



Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January 2024 PDL

Noted in Red Font that Become Effective January 19, 2024

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

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

For all other class medically-necessary coverage, quantity, and high dose requests use the following:

[Documentation of Medical Necessity PA Form](#)

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

ACNE AGENTS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
adapalene (generic Differin) CREAM, GEL (OTC/Rx), GEL PUMP benzoyl peroxide (BPO) WASH, LOTION clindamycin/BPO (generic BenzaClin) PUMP clindamycin phosphate PLEDGET clindamycin phosphate SOLUTION erythromycin GEL erythromycin SOLN erythromycin-BPO (generic for Benzamycin) RETIN-A (tretinoin) ^{AL} CREAM, GEL	adapalene/BPO (generic Epiduo) adapalene/BPO (generic Epiduo Forte) ALTRENO (tretinoin) ^{AL} AMZEEQ (minocycline) ARAZLO (tazarotene) ^{AL} ATRALIN (tretinoin) AVAR (sulfacetamide sodium/sulfur) AVITA (tretinoin) AZELEX (azelaic acid) BENZEFOAM (benzoyl peroxide) benzoyl peroxide CLEANSER, CLEANSING BAR OTC benzoyl peroxide FOAM (generic BenzePro) benzoyl peroxide GEL OTC benzoyl peroxide GEL Rx benzoyl peroxide TOWELETTE OTC CABTREO (clindamycin phosphate/BPO/adapalene) ^{AL,NR} GEL clindamycin FOAM, LOTION clindamycin GEL clindamycin phosphate (generic for Clindagel) GEL clindamycin/BPO (generic Acanya) GEL clindamycin/BPO (generic Duac) clindamycin/BPO PUMP (generic Onexton) ^{AL, NR} clindamycin/tretinoin (generic Veltin, Ziana) dapsone (generic Aczone) erythromycin PLEDGET erythromycin-BPO (generic for Benzamycin) EVOCLIN (clindamycin)	<ul style="list-style-type: none"> • Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class

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

CL – Prior Authorization / Class Criteria apply
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

ACNE AGENTS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	FABIOR (tazarotene foam) NEUAC (clindamycin/BPO) ONEXTON (clindamycin/BPO) OVACE PLUS (sulfacetamide sodium) RETIN-A MICRO (tretinoin) sulfacetamide sulfacetamide/sulfur SUMADAN (sulfacetamide/sulfur) tazarotene CREAM (generic Tazorac) tazarotene FOAM (generic Fabior) tazarotene GEL (generic Tazorac) TRETIN-X (tretinoin) tretinoin CREAM, GELAL (generic Avita, Retin-A) tretinoin microspheres (generic for Retin-A Micro) ^{AL} GEL, GEL PUMP WINLEVI (clascoterone) ^{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

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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)	

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

ANALGESICS, OPIOID LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BUTRANS (buprenorphine) ^{QL} PATCH fentanyl 25, 50, 75, 100 mcg PATCH ^{QL} morphine ER TABLET (generic MS Contin, Oramorph SR) OXYCONTIN ^{CL} (oxycodone ER) tramadol ER (generic Ultram ER) ^{CL} XTAMPZA (oxycodone) ER	BELBUCA (buprenorphine) ^{QL} BUCCAL buprenorphine BUCCAL (generic for Belbuca) ^{AL,QL} buprenorphine PATCH (generic Butrans) ^{QL} EMBEDA (morphine sulfate/ naltrexone) DURAGESIC MATRIX (fentanyl) ^{QL} fentanyl 37.5, 62.5, 87.5 mcg PATCH ^{QL} hydrocodone ER (generic 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

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
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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)	APADAZ (benzhydrocodone/APAP) ^{CL} benzhydrocodone/APAP (generic Apadaz) ^{CL} butalbital/caffeine/APAP/codeine butalbital compound w/codeine (butalbital/ASA/caffeine/codeine) carisoprodol compound-codeine (carisoprodol/ASA/codeine) dihydrocodeine/APAP/caffeine dihydrocodeine/aspirin/caffeine hydromorphone LIQUID, SUPPOSITORY (generic Dilaudid) levorphanol meperidine (generic Demerol) morphine SUPPOSITORIES NALOCET (oxycodone/APAP) NUCYNTA (tapentadol) ^{CL} oxycodone CAPS oxycodone/APAP SOLN oxycodone CONCENTRATE oxymorphone IR (generic Opana) pentazocine/naloxone PROLATE (oxycodone/APAP) SOLN, TAB ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol) ^{AL} tramadol 100mg (generic Ultram) ^{AL} tramadol (generic Qdolo) ^{AL, QL} SOLN tramadol/APAP (generic Ultracet)	<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

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

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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} testosterone PUMP (generic Androgel) ^{CL}	ANDRODERM (testosterone) ^{CL} NATESTO (testosterone) ^{CL} testosterone PACKET (generic Androgel) ^{CL} testosterone GEL, PACKET, PUMP (generic Vogelxo) testosterone (generic Axiron) testosterone (generic Fortesta) testosterone (generic Testim)	<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)

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
AL– Age Limit

QL – Quantity/Duration Limit
NR – Product was not reviewed - New Drug criteria will apply

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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 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 <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)	

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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		
amlodipine/benazepril (generic Lotrel) amlodipine/olmesartan (generic Azor) amlodipine/valsartan (generic Exforge) amlodipine/valsartan/HCTZ (generic Exforge HCT)	amlodipine/olmesartan/HCTZ (generic Tribenzor) amlodipine/telmisartan (generic Twynsta) PRESTALIA (perindopril/amlodipine) trandolapril/verapamil (generic Tarka)	
DIRECT RENIN INHIBITORS		
	aliskiren (generic Tekturna) ^{QL}	
DIRECT RENIN INHIBITOR COMBINATIONS		<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
	TEKTURNA/HCT (aliskiren/HCTZ)	
NEPRILYSIN INHIBITOR COMBINATION		
ENTRESTO (sacubitril/valsartan) ^{CL,QL}		
ANGIOTENSIN RECEPTOR BLOCKER/BETA-BLOCKER COMBINATIONS		Drug Specific Criteria <ul style="list-style-type: none"> Entresto: May be approved in patients ages >1 years old and with a diagnosis of heart failure
	BYVALSON (nevigolol/valsartan)	

ANTHELMINTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
albendazole (generic Albenza) BILTRICIDE (praziquantel) ivermectin (generic Stromectol)	EMVERM (mebendazole) ^{CL} praziquantel (generic Biltricide) STROMECTOL (ivermectin)	<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

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<p>GRASTEK (timothy grass pollen allergen)^{AL,QL}</p> <p>ODACTRA (Dermatophagoides farinae and Dermatophagoides pteronyssinus)^{AL,QL}</p> <p>ORALAIR (sweet vernal/orchard/rye/timothy/kentucky blue grass mixed pollen allergen extract)^{CL}</p> <p>PALFORZIA (peanut allergen powder-dnfp)^{AL,CL}</p> <p>RAGWITEK (weed pollen-short ragweed)^{AL,QL}</p>	<p>All agents require initial dose to be given in a healthcare setting</p> <p>Drug-specific criteria:</p> <p>GRASTEK</p> <ul style="list-style-type: none"> Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for Timothy grass or cross-reactive grass pollens. For use in persons 5 through 65 years of age. <p>ODACTRA</p> <ul style="list-style-type: none"> Confirmed by positive skin test to licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to Dermatophagoides farinae and Dermatophagoides pteronyssinus house dust mite For use in persons 12 through 65 years of age <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 <p>RAGWITEK</p> <ul style="list-style-type: none"> Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for short ragweed pollen. For use in patients 5 through 65 years of age.

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
AL– Age Limit

QL – Quantity/Duration Limit
NR – Product was not reviewed - New Drug criteria will apply

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FIRVANQ (vancomycin) ^{QL} SOLN metronidazole TABLET neomycin tinidazole (generic Tindamax) ^{CL}	DIFICID (fidaxomicin) ^{CL} TABLET, SUSP LIKMEZ (metronidazole) ^{NR} SUSP metronidazole ^{CL} CAPS nitazoxanide (generic Alinia) TABLET ^{AL, CL, QL} paromomycin SOLOSEC (secnidazole) vancomycin CAPS (generic Vancocin) ^{CL} vancomycin (generic Firvanq) ^{NR, QL} VOWST (fecal microbiota spores) ^{AL, NR, QL} XIFAXAN (rifaximin) ^{CL}	<ul style="list-style-type: none"> • Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization Drug-specific criteria: <ul style="list-style-type: none"> • Alinia[®]: Trial and failure with metronidazole is required for a diagnosis of giardiasis • Dificid[®]: For diagnosis of C. difficile diarrhea (pseudomembranous colitis), trial and failure or intolerance to oral vancomycin is required. For diagnosis of relapsed or recurrent C. difficile, an appropriate ICD-10 diagnosis code must be submitted for coverage. • Flagyl[®]/Metronidazole 375mg capsules and / Metronidazole 750mg ER tabs: Clinical reason why the generic regular-release cannot be used • tinidazole: <ul style="list-style-type: none"> Approvable diagnoses include: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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[®]

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
AL– Age Limit

QL – Quantity/Duration Limit
NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

ANTIBIOTICS, INHALED^{CL}

Preferred Agents ^{CL}	Non-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin) KITABIS PAK (tobramycin) tobramycin (generic Tobi) TOBI-PODHALER (tobramycin) ^{QL}	ARIKAYCE (amikacin liposomal inh) SUSP CAYSTON (aztreonam lysine) ^{QL} tobramycin (generic Bethkis)	<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

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

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CLEOCIN OVULES (clindamycin) clindamycin CREAM (generic Cleocin) CLINDESSE (clindamycin) metronidazole, vaginal NUVESSA (metronidazole)	CLEOCIN CREAM (clindamycin) VANDAZOLE (metronidazole) XACIATO (clindamycin phosphate) GEL ^{AL}	<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 CAP (dabigatran) warfarin (generic Coumadin) XARELTO (rivaroxaban) 10 mg, 15 mg, 20 mg XARELTO (rivaroxaban) 2.5 mg ^{CL,QL} XARELTO DOSE PACK (rivaroxaban)	dabigatran etexilate (generic Pradaxa) fondaparinux (generic Arixtra) FRAGMIN (dalteparin) PRADAXA (dabigatran) PELLETS SAVAYSA (edoxaban) ^{CL,QL} XARELTO (rivaroxaban) ^{CL} SUSP	<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.

