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 THE LIST IS NOT ALL INCLUSIVE PLEASE CONTACT OPLICITIES WITH ANY QUESTIONS
DDICTION	BUPRENORPHINI	E COMBINATIONS	Client must have a diagnosis of opioid dependence or abuse. This is not to be used for the	buprenorphine (oral)
		buprenorphine/naloxone tablets SUBOXONE FILM*	treatment of chronic pain Prior authorization will be required before any narcotic,	buprenorphine/naloxone film BRAND PREFERRED)
		SUBUXUNE FILM	benzodiazepine, or carisoprodol prescription will be allowed between fills. Prior authorization	ZUBSOLV
			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	
	KLOXXADO	.OXONE	Kloxxado, naloxone products, and Narcan nasal spray will be limited to one fill per 180 days without prior authorization.	ZIMHI
	naloxone nasal spray NARCAN			
	REXTOVY NALT	TREXONE	Naloxone formulations available in quantities of 10ml will require prior authorization. Client must have a diagnosis of alcohol or opioid dependance.	
	IVAL	naltrexone	eliciti muse na re a diagnosis or diconordi opporta dependance.	
		VIVITROL	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-	
	1		acting stimulant prescription from any doctor other than the prescriber of naltrexone or Vivitrol will be allowed between fills.	
LERGY / ASTHMA / COPD		S, MINIMALLY SEDATING	Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12	desloratadine
	cetirizine fexofenadine		months will be required before approval can be given for a non-preferred agent.	CLARINEX RDT/SYRUP levocetirizine
	loratadine			
	ANTIHISTAMINE/DECO cetirizine/pseudoephedrine	NGESTANT 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
	fexofenadine/pseudoephedrine loratadine/pseudoephedrine		montris will be required before approval can be given for a non-preferred agent.	
	ANTICHOLINERG	IC BRONCHODILATORS	Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will	TIOTROPIUM BROM (use brand)
	ATROVENT HFA		be required before approval can be given for a non-preferred agent.	TUDORZA
	INCRUSE ELLIPTA ipratropium			YUPELRI
	SPIRIVA HANDIHALER SPIRIVA RESPIMAT			
		COMBINATION AGENTS	Spiriva 5 day STARTER package will be allowed one (1) time per recipient Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will	BEVESPI
	ANORO ELLIPTA**	LOWIBINATION AGENTS	be required before approval can be given for a non-preferred agent.	BREZTRI
	COMBIVENT STIOLTO			DUAKLIR TRELEGY
	LELWOTRE	NE MODIFIERS	**Will also require the diagnosis of COPD.	- Calabara
	montelukast	INE 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.	zanriukast
		RONCHODILATORS	Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12	BROVANA
	arformoterol SEREVENT		months will be required before approval can be given for a non-preferred agent.	
	STRIVERDI			
		TIHISTAMINES	Trial and failure of preferred agent greater than or equal to 90 days in the last 12 months will be	
	azelastine 0.1%		required before approval can be given for a non-preferred agent.	DYMISTA (use separate agents) olopatadine 0.6% RYALTRIS
		STEROIDS	Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12	DYMISTA (use separate agents)
	budesonide flunisolide	1	months will be required before approval can be given for a non-preferred agent.	OMNARIS QNASL
	fluticasone mometasone		Budesonide will be approved for pregnancy.	XHANCE ZETONNA
		INCHODILATORS - INHALERS	Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will	levalbuterol (BRAND IS PREFERRED)
	albuterol HFA		be required before approval can be given for a non-preferred agent. Prior authorization will be	PROAIR DIGIHALER
	PROAIR RESPICLICK VENTOLIN HFA		required after a total of 12 albuterol inhalers are dispensed within 365 days.	PROVENTIL HFA
	XOPENEX HFA*	<u> </u>	Minimum day supply of 16 days is required	
		INHALANTS	Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12	AIRDUO DIGIHALER
	AIRDUO RESPICLICK ARNUITY FUPTA		months will be required before approval can be given for a non-preferred agent.	ALVESCO ARMONAIR
	ASMANEX TWISTHALER		*Fluticasone HFA and Asmanex HFA will be approved for pediatric clients 8 years of age or younger.	ASMANEX HFA*
	budesonide suspension PULMICORT FLEXHALER	1	Alvesco will be approved for a history of oral thrush with steroid inhalants.	fluticasone HFA* QVAR REDIHALER
		TO THE PARTY OF TH	Tribut 6th and 6th and an extended to the control of the control o	
	STEROID COM ADVAIR BREO ELLIPTA**	IBINATION 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.	fluticasone/vilanterol (use preferred agent fluticasone/salmeterol 55-14/113-14/232- fluticasone/salmeterol 100-50/250-50/500
	DULERA SYMBICORT*	1	**Will also require the diagnosis of COPD or uncontrolled asthma.	(RRAND IS PREFERRED) TRELEGY
	WIXELA	1		
	EPIN	EPHRINE	Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.	AUVI-Q (use preferred agent)
	epinephrine auto-injector pen			EPI-PEN (use preferred agent)
	EOSINOPHILIC	ASTHMA AGENTS	*Approval for these agents will require additional clinical criteria which can be found on the	FASENRA*
		DUPIXENT XOLAIR	Additional Therapeutic Criteria Chart	NUCALA* TEZSPIRE
	I	AOLAIN		LEED! IVE

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLI THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT Optimits WITH ANY QUESTIONS
THRITIS		MODULATORS SPONDYLITIS (AS)	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	CIMZIA** COSENTYX
	ANKIEOSING	ENBREL	preferred agents.	REMICADE
		HUMIRA	**Cimzia will be allowed for clients that are pregnant or breast-feeding	RINVOQ SIMPONI
			Quantity Limits apply for all diagnoses:	TALTZ
			Enbrel 25mg - limited to 10 per month	XELJANZ/XR
			Enbrel 50mg - limited to 5 per month Humira 20mg - limited to 10 per month	
			Humira 40mg - limited to 5 per month	
	JUVENILE IDIOPA	ATHIC ARTHRITIS (JIA)	Client must have diagnosis of JIA prior to approval of a preferred agent. To receive a non-	ACTEMRA
		ENBREL HUMIRA	preferred agent, client must have a diagnosis of JIA and a 56-day trial and failure of both preferred agents.	ILARIS ORENCIA
				XELJANZ/XR
	PSORIATIC	ARTHRITIS (PA) ENBREL	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	CIMZIA** COSENTYX
		HUMIRA	three preferred agents.	ORENCIA
		OTEZLA*		REMICADE RINVOQ
			*Otania startar neal is non professed	SIMPONI
			*Otezla starter pack is non-preferred	STELARA TALTZ
			**Cimzia will be allowed for clients that are pregnant or breast-feeding	TREMFYA XELJANZ/XR
	RHEUMATOII	ARTHRITIS (RA)	Client must have diagnosis of RA and a 56-day trial and failure of methotrexate prior to approval	
		ENBREL	of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of RA and	CIMZIA*
		HUMIRA	a 56-day trial and failure of both preferred agents.	KEVZARA KINERET
				OLUMIANT
			*Cimzia will be allowed for clients that are pregnant or breast-feeding	ORENCIA REMICADE
			See Dermatology criteria for Atopic Dermatitis approval	RINVOQ RITUXAN
			See Sermatology efficing for Atopic Sermatics approval	SIMPONI
/ULSIONS	INTERMITTENT STE	REOTYPIC SEIZURE EPISODES	*Nayzilam will be allowed for patients 12 years of age and older	XELJANZ/XR
. 0.2.10113	diazepam gel	MISSEL CONTROLL PRODES	nayanan and be allowed for patients 12 years of age and older	
	NAYZILAM* VALTOCO			
		CONVULSANTS	Preferred agents with clinical criteria will be limited to FDA approved indications related to	APTIOM
	carbamazepine	BANZEL (tablets only)	seizures and epilepsy. Non-preferred agents require 30 day trial and failure of two preferred	BRIVIACT
	divalproex FELBAMATE	clonazepam EPIDIOLEX	agents prior to approval.	clobazam** DIACOMIT**
	fosphenytoin lacosamide (tablets)	gabapentin pregabalin	For indications not related to seizures and epilepsy, please refer to the Additional Therapeutic	FINTEPLA** levetiracetam ER
	lamotrigine/XR	topiramate/ER sprinkle caps	Criteria chart at www.wymedicaid.org.	OXTELLAR
	levetiracetam oxcarbazepine		**Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific	TROKENDI XR XCOPRI
	phenytoin		requirements.	VIMPAT (tablets)
	subvenite valproate/valproic acid			zonisamide oral susp.
	VIMPAT (suspension) zonisamide			
HN'S		MODULATORS	Client must have diagnosis of Crohn's prior to approval of the preferred agent. To receive a non-	
		HUMIRA	preferred agent, client must have a diagnosis of Crohn's and a 56-day trial and failure of the	ENTYVIO* REMICADE
			preferred agent.	
				RINVOQ
			* Refer to Additional Therapeutics Clinical Criteria Chart for more info * Refer to Additional Therapeutics Clinical Criteria Chart for more info	SKYRIZI
44701069		COUNT ANY COURS	 Refer to Additional Therapeutics Clinical Criteria Chart for more info **Cimzia will be allowed for clients that are pregnant or breast-feeding 	SKYRIZI STELARA TYSABRI (additional criteria applies)
MATOLOGY	BENZOYL PEROXIDE	/CLINDAMYCIN COMBOs	* Refer to Additional Therapeutics Clinical Criteria Chart for more info **Cimzia will be allowed for clients that are pregnant or breast-feeding Clients must be 12 to 20 years of age. Requires prior authorization for clients less than 12 years	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA
MATOLOGY	BENZOYL PEROXIDE	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide	 Refer to Additional Therapeutics Clinical Criteria Chart for more info **Cimzia will be allowed for clients that are pregnant or breast-feeding 	SKYRIZI STELARA TYSABRI (additional criteria applies)
MATOLOGY		clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig)	* Refer to Additional Therapeutics Clinical Criteria Chart for more info **Cimzia will be allowed for clients that are pregnant or breast-feeding Clients must be 12 to 20 years of age. Requires prior authorization for clients less than 12 years	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON
MATOLOGY		clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide	* Refer to Additional Therapeutics Clinical Criteria Chart for more info **Cimzia will be allowed for clients that are pregnant or breast-feeding Clients must be 12 to 20 years of age. Requires prior authorization for clients less than 12 years	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA
MATOLOGY	ISOT AMNESTEEM CLARAVIS	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig)	* Refer to Additional Therapeutics Clinical Criteria Chart for more info **Cimzia will be allowed for clients that are pregnant or breast-feeding Clients must be 12 to 20 years of age. Requires prior authorization for clients less than 12 years	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON
MATOLOGY	AMNESTEEM CLARAVIS ISOTETINOIN ZENATANE	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig)	* Refer to Additional Therapeutics Clinical Criteria Chart for more info **Cimzia will be allowed for clients that are pregnant or breast-feeding 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.	SKYRIZI STELARA TYSABB (additional criteria applies) ACANYA ONEXTON ABSORICA
MATOLOGY	AMNESTEEM CLARAVIS ISOTRETION ZENATANE CORTICOSTER CORTICOSTER	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN	* Refer to Additional Therapeutics Clinical Criteria Chart for more info **Cimzia will be allowed for clients that are pregnant or breast-feeding Clients must be 12 to 20 years of age. Requires prior authorization for clients less than 12 years	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER C=CREAM; G=GEI;	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig)	* Refer to Additional Therapeutics Clinical Criteria Chart for more info **Cimzia will be allowed for clients that are pregnant or breast-feeding 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.	SKYRIZI STELARA TYSABB (additional criteria applies) ACANYA ONEXTON ABSORICA
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER C-CREAM; G-GEL; LOW alclometasone	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDS - STEP 1 AGENTS .=LOTION; O-OINTMENT	* Refer to Additional Therapeutics Clinical Criteria Chart for more info ***Cimzia wilb eallowed for clients that are pregnant or breast-feeding 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. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	SKYRIZI STELARA TYSABB (additional criteria applies) ACANYA ONEXTON ABSORICA
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER C=CREAM; G=GE1; alclometasone desonide*	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDS - STEP 1 AGENTS .=LOTION; O-OINTMENT	* Refer to Additional Therapeutics Clinical Criteria Chart for more info **Cimzia will be allowed for clients that are pregnant or breast-feeding 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.	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON ABSORICA
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER C-CREAM; G-GEL; LOW alclometasone desonide* fluocinolone 0.01% hydrocortisone butvrate 0.1% (C)	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDS - STEP 1 AGENTS .=LOTION; O-OINTMENT	* Refer to Additional Therapeutics Clinical Criteria Chart for more info ***Cimzia wilb eallowed for clients that are pregnant or breast-feeding 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. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON ABSORICA
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER C=CREAM; G=GEL; LOW alclometasone desonide* fluocinolone 0.01% hydrocortisone butvrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O)	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDS - STEP 1 AGENTSLOTION; G-DINTMENT POTENCY	* Refer to Additional Therapeutics Clinical Criteria Chart for more info ***Cimzia wilb eallowed for clients that are pregnant or breast-feeding 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. 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.	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (5)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER C=CREAM; G=GEL; LOW alclometasone desonide* fluocinolone 0.01% hydrocortisone butvrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O)	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDS - STEP 1 AGENTS .=LOTION; O-OINTMENT	* Refer to Additional Therapeutics Clinical Criteria Chart for more info ***Cimzia wilb eallowed for clients that are pregnant or breast-feeding 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. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (5)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER C=CREAM; G=GE; alciometasone desonide* fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone butyrate 0.1% (C) hydrocortisone 0.05% (C,L,O) MEDIU betamethasone valerate desoximetasone 0.05% (.0.25% (C)	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDS - STEP 1 AGENTSLOTION; G-DINTMENT POTENCY	* Refer to Additional Therapeutics Clinical Criteria Chart for more info ***Cimzia wilb eallowed for clients that are pregnant or breast-feeding 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. 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.	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (5) Clocortolone Pivalate flurandrenol fluticasone 0.05% (L)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE COREAM; G-GEL; LOW alclometasone desonide* fluocinolno 0.01% hydrocortisone butvrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) betamethasone valerate desoximetasone 0.05% 0.25% (C) fluocinolno 0.025%	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDS - STEP 1 AGENTSLOTION; G-DINTMENT POTENCY	* Refer to Additional Therapeutics Clinical Criteria Chart for more info ***Cimzia wilb eallowed for clients that are pregnant or breast-feeding 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. 