WYOMING MEDICAID
Preferred Drug List (PDL) February 7, 2024

Drug classes not included on this list are not managed through a Preferred Drug List (PDL).
HOWEVER, THIS EXCLUSION IS NOT A GUARANTEE OF PAYMENT OR COVERAGE. Dosage limits and other requirements may apply.
Drugs new to market are non-preferred until a clinical review has been completed. PA criteria will apply to both the pediatric population, as well as the adult population for those plans where PA/PDL limits are allowed.
Unless otherwise noted on the PDL, generic substitution is mandatory.
Yellow highlighted items below indicate new changes to the PDL. Red font indicates quantity/dosage limits apply. *Indicates BRAND is Preferred. May Use DAW 5.
Contact the OptumRx PA Helpdesk @ 877-207-1126 for prior authorization if client has primary insurance that will not cover the brand name medication.

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT OptumRx WITH ANY QUESTIONS
ADDICTION	**BUPRENORPHINE COMBINATIONS**	buprenorphine/naloxone tablets **SUBOXONE FILM***	Client must have a diagnosis of opioid dependence or abuse. This is not to be used for the treatment of chronic pain Prior authorization will be required before any narcotic, benzodiazepine, or carisoprodol prescription will be allowed between fills. Prior authorization will be required before any short-acting stimulant prescription from any doctor other than the prescriber of buprenorphine or Suboxone, will be allowed between fills. Oral buprenorphine will be approved for clients with a documented allergy to naloxone. Please submit PA requests on the "Oral Buprenorphine/Naloxone or Oral Buprenorphine" PA form available at www.wymedicaid.org. Dosage limits apply Prior authorization will be required for doses >24mg	buprenorphine (oral) buprenorphine/naloxone film BRAND PREFERRED) ZUBSOLV
	NALOXONE		Kloxxado, naloxone products, and Narcan nasal spray will be limited to one fill per 180 days without prior authorization. Naloxone formulations available in quantities of 10ml will require prior authorization.	naloxone nasal spray
	KLOXXADO naloxone NARCAN NASAL SPRAY			
	NALTREXONE		Client must have a diagnosis of alcohol or opioid dependance. Prior authorization will be required before any narcotic, carisoprodol, or benzodiazepine prescription will be allowed between fills. Prior authorization will be required before a short-acting stimulant prescription from any doctor other than the prescriber of naltrexone or Vivitrol will be allowed between fills.	
		naltrexone VIVITROL		
ALLERGY / ASTHMA / COPD	**ANTIHISTAMINES, MINIMALLY SEDATING**		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	desloratadine CLARINEX RDT/SYRUP levocetirizine
	cetirizine fexofenadine loratadine			
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	CLARINEX-D
	cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine			
	ANTICHOLINERGIC BRONCHODILATORS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Spiriva 5 day STARTER package will be allowed one (1) time per recipient	TIOTROPIUM BROM *(use brand)* TUDORZA YUPELRI
	ATROVENT HFA INCRUSE ELLIPTA ipratropium SPIRIVA HANDIHALER SPIRIVA RESPIMAT			
	ANTICHOLINERGIC COMBINATION AGENTS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. **Will also require the diagnosis of COPD.	BEVESPI BREZTRI DUAKLIR TRELEGY
	ANORO ELLIPTA** COMBIVENT STIOLTO			
	LEUKOTRIENE MODIFIERS		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	zafirlukast
	montelukast			
	LONG ACTING BRONCHODILATORS		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	BROVANA
	arformoterol SEREVENT STRIVERDI			
	NASAL ANTIHISTAMINES		Trial and failure of preferred agent greater than or equal to 90 days in the last 12 months will be required before approval can be given for a non-preferred agent.	azelastine 0.15% DYMISTA *(use separate agents)* olopatadine 0.6% RYALTRIS
	azelastine 0.1%			
	NASAL STEROIDS		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Budesonide will be approved for pregnancy.	DYMISTA *(use separate agents)* OMNARIS QNASL XHANCE ZETONNA
	budesonide flunisolide fluticasone mometasone			
	SHORT ACTING BRONCHODILATORS - INHALERS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Prior authorization will be required after a total of 12 albuterol inhalers are dispensed within 365 days. Minimum day supply of 16 days is required	levalbuterol (BRAND IS PREFERRED) PROAIR DIGIHALER PROVENTIL HFA
	albuterol HFA PROAIR RESPICLICK VENTOLIN HFA **XOPENEX HFA***			
	STEROID INHALANTS		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. *Fluticasone HFA and Asmanex HFA will be approved for pediatric clients 8 years of age or younger. Alvesco will be approved for a history of oral thrush with steroid inhalants.	AIRDUO DIGIHALER ALVESCO ARMONAIR ASMANEX HFA* fluticasone HFA* QVAR REDIHALER
	AIRDUO RESPICLICK ARNUITY ELIPTA ASMANEX TWISTHALER budesonide suspension PULMICORT FLEXHALER			
	STEROID COMBINATION AGENTS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. **Will also require the diagnosis of COPD or uncontrolled asthma. Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.	fluticasone/vilanterol *(use preferred agent)* fluticasone/salmeterol 55-14/113-14/232-14 fluticasone/salmeterol 100-50/250-50/500-50 (BRAND IS PREFERRED) TRELEGY
	BREO ELLIPTA** DULERA SYMBICORT* WIXELA			
	EPINEPHRINE			AUVI-Q *(use preferred agent)* EPI-PEN *(use preferred agent)*
	epinephrine auto-injector pen			
	EOSINOPHILIC ASTHMA AGENTS		*Approval for these agents will require additional clinical criteria which can be found on the Additional Therapeutic Criteria Chart	FASENRA* NUCALA* TEZSPIRE
		DUPIXENT XOLAIR		

