

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

## OVERVIEW OF CONTENTS

### **Preferred Drug Program (PDP) (Pages 2–40)**

***Last Update: February 22, 2018***

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

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

### **Clinical Drug Review Program (CDRP) (Page 41)**

***Last Update: February 21, 2013***

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

### **Drug Utilization Review (DUR) Program (Pages 42–48)**

***Last Update: December 14, 2017***

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

### **Brand Less Than Generic (BLTG) Program (Page 49)**

***Last Update: February 22, 2018***

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

### **Mandatory Generic Drug Program (Page 50)**

***Last Update: April 25, 2013***

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

### **Dose Optimization Program (Pages 51–54)**

***Last Update: July 20, 2017***

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

For more information on the NYS Medicaid Pharmacy Programs: [http://www.health.ny.gov/health\\_care/medicaid/program/pharmacy.htm](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](https://newyork.fhsc.com/providers/PA_forms.asp)

# NYS Medicaid Fee-For-Service Preferred Drug List

## PREFERRED DRUG LIST – TABLE OF CONTENTS

- I. ANALGESICS..... 3
- II. ANTI-INFECTIVES ..... 6
- III. CARDIOVASCULAR ..... 8
- IV. CENTRAL NERVOUS SYSTEM..... 13
- V. DERMATOLOGIC AGENTS ..... 21
- VI. ENDOCRINE AND METABOLIC AGENTS..... 24
- VII. GASTROINTESTINAL ..... 28
- VIII. HEMATOLOGICAL AGENTS..... 31
- IX. IMMUNOLOGIC AGENTS ..... 32
- X. MISCELLANEOUS AGENTS..... 32
- XI. MUSCULOSKELETAL AGENTS..... 33
- XII. OPHTHALMICS ..... 34
- XIII. OTICS..... 36
- XIV. RENAL AND GENITOURINARY ..... 36
- XV. RESPIRATORY ..... 37