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.	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (5) Clocortolone Pivalate flurandrenol fluticasone 0.05% (L) hydrocortisone butvrate 0.1% (O)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER C-CREAM; G-GEL; LOW alclometasone desonide* fluocinolone 0.01% hydrocortisone butvrate 0.1% (C, L, O) hydrocortisone butvrate 0.1% (C, L, O) betamethasone valerate desoximetasone 0.05% 0.25% (C) fluocinolone 0.025% fluocinolone 0.025% fluocinolone 0.05% (C) mometasone mometa	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDS - STEP 1 AGENTSLOTION; G-DINTMENT POTENCY	* Refer to Additional Therapeutics Clinical Criteria Chart for more info ***Cimzia wilb eallowed for clients that are pregnant or breast-feeding 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. 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.	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (5) Clocortolone Pivalate flurandrenol fluticasone 0.05% (L)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER CORTICOSTER CORTICOSTER LOW alciometasone desonide** fluocinolone 0.01% (1) hydrocortisone butvrate 0.1% (1) hydrocortisone butvrate 0.1% (1) hydrocortisone 0.05% (2,5% (C,LQ) betamethasone valerate desoximetasone 0.05% (2,0,5% (1) fluocinolone 0.025% (1) fluocinolone 0.025% (1) fluocinolone 0.05% (1) fluocinolone 0.05% (2) fluocinolone 0.05% (2,0) triamcinolone 0.05% (1)	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDSSTEP 1 AGENTSLOTION; O-OINTMENT POTENCY M POTENCY	* Refer to Additional Therapeutics Clinical Criteria Chart for more info ***Cimzia wilb eallowed for clients that are pregnant or breast-feeding 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. 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.	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANTA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (5) Clocortolone Pivalate flurandrenol fluticasone 0.05% (L) hydrocortisone butvrate 0.1% (O) triamcinolone 0.05% (0)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER CORTICOSTER CORTICOSTER CORTICOSTER CORTICOSTER CORTICOSTER CORTICOSTER LOW alclometasone desonide* fluocinolone 0.01% hydrocortisone butvrate 0.1% (C) hydrocortisone butvrate 0.1% (C) hydrocortisone 1%, 2.5% (C, L,O) MEDIU betamethasone valerate desoximetasone 0.05% (0, 25% (C) fluocinolone 0.025% fluticasone 0.05% (C) rometasone SYNALAR 0.025% (C, O) triamcinolone 0.025% (0.1%	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDS - STEP 1 AGENTS -LOTION; G-DINTMENT POTENCY	* Refer to Additional Therapeutics Clinical Criteria Chart for more info ***Cimzia wilb eallowed for clients that are pregnant or breast-feeding 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. 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.	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (5) Clocortolone Pivalate flurandrenol fluticasone 0.05% (L1) hvdrocortisone butvrate 0.1% (O) triamcinolone 0.05% (C) APEXICON 0.05% (C)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER C-CREAM, G-GEL; alciometasone desonide* fluocinolone 0.01% hydrocortisone butvrate 0.1% (C) hydrocortisone butvate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) MEDIU betamethasone valerate desoximetasone 0.05% (.0.25% (C) fluocinolone 0.025% (I) fluticasone 0.05% (C) mometasone SYNALAR 0.025% (C, C) triamcinolone 0.025%, 0.1% HIGH betamethasone dipropionate	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDSSTEP 1 AGENTSLOTION; O-OINTMENT POTENCY M POTENCY	*Refer to Additional Therapeutics Clinical Criteria Chart for more limits be allowed for clients that are pregnant or breast-feeding 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. 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. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	SKYRIZI STELARA TYSABR (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (S) Clocortolone Pivalate flurandrenol fluticasone 0.05% (L) hvdrocortisone butvrate 0.1% (O) triamcinolone 0.05% (O) APEXICON 0.05% (C) amcinonide 0.1% (C,L,O)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER C=CREAM, G=GEL; alciometasone desonide* fluocinolone 0.01% hydrocortisone butvrate 0.1% (C) hydrocortisone butvarse 0.1% (C) hydrocortisone 0.025% (C, L) MEDIU betamethasone valerate desoximetasone 0.05% (. 2.5% (C, I fluocinolone 0.025% (C) mometasone SYNALAR 0.025% (C, O) triamcinolone 0.025%, 0.1% HIGH betamethasone dipropionate clobetaso/f € 0.05% (C, G, O, S) diflorasone 0.05% (O, S)	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDSSTEP 1 AGENTSLOTION; O-OINTMENT POTENCY M POTENCY	*Refer to Additional Therapeutics Clinical Criteria Chart for more limits be allowed for clients that are pregnant or breast-feeding 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. 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. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	SKYRIZI STELARA TYSABR (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (S) Clocortolone Pivalate flurandrenol fluticasone 0.05% (L) hvdrocortisone butvrate 0.1% (O) triamcinolone 0.05% (C) amcinonide 0.1% (C,L,O) augmented betamethasone 0.05% (G,L,C) clobetasol 0.05% (C) augmented betamethasone 0.05% (G,L,C) clobetasol 0.05% (L)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CCORTICOSTER C"CREAM; G"=GEL; alciometasone desonide* fluocinolone 0.01% hydrocortisone butvrate 0.1% (C) hydrocortisone butvate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O) MEDIU betamethasone valerate desoximetasone 0.025% (C, 1) fluocinolone 0.025% (C, 0) SYNALAR 0.025% (C, 0) triamcinolone 0.025%, 0.1% HIGH betamethasone dipropionate clobetasol/E 0.05% (C, G,O,S) diflorasone 0.05% (O) fluocinonide flurandrenolide	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDSSTEP 1 AGENTSLOTION; O-OINTMENT POTENCY M POTENCY	*Refer to Additional Therapeutics Clinical Criteria Chart for more limits be allowed for clients that are pregnant or breast-feeding 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. 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. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	SKYRIZI STELARA TYSABR (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (\$) Clocortolone Pivalate flurandrenol fluticasone 0.05% (L) hvdrocortisone butvrate 0.1% (O) triamcinolone 0.05% (C) amcinonide 0.1% (C,L,O) augmented betamethasone 0.05% (G,L,G) clobetasol 0.05% (L) desoximetasone 0.05% (0.25% (G,O) diflorasone 0.05% (0.25% (G,O)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER CCREAM, G-GEL; alciometasone desonide* fluocinolone 0.01% hydrocortisone butvrate 0.1% (C) hydrocortisone butvrate 0.1% (C) hydrocortisone butvrate 0.25% (C,L,O) MEDIU betamethasone valerate desoximetasone 0.05% 0.25% (C) fluocinolone 0.025% (T) fluocinolone 0.025% (C) mometasone SYNALAR 0.025% (C, O, S) diflorasone 0.05% (C,G,O,S) diflorasone 0.05% (O) fluocinonide flurandrenolide	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDSSTEP 1 AGENTSLOTION; O-OINTMENT POTENCY M POTENCY	*Refer to Additional Therapeutics Clinical Criteria Chart for more limits be allowed for clients that are pregnant or breast-feeding 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. 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. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (S) Clocortolone Pivalate flurandrenol fluticasone 0.05% (L) hvdrocortisone butvrate 0.1% (O) triamcinolone 0.05% (O) APEXICON 0.05% (C) augmented betamethasone 0.05% (G,L,C) clobetasol 0.05% (C) desoximetasone 0.05% (O,25% (G,O) diflorasone 0.05% (C) fluocinonide 0.1% (C)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER CCCREAM, G-GEL; alclometasone desonide* fluocinolone 0.01% hydrocortisone butvrate 0.1% (C) hydrocortisone butvrate 0.1% (C) hydrocortisone butvrate 0.25% (C, L,O) MEDIU betamethasone valerate desoximetasone 0.05% (0.25% (C) fluocinolone 0.025% (T,O) fluocinolone 0.025% (C,O) triamcinolone 0.025% (C,O) triamcinolone 0.05% (C,G,O,S) difforasone 0.05% (C,G,O,S) difforasone 0.05% (O) fluocinonide flurtasone 0.05% (O) halobetasol TOPICORT 0.025% (C)	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDSSTEP 1 AGENTSLOTION; O-OINTMENT POTENCY M POTENCY	*Refer to Additional Therapeutics Clinical Criteria Chart for more limits be allowed for clients that are pregnant or breast-feeding 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. 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. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (5) Clocortolone Pivalate flurandrenol fluticasone 0.05% (L) hvdrocortisone butvrate 0.1% (O) triamcinolone 0.05% (C) aucinonide 0.1% (C,LO) augmented betamethasone 0.05% (G,Lr clobetasol 0.05% (L) desoximetasone 0.05% (.) desoximetasone 0.05% (.) desoximetasone 0.05% (.) desoximetasone 0.05% (.)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER C-CREAM, G-GEL; LOW alclometasone desonide* fluocinolone 0.01% hydrocortisone butvrate 0.1% (C) hydrocortisone butvrate 0.1% (C) hydrocortisone vulvate 0.1% (C) fluocinolone 0.05% (C, L) betamethasone valerate desoximetasone 0.05% (0.25% (C) fluocinolone 0.025% (C) triamcinolone 0.025%, 0.1% HIGH betamethasone dipropionate clobetasol/E 0.05% (C), G, O, S) diflorasone 0.05% (O) fluocinonide flurandrenolide flurandrenolide flurandrenolide flurandrenolide flurandrenolide flurocorrolide fl	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDSSTEP 1 AGENTSLOTION; O-OINTMENT POTENCY M POTENCY	*Refer to Additional Therapeutics Clinical Criteria Chart for more limits be allowed for clients that are pregnant or breast-feeding 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. 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. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (5) Clocortolone Pivalate flurandrenol fluticasone 0.05% (L) hvdrocortisone butvrate 0.1% (O) triamcinolone 0.05% (C) augmented betamethasone 0.05% (G,L) clobetasol 0.05% (L) desoximetasone 0.05% (.) desoximetasone 0.05% (.) fluocinonide 0.1% (C)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER CORTICOSTER CORTICOSTER CORTICOSTER LOW alciometasone desonide* fluocinolone 0.01% hydrocortisone butyvate 0.1% (C) hydrocortisone butyvate 0.1% (C) hydrocortisone 0.05% (O, 25% (C, I) betamethasone valerate desoximetasone 0.05% (O, 25% (C) fluocinolone 0.025% (I) fluciasone 0.05% (C) mometasone SYNALAR 0.025% (C, O) triamcinolone 0.025% (D, 1% HIGH betamethasone dipropionate clobetasol/E 0.05% (C) fluocinonide flutradrenolide fl	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDSSTEP 1 AGENTSLOTION; O-OINTMENT POTENCY M POTENCY	*Refer to Additional Therapeutics Clinical Criteria Chart for more limits be allowed for clients that are pregnant or breast-feeding 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. 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. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	SKYRIZI STELARA TYSABR (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (5) Clocortolone Pivalate flurandrenoi fluticasone 0.05% (L) hvdrocortisone butvrate 0.1% (O) triamcinolone 0.05% (C) amcinonide 0.1% (C,LO) augmented betamethasone 0.05% (G,L,C) clobetasol 0.05% (L) desoximetasone 0.05% (.0,25% (G,O) diflorasone 0.05% (C) fluocinonide 0.1% (C) fluocinonide 0.1% (C) fluocinonide 0.1% (C)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER CORTICOSTER CORTICOSTER CORTICOSTER LOW alciometasone desonide* fluocinolone 0.01% hydrocortisone butyvate 0.1% (C) hydrocortisone butyvate 0.1% (C) hydrocortisone 0.05% (O, 25% (C, I) betamethasone valerate desoximetasone 0.05% (O, 25% (C) fluocinolone 0.025% (I) fluciasone 0.05% (C) mometasone SYNALAR 0.025% (C, O) triamcinolone 0.025% (D, 1% HIGH betamethasone dipropionate clobetasol/E 0.05% (C) fluocinonide flutradrenolide fl	Clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDS - STEP 1 AGENTSLOTION; O-DINITMENT POTENCY M POTENCY LATORS - STEP 2 AGENTS ELIDEL LATORS - STEP 2 AGENTS ELIDEL	*Refer to Additional Theraceutics Clinical Criteria Chart for more in be allowed for clients that are pregnant or breast-feeding 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. 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. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	SKYRIZI STELARA TYSABR (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (\$) Clocortolone Pivalate flurandrenol fluticasone 0.05% (L) hvdrocortisone butvrate 0.1% (O) triamcinolone 0.05% (C) amcinonide 0.1% (C, L, O) augmented betamethasone 0.05% (G, L, (iobetasol 0.05% (I) desoximetasone 0.05% (.0, 25% (G, O) diflorasone 0.05% (C) fluocinonide 0.1% (C) halcimonide 0.1% (C) halcimonide 0.1% (C) HALOG 0.1% (O)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER CORTICOSTER CORTICOSTER CORTICOSTER LOW alciometasone desonide* fluocinolone 0.01% hydrocortisone butyvate 0.1% (C) hydrocortisone butyvate 0.1% (C) hydrocortisone 0.05% (O, 25% (C, I) betamethasone valerate desoximetasone 0.05% (O, 25% (C) fluocinolone 0.025% (I) fluciasone 0.05% (C) mometasone SYNALAR 0.025% (C, O) triamcinolone 0.025% (D, 1% HIGH betamethasone dipropionate clobetasol/E 0.05% (C) fluocinonide flutradrenolide fl	Clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDS - STEP 1 AGENTSLOTION; G-OINTMENT POTENCY M POTENCY LATORS - STEP 2 AGENTS	*Refer to Additional Theraceutics Clinical Criteria Chart for more in be allowed for clients that are pregnant or breast-feeding 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. 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. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (5) Clocortolone Pivalate flurandrenol fluticasone 0.05% (1) hvdrocortisone butvrate 0.1% (0) triamcinolone 0.05% (0) augmented betamethasone 0.05% (G.L.i clobetasol 0.05% (1) desoximetasone 0.05% (0.25% (G.O) difluocinonide 0.1% (C) halcinonide 0.1% (C)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER CORTICOSTER CORTICOSTER CORTICOSTER LOW alciometasone desonide* fluocinolone 0.01% hydrocortisone butyvate 0.1% (C) hydrocortisone butyvate 0.1% (C) hydrocortisone 0.05% (O, 25% (C, I) betamethasone valerate desoximetasone 0.05% (O, 25% (C) fluocinolone 0.025% (I) fluciasone 0.05% (C) mometasone SYNALAR 0.025% (C, O) triamcinolone 0.025% (D, 1% HIGH betamethasone dipropionate clobetasol/E 0.05% (C) fluocinonide flutradrenolide fl	Clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDS - STEP 1 AGENTSLOTION; O-DINITMENT POTENCY M POTENCY LATORS - STEP 2 AGENTS ELIDEL LATORS - STEP 2 AGENTS ELIDEL	*Refer to Additional Theraceutics Clinical Criteria Chart for more in be allowed for clients that are pregnant or breast-feeding 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. 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. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	SKYRIZI STELARA TYSABR (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (\$) Clocortolone Pivalate flurandrenol fluticasone 0.05% (L) hvdrocortisone butvrate 0.1% (O) triamcinolone 0.05% (C) amcinonide 0.1% (C, L, O) augmented betamethasone 0.05% (G, L, (iobetasol 0.05% (I) desoximetasone 0.05% (.0, 25% (G, O) diflorasone 0.05% (C) fluocinonide 0.1% (C) halcimonide 0.1% (C) halcimonide 0.1% (C) HALOG 0.1% (O)