WYOMING MEDICAID
Preferred Drug List (PDL) February 7, 2024

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT Optumrx WITH ANY QUESTIONS
ARTHRITIS	**IMMUNOMODULATORS** **ANKYLOSING SPONDYLITIS (AS)**	ENBREL HUMIRA	Client must have diagnosis of AS prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of AS and a 56-day trial and failure of both preferred agents. **Cimzia will be allowed for clients that are pregnant or breast-feeding Quantity Limits apply for all diagnoses: Enbrel 25mg - limited to 10 per month Enbrel 50mg - limited to 5 per month Humira 20mg - limited to 10 per month Humira 40mg - limited to 5 per month	CIMZIA** COSENTYX REMICADE RINVOQ SIMPONI TALTZ XELJANZ/XR
	JUVENILE IDIOPATHIC ARTHRITIS (JIA)	ENBREL HUMIRA	Client must have diagnosis of JIA prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of JIA and a 56-day trial and failure of both preferred agents.	ACTEMRA ILARIS ORENCIA XELJANZ/XR
	PSORIATIC ARTHRITIS (PA)	ENBREL HUMIRA OTEZLA*	Client must have diagnosis of PA prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of PA and a 56-day trial and failure of two of the three preferred agents. *Otezla starter pack is non-preferred **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** COSENTYX ORENCIA REMICADE RINVOQ SIMPONI STELARA TALTZ TREMFYA XELJANZ/XR
	RHEUMATOID ARTHRITIS (RA)	ENBREL HUMIRA	Client must have diagnosis of RA and a 56-day trial and failure of methotrexate prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of RA and a 56-day trial and failure of both preferred agents. *Cimzia will be allowed for clients that are pregnant or breast-feeding **See Dermatology criteria for Atopic Dermatitis approval	ACTEMRA CIMZIA* KEVZARA KINERET OLUMIANT ORENCIA REMICADE RINVOQ** RITUXAN SIMPONI XELJANZ/XR
CONVULSIONS	**INTERMITTENT, STEREOTYPIC SEIZURE EPISODES** diazepam gel NAYZILAM* VALTOCO		*Nayzilam will be allowed for patients 12 years of age and older	
	ORAL ANTICONVULSANTS carbamazepine divalproex FELBAMATE fosphenytoin lacosamide (tablets) lamotrigine/XR levetiracetam oxcarbazepine phenytoin subvenite valproate/valproic acid VIMPAT (suspension) zonisamide	BANZEL (tablets only) clonazepam EPIDIOLEX gabapentin pregabalin topiramate/ER sprinkle caps	Preferred agents with clinical criteria will be limited to FDA approved indications related to seizures and epilepsy. Non-preferred agents require 30 day trial and failure of two preferred agents prior to approval. For indications not related to seizures and epilepsy, please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org. **Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	APTIOM *(use preferred agent)* BRIVIACT *(use preferred agent)* clobazam** DIACOMIT** FINTEPLA** levetiracetam ER OXTELLAR (use preferred agent) TROKENDI XR (use preferred agent) XCOPRI VIMPAT (tablets) zonisamide oral susp. (use preferred agent)
CROHN'S	**IMMUNOMODULATORS**	HUMIRA	Client must have diagnosis of Crohn's prior to approval of the preferred agent. To receive a non-preferred agent, client must have a diagnosis of Crohn's and a 56-day trial and failure of the preferred agent. * Refer to Additional Therapeutics Clinical Criteria Chart for more info **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** ENTYVIO* REMICADE RINVOQ STELARA TYSABRI (additional criteria applies)
DERMATOLOGY	**BENZOYL PEROXIDE/CLINDAMYCIN COMBOs**	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig)	Clients must be 12 to 20 years of age. Requires prior authorization for clients less than 12 years of age. Acne combinations are limited to clients under the age of 21.	ACANYA *(use preferred agent)* ONEXTON *(use preferred agent)*
	ISOTRETINOIN AMNESTEEM CLARAVIS isotretinoin ZENATANE			ABSORICA *(use preferred agents)*
	CORTICOSTEROIDS - STEP 1 AGENTS **C=CREAM; G=GEL; L=LOTION; O=OINTMENT** **LOW POTENCY** alclometasone desonide* fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O)		Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days. *Cream, ointment, and lotion formulations of Desonide are preferred.	PANDEL TEXACORT 2.5% (S)
	MEDIUM POTENCY betamethasone valerate desoximetasone 0.05%, 0.25% (C) fluocinolone 0.025% fluticasone 0.05% (C) mometasone SYNALAR 0.025% (C, O) triamcinolone 0.025%, 0.1%		Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	Clocortolone Pivalate flurandrenol fluticasone 0.05% (L) hydrocortisone butyrate 0.1% (O) triamcinolone 0.05% (O)
	HIGH POTENCY betamethasone dipropionate clobetasol/E 0.05% (C,G,O,S) diflorasone 0.05% (O) fluocinonide flurandrenolide fluticasone 0.005% (O) halobetasol TOPICORT 0.025% (C) triamcinolone 0.5% ULTRAVATE 0.05% (C,O)		Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	APEXICON 0.05% (C) amcinonide 0.1% (C,L,O) augmented betamethasone 0.05% (G,L,O) clobetasol 0.05% (L) desoximetasone 0.05%, 0.25% (G,O) diflorasone 0.05% (C) fluocinonide 0.1% (C) halcinonide 0.1% (C) HALOG 0.1% (O)
	IMMUNOMODULATORS - STEP 2 AGENTS	ELIDEL tacrolimus	**To receive a step 2 agent:** Trial and failure of a preferred medium or high potency topical corticosteroid greater than or equal to a 21 day trial in the last 90 days. Exceptions will be made for application to the face and for clients age 12 and under, a trial and failure of a preferred low potency corticosteroid greater than or equal to a 21 day trial in the last 90 days will be required.	pimecrolimus (brand preferred)
	PHOSPHODIESTERASE 4 INHIBITOR - STEP 3 AGENT		**To receive a step 3 agent:** Trial and failure of a preferred step 2 agent (immunomodulator) greater than or equal to a 21 day trial within the last 30 days.	EUCRISA

