



Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

April 2023 PDL

Noted in Red Font that Become Effective April 1, 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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ACNE AGENTS, TOPICAL

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

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

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ALZHEIMER'S AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHOLINESTERASE INHIBITORS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 120-day trial of ONE preferred agent within this drug class within the last 6 months OR Current, stabilized therapy of the non-preferred agent within the previous 45 days <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Donepezil 23: Requires donepezil 10mg/day for at least 3 months AND clinical reason as to why 5mg or 10mg tablets can't be used (to deliver 20mg or 25mg)
donepezil (generic Aricept) donepezil ODT (generic Aricept ODT) rivastigmine PATCH (generic for Exelon Patch)	ADLARITY (donepezil) PATCH ARICEPT (donepezil) donepezil 23 (generic Aricept 23) ^{CL} EXELON (rivastigmine) PATCH galantamine (generic Razadyne) SOLN , TAB galantamine ER (generic Razadyne ER) rivastigmine CAPS (generic Exelon)	
NMDA RECEPTOR ANTAGONIST		
memantine (generic Namenda)	memantine ER (generic Namenda XR) memantine SOLN (generic Namenda) NAMENDA (memantine) NAMZARIC (memantine/donepezil)	

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ANALGESICS, OPIOID LONG-ACTING

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

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ANALGESICS, OPIOID SHORT-ACTING^{QL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		
acetaminophen/codeine ELIXIR, TAB codeine TAB hydrocodone/APAP SOLN, TAB hydrocodone/ibuprofen hydromorphone TAB morphine CONC SOLN, SOLN, TAB oxycodone TAB, SOLN oxycodone/APAP Tramadol 50 TAB^{AL} (generic Ultram) tramadol/APAP (generic Ultracet)	APADAZ (benzhydrocodone/APAP) ^{CL} benzhydrocodone/APAP (generic Apadaz) ^{CL} butalbital/caffeine/APAP/codeine butalbital compound w/codeine (butalbital/ASA/caffeine/codeine) carisoprodol compound-codeine (carisoprodol/ASA/codeine) dihydrocodeine/APAP/caffeine dihydrocodeine/aspirin/caffeine FIORINAL/CODEINE (butalbital/ASA/codeine/caffeine) hydromorphone LIQUID, SUPPOSITORY (generic Dilaudid) IBUDONE (hydrocodone/ibuprofen) levorphanol meperidine (generic Demerol) morphine SUPPOSITORIES NALOCET (oxycodone/APAP) NUCYNTA (tapentadol) ^{CL} oxycodone CAPS oxycodone/APAP SOLN oxycodone CONCENTRATE oxymorphone IR (generic Opana) pentazocine/naloxone PROLATE (oxycodone/APAP) ^{NR} SOLN, TAB ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol) ^{AL} tramadol 100mg (generic Ultram) ^{AL} tramadol (generic Qdolo) ^{AL, QL} SOLN ZAMICET (hydrocodone/APAP)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class within the last 12 months Note: for short acting opiate tablets and capsules there is a maximum quantity limit of #150 per 30 days. Beginning Oct. 11, 2018: Opiate limits for opiate naïve patients will consist of <ul style="list-style-type: none"> -prescriptions limited to a 7 day supply, AND -initial opiate prescription fill limited to maximum of 50 Morphine Milligram Equivalents (MME) per day These limits may only be exceeded with patient specific documentation of medical necessity, with examples such as, cancer diagnosis, end-of-life care, palliative care, Sickle Cell Anemia, or prescriber attestation that patient is not recently opiate naïve <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Apadaz: Approval for 14 days or less Nucynta®: Approved only for diagnosis of acute pain, for 30 days or less

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ANALGESICS, OPIOID SHORT-ACTING^{QL} (Continued)

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

ANDROGENIC AGENTS (Topical)^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANDROGEL (testosterone) PUMP ^{CL}	ANDRODERM (testosterone) ^{CL} NATESTO (testosterone) ^{CL} testosterone PACKET (generic Androgel) ^{CL} testosterone PUMP (generic Androgel) ^{CL} testosterone GEL, PACKET, PUMP (generic Vogelxo) testosterone (generic Axiron) testosterone (generic Fortesta) testosterone (generic Testim)	<ul style="list-style-type: none"> • Preferred agents approved for diagnosis of Primary hypogonadism (congenital or acquired) or Hypogonadotropic hypogonadism. Off label use for the following will be considered with documentation of necessity: female to male transsexual – gender dysphoria, weight gain, male osteoporosis, delayed puberty in males, corticosteroid-induced hypogonadism and osteoporosis, inoperable carcinoma of the breast, postpartum breast pain and engorgement, and menopause • In addition, non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: <ul style="list-style-type: none"> • Androderm[®]/Androgel[®]: Approved for Males only • Natesto[®]: Approved for Males only with diagnosis of: Primary hypogonadism (congenital or acquired) OR Hypogonadotropic hypogonadism (congenital or acquired)

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ANGIOTENSIN MODULATORS

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

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ANGIOTENSIN MODULATORS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class within the last 12 months Non-preferred combination products may be covered as individual prescriptions without prior authorization
irbesartan/HCTZ (generic Avalide) losartan/HCTZ (generic Hyzaar) olmesartan/HCTZ (generic Benicar-HCT) valsartan/HCTZ (generic Diovan-HCT)	candesartan/HCTZ (generic Atacand-HCT) EDARBYCLOR (azilsartan/chlorthalidone) telmisartan/HCTZ (generic Micardis-HCT)	
ANGIOTENSIN MODULATOR/ CALCIUM CHANNEL BLOCKER COMBINATIONS		<ul style="list-style-type: none"> Angiotensin Modulator/Calcium Channel Blocker Combinations: Combination agents may be approved if there has been a trial and failure of preferred agent
amlodipine/benazepril (generic Lotrel) amlodipine/olmesartan (generic Azor) amlodipine/valsartan (generic Exforge)	amlodipine/olmesartan/HCTZ (generic Tribenzor) amlodipine/telmisartan (generic Twynsta) amlodipine/valsartan/HCTZ (generic Exforge HCT) PRESTALIA (perindopril/amlodipine) trandolapril/verapamil (generic Tarka)	
DIRECT RENIN INHIBITORS		<ul style="list-style-type: none"> Direct Renin Inhibitors/Direct Renin Inhibitor Combinations: May be approved with history of TWO preferred ACE Inhibitors or Angiotensin Receptor Blockers within the last 12 months
	aliskiren (generic Tekturna) ^{QL}	
DIRECT RENIN INHIBITOR COMBINATIONS		Drug Specific Criteria <ul style="list-style-type: none"> Entresto: May be approved with a diagnosis of heart failure
	TEKTURNA/HCT (aliskiren/HCTZ)	
NEPRILYSIN INHIBITOR COMBINATION		
ENTRESTO (sacubitril/valsartan) ^{CL,QL}		
ANGIOTENSIN RECEPTOR BLOCKER/BETA-BLOCKER COMBINATIONS		
	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) ^{CL} praziquantel (generic for Biltricide) STROMECTOL (ivermectin)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: <ul style="list-style-type: none"> Emverm: Approval will be considered for indications not covered by preferred agents

ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ORALAIR (sweet vernal/orchard/rye/timothy/kentucky blue grass mixed pollen allergen extract) ^{CL} PALFORZIA (peanut allergen powder-dnfp) ^{AL,CL}	Drug-specific criteria: <p>ORALAIR</p> <ul style="list-style-type: none"> Confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens. For use in patients 5 through 65 years of age. <p>PALFORZIA</p> <ul style="list-style-type: none"> Confirmed diagnosis of peanut allergy by allergist For use in patients ages 4 to 17; it may be continued in patients 18 years and older with documentation of previous use within the past 90 days Initial dose and increase titration doses should be given in a healthcare setting Should not be used in patients with uncontrolled asthma or concurrently on a NSAID

