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

This is NOT an all-inclusive list of covered medications or medications that require prior authorization. Only PDL managed categories are included. Refer to cover page for complete list of rules governing this PDL.

Visit http://www.hidesigns.com/ndmedicaid for more information on medications not found in this list.

EFFECTIVE
01/01/2018
Version 2018.1b

- Prior authorization for a non-preferred agent with a preferred brand/generic equivalent in any category will be given only if DAW criteria is met in addition to clinical criteria and step therapy specific to that category.

- Prior authorization criteria applies 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 covered by ND Medicaid. Please use the NDC Drug Lookup tool at http://nddruglookup.hidinc.com/ to view coverage status, quantity limits, copay, and prior authorization information for all medications.

- This is NOT an all-inclusive list of medications that require prior authorization. Please visit http://www.hidesigns.com/ndmedicaid/pa-criteria.html for PA criteria for medications not found on the PDL.

- 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 PA criteria applies as indicated in the sidebar

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CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
ANALGESICS - NSAIDS - TOPICAL	diclofenac gel added to preferred	
ANALGESICS - NSAIDS - TOPICAL	VOLTAREN (diclofenac) GEL moved to non-preferred	
ANTICOAGULANTS - ORAL	BEVYXXA (Betrixaban) added to preferred	
ANTICONVULSANTS	POTIGA (ezogabine) removed from PDL	
DIABETES - DPP4 INHIBITORS/SGLT2 INHIBITOR COMBINATIONS		New Category
DIABETES - GLP1 AGONISTS	BYDUREON BCISE (exenatide microspheres) added to non-preferred	
DIABETES - GLP1 AGONISTS	OZEMPIC (semaglutide) added to non-preferred	
DIABETES - GLP1 AGONISTS		Category PA Changes
DIABETES - INSULIN		Fiasp criteria change
DIABETES - SGLT2 INHIBITORS		Category Criteria Changes
OTIC ANTI-INFECTIVES - FLUOROQUINOLONES	Labeler 24208 ofloxacin moved to non-preferred	
STEROIDs - INHALED	QVAR REDIHALER (beclomethasone) added to non-preferred	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ADHD AGENTS		
Category PA Criteria: Branded non-preferred agents: A 10-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. Generic non-preferred agents: A 10-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)	
Atomoxetine	DEXEDRINE (dextroamphetamine)	
Clonidine	Dexmethylphenidate ER	
COTEMPLA XR - ODT (methylphenidate)	Dextroamphetamine 5 mg/5 ml	
DAYTRANA (methylphenidate)	Dextroamphetamine/amphetamine ER - Labelers 00115, 00228, 00555, 66993	
DESOXYN (methamphetamine)	FOCALIN (dexmethylphenidate)	
Dexmethylphenidate	INTUNIV (guanfacine ER)	
Dextroamphetamine	METADATE ER (methylphenidate)	
Dextroamphetamine ER	METHYLIN (methylphenidate) chew tablets	
Dextroamphetamine/amphetamine	METHYLIN (methylphenidate) solution	
Dextroamphetamine/amphetamine ER - Labeler 00781	RITALIN (methylphenidate)	
DYANAVEL XR (amphetamine)	RITALIN LA (methylphenidate LA capsules - 50-50)	
EVEKEO (amphetamine)	STRATTERA (atomoxetine)	
FOCALIN XR (dexmethylphenidate)	ZENZEDI (dextroamphetamine)	
Guanfacine ER		
KAPVAY (clonidine)[PA***]		
Methamphetamine		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Methylphenidate CD 30-70		
Methylphenidate chew tablet		
Methylphenidate ER capsules 50-50		
Methylphenidate ER tablet		
Methylphenidate LA capsules - 50-50		
Methylphenidate solution		
Methylphenidate tablet		
MYDAYIS (amphetamine/dextroamphetamine)		
PROCENTRA (dextroamphetamine)		
QUILLICHEW ER (methylphenidate)		
QUILLIVANT XR (methylphenidate)		
VYVANSE (lisdexamfetamine)		
VYVANSE (lisdexamfetamine) CHEW TABLET		
ANGINA		
RANEXA (ranolazine)		
ANALGESICS - NSAIDS - TOPICAL		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. A medical reason must be provided why preferred agents do not work.		
