



Jim Pillen, Governor

## Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

January PDL

PDL updated January 2, 2026, **Highlights** indicate change from previous posting

For the most up to date list of covered drugs consult the **Drug Lookup** on the Nebraska Medicaid website at <https://ne.primetherapeutics.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].
- **Opioids** – The maximum opioid dose covered is 90 Morphine Milligram Equivalents (MME) per day.

### 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**

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**ACNE AGENTS, TOPICAL**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
adapalene (generic Differin) <sup>CL</sup> <b>GEL (OTC/Rx), GEL PUMP</b> adapalene/BPO (generic Epiduo) <sup>CL</sup> benzoyl peroxide (BPO) <b>WASH, LOTION</b> benzoyl peroxide <b>GEL</b> OTC clindamycin/BPO (generic BenzaClin) <b>GEL, PUMP</b> clindamycin/BPO (generic Duac) clindamycin phosphate <b>PLEDGET</b> clindamycin phosphate <b>SOLUTION</b> erythromycin <b>GEL</b> erythromycin <b>SOLN</b> erythromycin-BPO (generic for Benzamycin) tretinoin (generic Avita, Retin-A) <sup>AL, CL</sup> <b>CREAM, GEL</b>	adapalene (generic Differin) <sup>CL</sup> <b>CREAM</b> adapalene/BPO (generic Epiduo Forte) <sup>CL</sup> ALTRENO (tretinoin) <sup>AL, CL</sup> AMZEEQ (minocycline) ATRALIN (tretinoin) <sup>CL</sup> AVAR (sulfacetamide sodium/sulfur) AVITA (tretinoin) <sup>CL</sup> AZELEX (azelaic acid) BENZEFOAM (benzoyl peroxide) benzoyl peroxide <b>CLEANSE, CLEANSING BAR</b> OTC benzoyl peroxide <b>FOAM</b> (generic BenzePro) benzoyl peroxide <b>GEL Rx</b> benzoyl peroxide <b>TOWELETTE</b> OTC clindamycin <b>FOAM, LOTION</b> clindamycin <b>GEL</b> clindamycin phosphate (generic Clindagel) <b>GEL</b> clindamycin/BPO (generic Acanya) <b>GEL</b> clindamycin/BPO <b>PUMP</b> (generic Onexton) <sup>AL</sup> clindamycin/tretinoin (generic Veltin, Ziana) dapsone (generic Aczone) DIFFERIN (adapalene) <b>CREAM, GEL-OTC, GEL PUMP, LOTION</b> erythromycin <b>PLEDGET</b> EVOCLIN (clindamycin) <b>FOAM</b>	<ul style="list-style-type: none"> <li>▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class</li> <li>▪ All retinoid products have a maximum age limit of 20 without a diagnosis of acne</li> </ul>

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

Page 2 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**ACNE AGENTS, TOPICAL (Continued)**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<p>FABIOR (tazarotene) <b>FOAM</b> NEUAC (clindamycin/BPO) OVACE PLUS (sulfacetamide sodium) RETIN-A MICRO (tretinoin) sulfacetamide sulfacetamide/sulfur sulfacetamide sodium/ sulfur <b>CLEANER</b> SUMADAN (sulfacetamide/sulfur) tazarotene (generic Tazorac) <b>CREAM</b> tazarotene <b>FOAM</b> (generic Fabior) tazarotene <b>GEL</b> (generic Tazorac) TRETIN-X (tretinoin) tretinoin (generic Atralin) <sup>AL</sup><b>GEL</b> tretinoin microspheres (generic Retin-A Micro) <sup>AL</sup><b>GEL, GEL PUMP</b> WINLEVI (clascoterone)<sup>AL</sup></p>	<ul style="list-style-type: none"><li>▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class</li><li>▪ All retinoid products have a maximum age limit of 20 without a diagnosis of acne</li></ul>

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

Page 3 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**ALZHEIMER'S AGENTS**

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**ANALGESICS, OPIOID LONG-ACTING**

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

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

Page 5 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**ANALGESICS, OPIOID SHORT-ACTING QL**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<b>ORAL</b>	
acetaminophen/codeine <b>ELIXIR, TAB</b> codeine <b>TAB</b> hydrocodone/APAP <b>SOLN, TAB</b> hydrocodone/ibuprofen hydromorphone <b>TAB</b> morphine <b>CONC SOLN, SOLN, TAB</b> oxycodone <b>TAB, SOLN</b> oxycodone/APAP tramadol 50 <b>TAB<sup>AL</sup></b> (generic Ultram)	butalbital/caffeine/APAP/codeine butalbital compound w/codeine (butalbital/ASA/caffeine/codeine) carisoprodol compound-codeine (carisoprodol/ASA/codeine) dihydrocodeine/APAP/caffeine hydrocodone/APAP <b>SOLN</b> (generic Zolvit) <sup>NR</sup> hydromorphone <b>LIQUID,</b> <b>SUPPOSITORY</b> (generic Dilaudid) levorphanol meperidine (generic Demerol) morphine <b>SUPPOSITORIES</b> NALOCET (oxycodone/APAP) oxycodone <b>CAPS</b> oxycodone/APAP <b>SOLN</b> oxycodone <b>CONCENTRATE</b> oxymorphone IR (generic Opana) pentazocine/naloxone ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol) <sup>AL</sup> tramadol 25mg tramadol 75mg tramadol 100mg (generic Ultram) <sup>AL</sup> tramadol (generic Qdolo) <sup>AL,QL</sup> <b>SOLN</b> tramadol/APAP (generic Ultracet)	<ul style="list-style-type: none"> <li>▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class within the last 12 months</li> <li>▪ Note: for short acting opiate tablets and capsules there is a maximum quantity limit of #150 per 30 days.</li> <li>▪ Opiate limits for opiate naïve patients will consist of: <ul style="list-style-type: none"> <li>-prescriptions limited to a 7 day supply, AND</li> <li>-initial opiate prescription fill limited to maximum of 50 Morphine Milligram Equivalents (MME) per day</li> </ul> <p>These limits may only be exceeded with patient specific documentation of medical necessity, with examples such as, cancer diagnosis, end-of-life care, palliative care, Sickle Cell Anemia, or prescriber attestation that patient is not recently opiate naive</p> </li> </ul>

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

Page 6 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>NASAL</b>	butorphanol <b>SPRAY<sup>QL</sup></b>	Drug-specific criteria: ▪ <b>Actiq®/Fentora®/ fentanyl transmucosal/Onsolis</b> : Approved only for diagnosis of cancer AND current use of long-acting opiate
<b>BUCCAL/TRANSMUCOSAL <sup>CL</sup></b>	fentanyl <b>TRANSMUCOSAL</b> (generic <b>Actiq<sup>CL</sup></b> ) <b>FENTORA (fentanyl)<sup>CL</sup></b>	

**ANDROGENIC AGENTS (TOPICAL) <sup>CL</sup>**

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

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

Page 7 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**ANGIOTENSIN MODULATORS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<b>ACE INHIBITORS</b>	
benazepril (generic Lotensin) enalapril (generic Vasotec) lisinopril (generic Prinivil, Zestril) ramipril (generic Altace)	captopril (generic Capoten) EPANED (enalapril) <sup>CL</sup> <b>ORAL SOLN</b> enalapril (generic for Epaned) <sup>CL</sup> <b>ORAL SOLN</b> fosinopril (generic Monopril) moexepril (generic Univasc) perindopril (generic Aceon) QBRELIS (lisinopril) <sup>CL</sup> <b>ORAL SOLN</b> quinapril (generic Accupril) trandolapril (generic Mavik)	<ul style="list-style-type: none"> <li>▪ Non-preferred agents will be approved for patients who have failed TWO preferred agents within the last 12 months</li> <li>▪ Non-preferred combination products may be covered as individual prescriptions without prior authorization</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li>▪ <b>Epaned/enalapril oral solution/Qbrelis oral solution:</b> Clinical reason why oral tablet is not appropriate</li> </ul>
	<b>ACE INHIBITOR/DIURETIC COMBINATIONS</b>	
enalapril/HCTZ (generic Vaseretic) lisinopril/HCTZ (generic Prinzide, Zestoretic)	benazepril/HCTZ (generic Lotensin HCT) captopril/HCTZ (generic Capozide) fosinopril/HCTZ (generic Monopril HCT) moexipril/HCTZ (generic Uniretic) quinapril/HCTZ (generic Accuretic)	
	<b>ANGIOTENSIN RECEPTOR BLOCKERS</b>	
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

Page 8 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**ANGIOTENSIN MODULATORS (Continued)**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS</b>		
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)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed TWO preferred agents within the same subclass within the last 12 months</li> <li>Non-preferred combination products may be covered as individual prescriptions without prior authorization</li> </ul>
<b>ANGIOTENSIN MODULATOR/ CALCIUM CHANNEL BLOCKER COMBINATIONS</b>		
amlodipine/benazepril (generic Lotrel) amlodipine/olmesartan (generic Azor) amlodipine/valsartan (generic Exforge)	amlodipine/olmesartan/HCTZ (generic Tribenzor) amlodipine/telmisartan (generic Twynsta) amlodipine/valsartan/HCTZ (generic Exforge HCT) PRESTALIA (perindopril/amlodipine) trandolapril/verapamil (generic Tarka)	
<b>DIRECT RENIN INHIBITORS<sup>CL</sup></b>		
	aliskiren (generic Tekturna) <sup>QL</sup>	
<b>DIRECT RENIN INHIBITOR COMBINATIONS<sup>CL</sup></b>		
	TEKTURNA/HCTZ (aliskiren/HCTZ)	
<b>NEPRILYSIN INHIBITOR COMBINATION</b>		
ENTRESTO (sacubitril/valsartan) <sup>CL,QL</sup>	ENTRESTO (sacubitril/valsartan) <sup>CL,QL</sup> <b>SPRINKLE CAP</b> sacubitril/valsartan (generic Entresto) <sup>CL,NR,QL</sup>	<p><b>Direct Renin Inhibitors/Direct Renin Inhibitor Combinations:</b> May be approved with a history of TWO preferred ACE Inhibitors or Angiotensin Receptor Blockers within the last 12 months</p> <p><b>Drug Specific Criteria</b></p> <ul style="list-style-type: none"> <li><b>Entresto/ sacubitril-valsartan:</b> May be approved in patients ages <math>\geq 1</math> years old and with a diagnosis of heart failure</li> </ul>

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

Page 9 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**ANTHELMINTICS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
albendazole (generic Albenza) BILTRICIDE (praziquantel) ivermectin (generic Stromectol)	EMVERM (mebendazole) <sup>CL</sup> praziquantel (generic Biltricide) STROMECTOL (ivermectin)	<ul style="list-style-type: none"><li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months</li></ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"><li><b>Emverm:</b> Approval will be considered for indications not covered by preferred agents</li></ul>

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

Page 10 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**ANTI-ALLERGENS, ORAL**

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**ANTIBIOTICS, GASTROINTESTINAL**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metronidazole <b>TABLET</b> neomycin tinidazole (generic Tindamax) <sup>CL</sup> vancomycin (generic Firvanq) <sup>QL</sup> <b>SOLN</b>	AEMCOLO (rifamycin) <b>TAB</b> DIFICID (fidaxomicin) <sup>CL</sup> <b>TAB, SUSP</b> fidaxomicin (generic Difidic) <sup>CL,NR</sup> <b>TAB</b> FIRVANQ (vancomycin) <sup>QL</sup> <b>SOLN</b> LIKMEZ (metronidazole) <b>SUSP</b> metronidazole <sup>CL</sup> <b>CAPS</b> metronidazole 125mg <b>TAB</b> nitazoxanide (generic Alinia) <b>TAB<sup>AL, CL, QL</sup></b> paromomycin SOLOSEC (secnidazole) vancomycin <b>CAPS</b> (generic Vancocin) <sup>CL</sup> VOWST (fecal microbiota spores) <sup>AL,QL</sup>	<ul style="list-style-type: none"> <li>▪ Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li>▪ <b>Alinia /nitazoxanide tablet:</b> Trial and failure with metronidazole is required for a diagnosis of giardiasis</li> <li>▪ <b>Difidic®/ fidaxomicin:</b> For diagnosis of C. difficile diarrhea (pseudomembranous colitis), trial and failure or intolerance to oral vancomycin is required. For diagnosis of relapsed or recurrent C. difficile, an appropriate ICD-10 diagnosis code must be submitted for coverage.</li> <li>▪ <b>Flagyl®/Metronidazole 375mg capsules and / Metronidazole 750mg ER tabs:</b> Clinical reason why the generic regular release cannot be used</li> <li>▪ <b>tinidazole:</b>  Approvable diagnoses include:  Giardia  Amebiasis intestinal or liver abscess  Bacterial vaginosis or trichomoniasis</li> <li>▪ <b>vancomycin capsules:</b> Requires patient specific documentation of why the Firvanq/vancomycin solution is not appropriate for patient</li> </ul>

