

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

October 2026 PDL

PDL updated October 1, 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

Prior Authorization (PA) Renewal Requests:

All PAs require a positive clinical outcome for PA reauthorization approval

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 October 1, 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) GEL (OTC/Rx), GEL PUMP adapalene/BPO (generic Epiduo) benzoyl peroxide (BPO) WASH, LOTION benzoyl peroxide GEL OTC clindamycin/BPO (generic BenzaClin) GEL, PUMP clindamycin/BPO (generic Duac) clindamycin phosphate PLEDGET clindamycin phosphate SOLUTION erythromycin GEL erythromycin SOLN erythromycin-BPO (generic Benzamycin) tretinoin (generic Avita, Retin-A) ^{AL} , CREAM, GEL	adapalene (generic Differin) CREAM adapalene/BPO (generic Epiduo Forte) ALTRENO (tretinoin) ^{AL} AMZEEQ (minocycline) ATRALIN (tretinoin) AVAR (sulfacetamide sodium/sulfur) AVITA (tretinoin) AZELEX (azelaic acid) BENZEFOAM (benzoyl peroxide) benzoyl peroxide CLEANSER, CLEANSING BAR OTC benzoyl peroxide FOAM (generic BenzePro) benzoyl peroxide GEL Rx benzoyl peroxide TOWELETTE OTC clindamycin FOAM, LOTION clindamycin GEL clindamycin phosphate (generic Clindagel) GEL clindamycin/BPO (generic Acanya) GEL clindamycin/BPO PUMP (generic Onexton) ^{AL} clindamycin/tretinoin (generic Veltin, Ziana) dapsone (generic Aczone) DIFFERIN (adapalene) CREAM, GEL-OTC, GEL PUMP, LOTION erythromycin PLEDGET EVOCLIN (clindamycin) FOAM	- Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class - All retinoid products have a maximum age limit of 20 without a diagnosis of acne

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 October 1, 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
	FABIOR (tazarotene) FOAM NEUAC (clindamycin/BPO) OVACE PLUS (sulfacetamide sodium) RETIN-A MICRO (tretinoin) sulfacetamide sulfacetamide/sulfur sulfacetamide sodium/ sulfur CLEANSER SUMADAN (sulfacetamide/sulfur) tazarotene (generic Tazorac) CREAM tazarotene FOAM (generic Fabior) tazarotene GEL (generic Tazorac) TRETIN-X (tretinoin) tretinoin (generic Atralin) ^{AL}GEL tretinoin microspheres (generic Retin-A Micro) ^{AL} GEL, GEL PUMP WINLEVI (clascoterone)^{AL}	▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class ▪ All retinoid products have a maximum age limit of 20 without a diagnosis of acne

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 October 1, 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
CHOLINESTERASE INHIBITORS		- Non-preferred agents will be approved for patients who have failed a 120-day trial of ONE preferred agent within the last 6 months; OR - Current, stabilized therapy of the non-preferred agent within the previous 45 days Drug-specific criteria: Donepezil 23: Requires donepezil 10mg/day for at least 3 months AND clinical reason as to why 5mg or 10mg tablets can't be used (to deliver 20mg or 25mg)
donepezil (generic Aricept) donepezil ODT (generic Aricept ODT) rivastigmine PATCH (generic Exelon Patch)	ADLARITY (donepezil) PATCH ARICEPT (donepezil) donepezil 23 (generic Aricept 23) ^{CL} EXELON (rivastigmine) PATCH galantamine (generic Razadyne) SOLN, TAB galantamine ER (generic Razadyne ER) rivastigmine CAPS (generic Exelon) ZUNVEYL DR (benzgalantamine)	
NMDA RECEPTOR ANTAGONIST		
memantine (generic Namenda)	memantine ER (generic Namenda XR) memantine SOLN (generic Namenda) memantine/donepezil (generic Namzaric) 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

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 October 1, 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
BUTRANS (buprenorphine) ^{QL} PATCH fentanyl 25, 50, 75, 100 mcg PATCH ^{QL} morphine ER TABLET (generic MS Contin, Oramorph SR) OXYCONTIN ^{CL} (oxycodone ER) tramadol ER (generic Ultram ER)	BELBUCA (buprenorphine) ^{AL,QL} BUCCAL buprenorphine PATCH (generic Butrans) ^{QL} fentanyl 37.5/62.5/87.5 mcg PATCH ^{QL} hydrocodone ER (generic Hysingla ER) ^{QL} hydrocodone bitartrate ER (generic Zohydro ER) hydromorphone ER (generic Exalgo) HYSINGLA ER (hydrocodone ER) methadone TABLET ^{CL} methadone ORAL SYR ^{CL} methadone SOL TABLET ^{CL} morphine ER (generic Avinza, Kadian) CAPS NUCYNTA ER (tapentadol) oxycodone ER (generic Oxycontin) ^{CL} oxymorphone ER (generic Opana ER) tapentadol ER (Generic Nucynta ER) ^{NR} tramadol ER (generic ConZip)	The Center for Disease Control (CDC) does not recommend long-acting opioids when beginning opioid treatment. - Preferred agents require previous use of a long-acting opioid or documentation of a trial on a short acting agent within 90 days - Non-preferred agents will be approved with failure on, or intolerance to TWO preferred agents within this drug class Drug-specific criteria: Methadone (all formulations): Will only be approved for use in pain control or end of life care. Trial of preferred agent not required for end-of-life care Oxycontin/ oxycodone ER: Pain contract required for maximum quantity authorization

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

ANALGESICS, OPIOID SHORT-ACTING ^{QL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		
acetaminophen/codeine ELIXIR, TAB codeine TAB hydrocodone/APAP SOLN, TAB hydrocodone/ibuprofen hydromorphone TAB morphine CONC SOLN, SOLN, TAB oxycodone TAB, SOLN oxycodone/APAP tramadol 50 TAB^{AL} (generic Ultram)	butalbital/cafeine/APAP/codeine butalbital compound w/codeine (butalbital/ASA/cafeine/codeine) carisoprodol compound-codeine (carisoprodol/ASA/codeine) dihydrocodeine/APAP/cafeine hydrocodone/APAP SOLN (generic Zolvit) hydromorphone LIQUID, SUPPOSITORY (generic Dilaudid) levorphanol (generic Xyvona) meperidine (generic Demerol) morphine SUPPOSITORIES NALOCET (oxycodone/APAP) NUCYNTA (tapentadol) ^{CL} oxycodone CAPS oxycodone/APAP SOLN oxycodone CONCENTRATE oxymorphone IR (generic Opana) pentazocine/naloxone ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol) ^{AL} tapentadol (generic Nucynta) ^{CL} tapentadol SOLN^{NR} tramadol 25mg tramadol 75mg tramadol 100mg (generic Ultram) ^{AL} tramadol (generic Qdolo) ^{AL} SOLN tramadol/APAP (generic Ultracet)	- Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class within the last 12 months. - Note: for short acting opiate tablets and capsules there is a maximum quantity limit of #150 per 30 days. - Opiate limits for opiate naïve patients will consist of: -prescriptions limited to a 7 day supply, AND -initial opiate prescription fill limited to maximum of 50 Morphine Milligram Equivalents (MME) per day These limits may only be exceeded with patient specific documentation of medical necessity, with examples such as, cancer diagnosis, end-of-life care, palliative care, Sickle Cell Anemia, or prescriber attestation that patient is not recently opiate naïve Drug-specific criteria: Nucynta/ tapentadol: Approved only for diagnosis of acute pain, for 30 days or less

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

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

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

ANDROGENIC AGENTS (TOPICAL) ^{CL}

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

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ACE INHIBITORS		- Non-preferred agents will be approved for patients who have failed TWO preferred agents within the last 12 months - Non-preferred combination products may be covered as individual prescriptions without prior authorization Drug-specific criteria: Epaned/enalapril oral solution/Qbrelis oral solution: Clinical reason why oral tablet is not appropriate
benazepril (generic Lotensin) enalapril (generic Vasotec) lisinopril (generic Prinivil, Zestril) ramipril (generic Altace)	captopril (generic Capoten) EPANED (enalapril) ^{CL} ORAL SOLN enalapril (generic Epaned) ^{CL} ORAL SOLN fosinopril (generic Monopril) moexepiril (generic Univasc) perindopril (generic Aceon) QBRELIS (lisinopril) ^{CL} ORAL SOLN quinapril (generic Accupril) trandolapril (generic Mavik)	
ACE INHIBITOR/DIURETIC COMBINATIONS		
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)	
ANGIOTENSIN RECEPTOR BLOCKERS		
irbesartan (generic Avapro) losartan (generic Cozaar) olmesartan (generic Benicar) valsartan (generic Diovan)	azilsartan medoxomil (generic Edarbi) ^{NR} 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

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 October 1, 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
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		- Non-preferred agents will be approved for patients who have failed TWO preferred agents within the last 12 months - Non-preferred combination products may be covered as individual prescriptions without prior authorization
irbesartan/HCTZ (generic Avalide)	candesartan/HCTZ (generic Atacand-HCT)	
losartan/HCTZ (generic Hyzaar)	EDARBYCLOR (azilsartan/chlorthalidone)	
olmesartan/HCTZ (generic Benicar-HCT)	telmisartan/HCTZ (generic Micardis-HCT)	
valsartan/HCTZ (generic Diovan-HCT)		
ANGIOTENSIN MODULATOR/ CALCIUM CHANNEL BLOCKER COMBINATIONS		Direct Renin Inhibitors/Direct Renin Inhibitor Combinations: May be approved with a history of TWO preferred ACE Inhibitors or Angiotensin Receptor Blockers within the last 12 months Drug Specific Criteria Entresto/ sacubitril-valsartan: May be approved in patients ages ≥1 years old and with a diagnosis of heart failure
amlodipine/benazepril (generic Lotrel)	amlodipine/olmesartan/HCTZ (generic Tribenzor)	
amlodipine/olmesartan (generic Azor)	amlodipine/telmisartan (generic Twynsta)	
amlodipine/valsartan (generic Exforge)	amlodipine/valsartan/HCTZ (generic Exforge HCT)	
	PRESTALIA (perindopril/amlodipine)	
	trandolapril/verapamil (generic Tarka)	
	WIDAPLIK ^{NR, QL} (telmisartan/amlodipine/indapamide)	
DIRECT RENIN INHIBITORS		
	aliskiren (generic Tekturna) ^{QL}	
DIRECT RENIN INHIBITOR COMBINATIONS		
	TEKTURNA/HCTZ (aliskiren/HCTZ)	
NEPRILYSIN INHIBITOR COMBINATION		
sacubitril/valsartan (generic Entresto) ^{CL, QL}	ENTRESTO (sacubitril/valsartan) ^{CL, QL} ENTRESTO (sacubitril/valsartan) ^{CL, QL} SPRINKLE CAP	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

ANTHELMINTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
albendazole (generic Albenza) BILTRICIDE (praziquantel) ivermectin (generic Stromectol)	EMVERM (mebendazole) ^{CL} praziquantel (generic Biltricide) STROMECTOL (ivermectin)	- Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: Emverm: Approval will be considered for indications not covered by preferred agents

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 October 1, 2026, **Highlights** indicate change from previous posting

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

ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	GRASTEK (timothy grass pollen allergen) ^{AL,CL,QL} ODACTRA (Dermatophagoides farinae and Dermatophagoides pteronyssinus) ^{AL,CL,QL} ORALAIR (sweet vernal/orchard/rye/timothy/kentucky blue grass mixed pollen allergen extract) ^{CL} PALFORZIA (peanut allergen powder-dnfp) ^{AL,CL} RAGWITEK (weed pollen-short ragweed) ^{AL,CL,QL}	All agents require initial dose to be given in a healthcare setting Drug-specific criteria: GRASTEK - Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for Timothy grass or cross-reactive grass pollens. - For use in persons 5 through 65 years of age. ODACTRA - Confirmed by positive skin test to licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to Dermatophagoides farinae and Dermatophagoides pteronyssinus house dust mite - For use in persons 5 through 65 years of age ORALAIR - Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens. - For use in patients 5 through 65 years of age. PALFORZIA - Confirmed diagnosis of peanut allergy by allergist - For use in patients ages 4 to 17; it may be continued in patients 18 years and older with documentation of previous use within the past 90 days - Initial dose and increase titration doses should be given in a healthcare setting - Should not be used in patients with uncontrolled asthma or concurrently on a NSAID RAGWITEK - Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for short ragweed pollen. - For use in patients 5 through 65 years of age.

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Page 11 of 99

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

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metronidazole TAB neomycin tinidazole (generic Tindamax) vancomycin (generic Firvanq) ^{QL} SOLN vancomycin CAPS (generic Vancocin) ^{CL}	AEMCOLO (rifamycin) TAB DIFICID (fidaxomicin) ^{CL} TAB, SUSP fidaxomicin (generic Dificid) ^{CL} TAB FIRVANQ (vancomycin) ^{QL} SOLN LIKMEZ (metronidazole) SUSP metronidazole CAPS metronidazole 125mg TAB nitazoxanide (generic Alinia) TAB ^{AL, CL, QL} paromomycin SOLOSEC (secnidazole) VOWST (fecal microbiota spores) ^{AL, QL}	- Note: Although azithromycin, ciprofloxacin, and trimethoprim/sulfmethoxazole are not included in this review, they are available without prior authorization Drug-specific criteria: Alinia /nitazoxanide tablet: Trial and failure with metronidazole is required for a diagnosis of giardiasis Dificid®/ fidaxomicin: For diagnosis of C. difficile diarrhea (pseudomembranous colitis), trial and failure or intolerance to oral vancomycin is required: No trial required for diagnosis of relapsed or recurrent C. difficile with an appropriate ICD-10 diagnosis code or if immunocompromised; additionally, generic fidaxomicin tablets require a clinical reason why brand Dificid tablets can't be used. metronidazole CAPS/ metronidazole 125mg TAB: requires a clinical reason why preferred metronidazole tablet cannot be used

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

ANTIBIOTICS, INHALED ^{CL}

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

ANTIBIOTICS, TOPICAL

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

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 October 1, 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
CLEOCIN OVULES (clindamycin) clindamycin CREAM (generic Cleocin) metronidazole, vaginal NUVESSA (metronidazole)	CLEOCIN CREAM (clindamycin) CLINDESSE (clindamycin) metronidazole (generic Nuversa) ^{NR} VANDAZOLE (metronidazole) XACIATO (clindamycin phosphate) ^{AL} GEL	Non-preferred agents will be approved for patients who have failed a therapeutic trial (duration = 3 days) with ONE preferred agent within this drug class within the last 6 months

ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIQUIS (apixaban) DOSE PACK, TAB ELIQUIS (apixaban) SPRINKLE, SUSP enoxaparin (generic Lovenox) INJ warfarin (generic Coumadin) TAB XARELTO (rivaroxaban) 10 mg, 15 mg, 20 mg TAB XARELTO (rivaroxaban) 2.5 mg ^{CL,QL} TAB XARELTO DOSE PACK (rivaroxaban)	dabigatran etexilate (generic Pradaxa) CAPS fondaparinux (generic Arixtra) INJ FRAGMIN (dalteparin) INJ PRADAXA (dabigatran) CAPS, PELLETS rivaroxaban (generic Xarelto) TAB rivaroxaban (generic Xarelto) ^{AL,CL} SUSP SAVAYSA (edoxaban) ^{CL,QL} TAB XARELTO (rivaroxaban) ^{CL} SUSP	- Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 12 months Drug-specific criteria: Savaysa®: Approved diagnoses include: Stroke and systemic embolism (SE) risk reduction in nonvalvular atrial fibrillation (NVAf) OR Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) following 5-10 days of parenteral anticoagulant therapy Xarelto/ rivaroxaban Suspension: Approved for patients ≤12 years of age or if there is a clinical reason why a preferred solid dosage form cannot be used.

