

New York State Medicaid Fee-For-Service Pharmacy Programs

OVERVIEW OF CONTENTS

Preferred Drug Program (PDP) (Pages 2–38)

Last Update: May 26, 2017

The PDP promotes the use of less expensive, equally effective drugs when medically appropriate through a Preferred Drug List (PDL). All drugs currently covered by Fee-For-Service (FFS) Medicaid remain available under the PDP and the determination of preferred and non-preferred drugs does not prohibit a prescriber from obtaining any of the medications covered under Medicaid.

- Non-preferred drugs in these classes require prior authorization (PA), unless indicated otherwise.
- Preferred drugs that require prior authorization are indicated by footnote.
- Specific Clinical, Frequency/Quantity/Duration, Step Therapy criteria is listed in column at the right.

Clinical Drug Review Program (CDRP) (Page 39)

Last Update: February 21, 2013

The CDRP is aimed at ensuring specific drugs are utilized in a medically appropriate manner. Under the CDRP, certain drugs require prior authorization because there may be specific safety issues, public health concerns, the potential for fraud and abuse, or the potential for significant overuse and misuse.

Drug Utilization Review (DUR) Program (Pages 40–46)

Last Update: May 26, 2017

The DUR helps to ensure that prescriptions for outpatient drugs are appropriate, medically necessary, and not likely to result in adverse medical consequences. This program uses professional medical protocols and computer technology and claims processing to assist in the management of data regarding the prescribing and dispensing of prescriptions. Frequency/Quantity/Duration (F/Q/D) Program and Step Therapy parameters are implemented to ensure clinically appropriate and cost effective use of these drugs and drug classes.

Brand Less Than Generic (BLTG) Program (Page 47)

Last Update: May 26, 2017

The Brand Less Than Generic Program is a cost containment initiative which promotes the use of certain multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent. This program is in conformance with State Education Law, which intends that patients receive the lower cost alternative.

Mandatory Generic Drug Program (Page 48)

Last Update: April 25, 2013

State law excludes Medicaid coverage of brand name drugs that have a Federal Food and Drug Administration (FDA) approved A-rated generic equivalent, unless a prior authorization is obtained. Drugs subject to the Preferred Drug Program (PDP), Clinical Drug Review Program (CDRP), and/or the Brand Less Than Generic (BLTG) Program are not subject to the Mandatory Generic Program.

Dose Optimization Program (Pages 49–51)

Last Update: November 6, 2014

Dose optimization can reduce prescription costs by reducing the number of pills a patient needs to take each day. The Department has identified drugs to be included in this program, the majority of which have FDA approval for once-a-day dosing, have multiple strengths available in correlating increments at similar costs and are currently being utilized above the recommended dosing frequency.

For more information on the NYS Medicaid Pharmacy Programs: http://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm

To contact the NYS Medicaid Pharmacy Clinical Call Center please call 1-877-309-9493

To download a copy of the Prior Authorization fax form go to https://newyork.fhsc.com/providers/PA_forms.asp

NYS Medicaid Fee-For-Service Preferred Drug List

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. ANALGESICS		
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) – Prescription		
diclofenac sodium XR ibuprofen indomethacin ketorolac meloxicam (tablet) naproxen naproxen EC piroxicam sulindac Voltaren® Gel	Anaprox® DS Arthrotec® Cambia® Celebrex® ^{CC} celecoxib ^{CC} Daypro® diclofenac / misoprostol diclofenac potassium diclofenac sodium diclofenac topical gel diclofenac topical soln diflunisal Duexis® etodolac etodolac ER Feldene® fenoprofen Flector® patch flurbiprofen Indocin® indomethacin SR ketoprofen	ketoprofen SA meclofenamate mefenamic acid meloxicam (susp.) Mobic® nabumetone Nalfon® Naprelan® Naprosyn® Naprosyn® EC naproxen CR naproxen sodium oxaprozin Pennsaid® Ponstel® Tivorbex® tolmetin Vimovo® Vivlodex™ Voltaren® XR Zipsor® Zorvolex®
<p>CLINICAL CRITERIA (CC)</p> <ul style="list-style-type: none"> ➤ <u>Celebrex® (celecoxib)</u> – one of the following criteria will not require PA <ul style="list-style-type: none"> ▪ Over the age of 65 years ▪ Concurrent use of an anticoagulant agent ▪ History of GI Bleed/Ulcer or Peptic Ulcer Disease 		
Opioid Antagonists		
naloxone (syringe, vial) naltrexone Narcan® (nasal spray) ReVia®		
Opioid Dependence Agents ^{CC, F/Q/D}		
buprenorphine Suboxone® (film)	Bunavail® buprenorphine/ naloxone (tablet) Zubsolv®	<p>CLINICAL CRITERIA (CC)</p> <ul style="list-style-type: none"> ➤ PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy <p>QUANTITY LIMIT:</p> <ul style="list-style-type: none"> ➤ <u>Buprenorphine sublingual (SL)</u>: Six (6) tablets dispensed as a 2-day supply; not to exceed 24 mg per day ➤ <u>Buprenorphine/ naloxone tablet and film (Bunavail™, Suboxone®, Zubsolv®)</u>: Three (3) sublingual tablets or films per day; maximum of 90 tablets or films dispensed as a 30-day supply, not to exceed 24 mg-6 mg of Suboxone, or it's equivalent per day

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Opioids – Long-Acting CC, F/Q/D		
<p>Butrans® Embeda®¹ fentanyl patch (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg) morphine sulfate SR (tablet)</p>	<p>Arymo™ ER Belbuca™ Conzip®ST Duragesic® Exalgo® fentanyl patch (37.5 mcg, 62.5 mcg, 87.5 mcg) hydromorphone ER Hysingla® ER Kadian® morphine ER (capsule) (generic for Avinza) morphine ER (capsule) (generic for Kadian) MS Contin® Nucynta® ER ST Opana ER® oxycodone ER Oxycontin® oxymorphone ER tramadol ER ST Xtampza™ ER Zohydro® ER</p>	<p>CLINICAL CRITERIA (CC)</p> <ul style="list-style-type: none"> ➤ Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease ➤ PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy ➤ PA required for initiation of long-acting opioid therapy in opioid-naïve patients. <ul style="list-style-type: none"> ▪ Exemption for diagnosis of cancer or sickle cell disease. ➤ PA required for any additional long-acting opioid prescription for patients currently on long-acting opioid therapy. <ul style="list-style-type: none"> ▪ Exemption for diagnosis of cancer or sickle cell disease. ➤ PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy <p>STEP THERAPY (ST)</p> <ul style="list-style-type: none"> ➤ <u>Nucynta® ER (tapentadol ER)</u>: Trial with tapentadol IR before tapentadol ER for patients who are naïve to a long-acting opioid ➤ <u>Tramadol ER (tramadol naïve patients)</u>: Attempt treatment with IR formulations before the following ER formulations: Conzip®, tramadol ER <p>FREQUENCY/QUANTITY/DURATION (F/Q/D) - Exemption for diagnosis of cancer or sickle cell disease</p> <ul style="list-style-type: none"> ➤ <u>Belbuca™ (buprenorphine)</u> <ul style="list-style-type: none"> ▪ Maximum 2 (two) units per day ➤ <u>Butrans® (buprenorphine)</u> <ul style="list-style-type: none"> ▪ Maximum 4 patches per 28 days ➤ <u>Embeda® (morphine ER/naltrexone)</u>: <ul style="list-style-type: none"> ▪ Maximum 2 (two) units per day ➤ <u>Nucynta® ER (tapentadol ER)</u>: <ul style="list-style-type: none"> ▪ Maximum 2 (two) units per day ➤ <u>Nucynta® ER (tapentadol ER)</u>: <ul style="list-style-type: none"> ▪ Maximum daily dose of tapentadol IR and tapentadol ER formulations if used in combination should not exceed 500mg/day ➤ <u>Tramadol ER (Conzip®)</u>: <ul style="list-style-type: none"> ▪ Maximum 30 tablets dispensed as a 30 day supply ➤ <u>Zohydro ER (hydrocodone ER)</u>: <ul style="list-style-type: none"> ▪ Maximum 2 (two) units per day, 60 units per 30 days ➤ <u>Hysingla™ ER (hydrocodone ER)</u>: <ul style="list-style-type: none"> ▪ Maximum 1 (one) unit per day; 30 units per 30 days ➤ <u>Hydromorphone ER, oxymorphone ER</u>: <ul style="list-style-type: none"> ▪ Maximum 4 (four) units per day, 120 units per 30 days ➤ <u>Oxycodone ER (Xtampza ER™)</u>: <ul style="list-style-type: none"> ▪ Maximum 2 (two) units per day, 60 units per 30 days. Not to exceed a total daily dose of 160mg or its equivalent ➤ <u>Fentanyl transdermal patch (Duragesic®)</u>: <ul style="list-style-type: none"> ▪ Maximum 10 patches per 30 days; maximum 100mcg/hr (over a 72 hour dosing interval) ➤ <u>Morphine ER (excluding MS Contin products)</u>: <ul style="list-style-type: none"> ▪ Maximum 2 (two) units per day, 60 units per 30 days ➤ <u>Morphine ER (MS Contin & Arymo™ ER 15mg, 30mg, 60mg only)</u>: <ul style="list-style-type: none"> ▪ Maximum 3 (three) units per day, 90 units per 30 days ➤ <u>Morphine ER (MS Contin 100mg only)</u>: <ul style="list-style-type: none"> ▪ Maximum 4 units per day, up to 3 times a day, maximum 120 units per 30 days ➤ <u>Morphine ER (MS Contin 200mg only)</u>: <ul style="list-style-type: none"> ▪ Maximum 2 units per day, maximum 60 units per 30 days

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2 = Non-Preferred as of 6/22/2017

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Opioids – Short-Acting ^{CC}		
butalbital / APAP / caffeine / codeine ^{F/Q/D} codeine ^{F/Q/D} codeine / APAP ^{F/Q/D} hydrocodone / APAP ^{F/Q/D} hydrocodone / ibuprofen ^{F/Q/D} Lortab [®] (elixir) ^{F/Q/D} morphine IR ^{F/Q/D} oxycodone / APAP ^{F/Q/D} Repraxin [®] ^{F/Q/D} tramadol Verdrocet [™] ^{F/Q/D} Xylon [™] ^{F/Q/D}	butalbital compound/ codeine ^{F/Q/D} butorphanol nasal spray Demerol [®] dihydrocodeine / aspirin / caffeine ^{F/Q/D} dihydrocodeine / APAP / caffeine ^{F/Q/D} Dilaudid [®] ^{F/Q/D} Fioricet [®] / codeine ^{F/Q/D} Fiorinal [®] / codeine ^{F/Q/D} hydromorphone ^{F/Q/D} Ibudone [®] ^{F/Q/D} levorphanol meperidine Nucynta [®] ^{ST, F/Q/D} Opana [®] ^{F/Q/D} oxycodone ^{F/Q/D} oxycodone / aspirin ^{F/Q/D} oxycodone / ibuprofen ^{F/Q/D} oxymorphone ^{F/Q/D} pentazocine / naloxone Percocet [®] ^{F/Q/D} Primlev [™] ^{F/Q/D} Roxicodone [®] ^{F/Q/D} Synalgos [®] DC ^{F/Q/D} tramadol / APAP ^{F/Q/D} Tylenol [®] / codeine #3 ^{F/Q/D} Tylenol [®] / codeine #4 ^{F/Q/D} Ultracet [®] ^{F/Q/D} Ultram [®] Xartemis [®] XR ^{F/Q/D} Xodol [®] ^{F/Q/D} Zamicet [®] ^{F/Q/D}	<p><u>CLINICAL CRITERIA (CC)</u></p> <ul style="list-style-type: none"> ➤ Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease ➤ Initial prescription for opioid-naïve patients limited to a 15-day supply. ➤ Exception for diagnosis of cancer or sickle cell PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy ➤ PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy <p><u>STEP THERAPY (ST)</u></p> <ul style="list-style-type: none"> ➤ <u>Nucynta[®] (tapentadol IR)</u> – Trial with tramadol and one (1) preferred opioid before tapentadol immediate-release (IR) <p><u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u></p> <p><u>Quantity Limits:</u></p> <ul style="list-style-type: none"> ➤ <u>Nucynta[®] (tapentadol IR):</u> <ul style="list-style-type: none"> ▪ Maximum 6 (six) units per day; 180 units per 30 days ➤ <u>Nucynta[®] (tapentadol IR):</u> <ul style="list-style-type: none"> ▪ Maximum daily dose of <u>tapentadol IR</u> and <u>tapentadol ER</u> formulations used in combination not to exceed 500mg/day ➤ <u>Morphine and congeners immediate-release (IR)</u> non-combination products (codeine, hydromorphone, morphine, oxycodone, oxymorphone): <ul style="list-style-type: none"> ▪ Maximum 6 (six) units per day, 180 (one hundred eighty) units per 30 (thirty) days ➤ <u>Xartemis[®] XR</u> (oxycodone/acetaminophen): <ul style="list-style-type: none"> ▪ Maximum 4 (four) units per day, 120 (one hundred twenty) units per 30 (thirty) days <p>Additional/alternate parameters: To be applied to patients without a documented cancer or sickle cell diagnosis</p> <ul style="list-style-type: none"> ➤ <u>Morphine and congeners immediate-release (IR)</u> combination products maximum recommended: <ul style="list-style-type: none"> ▪ acetaminophen (4 grams) ▪ aspirin (4 grams) ▪ ibuprofen (3.2 grams) ▪ or the FDA approved maximum opioid dosage as listed in the PI, whichever is less <p><u>Duration Limits:</u></p> <ul style="list-style-type: none"> ▪ 90 days for patients without a diagnosis of cancer or sickle-cell disease.