FLECTOR (diclofenac) PATCH	DERMACINRX LEXITRAL (diclofenac/capsicum)	
PENNSAID (diclofenac)	VOLTAREN (diclofenac) GEL	
diclofenac gel	VOPAC MDS (diclofenac)	
	XRYLIX (diclofenac)	
ANDROGENS		
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) PACKET 1%PA	AXIRON (testosterone) TOPICAL SOLUTION	
ANDROGEL (testosterone) PACKET 1.62%PA	FORTESTA (testosterone)	
ANDRODERM (testosterone)	NATESTO (testosterone)	
	TESTIM (testosterone)	
	TESTOPEL (testosterone)	
	Testosterone gel	
	Testosterone Gel MD PMP	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	Testosterone topical solution	
	VOGELXO (testosterone) GEL MD PMP	
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.		
BEVYXXA (Betrixaban)PA	SAVAYSA (edoxaban)	
ELIQUIS (Apixaban)PA		
PRADAXA (dabigatran)PA		
XARELTO (rivaroxaban)PA		
ANTICONVULSANTS		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. 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)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
Felbamate oral suspension	LAMICTAL (lamotrigine)	
Felbamate tablet	LAMICTAL (lamotrigine) CHEWABLE TABLET	
FYCOMPA (perampanel)	LAMICTAL (lamotrigine) DOSE PACK	
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		
Phenytoin ER capsule		
Phenytoin suspension		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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		
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 pharmaceutically 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.		
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)***		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Rivastigmine		
ANTIDEPRESSANTS - NEW GENERATION		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. 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	Desvenlafaxine ER	
Citalopram oral solution	Desvenlafaxine fumarate ER	
Clomipramine	Desvenlafaxine succinate ER - labelers 00591, 51991, 68180	
Desvenlafaxine succinate ER - labeler 59762	EFFEXOR XR (venlafaxine)	
Duloxetine	FORFIVO XL (bupropion)	
Escitalopram	IRENKA (duloxetine)	
Escitalopram oral solution	KHEDEZLA ER (desvenlafaxine)	
FETZIMA (levomilnacipran)	LEXAPRO (escitalopram)	
Fluoxetine capsule	LEXAPRO (escitalopram) ORAL SOLUTION	
Fluoxetine DR	PAXIL (paroxetine)	
Fluoxetine solution	PAXIL CR (paroxetine)	
Fluoxetine tablet	PRISTIQ ER (desvenlafaxine)	
Fluvoxamine	PROZAC (fluoxetine)	
Fluvoxamine ER	venlafaxine ER tablets	
Nefazodone	WELLBUTRIN (bupropion)	
OLEPTRO ER (trazodone)	WELLBUTRIN SR (bupropion)	
Paroxetine	WELLBUTRIN XL (bupropion)	
Paroxetine ER	ZOLOFT (sertraline)	
PAXIL (paroxetine) ORAL SUSPENSION	ZOLOFT (sertraline) ORAL CONCENTRATE	
PEXEVA (paroxetine)		

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Sertraline		
Sertraline oral concentrate		
Trazodone		
TRINTELLIX (vortioxetine)		
Venlafaxine ER capsules		
Venlafaxine tablet		
VIIBRYD (vilazodone)		
ANTIRETROVIRALS - NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS		
Abacavir	EPIVIR (lamivudine)	
Abacavir/lamivudine	EPZICOM (abacavir)	
Abacavir/lamivudine/zidovudine	TRIZIVIR (abacavir/lamivudine)	
ATRIPLA (efavirenz/emtricitabine/tenofovir)	VIDEX EC (didanosine)	
COMBIVIR (lamivudine/zidovudine)	VIREAD (tenofovir)	
COMPLERA (emtricitabine/rilpivirine/tenofovir)	ZERIT (stavudine)	
DESCOVY (emtricitabine/tenofovir)	ZIAGEN (abacavir)	
Didanosine		
EMTRIVA (emtricitabine)		
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)		
Lamivudine		
Lamivudine/zidovudine		
ODEFSEY (emtricitabine/rilpivirine/tenofovir)		
RETROVIR (zidovudine)		
Stavudine		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)		
Tenofovir		
TRIUMEQ (abacavir/dolutegravir/lamivudine)		
TRUVADA (emtricitabine/tenofovir)		
VIDEX (didanosine)		
Zidovudine		
ANTIRETROVIRALS - PROTEASE INHIBITORS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
APTIVUS (tipranavir)	KALETRA (lopinavir/ritonavir)	
CRIXIVAN (indinavir)		
EVOTAZ (atazanavir/cobicistat)		
GENVOYA (elvitegravir, cobicistat, emtricitabine and tenofovir)		
INVERASE (saquinavir)		
LEXIVA (fosamprenavir)		
lopinavir/ritonavir		
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 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. 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 - labelers 00406, 16729, 49884, 52817	
FANAPT (iloperidone)	RISPERDAL (risperidone)	
FAZACLO (clozapine) RAPDIS	RISPERDAL (risperidone) ORAL SOLUTION	
LATUDA (lurasidone)	RISPERDAL M-TAB (risperidone)	