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 2026, **Highlights** indicate change from previous posting

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

ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CANNABINOIDS		Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the same subclass
dronabinol (generic Marinol) ^{AL}	dronabinol (generic Syndros) ^{AL, NR, QL} SOLN	
5HT3 RECEPTOR BLOCKERS		Drug-specific criteria: Akynzeo®: Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist <u>Regimens include:</u> AC combination (Doxorubicin or Epirubicin with Cyclophosphamide), Aldesleukin, Amifostine, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carmustine, Carbplatin, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Dactinomycin, Daunorubicin, Epirubicin, Etoposide, Hexamethylmelamine, Idarubicin, Ifosfamide, Imatinib, Interferon α, Irinotecan, Mechlorethamine, Melphalan, Methotrexate, Oxaliplatin, Procarbazine, Streptozotocin, Temozolomide Diclegis/doxylamine-pyridoxine)/ Bonjesta: Approved only for treatment of nausea and vomiting of pregnancy Sancuso®: Documentation of oral dosage form intolerance
ondansetron (generic Zofran/Zofran ODT) ^{QL}	ANZEMET (dolasetron) granisetron (generic Kytril) Nereus (tradipatant) ^{NR, QL} CAPS ondansetron 16mg ODT (generic Zofran ODT) SANCUSO (granisetron) ^{CL}	
NK-1 RECEPTOR ANTAGONIST		
aprepitant (generic Emend) CAPS ^{QL}	AKYNZEO (netupitant/palonosetron) ^{CL} aprepitant (generic Emend) PACK EMEND (aprepitant) CAPS, PACK, POWDER ^{QL}	
TRADITIONAL ANTIEMETICS		
DICLEGIS (doxylamine/pyridoxine) ^{CL, QL} dimenhydrinate (generic Dramamine) OTC meclizine (generic Antivert) metoclopramide (generic Reglan) phosphoric acid/dextrose/fructose (generic Emetrol) SOLN prochlorperazine(generic Compazine) promethazine (generic Phenergan) SYRUP, TAB promethazine 12.5mg, 25mg SUPPOSITORY scopolamine TRANSDERMAL TRANSDERM-SCOP (scopolamine)	BONJESTA (doxylamine/pyridoxine) ^{CL, QL} COMPRO (prochlorperazine) doxylamine/pyridoxine (generic Diclegis) ^{CL, QL} prochlorperazine SUPPOSITORY (generic Compazine) promethazine SUPPOSITORY 50mg trimethobenzamide TAB (generic Tigan)	

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Page 15 of 99

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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 SUSP, TAB (generic Diflucan) griseofulvin SUSP griseofulvin microsize TAB nystatin SUSP terbinafine (generic Lamisil)	BREXAFEMME (ibrexafungerp) ^{QL} CRESEMBA (isavuconazonium) ^{CL} flucytosine (generic Ancobon) ^{CL} griseofulvin ultramicrosize (generic GRIS-PEG) itraconazole (generic Sporanox) ^{CL} ketoconazole (generic Nizoral) ORAVIG (miconazole) ^{QL} BUCCAL NOXAFIL (posaconazole) ^{AL,CL} SUSP, TAB NOXAFIL (posaconazole) ^{AL,CL} POWDERMIX nystatin TAB posaconazole (generic Noxafil) ^{AL,CL} TOLSURA (itraconazole) ^{CL} VIVJOA (oteseconazole) CAPS voriconazole (generic VFEND) ^{CL}	- Non-preferred agents will be approved for patients who have failed a trial of TWO diagnosis-appropriate preferred agents within this drug class Drug-specific criteria: Cresemba®: Approved for diagnosis of invasive aspergillosis or invasive mucormycosis Flucytosine: Approved for diagnosis of: <u>Candida</u>: Septicemia, endocarditis, UTIs <u>Cryptococcus</u>: Meningitis, pulmonary infections Noxafil/ posaconazole DR tablets, oral suspension, PowderMix® for delayed oral suspension: For prophylaxis of invasive Aspergillus and Candida 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 Noxafil® Powdermix: pediatric patients 2 years of age and older who weigh 40 kg or less Noxafil/ posaconazole Suspension: Oropharyngeal/esophageal candidiasis refractory to itraconazole and/or fluconazole and; Prophylaxis of invasive Aspergillus and Candida infections Sporanox®/itraconazole: Approved for diagnosis of Aspergillosis, Blastomycosis, Histoplasmosis, Onychomycosis due to terbinafine-resistant dermatophytes, Oropharyngeal/ esophageal candidiasis refractory to fluconazole Sporanox® Liquid: Clinical reason solid oral cannot be used Tolsura: Approved for diagnosis of Aspergillosis, Blastomycosis, and Histoplasmosis and requires a trial and failure of generic itraconazole Vfend/voriconazole: No trial for diagnosis of Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Graft vs. Host disease (GVHD), Candidemia (candida krusei), Esophageal Candidiasis, Blastomycosis, <i>S. apiospermum</i> and <i>Fusarium spp.</i>, Oropharyngeal/esophageal candidiasis refractory to fluconazole

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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
ANTIFUNGAL		
clotrimazole CREAM (generic Lotrimin) RX, OTC clotrimazole (generic Lotrimin) SOLN -Rx ketoconazole CREAM, SHAMPOO (generic Nizoral) miconazole CREAM, POWDER OTC nystatin CREAM, POWDER terbinafine OTC (generic Lamisil AT) tolnaftate AERO-POWDER OTC, CREAM-OTC, SOLN-OTC (generic Tinactin) tolnaftate POWDER OTC tolnaftate SPRAY OTC	ALEVAZOL (clotrimazole) OTC ciclopirox CREAM, GEL, SUSP (generic Ciclodan, Loprox) ciclopirox SHAMPOO (generic Loprox) clotrimazole SOLN OTC DESENEX POWDER OTC (miconazole) econazole (generic Spectazole) ERTACZO (sertaconazole) FUNGOID (miconazole) OTC ketoconazole FOAM^{CL} (generic Extina, Ketodan) LASOLEX AG 2% (miconazole nitrate 2%) GEL^{NR, AL} LASOLEX (clotrimazole) ^{NR} SOLN (OTC) LOPROX (ciclopirox) SUSP, SHAMPOO, CREAM LOTRIMIN AF CREAM OTC (clotrimazole) LOTRIMIN ULTRA (butenafine) MICOCLEAR (clotrimazole) ^{NR} CREAM miconazole OTC OINT, SPRAY, SOLN miconazole/zinc oxide/petrolatum (generic Vusion) naftifine CREAM, GEL (generic Naftin) oxiconazole (generic Oxistat) tavaborole SOLN^{CL} (generic Kerydin) tolnaftate SPRAY^{NR} TRIPENICOL (undecylenic acid) CREAM-OTC VOTRIZA-AL (clotrimazole) LOTION OTC	- Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within the last 6 months Drug-specific criteria: Extina/ Ketodan/ ketoconazole foam: Requires trial and failure or contraindication to other ketoconazole forms tavaborole: Approved diagnoses include Onychomycosis of the toenails due to <i>T.rubrum</i> OR <i>T. Mentagrophytes</i> ciclopirox nail lacquer: No trial required in diabetes, peripheral vascular disease (PVD), immunocompromised OR contraindication to oral terbinafine
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone CREAM (generic Lotrisone) nystatin/triamcinolone (generic Mycolog) CREAM, OINT	clotrimazole/betamethasone LOTION (generic Lotrisone)	

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 2026, **Highlights** indicate change from previous posting

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

ANTI-HISTAMINES, MINIMALLY SEDATING

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

ANTI-HYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clonidine TAB (generic Catapres) clonidine TRANSDERMAL guanfacine (generic Tenex) methyl dopa	clonidine 0.05mg ^{NR} clonidine ER (generic Nexiclon) ^{CL} JAVADIN (clonidine) ^{NR} SOLN methyl dopa/hydrochlorothiazide NEXICLON XR (clonidine ER) ^{CL} TAB	- Non-preferred agents will be approved for patients who have failed a 30-day trial with ONE preferred agent within this drug class Drug Specific Criteria Nexiclon/ clonidine ER: Clinical reason why the preferred clonidine tablet or transdermal cannot be used

ANTI-HYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol (generic Zyloprim) colchicine TAB (generic Colcrys) probenecid	allopurinol 200mg colchicine CAPS (generic Mitigare) febuxostat (generic Uloric) ^{CL} GLOPERBA SOLN (colchicine) ^{CL, QL} MITIGARE (colchicine) probenecid/colchicine (generic Col-Probenecid)	- Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Gloperba: Approved for documented swallowing disorder Uloric/febuxostat: Clinical reason why allopurinol cannot be used

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

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

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AIMOVIG (erenumab-aooe) ^{CL,QL} AJOVY (fremanezumab-vfrm) ^{CL, QL} PEN, Autoinjector AJOVY (fremanezumab-vfrm) Autoinjector 3-pack ^{CL,QL} EMGALITY 120 mg/mL (galcanezumab-gnlm) ^{CL, QL} PEN, SYRINGE NURTEC ODT (rimegepant) ^{AL,CL,QL} QULIPTA (atogepant) ^{AL,CL,QL} UBRELVY (ubrogepant) ^{AL,CL, QL} TAB	BREKIYA (dihydroergotamine mesylate) diclofenac (generic Cambia) POWDER dihydroergotamine mesylate NASAL ELYXYB (celecoxib) ^{AL,QL} SOLN EMGALITY 100 mg (galcanezumab-gnlm) ^{CL,QL} SYR MIGERGOT (ergotamine/cafeine) RECTAL MIGRANAL (dihydroergotamine) NASAL REYVOW (lasmiditan) ^{AL, CL,QL} TAB ZAVZPRET (zavegepant) ^{AL,CL,QL} NASAL	- All non-preferred agents will require a failed trial or contraindication of a preferred agent of the same indication For Acute Treatment: agents will be approved for patients who have a failed trial or a contraindication to two triptans. For Prophylactic Treatment: 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) Drug-specific criteria: Emgality 100mg will only be approved for treatment of Episodic Cluster Headache Nurtec ODT: for use in acute treatment, will be approved for patients who have a failed trial or a contraindication to two triptans. For use in preventative treatment, will be approved for patients who have a failed trial of ONE preferred injectable CGRP. Qulipta: May be approved for patients who have a failed trial of ONE preferred injectable CGRP CGRP Antagonists: Use will be limited to one CGRP for acute use and one CGRP for prophylactic use.

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 2026, **Highlights** indicate change from previous posting

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

ANTIMIGRAINE AGENTS, TRIPTANS^{QL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		- Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class Drug-specific criteria: Zembrace: approved for patients who have failed ALL preferred agents
naratriptan (generic Amerge) rizatriptan (generic Maxalt) rizatriptan ODT (generic Maxalt MLT) sumatriptan	almotriptan (generic Axert) eletriptan (generic Relpax) frovatriptan (generic Frova) IMITREX (sumatriptan) RELPA (eletriptan) ^{QL} sumatriptan/naproxen (generic Treximet) SYMBRAVO (rizatriptan benzoate/meloxicam) ^{AL} TAB zolmitriptan (generic Zomig)	
NASAL		
sumatriptan (generic Imitrex Nasal)	TOSYMRA (sumatriptan) zolmitriptan (generic Zomig) ZOMIG (zolmitriptan)	
INJECTABLE		
sumatriptan SYRINGE, VIAL	sumatriptan KIT ZEMBRACE SYMTOUCH (sumatriptan) ^{CL}	

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) spinosad (generic Natroba)	CROTAN (crotamiton) LOTION EURAX (crotamiton) CREAM, LOTION ivermectin (generic Sklice) LOTION malathion (generic Ovide) PRURADIK (cromtamiton) LOTION VANALICE (piperonyl butoxide/pyrethrins)	Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class within the past 6 months

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 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
ANTICHOLINERGICS		Non-preferred agents will be approved for patients who have failed ONE preferred agent within the same subclass
benztropine (generic Cogentin) trihexyphenidyl (generic Artane)		
COMT INHIBITORS		Drug-specific criteria: Carbidopa/Levodopa ODT: Approved for documented swallowing disorder COMT Inhibitors: Approved if using as add-on therapy with levodopa-containing drug Gocovri: Required diagnosis of Parkinson's disease and had trial of or is intolerant to amantadine AND must be used as an add-on therapy with levodopa-containing drug Inbrija: Approval upon diagnosis of Parkinson's disease and concurrent treatment with carbidopa/levodopa agent Neupro®: - For Parkinsons: Clinical reason required why preferred agent cannot be used - For Restless Leg (RLS): Requires trial OR Contraindication to ropinirole AND pramipexole Nourianz: Approval upon diagnosis of Parkinson's disease and concurrent treatment with carbidopa/levodopa agent Osmolex ER: Required diagnosis of Parkinson's disease or drug-induced extrapyramidal reactions and had trial of or is intolerant to amantadine IR Pramipexole ER: Required diagnosis of Parkinson's along with preferred agent trial Ropinerole ER: Required diagnosis of Parkinson's along with preferred agent trial
entacapone (generic Comtan)	ONGENTYS (opicapone) tolcapone (generic Tasmar)	
DOPAMINE AGONISTS		
pramipexole (generic Mirapex) ropinirole (generic Requip)	bromocriptine (generic Parlodel) NEUPRO (rotigotine) ^{CL} pramipexole ER (generic Mirapex ER) ^{CL} ropinirole ER (generic Requip XL) ^{CL}	
MAO-B INHIBITORS		
selegiline CAPS, TABLET (generic Eldepryl)	rasagiline (generic Azilect) ^{QL} XADAGO (safinamide)	
OTHER ANTIPARKINSON'S DRUGS		
amantadine CAPS, SYRUP TABLET (generic Symmetrel) carbidopa/levodopa (generic Sinemet) carbidopa/levodopa ER (generic Sinemet CR)	carbidopa (generic Lodosyn) carbidopa/levodopa ODT (generic Parcopa) ^{CL} carbidopa/levodopa ER (generic Rytary) ^{NR} CREXONT (carbidopa and levodopa ER.) ^{QL} CAPS DHIVY (carbidopa/levodopa) ^{QL} DUOPA (carbidopa/levodopa) GOCOVRI (amantadine) ^{CL, QL} INBRIJA (levodopa) ^{CL, QL} INHALER levodopa/carbidopa/entacapone (generic Stalevo) NOURIANZ (istradefylline) ^{CL, QL} OSMOLEX ER (amantadine) ^{CL, QL} RYTARY (carbidopa/levodopa)	

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 October 1, 2026, **Highlights** indicate change from previous posting

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

ANTIPSORIATICS, ORAL

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

ANTIPSORIATICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcipotriene CREAM, OINT, SOLN	calcitriol (generic Vectical) ^{AL} OINT calcipotriene FOAM (generic Sorilux) calcipotriene/betamethasone OINT (generic Taclonex) calcipotriene/betamethasone SUSP (generic Taclonex Scalp) ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene) ZORYVE 0.3% (roflumilast) ^{AL} CREAM ZORYVE 0.3% (roflumilast) ^{AL,CL} FOAM	- Non-preferred agents will be approved for patients who have failed a trial with a preferred agent within this drug class Drug-Specific Criteria Zoryve Foam- For diagnosis of Seborrheic Dermatitis, requires trial of a topical steroid or a topical calcineurin inhibitor AND trial of a topical antifungal.

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 October 1, 2026, **Highlights** indicate change from previous posting

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

ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTI-COVID-19 DRUGS		Non-preferred agents will be approved for patients who have failed a 10-day trial of ONE preferred agent within the same subclass
PAXLOVID (nirmatrelvir/ritonavir) ^{CL, QL}		
ANTI-HERPETIC DRUGS		Drug-specific criteria:
acyclovir (generic Zovirax) famciclovir (generic Famvir) valacyclovir (generic Valtrex)	acyclovir (generic Zovirax) ^{CL} SUSP	Acyclovir Susp: Prior authorization NOT required for children ≤ 12 years old Paxlovid: Requires a diagnosis of COVID-19 and is limited to 1 dose pack per 30 days Xofluza: Requires clinical, patient specific reason that a preferred agent cannot be used
ANTI-INFLUENZA DRUGS		
oseltamivir (generic Tamiflu) ^{QL} CAPS, SUSP	rimantadine (generic Flumadine) RELENZA (zanamivir) ^{QL} TAMIFLU (oseltamivir) ^{QL} CAPS, SUSP XOFLUZA (baloxavir marboxil) ^{AL, CL, QL}	

ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acyclovir OINT docosanol OTC	acyclovir CREAM, (generic Zovirax) DENAVIR (penciclovir) ^{AL} penciclovir (generic Denavir) ^{AL}	Non-preferred agents will be approved for patients who have failed a trial with ONE preferred ORAL Antiviral agent

ANXIOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
alprazolam (generic Xanax) TAB buspirone (generic Buspar) chlordiazepoxide diazepam (generic Valium) TAB, SOLN lorazepam (generic Ativan) INTENSOL, TAB	alprazolam ER (generic Xanax XR) alprazolam INTENSOL ^{CL} alprazolam ODT BUCAPSOL (buspirone hcl) ^{CL} CAP clorazepate (generic Tranxene-T) diazepam INTENSOL ^{CL} LOREEV XR (lorazepam) ^{AL} meprobamate oxazepam	- Non-preferred agents will be approved for patients who have failed a trial with TWO preferred agents within this drug class Drug-specific criteria: Alprazolam Intensol®: Requires trial of diazepam solution OR lorazepam Intensol® Bucapsol: Requires clinical reason why preferred buspirone can't be used. Diazepam Intensol®: Requires clinical reason why diazepam solution cannot be used

