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- 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 criteria for non-preferred agents apply in addition to the 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. Refer to http://www.hidesigns.com/ndmedicaid for applicable quantity limits and therapeutic duplication edits.

- 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.

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

- This is not an all-inclusive list of medications that require PA. For more information visit http://www.hidesigns.com/ndmedicaid.

- This PDL is subject to change. Preferred positions and criteria will go into effect when an SRA is executed.

- Acronyms
  PA – Indicates preferred agents that require clinical prior authorization.
  *** - Indicates that additional criteria applies as indicated in the sidebar

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
NORTH DAKOTA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

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CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
ADHD		Category criteria updated
ANTICONVULSANTS - BENZODIAZEPINES - RECTAL	DIASTAT (diazepam) ACUDIAL RECTAL KIT added to preferred	
ATYPICAL ANTIPSYCHOTICS	quetiapine ER moved to non-preferred	
CONSTIPATION - IRRITABLE BOWEL SYNDROME/OPIOID INDUCED		Category PA Criteria updated
CONSTIPATION - IRRITABLE BOWEL SYNDROME/OPIOID INDUCED		Relistor tablets criteria added
CONSTIPATION - IRRITABLE BOWEL SYNDROME/OPIOID INDUCED		Relistor Syringe/Vial criteria updated
COPD	Brovana moved to preferred	Long Acting Combination products criteria removed
CYSTIC FIBROSIS ANTIINFECTIVES	TOBI moved to preferred	
CYTOKINE MODULATORS	KINERET moved to preferred	Xeljanz/Xeljanz XR criteria removed
DIABETES - DPP4 INHIBITORS	alogliptan/pioglitzone added to non-preferred	
DIABETES - DPP4 INHIBITORS	alogliptin/metformin addded to non-preferred	
DIABETES - DPP4 INHIBITORS	KOMBIGLYZE XR moved to preferred	
DIABETES - DPP4 INHIBITORS	ONGLYZA moved to preferred	Onglyza criteria added
INFLAMMATORY BOWEL AGENTS (ULCERATIVE COLITIS) - NONSTEROIDAL	DIPENTUM (olsalazine) moved to preferred	
INFLAMMATORY BOWEL AGENTS (ULCERATIVE COLITIS) - NONSTEROIDAL	PENTASA (mesalamine) 500mg moved to preferred	
LICE	EURAX (crotamiton) CREAM moved to preferred	
LICE	Lindane removed from PDL	

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CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
MIGRAINE PROPHYLAXIS - 5HT(1) AGONISTS	ZECUITY removed from PDL	ONZETRA XSAIL criteria removed
MIGRAINE PROPHYLAXIS - 5HT(1) AGONISTS		ZEMBRANCE SYMTOUCH criteria added
OPHTHALMIC ANTIHISTAMINES	ALOCRIL (nedocromil) moved to preferred	
OPHTHALMIC ANTIHISTAMINES	ALOMIDE (lodoxamide) moved to preferred	
OPHTHALMIC ANTIHISTAMINES	Azelastine moved to preferred	
OPHTHALMIC ANTIHISTAMINES	LASTACAFT (alcaftadine) moved to preferred	
OPHTHALMIC ANTIHISTAMINES		PATADAY criteria removed
OPHTHALMIC ANTIINFECTIVES	AZASITE (azithromycin) DROPS moved to preferred	
OPHTHALMIC ANTIINFECTIVES	BESIVANCE (besifloxacin) DROPS moved to preferred	
OPHTHALMIC ANTIINFECTIVES	Ofloxacin drops moved to preferred	
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES	MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS to preferred	
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES	Neomycin/polymyxin b/hydrocortisone drops to non-preferred	
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES	NEO-POLYCIN HC (neomycin SU/bacitracin/polymyxin B/hydrocortisone) OINTMENT to non-preferred	
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES	TOBRADEX ST moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	BROMSITE (bromfenac sodium) added to non-preferred	

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CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
OPHTHALMIC ANTIINFLAMMATORIES	ILUVIEN (fluocinolone) removed from PDL	
OPHTHALMIC ANTIINFLAMMATORIES	OZURDEX (dexamethasone) removed from PDL	
OPHTHALMIC ANTIINFLAMMATORIES	PROLENSA (bromfenac) moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	RETISERT removed from PDL	
OPHTHALMIC ANTIINFLAMMATORIES	TRIESENCE (triamcinolone) removed from PDL	
OPHTHALMIC GLAUCOMA COMBINATION AGENTS	Category removed - see GLAUCOMA - SYMPATHOMIMETICS	
OPIOID ANALGESIC - LONG ACTING		All non-preferred additional drug criteria has been updated
OTIC ANTI-INFECTIVES - FLUOROQUINOLONES	OTOVEL (ciprofloxacin/fluocinolone) moved to non-preferred	
PHOSPHATE BINDERS	FOSRENOL (lanthanum) 1000 MG CHEWABLE TABLET moved to non-preferred	
PHOSPHATE BINDERS	RENVELA (sevelamer) POWDER PACK moved to preferred	FOSRENOL (lanthanum) POWDER PACK criteria removed
PULMONARY HYPERTENSION		OPSUMIT criteria updated
PULMONARY HYPERTENSION		Category PA Criteria updated
STEROID INHALERS	ALVESCO (ciclesonide) moved to preferred	
STEROID/LONG ACTING BETA AGONIST (LABA) COMBINATION INHALERS		Category criteria updated
URINARY ANTISPASMODICS	GELNIQUE (oxybutynin) moved to preferred	
URINARY ANTISPASMODICS	OXYTROL (oxybutynin) PATCH moved to preferred	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ADHD		
Category PA Criteria: Branded non-preferred agents: A 14-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30-day trial of 2 preferred generics of the same medication will satisfy this requirement. Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. Rational of inability to swallow a solid dosage form must be provided after age 9 for all non-solid dosage forms.		
ADDERALL XR (dextroamphetamine/amphetamine)	ADDERALL (dextroamphetamine/amphetamine)	*** Kapvay will require a 1-month trial of immediate release clonidine.
ADZENYS XR - ODT (amphetamine)	Clonidine ER	
APTENSIO XR (methylphenidate)	CONCERTA (methylphenidate)	
Clonidine	DEXEDRINE (dextroamphetamine)	
DAYTRANA (methylphenidate)	Dexmethylphenidate ER	
DESOXYN (methamphetamine)	Dextroamphetamine/amphetamine ER	
Dexmethylphenidate	FOCALIN (dexmethylphenidate)	
Dextroamphetamine	INTUNIV (guanfacine ER)	
Dextroamphetamine 5 mg/5 ml	METADATE CD (methylphenidate CD)	
Dextroamphetamine ER	METADATE ER (methylphenidate)	
Dextroamphetamine/amphetamine	METHYLIN (methylphenidate) chew tablets	
DYANAVEL XR (amphetamine)	METHYLIN (methylphenidate) solution	
EVEKEO (amphetamine)	RITALIN (methylphenidate)	
FOCALIN XR (dexmethylphenidate)	RITALIN LA (methylphenidate LA capsules - 50-50)	
Guanfacine ER		
KAPVAY (clonidine)[PA***]		
Methamphetamine		
Methylphenidate CD 30-70		
Methylphenidate chew tablet		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Methylphenidate ER capsules 50-50		
Methylphenidate ER tablet		
Methylphenidate LA capsules - 50-50		
Methylphenidate solution		
Methylphenidate tablet		
PROCENTRA (dextroamphetamine)		
QUILLICHEW ER (methylphenidate)		
QUILLIVANT XR (methylphenidate)		
STRATTERA (atomoxetine)		
VYVANSE (lisdexamfetamine)		
ZENZEDI (dextroamphetamine)		
ALLERGENIC EXTRACTS		
Category PA Criteria: 1. Patient must not have severe, unstable, or uncontrolled asthma. 2. Patient must be an FDA-approved age. 3. Patient must have an FDA-approved diagnosis of allergic rhinitis due to a pollen contained in the requested product. 4. Patient's diagnosis must be confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies contained in the requested product. Non-preferred agents: 1. Must have failed a trial of 2 of the following: oral antihistamines, intranasal antihistamines, intranasal corticosteroids, or leukotriene inhibitors. 2. Must have failed a trial or have intolerance to subcutaneous allergen immunotherapy (allergy shots).		