WYOMING MEDICAID
Preferred Drug List (PDL) February 7, 2024

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT Optumrx WITH ANY QUESTIONS
DERMATOLOGY continued	**ATOPIC DERMATITIS**			
		DUPIXENT*	*Trial and failure of a preferred step 2 agent (immunomodulator) greater than or equal to a 21 day trial within the last 30 days required. Dupixent requires member be at least 6 months of age or older. No high-potency steroid trial will be necessary. **Trial and failure of all criteria to receive a step 3 agent as defined above including medium/high potency topical corticosteroid, preferred step 2 immunomodulator AND 56-day trial and failure of a preferred biologic for Atopic Dermatitis in Step 3 will be required for approval of the non-preferred agents.	ADBRY** CIBINQO** OPZELURA** RINVOQ**
	PLAQUE PSORIASIS (PP)			
		ENBREL HUMIRA OTEZLA SOTYKTU*	Client must have diagnosis of PP prior to approval of a preferred agent (Enbrel, Humira, or Otezla). To receive a non-preferred agent, client must have a diagnosis of PP and a 56-day trial and failure of two of the three preferred agents. *Sotyktu requires diagnosis of moderate to severe PP and 56 day trial and failure of Humira. **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** COSENTYX ILUMYA REMICADE SILIQ SKYRIZI STELARA TALTZ TREMFYA
	SCABICIDES/PEDICULICIDES		Trial and failure of a preferred agent in the last 12 months.	malathion lotion NATROBA spinosad (BRAND IS PREFERRED)
	permethrin VANALICE			
DIABETES	**DIABETES AGENTS**			metformin SR 24HR osmotic release *(use preferred agent)* metformin SR 24HR modified release *(use preferred agent)*
	BIGUANIDES			
	metformin/ER			
	GLUCOSIDASE INHIBITORS		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	miglitol
	acarbose			
	MEGLITINIDES		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	repaglinide
	nateglinide			
	THIAZOLIDINEDIONES		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ACTOPLUS MET *(use separate agents)*
	pioglitazone			
	SULFONYLUREAS		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	
	glimepiride/ER glipizide/ER glyburide/ER			
	DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITORS		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	alogliptin GLYXAMBI *(use separate preferred agents)* QTERN *(use separate preferred agents)* STEGLUJAN *(use separate preferred agents)*
		JANUVIA ONGLYZA TRADJENTA		
	DPP-4 INHIBITOR COMBO AGENTS		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	alogliptin/metformin alogliptin/pioglitazone *(use separate preferred agents)* JENTADUETO XR saxagliptin/metformin (use brand)
		JANUMET/XR JENTADUETO KOMBIGLYZE/XR		
	INCRETIN MIMETICS (GLP-1 RECEPTOR AGONISTS)		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent unless ASCVD or risk factors are present, in which case the trial of metform is waived. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent. *Rybelsus requires documentation of inability to use injectable agents. Dosage Limits Apply: Ozempic: 2mg/week Victoza: 1.8mg/day	BYDUREON MOUNJARO OZEMPIC* SOLIQUA RYBELSUS* *(additional criteria applies)* XULTOPHY (use separate preferred agents)
		BYETTA TRULICITY VICTOZA		
	SGLT2 INHIBITORS		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent unless there is a diagnosis of ASCVD, CKD, or heart failure, in which case the trial of metformin will be waived. A 90 day trial and failure of a preferred agent is required before approval can be given for a non-preferred agent.	GLYXAMBI *(use separate preferred agents)* QTERN *(use separate preferred agents)* SEGLUROMET *(use separate preferred agents)* STEGLATRO STEGLUJAN *(use separate preferred agents)* SYNJARDY XR *(use separate preferred agents)* TRIJARDY XR *(use separate preferred agents)*
		FARXIGA INVOKAMET INVOKANA JARDIANCE SYNJARDY XIGDUO XR		
	FAST-ACTING INSULIN		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently.	ADMELOG *(use preferred agent)* FIASP *(use preferred agent)* insulin lispro (use preferred agents) LYUMJEV
	HUMALOG HUMALOG 75/25 HUMALOG JR. HUMALOG MIX NOVOLOG MIX			
	LONG-ACTING INSULIN		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently.	BASAGLAR *(use preferred agent)* Insulin Glargine *(use preferred agent)* Insulin Degludec SOLIQUA TOUJEO (use preferred agent) TRESIBA* *(use preferred agent)* XULTOPHY *(use separate preferred agents)*
	LANTUS SOLOSTAR* LANTUS vial LEVEMIR			
	DIABETIC METERS/TEST STRIPS		Quantity limits apply: Insulin Dependent Clients: 10 strips/day Non-Insulin Dependent Clients: 4 strips/day Clients are limited to 1 meter/365 days	ALL OTHER METERS AND TEST STRIPS
	FREESTYLE (strips only) FREESTYLE FREEDOM FREESTYLE FREEDOM LITE FREESTYLE INSULINX FREESTYLE PRECISION NEO B FREESTYLE SIDEKICK II ONE TOUCH ULTRA II ONE TOUCH ULTRA MINI ONE TOUCH ULTRA BLUE ONE TOUCH VERIO ONE TOUCH VERIO FLEX ONE TOUCH VERIO REFLECT ONE TOUCH VERIO IQ PRECISION XTRA			
	EXTERNAL DIABETIC DEVICES			
	OMNIPOD DASH OMNIPOD CLASSIC OMNIPOD 5			
	CONTINUOUS BLOOD GLUCOSE MONITORS		Prior authorization will be required to verify if the client is injecting insulin daily. Monitors will also be limited to the labeled age.	GUARDIAN MINIMED
		DEXCOM G6 DEXCOM G7 FREESTYLE LIBRE FREESTYLE LIBRE 2 FREESTYLE LIBRE 3		
	ACUTE HYPOGLYCEMIA AGENTS			GVOKE *(use preferred agent)*
	BAQSIMI ZEGALOGUE (autoinjector)			

WYOMING MEDICAID
Preferred Drug List (PDL) February 7, 2024

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT Optumrx WITH ANY QUESTIONS
FIBROMYALGIA	**FIBROMYALGIA**		Trial and failure of a preferred agent greater than or equal to six (6) weeks in the last 12 months is required prior to approval of a non-preferred agent Clients will not be allowed to take gabapentin and pregabalin concurrently	pregabalin SAVELLA tablets *(savella titration pak will not be covered)*
	amitriptyline cyclobenzaprine duloxetine	gabapentin		
GASTROINTESTINAL	**BOWEL EVACUANTS**			CLENPIQ (use preferred agents) GAVILYTE H (use preferred agents) POLY-PREP (use preferred agents) SUFLAVE SUTAB
	GAVILYTE G, N GOLYTELY MOVIPREP PEG 3350 SOLUTION SUPREP			
	CHRONIC IDIOPATHIC CONSTIPATION		Client must have a diagnosis of chronic idiopathic constipation to receive a preferred agent. To receive a non-preferred agent, the client must have a diagnosis of chronic idiopathic constipation and a 30-day trial and failure of a preferred agent within the last 12 months.	MOTEGRITY
		AMITIZA LINZESS TRULANCE		
	DIGESTIVE ENZYMES		Prior authorization required.	PERTZYE VIOKACE
	CREON ZENPEP			
	IRRITABLE BOWEL SYNDROME WITH CONSTIPATION		Client must have a diagnosis of Irritable Bowel Syndrome (IBS) with constipation.	
		AMITIZA LINZESS TRULANCE		
	MESALAMINE		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	mesalamine DR tab 800mg, 1.2g (BRAND IS PREFERRED) mesalamine ER cap 0.375gm (BRAND IS PREFERRED) mesalamine sup 1000mg SFROWASA
	APRISO* **LIALDA*** mesalamine 400mg DR capsule mesalamine enema PENTASA			
	OPIOID-INDUCED CONSTIPATION AGENTS		Client must have a diagnosis of opioid-induced constipation and a three (3) month trial and failure of a stool softner to receive the preferred agent. To receive the non-preferred agent, the client must have a diagnosis of opioid-induced constipation, a three (3) month trial and failure of a secretory agent, and a three (3) month trial and failure of the preferred agent. *Movantik will be approved for a diagnosis of cancer or for clients in hospice or palliative care.	MOVANTIK* RELISTOR SYMPROIC
		AMITIZA		
	PREGNANCY INDUCED NAUSEA/VOMITING			
	BONJESTA DICLEGIS			
	PROTON PUMP INHIBITORS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. PREVACID solutabs will be approved for children less than or equal to 8 years of age.	amox/clarith/lanso pack DEXILANT dexlansoprazole esomeprazole omeprazole 20.6mg capsules omeprazole tablets omeprazole/sodium bicarbonate OMECLAMOX *(use separate agents)* **PREVACID solutabs*** rabeprazole TALICIA *(use separate agents)* VIMOVO *(use separate agents)*
	lansoprazole capsules omeprazole capsules pantoprazole			
GOUT	**COLCHICINE**			MITIGARE *(use preferred agent)*
	colchicine (tablets)			
	XANTHINE OXIDASE AND URAT1 INHIBITORS		Trial and failure of the preferred agent greater than or equal to a 60 day supply in the last 12 months will be required before approval can be given for a non- preferred agent.	**ULORIC***
	allopurinol			
HEMATOLOGY	**LOW MOLECULAR WEIGHT HEPARIN (LMWH)**		Prior authorization will be required for the 300mg/3ml strength.	FRAGMIN *(use preferred agent)* enoxaparin 300MG/3ML
	enoxaparin			
	DIRECT THROMBIN INHIBITOR		Client must have diagnosis of non-valvular atrial fibrillation and relative contraindication to warfarin for approval, treatment for deep vein thrombosis (DVT) or pulmonary embolism (PE), or for the reduction in the risk of recurrence of DVT and PE after initial therapy.	
		PRADAXA		
	SELECTIVE FACTOR XA INHIBITOR		*To receive Xarelto 2.5mg, client must have a diagnosis of chronic coronary artery disease or peripheral artery disease with the need to reduce risk of major cardiovascular events	ELIQUIS (starter pack) SAVAYSA *(use preferred agent)*
	ELIQUIS XARELTO 10mg, 15mg, 20mg, and starter pack	XARELTO 2.5mg* *(use preferred)*		
	CPTP DERIVATIVES		Client must have a diagnosis of acute coronary syndrome, history of myocardial infarction, or history of stroke and transient ischemic attack.	
		BRILINTA		
	PAR-1 ANTAGONIST		Client must have diagnosis of reduction of thrombotic cardiovascular events with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD). Must be used in conjunction with aspirin or clopidogrel.	
		ZONTIVITY		
	ANTIHEMOPHILIC FACTOR VIII			ALTUVIIIO KOVALTRY
	ADVATE ADYNOVATE AFSTYLA ELOCTATE ESPEROCT HEMOFIL M HEMLIBRA JIVI KOATE/KOATE-DVI KOGENATE FS/BIO-SET NOVOEIGHT NUWIQ OBIZUR RECOMBINATE XYNTHA/SOLOFUSE			
	COAGULATION FACTOR IX			
	ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY REBINYN RIXUBIS			
	ANTIHEMOPHILIC FACTOR/VWF			
	ALPHANATE HUMATE-P VONVENDI WILATE			
	ERYTHROPOIESIS STIMULATING AGENTS			ARANESP PROCRIT
	EPOGEN MIRCERA RETACRIT			
	SICKLE CELL ANEMIA			
	DROXIA SIKLOS			