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

Page 23 of 99

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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
BETA BLOCKERS		Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents . Drug-specific criteria: ▪ Coreg CR/carvedilol ER: Requires clinical reason generic IR product cannot be used ▪ Hemangeol®: Covered for diagnosis of Proliferating Infantile Hemangioma ▪ Sotalol®: Covered for diagnosis of life –threatening ventricular arrhythmias OR maintenance of normal sinus rhythm in highly symptomatic atrial fibrillation/flutter (AFIB/AFL) Requires clinical reason generic sotalol cannot be used
atenolol (generic Tenormin)	acebutolol (generic Sectral)	
atenolol/chlorthalidone (generic Tenoretic)	betaxolol (generic Kerlone)	
bisoprolol (generic Zebeta)	BYSTOLIC (nebivolol)	
bisoprolol/HCTZ (generic Ziac)	HEMANGEOL (propranolol) ^{AL,CL} SOLN	
metoprolol (generic Lopressor)	INDERAL/INNOPRAN XL (propranolol ER)	
metoprolol ER (generic Toprol XL)	KAPSPARGO SPRINKLE (metoprolol ER)	
nebivolol (generic Bystolic)	LOPRESSOR (metoprolol tartrate) SOLN	
propranolol (generic Inderal)	metoprolol/HCTZ (generic Lopressor HCT)	
propranolol ER (generic Inderal LA)	nadolol (generic Corgard)	
	pindolol (generic Viskin)	
	propranolol/HCTZ (generic Inderide)	
	timolol (generic Blocadren)	
	TOPROL XL (metoprolol ER)	
BETA- AND ALPHA-BLOCKERS		
carvedilol (generic Coreg)	carvedilol ER ^{CL} (generic Coreg CR)	
labetalol (generic Trandate)		
ANTIARRHYTHMIC		
sotalol (generic Betapace)	SOTYLIZE (sotalol) ^{CL}	

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

BILE SALTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ursodiol CAPSULE 300 mg (generic Actigall) ursodiol 250 mg TABLET (generic URSO) ursodiol 500 mg TABLET (generic URSO FORTE)	CHENODAL (chenodiol) CHOLBAM (cholic acid) CTEXLI (chenodiol) TAB IQIRVO (elafibranor) ^{AL,CL,QL} TAB LIVDELZI (seladelpar) ^{AL,CL,QL} CAP LYNAVOY (limerixibat) ^{NR} TAB RELTONE (ursodiol 200mg,400mg) CAP URSOLIGN (ursodiol) ^{NR} CAP	- Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug-specific criteria: Iqirvo /Livdelzi: - Requires ≥ 12-month trial and failure (ALP ≥ 1.67 times upper limit of normal) of ursodiol, unless contraindicated, or experienced clinically significant adverse effects; - AND must be used in combination with ursodiol unless contraindicated or clinically significant adverse effects experienced

BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
fesoterodine (generic Toviaz) MYRBETRIQ (mirabegron) ^{AL} TAB oxybutynin IR, ER (generic Ditropan/Ditropan XL)	darifenacin ER (generic Enblex) flavoxate HCL GEMTESA (vibegron) ^{AL,QL} mirabegron ER (generic Myrbetriq) TAB mirabegron ER (generic Myrbetriq) SUSP^{NR} MYRBETRIQ (mirabegron) SUSP^{AL,CL,QL} 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 SUSP (solifenacin) ^{AL}	- Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug-specific criteria: Myrbetriq suspension: Covered for pediatric patients ≥ 3 years old with a diagnosis of Neurogenic Detrusor Overactivity (NDO)

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 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
BISPHOSPHONATES		- Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass - Drug-specific criteria: Atelvia DR®: Requires clinical reason a preferred product cannot be taken on an empty stomach Binosto®: Requires clinical reason why alendronate tablets OR Fosamax® solution cannot be used BONSITY: Requires clinical reason why preferred Forteo cannot be used Forteo/ teriparatide: Covered for high risk of fracture High risk of fracture: - BMD -3 or worse - Postmenopausal women with history of non-traumatic fractures - Postmenopausal women with 2 or more clinical risk factors - Family history of non-traumatic fractures - DXA BMD T-score ≤ -2.5 at any site - Glucocorticoid use ≥ 6 months at 7.5 dose of prednisolone equivalent - Rheumatoid Arthritis - Postmenopausal women with BMD T-score ≤ -2.5 at any site with any clinical risk factors - More than 2 units of alcohol per day - Current smoker - Men with primary or hypogonadal osteoporosis - Osteoporosis associated with sustained systemic glucocorticoid therapy - Trial of calcitonin-salmon not required - Maximum of 24 months treatment per lifetime
alendronate (generic Fosamax) TAB ibandronate (generic Boniva) ^{QL}	alendronate SOLN (generic Fosamax) ^{QL} ATELVIA DR (risedronate) ^{CL} BINOSTO (alendronate) ^{CL} FOSAMAX PLUS D (alendronate sodium/ cholecalciferol) ^{QL} risedronate (generic Actonel) ^{QL}	
OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS		
calcitonin-salmon NASAL FORTEO (teriparatide) ^{CL,QL} raloxifene (generic Evista)	BONSITY (teriparatide) ^{QL} EVISTA (raloxifene) teriparatide (generic Forteo) ^{CL,QL} TYMLOS (abaloparatide)	

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Page 26 of 99

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

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALPHA BLOCKERS		Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass.
alfuzosin (generic Uroxatral) ^{CL} doxazosin (generic Cardura) tamsulosin (generic Flomax) ^{CL} terazosin (generic Hytrin)	CARDURA XL (doxazosin) ^{CL} silodosin (generic Rapaflo) TEZRULY (terazosin) ^{CL} SOLN	
5-ALPHA-REDUCTASE (5AR) INHIBITORS		Drug-specific criteria: Alfuzosin/dutasteride/finasteride - Covered for males only Cardura XL®: Requires clinical reason generic IR form cannot be used Flomax/ tamsulosin: Covered for males and may be covered for females for a 7-day supply with diagnosis of acute kidney stones Jalyn/ dutasteride-tamsulosin: Requires clinical reason why individual agents cannot be used Tezruly (terazosin) solution: Clinical reason why oral capsule is not appropriate
dutasteride (generic Avodart) ^{CL} finasteride (generic Proscar) ^{CL}	dutasteride/tamsulosin (generic Jalyn) ^{CL} ENTADFI (finasteride/tadalafil) finasteride/tadalafil (generic Entadfi) ^{NR}	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

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

PDL Update October 1, 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
INHALERS – Short Acting		- Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: Xopenex/levalbuterol solution: Covered for cardiac diagnoses or side effect of tachycardia with albuterol product
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 RESPICLICK (albuterol)	
INHALERS – Long Acting		
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)	
INHALATION SOLUTION		
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 Xopenex) ^{CL} PERFOROMIST (formoterol)	
ORAL		
albuterol SYRUP	albuterol TAB 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

Page 28 of 99

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

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

CALCIUM CHANNEL BLOCKERS, ORAL

Preferred Agents		Non-Preferred Agents	Prior Authorization/Class Criteria
SHORT-ACTING			- Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. - Drug-specific criteria: Katerzia/ Norliqva/ Sdamlo: May be approved with documented swallowing difficulty. Katerzia and Sdamlo also require a clinical reason why Norliqva cannot be used. Nifedipine: May be approved without trial for diagnosis of Preterm Labor or Pregnancy Induced Hypertension (PIH) Nimodipine: Covered without trial for diagnosis of subarachnoid hemorrhage Nimodipine solution: Covered without trial for diagnosis of subarachnoid hemorrhage and documented swallowing difficulty
Dihydropyridines			
	isradipine (generic Dynacirc)		
	nicardipine (generic Cardene)		
	nifedipine (generic Procardia) ^{CL}		
	nimodipine (generic Nimotop) ^{CL}		
	nimodipine (generic Nymalize) ^{CL}	SOLN	
	NYMALIZE (nimodipine)	SOLN	
Non-dihydropyridines			
diltiazem (generic Cardizem)			
verapamil (generic Calan/Isoptin)			
LONG-ACTING			
Dihydropyridines			
amlodipine (generic Norvasc)	felodipine ER (generic Plendil)		
nifedipine ER (generic Procardia XL/ Adalat CC)	KATERZIA (amlodipine) ^{CL,QL}	SUSP	
NORLIQVA (amlodipine) ^{AL,CL,QL}	levamlodipine (generic Conjupri)		
	nisoldipine (generic Sular)		
	SDAMLO (amlodipine) ^{AL,CL}	SOLN	
Non-dihydropyridines			
diltiazem ER (generic Cardizem CD)	diltiazem ER (generic Cardizem LA)		
verapamil ER TAB	MATZIM LA (diltiazem ER)		
	TIAZAC (diltiazem)		
	verapamil ER CAPS		
	verapamil 360mg CAPS		
	verapamil ER (generic Verelan PM)		
	verapamil SR (generic Verelan)		
	CAPS		

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		- Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within the same subclass Drug Specific Criteria Cefixime- May be approved for a diagnosis of gonorrhea, with an appropriate ICD-10 diagnosis code without a 3-day trial of a preferred agent
amoxicillin/clavulanate TAB, SUSP	amoxicillin/clavulanate CHEWABLE amoxicillin/clavulanate ER (generic Augmentin XR) AUGMENTIN (amoxicillin/clavulanate) SUSP, TAB	
CEPHALOSPORINS – First Generation		
cefadroxil CAPS, SUSP (generic Duricef) cephalexin CAPS, SUSP (generic Keflex)	cefadroxil TAB (generic Duricef) cephalexin TAB	
CEPHALOSPORINS – Second Generation		
cefprozil (generic Cefzil) cefuroxime TAB (generic Ceftin)	cefaclor (generic Ceclor)	
CEPHALOSPORINS – Third Generation		
cefdinir (generic Omnicef) cefpodoxime (generic Vantin)	cefixime (generic Suprax) ^{CL} CAPS, SUSP, TAB	

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FULPHILA (pegfilgrastim-jmdb) SUB-Q FYLNETRA (pegfilgrastim-pbbk) SUB-Q NEUPOGEN DISP SYR (SUB-Q) NEUPOGEN (filgrastim) VIAL (IV)	ARMLUPEG (pegfilgrastim-unne) ^{SYR^{NR}} FILKRI (filgrastim-laha) SYR^{NR} GRANIX (tbo-filgrastim) SUB-Q LEUKINE (sargramostim) INTRAVENOUS NEULASTA (pegfilgrastim) SYR, VIAL^{NR} NIVESTYM (filgrastim-aafi) SYR, VIAL NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim-ayow) SYR ROLVEDON (eflapegastim-xnst) SYR STIMUFEND (pegfilgrastim-fpgk) SUB-Q UDENYCA (pegfilgrastim-cbqv) AUTOINJ UDENYCA (pegfilgrastim-cbqv) SUB-Q ZARXIO (filgrastim-sndz) IV, SUB-Q ZIEXTENZO (pegfilgrastim-bmez) SUB-Q	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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
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: https://ne.primetherapeutics.com/drug-lookup		

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 October 1, 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
INHALERS		- 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. - Drug-specific criteria: Daliresp/roflumilast: - 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 Dupixent (For other indications, see Immunomodulators, Atopic Dermatitis and Asthma therapeutic classes): For COPD and an Eosinophilic Phenotype: Requires documentation of inadequately controlled COPD with eosinophils ≥ 300 cells/microliter AND two exacerbations OR one exacerbation that led to hospitalization while on and adherent to a ≥ 90-day trial of triple therapy (LABA + LAMA + ICS). Prescribed by, or in consultation with a pulmonologist, immunologist, or an allergist.
ANORO ELLIPTA (umeclidinium/vilanterol) ATROVENT HFA (ipratropium) COMBIVENT RESPIMAT (albuterol/ ipratropium) SPIRIVA (tiotropium) SPIRIVA RESPIMAT (tiotropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI AEROSPHERE (glycopyrolate/formoterol) DUAKLIR PRESSAIR (aclidinium br and formoterol fum) INCRUSE ELLIPTA (umeclidnium) tiotropium (generic Spiriva) TUDORZA PRESSAIR (aclidinium br) umeclidinium ellipta (generic Incruse) ^{NR} umeclidinium/vilanterol (generic Anoro Ellipta) ipratropium bromide HFA (Atrovent) ^{NR}	
INHALATION SOLUTION		
albuterol/ipratropium (generic Duoneb) ipratropium SOLN (generic Atrovent)	OHTUVAYRE (ensifentrine) inhalation suspension YUPELRI (revefenacin)	
ORAL AGENT		
roflumilast (generic Daliresp) ^{CL, QL}	DALIRESP (roflumilast) ^{CL, QL}	

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 2026, **Highlights** indicate change from previous posting

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

CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
IL-6 ANTAGONISTS		- Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. - Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this entire drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis.
	ACTEMRA (tocilizumab) PEN,SYR AVTOZMA (tocilizumab-anoh) AUTOINJ, SYR ^{AL,NR} ENSPRYNG (satralizumab-mwge) SYR KEVZARA (sarilumab) PEN, SYR TYENNE (tocilizumab-aazg) ^{AL}	
IL-17 ANTAGONISTS		
TALTZ (ixekizumab) ^{AL} AUTOINJ, SYR	BIMZELX (bimekizumab-bkzx) ^{AL} PEN, SYR COSENTYX (secukinumab) ^{AL,QL} PEN, SYR	
IL-23 ANTAGONISTS		Drug-specific criteria: Cibinqo/Rinvoq/RinvoqER: For diagnosis of moderate to severe Atopic Dermatitis requires treatment failure of TWO preferred systemic drug products, including biologics, within this entire drug class or the Immunomodulators, Atopic Dermatitis therapeutic class. JAK-Inhibitors: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication. Pyzchiva/Steqeyma: Requires a trial and failure of a preferred TNF blocker with the same indication.
PYZCHIVA (ustekinumab-ttwe, Stelara biosimilar) ^{AL,CL} SYR STEQEYMA (ustekinumab-stba) ^{AL,CL} SYR	ICOTYDE (icotrokinra) ^{AL, NR, QL} TAB ILUMYA (tildrakizumab) SUB-Q IMULDOSA (ustekinumab-srlf) ^{AL} SYR OMVOH (mirikizumab-mrkz) ^{AL} OTULFI (ustekinumab-aauz) ^{AL} SYR 100mg, 200mg,300mg PEN,SYR PYZCHIVA (ustekinumab-ttwe, Stelara biosimilar) ^{AL,CL} VIAL SELARSDI (ustekinumab-aekn) ^{AL} SYR, VIAL SKYRIZI (risankizumab-rzaa) SYR SKYRIZI (risankizumab-rzaa) ^{QL} ON-BODY SKYRIZI (risankizumab-rzaa) ^{QL} PEN STARJEMZA (ustekinumab-hmny) ^{AL,NR} SYR STARJEMZA (ustekinumab-hmny) ^{AL,NR} 45mg VIAL STELARA (ustekinumab) ^{AL} SYR STELARA (ustekinumab) ^{AL} VIAL STEQEYMA (ustekinumab-stba) ^{AL,CL,NR} VIAL TREMIFYA (guselkumab) AUTOINJ ^{AL,QL} , PEN ^{AL} SYR ^{AL} USTEKINUMAB ^{AL} SYR, VIAL USTEKINUMAB-AAUZ SYR (Otulfi biosimilar) ^{AL,NR} USTEKINUMAB-AEKN (biosimilar to Stelara) ^{AL} SYR USTEKINUMAB-TTWE ^{AL} SYR, VIAL ^{NR} YESINTEK (ustekinumab -kfce) ^{AL} SYR, VIAL	

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 October 1, 2026, **Highlights** indicate change from previous posting

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

CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
JAK-INHIBITORS^{CL}		- Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. - Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this entire drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. Drug-specific criteria: Cibinqo/Rinvoq/RinvoqER: For diagnosis of moderate to severe Atopic Dermatitis requires treatment failure of TWO preferred systemic drug products, including biologics, within this entire drug class or the Immunomodulators, Atopic Dermatitis therapeutic class. JAK-Inhibitors: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication. Pyzchiva/Steqeyma: Requires a trial and failure of a preferred TNF blocker with the same indication.
	CIBINQO (abrocitinib) ^{AL,CL,QL} TAB LEQSELVI (deuruxolitinib) TAB LISRAYA (brepocitinib)^{NR} TAB LITFULO (ritlecitinib) ^{AL} CAPS OLUMIANT (baricitinib) ^{QL} TAB RINVOQ ER (upadacitinib) ^{CL,QL} TAB RINVOQ (upadacitinib) ^{AL,CL,QL} LQ SOLN tofacitinib (generic Xeljanz) ^{NR,QL} SOLN tofacitinib (generic Xeljanz) ^{NR,QL} TAB tofacitinib ER (generic Xeljanz XR) ^{NR,QL} XELJANZ (tofacitinib) SOLN^{QL} XELJANZ (tofacitinib) TAB^{QL} XELJANZ XR (tofacitinib) TAB^{QL}	
TNF-BLOCKERS		
ADALIMUMAB-ADBM(CF) ^{AL} 50mg/mL KIT, PEN-KIT ADALIMUMAB-ADBM(CF) ^{AL} 100mg/mL KIT, PEN-KIT ENBREL (etanercept) KIT, MINI CART, PEN, SYR, VIAL^{QL} HADLIMA (adalimumab- bwwd) ^{AL} PUSHTOUCH, SYR HADLIMA (CF) (adalimumab- bwwd) ^{AL} PUSHTOUCH, SYR SIMLANDI (CF) (adalimumab-ryvk) ^{AL} PEN KIT	ABRILADA (adalimumab-afzb) ^{AL} (CF) KIT, PEN-KIT ADALIMUMAB-AACF (CF) ^{AL} PEN* KIT, SYR-KIT ADALIMUMAB-AATY (CF) ^{AL} PEN KIT ADALIMUMAB-ADAZ(CF)(biosim for Hyrimoz) ^{AL} KIT, PEN, SYR ADALIMUMAB-ADBM(CF) ^{AL} 50mg/mL KIT, PEN-KIT (Quallent) ADALIMUMAB-ADBM(CF) ^{AL} 100mg/mL KIT, PEN-KIT (Quallent) ADALIMUMAB-FKJP (biosim for Hulio) ^{AL} PEN, SYR ADALIMUMAB-RYVK ^{AL} (biosim for Simlandi) KIT, PEN-KIT AMJEVITA (adalimumab-atto) ^{AL} AUTOINJ, SYR AMJEVITA(adalimumab-atto) ^{AL} KIT, PEN-KIT CIMZIA (certolizumab pegol) ^{QL} CYLTEZO (adalimumab-adbm) ^{AL} 50mg/mL KIT, PEN-KIT CYLTEZO (adalimumab-adbm) ^{AL} 100mg/mL KIT, PEN-KIT	

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 October 1, 2026, **Highlights** indicate change from previous posting

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

CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
TNF-BLOCKERS (continued)		
	HULIO (adalimumab-fkjp) ^{AL} PEN, SYR HUMIRA (adalimumab) ^{QL} HYRIMOZ(CF) (adalimumab-adaz) ^{AL} PEN, SYR IDACIO (adalimumab-aacf) ^{AL} PEN, SYR SIMLANDI (CF) (adalimumab-ryvk) ^{AL} KIT SIMPONI (golimumab) YUFLYMA 100mg/mL (CF) (adalimumab-aaty) ^{AL} KIT,PEN-KIT YUFLYMA 80mg/mL (CF) (adalimumab-aaty) ^{AL} AUTOINJ, PEN, KIT YUSIMRY (CF) (adalimumab-aqvh) ^{AL} PEN KIT ZYMFENTRA (infliximab-dyyb) PEN, SYR	- Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. - Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this entire drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. JAK-Inhibitors: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication. Drug-specific criteria: Pyzchiva/Steqeyma: Requires a trial and failure of a preferred TNF blocker with the same indication. Cibinqo/Rinvoq/RinvoqER: For diagnosis of moderate to severe Atopic Dermatitis requires treatment failure of TWO preferred systemic drug products, including biologics, within this entire drug class or the Immunomodulators, Atopic Dermatitis therapeutic class.

