

**WYOMING MEDICAID  
Preferred Drug List (PDL) October 9, 2024**

Drug classes not included on this list are not managed through a Preferred Drug List (PDL).  
HOWEVER, THIS EXCLUSION IS NOT A GUARANTEE OF PAYMENT OR COVERAGE. Dosage limits and other requirements may apply.

Drugs new to market are non-preferred until a clinical review has been completed. PA criteria will apply to both the pediatric population,  
as well as the adult population for those plans where PA/PDL limits are allowed.

Unless otherwise noted on the PDL, generic substitution is mandatory.

Yellow highlighted items below indicate new changes to the PDL. Red font indicates quantity/dosage limits apply. \*Indicates BRAND is Preferred. May Use DAW 5.  
Contact the OptumRx PA Helpdesk @ 877-207-1126 for prior authorization if client has primary insurance that will not cover the brand name medication.

Please refer to the Additional Therapeutic Criteria Chart, [Dosage Limitation List](#) (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>THIS LIST IS NOT ALL-INCLUSIVE PLEASE CONTACT OptumRx WITH ANY QUESTIONS</small>
ADDICTION	BUPRENORPHINE COMBINATIONS		Client must have a diagnosis of opioid dependence or abuse. This is not to be used for the treatment of chronic pain. Prior authorization will be required before any narcotic, benzodiazepine, or carisoprodol prescription will be allowed between fills. Prior authorization will be required before any short-acting stimulant prescription from any doctor other than the prescriber of buprenorphine or Suboxone, will be allowed between fills.  Oral buprenorphine will be approved for clients with a documented allergy to naloxone.  Please submit PA requests on the "Oral Buprenorphine/Naloxone or Oral Buprenorphine" PA form available at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> .  Dosage limits apply Prior authorization will be required for doses >24mg	buprenorphine (oral) buprenorphine/naloxone film BRAND PREFERRED) ZUBSOLV
		buprenorphine/naloxone tablets SUBOXONE FILM*		
		NALOXONE	Kloxxado, naloxone products, and Narcan nasal spray will be limited to one fill per 180 days without prior authorization.  Naloxone formulations available in quantities of 10ml will require prior authorization.	ZIMHI
		KLOXXADO naloxone nasal spray NARCAN RETOVY		
	NALTREXONE		Client must have a diagnosis of alcohol or opioid dependence.  Prior authorization will be required before any narcotic, carisoprodol, or benzodiazepine prescription will be allowed between fills. Prior authorization will be required before a short-acting stimulant prescription from any doctor other than the prescriber of naltrexone or Vivitrol will be allowed between fills.	
		naltrexone VIVITROL		
ALLERGY / ASTHMA / COPD	ANTI-HISTAMINES, MINIMALLY SEDATING		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	desloratadine CLARINEX RDT/SYRUP levocetirizine
	cetirizine fexofenadine loratadine			
	ANTI-HISTAMINE/DECONGESTANT COMBINATIONS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	CLARINEX-D
	cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine			
	ANTICHOLINERGIC BRONCHODILATORS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.  Spiriva 5 day STARTER package will be allowed one (1) time per recipient	TIOTROPIUM BROM (use brand) TUDORZA YUPELRI
	ATROVENT HFA INCRUSE ELLIPTA ipratropium SPIRIVA HANDHALER SPIRIVA RESPIMAT			
	ANTICHOLINERGIC COMBINATION AGENTS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.  **Will also require the diagnosis of COPD.	BEVESPI BRETZRI DUJAKLIR TRELEGY
	ANORO ELLIPTA** COMBIVENT STIOLTO			
	LEUKOTRIENE MODIFIERS		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	zafirlukast
	montelukast			
	LONG ACTING BRONCHODILATORS		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	BROVANA
	arformoterol SEREVENT STRIVERDI			
	NASAL ANTIHISTAMINES		Trial and failure of preferred agent greater than or equal to 90 days in the last 12 months will be required before approval can be given for a non-preferred agent.	azelastine 0.15% DYMISTA (use separate agents) olopatadine 0.6% RYALTRIS
	azelastine 0.1%			
	NASAL STEROIDS		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.  Budesonide will be approved for pregnancy.	DYMISTA (use separate agents) OMNARIS QNASL XHANCE ZETONNA
	budesonide flunisolide fluticasone mometasone			
SHORT ACTING BRONCHODILATORS - INHALERS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Prior authorization will be required after a total of 12 albuterol inhalers are dispensed within 365 days.  Minimum day supply of 16 days is required	levalbuterol (BRAND IS PREFERRED) PROAIR DIGIHALER PROVENTIL HFA	
albuterol HFA PROAIR RESPICLICK VENTOLIN HFA XOPENEX HFA*				
STEROID INHALANTS		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.  *Fluticasone HFA and Asmanex HFA will be approved for pediatric clients 8 years of age or younger.  Alvesco will be approved for a history of oral thrush with steroid inhalants.	AIRDUO DIGIHALER ALVESCO ARMONAIR ASMANEX HFA* fluticasone HFA* QVAR REDIHALER	
AIRDUO RESPICLICK ARNJUTY ELIPTA ASMANEX TWISTHALER budesonide suspension PULMICORT FLEXHALER				
STEROID COMBINATION AGENTS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.  **Will also require the diagnosis of COPD or uncontrolled asthma.  Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.	fluticasone/vilanterol (use preferred agent) fluticasone/salmeterol 55-14/113-14/232-14 fluticasone/salmeterol 100-50/250-50/500-50 (RRAND IS PREFERRED) TRELEGY	
ADVAIR BREO ELLIPTA** DULERA SYMBICORT* WIXELA				
EPINEPHRINE			AUVI-Q (use preferred agent) EPI-PEN (use preferred agent)	
epinephrine auto-injector pen				
EOSINOPHILIC ASTHMA AGENTS		*Approval for these agents will require additional clinical criteria which can be found on the Additional Therapeutic Criteria Chart	FASENRA* NUCALA* TEZSPIRE	
	DUPIXENT XOLAIR			