# NYS Medicaid Fee-For-Service Preferred Drug List

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

# NYS Medicaid Fee-For-Service Preferred Drug List

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

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
<b>Opioids – Short-Acting <sup>CC</sup></b>		
butalbital / APAP / caffeine / codeine <sup>F/Q/D</sup> codeine <sup>F/Q/D</sup> codeine / APAP <sup>F/Q/D</sup> hydrocodone / APAP <sup>F/Q/D</sup> hydrocodone / ibuprofen <sup>F/Q/D</sup> Lortab <sup>®</sup> (elixir) <sup>F/Q/D</sup> morphine IR <sup>F/Q/D</sup> oxycodone / APAP <sup>F/Q/D</sup> Reprexain <sup>®</sup> <sup>F/Q/D</sup> tramadol Verdrocet <sup>™</sup> <sup>F/Q/D</sup> Xylon <sup>™</sup> <sup>F/Q/D</sup>	butalbital compound/ codeine <sup>F/Q/D</sup> butorphanol nasal spray Demerol <sup>®</sup> dihydrocodeine / aspirin / caffeine <sup>F/Q/D</sup> dihydrocodeine / APAP / caffeine <sup>F/Q/D</sup> Dilaudid <sup>®</sup> <sup>F/Q/D</sup> Fioricet <sup>®</sup> / codeine <sup>F/Q/D</sup> Fiorinal <sup>®</sup> / codeine <sup>F/Q/D</sup> hydromorphone <sup>F/Q/D</sup> Ibudone <sup>®</sup> <sup>F/Q/D</sup> levorphanol meperidine Nucynta <sup>®</sup> <sup>ST, F/Q/D</sup> Opana <sup>®</sup> <sup>F/Q/D</sup> oxycodone <sup>F/Q/D</sup> oxycodone / aspirin <sup>F/Q/D</sup> oxycodone / ibuprofen <sup>F/Q/D</sup> oxymorphone <sup>F/Q/D</sup> pentazocine / naloxone Percocet <sup>®</sup> <sup>F/Q/D</sup> Primlev <sup>™</sup> <sup>F/Q/D</sup> Roxicodone <sup>®</sup> <sup>F/Q/D</sup> Synalgos <sup>®</sup> DC <sup>F/Q/D</sup> tramadol / APAP <sup>F/Q/D</sup> Tylenol <sup>®</sup> / codeine #3 <sup>F/Q/D</sup> Tylenol <sup>®</sup> / codeine #4 <sup>F/Q/D</sup> Ultracet <sup>®</sup> <sup>F/Q/D</sup> Ultram <sup>®</sup> Xartemis <sup>®</sup> XR <sup>F/Q/D</sup> Xodol <sup>®</sup> <sup>F/Q/D</sup> Zamicet <sup>®</sup> <sup>F/Q/D</sup>	<p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>➤ Limited to a total of four (4) opioid prescriptions every 30 days.             <ul style="list-style-type: none"> <li>▪ Exception for diagnosis of cancer or sickle cell disease</li> </ul> </li> <li>➤ Initial prescription for opioid-naïve patients limited to a 7-day supply.             <ul style="list-style-type: none"> <li>▪ Exception for diagnosis of cancer or sickle cell disease</li> </ul> </li> <li>➤ PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy</li> <li>➤ PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy</li> </ul> <p><b>STEP THERAPY (ST)</b></p> <ul style="list-style-type: none"> <li>➤ <u>Nucynta<sup>®</sup> (tapentadol IR)</u> – Trial with tramadol and one (1) preferred opioid before tapentadol immediate-release (IR)</li> </ul> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <p><b>Quantity Limits:</b></p> <ul style="list-style-type: none"> <li>➤ <u>Nucynta<sup>®</sup> (tapentadol IR)</u>:             <ul style="list-style-type: none"> <li>▪ Maximum 6 (six) units per day; 180 units per 30 days</li> </ul> </li> <li>➤ <u>Nucynta<sup>®</sup> (tapentadol IR)</u>:             <ul style="list-style-type: none"> <li>▪ Maximum daily dose of <u>tapentadol IR</u> and <u>tapentadol ER</u> formulations used in combination not to exceed 500mg/day</li> </ul> </li> <li>➤ <u>Morphine and congeners immediate-release (IR)</u> non-combination products (codeine, hydromorphone, morphine, oxycodone, oxymorphone):             <ul style="list-style-type: none"> <li>▪ Maximum 6 (six) units per day, 180 (one hundred eighty) units per 30 (thirty) days</li> </ul> </li> <li>➤ <u>Xartemis<sup>®</sup> XR</u> (oxycodone/acetaminophen):             <ul style="list-style-type: none"> <li>▪ Maximum 4 (four) units per day, 120 (one hundred twenty) units per 30 (thirty) days</li> </ul> </li> </ul> <p>Additional/alternate parameters: To be applied to patients without a documented cancer or sickle cell diagnosis</p> <ul style="list-style-type: none"> <li>➤ <u>Morphine and congeners immediate-release (IR) combination</u> products maximum recommended:             <ul style="list-style-type: none"> <li>▪ acetaminophen (4 grams)</li> <li>▪ aspirin (4 grams)</li> <li>▪ ibuprofen (3.2 grams)</li> <li>▪ or the FDA-approved maximum opioid dosage as listed in the PI, whichever is less</li> </ul> </li> </ul> <p><b>Duration Limits:</b></p> <ul style="list-style-type: none"> <li>▪ 90 days for patients without a diagnosis of cancer or sickle-cell disease.</li> </ul>