Olanzapine	SEROQUEL (quetiapine)	
Olanzapine ODT	SEROQUEL XR (quetiapine)	

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Olanzapine/fluoxetine	ZYPREXA (olanzapine)	
Paliperidone ER	ZYPREXA ZYDIS (olanzapine)	
Quetiapine		
quetiapine ER - labeler 00310		
REXULTI (brexpiprazole)		
Risperidone		
Risperidone ODT		
Risperidone oral solution		
SAPHRIS (asenapine)		
SEROQUEL XR (quetiapine) 400mg		
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. For idiopathic constipation, a 30 day trial of all preferred agents will be required before a non-preferred 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
LINZESS (linaclotide)PA***	RELISTOR (methylnaltrexone) SYRINGE***	
	RELISTOR (methylnaltrexone) TABLET***	
	RELISTOR (methylnaltrexone) VIAL***	
	SYMPROIC (naldemedine)	
	TRULANCE (plecanatide)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		Relistor tablets will be authorized
COPD		
Category PA Criteria: 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		
Group PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
SPIRIVA (tiotropium)	INCRUSE ELLIPTA (umeclidinium)	***SPIRIVA RESPIMAT 2.5 MG (tiotropium) will require a 30 day trial of Incruse Ellipta and Tudorza Pressair in addition to Category PA Criteria
	SEEBRI NEOHALER (glycopyrrolate)	
	SPIRIVA RESPIMAT 2.5 MG (tiotropium)***	
	TUDORZA PRESSAIR (aclidinium)	
Long Acting Beta Agonists		
PERFOROMIST (formoterol)	ARCAPTA NEOHALER (indacaterol)***	***Arcapta Neohaler/Striverdi Respimat will require a 30 day trial of Serevent in addition to Category PA Criteria ***Brovana will require a 30 day trial of Perforomist in addition to Category PA Criteria
SEREVENT (salmeterol)	BROVANA (arformoterol)***	
	STRIVERDI RESPIMAT (olodaterol)***	
Combination Anticholinergics/Long Acting Beta Agonists		
Group PA Criteria: All preferred agents indicated only for COPD will require verification of FDA-approved indication for patients who are younger than 40 years of age. A 30-day trial of 2 long acting preferred products will be required before a non-preferred agent (short or long acting) will be authorized.		
Albuterol/ipratropium	COMBIVENT RESPIMAT (albuterol/ipratropium)	
ANORO ELLIPTA (umeclidinium/vilanterol)	DUONEB (albuterol/ipratropium)	
BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	STIOLTO RESPIMAT (tiotropium/olodaterol)	
	UTIBRON NEOHALER (glycopyrrolate/indacaterol)	
Combination Steroid/Anticholinergics/Long Acting Beta Agonists		
Group PA Criteria: In addition to the category PA criteria, patient must a 30 day trial of all preferred agents in the following combinations: 1. Steroid/Long Acting Beta Agonist (LABA) Combination Inhalers + Long Acting Anticholinergics 2. Combination Anticholinergics/Long Acting Beta Agonist + Inhaled Steriod		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	TRELEGY ELLIPTA (Fluticasone Furoate/Umeclidinium/Vilanterol)	
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 a 30 day trial with a medication in each of the following therapeutic classes from either single ingredient or combination products: 1. Long acting anticholinergic 2. Long acting beta agonist 3. Inhaled Steroid		
	DALIRESP (roflumilast)	
CYSTIC FIBROSIS INHALED ANTIBIOTICS		
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 less than 1 second (FEV1) of less than 40% or greater than 80% predicted. Patient must not have been colonized with *Burkholderia cepacia.*
KITABIS PAK (tobramycin/nebulizer)	TOBI PODHALER (Tobramycin)***	
	Tobramycin***	
	TOBI (Tobramycin)***	
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)	
ENBREL (etanercept)[PA]	CIMZIA (certolizumab)	
HUMIRA (adalimumab)[PA]	KEVZARA (sarilumab)	
HUMIRA PSORIASIS (adalimumab)[PA]	KINERET (anakinra)	
	ORENCIA (abatacept)	
	OTEZLA (apremilast)	
	SILIQ (brodalumab)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	SIMPONI (golimumab)	
	STELARA (ustekinumab)	
	TALTZ (ixekizumab)	
	TREMFYA (guselkumab)	
	XELJANZ (tofacitinib)	
	XELJANZ XR (tofacitinib)	
DIABETES - DPP4 INHIBITORS		
Category PA Criteria: Non preferred agents will require: 1. An FDA indication. 2. A 3-month trial of a metformin 3. A 30 day trial of 1 sitagliptin preferred product (Janumet, Janumet XR, or Januvia) and 1 linagliptin preferred product (Jentadueto or Tradjenta). 4. Concurrent metformin therapy – this condition will be considered met if requested product is a metformin combination agent.		