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria	
CANNABINOIDS			
dronabinol (generic Marinol) ^{AL}	CESAMET (nabilone)	<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 	
5HT3 RECEPTOR BLOCKERS			
ondansetron (generic Zofran/Zofran ODT) ^{QL}	ANZEMET (dolasetron) granisetron (generic Kytril) SANCUSO (granisetron) ^{CL} ZUPLENZ (ondansetron)	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Akynzeo®/Varubi®: Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist Regimens include: AC combination (Doxorubicin or Epirubicin with Cyclophosphamide), Aldesleukin, Amifostine, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carmustine, Carbplatin, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Dactinomycin, Daunorubicin, Epirubicin, Etoposide, Hexamethylmelamine, Idarubicin, Ifosfamide, Imatinib, Interferon α, Irinotecan, Mechlorethamine, Melphalan, Methotrexate, Oxaliplatin, Procarbazine, Streptozotocin, Temozolomide Diclegis®/Bonjesta: Approved only for treatment of nausea and vomiting of pregnancy Metozolv (metoclopramide) ODT®: Documentation of inability to swallow or Clinical reason oral liquid cannot be used Sancuso®/Zuplenz®: Documentation of oral dosage form intolerance 	
NK-1 RECEPTOR ANTAGONIST			
aprepitant (generic Emend) CAPS ^{QL}	AKYNZEO (netupitant/palonosetron) ^{CL} aprepitant (generic Emend) PACK EMEND (aprepitant) CAPS, PACK, POWDER ^{QL} VARUBI (rolapitant) TAB ^{CL}		
TRADITIONAL ANTIEMETICS			
DICLEGIS (doxylamine/pyridoxine) ^{CL,QL} dimenhydrinate (generic Dramamine) OTC meclizine (generic Antivert) metoclopramide (generic Reglan) phosphoric acid/dextrose/fructose 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)		

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole (mucous membrane, troche) fluconazole SUSP, TAB (generic Diflucan) griseofulvin SUSP griseofulvin microsize TAB nystatin SUSP, TAB terbinafine (generic Lamisil)	BREXAFEMME (ibrexafungerp) ^{QL} CRESEMBA (isavuconazonium) ^{CL} flucytosine (generic Ancobon) ^{CL} griseofulvin ultramicrosize (generic GRIS-PEG) itraconazole (generic Sporanox) ^{CL} ketoconazole (generic Nizoral) NOXAFIL (posaconazole) ^{AL} SUSP, TAB NOXAFIL (posaconazole) ^{AL,CL} POWDERMIX nystatin POWDER posaconazole (generic Noxafil) ^{AL,CL} TOLSURA (itraconazole) ^{CL} VIVJOA (oteseconazole) CAPS voriconazole (generic VFEND) ^{CL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO diagnosis-appropriate preferred agents within this drug class Drug-specific criteria: <ul style="list-style-type: none"> Cresemba®: Approved for diagnosis of invasive aspergillosis or invasive mucormycosis Flucytosine: Approved for diagnosis of: <u>Candida</u>: Septicemia, endocarditis, UTIs <u>Cryptococcus</u>: Meningitis, pulmonary infections Noxafil®: No trial for diagnosis of Neutropenia Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Neutropenic hematologic malignancies, Graft vs. Host disease(GVHD), Immunosuppression secondary to hematopoietic stem cell transplant Noxafil® Powdermix: pediatric patients 2 years of age and older who weigh 40 kg or less Noxafil® Suspension: Oropharyngeal/esophageal candidiasis refractory to itraconazole and/or fluconazole Sporanox®/itraconazole: Approved for diagnosis of Aspergillosis, Blastomycosis, Histoplasmosis, Onychomycosis due to terbinafine-resistant dermatophytes, Oropharyngeal/ esophageal candidiasis refractory to fluconazole Sporanox® Liquid: Clinical reason solid oral cannot be used Tolsura: Approved for diagnosis of Aspergillosis, Blastomycosis, and Histoplasmosis and requires a trial and failure of generic itraconazole Vfend®: No trial for diagnosis of Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Graft vs. Host disease (GVHD), Candidemia (candida krusei), Esophageal Candidiasis, Blastomycosis, <i>S. apiospermum</i> and <i>Fusarium spp.</i>, Oropharyngeal/esophageal candidiasis refractory to fluconazole

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
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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 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) 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 VOTRIZA-AL (clotrimazole) ^{NR} LOTION 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)	

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

ANTI-HISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine TAB (generic Zyrtec) cetirizine SOLN (OTC) (generic Zyrtec) loratadine TAB, SOLN (generic Claritin) levocetirizine TAB (generic Xyzal)	cetirizine CHEWABLE (generic Zyrtec) cetirizine SOLN (Rx) (generic Zyrtec) desloratadine (generic Clarinex) desloratadine ODT (generic Clarinex Reditabs) fexofenadine (generic Allegra) fexofenadine 180mg (generic Allegra 180mg) ^{QL} levocetirizine (generic Xyzal) SOLN loratadine CAPS, CHEWABLE, ODT (generic Claritin Reditabs)	<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

ANTI-HYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol (generic Zyloprim) colchicine TAB (generic Colcris) probenecid probenecid/colchicine (generic Col-Probenecid)	allopurinol 200mg colchicine CAPS (generic Mitigare) febuxostat (generic Uloric) ^{CL} GLOPERBA SOLN (colchicine) ^{CL,QL} MITIGARE (colchicine)	<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 Gloperba: Approved for documented swallowing disorder Uloric/febuxostat: Clinical reason why allopurinol cannot be used

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

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

ANTIMIGRAINE AGENTS, OTHER

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

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
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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 within the past 6 months

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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)	

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

ANTIPSORIATICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acitretin (generic Soriatane)	methoxsalen (generic Oxsoresalen-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) ^{AL} OINT calcipotriene/betamethasone OINT (generic Taclonex) calcipotriene/betamethasone SUSP (generic Taclonex Scalp) CALCITRENE (calcipotriene) DOVONEX CREAM (calcipotriene) DUOBRII (halobetasol prop/tazarotene) ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene) VTAMA (tapinarof) ^{AL} CREAM ZORYVE (roflumilast) ^{AL} CREAM	<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

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

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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} CAPS, SUSP	rimantadine (generic Flumadine) RELENZA (zanamivir) ^{QL} TAMIFLU (oseltamivir) ^{QL} CAPS, SUSP XOFLUZA (baloxavir marboxil) ^{AL,CL,QL}	Drug-specific criteria: <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) DENAVIR (penciclovir) penciclovir (generic Denavir) 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 Drug-specific criteria: <ul style="list-style-type: none"> Diazepam Intensol®: Requires clinical reason why diazepam solution cannot be used Alprazolam Intensol®: Requires trial of diazepam solution OR lorazepam Intensol®

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

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

BETA BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA BLOCKERS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Coreg CR®: Requires clinical reason generic IR product cannot be used Hemangeol®: Covered for diagnosis of Proliferating Infantile Hemangioma Sotylize®: Covered for diagnosis of life-threatening ventricular arrhythmias OR maintenance of normal sinus rhythm in highly symptomatic atrial fibrillation/flutter (AFIB/AFL) Requires clinical reason generic sotalol cannot be used
atenolol (generic Tenormin)	acebutolol (generic Sectral)	
atenolol/chlorthalidone (generic Tenoretic)	betaxolol (generic Kerlone)	
bisoprolol (generic Zebeta)	HEMANGEOL (propranolol) SOLN	
bisoprolol/HCTZ (generic Ziac)	INDERAL/INNOPRAN XL (propranolol ER)	
BYSTOLIC (nebivolol)	KAPSPARGO SPRINKLE (metoprolol ER)	
metoprolol (generic Lopressor)	metoprolol/HCTZ (generic Lopressor HCT)	
metoprolol ER (generic Toprol XL)	nadolol (generic Corgard)	
propranolol (generic Inderal)	nadolol/bendroflumethiazide	
propranolol ER (generic Inderal LA)	nebivolol (generic Bystolic)	
BETA- AND ALPHA-BLOCKERS		
carvedilol (generic Coreg)	carvedilol ER ^{CL} (generic Coreg CR)	
labetalol (generic Trandate)		
ANTIARRHYTHMIC		
sotalol (generic Betapace)	SOTYLIZE (sotalol)	

BILE SALTS

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

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>MYRBETRIQ (mirabegron)^{AL} TAB oxybutynin IR, ER (generic Ditropan/Ditropan XL) TOVIAZ (fesoterodine ER)</p>	<p>darifenacin ER (generic Enablex) fesoterodine (generic Toviaz) flavoxate HCL GELNIQUE (oxybutynin) GEMTESA (vibegron)^{AL,QL} MYRBETRIQ (mirabegron) SUSP^{AL,CL,QL} oxybutynin 2.5mg^{NR} OXYTROL (oxybutynin) solifenacin (generic Vesicare) tolterodine IR, ER (generic Detrol/ Detrol LA) trospium IR, ER (generic Sanctura/ Sanctura XR) VESICARE (solifenacin) VESICARE LS SUSP (solifenacin) ^{AL}</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"> • Myrbetriq suspension: Covered for pediatric patients ≥ 3 years old with a diagnosis of Neurogenic Detrusor Overactivity (NDO)

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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 Drug-specific criteria: <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 <ul style="list-style-type: none"> 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)	

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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) ENTADFI (finasteride/tadalafil)	

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS – 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"> • Xopenex/levalbuterol solution: Covered for cardiac diagnoses or side effect of tachycardia with albuterol product
albuterol HFA (generic Proventil HFA) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol HFA)	albuterol HFA (generic ProAir HFA and Ventolin HFA) levalbuterol HFA (generic Xopenex HFA) PROAIR DIGIHALER (albuterol) PROAIR RESPICLICK (albuterol)	
INHALERS – Long Acting		
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)	
INHALATION SOLUTION		
albuterol (2.5mg/3ml premix or 2.5mg/0.5ml) albuterol 100 mg/20 mL albuterol low dose (0.63mg/3ml & 1.25mg/3ml)	arformoterol tartrate (generic Brovana) BROVANA (arformoterol) formoterol fumarate (generic Perforomist) levalbuterol (generic for Xopenex) PERFOROMIST (formoterol)	
ORAL		
albuterol SYRUP	albuterol TAB albuterol ER (generic for Vospire ER) metaproterenol (formerly generic for Alupent) terbutaline (generic for Brethine)	