WYOMING MEDICAID
Preferred Drug List (PDL) February 7, 2024

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT Optumrx WITH ANY QUESTIONS
HEPATITIS C	**DIRECT ACTING ANTIVIRALS**		Limited to FDA approved indication. Prior authorization will be required prior to use of preferred agents. Please submit PA requests on the Hepatitis C PA form available at www.wymedicaid.org.	EPCLUSA *(use preferred agent)* HARVONI SOVALDI VOSEVI** ZEPATIER
		sofosbuvir/velpatasvir MAVYRET		
HIDRADENITIS SUPPURATIVA	**IMMUNOMODULATORS**		Humira will not be covered as a first line agent for the diagnosis for hidradenitis suppurativa.	
		HUMIRA		
HORMONES	**GnRH ANTAGONISTS**		*Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	ORILISSA
	MYFEMBREE ORIAHNN			
	GROWTH HORMONE			HUMATROPE NGENLA OMNITROPE SAIZEN SEROSTIM SKYTROFA SOGROYA ZOMACTON
		GENOTROPIN NORDITROPIN NUTROPIN AQ		
	TESTOSTERONE TOPICAL GELS		Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient	ANDRODERM *(use preferred agent)* FORTESTA *(use preferred agent)* JATENZO *(use preferred agent)* TESTOPEL *(use preferred agent)* testosterone gel *(use preferred agent)* testosterone solution *(use preferred agent)* XYOSTED *(use preferred agent)*
		ANDROGEL* TESTIM GEL		
	THYROID HORMONES		Ermeza will be covered with confirmed diagnosis of dysphagia.	THYQUIDITY TIROSINT
	ARMOUR THYROID LEVOXYL levothyroxine (tablets) LEVO-T liothyronine SYNTHROID UNITHROID	ERMEZA		
	ORAL CONTRACEPTIVES			alyacen 1-35, 7/7/7 aranelle BALCOLTRA balziva briellyn drospir/ethinyl estradiol/levomefolate enpresse ethynodiol/ethinyl estradiol FALESSA KIT fayosim kaitlib FE chew lavolis FE chew levonest levonorgest/ethinyl estradiol/LO (84-7) levonorgest/ethinyl estradiol 0.15- **MINASTRIN FE chew*** noreth/ethinyl estradiol/FE chew 0.8/25 nortrel philith rivelsa QUARTETTE SAFYRAL TAYTULLA tilia FE tri-legest FE TRIVORA TWIRLA tydemy vyfemla wera wymzya FE chew
	afirmelle altavera amethia amethyst apri ashlyna aubra/EQ aurovela 1-20/FE 1-20, 1-35 aviane ayuna azurette blisovi 1-20 FE, 1.5-30 FE bekyree bevaz camrese/LO chateal/EQ CHARLOTTE 24 FE chew cyred dasetta 1-35, 7/7/7 davsee deso/ethinyl estradiol drospir/ethinyl estradiol elinest enskyce estarylla falmina finzala FE chew gianvi hailey FE 1/20. 1/35 iclevia introvale isibloom jaimiess jolessa juleber junel 1-20/FE, 1.5-30/FE kalliga kariva kelnor kurvelo larin 1-20/FE, 1.5-30/FE leena lessina levora lo loestrin loestrin FE lorvna **LOSEASONIQUE*** low-ogestrel lutera marlissa melodetta mibelas FE chew microgestin 1-20/FE, 1.5-30/FE mili mono-linyah natazia NECON 0.5/35, 1/35, 1/50, 7/7/7, nikki noreth/ethinyl estradiol/FE chw noreth/ethinyl estradiol 1-20/FE norgest/ethinyl estradiol/LO norethindrone nylia nymyo ocella pimtrea portia previfem reclipsen safyral **SEASONIQUE*** setlakin simliya simpesse sprintec			