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ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FIRVANQ (vancomycin) SOLN metronidazole TABLET neomycin tinidazole (generic Tindamax) ^{CL}	DIFICID (fidaxomicin) ^{CL} TABLET, SUSP FLAGYL ER (metronidazole) ^{CL} metronidazole ^{CL} CAPS nitazoxanide (generic Alinia) TABLET ^{AL, CL, QL} paromomycin SOLOSEC (secnidazole) vancomycin CAPS (generic Vancocin) ^{CL} XIFAXAN (rifaximin) ^{CL}	<ul style="list-style-type: none"> • Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> • Alinia[®]: Trial and failure with metronidazole is required for a diagnosis of giardiasis • Dificid[®]: For diagnosis of C. difficile diarrhea (pseudomembranous colitis), trial and failure or intolerance to oral vancomycin is required. For diagnosis of relapsed or recurrent C. difficile, an appropriate ICD-10 diagnosis code must be submitted for coverage. • Flagyl ER[®]: Trial and failure with metronidazole is required • Flagyl[®]/Metronidazole 375mg capsules and Flagyl ER[®]/Metronidazole 750mg ER tabs: Clinical reason why the generic regular-release cannot be used • tinidazole: Approvable diagnoses include: Giardia Amebiasis intestinal or liver abscess Bacterial vaginosis or trichomoniasis • vancomycin capsules: Requires patient specific documentation of why the Firvanq/vancomycin solution is not appropriate for patient • Xifaxan[®]: Approvable diagnoses include: Travelers's diarrhea resistant to quinolones Hepatic encephalopathy with treatment failure of lactulose or neomycin Diarrhea-Predominant IBS (IBS-D) 550mg strength only with treatment failure of Lomotil[®] AND Imodium[®]

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ANTIBIOTICS, INHALED^{CL}

Preferred Agents ^{CL}	Non-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin) KITABIS PAK (tobramycin) TOBI-PODHALER (tobramycin) ^{QL}	ARIKAYCE (amikacin liposomal inh) SUSP CAYSTON (aztreonam lysine) ^{QL} tobramycin (generic Bethkis) tobramycin (generic Tobi)	<ul style="list-style-type: none"> Diagnosis of Cystic Fibrosis is required for all agents ICD10 Group = E84, ICD9 = 277.00, 277.01, 277.02, 277.03, 277.09 Drug-specific criteria: <ul style="list-style-type: none"> Arikayce: Requires diagnosis of refractory MAC lung disease defined as patients who did not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy Cayston®: Trial of tobramycin via nebulizer and demonstration of TOBI® compliance required Tobi Podhaler®: Requires trial of tobramycin via nebulizer or documentation why nebulized tobramycin cannot be used

ANTIBIOTICS, TOPICAL

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

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ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CLEOCIN OVULES (clindamycin) clindamycin CREAM (generic Cleocin) CLINDESSE (clindamycin) metronidazole, vaginal NUVESSA (metronidazole)	CLEOCIN CREAM (clindamycin) VANDAZOLE (metronidazole) XACIATO (clindamycin phosphate) vaginal gel ^{AL,NR}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a therapeutic trial (duration = 3 days) with ONE preferred agent within this drug class within the last 6 months

ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIQUIS (apixaban) enoxaparin (generic Lovenox) PRADAXA (dabigatran) warfarin (generic Coumadin) XARELTO (rivaroxaban) 10 mg, 15 mg, 20 mg XARELTO (rivaroxaban) 2.5 mg ^{CL,QL} XARELTO DOSE PACK (rivaroxaban)	BEVYXXA (betrixaban) ^{QL} dabigatran etexilate ^{NR} (generic Pradaxa) fondaparinux (generic Arixtra) FRAGMIN (dalteparin) PRADAXA (dabigatran) PELLETS ^{NR} SAVAYSA (edoxaban) ^{CL,QL} XARELTO (rivaroxaban) ^{CL} SUSP	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 12 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Coumadin®: Clinical reason generic warfarin cannot be used Savaysa®: Approved diagnoses include: Stroke and systemic embolism (SE) risk reduction in nonvalvular atrial fibrillation (NVAF) OR Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) following 5-10 days of parenteral anticoagulant therapy Xarelto 2.5mg: Use limited to reduction of risk of major cardiovascular events (cardiovascular death, myocardial infarction, and stroke) in patients with chronic coronary artery disease or peripheral artery disease Xarelto Suspension: Approved for patients ≤12 years of age or if there is a clinical reason why a preferred solid dosage form cannot be used.

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ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CANNABINOIDS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the same group
dronabinol (generic Marinol) ^{AL}	CESAMET (nabilone)	
5HT3 RECEPTOR BLOCKERS		Drug-specific criteria: <ul style="list-style-type: none"> Akynzeo®/Varubi®: Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist
ondansetron (generic Zofran/Zofran ODT) ^{QL}	ANZEMET (dolasetron) granisetron (generic Kytril) SANCUSO (granisetron) ^{CL} ZUPLLENZ (ondansetron)	
NK-1 RECEPTOR ANTAGONIST		<ul style="list-style-type: none"> Regimens include: AC combination (Doxorubicin or Epirubicin with Cyclophosphamide), Aldesleukin, Amifostine, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carmustine, Carbplatin, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Dactinomycin, Daunorubicin, Epirubicin, Etoposide, Hexamethylmelamine, Idarubicin, Ifosfamide, Imatinib, Interferon α, Irinotecan, Mechlorethamine, Melphalan, Methotrexate, Oxaliplatin, Procarbazine, Streptozotocin, Temozolomide Diclegis®/Bonjesta: Approved only for treatment of nausea and vomiting of pregnancy Metozolv ODT®: Documentation of inability to swallow or Clinical reason oral liquid cannot be used Sancuso®/Zuplenz®: Documentation of oral dosage form intolerance
EMEND (aprepitant) CAPS, CAPS PACK ^{QL}	aprepitant (generic Emend) ^{QL} AKYNZEO (netupitant/palonosetron) ^{CL} VARUBI (rolapitant) TAB ^{CL}	
TRADITIONAL ANTIEMETICS		
DICLEGIS (doxylamine/pyridoxine) ^{CL,QL} dimenhydrinate (generic Dramamine) OTC meclizine (generic Antivert) metoclopramide (generic Reglan) phosphoric acid/dextrose/fructose SOLN (generic Emetrol) prochlorperazine, oral (generic Compazine) promethazine SYRUP, TAB (generic Phenergan) promethazine SUPPOSITORY 12.5mg, 25mg TRANSDERM-SCOP (scopolamine)	BONJESTA (doxylamine/pyridoxine) ^{CL,QL} COMPRO (prochlorperazine) doxylamine/pyridoxine (generic Diclegis) ^{CL,QL} metoclopramide ODT (generic Metozolv ODT) prochlorperazine SUPPOSITORY (generic Compazine) promethazine SUPPOSITORY 50mg scopolamine TRANSDERMAL trimethobenzamide TAB (generic Tigan)	

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^{QL} – Quantity/Duration Limit