GRASTEK (GRASS POLLEN-TIMOTHY, STD)[PA]	ORALAIR (GR POL-ORC/SW VER/RYE/KENT/TIM)	
RAGWITEK (WEED POLLEN-SHORT RAGWEED)[PA]		
ANGINA		
RANEXA (ranolazine)		
ANTICOAGULANTS - ORAL		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All agents will require an FDA indication.		
ELIQUIS (Apixaban)[PA]	SAVAYSA (edoxaban)	
PRADAXA (dabigatran)[PA]		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
XARELTO (rivaroxaban)[PA]		
ANTICONVULSANTS		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30-day trial of 2 preferred generics of the same medication will satisfy this requirement. Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
APTIOM (eslicarbazepine)	CARBATROL (carbamazepine)	
BANZEL (rufinamide) ORAL SUSPENSION	DEPAKENE (valproic acid) CAPSULE	
BANZEL (rufinamide) TABLET	DEPAKENE (valproic acid) ORAL SOLUTION	
BRIVIACT (brivaracetam)	DEPAKOTE (divalproex sodium) TABLET	
Carbamazepine chewable tablet	DEPAKOTE ER (divalproex sodium)	
Carbamazepine ER capsule	DEPAKOTE SPRINKLE (divalproex sodium)	
Carbamazepine oral suspension	DILANTIN (phenytoin) CHEWABLE TABLET	
Carbamazepine tablet	DILANTIN (phenytoin) ORAL SUSPENSION	
Carbamazepine XR tablet	DILANTIN ER (phenytoin)	
CELONTIN (methsuximide)	EPITOL (carbamazepine)	
Divalproex ER	FELBATOL (felbamate)	
Divalproex sprinkle	FELBATOL (felbamate) ORAL SUSPENSION	
Divalproex tablet	KEPPRA (levetiracetam)	
Ethosuximide capsule	KEPPRA (levetiracetam) ORAL SOLUTION	
Ethosuximide oral solution	KEPPRA XR (levetiracetam)	
Felbamate oral suspension	LAMICTAL (lamotrigine)	
Felbamate tablet	LAMICTAL (lamotrigine) CHEWABLE TABLET	
FYCOMPA (perampanel)	LAMICTAL (lamotrigine) DOSE PACK	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
FYCOMPA (perampanel) ORAL SUSPENSION	MYSOLINE (primidone)	
Gabapentin capsule	NEURONTIN (gabapentin) CAPSULE	
Gabapentin oral solution	NEURONTIN (gabapentin) ORAL SOLUTION	
Gabapentin tablet	NEURONTIN (gabapentin) TABLET	
GABITRIL (tiagabine)	QUDEXY XR (topiramate)	
LAMICTAL ER (lamotrigine) DOSE PACK	TEGRETOL XR (carbamazepine)	
LAMICTAL ODT (lamotrigine)	TEGRETROL (carbamazepine oral suspension)	
LAMICTAL ODT (lamotrigine) DOSE PACK	TOPAMAX (topiramate)	
LAMICTAL XR (lamotrigine)	TOPAMAX (topiramate) SPRINKLE CAPSULE	
Lamotrigine chewable tablet	TRILEPTAL (oxcarbazepine)	
Lamotrigine dose pack	TRILEPTAL (oxcarbazepine) ORAL SUSPENSION	
Lamotrigine ER	ZARONTIN (ethosuximide)	
Lamotrigine ODT	ZARONTIN (ethosuximide) ORAL SOLUTION	
Lamotrigine tablet	ZONEGRAN (zonisamide)	
Levetiracetam ER		
Levetiracetam oral solution		
Levetiracetam tablet		
LYRICA (pregabalin)		
LYRICA (pregabalin) ORAL SOLUTION		
Oxcarbazepine oral solution		
Oxcarbazepine tablet		
OXTELLAR XR (oxcarbazepine)		
PEGANONE (Ethotoin)		
Phenobarbital elixir		
Phenobarbital tablet		
PHENYTEK (phenytoin)		
Phenytoin chewable tablet		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Phenytoin ER capsule		
Phenytoin suspension		
POTIGA (ezogabine)		
Primidone		
SABRIL (vigabatrin)		
SABRIL (vigabatrin) POWDER PACK		
SPRITAM (levetiracetam)		
TEGRETOL (carbamazepine)		
Tiagabine		
Topiramate ER		
Topiramate sprinkle capsule		
Topiramate tablet		
TROKENDI XR (topiramate)		
Valproic acid capsule		
Valproic acid oral solution		
VIMPAT (lacosamide)		
VIMPAT (lacosamide) ORAL SOLUTION		
Zonisamide		
ANTICONVULSANTS - BENZODIAZEPINES - RECTAL		
Category PA Criteria: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
DIASTAT (diazepam) RECTAL KIT	Diazepam rectal kit	
DIASTAT (diazepam) ACUDIAL RECTAL KIT		
ANTIDEMENTIA		
Category PA Criteria: All agents will require an FDA indication for patients younger than 30 years old. Branded non-preferred agents: A 30-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30-day trial of 2 preferred generics of the same medication will satisfy this requirement. Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Donepezil	ARICEPT (donepezil)	***Namenda XR – A 30-day trial of memantine IR will be required before Namenda XR will be authorized.