MATOLOGY	AMNESTEEM CLARAVIS isotretinoin ZENATANE CORTICOSTER CORTICOSTER CORTICOSTER CORTICOSTER LOW alciometasone desonide* fluocinolone 0.01% hydrocortisone butyvate 0.1% (C) hydrocortisone butyvate 0.1% (C) hydrocortisone 0.05% (O, 25% (C, I) betamethasone valerate desoximetasone 0.05% (O, 25% (C) fluocinolone 0.025% (I) fluciasone 0.05% (C) mometasone SYNALAR 0.025% (C, O) triamcinolone 0.025% (D, 1% HIGH betamethasone dipropionate clobetasol/E 0.05% (C) fluocinonide flutradrenolide fl	Clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig) RETINOIN IDS - STEP 1 AGENTSLOTION; O-DINITMENT POTENCY M POTENCY LATORS - STEP 2 AGENTS ELIDEL LATORS - STEP 2 AGENTS ELIDEL	*Refer to Additional Therapeutics Clinical Criteria Chart for more in be allowed for clients that are pregnant or breast-feeding 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. 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. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days. Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days. 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	SKYRIZI STELARA TYSABRI (additional criteria applies) ACANYA ONEXTON ABSORICA PANDEL TEXACORT 2.5% (5) Clocortolone Pivalate flurandrenol fluticasone 0.05% (1) hvdrocortisone butvrate 0.1% (O) triamcinolone 0.05% (O) augmented betamethasone 0.05% (G), clobetasol 0.05% (1) desoximetasone 0.05% (.0.25% (G, O) difluocinonide 0.1% (C) halcinonide 0.1% (C) halcinonide 0.1% (C) halcinonide 0.1% (C) halcinonide 0.1% (O)

	Security Control of the Control of t	THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIE THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT Optimiles. WITH ANY QUESTIONS
Service Programmer and any and the recoverage of the commerce	## with the Bally planting years of part of the remarks ## Thread and Linear Area in Secretary and years and should allow reliably the secretary and provided and parts ## Thread and Linear Area in Secretary and years and should allow reliably the secretary and provided and parts ## Linear Area in Secretary and years and parts and p	RMATOLOGY continued	ATOPIC I			
### The analysis and and care from the rest face, story 3, agent and story and care producting process. The care profession of the part of the care part of the	## The analysts and a security of a security agent of the property of the prop					
The control of process of the control of the contro	TEST OCCUPIED					
TOTAL CONTROL OF THE	Segment of the same presented agrees. Section 1. Secti					
CONTROL CONTRO	CONTRACT CONTRA					
And the face of two of the fives perferred agents. When the second of t	A STATE OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE SEA STATE STATE		PLAOUE P			
Supplementary (1) The state of the property of control (1) and of the control (1) and of t	Schrick under diagnost of inducent to some P2 and 56 day that and failure of 1900. **Total and the disorder direct that we appeared was preguent on between design.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the day 19 months.** **Total and the disorder direct in the day 19 months.** **Total and the day 19 months.** **			HUMIRA		
TELESCA INTERNATION OF THE CONTROL	TITLE SOLVETTE SOLVET					SILIQ
CALCADOR	***Contact all be about the citizen for each price program to reversible region (Contact Contact Conta				, , ,	
SCATTER MARCES (SALE) SOCIETY APPROACH (SALE)	Total and foliars of a preferred agent in the Cod 21 months. Cod Cod 2 months Cod 2 month					
AND CONTROL OF THE PRETENTS BOULDOORS THE PROPERTY OF THE PR	WANDOOD WAN		SCABICIDES	/PEDICULICIDES		malathion lotion
INCRESS MARKETS (MANUAL PROPERTY STREET) MARKETS (MANUAL PROPERTY STREET)	INTELLIGIONAL MINISTRATORS INTELLIGIONAL MINISTRATORS The analysis of membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater than or sequel to a 50 day apply in the first 2 membrane and a preferred agent greater and a sequel to a 50 day apply in the first 2 membrane and a preferred agent greater and a sequel to a 50 day apply in the first 2 membrane and a preferred agent greater and a sequel to a 50 day apply in the first 2 membrane and a preferred agent greater and a sequel to a 50 day apply in the first 2 membrane and a membrane and a sequel to a 50 day apply in the first 2 membrane and a membrane and a membrane and a sequel to a 50 day apply in the first 2					
SUCCOSIDES INNERTIONS To all and failure of motification and a performed quarter ground make a required to 3.00 day supply in the property of	mellomorphis set in the company of	ETES		ES AGENTS		
GLICOSIDANE (NUMETORS) Trial aret four or directions and appropriate flower or coal to 3 to a singly in register (Numerors) AMAGINATIONS Trial aret flower or directions and a preference sparse grows are coal to 3 to a singly in register (Numerors) Trial aret flower or directions and a preference sparse grows are coal to 3 to a singly in register (Numerors) Trial aret flower or directions and a preference sparse grows are coal to 3 to a singly in register (Numerors) Trial aret flower or directions and a preference sparse grows are coal to 3 to a singly in register (Numerors) Trial aret flower or directions and a preference sparse grows are coal to 3 to a singly in register (Numerors) Trial aret flower or directions and a preference sparse grows are coal to 3 to a singly in register (Numerors) Trial aret flower or directions and a preference sparse grows are coal to 3 to a singly in register (Numerors) Trial aret flower or directions and a preference sparse and to 3 to a singly in register (Numerors) Trial aret flower or directions agreed after a grown can be given for a non-preference agent. **DIRECTION OF STRUCK A EIPPF AIR REMITTORS** **DIRECTION OF STRUCK A EIPPF AIR REMITTORS** **Trial aret flower or directions grows or this pre- or an absorbing or any preference agent. **DIRECTION OF STRUCK AND ONLY TRIAL AND ONLY T	COLUMN AMERICANS THE ACCUMENTATION OF THE ACCUMENT			JANIDES		
Macrations the last 12 months will be required before approval on the given for an originative and originative and present again great from originative and originative and present against part and present against part than originative against upupits and present against part against part and present against part part against part part against part part part part part part part par	MICHITIMES The sixt 12 months will be required before approved and spined for an one performed agent. The recognition of the sixt 12 months will be required before approved and spined for an one performed agent. The recognition of the sixt 12 months will be required before approved and spined for an one performed agent, story supply in processing agent. The recognition of the sixt 12 months will be required before approved on the given for an one performed agent, story supply in processing agent. The recognition of the sixt 12 months will be required before approved on the given for an one performed agent, supply in the sixt 12 months will be required before approved on the given for an one performed agent. The recognition of the sixt 12 months will be required before approved on the given for an one performed agent. The recognition of the sixt 12 months will be required before approved on the given for an one performed agent. The recognition of the sixt 12 months will be required before approved on the given for an one performed agent. The recognition of the sixt 12 months will be required before approved on the given for an one performed agent. The recognition of the sixt 12 months will be required before approved on the given for an one performed agent. The recognition of the sixt 12 months will be required before approved on the given for a non-performed agent. The recognition of the sixt 12 months will be required before approved on the given for a non-performed agent. The recognition of the sixt 12 months will be required before agent and the given for a non-performed agent. The recognition of the sixt 12 months will be required before agent and the given for a non-performed agent. The recognition of the sixt 12 months will be required before agent and the given for a non-performed agent. ***MICHITIM MANTEL SEAL TRUET AGENT AG		metformin/ER			
Intelligence Intel	MECUNIONS The set of fairner of entirements and apperdent panel are part of any day to supply an experiment of the common of th			INHIBITORS		
INCRITION AMARTICE, CORP. A SECUTION ACCOUNTS 1 INCRITICAL ACCOUNTS 1 INCRITION AMARTICE, CORP. A SECUTION ACCOUNTS 1 INCRITION AMARTICE, CORP. A SECUTION ACCOUNTS 1 INCRITION ACC	Transportion (Control Activity			TTIMUDEC.		and a decide
This and failure of meritorium and an optional age parts for some required to 50 day supply in Company (Company) and Company (Compan	THANDOLOGICOMES The last 12 position will be required above grouped on the position of the programme of the			THINIDES		repaglinide
Integrations The last 12 months will be required before approval can be given for a non-preferred agent. SIGNOMURICAS The last 12 months will be required before approval can be given for a non-preferred agent. Province for the last 12 months will be required before approval can be given for a post preferred agent. Province for the last 12 months will be required before approval can be given for a post preferred agent. Province for the last 12 months will be required before approval can be given for a post preferred agent. Province for the last 12 months will be required before approval can be given for a preferred agent. Province for the last 12 months will be required before approval can be given for a preferred agent. Province for the last 12 months will be required before approval can be given for a post preferred agent. Province for the last 12 months will be required before approval can be given for a post preferred agent. Province for the last 12 months will be required before approval can be given for a post preferred agent. Province for the last 12 months will be required before approval can be given for a post preferred agent. Province for the last 12 months will be required before approval can be given for a post preferred agent. Province for the last 12 months will be required before approval can be given for a post preferred agent. Province for the last 12 months will be a post province for approval can be given for a post preferred agent. Province for the last 12 months will be a post province for approval can be given for a post preferred agent. Province for the last 12 months will be a post province for a month preferred agent. Province for the last 12 months will be a post province for approval can be given for a post preferred agent. Province for the last 12 months will be a post province for approval can be given for a post province for approval can be given for a post province for approval can be given for a post province for approval can be given for a post province for ap	Department of the last 12 months will be required before approach can be given for a non-preferred agent. Including the last 12 months will be required before approach can be given for a non-preferred agent. Including the last 12 months will be required before approach can be given for a non-preferred agent. Including the last 12 months will be required before approach can be given for a non-preferred agent. Including the last 12 months will be required before approach can be given for a non-preferred agent. Including the last 12 months will be required before approach can be given for a non-preferred agent. Including the last 12 months will be required before approach can be given for a non-preferred agent. Including the last 12 months will be required before approach can be given for a non-preferred agent. Including the last 12 months will be required approach can be given for a non-preferred agent. Including the last 12 months will be required approach can be given for a non-preferred agent. Including the last 12 months will be required agent to approach can be given for a non-preferred agent. Including the last 12 months will be required agent to approach can be given for a non-preferred agent. Including the last 12 months will be required approach can be given for a non-preferred agent to application of the last 12 months will be required agent application of the last 12 months will be required agent application of the last 12 months will be required agent application of the last 12 months will be required agent application of the last 12 months will be required agent application of the last 12 months will be required agent application of the last 12 months will be required agent application of the last 12 months will be required agent application of the last 12 months will be required agent application of the last 12 months will be required agent application of the last 12 months will be required agent application of the last 12 months will be required agent application of the last 12 months w			DINEDIONES		ACTOPLUS MET (use separate agents)
this control file stude (Fig.	timecrafor(ET plants and the last 2 conds will be required before approval can be given for non-preferred agent. All polyton for the preferred agent. All polyton for non-preferred agent. In particular polyton for polyton for preferred agent. In particular polyton for preferred agent polyton for preferred agent. In particular polyton, preferred agent polyton for preferred agent. In particular polyton, preferred agent. In particular p					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
the bas 12 months will be required before approved can be given for a non-perferred agent. Proceedings Process Process	timecrafor(ET plants and the last 2 conds will be required before approval can be given for non-preferred agent. All polyton for the preferred agent. All polyton for non-preferred agent. In particular polyton for polyton for preferred agent. In particular polyton for preferred agent polyton for preferred agent. In particular polyton, preferred agent polyton for preferred agent. In particular polyton, preferred agent. In particular p		SULFO	NYLUREAS	Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in	
INTERIOR MANUSCRIPTORS INTERI	DIFFERENCE AS INVESTIGATE AS INVESTI		glimepiride/ER glipizide/ER			
DIPAL NUMBERO COMES CARDINTS Treal and failure or merforman greater than or equal to a 90 day supply in the lists 12 months will be required before approval can be given for a more preferred agent. NUMBERO VECTOR NUMBER	DIRECTA INDUSTRIAN DIPPA BINISTRIC COMED ACENTS Trial and failure of meritoring present than or equal to a 90 day spapely in the last 12 months will adopted in the present degent. As 50 day trial of failure of the same type o			ASE 4 (DPP-4) INHIBITORS	Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will	alogliptin
## PARMINITION COMMON AGENTS Trial and failure of metforming greater than or equal to a 90 day supply in the last 12 months will adjust information in adjusting informat	INCLUSION ACTIVITY INTO ADMINISTRY COMPANIES (ACCOUNTY) DOPA HINISTRY COMPANIES (ACCOUNTY) INCLUSION (ACCOUN					
JANUMET/JAR JETYADUTO COMMIGUYEZ/AR INCRETIN MINISTERS (DAP-2 RECEPTOR ACCOUNTS) IT value of failure of meet form or greater than or equal to a 90 day supply in the last 12 months will apply	AMOUNTE/OR preferred agent is required before approval can be given for a preferred agent. A 90 day trail of failure of the preferred agent. ADMINISTRATION preferred agent is required before approval can be given for a propertient agent. ADMINISTRATION				preferred agent is required before approval can be give for a non-preferred agent.	