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	
JANUVIA (sitagliptin)	alogliptin/metformin	
JENTADUETO (linagliptin/metformin)	JENTADUETO XR (linagliptin/metformin)	
KOMBIGLYZE XR (saxagliptin/metformin)	KAZANO (alogliptin/metformin)	
ONGLYZA (saxagliptin)[PA***]	NESINA (alogliptin)	
TRADJENTA (linagliptin)	OSENI (alogliptin/pioglitazone)	
DIABETES - DPP4 INHIBITORS/SGLT2 INHIBITOR COMBINATIONS		
Category PA Criteria: Non preferred agents will require: 1. An FDA indication. 2. A 3-month trial of a metformin 3. A 30 day trial of a canagliflozin and a 3-month trial of a empagliflozin agent. 4. A 30 day trial of 1 sitagliptin preferred product (Janumet, Janumet XR, or Januvia) and 1 linagliptin preferred product (Jentadueto or Tradjenta). 5. Concurrent metformin therapy – this condition will be considered met if requested product is a metformin combination agent.		
	QTERN (Dapagliflozin/Saxagliptin)	
DIABETES - GLP1 AGONISTS		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: Preferred agents will require: 1. Concurrent metformin therapy. 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)	ADLYXIN (lixisenatide)	
BYETTA (exenatide)	BYDUREON BCISE (exenatide microspheres)	
VICTOZA (liraglutide)	OZEMPIC (semaglutide)	
	TANZEUM (albiglutide)	
	TRULICITY (dulaglutide)	
DIABETES - INSULIN/GLP1 AGONISTS		
Category PA Criteria: 1. A 30-day trial of exenatide and liraglutide GLP-1 agonists in combination with each of insulin glargine and insulin detemir insulins 2. An FDA indication. 3. Concurrent metformin therapy. 4. A 3-month trial of metformin		
	SOLIQUA (Insulin glargine/lixisenatide)	
	XULTOPHY (insulin degludec/liraglutide)	
DIABETES - INSULIN		
Syringe/Pens: • Prescriber must provide a reason why patient needs to use a syringe/pen instead of a vial, subject to clinical review **Vials of non-preferred insulin:** • Patient must have failed a 30 day trial of a preferred insulin: Humalog, Humalox Mix 50/50, Humalog Mix 75/25, Humulin 70/30, Humulin N, Humulin R, Humulin R U-500, Lantus, Levemir, Novolin R, Novolog, or Novolog Mix 70/30, as evidenced by paid claims or pharmacy print outs.		
APIDRA (insulin glulisine) VIAL	AFREZZA (insulin regular, human)	***Fiasp

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	BASAGLAR KWIKPEN U-100 (insulin glargine)***	•Patient must have had 3 month trial with Novolog, Humalog, and Apidra ***Tresiba U-1 00 & Basaglar: •Patient must fail a 3 month trial of both Lantus and Levemir with good compliance, as evidenced by paid claims or pharmacy print outs. ***Toujeo/Tresiba U-200: •Patient must require a minimum of 100 units/day of Lantus or Levemir for a minimum of 3 months with good compliance, as evidenced by paid claims or pharmacy print outs.