^{AL} – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ANTIFUNGALS, ORAL

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

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ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTIFUNGAL		
clotrimazole CREAM (generic Lotrimin) RX, OTC clotrimazole SOLN OTC ketoconazole CREAM, SHAMPOO (generic Nizoral) LAMISIL (terbinafine) SPRAY OTC LAMISIL AT CREAM (terbinafine) OTC miconazole CREAM, POWDER OTC nystatin terbinafine OTC (generic Lamisil AT) tolnaftate POWDER, CREAM, POWDER OTC (generic Tinactin)	ALEVAZOL (clotrimazole) OTC ciclopirox CREAM, GEL, SUSP (generic Ciclodan, Loprox) ciclopirox NAIL LACQUER ^{CL} (generic Penlac) ciclopirox SHAMPOO (generic Loprox) clotrimazole SOLN RX (generic Lotrimin) DESENEXT POWDER OTC (miconazole) econazole (generic Spectazole) ERTACZO (sertaconazole) EXELDERM (sulconazole) FUNGOID OTC JUBLIA (efinaconazole) ^{CL} ketoconazole FOAM ^{CL} (generic Extina, Ketodan) LAMISIL AT GEL, SPRAY (terbinafine) OTC LOPROX (ciclopirox) SUSP, SHAMPOO, CREAM LOTRIMIN AF CREAM OTC (clotrimazole) LOTRIMIN ULTRA (butenafine) luliconazole (generic Luzu) MENTAX (butenafine) miconazole OTC OINTMENT, SPRAY SOLN miconazole/zinc oxide/petrolatum (generic Vusion) naftifine CREAM, GEL (generic Naftin) oxiconazole (generic Oxistat) salicylic acid (generic Bensal HP) tavaborole SOLN ^{CL} (generic Kerydin) tolnaftate SPRAY , OTC	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class within the last 6 months Drug-specific criteria: <ul style="list-style-type: none"> Extina: Requires trial and failure or contraindication to other ketoconazole forms Jublia and tavaborole: Approved diagnoses include Onychomycosis of the toenails due to <i>T.rubrum</i> OR <i>T. Mentagrophytes</i> ciclopirox nail lacquer: No trial required in diabetes, peripheral vascular disease (PVD), immunocompromised OR contraindication to oral terbinafine
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone CREAM (generic Lotrisone) nystatin/triamcinolone (generic Mycolog) CREAM, OINT	clotrimazole/betamethasone LOTION (generic Lotrisone)	

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ANTI-HISTAMINES, MINIMALLY SEDATING

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

ANTI-HYPERTENSIVES, SYMPATHOLYTICS

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ANTIHYPERURICEMICS

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

ANTIMIGRAINE AGENTS, OTHER

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ANTIMIGRAINE AGENTS, TRIPTANS^{QL}

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

ANTIPARASITICS, TOPICAL

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

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ANTIPARKINSON'S AGENTS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		
benztropine (generic Cogentin) trihexyphenidyl (generic Artane)		<ul style="list-style-type: none"> • Non-preferred agents will be approved for patients who have failed ONE preferred agents within this drug class
COMT INHIBITORS		
	entacapone (generic Comtan) ONGENTYS (opicapone) tolcapone (generic Tasmar)	
DOPAMINE AGONISTS		
pramipexole (generic Mirapex) ropinirole (generic Requip)	bromocriptine (generic Parlodel) ropinirole ER (generic Requip ER) ^{CL} NEUPRO (rotigotine) ^{CL} pramipexole ER (generic Mirapex ER) ^{CL} ropinirole ER (generic Requip XL) ^{CL}	
MAO-B INHIBITORS		
selegiline CAPS, TABLET (generic Eldepryl)	rasagiline (generic Azilect) ^{QL} XADAGO (safinamide) ZELAPAR (selegiline) ^{CL}	
OTHER ANTIPARKINSON'S DRUGS		
amantadine CAPS, SYRUP TABLET (generic Symmetrel) carbidopa/levodopa (generic Sinemet) carbidopa/levodopa ER (generic Sinemet CR) levodopa/carbidopa/entacapone (generic Stalevo)	APOKYN (apomorphine) SUB-Q apomorphine (generic Apokyn) SUB-Q carbidopa (generic Lodosyn) carbidopa/levodopa ODT (generic Parcopa) DHIVY (carbidopa/levodopa) ^{QL} DUOPA (carbidopa/levodopa) GOCOVRI (amantadine)QL INBRIJA (levodopa) INHALERCL,QL KYNMOBI (apomorphine)QL, KIT, SUBLINGUAL NOURIANZ (istradefylline)CL,QL OSMOLEX ER (amantadine)QL RYTARY (carbidopa/levodopa) STALEVO (ledopa/carbidopa/entacapone)	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ANTIPSORIATICS, ORAL

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

ANTIPSORIATICS, TOPICAL

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

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ANTIVIRALS, ORAL

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

ANTIVIRALS, TOPICAL

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

ANXIOLYTICS

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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BETA BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA BLOCKERS		
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) SOLN 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)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents within this drug class Drug-specific criteria: <ul style="list-style-type: none"> Bystolic®: Only ONE trial is required with Diagnosis of Obstructive Lung Disease Coreg CR®: Requires clinical reason generic IR product cannot be used Hemangeol®: Covered for diagnosis of Proliferating Infantile Hemangioma Sotylize®: Covered for diagnosis of life –threatening ventricular arrhythmias OR maintenance of normal sinus rhythm in highly symptomatic atrial fibrillation/flutter (AFIB/AFL) Requires clinical reason generic sotalol cannot be used
BETA- AND ALPHA-BLOCKERS		
carvedilol (generic Coreg) labetalol (generic Trandate)	carvedilol ER ^{CL} (generic Coreg CR)	
ANTIARRHYTHMIC		
sotalol (generic Betapace)	SOTYLIZE (sotalol)	

BILE SALTS

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oxybutynin IR, ER (generic Ditropan/Ditropan XL) solifenacin (generic Vesicare) TOVIAZ (fesoterodine ER)	darifenacin ER (generic Enablex) fesoterodine ^{NR} (generic Toviaz) flavoxate GELNIQUE (oxybutynin) GEMTESA (vibegron) ^{AL,QL} MYRBETRIQ TABLET, SUSP ^{AL,CL,QL} (mirabegron) oxybutynin 2.5mg ^{NR} OXYTROL (oxybutynin) tolterodine IR, ER (generic Detrol/ Detrol LA) trospium IR, ER (generic Sanctura/ Sanctura XR) VESICARE (solifenacin) VESICARE LS SUSP (solifenacin) ^{AL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> Myrbetriq®: Covered without trial in contraindication to anticholinergic agents Myrbetriq suspension: Covered for pediatric patients ≥ 3 years old with a diagnosis of Neurogenic Detrusor Overactivity (NDO)

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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BONE RESORPTION SUPPRESSION AND RELATED DRUGS

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria	
INHALERS – Short Acting			
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)	<ul style="list-style-type: none"> • Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class • Drug-specific criteria: Xopenex®: Covered for cardiac diagnoses or side effect of tachycardia with albuterol product 	
INHALERS – Long Acting			
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)		
INHALATION SOLUTION			
albuterol (2.5mg/3ml premix or 2.5mg/0.5ml) albuterol 100 mg/20 mL albuterol low dose (0.63mg/3ml & 1.25mg/3ml)	arformoterol tartrate (generic Brovana) BROVANA (arformoterol) formoterol fumarate (generic Perforomist) levalbuterol (generic for Xopenex) PERFOROMIST (formoterol)		
ORAL			
albuterol SYRUP	albuterol TAB albuterol ER (generic for Vospire ER) metaproterenol (formerly generic for Alupent) terbutaline (generic for Brethine)		

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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CALCIUM CHANNEL BLOCKERS, ORAL

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

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

COLONY STIMULATING FACTORS

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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CONTRACEPTIVES, ORAL

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

COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class OR Patient specific documentation of inability to use traditional inhaler device. Drug-specific criteria: <ul style="list-style-type: none"> Daliresp®: <ul style="list-style-type: none"> Covered for diagnosis of severe COPD associated with chronic bronchitis Requires trial of a bronchodilator Requires documentation of one exacerbation in last year upon initial review
ANORO ELLIPTA (umeclidinium/vilanterol) ATROVENT HFA (ipratropium) COMBIVENT RESPIMAT (albuterol/ipratropium) SPIRIVA (tiotropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI AEROSPHERE (glycopyrolate/formoterol) DUAKLIR PRESSAIR (aclidinium br and formoterol fum) INCRUSE ELIPTA (umeclidinium) SPIRIVA RESPIMAT (tiotropium) TUDORZA PRESSAIR (aclidinium br)	
INHALATION SOLUTION		
albuterol/ipratropium (generic Duoneb) ipratropium SOLN (generic Atrovent)	LONHALA (glycopyrrolate inhalation soln) YUPELRI (revefenacin)	
ORAL AGENT		
	DALIRESP (roflumilast) ^{CL, QL} roflumilast (generic Daliresp) ^{CL,NR,QL}	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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COUGH AND COLD, OPIATE COMBINATION

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

CYSTIC FIBROSIS, ORAL

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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CYTOKINE & CAM ANTAGONISTS