INCRETIN MINISTERS (CLAS SECRETICA AGONESTS) INCRETIN MINISTERS (CLAS SECRETICA AGONESTS) TRUTTA TR	INFARLICED INCERTIN MAINTICS (DR.4) ESCEPTION ACOMISTS) INCERTIN MAINTICS (DR.4) ESCEPTION ACOMISTS INCERTIN MAINTICS (DR.4) ESCEPTION ACOMIS		DPP-4 INHIBITOR			
INCRETIN MIMETICS (QUAS I RECEPTION AGONISTS) This and failure of metiorming greater than or equal to a 90 day supply in the last 12 months will cave branch from which care the trial of referred agent unless ACVO or risk factors are invested before approval can be given for a preferred agent unless ACVO or risk factors are invested before approval can be given for a preferred agent or required before approval can be given for a non-preferred agent. SOLUZI INHIBITIONS Trial and failure of metiorming greater than or equal to a 90 day supply in the last 12 months will COVID-19 compice. 2 may week virtures 12 miles Apply Ocentre. 2 may be required before approval can be given for a preferred agent. SOLUZI INHIBITIONS Trial and failure of metiorming greater than or equal to a 90 day supply in the last 12 months will COVID-19 (as separate preferred agent in the separate preferred agent in the preferred agent in the separate preferred agent in the prefe	INCRETIN MINISTERS (GD-2 RECEPTOR AGONISTS) INCRETIN MINISTERS (G					
INCRETIN MIMETICS (GLP-3 RECEPTOR AGONSTS) Trial and failure of metforming greater than or equal to a 90 day supply in the last 12 months will WINDLEON BYSTTA TRUCKITY VICTORA TRUCKITY VICTORA TRUCKITY VICTORA TRUCKITY VICTORA TRUCKITY VICTORA Treatment of metforming greater than or equal to a 90 day supply in the last 12 months will will be required before approval can be given for a non preferred agent. Understood the preferred agent is required before approval can be given for a non preferred agent. Treatment in the preferred agent is required before approval can be given for a non preferred agent. WINDLEAD Trial and failure of metforming greater than or equal to a 90 day supply in the last 12 months will GLYAMBI (use separate preferred agent) TRACKICA	INCRETIN IMMETES (ILB-3 RECEPTOR ACQUISTS) PETETA TRULOTY VICTORA TRULOTY TRULOTY VICTORA TRULOTY TRULOTY VICTORA TRULOTY TRULO				preferred agent is required before approval can be give for a non-preferred agent.	JENTADUETO XR
De required before approval can be given for a preferred agent unless ACVD or risk factors are installated fuser branch present, in which case the trial of meetform is water of the preferred agent. **Popetrus required sourcementation of insbility to use injectable agents. **Popetrus required sourcementation of insbility to use injectable agents. **Popetrus required sourcementation of insbility to use injectable agents. **Popetrus required sourcementation of insbility to use injectable agents. **Popetrus required sourcementation of insbility to use injectable agents. **Popetrus required before approval can be given for a non-preferred agent United States of the Control of the Contro	De PERTIA NELLICITY NICTOZA PROBLICITY NICTOZA PROB					
TRULCITY VICTORA agents is required before approval can be give for a non-preferred agent. Truly and failure of the preferred preferred agent. Truly and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required agent. SOLT, INHIBITORS Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will offer a preferred agent in the same type of the preferred agent in the p	PROJUCTO victor vict		INCRETIN MIMETICS (G	LP-1 RECEPTOR AGONISTS)	Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will	BYDUREON
SGLT2 INHIBITORS Flaketisks required before approval can be give for a non-preferred agent.	AMULICO FAR INSULAN RESTRICT ENQUIRED EACH approach can be give for a non-preferred agent. **Pophosis requires documentation of inability to use injectable agents. **Discourse preferred agent to approach can be give for a preferred agent to approach can be given for a preferred agent to approach can be given for a preferred agent to approach can be given for a preferred agent unless there is a diagnosis of a NAVIO, CALO, or heart failure. In which case the trial of metormin will be waved. A 90 day trial and failure of a preferred agent unless there is a diagnosis of a NAVIO, CALO, or heart failure. In which case the trial of metormin will be waved. A 90 day trial and failure of a preferred agent unless there is a diagnosis of a NAVIO, CALO, or heart failure. In which case the trial of metormin will be waved. A 90 day trial and failure of a preferred agent unless there is a diagnosis of a NAVIO, CALO, or heart failure. In which case the trial of metormin will be waved. A 90 day trial and failure of a preferred agent is required before approval can be given for a non-preferred agent. **TASTACTING INSULANCE** **TASTA					
Pipebasus requires documentation of inability to use injectable agents. ***Decage Limits Apply ***Oceanics Tany livede** Votors: 1.8mg/day ***SELT2 INHIBITIORS** ***Fall and failure of metformin greater than or equal to a 90 day supply in the last 12 months will GLYXAMBI (see separate preferred agent VITAMBI (see separate preferred agent) or preferred agent or p	## Pybelsus requires documentation of inability to use Injectable agents. Documentary					OZEMPIC*
SGLYZINHBITORS Trail and failure of metforming greater than or equal to a 90 day supply in the last 12 months will MNOKAMET MNOKAMET ARXIX.A MNOKAMET ARXIV.D.COL or heart failure, in which we have when 40 paller to methor and preferred agent. JARDIANCE SYNLARDY ARXIV.D.COL or heart failure, in which are failure from the same type of agent. FAST.ACTING INSULIN Prior authorization will be required when using two different delivery forms of the same type of MRLOG (sue preferred agent) insulin concurrently. MNAMADO 75/25 HUMALOG 75/25 HUMALOG MIX NOVICIOS MIX NOVICIOS MIX LONG-ACTING INSULIN Prior authorization will be required when using two different delivery forms of the same type of MRLOG (sue preferred agent) insulin concurrently. WIND CONTINUOUS SUCCESSARY LATTUS SOLDSTAR* LATTUS SOLDSTAR* INSULIN DIABETIC METERS/TEST STRIPS Claunality limits apply: Insulin Concurrently. DIABETIC METERS/TEST STRIPS Claunality limits apply: Insulin Dependent Clients: 3 strips/day Non-insulin Dependent Clients: 4 strips/day RESSTYLE (RICKLINX) RESTRIPS RESSTYLE (RICKLINX) RESSTYLE (RICKLINX) RESTRIPS RESTRIPS	SGLY2 HHBITORS Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will GLY2AMBI (size separate preferred agent) in NOVCAMAF AND MOVCAMAF AND MOVCAMAF AND				*Rybelsus requires documentation of inability to use injectable agents.	
SGLT2 INBIBITIORS FARXIGA INVOKAMET	SGLY2 INHIBITORS Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will GLYAMBI (use separate preferred agent in MOKAMET INNOCAMET					XULTOPHY (use separate preferred agent
ASXIGA NVOKANA NVOKANA NVOKANA NVOKANA NASVIANCE STANADY NASVIANCE	INACKANA INNOKAMET INNOKAM					
ASXIGA NVOKANA NVOKANA NVOKANA ASVIANCE ASXIVA (X.D., or heart failure, in which case the trial of metformin will be waived. A 90 day trial sold failure of a preferred agent is required before approval can be given for a non-preferred agent. SCUID (X.D., or heart failure, in which case the trial of metformin will be waived. A 90 day trial sold failure of a preferred agent. SCUID (X.D., or heart failure, in which case the trial of metformin will be waived. A 90 day trial sold failure of a preferred agent is required before approval can be given for a non-preferred agent STEGLIARO (X.D., or heart failure, in which case the trial of metformin will be waived. A 90 day trial sold failure of a preferred agent is required when using two different delivery forms of the same type of ALMADOS (X.D., or heart failure, in which case the trial of metformin will be required when using two different delivery forms of the same type of ALMADOS (X.D., or heart failure, in which case the trial of metformin will be required when using two different delivery forms of the same type of ALMADOS (X.D., or heart failure, in which case the trial of metformin will be required when using two different delivery forms of the same type of ALMADOS (X.D., or heart failure, in which case the trial of metformin will be required when using two different delivery forms of the same type of ALMADOS (X.D., or heart failure, in which case the trial of the same type of ALMADOS (X.D., or heart failure, in which case the trial of the same type of ALMADOS (X.D., or heart failure, in which case the trial of the same type of ALMADOS (X.D., or heart failure, in which case the trial of metformin will be required when using two different delivery forms of the same type of ALMADOS (X.D., or heart failure, in which case the trial of the trial o	INACKANA INNOKAMET INNOKAM		COLTO	ALLUDITORS		CDOVANDI (
INVOKAMEN INVOKA	INVOKANET INVOKANET ASCUD, CRD, or heart failure, in which case the trial of metformin will be waived. A 90 day trial SECLUMONET (in exporter preferred a agent.) ASCUD, CRD, or heart failure, in which case the trial of metformin will be waived. A 90 day trial SECLUMONET (in exporter preferred a agent.) ASCUD, CRD, or heart failure, in which case the trial of metformin will be waived. A 90 day trial SECLUMONET (in exporter preferred agent.) TRIALADOR (INTERNATION INSULIN) Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently. INVONCOR MIX NOVICIOR MIX INVONCOR MIX INVO		3GL121			
IABRIDANCE STIGLIUAN (use separate preferred agent is required when using two different delivery forms of the same type of RIALAROY XR (use separate preferred agent) HUMALOG 75/25 HUMALOG IR. HUMALOG MX NOVUCLOG MIX LONG-ACTING INSULIN Prior authorization will be required when using two different delivery forms of the same type of Insulin concurrently. Prior authorization will be required when using two different delivery forms of the same type of Insulin concurrently. LANTUS SOLOSTAR* LANTUS SOLOSTAR* LANTUS Vall LEVEMIR LEVEMIR DIABETIC METERS/TEST STRIPS Quantity limits apply: Insulin concurrently. Quantity limits apply: Insulin pependent Clients: 10 strips/day Non-insulin Dependent Clients: 4 strips/day N	IARDIANCE SYNLARDY SIGNATURE STRIPS IN THE STRIPS IN Insulin concurrently. IARDIANCE SYNLARDY Rise separate preferred agent. STEGLIUAN (see separate preferred agent) and make or authorization will be required when using two different delivery forms of the same type of INJARDY Rise separate preferred agent) insulin insuration will be required when using two different delivery forms of the same type of INJARDY Rise separate preferred agent) insulin insuration will be required when using two different delivery forms of the same type of INJARDY Rise separate preferred agent) insulin insuration will be required when using two different delivery forms of the same type of INJARDY Rise separate preferred agent) insulin insuration will be required when using two different delivery forms of the same type of INJARDY RISE separate preferred agent) insulin insuration will be required when using two different delivery forms of the same type of INJARDY RISE separate preferred agent) insulin insuration will be required when using two different delivery forms of the same type of INJARDY RISE separate preferred agent) insulin insuration will be required when using two different delivery forms of the same type of INJARDY RISE separate preferred agent) insulin insuration will be required when using two different delivery forms of the same type of INJARDY RISE separate preferred agent) insulin insuration will be required when using two different delivery forms of the same type of INJARDY RISE separate preferred agent) insulin insulin insuration will be required when using two different delivery forms of the same type of INJARDY RISE separate preferred agent) insulin insuration will be required when using two different delivery forms of the same type of INJARDY RISE separate preferred agent) insulin insuration will be required when using two different delivery forms of the same type of INJARDY RISE separate preferred agent) insulin insuration will insulin insuration will be required when using two different delivery forms of the sa			INVOKAMET	ASCVD, CKD, or heart failure, in which case the trial of metformin will be waived. A 90 day trial	SEGLUROMET (use separate preferred ag
FAST-ACTING INSULIN HUMALOG HUMALOG 77:25 HUMALOG JR. HUMALOG JR. HUMALOG MIX NOVOLOG MIX NOVOLOG MIX LONG-ACTING INSULIN Prior authorization will be required when using two different delivery forms of the same type of Insulin concurrently. Prior authorization will be required when using two different delivery forms of the same type of Insulin Concurrently. LANTUS SOLOSTAR* LANTUS Val LEVEMIR LANTUS Val LEVEMIR DIABETIC METERS/TEST STRIPS Quantity limits apply: Insulin Dependent Clients: 10 strips/day REESTYLE (strips only) REESTYLE (strips only) REESTYLE PRECEDOM REESTYLE PRECEDOM LITE REESTYLE INSULINX REESTYLE PRECEDOM NO BO B REESTYLE PRECEDOM NO B REESTYLE PRECEDOM REESTRIPS REESTYLE PRECE	### ADMELOG (ase profered agent)			JARDIANCE		STEGLUJAN (use separate preferred agen
HUMALOG IN	### PAST-ACTING INSULIN HUMALOG 73/25 HUMALOG 73/25 HUMALOG 78/25 HUMALOG IR HUMALOG IR HUMALOG IR HUMALOG IR HUMALOG IR HUMALOG IR HUMALOG MIX NOVOLOG MIX **NOVOLOG MIX **NOVOLOG MIX **NOVOLOG MIX **NOVOLOG MIX **NOVOLOG MIX **INTUS SOLOSTAR** LANTUS Vall LEVEMIR **DIABETIC METERS/TEST STRIPS** **INTUS Vall LEVEMIR **DIABETIC METERS/TEST STRIPS** **INSUIN Concurrently.** *				agent.	
