Revised: April 19, 2018

# New York State Medicaid Fee-For-Service Pharmacy Programs

## OVERVIEW OF CONTENTS



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

## PREFERRED DRUG LIST – TABLE OF CONTENTS

# 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<br>ibuprofen<br>indomethacin<br>ketorolac<br>meloxicam (tablet)<br>naproxen<br>naproxen EC<br>piroxicam<br>sulindac<br>Voltaren® Gel | Anaprox® DS<br>Arthrotec®<br>Cambia®<br>Celebrex® CC<br>celecoxib CC<br>Daypro®<br>diclofenac / misoprostol<br>diclofenac potassium<br>diclofenac sodium<br>diclofenac topical gel<br>diclofenac topical soln<br>diflunisal<br>Duexis®<br>etodolac<br>etodolac ER<br>Feldene®<br>fenoprofen<br>Flector® patch<br>flurbiprofen<br>Indocin®<br>indomethacin SR<br>ketoprofen<br>ketoprofen SA<br>meclofenamate<br>mefenamic acid<br>meloxicam (susp.)<br>Mobic®<br>nabumetone<br>Nalfon®<br>Naprelan®<br>Naprosyn®<br>Naprosyn® EC<br>naproxen CR<br>naproxen sodium<br>oxaprozin<br>Pennsaid®<br>Tivorbex®<br>tolmetin<br>Vimovo®<br>Vivlodex™<br>Zipsor®<br>Zorvolex® | **CLINICAL CRITERIA (CC)**<br>➢ Celebrex® (celecoxib) – one of the following criteria will not require PA<br>▪ Over the age of 65 years<br>▪ Concurrent use of an anticoagulant agent<br>▪ History of GI Bleed/Ulcer or Peptic Ulcer Disease |
| **Opioid Antagonists** | | |
| naloxone (syringe, vial)<br>naltrexone<br>Narcan® (nasal spray) | | |
| **Opioid Dependence Agents** CC, F/Q/D | | |
| buprenorphine<br>Suboxone® (film) | Bunavail®<br>buprenorphine/ naloxone (tablet)<br>Zubsolv® | **CLINICAL CRITERIA (CC)**<br>➢ PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy<br>**QUANTITY LIMIT:**<br>➢ Buprenorphine sublingual (SL): Six (6) tablets dispensed as a 2-day supply; not to exceed 24 mg per day<br>➢ Buprenorphine/ naloxone tablet and film (Bunavail™, Suboxone®, Zubsolv®): 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 its equivalent per day |



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **Opioids – Long-Acting** CC, F/Q/D | | |
| Butrans®<br>Embeda®<br>fentanyl patch (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg)<br>morphine sulfate SR (tablet) | Arymo™ ER<br>Belbuca™<br>buprenorphine patches<br>Conzip® ST<br>Duragesic®<br>Exalgo®<br>fentanyl patch (37.5 mcg, 62.5 mcg, 87.5 mcg)<br>hydromorphone ER<br>Hysingla® ER<br>Kadian®<br>MorphaBond™ ER<br>morphine ER (capsule) (generic for Avinza)<br>morphine ER (capsule) (generic for Kadian)<br>MS Contin®<br>Nucynta® ER ST<br>oxycodone ER<br>Oxycontin®<br>oxymorphone ER<br>tramadol ER ST<br>Xtampza™ ER<br>Zohydro® ER | **CLINICAL CRITERIA (CC)**<br>➢ Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease<br>➢ PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy<br>➢ PA required for initiation of long-acting opioid therapy in opioid-naïve patients.<br>▪ Exception for diagnosis of cancer or sickle cell disease.<br>➢ PA required for any additional long-acting opioid prescription for patients currently on long-acting opioid therapy.<br>▪ Exception for diagnosis of cancer or sickle cell disease.<br>➢ PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy<br>➢ PA required for any codeine- or tramadol-containing products in pts < 12yrs<br>**STEP THERAPY (ST)**<br>➢ Nucynta® ER (tapentadol ER): Trial with tapentadol IR before tapentadol ER for patients who are naïve to a long-acting opioid<br>➢ Tramadol ER (tramadol naïve patients): Attempt treatment with IR formulations before the following ER formulations: Conzip®, tramadol ER<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D) - Exemption for diagnosis of cancer or sickle cell disease**<br>➢ Belbuca™ (buprenorphine)<br>▪ Maximum 2 (two) units per day<br>➢ Butrans® (buprenorphine)<br>▪ Maximum 4 patches per 28 days<br>➢ Embeda® (morphine ER/naltrexone):<br>▪ Maximum 2 (two) units per day<br>➢ Nucynta® ER (tapentadol ER):<br>▪ Maximum 2 (two) units per day<br>➢ Nucynta® ER (tapentadol ER):<br>▪ Maximum daily dose of tapentadol IR and tapentadol ER formulations if used in combination should not exceed 500mg/day<br>➢ Tramadol ER (Conzip®):<br>▪ Maximum 30 tablets dispensed as a 30-day supply<br>➢ Zohydro ER (hydrocodone ER):<br>▪ Maximum 2 (two) units per day, 60 units per 30 days<br>➢ Hysingla™ ER (hydrocodone ER):<br>▪ Maximum 1 (one) unit per day; 30 units per 30 days<br>➢ Hydromorphone ER, oxymorphone ER:<br>▪ Maximum 4 (four) units per day, 120 units per 30 days<br>➢ Oxycodone ER (Xtampza ER™):<br>▪ Maximum 2 (two) units per day, 60 units per 30 days. Not to exceed a total daily dose of 160mg or its equivalent<br>➢ Fentanyl transdermal patch (Duragesic®):<br>▪ Maximum 10 patches per 30 days; maximum 100mcg/hr (over a 72 hour dosing interval)<br>➢ Morphine ER (excluding MS Contin products):<br>▪ Maximum 2 (two) units per day, 60 units per 30 days<br>➢ Morphine ER (MS Contin & Arymo™ ER 15mg, 30mg, 60mg only):<br>▪ Maximum 3 (three) units per day, 90 units per 30 days<br>➢ Morphine ER (MS Contin 100mg only):<br>▪ Maximum 4 units per day, up to 3 times a day, maximum 120 units per 30 days<br>➢ Morphine ER (MS Contin 200mg only):<br>▪ Maximum 2 units per day, maximum 60 units per 30 days |

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# 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<br>codeine F/Q/D<br>codeine / APAP F/Q/D<br>hydrocodone / APAP F/Q/D<br>hydrocodone / ibuprofen F/Q/D<br>Lortab® (elixir) F/Q/D<br>morphine IR F/Q/D<br>oxycodone / APAP F/Q/D<br>Reprexain® F/Q/D<br>tramadol<br>Verdrocet™ F/Q/D<br>Xylon™ F/Q/D | butalbital compound/ codeine F/Q/D<br>butorphanol nasal spray<br>Demerol®<br>dihydrocodeine / aspirin / caffeine F/Q/D<br>dihydrocodeine / APAP / caffeine F/Q/D<br>Dilaudid® F/Q/D<br>Fiorinal® / codeine F/Q/D<br>hydromorphone F/Q/D<br>Ibudone® F/Q/D<br>levorphanol<br>meperidine<br>Nucynta® ST, F/Q/D<br>Opana® F/Q/D<br>oxycodone F/Q/D<br>oxycodone / aspirin F/Q/D<br>oxycodone / ibuprofen F/Q/D<br>oxymorphone F/Q/D<br>pentazocine / naloxone<br>Percocet® F/Q/D<br>Primlev™ F/Q/D<br>Roxicodone® F/Q/D<br>tramadol / APAP F/Q/D<br>Tylenol® / codeine #3 F/Q/D<br>Tylenol® / codeine #4 F/Q/D<br>Ultracet® F/Q/D<br>Ultram®<br>Xartemis® XR F/Q/D<br>Xodol® F/Q/D<br>Zamicet® F/Q/D | **CLINICAL CRITERIA (CC)**<br>➢ Limited to a total of four (4) opioid prescriptions every 30 days.<br>▪ Exception for diagnosis of cancer or sickle cell disease<br>➢ Initial prescription for opioid-naïve patients limited to a 7-day supply.<br>▪ Exception for diagnosis of cancer or sickle cell disease<br>➢ PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy<br>➢ PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy<br>➢ PA required for any codeine- or tramadol-containing products in pts < 12yrs<br>**STEP THERAPY (ST)**<br>➢ Nucynta® (tapentadol IR) – Trial with tramadol and one (1) preferred opioid before tapentadol immediate-release (IR)<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>**Quantity Limits:**<br>➢ Nucynta® (tapentadol IR):<br>▪ Maximum 6 (six) units per day; 180 units per 30 days<br>➢ Nucynta® (tapentadol IR):<br>▪ Maximum daily dose of tapentadol IR and tapentadol ER formulations used in combination not to exceed 500mg/day<br>➢ Morphine and congeners immediate-release (IR) non-combination products (codeine, hydromorphone, morphine, oxycodone, oxymorphone):<br>▪ Maximum 6 (six) units per day, 180 (one hundred eighty) units per 30 (thirty) days<br>➢ Xartemis® XR (oxycodone/acetaminophen):<br>▪ Maximum 4 (four) units per day, 120 (one hundred twenty) units per 30 (thirty) days<br>Additional/alternate parameters: To be applied to patients without a documented cancer or sickle cell diagnosis<br>➢ Morphine and congeners immediate-release (IR) combination products maximum recommended:<br>▪ acetaminophen (4 grams)<br>▪ aspirin (4 grams)<br>▪ ibuprofen (3.2 grams)<br>▪ or the FDA-approved maximum opioid dosage as listed in the PI, whichever is less<br>**Duration Limits:**<br>▪ 90 days for patients without a diagnosis of cancer or sickle-cell disease. |