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
II. ANTI-INFECTIVES				
Antibiotics – Inhaled CC, F/Q/D				
Bethkis® Cayston®	Kitabis® Pak	TOBI Podhaler™ TOBI® (solution)	tobramycin (solution)	CLINICAL CRITERIA (CC) Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication FREQUENCY/QUANTITY/DURATION (F/Q/D) <ul style="list-style-type: none"> ➢ Aztreonam (Cayston) <ul style="list-style-type: none"> ▪ 3 (three) ampules (3mL) per day ▪ 84 ampules (84 mL) per 56 day regimen (28 days on, 28 days off) ➢ Tobramycin inhalation solution (Bethkis, TOBI, Kitabis) <ul style="list-style-type: none"> ▪ 2 (two) ampules (8 mL Bethkis, 10 mL TOBI, Kitabis Pak) per day ▪ 56 ampules (224 mL Bethkis, 280 mL TOBI, Kitabis Pak) per 56 day regimen (28 days on-28 days off) ➢ Tobramycin capsules with inhalation powder (TOBI Podhaler) <ul style="list-style-type: none"> ▪ 8 capsules per day 224 capsules per 56 day regimen (28 days on-28 days off)
Anti-Fungals – Oral for Onychomycosis				
griseofulvin (suspension) griseofulvin ultramicrosized terbinafine (tablet)		Gris-PEG® griseofulvin micronized (tablet) itraconazole Lamisil® (tablet) Omnel® Sporanox®		
Anti-Virals – Oral				
acyclovir valacyclovir		famciclovir Famvir®	Valtrex® Zovirax®	
Cephalosporins – Third Generation				
cefdinir cefixime	cefepodoxime Suprax®	Cedax®	ceftibuten	
Fluoroquinolones – Oral				
Cipro® (suspension) ciprofloxacin (suspension, tablet) levofloxacin (tablet)		Avelox® Avelox ABC Pack® Cipro® (tablet) Cipro® XR ciprofloxacin ER	Levaquin® levofloxacin (solution) moxifloxacin ofloxacin (tablet)	
Hepatitis B Agents				
Baraclude® (solution) entecavir Epivir-HBV® (solution)	Hepsera® lamivudine 100mg Tyzeka®	adefovir dipivoxil Baraclude® (tablet)	Epivir-HBV® (tablet) Vemlidy®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Hepatitis C Agents – Injectable ^{F/Q/D}			
Pegasys®	PegIntron®	None	<p>FREQUENCY/QUANTITY/DURATION (F/Q/D)</p> <ul style="list-style-type: none"> ➤ PA required for the initial 14 weeks therapy to determine appropriate duration of therapy based on genotype, prior treatment and response, presence of cirrhosis, and HIV-coinfection. ➤ Further documentation required for continuation of therapy at weeks 14 and 26. ➤ After 12 weeks of therapy obtain a quantitative HCV RNA. Continuation is supported if undetectable HCV RNA or at least a 2 log decrease compared to baseline. ➤ After 24 weeks of therapy obtain a HCV RNA. Continuation for genotype 1 and 4 is supported if undetectable HCV RNA. <ul style="list-style-type: none"> ▪ Maximum duration of 48 weeks for: <ul style="list-style-type: none"> ❖ Treatment-naïve patients or prior relapsers with cirrhosis and HIV co-infection ❖ Prior non-responders (including prior partial and null responders) with or without cirrhosis and with or without HIV co-infection
Hepatitis C Agents – Direct Acting Antivirals			
Epclusa® (for GTs 2 & 3) ^{CC, F/Q/D} Harvoni® ^{CC, F/Q/D} ribavirin Technivie® ^{CC, F/Q/D} Viekira Pak® ^{CC, F/Q/D} Viekira XR™ ^{CC, F/Q/D} Zepatier™ ^{CC, F/Q/D}	Copegus® Daklinza™ ^{CC, F/Q/D} Moderiba™ Olysio® ^{CC, F/Q/D} Rebetol® Ribasphere® Sovaldi® ^{CC, F/Q/D}	<p>CLINICAL CRITERIA (CC)</p> <ul style="list-style-type: none"> ➤ Confirm diagnosis of FDA-approved or compendia-supported indication ➤ Require confirmation of prescriber experience and training <ul style="list-style-type: none"> ▪ Prescribed by hepatologist, gastroenterologist, infectious disease specialist, transplant physician or health care practitioner experienced and trained in the treatment of Hepatitis C viral (HCV) or a healthcare practitioner under the direct supervision of a listed specialist. AND ▪ Clinical experience is defined as the management and treatment of at least 10 patients with HCV infection in the last 12 months and at least 10 HCV- related CME credits in the last 12 months. OR ▪ Management and treatment of HCV infection in partnership (defined as consultation, preceptorship, or via telemedicine) with an experienced HCV provider who meets the above criteria. ➤ Require confirmation of patient readiness and adherence <ul style="list-style-type: none"> ▪ Evaluation by using scales or assessment tools readily to determine a patient’s readiness to initiate HCV treatment, specifically drug and alcohol abuse potential. Assessment tools are available to healthcare practitioners at: http://www.integration.samhsa.gov/clinical-practice/screening-tools OR https://prepc.org/. <p style="color: orange;">Click here to access the Hepatitis C Worksheets with Clinical Criteria requirements</p>	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Tetracyclines				
demeclocycline doxycycline hyclate minocycline (capsule) Morgidox® (capsule) tetracycline		Doryx® ^{ST, F/Q/D} Doryx MPC® ^{ST, F/Q/D} doxycycline hyclate DR ^{ST, F/Q/D} doxycycline monohydrate doxycycline monohydrate IR-DR minocycline (tablet) minocycline ER Mondoxyne™ Oracea® Solodyn® Vibramycin®		STEP THERAPY (ST) > Trial of doxycycline IR before progressing to doxycycline DR FREQUENCY/QUANTITY/DURATION (F/Q/D) > <u>doxycycline DR (Doryx®):</u> <ul style="list-style-type: none"> ▪ Maximum 28 tablets/capsules per fill
III. CARDIOVASCULAR				
Angiotensin Converting Enzyme Inhibitors (ACEIs)				
benazepril enalapril		lisinopril ramipril	Accupril® Altace® captopril ² Epaned™ fosinopril Lotensin® Mavik® moexipril perindopril	Prinivil® Qbrelis™ quinapril trandolapril Vasotec® Zestril®
ACE Inhibitor Combinations				
benazepril/ amlodipine benazepril/ HCTZ captopril/ HCTZ enalapril/ HCTZ lisinopril/ HCTZ moexipril/ HCTZ Tarka® trandolapril/ verapamil ER		Accuretic® fosinopril/ HCTZ Lotensin HCT® Prestalia®	quinapril/ HCTZ Vaseretic® Zestoretic®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Angiotensin Receptor Blockers (ARBs) ST		
Diovan [®] ^{DO} losartan valsartan	Atacand [®] Avapro [®] Benicar [®] ^{DO} candesartan Cozaar [®] Edarbi [™] eprosartan irbesartan Micardis [®] ^{DO} olmesartan telmisartan	<u>DOSE OPTIMIZATION (DO)</u> > See Dose Optimization Chart for affected drugs and strengths <u>STEP THERAPY (ST)</u> > Trial of a product containing ACE inhibitor prior to preferred ARB
ARBs Combinations ST		
Exforge HCT [®] losartan/ HCTZ valsartan/ amlodipine valsartan/ amlodipine / HCTZ valsartan/ HCTZ	Atacand HCT [®] Avalide [®] Azor [®] Benicar HCT [®] ^{DO} Byvalson [™] candesartan/ HCTZ Diovan HCT [®] ^{DO} Edarbyclor [™] ^{DO} Entresto [™] ^{CC} Exforge [®] ^{DO} Hyzaar [®] irbesartan/ HCTZ Micardis HCT [®] ^{DO} olmesartan/ amlodipine olmesartan/ amlodipine/ HCTZ olmesartan/ HCTZ telmisartan/ amlodipine telmisartan/ HCTZ Tribenzor [®] Twynsta [®]	<u>CLINICAL CRITERIA (CC)</u> > PA is not required if patient has chronic symptomatic HFREF (NYHA class II or III), can tolerate an ACE inhibitor or ARB, and transition to the non-preferred product is warranted to produce the desired health outcome <u>DOSE OPTIMIZATION (DO)</u> > See Dose Optimization Chart for affected drugs and strengths <u>STEP THERAPY (ST)</u> > Trial of product containing ACE Inhibitor prior to preferred ARB

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Beta Blockers				
atenolol carvedilol labetalol metoprolol succ. XL metoprolol tartrate propranolol (tablet)	acebutolol betaxolol bisoprolol Bystolic® ^{DO} Coreg® Coreg CR® ^{DO} Corgard® Inderal LA® Inderal XL® InnoPran XL® Levato®	Lopressor® nadolol ^{DO} pindolol propranolol (solution) propranolol ER/SA Sectral® Tenormin® timolol Toprol XL® ^{DO} Zebeta®	<u>DOSE OPTIMIZATION (DO)</u> ➤ See Dose Optimization Chart for affected drugs and strengths	
Beta Blockers / Diuretics				
atenolol/ chlorthalidone bisoprolol/ HCTZ propranolol/ HCTZ	Corzide® Dutoprol™ Lopressor HCT® metoprolol ER/ HCTZ metoprolol tartrate/ HCTZ nadolol/ bendroflumethiazide Tenoretic® Ziac®			
Calcium Channel Blockers (Dihydropyridine)				
Afeditab CR® amlodipine felodipine ER isradipine	nicardipine HCl Nifedical XL® nifedipine nifedipine ER/SA	Adalat® CC nisoldipine Norvasc®	Procardia® Procardia XL® Sular®	
Cholesterol Absorption Inhibitors				
cholestyramine cholestyramine light Colestid® (tablet)	colestipol (tablet) Prevalite®	Colestid (granules) colestipol (granules) Questran®	Questran Light® Welchol® Zetia®	
Direct Renin Inhibitors ST				
Tekturna®	Tekturna HCT®	None	<u>STEP THERAPY (ST)</u> ➤ Trial of product containing either an ACE inhibitor or an ARB prior to initiating preferred DRI	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
HMG-CoA Reductase Inhibitors (Statins)				
atorvastatin lovastatin pravastatin	rosuvastatin ¹ simvastatin	Altoprev® atorvastatin/amlodipine Caduet® Crestor® ^{DO} fluvastatin fluvastatin ER	Lescol XL® Lipitor® Livalo® Pravachol® Vytorin® Zocor®	<u>DOSE OPTIMIZATION (DO)</u> ➤ See Dose Optimization Chart for affected drugs and strengths
Niacin Derivatives				
niacin ER		Niaspan® ^{DO}		<u>DOSE OPTIMIZATION (DO)</u> ➤ See Dose Optimization Chart for affected drugs and strengths
Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH ^{CDRP}				
Adcirca®	sildenafil	Revatio®		<u>CLINICAL DRUG REVIEW PROGRAM (CDRP)</u> ➤ All prescriptions for <u>Adcirca®</u> , <u>Revatio®</u> and <u>sildenafil</u> must have PA ➤ Prescribers are required to respond to a series of questions that identify prescriber, patient and reason for prescribing drug ➤ Please be prepared to fax clinical documentation upon request ➤ Prescriptions can be written for a 30-day supply with up to 5 refills ➤ The <u>CDRP Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH Prescriber Worksheet</u> provides step-by-step assistance in completing the prior authorization process
Pulmonary Arterial Hypertension (PAH) Oral Agents, Other				
Letairis® Orenitram®	Tracleer®	Adempas® Opsumit®	Upravi®	
Triglyceride Lowering Agents				
gemfibrozil fenofibrate (48 mg, 145 mg) fenofibric acid		Antara® fenofibrate Fenoglide® Fibricor® Lipofen® Lofibra® Lopid® Lovaza® ^{ST, F/Q/D} omega-3 ethyl ester ^{ST, F/Q/D} Tricor® Triglide® Trilipix® Vascepa® ^{ST, F/Q/D}		<u>STEP THERAPY (ST)</u> ➤ <u>Lovaza® (omega-3-acid ethyl-esters)</u> and <u>Vascepa® (icosapent ethyl)</u> – Trial of fibric acid derivative OR niacin prior to treatment with omega-3-acid ethyl-esters <u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u> ➤ <u>Lovaza® (omega-3-acid ethyl-esters)</u> and <u>Vascepa® (icosapent ethyl)</u> – Required dosage equal to 4 (four) units per day