HUMALOG 18. HUMALOG 18. HUMALOG MIX NOVOLOG MIX LONG-ACTING INSULIN LANTUS SOLOSTAR* LANTUS Vail LEVEMIR DABETIC METERS/TEST STRIPS Quantity limits apply: Insulin Dependent Clients: 10 strips/day RREESTYLE (strips only) RREESTYLE (strips only) RRESTYLE FREEDOM RRESTYLE FRE	HUMALOG 75/25 HUMALOG IR. HUMALOG INX NOVOLOG MIX LONG-ACTING INSULIN LANTUS SOLOSTAR* LANTUS Vial LEVEMIR LEVEMIR DIABETIC METERS/TEST STRIPS Quantity limits apply: Insulin Dependent Clients: 0 strips/day RESSYTLE (RESDOM RESSYTLE RESDOM RESDOM UTRA BILLE RESSYTLE SUBERICK II ROME TOUCH ULTRA BILLE RESTOM RETLECT RESSYTLE SUBERICK II RESSYTLE RESDOM RESDOM RESDOM RETLECT RESSYTLE RESDOM RESDOM RESDOM RESDOM RESDOM RESDOM RESDOM RESSYTLE RESDOM RES		FAST-ACT		Prior authorization will be required when using two different delivery forms of the same type of	
HUMALOG IR. HUMALOG MIX NOVOLOG MIX LONG-ACTING INSULIN LANTUS SOLOSTAR* LANTUS SOLOSTAR* LANTUS VAILABLE LEVEMIR LONG-ACTING INSULIN LONG-ACTING INSULIN LEVEMIR Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently. BASAGLAR (use preferred agent) insulin concurrently. Insulin Concurrently. DIABETIC METERS / use preferred agent) TRESIBA* (use preferred agent)	HUMALGG MX 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 Gaingine		HUMALOG HUMALOG 75/25			FIASP (use preferred agent)
LONG-ACTING INSULIN 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 REESTYLE (strips only) REESTYLE REEDOM RESTYLE REEDOM RESTYLE SPECISION NEO B REESTYLE INSULINX REESTYLE PRECISION NEO B REESTYLE PRECISION NEO B REESTYLE SPECISION NEO B REESTYLE SECON NEO B REESTYLE SPECISION NEO B REESTYLE SPECISION NEO B REESTYLE SPECISION NEO B REESTYLE SECON NEO B REESTYLE SEC	NOVOLOG MIX LONG-ACTING INSULIN LANTUS SOLOSTAR* LANTUS Vail LEVEMIR DIABETIC METERS/TEST STRIPS DIABETIC METERS/TEST STRIPS PREESTYLE (using annity) FREESTYLE (using		HUMALOG JR.			
LANTUS SOLOSTAR* LANTUS VIAI LEVEMIR DIABETIC METERS/TEST STRIPS Quantity limits apply: Insulin Dependent Clients: 10 strips/day RRESSTYLE (strips only) RRESSTYLE RREDOM RRESSTYLE RREDOM LITE RREEDOM LITE RREESTYLE FREEDOM LITE RREESTYLE PRECISION NEO B RREESTYLE RIA III ONE TOUCH ULTRA III ONE TOUCH ULTRA III ONE TOUCH ULTRA BLUE ONE TOUCH VERIO REFLECT O	LONG-ACTING INSULIN LANTUS SOLOSTAR* LANTUS Val LEVEMIR LEVEMIR DIABETIC METERS/TEST STRIPS DIABETIC METERS/TEST STRIPS Quantity limits apply: FREESTYLE (strips only) FREESTYLE (strips only) FREESTYLE FREEDOM FREESTYLE FREEDOM FREESTYLE FREEDOM FREESTYLE FREEDOM FREESTYLE PRECISION NEO B FREESTYLE SIDEMICK II ONE TOUCH UHTRA BLUE ONE TOUCH UHTRA BLUE ONE TOUCH VERIO REFLECT ONE TOUCH VERIO BEFLECT ONE TOUCH VERIO REFLECT ONO					<u> </u>
LANTUS vial LEVEMIR DIABETIC METERS/TEST STRIPS Quantity limits apply: FREESTYLE (strips only) FREESTYLE (strips only) FREESTYLE (strips only) FREESTYLE FREEDOM FREESTYLE FREEDOM FREESTYLE FREEDOM FREESTYLE FREEDOM FREESTYLE FREEDOM LITE FREESTYLE SIDEKICK II ONE TOUCH ULTRA BILI ONE TOUCH ULTRA BILI ONE TOUCH ULTRA BILI ONE TOUCH VERIO FLEX ONE TOUCH VERI	LANTUS vial LEVEMIR DIABETIC METERS/TEST STRIPS Cuantity limits apply: FREESTYLE (strips only) FREESTYLE (strips only) FREESTYLE FREEDOM FREESTYLE SIDERICK II ONE TOUCH ULTRA III ONE TOUCH ULTRA BLUE ONE TOUCH VERIO REFLECT ONE TOUCH VERIOR REFLECT		LONG-ACT	TING INSULIN		
TOUJEO (use preferred agent) TRESINA* (use preferred agent) XULTOPHY (use separate preferred preferred prefer pref	DIABETIC METERS/TEST STRIPS DIABETIC METERS/TEST STRIPS Quantity limits apply: FREESTYLE (strips only) FREESTYLE FREEDOM FREESTYLE FREEDOM FREESTYLE FREEDOM FREESTYLE FREEDOM FREESTYLE FREEDOM FREESTYLE FREEDOM FREESTYLE PRECISION LITE REESTYLE PRECISION LITE REESTYLE PRECISION LITE REESTYLE PRECISION LITE REESTYLE PRECISION KE O RESTYLE SIDERICK ONE TOUCH ULTRA II ONE TOUCH ULTRA III ONE TOUCH ULTRA III ONE TOUCH ULTRA BLUE ONE TOUCH VERIO CONE FREE ONE TOUCH VERIO FLEX ONNIPOD DASH ONNIPOD DASH ONNIPOD DASH ONNIPOD DASH ONNIPOD DASH ONNIPOD DASH ONNIPOD S ACUTE HYPOGUSEM AGENTS ONNIPOD S ACUTE HYPOGUSEMA AGENTS GVOKE (use preferred agent) TOUCH VERIO FREE TREESTYLE LIBRE FREESTYLE LIBRE FRE		LANTUS vial		insuiin concurrently.	Insulin Degludec
TRESIBA* (use preferred agent) XULTOPHY (use separate preferred agent ALL OTHER METERS AND TEST STRIPS Insulin Dependent Clients: 10 strips/day Non-Insulin Dependent Clients: 1	DIABETIC METERS/TEST STRIPS Quantity limits apply: FREESTYLE (strips only) FREESTYLE FREEDOM FREESTYLE FREEDOM FREESTYLE FREEDOM LITE FREESTYLE LIBBE FREESTYLE FREEDOM FREESTYLE FREEDOM FREESTYLE FREEDOM		LEVEMIR			
DIABETIC METERS/TEST STRIPS Quantity limits apply: Insulin Dependent Clients: 10 strips/day RREESTYLE FREEDOM RREESTYLE FREEDOM LITE RREESTYLE FREEDOM LITE RREESTYLE INSULINX RREESTYLE INSULINX RREESTYLE INSULINX RREESTYLE STRIPS Clients are limited to 1 meter/365 days REESTYLE STRIPS ALL OTHER METERS AND TEST STRIPS Clients are limited to 1 meter/365 days Clients are limited t	DIABETIC METERS/TEST STRIPS Quantity limits apply: Insulin Dependent Clients: 10 strips/day Non-insulin Dependent Clients: 10 strips/day Non-insulin Dependent Clients: 4 strips/day Non-insulin Dependent Clients: 4 strips/day REESTYLE REEDOM LITE FREESTYLE INSULINX FREESTYLE SIRECTION NEO B FREESTYLE SIRECTION NEO B FREESTYLE SIRECTION ONE TOUCH ULTRA MINI ONE TOUCH ULTRA MINI ONE TOUCH ULTRA MINI ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO REFLECT ONE TOUCH VERIO REF					TRESIBA* (use preferred agent)
FREESTYLE (strips only) FREESTYLE (strips only) FREESTYLE FREEDOM FREESTYLE FREEDOM LITE FREESTYLE FREEDOM LITE FREESTYLE PREEDOM LITE FREESTYLE PREEDOM LITE FREESTYLE PREEDOM LITE FREESTYLE PREEDOM LITE FREESTYLE PREEDON BE B FREESTYLE PREEDON BE B FREESTYLE PREEDON LITE ONE TOUCH ULTRA III ONE TOUCH ULTRA III ONE TOUCH ULTRA BILUE ONE TOUCH ULTRA BILUE ONE TOUCH VERIO ONE TOUCH VERIO ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO REFLECT ONE TOUCH VERIOR ONE	FREESTYLE (strips only) FREESTYLE PREEDOM FREESTYLE PREEDOM FREESTYLE PREEDOM LITE FREESTYLE SIDEKICK II ONE TOUCH ULTRA III ONE TOUCH ULTRA III ONE TOUCH ULTRA BLUE ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO IQ PRECISION XTRA EXTERNAL DIABETIC DEVICES OMNIPOD DASH OMNIPOD SHOOD GLUCOSE MONITORS DEXCOM G6 DEXCOM G6 DEXCOM G6 PREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 3 ACUTE HYPOGLYCEMIA AGENTS Insulin Dependent Clients: 10 strips/day Non-Insulin Dependent Clients: 4 strips/day Clients are limited to 1 meter/365 days Clients are limited t					
RREESTYLE RREEDOM LITE FREESTYLE INSULINX FREESTYLE INSULINX FREESTYLE INSULINX FREESTYLE INSULINX FREESTYLE INSULINX FREESTYLE INSULINX FREESTYLE SPECIAL PRECISION NEO B FREESTYLE SPECIAL PRESENTED SPECIAL PRECISION NEO B FREESTYLE SPECIAL PRESENTED SPECIAL PRECISION NEO B FREESTYLE SPECIAL PRESENTED SPECIAL PRESENTED SPECIAL PRECISION NEO B FREESTYLE SPECIAL PRESENTED SPECIAL PRESENT	RREESTYLE FREEDOM LITE RREESTYLE INSULINX FREESTYLE SIDEKICK II ONE TOUCH ULITRA III ONE TOUCH ULITRA IIII ONE TOUCH ULITRA IIII ONE TOUCH ULITRA IIII ONE TOUCH ULITRA IIII ONE TOUCH URIO ONE TOUCH VERIO ONE TOUCH VERIO ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO REFLECT ONE TOUCH VERIO IQ PRECISION XTRA EXTERNAL DIABETIC DEVICES OMNIPOD DASH OMNIPOD DASH OMNIPOD S CONTINUOUS BLOOD GLUCOSE MONITORS DEXCOM G6 DEXCOM G7 FREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 3 ACUTE HYPOGLYCEMIA AGENTS OVAE (use preferred agent) Non-Insulin Dependent Clients: 4 strips/day Clients are limited to 1 meter/365 days ACUTE HYPOGLYCEMIA AGENTS SOURCE (use preferred agent)			ERS/TEST STRIPS		ALL OTHER METERS AND TEST STRIPS
FREESTYLE FREEDOM LITE FREESTYLE PRECISION NEO B FREESTYLE SPECISION NEO B ONE TOUCH ULTRA BIU ONE TOUCH ULTRA BIU ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO IQ PRECISION XTRA EXTERNAL DIABETIC DEVICES OMNIPOD 5 CONTINUOUS BLOOD GLUCOSE MONITORS DEXCOM G6 DEXCOM G7 Prior authorization will be required to verify if the client is injecting insulin daily. Monitors will also be limited to the labeled age. MINIMED	FREESTYLE PRECISION NEO B FREESTYLE SIDEKICK II ONE TOUCH ULTRA IIII ONE TOUCH ULTRA BILU ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO ONE PRECISION XTRA EXTERNAL DIABETIC DEVICES OMNIPOD DASH OMNIPOD DASH OMNIPOD DS CONTINUOUS BLOOD GLUCOSE MONITORS DEXCOM GF DEX.COM GF DEX.COM GF FREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 3 ACUTE HYPOGLYCEMIA AGENTS CIENTS are limited to 1 meter/365 days Clients are limited to 1 meter/365 days Friestytle Libre are limited to 1 meter/365 days Clients are limited to 1 meter/365 days Friestytle Libre are limited to 1 meter/365 days Clients are limited to 1 mete		FREESTYLE FREEDOM			
RREESTYLE SPECKIS IN REC B RREESTYLE SPECKIS II ONE TOUCH ULTRA III ONE TOUCH ULTRA MINI ONE TOUCH ULTRA MINI ONE TOUCH ULTRA MINI ONE TOUCH ULTRA BLUE ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO GENERATE EXTERNAL DIABETIC DEVICES OMNIPOD DASH OMNIPOD S CONTINUOUS BLOOD GLUCOSE MONITORS DEX.COM G6 DEX.COM G7 Clients are limited to 1 meter/365 days Clients are limited to 1 meter/365	RREESTYLE SIDEKICK II ONE TOUCH ULTRA III ONE TOUCH ULTRA III ONE TOUCH ULTRA BLUE ONE TOUCH VERIO ONE TOUCH VERIO ONE TOUCH VERIO FOR STUDY ONE STU		FREESTYLE FREEDOM LITE			
ONE TOUCH ULTRA III ONE TOUCH ULTRA MINI ONE TOUCH ULTRA BLUE ONE TOUCH VERIO BLUE ONE TOUCH VERIO FLEX ONE TOUCH	ONE TOUCH ULTRA MINI ONE TOUCH ULTRA MINI ONE TOUCH ULTRA BILUE ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO IQ PRECISION XTRA EXTERNAL DIABETIC DEVICES OMNIPOD DASH OMNIPOD DASH OMNIPOD 5 CONTINUOUS BLOOD GLUCOSE MONITORS DEXCOM G6 DEXCOM G7 FREESTYLE LIBRE 2 FREESTYLE LIBRE 3 ACUTE HYPOGLYCEMIA AGENTS GVOKE (use preferred agent)		FREESTYLE PRECISION NEO B		Clients are limited to 1 meter/365 days	
ONE TOUCH ULTRA MINI ONE TOUCH ULTRA BLUE ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO REFLECT ONE TOUCH VERIO REFLEX ONE TOUCH VERIOR REFLEX ONE	ONE TOUCH ULTRA MINI ONE TOUCH VERIO ONE TOUCH VERIO ONE TOUCH VERIO OLD ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO IQ PRECISION XTRA EXTERNAL DIABETIC DEVICES OMNIPOD DASH OMNIPOD S CONTINUOUS BLOOD GLUCOSE MONITORS DEXCOM G6 DEXCOM G7 FREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 3 ACUTE HYPOGLYCEMIA AGENTS GVOKE (use preferred agent)		ONE TOUCH ULTRA II			
ONE TOUCH VERIO ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO REFLECT ONE TOUCH VERIO IQ PRECISION XTRA EXTERNAL DIABETIC DEVICES OMNIPOD DASH OMNIPOD 5 CONTINUOUS BLOOD GLUCOSE MONITORS DEXCOM G6 DEXCOM G7 Prior authorization will be required to verify if the client is injecting insulin daily. Monitors will also be limited to the labeled age. MINIMED	ONE TOUCH VERIO DEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO FLEX ONE TOUCH VERIO TOU					
ONE TOUCH VERIO REFLECT ONE TOUCH VERIO IQ PRECISION XTRA EXTERNAL DIABETIC DEVICES OMNIPOD DASH OMNIPOD 5 CONTINUOUS BLOOD GLUCOSE MONITORS DEXCOM G6 DEXCOM G7 Prior authorization will be required to verify if the client is injecting insulin daily. Monitors will also be limited to the labeled age. MINIMED	ONE TOUCH VERIO REFLECT ONE TOUCH VERIO REPLECT ONNIPOD DASH OMNIPOD DASH OMNIPOD 5 CONTINUOUS BLOOD GLUCOSE MONITORS DEX.COM G6 DEX.COM G7 FREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 3 ACUTE HYPOGLYCEMIA AGENTS GVOKE (use preferred agent)		ONE TOUCH VERIO			
