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. This PDL is subject to change. 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.**

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- This is NOT an all-inclusive list of medications covered by ND Medicaid. Please use the NDC Drug Lookup tool at 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 for PA criteria for medications not found on the PDL.

- Prior authorization criteria applies in addition to the general Drug Utilization Review policy that is in effect for the entire pharmacy program. Refer to http://www.hidesigns.com/ndmedicaid for applicable drug utilization management and coverage rules and therapeutic duplication edits.

- Prior authorization for a non-preferred agent with a preferred brand/generic equivalent in any category will be given only if an authorized generic is not available and all other criteria is met, including all DAW criteria, clinical criteria, and step therapy specific to that category.

- 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.

- 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.

- A trial will be considered a failure if a product was not effective at maximum tolerated dose with good compliance or patient has a documented intolerance or adverse reaction to an ingredient.

- 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**
ADHD AGENTS	amphetamine added to non-preferred	
ATOPIC DERMATITIS		new category added
HEMATOPOIETIC, COLONY STIMULATING FACTORS	NIVESTYM (Filgratim-AAFI) added to non-preferred	
MIGRAINE PROPHYLAXIS - CGRP INHIBITORS	AJOVY (Fremanezumab-vfrm) added to non-preferred	
MIGRAINE PROPHYLAXIS - CGRP INHIBITORS	EMGALITY (Galcanazumab-gnlm) added to non-preferred	
PULMONARY HYPERTENSION - Endothelin Receptor Antagonist	TRACLEER (bosentan) added to preferred	OPSUMIT (macitentan) criteria removed
PULMONARY HYPERTENSION - Endothelin Receptor Antagonist	LETAIRIS (ambrisentan) moved to 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 all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. 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. 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)	*** Clonidine ER will require a 1-month trial of immediate release clonidine.
ADZENYS XR - ODT (amphetamine)	amphetamine	
ADZENYS XR (amphetamine) SOLUTION	DEXEDRINE (dextroamphetamine)	
APTENSIO XR (methylphenidate)	Dexmethylphenidate ER	
Atomoxetine	Dextroamphetamine 5 mg/5 ml	
Clonidine	Dextroamphetamine/amphetamine ER - Labelers 00115, 00228, 00555, 66993	
Clonidine ER[PA***]	FOCALIN (dexmethylphenidate)	
CONCERTA (methylphenidate)	INTUNIV (guanfacine ER)	
COTEMPLA XR - ODT (methylphenidate)	METADATE ER (methylphenidate)	
DAYTRANA (methylphenidate)	METHYLIN (methylphenidate) chew tablets	
DESOXYN (methamphetamine)	methylphenidate ER 72 mg	
Dexmethylphenidate	Methylphenidate ER tablet	
Dextroamphetamine	Methylphenidate solution	
Dextroamphetamine ER	RELEXXII (methylphenidate)	
Dextroamphetamine/amphetamine	RITALIN (methylphenidate)	
Dextroamphetamine/amphetamine ER - Labeler 00781	RITALIN LA (methylphenidate LA capsules - 50-50)	
DYANAVEL XR (amphetamine)	STRATTERA (atomoxetine)	
EVEKEO (amphetamine)	ZENZEDI (dextroamphetamine)	
FOCALIN XR (dexmethylphenidate)		
Guanfacine ER		
KAPVAY (clonidine)		

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Methamphetamine		
METHYLIN (methylphenidate) solution		
Methylphenidate CD 30-70		
Methylphenidate chew tablet		
Methylphenidate ER capsules 50-50		
Methylphenidate LA capsules - 50-50		
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	diclofenac gel	***Solaraze: Patient must have a diagnosis of actinic keratosis and have had a 6 month trial of imiquimod, as evidenced by paid claims or pharmacy print outs
PENNSAID (diclofenac)		
SOLARAZE (diclofenac) GEL[PA***]		
VOLTAREN (diclofenac) GEL		
ANDROGENS		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All agents require an FDA-approved indication.		
ANDROGEL (testosterone) PACKET 1%	AXIRON (testosterone) TOPICAL SOLUTION	
ANDROGEL (testosterone) PACKET 1.62%	FORTESTA (testosterone)	
ANDRODERM (testosterone)	NATESTO (testosterone)	
	TESTIM (testosterone)	
	TESTOPEL (testosterone)	
	Testosterone gel	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	Testosterone Gel MD PMP	
	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)	SAVAYSA (edoxaban)	
ELIQUIS (Apixaban)		
PRADAXA (dabigatran)		
XARELTO (rivaroxaban)		
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	Felbamate oral suspension	
Divalproex sprinkle	FELBATOL (felbamate)	
Divalproex tablet	KEPPRA (levetiracetam)	
Ethosuximide capsule	KEPPRA (levetiracetam) ORAL SOLUTION	