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>THE LIST IS NOT ALL INCLUSIVE PLEASE CONTACT ODHSMR WITH ANY QUESTIONS</small>
ARTHRITIS	<b>IMMUNOMODULATORS</b>		Client must have diagnosis of AS prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of AS and a 56-day trial and failure of both preferred agents.  **Cimzia will be allowed for clients that are pregnant or breast-feeding <b>Quantity Limits apply for all diagnoses:</b> Enbrel 25mg - limited to 10 per month Enbrel 50mg - limited to 5 per month Humira 20mg - limited to 10 per month Humira 40mg - limited to 5 per month	CIMZIA** COSENTYX REMICADE RINVOO SIMPONI TALTZ XELIANZ/XR
	<b>ANKYLOSING SPONDYLITIS (AS)</b>			
	ENBREL HUMIRA			
	<b>JUVENILE IDIOPATHIC ARTHRITIS (JIA)</b>			
	ENBREL HUMIRA			
ARTHRITIS	<b>PSORIATIC ARTHRITIS (PA)</b>		Client must have diagnosis of PA prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of PA and a 56-day trial and failure of two of the three preferred agents.  *Otezla starter pack is non-preferred  **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** COSENTYX ORENCIA REMICADE RINVOO SIMPONI STELARA TALTZ TREMIFYA XELIANZ/XR
	ENBREL HUMIRA OTEZLA*			
	<b>RHEUMATOID ARTHRITIS (RA)</b>			
	ENBREL HUMIRA			
	ENBREL HUMIRA			
CONVULSIONS	<b>INTERMITTENT, STEREOTYPIC SEIZURE EPISODES</b>		*Nayzilam will be allowed for patients 12 years of age and older	
	diazepam gel NAVZILAM* VALTOCO			
CONVULSIONS	<b>ORAL ANTICONVULSANTS</b>		Preferred agents with clinical criteria will be limited to FDA approved indications related to seizures and epilepsy. Non-preferred agents require 30 day trial and failure of two preferred agents prior to approval.  For indications not related to seizures and epilepsy, please refer to the Additional Therapeutic Criteria chart at www.wyomedicaid.org.  **Please refer to the Additional Therapeutic Criteria chart at www.wyomedicaid.org for specific requirements.	APTIOM BRIVIACT clobazam** DIACOMIT** FINTEPLA** levetiracetam ER OXTELLAR TROKENDI XR XCOPRI VIMPAT (tablets) zonisamide oral susp.
	carbamazepine divalproex FELBAMATE fosphenytoin lacosamide (tablets) lamotrigine/XR levetiracetam oxcarbazepine phenytoin subvenite valproate/valproic acid VIMPAT (suspension) zonisamide	BANZEL (tablets only) clonazepam EPIDIOLEX rabadentin pregabalin topiramate/ER sprinkle caps		
CROHN'S	<b>IMMUNOMODULATORS</b>		Client must have diagnosis of Crohn's prior to approval of the preferred agent. To receive a non-preferred agent, client must have a diagnosis of Crohn's and a 56-day trial and failure of the preferred agent.  * Refer to Additional Therapeutics Clinical Criteria Chart for more info * Refer to Additional Therapeutics Clinical Criteria Chart for more info **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** ENTYVIO* REMICADE RINVOO SKYRIZI STELARA TYSABRI (additional criteria applies)
		HUMIRA		
DERMATOLOGY	<b>BENZOYL PEROXIDE/CLINDAMYCIN COMBOS</b>		Clients must be 12 to 20 years of age. Requires prior authorization for clients less than 12 years of age. Acne combinations are limited to clients under the age of 21.	ACANYVA ONEXTON
		clindamycin/benzoyl peroxide 1-5% clindamycin/benzoyl peroxide 1.2-5% (Refrig)		
	<b>ISOTRETINOIN</b>			
	AMNESTEEM CLARAVIS isotretinoin ZENATANE			
	<b>CORTICOSTEROIDS - STEP 1 AGENTS C=CREAM; G=GEL; L=LOTION; O=OINTMENT</b>			
	<b>LOW POTENCY</b>			
	alclometasone desonide* fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O)			
	<b>MEDIUM POTENCY</b>			
	betamethasone valerate desoximetasone 0.05%, 0.25% (C) fluocinolone 0.025% fluticasone 0.05% (C) mometasone SYNALAR 0.025% (C, O) triamcinolone 0.025%, 0.1%			
	<b>HIGH POTENCY</b>			
betamethasone dipropionate clobetasol/E 0.05% (C,G,O,S) diflorasone 0.05% (O) fluocinonide flurandrenolide fluticasone 0.005% (O) halobetasol TOPICORT 0.025% (C) triamcinolone 0.5% ULTRAVATE 0.05% (C,O)				
<b>IMMUNOMODULATORS - STEP 2 AGENTS</b>		To receive a step 2 agent: Trial and failure of a preferred medium or high potency topical corticosteroid greater than or equal to a 21 day trial in the last 90 days.	pimecrolimus (brand preferred)	
	ELIDEL tacrolimus	Exceptions will be made for application to the face and for clients age 12 and under, a trial and failure of a preferred low potency corticosteroid greater than or equal to a 21 day trial in the last 90 days will be required.		
<b>PHOSPHODIESTERASE 4 INHIBITOR - STEP 3 AGENT</b>		To receive a step 3 agent: Trial and failure of a preferred step 2 agent (immunomodulator) greater than or equal to a 21 day trial within the last 30 days.	EUCRISA	