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

Page 12 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**ANTIBIOTICS, INHALED<sup>CL</sup>**

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

**ANTIBIOTICS, TOPICAL**

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

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

Page 13 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

## ANTIBIOTICS, VAGINAL

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**ANTIEMETICS/ANTIVERTIGO AGENTS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>CANNABINOIDs</b>		
dronabinol (generic Marinol) <sup>AL</sup>		<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the same subclass.</li> </ul>
<b>5HT3 RECEPTOR BLOCKERS</b>		
ondansetron (generic Zofran/Zofran ODT) <sup>QL</sup>	ANZEMET (dolasetron) granisetron (generic Kytril) ondansetron 16mg ODT (generic Zofran ODT) SANCUSO (granisetron) <sup>CL</sup>	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Akynzeo®:</b> Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist</li> <li><b>Regimens include:</b> AC combination (Doxorubicin or Epirubicin with Cyclophosphamide), Aldesleukin, Amifostine, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carmustine, Carboplatin, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Dactinomycin, Daunorubicin, Epirubicin, Etoposide, Hexamethylmelamine, Idarubicin, Ifosfamide, Imatinib, Interferon <math>\alpha</math>, Irinotecan, Mechlorethamine, Melphalan, Methotrexate, Oxaliplatin, Procarbazine, Streptozotocin, Temozolomide</li> </ul>
<b>NK-1 RECEPTOR ANTAGONIST</b>		
aprepitant (generic Emend) <b>CAPS</b> <sup>QL</sup>	AKYNZEO (netupitant/palonosetron) <sup>CL</sup> aprepitant (generic Emend) <b>PACK</b> EMEND (aprepitant) <b>CAPS, PACK, POWDER</b> <sup>QL</sup>	<ul style="list-style-type: none"> <li><b>Diclegis/doxylamine-pyridoxine)/ Bonjesta:</b> Approved only for treatment of nausea and vomiting of pregnancy</li> <li><b>Sancuso®:</b> Documentation of oral dosage form intolerance</li> </ul>
<b>TRADITIONAL ANTIEMETICS</b>		
DICLEGIS (doxylamine/pyridoxine) <sup>CL,QL</sup> dimenhydrinate (generic Dramamine) <b>OTC</b> meclizine (generic Antivert) metoclopramide (generic Reglan) phosphoric acid/dextrose/fructose (generic Emetrol) <b>SOLN</b> prochlorperazine(generic Compazine) promethazine (generic Phenergan) <b>SYRUP, TAB</b> promethazine 12.5mg, 25mg <b>SUPPOSITORY</b> scopolamine <b>TRANSDERMAL</b> TRANSDERM-SCOP (scopolamine)	BONJESTA (doxylamine/pyridoxine) <sup>CL,QL</sup> COMPROM (prochlorperazine) doxylamine/pyridoxine (generic Diclegis) <sup>CL,QL</sup> prochlorperazine <b>SUPPOSITORY</b> (generic Compazine) promethazine <b>SUPPOSITORY</b> 50mg trimethobenzamide <b>TAB</b> (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

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**

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**ANTIFUNGALS, ORAL**

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**ANTIFUNGALS, TOPICAL**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ANTIFUNGAL</b>		
clotrimazole <b>CREAM</b> (generic Lotrimin) RX, OTC clotrimazole (generic Lotrimin) <b>SOLN-Rx</b> ketoconazole <b>CREAM, SHAMPOO</b> (generic Nizoral) miconazole <b>CREAM, POWDER</b> OTC nystatin terbinafine OTC (generic Lamisil AT) tolnaftate <b>AERO-POWDER</b> OTC, <b>CREAM-OTC, SOLN-OTC</b> (generic Tinactin)	ALEVAZOL (clotrimazole) OTC ciclopirox <b>CREAM, GEL, SUSP</b> (generic Ciclodan, Loprox) ciclopirox <b>SHAMPOO</b> (generic Loprox) clotrimazole <b>SOLN</b> OTC DESENEX <b>POWDER</b> OTC (miconazole) econazole (generic Spectazole) ERTACZO (sertaconazole) FUNGOID (miconazole) <b>OTC</b> ketoconazole <b>FOAM<sup>CL</sup></b> (generic Extina, Ketodan) LOPROX (ciclopirox) <b>SUSP, SHAMPOO, CREAM</b> LOTRIMIN AF <b>CREAM</b> OTC (clotrimazole) LOTRIMIN ULTRA (butenafine) miconazole OTC <b>OINT, SPRAY, SOLN</b> miconazole/zinc oxide/petrolatum (generic Vusion) naftifine <b>CREAM, GEL</b> (generic Naftin) oxiconazole (generic Oxistat) tavaborole <b>SOLN<sup>CL</sup></b> (generic Kerydin) tolnaftate <b>POWDER</b> OTC TRIPENICOL (undecylenic acid) <b>CREAM-OTC</b> VOTRIZA-AL (clotrimazole) <b>LOTION</b> OTC	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within the last 6 months</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Extina/ Ketodan/ ketoconazole foam:</b> Requires trial and failure or contraindication to other ketoconazole forms</li> <li><b>tavaborole:</b> Approved diagnoses include Onychomycosis of the toenails due to <i>T. rubrum</i> OR <i>T. Mentagrophytes</i></li> <li><b>ciclopirox nail lacquer:</b> No trial required in diabetes, peripheral vascular disease (PWD), immunocompromised OR contraindication to oral terbinafine</li> </ul>
<b>ANTIFUNGAL/STEROID COMBINATIONS</b>		
clotrimazole/betamethasone <b>CREAM</b> (generic Lotrisone) nystatin/triamcinolone (generic Mycolog) <b>CREAM, OINT</b>	clotrimazole/betamethasone <b>LOTION</b> (generic Lotrisone)	

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**

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**ANTIHISTAMINES, MINIMALLY SEDATING**

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

**ANTIHYPERTENSIVES, SYMPATHOLYTICS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clonidine TAB (generic Catapres) <b>clonidine TRANSDERMAL</b> guanfacine (generic Tenex) methyldopa	clonidine ER (generic Nexilon) <b>JAVADIN (clonidine)<sup>NR</sup> SOLN</b> methyldopa/hydrochlorothiazide NEXICLON XR (clonidine ER) <b>TAB</b>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a 30-day trial with ONE preferred agent within this drug class</li> </ul> <p>Drug Specific Criteria</p> <ul style="list-style-type: none"> <li><b>Nexilon/ clonidine ER:</b> Clinical reason why the preferred clonidine tablet or transdermal cannot be used</li> </ul>

**ANTIHYPERURICEMICS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol (generic Zyloprim) colchicine <b>TAB</b> (generic Colcrys) probenecid	allopurinol 200mg colchicine <b>CAPS</b> (generic Mitigare) febuxostat (generic Uloric) <sup>CL</sup> <b>GLOPERBA SOLN</b> (colchicine) <sup>CL,QL</sup> MITIGARE (colchicine) probenecid/colchicine (generic Col-Probenecid)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class</li> <li><b>Gloperba:</b> Approved for documented swallowing disorder</li> <li><b>Uloric/febuxostat:</b> Clinical reason why allopurinol cannot be used</li> </ul>

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**

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**ANTIMIGRAINE AGENTS, OTHER**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AIMOVIG (erenumab-aoee) <sup>CL,QL</sup>	BREKIYA (dihydroergotamine mesylate) <sup>NR</sup>	
AJOVY (fremanezumab-vfrm) <sup>CL, QL</sup> <b>PEN, Autoinjector</b>	diclofenac (generic Cambia) <b>POWDER</b>	
AJOVY (fremanezumab-vfrm) <b>Autoinjector 3-pack<sup>CL,QL</sup></b>	dihydroergotamine mesylate <b>NASAL</b>	
EMGALITY 120 mg/mL (galcanezumab-gnlm) <sup>CL, QL</sup> <b>PEN, SYRINGE</b>	ELYXYB (celecoxib) <sup>AL,QL</sup> <b>SOLN</b>	
NURTEC ODT (rimegepant) <sup>AL,CL,QL</sup>	EMGALITY 100 mg (galcanezumab-gnlm) <sup>CL,QL</sup> <b>SYR</b>	
QULIPTA (atogepant) <sup>AL,CL,QL</sup>	MIGERGOT (ergotamine/caffeine) <b>RECTAL</b>	
UBRELVY (ubrogepant) <sup>AL,CL, QL</sup> <b>TAB</b>	MIGRALAN (dihydroergotamine) <b>NASAL</b>	
	REYVOW (lasmiditan) <sup>AL, CL,QL</sup> <b>TAB</b>	
	ZAVZPRET (zavegepant) <sup>AL,QL</sup> <b>NASAL</b>	
		<ul style="list-style-type: none"> <li>▪ All non-preferred agents will require a failed trial or contraindication of a preferred agent of the same indication</li> <li>▪ <b>For Acute Treatment:</b> agents will be approved for patients who have a failed trial or a contraindication to two triptans.</li> <li>▪ <b>For Prophylactic Treatment:</b> Require ≥ 4 migraines per month for ≥ 3 months and has tried and failed a ≥ 1 month trial of two medications: antidepressants (amitriptyline, venlafaxine), Beta blockers (propranolol, metoprolol, atenolol), anti-epileptics (divalproex, valproate, topiramate)</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li>▪ <b>Emgality 100mg</b> will only be approved for treatment of Episodic Cluster Headache</li> <li>▪ <b>Nurtec ODT:</b> for use in acute treatment, will be approved for patients who have a failed trial or a contraindication to two triptans. For use in preventative treatment, will be approved for patients who have a failed trial of ONE preferred injectable CGRP.</li> <li>▪ <b>Qulipta:</b> May be approved for patients who have a failed trial of ONE preferred injectable CGRP</li> <li>▪ <b>CGRP Antagonists:</b> Use will be limited to one CGRP for acute use and one CGRP for prophylactic use.</li> </ul>

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ORAL</b>		
rizatriptan (generic Maxalt) rizatriptan ODT (generic Maxalt MLT) sumatriptan	almotriptan (generic Axert) eletriptan (generic Relpax) frovatriptan (generic Frova) IMITREX (sumatriptan) naratriptan (generic Amerge) RELPAX (eletriptan) <sup>QL</sup> sumatriptan/naproxen (generic Treximet) SYMBRAVO (rizatriptan benzoate/meloxicam) <sup>AL,NR</sup> TAB zolmitriptan (generic Zomig)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Zembrace:</b> approved for patients who have failed ALL preferred agents</li> </ul>
<b>NASAL</b>		
IMITREX (sumatriptan) sumatriptan (generic Imitrex Nasal)	TOSYMRA (sumatriptan) zolmitriptan (generic Zomig) ZOMIG (zolmitriptan)	
<b>INJECTABLE</b>		
sumatriptan <b>SYRINGE, VIAL</b>	sumatriptan <b>KIT</b> 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) <b>LOTION</b> EURAX (crotamiton) <b>CREAM, LOTION</b> ivermectin (generic Sklice) <b>LOTION</b> malathion (generic Ovide) PRURADIK (cromtamiton) <sup>NR</sup> <b>LOTION</b> spinosad (generic Natroba) VANALICE (piperonyl butoxide/pyrethrins)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class within the past 6 months</li> </ul>

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**ANTIPARKINSON'S AGENTS, ORAL**

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**ANTIPSORIATICS, ORAL**

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

**ANTIPSORIATICS, TOPICAL**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcipotriene <b>CREAM, OINT, SOLN</b>	calcitriol (generic Vectical) <sup>AL</sup> <b>OINT</b> calcipotriene <b>FOAM</b> (generic Sorilux) calcipotriene/betamethasone <b>OINT</b> (generic Taclonex) calcipotriene/betamethasone <b>SUSP</b> (generic Taclonex Scalp) <b>ENSTILAR</b> (calcipotriene/betamethasone) <b>SORILUX</b> (calcipotriene) <b>ZORYVE 0.3% (roflumilast)<sup>AL</sup> <b>CREAM</b></b> <b>ZORYVE 0.3% (roflumilast)<sup>AL,CL</sup> <b>FOAM</b></b>	<ul style="list-style-type: none"> <li>▪ Non-preferred agents will be approved for patients who have failed a trial with a preferred agent within this drug class</li> </ul> <p><b>Drug-Specific Criteria</b></p> <ul style="list-style-type: none"> <li>• <b>Zoryve Foam</b>- For diagnosis of Seborrheic Dermatitis, requires trial of a topical steroid or a topical calcineurin inhibitor AND trial of a topical antifungal.</li> </ul>