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Ethosuximide oral solution	KEPPRA XR (levetiracetam)	
Felbamate tablet	LAMICTAL (lamotrigine)	
FELBATOL (felbamate) ORAL SUSPENSION	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	vigabatrin powder pack	
Lamotrigine ODT	ZARONTIN (ethosuximide)	
Lamotrigine tablet	ZARONTIN (ethosuximide) ORAL SOLUTION	
Levetiracetam ER	ZONEGRAN (zonisamide)	
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		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Phenytoin suspension		
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 all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. 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.		
Donepezil	ARICEPT (donepezil)	***Namenda XR – A 30-day trial of memantine IR will be required before Namenda XR will be authorized. Patient must not reside in nursing home. ***Non-Solid dosage forms: Patient must be unable to swallow verified by swallow study
Donepezil ODT***	NAMENDA (memantine)	
EXELON (rivastigmine)	NAMZARIC (memantine/donepezil)	
EXELON (rivastigmine) PATCH	RAZADYNE (galantamine)	
Galantamine	RAZADYNE ER (galantamine)	
Galantamine ER	Rivastigmine patch	
Galantamine oral solution***	NAMENDA XR (memantine)	
Memantine		
memantine oral solution***		
Memantine ER***		

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Rivastigmine		
ANTIDEPRESSANTS - NEW GENERATION		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. 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.		
APLENZIN ER (bupropion)	CELEXA (citalopram)	***Non-Solid dosage forms: Patients 9 years old and older must be unable to swallow verified by swallow study
Bupropion SR tablet	CYMBALTA (duloxetine)	
Bupropion tablet	Desvenlafaxine ER	
Bupropion XL tablet	Desvenlafaxine fumarate ER	
Citalopram	duloxetine 40mg	
Citalopram oral solution***	EFFEXOR XR (venlafaxine)	
Clomipramine	FORFIVO XL (bupropion)	
Desvenlafaxine succinate ER	IRENKA (duloxetine)	
Duloxetine 20mg, 30mg, 60mg	KHEDEZLA ER (desvenlafaxine)	
Escitalopram	LEXAPRO (escitalopram)	
Escitalopram oral solution***	LEXAPRO (escitalopram) ORAL SOLUTION	
FETZIMA (levomilnacipran)	PAXIL (paroxetine)	
Fluoxetine capsule	PAXIL CR (paroxetine)	
Fluoxetine DR	PRISTIQ ER (desvenlafaxine)	
Fluoxetine oral solution	PROZAC (fluoxetine)	
Fluoxetine tablet	venlafaxine ER tablets	
Fluvoxamine	WELLBUTRIN (bupropion)	
Fluvoxamine ER	WELLBUTRIN SR (bupropion)	
Nefazodone	WELLBUTRIN XL (bupropion)	
OLEPTRO ER (trazodone)	ZOLOFT (sertraline)	
Paroxetine	ZOLOFT (sertraline) ORAL CONCENTRATE	
Paroxetine ER		
PAXIL (paroxetine) ORAL SUSPENSION***		
PEXEVA (paroxetine)		
Sertraline		
Sertraline oral concentrate***		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Trazodone		
TRINTELLIX (vortioxetine)		
Venlafaxine ER capsules		
Venlafaxine tablet		
VIIBRYD (vilazodone)		
ANTIRETROVIRALS - INTEGRASE STRAND TRANSFER INHIBITORS		
BIKTARVY (bictegravir/Emtricitabine/Tenofovir)		
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)		
ISENTRESS (raltegravir)		
JULUCA (dolutegravir/rilpivirine)		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)		
TIVICAY (dolutegravir)		
TRIUMEQ (abacavir/dolutegravir/lamivudine)		
ANTIRETROVIRALS - NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. 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.		
Abacavir	COMBIVIR (lamivudine/zidovudine)	
Abacavir/lamivudine	EPIVIR (lamivudine)	
Abacavir/lamivudine/zidovudine	EPZICOM (abacavir)	
ATRIPLA (efavirenz/emtricitabine/tenofovir)	RETROVIR (zidovudine)	
BIKTARVY (bictegravir/Emtricitabine/Tenofovir)	TRIZIVIR (abacavir/lamivudine)	
CIMDUO (lamivudine/tenofovir)	VIDEX EC (didanosine)	
COMPLERA (emtricitabine/rilpivirine/tenofovir)	VIREAD (tenofovir)	
DESCOVY (emtricitabine/tenofovir)	ZERIT (stavudine) CAPSULE	
Didanosine	ZIAGEN (abacavir)	
EMTRIVA (emtricitabine)		
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)		

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Lamivudine		
Lamivudine/zidovudine		
ODEFSEY (emtricitabine/rilpivirine/tenofovir)		
SYMFI (efavirenz/lamivudine/tenofovir)		
SYMFI LO (efavirenz/lamivudine/tenofovir)		
Stavudine		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)		
SYMTUZA (darumavir/cobicistat/emtricitabine/tenofovir)		
Tenofovir		
TRIUMEQ (abacavir/dolutegravir/lamivudine)		
TRUVADA (emtricitabine/tenofovir)		
VIDEX (didanosine)		
ZERIT (stavudine) SOLUTION		
Zidovudine		
ANTIRETROVIRALS - PROTEASE INHIBITORS		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. 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.		
APTIVUS (tipranavir)	KALETRA (lopinavir/ritonavir) SOLUTION	
atazanavir	REYATAZ (atazanavir) CAPSULE	
CRIXIVAN (indinavir)	ritonavir	
EVOTAZ (atazanavir/cobicistat)		
INVIRASE (saquinavir)		
KALETRA (lopinavir/ritonavir) TABLET		
LEXIVA (fosamprenavir)		
lopinavir/ritonavir solution		
NORVIR (ritonavir)		
PREZCOBIX (darunavir/cobicistat)		