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Page 36 of 99

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

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MISCELLANEOUS MECHANISM OF ACTION		- Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. - Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this entire drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. Drug-specific criteria: Cibinqo/Rinvoq/RinvoqER: For diagnosis of moderate to severe Atopic Dermatitis requires treatment failure of TWO preferred systemic drug products, including biologics, within this entire drug class or the Immunomodulators, Atopic Dermatitis therapeutic class. JAK-Inhibitors: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication. Pyzchiva/Steqeyma: Requires a trial and failure of a preferred TNF blocker with the same indication.
OTEZLA (apremilast) TAB ^{QL}	ARCALYST (nilonaccept) KINERET (anakinra) ENTYVIO (vedolizumab) ^{AL} PEN ORENCIA (abatacept) CLICKJET ORENCIA (abatacept) SYR OTEZLA XR (apremilast) TAB SOTYKTU (deucravacitinib) TAB SPEVIGO (spesolimab-sbzo) ^{AL} SYR VELSIPITY (etrasimod) ^{QL} TAB	

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 37 of 99

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

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

DIABETES MELLITUS, ALPHA-GLUCOSIDASE INHIBITORS

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

DIABETES MELLITUS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST (GLP-1 RA)^{AL,CL,QL}		<u>GLP-1 RA Criteria</u>
OZEMPIC (semaglutide) ^{AL,QL} TRULICITY (dulaglutide) ^{AL,QL} VICTOZA (liraglutide) ^{AL,QL}	BYDUREON BCISE PEN (exenatide) ^{AL,QL} BYETTA (exenatide) ^{AL,QL} subcutaneous exenatide (generic Byetta) ^{AL,QL} liraglutide (generic Victoza) ^{AL,QL} MOUNJARO (tirzepatide) ^{AL,QL} PEN OZEMPIC (semaglutide) ^{AL, NR, QL} TAB RYBELSUS (semaglutide) ^{AL,QL} 1.5mg, 3mg, 4mg, 7mg, 9mg, 14mg TAB	Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin OR A diagnosis of ASCVD associated with a diagnosis of Type II diabetes (no metformin trial required) Non-preferred agents will be approved for patients who have: - Failed a trial of TWO preferred agents within GLP-1 RA AND - Diagnosis of diabetes with HbA1C ≥ 7 AND - Trial of metformin, or contraindication or intolerance to metformin
INSULIN/GLP-1 RA COMBINATIONS		
	SOLIQUA (insulin glargine/lixisenatide) XULTOPHY (insulin degludec/liraglutide)	
AMYLIN ANALOG^{CL}		<u>Amylin Analog Criteria</u>
	SYMLIN (pramlintide) subcutaneous	ALL criteria must be met - Concurrent use of short-acting mealtime insulin - Current therapy compliance - No diagnosis of gastroparesis - HbA1C ≤ 9% within last 90 days - Monitoring of glucose during initiation of therapy
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR^{AL,CL,QL}		<u>DPP-4 Inhibitor Criteria</u>
JANUMET (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin (generic Nesina) alogliptin/metformin (generic Kazano) alogliptin/pioglitazone (generic Oseni) BRYNOVIN (sitagliptin) SOLN dapagliflozin/saxagliptin (generic Qtern) ^{NR} GLYXAMBI (empagliflozin/linagliptin) JANUMET XR (sitagliptin/metformin) JENTADUETO XR (linagliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) linagliptin (generic Tradjenta) ^{NR} ONGLYZA (saxagliptin) QTERN (dapagliflozin/saxagliptin) sitagliptin (generic Januvia) ^{NR}	Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin. Non-preferred DPP-4s will be approved for patients who have failed a trial of ONE preferred agent within the DPP-4 inhibitor class

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

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

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

DIABETES MELLITUS, INCRETIN MIMETICS/ENHANCERS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR^{AL,CL,QL}		
	saxagliptin (generic Onglyza)	
	saxagliptin/metformin ER (generic Kombiglyze ER)	
	sitagliptin (generic Zituvio)	
	sitagliptin phos/metformin (generic Janumet) ^{NR}	
	sitagliptin phos-metformin er (generic Janumet XR) ^{AL,NR, QL}	
	sitagliptin/ metformin (Zituvimet)	
	sitagliptin/ metformin ER (generic Zituvimet XR)	
	STEGLUJAN (ertugliflozin/sitagliptin)	
	TRIJARDY XR (empagliflozin/linagliptin/metformin)	
	ZITUVIMET (sitagliptin/metformin) TAB^{QL}	
	ZITUVIMET XR (sitagliptin/ metformin ER) TAB^{QL}	
	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

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 October 1, 2026, **Highlights** indicate change from previous posting

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

DIABETES MELLITUS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HUMALOG U-100 CARTRIDGE, PEN, VIAL HUMALOG JR. (insulin lispro) U-100 KWIKPEN HUMALOG MIX PEN (insulin lispro protamine/lispro) HUMULIN (insulin) VIAL HUMULIN 70/30 VIAL HUMULIN U-500 VIAL HUMULIN U-500 PEN ^{CL} HUMULIN OTC PEN HUMULIN 70/30 OTC PEN insulin aspart/insulin aspart protamine PEN, VIAL (generic Novolog Mix) insulin lispro (generic Humalog) PEN, VIAL, JR KWIKPEN insulin lispro/lispro protamine KWIKPEN (Humalog Mix Kwikpen) LANTUS SOLOSTAR PEN (insulin glargine) LANTUS (insulin glargine) VIAL	ADMELOG (insulin lispro) PEN, VIAL AFREZZA (regular insulin) ^{CL} INHALATION APIDRA (insulin glulisine) SOLOSTAR, VIAL AWIQLI (insulin icodec-abae) FLEXTOUCH PEN ^{NR} BASAGLAR (insulin glargine, rec) PEN FIASP (insulin aspart) CARTRIDGE, PEN, VIAL HUMALOG U-100 TEMPO PEN HUMALOG (insulin lispro) ^{CL} U-200 PEN HUMALOG MIX VIAL (insulin lispro/lispro protamine) insulin degludec (generic Tresiba) 100U/mL PEN, VIAL insulin degludec (generic Tresiba) 200U/mL PEN insulin glargine PEN, VIAL insulin glargine (Toujeo) insulin glargine max (Toujeo Max) insulin glargine-YFGN PEN, VIAL (generic Semglee-YFGN) LEVEMIR (insulin detemir) PEN, VIAL LYUMJEV KWIKPEN, VIAL (insulin lispro-aabc) LYUMJEV (insulin lispro-aabc) TEMPO PEN	- Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: Afrezza®: Approved for T1DM on long-acting insulin with no current history of smoking or chronic lung disease Humulin® R U-500 Kwikpen: May be approved for patients who require >200 units/day Humalog U-200 Pen: May be approved for patients who require > 100 units/day

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 October 1, 2026, **Highlights** indicate change from previous posting

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

DIABETES MELLITUS, INSULIN AND RELATED DRUGS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	MERILOG (insulin aspart-szjj) SOLOSTAR PEN MERILOG (insulin aspart-szjj) VIAL NOVOLIN (insulin) PEN-OTC, VIAL-OTC NOVOLIN 70/30 VIAL (insulin) NOVOLOG (insulin aspart) CARTRIDGE, PEN, VIAL NOVOLOG MIX (insulin aspart/aspart protamine) PEN, VIAL REZVOGLAR (insulin glargine-aglr) KWIKPEN SEMGLEE (insulin glargine) PEN, VIAL SEMGLEE YFGN (insulin glargine) PEN, VIAL TOUJEO SOLOSTAR (insulin glargine)	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

DIABETES MELLITUS, MEGLITINIDES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
repaglinide (generic Prandin)	nateglinide (generic Starlix)	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

DIABETES MELLITUS, 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) ^{CL} metformin SOLN (generic Riomet) ^{CL} RIOMET ER (metformin ER) ^{AL}	Metformin ER (generic Fortamet®/Glumetza®): Requires clinical reason why generic Glucophage XR® cannot be used Metformin solution: Prior authorization not required for age <7 years

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 October 1, 2026, **Highlights** indicate change from previous posting

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

DIABETES MELLITUS, SGLT2^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
dapagliflozin (generic Farxiga) ^{CL,QL} JARDIANCE (empagliflozin) ^{QL} SYNJARDY (empagliflozin/metformin) ^{AL,QL} XIGDUO XR (dapagliflozin/metformin) ^{QL}	BRENZAVVY (bexagliflozin) ^{NR} dapagliflozin (AG) (generic Farxiga) ^{CL,QL} dapagliflozin/metformin (generic Xigduo) ^{QL} FARXIGA (dapagliflozin) ^{QL} INPEFA (sotagliflozin) ^{QL} TAB INVOKAMET (canagliflozin/metformin) ^{QL} INVOKAMET XR (canagliflozin/metformin) ^{QL} INVOKANA (canagliflozin) SEGLUROMET (ertugliflozin/metformin) ^{QL} STEGLATRO (ertugliflozin) ^{QL} SYNJARDY XR (empagliflozin/metformin) ^{AL,QL}	Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin, OR A diagnosis of ASCVD or Heart Failure, or Chronic Kidney Disease associated with a diagnosis of Type II diabetes (no metformin trial required) ▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug Specific Criteria: • Farxiga/ dapagliflozin: May be approved for a diagnosis of Heart Failure without a diagnosis of diabetes • May be approved for a diagnosis of chronic kidney disease at risk of progression without a diagnosis of diabetes • Jardiance: May be approved for a diagnosis of Heart Failure without a diagnosis of diabetes

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 October 1, 2026, **Highlights** indicate change from previous posting

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

DIABETES MELLITUS, 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) glipizide 15mg ^{NR} tolazamide tolbutamide	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
SULFONYLUREA COMBINATIONS		
glipizide/metformin glyburide/metformin (generic Glucovance)		

DIABETES MELLITUS, TZD

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
THIAZOLIDINEDIONES (TZDs)		Non-preferred agents will be approved for patients who have failed a trial of the preferred agent within this drug class
pioglitazone (generic Actos)		
TZD COMBINATIONS ^{CL}		Combination products: Require clinical reason why individual ingredients cannot be used
	pioglitazone/glimepiride (generic Duetact) pioglitazone/metformin (generic Actoplus Met)	

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 October 1, 2026, **Highlights** indicate change from previous posting

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

DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SINGLE-AGENT PRODUCTS		- Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class. Drug Specific Criteria: eplerenone: Will be approved with a failed trial or intolerance to spironolactone, a trial with two preferred agents is not required. Kerendia: For diagnosis of chronic kidney disease associated with Type-II diabetes in adults. Also for diagnosis of heart failure in adults with LVEF of 40% or greater. spironolactone suspension: May be approved without trial of a preferred agent if there is a clinical reason why preferred spironolactone solid dosage form cannot be used.
amiloride TAB bumetanide TAB chlorthalidone (generic Diuril) TAB furosemide (generic Lasix) SOLN, TAB hydrochlorothiazide (generic Microzide) CAPS, TAB indapamide TAB KERENDIA (finerenone) TAB ^{CL,QL} metolazone TAB spironolactone (generic Aldactone) ^{AL} TAB torsemide TAB	BAXFENDY (baxdrostat) TAB ^{NR,AL,QL} CAROSPIR (spironolactone) ^{AL} SUSP ENBUMYST (bumetanide) ^{NR} NASAL SPRAY eplerenone (generic Inspra) ^{CL} TAB ethacrynic acid (generic Edecrin) CAPS HEMICLOR (chlorthalidone) TAB INZIRQO (hydrochlorothiazide) ^{QL} SUSP spironolactone (generic Carospir) ^{AL,CL} SUSP THALITONE (chlorthalidone) TAB triamterene (generic Dyrenium)	
COMBINATION PRODUCTS		
amiloride/HCTZ TAB spironolactone/HCTZ TAB (generic Aldactazide) triamterene/HCTZ CAPS, TAB (generic Dyazide, Maxzide)		

ENZYME REPLACEMENT, GAUCHER'S DISEASE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ZAVESCA (miglustat) ^{CL}	CERDELGA (eliglustat) miglustat (generic Zavesca) ^{CL}	- Non-preferred agents require clinical documentation on why the preferred product within this drug class is not appropriate Drug-specific criteria: Zavesca/miglustat: Approved for mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

Page 45 of 99

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

EPINEPHRINE, SELF-ADMINISTERED ^{QL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUVI-Q 0.1mg (epinephrine) epinephrine (AUTHORIZED GENERIC Epipen/ Epipen Jr.) AUTOINJ EPIPEN (epinephrine) AUTOINJ EPIPEN JR. (epinephrine) AUTOINJ	AUVI-Q 0.15mg (epinephrine) AUVI-Q 0.3mg (epinephrine) epinephrine (generic Adrenaclick) epinephrine (generic Epipen/ Epipen Jr.) AUTOINJ NEFFY (epinephrine) NASAL ^{AL,QL}	Non-preferred agents require clinical documentation why the preferred products within this drug class are not appropriate

ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ARANESP (darbopoetine alfa) DISP SYR, VIAL EPOGEN (rHuEPO) RETACRIT (epoetin alfa-epbx) <i>Pfizer manufacturer only</i>	PROCRIT (rHuEPO) RETACRIT (epoetin alfa-epbx) <i>Vifor manufacturer only</i> VAFSEO (vadadustat) TAB	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

FLUOROQUINOLONES, ORAL

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

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 October 1, 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
LINZESS (linaclotide) ^{AL, QL} lubiprostone (generic Amitiza) ^{AL, QL}	alosetron (generic Lotronex) ^{CL} AMITIZA (lubiprostone) ^{AL, QL} IBSRELA (tenapanor) ^{AL, CL, QL} MOTEGRITY (prucalopride succinate) MOVANTIK (naloxegol oxalate) ^{QL} prucalopride (generic Motegrity) SYMPROIC (naldemedine) ^{CL} VIBERZI (eluxodoline) ^{CL}	- 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 Drug-specific criteria: Lotronex/ alosetron: Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate Viberzi®: Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate

GLUCAGON AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BAQSIMI (glucagon) ^{AL, QL} NASAL GLUCAGON EMERGENCY (glucagon) ^{QL} INJ KIT (Amphastar) GLUCAGON EMERGENCY (glucagon) ^{QL} INJ KIT (Fresenius) glucagon ^{QL} INJ GVOKE (glucagon) ^{AL, QL} PEN, SYR GVOKE (glucagon) ^{AL, QL} VIAL PROGLYCEM (diazoxide) SUSP ZEGALOGUE (dasiglucagon) ^{AL, QL} AUTO-INJ	diazoxide SUSP (generic Proglycem) GLUCAGON EMERGENCY (glucagon) INJ KIT (Lupin) ^{QL} GLUCAGON EMERGENCY (glucagon) ^{QL} INJ KIT (Mylan) ZEGALOGUE (dasiglucagon) ^{AL, QL} SYR	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