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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DIURETICS

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

ENZYME REPLACEMENT, GAUCHERS DISEASE

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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EPINEPHRINE, SELF-INJECTED^{QL}

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

ERYTHROPOIESIS STIMULATING PROTEINS

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

FLUOROQUINOLONES, ORAL

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

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GI MOTILITY, CHRONIC

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

GLUCAGON AGENTS

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

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GLUCOCORTICIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCOCORTICIDS		<ul style="list-style-type: none"> Non-preferred agents within the Glucocorticoids and Glucocorticoid/Bronchodilator Combo groups will be approved for patients who have failed a trial of TWO preferred agents within this drug class within the last 6 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> budesonide respules: Covered without PA for age ≤ 8 years OR for diagnosis of eosinophilic esophagitis in patients ≥ 9 years, by GI biopsy or upper endoscopy. For other indications, must have failed a trial of two preferred agents within this drug class, within the last 6 months.
ASMANEX (mometasone) ^{QL,AL} FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide)	ALVESCO (ciclesonide) ^{AL,CL} ARMONAIR DIGIHALER (fluticasone) ^{AL,QL} ARMONAIR RESPICLICK (fluticasone) ^{AL} ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) ^{CL,AL,QL} FLOVENT DISKUS (fluticasone) fluticasone HFA (generic Flovent HFA) QVAR (beclomethasone) QVAR Redihaler (beclomethasone)	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol) ^{QL} ADVAIR HFA (fluticasone/salmeterol) ^{QL} DULERA (mometasone/formoterol) SYMBICORT (budesonide/formoterol)	AIRDUO DIGIHALER (fluticasone/salmeterol) ^{AL,QL} BREO ELLIPTA (fluticasone/vilanterol) BREZTRI (budesonide/formoterol/glycopyrrolate) ^{QL} Budesonide/formoterol (generic for Symbicort) fluticasone/salmeterol (generic for Advair Diskus) ^{QL} fluticasone/salmeterol (generic for Advair HFA)^{NR,QL} fluticasone/salmeterol (generic for Airduo Respiclick) fluticasone/vilanterol (Breo Ellipta) TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol) WIXELA INHUB (generic for Advair Diskus) ^{QL}	
INHALATION SOLUTION		
	budesonide RESPULES (generic for Pulmicort)	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC CAPS (generic Entocort EC) dexamethasone ELIXIR, SOLN dexamethasone TABLET hydrocortisone TABLET methylprednisolone tablet (generic Medrol) prednisolone SOLN prednisolone sodium phosphate prednisone DOSE PAK prednisone TABLET	ALKINDI (hydrocortisone) GRANULES^{AL} CORTEF (hydrocortisone) cortisone TABLET dexamethasone INTENSOL EMFLAZA (deflazacort) SUSP, TABLET^{CL} ENTOCORT EC (budesonide) methylprednisolone 8mg, 16mg, 32mg ORTIKOS ER (budesonide) ^{AL,QL} prednisolone sodium phosphate (generic Millipred/Veripred) prednisolone sodium phosphate ODT prednisone SOLN prednisone INTENSOL RAYOS DR (prednisone) TABLET TARPEYO (budesonide) CAPS	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: <ul style="list-style-type: none"> Emflaza: Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older Intensol Products: Patient specific documentation of why the less concentrated solution is not appropriate for the patient Tarpeyo: Indicated for the treatment of primary immunoglobulin A nephropathy (IgAN)

GROWTH HORMONES

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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H. PYLORI TREATMENTS

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

HAE TREATMENTS^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BERINERT (C1 esterase inhibitor, human) INTRAVENOUS HAEGARDA (C1 esterase inhibitor, human) ^{AL,CL} SUB-Q icatibant acetate (generic for FIRAZYR) ^{AL} SUB-Q	CINRYZE (C1 esterase inhibitor, human) ^{AL,CL} INTRAVENOUS FIRAZYR (icatibant acetate) ^{AL} SUB-Q ORLADEYO (berotralstat) CAP ^{AL,QL} RUCONEST (recombinant human C1 inhibitor) ^{AL} INTRAVENOUS TAKHZYRO (lanadelumab-flyo) ^{AL,CL} VIAL, SYRINGE ^{NR}	<p style="text-align: center;">HAE Treatments PA Form</p> <ul style="list-style-type: none"> All agents require documentation of diagnosis of Type I or Type II HAE and deficient or dysfunctional C1 esterase inhibitor enzyme. Concomitant use with ACE inhibitors, NSAIDs, or estrogen-containing products is contraindicated Non-preferred agents will be approved for patients who have a failed trial or a contraindication to ONE preferred agent within this drug class with the same indication. <p>Drug-Specific Criteria</p> <ul style="list-style-type: none"> Cinryze, Haegarda, Orladeyo, and Takhzyro, require a history of two or more HAE attacks monthly, and trial and failure or contraindication to oral danazol

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AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

April 2023 PDL Highlighted in Red effective April 1, 2023

HEMOPHILIA TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FACTOR VIII		<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
ALPHANATE	ADVATE	
HELIXATE FS	ADYNOVATE	
HUMATE-P	AFSTYLA	
NOVOEIGHT	ALTUVIII ^{NR}	
NUWIQ	ELOCTATE	
XYNTHA KIT, SOLOFUSE	ESPEROCT	
	HEMOFIL-M	
	JIVI ^{AL}	
	KOATE-DVI KIT	
	KOATE-DVI VIAL	
	KOGENATE FS	
	KOVALTRY	
	OBIZUR	
	RECOMBINATE	
FACTOR IX		
ALPROLIX	ALPHANINE SD	
BENEFIX	IDELVION	
	IXINITY	
	MONONINE	
	PROFILNINE SD	
	REBINYN	
	RIXUBIS	
FACTOR VIIa AND PROTHROMBIN COMPLEX-PLASMA DERIVED		
NOVOSEVEN RT	FEIBA NF	
	SEVENFACT ^{AL}	
FACTOR X AND XIII PRODUCTS		
COAGADEX	TRETEN	
CORIFACT		
VON WILLEBRAND PRODUCTS		
WILATE	VONVENDI	
BISPECIFIC FACTORS		
HEMLIBRA		

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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HEPATITIS B TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
entecavir TABLET	adefovir dipivoxil BARACLUDE (entecavir) SOLN, TABLET EPIVIR HBV (lamivudine) TABLET, SOLN lamivudine hbv TABLET VEMLIDY (tenofovir alafenamide fumarate)	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug Specific Criteria <ul style="list-style-type: none"> ▪ tenofovir disoproxil fumarate (generic Viread) tablet: Diagnosis for use required. May be indicated for chronic hepatitis B or HIV-1 infection. <ul style="list-style-type: none"> ○ See HIV/AIDS class for drug listing and placement

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIRECT ACTING ANTI-VIRAL		Hepatitis C Treatments PA Form Hepatitis C Criteria <ul style="list-style-type: none"> ▪ Non-preferred products require trial of preferred agents within the same group and/or will only be considered with documentation of why the preferred product within this drug class is not appropriate for patient ▪ Patients newly eligible for Medicaid will be allowed to complete treatment with the original that treatment was initially authorized by another payor <p>Drug-specific criteria: Trial with a preferred agent not required in the following:</p> <ul style="list-style-type: none"> ▪ Harvoni: <ul style="list-style-type: none"> ○ Post liver transplant for genotype 1 or 4 ▪ Vosevi: Requires documentation of non-response after previous treatment course of Direct Acting Anti-viral agent (DAA) for genotype 1-6 without cirrhosis or with compensated cirrhosis
sofosbuvir/velpatasvir (generic Epclusa) ^{CL} MAVYRET (glecaprevir/pibrentasvir) TABLET ^{CL} , PELLET ^{AL,CL,NR} VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) ^{CL}	HARVONI 200/45MG, TABLET (sofosbuvir/ledipasvir) ^{CL} HARVONI (ledipasvir/sofosbuvir) ^{CL} PELLET sofosbuvir/ledipasvir (generic Harvoni) ^{CL} SOVALDI (sofosbuvir) ^{CL} PELLET SOVALDI TABLET (sofosbuvir) ^{CL} VIEKIRA PAK (ombitasvir/paritaprevir/ritonavir/dasabuvir) ^{CL} ZEPATIER (elbasvir/grazoprevir) ^{CL}	
RIBAVIRIN		
ribavirin 200mg CAPSULE, TABLET	REBETOL (ribavirin)	
INTERFERON		
PEGASYS (pegylated interferon alfa-2a) ^{CL} PEG-INTRON (pegylated interferon alfa-2b) ^{CL}		