EXELON (rivastigmine)	Donepezil ODT	
EXELON (rivastigmine) PATCH	NAMENDA (memantine)	
Galantamine	NAMZARIC (memantine/donepezil)	
Galantamine ER	RAZADYNE (galantamine)	
Galantamine oral solution	RAZADYNE ER (galantamine)	
Memantine	Rivastigmine patch	
NAMENDA (memantine) ORAL SOLUTION		
NAMENDA XR (memantine)***		
Rivastigmine		
ANTIDEPRESSANTS - NEW GENERATION		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30-day trial of 2 preferred generics of the same medication will satisfy this requirement. Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
Bupropion SR tablet	APLENZIN ER (bupropion)	
Bupropion tablet	CELEXA (citalopram)	
Bupropion XL tablet	CYMBALTA (duloxetine)	
Citalopram	EFFEXOR XR (venlafaxine)	
Citalopram oral solution	Fluoxetine DR	
Clomipramine	FORFIVO XL (bupropion)	
Desvenlafaxine ER	IRENKA (duloxetine)	
Duloxetine	LEXAPRO (escitalopram)	
Escitalopram	LEXAPRO (escitalopram) ORAL SOLUTION	
Escitalopram oral solution	PAXIL (paroxetine)	
FETZIMA (levomilnacipran)	PAXIL CR (paroxetine)	
Fluoxetine capsule	PROZAC (fluoxetine)	
Fluoxetine solution	WELLBUTRIN (bupropion)	
Fluoxetine tablet	WELLBUTRIN SR (bupropion)	

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Fluvoxamine	WELLBUTRIN XL (bupropion)	
Fluvoxamine ER	ZOLOFT (sertraline)	
KHEDEZLA ER (desvenlafaxine)	ZOLOFT (sertraline) ORAL CONCENTRATE	
Nefazodone		
OLEPTRO ER (trazodone)		
Paroxetine		
Paroxetine ER		
PAXIL (paroxetine) ORAL SUSPENSION		
PEXEVA (paroxetine)		
PRISTIQ ER (desvenlafaxine)		
PROZAC WEEKLY (fluoxetine)		
Sertraline		
Sertraline oral concentrate		
Trazodone		
TRINTELLIX (vortioxetine)		
Venlafaxine capsule		
Venlafaxine ER tablets		
Venlafaxine tablet		
VIIBRYD (vilazodone)		
ANTIHEMOPHILIC FACTORS		
Category PA Criteria: 1. Patient must visit an accredited Hemophilia Treatment Center for yearly checkups. 2. The doctor must provide the date of patient's last appointment at the treatment center. 3. The doctor must include the contact information for the treatment center last visited by the patient.		
ADVATE[PA]	ADYNOVATE	
AFSTYLA[PA]	ELOCTATE	
ALPHANATE[PA]		
ALPHANINE SD[PA]		
ALPROLIX[PA]		
BEBULIN[PA]		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
BENEFIX[PA]		
FEIBA[PA]		
HELIXATE FS[PA]		
HEMOFIL M[PA]		
HUMATE-P[PA]		
IDELVION[PA]		
IXINITY[PA]		
KOATE-DVI[PA]		
KOGENATE FS BIO-SET[PA]		
KOGENATE FS[PA]		
MONOCLATE-P[PA]		
MONONINE[PA]		
NOVOEIGHT[PA]		
NOVOSEVEN[PA]		
OBIZURE[PA]		
PROFILNINE SD[PA]		
RECOMBINATE[PA]		
RIXUBIS[PA]		
VONVENDI[PA]		
WILATE[PA]		
XYNTHA[PA]		
ANTIRETROVIRALS - NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS		
Abacavir		
Abacavir/lamivudine/zidovudine		
ATRIPLA (efavirenz/emtricitabine/tenofovir)		
COMBIVIR (lamivudine/zidovudine)		
COMPLERA (emtricitabine/rilpivirine/tenofovir)		
DESCOVY (emtricitabine/tenofovir)		
Didanosine		
Emtricitabine		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
EMTRIVA (emtricitabine)		
EPIVIR (lamivudine)		
EPIVIR HBV (lamivudine)		
EPZICOM (abacavir)		
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)		
Lamivudine		
Lamivudine HBV		
Lamivudine/zidovudine		
ODEFSEY (emtricitabine/rilpivirine/tenofovir)		
RETROVIR (zidovudine)		
Stavudine		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)		
Tenofovir		
TRIUMEQ (abacavir/dolutegravir/lamivudine)		
TRIZIVIR (abacavir/lamivudine)		
TRUVADA (emtricitabine/tenofovir)		
VIDEX (didanosine)		
VIDEX EC (didanosine)		
VIREAD (tenofovir)		
ZERIT (stavudine)		
ZIAGEN (abacavir)		
Zidovudine		
ANTIRETROVIRALS - PROTEASE INHIBITORS		
APTIVUS (tipranavir)		
CRIXIVAN (indinavir)		
EVOTAZ (atazanavir/cobicistat)		
GENVOYA (elvitegravir, cobicistat, emtricitabine and tenofovir)		
INVERASE (saquinavir)		
KALENTRA (lopinavir/ritonavir)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LEXIVA (fosamprenavir)		
NORVIR (ritonavir)		
PREZCOBIX (darunavir/cobicistat)		
PREZISTA (darunavir)		
RAYATAZ (atazanavir)		
VIRACEPT (nelfinavir)		
ATYPICAL ANTIPSYCHOTICS		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30-day trial of 2 preferred generics of the same medication will satisfy this requirement. Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
ABILIFY (aripiprazole) ORAL SOLUTION	ABILIFY (aripiprazole)	
ABILIFY DISCMELT (aripiprazole)	CLOZARIL (clozapine)	
Aripiprazole	GEODON (ziprasidone)	
Clozapine	INVEGA ER (paliperidone)	
Clozapine ODT	quetiapine ER	
FANAPT (iloperidone)	RISPERDAL (risperidone)	
FAZACLO (clozapine) RAPDIS	RISPERDAL (risperidone) ORAL SOLUTION	
LATUDA (lurasidone)	RISPERDAL M-TAB (risperidone)	
Olanzapine	SEROQUEL (quetiapine)	
Olanzapine ODT	ZYPREXA (olanzapine)	
Olanzapine/fluoxetine	ZYPREXA ZYDIS (olanzapine)	
Paliperidone ER		
Quetiapine		
REXULTI (brexpiprazole)		
Risperidone		
Risperidone ODT		
Risperidone oral solution		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
SAPHRIS (asenapine)		
SEROQUEL XR (quetiapine)		
SYMBYAX (olanzapine/fluoxetine)		
VRAYLAR (cariprazine)		
Ziprasidone		
ATYPICAL ANTIPSYCHOTICS - LONG ACTING		
ABILIFY MAINTENA (aripiprazole)		
ARISTADA (aripiprazole lauroxil)		
INVEGA SUSTENNA (paliperidone)		
INVEGA TRINZA (paliperidone)		
RISPERDAL CONSTA (risperidone)		
ZYPREXA RELPREVV (olanzapine)		
CONSTIPATION - IRRITABLE BOWEL SYNDROME/OPIOID INDUCED		
Category PA Criteria: Patients must be 18 years old. All medications will require an FDA indication. For opioid-induced constipation, a paid claim for an opioid must be on patient's profile and a 30 day trial of Amitiza will be required before a non-preferred oral agent will be authorized.		
AMITIZA (lubiprostone)	MOVANTIK (naloxegol)	***Linzess – A 30-day trial of Amitiza is required before Linzess will be authorized. ***Relistor Syringe/Vial – Documentation must be submitted to show inability to swallow a solid dosage form ***Relistor tablets - A 30 day trial of Movantik is required before Relistor tablets will be authorized
LINZESS (linaclotide)PA***	RELISTOR (methylnaltrexone) TABLET***	
	RELISTOR (methylnaltrexone) VIAL***	
	RELISTOR (methylnaltrexone) SYRINGE***	
COPD		
Category PA Criteria: A 30-day trial of all preferred agents (within the same group) will be required before a non-preferred agent will be authorized. All preferred agents indicated only for COPD will require verification of FDA-approved indication for patients who are younger than 40 years of age. All non-preferred agents will require an FDA-approved indication regardless of age.		