PRECISION XTRA EXTERNAL DIABETIC DEVICES OMNIPOD DASH OMNIPOD S CONTINUOUS BLOOD GLUCOSE MONITORS DEXCOM G6 DEXCOM G7 Prior authorization will be required to verify if the client is injecting insulin daily. Monitors will also be limited to the labeled age. MINIMED	EXTERNAL DIABETIC DEVICES OMNIPOD DASH OMNIPOD 5 CONTINUOUS BLOOD GLUCOSE MONITORS DEXCOM G6 DEXCOM G7 FREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 3 ACUTE HYPOGLYCEMIA AGENTS EXTERNAL DIABETIC DEVICES OMNIPOD 5 Prior authorization will be required to verify if the client is injecting insulin daily. Monitors will GUARDIAN MINIMED MINIMED GVOKE (use preferred agent)		ONE TOUCH VERIO REFLECT			
EXTERNAL DIABETIC DEVICES OMNIPOD DASH OMNIPOD D ASH CONTINUOUS BLOOD GLUCOSE MONITORS DEXCOM G6 DEXCOM G7 Prior authorization will be required to verify if the client is injecting insulin daily. Monitors will also be limited to the labeled age. MINIMED	EXTERNAL DIABETIC DEVICES OMNIPOD DASH OMNIPOD DASH CONTINUOUS BLOOD GLUCOSE MONITORS DEX.COM G6 DEX.COM G7 FREESTYLE LIBRE 1 FREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 3 ACUTE HYPOGLYCEMIA AGENTS GVOKE (use preferred agent)					
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. DEXCOM G7 GUARDIAN MINIMED	OMNIPOD 5 CONTINUOUS BLOOD GLUCOSE MONITORS DEXCOM G6 DEXCOM G7 FREESTYLE LIBRE 7 FREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 3 ACUTE HYPOGLYCEMIA AGENTS Prior authorization will be required to verify if the client is injecting insulin daily. Monitors will GUARDIAN MINIMED GUARDIAN MINIMED GUARDIAN G		EXTERNAL DIA	ABETIC DEVICES		
CONTINUOUS BLOOD GLUCOSE MONITORS Prior authorization will be required to verify if the client is injecting insulin daily. Monitors will DEXCOM G6 DEXCOM G7 GUARDIAN MINIMED	CONTINUOUS BLOOD GLUCOSE MONITORS DEXCOM G6 DEXCOM G7 FREESTYLE LIBRE 1 FREESTYLE LIBRE 2 FREESTYLE LIBRE 2 FREESTYLE LIBRE 3 ACUTE HYPOGLYCEMIA AGENTS Prior authorization will be required to verify if the client is injecting insulin daily. Monitors will MINIMED MINIMED GUARDIAN MINIMED GUARDIA		OMNIPOD 5			
DEXCOM G7	DEX.OM G7 FREESTYLE LIBRE FREESTYLE LIBRE 2 FREESTYLE LIBRE 3 ACUTE HYPOGLYCEMIA AGENTS GVOKE (use preferred agent)		CONTINUOUS BLOO			
FREESTYLE LIBRE	FREESTYLE LIBRE 2 FREESTYLE LIBRE 3 ACUTE HYPOGLYCEMIA AGENTS GVOKE (use preferred agent)			DEXCOM G7	also be limited to the labeled age.	IVIIIVIIVIED
	FREESTYLE LIBRE 3 ACUTE HYPOGLYCEMIA AGENTS GVOKE (use preferred agent)					
FREESTYLE LIBRE 3				FREESTYLE LIBRE 3		
	TOTAL LANDAU			SLYCEMIA AGENTS		GVOKE (use preferred agent)
BAQSIMI ZEGALOGUE (autoinjector)			ZEGALOGUE (automjector)			

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 Optumits WITH ANY QUESTIONS
ROMYALGIA	amitriptyline cyclobenzaprine	MYALGIA gabapentin	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	pregabalin SAVELLA tablets (savella titration pak will no be covered)
ASTROINTESTINAL	GAVILYTE G, N GOLYTELY MOVIPREP PEG 3350 SOLUTION	EVACUANTS	Clients will not be allowed to take gabapentin and pregabalin concurrently	CLENPIQ (use preferred agents) GAVILYTE H (use preferred agents) POLY-PREP (use preferred agents) SUFLAVE SUTAB
	SUPREP CHRONIC IDIOPA	THIC CONSTIPATION AMITIZA LINZESS TRULANCE	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
	CREON ZENPEP	/E ENZYMES	Prior authorization required.	PERTZYE VIOKACE
	IRRITABLE BOWEL SYN	DROME WITH CONSTIPATION AMITIZA LINZESS TRULANCE	Client must have a diagnosis of Irritable Bowel Syndrome (IBS) with constipation.	
	APRISO* LIALDA* mesalamine 400mg DR capsule mesalamine enema PENTASA	LAMINE	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
		CONSTIPATION AGENTS AMITIZA	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* RELISTOR
		ED NAUSEA/VOMITING	*Movantik will be approved for a diagnosis of cancer or for clients in hospice or palliative care.	
	BONIESTA DICLEGIS PROTON PLI lansoprazole capsules omeprazole capsules oantoorazole	MP INHIRITORS	Trial and faillure 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 esomeorazole omeprazole z0.6mg capsules omeprazole tablets omeprazole sodium bicarbonate OMECLAMOX (use separate agents) PREVACID solutabs* Tabebrazole TALICIA (use separate agents) VIMOVO (use separate agents)
DUT	COLi colchicine (tablets)	CHICINE		MITIGARE (use preferred agent)
		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*
MATOLOGY	enoxaparin	/EIGHT HEPARIN (LMWH)	Prior authorization will be required for the 300mg/3ml strength.	FRAGMIN (use preferred agent) enoxaparin 300MG/3ML
	DIRECT THRO	MBIN INHIBITOR PRADAXA	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.	
	ELIQUIS XARELTO 10mg, 15mg, 20mg, and starter pack	CTOR XA INHIBITOR XARELTO 2.5mg* (use preferred agent)	*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)
		BRILINTA NTAGONIST ZONTIVITY	Client must have a diagnosis of acute coronary syndrome, history of myocardial infarction, or history of stroke and transient ischemic attack. Client must have diagnosis of reduction of thrombotic cardiovascular events with a history of	
	ANTIHEMOPH ADVATE	ILIC FACTOR VIII	myocardial infarction (MI) or with peripheral arterial disease (PAD). Must be used in conjunction with aspirin or clopidogrel.	ALTUVIIIO KOVALTRY
	ADYNOVATE AFSTYLA ELOCTATE ESPEROCT HEMOFIL M HEMUBRA JIVI KOATE/KOATE-DVI KOGENATE FS/BIO-SET NOVOEIGHT NUWIQ OBIZUR RECOMBINATE XYNTHA/SOLOFUSE			
		ON FACTOR DX		
		ILIC FACTOR/VWF		
	ALPHANATE HUMATE-P VONVENDI WILATE			

SCHOOL LIGHT AND THE ADDRESS OF THE PROPERTY OF THE SINGER	HERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIE THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT Optumbs: WITH ANY QUESTIONS
MODIST STATEMENT OF THE PROPERTY OF THE PROPER	ATITIS C	DIRECT ACTIN			
SECTION SUPPRISABILITY PARTICIPATION PARTICIPATIO			sofosbuvir/velpatasvir MAVYRET		SOVALDI VOSEVI**
And Control of the Co	ADENITIS SUPPURATIVA	IMMUNO		Humira will not be covered as a first line agent for the diagnosis for hidradenitis suppurativa.	
COLOR ATE COLOR AND COLOR	MONES				ORILISSA
Interest August 2014		ORIAHNN		requirements.	
INTERIOR ACT INTERIOR TOWNERS (ALL) TEXTOR ACT INT		GROWTH	GENOTROPIN		
### Test Control ### Te					
TESTORISADE SIDEMAN GISS TOTAL (CL.) TOTAL					SEROSTIM
Testing the control of the control o					SOGROYA
TOTAL TOTAL CONTROL OF THE CONTROL O		TESTOSTERON		Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient	ANDRODERM (use preferred agent)
Section of the control of the contro			TESTIWI GEE		JATENZO (use preferred agent)
AMADUS TITORIO INTERNA will be converted with continued diagnosis of dysphage. Treatment to converte with continued diagnosis of dysphage. Treatment to continue with continued with continued diagnosis of dysphage. Treatment to continue with continued wi					testosterone gel (use preferred agent)
### ### ### ### ### ### ### ### ### ##					
ICOVOT IC		THYROID ARMOUR THYROID	HORMONES FRMEZA	Ermeza will be covered with confirmed diagnosis of dysphagia.	THYQUIDITY TIROSINT
100-71 Synthetic Control of the Cont		LEVOXYL			
SONTHERDIO MINISTRATION Allowage		LEVO-T			
All contents of the contents o		SYNTHROID			
alterers and the state of the s		ORAL CON	TRACEPTIVES		
santhwise satisfying santhwise santh		altavera			BALCOLTRA
animated ani		amethvst			briellvn
Jauronels 2,007E 1-20, 3-35 viviles viviles Jauronels 2,007E 1-25, 30 FE Bionel 1-20 FE 1-5-30 FE Bionel 1-20 FE 1-5-30 FE Bionels 2,007E 1-25, 30 FE Bionels 2,007					
swinner symme symm					
saverte blows 1.50 FE, 1.5.30 FE blows 1.50 FE, 1.5.30 FE breat camba beyeat camba control of the control of th		aviane			fayosim
Delayer Devert Devert Devert Cameras/L0 classes/L0 clas		azurette			lavolis FE chew
camison camsesCo CMARUTE 24 E chew cyced discrete 3.5. 7/17 discrete 4.5. 7/17 discrete 4		bekyree			levonorgest/ethinyl estradiol/LO (84-7)
thestayEG CHARLOTTE 24 Fit hew CHARLOTTE 24 Fit he CHARLOTTE 24		camila			MINASTRIN FE chew*
order dastets 1-35.7777 debilishing debilishing debilishing description(estration) drossiv/estimotestration) drossiv/estimotestration drossiv/esti		chateal/EQ			nortrel
device deciding and deciding an		cyred			philith
deno/ethmic estradiol discosar/ethmic estradiol discosar/ethmic estradiol ethosar/ethmic estradiol ethosar/ethmic estradiol ethosar/ethmic estradiol ethosar/ethmic estradiol ethosar/ethmic estradiol ethosar/ethmic estradiol/FE chw none-themic estra		daysee			QUARTETTE
sinest emzabh em		deso/ethinvl estradiol			SLYND
enskyce errin estarvily estarvily finals Echew danvi halley Et 1/20, 1/35 heather incassis introvale sibloom similes displayer college		elinest			tilia FE
estanvilla falmina (solum) falmina finzala FE chew (solum) finzala FE chew (solum) falmina finzala fin		enskyce			TRIVORA
Infinals FC chew glanvi hallev FE 1/20, 1/35 heather incastia introvale sibloom simies ploissa uleber unel 1-20/FE, 1.5-30/FE tallina tarviva buvveo larin 1-20/FE, 1.5-30/FE teena tessina t					
kalawi hallev FE 1/20, 1/35 heather kleede k					
heather iclevia incassia introvale subloom sub		gianvi			wymzya FE chew
incassia introvale isition introvale isition inimiess ienrycia ioless io		heather			
sibloom saminess lencycla lolessa luleber lunel 1 20/FE. 1.5-30/FE kalliga kariva kari					
iencvcla lolessa luleber lunel 1-20/FE. 1.5-30/FE kallika kariva kelnor delion lan 1-20/FE. 1.5-30/FE leena lessina levora lo loestrin loestrin FE loryna LOSEASONIOUE* low-orestret lutera marfissa mibelas FE chew microestin 1-20/FE. 1.5-30/FE mill mono-linvah natazia NECON 0.5/35, 1/35, 1/50, 7/7/7, nikki nora-be norest/etninvi estradiol/FE chw norest/etninvi estradiol/LO noreth/etninvi estr		isibloom			
uieber unell 1-20/FE, 1.5-30/FE tailliza tariva kelnor kurvelo tarin 1-20/FE, 1.5-30/FE teena tessina tevora to loestrin FE toryna toSEASONIOUE* tow-ogestrel tutera mibelas FE chew microsestin 1-20/FE, 1.5-30/FE mill mmo-linvah tosestin 1-20/FE, 1.5-30/FE mill mora-linvah tosestin 1-20/FE, 1.5-30/FE morest-fichinive stradiol/FE chw noreth/ethinive stradiol/FE chw noreth/ethinive stradiol/FE chw noreth/ethinive stradiol/FE chw noreth/ethinive stradiol/LO norethindrone nor/mda nyilia nyimo ocella pimtrea		jencycla			
kalliga kariva kelnor kurvelo larin 1-20/FE, 1.5-30/FE leena lessina levora lo loestrin loestrin FE lorvna LOSEASONIGUE* low-ogestrel lutera mariksa melodetta mibelas FE chew microesstin 1-20/FE. 1.5-30/FE mill moo-linyah lottinal meteon in the microesstin 1-20/FE, 1.5-30/FE mill moo-linyah meteon in the microesstin 1-20/FE, 1.5-30/FE mill moo-linyah mora-be noreth/ethinivl estradiol/FE chw nore-th/ethinivl estradiol/FE chw noreth/ethinivl estradiol/FE chw noreth/ethinivl estradiol/FE noreseytelhind on the microesstin 1-20/FE noreseytelhind estradiol/LO norethindrone norhyma mymo ocella pimtrea		juleber			
kelnor kurvelo larin 1-20/FE, 1.5-30/FE leena leesina levora lo loestrin loestrin FE loryna LOSEASONIOUE* low-ogestrel lutera marissa meiodetta mibelas FE chew microeestin 1-20/FE, 1.5-30/FE mill mono-linvah natazia NECON 0.5/35, 1/35, 1/50, 7/7/7, nikki nora-be noreth/ethinyl estradiol/LE chw noreth/ethinyl estradiol/LO norethindrone norlivrhad nylia		kalliga			
larin 1-20/FE, 15-30/FE leena lessina levora lo loestrin loestrin FE loryna LOSEASONIOUE* low-ogestrel luttera marissa melodetta mibelas FE chew microeestin 1-20/FE, 1.5-30/FE mili mono-linyah natazia NECON 0.5/35, 1/35, 1/35, 1/50, 7/7/7, nikki nora-be noreth/ethinyl estradiol/FE chw noreth/ethinyl estradiol/LO norethindrone norlynda nylia nyrmyo ocella jimtrea		kelnor			
lessina levora lo loestrin loestrin FE loryna LOSEASONIOUE* low-ogestrel lutera mariissa melodetta mibelas FE chew microæstin 1-20/FE. 1.5-30/FE mili mono-linvah natazia NECON 0.5/35, 1/35, 1/50, 7/7/7, nikki nora-be noreth/ethinyl estradiol/FE chw noreth/ethinyl estradiol 1-20/FE noræst/ethinyl estradiol/LO norethindrone norhyda nylia nymyo ocella pimtrea		larin 1-20/FE, 1.5-30/FE			