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. CENTRAL NERVOUS SYSTEM		
Alzheimer's Agents		
donepezil 5mg, 10mg Exelon® (patch) galantamine galantamine ER memantine Namenda® rivastigmine (capsule)	Aricept® donepezil 23 mg Exelon® (capsule) Namenda XR® CC, ST Namzaric® CC, ST rivastigmine (patch) Razadyne® Razadyne ER®	CLINICAL CRITERIA (CC) ➤ <u>Memantine extended-release containing products (Namenda XR™ and Namzaric™)</u> – Require confirmation of diagnosis of dementia or Alzheimer's disease STEP THERAPY (ST) ➤ <u>Memantine extended-release containing products (Namenda XR™ and Namzaric™)</u> – Require trial with memantine immediate-release (Namenda®)
Anticonvulsants – Second Generation		
gabapentin (capsule, solution) F/Q/D lamotrigine (tablet) levetiracetam levetiracetam ER Lyrica® (capsule) DQ, ST tiagabine topiramate CC zonisamide	Banzei® CC Briviact® felbamate ² Felbatol® CC Fycompa® gabapentin (tablet) CC, F/Q/D Gabitril® CC Keppra® CC Keppra XR® CC Lamictal® CC Lamictal® ODT Lamictal® XR CC lamotrigine ER CC lamotrigine ODT Lyrica® (solution) DQ, ST 2 Neurontin® CC, F/Q/D Onfi® CC, ST Potiga® CC Qudexy® XR CC Roweepra™ CC Sabril® CC Spritam® Topamax® CC topiramate ER CC Trokendi XR® CC Vimpat® CC Zonegran® CC	DOSE OPTIMIZATION (DO) ➤ See Dose Optimization Chart for affected drugs and strengths CLINICAL CRITERIA (CC) ➤ Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA ➤ <u>Topiramate IR/ER (Qudexy™ XR, Topamax®, Trokendi XR™)</u> – Require confirmation of FDA approved, compendia supported, or Medicaid covered diagnosis ➤ <u>Onfi® (clobazam):</u> ▪ Require confirmation of FDA approved or compendia supported use ▪ PA required for initiation of clobazam therapy in patients currently on opioid or oral buprenorphine therapy ▪ PA required for any clobazam prescription in patients currently on benzodiazepine therapy FREQUENCY/QUANTITY/DURATION (F/Q/D) Neurontin® (gabapentin) – Maximum daily dose of 3,600 mg per day STEP THERAPY (ST) ➤ <u>Lyrica® (pregabalin)</u> – Requires a trial with a tricyclic antidepressant OR gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN) ➤ <u>Onfi® (clobazam)</u> – Requires a trial with an SSRI or SNRI for treatment of anxiety

1 = Preferred as of 6/22/2017

2 = Non-Preferred as of 6/22/2017

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																										
Antipsychotics – Second Generation CC, ST																												
aripiprazole (oral solution, tablet) clozapine Latuda® DO olanzapine (tablet) DO quetiapine F/Q/D risperidone Saphris® Seroquel XR® DO, F/Q/D ziprasidone	Abilify® (oral solution, tablet) DO aripiprazole ODT clozapine ODT Clozaril® Fanapt® 2 FazaClo® Geodon® Invega® DO, F/Q/D olanzapine ODT DO Nuplazid™ paliperidone ER F/Q/D quetiapine ER F/Q/D Rexulti® Risperdal® Seroquel® F/Q/D Versacloz® Vraylar™ Zyprexa® DO	<p><u>DOSE OPTIMIZATION (DO)</u></p> <ul style="list-style-type: none"> ➤ See Dose Optimization Chart for affected drugs and strengths <p><u>CLINICAL CRITERIA (CC)</u></p> <ul style="list-style-type: none"> ➤ Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA ➤ Confirm diagnosis of FDA-approved or compendia-supported indication ➤ Aripiprazole (Abilify®)- PA is not required when prescribed for treatment of bipolar disorder or schizophrenia as verified by Medicaid claims information but will be subject to other clinical criteria ➤ PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below: <table border="1" data-bbox="1115 557 1810 979"> <tbody> <tr><td>aripiprazole (Abilify®)</td><td>6 years</td></tr> <tr><td>asenapine (Saphris®)</td><td>10 years</td></tr> <tr><td>brexpiprazole (Rexulti®)</td><td>18 years</td></tr> <tr><td>cariprazine (Vraylar™)</td><td>18 years</td></tr> <tr><td>clozapine (Clozaril®, FazaClo®, Versacloz™)</td><td>12 years</td></tr> <tr><td>iloperidone (Fanapt®)</td><td>18 years</td></tr> <tr><td>lurasidone HCl (Latuda®)</td><td>13 years</td></tr> <tr><td>olanzapine (Zyprexa®)</td><td>10 years</td></tr> <tr><td>paliperidone ER (Invega®)</td><td>12 years</td></tr> <tr><td>pimavanserin (Nuplazid™)</td><td>18 years</td></tr> <tr><td>quetiapine fum. (Seroquel®, Seroquel XR®)</td><td>10 years</td></tr> <tr><td>risperidone (Risperdal®)</td><td>5 years</td></tr> <tr><td>ziprasidone HCl (Geodon®)</td><td>18 years</td></tr> </tbody> </table> <ul style="list-style-type: none"> ➤ Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients < 18 years of age <p><u>STEP THERAPY (ST)</u></p> <ul style="list-style-type: none"> ➤ For all Second Generation Antipsychotics used in the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is required ➤ Trial of risperidone prior to paliperidone (Invega®) therapy <p><u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u></p> <ul style="list-style-type: none"> ➤ <u>paliperidone ER (Invega®) 1.5mg, 3mg, 9mg tablets</u>: Maximum 1 (one) unit/day ➤ <u>paliperidone ER (Invega®) 6mg tablets</u>: Maximum 2 (two) units/day ➤ <u>quetiapine/quetiapine ER (Seroquel®/Seroquel XR®)</u>: Minimum 100mg/day; maximum 800mg/day ➤ <u>quetiapine (Seroquel®)</u>: Maximum 3 (three) units per day, 90 units per 30 days ➤ <u>quetiapine ER (Seroquel XR®) 150mg, 200mg</u>: 1 (one) unit/day, 30 units/30 days ➤ <u>quetiapine ER (Seroquel XR®) 50mg, 300mg, 400mg</u>: 2 (two) units/day, 60 units/30 days 	aripiprazole (Abilify®)	6 years	asenapine (Saphris®)	10 years	brexpiprazole (Rexulti®)	18 years	cariprazine (Vraylar™)	18 years	clozapine (Clozaril®, FazaClo®, Versacloz™)	12 years	iloperidone (Fanapt®)	18 years	lurasidone HCl (Latuda®)	13 years	olanzapine (Zyprexa®)	10 years	paliperidone ER (Invega®)	12 years	pimavanserin (Nuplazid™)	18 years	quetiapine fum. (Seroquel®, Seroquel XR®)	10 years	risperidone (Risperdal®)	5 years	ziprasidone HCl (Geodon®)	18 years
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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Antipsychotics, Injectable		
Abilify Maintena® Aristada™ fluphenazine decanoate Haldol® decanoate haloperidol decanoate Invega Sustenna® Invega Trinza® Risperdal Consta® Zyprexa Relprevv™	None	
Benzodiazepines – Rectal		
Diastat® 2.5mg Diastat® AcuDial™	diazepam (rectal gel)	
Carbamazepine Derivatives		
carbamazepine (chewable, tablet) carbamazepine ER (capsule) Epitol® Equetro® oxcarbazepine Tegretol® (suspension) Tegretol XR®	Aptiom® ^{CC} carbamazepine (suspension) ^{CC} carbamazepine XR (tablet) ^{CC} Carbatrol® ^{CC} Oxtellar XR® ^{CC} Tegretol® (tablet) ^{CC} Trileptal® ^{CC}	<u>CLINICAL CRITERIA (CC)</u> ➤ Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Central Nervous System (CNS) Stimulants CC, CDRP, F/Q/D		
Adderall® Adderall XR® amphetamine salt combo IR Daytrana® dextroamphetamine (tablet) Focalin® ¹ Focalin XR® DO Methylin® methylphenidate (tablet) Quillivant XR® Vyvanse® (capsule) DO	Adzenys XR-ODT™ amphetamine salt combo ER Aptensio XR® armodafinil CC Concerta® DO Desoxyn® Dexedrine® dexamethylphenidate ² dexamethylphenidate ER (generic for Focalin XR®) dextroamphetamine ER dextroamphetamine (solution) Dyanavel XR™ Evekeo® Metadate CD® DO Metadate® ER ² methamphetamine methylphenidate (chewable tablet, solution) methylphenidate CD (generic Metadate CD®) methylphenidate ER (generic Concerta®) ² methylphenidate ER (generic Ritalin LA®) methylphenidate SR (generic Metadate®ER) ² modafinil Nuvigil® CC Procentra® Provigil® CC, DO Quillichew ER™ DO Ritalin® Ritalin LA® DO Vyvanse® (chewable tablet) Zenzedi®	<p><u>CLINICAL CRITERIA (CC)</u></p> <ul style="list-style-type: none"> ➤ Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication for beneficiaries less than 18 years of age. <ul style="list-style-type: none"> ▪ Prior authorization is required for initial prescriptions for stimulant therapy for beneficiaries less than 3 years of age ▪ Require confirmation of diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent ➤ Patient-specific considerations for drug selection include treatment of excessive sleepiness associated with shift work sleep disorder or as an adjunct to standard treatment for obstructive sleep apnea. <p><u>CLINICAL DRUG REVIEW PROGRAM (CDRP)</u></p> <ul style="list-style-type: none"> ➤ For patients 18 years of age and older: ➤ Confirm diagnosis of FDA approved, compendia supported, and Medicaid covered indication <p><u>DOSE OPTIMIZATION (DO)</u></p> <ul style="list-style-type: none"> ➤ See Dose Optimization Chart for affected drugs and strengths <p><u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u></p> <ul style="list-style-type: none"> ➤ Quantity limits based on daily dosage as determined by FDA labeling ➤ Quantity limits to include: <ul style="list-style-type: none"> ▪ Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration) ▪ Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days. Concerta 36mg not to exceed 2 units daily.

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Multiple Sclerosis Agents		
Avonex® Betaseron® Copaxone® 20 mg/mL Gilenya® ST Rebif® ¹	Aubagio® ST Copaxone® 40 mg/mL Extavia® Glatopa™ Plegridy® Tecfidera® ST Zinbryta™	<u>STEP THERAPY (ST)</u> > <u>Gilenya™ (fingolimod)</u> – requires a trial with a preferred injectable product > <u>Aubagio® (teriflunomide) and Tecfidera™ (dimethyl fumarate)</u> – require a trial with a preferred oral agent
Non-Ergot Dopamine Receptor Agonists		
pramipexole ropinirole	Mirapex® Requip® Mirapex ER® Requip XL® ^{DO} Neupro® ropinirole ER pramipexole ER	<u>DOSE OPTIMIZATION (DO)</u> > See Dose Optimization Chart for affected strengths
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD) ^{CC}		
guanfacine ER ^{DO} Strattera® ^{DO} Kapvay®	clonidine ER Intuniv® ^{DO}	<u>CLINICAL CRITERIA (CC)</u> > Confirm diagnosis for an FDA-approved or Compendia supported indication for beneficiaries < 18 years of age. > Prior authorization is required for initial prescriptions for non-stimulant therapy for beneficiaries less than 6 years of age <u>DOSE OPTIMIZATION (DO)</u> > See Dose Optimization Chart for affected strengths

