

## Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January 2023 PDL with November 2022 P&T Changes Implemented  
Noted in Red Font that Become Effective January 20, 2023

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>

- [Immunomodulators Self-Injectable 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) <b>WASH, LOTION</b> clindamycin/BPO (generic Benzacilin) <b>PUMP</b> clindamycin phosphate <b>PLEDGET</b> clindamycin phosphate <b>SOLUTION</b> DIFFERIN <b>LOTION, CREAM, Rx-GEL</b> (adapalene) DIFFERIN <b>GEL</b> (adapalene) OTC erythromycin <b>GEL</b> erythromycin <b>SOLN</b> erythromycin-BPO (generic for Benzamycin) RETIN-A (tretinoin) <sup>AL</sup> <b>CREAM, GEL</b>	adapalene (generic differin) adapalene/BPO (generic Epiduo) adapalene/BPO (generic Epiduo Forte) ALTRENO (tretinoin) <sup>AL</sup> AMZEEQ (minocycline) ARAZLO (tazarotene) <sup>AL</sup> ATRALIN (tretinoin) AVAR (sulfacetamide sodium/sulfur) AVITA (tretinoin) AZELEX (azelaic acid) BENZACLIN <b>PUMP</b> (clindamycin/BPO) BENZEFOAM (benzoyl peroxide) benzoyl peroxide <b>CLEANSER,</b> <b>CLEANSING BAR</b> OTC benzoyl peroxide <b>FOAM</b> (generic Benzepro) benzoyl peroxide <b>GEL</b> OTC benzoyl peroxide <b>GEL</b> Rx benzoyl peroxide <b>TOWELETTE</b> OTC clindamycin <b>FOAM, LOTION</b> clindamycin <b>GEL</b> clindamycin phosphate (generic for Clindagel) <b>GEL</b> clindamycin/BPO (generic Acanya) <b>GEL</b> clindamycin/BPO (generic Duac) clindamycin/tretinoin (generic Veltin, Ziana) dapsone (generic Aczone) EPIDUO FORTE <b>GEL PUMP</b> (adapalene/BPO) erythromycin <b>GEL, PLEDGET</b> 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 <sup>AL</sup> <b>GEL, CREAM</b> (tretinoin) sulfacetamide sulfacetamide/sulfur SUMADAN (sulfacetamide/sulfur) tazarotene <b>CREAM, GEL</b> <sup>NR</sup> (generic Tazorac) tazarotene FOAM (generic Fabior) TRETIN-X (tretinoin) tretinoin CREAM, GELAL (generic Avita, Retin-A) tretinoin microspheres (generic for Retin-A Micro) <sup>AL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class</li> </ul>

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CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

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## ALZHEIMER'S AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>CHOLINESTERASE INHIBITORS</b>		<ul style="list-style-type: none"> <li>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</li> <li><b>OR</b></li> <li>Current, stabilized therapy of the non-preferred agent within the previous 45 days</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Donepezil 23:</b> 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)</li> </ul>
donepezil (generic Aricept) donepezil ODT (generic Aricept ODT) <b>rivastigmine PATCH (generic for Exelon Patch)</b>	<b>ADLARTY (donepezil) PATCH</b> ARICEPT (donepezil) donepezil 23 (generic Aricept 23) <sup>CL</sup> <b>EXELON (rivastigmine) PATCH</b> galantamine (generic Razadyne) <b>SOLN, TAB</b> galantamine ER (generic Razadyne ER) rivastigmine <b>CAPS</b> (generic Exelon)	
<b>NMDA RECEPTOR ANTAGONIST</b>		
memantine (generic Namenda)	memantine ER (generic Namenda XR) memantine <b>SOLN</b> (generic Namenda) NAMENDA (memantine) NAMZARIC (memantine/donepezil)	

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## ANALGESICS, OPIOID LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BUTRANS (buprenorphine) <sup>QL</sup> <b>PATCH</b> fentanyl 25, 50, 75, 100 mcg <b>PATCH</b> <sup>QL</sup> morphine ER <b>TABLET</b> (generic MS Contin, Oramorph SR) OXYCONTIN <sup>CL</sup> (oxycodone ER) tramadol ER (generic Ultram ER) <sup>CL</sup>	BELBUCA (buprenorphine) <sup>QL</sup> <b>BUCCAL</b> buprenorphine <b>BUCCAL</b> (generic for Belbuca) <sup>AL, QL</sup> buprenorphine PATCH (generic Butrans) <sup>QL</sup> EMBEDA (morphine sulfate/naltrexone) DURAGESIC MATRIX (fentanyl) <sup>QL</sup> fentanyl 37.5, 62.5, 87.5 mcg <b>PATCH</b> <sup>QL</sup> hydrocodone ER (generic for Hysingla ER) <sup>QL</sup> hydrocodone bitartrate ER (generic for Zohydro ER) hydromorphone ER (generic for Exalgo) <sup>CL</sup> HYSINGLA ER (hydrocodone ER) KADIAN (morphine ER) methadone <b>TABLET</b> <sup>CL</sup> methadone <b>ORAL SYR</b> <sup>CL</sup> MORPHABOND ER (morphine sulfate) morphine ER (generic for Avinza, Kadian) <b>CAPS</b> NUCYNTA ER (tapentadol) <sup>CL</sup> oxycodone ER (generic Oxycontin) oxymorphone ER (generic Opana ER) tramadol ER (generic Conzip) <sup>CL</sup>	The Center for Disease Control (CDC) does not recommend long acting opioids when beginning opioid treatment.  <ul style="list-style-type: none"> <li>Preferred agents require previous use of a long acting opioid or documentation of a trial on a short acting agent within 90 days</li> <li>Non-preferred agents will be approved with failure on, or intolerance to TWO preferred agents within this drug class</li> </ul> Drug-specific criteria: <ul style="list-style-type: none"> <li><b>Methadone:</b> 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</li> <li><b>Oxycontin®:</b> Pain contract required for maximum quantity authorization</li> </ul>

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## ANALGESICS, OPIOID SHORT-ACTING<sup>QL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ORAL</b>		
acetaminophen/codeine <b>ELIXIR, TAB</b> codeine <b>TAB</b> hydrocodone/APAP <b>SOLN, TAB</b> hydrocodone/ibuprofen hydromorphone <b>TAB</b> morphine <b>CONC SOLN, SOLN, TAB</b> oxycodone <b>TAB, SOLN</b> oxycodone/APAP Tramadol 50 <b>TAB</b> <sup>AL</sup> (generic Ultram) tramadol/APAP (generic Ultracet)	APADAZ (benzhydrocodone/APAP) <sup>CL</sup> benzhydrocodone/APAP (generic Apadaz) <sup>CL</sup> 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 <b>LIQUID, SUPPOSITORY</b> (generic Dilaudid) IBUDONE (hydrocodone/ibuprofen) levorphanol meperidine (generic Demerol) morphine <b>SUPPOSITORIES</b> NALOCET (oxycodone/APAP) NUCYNTA (tapentadol) <sup>CL</sup> oxycodone <b>CAPS</b> oxycodone/APAP <b>SOLN</b> oxycodone/aspirin oxycodone <b>CONCENTRATE</b> oxycodone/ibuprofen oxymorphone IR (generic Opana) pentazocine/naloxone PROLATE (oxycodone/APAP) <sup>NR</sup> <b>SOLN, TAB</b> ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol) <sup>AL</sup> tramadol 100mg (generic Ultram) <sup>AL</sup> tramadol (generic Qdolo) <sup>AL, QL</sup> <b>SOLN</b> ZAMICET (hydrocodone/APAP)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class within the last 12 months</li> <li>Note: for short acting opiate tablets and capsules there is a maximum quantity limit of #150 per 30 days.</li> <li>Beginning Oct. 11, 2018: Opiate limits for opiate naïve patients will consist of <ul style="list-style-type: none"> <li>-prescriptions limited to a 7 day supply, AND</li> <li>-initial opiate prescription fill limited to maximum of 50 Morphine Milligram Equivalents (MME) per day</li> </ul> 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 naïve </li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Apadaz:</b> Approval for 14 days or less</li> <li><b>Nucynta®:</b> Approved only for diagnosis of acute pain, for 30 days or less</li> </ul>

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## ANALGESICS, OPIOID SHORT-ACTING<sup>QL</sup> (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>NASAL</b>		
	butorphanol <b>SPRAY</b> <sup>QL</sup> LAZANDA (fentanyl citrate)	
<b>BUCCAL/TRANSMUCOSAL</b> <sup>CL</sup>		Drug-specific criteria:
	ABSTRAL (fentanyl) <sup>CL</sup> fentanyl <b>TRANSMUCOSAL</b> (generic Actiq) <sup>CL</sup> FENTORA (fentanyl) <sup>CL</sup>	<ul style="list-style-type: none"> <li><b>Abstral®/Actiq®/Fentora®/Onsolis (fentanyl)</b>: Approved only for diagnosis of cancer AND current use of long-acting opiate</li> </ul>

## ANDROGENIC AGENTS (Topical)<sup>CL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ANDROGEL (testosterone) PUMP</b> <sup>CL</sup>	ANDRODERM (testosterone) <sup>CL</sup> NATESTO (testosterone) <sup>CL</sup> testosterone PACKET (generic Androgel) <sup>CL</sup> testosterone <b>PUMP</b> (generic Androgel) <sup>CL</sup> testosterone <b>GEL, PACKET, PUMP</b> (generic Vogelxo) testosterone (generic Axiron) testosterone (generic Fortesta) testosterone (generic Testim)	<ul style="list-style-type: none"> <li>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</li> <li>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</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Androderm®/Androgel®</b>: Approved for Males only</li> <li><b>Natesto®</b>: Approved for Males only with diagnosis of: Primary hypogonadism (congenital or acquired) OR Hypogonadotropic hypogonadism (congenital or acquired)</li> </ul>

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## ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ACE INHIBITORS		<ul style="list-style-type: none"><li>Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 12 months</li><li>Non-preferred combination products may be covered as individual prescriptions without prior authorization</li></ul> Drug-specific criteria: <ul style="list-style-type: none"><li><b>Epaned® and Qbrelis® Oral Solution:</b> Clinical reason why oral tablet is not appropriate</li></ul>
benazepril (generic Lotensin)	captopril (generic Capoten)	
enalapril (generic Vasotec)	EPANED (enalapril) <sup>CL</sup> <b>ORAL SOLN</b>	
lisinopril (generic Prinivil, Zestril)	enalapril (generic for Epaned) <sup>CL</sup> <b>ORAL SOLN</b>	
quinapril (generic Accupril)	fosinopril (generic Monopril)	
ramipril (generic Altace)	moexepiril (generic Univasc)	
	perindopril (generic Aceon)	
	QBRELIS (lisinopril) <sup>CL</sup> <b>ORAL SOLN</b>	
	trandolapril (generic Mavik)	
ACE INHIBITOR/DIURETIC COMBINATIONS		
benazepril/HCTZ (generic Lotensin HCT)	captopril/HCTZ (generic Capozide)	
enalapril/HCTZ (generic Vaseretic)	fosinopril/HCTZ (generic Monopril HCT)	
lisinopril/HCTZ (generic Prinzide, Zestoretic)	moexipril/HCTZ (generic Uniretic)	
quinapril/HCTZ (generic Accuretic)		
ANGIOTENSIN RECEPTOR BLOCKERS		
irbesartan (generic Avapro)	candesartan (generic Atacand)	
losartan (generic Cozaar)	EDARBI (azilsartan)	
olmesartan (generic Benicar)	eprosartan (generic Teveten)	
valsartan (generic Diovan)	telmisartan (generic Micardis)	

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## ANGIOTENSIN MODULATORS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS</b>		<ul style="list-style-type: none"><li>Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class within the last 12 months</li><li>Non-preferred combination products may be covered as individual prescriptions without prior authorization</li></ul>
irbesartan/HCTZ (generic Avalide)	candesartan/HCTZ (generic Atacand-HCT)	
losartan/HCTZ (generic Hyzaar)	EDARBYCLOR (azilsartan/chlorthalidone)	
olmesartan/HCTZ (generic Benicar-HCT)	telmisartan/HCTZ (generic Micardis-HCT)	<ul style="list-style-type: none"><li><b>Angiotensin Modulator/Calcium Channel Blocker Combinations:</b> Combination agents may be approved if there has been a trial and failure of preferred agent</li><li><b>Direct Renin Inhibitors/Direct Renin Inhibitor Combinations:</b> May be approved with a history of TWO preferred ACE Inhibitors or Angiotensin Receptor Blockers within the last 12 months</li></ul>
valsartan/HCTZ (generic Diovan-HCT)		
<b>ANGIOTENSIN MODULATOR/ CALCIUM CHANNEL BLOCKER COMBINATIONS</b>		<ul style="list-style-type: none"><li><b>Entresto:</b> May be approved with a diagnosis of heart failure</li></ul>
amlodipine/benazepril (generic Lotrel)	amlodipine/olmesartan/HCTZ (generic Tribenzor)	
amlodipine/olmesartan (generic Azor)	amlodipine/telmisartan (generic Twynsta)	
amlodipine/valsartan (generic Exforge)	amlodipine/valsartan/HCTZ (generic Exforge HCT)	Drug Specific Criteria
	PRESTALIA (perindopril/amlodipine)	
	trandolapril/verapamil (generic Tarka)	
<b>DIRECT RENIN INHIBITORS</b>		<ul style="list-style-type: none"><li><b>Entresto:</b> May be approved with a diagnosis of heart failure</li></ul>
	aliskiren (generic Tekturna) <sup>QL</sup>	
<b>DIRECT RENIN INHIBITOR COMBINATIONS</b>		
	TEKTURNA/HCT (aliskiren/HCTZ)	<ul style="list-style-type: none"><li><b>Entresto:</b> May be approved with a diagnosis of heart failure</li></ul>
<b>NEPRILYSIN INHIBITOR COMBINATION</b>		
ENTRESTO (sacubitril/valsartan) <sup>QL</sup>		
<b>ANGIOTENSIN RECEPTOR BLOCKER/BETA-BLOCKER COMBINATIONS</b>		<ul style="list-style-type: none"><li><b>Entresto:</b> May be approved with a diagnosis of heart failure</li></ul>
	BYVALSON (nevigolol/valsartan)	

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## ANTHELMINTICS

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

## 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 <sup>AL,CL</sup> (peanut allergen powder-dnfp)	<p>Drug-specific criteria:</p> <p><b>ORALAIR</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>For use in patients 5 through 65 years of age.</li> </ul> <p><b>PALFORZIA</b></p> <ul style="list-style-type: none"> <li>Confirmed diagnosis of peanut allergy by allergist</li> <li>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</li> <li>Initial dose and increase titration doses should be given in a healthcare setting</li> <li>Should not be used in patients with uncontrolled asthma or concurrently on a NSAID</li> </ul>

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## ANTIBIOTICS, GASTROINTESTINAL

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FIRVANQ (vancomycin) <b>SOLN</b> metronidazole <b>TABLET</b> neomycin tinidazole (generic Tindamax) <sup>CL</sup>	DIFICID (fidaxomicin) <sup>CL</sup> <b>TABLET, SUSP</b> FLAGYL ER (metronidazole) <sup>CL</sup> metronidazole <sup>CL</sup> <b>CAPS</b> nitazoxanide (generic Alinia) <b>TABLET</b> <sup>AL, CL, QL</sup> paromomycin SOLOSEC (secnidazole) vancomycin <b>CAPS</b> (generic Vancocin) <sup>CL</sup> XIFAXAN (rifaximin) <sup>CL</sup>	<ul style="list-style-type: none"> <li>Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Alinia®</b>: Trial and failure with metronidazole is required for a diagnosis of giardiasis</li> <li><b>Dificid®</b>: For diagnosis of C. difficile diarrhea (pseudomembranous colitis), trial and failure or intolerance to oral vancomycin is required. For diagnosis of relapsed or recurrent C. difficile, an appropriate ICD-10 diagnosis code must be submitted for coverage.</li> <li><b>Flagyl ER®</b>: Trial and failure with metronidazole is required</li> <li><b>Flagyl®/Metronidazole 375mg capsules and Flagyl ER®/ Metronidazole 750mg ER tabs</b>: Clinical reason why the generic regular-release cannot be used</li> <li><b>tinidazole</b>: Approvable diagnoses include: Giardia Amebiasis intestinal or liver abscess Bacterial vaginosis or trichomoniasis</li> <li><b>vancomycin capsules</b>: Requires patient specific documentation of why the Firvanq/vancomycin solution is not appropriate for patient</li> <li><b>Xifaxan®</b>: 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®</li> </ul>