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DERMATOLOGY continued	<b>ATOPIC DERMATITIS</b>		*Trial and failure of a preferred step 2 agent (immunomodulator) greater than or equal to a 21 day trial within the last 30 days required. Dupixent requires member be at least 6 months of age or older. No high-potency steroid trial will be necessary.  **Trial and failure of all criteria to receive a step 3 agent as defined above including medium/high potency topical corticosteroid, preferred step 2 immunomodulator AND 56-day trial and failure of a preferred biologic for Atopic Dermatitis in Step 3 will be required for approval of the non-preferred agents.	ADBRY** CIBINQO** OPZELURA** RINVOQ** ZORYVE
		DUPIXENT*		
		<b>PLAQUE PSORIASIS (PP)</b>	Client must have diagnosis of PP prior to approval of a preferred agent (Enbrel, Humira, or Otezla). To receive a non-preferred agent, client must have a diagnosis of PP and a 56-day trial and failure of two of the three preferred agents.  *Sotyktu requires diagnosis of moderate to severe PP and 56 day trial and failure of Humira.  **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** COSENTYX ILUMIYA REMICADE SILIQ SKYRIZI STELARA TALTZ TREMIFYA
	permethrin VANALICE	<b>SCABICIDES/PEDICULICIDES</b>	Trial and failure of a preferred agent in the last 12 months.	malathion lotion NATROBA spinosad (BRAND IS PREFERRED)
DIABETES	<b>DIABETES AGENTS</b>			
	<b>BIGUANIDES</b>			
	metformin/ER			metformin SR 24HR osmotic release (use preferred agent) metformin SR 24HR modified release (use preferred agent)
	<b>GLUCOSIDASE INHIBITORS</b>		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	miglitol
	<b>MEGLITINIDES</b>		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	repaglinide
	<b>THIAZOLIDINEDIONES</b>		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ACTOPLUS MET (use separate agents)
	pioglitazone			
	<b>SULFONYLUREAS</b>		Trial and failure of metformin and a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	
	glimepiride/ER gliozide/ER glyburide/ER			
	<b>DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITORS</b>		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	alogliptin GLYXAMBI (use separate preferred agents) QTERN (use separate preferred agents) STEGLUJIAN (use separate preferred agents)
	JANUVIA ONGLYZA TRAJENTA			
	<b>DPP-4 INHIBITOR COMBO AGENTS</b>		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.	alogliptin/metformin alogliptin/pioglitazone (use separate preferred agents) JENTADUETO XR saxagliptin/metformin (use brand) sitagliptin/metformin (use brand)
	JANUMET/XR JENTADUETO KOMBIGLYZE/XR			
	<b>INCRETIN MIMETICS (GLP-1 RECEPTOR AGONISTS)</b>		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent unless ASCVD or risk factors are present, in which case the trial of metformin is waived. A 90 day trial of failure of the preferred agent is required before approval can be give for a non-preferred agent.  *Rybelsus requires documentation of inability to use injectable agents.  <b>Dosage Limits Apply:</b> Ozempic: 2mg/week Victoza: 1.8mg/day	BYDUREON liraglutide (use brand) MOUNJARO OZEMPIC* SOLIQUA RYBELSUS* (additional criteria applies) XULTOPHY (use separate preferred agents)
	BYETTA TRULICITY VICTOZA			
	<b>SGLT2 INHIBITORS</b>		Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent unless there is a diagnosis of ASCVD, CKD, or heart failure, in which case the trial of metformin will be waived. A 90 day trial and failure of a preferred agent is required before approval can be given for a non-preferred agent.	GLYXAMBI (use separate preferred agents) QTERN (use separate preferred agents) SEGLUROMET (use separate preferred agents) STEGLATRO STEGLUJIAN (use separate preferred agents) SYNJARDY XR (use separate preferred agents) TRIJARDY XR (use separate preferred agents)
	FARXIGA INVOKAMET INVOKANA JARDIANCE SYNJARDY XIGDUO XR			
	<b>FAST-ACTING INSULIN</b>		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently.	ADMELOG (use preferred agent) FIASP (use preferred agent) insulin lispro (use preferred agents) LYUMJEV
	HUMALOG HUMALOG 75/25 HUMALOG JR. HUMALOG MIX NOVOLOG MIX			
	<b>LONG-ACTING INSULIN</b>		Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently.	BASAGLAR (use preferred agent) Insulin Glargine (use preferred agent) Insulin Deludec SOLIQUA TOUJEO (use preferred agent) TRESIBA* (use preferred agent) XULTOPHY (use separate preferred agents)
	LANTUS SOLOSTAR* LANTUS vial LEVEMIR			
	<b>DIABETIC METERS/TEST STRIPS</b>		Quantity limits apply: Insulin Dependent Clients: 10 strips/day Non-Insulin Dependent Clients: 4 strips/day  Clients are limited to 1 meter/365 days	ALL OTHER METERS AND TEST STRIPS
FREESTYLE (strips only) FREESTYLE FREEDOM FREESTYLE FREEDOM LITE FREESTYLE INSULINX FREESTYLE PRECISION NEO B FREESTYLE SIDEKICK II ONE TOUCH ULTRA II ONE TOUCH ULTRA MINI ONE TOUCH ULTRA BLUE ONE TOUCH VERIO ONE TOUCH VERIO FLEX ONE TOUCH VERIO REFLECT ONE TOUCH VERIO IQ PRECISION XTRA				
<b>EXTERNAL DIABETIC DEVICES</b>				
OMNIPOD DASH OMNIPOD 5				
<b>CONTINUOUS BLOOD GLUCOSE MONITORS</b>		Prior authorization will be required to verify if the client is injecting insulin daily. Monitors will also be limited to the labeled age.	GUARDIAN MINIMED	
DEXCOM G6 DEXCOM G7 FREESTYLE LIBRE FREESTYLE LIBRE 2 FREESTYLE LIBRE 3				
<b>ACUTE HYPOGLYCEMIA AGENTS</b>			GVOKE (use preferred agent)	
BAQSIMI ZEGALOGUE (autoinjector)				

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FIBROMYALGIA	FIBROMYALGIA		Trial and failure of a preferred agent greater than or equal to six (6) weeks in the last 12 months is required prior to approval of a non-preferred agent  Clients will not be allowed to take gabapentin and pregabalin concurrently	pregabalin SAVELLA tablets (savella titration pak will not be covered)
	amitriptyline cyclobenzaprine duloxetine	gabapentin		
GASTROINTESTINAL	BOWEL EVACUANTS		Client must have a diagnosis of chronic idiopathic constipation to receive a preferred agent. To receive a non-preferred agent, the client must have a diagnosis of chronic idiopathic constipation and a 30-day trial and failure of a preferred agent within the last 12 months.  Prior authorization required.  Client must have a diagnosis of Irritable Bowel Syndrome (IBS) with constipation.  Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.  Client must have a diagnosis of opioid-induced constipation and a three (3) month trial and failure of a stool softener to receive the preferred agent. To receive the non-preferred agent, the client must have a diagnosis of opioid-induced constipation, a three (3) month trial and failure of a secretory agent, and a three (3) month trial and failure of the preferred agent.  *Movantik will be approved for a diagnosis of cancer or for clients in hospice or palliative care.  Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. PREVACID solutabs will be approved for children less than or equal to 8 years of age.	CLENPIQ (use preferred agents) GAVILYTE H (use preferred agents) POLY-PREP (use preferred agents) SUFLAVE SUTAB  MOTEGRITY  PERTZYE VIOKACE  mesalamine DR tab 800mg, 1.2g (BRAND IS PREFERRED) mesalamine ER cap 0.375gm (BRAND IS PREFERRED) mesalamine sup 1000mg SFROWASA  MOVANTIK* RELISTOR SYMPROIC  amox/clarith/lanso pack DEXILANT dexlansoprazole esomeprazole omeprazole 20.6mg capsules omeprazole tablets omeprazole/sodium bicarbonate OMECLAMOX (use separate agents) PREVACID solutabs* rabeprazole TALICIA (use separate agents) VIMOVO (use separate agents) MITIGARE (use preferred agent)
	GAVILYTE G, N GOLYTELY MOVIPREP PEG 3350 SOLUTION SUPREP			
	CHRONIC IDIOPATHIC CONSTIPATION			
		AMITIZA LINZESS TRULANCE		
	DIGESTIVE ENZYMES			
	CREON ZENPEP			
	IRRITABLE BOWEL SYNDROME WITH CONSTIPATION			
		AMITIZA LINZESS TRULANCE		
	MESALAMINE			
	APRISO* LIALDA* mesalamine 400mg DR capsule mesalamine enema PENTASA			
	OPIOID-INDUCED CONSTIPATION AGENTS			
		AMITIZA		
	PREGNANCY INDUCED NAUSEA/VOMITING			
	BONIESTA DICLEGIS			
	PROTON PUMP INHIBITORS			
lansoprazole capsules omeprazole capsules pantoprazole				
GOUT	COLCHICINE			
	colchicine (tablets)			
	XANTHINE OXIDASE AND URICATE INHIBITORS		Trial and failure of the preferred agent greater than or equal to a 60 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ULORIC*
	allopurinol			
HEMATOLOGY	LOW MOLECULAR WEIGHT HEPARIN (LMWH)		Prior authorization will be required for the 300mg/3ml strength.  Client must have diagnosis of non-valvular atrial fibrillation and relative contraindication to warfarin for approval, treatment for deep vein thrombosis (DVT) or pulmonary embolism (PE), or for the reduction in the risk of recurrence of DVT and PE after initial therapy.  *To receive Xarelto 2.5mg, client must have a diagnosis of chronic coronary artery disease or peripheral artery disease with the need to reduce risk of major cardiovascular events  Client must have a diagnosis of acute coronary syndrome, history of myocardial infarction, or history of stroke and transient ischemic attack.  Client must have diagnosis of reduction of thrombotic cardiovascular events with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD). Must be used in conjunction with aspirin or clopidogrel.  Client must have a diagnosis of acute coronary syndrome, history of myocardial infarction, or history of stroke and transient ischemic attack.	FRAGMIN (use preferred agent) enoxaparin 300MG/3ML  ELIQUIS (starter pack) SAVAYA (use preferred agent)  ALTIUVIIO KOVALTRY  ARANESP PROCRIT
		enoxaparin		
	DIRECT THROMBIN INHIBITOR			
		PRADAXA		
	SELECTIVE FACTOR XA INHIBITOR			
	ELIQUIS XARELTO 10mg, 15mg, 20mg, and starter pack	XARELTO 2.5mg* (use preferred agent)		
	CPTP DERIVATIVES			
		BRILINTA		
	PAR-1 ANTAGONIST			
		ZONTIVITY		
	ANTITHROMBOTIC FACTOR VIII			
	ADVATE ADYNOVATE AFSTYLA ELOCTATE ESPEROCT HEMOFIL M HEMLIBRA JIVI KOATE/KOATE-DVI KOGENATE FS/BIO-SET NOVOEIGHT NUWIQ OBIZUR RECOMBINATE XYNTHA/SOLOFUSE			
	COAGULATION FACTOR IX			
	ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY REBINYN RIXUBIS			
	ANTITHROMBOTIC FACTOR/VWF			
ALPHANATE HUMATE-P VONVENDI WILATE				
ERYTHROPOIESIS STIMULATING AGENTS				
EPOGEN MIRCERA RETACRIT				
SICKLE CELL ANEMIA				
DROXIA SIKLOS				