lo loestrin loestrin FE loryna LOSEASONIOUE* low-ogestrel lutera mariissa melodetta mibelas FE chew microsestin 1-20/FE. 1.5-30/FE mill mono-linyah natazia NECON 0.5/35. 1/35. 1/50, 7/7/7. nikki nora-be noreth/ethiryl estradiol/FE chw noreth/ethiryl estradiol/LO norethindrone norlynda nylia nymyo ocella jimtrea		lessina			
lorvna LOSEASONIOUE* low-orestrel lutera mariissa melodetta mibelas FE chew microeestin 1-20/FE. 1.5-30/FE mili mono-linvah natazia NECON 0.5/35, 1/35, 1/50, 7/7/7, nikkl nora-be noreth/ethinvl estradiol/FE chw noreth/ethinvl estradiol/LO norethindrone nortwnda nylia nymyo ocelia pimtrea		lo loestrin			
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 nora-be noreth/ethirvl estradiol/FE chw noreth/ethirvl estradiol 1-20/FE noreset/ethirvl estradiol/LO norethindrone norlynda nylia nymvo ocelia pimtrea		loryna			
mariissa melodetta mibelas FE chew microeestin 1-20/FE. 1.5-30/FE mili mono-linvah natazia NECON 0.5/35, 1/35, 1/50, 7/7/7, nikki nora-be noreth/ethinvl estradiol/FE chw noreth/ethinvl estradiol 1-20/FE noresest/ethinvl estradiol/LO norethindrone norlvnda nylia nymvo ocella pimtrea		low-ogestrel			
mibelas FE chew microeestin 1-20/FE. 1.5-30/FE mili mono-linvah natazia NECON 0.5/35, 1/35, 1/50, 7/7/7, nikki nora-be noreth/ethinvil estradiol/FE chw noreth/ethinvil estradiol 1-20/FE noreest/ethinvil estradiol/LO norethindrone norhvnda nvila nvmvo ocella pimtrea		marlissa			
mili mono-linvah natazia NECON 0.5/35, 1/35, 1/50, 7/7/7, nikki nora-be noreth/ethinvl estradiol/FE chw noreth/ethinvl estradiol/FE chw noreth/ethinvl estradiol/LO norethindrone northvada nyla nymyo ocella pimtrea		mibelas FE chew			
mono-linyah natazia NECON 0.5/35, 1/35, 1/50, 7/7/7, nikki nora-be noreth/ethinyl estradiol/FE chw noreth/ethinyl estradiol 1-20/FE noresex/ethinyl estradiol 1-20/FE noresex/ethinyl estradiol/LO norethindrone norkynda nylia nymyo ocella pimtrea		microgestin 1-20/FE. 1.5-30/FE			
NECON 0.5/35, 1/35, 1/50, 7/7/7, nikki nora-be noreth/ethinyl estradiol/FE chw noreth/ethinyl estradiol 1-20/FE noreest/ethinwl estradiol/LO norethindrone norhynda nylia nymyo ocella pimtrea		mono-linyah			
nora-be noreth/ethinvl estradiol/FE chw noreth/ethinvl estradiol 1-20/FE noreset/ethinvl estradiol/LO norethindrone norhvnda nvlia nvmvo ocella pimtrea		NECON 0.5/35, 1/35, 1/50, 7/7/7,			
noreth/ethin/i estradio 1-20/FE noreest/ethin/i estradio I/LO norethindrone norlynda nylia nymyo ocelia pimtrea		nora-be			
norethindrone norhvnda nviia nvmyo ocella pimtrea		noreth/ethinvl estradiol 1-20/FE			
nylia nymyo ocella pimtrea		norethindrone			
ocella pimtrea		nylia			
pimtrea		nymyo			
non IId					

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE
ORMONES (continued)	reclipsen	CRITERIA		PLEASE CONTACT OptumRx WITH ANY QUESTIONS
rkiviones (continueu)	safyral			
	SEASONIQUE*			
	setlakin sharobel			
	simliva			
	simpesse			
	sprintec sronyx			
	sveda			
	tri-estaryll/LO			
	tri-femynor tri-linvah			
	tri-marzia LO			
	tri-mili/LO tri-sprintec/LO			
	tri-nymyo			
	tri-vylibra			
	velivet vestura			
	vienva			
	viorele			
	volnea vylibra			
	yasmin-28			
	YAZ			l
PERLIPIDEMIA	zumandimine	EQUESTRANT	Trial and failure of ALL professed agents greater then as asset to six (5) menths in the last 42	WELCHOL
FEREIPIDEIVIIA	cholestyramine/light	EQUESTRAINT	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.	WELCHUL
	colestipol		and the required before approval can be given for a noir preferred agent.	
		OW POTENCY	Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12	fluvastatin/ER
	lovastatin		months will be required before approval can be given for a non-preferred agent.	
	pravastatin		greater and processed agents	l
			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.	
		IGH POTENCY	Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12	EZALLOR
	atorvastatin rosuvastatin		months will be required before approval can be given for a non-preferred agent.	LIVALO ZYPITAMAG
	simvastatin			ZIIIIAWAG
			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.	
			Drive outhorization will be seen irod for all outs under the see of 10	
	CTATINI CO	AADINIA TIONIC	Prior authorization will be required for clients under the age of 10.	- Alwih diamakai (BRAND IS BREED
	amlodipine/atorvastatin	MBINATIONS	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.	ezetimibe/simvastatin (BRAND IS PREFERI
	VYTORIN*		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.	
	PCSK9-RELA	ATED AGENTS	Client must have a diagnosis of homozygous familial hypercholesterolemia; have a diagnosis of	LEOVIO
		PRALUENT	heterozygous familial hypercholesterolemia or atherosclerotic cardiovascular disease AND not	REPATHA
			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.	
	TRIGLYCERIDE LO	WERING AGENTS	Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12	fenofibric
	fenofibrate		months will be required before approval can be given for a non-preferred agent.	fenofibrate (43/50/120/130/150mg)
	gemfibrozil			icosapent LIPOFEN
	germbrozn			omega-3-acid
				VASCEPA
PERTENSION/ CARDIOLOGY	ANGIOTENSIN RECEPTOR BLOCKERS	(ARBS)	Non-preferred ARBs will require a history of ALL preferred ARBs before approval	candesartan eprosartan 600mg
	EDARBI irbesartan			eprosartan buumg
	losartan			l
	olmesartan			l
	telmisartan valsartan			l
	ARBs AND DIURETICS		Non-preferred ARB/diuretic combinations will require a history of ALL preferred	candesartan HCTZ
	EDARBYCLOR		1	telmisartan HCTZ
	irbesartan HCTZ			l
	losartan HCT olmesartan HCTZ			l
	valsartan HCTZ			l
	ALPHA-BLOCKERS			
	clonidine		1	l
	clonidine TD patches			
	COMBINATION PRODUCTS		Client must be greater than one year of age and have a diagnosis of Congestive Heart Failure	ENTRESTO SPRINKLES
		ENTRESTO	(CHF) NYHA Class II-IV. Angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor	VERQUVO
			blockers (ARBs) will not be allowed in combination with Entresto.	l
FECTIONS DISC		OI ONES	Discount of the Additional Theorem to Color 1 and 1 and 1	and the same of th
FECTIOUS DISEASE		OLONES	Please refer to the Additional Therapeutic Criteria Chart located at	moxifloxacin (use preferred agents)
	ciprofloxacin levofloxacin		http://www.wymedicaid.org/additional-therapeutic-criteria for Baxdela criteria.	l
	ofloxacin			l
		CYCLINE		DORYX (use preferred agent)
	doxycycline			
	minocycline/ER	CYCLINE	1	minocycline 65mg and 115mg ER (use
			<u> </u>	preferred agent) SOLODYN (use preferred aaent)
		OBRAMYCIN	*Tobi Podhaler requires a 28 day trial of a preferred agent, as well as 28 days off of that same	BETHKIS
	KITABIS		preferred agent prior to approval.	inhaled tobramycin
				TOBI PODHALER (use preferred agent)

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 OPLIMING WITH ANY QUESTIONS
INFECTIOUS DISEASE (continued)	ANTI-RE BIKTARVY CIMDUO DELSTRIGO DOVATO EVOTAZ GENVOYA ODEFSEY PIFELTRO PREZCOBIX ritonavir tablets SYMFI/LO TRIUMEQ	TROVIRALS CABENUVA* DESCOV* TRUVADA*	*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)
INFLAMMATION	TROGARZO	SAIDs	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 PREFERREI diclofenac 1.5% soln. diclofenac 3.5% eel fenoprofen mefenamic acid NEOPROFEN (use preferred agent)
		TICOSTEROIDS		CELESTONE (use preferred agent) EMFLAZA
INSOMNIA	BELSOMRA eszopicione zalepion zolpidem zolpidem ER	ODIAZEPINES	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 analy: zalenjon: 30me/day zaloidem: 15me/day	EDLUAR (additional criteria applies) DAYVIGO QUVIVIQ ROZEREM* zolpidem sublingual (additional criteria
MENTAL HEALTH	ANTIDE NORADRENERGIC/SPECI	eR'S AGENTS donepezil/ODT zalantamine/ER memantine tablets/solution PRESSANTS FIC SEROTONERGICS (NaSS)	Dosage limits apply: zaleplon: 30mg/day zolpidem: 15mg/day Client must have a diagnosis of dementia. Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks <u>WITHIN THE LAST 2 YEARS</u> will be required before approval can be given for a non-preferred agent.	donepezil 23mg (use preferred agent) memantine ER NAMZARIC (use separate agents) rivastigmine capsules/patches NaSS
	bupropion ER/SR/XL SELECTIVE SEROTONIN citalopram escitalopram fluoxetine caosules paroxetine (R/CR sertraline	MINE REUPTAKE INHIBITORS (NDRI) REUPTAKE INHIBITORS (SSRI) LINE REUPTAKE INHIBITORS (SNRI)	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.	mirtazapine rapid dissolve tablets (use preferred agent) NDRI APLENZIN AUVELITY FORFIVO XL* SSRI citalopram capsules fluoxetine tablets VIIBRYD SNRI desvenlafaxine FETZIMA
			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 mitrazapine: 67.5mg/day paroxetine IR/CR < 18 years of age: 75mg/day paroxetine (R > 18 years of age: 112.5mg/day paroxetine CR > 18 years of age: 112.5mg/day sertraline: 300mg/day ventafaxine ER: 337.5mg/day	venlafaxine ER tablets (use preferred agent OTHER TRINTELLIX***

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LEST IS NOT ALL INCLUSIVE PLEASE CONTACT OPLUMB: WITH ANY QUESTIONS
ENTAL HEALTH ntinued	ATYPICAL A ABILIFY MAINTENA ABILIFY ASIMTUFII aripiprazole tab/solution/ODT ARISTADA FANAPT** paliceridone INVEGA HAFYERA/	NTIPSYCHOTICS	*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.	GEODON 20MG INU LYBALVI (additional criteria applies) NUPLAZID olanzapine 10mg Ini SECUADO REXULTI***
	SUSTENNA/TRINZA lurasidone olanzapine PERSERIS quetiapine* quetiapine ER RISPERDAL CONSTA		***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	RYKINDO UZEDY ZYPREXA RELPREVV
	risperidone SAPHRIS** VRAYLAR ziprasidone		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 (S) 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 BUSTENNA: 1 injection per 28 days	
			INVEGA TRINZ: 1 injection per 84 days LATUDA 10-17 years of age: 80mg/day LATUDA 19-17 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	
	SPECIAL ATYPICA	AL ANTIPSYCHOTICS	RISPERDAL CONSTA: 2 injections per 28 days SAPHRIS: 20mg/day 2iprasidone e17 years of age: 120mg/day singeridage = 17 years of age: 300mg/day Dosage limits apply: 900mg/day	VERSACLOZ Suspension (use preferred ag
	clozapine/ODT	ETAMINES	Clients over the age of 17 must have a diagnosis for ADD, ADHD, (see ADD/ADHD criteria below),	AMPHETAMINES
		AMPHETAMINES ADDERALL XR amphetamine salts combo XR dextroamphetamine CR caps	narcolepsy, obstructive sleep apnea, shift work sleep disturbance, MS fatigue (see MS Fatigue criteria below), or refractory depression (see refractory depression criteria below).	ADZENYS XR ODT DYANAVEL XR EVEKEO/ODT MYDAYIS PROCENTEA
	METHYL	amphetamine salts combo dextroamphetamine tablets	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.	VYVANSE CHEWABLES ZENZEDI 2.5 AND 7.5MG TABLETS METHYLPHENIDATES
	LONG ACTING M	CONCERTA* dexmethylphenidate ER methylphenidate ER tablets	R 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	APTENSIO XR AZSTARYS COTEMPLA XR DAYTRANA FOCALIN XR JORNAY PM
	IMMEDIATE RELEAS	dexmethylphenidate methylphenidate chewables methylphenidate solution	 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. 	JONNAT PW methylphenidate ER osmotic release (BRAND IS PREFERRED) methylphenidate ER/CR/SR <u>capsules</u> (METADATE CD/RITALIN LA, APTENSIO XR OUILLICHEW ER
		methylphenidate solution methylphenidate tablets	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	QUILLIVANT
			(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 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	
amphetamine salt amphetamine salt DAYTRANA: 45mg	dextroamphetamine: 90mg/day			

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 Optumins WITH ANY QUESTIONS
MENTAL HEALTH		-ADRENERGIC AGONIST	Client must must have a diagnosis of ADD or ADHD.	
ntinued	clonidine, clonidine ER		Prior authorization will be required for clients under the age of 4.	