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## ANTIBIOTICS, INHALED

Preferred Agents <sup>CL</sup>	Non-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin) <sup>CL</sup> KITABIS PAK (tobramycin) <sup>CL</sup> TOBI-PODHALER (tobramycin) <sup>CL, QL</sup>	ARIKAYCE (amikacin liposomal inh) <sup>CL</sup> <b>SUSP</b> CAYSTON (aztreonam lysine) <sup>QL, CL</sup> tobramycin (generic Bethkis) tobramycin (generic Tobi) <sup>CL</sup>	<ul style="list-style-type: none"> <li>Diagnosis of Cystic Fibrosis is required for all agents ICD10 Group = E84, ICD9 = 277.00, 277.01, 277.02, 277.03, 277.09</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Arikayce:</b> 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</li> <li><b>Cayston®:</b> Trial of tobramycin via nebulizer and demonstration of TOBI® compliance required</li> <li><b>Tobi Podhaler®:</b> Requires trial of tobramycin via nebulizer or documentation why nebulized tobramycin cannot be used</li> </ul>

## ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bacitracin <b>OINT</b> bacitracin/polymyxin (generic Polysporin) mupirocin <b>OINT</b> (generic Bactroban) neomycin/polymyxin/bacitracin (generic Neosporin, Triple AB) neomycin/polymyxin/pramoxine neomycin/polymyxin/bacitracin/pramoxine	CENTANY (mupirocin) gentamicin <b>OINT, CREAM</b> mupirocin <b>CREAM</b> (generic Bactroban) <sup>CL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class within the last 12 months</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Mupirocin® Cream:</b> Clinical reason the ointment cannot be used</li> </ul>

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

<sup>QL</sup> – Quantity/Duration Limit

<sup>AL</sup> – Age Limit

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>CLEOCIN OVULES</b> (clindamycin) clindamycin <b>CREAM</b> (generic Cleocin) <b>CLINDESSE</b> (clindamycin) metronidazole, vaginal <b>NUVESSA</b> (metronidazole)	<b>CLEOCIN CREAM</b> (clindamycin) <b>METROGEL</b> (metronidazole) <b>VANDAZOLE</b> (metronidazole) <b>XACIATO</b> (clindamycin phosphate) vaginal gel <sup>AL,NR</sup>	<ul style="list-style-type: none"> <li>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</li> </ul>

## ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ELIQUIS</b> (apixaban) enoxaparin (generic Lovenox) <b>PRADAXA</b> (dabigatran) warfarin (generic Coumadin) <b>XARELTO</b> (rivaroxaban) 10 mg, 15 mg, 20 mg <b>XARELTO</b> (rivaroxaban) 2.5 mg <sup>CL,QL</sup> <b>XARELTO DOSE PACK</b> (rivaroxaban)	<b>BEVYXXA</b> (betrixaban) <sup>QL</sup> dabigatran etexilate <sup>NR</sup> (generic Pradaxa) fondaparinux (generic Arixtra) <b>FRAGMIN</b> (dalteparin) <b>SAVAYSA</b> (edoxaban) <sup>QL</sup> <b>XARELTO</b> (rivaroxaban) <sup>CL</sup> <b>SUSP</b>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 12 months</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Coumadin®</b>: Clinical reason generic warfarin cannot be used</li> <li><b>Savaysa®</b>: 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</li> <li><b>Xarelto 2.5mg</b>: 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</li> <li><b>Xarelto Suspension</b>: Approved for patients ≤12 years of age or if there is a clinical reason why a preferred solid dosage form cannot be used.</li> </ul>

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## ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>CANNABINOIDS</b>		<ul style="list-style-type: none"><li>Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the same group</li></ul>
dronabinol (generic Marinol) <sup>AL</sup>	CESAMET (nabilone)	
<b>5HT3 RECEPTOR BLOCKERS</b>		<p>Drug-specific criteria:</p> <ul style="list-style-type: none"><li><b>Akynzeo®/Varubi®:</b> Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist</li><li><u>Regimens include:</u> 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</li><li><b>Diclegis®/Bonjesta:</b> Approved only for treatment of nausea and vomiting of pregnancy</li><li><b>Metozolv ODT®:</b> Documentation of inability to swallow or Clinical reason oral liquid cannot be used</li><li><b>Sancuso®/Zuplenz®:</b> Documentation of oral dosage form intolerance</li></ul>
ondansetron (generic Zofran/Zofran ODT) <sup>QL</sup>	ANZEMET (dolasetron) granisetron (generic Kytril) SANCUSO (granisetron) <sup>CL</sup> ZUPLENZ (ondansetron)	
<b>NK-1 RECEPTOR ANTAGONIST</b>		
EMEND (aprepitant) <b>CAPS, CAPS PACK</b> <sup>QL</sup>	aprepitant (generic Emend) <sup>QL,CL</sup> AKYNZEO (netupitant/palonosetron) <sup>CL</sup> VARUBI (rolapitant) <b>TAB</b> <sup>CL</sup>	
<b>TRADITIONAL ANTIEMETICS</b>		
DICLEGIS (doxylamine/pyridoxine) <sup>CL,QL</sup> dimenhydrinate (generic Dramamine) OTC meclizine (generic Antivert) metoclopramide (generic Reglan) phosphoric acid/dextrose/fructose <b>SOLN</b> (generic Emetrol) prochlorperazine, oral (generic Compazine) promethazine <b>SYRUP, TAB</b> (generic Phenergan) promethazine <b>SUPPOSITORY</b> 12.5mg, 25mg TRANSDERM-SCOP (scopolamine)	BONJESTA (doxylamine/pyridoxine) <sup>CL,QL</sup> COMPRO (prochlorperazine) doxylamine/pyridoxine (generic Diclegis) <sup>CL,QL</sup> metoclopramide ODT (generic Metozolv ODT) prochlorperazine <b>SUPPOSITORY</b> (generic Compazine) promethazine <b>SUPPOSITORY</b> 50mg scopolamine <b>TRANSDERMAL</b> trimethobenzamide <b>TAB</b> (generic Tigan)	

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## ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole (mucous membrane, troche) fluconazole <b>SUSP, TAB</b> (generic Diflucan) griseofulvin <b>SUSP</b> griseofulvin microsize <b>TAB</b> nystatin <b>SUSP, TAB</b> terbinafine (generic Lamisil)	BREXAFEMME (ibrexafungerp) <sup>QL</sup> CRESEMBA (isavuconazonium) <sup>CL</sup> flucytosine (generic Ancobon) <sup>CL</sup> griseofulvin ultramicrosize (generic GRIS-PEG) itraconazole (generic Sporanox) <sup>CL</sup> ketoconazole (generic Nizoral) NOXAFIL (posaconazole) <b>POWDERMIX</b> <sup>AL,NR</sup> nystatin <b>POWDER</b> ONMEL (itraconazole) posaconazole (generic Noxafil) <sup>AL,CL</sup> TOLSURA (itraconazole) <sup>CL</sup> VIVJOA (oteseconazole) <b>CAPS</b> <sup>NR</sup> voriconazole (generic VFEND) <sup>CL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of TWO diagnosis-appropriate preferred agents within this drug class</li> </ul> Drug-specific criteria: <ul style="list-style-type: none"> <li><b>Cresemba®:</b> Approved for diagnosis of invasive aspergillosis or invasive mucormycosis</li> <li><b>Flucytosine:</b> Approved for diagnosis of:               <ul style="list-style-type: none"> <li>Candida: Septicemia, endocarditis, UTIs</li> <li>Cryptococcus: Meningitis, pulmonary infections</li> </ul> </li> <li><b>Noxafil®:</b> 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</li> <li><b>Noxafil® Suspension:</b> Oropharyngeal/esophageal candidiasis refractory to itraconazole and/or fluconazole</li> <li><b>Onmel®:</b> Requires trial and failure or contraindication to terbinafine</li> <li><b>Sporanox®/Itraconazole:</b> Approved for diagnosis of Aspergillosis, Blastomycosis, Histoplasmosis, Onychomycosis due to terbinafine-resistant dermatophytes, Oropharyngeal/ esophageal candidiasis refractory to fluconazole</li> <li><b>Sporanox®:</b> Requires trial and failure of generic itraconazole</li> <li><b>Sporanox® Liquid:</b> Clinical reason solid oral cannot be used</li> <li><b>Tolsura:</b> Approved for diagnosis of Aspergillosis, Blastomycosis, and Histoplasmosis and requires a trial and failure of generic itraconazole</li> <li><b>Vfend®:</b> No trial for diagnosis of Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Graft vs. Host disease (GVHD), Candidemia (candida krusei), Esophageal Candidiasis, Blastomycosis, <i>S. apiospermum</i> and <i>Fusarium spp.</i>, Oropharyngeal/esophageal candidiasis refractory to fluconazole</li> </ul>

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## ANTIFUNGALS, TOPICAL

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

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## ANTIHISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine <b>TABLET, SOLN (Rx only)</b> (generic Zyrtec) loratadine <b>TABLET, SOLN</b> (generic Claritin) levocetirizine <b>TABLET</b> (generic Xyzal)	cetirizine <b>CHEWABLE</b> (generic Zyrtec) cetirizine <b>SOLN (OTC)</b> desloratadine (generic Clarinex) desloratadine ODT (generic Clarinex Reditabs) fexofenadine (generic Allegra) fexofenadine 180mg (generic Allegra 180mg) <sup>QL</sup> levocetirizine (generic Xyzal) <b>SOLN</b> loratadine <b>CAPS, CHEWABLE, ODT</b> (generic Claritin Reditabs)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class</li> <li>Combination products not covered – individual products may be covered</li> </ul>

## ANTIHYPERTENSIVES, SYMPATHOLYTICS

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

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## ANTIHYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol (generic Zyloprim) MITIGARE (colchicine) probenecid probenecid/colchicine (generic Col-Probenecid)	allopurinol <sup>NR</sup> 200mg colchicine <b>TAB</b> (generic Colcrys) <sup>CL</sup> colchicine <b>CAPS</b> (generic Mitigare) febuxostat (generic Uloric) <sup>CL</sup> GLOPERBA <b>SOLN</b> (colchicine) <sup>CL,QL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class</li> <li><b>colchicine tablet</b><sup>®</sup>: Approved without trial for familial Mediterranean fever OR pericarditis</li> <li><b>Gloperba</b>: Approved for documented swallowing disorder</li> <li><b>Uloric</b><sup>®</sup>: Clinical reason why allopurinol cannot be used</li> </ul>

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## ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AJOVY (fremanezumab-vfrm) <sup>CL, QL</sup> <b>PEN, Autoinjector</b> AJOVY (fremanezumab-vfrm) <b>Autoinjector 3-pack</b> <sup>CL, QL</sup> EMGALITY 120 mg/mL (galcanezumab-gnlm) <sup>CL, QL</sup> <b>PEN, SYRINGE</b> NURTEC ODT (rimegepant) <sup>AL, CL, QL</sup> UBRELVY (ubrogepant) <sup>AL, CL, QL</sup> <b>TAB</b>	AIMOVIG (erenumab-aooe) <sup>CL, QL</sup> CAFERGOT (ergotamine/cafeine) diclofenac POWDER (generic Cambia) <sup>NR</sup> dihydroergotamine mesylate <b>NASAL</b> ELYXYB (celecoxib) <sup>AL, QL</sup> <b>SOLN</b> EMGALITY 100 mg (galcanezumab-gnlm) <sup>CL, QL</sup> <b>SYR</b> ERGOMAR <b>SUBLINGUAL</b> (ergotamine tartrate) MIGERGOT (ergotamine/cafeine) <b>RECTAL</b> MIGRANAL (dihydroergotamine) <b>NASAL</b> QULIPTA (atogepant) <sup>AL, QL</sup> REYVOW (lasmiditan) <sup>AL, CL, QL</sup> <b>TAB</b> TRUDHESA (dihydroergotamine mesylate) <sup>AL, QL</sup> <b>NASAL</b>	<ul style="list-style-type: none"> <li>All acute treatment agents will be approved for patients who have a failed trial or a contraindication to a triptan.</li> <li>In addition, all non-preferred agents will require a failed trial or contraindication of a preferred agent of the same indication</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Emgality 120mg</b> is recommended for preventative treatment of Migraine, <b>Emgality 100mg</b> is recommended for treatment of Episodic Cluster Headache</li> <li><b>For Prophylactic Treatment:</b> Require <math>\geq 4</math> migraines per month for <math>\geq 3</math> months and has tried and failed a <math>\geq 1</math> month trial of two medications listed in the 2012 American Academy of Neurology/American Headache Society guidelines (examples include: antidepressants (amitriptyline, venlafaxine), Beta blockers (propranolol, metoprolol, timolol, atenolol), anti-epileptics (valproate, topiramate), ACE/ARB (lisinopril, candesartan)</li> </ul>

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		<ul style="list-style-type: none"><li>Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class</li></ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"><li><b>Sumavel® Dosepro:</b> Requires clinical reason sumatriptan injection cannot be used</li><li><b>Onzetra, Zembrace:</b> approved for patients who have failed ALL preferred agents</li></ul>
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) <sup>QL</sup> 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 <b>KIT, SYRINGE, VIAL</b>	IMITREX (sumatriptan) <b>INJECTION</b> SUMAVEL DOSEPRO (sumatriptan) ZEMBRACE SYMTOUCH (sumatriptan)	

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## ANTIPARASITICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NATROBA (spinosad) permethrin 1% OTC (generic Nix) permethrin 5% RX (generic Elimite) pyrethrin/piperonyl butoxide (generic RID, A-200)	CROTAN (crotamiton) LOTION EURAX (crotamiton) <b>CREAM, LOTION</b> ivermectin (generic Sklice) <b>LOTION</b> lindane malathion (generic Ovide) spinosad (generic Natroba) VANALICE (piperonyl butoxide/pyrethrins)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class</li> </ul>

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## ANTIPARKINSON'S AGENTS, ORAL

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

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January 2023 PDL **Highlighted in Red** effective January 20, 2023

## ANTIPSORIATICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acitretin (generic for Soriatane)	methoxsalen (generic for Oxsoresalen-Ultra)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial with THE preferred agent within this drug class</li> <li>Trial of acitretin (Pregnancy category X) not required in pregnancy or while attempting or planning pregnancy</li> </ul>

## ANTIPSORIATICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcipotriene <b>CREAM, OINT, SOLN</b>	calcitriol (generic for Vectical) calcipotriene/betamethasone <b>OINT</b> (generic for Taclonex) calcipotriene/betamethasone <b>SUSP</b> (generic for Taclonex Scalp) CALCITRENE (calcipotriene) DOVONEX <b>CREAM</b> (calcipotriene) DUOBRII (halobetasol prop/tazarotene) ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene) VTAMA (tapinarof) <sup>AL,NR</sup> <b>CREAM</b> ZORYVE (roflumilast) <sup>AL,NR</sup> <b>CREAM</b>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class</li> </ul>