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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/ Norliqva: May be approved with documented swallowing difficulty
Dihydropyridines		
	isradipine (generic Dynacirc) nicardipine (generic Cardene) nifedipine (generic Procardia) nimodipine (generic Nimotop) NYMALIZE (nimodipine) SOLN	
Non-dihydropyridines		
diltiazem (generic Cardizem) verapamil (generic Calan/Isoptin)		
LONG-ACTING		
Dihydropyridines		
amlodipine (generic Norvasc) nifedipine ER (generic Procardia XL/ Adalat CC)	felodipine ER (generic Plendil) KATERZIA (amlodipine) ^{QL} SUSP levamlodipine (generic Conjupri) nisoldipine (generic Sular) NORLIQVA (amolidipine) ^{AL,CL,QL} SOLN	
Non-dihydropyridines		
diltiazem ER (generic Cardizem CD) verapamil ER TAB	CALAN SR (verapamil) diltiazem ER (generic Cardizem LA) MATZIM LA (diltiazem ER) TIAZAC (diltiazem) verapamil ER CAPS verapamil 360mg CAPS verapamil ER (generic Verelan PM)	

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		<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 <p>Drug Specific Criteria</p> <ul style="list-style-type: none"> Cefixime- May be approved for a diagnosis of gonorrhea, with an appropriate ICD-10 diagnosis code without a 3-day trial of a preferred agent Cefpodoxime- May be approved for a diagnosis of pyelonephritis, with an appropriate ICD-10 diagnosis code without a 3-day trial of a preferred agent
amoxicillin/clavulanate TAB, SUSP	amoxicillin/clavulanate CHEWABLE amoxicillin/clavulanate ER (generic Augmentin XR) AUGMENTIN (amoxicillin/clavulanate) SUSP, TAB	
CEPHALOSPORINS – First Generation		
cefadroxil CAPS, SUSP (generic Duricef) cephalexin CAPS, SUSP (generic Keflex)	cefadroxil TAB (generic Duricef) cephalexin TAB	
CEPHALOSPORINS – Second Generation		
cefprozil (generic Cefzil) cefuroxime TAB (generic Ceftin)	cefactor (generic Ceclor) CEFTIN (cefuroxime) TAB, SUSP	
CEPHALOSPORINS – Third Generation		
cefdinir (generic Omnicef)	cefixime (generic Suprax) CAPS, SUSP cefpodoxime (generic Vantin) SUPRAX (cefixime) CAPS, CHEWABLE TAB, SUSP, TAB	

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FYLNETRA (pegfilgrastim-pbbk) NEUPOGEN DISP SYR NEUPOGEN (filgrastim) VIAL	FULPHILA (pegfilgrastim-jmdb) SUB-Q • GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) SYR NIVESTYM (filgrastim-aafi) SYR, VIAL NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim-ayow) SYR, VIAL STIMUFEND (pegfilgrastim-fpgk) UDENYCA (pegfilgrastim-cbqv) AUTOINJ UDENYCA (pegfilgrastim-cbqv) SUB-Q ZARXIO (filgrastim-sndz) ZIEXTENZO SYR (pegfilgrastim-bmez)	<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

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
AL– Age Limit

QL – Quantity/Duration Limit
NR – Product was not reviewed - New Drug criteria will apply

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class
<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>JOYEAUX (levonorgestrel and ethinyl estradiol and ferrous fumarate kit)^{NR}</p> <p>levonorgestrel and ethinyl estradiol/ iron (generic Balcoltra)^{NR}</p> <p>TURQOZ (norgestrel and ethinyl estradiol kit)^{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. <p>Drug-specific criteria:</p> <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
<p>ANORO ELLIPTA (umeclidinium/vilanterol)</p> <p>ATROVENT HFA (ipratropium)</p> <p>COMBIVENT RESPIMAT (albuterol/ipratropium)</p> <p>SPIRIVA (tiotropium)</p> <p>STIOLTO RESPIMAT (tiotropium/olodaterol)</p>	<p>BEVESPI AEROSPHERE (glycopyrolate/formoterol)</p> <p>DUAKLIR PRESSAIR (aclidinium br and formoterol fum)</p> <p>INCRUSE ELIPTA (umeclidinium)</p> <p>SPIRIVA RESPIMAT (tiotropium)</p> <p>tiotropium (generic Spiriva)</p> <p>TUDORZA PRESSAIR (aclidinium br)</p>	
INHALATION SOLUTION		
<p>albuterol/ipratropium (generic Duoneb)</p> <p>ipratropium SOLN (generic Atrovent)</p>	<p>LONHALA (glycopyrrolate inhalation soln)</p> <p>YUPELRI (revefenacin)</p>	
ORAL AGENT		
<p>roflumilast (generic Daliresp)^{CL, QL}</p>	<p>DALIRESP (roflumilast)^{CL, QL}</p>	

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
AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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 \geq 18 years of age

CYSTIC FIBROSIS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	BRONCHITOL (mannitol) ^{AL,CL,QL} KALYDECO PACKET, TAB (ivacaftor) ^{QL, AL} ORKAMBI (lumacaftor/ivacaftor) PACKET, TAB ^{QL, AL} SYMDEKO (tezacaftor/ivacaftor) ^{QL, AL} TRIKAFTA(elexacaftor, tezacaftor, ivacaftor) ^{AL, CL} PACKET ^{CL,NR} , TAB	Drug-specific criteria: <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

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
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>COSENTYX (secukinumab)^{AL} PEN, SYRINGE</p> <p>ENBREL (etanercept) KIT, MINI CART, PEN, SYRINGE, VIAL^{QL}</p> <p>HUMIRA (adalimumab)^{QL}</p> <p>OTEZLA (apremilast) ORAL^{CL,QL}</p>	<p>ABRILADA KIT (adalimumab-afzb)^{AL,NR} (CF)</p> <p>ABRILADA PEN KIT (adalimumab-afzb)^{AL,NR} (CF)</p> <p>ACTEMRA (tocilizumab) SUB-Q</p> <p>ADALIMUMAB-AACF (CF)^{AL,NR} PEN KIT</p> <p>ADALIMUMAB-ADAZ(CF)(biosim for Hyrimoz)^{AL} PEN,SYRINGE</p> <p>ADALIMUMAB-ADB(CF) PEN CROHNS^{AL,NR}</p> <p>ADALIMUMAB-ADB(CF)^{AL,NR}</p> <p>ADALIMUMAB-FKJP (biosim for Hulio)^{AL} PEN, SYRINGE</p> <p>AMJEVITA (adalimumab-atto)^{AL} AUTOINJ, SYR</p> <p>AMJEVITA(adalimumab-atto)^{AL,NR} KIT</p> <p>AMJEVITA(adalimumab-atto)^{AL,NR} PEN KIT</p> <p>ARCALYST (niloncept)</p> <p>BIMZELX (bimekizumab-bkzx)^{AL,NR} PEN, SYR</p> <p>CIBINQO (abrocitinib)^{AL,QL}</p> <p>CIMZIA (certolizumab pegol)^{QL}</p> <p>CYLTEZO (adalimumab-adbm)^{AL} PEN SYRINGE</p> <p>ENSPRYNG (satralizumab-mwge) SUB-Q</p> <p>ENTYVIO (vedolizumab)^{AL,NR} PEN</p> <p>HADLIMA (adalimumab- bwwd)^{AL} PUSHTOUCH, SYRINGE</p> <p>HADLIMA (CF) (adalimumab- bwwd)^{AL} PUSHTOUCH, SYRINGE</p> <p>HULIO (adalimumab-fkjp)^{AL} PEN, SYRINGE</p> <p>HYRIMOZ(CF) (adalimumab-adaz)^{AL} PEN, SYRINGE</p> <p>IDACIO (adalimumab-aacf)^{AL} PEN, SYRINGE</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>OMVOH (mirikizumab-mrkz)^{AL,NR} PEN</p> <p>ORENCIA (abatcept) SUB-Q</p> <p>RINVOQ ER (upadacitinib)^{CL,QL}</p> <p>SILIQ (brodalumab)</p> <p>SIMPONI (golimumab)</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:</p> <p>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>

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
AL– Age Limit

QL – Quantity/Duration Limit
NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	SKYRIZI (risankizamab-rzaa) SYRINGE SKYRIZI ON-BODY (risankizamab-rzaa) ^{QL} SKYRIZI PEN (risankizamab-rzaa) ^{QL} SOTYKTU (deucravacitinib) TABLET STELARA (ustekinumab) SUB-Q TALTZ (ixekizumab) ^{AL} TREMFYA (guselkumab) ^{QL} VELSIPITY (etrasimod) ^{NR,QL} TAB XELJANZ (tofacitinib) TAB, SOLN ^{CL,QL} XELJANZ XR (tofacitinib) TAB ^{CL,QL} YUFLYMA 100mg/mL (CF) (adalimumab-aaty)^{AL} KIT, PEN KIT YUFLYMA 80mg/mL (CF) (adalimumab-aaty) ^{AL,NR} AUTOINJ, PEN, KIT YUSIMRY (CF) (adalimumab-aqvh)^{AL} PEN KIT	<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. Otezla: Requires a trial of Humira</p>

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

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SINGLE-AGENT PRODUCTS		
amiloride TAB bumetanide TAB chlorothiazide TAB chlorthalidone TAB (generic Diuril) furosemide SOLN, TAB (generic Lasix) hydrochlorothiazide CAPS, TAB (generic Microzide) indapamide TAB metolazone TAB spironolactone TAB (generic Aldactone) torsemide TAB	CAROSPIR (spironolactone) SUSP eplerenone TAB (generic Inspra) ^{CL} ethacrynic acid CAPS (generic Edecrin) KERENDIA (finerenone) TAB ^{CL,QL} spironolactone (generic Carospir) ^{NR} SUSP THALITONE (chlorthalidone) TAB triamterene (generic Dyrenium)	<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.
COMBINATION PRODUCTS		
amiloride/HCTZ TAB spironolactone/HCTZ TAB (generic Aldactazide) triamterene/HCTZ CAPS, TAB (generic Dyazide, Maxzide)		