WYOMING MEDICAID
Preferred Drug List (PDL) February 7, 2024

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT Optumrx WITH ANY QUESTIONS
HORMONES	sronyx sveda tri-estarvll/LO tri-femvnor tri-linyah tri-marzia LO tri-mili/LO tri-sprintec/LO tri-nvmyo tri-vvlibra velivet vestura vienva viorele volnea vvlibra vasmin-28 YAZ zumandimine			
HYPERLIPIDEMIA	**BILE ACID SEQUESTRANT**		Trial and failure of ALL preferred agents greater than or equal to six (6) months in the last 12 months will be required before approval can be given for a non- preferred agent.	WELCHOL
	cholestyramine/light colestipol			
	STATINS, LOW POTENCY		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization. Prior authorization will be required for clients under the age of 10.	fluvastatin/ER
	lovastatin pravastatin			
	STATINS, HIGH POTENCY		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization. Prior authorization will be required for clients under the age of 10.	EZALLOR LIVALO ZYPITAMAG
	atorvastatin rosuvastatin simvastatin			
	STATIN COMBINATIONS		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Prior authorization will be required for clients under the age of 10.	ezetimibe/simvastatin (BRAND IS PREFERRED)
	amlodipine/atorvastatin **VYTORIN***			
	PCSK9-RELATED AGENTS	PRALUENT	Client must have a diagnosis of homozygous familial hypercholesterolemia; have a diagnosis of heterozygous familial hypercholesterolemia or atherosclerotic cardiovascular disease AND not at goal with a maximum dose statin; or be intolerant to statin therapy.Approval for a non-preferred agent requires trial and failure of a preferred agent.	LEQVIO REPATHA
	TRIGLYCERIDE LOWERING AGENTS		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	fenofibric fenofibrate (43/50/120/130/150mg) icosapent LIPOFEN omega-3-acid VASCEPA
	fenofibrate gemfibrozil			
HYPERTENSION/ CARDIOLOGY	**ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)**		Non-preferred ARBs will require a history of ALL preferred ARBs before approval	candesartan eprosartan 600mg
	EDARBI irbesartan losartan olmesartan telmisartan valsartan			
	ARBs AND DIURETICS		Non-preferred ARB/diuretic combinations will require a history of ALL preferred	candesartan HCTZ telmisartan HCTZ
	EDARBYCLOR irbesartan HCTZ losartan HCT olmesartan HCTZ valsartan HCTZ			
	ALPHA-BLOCKERS			
	clonidine clonidine TD patches			
	COMBINATION PRODUCTS	ENTRESTO	Client must be greater than one year of age and have a diagnosis of Congestive Heart Failure (CHF) NYHA Class II-IV. Angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) will not be allowed in combination with Entresto.	VERQUVO
INFECTIOUS DISEASE	**QUINOLONES**		Please refer to the Additional Therapeutic Criteria Chart located at http://www.wymedicaid.org/additional-therapeutic-criteria for Baxdela criteria.	moxifloxacin *(use preferred agents)*
	ciprofloxacin levofloxacin ofloxacin			
	DOXYCYCLINE			DORYX *(use preferred agent)*
	doxycycline			
	MINOCYCLINE			*minocycline 65mg and 115mg ER (use preferred agent)*
	minocycline/ER			SOLODYN *(use preferred agent)*
	INHALED TOBRAMYCIN		*Tobi Podhaler requires a 28 day trial of a preferred agent, as well as 28 days off of that same preferred agent prior to approval. Minimum day supply of at 56 days is required	BETHKIS inhaled tobramycin TOBI PODHALER (use preferred agent)
	KITABIS			
	ANTI-RETROVIRALS		*Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements. **Rukobia aproval requires documentation of multi-drug resistance defined as failure of two medications from different classes.	JULUCA NORVIR RUKOBIA** STRIBILD (use separate agents) SUNLENCA SYMTUZA (use separate preferred agents)
	APRETUDE BIKTARVY CIMDUO DELSTRIGO DOVATO EVOTAZ GENVOYA ODEFSEY PIFELTRO PREZCOBIX ritonavir tablets SYMFI/LO TRIUMEQ TROGARZO	CABENUVA* DESCOVY* TRUVADA*		

WYOMING MEDICAID
Preferred Drug List (PDL) February 7, 2024

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT Optumrx WITH ANY QUESTIONS
INFLAMMATION	**NSAIDs**		Trial and failure of two (2) preferred agents each greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non- preferred agent. Dosing and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets).	CALDOLOR *(use preferred agent)* diclofenac 1.3% patch (BRAND IS PREFERRED) diclofenac 1.5% soln. diclofenac 3% gel fenoprofen mefenamic acid NEOPROFEN *(use preferred agent)*
	celecoxib diclofenac *tablets* etodolac **FLECTOR*** flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate meloxicam nabumetone naproxen oxaprozin piroxicam sulindac			
	ORAL CORTICOSTEROIDS			CELESTONE *(use preferred agent)*
	budesonide cortisone acetate dexamethasone/intensol hydrocortisone methylprednisolone prednisolone prednisone			
INSOMNIA	**NON-BENZODIAZEPINES**		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Prior Authorization will be required for clients under the age of 18 *Quviviq requires trial and failure of two preferred agents with different mechanisms of action **Rozerem is non-preferred without a history of substance abuse Prior authorization will be required when a client is taking more than one insomnia agent concurrently. Dosage limits apply: zaleplon: 30mg/day zolpidem: 15mg/day	EDLUAR *(additional criteria applies)* DAYVIGO QUVIVIQ **ROZEREM*** zolpidem sublingual *(additional criteria*
	BELSOMRA eszopiclone zaleplon zolpidem zolpidem ER			
MENTAL HEALTH	**ALZHEIMER'S AGENTS**		Client must have a diagnosis of dementia.	donepezil 23mg *(use preferred agent)* memantine ER NAMZARIC (use separate agents) rivastigmine capsules/patches
		donepezil/ODT galantamine/ER memantine tablets/solution		
	ANTIDEPRESSANTS		Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks WITHIN THE LAST 2 YEARS will be required before approval can be given for a non-preferred agent. One of the trials of preferred agents must be in the same class (NaSS, NDRI, SSRI, or SNRI) as the requested non-preferred agent. Trazodone, buspirone, fluvoxamine, MAO inhibitors, TCA's, bupropion IR, and venlafaxine IR do not require prior authorization but **will not count** towards meeting preferred therapy requirements. Clients will not be allowed to be on more than one antidepressant, including fluvoxamine, bupropion IR, and venlafaxine IR, at one time with the exception of mirtazapine or bupropion with a SSRI or SNRI. ***Trintellix requires trial and failure of two preferred agents in any class Clients five (5) years of age and younger will require prior authorization before approval. Dosage limits apply: bupropion ER/SR/XL: 450mg/day citalopram < 60 years of age: 60mg/day citalopram > 60 years of age: 30mg/day escitalopram: 30mg/day fluoxetine < 18 years of age: 90mg/day fluoxetine > 18 years of age: 120mg/day mirtazapine: 67.5mg/day paroxetine IR/CR < 18 years of age: 75mg/day paroxetine IR > 18 years of age: 90mg/day paroxetine CR > 18 years of age: 112.5mg/day sertraline: 300mg/day venlafaxine ER: 337.5mg/day	
	NORADRENERGIC/SPECIFIC SEROTONERGICS (NaSS)			**NaSS**
	mirtazapine tablets			mirtazapine rapid dissolve tablets *(use preferred agent)*
	NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)			**NDRI**
	bupropion ER/SR/XL			APLENZIN AUVELITY **FORFIVO XL***
	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)			**SSRI**
	citalopram escitalopram fluoxetine capsules paroxetine IR/CR sertraline			citalopram capsules fluoxetine tablets VIIBRYD
	SEROTONIN/NORPINEPHRINE REUPTAKE INHIBITORS (SNRI)			**SNRI**
	duloxetine venlafaxine ER capsules			desvenlafaxine FETZIMA venlafaxine ER tablets (use preferred agent)
				OTHER
				TRINTELLIX***