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## ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ANTI-HERPETIC DRUGS</b>		<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a 10-day trial of ONE preferred agent within the same group</li> </ul>
acyclovir (generic Zovirax) famciclovir (generic Famvir) valacyclovir (generic Valtrex)	acyclovir (generic for Zovirax) <sup>CL</sup> <b>SUSP</b> SITAVIG (acyclovir buccal) <sup>CL</sup>	
<b>ANTI-INFLUENZA DRUGS</b>		Drug-specific criteria: <ul style="list-style-type: none"> <li><b>Acyclovir Susp:</b> Prior authorization NOT required for children ≤ 12 years old</li> <li><b>Sitavig®:</b> Approved for recurrent herpes labialis (cold sores) in immunocompetent adults</li> <li><b>Xofluza:</b> Requires clinical, patient specific reason that a preferred agent cannot be used</li> </ul>
oseltamivir (generic Tamiflu) <sup>QL</sup>	rimantadine (generic Flumadine) RELENZA (zanamivir) <sup>QL</sup> TAMIFLU (oseltamivir) <sup>QL</sup> XOFLUZA (baloxavir marboxil) <sup>AL,CL,QL</sup>	

## ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acyclovir <b>OINT</b>	acyclovir CREAM, (generic Zovirax) DENAVIR (penciclovir) penciclovir (generic Denavir) <sup>NR</sup> XERESE (acyclovir/hydrocortisone)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial with ONE preferred ORAL Antiviral agent</li> </ul>

## ANXIOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
alprazolam <b>TABLET</b> (generic for Xanax) buspirone (generic for Buspar) chlordiazepoxide diazepam <b>TABLET, SOLN</b> (generic for Valium) lorazepam <b>INTENSOL, TABLET</b> (generic for Ativan)	alprazolam ER (generic for Xanax XR) alprazolam ODT alprazolam <b>INTENSOL</b> <sup>CL</sup> clorazepate (generic for Tranxene-T) diazepam <b>INTENSOL</b> <sup>CL</sup> lorazepam <b>ORAL SYRINGE</b> <sup>NR</sup> <b>LOREEV XR (lorazepam)</b> <sup>AL</sup> meprobamate oxazepam	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial with TWO preferred agents within this drug class</li> </ul> Drug-specific criteria: <ul style="list-style-type: none"> <li><b>Diazepam Intensol®:</b> Requires clinical reason why diazepam solution cannot be used</li> <li><b>Alprazolam Intensol®:</b> Requires trial of diazepam solution OR lorazepam Intensol®</li> </ul>

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## BETA BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>BETA BLOCKERS</b>		<ul style="list-style-type: none"><li>Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents within this drug class</li></ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"><li><b>Bystolic®</b>: Only ONE trial is required with Diagnosis of Obstructive Lung Disease</li><li><b>Coreg CR®</b>: Requires clinical reason generic IR product cannot be used</li><li><b>Hemangeol®</b>: Covered for diagnosis of Proliferating Infantile Hemangioma</li><li><b>Sotylize®</b>: 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</li></ul>
atenolol (generic Tenormin) atenolol/chlorthalidone (generic Tenoretic) bisoprolol (generic Zebeta) bisoprolol/HCTZ (generic Ziac) metoprolol (generic Lopressor) metoprolol ER (generic Toprol XL) propranolol (generic Inderal) propranolol ER (generic Inderal LA)	acebutolol (generic Sectral) betaxolol (generic Kerlone) BYSTOLIC (nebivolol) HEMANGEOL (propranolol) <b>SOLN</b> INDERAL/INNOPRAN XL (propranolol ER) KAPSPARGO SPRINKLE (metoprolol ER) LEVATOL (penbutolol) 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)	
<b>BETA- AND ALPHA-BLOCKERS</b>		
carvedilol (generic Coreg) labetalol (generic Trandate)	carvedilol ER <sup>CL</sup> (generic Coreg CR)	
<b>ANTIARRHYTHMIC</b>		
sotalol (generic Betapace)	SOTYLIZE (sotalol)	

## BILE SALTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ursodiol <b>CAPSULE</b> 300mg (generic Actigall) ursodiol 250mg <b>TABLET</b> (generic URSO) ursodiol 500mg <b>TABLET</b> (generic URSO FORTE)	BYLVAY (odevixibat) <b>CAP, PELLET</b> CHENODAL (chenodiol) CHOLBAM (cholic acid) LIVMARLI (maralixibat) <b>SOLN<sup>AL</sup></b> OCALIVA (obeticholic acid) RELTONE (ursodiol 200mg,400mg) <b>CAP</b>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class</li> </ul>

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## 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) <i>fesoterodine<sup>NR</sup></i> ( <i>generic Toviaz</i> ) flavoxate GELNIQUE (oxybutynin) GEMTESA (vibegron) <sup>AL,QL</sup> MYRBETRIQ <b>TABLET, SUSP</b> <sup>AL,CL,QL</sup> (mirabegron) OXYTROL (oxybutynin) tolterodine IR, ER (generic Detrol/ Detrol LA) trospium IR, ER (generic Sanctura/ Sanctura XR) VESICARE (solifenacin) VESICARE LS <b>SUSP</b> (solifenacin) <sup>AL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Myrbetriq®</b>: Covered without trial in contraindication to anticholinergic agents</li> <li><b>Myrbetriq suspension</b>: Covered for pediatric patients <math>\geq 3</math> years old with a diagnosis of Neurogenic Detrusor Overactivity (NDO)</li> </ul>

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## BONE RESORPTION SUPPRESSION AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>BISPHOSPHONATES</b>		<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Actonel® Combinations:</b> Covered as individual agents without prior authorization</li> <li><b>Atelvia DR®:</b> Requires clinical reason alendronate cannot be taken on an empty stomach</li> <li><b>Binosto®:</b> Requires clinical reason why alendronate tablets OR Fosamax® solution cannot be used</li> <li><b>Etidronate disodium:</b> Trial not required for diagnosis of heterotrophic ossification</li> <li><b>Forteo®:</b> Covered for high risk of fracture               <p>High risk of fracture:</p> <ul style="list-style-type: none"> <li>BMD -3 or worse</li> <li>Postmenopausal women with history of non-traumatic fractures</li> <li>Postmenopausal women with 2 or more clinical risk factors                   <ul style="list-style-type: none"> <li>Family history of non-traumatic fractures</li> <li>DXA BMD T-score <math>\leq</math> -2.5 at any site</li> <li>Glucocorticoid use <math>\geq</math> 6 months at 7.5 dose of prednisolone equivalent</li> <li>Rheumatoid Arthritis</li> </ul> </li> <li>Postmenopausal women with BMD T-score <math>\leq</math> -2.5 at any site with any clinical risk factors                   <ul style="list-style-type: none"> <li>More than 2 units of alcohol per day</li> <li>Current smoker</li> </ul> </li> <li>Men with primary or hypogonadal osteoporosis</li> <li>Osteoporosis associated with sustained systemic glucocorticoid therapy</li> <li>Trial of calcitonin-salmon not required</li> <li>Maximum of 24 months treatment per lifetime</li> </ul> </li> </ul>
alendronate (generic Fosamax) <b>TAB</b> ibandronate (generic Boniva) <sup>QL</sup>	alendronate <b>SOLN</b> (generic Fosamax) <sup>QL</sup> ATELVIA DR (risedronate) BINOSTO (alendronate) etidronate disodium (generic Didronel) FOSAMAX PLUS D <sup>QL</sup> risedronate (generic Actonel) <sup>QL</sup>	
<b>OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS</b>		
calcitonin-salmon <b>NASAL</b> FORTEO (teriparatide) <sup>CL,QL</sup> raloxifene (generic Evista)	EVISTA (raloxifene) teriparatide (generic Forteo) <sup>CL,QL</sup> TYMLOS (abaloparatide)	

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## BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ALPHA BLOCKERS</b>		<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>
alfuzosin (generic Uroxatral) doxazosin (generic Cardura) tamsulosin (generic Flomax) terazosin (generic Hytrin)	CARDURA XL (doxazosin) silodosin (generic Rapaflo)	
<b>5-ALPHA-REDUCTASE (5AR) INHIBITORS</b>		Drug-specific criteria: <ul style="list-style-type: none"> <li><b>Alfuzosin/dutasteride/finasteride</b> <ul style="list-style-type: none"> <li>Covered for males only</li> </ul> </li> <li><b>Cardura XL®</b>: Requires clinical reason generic IR form cannot be used</li> <li><b>Flomax®</b>: Females covered for a 7 day supply with diagnosis of acute kidney stones</li> <li><b>Jalyn®</b>: Requires clinical reason why individual agents cannot be used</li> </ul>
dutasteride (generic for Avodart) finasteride (generic for Proscar)	dutasteride/tamsulosin (generic for Jalyn)	

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## BRONCHODILATORS, BETA AGONIST

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

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## CALCIUM CHANNEL BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>SHORT-ACTING</b>		<ul style="list-style-type: none"><li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li></ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"><li><b>Nifedipine:</b> May be approved without trial for diagnosis of Preterm Labor or Pregnancy Induced Hypertension (PIH)</li><li><b>Nimodipine:</b> Covered without trial for diagnosis of subarachnoid hemorrhage</li><li><b>Katerzia:</b> May be approved with documented swallowing difficulty</li></ul>
<b>Dihydropyridines</b>		
	isradipine (generic Dynacirc) nicardipine (generic Cardene) nifedipine (generic Procardia) nimodipine (generic Nimotop) NYMALIZE (nimodipine) <b>SOLN</b>	
<b>Non-dihydropyridines</b>		
diltiazem (generic Cardizem) verapamil (generic Calan/Isoptin)		
<b>LONG-ACTING</b>		
<b>Dihydropyridines</b>		
amlodipine (generic Norvasc) nifedipine ER (generic Procardia XL/ Adalat CC)	felodipine ER (generic Plendil) KATERZIA (amlodipine) <sup>QL</sup> <b>SUSP</b> levamlodipine (generic Conjupri) <sup>NR</sup> nisoldipine (generic Sular) NORLIQVA (amolidipine) <sup>AL,NR,QL</sup> <b>SOLN</b>	
<b>Non-dihydropyridines</b>		
diltiazem ER (generic Cardizem CD) verapamil ER <b>TAB</b>	CALAN SR (verapamil) diltiazem ER (generic Cardizem LA) MATZIM LA (diltiazem ER) TIAZAC (diltiazem) verapamil ER <b>CAPS</b> verapamil 360mg <b>CAPS</b> verapamil ER (generic Verelan PM)	

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## CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

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

## COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NEUPOGEN (filgrastim) <b>VIAL</b> <span style="color: red;">NYVEPRIA (pegfilgrastim-apgf)</span>	<span style="color: red;">FULPHILA <b>SUB-Q</b> (pegfilgrastim-jmdb)</span> <span style="color: red;">FYLNETRA (pegfilgrastim-pbbk)<sup>NR</sup></span> GRANIX (tbo-filgrastim) <span style="color: red;">LEUKINE (sargramostim)</span> <span style="color: red;">NEULASTA SYR(pegfilgrastim)</span> NEUPOGEN <b>DISP SYR</b> (filgrastim) NIVESTYM <b>SYR,VIAL</b> (filgrastim-aafi) <span style="color: red;">RELEUKO (filgrastim-ayow) <b>SYR,VIAL</b></span> <span style="color: red;">STIMUFEND (pegfilgrastim-fpgk)<sup>NR</sup></span> <span style="color: red;">UDENYCA SUB-Q (pegfilgrastim-cbqv)</span> ZARXIO (filgrastim-sndz) ZIEXTENZO <b>SYR</b> (pegfilgrastim-bmez)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>

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## CONTRACEPTIVES, ORAL

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

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## COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>INHALERS</b>		<ul style="list-style-type: none"><li>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.</li></ul> Drug-specific criteria: <ul style="list-style-type: none"><li><b>Daliresp®:</b><ul style="list-style-type: none"><li>Covered for diagnosis of severe COPD associated with chronic bronchitis</li><li>Requires trial of a bronchodilator</li><li>Requires documentation of one exacerbation in last year upon initial review</li></ul></li></ul>
ANORO ELLIPTA (umeclidinium/vilanterol)	BEVESPI AEROSPHERE (glycopyrolate/formoterol)	
ATROVENT HFA (ipratropium)	DUAKLIR PRESSAIR (aclidinium br and formoterol fum)	
COMBIVENT RESPIMAT (albuterol/ipratropium)	INCRUSE ELIPTA (umeclidinium)	
SPIRIVA (tiotropium)	SPIRIVA RESPIMAT (tiotropium)	
STIOLTO RESPIMAT (tiotropium/olodaterol)	TUDORZA PRESSAIR (aclidinium br)	
<b>INHALATION SOLUTION</b>		
albuterol/ipratropium (generic Duoneb)	LONHALA (glycopyrrolate inhalation soln)	
ipratropium <b>SOLN</b> (generic Atrovent)	YUPELRI (revefenacin)	
<b>ORAL AGENT</b>		
	DALIRESP (roflumilast) <sup>CL, QL</sup>	
	roflumilast (generic Daliresp) <sup>CL,NR,QL</sup>	

## COUGH AND COLD, OPIATE COMBINATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	guaifenesin/codeine <b>LIQUID</b>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE dextromethorphan product</li> <li>All codeine or hydrocodone containing cough and cold combinations are limited to <math>\geq 18</math> years of age</li> </ul>
	hydrocodone/homatropine <b>SYRUP</b>	
	promethazine/codeine <b>SYRUP</b>	
	promethazine/phenylephrine/codeine <b>SYRUP</b>	

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## CYSTIC FIBROSIS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	BRONCHITOL (mannitol) <sup>AL,CL,QL</sup> KALYDECO <b>PACKET, TABLET</b> (ivacaftor) <sup>QL, AL</sup> ORKAMBI (lumacaftor/ivacaftor) <b>PACKET, TABLET</b> <sup>QL, AL</sup> SYMDEKO (tezacaftor/ivacaftor) <sup>QL, AL</sup> TRIKAFTA (elexacaftor, tezacaftor, ivacaftor) <sup>AL, CL</sup>	Drug-specific criteria: <ul style="list-style-type: none"> <li>• <b>Bronchitol</b>: Approved for diagnosis of CF and documentation that the patient has passed the BRONCHITOL Tolerance Test</li> <li>• <b>Kalydeco®</b>: Diagnosis of CF and documentation of the drug-specific, FDA-approved mutation of CFTR gene</li> <li>• <b>Orkambi®</b>: Diagnosis of CF and documentation of presence of two copies of the F580del mutation (homozygous) of CFTR gene</li> <li>• <b>Symdeko</b>: Diagnosis of CF and documentation of the drug specific, FDA approved mutation of CFTR gene.</li> <li>• <b>Trikafta</b>: Diagnosis of CF and documentation of at least one F508del mutation in the CFTR gene</li> </ul>