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

## ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ANTI-COVID-19 DRUGS</b>		
PAXLOVID (nirmatrelvir/ritonavir) <sup>CL,QL</sup>		<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a 10-day trial of ONE preferred agent within the same subclass.</li> </ul>
<b>ANTI-HERPETIC DRUGS</b>		
acyclovir (generic Zovirax) famciclovir (generic Famvir) valacyclovir (generic Valtrex)	acyclovir (generic for Zovirax) <sup>CL SUSP</sup>	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Acyclovir Susp:</b> Prior authorization NOT required for children <math>\leq</math> 12 years old</li> <li><b>Paxlovid:</b> Requires a diagnosis of COVID-19 and is limited to 1 dose pack per 30 days</li> <li><b>Xofluza:</b> Requires clinical, patient specific reason that a preferred agent cannot be used</li> </ul>
<b>ANTI-INFLUENZA DRUGS</b>		
oseltamivir (generic Tamiflu) <sup>QL</sup> <b>CAPS, SUSP</b>	rimantadine (generic Flumadine) RELENZA (zanamivir) <sup>QL</sup> TAMIFLU (oseltamivir) <sup>QL</sup> <b>CAPS, SUSP</b> XOFLUZA (baloxavir marboxil) <sup>AL,CL,QL</sup>	

## ANTIVIRALS, TOPICAL

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

## ANXIOLYTICS

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**BETA BLOCKERS, ORAL**

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

## BILE SALTS

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

## BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
fesoterodine (generic Toviaz) <b>MYRBETRIQ (mirabegron)<sup>AL</sup> TAB</b> oxybutynin IR, ER (generic Ditropan/Ditropan XL)	darifenacin ER (generic Enablex) flavoxate HCL GEMTESA (vibegron) <sup>AL,QL</sup> mirabegron ER TAB (generic Myrbetriq) <b>MYRBETRIQ (mirabegron) SUSP<sup>AL,CL,QL</sup></b> oxybutynin 2.5mg OXYTROL (oxybutynin) solifenacin (generic Vesicare) tolterodine IR, ER (generic Detrol/ Detrol LA) TOVIAZ (fesoterodine ER) trospium IR, ER (generic Sanctura/ Sanctura XR) VESICARE (solifenacin) VESICARE LS <b>SUSP</b> (solifenacin) <sup>AL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Myrbetriq suspension:</b> Covered for pediatric patients <math>\geq</math> 3 years old with a diagnosis of Neurogenic Detrusor Overactivity (NDO)</li> </ul>

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

Page 25 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**BONE RESORPTION SUPPRESSION AND RELATED DRUGS**

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

Page 26 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ALPHA BLOCKERS</b>		
alfuzosin (generic Uroxatral) doxazosin (generic Cardura) tamsulosin (generic Flomax) terazosin (generic Hytrin)	CARDURA XL (doxazosin) silodosin (generic Rapaflo) TEZRULY (terazosin) <sup>CL,NR</sup> <b>SOLN</b>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass.</li> </ul>
<b>5-ALPHA-REDUCTASE (5AR) INHIBITORS</b>		
dutasteride (generic Avodart) finasteride (generic Proscar)	dutasteride/tamsulosin (generic Jalyn) ENTADFI (finasteride/tadalafil) finasteride/tadalafil (generic Entadfi) <sup>NR</sup>	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Alfuzosin/dutasteride/finasteride</b> <ul style="list-style-type: none"> <li>Covered for males only</li> </ul> </li> <li><b>Cardura XL®:</b> Requires clinical reason generic IR form cannot be used</li> <li><b>Flomax/ tamsulosin:</b> Covered for males and may be covered for females for a 7-day supply with diagnosis of acute kidney stones</li> <li><b>Jalyn/ dutasteride-tamsulosin:</b> Requires clinical reason why individual agents cannot be used</li> <li><b>Tezruly:</b> Clinical reason why oral tablet is not appropriate</li> </ul>

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

Page 27 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**BRONCHODILATORS, BETA AGONIST**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>INHALERS – Short Acting</b>		
albuterol HFA (generic Proventil HFA) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol HFA)	albuterol HFA (generic ProAir HFA and Ventolin HFA) levalbuterol HFA (generic Xopenex HFA) PROAIR DIGIHALER (albuterol) PROAIR RESPCLICK (albuterol)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass.</li> </ul>
<b>INHALERS – Long Acting</b>		
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)	<p>Drug-specific criteria:  <b>Xopenex/levalbuterol solution:</b> Covered for cardiac diagnoses or side effect of tachycardia with albuterol product</p>
<b>INHALATION SOLUTION</b>		
albuterol (2.5mg/3ml premix or 2.5mg/0.5ml) albuterol low dose (0.63mg/3ml & 1.25mg/3ml)	arformoterol tartrate (generic Brovana) BROVANA (arformoterol) formoterol fumarate (generic Perforomist) levalbuterol (generic for Xopenex) PERFOROMIST (formoterol)	
<b>ORAL</b>		
albuterol <b>SYRUP</b>	albuterol <b>TAB</b> albuterol ER (generic Vospire ER) terbutaline (generic 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**

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**CALCIUM CHANNEL BLOCKERS, ORAL**

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL**

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

**COLONY STIMULATING FACTORS**

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

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

Page 30 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

## CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>All reviewed agents are recommended preferred at this time <i>Only those products for review are listed.</i> Brand name products may be subject to Maximum Allowable Cost (MAC) pricing or require substitution with a generic equivalent  Specific agents can be looked up using the Drug Look-up Tool at: <a href="https://ne.primetherapeutics.com/drug-lookup">https://ne.primetherapeutics.com/drug-lookup</a></p>	<p>AVERI (desogestrel and ethinyl estradiol kit)<sup>NR</sup></p> <p>GALBRIELA (norethindrone/ethinyl estradiol/ferrous fumarate)<sup>NR</sup> <b>CHEW</b></p> <p>LUIZZA (norethindrone ac/eth estradiol)<sup>NR</sup></p> <p>MELEYA (norethindrone)<sup>NR</sup></p> <p>ORQUIDEA (norethindrone)<sup>NR</sup></p> <p>ROSYRAH (levonorgestrel/ ethinyl estradiol/ ethinyl estradiol kit)<sup>NR</sup></p> <p>XARAH FE (norethindrone acetate and ethinyl estradiol and ferrous fumarate)<sup>NR</sup></p> <p>XELRIA FE (norethindrone and ethinyl estradiol and ferrous fumarate)<sup>NR</sup></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

Page 31 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) AGENTS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>INHALERS</b>		
ANORO ELLIPTA (umeclidinium/vilanterol) ATROVENT HFA (ipratropium) COMBIVENT RESPIMAT (albuterol/ ipratropium) SPIRIVA (tiotropium) SPIRIVA RESPIMAT (tiotropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI AEROSPHERE (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium br and formoterol fum) INCRUSE ELLIPTA (umeclidinium) tiotropium (generic Spiriva) TUDORZA PRESSAIR (aclidinium br) umeclidinium/vilanterol (generic Anoro Ellipta) <sup>NR</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass OR Patient specific documentation of inability to use traditional inhaler device.</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Daliresp/roflumilast:</b> 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</li> </ul>
<b>INHALATION SOLUTION</b>		
albuterol/ipratropium (generic Duoneb) ipratropium <b>SOLN</b> (generic Atrovent)	OHTUVAYRE (ensifentrine) inhalation suspension YUPELRI (revefenacin)	<ul style="list-style-type: none"> <li><b>Dupixent</b> (For other indications, see Immunomodulators, Atopic Dermatitis and Asthma therapeutic classes):           <ul style="list-style-type: none"> <li><b>For COPD and an Eosinophilic Phenotype:</b> Requires documentation of inadequately controlled COPD with eosinophils &gt; 300 cells/microliter AND two exacerbations OR one exacerbation that led to hospitalization while on and adherent to a &gt; 90-day trial of triple therapy (LABA + LAMA + ICS). Prescribed by, or in consultation with a pulmonologist, immunologist, or an allergist.</li> </ul> </li> </ul>
<b>ORAL AGENT</b>		
roflumilast (generic Daliresp) <sup>CL, QL</sup>	DALIRESP (roflumilast) <sup>CL, QL</sup>	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**COUGH AND COLD, OPIATE COMBINATION**

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

**CYSTIC FIBROSIS, ORAL**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ALYFTREK (vanzacaftor; tezacaftor; deutivacaftor) <sup>AL,CL</sup> <b>TAB</b> BRONCHITOL (mannitol) <sup>AL,CL,QL</sup> <b>Kalydeco PACKET, TAB</b> (ivacaftor) <sup>QL, AL</sup> <b>ORKAMBI</b> (lumacaftor/ivacaftor) <b>PACKET, TAB</b> <sup>QL, AL</sup> SYMDEKO (tezacaftor/ivacaftor) <sup>QL, AL</sup> TRIKAFTA(elexacaftor, tezacaftor, ivacaftor) <sup>AL, CL</sup> <b>PACKET<sup>CL</sup>, TAB</b>	Drug-specific criteria: <ul style="list-style-type: none"> <li><b>Alyfrek:</b> Diagnosis of CF and documentation of at least one F508del mutation or another responsive mutation in the CFTR gene.</li> <li><b>Bronchitol:</b> Approved for diagnosis of CF and documentation that the patient has passed the BRONCHITOL Tolerance Test</li> <li><b>Kalydeco®:</b> Diagnosis of CF and documentation of the drug-specific, FDA-approved mutation of CFTR gene</li> <li><b>Orkambi®:</b> Diagnosis of CF and documentation of presence of two copies of the F580del mutation (homozygous) of CFTR gene</li> <li><b>Symdeko:</b> Diagnosis of CF and documentation of the drug specific, FDA approved mutation of CFTR gene.</li> <li><b>Trikafta:</b> Diagnosis of CF and documentation of at least one F508del mutation in the CFTR gene or a mutation that is responsive to Trikafta based on clinical and/or in vitro data</li> </ul>

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**CYTOKINE & CAM ANTAGONISTS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ADALIMUMAB-ADBM(CF) <sup>AL</sup> 50mg/mL <b>KIT, PEN-KIT</b>	ABRILADA (adalimumab-afzb) <sup>AL</sup> (CF) <b>KIT, PEN-KIT</b>	<ul style="list-style-type: none"> <li>▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required.</li> </ul>
ADALIMUMAB-ADBM(CF) <sup>AL</sup> 100mg/mL <b>KIT, PEN-KIT</b>	ACTEMRA (tocilizumab) <b>SUB-Q</b>	<ul style="list-style-type: none"> <li>▪ 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.</li> </ul>
COSENTYX (secukinumab) <sup>AL,QL</sup> <b>PEN, SYR</b>	ADALIMUMAB-AACF (CF) <sup>AL</sup> <b>PEN* KIT, SYR-KIT</b>	
CYLTEZO (adalimumab-adbm) <sup>AL</sup> 50mg/mL <b>KIT, PEN-KIT</b>	ADALIMUMAB-AATY (CF) <sup>AL</sup> <b>PEN KIT</b>	
CYLTEZO (adalimumab-adbm) <sup>AL</sup> 100mg/mL <b>KIT, PEN-KIT</b>	ADALIMUMAB-ADAZ(CF)(biosim for Hyrimoz) <sup>AL</sup> <b>KIT<sup>NR</sup>, PEN, SYR</b>	
ENBREL (etanercept) <b>KIT, MINI CART, PEN, SYR, VIAL<sup>QL</sup></b>	ADALIMUMAB-ADBM(CF) <sup>AL</sup> 50mg/mL <b>KIT, PEN-KIT</b> (Quallent)	
HUMIRA (adalimumab) <sup>QL</sup>	ADALIMUMAB-ADBM(CF) <sup>AL</sup> 100mg/mL <b>KIT, PEN-KIT</b> (Quallent)	
OTEZLA (apremilast) <b>TAB<sup>QL</sup></b>	ADALIMUMAB-FKJP (biosim for Hulio) <sup>AL</sup> <b>PEN, SYR</b>	
	ADALIMUMAB-RYVK <sup>AL</sup> (biosim for Simlandi) <b>KIT, PEN-KIT</b>	
	AMJEVITA (adalimumab-atto) <sup>AL</sup> <b>AUTOINJ, SYR</b>	
	AMJEVITA(adalimumab-atto) <sup>AL</sup> <b>KIT, PEN-KIT</b>	
	ARCALYST (nilonacept)	
	BIMZELX (bimekizumab-bkzx) <sup>AL</sup> <b>PEN, SYR</b>	
	CIBINQO (abrocitinib) <sup>AL,QL</sup>	
	CIMZIA (certolizumab pegol) <sup>QL</sup>	
	ENSPRYNG (satralizumab-mwge) <b>SUB-Q</b>	
	ENTYVIO (vedolizumab) <sup>AL</sup> <b>PEN</b>	