Long Acting Anticholinergics		
SPIRIVA (tiotropium)	INCRUSE ELLIPTA (umeclidinium)	
	SPIRIVA RESPIMAT 2.5 MG (tiotropium)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	TUDORZA PRESSAIR (aclidinium)	
Long Acting Beta Agonists		
BROVANA (arformoterol)	ARCAPTA NEOHALER (indacaterol)	
FORADIL (formoterol)	STRIVERDI RESPIMAT (olodaterol)	
PERFOROMIST (formoterol)		
SEREVENT (salmeterol)		
Short Acting Combination		
Albuterol/ipratropium	DUONEB (albuterol/ipratropium)	
COMBIVENT RESPIMAT (albuterol/ipratropium)		
Long Acting Combination		
STIOLTO RESPIMAT (tiotropium/olodaterol)	UTIBRON NEOHALER (glycopyrrolate/indacaterol)	
ANORO ELLIPTA (umeclidinium/vilanterol)	BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	
PDE4 - Inhibitor		
Group PA Criteria: In addition to the category PA criteria, patient must have a history of exacerbations treated with corticosteroids within the last year for initial requests and must have had a decreased number of exacerbations treated with corticosteroids with Daliresp treatment with renewals. Patient must also have had the following 30-day trials: 1. One (1) agent in the Long Acting Anticholinergic group. 2. One (1) agent in the Long Acting Beta Agonist group or 1 agent in the Steroid/Anticholinergic Combination Inhalers category. 3. One (1) agent in the Steroid Inhalers category or 1 agent in the Steroid/Anticholinergic Combination Inhalers category.		
	DALIRESP (roflumilast)	
CYSTIC FIBROSIS ANTIINFECTIVES		
Category PA Criteria: A 28-day trial of 1 preferred agent will be required before a non-preferred agent will be authorized. Non-preferred agents will require that the patient not have been colonized with Burkholderia cepacia and an FDA-approved age and indication.		
BETHKIS (tobramycin)	CAYSTON (aztreonam)***	***Cayston – Patient must have a forced expiratory volume in less than 1 second (FEV1) of less than 25% or greater than 75% predicted. ***Tobramycin/TOBI Podhaler – Patient must have a forced expiratory volume in
KITABIS PAK (tobramycin/nebulizer)	TOBI PODHALER (Tobramycin)***	
TOBI (Tobramycin)	Tobramycin***	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		less than 1 second (FEV1) of less than 40% or greater than 80% predicted. Patient must not have been colonized with *Burkholderia cepacia.*
CYTOKINE MODULATORS		
Category PA Criteria: A 3-month trial of 2 preferred agents will be required before a non-preferred agent will be authorized. All agents will require an FDA-approved indication.		
COSENTYX (secukinumab)PA	ACTEMRA (tocilizumab)	***Otezla – Patient must be 18 years or older and have a rheumatology or dermatology specialist involved in therapy. Otezla must not be used in combination with other biologic therapies.
ENBREL (etanercept)PA	CIMZIA (certolizumab)	
HUMIRA (adalimumab)PA	ORENCIA (abatacept)	
HUMIRA PSORIASIS (adalimumab)PA	REMICADE (infliximab)	
KINERET (anakinra)PA	SIMPONI (golimumab)	
OTEZLA (apremilast)PA***	STELARA (ustekinumab)	
XELJANZ (tofacitinib)PA	TALTZ (ixekizumab)	
XELJANZ XR (tofacitinib)PA		
DIABETES - DPP4 INHIBITORS		
Category PA Criteria: Non preferred agents will require: 1. A 30-day trial of 1 sitagliptin preferred product (Janumet, Janumet XR, or Januvia) and 1 linagliptin preferred product (Jentadueto or Tradjenta). 2. An FDA approved indication. 3. Concurrent metformin therapy. 4. A 3-month trial of metformin		
JANUMET (sitagliptin/metformin)	alogliptan/pioglitzone	***Onglyza - will require an FDA indication, a 3 month trial of metformin and concurrent metformin therapy
JANUMET XR (sitagliptin/metformin)	alogliptin/metformin	
JANUVIA (sitagliptin)	JENTADUETO XR (linagliptin/metformin)	
JENTADUETO (linagliptin/metformin)	KAZANO (alogliptin/metformin)	
KOMBIGLYZE XR (saxagliptin/metformin)	NESINA (alogliptin)	
ONGLYZA (saxagliptin)PA***	OSENI (alogliptin/pioglitazone)	
TRADJENTA (linagliptin)		
DIABETES - GLP1 AGONISTS		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: Non preferred agents will require: 1. A 30-day trial of 2 preferred agents. 2. An FDA indication. 3. Concurrent metformin therapy. 4. A 3-month trial of metformin.		
BYDUREON (exenatide microspheres)	TRULICITY (dulaglutide)	***Victoza requires PA for an FDA-approved indication, concurrent metformin therapy, and a 3-month trial of metformin.
BYETTA (exenatide)		
TANZEUM (albiglutide)		
VICTOZA (liraglutide)PA***		
DIABETES - SGLT2 INHIBITORS		
Category PA Criteria: Non-preferred agents will require: 1. An FDA indication. 2. A 3-month trial of a metformin 3. A 3-month trial of a canagliflozin and a 3-month trial of a empagliflozin agent. 4. Concurrent metformin therapy – this condition will be considered met if requested product is a metformin combination agent.		
INVOKAMET (canagliflozin)	FARXIGA (dapagliflozin)	
INVOKAMET XR (canagliflozin/metformin)	GLYXAMBI (empagliflozin/linagliptin)	
INVOKANA (canagliflozin)	XIGDUO XR (dapagliflozin/metformin)	
JARDIANCE (empagliflozin)		
SYNJARDY (empagliflozin/metformin)		
DIARRHEA - IRRITABLE BOWEL SYNDROME		
Category PA Criteria: Patient must be 18 years of age or older. A 30-day trial of loperamide and Viberzi will be required before a non-preferred medication will be approved.		
VIBERZI (eluxadoline)	Alosetron***	***Alosetron– Patient must be a female.
	XIFAXIN (rifaximin) 550 mg tablet	
	LOTRONEX (alosetron)***	
DIGESTIVE ENZYMES		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
CREON (lipase/protease/amylase)	PANCREAZE (lipase/protease/amylase)	
ZENPEP (lipase/protease/amylase)	PANCRELIPASE (lipase/protease/amylase)	
	PERTZYE (lipase/protease/amylase)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ULTRESA (lipase/protease/amylase)	
	VIOKACE (lipase/protease/amylase)	
GOUT - COLCHICINE		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
MITIGARE (colchicine)	Colchicine capsule	
	Colchicine tablet	
	COLCRYS (colchicine) TABLET	
FIBROMYALGIA		
Category PA Criteria: A 30-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized. A 30-day trial of 2 preferred generics of the same medication will satisfy this requirement.		
Duloxetine	CYMBALTA (duloxetine)	
Gabapentin capsule	NEURONTIN (gabapentin) CAPSULE	
Gabapentin oral solution	NEURONTIN (gabapentin) TABLET	
Gabapentin tablet	NEURONTIN (gabapentin) ORAL SOLUTION	
LYRICA (pregabalin)		
LYRICA (pregabalin) ORAL SOLUTION		
SAVELLA (milnacipran)		
GLAUCOMA - SYMPATHOMIMETICS		
Category PA Criteria: A 30-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30-day trial of 2 preferred generics of the same medication will satisfy this requirement.		