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

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

GLUCOCORTICOID, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCOCORTICOIDS		- Non-preferred agents within the Glucocorticoids and Glucocorticoid/Bronchodilator Combo groups will be approved for patients who have failed a trial of TWO preferred agents within the last 6 months Drug-specific criteria: budesonide respules: Covered without PA for age ≤ 8 years OR for diagnosis of eosinophilic esophagitis in patients ≥ 9 years, by GI biopsy or upper endoscopy. For other indications, must have failed a trial of two preferred agents within this drug class, within the last 6 months.
ARNUITY ELLIPTA (fluticasone) ASMANEX (mometasone) ^{QL,AL} ASMANEX HFA (mometasone) ^{QL} fluticasone HFA (generic Flovent HFA)	ALVESCO (ciclesonide) ^{AL} ARMONAIR DIGIHALER (fluticasone) ^{AL,QL} beclomethasone (generic Qvar) ^{NR} fluticasone (generic Flovent Diskus) fluticasone furoate (generic Arnuity Ellipta) ^{AL} QVAR Redihaler (beclomethasone)	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol) ^{QL} ADVAIR HFA (fluticasone/salmeterol) ^{QL} DULERA (mometasone/formoterol) SYMBICORT (budesonide/ formoterol) TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)	AIRDUO DIGIHALER (fluticasone/salmeterol) ^{AL,QL} AIRSUPRA HFA (albuterol and budesonide) ^{AL} BREO ELLIPTA (fluticasone/vilanterol) BREZTRI (budesonide/formoterol/glycopyrrolate) ^{QL} budesonide/formoterol (generic Symbicort) fluticasone/salmeterol (generic Advair Diskus) ^{QL} fluticasone/salmeterol (generic Advair HFA) ^{QL} fluticasone/salmeterol (generic Airduo Respiclick) fluticasone/vilanterol (Breo Ellipta)	
INHALATION SOLUTION		
	budesonide RESPULES (generic Pulmicort) ^{CL}	

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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 CAPS (generic Entocort EC) dexamethasone ELIXIR, SOLN dexamethasone TAB hydrocortisone TAB methylprednisolone tablet (generic Medrol) prednisolone SOLN prednisolone sodium phosphate prednisone DOSE PAK prednisone TAB	ALKINDI (hydrocortisone) GRANULES^{AL} CORTEF (hydrocortisone) cortisone TAB dexamethasone ^{CL} INTENSOL DEXLYT (dexamethasone) ^{NR} TAB EOHILIA (budesonide) ^{AL, QL} SUSP HEMADY (dexamethasone) KHINDIVI (hydrocortisone) ^{AL} SOLN methylprednisolone 8mg, 16mg, 32mg prednisolone sodium phosphate (generic Millipred/Veripred) prednisolone sodium phosphate ODT prednisone SOLN prednisone ^{CL} INTENSOL prednisone DR ^{NR} TAB RAYOS DR (prednisone) TAB	- Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: Intensol Products: Patient specific documentation of why the less concentrated solution is not appropriate for the patient

GROWTH HORMONES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GENOTROPIN (somatropin) NORDITROPIN (somatropin)	HUMATROPE (somatropin) NGENLA (somatrogon-ghla) ^{AL} NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin-tcgd) SOGROYA (somapacitan-beco) ZOMACTON (somatropin)	Growth Hormone PA Form Growth Hormone Criteria

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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) ^{QL}	bismuth,metronidazole,tetracycline (generic Pylera) ^{QL} lansoprazole/amoxicillin/clarithromycin (generic Prevpac) ^{QL} OMECLAMOX-PAK (omeprazole, clarithromycin, amoxicillin) ^{QL} TALICIA (omeprazole/amoxicillin/rifabutin) VOQUEZNA (vonoprazan) ^{CL,QL}	- Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-Specific Criteria Voquezna: 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.

HAE TREATMENTS ^{CL}

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

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 October 1, 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
BISPECIFIC FACTORS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this entire drug class and with the same indication.
HEMLIBRA		
FACTOR VIII		
ALPHANATE	ADVATE	
HUMATE-P	ADYNOVATE	
KOVALTRY	AFSTYLA	
NOVOEIGHT	ALTUVIIIIO	
NUWIQ	ELOCTATE	
XYNTHA KIT, SOLOFUSE	ESPEROCT	
	HEMOFIL-M	
	JIVI ^{AL}	
	KOATE-DVI KIT	
	KOATE-DVI VIAL	
	KOGENATE FS	
	OBIZUR	
	RECOMBINATE	
FACTOR IX		
ALPROLIX	ALPHANINE SD	
BENEFIX	IDELVION	
	IXINITY	
	PROFILNINE SD	
	REBINYN	
	RIXUBIS	
FACTOR VIIa AND PROTHROMBIN COMPLEX-PLASMA DERIVED		
NOVOSEVEN RT	FEIBA NF	
	SEVENFACT ^{AL}	
FACTOR X AND XIII PRODUCTS		
COAGADEX	TRETTEN	
CORIFACT		
TISSUE FACTOR PATHWAY INHIBITOR/ ANTITHROMBIN INHIBITORS		
	ALHEMO ^{AL}	
	HYMPAVZI ^{AL}	
	QFITLIA (fitusiran) ^{AL} PEN, VIAL	
VON WILLEBRAND PRODUCTS		
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 October 1, 2026, **Highlights** indicate change from previous posting

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

HEPATITIS B AND RELATED AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
entecavir TAB	adefovir dipivoxil BARACLUDE (entecavir) SOLN , TAB HEPCLUDEX (bulevirtide) SUB-Q^{NR} lamivudine hbv TAB VEMLIDY (tenofovir alafenamide fumarate)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug Specific Criteria ▪ tenofovir disoproxil fumarate (generic Viread) tablet: Diagnosis for use required. May be indicated for chronic hepatitis B or HIV-1 infection. ○ See HIV/AIDS class for drug listing and placement

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

Page 52 of 99

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

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIRECT ACTING ANTI-VIRAL		Hepatitis C Treatments PA Form Hepatitis C Criteria
MAVYRET (glecaprevir/pibrentasvir) TAB^{CL}, PELLET^{AL,CL} sofosbuvir/velpatasvir (generic Epclusa) ^{CL} VOSEVI (sofosbuvir/velpatasvir/ voxilaprevir) ^{CL}	HARVONI 200/45MG (ledipasvir/sofosbuvir) ^{CL} TAB HARVONI (ledipasvir/sofosbuvir) ^{CL} PELLET ledipasvir/sofosbuvir (generic Harvoni) ^{CL} SOVALDI (sofosbuvir) ^{CL} PELLET SOVALDI TAB (sofosbuvir) ^{CL} ZEPATIER (elbasvir/grazoprevir) ^{CL}	- 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 - Patients newly eligible for Medicaid will be allowed to complete treatment with the original that treatment was initially authorized by another payor
RIBAVIRIN		
ribavirin 200mg CAPSULE, TAB		Drug-specific criteria:
INTERFERON		Trial with with a preferred agent not required in the following:
PEGASYS (pegylated interferon alfa-2a) ^{CL}		Harvoni/ ledipasvir-sofosbuvir: - Post liver transplant for genotype 1 or 4 Vosevi: Requires documentation of non-response after previous treatment course of Direct Acting Anti-viral agent (DAA) for genotype 1-6 without cirrhosis or with compensated cirrhosis

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 October 1, 2026, **Highlights** indicate change from previous posting

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

HISTAMINE II RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
famotidine TAB (generic Pepcid) famotidine SUSP	cimetidine (generic Tagamet) ^{CL} SOLN, TAB famotidine CHEW-TAB nizatidine CAPS (generic Axid) ranitidine SYRUP, TAB	- Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: Cimetidine: Approved for viral M. contagiosum or common wart V. Vulgaris treatment

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 October 1, 2026, **Highlights** indicate change from previous posting

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

HIV / AIDS^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CAPSID INHIBITOR		- All agents require: - Diagnosis of HIV/AIDS required, OR - Diagnosis of Pre and Post Exposure Prophylaxis
	SUNLENCA (lenacapavir) ^{QL} YEZTUGO (lenacapavir) ^{NR,QL} TAB	
CCR5 ANTAGONISTS		Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for the patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents
maraviroc (generic Selzentry) SELZENTRY (maraviroc) SOLN	SELZENTRY (maraviroc) TAB	
HIV-1 ATTACHMENT INHIBITOR		Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	RUKOBIA ER (fostemsavir) ^{AL,QL}	
INTEGRASE STRAND TRANSFER INHIBITORS (INSTIs)		Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
ISENTRESS (raltegravir) ^{QL} ISENTRESS HD (raltegravir) TIVICAY (dolutegravir)	TIVICAY PD (dolutegravir)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)		Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
EDURANT (rilpivirine) efavirenz CAPS, TABLET (generic Sustiva) INTELENCE (etravirine) ^{QL} PIFELTRO (doravirine) ^{QL}	etravirine (generic Intelence) ^{QL} nevirapine IR, ER (generic Viramune/Viramune XR) rilpivirine (generic Edurant) SUSTIVA CAPS, TABLET (efavirenz) VIRAMUNE (nevirapine) SUSP	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
abacavir SOLN, TABLET (generic Ziagen) emtricitabine CAPS (generic Emtriva) EMTRIVA SOLN (emtricitabine) lamivudine SOLN, TABLET (generic Epivir) zidovudine CAPS, SYRUP, TABLET (generic Retrovir)	didanosine DR (generic Videx EC) EMTRIVA CAPS (emtricitabine) EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine CAPS (generic Zerit) ZIAGEN (abacavir)	
NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
tenofovir TABLET (generic Viread)	VIREAD (tenofovir) POWDER	
PHARMACOKINETIC ENHANCER		Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	TYBOST (cobicistat) ^{QL}	

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 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
PROTEASE INHIBITORS		▪ All agents require: ○ Diagnosis of HIV/AIDS required, OR ○ Diagnosis of Pre and Post Exposure Prophylaxis ▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patients, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy.
atazanavir CAPS (generic Reyataz) darunavir ethanolate (generic Prezista) ^{AL} TAB ritonavir TAB (generic Norvir)	APTIVUS CAPS, SOLN (tipranavir) CRIXIVAN (indinavir) DARUNAVIR PROPYLENE GLYCOLATE ^{AL} TAB fosamprenavir TAB (generic Lexiva) LEXIVA SUSP (fosamprenavir) LEXIVA TAB (fosamprenavir) NORVIR POWDER, SOLN (ritonavir) NORVIR (ritonavir) TAB PREZISTA (darunavir) SUSP PREZISTA (darunavir) TAB REYATAZ POWDER (atazanavir) VIRACEPT (nelfinavir)	
COMBINATION PROTEASE INHIBITORS (PIs) or PIs plus PHARMACOKINETIC ENHANCER		
EVOTAZ (atazanavir/cobicistat) ^{QL} lopinavir/ritonavir SOLN, TAB (generic Kaletra)	KALETRA SOLN (lopinavir/ritonavir) KALETRA TAB (lopinavir/ritonavir) PREZCOBIX (darunavir/cobicistat) ^{QL}	
COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir/lamivudine (generic Epzicom) CIMDUO (lamivudine/tenofovir) ^{QL} DESCOVY (emtricitabine/tenofovir) ^{QL} emtricitabine/tenofovir (generic Truvada) lamivudine/zidovudine (generic Combivir)	abacavir/lamivudine/zidovudine (generic Trizivir) COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir sulfate/lamivudine) TRIZIVIR (abacavir/lamivudine/zidovudine) TRUVADA (emtricitabine/tenofovir)	

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 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
COMBINATION PRODUCTS – MULTIPLE CLASSES		
BIKTARVY (bictegravir/emtricitabine/tenofovir) ^{QL}	BIXLENVO (bictegravir/lenacapavir) TAB ^{NR}	- All agents require: - Diagnosis of HIV/AIDS required, OR - Diagnosis of Pre and Post Exposure Prophylaxis - Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patients, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents - Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
COMPLERA (rilpivirine/emtricitabine/tenofovir)	efavirenz/lamivudine/tenofovir (generic Symfi) ^{QL}	
DELSTRIGO (doravirine/lamivudine/tenofovir) ^{QL}	efavirenz/lamivudine/tenofovir (generic Symfi Lo) ^{QL}	
DOVATO (dolutegravir/lamivudine) ^{QL}	IDVYNSO (doravirine/islatravir) ^{AL, NR}	
efavirenz/emtricitabine/tenofovir (generic Atripla) ^{CL}	rilpivirine/emtricitabine/tenofovir (Complera) ^{NR}	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) ^{QL, AL}	TRIUMEQ PD (abacavir/dolutegravir/lamivudine) SUSP	
JULUCA (dolutegravir/rilpivirine) ^{QL}		
ODEFSEY (emtricitabine/rilpivirine/tenofovir) ^{QL}		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) ^{QL}		
SYMFI (efavirenz/lamivudine/tenofovir) ^{QL}		
SYMFI LO (efavirenz/lamivudine/tenofovir) ^{QL}		
SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir) ^{QL}		
TRIUMEQ (dolutegravir/abacavir/lamivudine)		

IDIOPATHIC PULMONARY FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
pirfenidone (generic Esbriet) ^{QL}	ESBRIET (pirfenidone) ^{QL} JASCAYD (nerandomilast) ^{NR} nintedanib (generic Ofev) ^{NR, QL} CAPS OFEV (nintedanib esylate) ^{QL} CAPS	- Non-preferred agent requires trial of preferred agent within this drug class with the same indication - FDA approved indication required – ICD-10 diagnosis code

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 2026, **Highlights** indicate change from previous posting

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

IMMUNOMODULATORS, ASTHMA^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FASENRA (benralizumab)^{AL} PEN XOLAIR (omalizumab) AUTO-INJ^{AL,QL}, SYR^{AL,QL}	EXDENSUR (depemokimab-ulaa)^{AL,NR} SYR NUCALA (mepolizumab)^{AL} AUTO-INJ, SYR OMLYCLO (omalizumab-igec)^{AL,NR,QL} SYR TEZSPIRE (tezepelumab-ekko)^{AL,CL} PEN	Immunomodulators Self-Injectable PA Form Immunomodulators: Self-Administered Injectables Criteria - All agents require prior authorization AND an FDA-approved diagnosis for approval - Non-preferred agents require a trial of a preferred agent within this drug class with the same indication - For asthma indications: All agents must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist - Agents listed may have other FDA approved indications, and will be subject to prior authorization (see links above) Drug Specific Criteria: Dupixent: (For other indications, see Immunomodulators, Atopic Dermatitis and COPD therapeutic classes). For Eosinophilic Asthma or Corticosteroid Dependent Asthma: Patients must be ages 6 and older. Documentation of moderate to severe asthma with either eosinophils $\geq 150 + 1$ exacerbation OR oral corticosteroid dependency AND prior drug therapy of med-high or max-tolerated inhaled corticosteroid + controller OR max-tolerated inhaled corticosteroid / long-acting beta agonist combo Tezspire Pen: Does not require a trial of a preferred agent for severe asthma that is non-Type 2 (EOS and IgE asthma). Prior authorization still applies for approval (see links above).