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Sedative Hypnotics/Sleep Agents ^{F/Q/D}		
estazolam ^{CC} flurazepam ^{CC} temazepam 15mg, 30mg ^{CC} zolpidem ^{CC}	Ambien [®] ^{CC} Ambien CR [®] ^{CC} Belsomra [®] Edluar [®] ^{CC} eszopiclone Halcion [®] ^{CC} Intermezzo [®] ^{CC} Lunesta [®] ^{DO} Restoril [®] ^{CC} Rozerem [®] Silenor [®] Sonata [®] temazepam 7.5mg, 22.5mg ^{CC} triazolam ^{CC} zaleplon zolpidem (sublingual) ^{CC} zolpidem ER ^{CC} Zolpimist [™] ^{CC}	<p><u>DOSE OPTIMIZATION (DO)</u></p> <ul style="list-style-type: none"> ➤ See Dose Optimization Chart for affected strengths <p><u>CLINICAL CRITERIA (CC)</u></p> <ul style="list-style-type: none"> ➤ <u>Zolpidem products</u>: Confirm dosage is consistent with FDA labeling for initial prescriptions ➤ <u>Benzodiazepine Agents (estazolam, flurazepam, Halcion[®], Restoril[®], temazepam, triazolam)</u>: <ul style="list-style-type: none"> ▪ Confirm diagnosis of FDA-approved or compendia-supported indication ▪ PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy ▪ PA required for any additional benzodiazepine prescription in patients currently on benzodiazepine therapy <p><u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u></p> <ul style="list-style-type: none"> ➤ Frequency and duration limits for the following products: <ul style="list-style-type: none"> ▪ For <u>non-zaleplon</u> and <u>non-benzodiazepine</u> containing products: <ul style="list-style-type: none"> ❖ 30 dosage units per fill/1 dosage unit per day/30 days ▪ For <u>zaleplon</u>-containing products: <ul style="list-style-type: none"> ❖ 60 dosage units per fill/2 dosage units per day/30 days ➤ Duration limit equivalent to the maximum recommended duration: <ul style="list-style-type: none"> ▪ 360 days for immediate-release <u>zolpidem</u> (Ambien[®], Edluar[™], Intermezzo[®], Zolpimist[™]) products ▪ 180 days for <u>eszopiclone</u> and <u>ramelteon</u> (Rozerem[®]) products ▪ 168 days for <u>zolpidem ER</u> (Ambien CR[®]) products ▪ 90 days for suvorexant (Belsomra[®]) ▪ 90 days for doxepin (Silenor[®]) ▪ 30 days for <u>zaleplon</u> (Sonata[®]) products ▪ 30 days for benzodiazepine agents (estazolam, flurazepam, Halcion[®], Restoril[®], temazepam, triazolam) for the treatment of insomnia ➤ Additional/Alternate parameters: <ul style="list-style-type: none"> ▪ For patients naive to non-benzodiazepine sedative hypnotics (NBSH): First-fill duration and quantity limit of 10 dosage units as a 10 day supply, except for zaleplon-containing products which the quantity limit is 20 dosage units as a 10 day supply

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Selective Serotonin Reuptake Inhibitors (SSRIs)		
citalopram escitalopram (tablet) fluoxetine (capsule, solution) paroxetine sertraline	Brisdelle® Celexa® escitalopram (soln) fluoxetine (tablet) fluoxetine DR weekly fluvoxamine ^{CC} fluvoxamine ER ^{CC} Lexapro® ^{DO} paroxetine CR Paxil® Paxil CR® Pexeva® Prozac® Sarafem® Trintellix™ Viibryd® ^{DO} Zoloft®	<u>DOSE OPTIMIZATION (DO)</u> ➤ See Dose Optimization Chart for affected strengths <u>CLINICAL CRITERIA (CC)</u> ➤ Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA ➤ Clinical editing to allow patients with a diagnosis of Obsessive Compulsive Disorder (OCD) to receive fluvoxamine and fluvoxamine ER without prior authorization
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)ST		
duloxetine 20mg, 30mg, 60mg (generic for Cymbalta®) venlafaxine venlafaxine ER (capsule)	Cymbalta® desvenlafaxine base ER desvenlafaxine fumarate ER desvenlafaxine succinate ER ^{DO} duloxetine 40mg (generic for Irenka™) Effexor XR® ^{DO} Fetzima® Irenka™ Khedezla™ Pristiq® ^{DO} Savella® venlafaxine ER (tablet)	<u>DOSE OPTIMIZATION (DO)</u> ➤ See Dose Optimization Chart for affected strengths <u>STEP THERAPY (ST)</u> ➤ Trial of an SSRI prior to an SNRI ▪ Step therapy is not required for the following indications: ❖ Chronic musculoskeletal pain (CMP) ❖ Fibromyalgia (FM) ❖ Diabetic peripheral neuropathy (DPN)* ➤ *duloxetine (Cymbalta® and Irenka™) – Requires a trial with a tricyclic antidepressant OR gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN)

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																																														
Serotonin Receptor Agonists (Triptans)																																																
rizatriptan ^{F/Q/D} sumatriptan ^{F/Q/D}	almotriptan ^{F/Q/D} Amerge® ^{F/Q/D} Axert® ^{F/Q/D} Frova® ^{F/Q/D} frovatriptan ^{F/Q/D} Imitrex® ^{F/Q/D} Maxalt® ^{F/Q/D} Maxalt® MLT ^{F/Q/D} naratriptan ^{F/Q/D} Onzetra Xsail™ ^{F/Q/D} Relpax® ^{F/Q/D} Sumavel® DosePro Treximet® ^{F/Q/D} Zembrace SymTouch™ zolmitriptan ^{F/Q/D} Zomig® ^{F/Q/D} Zomig® ZMT ^{F/Q/D}	<table border="1"> <thead> <tr> <th colspan="2" data-bbox="1022 214 1984 246">FREQUENCY/QUANTITY/DURATION (F/Q/D)</th> </tr> </thead> <tbody> <tr> <td data-bbox="1087 251 1606 284">almotriptan</td> <td data-bbox="1606 251 1984 284">18 units every 30 days</td> </tr> <tr> <td data-bbox="1087 289 1606 321">Amerge®</td> <td data-bbox="1606 289 1984 321"></td> </tr> <tr> <td data-bbox="1087 326 1606 358">Axert® 6.25mg</td> <td data-bbox="1606 326 1984 358"></td> </tr> <tr> <td data-bbox="1087 363 1606 396">Frova®</td> <td data-bbox="1606 363 1984 396"></td> </tr> <tr> <td data-bbox="1087 401 1606 433">frovatriptan</td> <td data-bbox="1606 401 1984 433"></td> </tr> <tr> <td data-bbox="1087 438 1606 470">Imitrex® Nasal Spray</td> <td data-bbox="1606 438 1984 470"></td> </tr> <tr> <td data-bbox="1087 475 1606 508">Imitrex® tablets</td> <td data-bbox="1606 475 1984 508"></td> </tr> <tr> <td data-bbox="1087 513 1606 545">naratriptan</td> <td data-bbox="1606 513 1984 545"></td> </tr> <tr> <td data-bbox="1087 550 1606 583">Relpax® 20mg</td> <td data-bbox="1606 550 1984 583"></td> </tr> <tr> <td data-bbox="1087 587 1606 620">sumatriptan nasal spray</td> <td data-bbox="1606 587 1984 620"></td> </tr> <tr> <td data-bbox="1087 625 1606 657">sumatriptan tablets</td> <td data-bbox="1606 625 1984 657"></td> </tr> <tr> <td data-bbox="1087 662 1606 695">Treximet®</td> <td data-bbox="1606 662 1984 695"></td> </tr> <tr> <td data-bbox="1087 699 1606 732">zolmitriptan (tablet, ODT) 2.5mg</td> <td data-bbox="1606 699 1984 732"></td> </tr> <tr> <td data-bbox="1087 737 1606 769">zolmitriptan (tablet, ODT) 5mg</td> <td data-bbox="1606 737 1984 769"></td> </tr> <tr> <td data-bbox="1087 774 1606 807">Zomig/Zomig® ZMT 2.5mg</td> <td data-bbox="1606 774 1984 807"></td> </tr> <tr> <td data-bbox="1087 812 1606 844">Zomig® /Zomig® ZMT 5mg</td> <td data-bbox="1606 812 1984 844"></td> </tr> <tr> <td data-bbox="1087 849 1606 881">Zomig® Nasal Spray</td> <td data-bbox="1606 849 1984 881"></td> </tr> <tr> <td data-bbox="1087 886 1606 919">Axert® 12.5mg</td> <td data-bbox="1606 886 1984 919">24 tablets every 30 days</td> </tr> <tr> <td data-bbox="1087 924 1606 956">Maxalt® /Maxalt MLT®</td> <td data-bbox="1606 924 1984 956"></td> </tr> <tr> <td data-bbox="1087 961 1606 993">Relpax® 40mg</td> <td data-bbox="1606 961 1984 993"></td> </tr> <tr> <td data-bbox="1087 998 1606 1031">rizatriptan (tablet, ODT)</td> <td data-bbox="1606 998 1984 1031"></td> </tr> <tr> <td data-bbox="1087 1036 1606 1068">Onzetra Xsail™</td> <td data-bbox="1606 1036 1984 1068">16 units (1 kit) every 30 days</td> </tr> </tbody> </table>	FREQUENCY/QUANTITY/DURATION (F/Q/D)		almotriptan	18 units every 30 days	Amerge®		Axert® 6.25mg		Frova®		frovatriptan		Imitrex® Nasal Spray		Imitrex® tablets		naratriptan		Relpax® 20mg		sumatriptan nasal spray		sumatriptan tablets		Treximet®		zolmitriptan (tablet, ODT) 2.5mg		zolmitriptan (tablet, ODT) 5mg		Zomig/Zomig® ZMT 2.5mg		Zomig® /Zomig® ZMT 5mg		Zomig® Nasal Spray		Axert® 12.5mg	24 tablets every 30 days	Maxalt® /Maxalt MLT®		Relpax® 40mg		rizatriptan (tablet, ODT)		Onzetra Xsail™	16 units (1 kit) every 30 days
FREQUENCY/QUANTITY/DURATION (F/Q/D)																																																
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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Acne Agents – Prescription, Topical		
Differin® Retin-A® (cream, gel) ^{CC} Tazorac® ^{CC}	Aczone® adapalene Atralin® ^{CC} Avita® ^{CC} Azelex® clindamycin/ tretinoin Epiduo®	Fabior® ^{CC} Retin-A Micro® ^{CC} tazarotene ^{CC} tretinoin ^{CC} tretinoin micro ^{CC} Veltin® ^{CC} Ziana® ^{CC}
CLINICAL CRITERIA		
➤ Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication		
Agents for Actinic Keratosis		
diclofenac 3% gel ^{F/Q/D} Efudex® fluorouracil (solution) fluorouracil 0.5% cream (generic for Carac) imiquimod	Aldara® Carac® fluorouracil 5% cream (generic for Efudex cream) Picato Solaraze® ^{F/Q/D} Tolak™ Zyclara®	FREQUENCY/QUANTITY/DURATION (F/Q/D) ➤ <u>Solaraze® / diclofenac 3% gel:</u> ▪ Maximum 100 (one hundred) grams as a 90-day supply ▪ Limited to one (1) prescription per year
Antibiotics – Topical		
mupirocin (ointment)	Altabax® Bactroban® Bactroban Nasal® ^{CC}	Centany® mupirocin (cream)
CLINICAL CRITERIA		
➤ <u>Bactroban Nasal® ointment</u> – Patient-specific considerations for drug selection include concerns related to use for the eradication of nasal colonization with methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) in patients older than 12 years.		
Anti-Fungals – Topical		
ciclopirox (cream, suspension) ¹ clotrimazole OTC clotrimazole / betamethasone (cream) ¹ miconazole OTC Nyamyc™ nystatin (cream, ointment, powder) Nystop® terbinafine OTC tolnaftate OTC	Alevazol OTC Ciclodan® (cream) ciclopirox (gel) clotrimazole / betamethasone (lotion) clotrimazole Rx econazole Ertaczo® Exelderm® Extina® ketoconazole Lamisil AT® OTC (spray) ² Lotrisone® Luzu® Mentax® naftifine Naftin® nystatin/ triamcinolone ² oxiconazole Oxistat® Vusion® ^{F/Q/D}	FREQUENCY/QUANTITY/DURATION (F/Q/D) ➤ <u>Vusion® 50 gm ointment</u> – Maximum 100 (one hundred) grams in a 90 day time period