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PREZISTA (darunavir)		
REYATAZ (atazanavir) POWDER PACK		
SYMTUZA (darumavir/cobicistat/emtricitabine/tenofovir)		
VIRACEPT (nelfinavir)		
ATYPICAL ANTIPSYCHOTICS		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. 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.		
aripiprazole solution***	ABILIFY (aripiprazole)	***Non-Solid dosage forms: Patients 9 years old and older must be unable to swallow verified by swallow study ***Olanzapine/fluoxetine: Plan prefers individual drugs prescribed separate
Aripiprazole	ABILIFY DISCMELT (aripiprazole)***	
Aripiprazole ODT***	CLOZARIL (clozapine)	
Clozapine	FAZACLO (clozapine) RAPDIS***	
Clozapine ODT***	GEODON (ziprasidone)	
FANAPT (iloperidone)	INVEGA ER (paliperidone)	
LATUDA (lurasidone)	Olanzapine/fluoxetine***	
Olanzapine	RISPERDAL (risperidone)	
Olanzapine ODT***	RISPERDAL (risperidone) ORAL SOLUTION***	
Paliperidone ER	RISPERDAL M-TAB (risperidone)***	
Quetiapine	SEROQUEL (quetiapine)	
quetiapine ER	SEROQUEL XR (quetiapine)	
REXULTI (brexpiprazole)	SYMBYAX (olanzapine/fluoxetine)	
Risperidone	ZYPREXA (olanzapine)	
Risperidone ODT***	ZYPREXA ZYDIS (olanzapine)***	
Risperidone oral solution***		
SAPHRIS (asenapine)		
VRAYLAR (cariprazine)		
Ziprasidone		
ATYPICAL ANTIPSYCHOTICS - LONG ACTING		
ABILIFY MAINTENA (aripiprazole)		
ARISTADA (aripiprazole lauroxil)		

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ARISTADA INITIO (aripiprazole lauroxil)		
INVEGA SUSTENNA (paliperidone)		
INVEGA TRINZA (paliperidone)		
RISPERDAL CONSTA (risperidone)		
ZYPREXA RELPREVV (olanzapine)		
ATOPIC DERMATITIS		
Category PA Criteria: Patient must have a FDA approved indication and age. A complete preferred drug list of topical corticosteroids may be found at: http://www.hidesigns.com/assets/files/ndmedicaid/2018/Criteria/PA_Criteria.pdf		
DERMA-SMOOTH-FS (Fluocinolone Acetonide) OIL 0.01%	Fluocinolone Acetonide Oil 0.01%	***Eucrisa: Patient must have had a 30 day trial within the past 180 days of either a topical calcineurin inhibitor (tacrolimus or pimecrolimus) or corticosteroid ***Dupixent: Patient must have had both a 6 week trial of a topical calcineurin inhibitor (tacrolimus or pimecrolimus) and a 30 day trial of at least a medium strength topical corticosteroid (or low strength if area is on face, groin, axilla, or under occlusion) ***Protopic: 0.1% strength is indicated for adults only
DUPIXENT (dupilumab)***	tacrolimus 0.03%	
ELIDEL (pimecrolimus) CREAM	tacrolimus 0.1%	
EUCRISA (crisaborole) OINTMENT***		
PROTOPIC (tacrolimus) OINTMENT 0.03%		
PROTOPIC (tacrolimus) OINTMENT 0.1%***		
CONSTIPATION - IRRITABLE BOWEL SYNDROME/OPIOID INDUCED		
Category PA Criteria: Patients must be 18 years old. All medications will require an FDA indication. For idiopathic constipation: -A 30 day trial of both Amitiza and Linzess will be required before a non-preferred agent will be authorized. For opioid-induced constipation: a paid claim for an opioid must be on patient's profile Patients able to swallow: -A 30 day trial of Amitiza will be required before a non-preferred oral agent will be authorized. Patients not able to take oral medications (as evidenced by swallow study documentation): -A 30-day trial of Relistor vial will be required prior to non-preferred medication		
AMITIZA (lubiprostone)	MOVANTIK (naloxegol)	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LINZESS (linaclotide)[PA***]	RELISTOR (methylnaltrexone) SYRINGE***	***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
RELISTOR (methylnaltrexone) VIAL[PA***]	RELISTOR (methylnaltrexone) TABLET***	
	SYMPROIC (naldemedine)	
	TRULANCE (plecanatide)	
COPD		
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. All non-preferred agents indicated only for COPD will require verification of FDA-approved indication.		
SPIRIVA HANDIHALER (tiotropium)	INCRUSE ELLIPTA (umeclidinium)	***Lonhala Magnair - Patients must have both of the following: - A failure of a 30 day trial of two inhaled, long-acting anticholenergic products before Lonhala Magnair will be authorized. One agent must be Spiriva Respimat. -Clinical justification must be given for why another product will not work in addition to Category PA Criteria. ***Seebri Neohaler - A 30 day trial of Incruse Ellipta will be required before Seebri Neohaler is authorized. Clinical justification must be given for why another product will not work in addition to Category PA Criteria.
TUDORZA PRESSAIR (aclidinium)	LONHALA MAGNAIR (glycopyrrolate)***	
	SEEBRI NEOHALER (glycopyrrolate)***	
	SPIRIVA RESPIMAT 2.5 MG (tiotropium)	
Long Acting Beta Agonists		
Group PA Criteria: All agents indicated only for COPD will require verification of FDA-approved indication.		
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)***	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Combination Anticholinergics/Beta Agonists		
Group PA Criteria: 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. All agents indicated only for COPD will require verification of FDA-approved indication.		
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 have an FDA approved indication and 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 Steroid		
	TRELEGY ELLIPTA (Fluticasone Furoate/Umeclidinium/Vilanterol)	
PDE4 - Inhibitor		
Group PA Criteria: In addition to the category PA criteria, patient must have an FDA approved indication, 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.
KITABIS PAK (tobramycin/nebulizer)	TOBI PODHALER (Tobramycin)***	
	Tobramycin***	
	TOBI (Tobramycin)***	