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>COSENTYX (secukinumab)</b> ENBREL (etanercept) <b>KIT, MINI CART, PEN, SYR, VIAL</b> <sup>QL</sup> HUMIRA (adalimumab) <sup>QL</sup> OTEZLA (apremilast) <b>ORAL</b> <sup>CL,QL</sup>	ACTEMRA (tocilizumab) <b>SUB-Q</b> ARCALYST (nilonacept) <b>CIBINQO (abrocitinib)</b> <sup>AL,QL</sup> CIMZIA (certolizumab pegol) <sup>QL</sup> ENSPRYNG (satralizumab-mwge) <b>SUB-Q</b> ILUMYA (tildrakizumab) <b>SUB-Q</b> KEVZARA (sarilumab) <b>SUB-Q, PEN, SYRINGE</b> KINERET (anakinra) OLUMIANT (baricitinib) <b>TABLET</b> <sup>CL,QL</sup> ORENCIA (abatacept) <b>SUB-Q</b> RINVOQ ER (upadacitinib) <sup>CL,QL</sup> SILIQ (brodalumab) SIMPONI (golimumab) SKYRIZI (risankizumab-rzaa) <b>SYRINGE</b> <b>SKYRIZI ON-BODY</b> (risankizumab-rzaa) <sup>QL</sup> SKYRIZI <b>PEN</b> (risankizumab-rzaa) <sup>QL</sup> SOTYKTU (deucravacitinib) <sup>NR</sup> <b>TABLET</b> STELARA (ustekinumab) <b>SUB-Q</b> TALTZ (ixekizumab) <sup>AL</sup> TREMFYA (guselkumab) <sup>QL</sup> XELJANZ (tofacitinib) <b>TABLET, SOLN</b> <sup>CL,QL</sup> XELJANZ XR (tofacitinib) <b>TABLET</b> <sup>CL,QL</sup>	<ul style="list-style-type: none"> <li>Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required.</li> <li>Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of <b>TWO</b> preferred agents within this drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis.</li> </ul> <p><b>JAK-Inhibitors:</b> For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response is required.</p> <p>Drug-specific criteria:  <b>Cosentyx:</b> Requires treatment failure of Enbrel OR Humira with the same FDA-approved indications and age limits.</p> <p><b>Otezla:</b> Requires a trial of Humira</p>

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## DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>SINGLE-AGENT PRODUCTS</b>		<ul style="list-style-type: none"><li>Non-preferred agents will be approved for patients who have failed a trial of <b>TWO</b> preferred agents within this drug class</li><li><b>Eplerenone</b>: Will be approved with a failed trial or intolerance to spironolactone, a trial with two preferred agents is not required.</li><li><b>Kerendia</b>: For diagnosis of chronic kidney disease associated with Type-II diabetes in adults, trial of a preferred agent not required.</li></ul>
amiloride <b>TABLET</b> bumetanide <b>TABLET</b> chlorothiazide <b>TABLET</b> chlorthalidone <b>TABLET</b> (generic Diuril) furosemide <b>SOLN, TABLET</b> (generic Lasix) hydrochlorothiazide <b>CAPS, TABLET</b> (generic Microzide) indapamide <b>TABLET</b> metolazone <b>TABLET</b> spironolactone <b>TABLET</b> (generic Aldactone) torsemide <b>TABLET</b>	CAROSPIR (spironolactone) <b>SUSP</b> eplerenone <b>TABLET</b> (generic Inspra) <sup>CL</sup> ethacrynic acid <b>CAPS</b> (generic Edecrin) KERENDIA (finerenone) <b>TABLET</b> <sup>CL,QL</sup> methyclothiazide <b>TABLET</b> THALITONE (chlorthalidone) <b>TABLET</b> triamterene (generic Dyrenium)	
<b>COMBINATION PRODUCTS</b>		
amiloride/HCTZ <b>TABLET</b> spironolactone/HCTZ <b>TABLET</b> (generic Aldactazide) triamterene/HCTZ <b>CAPSULE, TABLET</b> (generic Dyazide, Maxzide)		

## ENZYME REPLACEMENT, GAUCHERS DISEASE

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

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## EPINEPHRINE, SELF-INJECTED<sup>QL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
epinephrine (AUTHORIZED GENERIC Epipen/ Epipen Jr.) <b>AUTOINJECTOR</b> <b>EPIPEN (epinephrine) AUTOINJ</b> <b>EPIPEN JR. (epinephrine) AUTOINJ</b>	epinephrine (generic for Adrenaclick) epinephrine (generic for Epipen/ Epipen Jr.) <b>AUTOINJECTOR</b> SYMJEPI (epinephrine) <b>PFS</b>	<ul style="list-style-type: none"> <li>Non-preferred agents require clinical documentation why the preferred product within this drug class is not appropriate</li> </ul>

## ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>EPOGEN (rHuEPO)</b> RETACRIT (EPOETIN ALFA- EPBX)	PROCRIT (rHuEPO)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>

## FLUOROQUINOLONES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ciprofloxacin <b>TABLET</b> (generic Cipro) levofloxacin <b>TABLET</b> (generic Levaquin)	BAXDELA (delafloxacin) ciprofloxacin ER ciprofloxacin <b>SUSP</b> (generic Cipro) levofloxacin <b>SOLN</b> moxifloxacin (generic Avelox) ofloxacin	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Baxdela:</b> Coverable with documented intolerance or failure of preferred MRSA agents (clindamycin, doxycycline, linezolid, sulfamethoxazole/trimethoprim)</li> <li><b>Ciprofloxacin/Levofloxacin Suspension:</b> Coverable with documented swallowing disorders</li> <li><b>Ofloxacin:</b> Trial of preferred not required for diagnoses of Pelvic Inflammatory Disease OR Acute Epididymitis (non-gonorrhea)</li> </ul>

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## GI MOTILITY, CHRONIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AMITIZA (lubiprostone) <sup>AL, QL</sup> LINZESS (linaclotide) <sup>QL</sup> MOVANTIK (naloxegol oxalate) <sup>QL</sup>	alosetron (generic Lotronex) <i>IBSRELA (tenapanor)<sup>AL, NR, QL</sup></i> lubiprostone (generic Amitiza) <sup>AL, QL</sup> MOTEGRITY (prucalopride succinate) RELISTOR (methylnaltrexone) <b>TABLET<sup>QL</sup></b> SYMPROIC (naldemedine) TRULANCE (plecanatide) <sup>QL</sup> VIBERZI (eluxodoline)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Lotronex®</b>: Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate</li> <li><b>Relistor®</b>: 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</li> <li><b>Symproic</b>: 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</li> <li><b>Trulance®</b>: Covered for diagnosis of either chronic idiopathic constipation or IBS with constipation after trial of at least TWO OTC laxatives (senna, bisacodyl, etc.)</li> <li><b>Viberzi®</b>: Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate</li> </ul>

## GLUCAGON AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BAQSIMI (glucagon) <sup>AL, QL</sup> <b>NASAL</b> GLUCAGON EMERGENCY (glucagon) <sup>QL</sup> <b>INJ KIT</b> (Lilly) glucagon <sup>QL</sup> <b>INJECTION</b> PROGLYCEM (diazoxide) <b>SUSP</b>	diazoxide <b>SUSP</b> (generic Proglycem) GLUCAGON EMERGENCY (glucagon) <sup>QL</sup> <b>INJ KIT</b> (Fresenius) GVOKE (glucagon) <sup>AL, QL</sup> <b>KIT, PEN,</b> <b>SYRINGE, VIAL</b> ZEGALOGUE (dasiglucagon) <sup>AL, QL</sup> <b>AUTO-INJECTOR, SYRINGE</b>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>

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## GLUCOCORTICIDS, INHALED

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

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## GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC <b>CAPS</b> (generic Entocort EC) dexamethasone <b>ELIXIR, SOLN</b> dexamethasone <b>TABLET</b> hydrocortisone <b>TABLET</b> methylprednisolone tablet (generic Medrol) prednisolone <b>SOLN</b> prednisolone sodium phosphate prednisone <b>DOSE PAK</b> prednisone <b>TABLET</b>	ALKINDI (hydrocortisone) <b>GRANULES</b> <sup>AL</sup> CORTEF (hydrocortisone) cortisone <b>TABLET</b> dexamethasone <b>INTENSOL</b> EMFLAZA (deflazacort) <b>SUSP, TABLET</b> <sup>CL</sup> ENTOCORT EC (budesonide) methylprednisolone 8mg, 16mg, 32mg ORTIKOS ER (budesonide) <sup>AL, QL</sup> prednisolone sodium phosphate (generic Millipred/Veripred) prednisolone sodium phosphate <b>ODT</b> prednisone <b>SOLN</b> prednisone <b>INTENSOL</b> RAYOS DR (prednisone) <b>TABLET</b> <b>TARPEYO (budesonide) CAPS</b>	<ul style="list-style-type: none"> <li>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</li> </ul> Drug-specific criteria: <ul style="list-style-type: none"> <li><b>Emflaza:</b> Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older</li> <li><b>Intensol Products:</b> Patient specific documentation of why the less concentrated solution is not appropriate for the patient</li> <li><b>Tarpeyo:</b> Indicated for the treatment of primary immunoglobulin A nephropathy (IgAN)</li> </ul>

## 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)	<a href="#">Growth Hormone PA Form</a> <a href="#">Growth Hormone Criteria</a>

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## H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PYLERA (bismuth, metronidazole, tetracycline) <sup>QL</sup>	lansoprazole/amoxicillin/clarithromycin (generic Prevpac) <sup>QL</sup> OMECLAMOX-PAK (omeprazole, clarithromycin, amoxicillin) <sup>QL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>

## HAE TREATMENTS<sup>CL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BERINERT (C1 esterase inhibitor, human) <b>INTRAVENOUS</b> HAEGARDA (C1 esterase inhibitor, human) <sup>AL,CL</sup> <b>SUB-Q</b> icatibant acetate (generic for FIRAZYR) <sup>AL</sup> <b>SUB-Q</b>	CINRYZE (C1 esterase inhibitor, human) <sup>AL,CL</sup> <b>INTRAVENOUS</b> FIRAZYR (icatibant acetate) <sup>AL</sup> <b>SUB-Q</b> ORLADEYO (berotralstat) <sup>AL,QL</sup> <b>CAP</b> RUCONEST (recombinant human C1 inhibitor) <sup>AL</sup> <b>INTRAVENOUS</b> TAKHZYRO (lanadelumab-flyo) <sup>AL,CL</sup> <b>VIAL, SYRINGE<sup>NR</sup></b>	<p><a href="#">HAE Treatments PA Form</a></p> <ul style="list-style-type: none"> <li>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</li> <li>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.</li> </ul> <p>Drug-Specific Criteria</p> <ul style="list-style-type: none"> <li><b>Cinryze, Haegarda, Orladeyo, and Takhzyro</b>, require a history of two or more HAE attacks monthly, and trial and failure or contraindication to oral danazol</li> </ul>

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## HEMOPHILIA TREATMENTS

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

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## HEPATITIS B TREATMENTS

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

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## HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>DIRECT ACTING ANTI-VIRAL</b>		<a href="#">Hepatitis C Treatments PA Form</a> <a href="#">Hepatitis C Criteria</a>
sofosbuvir/velpatasvir (generic Epclusa) <sup>CL</sup> MAVYRET (glecaprevir/pibrentasvir) <b>TABLET<sup>CL</sup>, PELLET<sup>AL,CL,NR</sup></b> VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) <sup>CL</sup>	HARVONI 200/45MG, <b>TABLET</b> (sofosbuvir/ledipasvir) <sup>CL</sup> HARVONI (ledipasvir/sofosbuvir) <sup>CL</sup> <b>PELLET</b> sofosbuvir/ledipasvir (generic Harvoni) <sup>CL</sup> SOVALDI (sofosbuvir) <sup>CL</sup> <b>PELLET</b> SOVALDI <b>TABLET</b> (sofosbuvir) <sup>CL</sup> VIEKIRA <b>PAK</b> (ombitasvir/paritaprevir/ritonavir/dasabuvir) <sup>CL</sup> ZEPATIER (elbasvir/grazoprevir) <sup>CL</sup>	<ul style="list-style-type: none"> <li>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</li> <li>Patients newly eligible for Medicaid will be allowed to complete treatment with the original that treatment was initially authorized by another payor</li> </ul> <p>Drug-specific criteria: Trial with with a preferred agent not required in the following:</p> <ul style="list-style-type: none"> <li><b>Harvoni:</b> <ul style="list-style-type: none"> <li>Post liver transplant for genotype 1 or 4</li> </ul> </li> <li><b>Vosevi:</b> 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</li> </ul>
<b>RIBAVIRIN</b>		
ribavirin 200mg <b>CAPSULE, TABLET</b>	REBETOL (ribavirin)	
<b>INTERFERON</b>		
PEGASYS (pegylated interferon alfa-2a) <sup>CL</sup> PEG-INTRON (pegylated interferon alfa-2b) <sup>CL</sup>		

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## HISTAMINE II RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
famotidine <b>TABLET</b> (generic for Pepcid)  famotidine <b>SUSP</b>	cimetidine <b>TABLET, SOLN</b> <sup>CL</sup> (generic Tagamet) nizatidine <b>CAPS</b> (generic for Axid)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Cimetidine:</b> Approved for viral M. contagiosum or common wart V. Vulgaris treatment</li> </ul> <p>*</p>

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## HIV / AIDS<sup>CL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>CCR5 ANTAGONISTS</b>		<ul style="list-style-type: none"><li>All agents require:<ul style="list-style-type: none"><li>Diagnosis of HIV/AIDS required; OR</li><li>Diagnosis of Pre and Post Exposure Prophylaxis</li></ul></li><li>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</li><li>Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</li></ul>
SELZENTRY <b>SOLN, TAB</b> (maraviroc)	maraviroc (generic Selzentry)	
<b>FUSION INHIBITORS</b>		
FUZEON <b>SUB-Q</b> (enfuvirtide) <sup>QL</sup>		
<b>HIV-1 ATTACHMENT INHIBITOR</b>		
	RUKOBIA ER (fostemsavir) <sup>AL, QL</sup>	
<b>INTEGRASE STRAND TRANSFER INHIBITORS (INSTIs)</b>		
ISENTRESS (raltegravir) <sup>QL</sup> ISENTRESS HD (raltegravir) TIVICAY (dolutegravir)	TIVICAY PD (dolutegravir)	
<b>NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)</b>		
efavirenz <b>CAPS, TABLET</b> (generic Sustiva) INTELENCE (etravirine) <sup>QL</sup> PIFELTRO (doravirine) <sup>QL</sup>	EDURANT (rilpivirine) etravirine (generic Intelence) <sup>QL</sup> nevirapine IR, ER (generic Viramune/Viramune XR) RESCRIPTOR (delavirdine) SUSTIVA <b>CAPS, TABLET</b> (efavirenz) VIRAMUNE (nevirapine) <b>SUSP</b>	
<b>NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)</b>		
abacavir <b>SOLN, TABLET</b> (generic Ziagen) EMTRIVA <b>CAPS, SOLN</b> (emtricitabine) lamivudine <b>SOLN, TABLET</b> (generic Epivir) zidovudine <b>CAPS, SYRUP, TABLET</b> (generic Retrovir)	didanosine DR (generic Videx EC) emtricitabine <b>CAPS</b> (generic for Emtriva) EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine <b>CAPS</b> (generic Zerit) VIDEX (didanosine) <b>SOLN</b> ZIAGEN (abacavir)	
<b>NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)</b>		
tenofovir <b>TABLET</b> (generic Viread)	VIREAD (tenofovir) <b>POWDER</b>	
<b>PHARMACOKINETIC ENHANCER</b>		
	TYBOST (cobicistat) <sup>QL</sup>	

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

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

<sup>QL</sup> – Quantity/Duration Limit

<sup>AL</sup> – Age Limit

<sup>NR</sup> – Product was not reviewed - New Drug criteria will apply

# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January 2023 PDL **Highlighted in Red** effective January 20, 2023

## HIV / AIDS<sup>CL</sup> (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>PROTEASE INHIBITORS</b>		<ul style="list-style-type: none"> <li>▪ All agents require: <ul style="list-style-type: none"> <li>○ Diagnosis of HIV/AIDS required; OR</li> <li>○ Diagnosis of Pre and Post Exposure Prophylaxis</li> </ul> </li> <li>▪ 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</li> <li>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</li> </ul>
atazanavir <b>CAPS</b> (generic Reyataz)	APTIVUS <b>CAPS, SOLN</b> (tipranavir)	
ritonavir <b>TABLET</b> (generic Norvir)	CRIXIVAN (indinavir)	
	fosamprenavir <b>TAB</b> (generic Lexiva)	
	INVIRASE (saquinavir)	
	LEXIVA <b>SUSP</b> (fosamprenavir)	
	LEXIVA <b>TABLET</b> (fosamprenavir)	
	NORVIR <b>POWDER, SOLN</b> (ritonavir)	
	NORVIR (ritonavir) <b>TAB</b>	
	PREZISTA (darunavir) <b>SUSP, TABLET</b>	
	REYATAZ <b>POWDER</b> (atazanavir)	
	VIRACEPT (nelfinavir)	