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<b>HEPATITIS C</b>	<b>DIRECT ACTING ANTIVIRALS</b>		Limited to FDA approved indication. Prior authorization will be required prior to use of preferred agents. <i>Please submit PA requests on the Hepatitis C PA form available at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a>.</i>	EPLUSA ( <i>use preferred agent</i> ) HARVONI SOVALDI VOSEVI** ZEPATIER
<b>HIDRADENITIS SUPPURATIVA</b>	<b>IMMUNOMODULATORS</b>		Humira will not be covered as a first line agent for the diagnosis for hidradenitis suppurativa.	
<b>HORMONES</b>	<b>GnRH ANTAGONISTS</b>		*Please refer to the Additional Therapeutic Criteria chart at <a href="http://www.wymedicaid.org">www.wymedicaid.org</a> for specific requirements.	ORLISSA
	<b>GROWTH HORMONE</b>			HUMATROPE NGENLA OMNITROPE SAIZEN SEROSTIM SKYTROFA SOGROYA ZOMACTON
	<b>TESTOSTERONE TOPICAL GELS</b>		Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient	ANDRODERM ( <i>use preferred agent</i> ) FORTESTA ( <i>use preferred agent</i> ) JATENZO ( <i>use preferred agent</i> ) TESTOPEL ( <i>use preferred agent</i> ) testosterone gel ( <i>use preferred agent</i> ) testosterone solution ( <i>use preferred agent</i> ) XYOSTED ( <i>use preferred agent</i> )
	<b>THYROID HORMONES</b>		Ermeza will be covered with confirmed diagnosis of dysphagia.	THYQUIDITY TIROSINT
	<b>ORAL CONTRACEPTIVES</b>			alyacen 1-35, 7/7/7 aranelle BALCOLTRA balziva briellvn drospir/ethinyl estradiol/levomefolate enpresse ethynodiol/ethinyl estradiol FALESSA KIT favosim kaltlib FE chew lavolis FE chew levonest levonorgest/ethinyl estradiol/LO (84-7) levonorgest/ethinyl estradiol 0.15- <b>MINISTRIN FE chew*</b> noreth/ethinyl estradiol/FE chew 0.8/25 nortrel <b>OPILL</b> philit rivelsa QUARTETTE SAFYRAL SLYND TAYTULLA tilia FE tri-legest FE TRIVORA TWIRLA tvdemv vyfemla wera wymzya FE chew

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT ODHMR WITH ANY QUESTIONS</small>
HORMONES (continued)	reclipsen safral SEASONIQUE* setlakin sharobel simliva simpesse sprintec sronyx sveda tri-estaryl/LO tri-femvnr tri-linyah tri-marzia LO tri-mili/LO tri-sprintec/LO tri-nmvo tri-vilibra velivet vestura vienna viorele volnea vylibra vasmin-28 YAZ zumandimine			
HYPERLIPIDEMIA	<b>BILE ACID SEQUESTRANT</b>		Trial and failure of ALL preferred agents greater than or equal to six (6) months in the last 12 months will be required before approval can be given for a non- preferred agent.	WELCHOL
	cholestyramine/light colestipol			
	<b>STATINS, LOW POTENCY</b>		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.  If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization.  Prior authorization will be required for clients under the age of 10.	fluvastatin/ER
	lovastatin pravastatin			
	<b>STATINS, HIGH POTENCY</b>		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.  If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization.  Prior authorization will be required for clients under the age of 10.	EZALLOR LIVALO ZYPITAMAG
	atorvastatin rosuvastatin simvastatin			
	<b>STATIN COMBINATIONS</b>		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.  Prior authorization will be required for clients under the age of 10.	ezetimibe/simvastatin (BRAND IS PREFERRED)
	amlodipine/atorvastatin VYTORIN*			
<b>PCSK9-RELATED AGENTS</b>		Client must have a diagnosis of homozygous familial hypercholesterolemia; have a diagnosis of heterozygous familial hypercholesterolemia or atherosclerotic cardiovascular disease AND not at goal with a maximum dose statin; or be intolerant to statin therapy. Approval for a non-preferred agent requires trial and failure of a preferred agent.	LEOVIO REPATHA	
	PRALUENT			
<b>TRIGLYCERIDE LOWERING AGENTS</b>		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	fenofibric fenofibrate (43/50/120/130/150mg) icosapent LIPOFEN omega-3-acid VASCEPA	
fenofibrate gemfibrozil				
HYPERTENSION/ CARDIOLOGY	<b>ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)</b>		Non-preferred ARBs will require a history of ALL preferred ARBs before approval	candesartan erosartan 600mg
	EDARBI irbesartan losartan olmesartan telmisartan valsartan			
	<b>ARBs AND DIURETICS</b>		Non-preferred ARB/diuretic combinations will require a history of ALL preferred	candesartan HCTZ telmisartan HCTZ
	EDARBYCLOR irbesartan HCTZ losartan HCT olmesartan HCTZ valsartan HCTZ			
	<b>ALPHA-BLOCKERS</b>			
	<b>COMBINATION PRODUCTS</b>		Client must be greater than one year of age and have a diagnosis of Congestive Heart Failure (CHF) NYHA Class II-IV. Angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) will not be allowed in combination with Entresto.	ENTRESTO SPRINKLES VERQUVO
		ENTRESTO		
INFECTIOUS DISEASE	<b>QUINOLONES</b>		Please refer to the Additional Therapeutic Criteria Chart located at <a href="http://www.wyicaid.org/additional-therapeutic-criteria-for-Baxdela-criteria">http://www.wyicaid.org/additional-therapeutic-criteria-for Baxdela criteria</a> .	moxifloxacin (use preferred agents)
	ciprofloxacin levofloxacin ofloxacin			
	<b>DOXYCYCLINE</b>			DORYX (use preferred agent)
	doxycycline			
	<b>MINOCYCLINE</b>			minocycline 65mg and 115mg ER (use preferred agent) SOLODYN (use preferred agent)
	minocycline/ER			
<b>INHALED TOBRAMYCIN</b>		*Tobi Podhaler requires a 28 day trial of a preferred agent, as well as 28 days off of that same preferred agent prior to approval. <b>Minimum day supply of at 56 days is required</b>	BETHKIS inhaled tobramycin TOBI PODHALER (use preferred agent)	
KITABIS				