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**

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**CYTOKINE & CAM ANTAGONISTS, continued**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<p>HADLIMA (adalimumab- bwwd)<sup>AL</sup>  <b>PUSHTOUCH, SYR</b></p> <p>HADLIMA (CF) (adalimumab- bwwd)<sup>AL</sup>  <b>PUSHTOUCH, SYR</b></p> <p>HULIO (adalimumab-fkjp)<sup>AL</sup> <b>PEN, SYR</b></p> <p>HYRIMOZ(CF) (adalimumab-adaz)<sup>AL</sup>  <b>PEN, SYR</b></p> <p>IDACIO (adalimumab-aacf)<sup>AL</sup> <b>PEN, SYR</b></p> <p>ILUMYA (tildrakizumab) SUB-Q</p> <p>IMULDOSA (ustekinumab-srlf, Stelara biosimilar)<sup>AL,NR</sup> <b>SYR</b></p> <p>KEVZARA (sarilumab) <b>SUB-Q, PEN, SYR</b></p> <p>KINERET (anakinra)</p> <p>LEQSELVI (deuruxolitinib)<sup>NR</sup> <b>TAB</b></p> <p>LITFULO (ritlecitinib)<sup>AL</sup> <b>CAPS</b></p> <p>OLUMIANT (baricitinib) <b>TAB<sup>CL,QL</sup></b></p> <p>OMVOH (mirikizumab-mrkz)<sup>AL</sup>  100mg, 200mg,300mg  <b>PEN<sup>NR</sup>,SYR<sup>NR</sup></b></p> <p>ORENCIA (abatacept) <b>SUB-Q</b></p> <p>OTULFI (ustekinumab-aauz biosimilars for Stelara)<sup>AL, NR</sup> <b>SYR, VIAL</b></p> <p>PYZCHIVA (ustekinumab-ttwe, Stelara biosimilar)<sup>AL,NR</sup> <b>SYR,VIAL</b></p> <p>RINVOQ ER (upadacitinib)<sup>CL,QL</sup></p> <p>RINVOQ (upadacitinib)<sup>AL,QL</sup> <b>LQ SOLN</b></p>	<ul style="list-style-type: none"> <li>▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required.</li> <li>▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this entire drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis.</li> </ul> <p><b>JAK-Inhibitors:</b> For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication.</p> <p>Drug-specific criteria:  <b>Cosentyx:</b> Requires treatment failure of Enbrel OR Humira with the same FDA-approved indications and age limits.</p>

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**CYTOKINE & CAM ANTAGONISTS, continued**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<p>SELARSDI (ustekinumab-aekn)<sup>AL, NR</sup> <b>SYR, VIAL</b></p> <p>SIMLANDI (CF) (adalimumab-ryvk)<sup>AL</sup> <b>KIT, PEN KIT</b></p> <p>SIMPONI (golimumab)</p> <p>SKYRIZI (risankizumab-rzaa) <b>SYR</b></p> <p>SKYRIZI <b>ON-BODY</b> (risankizumab-rzaa)<sup>QL</sup></p> <p>SKYRIZI <b>PEN</b> (risankizumab-rzaa)<sup>QL</sup></p> <p>SOTYKTU (deucravacitinib) <b>TAB</b></p> <p>SPEVIGO (spesolimab-sbzo)<sup>AL</sup><b>SYR</b></p> <p>STARJEMZA (ustekinumab-hmny)<sup>AL,NR</sup><b>SYR</b></p> <p>STARJEMZA (ustekinumab-hmny)<sup>AL,NR</sup> 45mg <b>VIAL</b></p> <p>STELARA (ustekinumab)<sup>AL</sup><b>SUB-Q</b></p> <p>STEQEYMA (ustekinumab-stba)<sup>AL, NR</sup> <b>SYR</b></p> <p>TALTZ (ixekizumab)<sup>AL</sup></p> <p>TREMFYA (guselkumab) <b>AUTOINJ</b><sup>AL,NR,QL</sup>, <b>PEN</b><sup>AL,NR</sup> <b>SYR</b><sup>AL</sup></p> <p>TYENNE (tocilizumab-aa zg)<sup>AL</sup> <b>AUTOINJ, SYR</b></p> <p>USTEKINUMAB<sup>AL,NR</sup> <b>SYR, VIAL</b></p> <p>USTEKINUMAB-AAUZ <b>SYR</b> (Otulifi biosimilar)<sup>AL,NR</sup></p> <p>USTEKINUMAB-AEKN (biosimilar to Stelara)<sup>AL,NR</sup> <b>SYR</b></p> <p>USTEKINUMAB-TTWE<sup>AL,NR</sup> <b>SYR</b></p> <p>VELSIPITY (etrasimod)<sup>QL</sup> <b>TAB</b></p> <p>XELJANZ (tofacitinib) <b>TAB, SOLN</b><sup>CL,QL</sup></p> <p>XELJANZ XR (tofacitinib) <b>TAB</b><sup>CL,QL</sup></p> <p>YESINTEK (ustekinumab-kfce)<sup>AL,NR</sup> <b>SYR, VIAL</b></p> <p>YUFLYMA 100mg/mL (CF) (adalimumab-aa ty)<sup>AL</sup><b>KIT,PEN-KIT</b></p> <p>YUFLYMA 80mg/mL (CF) (adalimumab-aa ty)<sup>AL</sup> <b>AUTOINJ, PEN, KIT</b></p> <p>YUSIMRY (CF) (adalimumab-aqvh)<sup>AL</sup> <b>PEN KIT</b></p> <p>ZYMFENTRA (infliximab-dyyb) <b>PEN, SYR</b></p>	<ul style="list-style-type: none"> <li>▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required.</li> <li>▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of 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.</li> </ul> <p><b>JAK-Inhibitors:</b> For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication.</p> <p>Drug-specific criteria:</p> <p><b>Cosentyx:</b> Requires treatment failure of Enbrel OR Humira with the same FDA-approved indications and age limits.</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

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

## DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>SINGLE-AGENT PRODUCTS</b>		
amiloride <b>TAB</b> bumetanide <b>TAB</b> chlorthalidone (generic Diuril) <b>TAB</b> furosemide (generic Lasix) <b>SOLN, TAB</b> hydrochlorothiazide (generic Microzide) <b>CAPS, TAB</b> indapamide <b>TAB</b> KERENDIA (finerenone) <b>TAB CL,QL</b> metolazone <b>TAB</b> spironolactone (generic Aldactone) <sup>AL</sup> <b>TAB</b> torsemide <b>TAB</b>	CAROSPIR (spironolactone) <sup>AL</sup> <b>SUSP</b> eplerenone (generic Inspira) <sup>CL</sup> <b>TAB</b> ethacrynic acid (generic Edecrin) <b>CAPS</b> HEMICLOR (chlorthalidone) <sup>NR</sup> <b>TAB</b> INZIRQQ (hydrochlorothiazide) <sup>NR,QL</sup> <b>SUSP</b> spironolactone (generic Carospir) <sup>AL</sup> <b>SUSP</b> THALITONE (chlorthalidone) <b>TAB</b> triamterene (generic Dyrenium)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of <b>TWO</b> preferred agents within the same subclass.</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Eplerenone:</b> Will be approved with a failed trial or intolerance to spironolactone, a trial with two preferred agents is not required.</li> <li><b>Kerendia:</b> For diagnosis of chronic kidney disease associated with Type-II diabetes in adults. Also for diagnosis of heart failure in adults with LVEF of 40% or greater.</li> <li><b>spironolactone suspension:</b> May be approved without trial of a preferred agent if there is a clinical reason why preferred spironolactone solid dosage form cannot be used.</li> </ul>
<b>COMBINATION PRODUCTS</b>		
amiloride/HCTZ <b>TAB</b> spironolactone/HCTZ <b>TAB</b> (generic Aldactazide) triamterene/HCTZ <b>CAPS, TAB</b> (generic Dyazide, Maxzide)		

## ENZYME REPLACEMENT, GAUCHER'S DISEASE

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

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**

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**EPINEPHRINE, SELF-ADMINISTERED <sup>QL</sup>**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUVI-Q 0.1mg (epinephrine) epinephrine (AUTHORIZED GENERIC Epipen/ Epipen Jr.) <b>AUTOINJ</b> EPIPEN (epinephrine) <b>AUTOINJ</b> EPIPEN JR. (epinephrine) <b>AUTOINJ</b>	AUVI-Q 0.15mg (epinephrine) AUVI-Q 0.3mg (epinephrine) epinephrine (generic Adrenaclick) epinephrine (generic Epipen/ Epipen Jr.) <b>AUTOINJ</b> NEFFY (epinephrine) <b>NASAL <sup>AL,CL,NR</sup></b>	<ul style="list-style-type: none"> <li>Non-preferred agents require clinical documentation as to why the preferred products within this drug class are not appropriate</li> </ul> <p>Drug-specific criteria: <b>Neffy Nasal Spray:</b> Requires a documented clinical reason why a preferred agent in this class can't be used.</p>

**ERYTHROPOIESIS STIMULATING PROTEINS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ARANESP (darbopoetin alfa) <b>DISP SYR, VIAL</b> EPOGEN (rHuEPO) RETACRIT (epoetin alfa-epbx) <i>Pfizer manufacturer only</i>	PROCRIT (rHuEPO) RETACRIT (epoetin alfa-epbx) <i>Vifor manufacturer only</i> VAFSEO (vadadustat) <b>TAB</b>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>

**FLUOROQUINOLONES, ORAL**

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

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

Page 38 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

## GI MOTILITY, CHRONIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>LINZESS (linaclotide)<sup>AL,QL</sup> lubiprostone (generic Amitiza)<sup>AL,QL</sup></p>	<p>alosetron (generic Lotronex) AMITIZA (lubiprostone)<sup>AL, QL</sup> IBSRELA (tenapanor)<sup>AL,QL</sup> MOTEGRITY (prucalopride succinate) MOVANTIK (naloxegol oxalate)<sup>QL</sup> prucalopride (generic Motegrity) SYMPROIC (naldemedine) VIBERZI (eluxodoline)</p>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class with the same indication</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Ibsrela:</b> May be approved for diagnosis of IBS with constipation after trial of at least TWO OTC laxatives (senna, bisacodyl, etc.)</li> <li><b>Lotronex/ alosetron:</b> Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate</li> <li><b>Symproic:</b> Covered for diagnosis of opioid-induced constipation in adult patients with chronic non-cancer pain after trial on at least TWO OTC laxatives and failure of Movantik</li> <li><b>Viberzi®:</b> Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate</li> </ul>

## GLUCAGON AGENTS

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

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

Page 39 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**GLUCOCORTICOIDS, INHALED**

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

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**

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

## GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC <b>CAPS</b> (generic Entocort EC) dexamethasone <b>ELIXIR, SOLN</b> dexamethasone <b>TAB</b> hydrocortisone <b>TAB</b> methylprednisolone tablet (generic Medrol) prednisolone <b>SOLN</b> prednisolone sodium phosphate prednisone <b>DOSE PAK</b> prednisone <b>TAB</b>	ALKINDI (hydrocortisone) <b>GRANULES<sup>AL</sup></b> CORTEF (hydrocortisone) cortisone <b>TAB</b> dexamethasone <b>INTENSOL</b> EOHILIA (budesonide) <sup>AL,QL</sup> <b>SUSP</b> HEMADY (dexamethasone) KHINDIVI (hydrocortisone) <sup>AL,NR</sup> <b>SOLN</b> methylprednisolone 8mg, 16mg, 32mg prednisolone sodium phosphate (generic Millipred/Veripred) prednisolone sodium phosphate <b>ODT</b> prednisone <b>SOLN</b> prednisone <b>INTENSOL</b> RAYOS DR (prednisone) <b>TAB</b> TARPEYO (budesonide) <b>CAPS</b>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Intensol Products:</b> Patient specific documentation of why the less concentrated solution is not appropriate for the patient</li> <li><b>Tarpeyo:</b> Indicated for the treatment of primary immunoglobulin A nephropathy (IgAN)</li> </ul>

## GROWTH HORMONES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GENOTROPIN (somatropin) NORDITROPIN (somatropin)	HUMATROPE (somatropin) NGENLA (somatropin-ghla) <sup>AL</sup> NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin-tcgd) SOGROYA (smapacitan-boco) ZOMACTON (somatropin)	<a href="#">Growth Hormone PA Form</a> <a href="#">Growth Hormone Criteria</a>