HUMALOG (insulin lispro) VIAL	FIASP (insulin aspart) FLEXTOUCH***	
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	FIASP (insulin aspart) VIAL***	
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	HUMALOG (insulin lispro) CARTRIDGE	
HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL	HUMALOG (insulin lispro) KWIKPEN	
HUMULIN N (insulin NPH human isophane) VIAL	HUMALOG JUNIOR KWIKPEN (insulin lispro)	
HUMULIN R (insulin regular, human) VIAL	HUMALOG MIX 50/50 (insulin NPL/insulin lispro) KWIKPEN	
HUMULIN R U-500 (insulin regular, human) VIAL	HUMALOG MIX 75/25 (insulin NPL/insulin lispro) KWIKPEN	
LANTUS (insulin glargine) SOLOSTAR	HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN	
LANTUS (insulin glargine) VIAL	HUMULIN N (insulin NPH human isophane) KWIKPEN	
LEVEMIR (insulin detemir) VIAL	HUMULIN R (Insulin regular, human) U-500 KWIKPEN	
LEVEMIR (insulin detemir) FLEXTOUCH	NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL	
NOVOLIN R (insulin regular, human) VIAL	NOVOLIN N (insulin NPH human isophane) VIAL	
NOVOLOG (insulin aspart) CARTRIDGE	TOUJEO SOLOSTAR (insulin glargine)***	
NOVOLOG (insulin aspart) FLEXPEN	TRESIBA (insulin degludec) FLEXTOUCH U-100***	
NOVOLOG (insulin aspart) VIAL	TRESIBA (insulin degludec) FLEXTOUCH U-200***	
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN		
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL		
DIABETES - SGLT2 INHIBITORS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: Non-preferred agents will require: 1. An FDA indication. 2. A 3-month trial of a metformin 3. A 30 day trial of a canagliflozin and a 30 day 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)	
INVOKANA (canagliflozin)	GLYXAMBI (empagliflozin/linagliptin)	
JARDIANCE (empagliflozin)	INVOKAMET XR (canagliflozin/metformin)	
SYNJARDY (empagliflozin/metformin)	XIGDUO XR (dapagliflozin/metformin)	
SYNJARDY XR (empagliflozin/metformin)		
DIARRHEA - IRRITABLE BOWEL SYNDROME		
Category PA Criteria: Patient must be 18 years of age or older. A 30-day trial of all preferred agents will be required before a non-preferred medication will be approved.		
loperimide	alosetron***	***Alosetron– Patient must be a female.
LOTRONEX (alosetron)***		
VIBERZI (eluxadoline)		
XIFAXIN (rifaximin) 550 mg tablet		
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)	
	ULTRESA (lipase/protease/amylase)	
	VIOKACE (lipase/protease/amylase)	
EPINEPHRINE AUTOINJECTORS		
Category PA Criteria: Medical justification must be provided for why the preferred product will not work.		
epinephrine - labeler 49502	ADRENACLICK (epinephrine)	
	epinephrine - labelers 00115, 54505	
	EPIPEN (epinephrine)	
	EPIPEN JR (epinephrine)	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
GROWTH HORMONE		
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. Additional criteria applies. For details, see http://hidesigns.com/assets/files/ndmedicaid/2017/Criteria/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, COLONY STIMULATING FACTORS		
GRANIX (TBO-Filgrastim)		
LEUKINE (Sargramostim)		
NEULASTA (Pegfilgrastim)		
NEUPOGEN (Filgrastim)		
ZARXIO (Filgrastim-SNDZ)		
HEMATOPOIETIC, ERYTHROPOIESIS STIMULATING AGENTS		
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)	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
HEPATITIS C TREATMENTS		
Category PA Criteria: Non-preferred agents will require a failed trial of all preferred treatment options indicated for the patient's genotype and be labeled for failure of previous treatment. 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. HCV RNA level must be taken on week 4 and sent with a renewal request for any duration of treatment 12 weeks or longer. 7. Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment. 8. Patient must have established compliant behavior including attending scheduled provider visits (defined as 1 or less no-shows) and filling maintenance medications on time as shown in the prescription medication history for the past 12 months. 9. 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. 10. Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions. 11. PA approval duration will be based on label recommendation.		
EPCLUSA (sofosbuvir/velpatasvir)PA***	DAKLINZA (Daclatasvir)	***Epclusa: • Must be used with ribavirin for patients with decompensated cirrhosis (Child-Pugh B or Child-Pugh C). ***Mavyret/Vosevi: • Patient must not have decompensated cirrhosis (Child-Pugh B or Child-Pugh C)
MAVYRET (glecaprevir/pibrentasvir)PA***	HARVONI (ledipasvir/sofosbuvir)	
	OLYSIO (simeprevir)	
	SOVALDI (sofosbuvir)	
	TECHNIVIE (ombitasvir/paritaprevir/ritonavir)	
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)	
	VIEKIRA PAK XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)	
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)	
	ZEPATIER (elbasvir/grazoprevir)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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.		