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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HISTAMINE II RECEPTOR BLOCKERS

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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HIV / AIDS^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CAPSID INHIBITOR		<ul style="list-style-type: none"> ▪ All agents require: <ul style="list-style-type: none"> ○ Diagnosis of HIV/AIDS required; OR ○ Diagnosis of Pre and Post Exposure Prophylaxis ▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	SUNLENCA (lenacapavir) ^{NR, QL}	
CCR5 ANTAGONISTS		
SELZENTRY SOLN, TAB (maraviroc)	maraviroc (generic Selzentry)	
HIV-1 ATTACHMENT INHIBITOR		
	RUKOBIA ER (fostemsavir) ^{AL, QL}	
INTEGRASE STRAND TRANSFER INHIBITORS (INSTIs)		
ISENTRESS (raltegravir) ^{QL} ISENTRESS HD (raltegravir) TIVICAY (dolutegravir)	TIVICAY PD (dolutegravir)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)		
efavirenz CAPS, TABLET (generic Sustiva) INTELENCE (etravirine) ^{QL} PIFELTRO (doravirine) ^{QL}	EDURANT (rilpivirine) etravirine (generic Intelence) ^{QL} nevirapine IR, ER (generic Viramune/Viramune XR) RESCRIPTOR (delavirdine) SUSTIVA CAPS, TABLET (efavirenz) VIRAMUNE (nevirapine) SUSP	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
abacavir SOLN, TABLET (generic Ziagen) EMTRIVA CAPS, SOLN (emtricitabine) lamivudine SOLN, TABLET (generic EpiVir) zidovudine CAPS, SYRUP, TABLET (generic Retrovir)	didanosine DR (generic Videx EC) emtricitabine CAPS (generic for Emtriva) EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine CAPS (generic Zerit) VIDEX (didanosine) SOLN ZIAGEN (abacavir)	
NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
tenofovir TABLET (generic Viread)	VIREAD (tenofovir) POWDER	
PHARMACOKINETIC ENHANCER		
	TYBOST (cobicistat) ^{QL}	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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HIV / AIDS^{CL} (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROTEASE INHIBITORS		
atazanavir CAPS (generic Reyataz) ritonavir TABLET (generic Norvir)	APTIVUS CAPS, SOLN (tipranavir) CRIXIVAN (indinavir) fosamprenavir TAB (generic Lexiva) INVIRASE (saquinavir) LEXIVA SUSP (fosamprenavir) LEXIVA TABLET (fosamprenavir) NORVIR POWDER, SOLN (ritonavir) NORVIR (ritonavir) TAB PREZISTA (darunavir) SUSP, TABLET REYATAZ POWDER (atazanavir) VIRACEPT (nelfinavir)	<ul style="list-style-type: none"> ▪ All agents require: <ul style="list-style-type: none"> ○ Diagnosis of HIV/AIDS required; OR ○ Diagnosis of Pre and Post Exposure Prophylaxis ▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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HIV / AIDS^{CL} (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PROTEASE INHIBITORS (PIs) or PIs plus PHARMACOKINETIC ENHANCER		<ul style="list-style-type: none"> ▪ All agents require: <ul style="list-style-type: none"> ○ Diagnosis of HIV/AIDS required; OR ○ Diagnosis of Pre and Post Exposure Prophylaxis ▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
EVOTAZ (atazanavir/cobicistat) ^{QL} lopinavir/ritonavir SOLN (generic Kaletra)	KALETRA SOLN (lopinavir/ritonavir) KALETRA TAB (lopinavir/ritonavir) lopinavir/ritonavir TAB (generic Kaletra) PREZCOBIX (darunavir/cobicistat) ^{QL}	
COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir/lamivudine (generic Epzicom) CIMDUO (lamivudine/tenofovir) ^{QL} DESCOVY (emtricitabine/tenofovir) ^{QL} emtricitabine/tenofovir (generic Truvada) lamivudine/zidovudine (generic Combivir)	abacavir/lamivudine/zidovudine (generic Trizivir) COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir sulfate/lamivudine) TEMIXYS (lamivudine/tenofovir) ^{QL} TRIZIVIR (abacavir/lamivudine/zidovudine) TRUVADA (emtricitabine/tenofovir)	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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HIV / AIDS^{CL} (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PRODUCTS – MULTIPLE CLASSES		
BIKTARVY (bictegravir/emtricitabine/tenofovir) ^{QL} COMPLERA (rilpivirine/emtricitabine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir) ^{QL} DOVATO (dolutegravir/lamivudine) ^{QL} efavirenz/emtricitabine/tenofovir (generic Atripla) ^{CL} GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) ^{QL, AL} ODEFSEY (emtricitabine/rilpivirine/tenofovir) ^{QL} STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) ^{QL} SYMFI (efavirenz/lamivudine/tenofovir) ^{QL} SYMFI LO (efavirenz/lamivudine/tenofovir) ^{QL} SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir) ^{QL} TRIUMEQ (dolutegravir/abacavir/lamivudine)	ATRIPLA (efavirenz/emtricitabine/tenofovir) efavirenz/lamivudine/tenofovir (generic for Symfi) ^{QL} efavirenz/lamivudine/tenofovir (generic for Symfi Lo) ^{QL} JULUCA (dolutegravir/rilpivirine) ^{QL} TRIUMEQ PD (abacavir, dolutegravir, and lamivudine) SUSP^{NR}	<ul style="list-style-type: none"> ▪ All agents require: <ul style="list-style-type: none"> ○ Diagnosis of HIV/AIDS required; OR ○ Diagnosis of Pre and Post Exposure Prophylaxis ▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

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

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HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

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

HYPOGLYCEMICS, MEGLITINIDES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
repaglinide (generic for Prandin)	nateglinide (generic for Starlix) ^{CL} repaglinide/metformin (generic for Prandimet) ^{CL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients with: Failure of a trial of ONE preferred agent in another Hypoglycemic class OR T2DM and inadequate glycemic control

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HYPOGLYCEMICS, METFORMINS

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

HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin) ^{QL,CL} INVOKAMET (canagliflozin/metformin) ^{QL,CL} INVOKANA (canagliflozin) ^{CL} JARDIANCE (empagliflozin) ^{QL,CL} SYNJARDY (empagliflozin/metformin) ^{AL,CL,QL} XIGDUO XR (dapagliflozin/metformin) ^{QL,CL}	INVOKAMET XR (canagliflozin/metformin) ^{QL} SEGLUROMET (ertugliflozin/metformin) ^{QL} STEGLATRO (ertugliflozin) ^{QL} SYNJARDY XR (empagliflozin/ metformin) ^{AL,QL}	<p>Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin OR</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"> • Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class <p>Drug Specific Criteria:</p> <ul style="list-style-type: none"> • Farxiga: 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"> - May be approved for a diagnosis of chronic kidney disease at risk of progression without a diagnosis of diabetes • Jardiance: May be approved for a diagnosis of Heart Failure without a diagnosis of diabetes

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HYPOGLYCEMICS, SULFONYLUREAS

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

HYPOGLYCEMICS, TZD

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

IDIOPATHIC PULMONARY FIBROSIS

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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IMMUNOMODULATORS, ASTHMA^{CL}