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		***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.*
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)	ACTEMRA (tocilizumab)	***Stelara - For the diagnosis of Chron's disease, Category PA Criteria must be met. Remicade can be given and billed on the medical side. For all other indications, patient must fail a 3-month trial of one non-preferred agent in addition to Category PA Criteria. ***Ilumya, Siliq, Taltz, Tremfya - Patient must fail a 3-month trial of one non-preferred agent in addition to Category PA Criteria ***Kevzara, Orencia, Olumiant - Patient must fail a 3-month trial of 2 non-preferred agents in addition to all preferred agents
ENBREL (etanercept)	CIMZIA (certolizumab)	
HUMIRA (adalimumab)	ILUMYA (tildrakizumab-asmn)	
	KEVZARA (sarilumab)***	
	KINERET (anakinra)	
	OLUMIANT (baricitinib)***	
	ORENCIA (abatacept)***	
	OTEZLA (apremilast)	
	SILIQ (brodalumab)***	
	SIMPONI (golimumab)	
	STELARA (ustekinumab)***	
	TALTZ (ixekizumab)***	
	TREMFYA (guselkumab)***	
	XELJANZ (tofacitinib)	
	XELJANZ XR (tofacitinib)	
DIABETES - DPP4 INHIBITORS		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: All agents will require: 1. A diagnosis of an FDA-approved indication for use 2. One of the following: A: The requested agent is a combination product containing metformin B: The patient has been stable on metformin with good compliance over the past 3 months, as evidenced by paid claims or pharmacy print-outs AND the patient will be taking metformin concurrently with the requested agent In addition, non-preferred agents will require: 3. A failed trial of each of the following: a. 30 days of 1 sitagliptin preferred product (Janumet, Janumet XR, or Januvia) b. 30 days of 1 linagliptin preferred product (Jentadueto or Tradjenta) c. 30 days of Victoza		
JANUMET (sitagliptin/metformin)	alogliptan/pioglitizone	
JANUMET XR (sitagliptin/metformin)	alogliptin	
JANUVIA (sitagliptin)	alogliptin/metformin	
JENTADUETO (linagliptin/metformin)	JENTADUETO XR (linagliptin/metformin)	
TRADJENTA (linagliptin)	JUVISYNC (sitagliptin/simvastatin)	
	KAZANO (alogliptin/metformin)	
	KOMBIGLYZE XR (saxagliptin/metformin)	
	NESINA (alogliptin)	
	ONGLYZA (saxagliptin)	
	OSENI (alogliptin/pioglitazone)	
DIABETES - DPP4 INHIBITORS/SGLT2 INHIBITOR COMBINATIONS		
Category PA Criteria: The prescriber must provide medical justification explaining why the patient cannot use individual preferred products separately		
	GLYXAMBI (empagliflozin/linagliptin)	
	STEGLUJAN (Ertugliflozin/Sitagliptin)	
	QTERN (Dapagliflozin/Saxagliptin)	
DIABETES - GLP1 AGONISTS		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: All agents will require: 1. A diagnosis of an FDA-approved indication for use 2. The patient has been stable on metformin with good compliance over the past 3 months, as evidenced by paid claims or pharmacy print-outs 3. The patient will be taking metformin concurrently with the requested agent Non preferred agents will require: 1. A 30-day trial of 2 preferred agents.		
VICTOZA (liraglutide)	ADLYXIN (lixisenatide)	
BYDUREON (exenatide microspheres)	BYDUREON BCISE (exenatide microspheres)	
BYETTA (exenatide)	OZEMPIC (semaglutide)	
	TANZEUM (albiglutide)	
	TRULICITY (dulaglutide)	
DIABETES - INSULIN/GLP1 AGONISTS		
Category PA Criteria: The prescriber must provide medical justification explaining why the patient cannot use individual preferred products separately		
	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 **Non-preferred insulin:** •The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review).		
APIDRA (insulin glulisine) VIAL	ADMELOG (insulin lispro) VIAL	***Fiasp •Patient must have had 3 month trial with Novolog, Humalog, and Apidra ***Basaglar: •The prescriber must submit medical justification explaining why the patient cannot use the preferred
APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	ADMELOG SOLOSTAR (insulin lispro) INSULIN PEN	