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>OTHER DRUGS MAY ALSO BE INCLUDED PLEASE CONTACT DORAMIR WITH ANY QUESTIONS</small>	
INFECTIOUS DISEASE (continued)	<b>ANTI-RETROVIRALS</b>		*Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.  **Rukobia approval requires documentation of multi-drug resistance defined as failure of two medications from different classes.	JULUCA NORVIR RUKOBIA** STRIBILD (use separate agents) SUNLENCA SYMITUZA (use separate preferred agents)	
	APRETUDE BIKTARVY CIMDUO DELSTRIGO DOVATO EVOTAZ GENVOYA ODEFSEY PIFELTRO PREZCOBIX ritonavir tablets SYMP/LO TRIUMEQ TROGARZO	CABENUVA* DESCOVIY* TRUVADA*			
INFLAMMATION	<b>NSAIDs</b>		Trial and failure of two (2) preferred agents each greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. <b>Dosing and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets).</b>	CALDOLOR (use preferred agent) diclofenac 1.3% patch (BRAND IS PREFERRED) diclofenac 1.5% soln. diclofenac 3% eel fenoprofen mefenamic acid NEOPROFEN (use preferred agent)	
	celecoxib diclofenac tablets etodolac FLECTOR* flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate meloxicam nabumetone naproxen oxaprozin piroxicam sulindac				
	<b>ORAL CORTICOSTEROIDS</b>			CELESTONE (use preferred agent) <b>EMFLAZA</b>	
	budesonide cortisone acetate dexamethasone/intensol hydrocortisone methylprednisolone prednisolone prednisone				
INSOMNIA	<b>NON-BENZODIAZEPINES</b>		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Prior Authorization will be required for clients under the age of 18  *Quviviq requires trial and failure of two preferred agents with different mechanisms of action  **Rozerem is non-preferred without a history of substance abuse Prior authorization will be required when a client is taking more than one insomnia agent concurrently. <b>Dosage limits apply: zaleplon: 30mg/day zolpidem: 15mg/day</b>	EDLUAR (additional criteria applies) DAYVIGO QUVIVIQ ROZEREM* zolpidem sublingual (additional criteria)	
	BELSOMRA eszopiclone zaleplon zolpidem zolpidem ER				
MENTAL HEALTH	<b>ALZHEIMER'S AGENTS</b>		Client must have a diagnosis of dementia.	donepezil 23mg (use preferred agent) memantine ER NAMZARIC (use separate agents) rivastigmine capsules/patches	
	<b>ANTIDEPRESSANTS</b>		Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks <b>WITHIN THE LAST 2 YEARS</b> will be required before approval can be given for a non-preferred agent. <b>One of the trials of preferred agents must be in the same class (NaSS, NDRI, SSRI, or SNRI) as the requested non-preferred agent.</b>  Trazodone, bupropion, fluvoxamine, MAO inhibitors, TCA's, bupropion IR, and venlafaxine IR do not require prior authorization but <b>will not count</b> towards meeting preferred therapy requirements.  Clients will not be allowed to be on more than one antidepressant, including fluvoxamine, bupropion IR, and venlafaxine IR, at one time with the exception of mirtazapine or bupropion with a SSRI or SNRI.  ***Trintellix requires trial and failure of two preferred agents in any class  Clients five (5) years of age and younger will require prior authorization before approval.  <b>Dosage limits apply:</b> bupropion ER/SR/XL: 450mg/day citalopram < 60 years of age: 60mg/day citalopram > 60 years of age: 30mg/day escitalopram: 30mg/day fluoxetine < 18 years of age: 90mg/day fluoxetine > 18 years of age: 120mg/day mirtazapine: 67.5mg/day paroxetine IR/CR < 18 years of age: 75mg/day paroxetine IR > 18 years of age: 90mg/day paroxetine CR > 18 years of age: 112.5mg/day sertraline: 300mg/day venlafaxine ER: 337.5mg/day	donepezil 23mg (use preferred agent) memantine ER NAMZARIC (use separate agents) rivastigmine capsules/patches	
	<b>NORADRENERGIC/SPECIFIC SEROTONERGICS (NaSS)</b>				NaSS mirtazapine rapid dissolve tablets (use preferred agent)
	<b>NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)</b>				NDRI APLENZIN AUVELITY FORFIVO XL*
	<b>SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)</b>				SSRI citalopram capsules fluoxetine tablets VIIBRYD
	<b>SEROTONIN/NORPINEPHRINE REUPTAKE INHIBITORS (SNRI)</b>				SNRI desvenlafaxine FETZIMA venlafaxine ER tablets (use preferred agent)
	<b>OTHER</b>				OTHER TRINTELLIX***
	mirtazapine tablets				
	bupropion ER/SR/XL				
	citalopram escitalopram fluoxetine capsules paroxetine IR/CR sertraline				
duloxetine venlafaxine ER capsules					