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 58 of 99

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

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

IMMUNOMODULATORS, ATOPIC DERMATITIS^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ADBRY (tralokinumab-ldrm)^{AL,CL,QL} SUB-Q ADBRY 300mg/2mL (tralokinumab-ldrm)^{AL,CL,QL} AUTOINJ DUPIXENT (dupilumab)^{AL,CL} PEN,SYR EBGLYSS (lebrikizumab-lbkz)^{AL,CL,QL} PEN, SYRINGE ELIDEL (pimecrolimus) EUCRISA (crisaborole)^{CL,QL} pimecrolimus (generic Elidel) tacrolimus (generic Protopic)	ADQUEY (difamilast) OINT^{AL,NR} ANZUPGO (delgocitinib)^{QL} CREAM NEMLUVIO (nemolizumab-ilto)^{AL} OPZELURA (ruxolitinib phosphate) CREAM^{AL,CL,QL} VTAMA (tapinarof)^{AL} CREAM ZORYVE 0.15% (roflumilast)^{AL} CREAM ZORYVE 0.05% (roflumilast)^{AL,NR} CREAM	Immunomodulators Self-Injectable PA Form Immunomodulators: Self-Administered Injectables Criteria - Non-preferred agents require: Trial of a topical steroid AND Trial of one preferred product within this drug class with same indication. Non-preferred biologics also require treatment failure of a preferred biologic with the same indication. Drug-specific criteria: Adbry/Ebglyss: May be approved after a trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor Dupixent: (For other indications, see Immunomodulators, Asthma and COPD therapeutic classes, and links above): Atopic Dermatitis: May be approved after a minimum of a 14-day trial of a topical corticosteroid AND a 6-week topical calcineurin inhibitor Eucrisa: May be approved after a 30 day trial failure of a preferred topical corticosteroid (TCS) or topical calcineurin inhibitor (TCI) within the past 180 days; Maximum of 300 grams per year Opzelura: May be approved for a diagnosis of Atopic Dermatitis and after a trial/failure of a topical steroid and trial of a preferred agent

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

IMMUNOMODULATORS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
imiquimod (generic Aldara)	HYFTOR (sirolimus) ^{AL} GEL imiquimod (generic Zyclara) podofilox (generic Condyllox) GEL, SOLN VEREGEN (sinecatechins)	Non-preferred agents require clinical reason why preferred agent within this drug class cannot be used

IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathioprine (generic Imuran) azathioprine (generic Azasan) ^{NR} cyclosporine, modified (generic Neoral) CAPS everolimus (generic Zortress) ^{AL} mycophenolate (generic Cellcept) CAPS, TAB mycophenolic acid sirolimus (generic Rapamune) SOLN, TAB tacrolimus	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) cyclosporine CAP, SOFTGEL cyclosporine, modified (generic Neoral) SOLN ENVARUSUS XR (tacrolimus) GENGRAF (cyclosporine, modified) CAP, SOLN mycophenolate (generic Cellcept) SUSP MYFORTIC (mycophenolate sodium) MYHIBBIN (mycophenolate) ^{AL} SUSP PROGRAF (tacrolimus) CAPS, PACKET REZUROCK (belumosudil) ^{AL, QL} TAB SANDIMMUNE (cyclosporine) CAPS, SOLN TAVNEOS (avacopan) ^{CL, QL} CAPS ZORTRESS (everolimus) ^{AL}	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class - Patients established on existing therapy will be allowed to continue Drug Specific Criteria Tavneos (avacopan) - No trial of a preferred agent required with appropriate FDA indications with concurrent use of standard therapy, including glucocorticoids

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 2026, **Highlights** indicate change from previous posting

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

INTRANASAL RHINITIS AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within the same subclass. Drug-specific criteria: ▪ mometasone: Prior authorization NOT required for children ≤ 12 years ▪ budesonide: Approved for use in Pregnancy (Pregnancy Category B) ▪ Xhance: Indicated for treatment of nasal polyps in ≥ 18 years only
ipratropium (generic Atrovent)		
ANTI-HISTAMINES		
azelastine 0.1% (generic Astelin)	azelastine 0.15% (generic Astepro) azelastine/fluticasone (generic Dymista) olopatadine (generic Patanase) RYALTRIS (olopatadine/mometasone) ^{AL}	
CORTICOSTEROIDS		
fluticasone Rx (generic Flonase)	BECONASE AQ (beclomethasone) budesonide (Rhinocort) ^{CL} OTC flunisolide (generic Nasalide) fluticasone (generic Flonase) OTC mometasone (generic Nasonex) ^{CL} OTC, RX NASONEX (mometasone) OTC OMNARIS (ciclesonide) QNASL 40 & 80 (beclomethasone) triamcinolone (generic Nasacort) OTC XHANCE (fluticasone) ^{CL} ZETONNA (ciclesonide)	

LEUKOTRIENE MODIFIERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
montelukast (generic Singulair) TAB^{QL}/CHEWABLE^{AL}	montelukast GRANULES (generic Singulair) ^{CL, AL} 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: ▪ montelukast granules: PA not required for age < 2 years

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 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 CAPS clindamycin palmitate SOLN linezolid TAB	CLEOCIN (clindamycin) CAPS CLEOCIN PALMITATE (clindamycin) CLEOCIN PEDIATRIC (clindamycin) SOLN linezolid SUSP SIVEXTRO (tedizolid phosphate) ZYVOX (linezolid) SUSP, TAB	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		- Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: Colesevelam: Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate Juxtapid/ Kynamro: - Approved for diagnosis of homozygous familial hypercholesterolemia (HoFH) OR - Treatment failure/maximized dosing/contraindication to ALL the following: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, bile acid sequestrants - Require faxed copy of REMS PA form Redemplo/Tryngolza: 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
cholestyramine (generic Questran) colestipol TAB (generic Colestid)	colesevelam (generic Welchol) ^{CL} TAB, PACKET colestipol (generic Colestid) GRANULES QUESTRAN LIGHT (cholestyramine)	
TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA		
	JUXTAPID (lomitapide) ^{CL} KYNAMRO (mipomersen) ^{CL}	
TREATMENT OF FAMILIAL CHYLOMICRONEMIA SYNDROME (FCS)		
	TRYNGOLZA (olezarsen) ^{AL,CL,QL} INJ REDEMPLO (plozasiran) ^{CL} SYR	
FIBRIC ACID DERIVATIVES		
fenofibrate (generic Tricor) fenofibrate (generic Lofibra) gemfibrozil (generic Lopid)	fenofibric acid (generic Fibracor/Trilipix) fenofibrate (generic Antara/Fenoglide/ Lipofen/Triglide)	
NIACIN		
niacin ER (generic Niaspan)	NIACOR (niacin IR)	
OMEGA-3 FATTY ACIDS		
icosapent (generic Vascepa) omega-3 fatty acids (generic Lovaza)	omega-3 OTC	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe (generic Zetia)	NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ ezetimibe) ^{QL}	

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 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
PROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		Drug-Specific Criteria Praluent and Repatha: May be approved for diagnoses of: - Atherosclerotic cardiovascular disease (ASCVD) in adults - Heterozygous familial hypercholesterolemia (HeFH) - Praluent ≥ 8 years of age - Repatha ≥ 10 years of age - Homozygous familial hypercholesterolemia (HoFH) - Praluent ≥ 18 years of age - Repatha ≥ 10 years of age AND - Trial and failure or intolerance to a statin plus ezetimibe for 8 continuous weeks - Concurrent use of a maximally tolerated statin must continue, except for statin-induced rhabdomyolysis or a contraindication to a statin - Failure to reach target LDL-C levels: - ASCVD – < 70 mg/dL - Very high risk ASCVD – < 55mg/dL - HeFH – < 100 mg/dL
PRALUENT (alirocumab) ^{CL} REPATHA (evolocumab) ^{CL} SURECLICK, SYR	LIPFENDRA (enlicotide) ^{NR,QL} TAB REPATHA (evolocumab) ^{CL} PUSHTRONEX	

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 October 1, 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
STATINS		- Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class, within the last 12 months Drug-specific criteria: Altoprev®: One of the TWO trials must be IR lovastatin Combination products: Require clinical reason why individual ingredients cannot be used fluvastatin ER: Requires trial of TWO preferred agents AND trial of IR fluvastatin OR clinical reason IR cannot be used simvastatin/ezetimibe: Approved for 3-month continuous trial of ONE standard dose statin
atorvastatin (generic Lipitor) ^{QL} lovastatin (generic Mevacor) pravastatin (generic Pravachol) rosuvastatin (generic Crestor) simvastatin (generic Zocor)	ALTOPREV (lovastatin ER) ^{CL} ATORVALIQ (atorvastatin) ^{QL} SUSP EZALLOR SPRINKLE (rosuvastatin) ^{QL} fluvastatin ER (generic Lescol XL) ^{CL} fluvastatin IR (generic Lescol) LIVALO (pitavastatin) ^{AL,QL} pitavastatin (generic Livalo) ^{AL,QL} ZYPITAMAG (pitavastatin)	
STATIN COMBINATIONS^{CL}		
	atorvastatin/amlodipine (generic Caduet) simvastatin/ezetimibe (generic Vytorin) ^{CL}	

MACROLIDES AND KETOLIDES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MACROLIDES		Non-preferred agents require clinical reason why preferred products within this drug class cannot be used AND ≥ 3-day trial on a preferred product
azithromycin (generic Zithromax) clarithromycin SUSP, TAB (generic Biaxin) erythromycin ethylsuccinate SUSP	azithromycin (generic Zithromax) PACKET clarithromycin ER (generic Biaxin XL) E.E.S. SUSP (erythromycin ethylsuccinate) E.E.S. TAB (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYPED SUSP (erythromycin) ERYTHROCIN (erythromycin) erythromycin base CAPS, TAB	

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 October 1, 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 PF VIAL, TABLET, VIAL	JYLAMVO (methotrexate) SOLN OTREXUP (methotrexate) SUB-Q RASUVO (methotrexate) SUB-Q TREXALL (methotrexate) TAB XATMEP (methotrexate) ^{CL} SOLN	Non-preferred agents require a trial of the preferred agent AND will be approved for an FDA-approved indication Drug-specific criteria: ▪ Xatmep™: Indicated for pediatric patients only

MOVEMENT DISORDERS^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUSTEDO (deutetrabenazine) ^{AL,CL,QL} AUSTEDO XR (deutetrabenazine) ^{AL,CL,QL} AUSTEDO XR Titration Pack (deutetrabenazine) ^{AL,CL} INGREZZA (valbenazine) ^{AL,CLQL} CAPS, SPRINKLES tetrabenazine (generic Xenazine) ^{CL}	INGREZZA (valbenazine) ^{AL,CL} INITIATION PACK XENAZINE (tetrabenazine) ^{CL}	All drugs require an FDA approved indication – ICD-10 diagnosis code required. Non-preferred agents require a trial and failure of a preferred agent with the same indication or a clinical reason why a preferred agent in this class cannot be used. Drug-specific criteria: ▪ Austedo/Austedo XR/Ingrezza: Diagnosis of Tardive Dyskinesia or chorea associated with Huntington's Disease; Requires a Step through tetrabenazine with the diagnosis of chorea associated with Huntington's Disease ▪ tetrabenazine: Diagnosis of chorea with Huntington's Disease

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

MULTIPLE SCLEROSIS DRUGS

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

NITROFURAN DERIVATIVES

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

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

NSAIDs, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-1 SELECTIVE		- 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/ketoralac Nasal: Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs
diclofenac sodium (generic Voltaren) ibuprofen OTC, Rx (generic Advil, Motrin) CHEW, DROPS, SUSP, TAB ibuprofen OTC (generic Advil, Motrin) CAPS indomethacin (generic Indocin) CAPS ketorolac (generic Toradol) meloxicam (generic Mobic) TAB nabumetone (generic Relafen) naproxen Rx, OTC (generic Naprosyn) naproxen enteric coated sulindac (generic Clinoril)	diclofenac potassium (generic Cataflam, Zipsor) diclofenac SR (generic Voltaren-XR) diflunisal (generic Dolobid) etodolac & SR (generic Lodine/XL) fenoprofen (generic Nalfon) flurbiprofen (generic Ansaid) ibuprofen/famotidine (generic Duexis) ibuprofen 300mg TAB indomethacin ER (generic Indocin) ketoprofen & ER (generic Orudis) ketorolac (generic Sprix Nasal) ^{CL, QL} NASAL meclofenamate (generic Meclomen) ^{CL} mefenamic acid (generic Ponstel) meloxicam (generic Vivlodex) ^{QL} CAP meloxicam (generic Mobic) SUSP naproxen CR (generic Naprelan) naproxen (generic Naprosyn) SUSP naproxen sodium (generic Anaprox) naproxen-esomeprazole (generic Vimovo) ORUDIS (ketoprofen) ^{NR} CAP oxaprozin (generic Daypro) piroxicam (generic Feldene) tolmetin (generic Tolectin) ZYBIC (meloxicam) ^{NR, AL} SUSP	

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 October 1, 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
COX-I SELECTIVE (continued)		▪ All combination agents require a clinical reason why individual agents can't be used separately
	ALL BRAND NAME NSAIDs including: DOLOBID (diflunisal) ^{AL} 250mg TAB DUEXIS (ibuprofen/famotidine) ^{CL} NALFON (fenoprofen) RELAFEN DS (nabumetone)	
NSAID/GI PROTECTANT COMBINATIONS^{CL}		
	diclofenac/misoprostol (generic Arthrotec)	
COX-II SELECTIVE		
celecoxib (generic Celebrex)	VYSCOXIA SUSP (celecoxib) ^{AL,NR}	

NSAIDs, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
diclofenac sodium GEL (OTC only)	diclofenac PUMP (generic Pennsaid) diclofenac SOLN (generic Pennsaid) FLECTOR PATCH (diclofenac) LICART PATCH (diclofenac)	Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class AND a clinical reason why patient cannot use oral dosage form.

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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
CDK 4/6 INHIBITOR		- Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines - Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	IBRANCE (palbociclib) KISQALI (ribociclib) KISQALI FEMARA CO-PACK VERZENIO (abemaciclib)	
CHEMOTHERAPY		
capecitabine (generic Xeloda) cyclophosphamide	XELODA (capecitabine)	Drug-specific criteria anastrozole: May be approved for malignant neoplasm of male breast (male breast cancer) Fareston/toremifene: Require clinical reason why tamoxifen cannot be used letrozole: Approved for diagnosis of breast cancer with day supply greater than 12 – NOT approved for short term use Soltamox: May be approved with documented swallowing difficulty
HORMONE BLOCKADE		
anastrozole (generic Arimidex) ^{CL} exemestane (generic Aromasin) letrozole (generic Femara) ^{CL} tamoxifen citrate (generic Nolvadex)	INLURIYO (imlunestrant) ^{NR} ORSERDU (elacestrant) SOLTAMOX SOLN (tamoxifen) ^{CL} toremifene (generic Fareston) ^{CL}	
OTHER		
	ITOVEBI (inavolisib) NERLYNX (neratinib) PIQRAY (alpelisib) lapatinib (generic Tykerb) TALZENNA (talazoparib tosylate) ^{QL} TUKYSA (tucatinib) ^{QL} TRUQAP (capivasertib) VEPPANU (vepdegestrant) ^{NR,QL}	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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
ALL		Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines
mercaptopurine	PURIXAN (mercaptopurine) ^{AL,CL} mercaptopurine (generic Purixan) ^{AL,CL} SUSP	
AML		- Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy Drug-specific criteria Hydrea®: Requires clinical reason why generic cannot be used Purixan/ mercaptopurine: Prior authorization not required for age <12 or for documented swallowing disorder Xpovio: Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone
	DAURISMO (glasdegib maleate) ^{QL} IDHIFA (enasidenib) REZLIDHIA (olutasidenib) ^{QL} RYDAPT (midostaurin) TIBSOVO (ivosidenib) ^{QL} VANFLYTA (quizartinib) XOSPATA (gilteritinib) ^{QL}	
CLL		
	BEQALZI (sonrotoclax) TAB, Starter Pack^{NR} COPIKTRA (duvelisib) ^{QL} IMBRUVICA (ibrutinib) VENCLEXTA (venetoclax) ZYDELIG (idelalisib)	
CML		
hydroxyurea (generic Hydrea) imatinib (generic Gleevec)	BOSULIF (bosutinib) bosutinib (generic Bosulif) TAB^{NR} CAVHANZA ODT (nilotinib) ^{NR} DANZITEN (nilotinib) dasatinib (generic Sprycel) GLEEVEC (imatinib) HYDREA (hydroxyurea) ^{CL} ICLUSIG (ponatinib) IMKELDI (imatinib) nilotinib HCL (generic Tassigna) nilotinib TARTRATE (generic Dansiten) nilotinib TARTRATE ^{NR} (AG) CAPS PHYRAGO (dasatinib) ^{NR} 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

Page 70 of 99

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

PDL Update October 1, 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
MPN		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
	JAKAFI (ruxolitinib) ^{AL} JAKAFI XR (ruxolitinib) ^{AL,NR}	
MYELOMA		Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
REVLIMID ^{QL} (lenalidomide)	lenalidomide ^{QL} (generic Revlimid) NINLARO (ixazomib) pomalidomide (generic Pomalyst) ^{NR} POMALYST (pomalidomide) THALOMID (thalidomide) XPOVIO (71envatini) ^{CL} ZENBEXUS (iberdomide) ^{NR} CAPS	
OTHER		Drug-specific criteria Hydrea®: Requires clinical reason why generic cannot be used Purixan/ mercaptopurine: Prior authorization not required for age ≤12 or for documented swallowing disorder Xpovio: Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone
MATULANE (procarbazine) tretinoin (generic Vesanoid) ^{AL}	BRUKINSA (zanubrutinib) ^{QL} CALQUENCE (acalabrutinib) ^{QL} INREBIC (fedratinib dihydrochloride) ^{QL} INQOVI (decitabine/cedazuridine) OJJAARA (mometotinib) REVUFORJ (revumenib) TAB VONJO (pacritinib) ^{QL} ZOLINZA (vorinostat)	