ENZYME REPLACEMENT, GAUCHER'S DISEASE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ZAVESCA (miglustat) ^{CL}	CERDELGA (eliglustat) miglustat (generic Zavesca)	<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/miglustat: Approved for mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

EPINEPHRINE, SELF-INJECTED ^{QL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUVI-Q 0.1mg (epinephrine) epinephrine (AUTHORIZED GENERIC Epipen/ Epipen Jr.) AUTOINJ EPIPEN (epinephrine) AUTOINJ EPIPEN JR. (epinephrine) AUTOINJ	AUVI-Q 0.15mg (epinephrine) AUVI-Q 0.3mg (epinephrine) epinephrine (generic for Adrenaclick) epinephrine (generic for Epipen/ Epipen Jr.) AUTOINJ SYMJEPi (epinephrine) PFS	<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
ARANESP (darbopoetine alfa) DISP SYR, VIAL EPOGEN (rHuEPO) RETACRIT (epoetin alfa-epbx) <i>Pfizer manufacturer only</i>	JESDUVROQ (daprodustat) ^{NR} TAB PROCRIT (rHuEPO) RETACRIT (epoetin alfa-epbx) Vifor manufacturer only	<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 TAB (generic Cipro) levofloxacin TAB (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)

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
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

GI MOTILITY, CHRONIC

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

GLUCAGON AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BAQSIMI (glucagon) ^{AL, QL} NASAL GLUCAGON EMERGENCY (glucagon) ^{QL} INJ KIT (Lilly) glucagon ^{QL} INJ PROGLYCEM (diazoxide) SUSP ZEGALOGUE (dasiglucagon) ^{AL, QL} AUTO-INJ	diazoxide SUSP (generic Proglycem) GLUCAGON EMERGENCY (glucagon) ^{QL} INJ KIT (Fresenius) GVOKE (glucagon) ^{AL, QL} KIT, PEN, SYR, VIAL ZEGALOGUE (dasiglucagon) ^{AL, QL} SYR	<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

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

GLUCOCORTICIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCOCORTICIDS		
<p>ARNUITY ELLIPTA (fluticasone) ASMANEX (mometasone)^{QL,AL} ASMANEX HFA (mometasone)^{QL} FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide)</p>	<p>ALVESCO (ciclesonide)^{AL,CL} ARMONAIR DIGIHALER (fluticasone)^{AL,QL} ARMONAIR RESPICLICK (fluticasone)^{AL} FLOVENT DISKUS (fluticasone) fluticasone (generic Flovent Diskus)^{NR} fluticasone HFA (generic Flovent HFA)</p>	<ul style="list-style-type: none"> Non-preferred agents within the 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.
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
<p>ADVAIR DISKUS (fluticasone/salmeterol)^{QL} ADVAIR HFA (fluticasone/salmeterol)^{QL} DULERA (mometasone/formoterol) SYMBICORT (budesonide/ formoterol) TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)</p>	<p>AIRDUO DIGIHALER (fluticasone/salmeterol)^{AL,QL} AIRSUPRA HFA (albuterol and budesonide)^{AL} 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)^{QL} fluticasone/salmeterol (generic for Airduo Resplick) fluticasone/vilanterol (Breo Ellipta) WIXELA INHUB (generic for Advair Diskus)^{QL}</p>	
INHALATION SOLUTION		
	<p>budesonide RESPULES (generic for Pulmicort)</p>	

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
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC CAPS (generic Entocort EC) dexamethasone ELIXIR, SOLN dexamethasone TAB hydrocortisone TAB methylprednisolone tablet (generic Medrol) prednisolone SOLN prednisolone sodium phosphate prednisone DOSE PAK prednisone TAB	ALKINDI (hydrocortisone) GRANULES^{AL} CORTEF (hydrocortisone) cortisone TAB dexamethasone INTENSOL EMFLAZA (deflazacort) SUSP, TAB^{CL} ENTOCORT EC (budesonide) HEMADY (dexamethasone) methylprednisolone 8mg, 16mg, 32mg ORTIKOS ER (budesonide) ^{AL,QL} prednisolone sodium phosphate (generic Millipred/Veripred) prednisolone sodium phosphate ODT prednisone SOLN prednisone INTENSOL RAYOS DR (prednisone) TAB TARPEYO (budesonide) CAPS	<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) NGENLA (somatrogon-ghla) ^{AL,NR} OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin-tcgd) SOGROYA (somapacitan-beco) ^{NR} ZOMACTON (somatropin) ZORBTIVE (somatropin)	Growth Hormone PA Form Growth Hormone Criteria

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

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PYLERA (bismuth, metronidazole, tetracycline) ^{QL}	lansoprazole/amoxicillin/clarithromycin (generic Prevpac) ^{QL} OMECLAMOX-PAK (omeprazole, clarithromycin, amoxicillin) ^{QL} bismuth,metronidazole,tetracycline (generic Pylera) ^{NR,QL} TALICIA (omeprazole/amoxicillin/rifabutin)	<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 TAKHZYRO (lanadelumab-flyo) ^{AL,CL} SYRINGE	<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

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

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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		
HUMATE-P	ADYNOVATE		
KOVALTRY	AFSTYLA		
NOVOEIGHT	ALTUVIIIIO		
NUWIQ	ELOCTATE		
XYNTHA KIT, SOLOFUSE	ESPEROCT		
	HEMOFIL-M		
	JIVI ^{AL}		
	KOATE-DVI KIT		
	KOATE-DVI VIAL		
	KOGENATE FS		
	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 CORIFACT	TRETTEN		
VON WILLEBRAND PRODUCTS			
WILATE	VONVENDI		
BISPECIFIC FACTORS			
HEMLIBRA			

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

HEPATITIS B TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
entecavir TAB	adefovir dipivoxil BARACLUDE (entecavir) SOLN, TAB EPIVIR HBV (lamivudine) TAB, SOLN lamivudine hbv TAB VEMLIDY (tenofovir alafenamide fumarate)	<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

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
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

HEPATITIS C TREATMENTS

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

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
AL– Age Limit

QL – Quantity/Duration Limit
NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

HISTAMINE II RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
famotidine TAB (generic for Pepcid) famotidine SUSP	cimetidine TAB, SOLN^{CL} (generic Tagamet) famotidine ^{NR} CHEW-TAB nizatidine CAPS (generic for Axid)	<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

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
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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) ^{QL}	
CCR5 ANTAGONISTS		
SELZENTRY SOLN, TAB (maraviroc)	maraviroc (generic Selzentry)	
FUSION INHIBITORS		
FUZEON SUB-Q (enfuvirtide) ^{QL}		
HIV-1 ATTACHMENT INHIBITOR		
	RUKOBIA ER (fostemsavir) ^{AL,QL}	
INTEGRASE STRAND TRANSFER INHIBITORS (INSTIs)		
ISENTRESS (raltegravir) ^{QL} ISENTRESS HD (raltegravir) TIVICAY (dolutegravir)	TIVICAY PD (dolutegravir)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)		
EDURANT (rilpivirine) efavirenz CAPS, TABLET (generic Sustiva) INTELENCE (etravirine) ^{QL} PIFELTRO (doravirine) ^{QL}	etravirine (generic Intelence) ^{QL} nevirapine IR, ER (generic Viramune/Viramune XR) basglaSUSTIVA CAPS, TABLET (efavirenz) VIRAMUNE (nevirapine) SUSP	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
abacavir SOLN, TABLET (generic Ziagen) EMTRIVA CAPS, SOLN (emtricitabine) lamivudine SOLN, TABLET (generic EpiVir) zidovudine CAPS, SYRUP, TABLET (generic Retrovir)	didanosine DR (generic Videx EC) emtricitabine CAPS (generic for Emtriva) EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine CAPS (generic Zerit) ZIAGEN (abacavir)	
NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
tenofovir TABLET (generic Viread)	VIREAD (tenofovir) POWDER	
PHARMACOKINETIC ENHANCER		
	TYBOST (cobicistat) ^{QL}	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

HIV / AIDS^{CL} (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROTEASE INHIBITORS		<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
atazanavir CAPS (generic Reyataz) NORVIR (ritonavir) TAB	APTIVUS CAPS, SOLN (tipranavir) CRIXIVAN (indinavir) DARUNAVIR PROPYLENE GLYCOLATE ^{AL,NR} TAB darunavir ethanolate (generic Prezista) ^{AL,NR} TAB fosamprenavir TAB (generic Lexiva) LEXIVA SUSP (fosamprenavir) LEXIVA TAB (fosamprenavir) NORVIR POWDER, SOLN (ritonavir) PREZISTA (darunavir) SUSP, TAB REYATAZ POWDER (atazanavir) ritonavir TAB (generic Norvir) VIRACEPT (nelfinavir)	
COMBINATION PROTEASE INHIBITORS (PIs) or PIs plus PHARMACOKINETIC ENHANCER		<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, TAB (generic Kaletra)	KALETRA SOLN (lopinavir/ritonavir) KALETRA TAB (lopinavir/ritonavir) PREZCOBIX (darunavir/cobicistat) ^{QL}	
COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir/lamivudine (generic Epzicom) CIMDUO (lamivudine/tenofovir) ^{QL} DESCOVY (emtricitabine/tenofovir) ^{QL} emtricitabine/tenofovir (generic Truvada) lamivudine/zidovudine (generic Combivir)	abacavir/lamivudine/zidovudine (generic Trizivir) COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir sulfate/lamivudine) TRIZIVIR (abacavir/lamivudine/zidovudine) TRUVADA (emtricitabine/tenofovir)	

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

CL – Prior Authorization / Class Criteria apply
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