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# 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®<br>Cayston®<br>Kitabis® Pak | TOBI Podhaler™<br>TOBI® (solution)<br>tobramycin (solution) | **CLINICAL CRITERIA (CC)**<br>Confirm diagnosis of FDA-approved or compendia-supported indication<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Aztreonam (Cayston)<br>▪ 3 (three) ampules (3mL) per day<br>▪ 84 ampules (84 mL) per 56 day regimen (28 days on, 28 days off)<br>➢ Tobramycin inhalation solution (Bethkis, TOBI, Kitabis)<br>▪ 2 (two) ampules (8 mL Bethkis, 10 mL TOBI, Kitabis Pak) per day<br>▪ 56 ampules (224 mL Bethkis, 280 mL TOBI, Kitabis Pak) per 56 day regimen (28 days on-28 days off)<br>➢ Tobramycin capsules with inhalation powder (TOBI Podhaler)<br>▪ 8 capsules per day 224 capsules per 56 day regimen (28 days on-28 days off) |
| **Anti-Fungals – Oral for Onychomycosis** | | |
| griseofulvin (suspension)<br>griseofulvin ultramicronized<br>terbinafine (tablet) | Gris-PEG®<br>griseofulvin micronized (tablet)<br>itraconazole<br>Lamisil® (tablet)<br>Onmel®<br>Sporanox® | |
| **Anti-Virals – Oral** | | |
| acyclovir<br>valacyclovir | famciclovir<br>Valtrex®<br>Zovirax® | |
| **Cephalosporins – Third Generation** | | |
| cefdinir<br>cefixime<br>cefpodoxime<br>Suprax® | | |
| **Fluoroquinolones – Oral** | | |
| Cipro® (suspension)<br>ciprofloxacin (suspension, tablet)<br>levofloxacin (tablet) | Avelox®<br>Cipro® (tablet)<br>Cipro® XR<br>ciprofloxacin ER<br>Levaquin®<br>levofloxacin (solution)<br>moxifloxacin<br>ofloxacin (tablet) | |
| **Hepatitis B Agents** | | |
| Baraclude® (solution)<br>entecavir<br>Epivir-HBV® (solution)<br>Hepsera®<br>lamivudine 100mg | adefovir dipivoxil<br>Baraclude® (tablet)<br>Epivir-HBV® (tablet)<br>Vemlidy® | |

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# 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 | **FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ 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.<br>➢ Further documentation required for continuation of therapy at weeks 14 and 26.<br>➢ 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.<br>➢ After 24 weeks of therapy obtain a HCV RNA. Continuation for genotype 1 and 4 is supported if undetectable HCV RNA.<br>▪ Maximum duration of 48 weeks for:<br>❖ Treatment-naïve patients or prior relapsers with cirrhosis and HIV co-infection<br>❖ 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® CC, F/Q/D<br>Mavyret™ 1 CC, F/Q/D<br>ribavirin<br>Vosevi® 1 CC, F/Q/D | Daklinza™ CC, F/Q/D<br>Harvoni® 2, CC, F/Q/D<br>Moderiba™<br>Olysio® CC, F/Q/D<br>Rebetol®<br>Ribasphere®<br>Sovaldi® CC, F/Q/D<br>Technivie® 2, CC, F/Q/D<br>Viekira Pak® 2, CC, F/Q/D<br>Viekira XR™ 2, CC, F/Q/D<br>Zepatier™ 2, CC, F/Q/D | **CLINICAL CRITERIA (CC)**<br>➢ Confirm diagnosis of FDA-approved or compendia-supported indication<br>➢ Require confirmation of prescriber experience and training<br>▪ 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**<br>▪ 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**<br>▪ 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.<br>➢ Require confirmation of patient readiness and adherence<br>▪ 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/.<br>Click here to access the Hepatitis C Worksheet with Clinical Criteria requirements |

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf

1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **Tetracyclines** | | |
| demeclocycline<br>doxycycline hyclate<br>minocycline (capsule)<br>Morgidox® (capsule)<br>tetracycline | Doryx® ST, F/Q/D<br>Doryx MPC® ST, F/Q/D<br>doxycycline hyclate DR ST, F/Q/D<br>doxycycline monohydrate<br>doxycycline monohydrate IR-DR<br>minocycline (tablet)<br>minocycline ER<br>Oracea®<br>Solodyn®<br>Vibramycin®<br>Ximino™ ER | **STEP THERAPY (ST)**<br>➢ Trial of doxycycline IR before progressing to doxycycline DR<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ doxycycline DR (Doryx®):<br>▪ Maximum 28 tablets/capsules per fill |
| **III. CARDIOVASCULAR** | | |
| **Angiotensin Converting Enzyme Inhibitors (ACEIs)** | | |
| benazepril<br>enalapril<br>lisinopril<br>ramipril | Accupril®<br>Altace®<br>captopril<br>Epaned™<br>fosinopril<br>Lotensin®<br>moexipril<br>perindopril<br>Prinivil®<br>Qbrelis™<br>quinapril<br>trandolapril<br>Vasotec®<br>Zestril® | |
| **ACE Inhibitor Combinations** | | |
| benazepril/ amlodipine<br>benazepril/ HCTZ<br>captopril/ HCTZ<br>enalapril/ HCTZ<br>lisinopril/ HCTZ<br>Lotrel®<br>moexipril/ HCTZ<br>Tarka®<br>trandolapril/ verapamil ER | Accuretic®<br>fosinopril/ HCTZ<br>Lotensin HCT®<br>Prestalia®<br>quinapril/ HCTZ<br>Vaseretic®<br>Zestoretic® | |



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **Angiotensin Receptor Blockers (ARBs)** | | |
| Diovan® DO<br>losartan<br>valsartan | Atacand®<br>Avapro®<br>Benicar® DO<br>candesartan<br>Cozaar®<br>Edarbi™<br>eprosartan<br>irbesartan<br>Micardis® DO<br>olmesartan<br>telmisartan | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected drugs and strengths |
| **ARBs Combinations** | | |
| Exforge HCT®<br>losartan/ HCTZ<br>valsartan/ amlodipine<br>valsartan/ amlodipine / HCTZ<br>valsartan/ HCTZ | Atacand HCT®<br>Avalide®<br>Azor®<br>Benicar HCT® DO<br>Byvalson™<br>candesartan/ HCTZ<br>Diovan HCT® DO<br>Edarbyclor™ DO<br>Entresto™ CC<br>Exforge® DO<br>Hyzaar®<br>irbesartan/ HCTZ<br>Micardis HCT® DO<br>olmesartan/ amlodipine<br>olmesartan/ amlodipine/ HCTZ<br>olmesartan/ HCTZ<br>telmisartan/ amlodipine<br>telmisartan/ HCTZ<br>Tribenzor®<br>Twynsta® | **CLINICAL CRITERIA (CC)**<br>➢ 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<br>**DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected drugs and strengths |

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

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



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

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

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

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



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **Antipsychotics – Second Generation** CC, ST, F/Q/D | | |
| aripiprazole (oral solution, tablet) DO<br>clozapine<br>Latuda® DO<br>olanzapine (tablet) DO<br>quetiapine F/Q/D<br>quetiapine ER F/Q/D<br>risperidone<br>Saphris®<br>ziprasidone | Abilify® (oral solution, tablet) DO<br>aripiprazole ODT<br>clozapine ODT<br>Clozaril®<br>Fanapt®<br>FazaClo®<br>Geodon®<br>Invega® DO, F/Q/D<br>olanzapine ODT DO<br>Nuplazid™<br>paliperidone ER F/Q/D<br>Rexulti® DO<br>Risperdal®<br>Seroquel® F/Q/D<br>Seroquel XR® DO, F/Q/D<br>Versacloz®<br>Vraylar™<br>Zyprexa® DO | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected drugs and strengths<br>**CLINICAL CRITERIA (CC)**<br>➢ Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA<br>➢ Confirm diagnosis of FDA-approved or compendia-supported indication<br>➢ PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below: |

| | |
|---|---|
| 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®) | 10 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 |

➢ Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients < 18 years of age

**STEP THERAPY (ST)**

➢ 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

**FREQUENCY/QUANTITY/DURATION (F/Q/D)**

➢ PA required if 3 or more different oral second generation antipsychotics are used for > 180 days.