# NYS Medicaid Fee-For-Service Preferred Drug List

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

# NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>Hepatitis C Agents – Injectable <sup>F/Q/D</sup></b>			
Pegasys®	PegIntron®	None	<p><b><u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u></b></p> <ul style="list-style-type: none"> <li>➤ 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.</li> <li>➤ Further documentation required for continuation of therapy at weeks 14 and 26.</li> <li>➤ 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.</li> <li>➤ After 24 weeks of therapy obtain a HCV RNA. Continuation for genotype 1 and 4 is supported if undetectable HCV RNA.                             <ul style="list-style-type: none"> <li>▪ Maximum duration of 48 weeks for:                                     <ul style="list-style-type: none"> <li>❖ Treatment-naïve patients or prior relapsers with cirrhosis and HIV co-infection</li> <li>❖ Prior non-responders (including prior partial and null responders) with or without cirrhosis and with or without HIV co-infection</li> </ul> </li> </ul> </li> </ul>
<b>Hepatitis C Agents – Direct Acting Antivirals</b>			
Epclusa® <sup>CC, F/Q/D</sup> Mavyret™ <sup>1 CC, F/Q/D</sup> ribavirin Vosevi® <sup>1 CC, F/Q/D</sup>	Daklinza™ <sup>CC, F/Q/D</sup> Harvoni® <sup>2, CC, F/Q/D</sup> Moderiba™ Olysio® <sup>CC, F/Q/D</sup> Rebetol® Ribasphere® Sovaldi® <sup>CC, F/Q/D</sup> Technivie® <sup>2, CC, F/Q/D</sup> Viekira Pak® <sup>2, CC, F/Q/D</sup> Viekira XR™ <sup>2, CC, F/Q/D</sup> Zepatier™ <sup>2, CC, F/Q/D</sup>	<p><b><u>CLINICAL CRITERIA (CC)</u></b></p> <ul style="list-style-type: none"> <li>➤ Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>➤ Require confirmation of prescriber experience and training                             <ul style="list-style-type: none"> <li>▪ 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. <b>AND</b></li> <li>▪ 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. <b>OR</b></li> <li>▪ 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.</li> </ul> </li> <li>➤ Require confirmation of patient readiness and adherence                             <ul style="list-style-type: none"> <li>▪ 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: <a href="http://www.integration.samhsa.gov/clinical-practice/screening-tools">http://www.integration.samhsa.gov/clinical-practice/screening-tools</a> OR <a href="https://prepc.org/">https://prepc.org/</a>.</li> </ul> </li> </ul> <p style="color: orange;">Click here to access the Hepatitis C Worksheet with Clinical Criteria requirements</p>	

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



# NYS Medicaid Fee-For-Service Preferred Drug List

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

# NYS Medicaid Fee-For-Service Preferred Drug List

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

# NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
<b>HMG-CoA Reductase Inhibitors (Statins)</b>				
atorvastatin lovastatin pravastatin	rosuvastatin simvastatin	Altoprev® atorvastatin/amlodipine Caduet® Crestor® <sup>DO</sup> ezetimibe/simvastatin fluvastatin fluvastatin ER	Lescol XL® Lipitor® Livalo® Pravachol® Vytorin® Zocor®	<b><u>DOSE OPTIMIZATION (DO)</u></b> ➤ See Dose Optimization Chart for affected drugs and strengths
<b>Niacin Derivatives</b>				
niacin ER		Niaspan® <sup>DO</sup>		<b><u>DOSE OPTIMIZATION (DO)</u></b> ➤ See Dose Optimization Chart for affected drugs and strengths
<b>Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH <sup>CDRP</sup></b>				
Adcirca®	sildenafil	Revatio®		<b><u>CLINICAL DRUG REVIEW PROGRAM (CDRP)</u></b> ➤ All prescriptions for <u>Adcirca®</u> , <u>Revatio®</u> , and <u>sildenafil</u> must have PA ➤ Prescribers are required to respond to a series of questions that identify prescriber, patient and reason for prescribing drug ➤ Please be prepared to fax clinical documentation upon request ➤ Prescriptions can be written for a 30-day supply with up to 5 refills ➤ The <a href="#">CDRP Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH Prescriber Worksheet</a> provides step-by-step assistance in completing the prior authorization process
<b>Pulmonary Arterial Hypertension (PAH) Oral Agents, Other</b>				
Letairis® Orenitram®	Tracleer®	Adempas® Opsumit®	Tracleer® tabs for suspension Upravi®	

# NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>Triglyceride Lowering Agents</b>		
gemfibrozil fenofibrate (48 mg, 145 mg) fenofibric acid	Antara® fenofibrate Fenoglide® Fibricor® Lipofen® Lofibra® Lopid® Lovaza® <i>ST, F/Q/D</i> omega-3 ethyl ester <i>ST, F/Q/D</i> Tricor® Triglide® Trilipix® Vascepa® <i>ST, F/Q/D</i>	<p><b><u>STEP THERAPY (ST)</u></b></p> <p>➤ <u>Lovaza® (omega-3-acid ethyl-esters) and Vascepa® (icosapent ethyl)</u> – Trial of fibric acid derivative OR niacin prior to treatment with omega-3-acid ethyl-esters</p> <p><b><u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u></b></p> <p>➤ <u>Lovaza® (omega-3-acid ethyl-esters) and Vascepa® (icosapent ethyl)</u> – Required dosage equal to 4 (four) units per day</p>