HIV / AIDS^{CL} (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PRODUCTS – MULTIPLE CLASSES		
BIKTARVY (bictegravir/emtricitabine/tenofovir) ^{QL}	ATRIPLA (efavirenz/emtricitabine/tenofovir)	<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
COMPLERA (rilpivirine/emtricitabine/tenofovir)	efavirenz/lamivudine/tenofovir (generic for Symfi) ^{QL}	
DELSTRIGO (doravirine/lamivudine/tenofovir) ^{QL}	efavirenz/lamivudine/tenofovir (generic for Symfi Lo) ^{QL}	
DOVATO (dolutegravir/lamivudine) ^{QL} efavirenz/emtricitabine/tenofovir (generic Atripla) ^{CL}	TRIUMEQ PD (abacavir, dolutegravir, and lamivudine) SUSP	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) ^{QL, AL}		
JULUCA (dolutegravir/rilpivirine) ^{QL}		
ODEFSEY (emtricitabine/rilpivirine/tenofovir) ^{QL}		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) ^{QL}		
SYMFI (efavirenz/lamivudine/tenofovir) ^{QL}		
SYMFI LO (efavirenz/lamivudine/tenofovir) ^{QL}		
SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir) ^{QL}		
TRIUMEQ (dolutegravir/abacavir/lamivudine)		

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

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
AL– Age Limit

QL – Quantity/Duration Limit
NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

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

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
APIDRA (insulin glulisine) SOLOSTAR, VIAL HUMALOG (insulin lispro) U-100 CARTRIDGE, PEN, VIAL HUMALOG JR. (insulin lispro) U-100 KWIKPEN HUMALOG MIX VIAL (insulin lispro/lispro protamine) HUMALOG MIX KWIKPEN (insulin lispro/lispro protamine) HUMULIN (insulin) VIAL HUMULIN 70/30 VIAL HUMULIN U-500 VIAL HUMULIN R U-500 KWIKPEN^{CL} HUMULIN OTC PEN HUMULIN 70/30 OTC PEN insulin aspart (generic for Novolog) insulin aspart/insulin aspart protamine PEN, VIAL (generic for Novolog Mix) insulin glargine PEN, VIAL insulin lispro (generic for Humalog) PEN, VIAL, JR KWIKPEN LANTUS SOLOSTAR PEN (insulin glargine) LANTUS (insulin glargine) VIAL LEVEMIR (insulin detemir) PEN, VIAL NOVOLIN (insulin) PEN NOVOLOG (insulin aspart) CARTRIDGE, FLEXPEN, VIAL NOVOLOG MIX FLEXPEN (insulin aspart/aspart protamine)	ADMELOG (insulin lispro) PEN, VIAL AFREZZA (regular insulin) INHALATION BASAGLAR (insulin glargine, rec) PEN, TEMPO PEN^{NR} FIASP (insulin aspart) CARTRIDGE, PEN, VIAL HUMALOG U-100 TEMPO PEN^{NR} HUMALOG (insulin lispro) ^{CL} U-200 KWIKPEN insulin degludec (generic Tresiba) 100U/mL PEN, VIAL insulin degludec (generic Tresiba) 200U/mL PEN insulin Glargine-YFGN PEN, VIAL (generic for Semglee-YFGN) insulin lispro/lispro protamine KWIKPEN (Humalog Mix Kwikpen) LYUMJEV KWIKPEN, VIAL (insulin lispro-aabc) LYUMJEV (insulin lispro-aabc) TEMPO PEN NOVOLIN (insulin) NOVOLIN 70/30 VIAL (insulin) NOVOLOG MIX (insulin aspart/aspart protamine) VIAL REZVOGLAR (insulin glargine-aglr) ^{NR} KWIKPEN SEMGLEE (insulin glargine) PEN, VIAL SEMGLEE YFGN (insulin glargine) PEN, VIAL TOUJEO SOLOSTAR (insulin glargine) TRESIBA (insulin degludec)	<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: May be approved for patients who require >200 units/day • Humalog U-200 Pen: May be approved for patients who require > 100 units/day AND using an insulin pump

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
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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}	INPEFA (sotagliflozin) ^{NR,QL} TAB INVOKAMET XR (canagliflozin/metformin) ^{QL} SEGLUOMET (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 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

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
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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 Combination products: Require clinical reason why individual ingredients cannot be used
pioglitazone (generic for Actos)		
TZD COMBINATIONS		
	pioglitazone/glimepiride (generic for Duetact) pioglitazone/metformin (generic for Actoplus Met)	

IDIOPATHIC PULMONARY FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
OFEV (nintedanib esylate) ^{CL} pirfenidone (generic Esbriet) ^{QL}	ESBRIET (pirfenidone) ^{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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

IMMUNOMODULATORS, ASTHMA ^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FASENRA (benralizumab) ^{AL} PEN XOLAIR (omalizumab) SYR ^{AL,QL}	NUCALA (mepolizumab) ^{AL} AUTO-INJ, SYR TEZSPIRE (tezepelumab-ekko)^{AL} PEN	Immunomodulators Self-Injectable PA Form <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> <ul style="list-style-type: none"> Dupixent: (For other indications, see Immunomodulators, Atopic Dermatitis therapeutic class) For Eosinophilic Asthma or Corticosteroid Dependent Asthma: Patients must be ages 6 and older. Documentation of moderate to severe asthma with either eosinophils ≥ 150 + 1 exacerbation OR oral corticosteroid dependency AND prior drug therapy of med-high or max-tolerated inhaled corticosteroid + controller OR max-tolerated inhaled corticosteroid / long acting beta agonist combo

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

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

IMMUNOMODULATORS, ATOPIC DERMATITIS^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>ADBRY (tralokinumab-ldrm)^{AL,CL,QL} SUB-Q</p> <p>DUPIXENT (dupilumab)^{AL,CL} PEN,SYR</p> <p>ELIDEL (pimecrolimus)</p> <p>EUCRISA (crisaborole)^{CL,QL} tacrolimus (generic for Protopic)</p>	<p>OPZELURA (ruxolitinib phosphate) CREAM^{AL,CL,QL}</p> <p>pimecrolimus (generic for Elidel)</p> <p>PROTOPIC (tacrolimus)</p> <p>ZORYVE (roflumilast)^{AL,NR} FOAM</p>	<p>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"> • ADBRY: May be approved after a trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor • Dupixent: <ol style="list-style-type: none"> 1. Atopic Dermatitis: May be approved after a maximum of a 90-day trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor 2. Eosinophilic Esophagitis: Trial, failure, or technique difficulty to a swallowed topical corticosteroid or treatment failure of a proton pump inhibitor. Prescribed by, or in consultation with an allergist, gastroenterologist, or immunologist. Documentation that the Patient has a confirmed diagnosis of eosinophilic esophagitis with > 15 eosinophils/high-power field. 3. Nasal Polyps: May be approved with documentation of treatment failure or contraindication within the previous year to an intranasal corticosteroid OR systemic corticosteroid therapy OR prior nasal surgery. Prescribed by, or in consultation with an allergist, pulmonologist, or otolaryngologist [ENT]. 4. Prurigo Nodularis: Patient must have a diagnosis of Prurigo Nodularis with provider attestation of > 20 nodular lesions. Trial and failure of a topical corticosteroid. Prescribed by, or in consultation with an allergist, dermatologist, or immunologist. • Eucrisa: May be approved after a 30 day trial failure of a preferred topical corticosteroid (TCS) or topical calcineurin inhibitor (TCI) within the past 180 days; Maximum of 300 grams per year • Opzelura: May be approved for a diagnosis of Atopic Dermatitis and after a trial/failure of a topical steroid and trial of a preferred agent

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

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

IMMUNOMODULATORS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
imiquimod (generic for Aldara)	HYFTOR (sirolimus)^{AL} GEL imiquimod (generic Zyclara) podofilox (generic Condylox) GEL^{NR}, SOLN VEREGEN (sinecatechins) ZYCLARA (imiquimod)	<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 (generic Neoral) CAPS everolimus (generic for Zortress) ^{AL} mycophenolate (generic Cellcept) CAPS, TAB RAPAMUNE (sirolimus) SOLN RAPAMUNE (sirolimus) TAB tacrolimus	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) cyclosporine CAP, SOFTGEL cyclosporine, modified (generic Neoral) SOLN ENVARSUS XR (tacrolimus) GENGRAF (cyclosporine, modified) CAP, SOLN mycophenolate (generic Cellcept) SUSP mycophenolic acid MYFORTIC (mycophenolate sodium) PROGRAF (tacrolimus) CAPS, PACKET REZUROCK (belumosudil) ^{AL,QL} TAB SANDIMMUNE (cyclosporine) CAPS, SOLN sirolimus (generic Rapamune) SOLN, TAB 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 Drug Specific Criteria <ul style="list-style-type: none"> Tavneos (avacopan) <ul style="list-style-type: none"> No trial of a preferred agent required with appropriate FDA indications with concurrent use of standard therapy, including glucocorticoids

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

INTRANASAL RHINITIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		
ipratropium (generic for Atrovent)		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
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}	
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 (generic for Singulair) TAB^{QL}/CHEWABLE^{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

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
AL– Age Limit

QL – Quantity/Duration Limit
NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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 <p>Drug-specific criteria:</p> <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
cholestyramine (generic Questran) colestipol TAB (generic Colestid)	colesevelam (generic Welchol) TAB, PACKET colestipol GRANULES (generic Colestid) QUESTRAN LIGHT (cholestyramine)	
TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA		
	JUXTAPID (lomitapide) ^{CL} KYNAMRO (mipomersen) ^{CL}	
FIBRIC ACID DERIVATIVES		
fenofibrate (generic Tricor) fenofibrate (generic Lofibra) gemfibrozil (generic Lopid)	fenofibric acid (generic Fibricor/Trilipix) fenofibrate (generic Antara/Fenoglide/ Lipofen/Triglide)	
NIACIN		
niacin ER (generic Niaspan)	NIACOR (niacin IR)	
OMEGA-3 FATTY ACIDS		
omega-3 fatty acids (generic Lovaza) VASCEPA (icosapent)	icosapent (generic Vascepa) ^{CL} omega-3 OTC	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe (generic Zetia)	NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ ezetimibe) ^{QL}	