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Anti-Infectives – Topical		
BenzaClin® (gel, pump) clindamycin (solution) erythromycin (solution)	Acanya® Benzamycin® Cleocin T® Clindacin® Clindagel® clindamycin (foam, gel ² , lotion ² , pledget) clindamycin / benzoyl peroxide Duac® Erygel® erythromycin (gel ² , pledget) erythromycin / benzoyl peroxide Evoclin® Neuac® Onexton®	
Anti-Virals – Topical		
Abreva® Zovirax® (cream)	acyclovir (ointment) Denavir® Sitavig® Xerese® Zovirax® (ointment)	
Immunomodulators – Topical <u>CDRP</u>		
Elidel® Protopic®	tacrolimus	<u>CLINICAL DRUG REVIEW PROGRAM (CDRP)</u> > All prescriptions require prior authorization > Refills on prescriptions are allowed > Click here for CDRP Topical Immunomodulators Prescriber Worksheet
Psoriasis Agents – Topical		
calcipotriene (cream, ointment, scalp solution)	calcipotriene / betamethasone dipropionate Calcitrene® (ointment) calcitriol (ointment) Dovonex® (cream) Enstilar® Sorilux® Taclonex® Taclonex® Scalp® Vectical®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Steroids, Topical – Low Potency		
hydrocortisone acetate OTC hydrocortisone acetate Rx hydrocortisone/ aloe vera OTC	alclometasone Derma-Smoothe/FS® Desonate® desonide fluocinolone (oil)	Micort HC® Texacort® Tridesilon®
Steroids, Topical – Medium Potency		
clocortolone hydrocortisone butyrate (ointment, solution) hydrocortisone valerate mometasone furoate	Cloderm® Cordran® Cutivate® Dermatop® Elocon® fluocinolone acetonide (cream, ointment, soln.) flurandrenolide fluticasone propionate hydrocortisone butyrate (cream) Luxiq® Pandel® prednicarbate Synalar®	
Steroids, Topical – High Potency		
betamethasone dipropionate (cream, lotion) betamethasone valerate (cream, ointment) fluocinonide (cream, gel, solution) fluocinonide emollient fluocinonide-E triamcinolone acetonide	amcinonide Apexicon-E® betamethasone dipropionate (gel, ointment) betamethasone dipropionate, augmented betamethasone valerate (foam, lotion) desoximetasone diflorasone Diprolene® Diprolene® AF fluocinonide 0.1% cream (generic for Vanos) fluocinonide (ointment) Halog® Kenalog® Psorcon Sernivo™ Topicort® triamcinolone spray Trianex® Vanos®	
Steroids, Topical – Very High Potency		
clobetasol (cream, gel, ointment, solution) halobetasol	clobetasol (foam, lotion, spray) Clobex® Olux® Olux-E® Temovate® Temovate-E® Ultravate®	

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NYS Medicaid Fee-For-Service Preferred Drug List

VI. ENDOCRINE AND METABOLIC AGENTS		
Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Alpha-Glucosidase Inhibitors ST		
acarbose Glyset [®]	miglitol Precose [®]	<u>STEP THERAPY (ST)</u> ➤ Requires a trial with metformin with or without insulin prior to initiating alpha-glucosidase inhibitor therapy, unless there is a documented contraindication.
Amylin Analogs ST		
Symlin [®]	None	<u>STEP THERAPY (ST)</u> ➤ Requires a trial with metformin with or without insulin prior to initiating amylin analogue therapy, unless there is a documented contraindication.
Anabolic Steroids – Topical ^{CDRP, F/Q/D}		
Androgel [®]	Androderm [®] Axiron [®] Fortesta [®] Natesto [™] Testim [®] testosterone gel Vogelxo [®]	<u>CLINICAL DRUG REVIEW PROGRAM (CDRP)</u> ➤ For diagnosis of hypogonadotropic or primary hypogonadism: <ul style="list-style-type: none"> ▪ Requires documented low testosterone concentration with two tests prior to initiation of therapy. ▪ Require documented testosterone therapeutic concentration to confirm response after initiation of therapy. ➤ For diagnosis of delayed puberty: <ul style="list-style-type: none"> ▪ Requires documentation that growth hormone deficiency has been ruled out prior to initiation of therapy. ➤ Click here for a copy of the Anabolic Steroid fax form <u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u> ➤ Limitations for anabolic steroid products based on approved FDA labeled daily dosing and documented diagnosis: <ul style="list-style-type: none"> ▪ Duration limit of six (6) months for delayed puberty

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs	Prior Authorization/Coverage Parameters	
Biguanides				
metformin HCl metformin ER (generic for Glucophage XR®)		Fortamet® Glucophage® Glucophage XR® Glumetza® metformin ER (generics for Fortamet®, Glumetza®) Riomet® (solution)		
Bisphosphonates – Oral F/Q/D				
alendronate		Actonel® Atelvia® Binosto® Boniva® Fosamax® Fosamax® Plus D Ibandronate risedronate	FREQUENCY/QUANTITY/DURATION (F/Q/D)	
			ibandronate sodium 150 mg (Boniva® 150 mg)	1 tablet every 28 days
			risedronate sodium 150 mg (Actonel® 150 mg)	
			alendronate sodium 35 mg (Fosamax® 35 mg)	4 tablets every 28 days
			alendronate sodium 70 mg (Fosamax® 70 mg)	
			alendronate sodium and cholecalciferol (Fosamax® Plus D)	
			risedronate sodium 35 mg (Actonel® 35 mg)	
			risedronate sodium 35 mg (Atelvia® 35 mg)	
			alendronate solution 70 mg/75 mL single-dose bottle	4 bottles every 28 days
Calcitonins – Intranasal				
calcitonin-salmon	Miacalcin®	Fortical®		
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors ST				
Janumet® Janumet® XR Januvia® DO	Jentadueto® Jentadueto® XR Tradjenta®	alogliptin alogliptin / metformin alogliptin / pioglitazone Glyxambi® Kazano™ Kombiglyze® XR Nesina™ Onglyza® DO Oseni™	DOSE OPTIMIZATION (DO) ➤ See Dose Optimization Chart for affected strengths STEP THERAPY (ST) ➤ Requires a trial with metformin with or without insulin prior to DPP-4 Inhibitor therapy, unless there is a documented contraindication.	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Glucagon-like Peptide-1 (GLP-1) Agonists ST				
Bydureon® Byetta® Victoza® ¹	Adlyxin™ Soliqua™ Tanzeum® ² Trulicity®	Xultophy®		<u>STEP THERAPY (ST)</u> > Requires a trial with metformin with or without insulin prior to a GLP-1 agonist. > Prior authorization is required with lack of covered diagnosis in medical history.
Glucocorticoids – Oral				
cortisone dexamethasone (tablet, solution) hydrocortisone methylprednisolone (4mg, 8mg, 32mg) methylprednisolone (dose-pack) prednisolone (solution) prednisone (dose-pack, solution, tablet)	budesonide EC Cortef® dexamethasone (elixir) dexamethasone intensol Dexpak® Emflaza™ Entocort EC® Medrol® (dose-pack, tablet) methylprednisolone 16mg Millipred® Orapred® prednisolone ODT prednisone intensol Rayos® Uceris® Veripred®			
Growth Hormones ^{CC, CDRP}				
Genotropin® Norditropin®	Nutropin AQ®	Humatrope® Omnitrope® Saizen®	Zomacton® Zorbtive®	<u>CLINICAL DRUG REVIEW PROGRAM (CDRP)</u> > Prescribers , not authorized agents, are required to call for a PA for beneficiaries 21 years of age or older <u>CLINICAL CRITERIA (CC)</u> > Patient-specific considerations for drug selection include concerns related to use of a non-preferred agent for FDA approved indications that are not listed for a preferred agent. > Appropriate diagnosis is required for all Growth Hormones, regardless of age or preferred status.
Insulin – Long-Acting				
Lantus®	Levemir®	Basaglar® Toujeo®	Tresiba®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Insulin – Mixes				
Humalog® Mix	Novolog® Mix	None		
Insulin – Rapid-Acting				
Apidra®	Novolog®	Afrezza®		
Humalog® 100 U/mL		Humalog® 200 U/mL		
Meglitinides ST				
nateglinide	repaglinide	Prandimet®	repaglinide/ metformin	STEP THERAPY (ST) ➤ Requires a trial with metformin with or without insulin prior to initiating meglitinide therapy, unless there is a documented contraindication.
		Prandin®	Starlix®	
Pancreatic Enzymes				
Creon®	Zenpep®	Pancreaze®	Ultresa®	
pancrelipase		Pertzye®	Viokace®	
Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors ST				
Farxiga™ ¹		Invokamet®	Jardiance®	STEP THERAPY (ST) ➤ Requires a trial with metformin with or without insulin prior to initiating SGLT2 Inhibitor therapy, unless there is a documented contraindication.
Invokana®		Invokamet® XR	Synjardy®	
			Synjardy® XR	
			Xigduo® XR	
Thiazolidinediones (TZDs) ST				
pioglitazone		Actoplus Met®		DOSE OPTIMIZATION (DO) ➤ See Dose Optimization Chart for affected strengths STEP THERAPY (ST) ➤ Requires a trial with metformin with or without insulin prior to initiating TZD therapy, unless there is a documented contraindication.
		Actoplus Met® XR ^{DO}		
		Actos® ^{DO}		
		Avandia®		
		Duetact®		
		pioglitazone / glimepiride		
		pioglitazone / metformin		
VII. GASTROINTESTINAL				
Anti-Emetics				
ondansetron (ODT, solution, tablet)		Anzemet®		
		granisetron (tablet)		
		Sancuso®		
		Zofran® (ODT, solution, tablet)		
		Zuplenz®		

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Gastrointestinal Antibiotics		
metronidazole (tablet) neomycin vancomycin	Alinia® Difucid® Flagyl® Flagyl® ER metronidazole (capsule) paromomycin Tindamax® tinidazole Vancocin® Xifaxan® CC, ST, F/Q/D	<p><u>CLINICAL CRITERIA (CC)</u></p> <p>➤ <u>Xifaxan®</u>: Confirm diagnosis of FDA-approved or compendia-supported indication</p> <p><u>STEP THERAPY (ST)</u></p> <p>➤ <u>Xifaxan®</u>: Requires trial of a preferred fluoroquinolone antibiotic before rifaximin for treatment of Traveler's diarrhea</p> <p><u>QUANTITY LIMITS:</u></p> <p>➤ <u>Xifaxan®</u>:</p> <ul style="list-style-type: none"> ▪ Traveler's diarrhea (200 mg tablet) – 9 (nine) tablets per 30 days (Dose = 200 mg three times a day for three days) ▪ Hepatic encephalopathy (550 mg tablets) – 60 tablets per 30 days (Dose = 550 mg twice a day) ▪ Irritable bowel syndrome with diarrhea (550 mg tablets) – 42 tablets per 30 days (Dose = 550 mg three times a day for 14 days) <ul style="list-style-type: none"> ❖ Maximum of 42 days supply (126 units) per 365 (three rounds of therapy).
Gastrointestinal Preparatory Agents		
Clearlax® Gavilax® Gavilyte®-C Gavilyte®-G Glycolax® Miralax® OTC PEG 3350 powder OTC PEG 3350/ electrolytes solution Rx	Colyte® Gavilyte®-N Golytely® Moviprep® Nulytely® Osmoprep® PEG 3350 powder pack OTC PEG 3350 with flavor packs Prepopik® Suprep® Trilyte®	
Helicobacter pylori Agents		
lansoprazole / amoxicillin / clarithromycin Pylera®	Omeclamox-Pak® Prevpac®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Proton Pump Inhibitors (PPIs) ^{F/Q/D}				
omeprazole Rx pantoprazole		Aciphex® Dexilant™ ^{DO} esomeprazole magnesium (generic for Nexium) esomeprazole strontium lansoprazole Rx (capsule, ODT) Nexium® RX ^{DO} omeprazole OTC omeprazole/ sodium bicarbonate Rx Prevacid® OTC Prevacid® Rx ^{DO} Prilosec® Rx Protonix® rabeprazole Zegerid®		<p><u>DOSE OPTIMIZATION (DO)</u></p> <ul style="list-style-type: none"> ➤ See Dose Optimization Chart for affected strengths <p><u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u></p> <ul style="list-style-type: none"> ➤ Quantity limits: <ul style="list-style-type: none"> ▪ Once daily dosing for: <ul style="list-style-type: none"> ❖ GERD ❖ erosive esophagitis ❖ healing and maintenance of duodenal/gastric ulcers (including NSAID-induced) ❖ prevention of NSAID-induced ulcers ▪ Twice daily dosing for: <ul style="list-style-type: none"> ❖ hypersecretory conditions ❖ Barrett's esophagitis ❖ H. pylori ❖ refractory GERD ➤ Duration limits: <ul style="list-style-type: none"> ▪ 60 days for: <ul style="list-style-type: none"> ❖ Mild/moderate GERD ❖ acute healing of duodenal/gastric ulcers (including NSAID-induced) ▪ 365 days for: <ul style="list-style-type: none"> ❖ Maintenance treatment of duodenal ulcers ▪ 14 days for: <ul style="list-style-type: none"> ❖ H. pylori
Sulfasalazine Derivatives				
Apriso® Delzicol® Dipentum® sulfasalazine DR/EC	sulfasalazine IR Sulfazine Sulfazine EC	Asacol HD® Azulfidine® Azulfidine Entab® balsalazide	Colazal® Giazo® Lialda® mesalamine DR Pentasa®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
VIII. HEMATOLOGICAL AGENTS				
Anticoagulants – Injectable ^{CC F/Q/D}				
enoxaparin sodium	Fragmin [®]	Arixtra [®] ^{CC} fondaparinux ^{CC}	Lovenox [®]	CLINICAL CRITERIA (CC) <ul style="list-style-type: none"> ➤ For patients requiring >30 days of therapy: Require confirmation of FDA approved or compendia-supported indication ➤ Arixtra[®] (fondaparinux) Clinical editing to allow patients with a diagnosis of Heparin Induced Thrombocytopenia (HIT) to receive therapy without prior authorization. FREQUENCY/QUANTITY/DURATION (F/Q/D) <ul style="list-style-type: none"> ➤ Duration Limit: No more than 30 days for members initiating therapy
Anticoagulants – Oral				
Coumadin [®] Eliquis [®] ¹ Jantoven [®] Pradaxa [®]	warfarin Xarelto [®]	Savaysa [®] Xarelto [®] (dose pack)		
Erythropoiesis Stimulating Agents (ESAs) ^{CC}				
Aranesp [®]	Procrit [®]	Epogen [®]	Mircera [®]	CLINICAL CRITERIA (CC) <ul style="list-style-type: none"> ➤ Confirm diagnosis for FDA or Compendia supported uses
Platelet Inhibitors				
Aggrenox [®] Brilinta [®] clopidogrel dipyridamole		dipyridamole / aspirin Durlaza [®] Effient [®] ² Plavix [®] ticlopidine Yosprala [™] Zontivity [®]		