WYOMING MEDICAID
Preferred Drug List (PDL) February 7, 2024

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT OptumRx WITH ANY QUESTIONS
MENTAL HEALTH **continued**	**ATYPICAL ANTIPSYCHOTICS**		*Quetiapine doses less than 100mg will require prior authorization without a diagnosis of mood disorder or major depressive disorder. For titration doses, contact the OptumRx Pharmacy Help Desk for an override. **Clients nine (9) years of age and younger will require a prior authorization to receive approval of Latuda and Saphris. Clients eighteen (18) years of age and younger will require a prior authorization to receive approval of Fanapt. ***Rexulti approval for MDD treatment requires concurrent antidepressant therapy as well as a trial and failure of aripiprazole or other preferred atypical antipsychotic indicated for adjunct MDD treatment. Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent unless otherwise specified. Prior authorization will be required for any client five (5) years of age or younger, or for any client taking both an injectable and oral dosage form of the same medication concurrently. Dosage limits apply: aripiprazole <13 years of age: 15mg/day aripiprazole ≥13 years of age: 30mg/day ABILIFY MAINTENA: 400mg per 26 days ARISTADA 441/662/882mg: 1 injection per 28 days ARISTADA 1064mg: 1 injection per 56 days ARISTADA INITIO: 1 injection per 365 days FANAPT: 24mg/day INVEGA HAFYERA: 1 injection per 6 months INVEGA SUSTENNA: 1 injection per 28 days INVEGA TRINZ: 1 injection per 84 days LATUDA 10-17 years of age: 80mg/day LATUDA >17 years of age: 160mg/day olanzapine <13 years of age: 10mg/day olanzapine ≥13 years of age: 20mg/day paliperidone: 12mg/day PERSERIS: 1 injection per 28 days quetiapine <13 years of age: 400mg/day quetiapine 13-17 years of age: 600mg/day quetiapine >17 years of age: 800mg/day risperidone <10 years of age: 3mg/day risperidone 10-17 years of age: 6mg/day risperidone >17 years of age: 16mg/day RISPERDAL CONSTA: 2 injections per 28 days SAPHRIS: 20mg/day ziprasidone ≤17 years of age: 120mg/day ziprasidone >17 years of age: 200mg/day	ABILIFY MYCITE (use preferred agent) CAPLYTA GEODON 20MG INJ LYBALVI (additional criteria applies) NUPLAZID olanzapine 10mg Inj SECUADO REXULTI*** RYKINDO UZEDY ZYPREXA RELPREVV
	ABILIFY MAINTENA ABILIFY ASIMTUFII aripiprazole tab/solution/ODT ARISTADA FANAPT** paliperidone INVEGA lurasidone olanzapine PERSERIS quetiapine* quetiapine ER RISPERDAL CONSTA risperidone SAPHRIS** VRAYLAR ziprasidone			
	SPECIAL ATYPICAL ANTIPSYCHOTICS		Dosage limits apply: 900mg/day	VERSACLOZ Suspension *(use preferred agent)*
	clozapine/ODT			
	AMPHETAMINES		Clients over the age of 17 must have a diagnosis for ADD, ADHD, (see ADD/ADHD criteria below), narcolepsy, obstructive sleep apnea, shift work sleep disturbance, MS fatigue (see MS Fatigue criteria below), or refractory depression (see refractory depression criteria below). For clients over the age of 17, they must meet the DSM-5 criteria for diagnosis of ADHD. These criteria include: • Five or more symptoms of inattention, present for at least 6 months, inappropriate for developmental level. OR • Five or more symptoms of hyperactivity and impulsivity, present for at least 6 months, to an extent that is disruptive and inappropriate for developmental level. AND • Symptoms must be present in two or more settings (home, school or work); • There must be clear evidence that the symptoms interfere or reduce the quality of social, school or work functioning; and • The symptoms must not be better explained by another mental disorder. Diagnosis of MS fatigue will require a fatigue severity scale score of 5.0, a 60-day trial of amantadine and discontinuation of medications that may contribute to drowsiness and fatigue. Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant. **Vyvanse will be approved for the diagnosis of binge-eating disorder for clients 18 years of age and older. Authorizations will be approved for 12 weeks. After initiation a one-year prior authorization of Vyvanse for this diagnosis will require additional documentation prior to approval. Claims will require Prior Authorization if client is under the age of 4, or has a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use. Trial and failure of two (2) preferred agents (each from a different class: methylphenidate and amphetamine) greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Two or more long-acting agents will not be allowed concurrently. Dosage limits apply: amphetamine salts combo XR: 60mg/day amphetamine salts combo: 60mg/day amphetamine salts combo (narcolepsy): 90mg/day DAYTRANA: 45mg/9 hour patch/day dextroamphetamine: 90mg/day dextroamphetamine CR: 90mg/day dexmethylphenidate: 30mg/day FOCALIN XR < 13 years of age: 45mg/day FOCALIN XR > 13 years of age: 60mg/day JORNAY PM: 100mg/day methylin/methylphenidate/ER: 90mg/day VYVANSE: 105mg/day	**AMPHETAMINES** ADZENYS XR ODT DYANAVEL XR EVEKEO/ODT MYDAYIS PROCENTRA VYVANSE CHEWABLES ZENZEDI 2.5 AND 7.5MG TABLETS **METHYLPHENIDATES** APTENSIO XR AZSTARYS COTEMPLA XR DAYTRANA FOCALIN XR JORNAY PM methylphenidate ER osmotic release (BRAND IS PREFERRED) methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA, APTENSIO XR) QUILLICHEW ER QUILLIVANT
	LONG ACTING AMPHETAMINES			
	ADDERALL XR amphetamine salts combo XR dextroamphetamine CR caps VYVANSE CAPSULES**			
	IMMEDIATE RELEASE AMPHETAMINES			
	amphetamine salts combo dextroamphetamine tablets			
	METHYLPHENIDATES			
	LONG ACTING METHYLPHENIDATES			
	CONCERTA* dexmethylphenidate ER methylphenidate ER tablets			
	IMMEDIATE RELEASE METHYLPHENIDATES			
	dexmethylphenidate methylphenidate chewables methylphenidate solution methylphenidate tablets			