➢ paliperidone ER (Invega®) 1.5mg, 3mg, 9mg tablets: Maximum 1 (one) unit/day

➢ paliperidone ER (Invega®) 6mg tablets: Maximum 2 (two) units/day

➢ quetiapine/quetiapine ER (Seroquel®/Seroquel XR®): Minimum 100mg/day; maximum 800mg/day

➢ quetiapine (Seroquel®): Maximum 3 (three) units per day, 90 units per 30 days

➢ quetiapine ER (Seroquel XR®) 150mg, 200mg: 1 (one) unit/day, 30 units/30 days

➢ quetiapine ER (Seroquel XR®) 50mg, 300mg, 400mg: 2 (two) units/day, 60 units/30 days

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

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



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# 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 XR® DO<br>amphetamine salt combo IR<br>Daytrana®<br>dextroamphetamine (tablet)<br>Focalin®<br>Focalin XR® DO<br>Methylin®<br>methylphenidate (tablet)<br>Quillivant XR®<br>Vyvanse® (capsule) DO | Adzenys ER™<br>Adzenys XR-ODT™<br>amphetamine salt combo ER DO<br>Aptensio XR®<br>armodafinil CC<br>Concerta® DO<br>Cotempla XR-ODT™<br>Desoxyn®<br>Dexedrine®<br>dexmethylphenidate<br>dexmethylphenidate ER (generic for Focalin XR®)<br>dextroamphetamine ER<br>dextroamphetamine (solution)<br>Dyanavel XR™<br>Evekeo®<br>Metadate® ER<br>methamphetamine<br>methylphenidate (chewable tablet, solution)<br>methylphenidate CD methylphenidate ER (generic Concerta®)<br>methylphenidate ER (generic Ritalin LA®) methylphenidate ER (generic Metadate® ER)<br>modafinil DO<br>Mydayis™<br>Nuvigil® CC<br>Procentra®<br>Provigil® CC, DO<br>Quillichew ER™ DO<br>Ritalin®<br>Ritalin LA® DO<br>Vyvanse® (chewable tablet)<br>Zenzedi® | **CLINICAL CRITERIA (CC)**<br>➢ Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication for beneficiaries **less than 18 years of age**.<br>▪ Prior authorization is required for initial prescriptions for stimulant therapy for beneficiaries **less than 3 years of age**<br>▪ Require confirmation of diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent<br>➢ 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.<br>**CLINICAL DRUG REVIEW PROGRAM (CDRP)**<br>➢ For patients **18 years of age and older**:<br>➢ Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication<br>**DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected drugs and strengths<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Quantity limits based on daily dosage as determined by FDA labeling<br>➢ Quantity limits to include:<br>▪ Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration)<br>▪ Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days. Concerta 36mg and Cotempla XR-ODT 25.9mg not to exceed 2 units daily. |



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

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



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# 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<br>flurazepam CC<br>temazepam 15mg, 30mg CC<br>zolpidem CC | Ambien® CC<br>Ambien CR® CC<br>Belsomra®<br>Edluar® CC<br>eszopiclone<br>Halcion® CC<br>Intermezzo® CC<br>Lunesta® DO<br>Restoril® CC<br>Rozerem®<br>Silenor®<br>Sonata®<br>temazepam 7.5mg, 22.5mg CC<br>triazolam CC<br>zaleplon<br>zolpidem (sublingual) CC<br>zolpidem ER CC<br>Zolpimist™ CC | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected strengths<br>**CLINICAL CRITERIA (CC)**<br>➢ Zolpidem products: Confirm dosage is consistent with FDA labeling for initial prescriptions<br>➢ Benzodiazepine Agents (estazolam, flurazepam, Halcion®, Restoril®, temazepam, triazolam):<br>▪ Confirm diagnosis of FDA-approved or compendia-supported indication<br>▪ PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy<br>▪ PA required for any additional benzodiazepine prescription in patients currently on benzodiazepine therapy<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Frequency and duration limits for the following products:<br>▪ For non-zaleplon and non-benzodiazepine containing products:<br>❖ 30 dosage units per fill/1 dosage unit per day/30 days<br>▪ For zaleplon-containing products:<br>❖ 60 dosage units per fill/2 dosage units per day/30 days<br>➢ Duration limit equivalent to the maximum recommended duration:<br>▪ 180 days for immediate-release zolpidem (Ambien®, Edluar™, Intermezzo®, Zolpimist™) products<br>▪ 180 days for eszopiclone and ramelteon (Rozerem®) products<br>▪ 168 days for zolpidem ER (Ambien CR®) products<br>▪ 90 days for suvorexant (Belsomra®)<br>▪ 90 days for doxepin (Silenor®)<br>▪ 30 days for zaleplon (Sonata®) products<br>▪ 30 days for benzodiazepine agents (estazolam, flurazepam, Halcion®, Restoril®, temazepam, triazolam) for the treatment of insomnia<br>➢ Additional/Alternate parameters:<br>▪ For patients naïve 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 |



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | | Prior Authorization/Coverage Parameters |
|---|---|---|---|
| **Selective Serotonin Reuptake Inhibitors (SSRIs)** | | | |
| citalopram<br>escitalopram (tablet)<br>fluoxetine (capsule, solution)<br>paroxetine<br>sertraline | Brisdelle®<br>Celexa®<br>escitalopram (soln)<br>fluoxetine (tablet)<br>fluoxetine DR weekly<br>fluvoxamine CC<br>fluvoxamine ER CC<br>Lexapro® DO<br>paroxetine 7.5mg | paroxetine CR<br>Paxil®<br>Paxil CR®<br>Pexeva®<br>Prozac®<br>Sarafem®<br>Trintellix™ DO<br>Viibryd® DO<br>Zoloft® | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected strengths<br>**CLINICAL CRITERIA (CC)**<br>➢ Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA<br>➢ 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®)<br>venlafaxine<br>venlafaxine ER DO (capsule) | Cymbalta®<br>desvenlafaxine base ER<br>desvenlafaxine fumarate ER<br>desvenlafaxine succinate ER DO<br>duloxetine 40mg<br>Effexor XR® DO<br>Fetzima®<br>Khedezla™<br>Pristiq® DO<br>Savella®<br>venlafaxine ER (tablet) | | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected strengths<br>**STEP THERAPY (ST)**<br>➢ Trial of an SSRI prior to an SNRI*<br>*Step therapy is not required for the following indications:<br>▪ Chronic musculoskeletal pain (CMP)<br>▪ Fibromyalgia (FM)<br>▪ Diabetic peripheral neuropathy (DPN)*<br>❖ *duloxetine (Cymbalta®) – Requires a trial with a tricyclic antidepressant **OR** gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN) |



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# 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<br>sumatriptan F/Q/D | almotriptan F/Q/D<br>Amerge® F/Q/D<br>Axert® F/Q/D<br>eletriptan F/Q/D<br>Frova® F/Q/D<br>frovatriptan F/Q/D<br>Imitrex® F/Q/D<br>Maxalt® F/Q/D<br>Maxalt® MLT F/Q/D<br>naratriptan F/Q/D<br>Onzetra Xsail™ F/Q/D<br>Relpax® F/Q/D<br>sumatriptan-naproxen F/Q/D<br>Treximet® F/Q/D<br>Zembrace SymTouch™<br>zolmitriptan F/Q/D<br>Zomig® F/Q/D<br>Zomig® ZMT F/Q/D | **FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>almotriptan; Amerge®; Axert® 6.25mg; Frova®; frovatriptan; Imitrex® Nasal Spray; Imitrex® tablets; naratriptan; Relpax® 20mg; sumatriptan nasal spray; sumatriptan tablets; Treximet® and generic; zolmitriptan (tablet, ODT) 2.5mg; zolmitriptan (tablet, ODT) 5mg; Zomig/Zomig® ZMT 2.5mg; Zomig® /Zomig® ZMT 5mg; Zomig® Nasal Spray — 18 units every 30 days<br>Axert® 12.5mg; Maxalt® /Maxalt MLT®; Relpax® 40mg; rizatriptan (tablet, ODT) — 24 tablets every 30 days<br>Onzetra Xsail™ — 16 units (1 kit) every 30 days |