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 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
ALK		- Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines - Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	ALECENSA (alectinib) ALUNBRIG (brigatinib) ^{QL} ENSACOVE (ensartinib) ^{NR} LORBRENA (lorlatinib) ^{QL} ZYKADIA (ceritinib) CAPS, TAB	
ALK / ROS1 / NTRK		
	AUGTYRO (repotrectinib) CAPS ROZLYTREK (entrectinib) ^{QL} CAPS, PELLETS XALKORI (crizotinib) CAPS, PELLETS	
EGFR		
erlotinib (generic Tarceva)	afatinib dimaleate (generic Gilotrif)^{NR} gefitinib (generic Iressa) GILOTRIF (afatinib) IRESSA (gefitinib) LAZCLUZE (72envatinib) TAGRISSO (72envatinib72) TARCEVA (erlotinib) VIZIMPRO (dacomitinib) ^{QL}	
HER2/ TKD		
	HERNEXEOS (zongertinib) ^{NR} HYRNUO (sevabertinib) ^{NR}	
OTHER		
	GAVRETO (pralsetinib) ^{QL} HYCAMTIN (topotecan) JIDEYTRO (zidesamtinib) ^{NR} KRAZATI (adagrasib) LUMAKRAS (sotrasib) ^{QL} RETEVMO (selpercatinib) ^{AL} TABRECTA (capmatinib) ^{QL} TEPMETKO (tepotinib) ^{QL}	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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) Combo-Pack AYVAKIT (avapritinib) ^{AL,QL} BALVERSA (erdafitinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) FRUZAQLA (fruquintinib) CAPS GOMEKLI (mirdametinib) ^{AL} CAPS, TABS FOR ORAL SUSP IWILFIN (eflornithine) JAYPIRCA (pirtobrutinib) KOSELUGO (selumetinib) ^{AL} LIFYORLI (relacorilant) ^{NR} CAPS LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) LYTGGOBI (futibatinib) MODEYSO (dordaviprone) ^{NR} OGSIVEO (nirogacestat) TAB PEMAZYRE (pemigatinib) ^{QL} QINLOCK (ripretinib) RASONQUE (daraxonrasib)^{NR} ROMVIMZA (vimseltinib) CAPS RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat) ^{AL} TURALIO (pexidartinib) ^{QL} VITRAKVI (73envatinib73ib) CAPS, SOLN VORANIGO (vorasidenib) ^{AL} TAB ZEJULA (niraparib) TAB	- Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines - Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

ONCOLOGY AGENTS, ORAL, PROSTATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
abiraterone (generic Zytiga) ^{AL,QL} bicalutamide (generic Casodex)	AKEEGA (niraparib/abiraterone) ERLEADA (apalutamide) ^{QL} nilutamide (generic Nilandron) NUBEQA (darolutamide) ^{QL} ORGOVYX (relugolix) ^{AL} XTANDI (enzalutamide) ^{AL,QL} YONSA (abiraterone acetone, submicronized) ZYTIGA (abiraterone) ^{AL,QL}	- Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines - Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 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) TAB sunitinib malate (generic Sutent) CAPS VOTRIENT (pazopanib)	AFINITOR DISPERZ (everolimus) ^C CABOMETYX (cabozantinib) everolimus SUSP (generic Afinitor Disperz) everolimus TAB (generic Yulithira) ^{NR} FOTIVDA (tivozanib) INLYTA (axitinib) LENVIMA (lenvatinib) NEXAVAR (sorafenib) pazopanib (generic Votrient) TAB sorafenib (generic Nexavar) SUTENT (sunitinib) CAPS TORPENZ (generic everolimus) TAB WELIREG (belzutifan) ^{QL}	- Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines - Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

ONCOLOGY AGENTS, ORAL, SKIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BASAL CELL		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
	ERIVEDGE (vismodegib) ODOMZO (sonidegib)	
BRAF MUTATION		Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
MEKINIST (trametinib) TAFINLAR (dabrafenib)	BRAFTOVI (encorafenib) COTELLIC (cobimetinib) MEKINIST (trametinib) SOLN MEKTOVI (binimetinib) OJEMDA (tovorafenib) SUSP^{AL}, TAB TAFINLAR (dabrafenib) SUSP ZELBORAF (vemurafenib)	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

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

PDL Update October 1, 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 OTC (generic Zaditor) olopatadine OTC (Pataday once daily) olopatadine OTC (Pataday twice daily)	ALOCRIL (nedocromil) ALOMIDE (Iodoxamide) azelastine (generic Optivar) BEPREVE (bepotastine besilate) bepotastine besilate (generic Bepreve) epinastine (generic Elestat) LASTACFT (alcaftadine) OTC loteprednol 0.2% (generic Alrex) olopatadine DROPS (generic Pataday) olopatadine 0.1% (generic Patanol) olopatadine OTC (PATADAY XS) ^{NR} PATADAY OTC (olopatadine 0.2%) PATADAY XS (olopatadine 0.7%) ZERVIAE (certirizine) ^{AL}	Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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
FLUOROQUINOLONES		- Non-preferred agents will be approved for patients who have failed a one-month trial of TWO preferred agents within the same subclass Drug-specific criteria: Azasite®: Approval only requires trial of erythromycin Natacyn®: Approved for documented fungal infection
ciprofloxacin SOLN (generic Ciloxan) ofloxacin (generic Ocuflox)	besifloxacin (generic Besivance) ^{NR} BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) gatifloxacin 0.5% (generic Zymaxid) moxifloxacin (generic Vigamox) moxifloxacin (generic Moxeza) VIGAMOX (moxifloxacin)	
MACROLIDES		
erythromycin	AZASITE (azithromycin) ^{CL}	
AMINOGLYCOSIDES		
gentamicin SOLN tobramycin (generic Tobrex drops)	TOBREX OINT (tobramycin)	
OTHER OPHTHALMIC AGENTS		
bacitracin/polymyxin B (generic Polysporin) polymyxin B/trimethoprim (generic Polytrim)	bacitracin NATACYN (natamycin) ^{CL} neomycin/bacitracin/polymyxin B OINT neomycin/polymyxin B/gramicidin sulfacetamide SOLN (generic Bleph-10) sulfacetamide OINT	

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 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 TOBRADEX OINT (tobramycin and dexamethasone) tobramycin/dexamethasone SUSP (generic TobraDex)	neomycin/bacitracin/poly/HC neomycin/polymyxin/HC TOBRADEX S.T. (tobramycin and dexamethasone) ZYLET (loteprednol, tobramycin)	Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

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 October 1, 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
CORTICOSTEROIDS		- ALL sub-classes unless listed below: Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class NSAID class: Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same sub-class
fluorometholone 0.1% (generic FML) OINT MAXIDEX (dexamethasone) PRED MILD (prednisolone 0.12%) prednisolone acetate 1% (generic Omnipred, Pred Forte)	BYQLOVI (clobetasol) ^{NR} dexamethasone (generic Maxidex) difluprednate (generic Durezol) DUREZOL (difluprednate) FLAREX (fluorometholone) FML (fluorometholone 0.1% SOLN) FML FORTE (fluorometholone 0.25%) INVELTYS (loteprednol etabonate) LOTEMAX OINT, GEL (loteprednol) loteprednol GEL (generic Lotemax Gel) loteprednol 0.5% SOLN (generic Lotemax SOLN) prednisolone sodium phosphate prednisolone sodium phosphate 1%	
NSAID		
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

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

PDL Update October 1, 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) ^{QL} cyclosporine (generic Restasis) EYSUVIS (loteprednol etabonate) ^{QL} MIEBO (perfluorohexyloctane) TRYPTYR (acoltremon) SOLN TYRVAYA (varenicline tartrate) ^{QL} VERKAZIA (cyclosporine emulsion) VEVYE (cyclosporine)	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

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

PDL Update October 1, 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
MIOTICS			- Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: Rhopressa and Rocklatan: Electronically approved for patients who have a trial of ONE generic agent, within ophthalmic – glaucoma within 180 days
pilocarpine		VUITY (pilocarpine)	
SYMPATHOMIMETICS			
ALPHAGAN P (brimonidine 0.15%) brimonidine 0.2% (generic Alphagan)		ALPHAGAN P (brimonidine 0.1%) apraclonidine (generic Iopidine) brimonidine P 0.15% (generic Alphagan P 0.15%) brimonidine 0.1% (generic Alphagan P 0.1%)	
BETA BLOCKERS			
levobunolol (generic Betagan) timolol (generic Timoptic)		betaxolol (generic Betoptic) BETIMOL (timolol) BETOPTIC S (betaxolol) carteolol (generic Ocupress) timolol (generic Betimol) timolol (generic Istalol) timolol (generic Timoptic Ocudose) TIMOPTIC (timolol) OCUDOSE	
CARBONIC ANHYDRASE INHIBITORS			
dorzolamide (generic Trusopt)		AZOPT (brinzolamide) brinzolamide (generic Azopt)	
PROSTAGLANDIN ANALOGS			
latanoprost (generic Xalatan) TRAVATAN Z (travoprost)		bimatoprost (generic Lumigan) ^{NR} 0.01% bimatoprost (generic Lumigan) 0.03% IYUZEH (latanoprost) OMLONTI (omidenepag isopropyl) ^{NR} tafluprost (generic Zioptan) travoprost (generic Travatan Z) VYZULTA (latanoprostene) XALATAN (latanoprost) ZIOPTAN (tafluprost) ZOLYMBUS GEL (bimatoprost) ^{NR}	
COMBINATION DRUGS			
COMBIGAN (brimonidine/timolol) dorzolamide/timolol (generic Cosopt)		brimonidine/timolol (generic Combigan) COSOPT (dorzolamide/timolol) dorzolamide/timolol PF (generic Cosopt PF) SIMBRINZA (brinzolamide/brimonidine) YUVEZZI (carbachol/brimonidine tartrate) ^{NR}	

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 2026, **Highlights** indicate change from previous posting

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

OPHTHALMICS, GLAUCOMA (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
OTHER		- Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: Rhopressa and Rocklatan: Electronically approved for patients who have a trial of ONE generic agent, within the ophthalmic - glaucoma class within 180 days
RHOPRESSA (netarsudil) ^{CL} ROCKLATAN (netarsudil and latanoprost) ^{CL}		

OPIOID DEPENDENCE TREATMENTS

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

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 October 1, 2026, **Highlights** indicate change from previous posting

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

OPIOID-REVERSAL TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
naloxone VIAL naloxone (generic Narcan) OTC NASAL NARCAN (naloxone) NASAL (OTC)	KLOXXADO (naloxone) NASAL naloxone (generic Narcan) (Rx) SYR NARCAN (naloxone) NASAL (Rx) OPVEE (nalmeferene) ^{AL} NASAL REXTOVY (naloxone) NASAL REZENOPY (naloxone) NASAL^{NR} ZIMHI (naloxone) SYR ZURNAL (nalmeferene injection)	Non-preferred agents will be approved with documentation of why preferred products within this drug class are not appropriate for the patient

OTIC ANTI-INFECTIVES & ANESTHETICS

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

OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CIPRO HC (ciprofloxacin/hydrocortisone) ciprofloxacin/dexamethasone (generic Ciprodex) neomycin/polymyxin/hydrocortisone (generic Cortisporin) ofloxacin (generic Floxin)	ciprofloxacin ciprofloxacin/fluocinolone (generic Otovel) ciprofloxacin/ hydrocortisone (generic Cipro HC) ^{NR} CORTISPORIN TC (colistin/neomycin thonzonium/hydrocortisone) OTOVEL (ciprofloxacin/fluocinolone)	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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) TAB REVATIO (sildenafil) ^{CL,QL} TAB sildenafil (generic Revatio) ^{CL} SUSP tadalafil (generic Adcirca) ^{CL} TAB TRACLEER (bosentan) TAB	ADEMPAS (riociguat) ^{CL} TAB ADCIRCA (tadalafil) ^{CL} TAB bosentan (generic Tracleer) TAB , TAB for SUSPENSION LETAIRIS (ambrisentan) TAB LIQREV (sildenafil) ^{CL} SUSP macitentan (generic Opsumit) ^{NR} TAB OPSUMIT (macitentan) TAB OPSYNVI (macitentan and tadalafil) TAB ORENITRAM ER (treprostinil) TAB , TITRATION KIT REVATIO (sildenafil) ^{CL} SUSP sildenafil (generic Revatio) ^{CL} TAB TADLIQ (tadalafil) ^{CL} SUSP TRACLEER (bosentan) TAB FOR SUSPENSION TYVASO DPI (treprostinil) INHL TYVASO (treprostinil) INHL PWDR UPTRAVI (selexipag) TAB VENTAVIS (iloprost) INHALATION YUTREPIA (treprostinil) INHAL CAP	- Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: Adcirca/Liqrev/Revatio/sildenafil tablets and suspension/Tadliq/tadalafil: Approved for diagnosis of Pulmonary Arterial Hypertension (PAH) Adempas®: PAH: Requires clinical reason preferred agent cannot be used CTEPH: Approved for persistent/recurrent diagnosis after surgical treatment or inoperable CTEPH NOT for use in Pregnancy Liqrev/ Revatio/Tadliq suspension: Requires clinical reason why preferred sildenafil suspension cannot be used

PANCREATIC ENZYMES

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

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 October 1, 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, CHILD MVI (mvi, ped mvi no. 19/FA, ped mvi no. 17) OTC CHEW	DEKAs PLUS ^{AL, CL} FLORAFOL (pedi mv no.257/sodium fluoride) PEDIATRIC DROPS OTC	- Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class Drug specific criteria: DEKAs Plus: Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent
CHILDREN'S CHEWABLES OTC (ped mvi no. 25/FA, ped mvi no. 31 /iron/FA, ped mvi no.17/iron sulf)	FLORAFOL FE PEDIATRIC (ped multivit 257/fluoride/iron) DROPS OTC	
FLINSTONES COMPLETE CHEW ^{NR} OTC	MULTI-VIT-FLOR (pedi multivit no.228/fluoride, pedi multivit no.219/fluoride) CHEW	
FLUORIDE/VITAMINS A,C,AND D DROPS (ped mvi A,C,D3 no.21/fluoride)	PEDI MULTIVIT A,C,AND D3 NO.21 DROPS OTC	
MULTIVITAMINS W/ FLUORIDE (PEDI MVI NO.2 W-FLUORIDE) DROPS	PEDI MVI NO.22 WITH FLUORIDE ^{NR} DROPS-OTC	
MULTIVITS W/ IRON & FLUORIDE DROPS (ped mvi no. 45/fluoride/iron)	PEDI MVI NO.242/FLUORIDE CHEW-OTC	
PED MVI NO.17 W/ FLUORIDE CHEW	POLY-VI-FLOR (ped mvi no.217/fluoride, ped mvi no. 205/fluoride) CHEW	
POLY-VITAMIN (ped mvi no. 212) DROPS OTC	POLY-VI-FLOR (ped mvi no.213 w/fluoride) DROPS	
POLY-VITAMIN W/ IRON (ped mvi no. 207 w/ferrous sulf) DROPS OTC	POLY-VI-FLOR W/ IRON (ped mvi no. 205/fluoride/iron) CHEW	
TRI-VITAMIN W/ FLUORIDE (ped mvi A,C, D3 no. 21/fluoride)	POLY-VI-FLOR W/ IRON (ped mvi no. 214/fluoride/iron) DROPS	

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 October 1, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDLlistings.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) QUFLORA FE (ped mvi 142/iron/fluoride, ped mvi no. 151/iron/fluoride) CHEW QUFLORA (ped mvi no.157/ fluoride) OTC SOLUVITA A,C,D WITH FLUORIDE DROPS OTC SOLUVITA MULTIVITAMIN FLUORIDE DROPS OTC TRI-VI-FLOR (ped mvi A,C,D3 no.38/fluoride) DROPS	- Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class Drug specific criteria: DEKAs Plus: Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent

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 October 1, 2026, **Highlights** indicate change from previous posting

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

PENICILLINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
amoxicillin CAPS, CHEWABLE TAB, SUSP, TAB ampicillin CAPS dicloxacillin penicillin VK	PIVYA (pivmecillinam) ^{AL,CL} , TAB	Drug Specific Criteria • Pivya tablets: Approved for treatment of female patients 18 years of age and older with uncomplicated urinary tract infections (uUTI) caused by E. coli, Proteus mirabilis and Staphylococcus saprophyticus. Also requires a trial/failure of nitrofurantoin ER, trimethoprim, or trimethoprim/sulfamethoxazole or clinical reason why they can't be used.

