with: Failure of a trial of ONE preferred agent in another Hypoglycemic class OR T2DM and inadequate glycemic control

HYPOGLYCEMICS, METFORMINS

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

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]	Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin **OR** A diagnosis of ASCVD or Heart Failure, or Chronic Kidney Disease associated with a diagnosis of Type II diabetes (no metformin trial required) • Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug Specific Criteria: • **Farxiga:** May be **a**pproved for a diagnosis of heart failure with reduced ejection fraction (NYHA class II-IV) without a diagnosis of diabetes - May be approved for a diagnosis of chronic kidney disease at risk of progression without a diagnosis of diabetes • **Jardiance:** May be approved for a diagnosis of Heart Failure without a diagnosis of diabetes

HYPOGLYCEMICS, SULFONYLUREAS

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

HYPOGLYCEMICS, TZD

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
THIZAOLIDINEDIONES (TZDs)		▪ Non-preferred agents will be approved for patients who have failed a trial of THE preferred agent within this drug class ▪ **Combination products:** Require clinical reason why individual ingredients cannot be used
pioglitazone (generic for Actos)	AVANDIA (rosiglitazone)	
TZD COMBINATIONS		
	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)[QL] pirfenidone (generic for Esbriet)[NR,QL]	• Non-preferred agent requires trial of preferred agent within this drug class • FDA approved indication required – ICD-10 diagnosis code

IMMUNOMODULATORS, ASTHMA[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FASENRA (benralizumab)[AL] **PEN** XOLAIR (omalizumab) **SYR**[AL,QL]	NUCALA (mepolizumab)[AL] **AUTO-INJ, SYR**	Asthma Immunomodulator PA Form • Non-preferred agents require a trial of a preferred agent within this drug class with the same indication Drug Specific Criteria: **Dupixent**: is indicated for - 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 **Fasenra**: is indicated for - Patient 12 years and older for add on maintenance treatment of severe asthma, and with an eosinophilic phenotype **Nucala**: is indicated for -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 **Xolair Syringe-** is indicated for -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

IMMUNOMODULATORS, ATOPIC DERMATITIS[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIDEL (pimecrolimus) EUCRISA (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]	▪ 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 months 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) - for treatment of eosinophilic esophagitis in adult and pediatric patients aged 12 years and older, weighing at least 40 kg • **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) HYFTOR (sirolimus)[AL,NR] **GEL** imiquimod (generic for Zyclara) podofilox (generic for Condylox) VEREGEN (sinecatechins) ZYCLARA (imiquimod)	• Non-preferred agents require clinical reason why preferred agent within this drug class cannot be used

IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathioprine (generic Imuran) *azathioprine (generic Azasan)*[NR] cyclosporine, modified **CAPS** (generic Neoral) everolimus (generic for Zortress)[AL] mycophenolate **CAPS, TABLET** (generic Cellcept) RAPAMUNE (sirolimus) **SOLN** RAPAMUNE (sirolimus) **TABLET** tacrolimus	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) cyclosporine **CAP**, **SOFTGEL** cyclosporine, modified **SOLN** (generic Neoral) ENVARSUS XR (tacrolimus) GENGRAF (cyclosporine, modified) **CAP, SOLN** mycophenolate **SUSP** (generic Cellcept) mycophenolic acid MYFORTIC (mycophenolate sodium) PROGRAF (tacrolimus) **CAPS, PACKET** REZUROCK (belumosudil)[AL,QL] **TAB** SANDIMMUNE (cyclosporine) **CAPS, SOLN** sirolimus **SOLN, TABLET** (generic Rapamune) TAVNEOS (avacopan)[QL] **CAPS** ZORTRESS (everolimus) [AL]	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class ▪ Patients established on existing therapy will be allowed to continue

INTRANASAL RHINITIS DRUGS

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

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)	• Non-preferred agents will be approved for patients who have failed a 30-day trial of THE preferred agent within this drug class Drug-specific criteria: • **montelukast granules:** PA not required for age < 2 years

LINCOSAMIDES / OXAZOLIDINONES / STREPTOGRAMINS

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

LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Colesevelam**: Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate ▪ **Juxtapid®/ Kynamro®:** ○ Approved for diagnosis of homozygous familial hypercholesterolemia (HoFH) OR ○ Treatment failure/maximized dosing/contraindication to ALL the following: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, bile acid sequestrants ○ Require faxed copy of REMS PA form ▪ **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 Fibricor/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)	NEXLIZET (bempedoic acid/ ezetimibe)[QL]	