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>THESE AGENTS MAY ALSO BE INCLUDED. PLEASE CONTACT OptumRx WITH ANY QUESTIONS</small>
<b>MENTAL HEALTH</b> continued	<b>ATYPICAL ANTIPSYCHOTICS</b> ABILIFY MAINTENA ABILIFY ASIMTUFI aripiprazole tab/solution/ODT ARISTADA FANAPT** galoperidone INVEGA HAFYERA/ SUSTENNA/TRINZA lurasidone olanzapine PERSERIS quetiapine* quetiapine ER RISPERDAL CONSTA risperidone SAPHRIS** VRAYLAR ziprasidone		*Quetiapine doses less than 100mg will require prior authorization <u>without</u> a diagnosis of mood disorder or major depressive disorder. For titration doses, contact the OptumRx Pharmacy Help Desk for an override.  **Clients nine (9) years of age and younger will require a prior authorization to receive approval of Latuda and Saphris. Clients eighteen (18) years of age and younger will require a prior authorization to receive approval of Fanapt.  ***Reulti approval for MDD treatment requires concurrent antidepressant therapy as well as a trial and failure of aripiprazole or other preferred atypical antipsychotic indicated for adjunct MDD treatment.  Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent unless otherwise specified.  Prior authorization will be required for any client five (5) years of age or younger, or for any client taking both an injectable and oral dosage form of the same medication concurrently. <b>Dosage limits apply:</b> aripiprazole <13 years of age: 15mg/day aripiprazole ≥13 years of age: 30mg/day ABILIFY MAINTENA: 400mg per 26 days ARISTADA 441/662/882mg: 1 injection per 28 days ARISTADA 1064mg: 1 injection per 56 days ARISTADA INITIO: 1 injection per 365 days FANAPT: 24mg/day INVEGA HAFYERA: 1 injection per 6 months INVEGA SUSTENNA: 1 injection per 28 days INVEGA TRINZ: 1 injection per 84 days LATUDA 10-17 years of age: 80mg/day LATUDA >17 years of age: 160mg/day olanzapine <13 years of age: 10mg/day olanzapine ≥13 years of age: 20mg/day paliperidone: 12mg/day PERSERIS: 1 injection per 28 days quetiapine <13 years of age: 400mg/day quetiapine 13-17 years of age: 600mg/day quetiapine >17 years of age: 800mg/day risperidone <10 years of age: 3mg/day risperidone 10-17 years of age: 6mg/day risperidone >17 years of age: 16mg/day RISPERDAL CONSTA: 2 injections per 28 days SAPHRIS: 20mg/day ziprasidone ≤17 years of age: 120mg/day ziprasidone >17 years of age: 200mg/day <b>Dosage limits apply: 900mg/day</b>	ABILIFY MYCITE (use preferred agent) CAPLYTA GEODON 20MG INJ LYBALMI (additional criteria applies) NUPLAZID olanzapine 10mg Inj SECUADO REKULTI*** RYKINDO UZEDY ZYPREXA RELPREVV
	<b>SPECIAL ATYPICAL ANTIPSYCHOTICS</b> clozapine/ODT		<b>Dosage limits apply: 900mg/day</b>	VERSACLOZ Suspension (use preferred agent)
	<b>AMPHETAMINES</b>		Clients over the age of 17 must have a diagnosis for ADD, ADHD, (see ADD/ADHD criteria below), narcolepsy, obstructive sleep apnea, shift work sleep disturbance, MS fatigue (see MS Fatigue criteria below), or refractory depression (see refractory depression criteria below).	<b>AMPHETAMINES</b>
	<b>LONG ACTING AMPHETAMINES</b>	ADDERALL XR amphetamine salts combo XR dextroamphetamine CR caps VYVANSE CAPSULES**		ADZENYS XR ODT DYANAVAL XR EVEKEO/ODT MYDAYIS PROCENTRA VYVANSE CHEWABLES ZENZEDI 2.5 AND 7.5MG TABLETS
	<b>IMMEDIATE RELEASE AMPHETAMINES</b>	amphetamine salts combo dextroamphetamine tablets	For clients over the age of 17, they must meet the DSM-5 criteria for diagnosis of ADHD. These criteria include: • Five or more symptoms of inattention, present for at least 6 months, inappropriate for developmental level. OR • Five or more symptoms of hyperactivity and impulsivity, present for at least 6 months, to an extent that is disruptive and inappropriate for developmental level. AND • Symptoms must be present in two or more settings (home, school or work); • There must be clear evidence that the symptoms interfere or reduce the quality of social, school or work functioning; and • The symptoms must not be better explained by another mental disorder.	<b>METHYLPHENIDATES</b>
	<b>METHYLPHENIDATES</b>	<b>LONG ACTING METHYLPHENIDATES</b>		<b>METHYLPHENIDATES</b>
	<b>CONCERTA*</b> dexamethylphenidate ER methylphenidate ER tablets			APTENSIO XR AZSTARVY COTEMPLA XR DAYTRANA FOCALIN XR JORNAY PM methylphenidate ER osmotic release (BRAND IS PREFERRED) methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA, APTENSIO XR) QUILLICHEW ER QUILLIVANT
	<b>IMMEDIATE RELEASE METHYLPHENIDATES</b>	dexamethylphenidate methylphenidate chewables methylphenidate solution methylphenidate tablets	Diagnosis of MS fatigue will require a fatigue severity scale score of 5.0, a 60-day trial of amantadine and discontinuation of medications that may contribute to drowsiness and fatigue.  Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant.  **Vyvanse will be approved for the diagnosis of binge-eating disorder for clients 18 years of age and older. Authorizations will be approved for 12 weeks. After initiation a one-year prior authorization of Vyvanse for this diagnosis will require additional documentation prior to approval.  Claims will require Prior Authorization if client is under the age of 4, or has a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use.  Trial and failure of two (2) preferred agents (each from a different class: methylphenidate and amphetamine) greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Two or more long-acting agents will not be allowed concurrently.  <b>Dosage limits apply:</b> amphetamine salts combo XR: 60mg/day amphetamine salts combo: 60mg/day amphetamine salts combo (narcolepsy): 90mg/day DAYTRANA: 45mg/9 hour patch/day dextroamphetamine: 90mg/day dextroamphetamine CR: 90mg/day dexamethylphenidate: 30mg/day FOCALIN XR < 13 years of age: 45mg/day FOCALIN XR > 13 years of age: 60mg/day JORNAY PM: 100mg/day methylin/methylphenidate/ER: 90mg/day VYVANSE: 105mg/day	