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate TAB (OTC) sevelamer carbonate (generic Renvela) PWD PACK, TAB	AURYXIA (ferric citrate) calcium acetate CAPS calcium acetate TAB (Rx) CALPHRON OTC (calcium acetate) ferric citrate (generic Auryxia) lanthanum (generic FOSRENOL) PHOSLYRA (calcium acetate) RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate) PWD PACK, TAB sevelamer HCl (generic Renagel) VELPHORO (sucroferric oxyhydroxide) XPHOZAH (tenapanor) TAB	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
aspirin clopidogrel (generic Plavix) dipyridamole (generic Persantine) prasugrel (generic Effient) ticagrelor (generic Brilinta)	aspirin/dipyridamole (generic Aggrenox) BRILINTA (ticagrelor) ticlopidine (generic Ticlid) YOSPRALA (aspirin/omeprazole)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class OR documented clopidogrel resistance

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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
CONCEPT OB CONCEPT DHA FE C/FA PNV 2/IRON B-G SUC-P/FA/OMEGA-3 PNV NO.118/IRON FUMARATE/FA CHEW TAB PNV NO.15/IRON FUM & PS CMP/FA PNV WITH CA, NO.72/IRON/FA PNV WITH CA, NO.74/IRON/FA OTC PNV#16/IRON FUM & PS/FA/OM-3 PNV119/IRON FUMARATE/FA/DSS PRENATAL MULTI OTC PRENATAL VIT #76/IRON, CARB/FA PRENATAL VIT/FE FUMARATE/FA OTC SELECT-OB + DHA STUART ONE OTC TRICARE TRINATAL RX 1 VITAFOL CHEW TAB VITAFOL FE+ VITAFOL ULTRA VITAFOL-OB VITAFOL-OB+DHA VITAFOL-ONE	ALTRIXA OB OTC AZENTRA ^{NR} CITRANATAL B-CALM COMPLETENATE CHEW TAB ENBRACE HR MARNATAL-F MATRONEX TABLET OTC MULTI-MAC OTC NATAL PNV (pnv no.164/iron/folate no.6) NEO-VITAL RX TAB OTC NESTABS NESTABS ABC NESTABS DHA NESTABS ONE OB COMPLETE ONE OB COMPLETE PETITE OB COMPLETE PREMIER OB COMPLETE TAB OB COMPLETE WITH DHA OTC ONE NATAL RX TAB OTC 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 PRENATAL + DHA OTC PRENATE AM PRENATE CHEW TAB PRENATE DHA PRENATE ELITE PRENATE ENHANCE PRENATE ESSENTIAL PRENATE MINI PRENATE PIXIE PRENATE RESTORE PRENATE STAR PRENOVA ^{NR} PRIMACARE PROVIDA OB SELECT-OB CHEW TAB TRISTART DHA VITAFOL NANO WESTGEL DHA	Non-preferred agents will be approved for patients who have failed a trial of or are intolerant to TWO preferred agents within this drug class

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 October 1, 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) RX ^{QL} omeprazole (generic Prilosec) RX pantoprazole (generic Protonix) ^{QL} PROTONIX SUSP (pantoprazole)	DEXILANT (dexlansoprazole) dexlansoprazole (generic Dexilant) esomeprazole magnesium (generic Nexium) OTC ^{QL} esomeprazole strontium KONVOMEF (omeprazole/sodium bicarb) SUSP lansoprazole (generic Prevacid) ^{QL} NEXIUM SUSP (esomeprazole) omeprazole/sodium bicarbonate (generic Zegerid RX) pantoprazole GRANULES ^{QL} rabeprazole (generic Aciphex)	- Non-preferred agents will be approved for patients who have failed an 8-week trial of THREE preferred agents. Pediatric Patients: Patients ≤ 4 years of age – No PA required for Prevacid 30mg/ lansoprazole 30mg capsules (used to compound suspensions). Drug-specific criteria: Omeprazole OTC/ Prilosec® OTC: EXCLUDED from coverage Acceptable as trial instead of Omeprazole 20mg Prevacid (lansoprazole) Solutab: may be approved after trial of compounded suspension. Patients ≥ 5 years of age- Only approve non-preferred for GI diagnosis if: - Child can not swallow whole generic omeprazole capsules OR, - Documentation that contents of capsule may not be sprinkled in applesauce

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Page 88 of 99

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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
BENZODIAZEPINES		Benzodiazepines Criteria
temazepam 15 mg, 30 mg (generic Restoril)	estazolam (generic ProSom) quazepam (generic Doral) temazepam (generic Restoril) ^{CL} 7.5 mg, 22.5 mg triazolam (generic Halcion)	- Non-preferred agents require a trial of the preferred benzodiazepine agent temazepam 7.5/22.5 mg: Requires clinical reason why 15 mg/30 mg cannot be used
OTHERS^{CL}		Others Criteria
eszopiclone (generic Lunesta) ^{AL} zaleplon (generic Sonata) zolpidem (generic Ambien) ^{CL}	BELSOMRA (suvorexant) ^{AL,QL} DAYVIGO (lemborexant) ^{AL,QL} doxepin (generic Silenor) ^{CL} EDLUAR (zolpidem sublingual) HETLIOZ (tasimelteon) ^{AL} HETLIOZ LQ (tasimelteon) SUSP^{AL,QL} QUVIVIQ (daridorexant) ^{QL} ramelteon (generic Rozerem) ^{AL} tasimelteon (generic HetlioZ) ^{AL} zolpidem ^{QL} CAP zolpidem ER (generic Ambien CR) ^{CL} zolpidem SL (generic Intermezzo) ^{CL}	- Non-preferred agents require a trial of TWO preferred agents in the OTHERS sub-category Silenor/doxepin Tablet: Must meet ONE of the following: - Contraindication to all of the preferred oral sedative hypnotics agents in the OTHERS sub-category - Medical necessity for doxepin dose < 10 mg - Age greater than 65 years old or hepatic impairment (3 mg dose will be approved if this criterion is met) zolpidem/zolpidem ER: Maximum daily dose for females: zolpidem 5 mg; zolpidem ER 6.25 mg zolpidem SL: Requires clinical reason why half of zolpidem tablet cannot be used or documented swallowing disorder

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 October 1, 2026, **Highlights** indicate change from previous posting

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

SICKLE CELL ANEMIA TREATMENT^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ENDARI (L-glutamine) ^{CL}	GLUTAMINE POWD PACK (generic Endari) OXBRYTA (voxelotor) ^{CL} SIKLOS (hydroxyurea) ^{CL} TAB XROMI (hydroxyurea) ^{CL} SOLN	Drug-Specific Criteria ▪ Endari: Patient must have documented two or more hospital admissions per year due to sickle cell crisis despite maximum hydroxyurea dosage. ▪ Oxbryta: Not indicated for sickle cell crisis. Patient must have had at least one sickle cell-related vaso-occlusive event within the past 12 months; AND baseline hemoglobin is 5.5 g/dL ≤ 10.5 g/dL; AND patient is not receiving concomitant, prophylactic blood transfusion therapy ▪ Siklos: May be approved for use in patients ages 2 to 17 years old. ▪ Xromi solution: May be approved for use in patients ages 6 months to 2 years old.

SINUS NODE INHIBITORS

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

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

Page 90 of 99

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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) cyclobenzaprine (generic Flexeril) ^{QL} methocarbamol (generic Robaxin) tizanidine TAB (generic Zanaflex)	ATMEKSI (methocarbamol) ^{NR, AL} SUSP ▪ baclofen (generic Fleqsuvy) ^{QL} SUSP baclofen (generic Ozobax) ^{QL} SOLN baclofen (generic Ozobax DS) SUSP carisoprodol (generic Soma) ^{CL, QL} carisoprodol compound chlorzoxazone (generic Parafon Forte) cyclobenzaprine ER (generic Amrix) ^{CL} dantrolene (generic Dantrium) ^{CL} FEXMID (cyclobenzaprine ER) FLEQSUVY (baclofen) ^{QL} SUSP LORZONE (chlorzoxazone) ^{CL} LYVISPAH (baclofen) ^{QL} GRANULES metaxalone (generic Skelaxin) NORGESIC FORTE (orphenadrine/ASA/caffeine) ONTRALFY (tizanidine) SOLN orphenadrine ER PARAFON FORTE (chlorzoxazone) TANLOR (methocarbamol) TAB tizanidine ^{CL} CAPS ZANAFLEX (tizanidine) ^{CL} CAPS, TAB ▪	▪ Non-preferred agents will be approved for patients who have failed a 1-week trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ cyclobenzaprine ER: - Requires clinical reason why IR cannot be used - Approved only for acute muscle spasms - NOT approved for chronic use ▪ carisoprodol: - Approved for Acute, musculoskeletal pain - NOT for chronic pain - Use is limited to no more than 30 days - Additional authorizations will not be granted for at least 6 months following the last day of previous course of therapy ▪ dantrolene: Trial NOT required for treatment of spasticity from spinal cord injury ▪ Lorzone®: Requires clinical reason why chlorzoxazone cannot be used ▪ Zanaflex capsules/tablets: Requires clinical reason generic cannot be used

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

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

PDL Update October 1, 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
LOW POTENCY		Low Potency Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
DERMA-SMOOTH FS (fluocinolone) hydrocortisone OTC & RX CREAM, LOTION, OINT (Rx only)	alclometasone dipropionate (generic Aclovate) desonide LOTION (generic Desowen) desonide CREAM, OINT (generic Desowen, Tridesilon) fluocinolone 0.01% OIL (generic DERMA-SMOOTH-FS) hydrocortisone/aloe CREAM hydrocortisone OTC OINT hydrocortisone SOLN (generic Texacort) HYDROXYM (hydrocortisone) GEL TEXACORT (hydrocortisone)	
MEDIUM POTENCY		Medium Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
fluticasone propionate CREAM, OINT (generic Cutivate) mometasone furoate CREAM, OINT, SOLN (generic Elocon)	betamethasone valerate (generic Luxiq) clocortolone (generic Cloderm) fluocinolone acetonide (generic Synalar) flurandrenolide (generic Cordran) fluticasone propionate LOTION (generic Cutivate) hydrocortisone butyrate (generic Locoid) hydrocortisone butyrate/emoll (generic Locoid Lipocream) hydrocortisone valerate (generic Westcort) PANDEL (hydrocortisone probutate 0.1%)	

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 October 1, 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
HIGH POTENCY		High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
triamcinolone acetonide OINTMENT, CREAM triamcinolone LOTION	amcinonide CREAM betamethasone dipropionate betamethasone / propylene glycol betamethasone valerate clobetasol propionate (generic Impoyz) CREAM desoximetasone diflorasone diacetate fluocinonide CREAM, GEL, OINT fluocinonide emollient fluocinonide SOLN halcinonide CREAM, SOLN (generic Halog) HALOG (halcinonide) CREAM, OINT, SOLN KENALOG AEROSOL (triamcinolone) triamcinolone SPRAY (generic Kenalog spray) VANOS (fluocinonide)	
VERY HIGH POTENCY		Very High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
clobetasol emollient (generic Temovate-E) clobetasol propionate CREAM, OINT, SOLN halobetasol propionate (generic Ultravate) CREAM	APEXICON-E (diflorasone) clobetasol LOTION, SHAMPOO clobetasol propionate GEL, FOAM, SPRAY halobetasol propionate (generic Lexette) ^{AL, QL} FOAM halobetasol propionate (generic Ultravate) ^{NR} LOTION	

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 October 1, 2026, **Highlights** indicate change from previous posting

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

STIMULANTS AND RELATED ADHD DRUGS ^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CNS STIMULANTS		Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this subclass.
Amphetamine type		
amphetamine salt combination ER (generic Adderall XR)	ADDERALL XR (amphetamine salt combo)	Drug-specific criteria: Procentra/ dextroamphetamine soln: May be approved with documentation of swallowing disorder Zenzedi®: Requires clinical reason generic dextroamphetamine IR cannot be used
amphetamine salt combination IR	ADZENYS XR (amphetamine) ODT amphetamine salt combination ER (generic Mydayis) CAP	
DYANAVEL XR (amphetamine) ^{QL}	amphetamine ER ODT ^{AL, NR} (generic Adzenys XR ODT)	
lisdexamfetamine (generic Vyvanse Chew) ^{QL} CHEW	amphetamine sulfate (generic Evekeo) ARYNTA (lisdexamfetamine dimesylate) ^{AL,NR} SOLN	
lisdexamfetamine (generic Vyvanse) ^{QL} CAP	dextroamphetamine (generic Dexedrine) TAB	
VYVANSE (lisdexamfetamine) ^{QL} CAPS, CHEWABLE	dextroamphetamine (generic Procentra) ^{CL} SOLN	
	dextroamphetamine ER (generic Dexedrine ER Spansule) CAPS	
	EVEKEO ODT (amphetamine sulfate)	
	methamphetamine (generic Desoxyn)	
	MYDAYIS (amphetamine salt combo) ^{QL}	
	XELSTRYM (detroamphetamine) ^{QL} PATCH	
	ZENZEDI (dextroamphetamine) ^{CL}	

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

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

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

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

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

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

PDL Update October 1, 2026, **Highlights** indicate change from previous posting

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

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MISCELLANEOUS		Note: generic guanfacine IR and clonidine IR are available without prior authorization - Non-preferred agents will be approve for patients who have failed a trial of ONE preferred agent within this subclass Drug-specific criteria: Wakix and Sunosi: Require trial of armodafinil or modafinil armodafinil and modafinil: approved only for: - Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed - Narcolepsy with documentation of diagnosis via sleep study - Shift Work Sleep Disorder (only approvable for 6 months) with work schedule verified and documented. Shift work is defined as working the all night shift Sunosi approved only for: - Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed - Narcolepsy with documentation of diagnosis via sleep study Wakix: approved only for excessive daytime sleepiness in adults with narcolepsy with documentation of narcolepsy diagnosis via sleep study
atomoxetine (generic Strattera) ^{QL} guanfacine ER (generic Intuniv) ^{QL} QELBREE (viloxazine) ^{QL}	ATONCY SOLN (atomoxetine) ^{AL, NR} atomoxetine (generic ATONCY) ^{AL, NR} clonidine ER (generic Kapvay) ^{QL} INTUNIV (guanfacine) Onyda XR (clonidine suspension, extended release) ^{QL} STRATTERA (atomoxetine)	
ANALEPTICS		
	armodafinil (generic Nuvigil) ^{CL} modafanil (generic Provigil) ^{CL} SUNOSI (solriamfetol) ^{CL, QL} WAKIX (pitolisant) ^{CL, QL}	

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL– Age Limit

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

Page 96 of 99

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Update October 1, 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 (generic Vibramycin) CAPS doxycycline monohydrate (generic Vibramycin) ^{CL} SUSP doxycycline monohydrate TAB (generic Vibramycin) minocycline HCl (generic Dynacin/Myrac) TAB tetracycline	demeclocycline (generic Declomycin) ^{CL} DORYX MPC DR (doxycycline pelletized) doxycycline hyclate 75MG CAPS ^{NR} doxycycline hyclate IR TAB (generic Vibramycin) doxycycline hyclate DR (generic Doryx) doxycycline monohydrate 50MG, 100MG CAPS doxycycline monohydrate 40MG, 75MG and 150MG CAP (generic Adoxa/Monodox/ Oracea) minocycline HCl CAPS (generic Dynacin/ Minocin/Myrac) minocycline HCl ER (generic Solodyn) NUZYRA (omadacycline)	- Non-preferred agents will be approved for patients who have failed a sequential 3-day trial of TWO preferred agents within this drug class Drug-specific criteria: demeclocycline: Approved for diagnosis of SIADH doxycycline suspension: May be approved with documented swallowing difficulty

THROMBOPOIESIS STIMULATING PROTEINS^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROMACTA (eltrombopag) TAB	ALVAIZ (eltrombopag choline) ^{AL} DOPTELET (avatrombopag) ^{AL} TAB, SPRINKLES ^{AL,NR} eltrombopag (generic Promacta) SUSP, TAB MULPLETA (lusutrombopag) ^{CL} PROMACTA (eltrombopag) SUSP TAVALLISSE (fostamatinib) WAYRILZ (rilzabrutinib) ^{NR}	- All agents will be approved with FDA-approved indication, ICD-10 code is required. - Non-preferred agents require a trial of a preferred agent with the same indication or a contraindication. Drug-Specific Criteria Mulpleta: Approved for one course of therapy for a scheduled procedure with a risk of bleeding for treatment of thrombocytopenia in adult patients with chronic liver disease

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

CL – Prior Authorization / Class Criteria apply

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 October 1, 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) TAB liothyronine (generic Cytomel) TAB thyroid, pork TAB UNITHROID (levothyroxine)	ADTHYZA (thyroid, pork) ERMEZA (levothyroxine) SOLN EUTHYROX (levothyroxine) LEVO-T (levothyroxine) levothyroxine CAPS (generic Tirosint) RENTHYROID (thyroid, pork) TAB SYNTHROID (levothyroxine) TAB THYQUIDITY (levothyroxine) SOLN	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

ULCERATIVE COLITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		- Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: Asacol HD®/Delzicol DR®: Requires clinical reason why preferred mesalamine products cannot be used
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) ^{CL}	
RECTAL		
mesalamine (generic Canasa) SUPPOSITORY Sulfite-Free ROWASA (mesalamine) ENEMA	CANASA (mesalamine) mesalamine (generic Rowasa) ENEMA 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

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 October 1, 2026, **Highlights** indicate change from previous posting

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

UTERINE DISORDER TREATMENT

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MYFEMBREE (relugolix/ estradiol/ norethindrone acetate) ^{AL, CL, QL} ORIAHNN (elagolix/ estradiol/ norethindrone) ^{AL, CL} ORILISSA (elagolix sodium) ^{QL, CL}		Drug-specific criteria: • Myfembree, Orilissa, and Oriahnn: Requires an FDA approved indication, must follow FDA dosing guidelines, and have had a trial and failure of an NSAID and oral contraceptive ○ Total duration of treatment is max of 24 months

VASODILATORS, CORONARY

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

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

CL – Prior Authorization / Class Criteria apply

AL– Age Limit

QL – Quantity/Duration Limit

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

Page 99 of 99