LIPOTROPICS, OTHER (continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		
	PRALUENT (alorocumab)[CL] REPATHA (evolocumab)[CL]	▪ **Praluent®:** Approved for diagnoses of: • atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) • Homozygous familial hypercholesterolemia (HoFH) as an adjunct to other LDL-C lowering therapies • AND • 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: • adult diagnoses of atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) • homozygous familial hypercholesterolemia (HoFH) in age ≥ 13 • statin-induce rhabdomyolysis AND • Maximized high-intensity statin WITH ezetimibe for 3+ continuous months • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL • Concurrent use of maximally-tolerated statin must continue, except for statin-induced rhabdomyolysis or a contraindication to a statin

LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
STATINS		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agent within this drug class, within the last 12 months Drug-specific criteria: ▪ **Altoprev®:** One of the TWO trials must be IR lovastatin ▪ **Combination products:** Require clinical reason why individual ingredients cannot be used ▪ **fluvastatin ER:** Requires trial of TWO preferred agents AND trial of IR fluvastatin OR clinical reason IR cannot be used ▪ **simvastatin/ezetimibe:** Approved for 3-month continuous trial of ONE standard dose statin
atorvastatin (generic Lipitor)QL lovastatin (generic Mevacor) pravastatin (generic Pravachol) rosuvastatin (generic Crestor) simvastatin (generic Zocor)	ALTOPREV (lovastatin ER)CL 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		• 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, SUSP** (generic Biaxin) E.E.S. **SUSP** (erythromycin ethylsuccinate)	clarithromycin ER (generic Biaxin XL) E.E.S. **TABLET** (erythromycin ethylsuccinate) ERY-TAB (erythromycin) erythromycin ethylsuccinate **SUSP** ERYPED **SUSP** (erythromycin) ERYTHROCIN (erythromycin) erythromycin base **TABLET, CAPS**	

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** TREXALL (methotrexate) **TABLET** XATMEP (methotrexate) **SOLN**	Non-preferred agents require a trial of the preferred agent AND will be approved for an FDA-approved indication Drug-specific criteria: • **Xatmep™**:Indicated for pediatric patients only

MOVEMENT DISORDERS

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

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2022 PDL Highlighted in Red effective November 1, 2022

MULTIPLE SCLEROSIS DRUGS

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

NITROFURAN DERIVATIVES

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

NSAIDs, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE		• Non-preferred agents within COX-1 SELECTIVE group will be approved for patients who have failed no less than 30-day trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **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 ▪ **Sprix®:** Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs
diclofenac sodium (generic Voltaren) ibuprofen OTC, Rx (generic fAdvil, Motrin) **CHEW, DROPS, SUSP, TAB** indomethacin **CAPS** (generic Indocin) ketorolac (generic Toradol) meloxicam **TABLET** (generic Mobic) nabumetone (generic Relafen) naproxen Rx, OTC (generic Naprosyn) naproxen enteric coated sulindac (generic Clinoril)	diclofenac potassium (generic Cataflam, Zipsor) diclofenac SR (generic Voltaren-XR) diflunisal (generic Dolobid) etodolac & SR (generic Lodine/XL) fenoprofen (generic Nalfon) flurbiprofen (generic Ansaid) ibuprofen OTC (generic Advil, Motrin) **CAPS** indomethacin ER (generic Indocin) INDOCIN **RECTAL, SUSP** ketoprofen & ER (generic Orudis) meclofenamate (generic Meclomen) mefenamic acid (generic Ponstel) meloxicam **CAP** (generic Vivlodex)[CL, QL] naproxen CR (generic Naprelan) naproxen **SUSP** (generic Naprosyn) naproxen sodium (generic Anaprox) naproxen-esomeprazole (generic Vimovo) oxaprozin (generic Daypro) piroxicam (generic Feldene) RELAFEN DS (nabumetone) tolmetin (generic Tolectin) Ketorolac Nasal [QL] (generic Sprix)	

NSAIDs, ORAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE (continued)		
	ALL BRAND NAME NSAIDs including: DUEXIS (ibuprofen/famotidine)[CL] ibuprofen/famotidine (generic Duexis)[CL]	
NSAID/GI PROTECTANT COMBINATIONS		
	diclofenac/misoprostol (generic for Arthrotec)	
COX-II SELECTIVE		
celecoxib (generic for Celebrex)		

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 • **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 resaon patient cannot use oral dosage form

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2022 PDL Highlighted in Red effective November 1, 2022