	SELECTIVE NOREPINEPH	IRINE REUPTAKE INHIBITOR	Atomoxetine: Clients must have a diagnosis for ADD, ADHD, narcolepsy, obstructive sleep	QELBREE
		atomoxetine	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	
CDAINE	MICDANIC	PROPHYLAXIS	Trial and failure of both an anticonvulsant and a beta blocker (Step 1 agents) greater than or	NURTEC
GRAINE	STEP 1	AGENTS	equal to three (3) months will be required before approval can be given for the step 2 agents.	WORTEC
	beta blockers	divalproex topiramate	Concurrent use of Botox will not be approved.	
	CTED O	AGENTS	Nurtec will be limited to 16 tabs/30 days. *Starting dose will be limited to 70mg	OUII IPTA**
	STEP 2	AIMOVIG*	*Starting dose will be limited to 70mg **Approval for non-preferred agents requires trial and failure of a preferred agent along with	QULIPTA**
		AJOVY EMGALITY	the trial and failures described with Step 1 Agents' criteria above.	
		INE TREATMENT		
	frovatriptan	AGENTS	Trial and failure of two preferred agents will be required for approval of a non- preferred agent.	almotriptan ELYXYB
	naratriptan RELPAX*		Rizatriptan will be limited to clients 6 years of age or older	Sumatriptan-Naproxen Sodium TOSYMRA (use preferred agent)
	sumatriptan rizatriptan		Quantity limits apply:	ZEMBRACE (use preferred agent)
	nzaciotan		naratriptan 1mg: 25 tabs/34 days naratriptan 2.5mg: 10 tabs/34 days	zolmitriptan
			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	
	STEP 2	AGENTS	Trial and failure of two triptan agents required for Step 2 Agent approval	REYVOW
		NURTEC	Trial and failure of two preferred triptan agents AND Nurtec will be required for approval of a non-preferred agent.	UBRELVY
			Quantity limits apply:	
			NURTEC 75mg: limited to 8 tabs/30 davs REYVOW: 200mg/day or 1 tab/day, 4 tab/30 days	
OVEMENT DISORDERS		NHIBITORS	Quantity limits apply:	
	AUSTEDO/XR* INGREZZA*		AUSTEDO: limited to 4 tabs/day INGREZZA: limited to 4 tabs/day	
	TETRABENAZINE		*Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	
ILTIPLE SCLEROSIS		GENTS	Gilenya, Kesimpta, Lemtrada, Ocrevus, and Tysabri will be approved for highly active disease,	AUBAGIO
	AVONEX BETASERON	GILENYA KESIMPTA	please refer to the ATCC for additional information.	BAFIERTAM BRIUMVI
	COPAXONE 20MG/ML* dimethyl fumarate	LEMTRADA OCREVUS	Trial and failure of two preferred agents for at least 56 days (each from a separat class) will be	EXTAVIA glatiramer (BRAND IS PREFERRED)
	REBIF	TYSABRI	required before approval can be given for a non-preferred agent.	GLATOPA (use preferred agent)
	teriflunomide VUMERITY			MAVENCLAD MAYZENT
			For Mavenclad, in addition to the above criteria, approval will be granted on a case- by-case basis.	PLEGRIDY PONVORY
				TECFIDERA ZEPOSIA
RCOLEPSY	STIMULANTS		Modafinil and Nuvigil: Client must be > 16 years of age. Client must have a diagnosis of	
		modafinil NUVIGIL*	narcolepsy, obstructive sleep apnea, shift work sleep disorder, Multiple Sclerosis (MS) Fatigue, or ADD/ADHD with a concurrent diagnosis of substance abuse.	
	NON-STIMULANTS	- 	Diagnosis of MS will require a fatigue severity scale score of 5.0, a 60 day trial of amantadine	SUNOSI
			AND discontinuation of medications that may contribute to drowsiness or fatigue.	WAKIX
				XYREM
			Clients will not be allowed to take two or more agents in this class concurrently	
UROPATHIC PAIN	GABA	PENTIN 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	
		pregabalin	less than or equal to 14 day supplies	
	TOPICAL Lidocaine Patches	LIDOCAINE		ZTLIDO
		IAL AGENTS	Trial and failure of a tricyclic antidepressant greater than or equal to a 12 week supply AND trial	carbamazepine
	amitriptyline desipramine		and failure of gabapentin at a dose of 3600mg per day OR pregabalin for greater than or equal	imipramine (capsules) oxcarbazepine
	imipramine (tablets) nortriptyline		to a 12 week supply in the last 12 months will be required before approval can be given for a non-preferred agent.	valproic acid

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS UST IS NOT ALL INCLUSIVE PLEASE CONTACT Optumils WITH ANY QUESTIONS
PHTHALMICS	ALREX azelastine BEPREVE* cromolyn 0.4%	-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
	OPANTIBIOT ciprofloxacin BESIVANCE eentamicin moxifloxacin 0.5% ofloxacin tobramycin	ics- 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
	OPANTI-IN flurbiprofen diclofenac LOTEMAX* ketorolac NEVANAC	FLAMMATORY	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 ogent) ACUVAIL bromfenac 0.9% BROMSITE DUREZOL ILEVRO INVELTYS LOTEMAX SM loteorednol 0.5% (BRAND PREFERRED) PROLENSA
	OPBETA betaxolol carteolol levobunolol timolol	A-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*
	AZOPT dorzolamide	NHYDRASE INHIBITOR O PRODUCTS	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) dorzolamide/timolol (BRAND PREFERRED)
	COMBIGAN* ROCKLATAN SIMBRINZA	EYE AGENTS	Trial and failure of the preferred agent greater than or equal to 12 weeks will be required	CEQUA
	RESTASIS* XIIDRA		before approval can be given for the non-preferred agent.	cyclosporine (BRAND PREFERRED) EYSUVIS MIEBO RESTASIS MULTIDOSE (see preferred) TYRVAYA
	OPPROS' latanoprost LUMIGAN TRAVATAN Z XALATAN ZIOPTAN	TAGLANDINS	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
	OPRHO KINA RHOPRESSA	SE INHIBITOR		
		THOMIMETICS	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)
STEOPOROSIS		PHONATES	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.	EVENITY** FORTEO*** FOSAMAX-D TYMLOS***
			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	
		ALCITONIN	will be littliced to 2 years of use	
TIC	calcitonin-salmon ANTIBIOTIC/STER ciprofloxacin/dexamethasone Neo/Polv/HC Suspension and ofloxacin tobramycin/dexamethasone	OID 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)
/ERACTIVE BLADDER	OVERACTIVE B MYRBETRIQ OXYBUTYNIN /ER solifenacin TOVIAZ TOVIAZ	LADDER 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 mirabezron (BRAND IS PREFERRED) OXYTROL DIS tolterodine/ER
AIN	LONG-AI morphine ER <u>tablets</u>	CTING 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.	trospium fentanyl patches hydrocodone ER hydromorphone ER
			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).	HYSINGLA ER METHADONE morphine ER capsules <i>(use preferred agen</i> NUCYNTA ER** oxymorphone ER
			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.	OXYCONTIN XTAMPZA ER (additional criteria applies)
			**Nucynta ER will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics.	
			Fentanyl: S0mcg, 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	

	PREFERRED AGENTS			NON-PREFERRED AGENTS
THERAPEUTIC CLASS	PREFERRED AGENTS	REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT OptumRx WITH ANY QUESTIONS
AIN		CTING C-IIs	Trial and failure of three (3) preferred agents greater than or equal to a 6 day supply in the last	levorphanol
continued	codeine sulfate hydrocodone/APAP		90 days will be required before approval can be given for a non-preferred agent.	NUCYNTA* oxymorphone
	hydrocodone/IBU hydromorphone			ROXYBOND
	meperidine		*Nucynta will be allowed for diabetic peripheral neuropathy or clients with	
	morphine oxycodone		significant gastrointestinal concerns with other CII narcotics.	
	oxycodone/APAP		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	
	C-III/C-	V AGENTS	Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12	BELBUCA
	BUTRANS	VAGENTS	months will be required before approval can be given for a non- preferred agent.	tramadol/apap
	tramadol		Quantity and dosage limits apply (max 8 tabs/day).	tramadol ER capsules/tablets
			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.	
DWINGONIC DISEASE	CHORT AC	TING A CENTS		
ARKINSON'S DISEASE	amantadine SHORT-AC	TING AGENTS		
	benztropine tablets carbidopa/levodopa			
	pramipexole			
	ropinirole LONG-ACT	ING AGENTS	**Non-preferred Parkinson's agents will require a 30 day trial and failure of 2 preferred	APOKYN
	ropinirole ER		medications including at least one short-acting agent and one long-acting agent	benztropine injectables
	RYTARY			GOCOVRI INBRIJA
			Neupro will be approved for clients with difficulty swallowing	NEUPRO ONGENTYS
				pramipexole ER
				XADAGO
HOSPHATE BINDERS		TE BINDERS	Prior authorization required for non-preferred agents.	AURYXIA
	calcium acetate			lanthanum sevelamer
				VELPHORO
ROSTATE	5-ALPHA-REDI finasteride	ICTASE INHIBITORS	Trial and failure of a preferred agent greater than or equal to a 30 day supply in the last 12	dutasteride dutasteride/tamsulosin (use separate agei
	imasteride		months will be required before approval can be given for a non-preferred agent.	dutasteride/tairisdiosiii (ase separate agei
	ALPHA	BLOCKERS	Trial and failure of a preferred agent greater than or equal to a 30 day supply in the last 12	alfuzosin
	doxazosin tamsulosin		months will be required before approval can be given for a non-preferred agent.	dutasteride/tamsulosin (use separate ager silodosin
	terazosin			
ULMONARY NTIHYPERTENSIVES	5-ALPHA-REDU	ALYO	Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	OPSYNVI sildenafil suspension (BRAND IS PREFERRE
		tadalafil		(
		REVATIO SUSPENSION* sildenafil (Revatio A/B rated generic)		
	ENDOTHELIN REC	EPTOR ANTAGONISTS	Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	bosentan (BRAND IS PREFERRED)
		LETAIRIS TRACLEER TABS*		OPSUMIT (use preferred agent) TRACLEER TABS FOR ORAL SUSP
				(use preferred agent)
	GUANYLATE C	YCLASE INHIBITORS	Prior authorization required.	WINREVAIR ADEMPAS (use preferred agent)
	PROSTACYCLIN	NE VASODILATORS	Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	
		ORENITRAM		
	PROSTACYCLINE I	RECEPTOR AGONIST	Prior authorization required.	UPTRAVI (use preferred agent)
STLESS LEG SYNDROME	RESTLESS LE	G SYNDROME	Client must have a diagnosis of Restless Leg Syndrome (RLS). Trial and failure of gabapentin	HORIZANT
	pramipexole	gabapentin	greater than or equal to 60 days <u>and</u> a trial and failure of a dopamine agonist greater than or	NEUPRO*
		gabapentin	and the CO desired she had 20 months will be used to 100 ft.	
	ropinirole	gabapentin	equal to 60 days in the last 12 months will be required before approval can be given for a non- preferred agent.	
		ваовренен	preferred agent. *Neupro will be approved for clients with difficulty swallowing or for clients with a diagnosis of	
		Baocherian	preferred agent.	
		geosperian	preferred agent. *Neupro will be approved for clients with difficulty swallowing or for clients with a diagnosis of Parkinson's Disease.	
	ropinirole		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	
(ELETAL MUSCLE RELAXANTS	ropinirole MUSCLE	RELAXANTS	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 Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12	carisoprodol chlorzoxazone
KELETAL MUSCLE RELAXANTS	ropinirole MUSCLE baclofen (5, 10, 15mg tablets) cyclobenzaprine		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	chlorzoxazone cyclobenzaprine ER
KELETAL MUSCLE RELAXANTS	ropinirole MUSGLE baclofen (5, 10, 15mg tablets)		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 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.	chlorzoxazone cyclobenzaprine ER LYVISPAH metaxalone
KELETAL MUSCLE RELAXANTS	ropinirole MUSCLE baclofen (5, 10, 15mg tablets) cyclobenzaprine		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 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	chlorzoxazone cyclobenzaprine ER LYVISPAH metaxalone methocarbamol
KELETAL MUSCLE RELAXANTS	ropinirole MUSCLE baclofen (5, 10, 15mg tablets) cyclobenzaprine		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 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.	chlorzoxazone cyclobenzaprine ER LYVISPAH metaxalone
	muscle baclofen (5, 10, 15mg tablets) cvclobenzaprine tizanidine tablets		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 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.	chlorzoxazone cyclobenzaprine ER LYVISPAH metaxalone methocarbamol orphenadrine
	muscle baclofen (5, 10, 15mg tablets) cvclobenzaprine tizanidine tablets	RELAXANTS	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 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 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	chlorzoxazone cyclobenzaprine ER LYVISPAH metaxalone methocarbamol orphenadrine tizanidine capsules (use preferred agent) ENTYVIO* REMICADE
	muscle baclofen (5, 10, 15mg tablets) cvclobenzaprine tizanidine tablets	RELAXANTS AODULATORS	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 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 Client must have diagnosis of UC prior to approval of a preferred agent. To receive a non-	chlorzowazone cyclobenzaprine ER LYVISPAH metaxalone methocarbamol orphenadrine tizanidine capsules (use preferred agent) ENTYVIO* REMICADE RINVOQ
KELETAL MUSCLE RELAXANTS LICERATIVE COLITIS	muscle baclofen (5, 10, 15mg tablets) cvclobenzaprine tizanidine tablets	RELAXANTS AODULATORS	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 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 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.	chlorzoxazone cyclobenzaprine ER LYVISPAH metaxalone methocarbamol orphenadrine tizanidine capsules (use preferred agent) ENTYVIO* REMICADE RINVOQ SIMPONI SKYRIZI
	MUSCLE baclofen (5, 10, 15mg tablets) cyclobenzaprine tizanidine tablets	RELAXANTS AODULATORS	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 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 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	chlorzoxazone cyclobenzaprine ER LYVISPAH metaxalone methocarbamol orphenadrine tizanidine capsules (use preferred agent) ENTYVIO* REMICADE RINVOQ SIMPONI