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January 2023 PDL **Highlighted in Red** effective January 20, 2023

## HIV / AIDS<sup>CL</sup> (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>COMBINATION PROTEASE INHIBITORS (PIs) or PIs plus PHARMACOKINETIC ENHANCER</b>		<ul style="list-style-type: none"> <li>▪ All agents require: <ul style="list-style-type: none"> <li>○ Diagnosis of HIV/AIDS required; OR</li> <li>○ Diagnosis of Pre and Post Exposure Prophylaxis</li> </ul> </li> <li>▪ 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</li> <li>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</li> </ul>
EVOTAZ (atazanavir/cobicistat) <sup>QL</sup> lopinavir/ritonavir <b>SOLN</b> (generic Kaletra)	KALETRA <b>SOLN</b> (lopinavir/ritonavir) KALETRA <b>TAB</b> (lopinavir/ritonavir) lopinavir/ritonavir <b>TAB</b> (generic Kaletra) PREZCOBIX (darunavir/cobicistat) <sup>QL</sup>	
<b>COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS</b>		
abacavir/lamivudine (generic Epzicom) CIMDUO (lamivudine/tenofovir) <sup>QL</sup> DESCOVY (emtricitabine/tenofovir) <sup>QL, CL</sup> emtricitabine/tenofovir (generic Truvada) <sup>CL</sup> lamivudine/zidovudine (generic Combivir)	abacavir/lamivudine/zidovudine (generic Trizivir) COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir sulfate/lamivudine) TEMIXYS (lamivudine/tenofovir) <sup>QL</sup> TRIZIVIR (abacavir/lamivudine/zidovudine) TRUVADA (emtricitabine/tenofovir)	

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

<sup>QL</sup> – Quantity/Duration Limit

<sup>AL</sup> – Age Limit

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

# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January 2023 PDL Highlighted in Red effective January 20, 2023

## HIV / AIDS<sup>CL</sup> (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>COMBINATION PRODUCTS – MULTIPLE CLASSES</b>		<ul style="list-style-type: none"> <li>▪ All agents require: <ul style="list-style-type: none"> <li>○ Diagnosis of HIV/AIDS required; OR</li> <li>○ Diagnosis of Pre and Post Exposure Prophylaxis</li> </ul> </li> <li>▪ 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</li> <li>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</li> </ul>
BIKTARVY (bictegravir/emtricitabine/tenofovir) <sup>QL</sup>	ATRIPLA (efavirenz/emtricitabine/tenofovir)	
COMPLERA (rilpivirine/emtricitabine/tenofovir)	efavirenz/lamivudine/tenofovir (generic for Symfi) <sup>QL</sup>	
DELSTRIGO (doravirine/lamivudine/tenofovir) <sup>QL</sup>	efavirenz/lamivudine/tenofovir (generic for Symfi Lo) <sup>QL</sup>	
DOVATO (dolutegravir/lamivudine) <sup>QL</sup>	JULUCA (dolutegravir/rilpivirine) <sup>QL</sup>	
efavirenz/emtricitabine/tenofovir (generic Atripla) <sup>CL</sup>	TRIUMEQ PD (abacavir, dolutegravir, and lamivudine) <b>SUSP<sup>NR</sup></b>	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) <sup>QL, AL</sup>		
ODEFSEY (emtricitabine/rilpivirine/tenofovir) <sup>QL</sup>		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) <sup>QL</sup>		
SYMFI (efavirenz/lamivudine/tenofovir) <sup>QL</sup>		
SYMFI LO (efavirenz/lamivudine/tenofovir) <sup>QL</sup>		
SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir) <sup>QL</sup>		
TRIUMEQ (dolutegravir/abacavir/lamivudine)		

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

<sup>QL</sup> – Quantity/Duration Limit

<sup>AL</sup> – Age Limit

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January 2023 PDL **Highlighted in Red** effective January 20, 2023

## HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

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

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January 2023 PDL **Highlighted in Red** effective January 20, 2023

## HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST (GLP-1 RA)<sup>CL</sup></b>		<b>GLP-1 RA Criteria</b>
OZEMPIC (semaglutide) TRULICITY (dulaglutide) VICTOZA (liraglutide) subcutaneous	ADLYXIN (lixisenatide) BYDUREON BCISE <b>PEN</b> (exenatide) <sup>QL</sup> BYDUREON (exenatide ER) BYDUREON <b>PEN</b> (exenatide ER) subcutaneous BYETTA (exenatide) subcutaneous MOUNJARO (tirazepatide) <sup>NR</sup> <b>PEN</b> RYBELSUS (semaglutide)	Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin <b>OR</b> 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: <ul style="list-style-type: none"> <li>Failed a trial of TWO preferred agents within GLP-1 RA</li> </ul>
<b>INSULIN/GLP-1 RA COMBINATIONS</b>		<b>AND</b>
	SOLIQUA (insulin glargine/lixisenatide) XULTOPHY (insulin degludec/liraglutide)	<ul style="list-style-type: none"> <li>Diagnosis of diabetes with HbA1C <math>\geq 7</math> AND</li> <li>Trial of metformin, or contraindication or intolerance to metformin</li> </ul>
<b>AMYLIN ANALOG</b>		<b>Amylin Analog Criteria</b>
	SYMLIN (pramlintide) subcutaneous	ALL criteria must be met <ul style="list-style-type: none"> <li>Concurrent use of short-acting mealtime insulin</li> <li>Current therapy compliance</li> <li>No diagnosis of gastroparesis</li> <li>HbA1C <math>\leq 9\%</math> within last 90 days</li> <li>Monitoring of glucose during initiation of therapy</li> </ul>
<b>DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR<sup>QL</sup></b>		<b>DPP-4 Inhibitor Criteria</b>
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) <sup>AL</sup>	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 <b>ONE</b> preferred agent within the DPP-4 inhibitor class

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January 2023 PDL **Highlighted in Red** effective January 20, 2023

## HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

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

## HYPOGLYCEMICS, MEGLITINIDES

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

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<sup>QL</sup> – Quantity/Duration Limit

<sup>AL</sup> – Age Limit

<sup>NR</sup> – Product was not reviewed - New Drug criteria will apply

# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January 2023 PDL **Highlighted in Red** effective January 20, 2023

## HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metformin IR & ER (generic Glucophage/Glucophage XR)	metformin ER (generic Fortamet/Glumetza) metformin <b>SOLN</b> (generic Riomet) RIOMET ER (metformin ER) <sup>AL</sup>	<ul style="list-style-type: none"> <li><b>Metformin ER (generic Fortamet®)/Glumetza®:</b> Requires clinical reason why generic Glucophage XR® cannot be used</li> <li><b>Metformin solution:</b> Prior authorization not required for age &lt;7 years</li> </ul>

## HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin) <sup>QL,CL</sup> INVOKAMET (canagliflozin/metformin) <sup>QL, CL</sup> INVOKANA (canagliflozin) <sup>CL</sup> JARDIANCE (empagliflozin) <sup>QL, CL</sup> SYNJARDY (empagliflozin/metformin) <sup>AL,CL,QL</sup> XIGDUO XR (dapagliflozin/metformin) <sup>QL,CL</sup>	INVOKAMET XR (canagliflozin/metformin) <sup>QL</sup> SEGLUROMET (ertugliflozin/metformin) <sup>QL</sup> STEGLATRO (ertugliflozin) <sup>QL</sup> SYNJARDY XR (empagliflozin/ metformin) <sup>AL,QL</sup>	<p>Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin <b>OR</b></p> <p>A diagnosis of ASCVD or Heart Failure, or Chronic Kidney Disease associated with a diagnosis of Type II diabetes (no metformin trial required)</p> <ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class</li> </ul> <p>Drug Specific Criteria:</p> <ul style="list-style-type: none"> <li><b>Farxiga:</b> May be approved for a diagnosis of heart failure with reduced ejection fraction (NYHA class II-IV) without a diagnosis of diabetes               <ul style="list-style-type: none"> <li>May be approved for a diagnosis of chronic kidney disease at risk of progression without a diagnosis of diabetes</li> </ul> </li> <li><b>Jardiance:</b> May be approved for a diagnosis of Heart Failure without a diagnosis of diabetes</li> </ul>

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January 2023 PDL **Highlighted in Red** effective January 20, 2023

## HYPOGLYCEMICS, SULFONYLUREAS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
glimepiride (generic Amaryl) glipizide IR & ER (generic Glucotrol/ Glucotrol XL) glyburide (generic Diabeta/Glynase)	chlorpropamide tolazamide tolbutamide	<ul style="list-style-type: none"><li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li></ul>
SULFONYLUREA COMBINATIONS		
glipizide/metformin glyburide/metformin (generic Glucovance)		

## HYPOGLYCEMICS, TZD

Preferred Agents		Non-Preferred Agents	Prior Authorization/Class Criteria
THIAZOLIDINEDIONES (TZDs)			<ul style="list-style-type: none"><li>Non-preferred agents will be approved for patients who have failed a trial of THE preferred agent within this drug class</li></ul>
pioglitazone (generic for Actos)	AVANDIA (rosiglitazone)		
TZD COMBINATIONS			
	pioglitazone/glimepiride (generic for Duetact) pioglitazone/metformin (generic for Actoplus Met)		<ul style="list-style-type: none"><li><b>Combination products:</b> Require clinical reason why individual ingredients cannot be used</li></ul>

## IDIOPATHIC PULMONARY FIBROSIS

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

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<sup>QL</sup> – Quantity/Duration Limit

<sup>AL</sup> – Age Limit

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January 2023 PDL **Highlighted in Red** effective January 20, 2023

## IMMUNOMODULATORS, ASTHMA<sup>CL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FASENRA (benralizumab) <sup>AL</sup> <b>PEN</b> XOLAIR (omalizumab) <b>SYR<sup>AL,QL</sup></b>	NUCALA (mepolizumab) <sup>AL</sup> <b>AUTO-INJ, SYR</b>	<p><u><a href="#">Immunomodulators Self-Injectable PA Form</a></u></p> <ul style="list-style-type: none"> <li>• All agents require prior authorization AND an FDA-approved diagnosis for approval</li> <li>• Non-preferred agents require a trial of a preferred agent within this drug class with the same indication</li> <li>• For asthma indications: All agents must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist</li> <li>• Agents listed may have other FDA approved indications, and will be subject to prior authorization</li> </ul> <p>Drug Specific Criteria:  <b>Dupixent:</b> (For other indications, see Immunomodulators, Atopic Dermatitis therapeutic class)- <b>For Eosinophilic Asthma or Corticosteroid Dependent Asthma:</b> Patients must be ages 6 and older. Documentation of moderate to severe asthma with either eosinophils <math>\geq 150 + 1</math> exacerbation OR oral corticosteroid dependency AND prior drug therapy of med-high or max-tolerated inhaled corticosteroid + controller OR max-tolerated inhaled corticosteroid / long acting beta agonist combo</p>

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January 2023 PDL **Highlighted in Red** effective January 20, 2023

## IMMUNOMODULATORS, ATOPIC DERMATITIS<sup>AL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>DUPIXENT (dupilumab)<sup>AL,CL</sup> <b>PEN,SYR</b></b> ELIDEL (pimecrolimus) EUCRISA (crisaborole) <sup>CL,QL</sup> <b>PROTOPIC (tacrolimus)</b>	ADBRY (tralokinumab-ldrm) <b>SUB-Q<sup>AL,QL</sup></b> OPZELURA (ruxolitinib phosphate) <b>CREAM<sup>AL,QL</sup></b> pimecrolimus (generic for Elidel) tacrolimus (generic for Protopic) <sup>CL</sup>	<p><a href="#">Immunomodulators Self-Injectable PA Form</a> (For Adbry and Dupixent only)</p> <ul style="list-style-type: none"> <li>Non-preferred agents require: Trial of a topical steroid AND Trial of one preferred product within this drug class</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Dupixent:</b> <ol style="list-style-type: none"> <li><b>Atopic Dermatitis:</b> Trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor</li> <li><b>Eosinophilic Esophagitis:</b> Trial, failure, or technique difficulty to a swallowed topical corticosteroid or treatment failure of a proton pump inhibitor. Prescribed by, or in consultation with an allergist, gastroenterologist, or immunologist. Documentation that the Patient has a confirmed diagnosis of eosinophilic esophagitis with &gt; 15 eosinophils/high-power field.</li> <li><b>Nasal Polyps:</b> Documentation of treatment failure or contraindication to an intranasal corticosteroid OR systemic corticosteroid therapy OR prior nasal surgery. Prescribed by, or in consultation with an allergist, pulmonologist, or otolaryngologist [ENT]</li> <li><b>Prurigo Nodularis:</b> Patient must have a diagnosis of Prurigo Nodularis with provider attestation of &gt; 20 nodular lesions. Trial and failure of a topical corticosteroid. Prescribed by, or in consultation with an allergist, dermatologist, or immunologist.</li> </ol> </li> <li><b>Eucrisa:</b> Requires trial and failure of 1 topical steroid or Elidel.</li> <li><b>Opzelura:</b> May be approved for a diagnosis of Atopic Dermatitis and after a trial/failure of a topical steroid and trial of a preferred agent</li> </ul>

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## IMMUNOMODULATORS, TOPICAL

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

## IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathioprine (generic Imuran) azathioprine (generic Azasan) <sup>NR</sup> cyclosporine, modified <b>CAPS</b> (generic Neoral) everolimus (generic for Zortress) <sup>AL</sup> mycophenolate <b>CAPS, TABLET</b> (generic Cellcept) RAPAMUNE (sirolimus) <b>SOLN</b> RAPAMUNE (sirolimus) <b>TABLET</b> tacrolimus	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) cyclosporine <b>CAP, SOFTGEL</b> cyclosporine, modified <b>SOLN</b> (generic Neoral) ENVARSUS XR (tacrolimus) GENGRAF (cyclosporine, modified) <b>CAP, SOLN</b> mycophenolate <b>SUSP</b> (generic Cellcept) mycophenolic acid MYFORTIC (mycophenolate sodium) PROGRAF (tacrolimus) <b>CAPS, PACKET</b> REZUROCK (belumosudil) <sup>AL,QL</sup> <b>TAB</b> SANDIMMUNE (cyclosporine) <b>CAPS, SOLN</b> sirolimus <b>SOLN, TABLET</b> (generic Rapamune) TAVNEOS (avacopan) <sup>QL</sup> <b>CAPS</b> ZORTRESS (everolimus) <sup>AL</sup>	<p>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</p> <ul style="list-style-type: none"> <li>Patients established on existing therapy will be allowed to continue</li> </ul>

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CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January 2023 PDL **Highlighted in Red** effective January 20, 2023

## INTRANASAL RHINITIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ANTICHOLINERGICS</b>		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: <ul style="list-style-type: none"><li>▪ <b>mometasone:</b> Prior authorization NOT required for children ≤ 12 years</li><li>▪ <b>budesonide:</b> Approved for use in Pregnancy (Pregnancy Category B)</li><li>▪ <b>Xhance:</b> Indicated for treatment of nasal polyps in ≥ 18 years only</li></ul>
ipratropium (generic for Atrovent)		
<b>ANTI-HISTAMINES</b>		
azelastine 0.1% (generic for Astelin)	azelastine 0.15% (generic for Astepro) azelastine/fluticasone (generic for Dymista) olopatadine (generic for Patanase) RYALTRIS (olopatadine/mometasone) <sup>AL,NR</sup>	
<b>CORTICOSTEROIDS</b>		
fluticasone <b>Rx</b> (generic Flonase)	BECONASE AQ (beclomethasone) budesonide Rx (generic for Rhinocort) flunisolide (generic for Nasalide) fluticasone OTC (generic Flonase OTC) mometasone (generic for Nasonex) OMNARIS (ciclesonide) QNASL 40 & 80 (beclomethasone) XHANCE (fluticasone) ZETONNA (ciclesonide)	