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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IMMUNOMODULATORS, ATOPIC DERMATITIS^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DUPIXENT (dupilumab) ^{AL,CL} PEN,SYR ELIDEL (pimecrolimus) EUCRISA (crisaborole) ^{CL,QL}	ADBRY (tralokinumab-ldm) SUB-Q^{AL,QL} OPZELURA (ruxolitinib phosphate) CREAM^{AL,QL} pimecrolimus (generic for Elidel) tacrolimus (generic for Protopic) ^{CL}	<p style="text-align: center;">Immunomodulators Self-Injectable PA Form (For Adbry and Dupixent only)</p> <ul style="list-style-type: none"> ▪ Non-preferred agents require: Trial of a topical steroid AND Trial of one preferred product within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> • Dupixent: <ol style="list-style-type: none"> 1. Atopic Dermatitis: Trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor 2. Eosinophilic Esophagitis: Trial, failure, or technique difficulty to a swallowed topical corticosteroid or treatment failure of a proton pump inhibitor. Prescribed by, or in consultation with an allergist, gastroenterologist, or immunologist. Documentation that the Patient has a confirmed diagnosis of eosinophilic esophagitis with > 15 eosinophils/high-power field. 3. Nasal Polyps: 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] 4. Prurigo Nodularis: Patient must have a diagnosis of Prurigo Nodularis with provider attestation of > 20 nodular lesions. Trial and failure of a topical corticosteroid. Prescribed by, or in consultation with an allergist, dermatologist, or immunologist. <ul style="list-style-type: none"> • Eucrisa: Requires trial and failure of 1 topical steroid or Elidel. • Opzelura: May be approved for a diagnosis of Atopic Dermatitis and after a trial/failure of a topical steroid and trial of a preferred agent

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

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

AL – Age Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

April 2023 PDL **Highlighted in Red** effective April 1, 2023

IMMUNOMODULATORS, TOPICAL

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

IMMUNOSUPPRESSIVES, ORAL

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

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AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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INTRANASAL RHINITIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> ▪ mometasone: Prior authorization NOT required for children ≤ 12 years ▪ budesonide: Approved for use in Pregnancy (Pregnancy Category B) ▪ Xhance: Indicated for treatment of nasal polyps in ≥ 18 years only
ipratropium (generic for Atrovent)		
ANTI-HISTAMINES		
azelastine 0.1% (generic for Astelin)	azelastine 0.15% (generic for Astepro) azelastine/fluticasone (generic for Dymista) olopatadine (generic for Patanase) RYALTRIS (olopatadine/mometasone) ^{AL,NR}	
CORTICOSTEROIDS		
fluticasone Rx (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)	

LEUKOTRIENE MODIFIERS

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

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

AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

April 2023 PDL **Highlighted in Red** effective April 1, 2023

LINCOSAMIDES / OXAZOLIDINONES / STREPTOGRAMINS

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

LIPOTROPICS, OTHER

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

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

AL – Age Limit

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

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LIPOTROPICS, OTHER (continued)

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

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AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

April 2023 PDL **Highlighted in Red** effective April 1, 2023

LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
STATINS		<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agent within this drug class, within the last 12 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Altoprev®: One of the TWO trials must be IR lovastatin ▪ Combination products: Require clinical reason why individual ingredients cannot be used ▪ fluvastatin ER: Requires trial of TWO preferred agents AND trial of IR fluvastatin OR clinical reason IR cannot be used ▪ simvastatin/ezetimibe: Approved for 3-month continuous trial of ONE standard dose statin
atorvastatin (generic Lipitor) ^{QL} lovastatin (generic Mevacor) pravastatin (generic Pravachol) rosuvastatin (generic Crestor) simvastatin (generic Zocor)	ALTOPREV (lovastatin ER) ^{CL} ATORVALIQ (atorvastatin)^{NR,QL} SUSP EZALLOR SPRINKLE (rosuvastatin) ^{QL} fluvastatin IR/ER (generic Lescol/ Lescol XL) LIVALO (pitavastatin) ZYPITAMAG (pitavastatin)	
STATIN COMBINATIONS		
	atorvastatin/amlodipine (generic Caduet) simvastatin/ezetimibe (generic Vytorin)	

MACROLIDES AND KETOLIDES, ORAL

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

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AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

April 2023 PDL **Highlighted in Red** effective April 1, 2023

METHOTREXATE

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

MOVEMENT DISORDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUSTEDO (deutetrabenazine) ^{CL} INGREZZA (valbenazine) ^{AL,CL,QL} CAPS tetrabenazine (generic for Xenazine) ^{CL}	INGREZZA (valbenazine) ^{CL} INITIATION PACK XENAZINE (tetrabenazine) ^{CL}	All drugs require an FDA approved indication – ICD-10 diagnosis code required. Non-preferred agents require a trial and failure of a preferred agent with the same indication or a clinical reason why a preferred agent in this class cannot be used. Drug-specific criteria: <ul style="list-style-type: none"> Austedo: Diagnosis of Tardive Dyskinesia or chorea associated with Huntington's Disease; Requires a Step through tetrabenazine with the diagnosis of chorea associated with Huntington's Disease Ingrezza: Diagnosis of Tardive Dyskinesia in adults tetrabenazine: Diagnosis of chorea with Huntington's Disease

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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

April 2023 PDL **Highlighted in Red** effective April 1, 2023

MULTIPLE SCLEROSIS DRUGS

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

NITROFURAN DERIVATIVES

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

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AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

April 2023 PDL **Highlighted in Red** effective April 1, 2023

NSAIDs, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE		<ul style="list-style-type: none"> Non-preferred agents within COX-1 SELECTIVE group will be approved for patients who have failed no less than 30-day trial of TWO preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> meclofenamate: Approvable without trial of preferred agents for menorrhagia Sprix®: Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs
diclofenac sodium (generic Voltaren) ibuprofen OTC, Rx (generic fAdvil, Motrin) CHEW, DROPS, SUSP, TAB ibuprofen OTC (generic Advil, Motrin) CAPS indomethacin CAPS (generic Indocin) ketorolac (generic Toradol) meloxicam TAB (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) ^{CL} indomethacin ER (generic Indocin) ketoprofen & ER (generic Orudis) meclufenamate (generic Meclomen) mefenamic acid (generic Ponstel) meloxicam CAP (generic Vivlodex) ^{CL, QL} naproxen CR (generic Naprelan) naproxen SUSP (generic Naprosyn) naproxen sodium (generic Anaprox) naproxen-esomeprazole (generic Vimovo) oxaprozin (generic Daypro) piroxicam (generic Feldene) tolmetin (generic Tolectin) ketorolac NASAL ^{QL} (generic Sprix)	

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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

April 2023 PDL **Highlighted in Red** effective April 1, 2023

NSAIDs, ORAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE (continued)		<ul style="list-style-type: none"> All combination agents require a clinical reason why individual agents can't be used separately
	ALL BRAND NAME NSAIDs including: DUEXIS (ibuprofen/famotidine)CL INDOCIN (indomethacin) SUSP NALFON (fenoprofen) RELAFEN DS (nabumetone)	
NSAID/GI PROTECTANT COMBINATIONS		
	diclofenac/misoprostol (generic Arthrotec)	
COX-II SELECTIVE		
celecoxib (generic Celebrex)		

NSAIDs, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
diclofenac sodium GEL (OTC only) diclofenac SOLN (generic Pennsaid Soln)CL	FLECTOR PATCH (diclofenac)CL LICART PATCH (diclofenac)CL PENNSAID PACKET, PUMP (diclofenac)CL VOLTAREN GEL (diclofenac)CL	<ul style="list-style-type: none"> 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.