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf

1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

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



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

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

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

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



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# 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<br>miglitol<br>Glyset® | Precose® | **STEP THERAPY (ST)**<br>➢ 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 | **STEP THERAPY (ST)**<br>➢ 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®<br>Axiron®<br>Fortesta®<br>Natesto™<br>Testim®<br>testosterone gel<br>testosterone pump<br>Vogelxo | **CLINICAL DRUG REVIEW PROGRAM (CDRP)**<br>➢ For diagnosis of hypogonadotropic or primary hypogonadism:<br>▪ Requires documented low testosterone concentration with two tests prior to initiation of therapy.<br>▪ Require documented testosterone therapeutic concentration to confirm response after initiation of therapy.<br>➢ For diagnosis of delayed puberty:<br>▪ Requires documentation that growth hormone deficiency has been ruled out prior to initiation of therapy.<br>➢ Click here for a copy of the Anabolic Steroid fax form<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Limitations for anabolic steroid products based on approved FDA labeled daily dosing and documented diagnosis:<br>▪ Duration limit of six (6) months for delayed puberty |



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **Biguanides** | | |
| metformin HCl<br>metformin ER (generic for Glucophage XR®) | Fortamet®<br>Glucophage®<br>Glucophage XR®<br>Glumetza®<br>metformin ER (generics for Fortamet®, Glumetza®)<br>Riomet® (solution) | |
| **Bisphosphonates – Oral F/Q/D** | | |
| alendronate | Actonel®<br>Atelvia®<br>Binosto®<br>Boniva®<br>Fosamax®<br>Fosamax® Plus D<br>Ibandronate<br>risedronate | **FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>ibandronate sodium 150 mg (Boniva® 150 mg) — 1 tablet every 28 days<br>risedronate sodium 150 mg (Actonel® 150 mg)<br>alendronate sodium 35 mg (Fosamax® 35 mg) — 4 tablets every 28 days<br>alendronate sodium 70 mg (Fosamax® 70 mg, Binosto)<br>alendronate sodium and cholecalciferol (Fosamax® Plus D)<br>risedronate sodium 35 mg (Actonel® 35 mg)<br>risedronate sodium 35 mg (Atelvia® 35 mg)<br>alendronate solution 70 mg/75 mL single-dose bottle — 4 bottles every 28 days |
| **Calcitonins – Intranasal** | | |
| calcitonin-salmon | | |
| **Dipeptidyl Peptidase-4 (DPP-4) Inhibitors ST** | | |
| Janumet®<br>Janumet® XR<br>Januvia® DO<br>Jentadueto®<br>Jentadueto® XR<br>Tradjenta® | Alogliptin<br>alogliptin / metformin<br>alogliptin / pioglitazone<br>Glyxambi®<br>Kazano™<br>Kombiglyze® XR<br>Nesina™<br>Onglyza® DO<br>Oseni™<br>Qtern®<br>Steglujan™ | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected strengths<br>**STEP THERAPY (ST)**<br>➢ Requires a trial with metformin with or without insulin prior to DPP-4 Inhibitor therapy, unless there is a documented contraindication. |
| **Glucagon-like Peptide-1 (GLP-1) Agonists ST** | | |
| Bydureon®<br>Byetta®<br>Victoza® | Adlyxin™<br>Bydureon® BCise™<br>Ozempic®<br>Soliqua™<br>Tanzeum®<br>Trulicity®<br>Xultophy® | **STEP THERAPY (ST)**<br>➢ Requires a trial with metformin with or without insulin prior to a GLP-1 agonist.<br>➢ Prior authorization is required with lack of covered diagnosis in medical history. |

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **Glucocorticoids – Oral** | | |
| dexamethasone (tablet)<br>hydrocortisone<br>methylprednisolone (dose-pack)<br>prednisolone (solution)<br>prednisone (dose-pack, tablet) | budesonide EC<br>Cortef®<br>cortisone [2]<br>dexamethasone (elixir, solution [2])<br>dexamethasone intensol<br>Dexpak®<br>Emflaza™<br>Entocort EC®<br>Medrol® (dose-pack, tablet)<br>methylprednisolone (4mg [2], 8mg [2] 16mg, 32mg [2])<br>Millipred®<br>Orapred® ODT<br>prednisolone ODT<br>prednisone (intensol, solution [2])<br>Rayos®<br>TaperDex®<br>Uceris®<br>Veripred®<br>ZoDex™ | |
| **Growth Hormones** [CC, CDRP] | | |
| Genotropin®<br>Norditropin®<br>Nutropin AQ® | Humatrope®<br>Omnitrope®<br>Saizen®<br>Zomacton®<br>Zorbtive® | **CLINICAL DRUG REVIEW PROGRAM (CDRP)**<br>➢ **Prescribers**, not authorized agents, are required to call for a PA for beneficiaries 21 years of age or older<br>**CLINICAL CRITERIA (CC)**<br>➢ 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.<br>➢ Confirm diagnosis of FDA-approved or compendia-supported indication |
| **Insulin – Long-Acting** | | |
| Lantus®<br>Levemir® | Basaglar®<br>Toujeo®<br>Tresiba® | |
| **Insulin – Mixes** | | |
| Humalog® Mix<br>Novolog® Mix | None | |

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **Insulin – Rapid-Acting** | | |
| Apidra®<br>Humalog® 100 U/mL<br>Humalog® Jr 100U/mL<br>Novolog® | Admelog®<br>Afrezza®<br>Fiasp®<br>Humalog® 200 U/mL | |
| **Meglitinides** ST | | |
| nateglinide<br>repaglinide | Prandin®<br>repaglinide/ metformin<br>Starlix® | **STEP THERAPY (ST)**<br>➢ Requires a trial with metformin with or without insulin prior to initiating meglitinide therapy, unless there is a documented contraindication. |
| **Pancreatic Enzymes** | | |
| Creon®<br>Zenpep® | Pancreaze®<br>Pertzye®<br>Viokace® | |
| **Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors** ST | | |
| Farxiga™<br>Invokana® | Invokamet®<br>Invokamet® XR<br>Jardiance®<br>Segluromet™<br>Steglatro™<br>Synjardy®<br>Synjardy® XR<br>Xigduo® XR | **STEP THERAPY (ST)**<br>➢ Requires a trial with metformin with or without insulin prior to initiating SGLT2 Inhibitor therapy, unless there is a documented contraindication. |
| **Thiazolidinediones (TZDs)** ST | | |
| pioglitazone | Actoplus Met®<br>Actoplus Met® XR DO<br>Actos® DO<br>Avandia®<br>Duetact®<br>pioglitazone / glimepiride<br>pioglitazone / metformin | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected strengths<br>**STEP THERAPY (ST)**<br>➢ Requires a trial with metformin with or without insulin prior to initiating TZD therapy, unless there is a documented contraindication. |



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **VII. GASTROINTESTINAL** | | |
| **Anti-Emetics** | | |
| Diclegis® CC 1<br>Emend Pack® 1<br>ondansetron (ODT, solution, tablet) | Akynzeo® 2<br>Anzemet®<br>aprepitant (capsule, pack) 2<br>Emend® (capsule, powder packet) 2<br>granisetron (tablet)<br>Sancuso®<br>Varubi® 2<br>Zofran® (ODT, solution, tablet)<br>Zuplenz® | **CLINICAL CRITERIA (CC)**<br>➢ Diclegis®: Confirm diagnosis of FDA-approved or compendia-supported indication |
| **Gastrointestinal Antibiotics** | | |
| metronidazole (tablet)<br>neomycin<br>vancomycin | Alinia®<br>Dificid®<br>Flagyl®<br>metronidazole (capsule)<br>paromomycin<br>Tindamax®<br>tinidazole<br>Vancocin®<br>Xifaxan® CC, ST, F/Q/D | **CLINICAL CRITERIA (CC)**<br>➢ Xifaxan®: Confirm diagnosis of FDA-approved or compendia-supported indication<br>**STEP THERAPY (ST)**<br>➢ Xifaxan®: Requires trial of a preferred fluoroquinolone antibiotic before rifaximin for treatment of Traveler's diarrhea<br>**QUANTITY LIMITS:**<br>➢ Xifaxan:<br>▪ Traveler's diarrhea (200 mg tablet) – 9 (nine) tablets per 30 days (Dose = 200 mg three times a day for three days)<br>▪ Hepatic encephalopathy (550 mg tablets) – 60 tablets per 30 days (Dose = 550 mg twice a day)<br>▪ Irritable bowel syndrome with diarrhea (550 mg tablets) – 42 tablets per 30 days (Dose = 550 mg three times a day for 14 days)<br>❖ Maximum of 42 days' supply (126 units) per 365 (three rounds of therapy). |
| **Gastrointestinal Preparatory Agents** | | |
| Clearlax®<br>Gavilax®<br>Gavilyte®-C<br>Gavilyte®-G<br>Glycolax®<br>Miralax® OTC<br>PEG 3350 powder OTC<br>PEG 3350/ electrolytes solution Rx | Clenpiq™<br>Colyte®<br>Gavilyte®-N<br>Golytely®<br>Moviprep®<br>Nulytely®<br>Osmoprep®<br>PEG 3350 powder pack OTC<br>PEG 3350 with flavor packs<br>Prepopik®<br>Suprep®<br>Trilyte® | |
| **Helicobacter pylori Agents** | | |
| lansoprazole / amoxicillin / clarithromycin<br>Pylera® | Omeclamox-Pak®<br>Prevpac® | |