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MENTAL HEALTH continued	SELECTIVE ALPHA-ADRENERGIC AGONIST		Client must must have a diagnosis of ADD or ADHD. Prior authorization will be required for clients under the age of 4.	
	clonidine, clonidine ER			
	SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR		Atomoxetine: Clients must have a diagnosis for ADD, ADHD, narcolepsy, obstructive sleep apnea, shift work sleep disturbance, or refractory depression (see refractory depression criteria below).  Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant.  Prior Authorization required for clients under the age of 4.  Claims will require Prior Authorization if clients have a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use.  Qelbree: Clients must have a 30-day trial and failure of a preferred non-stimulant. Approval will be limited to a max dose of 400mg in clients 6-17 years of age, and 600mg for clients 18 years of age or older. <b>Dosage limits apply: atomoxetine: 100mg/day</b>	QELBREE
MIGRAINE	MIGRAINE PROPHYLAXIS		Trial and failure of both an anticonvulsant and a beta blocker (Step 1 agents) greater than or equal to three (3) months will be required before approval can be given for the step 2 agents. Concurrent use of Botox will not be approved. <b>Nurtec will be limited to 16 tabs/30 days.</b>	NURTEC
	STEP 1 AGENTS			
	beta blockers	divalproex topiramate		
	STEP 2 AGENTS		*Startline dose will be limited to 70me **Approval for non-preferred agents requires trial and failure of a preferred agent along with the trial and failures described with Step 1 Agents' criteria above.	QULIPTA**
AIMOVIG* AJOVY EMGALITY				
ACUTE MIGRAINE TREATMENT			Trial and failure of two preferred agents will be required for approval of a non- preferred agent.  Rizatriptan will be limited to clients 6 years of age or older Quantity limits apply: naratriptan 1mg: 25 tabs/34 days naratriptan 2.5mg: 10 tabs/34 days RELPAx 20mg: 20 tabs/34 days RELPAx 40mg: 14 tabs/34 days rizatriptan 5mg: 27 doses/34 days rizatriptan 10mg: 14 doses/34 days sumatriptan vials: 2 vials/34 days sumatriptan nasal 20mg: 6 bottles/34 days; 5mg: 12 bottles/34 days sumatriptan 25mg: 41 tabs/34 days sumatriptan 50mg: 20 tabs/34 days sumatriptan 100mg: 10 tabs/34 days	almotriptan ELYXYB Sumatriptan-Naproxen Sodium TOSYMRA (use preferred agent) ZEMBRACE (use preferred agent) ZAVZPRET zolmitriptan
STEP 1 AGENTS				
	frovatriptan naratriptan RELPAx* sumatriptan rizatriptan			
STEP 2 AGENTS			Trial and failure of two triptan agents required for Step 2 Agent approval Trial and failure of two preferred triptan agents AND Nurtec will be required for approval of a non-preferred agent. Quantity limits apply: NURTEC 75mg: limited to 8 tabs/30 days REYVOW: 200mg/day or 1 tab/day, 4 tab/30 days	REYVOW UBRELVY
		NURTEC		
MOVEMENT DISORDERS	VMAT 2 INHIBITORS		Quantity limits apply: AUSTEDO: limited to 4 tabs/dav INGREZZA: limited to 4 tabs/dav *Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	
	AUSTEDO/XR* INGREZZA* TETRABENAZINE			
MULTIPLE SCLEROSIS	MS AGENTS		Gilenya, Kesimpta, Lemtrada, Ocrevus, and Tysabri will be approved for highly active disease, please refer to the ATCC for additional information.  Trial and failure of two preferred agents for at least 56 days (each from a separate class) will be required before approval can be given for a non-preferred agent.  For Mavenclad, in addition to the above criteria, approval will be granted on a case-by-case basis.	AUBAGIO BAFIERTAM BRIUMVI EXTAVIA glatramer (BRAND IS PREFERRED) GLATOPA (use preferred agent) MAVENCLAD MAYZENT PLEGRIDY PONVORY TECFIDERA ZEPOSIA
	AVONEX BETASERON COPAXONE 20MG/ML* dimethyl fumarate REBIF teriflunomide VUMERITY	GILENYA KESIMPTA LEMTRADA OCREVUS TYSABRI		
NARCOLEPSY	STIMULANTS		Modafinil and Nuvigil: Client must be > 16 years of age. Client must have a diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, Multiple Sclerosis (MS) Fatigue, or ADD/ADHD with a concurrent diagnosis of substance abuse.  Diagnosis of MS will require a fatigue severity scale score of 5.0, a 60 day trial of amantadine AND discontinuation of medications that may contribute to drowsiness or fatigue.  Clients will not be allowed to take two or more agents in this class concurrently	
		modafinil NUVIGIL*		SUNOSI WAKIX XYREM
	NON-STIMULANTS			
NEUROPATHIC PAIN	GABAPENTIN		Clients will not be allowed to take gabapentin and pregabalin concurrently Prior authorizations for perioperative pain will be approved for gabapentin OR pregabalin for less than or equal to 14 day supplies	
		gabapentin pregabalin		
	TOPICAL LIDOCAINE			ZTLIDO
		Lidocaine Patches		
	ADDITIONAL AGENTS		Trial and failure of a tricyclic antidepressant greater than or equal to a 12 week supply AND trial and failure of gabapentin at a dose of 3600mg per day OR pregabalin for greater than or equal to a 12 week supply in the last 12 months will be required before approval can be given for a non-preferred agent.	carbamazepine imipramine (capsules) oxcarbazepine valproic acid
	amitriptyline desipramine imipramine (tablets) nortriptyline			

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OPHTHALMICS	OP. -ANTI-ALLERGENICS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Alomide and Alocril will be approved for pregnancy. Alomide will be approved for children under the age of 3.	ALOCRIL ALOMIDE bepotastine epinastine ZERVATE
	ALREX azelastine BEPREVE* cromolyn 0.4%			
	OP. -ANTIBIOTICS- QUINOLONES		Trial and failure of a preferred agent greater than or equal to 5 days in the last 12 months will be required before approval can be given for a non-preferred agent.	gatifloxacin ZYMADIX
	ciprofloxacin BESIVANCE ceftamcin moxifloxacin 0.5% ofloxacin tobramycin			
	OP. -ANTI-INFLAMMATORY		Trial and failure of ALL preferred agents each greater than or equal to 5 day supply in the last 12 months will be required before approval can be given for a non- preferred agent.	ACULAR/Ls/PF (use preferred agent) ACUVAIL bromfenac 0.9% BROMSITE DUREZOL ILEVRO INVELTYS LOTEMAX SM loteprednol 0.5% (BRAND PREFERRED) PROLENSA
	flurbiprofen diclofenac LOTEMAX* ketorolac NEVANAC			
	OP. -BETA-BLOCKERS		Trial and failure of three (3) preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non- preferred agent. *Betoptic 5 will be approved for those with heart and lung conditions.	BETIMOL BETOPTIC S*
	betaxolol carteolol levobunolol timolol			
	OP. -CARBONIC ANHYDRASE INHIBITOR		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	brinzolamide (BRAND PREFERRED)
	AZOPT dorzolamide			
	OP. -COMBO PRODUCTS			dorzolamide/timolol (BRAND PREFERRED)
	COMBIGAN* ROCKLATAN SIMBRINZA			
	OP. -DRY EYE AGENTS		Trial and failure of the preferred agent greater than or equal to 12 weeks will be required before approval can be given for the non-preferred agent.	CEQUA cyclosporine (BRAND PREFERRED) EYSUVIS MIEBO RESTASIS MULTIDOSE (see preferred) TYRVAYA
RESTASIS* XIIDRA				
OP. -PROSTAGLANDINS		Trial and failure of ALL preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non- preferred agent.	bimatoprost IYUZEH tafluprost	
latanoprost LUMIGAN TRAVATAN Z XALATAN ZIOPTAN				
OP. -RHO KINASE INHIBITOR				
RHOPRESSA				
OP. -SYMPATHOMIMETICS		Trial of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	brimonidine 0.15% (BRAND IS PREFERRED)	
ALPHAGAN P 0.1% ALPHAGAN P 0.15%* brimonidine 0.2%				
OSTEOPOROSIS	BISPHOSPHONATES		Trial and failure of a preferred agent greater than or equal to 12 months will be required before approval can be given for a non-preferred agent.  Fosamax liquid will be approved for clients that have difficulty swallowing.  **Evinity will only be allowed for a maximum of 12 months of treatment, will not be allowed with any concurrent osteoporosis treatment, and will be limited to approved indication  ***Will be limited to 2 years of use	EVENITY** FORTEO*** FOSAMAX-D TYMLOS***
	alendronate ibandronate risedronate			
	NASAL CALCITONIN			
	calcitonin-salmon			
OTIC	ANTIBIOTIC/STEROID COMBINATION			ciprofloxacin 0.2% (use preferred agent) CIPRO HC (use preferred agent) CORTISPORIN-TC (use preferred agent) FLUOCINOLONE ACET OIL 0.01% (use preferred agent)
	ciprofloxacin/dexamethasone Neo/Poly/HC Suspension and ofloxacin tobramycin/dexamethasone			
OVERACTIVE BLADDER	OVERACTIVE BLADDER AGENTS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Oxytrol will be approved for clients that have an inability to swallow.	darifenacin GELNIQUE GEL 10% GEMTESA mirabeeron (BRAND IS PREFERRED) OXYTROL DIS tolterodine/ER trospium
	MYRBETRIQ oxybutynin /ER solfenacin TOVIAZ TOVIAZ			
PAIN	LONG-ACTING C-III's		Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non- preferred agent.  C-III's and C-IV's that are not included on the PDL and are available without prior authorization with the exception of Butrans (generic substitution is mandatory).  Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid.  **Nucynta ER will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics.  Fentanyl: 50mcg, 1 strength at a time, 1 patch every 3 days Hydromorphone ER: 30mg/day Hysingla ER: 120mg/day Methadone: Limited to 3 tablets per day Morphine ER: 90mg/day Nucynta ER: 327mg/day Oxycontin: 80mg/day Oxymorphone: 40mg/day Xtampza ER: 80mg/day	Fentanyl patches hydrocodone ER hydromorphone ER HYSINGLA ER METHADONE morphine ER capsules (use preferred agents) NUCYNTE ER** oxymorphone ER OXYCONTIN XTAMPZA ER (additional criteria applies)
	morphine ER tablets			
				Clients will be limited to one long-acting narcotic at a time.