EURAX (crotamiton) CREAM	ELIMITE (permethrin) CREAM	
LICE SOLUTION (piperonyl butoxide/pyrethrins)	EURAX (crotamiton) LOTION	
NATROBA (spinosad)	Malathion	
Permethrin cream	OVIDE (malathion)	
SKLICE (ivermectin)	Spinosad	
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	Eletriptan	
	FROVA (frovatriptan)***	
	Frovatriptan	
	IMITREX (sumatriptan) CARTRIDGE***	
	IMITREX (sumatriptan) PEN INJCTR***	
	IMITREX (sumatriptan) SPRAY	
	IMITREX (sumatriptan) TABLET	
	IMITREX (sumatriptan) VIAL***	
	MAXALT (rizatriptan)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	MAXALT MLT (rizatriptan)	
	Naratriptan	
	ONSETRA XSAIL (sumatriptan)***	
	Sumatriptan cartridge***	
	Sumatriptan pen injctr***	
	Sumatriptan spray	
	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) PEN	EXTAVIA (interferon beta-1B)	
AVONEX (interferon beta-1A) SYRINGE	PLEGRIDY (peginterferon beta-1A) PEN	
AVONEX (interferon beta-1A) VIAL	PLEGRIDY (peginterferon beta-1A) SYRINGE	
BETASERON (interferon beta-1B)	REBIF (interferon beta-1A)	
	REBIF REBIDOSE (interferon beta-1A)	
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***	***Zinbryta: • Transaminase and bilirubin levels must have been obtained within 6 months of request. • Patient must not have hepatitis B or C.
	Glatopa (glatiramer)***	
	ZINBRYTA (daclizumab)***	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		• 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 ALPHA ADRENERGICS - GLAUCOMA		
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)	Apraclonidine	
ALPHAGAN P 0.15% (brimonidine)	brimonidine 0.15%	
brimonidine 0.2%	IOPIDINE (apraclonidine)	
COMBIGAN (brimonidine/timolol)		
SIMBRINZA (brinzolamide/brimonidine)		
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)	EMADINE (emedastine)	
Azelastine	Olopatadine 0.2%	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
BEPREVE (bepotastine)	PATANOL 0.1% (olopatadine)	
Cromolyn		
Epinastine		
LASTACAFT (alcaftadine)		
Olopatadine 0.1%		
PATADAY 0.2% (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	Bacitracin ointment	
Bacitracin/polymyxin ointment	BLEPH-10 (sulfacetamide) DROPS	
BESIVANCE (besifloxacin) DROPS	CILOXAN (ciprofloxacin) DROPS	
CILOXAN (ciprofloxacin) OINTMENT	Gatifloxacin drops	
Ciprofloxacin drops	GENTAK (gentamicin sulfate) OINTMENT	
Erythromycin ointment	Levofloxacin drops	
Gentamicin sulfate drops	moxifloxacin drops	
Gentamicin sulfate ointment	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) OINTMENT	
MOXEZA (moxifloxacin) 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	Sulfacetamide ointment	
Sulfacetamide drops	TOBREX (tobramycin) DROPS	
Tobramycin drops	VIGAMOX (moxifloxacin) DROPS	
TOBREX (tobramycin) OINTMENT	ZYMAXID (gatifloxacin) 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.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Neomycin/bacitracin/polymyxin b/hydrocortisone ointment	BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone) ointment	
BLEPHAMIDE (sulfacetamide/prednisolone) DROPS	MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS	
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)	
Diclofenac sodium	Bromfenac sodium	
FLAREX (fluorometholone)	BROMSITE (bromfenac sodium)	
Fluorometholone	Dexamethasone sodium phosphate	
Flurbiprofen sodium	DUREZOL (difluprednate)	
FML FORTE (fluorometholone)	FML (fluorometholone)	
FML S.O.P. (fluorometholone)	LOTEMAX (loteprednol) GEL DROPS	
ILEVRO (nepafenac)	LOTEMAX (loteprednol) OINTMENT	
ketorolac tromethamine 0.4%	NEVANAC (nepafenac)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Ketorolac tromethamine 0.5%	OCUFEN (flurbiprofen)	
LOTEMAX (loteprednol) DROPS	OMNIPRED 1% (prednisolone acetate)	
MAXIDEX (dexamethasone)	PRED FORTE 1% (prednisolone acetate)	
PRED MILD 0.12% (prednisolone acetate)	Prednisolone acetate 1%	
Prednisolone sodium phosphate 1%	PROLENSA (bromfenac)	
OPHTHALMIC IMMUNOMODULATORS - DRY EYE SYNDROME		
Restasis (cyclosporine)		
Restasis multidose (cyclosporine)		
Xiidra (lifitegrast)		
OPIOID ANALGESIC - LONG ACTING		
Category PA Criteria: For non-preferred agents to be authorized: 1. Patient must have required around-the-clock pain relief for the past 90 days 2. The past 3 months of North Dakota PDMP reports must have been reviewed by the prescriber.		