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# 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<br>pantoprazole | Aciphex®<br>Dexilant™ DO<br>esomeprazole magnesium (generic for Nexium)<br>esomeprazole strontium<br>lansoprazole Rx (capsule, ODT)<br>Nexium® RX DO<br>omeprazole OTC<br>omeprazole/ sodium bicarbonate Rx<br>Prevacid® OTC<br>Prevacid® Rx DO<br>Prilosec® Rx<br>Protonix®<br>rabeprazole<br>Zegerid® | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected strengths<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ **Quantity limits:**<br>▪ Once daily dosing for:<br>❖ GERD<br>❖ erosive esophagitis<br>❖ healing and maintenance of duodenal/gastric ulcers (including NSAID-induced)<br>❖ prevention of NSAID-induced ulcers<br>❖ Twice daily dosing for:<br>❖ hypersecretory conditions<br>❖ Barrett's esophagitis<br>❖ H. pylori<br>❖ refractory GERD<br>➢ **Duration limits:**<br>▪ 90 days for:<br>❖ GERD<br>▪ 365 days for:<br>❖ Maintenance treatment of duodenal ulcers, or erosive esophagitis<br>▪ 14 days for:<br>❖ H. pylori |
| **Sulfasalazine Derivatives** | | |
| Apriso®<br>Delzicol®<br>Dipentum®<br>sulfasalazine DR/EC<br>sulfasalazine IR<br>Sulfazine<br>Sulfazine EC | Asacol HD®<br>Azulfidine®<br>Azulfidine Entab®<br>balsalazide<br>Colazal®<br>Giazo®<br>Lialda®<br>mesalamine DR (gen for Lialda)<br>mesalamine DR<br>Pentasa® | |



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# 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<br>fondaparinux CC | Lovenox® | **CLINICAL CRITERIA (CC)**<br>➢ For patients requiring >30 days of therapy: Require confirmation of FDA-approved or compendia-supported indication<br>➢ Arixtra® (fondaparinux) Clinical editing to allow patients with a diagnosis of Heparin Induced Thrombocytopenia (HIT) to receive therapy without prior authorization.<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Duration Limit: No more than 30 days for members initiating therapy |
| **Anticoagulants – Oral** | | | | |
| Coumadin®<br>Eliquis®<br>Jantoven®<br>Pradaxa® | warfarin<br>Xarelto® | Savaysa®<br>Xarelto® (dose pack) | | |
| **Erythropoiesis Stimulating Agents (ESAs)** CC | | | | |
| Aranesp® | Procrit® | Epogen® | Mircera® | **CLINICAL CRITERIA (CC)**<br>➢ Confirm diagnosis for FDA- or compendia-supported uses |
| **Platelet Inhibitors** | | | | |
| Aggrenox®<br>Brilinta®<br>clopidogrel<br>dipyridamole | | dipyridamole / aspirin<br>Effient®<br>Plavix®<br>prasugrel<br>ticlopidine<br>Yosprala™<br>Zontivity® | | |



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|---|
| **IX. IMMUNOLOGIC AGENTS** | | | |
| **Immunomodulators – Systemic** CC, ST | | | |
| Enbrel® | Humira® | Actemra® (subcutaneous)<br>Benlysta® (subcutaneous)<br>Cimzia®<br>Cosentyx®<br>Enbrel® Mini™<br>Kevzara®<br>Kineret®<br>Orencia® (subcutaneous)<br>Otezla®<br>Siliq™<br>Simponi®<br>Stelara®<br>Taltz®<br>Tremfya™<br>Xeljanz®<br>Xeljanz® XR | **CLINICAL CRITERIA (CC)**<br>➢ Confirm diagnosis for FDA- or compendia-supported uses<br>**STEP THERAPY (ST)**<br>➢ Trial of a disease-modifying anti-rheumatic drug (DMARD) prior to treatment with an immunomodulator |
| **X. MISCELLANEOUS AGENTS** | | | |
| **Progestins (for Cachexia)** | | | |
| megestrol acetate (suspension) | | Megace® (suspension)<br>Megace ES®<br>megestrol ES (suspension) | |
| **Epinephrine, Self-injected** | | | |
| epinephrine (generic for EpiPen®)<br>epinephrine (generic for EpiPen Jr.®) | | epinephrine (generic for Adrenaclick®)<br>EpiPen®<br>EpiPen Jr.® | |



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **XI. MUSCULOSKELETAL AGENTS** | | |
| **Skeletal Muscle Relaxants** | | |
| baclofen<br>chlorzoxazone<br>cyclobenzaprine 5mg, 10mg<br>dantrolene<br>methocarbamol<br>orphenadrine ER<br>tizanidine (tablet) | Amrix®<br>carisoprodol ST, F/Q/D<br>carisoprodol compound ST, F/Q/D<br>carisoprodol compound / codeine CC, ST, F/Q/D<br>cyclobenzaprine 7.5mg<br>Dantrium®<br>Fexmid®<br>Lorzone®<br>metaxalone<br>Parafon Forte® DSC<br>Robaxin®<br>Skelaxin®<br>Soma® ST, F/Q/D<br>Soma® 250 ST, F/Q/D<br>tizanidine (capsule)<br>Zanaflex® | **CLINICAL CRITERIA (CC)**<br>For carisoprodol/codeine products:<br>➢ Limited to a total of four (4) opioid prescriptions every 30 days; exemption for diagnosis of cancer or sickle cell disease<br>➢ Medical necessity rationale for opioid therapy is required for patients on established buprenorphine opioid dependence therapy<br>➢ PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy<br>➢ PA required for any codeine containing products in patients < 12yrs<br>**STEP THERAPY (ST)**<br>➢ Trial with one (1) preferred analgesic and two (2) preferred skeletal muscle relaxants prior to use of carisoprodol containing products:<br>▪ carisoprodol<br>▪ carisoprodol/ASA<br>▪ carisoprodol/ASA/codeine<br>▪ Soma®<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Maximum 84 cumulative units per a year<br>➢ Carisoprodol – Maximum 4 (four) units per day, 21-day supply<br>➢ Carisoprodol combinations – Maximum 8 (eight) units per day, 21- day supply (not to exceed the 84 cumulative units per year limit) |



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# 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®<br>brimonidine 0.2%<br>Simbrinza® | apraclonidine<br>brimonidine P 0.15%<br>Iopidine® | |
| **Antibiotics – Ophthalmic** | | |
| bacitracin / polymyxin B<br>erythromycin<br>gentamicin<br>Natacyn®<br>neomycin / gramicidin / polymyxin<br>polymyxin / trimethoprim<br>sulfacetamide (solution)<br>tobramycin | Azasite®<br>bacitracin<br>Bleph®-10<br>neomycin / bacitracin / polymyxin<br>Polytrim®<br>sulfacetamide (ointment)<br>Tobrex® | |
| **Antibiotics/Steroid Combinations – Ophthalmic** | | |
| Blephamide®<br>neomycin/ polymyxin / dexamethasone<br>sulfacetamide / prednisolone<br>TobraDex® (ointment, suspension) | Maxitrol®<br>neomycin / bacitracin / polymyxin / HC<br>neomycin / polymyxin / HC<br>Pred-G®<br>TobraDex® ST<br>tobramycin / dexamethasone (suspension)<br>Zylet® | |
| **Antihistamines – Ophthalmic** | | |
| Pataday® | azelastine<br>Bepreve®<br>Elestat®<br>Emadine®<br>epinastine<br>Lastacaft®<br>olopatadine 0.1%<br>olopatadine 0.2%<br>Patanol®<br>Pazeo® | |