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XI. MUSCULOSKELETAL AGENTS		
Skeletal Muscle Relaxants		
baclofen chlorzoxazone cyclobenzaprine 5mg, 10mg dantrolene methocarbamol orphenadrine ER tizanidine (tablet)	Amrix® carisoprodol <i>ST, F/Q/D</i> carisoprodol compound <i>ST, F/Q/D</i> carisoprodol compound / codeine <i>CC, ST, F/Q/D</i> cyclobenzaprine 7.5mg Dantrium® Fexmid® Lorzone® metaxalone Parafon Forte® DSC Robaxin® Skelaxin® Soma® <i>ST, F/Q/D</i> Soma® 250 <i>ST, F/Q/D</i> tizanidine (capsule) Zanaflex®	<p><u>CLINICAL CRITERIA (CC)</u></p> <p>For carisoprodol/codeine products:</p> <ul style="list-style-type: none"> ➤ Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease ➤ Medical necessity rationale for opioid therapy is required for patients on established buprenorphine opioid dependence therapy ➤ PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy <p><u>STEP THERAPY (ST)</u></p> <ul style="list-style-type: none"> ➤ Trial with one (1) preferred analgesic and two (2) preferred skeletal muscle relaxants prior to use of <u>carisoprodol</u> containing products: <ul style="list-style-type: none"> ▪ carisoprodol ▪ carisoprodol/ASA ▪ carisoprodol/ASA/codeine ▪ Soma® <p><u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u></p> <ul style="list-style-type: none"> ➤ Maximum 84 cumulative units per a year ➤ <u>Carisoprodol</u> – Maximum 4 (four) units per day, 21 day supply ➤ <u>Carisoprodol combinations</u> – Maximum 8 (eight) units per day, 21 (twenty-one) day supply (not to exceed the 84 cumulative units per year limit)

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. OPHTHALMICS		
Alpha-2 Adrenergic Agonists (for Glaucoma) – Ophthalmic		
Alphagan P® brimonidine 0.2%	Simbrinza® apraclonidine lopidine® brimonidine 0.15%	
Antibiotics – Ophthalmic		
bacitracin / polymyxin B erythromycin gentamicin Natacyn® neomycin / gramicidin / polymyxin polymyxin / trimethoprim sulfacetamide (solution) tobramycin	Azasite® bacitracin Bleph®-10 Garamycin® neomycin / bacitracin / polymyxin Neosporin® Polytrim® sulfacetamide (ointment) Tobrex®	
Antibiotics/Steroid Combinations – Ophthalmic		
Blephamide® neomycin/ polymyxin / dexamethasone sulfacetamide / prednisolone TobraDex® (ointment, suspension)	Maxitrol® neomycin / bacitracin / polymyxin / HC neomycin / polymyxin / HC Pred-G® TobraDex® ST tobramycin / dexamethasone (suspension) Zylet®	
Antihistamines – Ophthalmic		
Pataday®	azelastine Bepreve® Elestat® Emadine® epinastine	Lastacaft® olopatadine 0.1% Patanol® Pazeo®

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Beta Blockers – Ophthalmic				
betaxolol Betoptic S® carteolol Combigan® Istalol® levobunolol timolol maleate (gel, solution)		Betagan® Timoptic® Timoptic® in Ocudose® Timoptic-XE®		
Fluoroquinolones – Ophthalmic ST				
ciprofloxacin Vigamox® ofloxacin		Besivance® Moxeza® Ciloxan® Ocuflox® gatifloxacin Zymaxid® levofloxacin		<u>STEP THERAPY (ST)</u> ➤ For patients 21 years or younger, attempt treatment with a non-fluoroquinolone ophthalmic antibiotic before progressing to the a fluoroquinolone ophthalmic product ➤ Examples of Non-Fluoroquinolone Ophthalmic Antibiotics <ul style="list-style-type: none"> ▪ AK-Poly-Bac eye ointment ▪ bacitracin-polymyxin eye ointment ▪ erythromycin eye ointment ▪ Gentak (3 mg/gm eye ointment, 3 mg/mL eye drops) ▪ gentamicin (3 mg/gm eye ointment, 3 mg/mL eye drops) ▪ neomycin-polymyxin-gramicidin eye drops ▪ polymyxin B-TMP eye drops ▪ Romycin eye ointment ▪ sulfacetamide 10% eye drops ▪ Sulfamide 10% eye drops ▪ tobramycin 0.3% eye drops ▪ Tobrasol 0.3% eye drops
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) – Ophthalmic				
diclofenac ketorolac flurbiprofen Ilevro® ¹		Acular® Nevanac® Acular LS® Ocufen® Acuvail® Prolensa® bromfenac BromSite™		
Prostaglandin Agonists – Ophthalmic				
latanoprost		bimatoprost travoprost Lumigan® Xalatan® Travatan Z® Zioptan®		

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XIII. OTICS		
Fluoroquinolones – Otic		
Cipro HC® Ciprodex® ciprofloxacin	Floxin® ofloxacin Otovel™	
XIV. RENAL AND GENITOURINARY		
Alpha Reductase Inhibitors for BPH		
finasteride	Avodart® dutasteride dutasteride / tamsulosin Jalyn® Proscar®	
Cystine Depleting Agents ^{CC}		
Cystagon®	Procysbi® ST	CLINICAL CRITERIA (CC) ➤ Confirm diagnosis of FDA-approved or compendia-supported indication STEP THERAPY (ST) ➤ Requires a trial with Cystagon immediate-release capsules
Phosphate Binders/Regulators		
calcium acetate Eliphos® Fosrenol®	Renagel® Auryxia™ Phoslyra®	Renvela® Velphoro®
Selective Alpha Adrenergic Blockers		
alfuzosin tamsulosin	Flomax Rapaflo®	Uroxatral®
Urinary Tract Antispasmodics		
oxybutynin Toviaz® ^{DO}	Vesicare® ^{DO} darifenacin Detrol® Detrol LA® ^{DO} Ditropan XL® Enablex® ^{DO} Gelnique® Myrbetriq®	oxybutynin ER ^{DO} Oxytrol® tolterodine tolterodine ER trospium trospium ER DOSE OPTIMIZATION (DO) ➤ See Dose Optimization Chart for affected strengths
Xanthine Oxidase Inhibitors		
allopurinol	Uloric®	Zyloprim®

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XV. RESPIRATORY		
Anticholinergics / COPD Agents		
Atrovent HFA® Combivent Respimat® ipratropium ipratropium / albuterol Spiriva® Stiolto Respimat® ¹	Anoro Ellipta® Bevespi Aerosphere™ Daliresp® Incruse Ellipta® Seebri Neohaler®	Spiriva Respimat® Tudorza Pressair® Utibron Neohaler®
Antihistamines – Intranasal		
azelastine Patanase®	Astepro® olopatadine	
Antihistamines – Second Generation		
cetirizine OTC (tablet) cetirizine OTC (syrup/solution 1mg/ 1mL) fexofenadine OTC (suspension) levocetirizine (tablet) loratadine OTC	cetirizine OTC (chewable) cetirizine OTC (syrup/solution 5mg/ 5mL) cetirizine-D OTC Clarinetx® ^{CC} Clarinetx-D® OTC desloratadine fexofenadine OTC (tablet) levocetirizine (solution) loratadine-D OTC Semprex-D Xyzal® OTC ^{CC}	<u>CLINICAL CRITERIA (CC)</u> ➤ No prior authorization required for patients less than 24 months of age

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																								
Beta₂ Adrenergic Agents – Inhaled Long-Acting CC, F/Q/D																										
Foradil® Perforomist® Serevent Diskus®	Arcapta Neohaler® Brovana® Striverdi Respimat®	<p>CLINICAL CRITERIA (CC)</p> <p>PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA or compendia supported age as indicated:</p> <table border="1" data-bbox="1094 321 1982 561"> <tr> <td>Arcapta Neohaler®</td> <td>≥18 years</td> </tr> <tr> <td>Brovana®</td> <td>≥18 years</td> </tr> <tr> <td>Foradil®</td> <td>≥ 5 years</td> </tr> <tr> <td>Perforomist®</td> <td>≥18 years</td> </tr> <tr> <td>Serevent Diskus®</td> <td>≥4 years</td> </tr> <tr> <td>Striverdi Respimat®</td> <td>≥18 years</td> </tr> </table> <p>FREQUENCY/QUANTITY/DURATION (F/Q/D)</p> <p>Maximum units per 30 days</p> <table border="1" data-bbox="1087 659 1986 899"> <tr> <td>Arcapta Neohaler®</td> <td>30 units (1 box of 30 unit dose capsules)</td> </tr> <tr> <td>Brovana®</td> <td>60 units (1 carton of 60 vials or 120 mL)</td> </tr> <tr> <td>Foradil®</td> <td>60 units (1 box of 60 unit dose capsules)</td> </tr> <tr> <td>Perforomist®</td> <td>60 units (1 carton of 60 vials or 120 mL)</td> </tr> <tr> <td>Serevent Diskus®</td> <td>1 diskus (60 blisters)</td> </tr> <tr> <td>Striverdi Respimat®</td> <td>1 unit (one cartridge and one Respimat inhaler)</td> </tr> </table>	Arcapta Neohaler®	≥18 years	Brovana®	≥18 years	Foradil®	≥ 5 years	Perforomist®	≥18 years	Serevent Diskus®	≥4 years	Striverdi Respimat®	≥18 years	Arcapta Neohaler®	30 units (1 box of 30 unit dose capsules)	Brovana®	60 units (1 carton of 60 vials or 120 mL)	Foradil®	60 units (1 box of 60 unit dose capsules)	Perforomist®	60 units (1 carton of 60 vials or 120 mL)	Serevent Diskus®	1 diskus (60 blisters)	Striverdi Respimat®	1 unit (one cartridge and one Respimat inhaler)
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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																																						
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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters																						
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montelukast ST zafirlukast		Accolate [®] Singulair ^{®ST}		<p>STEP THERAPY (ST)</p> <p>➤ For non-asthmatic patients, trial of intranasal corticosteroid or a 2nd generation oral antihistamine before montelukast (Singulair[®])</p>																						

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New York State Medicaid Fee-For-Service Pharmacy Programs

NYS Medicaid Fee-For-Service Clinical Drug Review Program (CDRP)

The Clinical Drug Review Program (CDRP) is aimed at ensuring specific drugs are utilized in a medically appropriate manner.

Under the CDRP, certain drugs require prior authorization because there may be specific safety issues, public health concerns, the potential for fraud and abuse or the potential for significant overuse and misuse.

Prior Authorization

Prior authorization for some drugs subject to the CDRP must be obtained through a representative at the clinical call center. Prior authorization is required for original prescriptions, not refills. For some drugs subject to the CDRP, only prescribers, not their authorized agents, can initiate the prior authorization process.

Fax requests for prior authorization are not permitted. Each CDRP drug has specific clinical information that must be provided to the clinical call center before prior authorization will be issued. Prescribers may be asked to fax that information. Clinical guidelines for the CDRP as well as prior authorization worksheets are available online at http://newyork.fhsc.com/providers/CDRP_forms.asp.