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

ONCOLOGY AGENTS, ORAL, BREAST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CDK 4/6 INHIBITOR		• Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Drug-specific critera ▪ **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
IBRANCE (palbociclib)	KISQALI (ribociclib) KISQALI FEMARA **CO-PACK** VERZENIO (abemaciclib)	
CHEMOTHERAPY		
cyclophosphamide XELODA (capecitabine)	capecitabine (generic for Xeloda)[CL]	
HORMONE BLOCKADE		
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]	

Nebraska Medicaid
Preferred Drug List
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ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALL		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Drug-specific critera ▪ **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] IMBRUVICA (ibrutinib)[NR] **SUSP** 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[QL] (lenalidomide)	FARYDAK (panobinostat) lenalidomide[NR,QL] (generic for Revlimid) melphalan (generic for Alkeran) NINLARO (ixazomib) POMALYST (pomalidomide) THALOMID (thalidomide) XPOVIO (selinexor) [CL]	
OTHER		
MATULANE (procarbazine) TABLOID (thioguanine) tretinoin (generic for Vesanoid)[AL]	BRUKINSA (zanubrutinib[QL] CALQUENCE (acalabrutinib)[QL] INREBIC (fedratinib dihydrochloride)[QL] INQOVI (decitabine/cedazuridine) *VONJO (pacritinib)[NR,QL]* ZOLINZA (vorinostat)	

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

[CL] – Prior Authorization / Class Criteria apply [QL] – Quantity/Duration Limit [AL] – Age Limit

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

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2022 PDL Highlighted in Red effective November 1, 2022

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ONCOLOGY AGENTS, ORAL, LUNG

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALK		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Drug-Specific Criteria ▪ **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
ALECENSA (alectinib)	ALUNBRIG (brigatinib)[QL] LORBRENA (lorlatinib) [QL] ZYKADIA (ceritinib) **CAPS, TABLET**	
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 (pralsetinib)[QL] HYCAMTIN (topotecan) *LUMAKRAS (sotrasib)*[QL] *RETEVMO (selpercatinib)*[AL] *TABRECTA (capmatinib)*[QL] *TEPMETKO (tepotinib)* [QL]	

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2022 PDL Highlighted in Red effective November 1, 2022

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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) **CAPS** VITRAKVI (larotrectinib) **CAPS, SOLN**	• 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

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2022 PDL Highlighted in Red effective November 1, 2022

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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] ORGOVYX (relugolix)[AL,NR] YONSA (abiraterone acetonide, submicronized)	• 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) *sorafenib (generic Nexavar)[NR]* sunitinib malate (generic for Sutent) WELIREG (belzutifan)[NR,QL]	• Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Drug-specific critera ▪ **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		▪ 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 critera ▪ **Odomzo:** Patients receiving Odomzo, which changed from preferred to non-preferred on 1-17-19 will be allowed to continue therapy
ERIVEDGE (vismodegib)	ODOMZO (sonidegib)[CL]	
BRAF MUTATION		
MEKINIST (trametinib) TAFINLAR (dabrafenib)	BRAFTOVI (encorafenib) COTELLIC (cobimetinib) MEKTOVI (binimetinib) ZELBORAF (vemurafenib)	

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 (lodoxamide) azelastine (generic for Optivar) BEPREVE (bepotastine besilate) bepotastine besilate (generic for Bepreve) EMADINE (emedastine) epinastine (generic for Elestat) LASTACAFT (alcaftadine) LASTACAFT (alcaftadine)[NR] **OTC** PATADAY XS (olopatadine 0.7%) PATADAY OTC (olopatadine 0.2%) PAZEO (olopatadine 0.7%) ZERVIATE (certirizine)[AL]	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

OPHTHALMICS, ANTIBIOTICS

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

OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

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

OPHTHALMICS, ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CORTICOSTEROIDS		▪ 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) *loteprednol **GEL** (generic for Lotemax Gel)* 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 Ocufen) 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)	CEQUA (cyclosporine) [QL] maravi EYSUVIS (loteprednol etabonate)[QL] *TYRVAYA (varenicline tartrate)[NR, QL]*	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

OPHTHALMICS, GLAUCOMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MIOTICS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide) VUITY (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) *timolol (generic for Timoptic Ocudose)* TIMOPTIC OCUDOSE TIMOPTIC XE (timolol gel forming solution)	
CARBONIC ANHYDRASE INHIBITORS		
dorzolamide (generic for Trusopt)	AZOPT (brinzolamide) *brinzolamide (generic for Azopt)*	
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]		Drug-specific criteria: ▪ **Rhopressa and Rocklatan:** Electronically approved for patients who have a trial of ONE generic agent, within ophthalmics - glaucoma within 60 days