ALPHAGAN P 0.1% (brimonidine)	ALPHAGAN P 0.15% (brimonidine)	
Apraclonidine	IOPIDINE (apraclonidine)	
brimonidine 0.15%		
brimonidine 0.2%		
COMBIGAN (brimonidine/timolol)		
SIMBRINZA (brinzolamide/brimonidine)		
GROWTH HORMONE		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: 1. Patients new to GH therapy must meet the criteria below and be started on a preferred growth hormone. 2. Patients continuing GH therapy and having met the criteria listed below must be switched to a preferred growth hormone. 3. Patients must not have an active malignancy. Additional criteria applies. For details, see http://www.hidesigns.com/assets/files/ndmedicaid/Criteria/2016/growth_hormone_criteria.pdf.		
GENOTROPIN (somatropin)PA	HUMATROPE (somatropin)	
GENOTROPIN MINIQUICK (somatropin)PA	NUTROPIN AQ (somatropin)	
NORDITROPIN FLEXPRO (somatropin)PA	OMNITROPE (somatropin)	
	SAIZEN (somatropin)	
	ZOMACTON (somatropin)	
HEART FAILURE - NEPRILYSIN INHIBITOR/ANGIOTENSIN RECEPTOR BLOCKER		
Category PA Criteria: 1. Patient must have symptomatic chronic heart failure (NYHA class II-IV). 2. Patient must have systolic dysfunction (left ventricular ejection fraction ≤ 40%).		
ENTRESTO (sacubitril/valsartan)		
HEMATOPOIETIC, GROWTH FACTOR		
Category PA Criteria: All agents will require an FDA indication. A 4-week trial of all preferred products will be required before non-preferred agents will be authorized.		
ARANESP (darbepoetin alfa)PA	EPOGEN (epoetin alfa)	
PROCRIT (epoetin alfa)PA	MIRCERA (methoxy polyethylene glycol-epoetin beta)	
HEPATITIS C TREATMENTS		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: Non-preferred agents will require a failed trial of all preferred treatment options indicated for the patient's genotype. 1. Patient must have an FDA-approved diagnosis. 2. Patient must be an FDA-approved age. 3. Patient must attest that they will continue treatment without interruption for the duration of therapy. 4. Prescriber must be, or consult with, a hepatologist, gastroenterologist, or infectious disease specialist. 5. Prescriber must provide documentation that the patient has been drug and alcohol free for the past 12 months. Documentation includes at least 2 drug and alcohol tests dated at least 3 months apart and chart notes addressing patient's alcohol and drug free status throughout the past year. 6. Patient must provide documentation of liver biopsy or non-invasive test that shows a Metavir score of 1 or greater, Ishak score of 2 or greater. 7. HCV RNA level must be taken on week 4 and sent with a renewal request for any duration of treatment 12 weeks or longer. 8. Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment. 9. Patient must have established compliant behavior including attending scheduled provider visits and filling maintenance medications on time as shown in the prescription medication history. 10. Patient must be tested for hepatitis B, and if the test is positive, hepatitis B must either be treated or closely monitored if patient does not need treatment. 11. Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions. 12. PA approval duration will be based on label recommendation.		
EPCLUSA (sofosbuvir/velpatasvir)PA***	DAKLINZA (Daclatasvir)	***Epclusa: • Must must be used with ribavirin for patients with decompensated cirrhosis (Child-Pugh B or Child-Pugh C). • Is ONLY preferred for genotype 2 and 3; for all other genotypes Epclusa is non-preferred. ***Harvoni: • Patient must have eGFR > 30 mL/min/1.73m2. ***Technivie: • Patients must not have moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment. • Patients must not have cirrhosis. • Technivie must be used with ribavirin in treatment experienced patients.
HARVONI (ledipasvir/sofosbuvir)PA***	OLYSIO (simeprevir)***	
SOVALDI (sofosbuvir)PA		
TECHNIVIE (ombitasvir/paritaprevir/ritonavir)PA***		
VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)PA***		
VIEKIRA PAK XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)PA***		
ZEPATIER (elbasvir/grazoprevir)PA***		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		***Olysio: • Must be taken in conjunction with pegylated interferon and ribavirin. ***Viekira Pak/Viekira Pak XR: • Patients must have hepatic laboratory tests before treatment and 4 weeks after treatment begins. • Patients must not have moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment. • Viekira Pak must be used with ribavirin except for genotype 1b without cirrhosis or mild (Child-Pugh A) hepatic impairment. ***Zepatier: • Patients must not have moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment. • Genotype 1a: Patient must be tested for baseline NS5A polymorphisms. • Zepatier must be used with ribavirin in patients with baseline NS5A polymorphisms. • Zepatier must be used with ribavirin in patients who have failed HCV NS3/4A protease inhibitor (PI) + RBV + PegIFN treatment. • Patients who have failed HCV NS3/4A protease inhibitor (PI) + RBV + PegIFN treatment must not have baseline NS5A polymorphisms.
IMMUNOGLOBULINS		
Category PA Criteria: 1. Indication must be provided. 2. If patient's BMI is > 30, patient's adjusted body weight must be provided and a calculated dose based on adjusted body weight must be provided.		
BIVIGAM (human immunoglobulin gamma)	HIZENTRA (human immunoglobulin gamma)***	***Gammagard S/D: Patient must be intolerant to IgA (ie. treatment of an autoimmune process in a patient with undetectable levels of IgA) ***Hizentra, Cuvitru or Hyqvia: Patient must not be able to tolerate IV administration. Patient must fail a trial of two products of the following products: Gamaunex-C, Gammaked, or Gammgard
CARIMUNE NF (human immunoglobulin gamma)	CUVITRU (human immunoglobulin gamma)***	
FLEBOFAMMA DIF (human immunoglobulin gamma)	GAMMAGARD S-D (human immunoglobulin gamma)***	
GAMANEX-C (human immunoglobulin gamma)	HYQVIA (human immune globulin G and hyaluronidase***	
GAMASTAN S-D		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
GAMMAGARD LIQUID (human immunoglobulin gamma)		
GAMMAKED (human immunoglobulin gamma)		
GAMMAPLEX (human immunoglobulin gamma)		
OCTAGAM (human immunoglobulin gamma)		
PRIVIGEN (human immunoglobulin gamma)		
INFLAMMATORY BOWEL AGENTS (ULCERATIVE COLITIS) - NONSTEROIDAL		
Category PA Criteria: A 30-day trial of each of the preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents will require an FDA indication.		