butorphanol	ARYMO ER (oxycodone)***	*** Hysingla ER, oxymorphone ER, Zohydro ER require 30-day trials of fentanyl, morphine, and oxycodone products in addition to Category PA Criteria ***Belbuca- Patient must have failed 30-day trials of Butrans, Nucynta ER, and tramadol ER in additional 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. Patient must have failed 30-day trials of fentanyl, morphine, and oxycodone products in addition to Category PA Criteria ***Methadone, Fentanyl Patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr, morphine ER capsules, Arymo ER, Morphabond ER, and Oxycontin - Clinical justification must be given for why another product will not work in additional to Category PA Criteria. *** Fentanyl 12 mcg/hr – The total daily opioid dose must be less than 60 Morphine Equivalent Dose (MED) in additional to
BUTRANS (buprenorphine) PATCHES	BELBUCA (buprenorphine)***	
EMBEDA (morphine/naltrexone)	buprenorphine patches	
Fentanyl 12 mcg/hr[PA***]	DURAGESIC (fentanyl)	
Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	EXALGO (hydromorphone)***	
levorphanol	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)***	
pentazocine-naloxone	KADIAN (morphine)***	
	Methadone***	
	MORPHABOND ER (morphine)***	
	Morphine ER capsules***	
	MS CONTIN (morphine)	
	Oxycodone ER***	
	OXYCONTIN (oxycodone)***	
	Oxymorphone ER tablets***	
	Tramadol ER	
	ULTRAM ER (tramadol ER)	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	XTAMPZA ER (oxycodone)***	Category PA Criteria ***Tramadol ER Patient must have failed two 30-day trials of preferred medications in additional to Category PA Criteria ***Xtampza ER - Patient must have failed 30-day trials of fentanyl and morphine products in addition to Category PA Criteria
	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 the last 3 months of North Dakota PDMP reports must have been reviewed by the prescriber. 7. The prescriber must be enrolled with ND Medicaid.		
ZUBSOLV (buprenorphine/naloxone)[PA]	BUNAVAIL FILM (buprenorphine/naloxone)***	*** Bunavail/Suboxone Film 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 2 preferred agents will be required before a non-preferred agent will be authorized. A 7-day trial of 2 preferred generics of the same medication will satisfy this requirement.		
CIPRO HC (ciprofloxacin/hydrocortisone)	FLOXIN (ofloxacin)	
CIPRODEX (ciprofloxacin/dexamethasone)	Ofloxacin drops	
OTOVEL (ciprofloxacin/fluocinolone)		
PHOSPHATE BINDERS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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.		
Calcium acetate capsule	AURYXIA (ferric citrate) TABLET	
Calcium acetate tablet	ELIPHOS (calcium acetate) TABLET	
FOSRENOL (lanthanum) 500 MG AND 750 MG CHEWABLE TABLET	FOSRENOL (lanthanum) 1000 MG CHEWABLE TABLET	
PHOSLYRA (calcium acetate) ORAL solution	FOSRENOL (lanthanum) POWDER PACK	
RENAGEL (sevelamer) TABLET	Lanthanum	
RENVELA (sevelamer carbonate) TABLET	sevelamer powder pack	
RENVELA (sevelamer) POWDER PACK	VELPHORO (sucroferric oxyhydroxide)	
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)	Clopidogrel 300mg	
Clopidogrel 75 mg	DURLAZA (aspirin ER)***	
Dipyridamole	EFFIENT (prasugrel)	
Ticlopidine	PERSANTINE (dipyridamole)	
	PLAVIX (clopidogrel)	
	prasugrel	
	YOSPRALA DR (aspirin/omeprazole)***	
	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. Patient cannot be taking nitrates of any form.		
Sildenafil[PA]	REVATIO (sildenafil) SUSPENSION***	***Revatio Suspension – Patients 7 years and older will be required to submit documentation of their inability to ingest a
ADCIRCA (tadalafil)	REVATIO (sildenafil) TABLET	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		solid dosage form.