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**

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

## H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PYLERA (bismuth, metronidazole, tetracycline) <sup>QL</sup>	bismuth,metronidazole,tetracycline (generic Pylera) <sup>QL</sup> lansoprazole/amoxicillin/clarithromycin (generic Prevpac) <sup>QL</sup> OMECLAMOX-PAK (omeprazole, clarithromycin, amoxicillin) <sup>QL</sup> TALICIA (omeprazole/amoxicillin/rifaxitin) VOQUEZNA (vonoprazan) <sup>QL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul> <p><b>Drug-Specific Criteria</b></p> <ul style="list-style-type: none"> <li><b>Voquezna:</b> For the diagnosis of erosive esophagitis or heartburn associated with non-erosive GERD, will require confirmation by initial endoscopy and a trial/failure or a contraindication of two different PPIs (8 weeks each) up to maximally indicated doses in the past 180days. Length of therapy for erosive esophagitis is 240 days max per calendar year and 4 weeks for heartburn associated with non-erosive GERD.</li> </ul>

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

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

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

Page 42 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**HEMOPHILIA TREATMENTS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>BISPECIFIC FACTORS</b>		
HEMLIBRA	HYMPAVZ <sup>AL,NR</sup> QFITLIA (fitusiran) <sup>AL,NR</sup> <b>PEN, VIAL</b>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this entire drug class and with same indication.</li> </ul>
<b>FACTOR VIII</b>		
ALPHANATE HUMATE-P KOVALTRY NOVOEIGHT NUWIQ <b>XYNTHA KIT, SOLOFUSE</b>	ADVATE ADYNOVATE AFSTYLA ALTUVIPIO ELOCTATE ESPEROCT HEMOFIL-M JIV <sup>AL</sup> KOATE-DVI <b>KIT</b> KOATE-DVI <b>VIAL</b> KOGENATE FS OBIZUR RECOMBINATE	
<b>FACTOR IX</b>		
ALPROLIX BENEFIX	ALPHANINE SD IDELVION IXINITY PROFILNINE SD REBINYN RIXUBIS	
<b>FACTOR VIIa AND PROTHROMBIN COMPLEX-PLASMA DERIVED</b>		
NOVOSEVEN RT	FEIBA NF SEVENFACT <sup>AL</sup>	
<b>FACTOR X AND XIII PRODUCTS</b>		
COAGADEX CORIFACT	TRETEN	
<b>TISSUE FACTOR PATHWAY INHIBITOR (TFPI)</b>		
	ALHEMO <sup>AL,NR</sup>	
<b>VON WILLEBRAND PRODUCTS</b>		
WILATE	VONVENDI	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

## HEPATITIS B TREATMENTS

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

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

Page 44 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

## HEPATITIS C TREATMENTS

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

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

Page 45 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**HISTAMINE II RECEPTOR BLOCKERS**

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

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

Page 46 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**HIV / AIDS<sup>CL</sup>**

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**HIV / AIDS CL (Continued)**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>PROTEASE INHIBITORS</b>		
atazanavir <b>CAPS</b> (generic Reyataz) NORVIR (ritonavir) <b>TAB</b> PREZISTA (darunavir) <b>TAB</b> ritonavir TAB (generic Norvir)	APTIVUS <b>CAPS, SOLN</b> (tipranavir) CRIXIVAN (indinavir) DARUNAVIR PROPYLENE GLYCOLATE <sup>AL</sup> <b>TAB</b> darunavir ethanolate (generic Prezista) <sup>AL</sup> <b>TAB</b> fosamprenavir <b>TAB</b> (generic Lexiva) LEXIVA <b>SUSP</b> (fosamprenavir) LEXIVA <b>TAB</b> (fosamprenavir) NORVIR <b>POWDER, SOLN</b> (ritonavir) PREZISTA (darunavir) <b>SUSP</b> REYATAZ <b>POWDER</b> (atazanavir) VIRACEPT (nelfinavir)	<ul style="list-style-type: none"> <li>▪ All agents require: <ul style="list-style-type: none"> <li>○ Diagnosis of HIV/AIDS required, OR</li> <li>○ Diagnosis of Pre and Post Exposure Prophylaxis</li> </ul> </li> <li>▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patients, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents</li> <li>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</li> </ul>
<b>COMBINATION PROTEASE INHIBITORS (PIs) or PIs plus PHARMACOKINETIC ENHANCER</b>		
EVOTAZ (atazanavir/cobicistat) <sup>QL</sup> lopinavir/ritonavir <b>SOLN, TAB</b> (generic Kaletra)	KALETRA <b>SOLN</b> (lopinavir/ritonavir) KALETRA <b>TAB</b> (lopinavir/ritonavir) PREZCOBIX (darunavir/cobicistat) <sup>QL</sup>	<ul style="list-style-type: none"> <li>▪ All agents require: <ul style="list-style-type: none"> <li>○ Diagnosis of HIV/AIDS required; OR</li> <li>○ Diagnosis of Pre and Post Exposure Prophylaxis</li> </ul> </li> <li>▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patients, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents</li> <li>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</li> </ul>
<b>COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS</b>		
abacavir/lamivudine (generic Epzicom) CIMDUO (lamivudine/tenofovir) <sup>QL</sup> DESCOVY (emtricitabine/tenofovir) <sup>QL</sup> 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

Page 48 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**HIV / AIDS CL (Continued)**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>COMBINATION PRODUCTS – MULTIPLE CLASSES</b>		
BIKTARVY (bictegravir/emtricitabine/tenofovir) <sup>QL</sup>	efavirenz/lamivudine/tenofovir (generic for Symfi) <sup>QL</sup>	
COMPLERA (rilpivirine/emtricitabine/tenofovir)	efavirenz/lamivudine/tenofovir (generic for Symfi Lo) <sup>QL</sup>	
DELSTRIGO (doravirine/lamivudine/tenofovir) <sup>QL</sup>	rilpivirine/emtricitabine/tenofovir (Complera) <sup>NR</sup>	
DOVATO (dolutegravir/lamivudine) <sup>QL</sup>	TRIUMEQ PD (abacavir/dolutegravir/lamivudine) <b>SUSP</b>	
efavirenz/emtricitabine/tenofovir (generic Atripla) <sup>CL</sup>		
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) <sup>QL, AL</sup>		
JULUCA (dolutegravir/rilpivirine) <sup>QL</sup>		
ODEFSEY (emtricitabine/rilpivirine/tenofovir) <sup>QL</sup>		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) <sup>QL</sup>		
SYMF1 (efavirenz/lamivudine/tenofovir) <sup>QL</sup>		
SYMF1 LO (efavirenz/lamivudine/tenofovir) <sup>QL</sup>		
SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir) <sup>QL</sup>		
TRIUMEQ (dolutegravir/abacavir/lamivudine)		

**HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acarbose (generic Precose)	miglitol (generic Glyset)	

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

Page 49 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST (GLP-1 RA)<sup>AL,CL,QL</sup></b>		
OZEMPIC (semaglutide) <sup>AL,QL</sup> TRULICITY (dulaglutide) <sup>AL,QL</sup> VICTOZA (liraglutide) <sup>AL,QL</sup> subcutaneous	BYDUREON BCISE <b>PEN</b> (exenatide) <sup>AL,QL</sup> BYETTA (exenatide) <sup>AL,QL</sup> subcutaneous exenatide (generic Byetta) <sup>AL,QL</sup> liraglutide (generic Victoza) <sup>AL,QL</sup> MOUNJARO (tirzepatide) <sup>AL,QL</sup> <b>PEN</b> RYBELSUS (semaglutide) <sup>AL,QL</sup> 1.5mg <sup>NR</sup> , 3mg, 4mg <sup>NR</sup> , 7mg, 9mg <sup>NR</sup> , 14mg TAB	<p><b>GLP-1 RA Criteria</b></p> <p>Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin <b>OR</b> A diagnosis of ASCVD associated with a diagnosis of Type II diabetes (no metformin trial required)</p> <p>Non-preferred agents will be approved for patients who have:</p> <ul style="list-style-type: none"> <li>Failed a trial of TWO preferred agents within GLP-1 RA AND</li> <li>Diagnosis of diabetes with HbA1C <math>\geq 7</math> AND</li> <li>Trial of metformin, or contraindication or intolerance to metformin</li> </ul>
<b>INSULIN/GLP-1 RA COMBINATIONS</b>		
	SOLIQUA (insulin glargine/lixisenatide) XULTOPHY (insulin degludec/liraglutide)	
<b>AMYLIN ANALOG</b>		
	SYMLIN (pramlintide) subcutaneous	<p><b>Amylin Analog Criteria</b></p> <p>ALL criteria must be met</p> <ul style="list-style-type: none"> <li>Concurrent use of short-acting mealtime insulin</li> <li>Current therapy compliance</li> <li>No diagnosis of gastroparesis</li> <li>HbA1C <math>\leq 9\%</math> within last 90 days</li> <li>Monitoring of glucose during initiation of therapy</li> </ul>
<b>DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR<sup>AL,QL</sup></b>		
JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin (generic Nesina) alogliptin/metformin (generic Kazano) alogliptin/pioglitazone (generic Oseni) BRYNOVIN (sitagliptin) <sup>NR,QL</sup> SOLN GLYXAMBI (empagliflozin/linagliptin) JENTADUETO XR (linagliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) ONGLYZA (saxagliptin) QTERN (dapagliflozin/saxagliptin)	<p><b>DPP-4 Inhibitor Criteria</b></p> <p>Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin.</p> <p>Non-preferred DPP-4s will be approved for patients who have failed a trial of ONE preferred agent within the DPP-4 inhibitor class</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

Page 50 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS (Continued)**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR<sup>AL,QL</sup></b>	saxagliptin (generic Onglyza) saxagliptin/metformin ER (generic Kombiglyze ER) sitagliptin (generic Zituvio) sitagliptin/ metformin (Zituvimet) sitagliptin/ metformin ER (Zituvimet XR) <sup>NR</sup> STEGLUJAN (ertugliflozin/sitagliptin) TRIJARDY XR (empagliflozin/linagliptin/metformin) ZITUVIMET (sitagliptin/metformin) <b>TAB<sup>QL</sup></b> ZITUVIMET XR (sitagliptin/ metformin ER) <b>TAB<sup>QL</sup></b> ZITUVIO (sitagliptin)	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**HYPOLYCEMICS, INSULIN AND RELATED DRUGS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HUMULIN (insulin) <b>VIAL</b>	ADMELOG (insulin lispro) <b>PEN, VIAL</b>	
HUMULIN 70/30 <b>VIAL</b>	AFREZZA (regular insulin) <b>INHALATION</b>	
HUMULIN U-500 <b>VIAL</b>	APIDRA (insulin glulisine) <b>SOLOSTAR, VIAL</b>	
HUMULIN U-500 <b>PEN<sup>CL</sup></b>	BASAGLAR (insulin glargine, rec) <b>PEN, TEMPO PEN</b>	
HUMULIN OTC <b>PEN</b>	FIASP (insulin aspart) <b>CARTRIDGE, PEN, VIAL</b>	
HUMULIN 70/30 OTC <b>PEN</b>	HUMALOG U-100 <b>TEMPO PEN</b>	
insulin aspart (generic for Novolog) <b>CARTRIDGE, PEN, VIAL</b>	HUMALOG (insulin lispro) <sup>CL</sup> U-200 <b>KWIKPEN</b>	
insulin aspart/insulin aspart protamine <b>PEN, VIAL</b> (generic for Novolog Mix)	HUMALOG (insulin lispro) U-100 <b>CARTRIDGE, PEN, VIAL</b>	
insulin lispro (generic for Humalog) <b>PEN, VIAL, JR KWIKPEN</b>	HUMALOG JR. (insulin lispro) U-100 <b>KWIKPEN</b>	
insulin lispro/lispro protamine <b>KWIKPEN</b> (Humalog Mix Kwikpen)	HUMALOG MIX <b>VIAL</b> (insulin lispro/lispro protamine)	
LANTUS SOLOSTAR <b>PEN</b> (insulin glargine)	HUMALOG MIX <b>KWIKPEN</b> (insulin lispro/lispro protamine)	
LANTUS (insulin glargine) <b>VIAL</b>	insulin degludec (generic Tresiba) 100U/mL <b>PEN, VIAL</b>	
	insulin degludec (generic Tresiba) 200U/mL <b>PEN</b>	
	insulin glargine <b>PEN, VIAL</b>	
	insulin glargine (Toujeo)	
	insulin glargine max (Toujeo Max)	
	insulin glargine-YFGN <b>PEN, VIAL</b> (generic for Semglee-YFGN)	
	LEVEMIR (insulin detemir) <b>PEN, VIAL</b>	
	LYUMJEV <b>KWIKPEN, VIAL</b> (insulin lispro-aabc)	
	LYUMJEV (insulin lispro-aabc) <b>TEMPO PEN</b>	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**HYPOLYCEMICS, INSULIN AND RELATED DRUGS, continued**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	MERILOG (insulin aspart-szjj) <sup>NR</sup> <b>SOLOSTAR PEN</b> MERILOG (insulin aspart-szjj) <sup>NR</sup> <b>VIAL</b> NOVOLIN (insulin) <b>PEN-OTC, VIAL-OTC</b> NOVOLIN 70/30 VIAL (insulin) NOVOLOG (insulin aspart) <b>CARTRIDGE, PEN, VIAL</b> NOVOLOG MIX (insulin aspart/aspart protamine) <b>PEN, VIAL</b> REZVOGLAR (insulin glargine-aglr) <b>KWIKPEN</b> SEMGLEE (insulin glargine) <b>PEN, VIAL</b> SEMGLEE YFGN (insulin glargine) <b>PEN, VIAL</b> TOUJEO SOLOSTAR (insulin glargine)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>