WYOMING MEDICAID
Preferred Drug List (PDL) February 7, 2024

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT Optumrx WITH ANY QUESTIONS
MENTAL HEALTH continued	**SELECTIVE ALPHA-ADRENERGIC AGONIST**		To obtain the **non-preferred agent**, client must meet the following criteria: Client must have a diagnosis of ADD or ADHD Prior authorization will be required for clients under the age of 4. To receive clonidine ER, clients must have completed a 14 day trial of clonidine IR with benefit in the previous 12 months.	clonidine ER
	clonidine			
	SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR		Atomoxetine: Clients must have a diagnosis for ADD, ADHD, narcolepsy, obstructive sleep apnea, shift work sleep disturbance, or refractory depression (see refractory depression criteria below). Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant. Prior Authorization required for clients under the age of 4. Claims will require Prior Authorization if clients have a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use. Qelbree: Clients must have a 30-day trial and failure of a preferred non-stimulant. Approval will be limited to a max dose of 400mg in clients 6-17 years of age, and 600mg for clients 18 years of age or older. Dosage limits apply: atomoxetine: 100mg/day	QELBREE
		atomoxetine		
MIGRAINE	**MIGRAINE PROPHYLAXIS**		Trial and failure of both an anticonvulsant and a beta blocker (Step 1 agents) greater than or equal to three (3) months will be required before approval can be given for the step 2 agents. Concurrent use of Botox will not be approved. Nurtec will be limited to 16 tabs/30 days.	NURTEC
	STEP 1 AGENTS			
	beta blockers	divalproex topiramate		
	STEP 2 AGENTS		*Starting dose will be limited to 70mg **Approval for non-preferred agents requires trial and failure of a preferred agent along with the trial and failures described with Step 1 Agents' criteria above.	QULIPTA**
		AIMOVIG* AJOVY EMGALITY		
	ACUTE MIGRAINE TREATMENT			
	STEP 1 AGENTS		Trial and failure of two preferred agents will be required for approval of a non- preferred agent. Rizatriptan will be limited to clients 6 years of age or older Quantity limits apply: naratriptan 1mg: 25 tabs/34 days naratriptan 2.5mg: 10 tabs/34 days RELPAX 20mg: 20 tabs/34 days RELPAX 40mg: 14 tabs/34 days rizatriptan 5mg: 27 doses/34 days rizatriptan 10mg: 14 doses/34 days sumatriptan vials: 2 vials/34 days sumatriptan nasal 20mg: 6 bottles/34 days; 5mg: 12 bottles/34 days sumatriptan 25mg: 41 tabs/34 days sumatriptan 50mg: 20 tabs/34 days sumatriptan 100mg: 10 tabs/34 days	almotriptan ELYXYB Sumatriptan-Naproxen Sodium TOSYMRA (use preferred agent) TROKENDI XR ZEMBRACE (use preferred agent) zolmitriptan
	frovatriptan naratriptan RELPAX* sumatriptan rizatriptan			
	STEP 2 AGENTS		Trial and failure of two triptan agents required for Step 2 Agent approval Trial and failure of two preferred triptan agents AND Nurtec will be required for approval of a non-preferred agent. Quantity limits apply: NURTEC 75mg: limited to 8 tabs/30 days REYVOW: 200mg/day or 1 tab/day, 4 tab/30 days	REYVOW UBRELVY
		NURTEC		
MOVEMENT DISORDERS	**VMAT 2 INHIBITORS**		Quantity limits apply: AUSTEDO: limited to 4 tabs/day INGREZZA: limited to 4 tabs/day *Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	
	AUSTEDO/XR* INGREZZA* TETRABENAZINE			
MULTIPLE SCLEROSIS	**MS AGENTS**		Kesimpta, Lemtrada, Ocrevus, and Tysabri will be approved for highly active disease, please refer to the ATCC for additional information. Trial and failure of two preferred agents for at least 56 days (each from a separat class) will be required before approval can be given for a non-preferred agent. For Mavenclad, in addition to the above criteria, approval will be granted on a case- by-case basis.	AUBAGIO BAFIERTAM BRIUMVI EXTAVIA glatiramer (BRAND IS PREFERRED) GLATOPA (use preferred agent) MAVENCLAD MAYZENT PLEGRIDY PONVORY TECFIDERA ZEPOSIA
	AVONEX BETASERON **COPAXONE 20MG/ML*** dimethyl fumarate REBIF teriflunomide VUMERITY	GILENYA KESIMPTA LEMTRADA OCREVUS TYSABRI		
NARCOLEPSY	**STIMULANTS**		Modafinil and Nuvigil: Client must be > 16 years of age. Client must have a diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, Multiple Sclerosis (MS) Fatigue, or ADD/ADHD with a concurrent diagnosis of substance abuse. Diagnosis of MS will require a fatigue severity scale score of 5.0, a 60 day trial of amantadine AND discontinuation of medications that may contribute to drowsiness or fatigue. Clients will not be allowed to take two or more agents in this class concurrently	
		modafinil NUVIGIL*		
	NON-STIMULANTS			SUNOSI WAKIX XYREM
NEUROPATHIC PAIN	**GABAPENTIN**		Clients will not be allowed to take gabapentin and pregabalin concurrently Prior authorizations for perioperative pain will be approved for gabapentin OR pregabalin for less than or equal to 14 day supplies	
		gabapentin pregabalin		
	TOPICAL LIDOCAINE			ZTLIDO
	Lidocaine Patches			
	ADDITIONAL AGENTS		Trial and failure of a tricyclic antidepressant greater than or equal to a 12 week supply AND trial and failure of gabapentin at a dose of 3600mg per day OR pregabalin for greater than or equal to a 12 week supply in the last 12 months will be required before approval can be given for a non-preferred agent.	carbamazepine imipramine (capsules) oxcarbazepine valproic acid
	amitriptyline desipramine imipramine (tablets) nortriptyline			

WYOMING MEDICAID
Preferred Drug List (PDL) February 7, 2024

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT Optumrx WITH ANY QUESTIONS
OPHTHALMICS	**OP. -ANTI-ALLERGICS**		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Alomide and Alocril will be approved for pregnancy. Alomide will be approved for children under the age of 3.	ALOCRIL ALOMIDE bepotastine epinastine ZERVIATE
	ALREX azelastine BEPREVE* cromolyn 0.4%			
	OP. -ANTIBIOTICS- QUINOLONES		Trial and failure of a preferred agent greater than or equal to 5 days in the last 12 months will be required before approval can be given for a non-preferred agent.	gatifloxacin ZYMAXID
	ciprofloxacin BESIVANCE gentamicin moxifloxacin 0.5% ofloxacin tobramycin			
	OP. -ANTI-INFLAMMATORY		Trial and failure of ALL preferred agents each greater than or equal to 5 day supply in the last 12 months will be required before approval can be given for a non- preferred agent.	ACULAR/LS/PF *(use preferred agent)* ACUVAIL bromfenac 0.9% BROMSITE DUREZOL ILEVRO INVELTYS LOTEMAX SM loteprednol 0.5% (BRAND PREFERRED) PROLENSA
	flurbiprofen diclofenac **LOTEMAX*** ketorolac NEVANAC			
	OP. -BETA-BLOCKERS		Trial and failure of three (3) preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non- preferred agent. *Betoptic S will be approved for those with heart and lung conditions.	BETIMOL BETOPTIC S*
	betaxolol carteolol levobunolol timolol			
	OP. -CARBONIC ANHYDRASE INHIBITOR		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	brinzolamide (BRAND PREFERRED)
	AZOPT dorzolamide			
	OP. -COMBO PRODUCTS			dorzolamide/timolol (BRAND PREFERRED)
	COMBIGAN* COSOPT* ROCKLATAN SIMBRINZA			
	OP. -DRY EYE AGENTS		Trial and failure of the preferred agent greater than or equal to 12 weeks will be required before approval can be given for the non-preferred agent.	CEQUA cyclosporine (BRAND PREFERRED) EYSUVIS MIEBO RESTASIS MULTIDOSE (see preferred) TYRVAYA
	RESTASIS* XIIDRA			
	OP. -PROSTAGLANDINS		Trial and failure of ALL preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non- preferred agent.	bimatoprost IYUZEH tafluprost
	latanoprost LUMIGAN TRAVATAN Z XALATAN ZIOPTAN			
	OP. -RHO KINASE INHIBITOR			
	RHOPRESSA			
	OP. -SYMPATHOMIMETICS		Trial of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	brimonidine 0.15% (BRAND IS PREFERRED)
	ALPHAGAN P 0.1% **ALPHAGAN P 0.15%*** brimonidine 0.2%			
OSTEOPOROSIS	**BISPHOSPHONATES**		Trial and failure of a preferred agent greater than or equal to 12 months will be required before approval can be given for a non-preferred agent. Fosamax liquid will be approved for clients that have difficulty swallowing. **Evinity will only be allowed for a maximum of 12 months of treatment, will not be allowed with any concurrent osteoporosis treatment, and will be limited to approved indication ***Will be limited to 2 years of use	EVENITY** FORTEO*** FOSAMAX-D TYMLOS***
	alendronate ibandronate risedronate			
	NASAL CALCITONIN			
	calcitonin-salmon			
OTIC	**ANTIBIOTIC/STEROID COMBINATION**			ciprofloxacin 0.2% *(use preferred agent)* CIPRO HC *(use preferred agent)* CORTISPORIN-TC *(use preferred agent)* FLUOCINOLONE ACET OIL 0.01% *(use preferred agent)*
	ciprofloxacin/dexamethasone Neo/Poly/HC Suspension and ofloxacin tobramycin/dexamethasone			
OVERACTIVE BLADDER	**OVERACTIVE BLADDER AGENTS**		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Oxytrol will be approved for clients that have an inability to swallow.	darifenacin GELNIQUE GEL 10% GEMTESA OXYTROL DIS tolterodine/ER trospium
	MYRBETRIQ oxybutynin /ER solifenacin TOVIAZ			
PAIN	**LONG-ACTING C-IIs**		Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non- preferred agent. C-IIIs and C-IVs that are not included on the PDL and are available without prior authorization with the exception of Butrans (generic substitution is mandatory). Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid. **Nucynta ER will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics. Fentanyl: 50mcg, 1 strength at a time, 1 patch every 3 days Hydromorphone ER: 30mg/day Hysingla ER: 120mg/day Methadone: Limited to 3 tablets per day Morphine ER: 90mg/day Nucynta ER: 327mg/day Oxycontin: 80mg/day Oxymorphone: 40mg/day Xtampza ER: 80mg/day Clients will be limited to one long-acting narcotic at a time	fentanyl patches hydrocodone ER hydromorphone ER HYSINGLA ER METHADONE morphine ER caosules *(use preferred agents)* NUCYNTA ER** oxymorphone ER OXYCONTIN XTAMPZA ER *(additional criteria applies)*
	morphine ER tablets			