**WYOMING MEDICAID  
Preferred Drug List (PDL) October 9, 2024**

Please refer to the Additional Therapeutic Criteria Chart, **Dosage Limitation List** (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES <small>OTHER AGENTS MAY ALSO BE COVERED PLEASE CONTACT ODHSM WITH ANY QUESTIONS</small>		
PAIN continued	<b>SHORT-ACTING C-II's</b>		Trial and failure of three (3) preferred agents greater than or equal to a 6 day supply in the last 90 days will be required before approval can be given for a non-preferred agent.  *Nucynta will be allowed for diabetic peripheral neuropathy or clients with significant gastrointestinal concerns with other CII narcotics.  Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid.  <b>All short-acting narcotics, after 42 days of consecutive use of any combination of short-acting narcotics, will be limited to 4 tablets per day (liquids have specific dosing limits per medication - please refer to dosage limitation chart at www.wyomedicaid.org)</b>  <b>Clients will be limited to one short-acting narcotic at a time</b>	levorphanol NUCYNTA* oxycodone ROXYBOND		
	codeine sulfate hydrocodone/APAP hydrocodone/IBU hydromorphone meperidine morphine oxycodone oxycodone/APAP					
	<b>C-III/C-V AGENTS</b>		Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. <b>Quantity and dosage limits apply (max 8 tabs/day).</b>  Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid.	BELBUCA tramadol/apap tramadol ER capsules/tablets		
	BUTRANS tramadol					
PARKINSON'S DISEASE	<b>SHORT-ACTING AGENTS</b>		**Non-preferred Parkinson's agents will require a 30 day trial and failure of 2 preferred medications including at least one short-acting agent and one long-acting agent  *Neupro will be approved for clients with difficulty swallowing	APOKYN benztropine injectables GOCOVRI INBRIA NEUPRO* ONGENTYS pramipexole ER XADAGO		
	amantadine benztropine tablets carbidopa/levodopa pramipexole ropinirole					
	<b>LONG-ACTING AGENTS</b>					
	ropinirole ER RYTARY					
PHOSPHATE BINDERS	<b>PHOSPHATE BINDERS</b>		Prior authorization required for non-preferred agents.	AURYXIA lanthanum sevelamer VELPHORO		
	calcium acetate					
PROSTATE	<b>5-ALPHA-REDUCTASE INHIBITORS</b>		Trial and failure of a preferred agent greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	dutasteride dutasteride/tamsulosin (use separate agents)		
	finasteride					
	<b>ALPHA BLOCKERS</b>		Trial and failure of a preferred agent greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	alfuzosin dutasteride/tamsulosin (use separate agents) silodosin		
doxazosin tamsulosin terazosin						
PULMONARY ANTIHYPERTENSIVES	<b>5-ALPHA-REDUCTASE INHIBITORS</b>		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	OPSYNVI sildenafil suspension (BRAND IS PREFERRED)		
	ALYQ tadalafil REVATIO SUSPENSION* sildenafil (Revatio A/B rated generic)					
	<b>ENDOTHELIN RECEPTOR ANTAGONISTS</b>				Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	bosentan (BRAND IS PREFERRED) OPSUMIT (use preferred agent) TRACLEER TABS FOR ORAL SUSP (use preferred agent) WINREVAIR
	LETAIRIS TRACLEER TABS*					
	<b>GUANYLATE CYCLASE INHIBITORS</b>				Prior authorization required.	ADEMPAS (use preferred agent)
	<b>PROSTACYCLINE VASODILATORS</b>				Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	
	ORENTRAM					
<b>PROSTACYCLINE RECEPTOR AGONIST</b>		Prior authorization required.	UPTRAVI (use preferred agent)			
RESTLESS LEG SYNDROME	<b>RESTLESS LEG SYNDROME</b>		Client must have a diagnosis of Restless Leg Syndrome (RLS). Trial and failure of gabapentin greater than or equal to 60 days and a trial and failure of a dopamine agonist greater than or equal to 60 days in the last 12 months will be required before approval can be given for a non-preferred agent.  *Neupro will be approved for clients with difficulty swallowing or for clients with a diagnosis of Parkinson's Disease.  Clients will not be allowed to take gabapentin and pregabalin concurrently	HORIZANT NEUPRO*		
pramipexole ropinirole	gabapentin					
SKELETAL MUSCLE RELAXANTS	<b>MUSCLE RELAXANTS</b>		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.  Cyclobenzaprine will require a prior authorization for clients concurrently taking a tricyclic antidepressant. <b>Carisoprodol is limited to 84 tabs/365 days</b>	carisoprodol chlorzoxazone cyclobenzaprine ER LYVISPAH metaxalone methocarbamol orphenadrine tizanidine capsules (use preferred agent)		
	baclofen (5, 10, 15mg tablets) cyclobenzaprine tizanidine tablets					
ULCERATIVE COLITIS	<b>IMMUNOMODULATORS</b>		Client must have diagnosis of UC prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of UC and a 56-day trial and failure of the preferred agent.  * Refer to Additional Therapeutics Clinical Criteria Chart for more information	ENTYVIO* REMICADE RINVOQ SIMPONI SKYRIZI STELARA XELJANZ/XR		
		HUMIRA				
UVEITIS	<b>IMMUNOMODULATORS</b>		Client must have diagnosis of non-infectious intermediate, posterior, or panuveitis			
		HUMIRA				