Wyoming
Department
of Health

Division of Healthcare Financing

Medicaid Pharmacy News

Dear Providers: 3/20/2025

PREFERRED DRUG LIST (PDL) CHANGES (Effective 3/21/2025)

Please refer to www.wymedicaid.org for the complete PDL.

THERAPEUTIC CATEGORY	PREFERRED DRUG LIST CHANGES
Arthritis	Skyrizi will be non-preferred for diagnosis of psoriatic arthritis (PA).
Dermatology Step 3 Topical Agents	Zoryve will be non-preferred.
Dermatology Atopic Dermatitis	Nemluvio will be non-preferred. Additionally, Dupixent criteria has been updated to remove immunomodulator trial and failure for clients with >20% body surface area.
Dermatology Plaque Psoriasis	Zoryve will be allowed for plaque psoriasis (PP) after a 21-day trial and failure of a high-potency corticosteroid or a mild-potency corticosteroid if it is being used in intertriginous areas.
Gastrointestinal Potassium Competitive Acid Reducers	New category has been added to the PDL; Voquezna will be non-preferred and requires trial and failure of two proton pump inhibitors twice daily at max dose for 30 days.
Mental Health Selective Alpha-Adrenergic Agonists	Guanfacine and guanfacine ER will be preferred, Onyda XR will be non-preferred.
Obstructive Sleep Apnea GLP-1 Agonists	New category has been added to the PDL. Zepbound will be preferred with diagnosis of moderate to severe obstructive sleep apnea. Zepbound will be approved for obese adults with an AHI (apnea-hypopnea index) of greater than 15. Prior authorization will be required again at 6 months to show at least 5% weight loss. Prior authorization will be required again at 12 months to demonstrate improvement in obstructive sleep apnea.
Pulmonary Antihypertensives 5-Alpha Reductase Inhibitors	Sildenafil (A/B rated generics) will be preferred when client has diagnosis of pulmonary hypertension.

ADDITIONAL THERAPEUTIC CRITERIA CHART (ATCC) CHANGES (Effective 3/21/2025)

- Alyftrek requires that the client be 6 years or age or older and have diagnosis of cystic fibrosis with at least one F508del mutation or another responsive mutation in the CFTR gene.
- Attruby requires that the client have a diagnosis of cardiomyopathy of wild-type or variant transthyretin-mediated amyloidosis.
- Crenessity requires that the client be 4 years of age or older, and product is to be used as an adjunctive treatment to glucocorticoid replacement to control androgens in diagnosed congenital adrenal hyperplasia (CAH).
- Dupixent must be used as add-on maintenance treatment for moderate-to-severe asthma in clients aged 6 and older with eosinophilic or oral corticosteroid-dependent asthma OR for clients 1 year and older and weighing at least 15kg for eosinophilic esophagitis OR used as therapy for clients 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyposis as add-on maintenance therapy, or prurigo nodularis. Dupixent will also be approved as an add-on maintenance treatment of adult patients with inadequately controlled COPD and a documented eosinophilic phenotype. Dupixent use will not be approved for acute bronchospasm relief. *Client must be 6 months of age or older and meet the required criteria for the diagnosis of Atopic Dermatitis as described on the Preferred Drug List (PDL).
- Tryngolza requires that the client have diagnosis of familial chylomicronemia syndrome (FCS) to be used as an adjunct to diet.
- Tryvio requires that the client have a diagnosis of hypertension and requires concurrent use of three hypertension medications from different pharmacological classes for at least 4 weeks prior to initiation of therapy.
- Zepbound requires that a client have diagnosis of moderate to severe obstructive sleep apnea. Will be approved for obese adults with an AHI (Apnea-Hypopnea Index) of greater than 15. Prior authorization will be required again at 6 months to show at least 5% weight loss. Prior authorization will be required again at 12 months to demonstrate improvement in obstructive sleep apnea.

SHORT DAY SUPPLY FILLS REMINDER

Please be aware that Wyoming Medicaid requires that pharmacies fill at least a fourteen (14) day supply with each fill unless otherwise supported by the prescription. A pharmacy should not fill less than a fourteen (14) day supply unless the prescription has been written specifically for less than fourteen (14) days, or the shorter day supply has been approved through the prior authorization process. Claims that do not meet this requirement will be subject to recovery and further audit proceedings.

For any questions, please call the Change Healthcare Pharmacy Help Desk at 877-209-1264.