HUMALOG (insulin lispro) VIAL	AFREZZA (insulin regular, human)	
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	BASAGLAR KWIKPEN U-100 (insulin glargine)***	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	FIASP (insulin aspart) FLEXTOUCH***	product (subject to clinical review). ***Toujeo/Tresiba - Initial Criteria: Approval 6 months 1. Patient must have one of the following: a. Recurrent episodes of hypoglycemia on Insulin glargine U100, insulin detemir U100, or U-500R despite adjustments to current regimen (pradial insulin, interacting drugs, meal and excersise timing) b. Inconsistant blood sugars with a basal insulin requirement of a minimum of 100 units/day for a minimum of 3 months with good compliance, as evidenced by paid claims or pharmacy print outs. 2. Must be prescribed by or in consultation with a endocrinologist or diabetes specialist 3. Patient must provide clinical explanation for the following: a. If dose is greater than 200 units of insulin per day, why patient is not a candidate for U-500R (Toujeo and Tresiba are not intended as replacements for U500 insulin) b. Need for smaller volume of insulin (max is 80 units/injection for both Insulin glargine 300 units/mL and 100 units/mL. Patients using Insulin glargine 300 unit/mL may require more basal insulin than those receiving 100 units/mL) Renewal Criteria: Approval 12 months One of the following, evidenced by clinical notes or labs: 1. Improvement in frequency and/or severity of hypoglycemia 2. Improved glycemic control (A1C)
HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL	FIASP (insulin aspart) VIAL***	
HUMULIN N (insulin NPH human isophane) VIAL	HUMALOG (insulin lispro) CARTRIDGE	
HUMULIN R (insulin regular, human) VIAL	HUMALOG JUNIOR KWIKPEN (insulin lispro)	
HUMULIN R U-500 (insulin regular, human) VIAL	HUMALOG MIX 50/50 (insulin NPL/insulin lispro) KWIKPEN	
LANTUS (insulin glargine) SOLOSTAR	HUMALOG MIX 75/25 (insulin NPL/insulin lispro) KWIKPEN	
LANTUS (insulin glargine) VIAL	HUMALOG U-100 (insulin lispro) KWIKPEN	
LEVEMIR (insulin detemir) VIAL	HUMALOG U-200 (insulin lispro) KWIKPEN	
LEVEMIR (insulin detemir) FLEXTOUCH	HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN	
NOVOLIN R (insulin regular, human) VIAL	HUMULIN N (insulin NPH human isophane) KWIKPEN	
NOVOLOG (insulin aspart) CARTRIDGE	HUMULIN R (Insulin regular, human) U-500 KWIKPEN	
NOVOLOG (insulin aspart) FLEXPEN	NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL	
NOVOLOG (insulin aspart) VIAL	NOVOLIN N (insulin NPH human isophane) VIAL	
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN	TOUJEO MAX SOLOSTAR (insulin glargine)***	
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL	TOUJEO SOLOSTAR (insulin glargine)***	
	TRESIBA (insulin degludec) FLEXTOUCH U-100***	
	TRESIBA (insulin degludec) FLEXTOUCH U-200***	
DIABETES - SGLT2 INHIBITORS		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: All agents will require: 1. A diagnosis of an FDA-approved indication for use 2. One of the following: A: The requested agent is a combination product containing metformin B: The patient has been stable on metformin with good compliance over the past 3 months, as evidenced by paid claims or pharmacy print-outs AND the patient will be taking metformin concurrently with the requested agent In addition, non-preferred agents will require: 3. A 30 day trial of a canagliflozin and a 30 day trial of a empagliflozin agent.		
INVOKAMET (canagliflozin)	FARXIGA (dapagliflozin)	
INVOKANA (canagliflozin)	INVOKAMET XR (canagliflozin/metformin)	
JARDIANCE (empagliflozin)	STEGLATRO (ertugliflozin)	
SYNJARDY (empagliflozin/metformin)	STEGLATROMET (ertugliflozin/metformin)	
SYNJARDY XR (empagliflozin/metformin)	XIGDUO XR (dapagliflozin/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 patient stable on a pancreatic enzyme written by a gastroenterologist or pancrease disease specialist		
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)	