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **Beta Blockers – Ophthalmic** | | |
| betaxolol<br>Betoptic S®<br>carteolol<br>Combigan®<br>Istalol®<br>levobunolol<br>timolol maleate (gel, solution) | Betagan®<br>Timoptic®<br>Timoptic® in Ocudose®<br>Timoptic-XE® | |
| **Fluoroquinolones – Ophthalmic ST** | | |
| ciprofloxacin<br>ofloxacin<br>Vigamox® | Besivance®<br>Ciloxan®<br>gatifloxacin<br>levofloxacin<br>Moxeza®<br>moxifloxacin<br>Ocuflox®<br>Zymaxid® | **STEP THERAPY (ST)**<br>➢ For patients 21 years or younger, attempt treatment with a non-fluoroquinolone ophthalmic antibiotic before progressing to the a fluoroquinolone ophthalmic product<br>➢ Examples of Non-Fluoroquinolone Ophthalmic Antibiotics<br>▪ AK-Poly-Bac eye ointment<br>▪ bacitracin-polymyxin eye ointment<br>▪ erythromycin eye ointment<br>▪ Gentak (3 mg/gm eye ointment, 3 mg/mL eye drops)<br>▪ gentamicin (3 mg/gm eye ointment, 3 mg/mL eye drops)<br>▪ neomycin-polymyxin-gramicidin eye drops<br>▪ polymyxin B-TMP eye drops<br>▪ Romycin eye ointment<br>▪ sulfacetamide 10% eye drops<br>▪ Sulfamide 10% eye drops<br>▪ tobramycin 0.3% eye drops<br>▪ Tobrasol 0.3% eye drops |
| **Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Ophthalmic** | | |
| diclofenac<br>flurbiprofen<br>Ilevro® 1<br>ketorolac | Acular®<br>Acular LS®<br>Acuvail®<br>bromfenac<br>BromSite™<br>Nevanac®<br>Prolensa® | |
| **Prostaglandin Agonists – Ophthalmic** | | |
| latanoprost | bimatoprost<br>Lumigan®<br>Travatan Z®<br>travoprost<br>Xalatan®<br>Vyzulta™<br>Zioptan® | |

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

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

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">XV. RESPIRATORY</td></tr>
<tr><td colspan="3">Anticholinergics / COPD Agents</td></tr>
<tr><td>Atrovent HFA®<br>Combivent Respimat®<br>ipratropium<br>ipratropium / albuterol<br>Spiriva®<br>Stiolto Respimat®</td><td>Anoro Ellipta®<br>Bevespi Aerosphere™<br>Daliresp®<br>Incruse Ellipta®<br>Lonhala™ Magnair™<br>Seebri Neohaler®<br>Spiriva Respimat®<br>Trelegy Ellipta®<br>Tudorza Pressair®<br>Utibron Neohaler®</td><td></td></tr>
<tr><td colspan="3">Antihistamines – Intranasal</td></tr>
<tr><td>azelastine<br>olopatadine</td><td>Astepro®<br>Patanase®</td><td></td></tr>
<tr><td colspan="3">Antihistamines – Second Generation</td></tr>
<tr><td>cetirizine OTC (tablet)<br>cetirizine OTC (syrup/solution 1mg/ 1mL)<br>fexofenadine OTC (suspension)<br>levocetirizine (tablet)<br>loratadine OTC</td><td>cetirizine OTC (chewable)<br>cetirizine OTC (syrup/solution 5mg/ 5mL)<br>cetirizine-D OTC<br>Clarinex® CC<br>Clarinex-D® OTC<br>desloratadine<br>fexofenadine OTC (tablet)<br>levocetirizine (solution)<br>loratadine-D OTC<br>Semprex-D<br>Xyzal® OTC CC</td><td><u>CLINICAL CRITERIA (CC)</u><br>➢ No prior authorization required for patients less than 24 months of age</td></tr>
<tr><td colspan="3">Beta<sub>2</sub> Adrenergic Agents – Inhaled Long-Acting CC, F/Q/D</td></tr>
<tr><td>Perforomist®<br>Serevent Diskus®</td><td>Arcapta Neohaler®<br>Brovana®<br>Striverdi Respimat®</td><td><u>CLINICAL CRITERIA (CC)</u><br>PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA- or compendia-supported age as indicated:
<table>
<tr><td>Arcapta Neohaler®</td><td>≥18 years</td></tr>
<tr><td>Brovana®</td><td>≥18 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>
<u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u><br>
Maximum units per 30 days
<table>
<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>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></td></tr>
</table>

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **Beta$_2$ Adrenergic Agents – Inhaled Short-Acting** | | |
| albuterol<br>Proventil HFA®<br>ProAir HFA® | levalbuterol (solution)<br>Ventolin HFA®<br>levalbuterol HFA<br>Xopenex® (solution)<br>ProAir® RespiClick<br>Xopenex HFA® | |
| **Corticosteroids – Inhaled** F/Q/D | | |
| Asmanex®<br>Flovent Diskus®<br>Flovent HFA®<br>Pulmicort® Flexhaler<br>QVAR® | Aerospan®<br>Alvesco®<br>ArmonAir™ Respiclick®<br>Arnuity Ellipta®<br>Asmanex® HFA<br>QVAR® Redihaler™ | **FREQUENCY/QUANTITY/DURATION (F/Q/D)** |

| | |
|---|---|
| Aerospan® 80 mcg | 2 inhalers every 30 days |
| Alvesco® 80 mcg | 1 inhaler every 30 days |
| Alvesco® 160 mcg | 1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use. |
| ArmonAir™ Respiclick® 55mcg, 113mcg | 1 inhaler every do days |
| ArmonAir™ Respiclick® 232mcg | 1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use |
| Arnuity Ellipta | 1 inhaler every 30 days |
| Asmanex® 110 mcg | 1 inhaler every 30 days |
| Asmanex® 220 mcg (30 units) | 1 inhaler every 30 days |
| Asmanex® 220 mcg (60 units) | 1 inhaler every 30 days<br>Up to 1 inhaler every 15 days with previous oral corticosteroid use. |
| Asmanex® 220 mcg (120 units) | 1 inhaler every 60 days. Up to 1 inhaler every 30 days with previous oral corticosteroid use. |
| Asmanex® HFA 100 mcg | 1 inhaler every 30 days |
| Asmanex® HFA 200 mcg | 1 inhaler every 30 days |
| Flovent Diskus® 50mcg, 100 mcg | 1 diskus every 30 days |
| Flovent Diskus® 250mcg | 1 diskus every 15 days. Up to 1 diskus every 7 days with previous oral corticosteroid use. |
| Flovent HFA® 44mcg, 110 mcg | 1 inhaler every 30 days |
| Flovent HFA® 220mcg | 1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use. |
| Pulmicort 90mcg | 1 inhaler every 30 days |
| Pulmicort 180mcg | 1 inhaler every 15 days |
| QVAR® 40mcg | 1 inhaler every 25 days |
| QVAR® 80mcg | 1 inhaler every 12 days |
| QVAR® Redihaler™ 40mcg | 1 inhaler every 30 days |
| QVAR® Redihaler™ 80mcg | 1 inhaler every 15 days |

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **Corticosteroid/Beta$_2$ Adrenergic Agent (Long-Acting) Combinations – Inhaled** CC, F/Q/D | | |
| Advair Diskus®<br>Dulera®<br>Symbicort® | Advair HFA®<br>AirDuo™ RespiClick®<br>Breo Ellipta®<br>fluticasone-salmeterol (gen for AirDuo™ RespiClick®) | **CLINICAL CRITERIA (CC)**<br>➢ PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA- or compendia-supported age as indicated:<br>Advair Diskus® ≥4 years<br>Advair HFA® ≥12 years<br>AirDuo™ RespiClick® >12 years<br>Breo Ellipta™ ≥18 years<br>Dulera® ≥12 years<br>fluticasone-salmeterol >12 years<br>Symbicort® 80/4.5 mcg ≥6 years<br>Symbicort® 160/4.5 mcg ≥12 years<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>Advair Diskus®, Advair HFA®, AirDuo™ RespiClick®, Breo Ellipta™, Dulera®, fluticasone-salmeterol, Symbicort®: One (1) inhaler/diskus every 30 days |
| **Corticosteroids – Intranasal** F/Q/D | | |
| fluticasone | Beconase AQ® CC<br>budesonide<br>Dymista®<br>flunisolide<br>mometasone<br>Nasonex®<br>Omnaris®<br>QNASL® CC<br>Xhance™<br>Zetonna® | **CLINICAL CRITERIA (CC)**<br>➢ Clinical consideration in regard to drug interactions will be given to patients with HIV/AIDs diagnosis or antiretroviral therapy in history<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>flunisolide: One (1) inhaler every 12 days<br>budesonide, mometasone, Nasonex®, Xhance™: One (1) inhaler every 15 days<br>Beconase AQ®: One (1) inhaler every 22 days<br>Dymista™, fluticasone, Nasacort AQ®, Omnaris®, QNASL®, Zetonna™: One (1) inhaler every 30 days |
| **Leukotriene Modifiers** | | |
| montelukast ST<br>zafirlukast | Accolate®<br>Singulair® ST | **STEP THERAPY (ST)**<br>➢ For non-asthmatic patients, trial of intranasal corticosteroid or a 2nd generation oral antihistamine before montelukast (Singulair®) |