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## LEUKOTRIENE MODIFIERS

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

## LINCOSAMIDES / OXAZOLIDINONES / STREPTOGRAMINS

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

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

<sup>QL</sup> – Quantity/Duration Limit

<sup>AL</sup> – Age Limit

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>BILE ACID SEQUESTRANTS</b>		<ul style="list-style-type: none"><li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li><li>Drug-specific criteria:<ul style="list-style-type: none"><li><b>Colesevelam:</b> Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate</li><li><b>Juxtapid®/ Kynamro®:</b><ul style="list-style-type: none"><li>Approved for diagnosis of homozygous familial hypercholesterolemia (HoFH) OR</li><li>Treatment failure/maximized dosing/contraindication to ALL the following: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, bile acid sequestrants</li><li>Require faxed copy of REMS PA form</li></ul></li><li><b>Vascepa®:</b> Approved for TG ≥ 500</li></ul></li></ul>
cholestyramine (generic Questran) colestipol <b>TABLETS</b> (generic Colestid)	colesevelam (generic Welchol) <b>TABLET, PACKET</b> colestipol <b>GRANULES</b> (generic Colestid) QUESTRAN LIGHT (cholestyramine)	
<b>TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA</b>		
	JUXTAPID (lomitapide) <sup>CL</sup> KYNAMRO (mipomersen) <sup>CL</sup>	
<b>FIBRIC ACID DERIVATIVES</b>		
fenofibrate (generic Tricor) fenofibrate (generic Lofibra) gemfibrozil (generic Lopid)	fenofibric acid (generic Fibracor/Trilipix) fenofibrate (generic Antara/Fenoglide/Lipofen/Triglide)	
<b>NIACIN</b>		
niacin ER (generic Niaspan)	NIACOR (niacin IR) NIASPAN (niacin ER)	
<b>OMEGA-3 FATTY ACIDS</b>		
omega-3 fatty acids (generic Lovaza)	icosapent (generic Vascepa) <sup>CL</sup> omega-3 OTC VASCEPA (icosapent) <sup>CL</sup>	
<b>CHOLESTEROL ABSORPTION INHIBITORS</b>		
ezetimibe (generic Zetia)	NEXLIZET (bempedoic acid/ezetimibe) <sup>QL</sup>	

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<sup>QL</sup> – Quantity/Duration Limit

<sup>AL</sup> – Age Limit

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**Nebraska Medicaid  
Preferred Drug List  
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**LIPOTROPICS, OTHER (continued)**

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

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>STATINS</b>		<ul style="list-style-type: none"> <li>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</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Altoprev®:</b> One of the TWO trials must be IR lovastatin</li> <li><b>Combination products:</b> Require clinical reason why individual ingredients cannot be used</li> <li><b>fluvastatin ER:</b> Requires trial of TWO preferred agents AND trial of IR fluvastatin OR clinical reason IR cannot be used</li> <li><b>simvastatin/ezetimibe:</b> Approved for 3-month continuous trial of ONE standard dose statin</li> </ul>
atorvastatin (generic Lipitor) <sup>QL</sup> lovastatin (generic Mevacor) pravastatin (generic Pravachol) rosuvastatin (generic Crestor) simvastatin (generic Zocor)	ALTOPREV (lovastatin ER) <sup>CL</sup> EZALLOR SPRINKLE (rosuvastatin) <sup>QL</sup> fluvastatin IR/ER (generic Lescol/Lescol XL) LIVALO (pitavastatin) ZYPITAMAG (pitavastatin)	
<b>STATIN COMBINATIONS</b>		
	atorvastatin/amlodipine (generic Caduet) simvastatin/ezetimibe (generic Vytorin)	

## MACROLIDES AND KETOLIDES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>MACROLIDES</b>		<ul style="list-style-type: none"> <li>Non-preferred agents require clinical reason why preferred products within this drug class cannot be used AND ≥ 3-day trial on a preferred product</li> </ul>
azithromycin (generic Zithromax) clarithromycin <b>TABLET, SUSP</b> (generic Biaxin) E.E.S. <b>SUSP</b> (erythromycin ethylsuccinate)	clarithromycin ER (generic Biaxin XL) E.E.S. <b>TABLET</b> (erythromycin ethylsuccinate) ERY-TAB (erythromycin) erythromycin ethylsuccinate <b>SUSP</b> ERYPED <b>SUSP</b> (erythromycin) ERYTHROCIN (erythromycin) erythromycin base <b>TABLET, CAPS</b>	

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## METHOTREXATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
methotrexate <b>PF VIAL, TABLET, VIAL</b>	OTREXUP (methotrexate) <b>SUB-Q</b> RASUVO (methotrexate) <b>SUB-Q</b> REDITREX (methotrexate) <b>SUB-Q</b> Trexall (methotrexate) <b>TABLET</b> Xatmep (methotrexate) <b>SOLN</b>	Non-preferred agents require a trial of the preferred agent AND will be approved for an FDA-approved indication  Drug-specific criteria: <ul style="list-style-type: none"> <li><b>Xatmep™</b>: Indicated for pediatric patients only</li> </ul>

## MOVEMENT DISORDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUSTEDO (deutetrabenazine) <sup>CL</sup> INGREZZA (valbenazine) <sup>AL,CL,QL</sup> <b>CAPS</b> tetrabenazine (generic for Xenazine) <sup>CL</sup>	INGREZZA (valbenazine) <sup>CL</sup> <b>INITIATION PACK</b> XENAZINE (tetrabenazine) <sup>CL</sup>	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: <ul style="list-style-type: none"> <li><b>Austedo</b>: 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</li> <li><b>Ingrezza</b>: Diagnosis of Tardive Dyskinesia in adults</li> <li><b>tetrabenazine</b>: Diagnosis of chorea with Huntington's Disease</li> </ul>

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AVONEX (interferon beta-1a) <sup>QL</sup> BETASERON (interferon beta-1b) <sup>QL</sup> COPAXONE 20mg (glatiramer) <sup>QL</sup> dimethyl fumarate (generic for Tecfidera) KESIMPTA (Ofatumumab) <sup>CL,QL</sup>	AUBAGIO (teriflunomide) BAFIERTAM (monomethyl fumarate) <sup>QL</sup> dalfampridine (generic Ampyra) <sup>QL</sup> EXTAVIA (interferon beta-1b) <sup>QL</sup> fingolimod (generic Gilenya) <sup>NR,QL</sup> GILENYA (fingolimod) <sup>QL</sup> glatiramer (generic Copaxone) <sup>QL</sup> MAVENCLAD (cladribine) MAYZENT (siponimod) <sup>QL</sup> PLEGRIDY (peginterferon beta-1a) <sup>QL</sup> PONVORY (ponesimod) REBIF (interferon beta-1a) <sup>QL</sup> TASCENSO ODT (fingolimod) <b>TAB</b> <sup>AL,NR</sup> TECFIDERA (dimethyl fumarate) VUMERITY (diroximel) <sup>QL</sup> ZEPOSIA (ozanimod) <sup>AL,CL,QL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agent within this drug class</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Ampyra</b>®: Approved for diagnosis of gait disorder associated with MS AND EDSS score ≤ 7</li> <li><b>Plegridy</b>: Approved for diagnosis of relapsing MS</li> <li><b>Kesimpta</b>: Approved for patients who have failed a trial of a preferred injectable agent within this class</li> <li><b>Zeposia</b>: 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.</li> </ul>

## NITROFURAN DERIVATIVES

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

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## NSAIDs, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>COX-1 SELECTIVE</b>		<ul style="list-style-type: none"> <li>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</li> <li>Drug-specific criteria: <ul style="list-style-type: none"> <li><b>meclofenamate</b>: Approvable without trial of preferred agents for menorrhagia</li> <li><b>Sprix®</b>: Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs</li> </ul> </li> </ul>
diclofenac sodium (generic Voltaren) ibuprofen OTC, Rx (generic fAdvil, Motrin) <b>CHEW, DROPS, SUSP, TAB</b> <b>ibuprofen OTC (generic Advil, Motrin) CAPS</b> indomethacin <b>CAPS</b> (generic Indocin) ketorolac (generic Toradol) meloxicam <b>TAB</b> (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/famotidine (generic Duexis) <sup>CL</sup> indomethacin ER (generic Indocin) ketoprofen & ER (generic Orudis) meclofenamate (generic Meclomen) mefenamic acid (generic Ponstel) meloxicam <b>CAP</b> (generic Vivlodex) <sup>CL, QL</sup> naproxen CR (generic Napreelan) naproxen <b>SUSP</b> (generic Naprosyn) naproxen sodium (generic Anaprox) naproxen-esomeprazole (generic Vimovo) oxaprozin (generic Daypro) piroxicam (generic Feldene) tolmetin (generic Tolectin) ketorolac <b>NASAL</b> <sup>QL</sup> (generic Sprix)	

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January 2023 PDL **Highlighted in Red** effective January 20, 2023

## NSAIDs, ORAL (Continued)

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

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## NSAIDs, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
diclofenac sodium <b>GEL (OTC only)</b> diclofenac <b>SOLN</b> (generic Pennsaid Soln) <sup>CL</sup>	FLECTOR <b>PATCH</b> (diclofenac) <sup>CL</sup> LICART <b>PATCH</b> (diclofenac) <sup>CL</sup> PENNSAID <b>PACKET, PUMP</b> (diclofenac) <sup>CL</sup> VOLTAREN <b>GEL</b> (diclofenac) <sup>CL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class AND a clinical reason why patient cannot use oral dosage form.</li> </ul>

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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

## ONCOLOGY AGENTS, ORAL, BREAST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>CDK 4/6 INHIBITOR</b>		<ul style="list-style-type: none"><li>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</li><li>Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</li></ul> Drug-specific criteria <ul style="list-style-type: none"><li><b>anastrozole:</b> May be approved for malignant neoplasm of male breast (male breast cancer)</li><li><b>Fareston®:</b> Require clinical reason why tamoxifen cannot be used</li><li><b>letrozole:</b> Approved for diagnosis of breast cancer with day supply greater than 12 – NOT approved for short term use</li><li><b>Soltamox:</b> May be approved with documented swallowing difficulty</li></ul>
	<b>IBRANCE (palbociclib)</b> KISQALI (ribociclib) KISQALI FEMARA <b>CO-PACK</b> VERZENIO (abemaciclib)	
<b>CHEMOTHERAPY</b>		
<b>capecitabine (generic Xeloda)</b> cyclophosphamide	<b>XELODA (capecitabine)</b>	
<b>HORMONE BLOCKADE</b>		
anastrozole (generic Arimidex) exemestane (generic Aromasin) letrozole (generic Femara) tamoxifen citrate (generic Nolvadex)	SOLTAMOX <b>SOLN</b> (tamoxifen) <sup>CL</sup> toremifene (generic Fareston) <sup>CL</sup>	
<b>OTHER</b>		
	NERLYNX (neratinib) PIQRAY (alpelisib) lapatinib (generic Tykerb) <sup>CL</sup> TALZENNA (talazoparib tosylate) <sup>QL</sup> TUKYSA(tucatinib) <sup>QL</sup>	

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January 2023 PDL **Highlighted in Red** effective January 20, 2023

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## ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALL		<ul style="list-style-type: none"><li>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</li><li>Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</li></ul> <p>Drug-specific criteria</p> <ul style="list-style-type: none"><li><b>Hydrea®:</b> Requires clinical reason why generic cannot be used</li><li><b>Melphalan:</b> Requires trial of Alkeran or clinical reason Alkeran cannot be used</li><li><b>Purixan:</b> Prior authorization not required for age ≤12 or for documented swallowing disorder</li><li><b>Tabloid:</b> Prior authorization not required for age &lt;19</li><li><b>Xpovio:</b> Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone</li></ul>
mercaptopurine	PURIXAN (mercaptopurine) <sup>AL</sup>	
AML		
	DAURISMO (glasdegib maleate) <sup>QL</sup> IDHIFA (enasidenib) REZLIDHIA (olutasidenib) <sup>NR,QL</sup> RYDAPT (midostaurin) TIBSOVO (ivosidenib) <sup>QL</sup> XOSPATA (gilteritinib) <sup>QL</sup>	
CLL		
LEUKERAN (chlorambucil)	COPIKTRA (duvelisib) <sup>QL</sup> IMBRUVICA (ibrutinib) VENCLEXTA (venetoclax) ZYDELIG (idelalisib)	
CML		
hydroxyurea (generic for Hydrea) imatinib (generic for Gleevec) MYLERAN (busulfan)	BOSULIF (bosutinib) GLEEVEC (imatinib) HYDREA (hydroxyurea) ICLUSIG (ponatinib) SCEMBLIX (asciminib) SPRYCEL (dasatinib) TASIGNA (nilotinib) <sup>CL</sup>	
MPN		
	JAKAFI (ruxolitinib)	
MYELOMA		
ALKERAN (melphalan) REVLIMID <sup>QL</sup> (lenalidomide)	lenalidomide <sup>QL</sup> (generic Revlimid) melphalan (generic Alkeran) NINLARO (ixazomib) POMALYST (pomalidomide) THALOMID (thalidomide) XPOVIO (selinexor) <sup>CL</sup>	
OTHER		
MATULANE (procarbazine) TABLOID (thioguanine) tretinoin (generic for Vesanoide) <sup>AL</sup>	BRUKINSA (zanubrutinib) <sup>QL</sup> CALQUENCE (acalabrutinib) <sup>QL</sup> INREBIC (fedratinib dihydrochloride) <sup>QL</sup> INQOVI (decitabine/cedazuridine) VONJO (pacritinib) <sup>QL</sup> ZOLINZA (vorinostat)	

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## ONCOLOGY AGENTS, ORAL, LUNG

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ALK</b>		<ul style="list-style-type: none"><li>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</li><li>Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</li></ul>
	<b>ALECENSA (alectinib)</b> ALUNBRIG (brigatinib) <sup>QL</sup> LORBRENA (lorlatinib) <sup>QL</sup> ZYKADIA (ceritinib) <b>CAPS, TAB</b>	
<b>ALK / ROS1 / NTRK</b>		
	ROZLYTREK (entrectinib) <sup>AL,QL</sup> XALKORI (crizotinib)	
<b>EGFR</b>		
	erlotinib (generic for Tarceva) <b>EXKIVITY (mobocertinib)</b> <sup>QL</sup> GILOTRIF (afatinib) IRESSA (gefitinib) <b>TAGRISSO (osimertinib)</b> TARCEVA (erlotinib) VIZIMPRO (dacomitinib) <sup>QL</sup>	
<b>OTHER</b>		
	GAVRETO (pralsetinib) <sup>QL</sup> HYCAMTIN (topotecan) LUMAKRAS (sotrasib) <sup>QL</sup> RETEVMO (selpercatinib) <sup>AL</sup> TABRECTA (capmatinib) <sup>QL</sup> TEPMETKO (tepotinib) <sup>QL</sup>	

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## ONCOLOGY AGENTS, ORAL, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
temozolomide (generic Temodar)	<b>AYVAKIT (avapritinib)<sup>AL, QL</sup></b> BALVERSA (erdafitinib) <b>CAPRELSA (vandetanib)</b> COMETRIQ (cabozantinib) HEXALEN (altretamine) KOSELUGO (selumetinib) <sup>AL</sup> LONSURF (trifluridine/tipiracil) <b>LYNPARZA (olaparib)</b> LYTGOBI (futibatinib) <sup>NR</sup> PEMAZYRE (pemigatinib) <sup>QL</sup> RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat) <sup>AL</sup> TURALIO (pexidartinib) <sup>QL</sup> TRUSELTIQ (infigratinib) <b>CAPS</b> VITRAKVI (larotrectinib) <b>CAPS, SOLN</b> <b>ZEJULA (niraparib)</b>	<ul style="list-style-type: none"> <li>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</li> <li><b>Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</b></li> </ul>

