- Prior authorization for a non-preferred agent in any category will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient, at a therapeutic dose, that resulted in a partial response with a documented intolerance.

- Prior authorization of a non-preferred isomer, pro-drug, or metabolite will be considered with a trial of a preferred parent drug of the same chemical entity, at a therapeutic dose, that resulted in a partial response with documented intolerance or a previous trial and therapy failure, at a therapeutic dose, with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. (The required trial may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.)

- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC drugs are not covered unless specified.

- PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to; appropriate dosing, duplication of therapy, etc.

- The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

- Quantity limits may apply. Refer to the Limits List at: http://www.hidesigns.com/ndmedicaid

- Acronyms
  - CL - Requires clinical PA. For detailed clinical criteria, please refer to: http://www.hidesigns.com/ndmedicaid/pa-criteria.html

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HEPATITIS C TREATMENTS[CL]			
	HARVONI (ledipasvir/sofosbuvir)* VIEKIRA PAK (dasabuvir/ombitasvir/ paritaprevir/ritonavir) SOVALDI (sofosbuvir)* TECHNIVIE (Ombitasvir/Paritaprevir/ Ritonavir)*	OLYSIO (simeprevir)* DAKLINZA (Daclatasvir)*	For patients starting therapy in this class, a trial of the preferred agent of a dosage form is required before a non-preferred agent of that dosage form will be authorized. *Full PA criteria may be found at http://www.hidesigns.com/ndmedicaid/pa-criteria.html