The following drugs are subject to the Clinical Drug Review Program:

- [becaplermin gel \(Regranex®\)](#)
- [emtricitabine/tenofovir \(Truvada®\)](#)
- [fentanyl mucosal agents](#)
- [lidocaine patch \(Lidoderm®\)](#)
- [oxazolidinone antibiotics \(Sivextro™, Zyvox®\)](#)
- [palivizumab \(Synagis®\)](#)
- [sodium oxybate \(Xyrem®\)](#)
- [somatropin \(Serostim®\)](#)

The following drug classes are subject to the Clinical Drug Review Program and are also included on the Preferred Drug List:

- [Anabolic Steroids](#)
- [Central Nervous System \(CNS\) Stimulants](#) for 18 years and older
- [Growth Hormones](#) for 21 years and older
- [Phosphodiesterase type-5 \(PDE-5\) Inhibitors for PAH](#)
- [Topical Immunomodulators](#)

For more information on the NYS Medicaid Pharmacy Programs: http://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm

To contact the NYS Medicaid Pharmacy Clinical Call Center please call 1-877-309-9493

To download a copy of the Prior Authorization fax form go to https://newyork.fhsc.com/providers/PA_forms.asp

NYS Medicaid Fee-For-Service Drug Utilization Review (DUR) Program

Frequency/Quantity/Duration (F/Q/D) Program and Step Therapy parameters are implemented to ensure clinically appropriate and cost effective use of these drugs and drug classes.

For additional Step Therapy and Frequency/Quantity/Duration parameters for drugs and drug classes that are also included on the Preferred Drug List (PDL), please see pages 3 through 31.

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Acthar® (ACTH injectable)	<p>Requires trial of first-line therapy for all FDA-approved indications, other than infantile spasms.</p> <p>Note: Acthar is first line therapy for infantile spasms in children less than 2 years of age – step therapy not required.</p>	<p>QUANTITY LIMITS:</p> <ul style="list-style-type: none"> ➤ Infantile spasms – 30 mL (six 5 mL vials) ➤ Multiple sclerosis – 35 mL (seven 5 mL vials) <p>DURATION LIMITS:</p> <ul style="list-style-type: none"> ➤ Infantile spasms – 4 weeks; indicated for < 2 years of age ➤ Multiple sclerosis – 5 weeks ➤ Rheumatic disorders – 5 weeks ➤ Dermatologic conditions – 5 weeks ➤ Allergic states (serum sickness) – 5 weeks 	<p>Confirm diagnosis of FDA-approved or compendia-supported indication</p> <p>Not covered for diagnostic purposes</p>
		FDA Indication	First line Therapy
Multiple Sclerosis (MS) exacerbations		Corticosteroid or plasmapheresis	
Polymyositis/ dermatomyositis		Corticosteroid	
Idiopathic nephrotic syndrome		ACE Inhibitor, diuretic, corticosteroid (and for refractory patients: an immunosuppressive)	
Systemic lupus erythematosus (SLE)		Corticosteroid, antimalarial, or cytotoxic/immunosuppressive agent	
Nephrotic syndrome due to SLE		Immunosuppressive, corticosteroid, or ACE Inhibitor	
Rheumatic disorders (specifically: psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis)		Corticosteroid, topical retinoid, biologic disease-modifying antirheumatic drugs (DMARD), non-biologic DMARD, or a non-steroidal anti-inflammatory drug (NSAID)	
Dermatologic diseases (specifically Stevens-Johnson syndrome and erythema multiforme)		Corticosteroid or analgesic	
Allergic states (specifically serum sickness)		Topical or oral corticosteroid, antihistamine, or NSAID	
Ophthalmic diseases (keratitis, iritis, iridocyclitis, diffuse posterior uveitis/choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation)		Analgesic, anti-infective agent, and agents to reduce inflammation, such as NSAIDs and steroids	
Respiratory diseases (systemic sarcoidosis)		Oral corticosteroid or an immunosuppressive.	

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Amoxicillin ER (Moxatag®)	Prescribers should attempt treatment with an immediate-release amoxicillin first before progressing to extended-release amoxicillin	QUANTITY LIMIT: ➤ Equal to 10 tablets per fill	
Anabolic Steroids – Injectable ➤ Depo-Testosterone® ➤ testosterone cypionate* ➤ testosterone enanthate *for additional parameters, see Cross-Sex Hormones section below. Anabolic Steroids – Oral ➤ Anadrol-50® ➤ Android® ➤ Androxy™ ➤ Methitest® ➤ Oxandrin® ➤ oxandrolone ➤ Testred®		Limitations for anabolic steroid products is based on approved FDA labeled daily dosing and documented diagnosis not to exceed a 90-day supply (30-day supply for oxandrolone): ➤ Initial duration limit of 3 months (for all products except oxandrolone), requiring documented follow-up monitoring for response and/or adverse effects before continuing treatment ➤ Duration limit of 6 months for delayed puberty ➤ Duration limit of 1 month for all uses of oxandrolone products	
Anti-Retroviral (ARV) Interventions		QUANTITY LIMITS: ➤ Limit ARV active ingredient duplication ➤ Limit ARV utilization to a maximum of five products concurrently - excluding boosting with ritonavir (dose limit 600 mg or less) or cobicistat ➤ Limit Protease Inhibitor utilization to a maximum of two products concurrently ➤ Limit Integrase inhibitor utilization to a maximum of one product concurrently	➤ Require confirmation of FDA approved or compendia supported use ➤ Point of service edit for contraindicated antiretroviral / non-antiretroviral combinations ➤ Point of service edit for contraindicated antiretroviral / antiretroviral combinations
Antidiabetic agents (not on the PDL) ➤ chlorpropamide ➤ glimepiride ➤ glipizide (Glucotrol®, Glucotrol XL®) ➤ glyburide (DiaBeta®, Glynase®) ➤ glyburide, micronized ➤ tolazamide ➤ tolbutamide	➤ Requires a trial with metformin with or without insulin prior to initiating other antidiabetic agents, unless there is a documented contraindication. ➤ Clinical editing to allow patients with a diagnosis of gestational diabetes to receive glyburide without a trial of metformin first.		

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Antifungals, Topical – for Onychomycosis ➤ ciclopirox 8% solution ➤ Jublia® ➤ Kerydin® ➤ Penlac®	➤ Trial with an oral antifungal agent* prior to use of ciclopirox 8% solution (Penlac) <ul style="list-style-type: none"> ▪ terbinafine (Lamisil®) tablets; griseofulvin (Gris PEG®) oral suspension, ultramicrozoned tablets micronized tablets; itraconazole (Sporanox®, Onmel™) tablets, oral solution ➤ Trial with ciclopirox 8% solution prior to the use of other topical antifungals [efinaconazole (Jublia) or tavaborole (Kerydin)]		
Becaplermin (Regranex®)		QUANTITY LIMIT: ➤ 2 (two) 15 gram tubes in a lifetime	
Benzodiazepine agents – oral ➤ alprazolam (Niravam™, Xanax®, Xanax® XR) ➤ chlordiazepoxide (Librium®) ➤ chlordiazepoxide/amitriptyline (Limbitrol®) ➤ clonazepam (Klonopin®) ➤ clorazepate (Tranxene®, Tranxene T-Tab®) ➤ diazepam (Valium®) ➤ lorazepam (Ativan®, Lorazepam Intenso®) ➤ oxazepam (Serax®)	➤ For diagnosis of Generalized Anxiety Disorder (GAD) or Social Anxiety Disorder (SAD): Require trial with a Selective-Serotonin Reuptake Inhibitor (SSRI) or a Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) prior to initial benzodiazepine prescription ➤ For diagnosis of Panic Disorder: Require concurrent therapy with an antidepressant (SSRI, SNRI, or Tricyclic antidepressant [TCA]). ➤ For diagnosis of skeletal muscle spasms: Require trial with a skeletal muscle relaxant prior to a benzodiazepine	DURATION LIMIT: ➤ For Insomnia: 30 consecutive days ➤ For Panic Disorder: 30 consecutive days	➤ Require confirmation of FDA approved or compendia supported use ➤ PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy ➤ PA required for any additional oral benzodiazepine prescription in patients currently on benzodiazepine therapy
Crofelemer (Mytesi™)	Requires trial with an alternative anti-diarrheal agent		Confirm diagnosis of HIV/AIDS or antiretroviral therapy in claims history
Cross-Sex Hormones ➤ conjugated estrogens ➤ estradiol ➤ testosterone cypionate			Refer to page 19 of the May 2016 Medicaid Update Article for Transgender Related Care and Services Update

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
<ul style="list-style-type: none"> ➤ cyclosporine ophthalmic emulsion (Restasis®, Restasis MultiDose™) ➤ lifitegrast ophthalmic solution (Xiidra™) 	Diagnosis documentation required to justify utilization as a first line agent or attempt treatment with an artificial tear, gel or ointment	<p>QUANTITY LIMIT:</p> Restasis, Xiidra: <ul style="list-style-type: none"> ➤ 60 vials dispensed as a 30-day supply; Restasis Multidose: <ul style="list-style-type: none"> ➤ 5.5 mL dispensed as a 25-day supply 	
Cystic fibrosis agents <ul style="list-style-type: none"> ➤ ivacaftor (Kalydeco™) ➤ ivacaftor / lumacaftor (Orkambi™) 			<ul style="list-style-type: none"> ➤ Confirm diagnosis of FDA-approved or compendia-supported indication ➤ Genetic testing required to verify appropriate mutations
Dextromethorphan / quinidine (Nuedexta®)		<p>QUANTITY LIMIT:</p> <ul style="list-style-type: none"> ➤ Two (2) capsules per day; 60 units per 30 days <p>DURATION LIMIT:</p> <ul style="list-style-type: none"> ➤ 90 days of therapy 	For patients ≥ 18 years of age: Confirm diagnosis of FDA-approved or compendia-supported indication
Dronabinol (Marinol®)	<ul style="list-style-type: none"> ➤ Step therapy for beneficiaries with HIV/AIDS, or cancer, AND eating disorder: trial with megestrol acetate suspension prior to dronabinol ➤ Step therapy for beneficiaries with diagnosis of cancer and nausea/vomiting: trial with a NYS Medicaid-preferred 5-HT3 receptor antagonist prior to dronabinol 		Confirm diagnosis of FDA-approved or compendia-supported indication
Fentanyl Transmucosal Agents <ul style="list-style-type: none"> ➤ Abstral® (sublingual tablet) ➤ Actiq® (lozenge) ➤ Fentora® (buccal tablet) ➤ Lazanda® (nasal spray) ➤ Onsolis® (buccal film) ➤ Subsys® (sublingual spray) 		<p>QUANTITY LIMIT:</p> Abstral, Actiq, Fentora, Onsolis, and Subsys: <ul style="list-style-type: none"> ➤ 4 units per day, 120 units per 30 days Lazanda: <ul style="list-style-type: none"> ➤ 5 mL (1 bottle) per day, 150 mL (5 bottles) per 30 days <p>DURATION LIMIT:</p> <ul style="list-style-type: none"> ➤ 90 days ➤ Quantity and duration limits are not applicable to patients with a documented cancer or sickle cell diagnosis 	<ul style="list-style-type: none"> ➤ Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease ➤ For opioid-naïve patients - limited to a 15 days supply for all initial opioid prescriptions, Exemption for diagnosis of cancer or sickle cell disease ➤ PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy ➤ PA is required for initiation of opioid therapy in patients currently on benzodiazepine therapy

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Irritable Bowel Syndrome – assoc. with constipation (IBS-C) Agents ➤ linaclotide (Linzess®) ➤ lubiprostone (Amitiza®)* *for opioid induced constipation (OIC) parameters see OIC agents section below	Step therapy with trials of both a bulking-agent and an osmotic laxative prior (defined as within 89 days) to lubiprostone or linaclotide	<u>DURATION LIMIT:</u> ➤ 30 days with 2 refills/prescription	
Irritable Bowel Syndrome – assoc. with diarrhea (IBS-D) Agents ➤ alosetron (Lotronex®) ➤ eluxadoline (Viberzi®)	Step therapy with both eluxadoline AND rifaximin prior to using alosetron		Confirm diagnosis of FDA-approved or compendia-supported indication
Lipid Lowering Agents - Proprotein Convertase Subtilisin Kexin 9 (PCSK9) Inhibitors ➤ alirocumab (Praluent™) ➤ evolocumab (Repatha™)	Require trial of a HMG-CoA Reductase Inhibitors (Statin) at maximum tolerated dosage		Confirm diagnosis of FDA-approved or compendia-supported indication Require concurrent statin therapy
Lipid Lowering Agents - Triglyceride transfer protein inhibitors: ➤ lomitapide (Juxtapid®) ➤ mipomersen (Kynamro®)	Requires trial with high intensity statin therapy		Confirm diagnosis of FDA-approved or compendia-supported indication
Metozolv® ODT (metoclopramide)	Requires a trial with conventional metoclopramide before metoclopramide orally disintegrating tablet (ODT), except with diagnosis of diabetes mellitus	<u>QUANTITY LIMIT:</u> ➤ 4 units per day, 120 units per 30 days <u>DURATION LIMIT:</u> ➤ 90 days	