Oral		
Balsalazide capsule	APRISO (mesalamine) CAPSULE	
DELZICOL (mesalamine) CAPSULE	ASACOL HD (mesalamine)	
DIPENTUM (olsalazine)	AZULFIDINE (sulfasalazine)	
PENTASA (mesalamine)	AZULFIDINE DR (sulfasalazine)	
Sulfasalazine DR tablet	COLAZAL (balsalazide)	
Sulfasalazine tablet	GIAZO (balsalazide)	
	LIALDA (mesalamine) TABLET	
	Mesalamine DR	
	SULFAZINE (sulfasalazine)	
Rectal		
CANASA (mesalamine) RECTAL SUPPOSITORY	Mesalamine enema kit	
Mesalamine enema	SF ROWASA (mesalamine) ENEMA	
LICE		
Category PA Criteria: A 28-day/2-application trial of each of the preferred agents will be required before a non-preferred agent will be authorized. This requirement will be waived in the presence of a documented community breakout of a resistant strain that is only susceptible to a non-preferred agent.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
EURAX (crotamiton) CREAM	ELIMITE (permethrin) CREAM	
LICE SOLUTION (piperonyl butoxide/pyrethrins)	EURAX (crotamiton) LOTION	
NATROBA (spinosad)	Malathion	
Permethrin cream	OVIDE (malathion)	
Permethrin liquid	Spinosad	
SKLICE (ivermectin)		
ULESFIA (benzyl alcohol)		
MIGRAINE PROPHYLAXIS - 5HT(1) AGONISTS		
Category PA Criteria: Patients 18 years old or older: A 30-day trial of all preferred agents in the past 24 months will be required before a non-preferred agent will be authorized. Patients 6 to 17 years of age: A 30-day trial of rizatriptan in the past 24 months will be required before a non-preferred agent will be authorized.		
RELPAX (eletriptan)	Almotriptan	***Treximet – For patients 18 years or older, the patient must be stable on the combination product and have had a 30-day trial of naproxen in addition to sumatriptan to be approved. This criteria is in addition to the class criteria. ***Frovatriptan – A 30-day trial of naratriptan 2.5 mg within the past 24 months will be required in addition to the class criteria. The patient's migraine headaches must either menstrual, long in duration, and/or recurring. ***Almotriptan – A 30-day trial of Zolmitriptan 5 mg in the past 24 months will be required in addition to the class criteria. **Zembrance Symtouch/Sumatriptan Injection – A 30-day trial of Naratriptan 2.5 mg, Sumatriptan Nasal Spray 20 mg, Zomig Nasal Spray 5 mg, Zolmitriptan 5 mg, Axert 12.5 mg, Treximet, and Frova in the past 24 months will be required in addition to the class criteria.
Rizatriptan	ALSUMA (sumatriptan) PEN INJCTR***	
Rizatriptan tab rap. dis.	AMERGE (naratriptan)	
Sumatriptan tablet	FROVA (frovatriptan)***	
	IMITREX (sumatriptan) CARTRIDGE***	
	IMITREX (sumatriptan) PEN INJCTR***	
	IMITREX (sumatriptan) SPRAY	
	IMITREX (sumatriptan) TABLET	
	IMITREX (sumatriptan) VIAL***	
	MAXALT (rizatriptan)	
	MAXALT MLT (rizatriptan)	
	Naratriptan	
	ONSETRA XSAIL (sumatriptan)***	
	Sumatriptan cartridge***	
	Sumatriptan pen injctr***	
	Sumatriptan spray	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	Sumatriptan syringe***	
	Sumatriptan vial***	
	SUMAVEL DOSEPRO (sumatriptan)	
	TREXIMET (sumatriptan/naproxen)***	
	Zolmitriptan	
	Zolmitriptan ODT	
	ZOMIG (zolmitriptan)	
	ZOMIG (zolmitriptan) SPRAY	
	ZOMIG ODT (zolmitriptan)	
MULTIPLE SCLEROSIS		
Interferons		
Category PA Criteria: A 3-month long trial of a preferred agent will be required before a non-preferred agent will be authorized. An FDA indication is required.		
AVONEX (interferon beta-1A) VIAL	AVONEX (interferon beta-1A) SYRINGE	
BETASERON (interferon beta-1B)	AVONEX (interferon beta-1A) PEN	
REBIF (interferon beta-1A)	EXTAVIA (interferon beta-1B)	
REBIF REBIDOSE (interferon beta-1A)	PLEGRIDY (peginterferon beta-1A) SYRINGE	
	PLEGRIDY (peginterferon beta-1A) PEN	
Injectable Non-Interferons		
Category PA Criteria: A 3-month long trial of all preferred agents and 3-month trials of Aubagio, Tecfidera, and Gilenya will be required before a non-preferred agent will be authorized. If patient has a documented intolerance, hypersensitivity, or labeled contraindication to Copaxone, a 3-month trial of interferon beta-1 is required. An FDA indication is required. Prescriber must be a neurologist		
COPAXONE (glatiramer) 20 MG/ML	COPAXONE (glatiramer) 40 MG/ML***	***Lemtrada: • If patient has early aggressive disease defined as ≥ 2 relapses in the year and ≥ 1 Gadolinium (Gd)+ lesion, the trials of oral non-interferons will not be required. • If patient has not been vaccinated or have a history of varicella zoster virus (VZV), patient must have an VZV antibody titer. • Patient must have had a urinalysis with urine cell counts.
	Glatopa (glatiramer)***	
	LEMTRADA (alemtuzumab)***	
	TYSABRI (natalizumab)***	
	ZINBRYTA (daclizumab)***	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		• Patient must have had a thyroid function test. • Patient must be screened for TB and have been treated if TB positive. • - Patient must have SCr levels. ***Tysabri: • If patient has early aggressive disease defined as ≥ 2 relapses in the year and ≥ 1 Gadolinium (Gd)+ lesion, the trials of oral non-interferons will not be required. • Patient must have Anti-JC virus antibodies taken. • Patient must have had an MRI scan. ***Zinbryta: • Transaminase and bilirubin levels must have been obtained within 6 months of request. • Patient must not have hepatitis B or C. • Patient must be screened for TB and have been treated if TB positive. • If patient has early aggressive disease defined as ≥ 2 relapses in the year and ≥ 1 Gadolinium (Gd)+ lesion, the trials of oral non-interferons will not be required. • Patient must have Anti-JC virus antibodies taken. ***Copaxone/Glatopa: • A reason must be indicated why Copaxone 20 mg/mL will not work.
Oral Non-Interferons		
Category PA Criteria: A 3-month long trial of all preferred agents and Copaxone will be required before a non-preferred agent will be authorized. If patient has a documented intolerance, hypersensitivity, or labeled contraindication to Copaxone, a 3-month trial of interferon beta-1 is required for non-preferred agents. An FDA indication is required. Prescriber must be a neurologist.		
AUBAGIO (teriflunomide)	TECFIDERA (dimethyl fumarate)***	*** Tecfidera: Patient must have had a CBC with lymphocyte count within 6 months of request.
GILENYA (fingolimod)		
OPHTHALMIC ANTIHISTAMINES		
Category PA Criteria: A 30-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized.		