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
EPIPEN (epinephrine)	AUVI-Q (epinephrine)	
EPIPEN JR (epinephrine)	epinephrine - labelers 00115, 54505	
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		
Category PA Criteria: Patient must have FDA indication. The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review).		
GRANIX (TBO-Filgrastim)	FULPHILA (Pegfilgrastrim-JMDB)	
LEUKINE (Sargramostim)	NIVESTYM (Filgratim-AAFI)	
NEULASTA (Pegfilgrastim)	ZARXIO (Filgrastim-SNDZ)	
NEUPOGEN (Filgrastim)		
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**
	RETACRIT (epoetin alfa - EPBX)	
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 a documented FDA-approved diagnosis. Chronic Hepatitis C must be documented by one of the following:
   a. Liver fibrosis F1 and below: 2 positive HCV RNA levels at least 6 months apart
   b. Liver fibrosis F2 and above: 1 positive HCV RNA test within the last 12 months
2. Patient must be an FDA-approved age.
3. Patient must be drug (illicit use of drugs by injection) and alcohol free as documented by 2 drug and alcohol tests dated at least 3 months apart and meet criteria as outlined below:

   a. If the patient has a history of alcohol use disorder, the patient must have abstained from alcohol for at least 12 months OR patient must:
      i. have abstained from alcohol for at least 3 months AND
      ii. be receiving treatment from an enrolled provider and agree to abstain from alcohol during treatment AND
      iii. be under the care of an addiction medicine/chemical dependency treatment provider and the provider attests the patient has abstained from alcohol use for at least 3 months
   b. If the patient has a history of illicit use of drugs by injection, the patient must have abstained from drug use for at least 12 months OR patient must:
      i. have abstained from drug use for at least 3 months AND
      ii. be receiving treatment from an enrolled provider and agree to abstain from said drug use during treatment AND
      iii. be under the care of an addiction medicine/chemical dependency treatment (or buprenorphine waived provider) provider and the provider attests the patient agrees to abstain from drug use for at least 3 months
4. Patient must not be receiving a known recreationally used high risk combination of drugs (e.g. “the holy trinity”) for the past 6 months
5. Patient must attest that they will continue treatment without interruption for the duration of therapy.
6. Prescriber must be, or consult with, a hepatologist, gastroenterologist, or infectious disease specialist.
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 (defined as 1 or less no-shows) and filling maintenance medications on time as shown in the prescription medication history for the past 6 months.
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.

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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)	
	SOVALDI (sofosbuvir)	
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)	
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)	
	ZEPATIER (elbasvir/grazoprevir)	
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 KILLING SHAMPOO (piperonyl butoxide/pyrethrins)	EURAX (crotamiton) LOTION	
NATROBA (spinosad)	Malathion	
NIX 1% (Permethrin) CRÈME RINSE LIQUID	OVIDE (malathion)	
Permethrin 5% cream	Spinosad	
SKLICE (ivermectin)		
SM LICE TREATMENT (Permethrin) 1% CRÈME RINSE LIQUID		
ULESFIA (benzyl alcohol)		
MIGRAINE TREATMENT - 5HT(1) AGONISTS		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: Patients able to take oral medications: -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 mg in the past 24 months will be required before a non-preferred agent will be authorized. Patients not able to take oral medications (as evidenced by swallow study documentation): -A 30-day trial of rizatriptan ODT in the past 24 months will be required before a non-preferred agent will be authorized.		
RELPAX (eletriptan)	Almotriptan***	***Sumatriptan Nasal Spray: - Patient must fail a 30 day trial of all of the following within the past 24 months, as evidenced by paid claims or pharmacy print outs: o Zomig Nasal Spray 5mg o Onzetra Xsail 22mg ***Zolmitriptan tablet: - Patient must fail a 30 day trial of naratriptan 2.5mg within the past 24 months, as evidenced by paid claims or pharmacy print outs ***Sumatriptan pen/syringe/cartridge, Frovatriptan, Almotriptan, Treximet: - Medical justification must be provided as to why another triptans won't work - Patient must fail a 30 day trial of all other available triptans within the past 24 months, as evidenced by paid claims or pharmacy print outs
Rizatriptan	ALSUMA (sumatriptan) PEN INJCTR***	
Rizatriptan ODT	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)	
	MAXALT MLT (rizatriptan)	
	Naratriptan	
	ONSETRA XSAIL (sumatriptan)	
	Sumatriptan cartridge***	
	Sumatriptan pen injctr***	
	Sumatriptan spray***	
	Sumatriptan syringe***	
	Sumatriptan vial	
	TREXIMET (sumatriptan/naproxen)***	
	Zolmitriptan***	
	Zolmitriptan ODT	

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ZOMIG (zolmitriptan)***	
	ZOMIG (zolmitriptan) SPRAY	
	ZOMIG ODT (zolmitriptan)	
MIGRAINE PROPHYLAXIS - CGRP INHIBITORS		
Category PA Criteria: Initial: Patient must experience 4 or more migraine days per month. Prescriber must submit documentation of treatment failure of a 2 month trial of two preferred agents from different therapeutic classes. - Documentation must include clinical notes regarding failure to reduce migraine frequency. Renewal: Patient must experience a reduction in migraines of at least 50%		
Amitriptyline	AIMOVIG (Erenumab-aooe)	
Atenolol	AJOVY (Fremanezumab-vfrm)	
Divalproex Sodium	EMGALITY (Galcanazumab-gnlm)	
Metoprolol		
Nadolol		
Propranolol		
Timolol		
Topiramate		
Venlafaxine		
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		