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

OPIOID DEPENDENCE TREATMENTS

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

OPIOID-REVERSAL TREATMENTS

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

OTIC ANTI-INFECTIVES & ANESTHETICS

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

OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
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)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

PAH (PULMONARY ARTERIAL HYPERTENSION AGENTS), ORAL AND INHALED

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

PANCREATIC ENZYMES

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

PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHILD CHEW + IRON (MULTIVITAMIN WITH IRON) **CHEW** CHILDREN'S CHEWABLES (PEDI MULTIVIT NO.31/IRON/FOLIC, PEDI MULTIVIT NO.25/FOLIC ACID, PEDI MULTIVIT NO.23/FOLIC ACID) MULTIVIT-FLUOR (PEDI MULTIVIT NO.17 W-FLUORIDE, PEDI MULTIVIT NO.16 W-FLUORIDE) **CHEW** MULTIVIT-FLUOR (PEDI MULTIVIT NO.2 W-FLUORIDE) **DROP** MULTIVIT-IRON-FLUOR (PEDI MULTIVIT 45/FLUORIDE/IRON) PED MVIT A,C,D3 NO.21/FLUORIDE POLY-VI-SOL WITH IRON (PEDI MV NO.189/FERROUS SULFATE) **DROPS** TRI-VI-SOL (VIT A PALMITATE/VIT C/VIT D3) **DROP**S TRI-VITE-FLUORIDE (PED MVIT A,C,D3 NO.21/FLUORIDE)	DEKAs PLUS **LIQUID**[AL] FLORIVA (PEDI MULTIVIT NO.85/FLUORIDE) **CHEW** FLORIVA PLUS (PEDI MULTIVIT NO.161/FLUORIDE **DROP** MULTI-VIT-FLOR (PEDI MULTIVIT NO.205/FLUORIDE) **CHEW** POLY-VI-FLOR (PEDI MULTIVIT NO.33/FLUORIDE) **CHEW** POLY-VI-FLOR (PEDI MULTIVIT NO.37 W-FLUORIDE) **DROPS** POLY-VI-FLOR /0.25mg IRON (PEDI MULTIVIT 37/FLUORIDE/IRON) POLY-VI-FLOR /0.5mg IRON (PEDI MULTIVIT 33/FLUORIDE/IRON) POLY-VI-SOL (PEDIATRIC MULTIVITAMIN NO.192) **DROP** QUFLORA (PEDI MULTIVIT NO.157/FLUORIDE) **GUMMIES** QUFLORA FE (PED MULTIVIT 142/IRON/FLUORIDE) **CHEW** QUFLORA FE (PED MULTIVIT 151/IRON/FLUORIDE) **DROP** QUFLORA PED (PEDI MULTIVIT NO.63 W-FLUORIDE) **CHEW** QUFLORA PED (PEDI MULTIVIT 84 WITH FLUORIDE, PEDI MULTIVIT NO.83 W-FLUORIDE) **DROP** TRI-VI-FLOR (PED MVIT A,C,D3 NO.38/FLUORIDE) **DROPS**	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class Drug specific criteria: ▪ **DEKAs Plus**: Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent

PENICILLINS

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

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate **TABLET** CALPHRON OTC (calcium acetate) RENVELA (sevelamer carbonate)	AURYXIA (ferric citrate) calcium acetate **CAPSULE** 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)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
aspirin BRILINTA (ticagrelor) clopidogrel (generic Plavix) dipyridamole (generic Persantine) prasugrel (generic Effient)	aspirin/dipyridamole (generic Aggrenox) ticlopidine (generic Ticlid) YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar)[CL]	▪ 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 Drug-specific criteria: ▪ **Zontivity®:** Approved for reduction of thrombotic cardiovascular events in history of MI or with peripheral artery disease (PAD) Use with aspirin and/or clopidogrel

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2022 PDL Highlighted in Red effective November 1, 2022

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

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**	▪ When filled as outpatient prescription, use limited to: ▪ 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) esomeprazole magnesium (generic Nexium) **RX**[QL] esomeprazole magnesium (generic Nexium) **OTC**[QL] esomeprazole strontium lansoprazole (generic Prevacid)[QL] NEXIUM **SUSPENSION** (esomeprazole) omeprazole/sodium bicarbonate (generic Zegerid RX) pantoprazole **GRANULES** [QL] rabeprazole (generic Aciphex)	▪ Non-preferred agents will be approved for patients who have failed an 8-week trial of both preferred omeprazole Rx AND pantoprazole OR Protonix SUSP. **Pediatric Patients:** Patients ≤ 4 years of age – No PA required for Prevacid 30mg or omeprazole 20mg capsules (used to compound suspensions). Drug-specific criteria: ▪ **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 of age- Only approve non-preferred for GI diagnosis if: ▪ Child can not swallow whole generic omeprazole capsules OR, ▪ Documentation that contents of capsule may not be sprinkled in applesauce

SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BENZODIAZEPINES		
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)	▪ **Lunesta®/ Rozerem®/zolpidem ER:** Requires a trial with generic zolpidem within the last 12 months AND Trial OR Clinical reason why zaleplon and preferred benzodiapine cannot be used ▪ **Edluar®:** Requires a trial with generic zolpidem within the last 12 months AND Trial OR Clinical reason why zaleplon and preferred benzodiapine cannot be used and Requires documentation of swallowing disorder ▪ **flurazepam/triazolam:** Requires trial of preferred benzodiazepine ▪ **Hetlioz®:** 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: ○ 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)[ALQL] doxepin (generic for Silenor) EDLUAR (zolpidem sublingual) eszopiclone (generic for Lunesta) HETLIOZ (tasimelteon)[CL] HETLIOZ LQ (tasimelteon) **SUSP** [AL,QL] QUVIVIQ (daridorexant)[NR,QL] ramelteon (generic for Rozerem) zolpidem ER (generic for Ambien CR) zolpidem SL (generic for Intermezzo)	

SICKLE CELL ANEMIA TREATMENT[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DROXIA (hydroxyurea)	ENDARI (L-glutamine)[CL] OXBRYTA (voxelotor)[CL] SIKLOS (hydroxyurea)	Drug-Specific Criteria ▪ **Endari:** Patient must have documented two or more hospital admissions per year due to sickle cell crisis despite maximum hydroxyurea dosage. ▪ **Oxbryta**: Not inidcated for sickle cell crisis. Patient must have had at least one sickle cell-related vaso-occlusive event within the past 12 months; AND baseline hemoglobin is 5.5 g/dL ≤ 10.5 g/dL; AND patient is not receiving concomitant, prophylactic blood tranfusion therapy ▪ **Siklos**: Approved for use in patients ages 2 to 17 years old

SINUS NODE INHIBITORS

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

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

STEROIDS, TOPICAL

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

STEROIDS, TOPICAL (Continued)

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

STIMULANTS AND RELATED AGENTS[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CNS STIMULANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Procentra®:** 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] **CAPS, CHEWABLE**	ADZENYS XR (amphetamine) amphetamine ER (generic Adzenys ER) **SUSP** amphetamine salt combination ER (generic for Adderall XR) amphetamine sulfate (generic for Evekeo) dextroamphetamine (generic for Dexedrine) dextroamphetamine **SOLN** (generic Procentra) dextroamphetamine ER (generic for Dexedrine ER) DYANAVEL XR (amphetamine)[QL] EVEKEO ODT (amphetamine sulfate) MYDAYIS (amphetamine salt combo)[QL] methamphetamine (generic for Desoxyn) ZENZEDI (dextroamphetamine)	

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2022 PDL Highlighted in Red effective November 1, 2022

STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

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

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

STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

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

TETRACYCLINES

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

THROMBOPOIESIS STIMULATING PROTEINS[CL]

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

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) levothyroxine **CAPSULE** (generic Tirosint) THYROLAR **TABLET** (liotrix) THYQUIDITY (levothyroxine) **SOLN** TIROSINT **CAPS** (levothyroxine) TIROSINT-SOL **LIQUID** (levothyroxine)[CL]	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Tirosint-Sol**: May be approved with documented swallowing difficulty

ULCERATIVE COLITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Asacol HD®/Delzicol DR®/ Pentasa®:** Requires clinical reason why preferred mesalamine products cannot be used ▪ **Giazo®:** Requires clinical reason why generic balsalazide cannot be used NOT covered in females
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 ER (generic Pentasa)[NR] mesalamine (generic Asacol HD/ Delzicol/Lialda) PENTASA (mesalamine)	
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
MYFEMBREE (relugolix/ estradiol/ norethindrone acetate)[AL, CL,QL] *ORIAHNN (elagolix/ estradiol/ norethindrone)[AL,CL]* ORILISSA (elagolix sodium)[QL,CL]		Drug-specific criteria: • **Myfembree, Orilissa, and Oriahnn:** Requires an FDA approved indication, must follow FDA dosing guidelines, and have had a trial and failure of an NSAID and oral contraceptive ○ Total duration of treatment is max of 24 months

VASODILATORS, CORONARY

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