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

LIPOTROPICS, OTHER (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		
PRALUENT (alorocumab) ^{CL}	REPATHA (evolocumab) ^{CL}	<ul style="list-style-type: none"> ▪ Praluent®: Approved for diagnoses of: <ul style="list-style-type: none"> • atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) • homozygous familial hypercholesterolemia (HoFH) as an adjunct to other LDL-C lowering therapies • AND <ul style="list-style-type: none"> • Trial and failure or intolerance to a statin for 8 continuous weeks • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL ▪ Repatha®: May be approved for: <ul style="list-style-type: none"> • adult diagnoses of atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) in adults and pediatric patients aged 10 years and older • homozygous familial hypercholesterolemia (HoFH) in adults and pediatric patients aged 10 years and older • AND <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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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) ^{AL,QL} pitavastatin (generic Livalo) ^{AL,NR,QL} ZYPITAMAG (pitavastatin)	
STATIN COMBINATIONS		
	atorvastatin/amlodipine (generic Caduet) simvastatin/ezetimibe (generic Vytorin)	

MACROLIDES AND KETOLIDES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MACROLIDES		<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 TAB, SUSP (generic Biaxin) E.E.S. SUSP (erythromycin ethylsuccinate)	clarithromycin ER (generic Biaxin XL) E.E.S. TAB (erythromycin ethylsuccinate) ERY-TAB (erythromycin) erythromycin ethylsuccinate SUSP ERYPED SUSP (erythromycin) ERYTHROCIN (erythromycin) erythromycin base TAB, CAPS	

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

METHOTREXATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
methotrexate PF VIAL, TABLET, VIAL	JYLAMVO (methotrexate) ^{NR} SOLN OTREXUP (methotrexate) SUB-Q RASUVO (methotrexate) SUB-Q REDITREX (methotrexate) SUB-Q TREXALL (methotrexate) TABLET XATMEP (methotrexate) SOLN	Non-preferred agents require a trial of the preferred agent AND will be approved for an FDA-approved indication Drug-specific criteria: <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} AUSTEDO XR (deutetrabenazine)^{CL} AUSTEDO XR Titration Pack (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/Austedo XR/Ingrezza: Diagnosis of Tardive Dyskinesia or chorea associated with Huntington's Disease; Requires a Step through tetrabenazine with the diagnosis of chorea associated with Huntington's Disease tetrabenazine: Diagnosis of chorea with Huntington's Disease

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

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AVONEX (interferon beta-1a) ^{QL} BETASERON (interferon beta-1b) ^{QL} COPAXONE 20mg (glatiramer) ^{QL} dimethyl fumarate (generic for Tecfidera) fingolimod (generic Gilenya) ^{QL} KESIMPTA (Ofatumumab) ^{CL, QL} teriflunomide (generic Aubagio) ^{QL}	AUBAGIO (teriflunomide) ^{QL} BAFIERTAM (monomethyl fumarate) ^{QL} dalfampridine (generic Ampyra) ^{QL} EXTAVIA (interferon beta-1b) ^{QL} GILENYA (fingolimod) ^{QL} glatiramer (generic Copaxone) ^{QL} MAVENCLAD (cladribine) MAYZENT (siponimod) ^{QL} PLEGRIDY (peginterferon beta-1a) ^{QL} PONVORY (ponesimod) REBIF (interferon beta-1a) ^{QL} TASCENSO ODT (fingolimod) TAB^{AL} TECFIDERA (dimethyl fumarate) VUMERITY (diroximel) ^{QL} ZEPOSIA (ozanimod) ^{AL, CL, QL}	<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

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
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

NSAIDs, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE		<ul style="list-style-type: none"> • Non-preferred agents within COX-1 SELECTIVE group will be approved for patients who have failed no less than 30-day trial of TWO preferred agents within this drug class Drug-specific criteria: <ul style="list-style-type: none"> ▪ meclofenamate: Approvable without trial of preferred agents for menorrhagia ▪ Sprix/ketoralac Nasal: Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs
diclofenac sodium (generic Voltaren) ibuprofen OTC, Rx (generic Advil, Motrin) CHEW, DROPS, SUSP, TAB ibuprofen OTC (generic Advil, Motrin) CAPS indomethacin (generic Indocin) CAPS ketorolac (generic Toradol) meloxicam (generic Mobic) TAB nabumetone (generic Relafen) naproxen Rx, OTC (generic Naprosyn) naproxen enteric coated sulindac (generic Clinoril)	diclofenac potassium (generic Cataflam, Zipsor) diclofenac SR (generic Voltaren-XR) diflunisal (generic Dolobid) etodolac & SR (generic Lodine/XL) fenoprofen (generic Nalfon) flurbiprofen (generic Ansaid) ibuprofen/famotidine (generic Duexis) ^{CL} indomethacin ER (generic Indocin) ketoprofen & ER (generic Orudis) meclufenamate (generic Meclomen) mefenamic acid (generic Ponstel) meloxicam (generic Vivlodex) ^{CL, QL} CAP meloxicam (generic Mobic) SUSP naproxen CR (generic Naprelan) naproxen (generic Naprosyn) SUSP naproxen sodium (generic Anaprox) naproxen-esomeprazole (generic Vimovo) oxaprozin (generic Daypro) piroxicam (generic Feldene) tolmetin (generic Tolectin) ketorolac (generic Sprix Nasal) ^{QL} NASAL	

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

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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} NALFON (fenoprofen) RELAFEN DS (nabumetone)	
NSAID/GI PROTECTANT COMBINATIONS		
	diclofenac/misoprostol (generic Arthrotec)	
COX-II SELECTIVE		
celecoxib (generic Celebrex)		

NSAIDs, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
diclofenac sodium GEL (OTC only) PENNSAID PUMP (diclofenac)^{CL}	diclofenac PUMP (generic Pennsaid)^{CL} diclofenac SOLN (generic Pennsaid) FLECTOR PATCH (diclofenac)^{CL} LICART PATCH (diclofenac)^{CL} PENNSAID PACKET (diclofenac)^{CL} VOLTAREN GEL (diclofenac)^{CL}	<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.

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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

ONCOLOGY AGENTS, ORAL, BREAST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CDK 4/6 INHIBITOR		<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/toremifene: Require clinical reason why tamoxifen cannot be used letrozole: Approved for diagnosis of breast cancer with day supply greater than 12 – NOT approved for short term use Soltamox: May be approved with documented swallowing difficulty
	IBRANCE (palbociclib) KISQALI (ribociclib) KISQALI FEMARA CO-PACK VERZENIO (abemaciclib)	
CHEMOTHERAPY		
capecitabine (generic Xeloda) cyclophosphamide	XELODA (capecitabine)	
HORMONE BLOCKADE		
anastrozole (generic Arimidex) exemestane (generic Aromasin) letrozole (generic Femara) tamoxifen citrate (generic Nolvadex)	ORSERDU (elacestrant) SOLTAMOX SOLN (tamoxifen) ^{CL} toremifene (generic Fareston) ^{CL}	
OTHER		
	NERLYNX (neratinib) PIQRAY (alpelisib) lapatinib (generic Tykerb) TALZENNA (talazoparib tosylate) ^{QL} TUKYSA(tucatinib) ^{QL} TRUQAP (capiivasertib) ^{NR}	

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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

ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ALL	<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 ▪ Purixan: Prior authorization not required for age <12 or for documented swallowing disorder ▪ Tabloid: Prior authorization not required for age <19 ▪ Xpovio: Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone
mercaptopurine	PURIXAN (mercaptopurine) ^{AL}	
	AML	
	DAURISMO (glasdegib maleate) ^{QL} IDHIFA (enasidenib) REZLIDHIA (olutasidenib)^{QL} RYDAPT (midostaurin) TIBSOVO (ivosidenib) ^{QL} VANFLYTA (quizartinib) XOSPATA (gilteritinib) ^{QL}	
	CLL	
LEUKERAN (chlorambucil)	COPIKTRA (duvelisib) ^{QL} IMBRUVICA (ibrutinib) VENCLEXTA (venetoclax) ZYDELIG (idelalisib)	
	CML	
hydroxyurea (generic for Hydrea) imatinib (generic for Gleevec) MYLERAN (busulfan)	BOSULIF (bosutinib) GLEEVEC (imatinib) HYDREA (hydroxyurea) ICLUSIG (ponatinib) SCEMBLIX (asciminib) SPRYCEL (dasatinib) TASIGNA (nilotinib) ^{CL}	
	MPN	
	JAKAFI (ruxolitinib)	
	MYELOMA	
melphalan (generic Alkeran) REVLIMID ^{QL} (lenalidomide)	lenalidomide ^{QL} (generic Revlimid) NINLARO (ixazomib) POMALYST (pomalidomide) THALOMID (thalidomide) XPOVIO (selinexor) ^{CL}	
	OTHER	
MATULANE (procarbazine) TABLOID (thioguanine) tretinoin (generic for Vesanoid) ^{AL}	BRUKINSA (zanubrutinib) ^{QL} CALQUENCE (acalabrutinib) ^{QL} INREBIC (fedratinib dihydrochloride) ^{QL} INQOVI (decitabine/cedazuridine) OJJAARA (mometotinib) ^{NR} VONJO (pacritinib) ^{QL} ZOLINZA (vorinostat)	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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

ONCOLOGY AGENTS, ORAL, LUNG

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALK		<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
	ALECENSA (alectinib) ALUNBRIG (brigatinib) ^{QL} LORBRENA (lorlatinib) ^{QL} ZYKADIA (ceritinib) CAPS, TAB	
ALK / ROS1 / NTRK		
	AUGTYRO (repotrectinib) ^{NR} ROZLYTREK (entrectinib) ^{QL} CAPS, PELLETS^{NR} XALKORI (crizotinib) CAPS, PELLETS^{NR}	
EGFR		
erlotinib (generic for Tarceva)	EXKIVITY (mobocertinib) ^{QL} gefitinib (generic Iressa) GILOTRIF (afatinib) IRESSA (gefitinib) TAGRISSO (osimertinib) TARCEVA (erlotinib) VIZIMPRO (dacomitinib) ^{QL}	
OTHER		
	GAVRETO (pralsetinib) ^{QL} HYCAMTIN (topotecan) KRAZATI (adagrasib) LUMAKRAS (sotrasib) ^{QL} RETEVMO (selpercatinib) ^{AL} TABRECTA (capmatinib) ^{QL} TEPMETKO (tepotinib) ^{QL}	