Standard PA fax form: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf



1 = Preferred as of 12/14/2017
2 = Non-Preferred as of 12/14/2017

# 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 40.

| Drug / Class Name | Step Therapy (ST) Parameters | Frequency / Quantity / Duration (F/Q/D) Parameters | Additional / Alternate Parameter(s) |
|---|---|---|---|
| Acthar® (ACTH injectable) | Requires trial of first-line therapy for all FDA-approved indications, other than infantile spasms.<br>**Note**: Acthar is first line therapy for infantile spasms in children less than 2 years of age – step therapy not required. | **QUANTITY LIMITS:**<br>➢ Infantile spasms – 30 mL (six 5 mL vials)<br>➢ Multiple sclerosis – 35 mL (seven 5 mL vials)<br>**DURATION LIMITS:**<br>➢ Infantile spasms – 4 weeks; indicated for < 2 years of age<br>➢ Multiple sclerosis – 5 weeks<br>➢ Rheumatic disorders – 5 weeks<br>➢ Dermatologic conditions – 5 weeks<br>➢ Allergic states (serum sickness) – 5 weeks | Confirm diagnosis of FDA-approved or compendia-supported indication<br>Not covered for diagnostic purposes |

| 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:**<br>➢ Equal to 10 tablets per fill | |
| Anabolic Steroids – Injectable<br>➢ Depo-Testosterone®<br>➢ testosterone cypionate*<br>➢ testosterone enanthate<br><br>*for additional parameters, see Cross-Sex Hormones section below.<br><br>Anabolic Steroids – Oral<br>➢ Anadrol-50®<br>➢ Android®<br>➢ Androxy™<br>➢ Methitest®<br>➢ Oxandrin®<br>➢ oxandrolone<br>➢ 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):<br>➢ 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<br>➢ Duration limit of 6 months for delayed puberty<br>➢ Duration limit of 1 month for all uses of oxandrolone products | |
| Anti-Diabetic agents (not on the PDL)<br>➢ chlorpropamide<br>➢ glimepiride<br>➢ glipizide (Glucotrol®, Glucotrol XL®)<br>➢ glyburide (DiaBeta®, Glynase®)<br>➢ glyburide, micronized<br>➢ tolazamide<br>➢ tolbutamide | ➢ Requires a trial with metformin with or without insulin prior to initiating other antidiabetic agents, unless there is a documented contraindication.<br>➢ Clinical editing to allow patients with a diagnosis of gestational diabetes to receive glyburide without a trial of metformin first. | | |
| Anti-Diarrheal Agents<br>➢ alosetron (Lotronex)<br>➢ crofelemer (Mytesi)<br>➢ eluxadoline (Viberzi)<br>➢ telotristat (Xermelo) | Irritable Bowel Syndrome w/Diarrhea<br>➢ Trial of eluxadoline and rifaximin prior to alosetron.<br>Symptomatic relief of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy<br>➢ Trial with an alternative anti-diarrheal agent.<br>Carcinoid Syndrome<br>➢ Trial with and concurrent use with a somatostatin analog | | Confirmation of FDA-approved or compendia-supported indication. |

| Drug / Class Name | Step Therapy (ST) Parameters | Frequency / Quantity / Duration (F/Q/D) Parameters | Additional / Alternate Parameter(s) |
|---|---|---|---|
| Anti-Fungals, Topical – for Onychomycosis<br>➢ ciclopirox 8% solution<br>➢ Jublia®<br>➢ Kerydin®<br>➢ Penlac® | ➢ Trial with an oral antifungal agent* prior to use of ciclopirox 8% solution (Penlac)<br>▪ terbinafine (Lamisil®) tablets; griseofulvin (Gris PEG®) oral suspension, ultramicronized tablets micronized tablets; itraconazole (Sporanox®, Onmel™) tablets, oral solution<br>➢ Trial with ciclopirox 8% solution prior to the use of other topical antifungals [efinaconazole (Jublia) or tavaborole (Kerydin)] | | |
| Anti-Retroviral (ARV) Interventions | | **QUANTITY LIMITS:**<br>➢ Limit ARV active ingredient duplication<br>➢ Limit ARV utilization to a maximum of five products concurrently - excluding boosting with ritonavir (dose limit 600 mg or less) or cobicistat<br>➢ Limit Protease Inhibitor utilization to a maximum of two products concurrently<br>➢ Limit Integrase inhibitor utilization to a maximum of one product concurrently | ➢ Require confirmation of FDA-approved or compendia-supported use<br>➢ Point of service edit for contraindicated antiretroviral / non-antiretroviral combinations<br>➢ Point of service edit for contraindicated antiretroviral / antiretroviral combinations |
| Atopic Dermatitis Agents<br>➢ crisaborole (Eucrisa™)<br>➢ dupilumab (Dupixent®) | Crisaborole (Eucrisa)<br>➢ Trial with a medium or high potency prescription topical steroid within the last 3 months<br>Dupilumab (Dupixent)<br>➢ Trial with a medium or high potency prescription topical steroid AND one other topical prescription agent other than a steroid (within a different class) indicated for atopic dermatitis for a combined duration of at least 6 months prior | **QUANTITY LIMITS:**<br>Crisaborole (Eucrisa)<br>➢ 100GM/30 days<br>Dupilumab (Dupixent)<br>➢ 4 syringes for first 30 days followed by 2 syringes/30 days. | Confirm diagnosis of FDA-approved or compendia-supported indication |
| Becaplermin (Regranex®) | | **QUANTITY LIMIT:**<br>➢ 2 (two) 15 gram tubes in a lifetime | |

| Drug / Class Name | Step Therapy (ST) Parameters | Frequency / Quantity / Duration (F/Q/D) Parameters | Additional / Alternate Parameter(s) |
|---|---|---|---|
| Benzodiazepine agents – oral<br>➢ alprazolam (Niravam™, Xanax®, Xanax® XR)<br>➢ chlordiazepoxide (Librium®)<br>➢ chlordiazepoxide/amitriptyline (Limbitrol®)<br>➢ clonazepam (Klonopin®)<br>➢ clorazepate (Tranxene®, Tranxene T-Tab®)<br>➢ diazepam (Valium®)<br>➢ lorazepam (Ativan®, Lorazepam Intensol®)<br>➢ 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<br>➢ For diagnosis of Panic Disorder: Require concurrent therapy with an antidepressant (SSRI, SNRI, or Tricyclic antidepressant [TCA]).<br>➢ For diagnosis of skeletal muscle spasms: Require trial with a skeletal muscle relaxant prior to a benzodiazepine | **DURATION LIMIT:**<br>➢ For Insomnia: 30 consecutive days<br>➢ For Panic Disorder: 30 consecutive days | ➢ Require confirmation of FDA-approved or compendia-supported use<br>➢ PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy<br>➢ PA required for any additional oral benzodiazepine prescription in patients currently on benzodiazepine therapy |
| Constipation Agents<br>➢ linaclotide (Linzess)<br>➢ lubiprostone (Amitiza)<br>➢ methylnaltrexone (Relistor)<br>➢ naldemedine (Symproic)<br>➢ naloxegol (Movantik)<br>➢ plecanatide (Trulance) | Opioid Induced Constipation (OIC) & Chronic Idiopathic Constipation (CIC)<br>➢ Trial with an osmotic laxative, a stimulant laxative and a stool softener prior to use.<br>Irritable Bowel Syndrome w/ Constipation (IBS-C)<br>➢ Trial with a bulking agent and an osmotic laxative within 89 days of use. | **QUANTITY LIMIT:**<br>➢ linaclotide, naldemedine, naloxegol, plecanatide: 1 tablet/day; 30 tablets/month<br>➢ lubiprostone: 2 capsules/day; 60 capsules/month<br>methylnaltrexone: 1 vial or syringe/day; 30/month; 4 kits/28 days; 90 tablets/30 days | Confirmation of FDA-approved or compendia-supported indication. |
| Cross-Sex Hormones<br>➢ conjugated estrogens<br>➢ estradiol<br>➢ testosterone cypionate | | | ➢ Confirm diagnosis of FDA-approved or compendia-supported indication<br>Refer to: https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender for Transgender Related Care and Services Update |
| ➢ cyclosporine ophthalmic emulsion (Restasis®, Restasis MultiDose™)<br>➢ 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 | **QUANTITY LIMIT:**<br>Restasis, Xiidra:<br>➢ 60 vials dispensed as a 30-day supply;<br>Restasis Multidose:<br>➢ 5.5 mL dispensed as a 25-day supply | |
| Cystic fibrosis agents<br>➢ ivacaftor (Kalydeco™)<br>➢ ivacaftor / lumacaftor (Orkambi™) | | | ➢ Confirm diagnosis of FDA-approved or compendia-supported indication<br>➢ Genetic testing required to verify appropriate mutations |