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AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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

ONCOLOGY AGENTS, ORAL, BREAST

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

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CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

April 2023 PDL **Highlighted in Red** effective April 1, 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"> ▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy <p>Drug-specific criteria</p> <ul style="list-style-type: none"> ▪ Hydrea®: Requires clinical reason why generic cannot be used ▪ Melphalan: Requires trial of Alkeran or clinical reason Alkeran cannot be used ▪ Purixan: Prior authorization not required for age ≤12 or for documented swallowing disorder ▪ Tabloid: Prior authorization not required for age <19 ▪ Xpovio: Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone
mercaptopurine	PURIXAN (mercaptopurine) ^{AL}	
AML		
	DAURISMO (glasdegib maleate) ^{QL} IDHIFA (enasidenib) REZLIDHIA (olutasidenib) ^{NR,QL} RYDAPT (midostaurin) TIBSOVO (ivosidenib) ^{QL} XOSPATA (gilteritinib) ^{QL}	
CLL		
LEUKERAN (chlorambucil)	COPIKTRA (duvelisib) ^{QL} IMBRUVICA (ibrutinib) VENCLEXTA (venetoclax) ZYDELIG (idelalisib)	
CML		
hydroxyurea (generic for Hydrea) imatinib (generic for Gleevec) MYLERAN (busulfan)	BOSULIF (bosutinib) GLEEVEC (imatinib) HYDREA (hydroxyurea) ICLUSIG (ponatinib) SCEMBLIX (asciminib) SPRYCEL (dasatinib) TASIGNA (nilotinib) ^{CL}	
MPN		
	JAKAFI (ruxolitinib)	
MYELOMA		
ALKERAN (melphalan) REVLIMID ^{QL} (lenalidomide)	lenalidomide ^{QL} (generic Revlimid) melphalan (generic Alkeran) NINLARO (ixazomib) POMALYST (pomalidomide) THALOMID (thalidomide) XPOVIO (selinexor) ^{CL}	
OTHER		
MATULANE (procarbazine) TABLOID (thioguanine) tretinoin (generic for Vesanoide) ^{AL}	BRUKINSA (zanubrutinib) ^{QL} CALQUENCE (acalabrutinib) ^{QL} INREBIC (fedratinib dihydrochloride) ^{QL} INQOVI (decitabine/cedazuridine) VONJO (pacritinib) ^{QL} ZOLINZA (vorinostat)	

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QL – Quantity/Duration Limit

AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

April 2023 PDL **Highlighted in Red** effective April 1, 2023

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ONCOLOGY AGENTS, ORAL, LUNG

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALK	ALECENSA (alectinib) ALUNBRIG (brigatinib) ^{QL} LORBRENA (lorlatinib) ^{QL} ZYKADIA (ceritinib) CAPS, TAB	<ul style="list-style-type: none"> ▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
ALK / ROS1 / NTRK		
	ROZLYTREK (entrectinib) ^{AL,QL} XALKORI (crizotinib)	
EGFR	erlotinib (generic for Tarceva) EXKIVITY (mobocertinib) ^{QL} GILOTRIF (afatinib) IRESSA (gefitinib) TAGRISSO (osimertinib) TARCEVA (erlotinib) VIZIMPRO (dacomitinib) ^{QL}	
OTHER	GAVRETO (pralsetinib) ^{QL} HYCAMTIN (topotecan) KRAZATI (adagrasib) ^{NR} LUMAKRAS (sotrasib) ^{QL} RETEVMO (selpercatinib) ^{AL} TABRECTA (capmatinib) ^{QL} TEPMETKO (tepotinib) ^{QL}	

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QL – Quantity/Duration Limit

AL – Age Limit

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ONCOLOGY AGENTS, ORAL, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
temozolomide (generic Temodar)	AYVAKIT (avapritinib) ^{AL,QL} BALVERSA (erdafitinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) HEXALEN (altretamine) JAYPIRCA (pirtobrutinib) ^{NR} KOSELUGO (selumetinib) ^{AL} LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) LYTGOBI (futibatinib) ^{NR} PEMAZYRE (pemigatinib) ^{QL} RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat) ^{AL} TURALIO (pexidartinib) ^{QL} TRUSELTIQ (infigratinib) CAPS VITRAKVI (larotrectinib) CAPS, SOLN ZEJULA (niraparib)	<ul style="list-style-type: none"> Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

ONCOLOGY AGENTS, ORAL, PROSTATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
abiraterone (generic Zytiga) ^{AL,QL} bicalutamide (generic Casodex) flutamide	EMCYT (estramustine) ERLEADA (apalutamide) ^{QL} nilutamide (generic Nilandron) NUBEQA (darolutamide) ^{QL} ORGOVYX (relugolix) ^{AL} XTANDI (enzalutamide) ^{AL,QL} YONSA (abiraterone acetone, submicronized) ZYTIGA (abiraterone) ^{AL,QL}	<ul style="list-style-type: none"> Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

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

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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, RENAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SUTENT (sunitinib)	AFINITOR DISPERZ (everolimus) ^{CL} CABOMETYX (cabozantinib) everolimus (generic Afinitor) everolimus SUSP (generic Afinitor Disperz) FOTIVDA (tivozanib) INLYTA (axitinib) LENVIMA (lenvatinib) NEXAVAR (sorafenib) sorafenib (generic Nexavar) sunitinib malate (generic Sutent) VOTRIENT (pazopanib) WELIREG (belzutifan) ^{QL}	<ul style="list-style-type: none"> Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

ONCOLOGY AGENTS, ORAL, SKIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BASAL CELL		<ul style="list-style-type: none"> Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
ERIVEDGE (vismodegib)	ODOMZO (sonidegib) ^{CL}	
BRAF MUTATION		<ul style="list-style-type: none"> Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
MEKINIST (trametinib) TAFINLAR (dabrafenib)	BRAFTOVI (encorafenib) COTELLIC (cobimetinib) MEKTOVI (binimetinib) ZELBORAF (vemurafenib)	

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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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) LASTACAFT (alcaftadine) OTC olopatadine DROPS (generic Pataday) olopatadine OTC (Pataday twice daily) PATADAY XS (olopatadine 0.7%) PATADAY OTC (olopatadine 0.2%) PAZEO (olopatadine 0.7%) ZERVIAE (certirizine) ^{AL}	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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OPHTHALMICS, ANTIBIOTICS

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

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

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OPHTHALMICS, ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CORTICOSTEROIDS		<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class ▪ NSAID class: Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent
fluorometholone 0.1% (generic FML) OINT LOTEMAX SOLN (loteprednol 0.5%) MAXIDEX (dexamethasone) PRED MILD (prednisolone 0.12%)	dexamethasone (generic Maxidex) difluprednate (generic Durezol) DUREZOL (difluprednate) FLAREX (fluorometholone) FML (fluorometholone 0.1% SOLN) FML FORTE (fluorometholone 0.25%) FML S.O.P. (fluorometholone 0.1%) INVELTYS (loteprednol etabonate) LOTEMAX OINT, GEL (loteprednol) loteprednol GEL (generic Lotemax Gel) loteprednol 0.5% SOLN (generic Lotemax SOLN) prednisolone acetate 1% (generic Omnipred, Pred Forte) prednisolone sodium phosphate prednisolone sodium phosphate 1%	
NSAID		
diclofenac (generic Voltaren) ketorolac 0.5% (generic Acular)	ACUVAIL (ketorolac 0.45%) 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) ^{QL} maravi EYSUVIS (loteprednol etabonate) ^{QL} TYRVAYA (varenicline tartrate) ^{QL}	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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OPHTHALMICS, GLAUCOMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MIOTICS		<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ Rhopressa and Rocklatan: Electronically approved for patients who have a trial of ONE generic agent, within ophthalmics - glaucoma within 60 days ▪
pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide) Vuity (pilocarpine)	
SYMPATHOMIMETICS		
Alphagan P (brimonidine 0.15%) brimonidine 0.2% (generic for Alphagan)	Alphagan P (brimonidine 0.1%) apraclonidine (generic 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) ^{NR} travoprost (generic Travatan Z) VYZULTA (latanoprostene) XALATAN (latanoprost) ZIOPTAN (tafluprost)	
COMBINATION DRUGS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol (generic for Cosopt)	brimonidine/timolol (generic Combigan) COSOPT (dorzolamide/timolol) dorzolamide/timolol PF (generic Cosopt PF) SIMBRINZA (brinzolamide/brimonidine)	
OTHER		
RHOPRESSA (netarsudil) ^{CL} ROCKLATAN (netarsudil and latanoprost) ^{CL}		

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OPIOID DEPENDENCE TREATMENTS