**HYPOLYCEMICS, MEGLITINIDES**

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

**HYPOLYCEMICS, METFORMINS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metformin IR & ER (generic Glucophage/Glucophage XR)	metformin IR 750 mg metformin ER (generic Fortamet/Glumetza) metformin <b>SOLN</b> (generic Riomet) RIOMET ER (metformin ER) <sup>AL</sup>	<ul style="list-style-type: none"> <li><b>Metformin ER (generic Fortamet®)/Glumetza®:</b> Requires clinical reason why generic Glucophage XR® cannot be used</li> <li><b>Metformin solution:</b> Prior authorization not required for age &lt;7 years</li> </ul>

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**HYPOLYCEMICS, SGLT2<sup>CL</sup>**

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

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

Page 54 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

## **HYPOGLYCEMICS, SULFONYLUREAS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
glimepiride 1mg, 2mg, 4mg, 6mg, 8mg (generic Amaryl) glipizide IR & ER (generic Glucotrol/ Glucotrol XL) glyburide (generic Diabeta/Glynase)	chlorpropamide glimepiride 3mg (generic Amaryl) tolazamide tolbutamide	<ul style="list-style-type: none"> <li>▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>
<b>SULFONYLUREA COMBINATIONS</b>		
glipizide/metformin glyburide/metformin (generic Glucovance)		

## **HYPOGLYCEMICS, TZD**

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

## **IDIOPATHIC PULMONARY FIBROSIS**

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

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

Page 55 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

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

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

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

Page 56 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>ADBRY (tralokinumab-ldrm) <small>AL,CL,QL</small>  <b>SUB-Q</b>  ADBRY 300mg/2mL  <small>(tralokinumab-ldrm)</small> <small>AL,CL,QL</small> <b>AUTOINJ</b></p> <p>DUPIXENT (dupilumab) <small>AL,CL</small> <b>PEN,SYR</b></p> <p>ELIDEL (pimecrolimus)</p> <p>EUCRISA (crisaborole) <small>CL,QL</small></p> <p>pimecrolimus (generic Elidel)</p> <p>tacrolimus (generic Protopic)</p>	<p>ANZUPGO (delgocitinib) <small>NR,QL</small>  <b>CREAM</b></p> <p>EBGLYSS (lebrikizumab-lbkz) <small>AL,NR,QL</small>  <b>PEN, SYRINGE</b></p> <p>NEMLUVIO (nemolizumab-ilto) <small>AL,NR</small></p> <p>OPZELURA (ruxolitinib phosphate)  <b>CREAM</b> <small>AL,CL,QL</small></p> <p>VTAMA (tapinarof) <small>AL</small> <b>CREAM</b></p> <p>ZORYVE 0.15% (roflumilast) <small>AL</small>  <b>CREAM</b></p> <p>ZORYVE 0.05% (roflumilast) <small>AL, NR</small>  <b>CREAM</b></p>	<p><u><a href="#">Immunomodulators Self-Injectable PA Form</a></u></p> <ul style="list-style-type: none"> <li>Non-preferred agents require: Trial of a topical steroid AND Trial of one preferred product within this drug class with same indication.</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Adbry:</b> May be approved after a trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor</li> <li><b>Dupixent:</b> (For other indications, see Immunomodulators, Asthma and COPD therapeutic classes): <ol style="list-style-type: none"> <li><b>Atopic Dermatitis:</b> May be approved after a minimum of a 14-day trial of a topical corticosteroid AND a 6-week topical calcineurin inhibitor</li> <li><b>Eosinophilic Esophagitis:</b> Trial, failure, or technique difficulty to a swallowed topical corticosteroid or treatment failure of a proton pump inhibitor. Prescribed by, or in consultation with an allergist, gastroenterologist, or immunologist. Documentation that the Patient has a confirmed diagnosis of eosinophilic esophagitis with <math>\geq 15</math> eosinophils/high-power field.</li> <li><b>Nasal Polyps:</b> 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].</li> <li><b>Prurigo Nodularis:</b> Patient must have a diagnosis of Prurigo Nodularis with provider attestation of <math>\geq 20</math> nodular lesions. Trial and failure of a topical corticosteroid. Prescribed by, or in consultation with an allergist, dermatologist, or immunologist.</li> </ol> </li> <li><b>Eucrisa:</b> 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</li> <li><b>Opzelura:</b> May be approved for a diagnosis of Atopic Dermatitis and after a trial/failure of a topical steroid and trial of a preferred agent</li> </ul>

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**

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**IMMUNOMODULATORS, TOPICAL**

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

**IMMUNOSUPPRESSIVES, ORAL**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathioprine (generic Imuran) azathioprine (generic Azasan) <sup>NR</sup> cyclosporine, modified (generic Neoral) <b>CAPS</b> everolimus (generic for Zortress) <sup>AL</sup> mycophenolate (generic Cellcept) <b>CAPS, TAB</b> mycophenolic acid RAPAMUNE (sirolimus) <b>SOLN</b> RAPAMUNE (sirolimus) <b>TAB</b> sirolimus (generic Rapamune) <b>SOLN, TAB</b> tacrolimus	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) cyclosporine <b>CAP, SOFTGEL</b> cyclosporine, modified (generic Neoral) <b>SOLN</b> ENVARSUS XR (tacrolimus) GENGRAF (cyclosporine, modified) <b>CAP, SOLN</b> mycophenolate (generic Cellcept) <b>SUSP</b> MYFORTIC (mycophenolate sodium) MYHIBBIN (mycophenolate) <sup>AL</sup> <b>SUSP</b> PROGRAF (tacrolimus) <b>CAPS, PACKET</b> REZUROCK (belumosudil) <sup>AL,QL</sup> <b>TAB</b> SANDIMMUNE (cyclosporine) <b>CAPS, SOLN</b> TAVNEOS (avacopan) <sup>QL</sup> <b>CAPS</b> ZORTRESS (everolimus) <sup>AL</sup>	<p>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</p> <ul style="list-style-type: none"> <li>Patients established on existing therapy will be allowed to continue</li> </ul> <p><b>Drug Specific Criteria</b></p> <ul style="list-style-type: none"> <li><b>Tavneos</b> (avacopan) <ul style="list-style-type: none"> <li>No trial of a preferred agent required with appropriate FDA indications with concurrent use of standard therapy, including glucocorticoids</li> </ul> </li> </ul>

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

## INTRANASAL RHINITIS AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ANTICHOLINERGICS</b>		
ipratropium (generic for Atrovent)		Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within the same subclass.
<b>ANTIHISTAMINES</b>		
azelastine 0.1% (generic for Astelin)	azelastine 0.15% (generic for Astepro) azelastine/fluticasone (generic for Dymista) olopatadine (generic for Patanase) RYALTRIS (olopatadine/mometasone) <sup>AL</sup>	Drug-specific criteria: <ul style="list-style-type: none"><li>▪ <b>mometasone:</b> Prior authorization NOT required for children ≤ 12 years</li><li>▪ <b>budesonide:</b> Approved for use in Pregnancy (Pregnancy Category B)</li><li>▪ <b>Xhance:</b> Indicated for treatment of nasal polyps in ≥ 18 years only</li></ul>
<b>CORTICOSTEROIDS</b>		
fluticasone Rx (generic Flonase)	BECONASE AQ (beclomethasone) budesonide (Rhinocort) OTC flunisolide (generic Nasalide) fluticasone (generic Flonase) OTC mometasone (generic Nasonex) OTC, RX NASONEX (mometasone) OTC OMNARIS (ciclesonide) QNASL 40 & 80 (beclomethasone) triamcinolone (generic Nasacort) OTC XHANCE (fluticasone) ZETONNA (ciclesonide)	

## LEUKOTRIENE MODIFIERS

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

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

Page 59 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**LINCOSAMIDES / OXAZOLIDINONES / STREPTOGRAMINS**

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

**LIPOTROPICS, OTHER**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>BILE ACID SEQUESTRANTS</b>		
cholestyramine (generic Questran) colestipol <b>TAB</b> (generic Colestid)	colesevelam (generic Welchol) <b>TAB, PACKET</b> colestipol <b>GRANULES</b> (generic Colestid) QUESTRAN LIGHT (cholestyramine)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass.</li> </ul>
<b>TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA</b>		
	JUXTAPID (lomitapide) <sup>CL</sup> KYNAMRO (mipomersen) <sup>CL</sup>	<ul style="list-style-type: none"> <li>Drug-specific criteria:           <ul style="list-style-type: none"> <li><b>Colesevelam:</b> Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate</li> <li><b>Juxtapid/ Kynamro:</b> <ul style="list-style-type: none"> <li>Approved for diagnosis of homozygous familial hypercholesterolemia (HoFH) OR</li> <li>Treatment failure/maximized dosing/contraindication to ALL the following: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, bile acid sequestrants</li> <li>Require faxed copy of REMS PA form</li> </ul> </li> </ul> </li> </ul>
<b>TREATMENT OF FAMILIAL CHYLOMICRONEMIA SYNDROME (FCS)</b>		
	TRYNGOLZA (olezarsen) <sup>AL,QL</sup> <b>INJ</b>	<ul style="list-style-type: none"> <li><b>Tryngolza:</b> Approved for diagnosis of familial chylomicronemia syndrome and fasting triglycerides equal to or greater than 880 mg/dL within the past 90 days and used in combination with a low-fat diet of 20 gm or less of fat per day</li> </ul>
<b>FIBRIC ACID DERIVATIVES</b>		
fenofibrate (generic Tricor) fenofibrate (generic Lofibra) gemfibrozil (generic Lopid)	fenofibric acid (generic Fibrincor/Trilipix) fenofibrate (generic Antara/Fenoglide/ Lipofen/Triglide)	
<b>NIACIN</b>		
niacin ER (generic Niaspan)	NIACOR (niacin IR)	
<b>OMEGA-3 FATTY ACIDS</b>		
omega-3 fatty acids (generic Lovaza)	icosapent (generic Vascepa) <sup>CL</sup> omega-3 OTC	
<b>CHOLESTEROL ABSORPTION INHIBITORS</b>		
ezetimibe (generic Zetia)	NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ ezetimibe) <sup>QL</sup>	

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

Page 60 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**LIPOTROPICS, OTHER (Continued)**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS</b> <p>PRALUENT (alorocumab)<sup>CL</sup> REPATHA (evolocumab)<sup>CL</sup> <b>SURECLICK, SYR</b></p> <p>○</p>	<b>REPATHA (evolocumab)<sup>CL</sup></b> <b>PUSHTRONEX</b>	<b>Drug-Specific Criteria</b> <b>Praluent and Repatha:</b> May be approved for diagnoses of: <ul style="list-style-type: none"> <li>• Atherosclerotic cardiovascular disease (ASCVD) in adults</li> <li>• Heterozygous familial hypercholesterolemia (HeFH)               <ul style="list-style-type: none"> <li>○ Praluent <math>\geq</math> 8 years of age</li> <li>○ Repatha <math>\geq</math> 10 years of age</li> </ul> </li> <li>• Homozygous familial hypercholesterolemia (HoFH)               <ul style="list-style-type: none"> <li>○ Praluent <math>\geq</math> 18 years of age</li> <li>○ Repatha <math>\geq</math> 10 years of age</li> </ul> </li> </ul> <b>AND</b> <ul style="list-style-type: none"> <li>• Trial and failure or intolerance to a statin for 8 continuous weeks</li> <li>• Concurrent use of a maximally tolerated statin must continue, except for statin-induced rhabdomyolysis or a contraindication to a statin</li> <li>• Failure to reach target LDL-C levels:               <ul style="list-style-type: none"> <li>○ ASCVD – <math>&lt;</math> 70 mg/dL</li> <li>○ Very high risk ASCVD – <math>&lt;</math> 55mg/dL</li> <li>○ HeFH – <math>&lt;</math> 100 mg/dL</li> </ul> </li> </ul>