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

# NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																										
<b>Antipsychotics – Second Generation</b> <span style="color: red;">CC, ST</span>																												
aripiprazole (oral solution, tablet) <span style="color: red;">DO</span> clozapine Latuda® <span style="color: red;">DO</span> olanzapine (tablet) <span style="color: red;">DO</span> quetiapine <span style="color: red;">F/Q/D</span> quetiapine ER <span style="color: red;">F/Q/D</span> risperidone Saphris® ziprasidone	Abilify® (oral solution, tablet) <span style="color: red;">DO</span> aripiprazole ODT clozapine ODT Clozaril® Fanapt® FazaClo® Geodon® Invega® <span style="color: red;">DO, F/Q/D</span> olanzapine ODT <span style="color: red;">DO</span> Nuplazid™ paliperidone ER <span style="color: red;">F/Q/D</span> Rexulti® <span style="color: red;">DO</span> Risperdal® Seroquel® <span style="color: red;">F/Q/D</span> Seroquel XR® <span style="color: red;">DO, F/Q/D</span> Versacloz® Vraylar™ Zyprexa® <span style="color: red;">DO</span>	<p><b><u>DOSE OPTIMIZATION (DO)</u></b></p> <ul style="list-style-type: none"> <li>➤ See Dose Optimization Chart for affected drugs and strengths</li> </ul> <p><b><u>CLINICAL CRITERIA (CC)</u></b></p> <ul style="list-style-type: none"> <li>➤ Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA</li> <li>➤ Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>➤ PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below:</li> </ul> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td>aripiprazole (Abilify®)</td> <td style="text-align: center;">6 years</td> </tr> <tr> <td>asenapine (Saphris®)</td> <td style="text-align: center;">10 years</td> </tr> <tr> <td>brexpiprazole (Rexulti®)</td> <td style="text-align: center;">18 years</td> </tr> <tr> <td>cariprazine (Vraylar™)</td> <td style="text-align: center;">18 years</td> </tr> <tr> <td>clozapine (Clozaril®, Fazaclo®, Versacloz™)</td> <td style="text-align: center;">12 years</td> </tr> <tr> <td>iloperidone (Fanapt®)</td> <td style="text-align: center;">18 years</td> </tr> <tr> <td>lurasidone HCl (Latuda®)</td> <td style="text-align: center;">13 years</td> </tr> <tr> <td>olanzapine (Zyprexa®)</td> <td style="text-align: center;">10 years</td> </tr> <tr> <td>paliperidone ER (Invega®)</td> <td style="text-align: center;">12 years</td> </tr> <tr> <td>pimavanserin (Nuplazid™)</td> <td style="text-align: center;">18 years</td> </tr> <tr> <td>quetiapine fum. (Seroquel®, Seroquel XR®)</td> <td style="text-align: center;">10 years</td> </tr> <tr> <td>risperidone (Risperdal®)</td> <td style="text-align: center;">5 years</td> </tr> <tr> <td>ziprasidone HCl (Geodon®)</td> <td style="text-align: center;">18 years</td> </tr> </tbody> </table> <ul style="list-style-type: none"> <li>➤ Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients &lt; 18 years of age</li> </ul> <p><b><u>STEP THERAPY (ST)</u></b></p> <ul style="list-style-type: none"> <li>➤ 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</li> <li>➤ Trial of risperidone prior to paliperidone (Invega®) therapy</li> </ul> <p><b><u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u></b></p> <ul style="list-style-type: none"> <li>➤ <u>paliperidone ER (Invega®)</u> 1.5mg, 3mg, 9mg tablets: Maximum 1 (one) unit/day</li> <li>➤ <u>paliperidone ER (Invega®)</u> 6mg tablets: Maximum 2 (two) units/day</li> <li>➤ <u>quetiapine/quetiapine ER (Seroquel®/Seroquel XR®)</u>: Minimum 100mg/day; maximum 800mg/day</li> <li>➤ <u>quetiapine (Seroquel®)</u>: Maximum 3 (three) units per day, 90 units per 30 days</li> <li>➤ <u>quetiapine ER (Seroquel XR®)</u> 150mg, 200mg: 1 (one) unit/day, 30 units/30 days</li> <li>➤ <u>quetiapine ER (Seroquel XR®)</u> 50mg, 300mg, 400mg: 2 (two) units/day, 60 units/30 days</li> </ul>	aripiprazole (Abilify®)	6 years	asenapine (Saphris®)	10 years	brexpiprazole (Rexulti®)	18 years	cariprazine (Vraylar™)	18 years	clozapine (Clozaril®, Fazaclo®, Versacloz™)	12 years	iloperidone (Fanapt®)	18 years	lurasidone HCl (Latuda®)	13 years	olanzapine (Zyprexa®)	10 years	paliperidone ER (Invega®)	12 years	pimavanserin (Nuplazid™)	18 years	quetiapine fum. (Seroquel®, Seroquel XR®)	10 years	risperidone (Risperdal®)	5 years	ziprasidone HCl (Geodon®)	18 years
aripiprazole (Abilify®)	6 years																											
asenapine (Saphris®)	10 years																											
brexpiprazole (Rexulti®)	18 years																											
cariprazine (Vraylar™)	18 years																											
clozapine (Clozaril®, Fazaclo®, Versacloz™)	12 years																											
iloperidone (Fanapt®)	18 years																											
lurasidone HCl (Latuda®)	13 years																											
olanzapine (Zyprexa®)	10 years																											
paliperidone ER (Invega®)	12 years																											
pimavanserin (Nuplazid™)	18 years																											
quetiapine fum. (Seroquel®, Seroquel XR®)	10 years																											
risperidone (Risperdal®)	5 years																											
ziprasidone HCl (Geodon®)	18 years																											