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

OPIOID-REVERSAL TREATMENTS

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

OTIC ANTI-INFECTIVES & ANESTHETICS

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

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OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CIPRO HC (ciprofloxacin/hydrocortisone) 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"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

PAH (PULMONARY ARTERIAL HYPERTENSION AGENTS), ORAL AND INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ambrisentan (generic Letairis) REVATIO (sildenafil) ^{CL} SUSP, TAB tadalafil (generic for Adcirca) ^{CL} TRACLEER (bosentan) TAB TYVASO (treprostinil) INHALATION VENTAVIS (iloprost) INHALATION	ADEMPAS (riociguat) ^{CL} ADCIRCA (tadalafil) ^{CL} bosentan (generic Tracleer) TAB LETAIRIS (ambrisentan) OPSUMIT (macitentan) ORENITRAM ER (treprostinil) sildenafil (generic Revatio) ^{CL} SUSP, TAB TADLIQ (tadalafil) ^{NR} SUSP TRACLEER (bosentan) TAB FOR SUSPENSION TYVASO DPI (treprostinil) ^{NR} INHALATION POWDER UPTRAVI (selexipag)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Adcirca®/Revatio®: Approved for diagnosis of Pulmonary Arterial Hypertension (PAH) Adempas®: PAH: Requires clinical reason preferred agent cannot be used CTEPH: Approved for persistent/recurrent diagnosis after surgical treatment or inoperable CTEPH NOT for use in Pregnancy sildenafil suspension: Requires clinical reason why sildenafil tablets cannot be used

PANCREATIC ENZYMES

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

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PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHILD CHEW + IRON (MULTIVITAMIN WITH IRON) CHEW	DEKAs PLUS ^{AL}	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class <p>Drug specific criteria:</p> <ul style="list-style-type: none"> ▪ DEKAs Plus: Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent
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) CHEW	
MULTIVIT-FLUOR (PEDI MULTIVIT NO.17 W-FLUORIDE, PEDI MULTIVIT NO.16 W-FLUORIDE) CHEW	FLORIVA PLUS (PEDI MULTIVIT NO.161/FLUORIDE) DROP	
MULTIVIT-FLUOR (PEDI MULTIVIT NO.2 W-FLUORIDE) DROP	MULTI-VIT-FLOR (PEDI MULTIVIT NO.205/FLUORIDE) CHEW	
MULTIVIT-IRON-FLUOR (PEDI MULTIVIT 45/FLUORIDE/IRON)	POLY-VI-FLOR (PEDI MULTIVIT NO.33/FLUORIDE) CHEW	
PED MVIT A,C,D3 NO.21/FLUORIDE	POLY-VI-FLOR (PEDI MULTIVIT NO.37 W-FLUORIDE) DROPS	
POLY-VI-SOL WITH IRON (PEDI MV NO.189/FERROUS SULFATE) DROPS	POLY-VI-FLOR /0.25mg IRON (PEDI MULTIVIT 37/FLUORIDE/IRON)	
TRI-VI-SOL (VIT A PALMITATE/VIT C/VIT D3) DROPS	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) DROP	
	POLY-VI-FLOR 0.5 MG (PED MVI NO. 217/Fluoride) GUMMY	
	QUFLORA (PEDI MULTIVIT NO.157/FLUORIDE) GUMMIES	
	QUFLORA FE (PED MULTIVIT 142/IRON/FLUORIDE) CHEW	
	QUFLORA FE (PED MULTIVIT 151/IRON/FLUORIDE) DROP	
	QUFLORA PED (PEDI MULTIVIT NO.63 W-FLUORIDE) CHEW	
	QUFLORA PED (PEDI MULTIVIT 84 WITH FLUORIDE, PEDI MULTIVIT NO.83 W-FLUORIDE) DROP	
	TRI-VI-FLOR (PED MVIT A,C,D3 NO.38/FLUORIDE) DROPS	

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PENICILLINS

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

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate TAB CALPHRON OTC (calcium acetate) RENVELA (sevelamer carbonate)	AURYXIA (ferric citrate) calcium acetate CAPS ELIPHOS (calcium acetate) lanthanum (generic FOSRENOL) PHOSLO (calcium acetate) PHOSLYRA (calcium acetate) RENAGEL (sevelamer HCl) sevelamer HCl (generic Renagel) sevelamer carbonate (generic Renvela) VELPHORO (sucroferric oxyhydroxide)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
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"> 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

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

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

PRENATAL VITAMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>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</p>	<p>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</p>	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of or are intolerant to TWO preferred agents within this drug class

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PROGESTERONE (hydroxyprogesterone caproate)

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

PROTON PUMP INHIBITORS

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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SEDATIVE HYPNOTICS

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

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SICKLE CELL ANEMIA TREATMENT^{AL}

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

SINUS NODE INHIBITORS

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

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SKELETAL MUSCLE RELAXANTS

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

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STEROIDS, TOPICAL

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

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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STIMULANTS AND RELATED AGENTS^{AL}

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

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

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

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Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MISCELLANEOUS		<p>Note: generic guanfacine IR and clonidine IR are available without prior authorization</p> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ armodafinil and Sunosi: Require trial of modafinil ▪ armodafinil and modafinil: approved only for: <ul style="list-style-type: none"> ○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed ○ Narcolepsy with documentation of diagnosis via sleep study ○ Shift Work Sleep Disorder (only approvable for 6 months) with work schedule verified and documented. Shift work is defined as working the all night shift ▪ Sunosi approved only for: <ul style="list-style-type: none"> ○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed ○ Narcolepsy with documentation of diagnosis via sleep study ▪ Wakix: approved only for excessive daytime sleepiness in adults with narcolepsy with documentation of narcolepsy diagnosis via sleep study
atomoxetine (generic Strattera) ^{QL} guanfacine ER (generic Intuniv) ^{QL} QELBREE (viloxazine) ^{QL}	clonidine ER (generic Kapvay) ^{QL} STRATTERA (atomoxetine)	
ANALEPTICS		
	armodafinil (generic Nuvigil) ^{CL} modafanil (generic Provigil) ^{CL} SUNOSI (solriamfetol) ^{CL,QL} WAKIX (pitolisant) ^{CL,QL}	

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TETRACYCLINES

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

THROMBOPOIESIS STIMULATING PROTEINS^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROMACTA (eltrombopag) TAB	DOPTELET (avatrombopag) MULPLETA (lusutrombopag) PROMACTA (eltrombopag) SUSP TAVALISSE (fostamatinib)	<ul style="list-style-type: none"> ▪ All agents will be approved with FDA-approved indication, ICD-10 code is required. ▪ Non-preferred agents require a trial of a preferred agent with the same indication or a contraindication. Drug-Specific Criteria <ul style="list-style-type: none"> ▪ Doptelet/Mulpleta: Approved for one course of therapy for a scheduled procedure with a risk of bleeding for treatment of thrombocytopenia in adult patients with chronic liver disease

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THYROID HORMONES

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

ULCERATIVE COLITIS

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

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UTERINE DISORDER TREATMENT

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

VASODILATORS, CORONARY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
isosorbide dinitrate TAB isosorbide dinitrate ER, SA TAB (generic Dilatrate-SR/Isordil) isosorbide mono IR/SR TAB nitroglycerin SUBLINGUAL, TRANSDERMAL nitroglycerin ER TAB	BIDIL (isosorbide dinitrate/ hydralazine) ^{CL} GONITRO (nitroglycerin) isosorbide dinitrate TAB (Oceanside Pharm MFR only) isosorbide dinitrate/hydralazine (Bidil) ^{CL, NR} NITRO-BID OINT (nitroglycerin) NITRO-DUR (nitroglycerin) nitroglycerin TRANSLINGUAL (generic Nitrolingual) VERQUVO (vericiguat) ^{AL, CL, QL}	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> ▪ BiDil: Approved for the treatment of heart failure as an adjunct therapy to standard therapy in self-identified black patients ▪ Verquvo: Approved for use in patients following a recent hospitalization for HF within the past 6 months OR need for outpatient IV diuretics, in adults with symptomatic chronic HF and EF less than 45%

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