ALOCRIL (nedocromil)	ELESTAT (epinastine)	
ALOMIDE (lodoxamide)	Epinastine	
Azelastine	PATADAY (olopatadine)	
BEPREVE (bepotastine)	PATANOL (olopatadine)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Cromolyn		
EMADINE (emedastine)		
LASTACAFT (alcaftadine)		
Olopatadine		
PAZEO (olopatadine)		
OPHTHALMIC ANTIINFECTIVES		
Category PA Criteria: A 3-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
AZASITE (azithromycin) DROPS	AK-POLY-BAC (bacitracin/polymyxin) OINTMENT	
Bacitracin ointment	BLEPH-10 (sulfacetamide) DROPS	
Bacitracin/polymyxin ointment	CILOXAN (ciprofloxacin) DROPS	
BESIVANCE (besifloxacin) DROPS	CILOXAN (ciprofloxacin) OINTMENT	
Ciprofloxacin drops	Gatifloxacin drops	
Erythromycin ointment	GENTAK (gentamicin sulfate) OINTMENT	
Gentamicin sulfate drops	ILOTYCIN (erythromycin) OINTMENT	
Gentamicin sulfate ointment	Levofloxacin drops	
MOXEZA (moxifloxacin) DROPS	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) DROPS	
Neomycin SU/bacitracin/polymyxin B drops	NEOSPORIN (neomycin SU/polymyxin B/gramicidin) DROPS	
Neomycin SU/bacitracin/polymyxin B ointment	OCUFLOX (ofloxacin) DROPS	
Neomycin SU/polymyxin B/gramicidin drops	POLYCIN (bacitracin/polymyxin) OINTMENT	
Ofloxacin drops	POLYTRIM (polymyxin B/trimethoprim) DROPS	
Polymyxin B/trimethoprim drops	TOBREX (tobramycin) DROPS	
Sulfacetamide drops	ZYMAXID (gatifloxacin) DROPS	
Sulfacetamide ointment		
Tobramycin drops		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
TOBREX (tobramycin) OINTMENT		
VIGAMOX (moxifloxacin) DROPS		
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES		
Category PA Criteria: A 7-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS	BLEPHAMIDE (sulfacetamide/prednisolone) DROPS	
Neomycin/bacitracin/polymyxin b/hydrocortisone ointment	BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone) ointment	
Neomycin/polymyxin b/dexamethasone drops	MAXITROL (neomycin/polymyxin b/dexamethasone) OINTMENT	
Neomycin/polymyxin b/dexamethasone ointment	Neomycin/polymyxin b/hydrocortisone drops	
PRED-G (gentamicin/prednisol ac) DROPS	NEO-POLYCIN HC (neomycin SU/bacitracin/polymyxin B/hydrocortisone) OINTMENT	
PRED-G (gentamicin/prednisol ac) OINTMENT	TOBRADEX ST (tobramycin/dexamethasone) DROPS	
Sulfacetamide/prednisolone drops	Tobramycin/dexamethasone	
TOBRADEX (tobramycin/dexamethasone) DROPS		
TOBRADEX (tobramycin/dexamethasone) OINTMENT		
ZYLET (tobramycin/lotepred etab) DROPS		
OPHTHALMIC ANTIINFLAMMATORIES		
Category PA Criteria: A 5-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
ACUVAIL (ketorolac)	ACULAR (ketorolac)	
ALREX (loteprednol)	ACULAR LS (ketorolac)	
Dexamethasone sodium phosphate	Bromfenac sodium	
Diclofenac sodium	BROMSITE (bromfenac sodium)	
DUREZOL (difluprednate)	FML (fluorometholone)	
FLAREX (fluorometholone)	OCUFEN (flurbiprofen)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Fluorometholone	OMNIPRED (prednisolone acetate)	
Flurbiprofen sodium	PRED FORTE (prednisolone acetate)	
FML FORTE (fluorometholone)	Prednisolone acetate	
FML S.O.P. (fluorometholone)	Prednisolone sodium phosphate	
ILEVRO (nepafenac)	PROLENSA (bromfenac)	
Ketorolac tromethamine		
LOTEMAX (loteprednol)		
MAXIDEX (dexamethasone)		
NEVANAC (nepafenac)		
PRED MILD (prednisolone)		
VEXOL (rimexolone)		
OPIOID ANALGESIC - LONG ACTING		
Category PA Criteria: A 30-day trial of a product containing fentanyl and one containing morphine will be required before a non-preferred agent will be authorized. For non-preferred agents to be authorized, patient must have required around-the-clock pain relief for the past 90 days and 3 months of the PDMP report must be reviewed and attached.		
BUTRANS (buprenorphine)	BELBUCA (buprenorphine)***	*** Fentanyl 12 mcg/hr – The total daily opioid dose must be less than 60 Morphine Equivalent Dose (MED) and 3 months of the PDMP report must be reviewed and attached. *** Zohydro ER and Xtampza ER require a 30-day failed trial of oxymorphone ER in addition to category PA criteria. ***Belbuca, Oxycodone ER, Hysingla ER, and Morphine ER Cap – A 30-day failed trial of oxymorphone ER and a long acting oxycodone will be required in addition to category PA criteria. ***Hydromorphone ER and Exalgo – The 90-day around-the-clock pain relief requirement must be met by an equianalgesic dose of 60 mg oral morphine daily, 25 mcg transdermal fentanyl/hour, 30 mg oxycodone daily, 8 mg of oral hydromorphone daily, or another opioid daily. A 30-day failed trial of oxymorphone ER and a long acting oxycodone is required in addition to category PA criteria. ***Methadone, and Fentanyl Patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr requires a 30-day failed trial of oxymorphone ER, a long acting oxycodone,
EMBEDA (morphine/naltrexone)	DURAGESIC (fentanyl)	
Fentanyl 12 mcg/hr[PA***]	EXALGO (hydromorphone)***	
Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr***	
Morphine ER tablets	Hydromorphone ER tablets***	
NUCYNTA ER (tapentadol)	HYSINGLA ER (hydrocodone)***	
Tramadol ER	KADIAN (morphine)***	
	Methadone***	
	Morphine ER capsules***	
	MS CONTIN (morphine)	
	OPANA ER (oxymorphone)	
	Oxycodone ER***	
	OXYCONTIN (oxycodone)***	
	Oxymorphone ER tablets	
	ULTRAM ER (tramadol ER)	
	XARTEMIS XR	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	(oxycodone/acetaminophen)	Butrans, tramadol ER, Nucynta ER in addition to category PA criteria.
	XTAMPZA ER (oxycodone)***	
	ZOHYDRO ER (hydrocodone)***	
OPIOID ANTAGONIST - OPIOID AND ALCOHOL DEPENDENCE		
VIVITROL (Naltrexone Microspheres)		
OPIOID PARTIAL ANTAGONIST - OPIOID DEPENDENCE		
Category PA Criteria: A 30-day trial of 1 preferred agent will be required before a non-preferred agent will be authorized. 1. Patient must be 16 years of age or older. 2. Patient must not be taking other opioids, tramadol, or carisoprodol concurrently. 3. The prescriber must be registered to prescribe under the Substance Abuse and Mental Health Services Administration (SAMHSA) and provide his/her DEA number. 4. The prescriber and patient must have a contract or the prescriber must have developed a treatment plan. 5. The prescriber must perform routine drug screens. 6. The prescriber must routinely check the PDMP and attach the last 3 months of PDMP reports that have been reviewed. 7. The prescriber must be enrolled with ND Medicaid.		
ZUBSOLV (buprenorphine/naloxone)[PA]	BUNAVAIL FILM (buprenorphine/naloxone)***	*** Bunavail/Suboxone Film/buprenorphine will require a 30-day trial of buprenorphine/naloxone tablets in addition to the category PA criteria. ***Buprenorphine tablets will be allowed during a period that a patient is pregnant or breastfeeding.
	Buprenorphine tablets***	
	Buprenorphine-naloxone tablets	
	SUBOXONE FILM (buprenorphine/naloxone)***	
OTIC ANTI-INFECTIVES - FLUOROQUINOLONES		
Category PA Criteria: A 7-day trial of 1 preferred product in the past 3 months is required before a non-preferred product will be approved.		