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## ONCOLOGY AGENTS, ORAL, PROSTATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
abiraterone (generic Zytiga) <sup>AL,QL</sup> bicalutamide (generic Casodex) flutamide	EMCYT (estramustine) ERLEADA (apalutamide) <sup>QL</sup> nilutamide (generic Nilandron) NUBEQA (darolutamide) <sup>QL</sup> <b>ORGOVYX (relugolix)<sup>AL</sup></b> <b>XTANDI (enzalutamide)<sup>AL,QL</sup></b> YONSA (abiraterone acetone, submicronized) <b>ZYTIGA (abiraterone)<sup>AL,QL</sup></b>	<ul style="list-style-type: none"> <li>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</li> <li><b>Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</b></li> </ul>

## ONCOLOGY AGENTS, ORAL, RENAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SUTENT (sunitinib)	AFINITOR DISPERZ (everolimus) <sup>CL</sup> CABOMETYX (cabozantinib) everolimus (generic Afinitor) <b>everolimus <b>SUSP</b> (generic Afinitor Disperz)</b> <b>FOTIVDA (tivozanib)</b> <b>INLYTA (axitinib)</b> <b>LENVIMA (lenvatinib)</b> NEXAVAR (sorafenib) <b>sorafenib (generic Nexavar)</b> sunitinib malate (generic Sutent) <b>VOTRIENT (pazopanib)</b> <b>WELIREG (belzutifan)<sup>QL</sup></b>	<ul style="list-style-type: none"> <li>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</li> <li><b>Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</b></li> </ul>

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## ONCOLOGY AGENTS, ORAL, SKIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>BASAL CELL</b>		<ul style="list-style-type: none"> <li>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</li> <li><b>Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</b></li> </ul>
ERIVEDGE (vismodegib)	ODOMZO (sonidegib) <sup>CL</sup>	
<b>BRAF MUTATION</b>		
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 Opticrom) ketotifen OTC (generic Zaditor) olopatadine 0.1% (generic Patanol) olopatadine OTC (Pataday once daily)	ALOCRIL (nedocromil) ALOMIDE (Iodoxamide) azelastine (generic Optivar) BEPREVE (bepotastine besilate) bepotastine besilate (generic Bepreve) EMADINE (emedastine) epinastine (generic Elestat) LASTACAFT (alcaftadine) <b>LASTACAFT (alcaftadine) OTC</b> <b>olopatadine DROPS (generic Pataday)</b> <b>olopatadine OTC (Pataday twice daily)</b> PATADAY XS (olopatadine 0.7%) PATADAY OTC (olopatadine 0.2%) PAZEO (olopatadine 0.7%) ZERVIAE (cetirizine) <sup>AL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> </ul>

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## OPHTHALMICS, ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>FLUOROQUINOLONES</b>		<ul style="list-style-type: none"><li>Non-preferred agents will be approved for patients who have failed a one-month trial of TWO preferred agent within this drug class</li><li><b>Azasite®</b>: Approval only requires trial of erythromycin</li></ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"><li><b>Natacyn®</b>: Approved for documented fungal infection</li></ul>
ciprofloxacin <b>SOLN</b> (generic Ciloxan) ofloxacin (generic Ocuflox)	BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) gatifloxacin 0.5% (generic Zymaxid) levofloxacin MOXEZA (moxifloxacin) moxifloxacin (generic Vigamox) moxifloxacin (generic Moxeza) VIGAMOX (moxifloxacin)	
<b>MACROLIDES</b>		
erythromycin	AZASITE (azithromycin) <sup>CL</sup>	
<b>AMINOGLYCOSIDES</b>		
gentamicin <b>OINT</b> gentamicin <b>SOLN</b> tobramycin (generic Tobrex drops)	TOBREX <b>OINT</b> (tobramycin)	
<b>OTHER OPHTHALMIC AGENTS</b>		
bacitracin/polymyxin B (generic Polysporin) polymyxin B/trimethoprim (generic Polytrim)	bacitracin neomycin/bacitracin/polymyxin B <b>OINT</b> neomycin/polymyxin B/gramicidin NEOSPORIN (neomycin/polymyxin B/gramicidin) sulfacetamide <b>SOLN</b> (generic Bleph-10) sulfacetamide <b>OINT</b>	

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<sup>QL</sup> – Quantity/Duration Limit

<sup>AL</sup> – Age Limit

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

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

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## OPHTHALMICS, ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>CORTICOSTEROIDS</b>		<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> <li><b>NSAID class:</b> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent</li> </ul>
fluorometholone 0.1% (generic FML) <b>OINT</b> LOTEMAX <b>SOLN</b> (loteprednol 0.5%) MAXIDEX (dexamethasone) PRED MILD (prednisolone 0.12%)	dexamethasone (generic Maxidex) <b>difluprednate (generic Durezol)</b> DUREZOL (difluprednate) FLAREX (fluorometholone) FML (fluorometholone 0.1% <b>SOLN</b> ) FML FORTE (fluorometholone 0.25%) FML S.O.P. (fluorometholone 0.1%) INVELTYS (loteprednol etabonate) LOTEMAX <b>OINT, GEL</b> (loteprednol) loteprednol <b>GEL</b> (generic Lotemax Gel) loteprednol 0.5% <b>SOLN</b> (generic Lotemax SOLN) prednisolone acetate 1% (generic Omnipred, Pred Forte) prednisolone sodium phosphate prednisolone sodium phosphate 1%	
<b>NSAID</b>		
diclofenac (generic Voltaren) ketorolac 0.5% (generic Acular)	ACUVAIL (ketorolac 0.45%) BROMSITE (bromfenac) bromfenac 0.09% (generic Bromday) flurbiprofen (generic Ocufen) ILEVRO (nepafenac 0.3%) ketorolac LS 0.4% (generic Acular LS) NEVANAC (nepafenac) PROLENSA (bromfenac 0.07%)	

## OPHTHALMICS, ANTI-INFLAMMATORY / IMMUNOMODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RESTASIS (cyclosporine) RESTASIS MULTIDOSE (cyclosporine) XIIDRA (lifitegrast)	CEQUA (cyclosporine) <sup>QL</sup> maravi EYSUVIS (loteprednol etabonate) <sup>QL</sup> <b>TYRVAYA (varenicline tartrate)<sup>QL</sup></b>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>

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## OPHTHALMICS, GLAUCOMA

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

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## OPIOID DEPENDENCE TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
buprenorphine <b>SL</b> buprenorphine/naloxone <b>TAB (SL)</b> SUBOXONE <b>FILM</b> (buprenorphine/ naloxone)	buprenorphine/naloxone <b>FILM</b> LUCEMYRA (lofexidine) <sup>CL,QL</sup> ZUBSOLV (buprenorphine/naloxone)	<a href="#">Buprenorphine PA Form</a> <a href="#">Buprenorphine Informed Consent</a> <ul style="list-style-type: none"> <li>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.</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Lucemyra</b>: Approved for FDA approved indication and dosing per label. Trial of preferred product not required.</li> </ul>

## OPIOID-REVERSAL TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
naloxone <b>SYRINGE, VIAL</b> naltrexone <b>TAB</b> NARCAN (naloxone) <b>SPRAY</b>	KLOXXADO (naloxone) <b>NASAL</b> naloxone <b>SPRAY</b> (generic for Narcan) ZIMHI (naloxone) <sup>AL</sup> <b>SYRINGE</b>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved with documentation of why preferred products within this drug class are not appropriate for the patient</li> </ul>

## OTIC ANTI-INFECTIVES & ANESTHETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acetic acid (generic for Vosol)	acetic acid/hydrocortisone (generic for Vosol HC)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of the preferred agent within this drug class</li> </ul>

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## OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>CIPRO HC (ciprofloxacin/ hydrocortisone)</b> CIPRODEX (ciprofloxacin/dexamethasone) neomycin/polymyxin/hydrocortisone (generic Cortisporin) ofloxacin (generic Floxin)	ciprofloxacin ciprofloxacin/dexamethasone (generic for CIPRODEX) COLY-MYCIN S(neomycin/ hydrocortisone/colistin) OTOVEL (ciprofloxacin/fluocinolone)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>

## PAH (PULMONARY ARTERIAL HYPERTENSION AGENTS), ORAL AND INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ambrisentan (generic Letairis) REVATIO (sildenafil) <sup>CL</sup> <b>SUSP, TAB</b> tadalafil (generic for Adcirca) <sup>CL</sup> TRACLEER (bosentan) <b>TAB</b> TYVASO (treprostinil) <b>INHALATION</b> VENTAVIS (iloprost) <b>INHALATION</b>	ADEMPAS (riociguat) <sup>CL</sup> ADCIRCA (tadalafil) <sup>CL</sup> bosentan (generic Tracleer) <b>TAB</b> LETAIRIS (ambrisentan) OPSUMIT (macitentan) ORENITRAM ER (treprostinil) sildenafil (generic Revatio) <sup>CL</sup> <b>SUSP, TAB</b> TADLIQ (tadalafil) <sup>NR</sup> <b>SUSP</b> TRACLEER (bosentan) <b>TAB FOR SUSPENSION</b> TYVASO DPI (treprostinil) <sup>NR</sup> <b>INHALATION POWDER</b> UPTRAVI (selexipag)	<ul style="list-style-type: none"> <li>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</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Adcirca®/Revatio®:</b> Approved for diagnosis of Pulmonary Arterial Hypertension (PAH)</li> <li><b>Adempas®:</b> 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</li> <li><b>sildenafil suspension:</b> Requires clinical reason why sildenafil tablets cannot be used</li> </ul>

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## PANCREATIC ENZYMES

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

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## PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHILD CHEW + IRON (MULTIVITAMIN WITH IRON) <b>CHEW</b>	DEKAs PLUS <sup>AL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> </ul> <p>Drug specific criteria:</p> <ul style="list-style-type: none"> <li><b>DEKAs Plus:</b> Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent</li> </ul>
CHILDREN'S CHEWABLES (PEDI MULTIVIT NO.31/IRON/FOLIC, PEDI MULTIVIT NO.25/FOLIC ACID, PEDI MULTIVIT NO.23/FOLIC ACID)	FLORIVA (PEDI MULTIVIT NO.85/FLUORIDE) <b>CHEW</b>	
MULTIVIT-FLUOR (PEDI MULTIVIT NO.17 W-FLUORIDE, PEDI MULTIVIT NO.16 W-FLUORIDE) <b>CHEW</b>	FLORIVA PLUS (PEDI MULTIVIT NO.161/FLUORIDE) <b>DROP</b>	
MULTIVIT-FLUOR (PEDI MULTIVIT NO.2 W-FLUORIDE) <b>DROP</b>	MULTI-VIT-FLOR (PEDI MULTIVIT NO.205/FLUORIDE) <b>CHEW</b>	
MULTIVIT-IRON-FLUOR (PEDI MULTIVIT 45/FLUORIDE/IRON)	POLY-VI-FLOR (PEDI MULTIVIT NO.33/FLUORIDE) <b>CHEW</b>	
PED MVIT A,C,D3 NO.21/FLUORIDE	POLY-VI-FLOR (PEDI MULTIVIT NO.37 W-FLUORIDE) <b>DROPS</b>	
POLY-VI-SOL WITH IRON (PEDI MV NO.189/FERROUS SULFATE) <b>DROPS</b>	POLY-VI-FLOR /0.25mg IRON (PEDI MULTIVIT 37/FLUORIDE/IRON)	
TRI-VI-SOL (VIT A PALMITATE/VIT C/VIT D3) <b>DROPS</b>	POLY-VI-FLOR /0.5mg IRON (PEDI MULTIVIT 33/FLUORIDE/IRON)	
TRI-VITE-FLUORIDE (PED MVIT A,C,D3 NO.21/FLUORIDE)	POLY-VI-SOL (PEDIATRIC MULTIVITAMIN NO.192) <b>DROP</b>	
	QUFLORA (PEDI MULTIVIT NO.157/FLUORIDE) <b>GUMMIES</b>	
	QUFLORA FE (PED MULTIVIT 142/IRON/FLUORIDE) <b>CHEW</b>	
	QUFLORA FE (PED MULTIVIT 151/IRON/FLUORIDE) <b>DROP</b>	
	QUFLORA PED (PEDI MULTIVIT NO.63 W-FLUORIDE) <b>CHEW</b>	
	QUFLORA PED (PEDI MULTIVIT 84 WITH FLUORIDE, PEDI MULTIVIT NO.83 W-FLUORIDE) <b>DROP</b>	
	TRI-VI-FLOR (PED MVIT A,C,D3 NO.38/FLUORIDE) <b>DROPS</b>	

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## PENICILLINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
amoxicillin <b>CAPS, CHEWABLE TAB, SUSP, TAB</b> ampicillin <b>CAPS</b> dicloxacillin penicillin VK		<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class</li> </ul>

## PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate <b>TAB</b> CALPHRON OTC (calcium acetate) REVELA (sevelamer carbonate)	AURYXIA (ferric citrate) calcium acetate <b>CAPS</b> ELIPHOS (calcium acetate) lanthanum (generic FOSRENOL) PHOSLO (calcium acetate) PHOSLYRA (calcium acetate) RENAGEL (sevelamer HCl) sevelamer HCl (generic Renagel) sevelamer carbonate (generic Renvela) VELPHORO (sucroferric oxyhydroxide)	<ul style="list-style-type: none"> <li>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</li> </ul>

## 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)	<ul style="list-style-type: none"> <li>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</li> </ul>

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## PRENATAL VITAMINS

Additional covered agents can be looked up using the Drug Look-up Tool at:

<https://druglookup.fhsc.com/druglookupweb/?client=nestate>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
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

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## PROGESTERONE (hydroxyprogesterone caproate )

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

## PROTON PUMP INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
omeprazole (generic Prilosec) <b>RX</b> pantoprazole (generic Protonix) <sup>QL</sup> PROTONIX <b>SUSP</b> (pantoprazole)	DEXILANT (dexlansoprazole) dexlansoprazole (generic Dexilant) esomeprazole magnesium (generic Nexium) <b>RX</b> <sup>QL</sup> esomeprazole magnesium (generic Nexium) <b>OTC</b> <sup>QL</sup> esomeprazole strontium lansoprazole (generic Prevacid) <sup>QL</sup> NEXIUM <b>SUSPENSION</b> (esomeprazole) omeprazole/sodium bicarbonate (generic Zegerid RX) pantoprazole <b>GRANULES</b> <sup>QL</sup> rabeprazole (generic Aciphex)	<ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>Pediatric Patients:</b>            Patients <math>\leq 4</math> years of age – No PA required for Prevacid 30mg or omeprazole 20mg capsules (used to compound suspensions).</p> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Prilosec®OTC/Omeprazole OTC:</b> EXCLUDED from coverage Acceptable as trial instead of Omeprazole 20mg</li> <li><b>Prevacid Solutab:</b> may be approved after trial of compounded suspension.              Patients <math>\geq 5</math> years of age- Only approve non-preferred for GI diagnosis if:               <ul style="list-style-type: none"> <li>Child can not swallow whole generic omeprazole capsules OR,</li> <li>Documentation that contents of capsule may not be sprinkled in applesauce</li> </ul> </li> </ul>