WYOMING MEDICAID
Preferred Drug List (PDL) February 7, 2024

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT Optumrx WITH ANY QUESTIONS
PAIN continued	**SHORT-ACTING C-IIs** codeine sulfate hydrocodone/APAP hydrocodone/IBU hydromorphone meperidine morphine oxycodone oxycodone/APAP		Trial and failure of three (3) preferred agents greater than or equal to a 6 day supply in the last 90 days will be required before approval can be given for a non-preferred agent. *Nucynta will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics. Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid. All short-acting narcotics, after 42 days of consecutive use of any combination of short-acting narcotics, will be limited to **4 tablets** per day (liquids have specific dosing limits per medication - please refer to dosage limitation chart at www.wymedicaid.org) Clients will be limited to one short-acting narcotic at a time	levorphanol NUCYNTA* oxymorphone ROXYBOND
	C-III/C-V AGENTS BUTRANS tramadol		Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non- preferred agent. Quantity and dosage limits apply (max 8 tabs/day). Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid.	BELBUCA tramadol/apap tramadol ER capsules/tablets
PARKINSON'S DISEASE	**SHORT-ACTING AGENTS** amantadine benztropine tablets carbidopa/levodopa pramipexole ropinirole			
	LONG-ACTING AGENTS ropinirole ER RYTARY		**Non-preferred Parkinson's agents will require a 30 day trial and failure of 2 preferred medications including at least one short-acting agent and one long-acting agent *Neupro will be approved for clients with difficulty swallowing	APOKYN benztropine injectables GOCOVRI INBRIJA NEUPRO* ONGENTYS pramipexole ER XADAGO
PHOSPHATE BINDERS	**PHOSPHATE BINDERS** calcium acetate		Prior authorization required for non-preferred agents.	AURYXIA lanthanum sevelamer VELPHORO
PROSTATE	**5-ALPHA-REDUCTASE INHIBITORS** finasteride		Trial and failure of a preferred agent greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	dutasteride dutasteride/tamsulosin *(use separate agents)*
	ALPHA BLOCKERS doxazosin tamsulosin terazosin		Trial and failure of a preferred agent greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	alfuzosin dutasteride/tamsulosin *(use separate agents)* silodosin
PULMONARY ANTIHYPERTENSIVES	**5-ALPHA-REDUCTASE INHIBITORS**	ALYQ tadalafil **REVATIO SUSPENSION*** sildenafil (Revatio A/B rated generic)	Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	sildenafil suspension (BRAND IS PREFERRED)
	ENDOTHELIN RECEPTOR ANTAGONISTS	LETAIRIS **TRACLEER TABS***	Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	bosentan (BRAND IS PREFERRED) OPSUMIT *(use preferred agent)* TRACLEER TABS FOR ORAL SUSP *(use preferred agent)*
	GUANYLATE CYCLASE INHIBITORS		Prior authorization required.	ADEMPAS *(use preferred agent)*
	PROSTACYCLINE VASODILATORS	ORENITRAM	Prior authorization required. Client must have a diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis.	
	PROSTACYCLINE RECEPTOR AGONIST		Prior authorization required.	UPTRAVI *(use preferred agent)*
RESTLESS LEG SYNDROME	**RESTLESS LEG SYNDROME** pramipexole ropinirole	gabapentin	Client must have a diagnosis of Restless Leg Syndrome (RLS). Trial and failure of gabapentin greater than or equal to 60 days and a trial and failure of a dopamine agonist greater than or equal to 60 days in the last 12 months will be required before approval can be given for a non-preferred agent. *Neupro will be approved for clients with difficulty swallowing or for clients with a diagnosis of Parkinson's Disease. Clients will not be allowed to take gabapentin and pregabalin concurrently	HORIZANT NEUPRO*
SKELETAL MUSCLE RELAXANTS	**MUSCLE RELAXANTS** baclofen (tablets) cyclobenzaprine tizanidine tablets		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Cyclobenzaprine will require a prior authorization for clients concurrently taking a tricylic antidepressant. Carisoprodol is limited to 84 tabs/365 days	carisoprodol chlorzoxazone cyclobenzaprine ER LYVISPAH metaxalone methocarbamol orphenadrine tizanidine capsules (use preferred agent)
ULCERATIVE COLITIS	**IMMUNOMODULATORS**	HUMIRA	Client must have diagnosis of UC prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of UC and a 56-day trial and failure of the preferred agent. * Refer to Additional Therapeutics Clinical Criteria Chart for more information	ENTYVIO* REMICADE RINVOQ SIMPONI STELARA XELJANZ/XR
UVEITIS	**IMMUNOMODULATORS**	HUMIRA	Client must have diagnosis of non-infectious intermediate, posterior, or panuveitis in adult patients	