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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

ONCOLOGY AGENTS, ORAL, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
temozolomide (generic Temodar)	AYVAKIT (avapritinib) ^{AL,QL} BALVERSA (erdafitinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) FRUZAQLA (fruquintinib) ^{NR} CAPS HEXALEN (altretamine) IWILFIN (eflornithine) ^{NR} JAYPIRCA (pirtobrutinib) KOSELUGO (selumetinib) ^{AL} LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) LYTGOBI (futibatinib) PEMAZYRE (pemigatinib) ^{QL} QINLOCK (ripretinib) RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat) ^{AL} TURALIO (pexidartinib) ^{QL} TRUSELTIQ (infigratinib) CAPS VITRAKVI (larotrectinib) CAPS, SOLN ZEJULA (niraparib) CAPS, TABS	<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 XTANDI (enzalutamide)^{AL,QL}	AKEEGA (niraparib/abiraterone) EMCYT (estramustine) ERLEADA (apalutamide) ^{QL} nilutamide (generic Nilandron) NUBEQA (darolutamide) ^{QL} ORGOVYX (relugolix) ^{AL} 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

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

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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

ONCOLOGY AGENTS, ORAL, RENAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SUTENT (sunitinib) VOTRIENT (pazopanib)	AFINITOR DISPERZ (everolimus) ^{CL} CABOMETYX (cabozantinib) everolimus (generic Afinitor) everolimus SUSP (generic Afinitor Disperz) FOTIVDA (tivozanib) INLYTA (axitinib) LENVIMA (lenvatinib) NEXAVAR (sorafenib) PAZOPANIB (generic Votrient) ^{NR} TAB sorafenib (generic Nexavar) sunitinib malate (generic Sutent) WELIREG (belzutifan) ^{QL}	<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) MEKINIST (trametinib) SOLN MEKTOVI (binimetinib) TAFINLAR (dabrafenib) SUSP ZELBORAF (vemurafenib)	

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALREX (loteprednol 0.2%) cromolyn (generic Opticrom) ketotifen OTC (generic Zaditor) olopatadine OTC (Pataday once daily) olopatadine OTC (Pataday twice daily)	ALOCRIL (nedocromil) ALOMIDE (Iodoxamide) azelastine (generic Optivar) BEPREVE (bepotastine besilate) bepotastine besilate (generic Bepreve) epinastine (generic Elestat) LASTACAFT (alcaftadine) LASTACAFT (alcaftadine) OTC olopatadine DROPS (generic Pataday) olopatadine 0.1% (generic Patanol) PATADAY XS (olopatadine 0.7%) PATADAY OTC (olopatadine 0.2%) 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

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

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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 SOLN tobramycin (generic Tobrex drops)	TOBREX OINT (tobramycin)	
OTHER OPHTHALMIC AGENTS		
bacitracin/polymyxin B (generic Polysporin) polymyxin B/trimethoprim (generic Polytrim)	bacitracin NATACYN (natamycin) ^{CL} neomycin/bacitracin/polymyxin B OINT neomycin/polymyxin B/gramicidin NEOSPORIN (neomycin/polymyxin B/gramicidin) sulfacetamide SOLN (generic Bleph-10) sulfacetamide OINT	

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
neomycin/polymyxin/dexamethasone (generic Maxitrol) sulfacetamide/prednisolone TOBRADEX SUSP, OINT (tobramycin and dexamethasone) tobramycin/dexamethasone SUSP (generic TobraDex) <i>all other manufacturers</i>	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) <i>Falcon manufacturer only</i> 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

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

OPHTHALMICS, ANTI-INFLAMMATORIES

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

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

OPHTHALMICS, ANTI-INFLAMMATORY / IMMUNOMODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RESTASIS (cyclosporine) RESTASIS MULTIDOSE (cyclosporine) XIIDRA (lifitegrast)	CEQUA (cyclosporine) ^{QL} EYSUVIS (loteprednol etabonate) ^{QL} MIEBO (perfluorohexyloctane) TYRVAYA (varenicline tartrate) ^{QL} VERKAZIA (cyclosporine emulsion) VEVYE (cyclosporine) ^{NR}	<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

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
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

OPHTHALMICS, GLAUCOMA

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

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

OPHTHALMICS, GLAUCOMA (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
OTHER		
RHOPRESSA (netarsudil) ^{CL} ROCKLATAN (netarsudil and latanoprost) ^{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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Rhopressa and Rocklatan: Electronically approved for patients who have a trial of ONE generic agent, within ophthalmics - glaucoma within 60 days

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;">Opioid Dependence Treatment PA Form Opioid Dependence Treatment 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 NASAL(Rx), SYR, VIAL naltrexone TAB	KLOXXADO (naloxone) NASAL naloxone (generic Narcan) OTC NASAL NARCAN (naloxone) NASAL NARCAN (naloxone) NASAL OTC OPVEE (nalmeffene)^{AL} NASAL ZIMHI (naloxone) SYR	<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

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

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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

OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CIPRO HC (ciprofloxacin/hydrocortisone) CIPRODEX (ciprofloxacin/dexamethasone) ciprofloxacin/dexamethasone (generic CIPRODEX) neomycin/polymyxin/hydrocortisone (generic Cortisporin) ofloxacin (generic Floxin)	ciprofloxacin ciprofloxacin/fluocinolone (generic Otovel) CORTISPORIN TC (colistin/neomycin thonzonium/hydrocortisone) OTOVEL (ciprofloxacin/fluocinolone)	<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^{QL} tadalafil (generic for Adcirca) ^{CL} TRACLEER (bosentan) TAB TYVASO (treprostinil) INHALATION VENTAVIS (iloprost) INHALATION	ADEMPAS (riociguat) ^{CL} ADCIRCA (tadalafil) ^{CL} bosentan (generic Tracleer) TAB LETAIRIS (ambrisentan) LIQREV (sildenafil) ^{NR} SUSP OPSUMIT (macitentan) ORENITRAM ER (treprostinil) sildenafil (generic Revatio) ^{CL} SUSP, TAB TADLIQ (tadalafil) SUSP TRACLEER (bosentan) TAB FOR SUSPENSION TYVASO DPI (treprostinil) 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 (Liqrev, generic Revatio): Requires clinical reason why preferred Revatio® suspension cannot be used

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

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHILD MVI (mvi, ped mvi no. 19/FA, ped mvi no. 17) OTC CHEW	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 MVI-IRON OTC CHEW (ped mvi no. 91/iron fum)	FLORIVA (ped mvi no.85/fluoride) CHEW	
CHILDREN'S CHEWABLES OTC (ped mvi no. 25/FA, ped mvi no. 31 /iron/FA, ped mvi no.17/iron sulf)	FLORIVA PLUS (ped mvi no.161/fluoride) OTC DROP	
CHILDREN'S VITAMINS W/ IRON CHEW OTC (mvi with iron)	MULTI-VIT-FLOR (ped mvi no.205/fluoride) CHEW	
FLUORIDE/VITAMINS A,C,AND D DROPS (ped mvi A,C,D3 no.21/fluoride)	POLY-VI-FLOR (ped mvi no.217/fluoride, ped mvi no. 205/fluoride) CHEW	
MULTIVITAMINS W/ FLUORIDE (PEDI MVI NO.2 W-FLUORIDE) DROPS	POLY-VI-FLOR (ped mvi no.213 w/fluoride) DROPS	
MULTIVITS W/ IRON & FLUORIDE DROPS (ped mvi no. 45/fluoride/iron)	POLY-VI-FLOR W/ IRON (ped mvi no. 205/fluoride/iron) CHEW	
PED MVI NO. 16 w/ FLUORIDE CHEW	POLY-VI-FLOR W/ IRON (ped mvi no. 214/fluoride/iron) DROP	
PED MVI NO.17 W/ FLUORIDE CHEW	QUFLORA (ped mvi no.84/fluoride, ped mvi no. 63/fluoride, ped mvi no. 83/fluoride)	
POLY-VITAMIN (ped mvi no. 212) DROPS OTC	QUFLORA FE (ped mvi 142/iron/fluoride, ped mvi no. 151/iron/fluoride) CHEW	
POLY-VITAMIN W/ IRON (ped mvi no. 207 w/ferrous sulf) DROPS OTC	QUFLORA (ped mvi no.157/ fluoride) OTC	
TRI-VI-SOL (vit A palmitate/vit C/vit D3)	TRI-VI-FLOR (ped mvi A,C,D3 no.38/fluoride) DROPS	
TRI-VITAMIN W/ FLUORIDE (ped mvi A,C, D3 no. 21/fluoride)		

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
AL– Age Limit

QL – Quantity/Duration Limit
NR – Product was not reviewed - New Drug criteria will apply

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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) PWD PACK, TAB	AURYXIA (ferric citrate) calcium acetate CAPS lanthanum (generic FOSRENOL) PHOSLYRA (calcium acetate) RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate) PWD PACK sevelamer HCl (generic Renagel) sevelamer carbonate (generic Renvela) VELPHORO (sucroferric oxyhydroxide) XPHOZAH (tenapanor) ^{NR} TAB	<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

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

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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