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

Page 61 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**LIPOTROPICS, STATINS**

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

**MACROLIDES AND KETOLIDES, ORAL**

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

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**

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

## METHOTREXATE

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

## MOVEMENT DISORDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUSTEDO (deutetrabenazine) <sup>AL,CL,QL</sup> AUSTEDO XR (deutetrabenazine) <sup>AL,CL,QL</sup> AUSTEDO XR Titration Pack (deutetrabenazine) <sup>AL,CL</sup> INGREZZA (valbenazine) <sup>AL,CL,QL</sup> <b>CAPS, SPRINKLES</b> tetabenazine (generic for Xenazine) <sup>CL</sup>	INGREZZA (valbenazine) <sup>AL,CL</sup> <b>INITIATION PACK</b> XENAZINE (tetrabenazine) <sup>CL</sup>	<p>All drugs require an FDA approved indication – ICD-10 diagnosis code required.</p> <p>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.</p> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li>▪ <b>Austedo/Austedo XR/Ingrezza</b>: Diagnosis of Tardive Dyskinesia or chorea associated with Huntington's Disease; Requires a Step through tetrabenazine with the diagnosis of chorea associated with Huntington's Disease</li> <li>▪ <b>tetabenazine</b>: Diagnosis of chorea with Huntington's Disease</li> </ul>

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**MULTIPLE SCLEROSIS DRUGS**

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

**NITROFURAN DERIVATIVES**

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

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

Page 64 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**NSAIDs, ORAL**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<b>COX-I SELECTIVE</b>	

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 (genericAnsaid)  
ibuprofen/famotidine (generic Duexis)<sup>CL</sup>  
ibuprofen 300mg **TAB**  
indomethacin ER (generic Indocin)  
ketoprofen & ER (generic Orudis)  
meclofenamate (generic Meclofenamate)  
mefenamic acid (generic Ponstel)  
meloxicam (generic Vivlodex)<sup>CL, QL</sup> **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)<sup>QL</sup>  
**NASAL**

- Non-preferred agents within COX-1 SELECTIVE subclass will be approved for patients who have failed no less than 30-day trial of TWO preferred agents within the same subclass.

Drug-specific criteria:

- meclofenamate:** Approvable without trial of preferred agents for menorrhagia
- Sprix/ketorolac Nasal:** Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**NSAIDs, ORAL (Continued)**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<b>COX-I SELECTIVE (continued)</b>	
	<b>ALL BRAND NAME NSAIDS including:</b> DOLOBID (diflunisal) 250 MG TABLET <sup>AL,NR</sup> DUEXIS (ibuprofen/famotidine) <sup>CL</sup> NALFON (fenoprofen)	<ul style="list-style-type: none"> <li>▪ All combination agents require a clinical reason why individual agents can't be used separately</li> </ul>
	<b>NSAID/GI PROTECTANT COMBINATIONS</b>	
	diclofenac/misoprostol (generic Arthrotec)	
	<b>COX-II SELECTIVE</b>	
celecoxib (generic Celebrex)	VYSCOXA SUSP (celecoxib) <sup>AL,NR</sup>	

**NSAIDs, TOPICAL**

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

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

**ONCOLOGY AGENTS, ORAL, BREAST**

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**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
	<b>ALL</b>	
mercaptopurine	PURIXAN (mercaptopurine) <sup>AL</sup> mercaptopurine (generic Purixan) <sup>NR</sup>	<ul style="list-style-type: none"> <li>▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines</li> </ul>
	<b>SUSP</b>	
	<b>AML</b>	<ul style="list-style-type: none"> <li>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</li> </ul>
	DAURISMO (glasdegib maleate) <sup>QL</sup> IDHIFA (enasidenib) REZLIDHIA (olutasidenib) <sup>QL</sup> RYDAPT (midostaurin) TIBSOVO (ivosidenib) <sup>QL</sup> VANFLYTA (quizartinib) XOSPATA (gilteritinib) <sup>QL</sup>	
	<b>CLL</b>	<p>Drug-specific criteria</p> <ul style="list-style-type: none"> <li>▪ <b>Hydrea®:</b> Requires clinical reason why generic cannot be used</li> <li>▪ <b>Purixan:</b> Prior authorization not required for age <math>\leq 12</math> or for documented swallowing disorder</li> <li>▪ <b>Xpovio:</b> Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone</li> </ul>
	<b>CML</b>	
hydroxyurea (generic for Hydrea) imatinib (generic for Gleevec)	BOSULIF (bosutinib) DANZITEN (nilotinib) <sup>NR</sup> dasatinib (generic Sprycel) <sup>NR</sup> GLEEVEC (imatinib) HYDREA (hydroxyurea) ICLUSIG (ponatinib) IMKELDI (imatinib) <sup>NR</sup> nilotinib HCL (generic Tasigna) <sup>NR</sup> nilotinib TARTRATE (generic Dansiten) <sup>NR</sup> nilotinib TARTRATE <sup>NR</sup> <b>CAPS</b> PHYRAGO (dasatinib) <sup>NR</sup> SCEMBLIX (asciminib) SPRYCEL (dasatinib) TASIGNA (nilotinib)	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**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, continued**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>MPN</b>		
JAKAFI (ruxolitinib)		
REVLIMID <sup>QL</sup> (lenalidomide)	lenalidomide <sup>QL</sup> (generic Revlimid) NINLARO (ixazomib) POMALYST (pomalidomide) THALOMID (thalidomide) XPOVIO (selinexor) <sup>CL</sup>	
<b>MYELOMA</b>		
MATULANE (procarbazine) tretinoin (generic for Vesanoid) <sup>AL</sup>	BRUKINSA (zanubrutinib) <sup>QL</sup> CALQUENCE (acalabrutinib) <sup>QL</sup> INREBIC (federatinib dihydrochloride) <sup>QL</sup> INQOVI (decitabine/cedazuridine) OJJAARA (momelotinib) REVUFORJ (revumenib) <sup>NR</sup> <b>TAB</b> VONJO (pacritinib) <sup>QL</sup> ZOLINZA (vorinostat)	
<b>OTHER</b>		

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**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
	<b>ALK</b> ALECENSA (alectinib) ALUNBRIG (brigatinib) <sup>QL</sup> LORBRENA (lorlatinib) <sup>QL</sup> ZYKADIA (ceritinib) <b>CAPS, TAB</b>	<ul style="list-style-type: none"> <li>Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines</li> </ul>
	<b>ALK / ROS1 / NTRK</b> AUGTYRO (repotrectinib) <b>CAPS</b> ROZLYTREK (entrectinib) <sup>QL</sup> <b>CAPS, PELLETS</b> XALKORI (crizotinib) <b>CAPS, PELLETS</b>	<ul style="list-style-type: none"> <li>Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</li> </ul>
erlotinib (generic for Tarceva)	gefitinib (generic Iressa) GILOTRIF (afatinib) IRESSA (gefitinib) LAZCLUZE (lazertinib) TAGRISSO (osimertinib) TARCEVA (erlotinib) VIZIMPRO (dacomitinib) <sup>QL</sup>	
	<b>HER2/ TKD</b> HERNEXEOS (zongertinib) <sup>NR</sup> <b>HYRNUO (sevabertinib)</b> <sup>NR</sup>	
	<b>OTHER</b> GAVRETO (pralsetinib) <sup>QL</sup> HYCAMTIN (topotecan) KRAZATI (adagrasib) LUMAKRAS (sotrasib) <sup>QL</sup> RETEVMO (selpercatinib) <sup>AL</sup> TABRECTA (capmatinib) <sup>QL</sup> TEPMETKO (tepotinib) <sup>QL</sup>	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**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)	AVMAPKI-FAKZYNJA (avutometinib/defactinib) <sup>NR</sup> <b>Combo-Pack</b> AYVAKIT (avapritinib) <sup>AL,QL</sup> BALVERSA (erdafitinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) FRUZAQLA (fruquintinib) <b>CAPS</b> GOMEKLI (mirdametinib) <sup>AL,NR</sup> <b>CAPS, TABS FOR ORAL SUSP</b> IWILFIN (eflornithine) JAYPIRCA (pirtobrutinib) KOSELUGO (selumetinib) <sup>AL</sup> <b>CAPS, GRANULES<sup>NR</sup></b> LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) LYTGOBI (futibatinib) MODEYSO (dordaviprone) <sup>NR</sup> OGSIVEO (nirogacestat) <b>TAB</b> PEMAZYRE (pemigatinib) <sup>QL</sup> QINLOCK (ripretinib) ROMVIMZA (vimseltinib) <sup>NR</sup> <b>CAPS</b> RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat) <sup>AL</sup> TURALIO (pexidartinib) <sup>QL</sup> VITRAKVI (larotrectinib) <b>CAPS, SOLN</b> VORANIGO (vorasidenib) <sup>AL</sup> <b>TABS</b> ZEJULA (niraparib) <b>TABS</b>	<ul style="list-style-type: none"> <li>▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines</li> <li>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy</li> </ul>

## ONCOLOGY AGENTS, ORAL, PROSTATE

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

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

Page 71 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

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

**ONCOLOGY AGENTS, ORAL, SKIN**

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**OPHTHALMICS, ALLERGIC CONJUNCTIVITIS**

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**OPHTHALMICS, ANTIBIOTICS**

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS**

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

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

Page 75 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**OPHTHALMICS, ANTI-INFLAMMATORIES**

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

AL – Age Limit

QL – Quantity/Duration Limit

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

Page 76 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**OPHTHALMICS, DRY EYE AGENTS**

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

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

Page 77 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**OPHTHALMICS, GLAUCOMA**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>MIOTICS</b>		
pilocarpine	VURITY (pilocarpine)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass.</li> </ul>
<b>SYMPATHOMIMETICS</b>		
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%)	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Rhopressa and Rocklatan:</b> Electronically approved for patients who have a trial of ONE generic agent, within ophthalmic - glaucoma within 180 days</li> </ul>
<b>BETA BLOCKERS</b>		
levobunolol (generic for Betagan) timolol (generic for Timoptic)	betaxolol (generic Betoptic) BETIMOL (timolol) BETOPTIC S (betaxolol) carteolol (generic Ocupress) timolol (generic Betimol) <sup>NR</sup> timolol (generic Istalol) timolol (generic Timoptic Ocudose) TIMOPTIC OCUDOSE	
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
dorzolamide (generic for Trusopt)	AZOPT (brinzolamide) brinzolamide (generic Azopt)	
<b>PROSTAGLANDIN ANALOGS</b>		
latanoprost (generic for Xalatan) TRAVATAN Z (travoprost)	bimatoprost (generic Lumigan) IYUZEH (latanoprost) <b>OMLONTI (omidenepag isopropyl)<sup>NR</sup></b> tafluprost (generic Zioptan) travoprost (generic Travatan Z) VYZULTA (latanoprostene) XALATAN (latanoprost) ZIOPTAN (tafluprost)	
<b>COMBINATION DRUGS</b>		
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

Page 78 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**OPHTHALMICS, GLAUCOMA (Continued)**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>OTHER</b>		
RHOPRESSA (netarsudil) <sup>CL</sup> ROCKLATAN (netarsudil and latanoprost) <sup>CL</sup>		<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass.</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Rhopressa and Rocklatan:</b> Electronically approved for patients who have a trial of ONE generic agent, within the ophthalmic - glaucoma class within 180 days</li> </ul>

**OPIOID DEPENDENCE TREATMENTS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
buprenorphine <sup>AL,QL</sup> <b>SL</b> buprenorphine/naloxone <sup>AL,QL</sup> <b>TAB (SL)</b> naltrexone <b>TAB</b> SUBOXONE (buprenorphine/naloxone) <sup>AL,QL</sup> <b>FILM</b>	buprenorphine/naloxone <sup>AL,QL</sup> <b>FILM</b> lofexidine (generic Lucemyra) <sup>CL,QL</sup> LUCEMYRA (lofexidine) <sup>CL,QL</sup> ZUBSOLV (buprenorphine/naloxone) <sup>AL,QL</sup>	<p><a href="#">Opioid Dependence Treatment PA Form</a></p> <p><a href="#">Opioid Dependence Treatment Informed Consent</a></p> <ul style="list-style-type: none"> <li>Non-preferred agents require a treatment failure of a preferred drug or patient-specific documentation of why a preferred product is not appropriate for the patient.</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Lucemyra/ Lofexidine:</b> Approved for FDA approved indication and dosing per label. Trial of preferred product not required.</li> </ul>