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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***	***Copaxone 40mg/ml/Glatopa/glatiramir: • Clinical justification must be provided why Copaxone 20 mg/mL will not work.
	glatiramer 20mg/ml***	
	glatiramer 40mg/ml***	
	Glatopa (glatiramer)***	
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: Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. 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.		
ALPHAGAN P 0.1% (brimonidine)	brimonidine 0.15%	
ALPHAGAN P 0.15% (brimonidine)	IOPIDINE (apraclonidine)	
apraclonidine		
brimonidine 0.2%		
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.		
ALOMIDE (lodoxamide)	ALOCRIL (nedocromil)	

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Azelastine	ELESTAT (epinastine)	
BEPREVE (bepotastine)	EMADINE (emedastine)	
Cromolyn	Epinastine	
LASTACAFT (alcaftadine)	Olopatadine 0.2%	
Olopatadine 0.1%	PATANOL 0.1% (olopatadine)	
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.		
Bacitracin/polymyxin ointment	AZASITE (azithromycin)	
BESIVANCE (besifloxacin) DROPS	Bacitracin ointment	
CILOXAN (ciprofloxacin) OINTMENT	BLEPH-10 (sulfacetamide) DROPS	
Ciprofloxacin drops	CILOXAN (ciprofloxacin) DROPS	
Erythromycin ointment	Gatifloxacin drops	
Gentamicin sulfate drops	GENTAK (gentamicin sulfate) OINTMENT	
Gentamicin sulfate ointment	Levofloxacin drops	
MOXEZA (moxifloxacin) DROPS	moxifloxacin drops	
Neomycin SU/bacitracin/polymyxin B ointment	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) OINTMENT	
Neomycin SU/polymyxin B/gramicidin drops	NEOSPORIN (neomycin SU/polymyxin B/gramicidin) DROPS	
Ofloxacin drops	OCUFLOX (ofloxacin) DROPS	
Polymyxin B/trimethoprim drops	POLYCIN (bacitracin/polymyxin) OINTMENT	
Sulfacetamide drops	POLYTRIM (polymyxin B/trimethoprim) DROPS	
Tobramycin drops	Sulfacetamide ointment	
TOBREX (tobramycin) OINTMENT	TOBREX (tobramycin) DROPS	
	VIGAMOX (moxifloxacin) DROPS	
	ZYMAXID (gatifloxacin) DROPS	
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES		

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PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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.		
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	
Neomycin/polymyxin b/hydrocortisone ointment	NEO-POLYCIN HC (neomycin SU/bacitracin/polymyxin B/hydrocortisone) OINTMENT	
PRED-G (gentamicin/prednisol ac) DROPS	TOBRADEX ST (tobramycin/dexamethasone) DROPS	
PRED-G (gentamicin/prednisol ac) OINTMENT	Tobramycin/dexamethasone	
Sulfacetamide/prednisolone drops		
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	
DUREZOL (difluprednate)	BROMSITE (bromfenac sodium)	
FLAREX (fluorometholone)	Dexamethasone sodium phosphate	
Fluorometholone	FML (fluorometholone)	
Flurbiprofen sodium	LOTEMAX (loteprednol) GEL DROPS	
FML FORTE (fluorometholone)	LOTEMAX (loteprednol) OINTMENT	
FML S.O.P. (fluorometholone)	OCUFEN (flurbiprofen)	

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ILEVRO (nepafenac)	OMNIPRED 1% (prednisolone acetate)	
ketorolac tromethamine 0.4%	PRED FORTE 1% (prednisolone acetate)	
Ketorolac tromethamine 0.5%	PROLENSA (bromfenac)	
LOTEMAX (loteprednol) DROPS		
MAXIDEX (dexamethasone)		
NEVANAC (nepafenac)		
PRED MILD 0.12% (prednisolone acetate)		
Prednisolone acetate 1%		
Prednisolone sodium phosphate 1%		
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
BUTRANS (buprenorphine) PATCHES 5mcg/hr, 10 mcg/hr, 20 mcg/hr	BELBUCA (buprenorphine)***	
EMBEDA (morphine/naltrexone)	buprenorphine patches	
Fentanyl 12 mcg/hr[PA***]	BUTRANS (buprenorphine) PATCHES 7.5 mcg/hr, 15 mcg/hr	
Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	CONZIP (tramadol ER)	
levorphanol	DURAGESIC (fentanyl)	
Morphine ER tablets	EXALGO (hydromorphone)***	
NUCYNTA ER (tapentadol)	Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr***	
pentazocine-naloxone	Hydromorphone ER tablets***	
	HYSINGLA ER (hydrocodone)***	
	KADIAN (morphine)***	
	Methadone***	

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	MORPHABOND ER (morphine)***	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 addition 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 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
	Morphine ER capsules***	
	MS CONTIN (morphine)	
	Oxycodone ER***	
	OXYCONTIN (oxycodone)***	
	Oxymorphone ER tablets***	
	Tramadol ER***	
	ULTRAM ER (tramadol ER)	
	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 all preferred agents will be required before a non-preferred agent will be authorized. The prescriber must submit medical justification explaining why the patient cannot use the preferred products (subject to clinical review). A FDA MedWatch form for the failed product must be faxed to the FDA and submitted with request for all non-preferred buprenorphine/naloxone products. 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.		
Buprenorphine-naloxone tablets[PA]	BUNAVAIL FILM (buprenorphine/naloxone)	***Buprenorphine tablets will be allowed during a period that a patient is pregnant or breastfeeding.
ZUBSOLV (buprenorphine/naloxone)[PA]	Buprenorphine tablets***	
	buprenorphine/naloxone film	