Soluble Guanylate Cyclase Stimulators		
Category PA Criteria: All medications require an FDA-approved indication. 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. Patient may not be taking with nitrates of any form or specific (sildenafil or tadalafil) or non-specific (dipyridamole or theophylline) PDE-5 inhibitors.		
ADEMPAS (riociguat)PA		
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: All medications require an FDA-approved indication. A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
ORENITRAM ER (treprostinil)PA	TYVASO (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.
REMODULIN (treprostinil)	UPTRAVI (selexipag)	
VENTAVIS (iloprost) 10 mcg/mLPA	VENTAVIS (iloprost) 20 mcg/mL***	
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: EITHER both of 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, or Seebri Neohaler 2. A 30-day trial of Brovana, Arcapta Neohaler, Striverdi Respimat, Perforomist, or Serevent. OR A 30-day trial of Anoro Ellipta, Stiolto Respimat, Utibron NeoHaler, Bevespi Aerosphere, or Trelegy Ellipta For asthma diagnosis, patient must have been reviewed for step down therapy for all renewal requests.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ADVAIR DISKUS (fluticasone/salmeterol)	ADVAIR HFA (fluticasone/salmeterol)	***Airduo Respiclick - Clinical justification must be provided as to why Advair Diskus or Advair HFA will not work
DULERA (mometasone/formoterol)	AIRDUO RESPICLICK (fluticasone/salmeterol)***	
SYMBICORT (budesonide/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)	
	fluticasone/salmeterol	
STEROIDs - INHALED		
Category PA Criteria: Inhalers: A 30-day trial of all preferred inhalers will be required before a non-preferred agent will be authorized. Inhaled suspensions (nebulizers): Non-preferred Brand medication: A 30-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. Non-preferred Generic medication: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized.		
ALVESCO (ciclesonide)	AEROSPAN (flunisolide)	
ASMANEX (mometasone) TWISTHALER	ARMONAIR RESPICLICK (fluticasone)	
budesonide suspension 0.25 mg/2 mL	ARNUITY ELLIPTA (fluticasone)	
budesonide suspension 0.5 mg/2 mL	ASMANEX HFA (mometasone)	
FLOVENT HFA (fluticasone)	budesonide suspension 1 mg/2 mL	
PULMICORT FLEXHALER (budesonide)	FLOVENT DISKUS (fluticasone)	
PULMICORT RESPULES (budesonide) 1 MG/2 ML	PULMICORT RESPULES (budesonide) 0.25 mg/2 mL	
QVAR (beclomethasone)	PULMICORT RESPULES (budesonide) 0.5 mg/2 mL	
	QVAR REDIHALER (beclomethasone)	
ULCERATIVE COLITIS AGENTS - 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		
APRISO (mesalamine) CAPSULE	ASACOL HD (mesalamine)	***Giazo - Patient must be a male.
Balsalazide capsule	AZULFIDINE (sulfasalazine)	
DELZICOL (mesalamine) CAPSULE	AZULFIDINE DR (sulfasalazine)	
DIPENTUM (olsalazine)	COLAZAL (balsalazide)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LIALDA (mesalamine) TABLET	GIAZO (balsalazide)***	
PENTASA (mesalamine)	Mesalamine DR	
Sulfasalazine DR tablet	SULFAZINE (sulfasalazine)	
Sulfasalazine tablet		
Rectal		
CANASA (mesalamine) RECTAL SUPPOSITORY	Mesalamine enema kit	
Mesalamine enema	ROWASA (mesalamine) ENEMA KIT	
SF ROWASA (mesalamine) ENEMA		
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.		
ENABLEX (darifenacin)	Darifenacin ER	***SANCTURA ER/Trospium ER and Myrbetriq will require a 1-month trial of trospium and tolterodine/tolterodine ER in addition to the category PA criteria.
Flavoxate	DETROL (tolterodine)	
GELNIQUE (oxybutynin)	DETROL LA (tolterodine)	
Oxybutynin ER	DITROPAN XL (oxybutynin)	
Oxybutynin syrup	MYRBETRIQ (mirabegron)***	
Oxybutynin tablet	SANCTURA (trospium)	
OXYTROL (oxybutynin) PATCH	SANCTURA ER (trospium)***	
TOVIAZ (fesoterodine)	Tolterodine	
VESICARE (solifenacin)	Tolterodine ER	
	Trospium	
	Trospium ER***	