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

## OPIOID-REVERSAL TREATMENTS

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

## OTIC ANTI-INFECTIVES & ANESTHETICS

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

## OTIC ANTIBIOTICS

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

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

Page 80 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

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

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

**PANCREATIC ENZYMES**

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

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**

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**PEDIATRIC VITAMIN PREPARATIONS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHILD MVI (mvi, ped mvi no. 19/FA, ped mvi no. 17) <b>OTC CHEW</b>	DEKAs PLUS <sup>AL, CL</sup>	<ul style="list-style-type: none"> <li>▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> </ul>
CHILDREN'S MVI-IRON <b>OTC CHEW</b> (ped mvi no. 91/iron fum)	DAVIMET W/ FLUORIDE (ped mvi no.247/ fluoride) <b>CHEW OTC</b>	Drug specific criteria:
CHILDREN'S CHEWABLES <b>OTC</b> (ped mvi no. 25/FA, ped mvi no. 31 /iron/FA, ped mvi no.17/iron sulf)	FLORAFOL(mvi and fluoride) <b>CHEW OTC, DROPS-OTC</b>	<ul style="list-style-type: none"> <li>▪ <b>DEKAs Plus:</b> Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent</li> </ul>
CHILDREN'S VITAMINS W/ IRON <b>CHEW OTC</b> (mvi with iron)	FLORAFOL FE PEDIATRIC <b>DROPS OTC</b>	
FLUORIDE/VITAMINS A,C,AND D <b>DROPS</b> (ped mvi A,C,D3 no.21/ fluoride)	FLORIVA (ped mvi no.85/fluoride) <b>CHEW</b>	
MULTIVITAMINS W/ FLUORIDE (PEDI MVI NO.2 W-FLUORIDE) <b>DROPS</b>	FLORIVA PLUS (ped mvi no.161/fluoride) <b>OTC-DROPS</b>	
MULTIVITS W/ IRON & FLUORIDE <b>DROPS</b> (ped mvi no. 45/fluoride/iron)	MULTI-VIT-FLOR (ped mvi no.205/fluoride) <b>CHEW</b>	
PED MVI NO.17 W/ FLUORIDE <b>CHEW</b>	PEDI MULTIVIT A,C,AND D3 NO.21 <b>DROPS OTC</b>	
POLY-VITAMIN (ped mvi no. 212) <b>DROPS OTC</b>	PEDI MVI NO.22 WITH FLUORIDE <sup>NR</sup> <b>DROPS-OTC</b>	
POLY-VITAMIN W/ IRON (ped mvi no. 207 w/ferrous sulf) <b>DROPS OTC</b>	PEDI MVI NO.242/FLUORIDE <b>CHEW-OTC</b>	
TRI-VITAMIN W/ FLUORIDE (ped mvi A,C, D3 no. 21/fluoride)	POLY-VI-FLOR (ped mvi no.217/fluoride, ped mvi no. 205/fluoride) <b>CHEW</b>	
	POLY-VI-FLOR (ped mvi no.213 w/fluoride) <b>DROPS</b>	
	POLY-VI-FLOR W/ IRON (ped mvi no. 205/fluoride/iron) <b>CHEW</b>	
	POLY-VI-FLOR W/ IRON (ped mvi no. 214/fluoride/iron) <b>DROPS</b>	

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

Page 82 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

**PEDIATRIC VITAMIN PREPARATIONS, continued**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	QUFLORA (ped mvi no.84/fluoride, ped mvi no. 63/fluoride, ped mvi no. 83/fluoride)	<ul style="list-style-type: none"><li>Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li></ul>
	QUFLORA FE (ped mvi 142/iron/fluoride, ped mvi no. 151/iron/fluoride) <b>CHEW</b>	Drug specific criteria: <ul style="list-style-type: none"><li><b>DEKAs Plus:</b> Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent</li></ul>
	QUFLORA (ped mvi no.157/ fluoride) <b>OTC</b>	
	SOLUVITA A,C,D WITH FLUORIDE <b>DROPS OTC</b>	
	TRI-VI-FLOR (ped mvi A,C,D3 no.38/fluoride) <b>DROPS</b>	

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

Page 83 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

## PENICILLINS

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

## PHOSPHATE BINDERS

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

## PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
aspirin BRILINTA (ticagrelor) clopidogrel (generic Plavix) dipyridamole (generic Persantine) prasugrel (generic Effient)	aspirin/dipyridamole (generic Aggrenox) ticlopidine (generic Ticlid) ticagrelor (generic Brilinta) <sup>NR</sup> YOSPRALA (aspirin/omeprazole)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class OR documented clopidogrel resistance</li> </ul>

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

Page 84 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

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

<https://ne.primetherapeutics.com/drug-lookup>

**PRENATAL VITAMINS**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FE C/FA PNV 2/IRON B-G SUC-P/FA/OMEGA-3 <b>PNV NO.118/IRON FUMARATE/FA CHEW TAB</b> PNV NO.15/IRON FUM & PS CMP/FA PNV WITH CA, NO.72/IRON/FA PNV WITH CA, NO.74/IRON/FA <b>OTC</b> PNV#16/IRON FUM & PS/FA/OM-3 PNV119/IRON FUMARATE/FA/DSS <b>PRENATAL MULTI OTC</b> PRENATAL VIT #76/IRON, CARB/FA <b>PRENATAL VIT/FE FUMARATE/FA OTC</b> SELECT-OB + DHA <b>STUART ONE OTC</b> <b>TENDER-OB OTC</b> <b>TRICARE</b> <b>TRINATAL RX 1</b> <b>VITAFOL CHEW TAB</b> VITAFOL FE+ VITAFOL ULTRA VITAFOL-OB VITAFOL-OB+DHA VITAFOL-ONE	ALTRIXA OB <sup>NR</sup> <b>OTC</b> CITRANATAL B-CALM <b>COMPLETENATE CHEW TAB</b> DERMACINRX PRENATRIX <b>OTC</b> DERMACINRX PRETRATE TAB ENBRACE HR MARNATAL-F MULTI-MAC <b>OTC</b> NATAL PNV (pnv no.164/iron/folate no.6) <b>NEO-VITAL RX TAB OTC</b> NESTABS NESTABS ABC NESTABS DHA NESTABS ONE OB COMPLETE ONE OB COMPLETE PETITE OB COMPLETE PREMIER OB COMPLETE TAB OB COMPLETE WITH DHA <b>OTC</b> ONE NATAL RX <b>TAB OTC<sup>NR</sup></b> PNV 11-IRON FUM-FOLIC ACID-OM3 PNV COMBO#47/IRON/FA #1/DHA PNV W-CA NO.40/IRON FUM/FA CMB NO.1 PNV WITH CA NO.68/IRON/FA NO.1/DHA <b>PRENATAL + DHA OTC</b> PRENATE AM <b>PRENATE CHEW TAB</b> PRENATE DHA PRENATE ELITE PRENATE ENHANCE PRENATE ESSENTIAL PRENATE MINI PRENATE PIXIE PRENATE RESTORE PRENATE STAR PRIMACARE <b>SELECT-OB CHEW TAB</b> TRISTART DHA VITAFOL NANO WESTGEL DHA	<ul style="list-style-type: none"> <li>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</li> </ul>

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**PROTON PUMP INHIBITORS**

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

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

Page 86 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**SEDATIVE HYPNOTICS**

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

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

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

**SINUS NODE INHIBITORS**

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

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

Page 88 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**SKELETAL MUSCLE RELAXANTS**

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

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

Page 89 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**STEROIDS, TOPICAL**

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

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

Page 90 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**STEROIDS, TOPICAL (Continued)**

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

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

Page 91 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**STIMULANTS AND RELATED ADHD DRUGS <sup>AL</sup>**

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Methylphenidate type</b>		
CONCERTA (methylphenidate ER) <sup>QL</sup> 18 mg, 27 mg, 36 mg, 54 mg	APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphenidate and dexmethylphenidate) <sup>QL</sup>	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this subclass.
DAYTRANA PATCH (methylphenidate) <sup>QL</sup>	COTEMPLA XR-ODT (methylphenidate) <sup>QL</sup>	▪ Maximum accumulated dose of 108mg per day for ages < 18
dexmethylphenidate (generic for Focalin IR)	FOCALIN IR (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) JORNAY PM (methylphenidate) <sup>QL</sup> methylphenidate <b>CHEW</b>	▪ Maximum accumulated dose of 72mg per day for ages > 19
dexmethylphenidate ER (generic Focalin XR)	methylphenidate ER (45 mg and 63 mg) <sup>QL</sup>	Drug-specific criteria:
METHYLIN SOLN (methylphenidate)	methylphenidate 50/50 (generic Ritalin LA)	▪ <b>Daytrana/methylphenidate patch:</b> May be approved in history of substance use disorder by parent, caregiver, or patient. May be approved with documentation of difficulty swallowing
methylphenidate (generic Ritalin)	methylphenidate 30/70 (generic Metadate CD)	
methylphenidate <b>SOLN</b> (generic Methylin)	methylphenidate ER 18 mg, 27 mg, 36 mg, 54 mg (generic Concerta) <sup>QL</sup>	▪ <b>QuilliChew ER:</b> May be approved for children $\leq$ 12 years of age OR with documentation of difficulty swallowing
QUILLICHEW ER <b>CHEWTAB</b> (methylphenidate)	methylphenidate ER <b>CAP</b> (generic Aptensio XR) <sup>QL</sup>	
QUILLIVANT XR (methylphenidate) <b>SUSP</b>	methylphenidate ER (generic Metadate ER)	
	methylphenidate ER 72 mg (generic RELEXXII) <sup>QL</sup>	
	methylphenidate ER (generic Ritalin LA)	
	methylphenidate TD24 <b>PATCH</b> (generic Daytrana)	
	RELEXXII ER (methylphenidate 45mg and 63mg) <sup>QL</sup> <b>TAB</b>	
	RITALIN (methylphenidate)	

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

CL – Prior Authorization / Class Criteria apply

AL – Age Limit

QL – Quantity/Duration Limit

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

Page 93 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>MISCELLANEOUS</b>		
atomoxetine (generic Strattera) <sup>QL</sup> guanfacine ER (generic Intuniv) <sup>QL</sup> QELBREE (viloxazine) <sup>QL</sup>	clonidine ER (generic Kapvay) <sup>QL</sup> INTUNIV (guanfacine) Onyda XR (clonidine suspension, extended release) <sup>QL</sup> STRATTERA (atomoxetine)	<p><b>Note:</b> generic guanfacine IR and clonidine IR are available without prior authorization</p> <ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this subclass.</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Wakix and Sunosi:</b> Require trial of armodafinil or modafinil</li> <li><b>armodafinil and modafinil:</b> approved only for: <ul style="list-style-type: none"> <li>Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed</li> <li>Narcolepsy with documentation of diagnosis via sleep study</li> <li>Shift Work Sleep Disorder (only approvable for 6 months) with work schedule verified and documented. Shift work is defined as working the all night shift</li> </ul> </li> <li><b>Sunosi</b> approved only for: <ul style="list-style-type: none"> <li>Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed</li> <li>Narcolepsy with documentation of diagnosis via sleep study</li> </ul> </li> <li><b>Wakix:</b> approved only for excessive daytime sleepiness in adults with narcolepsy with documentation of narcolepsy diagnosis via sleep study</li> </ul>
<b>ANALEPTICS</b>		
	armodafinil (generic Nuvigil) <sup>CL</sup> modafanil (generic Provigil) <sup>CL</sup> SUNOSI (solriamfetol) <sup>CL,QL</sup> WAKIX (pitolisant) <sup>CL,QL</sup>	

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

Page 94 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**TETRACYCLINES**

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

**THROMBOPOEISIS STIMULATING PROTEINS<sup>CL</sup>**

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

## THYROID HORMONES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
levothyroxine (generic Synthroid) <b>TAB</b> liothyronine (generic Cytomel) <b>TAB</b> thyroid, pork <b>TAB</b> UNITHROID (levothyroxine)	ADTHYZA (thyroid, pork) ERMEZA (levothyroxine) <b>SOLN</b> EUTHYROX (levothyroxine) LEVO-T (levothyroxine) levothyroxine <b>CAPS</b> (generic Tirosint) SYNTHROID (levothyroxine) <b>TAB</b> THYQUIDITY (levothyroxine) <b>SOLN</b>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>

## ULCERATIVE COLITIS

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

Page 96 of 97

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

PDL Update January 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.asp>

**UTERINE DISORDER TREATMENT<sup>CL</sup>**

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

**VASODILATORS, CORONARY**

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

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

Page 97 of 97