CIPRO HC (ciprofloxacin/hydrocortisone)	FLOXIN (ofloxacin)	
CIPRODEX (ciprofloxacin/dexamethasone)	Ofloxacin	
	OTOVEL (ciprofloxacin/fluocinolone)	
PHOSPHATE BINDERS		
Category PA Criteria: The following criteria will be required before a non-preferred agent will be authorized: 1. Patient must have had a 3-month trial of 3 preferred different chemical entities. 2. Patient must have end stage renal disease or chronic kidney disease. 3. Patients with chronic kidney disease stage 5 must have a phosphate level greater than 5.5 mg/dL. 4. All other patients must have a phosphate level greater than 4.6 mg/dL.		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Calcium acetate capsule	AURYXIA (ferric citrate) TABLET	*** Velphoro – A 3-month trial of Auryxia will be required in addition to category PA criteria.
Calcium acetate tablet	FOSRENOL (lanthanum) POWDER PACK	
ELIPHOS (calcium acetate) TABLET	VELPHORO (sucroferric oxyhydroxide)***	
FOSRENOL (lanthanum) 500 MG AND 750 MG CHEWABLE TABLET	FOSRENOL (lanthanum) 1000 MG CHEWABLE TABLET	
PHOSLO (calcium acetate) CAPSULE		
PHOSLYRA (calcium acetate) ORAL solution		
RENAGEL (sevelamer) TABLET		
RENVELA (sevelamer) POWDER PACK		
RENVELA (sevelamer) TABLET		
PLATELET AGGREGATION INHIBITORS		
Category PA Criteria: A 30 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions is indicated on the form.		
Aspirin/dipyridamole ER	AGGRENOX (aspirin/dipyridamole)	***Zontivity – Patient must be 18 years of age or older. Zontivity must be taken with aspirin and/or clopidogrel. Patient must not have a history of stroke, transient ischemic attack, or intracranial hemorrhage. ***Durlaza/Yosprala DR – Patient must have a reason that immediate release aspirin is not an option.
BRILINTA (ticagrelor)	DURLAZA (aspirin ER)***	
Clopidogrel	PERSANTINE (dipyridamole)	
Dipyridamole	PLAVIX (clopidogrel)	
EFFIENT (prasugrel)	YOSPRALA DR (aspirin/omeprazole)***	
Ticlopidine	ZONTIVITY (vorapaxar)***	
PULMONARY HYPERTENSION		
PDE-5 Inhibitors		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All medications require an FDA-approved indication.		
ADCIRCA (tadalafil)[PA]	REVATIO (sildenafil) SUSPENSION***	***Revatio Suspension – Patients 7 years and older will be required to submit documentation of their inability to ingest a solid dosage form. ***Sildenafil – A 30-day trial of Adcirca will be required for all patients younger than 18 years old.
Sildenafil[PA]***	REVATIO (sildenafil) TABLET	
Soluble Guanylate Cyclase Stimulators		
Category PA Criteria: Patients of childbearing potential must not be pregnant, be taking a reliable form of birth control, and have a pregnancy test before initiation and monthly during therapy. All medications require an FDA-approved indication.		
ADEMPAS (riociguat)[PA]		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Endothelin Receptor Antagonist		
Category PA Criteria: Patients of childbearing potential must not be pregnant, be taking a reliable form of birth control, and have a pregnancy test before initiation and monthly during therapy. All medications require an FDA-approved indication. Non-preferred agents will require a 30-day trial of all preferred medications.		
TRACLEER (bosentan)PA***	LETAIRIS (ambrisentan)	***Tracleer – LFTs must be measured at baseline and monthly during therapy. ***Opsumit - A 30 day trial of Letairis will be required in addition to category PA criteria
	OPSUMIT (macitentan)***	
Prostacyclins		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
EpoprostenolPA	REMODULIN (treprostinil)	***Ventavis 20 mcg/mL – A patient must be maintained at a 5 mcg dose and repeatedly experiencing incomplete dosing due to extended treatment time to be approved.
FLOLAN (epoprostenol)PA	TYVASO (treprostinil)	
ORENITRAM ER (treprostinil)PA	UPTRAVI (selexipag)	
VELETRI (epoprostenol)PA	VENTAVIS (iloprost) 20 mcg/mL***	
VENTAVIS (iloprost) 10 mcg/mLPA		
STEROID/LONG ACTING BETA AGONIST (LABA) COMBINATION INHALERS		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents must have an FDA-approved indication. For COPD diagnosis, the following will be required in addition to the category PA criteria: 1. A 30-day trial of Tudorza Pressair, Spiriva, Spiriva Respimat, Incruse Ellipta, Anoro Ellipta, or Stiolto Respimat. 2. A 30-day trial of Anoro Ellipta, Stiolto Respimat, Foradil, Brovana, Arcapta Neohaler, Striverdi Respimat, Perforomist, or Serevent. For asthma diagnosis, patient must have been reviewed for step down therapy for all renewal requests.		
ADVAIR DISKUS (fluticasone/salmeterol)	ADVAIR HFA (fluticasone/salmeterol)	
DULERA (mometasone/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)	
SYMBICORT (budesonide/formoterol)		
STEROID INHALERS		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
AEROSPAN (flunisolide)	ARNUITY ELLIPTA (fluticasone)	
ALVESCO (ciclesonide)	ASMANEX HFA (mometasone)	
ASMANEX (mometasone) TWISTHALER		
FLOVENT DISKUS (fluticasone)		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
FLOVENT HFA (fluticasone)		
PULMICORT FLEXHALER (budesonide)		
QVAR (beclomethasone)		
TESTOSTERONE TOPICAL		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All medications require an FDA-approved indication.		
ANDROGEL (testosterone) GEL MD PMP PA	ANDRODERM (testosterone)	
ANDROGEL (testosterone) PACKET 1%PA	FORTESTA (testosterone)	
ANDROGEL (testosterone) PACKET 1.62%PA	NATESTO (testosterone)	
AXIRON (testosterone)PA	TESTIM (testosterone)	
	TESTOPEL (testosterone)	
	Testosterone gel	
	Testosterone Gel MD PMP	
	VOGELXO (testosterone) GEL MD PMP	
URINARY ANTISPASMODICS		
Category PA Criteria: A 30-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents require an FDA-approved indication.		
Flavoxate	Darifenacin ER***	***SANCTURA ER/Trospium ER and ENABLEX/darifenacin ER will require a 1-month trial of Myrbetriq, trospium, and tolterodine in addition to the category PA criteria. ***MYRBETRIQ and DETROL LA/Tolterodine ER will require a 1-month trial of trospium and tolterodine in addition to the category PA criteria. ***SACTURA/Trospium will require a 1-month trial of tolterodine in addition to the category PA criteria.
GELNIQUE (oxybutynin)	DETROL (tolterodine)	
Oxybutynin ER	DETROL LA (tolterodine)***	
Oxybutynin syrup	DITROPAN XL (oxybutynin)	
Oxybutynin tablet	ENABLEX (darifenacin)***	
OXYTROL (oxybutynin) PATCH	MYRBETRIQ (mirabegron)***	
TOVIAZ (fesoterodine)	SANCTURA (trospium)***	
VESICARE (solifenacin)	SANCTURA ER (trospium)***	
	Tolterodine	
	Tolterodine ER***	
	Trospium***	
	Trospium ER***	