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>BENZODIAZEPINES</b>		<p><b>Benzodiazepines Criteria</b></p> <ul style="list-style-type: none"> <li>Non-preferred agents require a trial of the preferred benzodiazepine agent</li> <li>temazepam 7.5/22.5mg: Requires clinical reason why 15mg/30mg cannot be used</li> </ul> <p><b>Others Criteria</b></p> <ul style="list-style-type: none"> <li>Non-preferred agents require a trial of TWO preferred agents in the OTHERS sub-category</li> <li><b>Silenor:</b> Must meet ONE of the following: <ul style="list-style-type: none"> <li>Contraindication to all of the preferred oral sedative hypnotics agents in the OTHERS sub-category</li> <li>Medical necessity for doxepin dose &lt; 10mg</li> <li>Age greater than 65 years old or hepatic impairment (3mg dose will be approved if this criteria is met)</li> </ul> </li> <li><b>zolpidem/zolpidem ER:</b> Maximum daily dose for females: zolpidem 5mg; zolpidem ER 6.25mg</li> <li><b>zolpidem SL:</b> Requires clinical reason why half of zolpidem tablet cannot be used or documented swallowing disorder</li> </ul>
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)	
<b>OTHERS</b>		
zaleplon (generic for Sonata) zolpidem (generic for Ambien)	BELSOMRA (suvorexant) <sup>AL,QL</sup> DAYVIGO (lemborexant) <sup>AL,QL</sup> doxepin (generic for Silenor) EDLUAR (zolpidem sublingual) eszopiclone (generic for Lunesta) HETLIOZ (tasimelteon) <sup>CL</sup> HETLIOZ LQ (tasimelteon) <b>SUSP</b> <sup>AL,QL</sup> <b>QUVIVIQ (daridorexant)<sup>QL</sup></b> ramelteon (generic for Rozerem) zolpidem ER (generic for Ambien CR) zolpidem SL (generic for Intermezzo)	

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## SICKLE CELL ANEMIA TREATMENT<sup>AL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DROXIA (hydroxyurea) <b>ENDARI (L-glutamine)<sup>CL</sup></b>	OXBRYTA (voxelotor) <sup>CL</sup> SIKLOS (hydroxyurea)	<p>Drug-Specific Criteria</p> <ul style="list-style-type: none"> <li>▪ <b>Endari:</b> Patient must have documented two or more hospital admissions per year due to sickle cell crisis despite maximum hydroxyurea dosage.</li> <li>▪ <b>Oxbryta:</b> Not indicated for sickle cell crisis. Patient must have had at least one sickle cell-related vaso-occlusive event within the past 12 months; AND baseline hemoglobin is 5.5 g/dL ≤ 10.5 g/dL; AND patient is not receiving concomitant, prophylactic blood transfusion therapy</li> <li>▪ <b>Siklos:</b> May be approved for use in patients ages 2 to 17 years old without a trial of Droxia</li> </ul>

## SINUS NODE INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	CORLANOR <b>SOLN, TAB</b> (ivabradine)	<ul style="list-style-type: none"> <li>▪ Diagnosis of Chronic Heart Failure with left ventricular ejection fraction less than or equal to 35%, AND</li> <li>▪ Sinus rhythm with resting heart rate greater than or equal to 70 beats per minute, AND</li> <li>▪ On maximally tolerated doses of beta-blockers OR have a contraindication to beta-blocker use</li> </ul>

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<sup>QL</sup> – Quantity/Duration Limit

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
baclofen (generic Lioresal) chlorzoxazone (generic Parafon Forte) cyclobenzaprine (generic Flexeril) <sup>QL</sup> methocarbamol (generic Robaxin) tizanidine <b>TAB</b> (generic Zanaflex)	<i>baclofen (generic for Ozobax)</i> <sup>NR, QL</sup> <b>SOLN</b> carisoprodol (generic Soma) <sup>CL, QL</sup> carisoprodol compound cyclobenzaprine ER (generic Amrix) <sup>CL</sup> dantrolene (generic Dantrium) FEXMID (cyclobenzaprine ER) FLEQSUVY (baclofen) <b>SUSP</b> LORZONE (chlorzoxazone) <sup>CL</sup> LYVISPAH (baclofen) <sup>NR, QL</sup> <b>GRANULES</b> metaxalone (generic Skelaxin) NORGESIC FORTE (orphenadrine/ASA/caffeine) orphenadrine ER PARAFON FORTE (chlorzoxazone) tizanidine <b>CAPS</b> ZANAFLEX (tizanidine) <b>CAPS, TAB</b>	<ul style="list-style-type: none"> <li>▪ Non-preferred agents will be approved for patients who have failed a 1-week trial of TWO preferred agents within this drug class</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li>▪ <b>cyclobenzaprine ER:</b> <ul style="list-style-type: none"> <li>○ Requires clinical reason why IR cannot be used</li> <li>○ Approved only for acute muscle spasms</li> <li>○ NOT approved for chronic use</li> </ul> </li> <li>▪ <b>carisoprodol:</b> <ul style="list-style-type: none"> <li>○ Approved for Acute, musculoskeletal pain - NOT for chronic pain</li> <li>○ Use is limited to no more than 30 days</li> <li>○ Additional authorizations will not be granted for at least 6 months following the last day of previous course of therapy</li> </ul> </li> <li>▪ <b>Dantrolene:</b> Trial NOT required for treatment of spasticity from spinal cord injury</li> <li>▪ <b>Lorzone®:</b> Requires clinical reason why chlorzoxazone cannot be used</li> <li>▪ <b>Soma® 250mg:</b> Requires clinical reason why 350mg generic strength cannot be used</li> <li>▪ <b>Zanaflex® Capsules:</b> Requires clinical reason generic cannot be used</li> </ul>

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>LOW POTENCY</b>		<ul style="list-style-type: none"> <li>Low Potency Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>
<b>DERMA-SMOOTH FS (fluocinolone)</b> hydrocortisone OTC & RX <b>CREAM, LOTION, OINT (Rx only)</b> hydrocortisone/aloe <b>OINT</b>	alclometasone dipropionate (generic for Aclovate) DESONATE (desonide) <b>GEL</b> desonide <b>LOTION</b> (generic for Desowen) desonide <b>CREAM, OINT</b> (generic Desowen, Tridesilon) fluocinolone 0.01% <b>OIL</b> (generic DERMA-SMOOTH-FS) hydrocortisone/aloe <b>CREAM</b> hydrocortisone <b>OTC OINT</b> TEXACORT (hydrocortisone)	
<b>MEDIUM POTENCY</b>		<ul style="list-style-type: none"> <li>Medium Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> </ul>
fluticasone propionate <b>CREAM, OINT</b> (generic for Cutivate) mometasone furoate <b>CREAM, OINT, SOLN</b> (generic for Elocon)	betamethasone valerate (generic for Luxiq) clocortolone (generic for Cloderm) fluocinolone acetonide (generic for Synalar) flurandrenolide (generic for Cordran) fluticasone propionate <b>LOTION</b> (generic for Cutivate) hydrocortisone butyrate (generic for Locoid) hydrocortisone butyrate/emoll (generic for Locoid Lipocream) hydrocortisone valerate (generic for Westcort) PANDEL (hydrocortisone probutate 0.1%) prednicarbate (generic for Dermatop)	

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## STEROIDS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>HIGH POTENCY</b>		<ul style="list-style-type: none"> <li>High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> </ul>
triamcinolone acetonide <b>OINTMENT, CREAM</b> triamcinolone <b>LOTION</b>	amcinonide <b>CREAM, LOTION, OINTMENT</b> betamethasone dipropionate betamethasone / propylene glycol betamethasone valerate desoximetasone diflorasone diacetate fluocinonide <b>SOLN</b> fluocinonide <b>CREAM, GEL, OINT</b> fluocinonide emollient halcinonide <b>CREAM</b> (generic for Halog) HALOG (halcinonide) <b>CREAM, OINT, SOLN</b> KENALOG AEROSOL (triamcinolone) SERNIVO (betamethasone dipropionate) triamcinolone <b>SPRAY</b> (generic for Kenalog spray) TRIANEX <b>OINT</b> (triamcinolone) VANOS (fluocinonide)	
<b>VERY HIGH POTENCY</b>		<ul style="list-style-type: none"> <li>Very High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> </ul>
clobetasol emollient (generic Temovate-E) clobetasol propionate <b>CREAM, OINT, SOLN</b> halobetasol propionate (generic Ultravate)	APEXICON-E (diflorasone) BRYHALI (halobetasol prop) <b>LOTION</b> clobetasol <b>SHAMPOO, LOTION</b> clobetasol propionate <span style="color: red;">GEL</span> , <b>FOAM, SPRAY</b> CLOBEX (clobetasol) halobetasol propionate <b>FOAM</b> (generic for Lexette) <sup>AL, QL</sup> IMPEKLO (clobetasol) <b>LOTION</b> <sup>AL</sup> LEXETTE (halobetasol propionate) <sup>AL, QL</sup> OLUX-E /OLUX/OLUX-E CP (clobetasol)	

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## STIMULANTS AND RELATED AGENTS<sup>AL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>CNS STIMULANTS</b>		<ul style="list-style-type: none"><li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li></ul> Drug-specific criteria: <ul style="list-style-type: none"><li><b>Procentra®</b>: May be approved with documentation of swallowing disorder</li><li><b>Zenedi®</b>: Requires clinical reason generic dextroamphetamine IR cannot be used</li></ul>
<b>Amphetamine type</b>		
ADDERALL XR (amphetamine salt combo) amphetamine salt combination IR VYVANSE (lisdexamfetamine) <sup>QL</sup> <b>CAPS, CHEWABLE</b>	ADZENYS XR (amphetamine) amphetamine ER (generic Adzenys ER) <b>SUSP</b> amphetamine salt combination ER (generic for Adderall XR) amphetamine sulfate (generic for Evekeo) dextroamphetamine (generic for Dexedrine) dextroamphetamine <b>SOLN</b> (generic Procentra) dextroamphetamine ER (generic for Dexedrine ER) DYANAVEL XR (amphetamine) <sup>QL</sup> EVEKEO ODT (amphetamine sulfate) MYDAYIS (amphetamine salt combo) <sup>QL</sup> methamphetamine (generic for Desoxyn) XELSTRYM (detroamphetamine) <sup>AL,NR,QL</sup> <b>PATCH</b> ZENZEDI (dextroamphetamine)	

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## STIMULANTS AND RELATED ADHD DRUGS (Continued)<sup>AL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Methylphenidate type</b>		
CONCERTA (methylphenidate ER) <sup>QL</sup> 18mg, 27mg, 36mg, 54mg dexamethylphenidate (generic for Focalin IR) <span style="color: red;">dexamethylphenidate (generic Focalin XR)</span> METHYLIN <b>SOLN</b> (methylphenidate) methylphenidate (generic Ritalin) methylphenidate <b>SOLN</b> (generic Methylin) QUILLICHEW ER <b>CHEWTAB</b> (methylphenidate)	ADHANSIA XR (methylphenidate) <sup>QL</sup> APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphenidate and dexamethylphenidate) <sup>QL</sup> COTEMPLA XR-ODT (methylphenidate) <sup>QL</sup> DAYTRANA <b>PATCH</b> (methylphenidate) <sup>QL</sup> FOCALIN IR (dexamethylphenidate) <span style="color: red;">FOCALIN XR (dexamethylphenidate)</span> JORNAY PM (methylphenidate) <sup>QL</sup> <span style="color: red;">methylphenidate CHEW</span> methylphenidate ER (45mg and 63mg) <sup>NR, QL</sup> methylphenidate 50/50 (generic Ritalin LA) methylphenidate 30/70 (generic Metadate CD) methylphenidate ER 18mg, 27mg, 36mg, 54mg (generic Concerta) <sup>QL</sup> methylphenidate ER <b>CAP</b> (generic Aptensio XR) <sup>QL</sup> methylphenidate ER (generic Metadate ER) methylphenidate ER 72mg (generic RELEXXII) <sup>QL</sup> methylphenidate ER (generic Ritalin SR) methylphenidate TD24 <sup>AL</sup> <b>PATCH</b> (generic Daytrana) QUILLIVANT XR (methylphenidate) <b>SUSP</b> RELEXXII ER (methylphenidate 45mg and 63mg) <sup>AL, NR, QL</sup> <b>TAB</b> RITALIN (methylphenidate)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> <li>Maximum accumulated dose of 108mg per day for ages &lt; 18</li> <li>Maximum accumulated dose of 72mg per day for ages &gt; 19</li> </ul> Drug-specific criteria: <ul style="list-style-type: none"> <li><b>Daytrana®:</b> May be approved in history of substance use disorder by parent, caregiver, or patient. May be approved with documentation of difficulty swallowing</li> <li><span style="color: red;"><b>Quillichew ER:</b> May be approved for children ≤ 12 years of age OR with documentation of difficulty swallowing</span></li> </ul>

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## STIMULANTS AND RELATED ADHD DRUGS (Continued)<sup>AL</sup>

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

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## TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR (generic Vibramycin) doxycycline monohydrate <b>50MG, 100MG CAPS</b> doxycycline monohydrate <b>SUSP, TAB</b> (generic Vibramycin) minocycline HCl <b>CAPS, TAB</b> (generic Dynacin/ Minocin/ Myrac)	demeclocycline (generic Declomycin) <sup>CL</sup> DORYX MPC DR (doxycycline pelletized) doxycycline hyclate DR (generic Doryx) doxycycline monohydrate 40MG, 75MG and 150MG <b>CAP</b> (generic Adoxa/Monodox/ Oracea) minocycline HCl ER (generic Solodyn) NUZYRA (omadacycline) tetracycline VIBRAMYCIN <b>SUSP</b> (doxycycline) XIMINO (minocycline ER) <sup>QL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a 3-day trial of TWO preferred agents within this drug class</li> </ul> Drug-specific criteria: <ul style="list-style-type: none"> <li><b>Demeclocycline:</b> Approved for diagnosis of SIADH</li> <li><b>doxycycline suspension:</b> May be approved with documented swallowing difficulty</li> </ul>

## THROMBOPOIESIS STIMULATING PROTEINS<sup>CL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROMACTA (eltrombopag) <b>TAB</b> <sup>CL</sup>	DOPTelet (avatrombopag) MULPleta (lusutrombopag) PROMACTA (eltrombopag) <b>SUSP</b> TAVAlisse (fostamatinib)	<ul style="list-style-type: none"> <li>All agents will be approved with FDA-approved indication, ICD-10 code is required.</li> <li>Non-preferred agents require a trial of a preferred agent with the same indication or a contraindication.</li> </ul> Drug-Specific Criteria <ul style="list-style-type: none"> <li><b>Doptelet/Mulpleta:</b> 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</li> </ul>

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

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

<sup>QL</sup> – Quantity/Duration Limit

<sup>AL</sup> – Age Limit

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



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

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# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## ULCERATIVE COLITIS

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

## UTERINE DISORDER TREATMENT

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

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CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

# Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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## VASODILATORS, CORONARY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
isosorbide dinitrate <b>TAB</b> isosorbide dinitrate ER, SA <b>TAB</b> <b>(generic Dilatrate-SR/Isordil)</b> isosorbide mono IR/SR <b>TAB</b> nitroglycerin <b>SUBLINGUAL,</b> <b>TRANSDERMAL</b> nitroglycerin ER <b>TAB</b>	BIDIL (isosorbide dinitrate/ hydralazine) <sup>CL</sup> GONITRO (nitroglycerin) isosorbide dinitrate <b>TAB (Oceanside</b> <b>Pharm MFR only)</b> isosorbide dinitrate/hydralazine (Bidil) <sup>CL,NR</sup> NITRO-BID <b>OINT</b> (nitroglycerin) NITRO-DUR (nitroglycerin) nitroglycerin <b>TRANSLINGUAL</b> (generic Nitrolingual) VERQUVO (vericiguat) <sup>AL,CL,QL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul> Drug-specific criteria: <ul style="list-style-type: none"> <li><b>BiDil:</b> Approved for the treatment of heart failure as an adjunct therapy to standard therapy in self-identified black patients</li> <li><b>Verquvo:</b> 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%</li> </ul>

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CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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