| Drug / Class Name | Step Therapy (ST) Parameters | Frequency / Quantity / Duration (F/Q/D) Parameters | Additional / Alternate Parameter(s) |
|---|---|---|---|
| Dextromethorphan / quinidine (Nuedexta®) | | **QUANTITY LIMIT:**<br>➢ Two (2) capsules per day; 60 units per 30 days<br>**DURATION LIMIT:**<br>➢ 90 days of therapy | For patients ≥ 18 years of age:<br>Confirm diagnosis of FDA-approved or compendia-supported indication |
| Diabetic Test Strips | | **QUANTITY LIMIT:**<br>➢ Type I DM – max 300 test strips per 30-day supply<br>➢ Type II DM – max 100 test strips per 30-day supply | Preferred diabetic supply program https://newyork.fhsc.com/providers/diabeticsupplies.asp |
| Dronabinol (Marinol®,Syndros) | ➢ Step therapy for beneficiaries with HIV/AIDS, or cancer, AND eating disorder: trial with megestrol acetate suspension prior to dronabinol<br>➢ 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<br>➢ Abstral® (sublingual tablet)<br>➢ Actiq® (lozenge)<br>➢ Fentora® (buccal tablet)<br>➢ Lazanda® (nasal spray)<br>➢ Onsolis® (buccal film)<br>➢ Subsys® (sublingual spray) | | **QUANTITY LIMIT:**<br>Abstral, Actiq, Fentora, Onsolis, and Subsys:<br>➢ 4 units per day, 120 units per 30 days<br>Lazanda:<br>➢ 5 mL (1 bottle) per day, 150 mL (5 bottles) per 30 days<br>**DURATION LIMIT:**<br>➢ 90 days<br>➢ Quantity and duration limits are not applicable to patients with a documented cancer or sickle cell diagnosis | ➢ Limited to a total of four (4) opioid prescriptions every 30 days; exemption for diagnosis of cancer or sickle cell disease<br>➢ For opioid-naïve patients - limited to a 15 days' supply for all initial opioid prescriptions, exemption for diagnosis of cancer or sickle cell disease<br>➢ PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy<br>➢ PA is required for initiation of opioid therapy in patients currently on benzodiazepine therapy |
| Lipid Lowering Agents –<br>Proprotein Convertase Subtilisin Kexin 9 (PCSK9) Inhibitors<br>➢ alirocumab (Praluent™)<br>➢ evolocumab (Repatha™) | Require trial of a HMG-CoA Reductase Inhibitors (Statin) at maximum tolerated dosage | | Confirm diagnosis of FDA-approved or compendia-supported indication<br><br>Require concurrent statin therapy |
| Lipid Lowering Agents –<br>Triglyceride transfer protein inhibitors:<br>➢ lomitapide (Juxtapid®)<br>➢ mipomersen (Kynamro®) | Requires trial with high intensity statin therapy | | Confirm diagnosis of FDA-approved or compendia-supported indication |

| Drug / Class Name | Step Therapy (ST) Parameters | Frequency / Quantity / Duration (F/Q/D) Parameters | Additional / Alternate Parameter(s) |
|---|---|---|---|
| Methadone | Requires a trial of a long-acting opioid prior to initiation for the management of chronic non-cancer pain | **QUANTITY LIMIT:**<br>➢ 12 units per day, 360 units per 30 days<br>➢ Exemption for diagnosis of cancer or sickle cell disease | ➢ Confirm diagnosis of chronic non-cancer pain<br>➢ Limited to a total of four (4) opioid prescriptions every 30 days; exemption for diagnosis of cancer or sickle cell disease<br>➢ PA required for initiation of methadone for patients on established buprenorphine opioid dependence therapy<br>➢ PA required for methadone prescriptions for patients currently on long-acting opioid therapy. Exemption for diagnosis of cancer or sickle cell disease<br>➢ PA required for initiation of long-acting opioid therapy in opioid-naïve patients. Exemption for diagnosis of cancer or sickle cell disease<br>➢ PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy |
| Metozolv® ODT (metoclopramide) | Requires a trial with conventional metoclopramide before metoclopramide orally disintegrating tablet (ODT), except with diagnosis of diabetes mellitus | **QUANTITY LIMIT:**<br>➢ 4 units per day, 120 units per 30 days<br>**DURATION LIMIT:**<br>➢ 90 days | |
| Metreleptin (Myalept®) | | | 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 |
| 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<br>➢ goserelin acetate<br>➢ leuprolide acetate<br>➢ nafarelin acetate | | | ➢ Confirm diagnosis of FDA-approved or compendia-supported indication<br>Refer to the January 2017 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<br>➢ Ofev®<br>➢ Esbriet® | | | Confirm diagnosis of FDA-approved or compendia-supported indication |
| Pyrimethamine (Daraprim®) | | | Confirmation of FDA-approved or compendia-supported indications<br>Require concurrent utilization of leucovorin |
| Quinine | | **QUANTITY AND DURATION LIMITS:**<br>➢ Maximum 42 capsules as a 7-day supply<br>➢ limited to 1 prescription per year | |
| Rosacea Agents<br>➢ azelaic acid (Finacea®)<br>➢ brimonidine (Mirvaso®)<br>➢ ivermectin (Soolantra®)<br>➢ oxymetazoline HCL (Rhofade™)<br>➢ doxycycline (Oracea®) | Trial with topical metronidazole product. | | Confirmation of FDA-approved or compendia-supported indication |
| Tasimelteon (Hetlioz®) | | **QUANTITY LIMIT:**<br>➢ One unit per day; 30 units per 30 days | Confirm diagnosis of FDA-approved or compendia-supported indication |
| Parathyroid Hormone Analogs<br>➢ Forteo<br>➢ Tymlos | Requires a trial with a preferred oral bisphosphonate | **QUANTITY LIMIT:**<br>➢ One unit per 30-day period<br>**LIFETIME QUANTITY LIMIT:**<br>➢ 25 months' cumulative use of a PTH analog | |
| Vesicular monoamine transport 2 inhibitors<br>➢ Austedo®<br>➢ Xenazine®<br>➢ Ingrezza™ | | | Confirm diagnosis of FDA-approved or compendia-supported indication |

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 February 22, 2018:

- Reyataz capsule will be **added** to the program
- Tegretol XR, Efudex cream, Benzaclin gel & pump, Retin-A gel, Valcyte tablets, Pulmicort Respules 0.25mg & 0.5mg, Myfortic will be **removed** from the program

| List of Brand Name Drugs included in this program** | | |
|---|---|---|
| Adderall XR | Focalin XR | Tobradex suspension |
| Aggrenox | Fosrenol Chew tabs | Transderm-Scop |
| Alphagan P 0.15% | Gleevec | Trizivir |
| Butrans | Hepsera | Valcyte solution |
| Catapres-TTS | Kapvay | Vigamox |
| Cellcept suspension | Lexiva tablets | Voltaren Gel |
| Copaxone 20mg SQ | Pataday | Xeloda |
| Diastat | Protopic | Xenazine |
| Edecrin | Pulmicort Respules 1mg | Zyflo CR |
| Emend Tripack | Retin-A cream | |
| Exelon patch | **Reyataz capsules** | |
| Focalin | Tegretol suspension | |

**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 https://www.emedny.org/HIPAA/5010/transactions/NCPDP_D.0_Companion_Guide.pdf
- 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 case of dose titration for these medications, the Department will allow for multi-day dosing (up to 2 doses/daily) for titration purposes for three months. |
| aripiprazole 5mg, 10mg, 15mg | 1 daily | Tablet | |
| 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 | |
| Rexulti 0.5mg, 1mg, 2mg | 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** | | | |
| Adderall XR 5mg, 10mg, 15mg | 1 daily | Capsule | |
| Concerta ER 18mg, 27mg, 54mg | 1 daily | Tablet | |
| Concerta ER 36mg | 2 daily | Tablet | |
| amphetamine salt combo ER 5mg, 10mg, 15mg | 1 daily | Capsule | |
| Focalin XR 5mg, 10mg, 15mg, 20mg | 1 daily | Capsule | |
| methylphenidate CD 10mg, 20mg | 1 daily | Capsule | |
| modafinil 100mg | 1 daily | Tablet | |
| 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 | |

| Brand Name | Dose Optimization Limitations | | |
|---|---|---|---|
| **CENTRAL NERVOUS SYSTEM** | | | |
| **Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)** | | | |
| guanfacine ER 1mg, 2mg, 3 mg, 4mg | 1 daily | Tablet | |
| atomoxetine 40mg | 1 daily | Capsule | |
| Intuniv 1mg, 2mg | 1 daily | Tablet | |
| Strattera 40mg | 1 daily | Capsule | |
| **Sedative Hypnotics** | | | |
| Lunesta 1mg | 1 daily | Tablet | |
| **Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)** | | | |
| Effexor XR 37.5mg, 75mg | 1 daily | Capsule | In the case of dose titration for these 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 | |
| Trintellix 5mg, 10mg | 1 daily | Tablet | |
| venlafaxine ER 37.5mg, 75mg | 1 daily | Capsule | |
| **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 | |

| Brand Name | Dose Optimization Limitations | | |
|---|---|---|---|
| **RENAL AND GENITOURINARY** | | | |
| **Urinary Tract Antispasmodics** | | | |
| Detrol LA 2mg | 1 daily | Capsule | |
| Enablex 7.5mg | 1 daily | Tablet | |
| Myrbetriq 25mg | 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.