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

PRENATAL VITAMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>COMPLETENATE CHEW TAB EXPECTA PRENATAL OTC FE C/FA FE C/MIT C/MIT B12/FA OTC MARNATAL-F O-CAL FA PNV2/IRON B-G SUC-P/FA/OMEGA-3 PNV 11-IRON FUM-FOLIC ACID-OM3 PNV NO.118/IRON FUMARATE/FA CHEW TAB PNV NO.15/IRON FUM & PS CMP/FA PNV W-CA NO.40/IRON FUM/FA CMB NO.1 PNV WITH CA,NO.72/IRON/FA PNV#16/IRON FUM & PS/FA/OM-3 PNV2/IRON B-G SUC-P/FA/OMEGA-3 PRENATAL VIT #76/IRON,CARB/FA PRENATAL VIT NO.78/IRON/FA PRENATAL VIT/FE FUMARATE/FA OTC PUREFE OB PLUS PUREFE PLUS STUART ONE OTC TRINATAL RX 1 VITAFOL CHEW TAB VITAFOL ULTRA</p>	<p>CITRANATAL B-CALM COMPLETENATE CHEW TAB DERMACINRX PRENATRIX OTC DERMACINRX PRETRATE TAB OTC ENBRACE HR MULTI-MAC OTC NATAL PNV (pnv no.164/iron/folate no.6)^{NR} NESTABS NESTABS ABC NESTABS DHA NESTABS ONE OB COMPLETE ONE OB COMPLETE PETITE OB COMPLETE PREMIER OB COMPLETE TAB OB COMPLETE WITH DHA PNV COMBO#47/IRON/FA #1/DHA PNV WITH CA NO.68/IRON/FA NO.1/DHA PNV WITH CA,NO.72/IRON/FA PNV WITH CA,NO.74/IRON/FA OTC PNV119/IRON FUMARATE/FA/DSS PRENATAL + DHA OTC PRENATAL MULTI OTC PRENATE AM PRENATE CHEW TAB PRENATE DHA PRENATE ELITE PRENATE ENHANCE PRENATE ESSENTIAL PRENATE MINI PRENATE PIXIE PRENATE RESTORE PRENATE STAR PRIMACARE SELECT-OB + DHA SELECT-OB CHEW TAB TENDERA-OB OTC TRICARE TRINATAL RX 1 TRISTART DHA VITAFOL FE+ VITAFOL NANO VITAFOL-OB VITAFOL-OB+DHA VITAFOL-ONE WESTGEL DHA</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

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

PROTON PUMP INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DEXILANT (dexlansoprazole) omeprazole (generic Prilosec) RX pantoprazole (generic Protonix) ^{QL} PROTONIX SUSP (pantoprazole)	dexlansoprazole (generic Dexilant) esomeprazole magnesium (generic Nexium) RX^{QL} esomeprazole magnesium (generic Nexium) OTC^{QL} esomeprazole strontium KONVOMEF (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 preferred Dexilant (dexlansoprazole), 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 (lansoprazole) 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

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

AL– Age Limit

QL – Quantity/Duration Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BENZODIAZEPINES		
temazepam 15 mg, 30 mg (generic for Restoril)	estazolam (generic for ProSom) temazepam (generic for Restoril) 7.5 mg, 22.5 mg triazolam (generic for Halcion)	<p>Benzodiazepines Criteria</p> <ul style="list-style-type: none"> ▪ Non-preferred agents require a trial of the preferred benzodiazepine agent ▪ temazepam 7.5/22.5 mg: Requires clinical reason why 15 mg/30 mg 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/doxepin Tablet: 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 < 10 mg ○ Age greater than 65 years old or hepatic impairment (3 mg dose will be approved if this criteria is met) ▪ zolpidem/zolpidem ER: Maximum daily dose for females: zolpidem 5 mg; zolpidem ER 6.25 mg ▪ zolpidem SL: Requires clinical reason why half of zolpidem tablet cannot be used or documented swallowing disorder
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 Hetlioiz) ^{CL} zolpidem^{QL} CAP zolpidem ER (generic for Ambien CR) zolpidem SL (generic for Intermezzo)	

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
AL– Age Limit

QL – Quantity/Duration Limit
NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
baclofen (generic Lioresal) chlorzoxazone (generic Parafon Forte) cyclobenzaprine (generic Flexeril) ^{QL} methocarbamol (generic Robaxin) tizanidine TAB (generic Zanaflex)	baclofen (generic Fleqsuvy) ^{NR,QL} SUSP baclofen (generic Ozobax) ^{QL} SOLN baclofen (generic Ozobax DS) ^{NR} SOLN carisoprodol (generic Soma) ^{CL,QL} carisoprodol compound cyclobenzaprine ER (generic Amrix) ^{CL} dantrolene (generic Dantrium) FEXMID (cyclobenzaprine ER) FLEQSUVY (baclofen) ^{QL} SUSP LORZONE (chlorzoxazone) ^{CL} LYVISPAH (baclofen) ^{QL} GRANULES metaxalone (generic Skelaxin) NORGESIC FORTE (orphenadrine/ASA/caffeine) orphenadrine ER PARAFON FORTE (chlorzoxazone) tizanidine CAPS ZANAFLEX (tizanidine) CAPS, TAB	<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[®] 250 mg: Requires clinical reason why 350 mg generic strength cannot be used ▪ Zanaflex[®] Capsules: Requires clinical reason generic cannot be used

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
 AL– Age Limit

QL – Quantity/Duration Limit
 NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
LOW POTENCY		
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 HYDROXYM (hydrocortisone) GEL TEXACORT (hydrocortisone)	<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
MEDIUM POTENCY		
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 acetone (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)	<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

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
AL– Age Limit

QL – Quantity/Duration Limit
NR – Product was not reviewed - New Drug criteria will apply

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

STEROIDS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HIGH POTENCY		
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)	<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
VERY HIGH POTENCY		
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)	<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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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 DYANAVEL XR (amphetamine)^{QL} VYVANSE (lisdexamfetamine) ^{QL} CAPS, CHEWABLE	ADZENYS XR (amphetamine) amphetamine ER (generic Adzenys ER) SUSP amphetamine salt combination ER (generic for Adderall XR) amphetamine salt combination ER (generic Mydayis) ^{AL, NR} CAP amphetamine sulfate (generic for Evekeo) dextroamphetamine (generic for Dexedrine) dextroamphetamine SOLN (generic Procentra) dextroamphetamine ER (generic for Dexedrine ER) EVEKEO ODT (amphetamine sulfate) lisdexamfetamine (generic Vyvanse Chew)^{AL, QL} CHEW lisdexamfetamine (generic Vyvanse)^{AL, QL} CAP methamphetamine (generic for Desoxyn) MYDAYIS (amphetamine salt combo) ^{QL} XELSTRYM (detroamphetamine)^{AL, QL} PATCH ZENZEDI (dextroamphetamine)	Drug-specific criteria: <ul style="list-style-type: none"> ▪ Procentra/ dextroamphetamine soln: May be approved with documentation of swallowing disorder ▪ Zenedi[®]: Requires clinical reason generic dextroamphetamine IR cannot be used

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Methylphenidate type		
CONCERTA (methylphenidate ER) ^{QL} 18 mg, 27 mg, 36 mg, 54 mg DAYTRANA PATCH (methylphenidate) ^{QL} dexmethylphenidate (generic for Focalin IR) dexmethylphenidate (generic Focalin XR) METHYLIN SOLN (methylphenidate) methylphenidate (generic Ritalin) methylphenidate SOLN (generic Methylin) QUILLICHEW ER CHEWTAB (methylphenidate) QUILLIVANT XR (methylphenidate) SUSP	ADHANSIA XR (methylphenidate) ^{QL} APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphenidate and dexmethylphenidate) ^{QL} COTEMPLA XR-ODT (methylphenidate) ^{QL} FOCALIN IR (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) JORNAY PM (methylphenidate) ^{QL} methylphenidate CHEW methylphenidate ER (45 mg and 63 mg)^{QL} methylphenidate 50/50 (generic Ritalin LA) methylphenidate 30/70 (generic Metadate CD) methylphenidate ER 18 mg, 27 mg, 36 mg, 54 mg (generic Concerta) ^{QL} methylphenidate ER CAP (generic Aptensio XR) ^{QL} methylphenidate ER (generic Metadate ER) methylphenidate ER 72 mg (generic RELEXXII) ^{QL} methylphenidate ER (generic Ritalin SR) methylphenidate TD24 ^{AL} PATCH (generic Daytrana) RELEXXII ER (methylphenidate 45mg and 63mg)^{AL,QL} TAB RITALIN (methylphenidate)	<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/methylphenidate patch: May be approved in history of substance use disorder by parent, caregiver, or patient. May be approved with documentation of difficulty swallowing ▪ QuilliChew ER: May be approved for children ≤ 12 years of age OR with documentation of difficulty swallowing

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

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> <ul style="list-style-type: none"> Non-preferred agents will be approve for patients who have failed a trial of ONE preferred agent within this class
atomoxetine (generic Strattera) ^{QL} guanfacine ER (generic Intuniv) ^{QL} QELBREE (viloxazine) ^{QL}	clonidine ER (generic Kapvay) ^{QL} STRATTERA (atomoxetine)	
ANALEPTICS		<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
	armodafinil (generic Nuvigil) ^{CL} modafanil (generic Provigil) ^{CL} SUNOSI (solriamfetol) ^{CL,QL} WAKIX (pitolisant) ^{CL,QL}	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

TETRACYCLINES

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

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**

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

THYROID HORMONES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
levothyroxine TAB (generic Synthroid) liothyronine TAB (generic Cytomel) thyroid, pork TAB UNITHROID (levothyroxine)	ERMEZA (levothyroxine) SOLN EUTHYROX (levothyroxine) LEVO-T (levothyroxine) levothyroxine CAPS (generic Tirosint) 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) 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		
Sulfite-Free ROWASA (mesalamine) mesalamine SUPPOSITORY (generic Canasa)	CANASA (mesalamine) mesalamine ENEMA (generic Rowasa) ROWASA (mesalamine) UCERIS (budesonide)	

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

Entire January PDL **Highlighted in Red** that become effective January 19, 2024

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

UTERINE DISORDER TREATMENT

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MYFEMBREE (relugolix/ estradiol/ norethindrone acetate) ^{AL, CL, QL} ORIAHNN (elagolix/ estradiol/ norethindrone) ^{AL, CL} ORILISSA (elagolix sodium) ^{QL, CL}		Drug-specific criteria: <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
BIDIL (isosorbide dinitrate/ hydralazine) ^{CL} isosorbide dinitrate TAB isosorbide dinitrate ER, SA TAB (generic Dilatrate-SR/Isordil) isosorbide mono IR/SR TAB nitroglycerin SUBLINGUAL, TRANSDERMAL nitroglycerin ER TAB	GONITRO (nitroglycerin) isosorbide dinitrate TAB (Oceanside Pharm MFR only) isosorbide dinitrate/hydralazine (Bidil) ^{CL} NITRO-BID OINT (nitroglycerin) NITRO-DUR (nitroglycerin) nitroglycerin TRANSLINGUAL (generic Nitrolingual) VERQUVO (vericiguat) ^{AL, CL, QL}	<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%

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

AL– Age Limit

QL – Quantity/Duration Limit

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