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Methadone		QUANTITY LIMIT: <ul style="list-style-type: none"> ➤ 12 units per day, 360 units per 30 days ➤ Exemption for diagnosis of cancer or sickle cell disease 	<ul style="list-style-type: none"> ➤ Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease ➤ PA required for initiation of methadone for patients on established buprenorphine opioid dependence therapy ➤ PA required for methadone prescriptions for patients currently on long-acting opioid therapy. Exemption for diagnosis of cancer or sickle cell disease ➤ PA required for initiation of long-acting opioid therapy in opioid-naïve patients. Exemption for diagnosis of cancer or sickle cell disease ➤ PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy
Methadone			Confirm diagnosis of FDA-approved or compendia-supported indication
Olanzapine / Fluoxetine (Symbyax®)	When prescribing for the treatment of major depressive disorder (MDD) in the absence of other psychiatric comorbidities, trial with at least one different antidepressant agent is required		PA is required for the initial prescription for beneficiaries younger than 18 years
Opioid Induced Constipation (OIC) Agents <ul style="list-style-type: none"> ➤ lubiprostone (Amitiza®)* ➤ methylxaltrexone (Relistor®) ➤ naloxegol (Movantik™) <small>*for lubiprostone parameters for IBS-C, see IBS-C agents section above</small>	Trial with an osmotic laxative, a stimulant laxative and a stool softener prior to use of lubiprostone, methylxaltrexone, or naloxegol	QUANTITY LIMIT: <ul style="list-style-type: none"> ➤ lubiprostone: 2 capsules per day; 60 capsules per 30 days ➤ methylxaltrexone: 1 vial or syringe per day (30 vials/syringes per 30 days; 4 kits per 28 days; 90 tablets per 30 days) ➤ naloxegol: 1 tablet per day; 30 tablets per 30 days 	Confirmation of FDA-approved or compendia-supported indications
Oral Pollen/Allergen Extracts (Grastek®, Oralair®, Ragwitek®)	Trial with a preferred intranasal corticosteroid		Confirm diagnosis for the FDA-approved indication of Pollen-induced allergic rhinitis confirmed by positive skin or in vitro testing for pollen-specific IgE antibodies
Pubertal Suppressants <ul style="list-style-type: none"> ➤ goserelin acetate ➤ leuprolide acetate ➤ nafarelin acetate 			Refer to page 19 of the May 2016 Medicaid Update Article for Transgender Related Care and Services Update

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Pulmonary Fibrosis Agents ➤ Ofev® ➤ Esbriet®			Confirm diagnosis of FDA-approved or compendia-supported indication
Pyrimethamine (Daraprim®)			Confirmation of FDA-approved or compendia-supported indications Require concurrent utilization of leucovorin
Quinine		QUANTITY AND DURATION LIMITS: ➤ Maximum 42 capsules as a 7-day supply ➤ limited to 1 prescription per year	
Tasimelteon (Hetlioz®)		QUANTITY LIMIT: ➤ One unit per day; 30 units per 30 days	Confirm diagnosis of FDA-approved or compendia-supported indication
Teriparatide (Forteo®)	Requires a trial with a preferred oral bisphosphonate prior to teriparatide	QUANTITY LIMIT: ➤ One unit (2.4 mL) per 30-day period LIFETIME QUANTITY LIMIT: ➤ 25 months of therapy	
Vesicular monoamine transport 2 inhibitors ➤ Austedo® ➤ Xenazine®			Confirm diagnosis of FDA-approved or compendia-supported indication in patients ≥ 18 years of age

For more information on DUR Program, please refer to http://nyhealth.gov/health_care/medicaid/program/dur/index.htm.

NYS Medicaid Fee-For-Service Brand Less Than Generic (BLTG) Program

On April 26, 2010, New York Medicaid implemented a new cost containment initiative, which promotes the use of certain multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent.

In conformance with State Education Law, which intends that patients receive the lower cost alternative, brand name drugs included in this program:

- **Do not require “Dispense as Written” (DAW) or “Brand Medically Necessary” on the prescription**
- Have a generic copayment
- Are paid at the Brand Name Drug reimbursement rate or usual and customary price, whichever is lower (SMAC/FUL are not applied)
- Do not require a new prescription if the drug is removed from this program

Effective June 22, 2017:

- Focalin, Tazorac cream and Zylflo CR will be **added to** the program

List of Brand Name Drugs included in this program**		
Adderall XR	Focalin	Tazorac cream
Aggrenox	Focalin XR	Tegretol suspension
Alphagan P 0.15%	Gleevec	Tegretol XR
BenzaClin gel, pump	Hepsera	Tobradex suspension
Catapres-TTS	Kapvay	Trizivir
Cellcept suspension	Myfortic	Valcyte tablet, solution
Copaxone 20ml SQ	Patanase	Voltaren Gel
Diastat	Protopic	Xeloda
Differin	Pulmicort Respules	Xenazine
Edecrin	Retin-A cream, gel	Zylflo CR
Exelon Patch	Seroquel XR	

**List is subject to change

Please keep in mind that drugs in this program may be subject to prior authorization requirements of other pharmacy programs; again promoting the use of the most cost-effective product.

IMPORTANT BILLING INFORMATION

- Prescription claims submitted to the Medicaid program **DO NOT require** the submission of Dispense As Written/Product Selection Code of ‘1’;
- Pharmacies can submit any valid NCPDP field (408-D8) value

For more information on the Brand Less Than Generic (BLTG) Program, please refer to https://newyork.fhsc.com/providers/bltgp_about.asp.

NYS Medicaid Fee-For-Service Mandatory Generic Drug Program

State law excludes Medicaid coverage of brand name drugs that have a Federal Food and Drug Administration (FDA) approved A-rated generic equivalent, unless a prior authorization is obtained.

Coverage parameters under the Preferred Drug Program (PDP), Clinical Drug Review Program (CDRP), and/or the Brand Less Than Generic (BLTG) Program are applicable for certain products subject to the Mandatory Generic Drug Program (MGDP), including exemptions (as listed below).

Prior Authorization Process

- Prescribers, or an agent of the prescriber, must call the prior authorization line at **1-877-309-9493** and respond to a series of questions that identify the prescriber, the patient and the reason for prescribing this drug. The [Mandatory Generic Program Prescriber Worksheet and Instructions](#) provide step-by-step assistance in completing the prior authorization process.
- The prescriber must write “DAW and Brand Medically Necessary” on the face of the prescription.
- The call line **1-877-309-9493** is in operation 24 hours a day, seven days a week.

Exempt Drugs

- Based on specific characteristics of the drug and/or disease state generally treated, the following brand name drugs are exempt from the program and do **NOT** require PA:

EXEMPT DRUGS	
Clozaril®	Levothyroxine Sodium (Unithroid®, Synthroid®, Levoxyl®)
Coumadin®	Neoral®
Dilantin®	Sandimmune®
Gengraf®	Tegretol®
Lanoxin®	Zarontin®

For more information on the Mandatory Generic Program, please refer to https://newyork.fhsc.com/providers/MGDP_about.asp.

NYS Medicaid Fee-For-Service Dose Optimization Program

On November 14, 2013, the Medicaid Fee-for-Service program instituted a Dose Optimization initiative. Dose optimization can reduce prescription costs by reducing the number of pills a patient needs to take each day. The Department has identified drugs to be included in this program, the majority of which have FDA approval for once-a-day dosing, have multiple strengths available in correlating increments at similar costs and are currently being utilized above the recommended dosing frequency. Prior authorization will be required to obtain the following medication beyond the following limits:

Dose Optimization Chart

Brand Name	Dose Optimization Limitations		
CARDIOVASCULAR			
Angiotensin Receptor Blockers (ARBs)			
Benicar 20mg	1 daily	Tablet	
Micardis 20mg, 40mg	1 daily	Tablet	
Diovan 40mg, 80mg, 160mg	1 daily	Tablet	
ARBs/ Calcium Channel Blockers			
Exforge 5–160mg	1 daily	Tablet	
ARBs/ Diuretics			
Benicar HCT 20–12.5mg	1 daily	Tablet	
Diovan HCT 80–12.5mg, 160–12.5mg	1 daily	Tablet	
Edarbyclor 40–12.5mg	1 daily	Tablet	
Micardis HCT 40–12.5mg, 80–12.5mg	1 daily	Tablet	
Beta Blockers			
Bystolic 2.5mg, 5mg, 10mg	1 daily	Tablet	
Coreg CR 20mg,40mg	1 daily	Tablet	
nadolol 40mg	1 daily	Tablet	
Toprol XL 25mg, 50mg, 100mg	1 daily	Tablet	
HMG Co A Reductase Inhibitors			
Crestor 5mg, 10mg, 20mg	1 daily	Tablet	
Niacin Derivatives			
Niaspan 500mg	1 daily	Tablet	
Anticonvulsants – Second Generation			
Lyrica 25mg, 50mg, 75mg, 100mg, 150mg, 200mg	3 daily	Capsule	Electronic bypass for diagnosis of seizure disorder identified in medical claims data.
Lyrica 225mg and 300mg	2 daily	Capsule	

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Antiparkinson Agents			
Azilect 0.5mg	1 daily	Tablet	
Antipsychotics – Second Generation			
Abilify 2mg	4 daily	Tablet	
Abilify 5mg, 10mg, 15mg	1 daily	Tablet	In the case of dose titration for these once daily medications, the Department will allow for multi-day dosing (up to 2 doses/daily) for titration purposes for 3 months.
Invega 1.5mg, 3mg	1 daily	Tablet	
Latuda 20mg, 40mg, 60mg	1 daily	Tablet	
olanzapine 5mg	1 daily	Tablet	
olanzapine ODT 5mg	1 daily	Tablet	
Seroquel XR 150mg, 200mg	1 daily	Tablet	
Symbyax 3–25mg, 6–25mg, 12–25mg	1 daily	Capsule	
Zyprexa Zydis 5mg, 10mg	1 daily	Tablet	
CNS Stimulants			
Concerta ER 18mg, 27mg, 54mg	1 daily	Tablet	
Concerta ER 36mg	2 daily	Tablet	
Focalin XR 5mg, 10mg, 15mg, 20mg	1 daily	Capsule	
Metadate CD 10mg, 20mg	1 daily	Capsule	
Provigil 100mg	1 daily	Tablet	
Quillichew ER 20mg, 40mg	1 daily	Tablet	
Quillichew ER 30mg	2 daily	Tablet	
Ritalin LA 10mg, 20mg	1 daily	Capsule	
Vyvanse 20mg, 30mg	1 daily	Capsule	
Non-Ergot Dopamine Receptor Agonists			
Requip XL 2mg, 4mg, 6mg	1 daily	Tablet	
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)			
guanfacine ER 1mg, 2mg, 3 mg, 4mg	1 daily	Tablet	
Intuniv 1mg, 2mg	1 daily	Tablet	
Strattera 40mg	1 daily	Capsule	
Sedative Hypnotics			
Lunesta 1mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)			
Effexor XR 37.5mg, 75mg	1 daily	Capsule	In the case of dose titration for these once daily medications, the Department will allow for multi-day dosing (up to 2 doses/daily) for titration purposes for three months.
Pristiq ER 50mg	1 daily	Tablet	
Selective Serotonin Reuptake Inhibitors (SSRIs)			
Lexapro 5mg, 10mg	1 daily	Tablet	In the case of dose titration for these once daily medications, the Department will allow for multi-day dosing (up to 2 doses/daily) for titration purposes for three months.
Viibryd 10mg, 20mg	1 daily	Tablet	
ENDOCRINE AND METABOLIC			
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors			
Januvia 25mg, 50mg	1 daily	Tablet	
Onglyza 2.5mg	1 daily	Tablet	
Thiazolidinediones (TZDs)			
Actos 15mg	1 daily	Tablet	
ACTOplus Met XR 15–1000mg	1 daily	Tablet	
GASTROINTESTINAL			
Proton Pump Inhibitors			
Dexilant 30mg	1 daily	Capsule	
Nexium 20mg	1 daily	Capsule	
Prevacid DR 15mg	1 daily	Capsule	
RENAL AND GENITOURINARY			
Urinary Tract Antispasmodics			
Detrol LA 2mg	1 daily	Capsule	
Enablex 7.5mg	1 daily	Tablet	
oxybutynin chloride ER 5mg	1 daily	Tablet	
Toviaz ER 4mg	1 daily	Tablet	
Vesicare 5mg	1 daily	Tablet	

PA requirements are not dependent on the date a prescription is written. New prescriptions and refills on existing prescriptions require PA even if the prescription was written before the date the drug was determined to require PA.

To obtain a prior authorization (PA), please call the prior authorization Clinical Call Center at 1-877-309-9493. The Clinical Call Center is available 24 hours per day, 7 days per week with pharmacy technicians and pharmacists who will work with you, or your agent, to quickly obtain PA.

Medicaid enrolled prescribers with an active e-PACES account can initiate PA requests through the web-based application PAXpress®. The website for PAXpress is <https://paxpress.nypa.hidinc.com>.