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	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)		
Ciprofloxacin drops		
Ofloxacin drops		
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.		
Calcium acetate capsule	AURYXIA (ferric citrate) TABLET	
Calcium acetate tablet	ELIPHOS (calcium acetate) TABLET	
FOSRENOL (lanthanum) CHEWABLE TABLET	FOSRENOL (lanthanum) POWDER PACK	
PHOSLYRA (calcium acetate) ORAL solution	Lanthanum chew tab	
RENAGEL (sevelamer) TABLET	sevelamer tablet	
RENVELA (sevelamer) POWDER PACK	sevelamer powder pack	
RENVELA (sevelamer carbonate) TABLET	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.		
AGGRENOX (aspirin/dipyridamole)	Aspirin/dipyridamole ER	***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
BRILINTA (ticagrelor)	Clopidogrel 300mg	
Clopidogrel 75 mg	DURLAZA (aspirin ER)***	

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Dipyridamole	EFFIENT (prasugrel)	hemorrhage. ***Durlaza/Yosprala DR – Patient must have a reason that immediate release aspirin is not an option.
Prasugrel	PERSANTINE (dipyridamole)	
Ticlopidine	PLAVIX (clopidogrel)	
	YOSPRALA DR (aspirin/omeprazole)***	
	ZONTIVITY (vorapaxar)***	
PROGESTERONES		
Category PA Criteria: All medications require an FDA-approved indication. Non-preferred agents will require a 30-day trial of all preferred medications.		
MAKENA (hydroxyprogesterone caproate)PA	hydroxyprogesterone caproate	
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.		
ADCIRCA (tadalafil)PA	REVATIO (sildenafil) TABLET	***Revatio Suspension – Patients 7 years and older will be required to submit documentation of their inability to ingest a solid dosage form.
REVATIO (sildenafil) SUSPENSIONPA***	tadalafil	
Sildenafil tabletPA		
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. 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)		
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.		
LETAIRIS (ambrisentan)	OPSUMIT (macitentan)	
TRACLEER (bosentan)		
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)	TYVASO (treprostinil)	

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REMODULIN (treprostinil)	UPTRAVI (selexipag)	
VENTAVIS (iloprost)		
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.		
ADVAIR DISKUS (fluticasone/salmeterol)	BREO ELLIPTA (fluticasone/vilanterol)	
ADVAIR HFA (fluticasone/salmeterol)	fluticasone/salmeterol	
DULERA (mometasone/formoterol)	AIRDUO RESPICLICK (fluticasone/salmeterol)	
SYMBICORT (budesonide/formoterol)		
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 all accessible 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)	ARMONAIR RESPICLICK (fluticasone)	
ASMANEX (mometasone) TWISTHALER	ARNUITY ELLIPTA (fluticasone)	
budesonide suspension 0.25 mg/2 mL	ASMANEX HFA (mometasone)	
budesonide suspension 0.5 mg/2 mL	budesonide suspension 1 mg/2 mL	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
FLOVENT DISKUS (fluticasone)	PULMICORT RESPULES (budesonide) 0.25 mg/2 mL	
FLOVENT HFA (fluticasone)	PULMICORT RESPULES (budesonide) 0.5 mg/2 mL	
PULMICORT FLEXHALER (budesonide)	QVAR REDIHALER (beclomethasone)	
PULMICORT RESPULES (budesonide) 1 MG/2 ML		
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)	
Balsalazide capsule	AZULFIDINE (sulfasalazine)	
DELZICOL (mesalamine) CAPSULE	AZULFIDINE DR (sulfasalazine)	
DIPENTUM (olsalazine)	COLAZAL (balsalazide)	
LIALDA (mesalamine) TABLET	Mesalamine DR	
PENTASA (mesalamine)	SULFAZINE (sulfasalazine)	
Sulfasalazine DR tablet		
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.		
Flavoxate	Darifenacin ER	***SANCTURA ER/Trospium ER and Myrbetriq will require a 1-month trial of trospium and
GELNIQUE (oxybutynin)	DETROL (tolterodine)	
Oxybutynin ER	DETROL LA (tolterodine)	
Oxybutynin syrup	DITROPAN XL (oxybutynin)	

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

EFFECTIVE
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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Oxybutynin tablet	ENABLEX (darifenacin)	tolterodine/tolterodine ER in addition to the category PA criteria.
OXYTROL (oxybutynin) PATCH	MYRBETRIQ (mirabegron)***	
TOVIAZ (fesoterodine)	SANCTURA (trospium)	
VESICARE (solifenacin)	SANCTURA ER (trospium)***	
	Tolterodine	
	Tolterodine ER	
	Trospium	
	Trospium ER***	