# NYS Medicaid Fee-For-Service Preferred Drug List

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

# NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>Central Nervous System (CNS) Stimulants</b> <span style="color: red;">CC, CDRP, F/Q/D</span>		
Adderall XR® <span style="color: red;">DO</span> amphetamine salt combo IR Daytrana® dextroamphetamine (tablet) Focalin® Focalin XR® <span style="color: red;">DO</span> Methylin® methylphenidate (tablet) Quillivant XR® Vyvanse® (capsule) <span style="color: red;">DO</span>	Adzenys XR-ODT™ amphetamine salt combo ER <span style="color: red;">DO</span> Aptensio XR® armodafinil <span style="color: red;">CC</span> Concerta® <span style="color: red;">DO</span> Cotelpla XR-ODT™ Desoxyn® Dexedrine® dexmethylphenidate dexmethylphenidate ER (generic for Focalin XR®) dextroamphetamine ER dextroamphetamine (solution) Dyanavel XR™ Evekeo® Metadate CD® <span style="color: red;">DO</span> Metadate® ER methamphetamine methylphenidate (chewable tablet, solution) methylphenidate CD (generic Metadate CD®) methylphenidate ER (generic Concerta®) methylphenidate ER (generic Ritalin LA®) methylphenidate SR (generic Metadate®ER) modafinil <span style="color: red;">DO</span> Mydayis™ Nuvigil® <span style="color: red;">CC</span> Procentra® Provigil® <span style="color: red;">CC, DO</span> Quillichew ER™ <span style="color: red;">DO</span> Ritalin® Ritalin LA® <span style="color: red;">DO</span> Vyvanse® (chewable tablet) Zenzedi®	<p><b><u>CLINICAL CRITERIA (CC)</u></b></p> <ul style="list-style-type: none"> <li>➤ Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication for beneficiaries <b>less than 18 years of age</b>.             <ul style="list-style-type: none"> <li>▪ Prior authorization is required for initial prescriptions for stimulant therapy for beneficiaries <b>less than 3 years of age</b></li> <li>▪ Require confirmation of diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent</li> </ul> </li> <li>➤ 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.</li> </ul> <p><b><u>CLINICAL DRUG REVIEW PROGRAM (CDRP)</u></b></p> <ul style="list-style-type: none"> <li>➤ For patients <b>18 years of age and older</b>:</li> <li>➤ Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication</li> </ul> <p><b><u>DOSE OPTIMIZATION (DO)</u></b></p> <ul style="list-style-type: none"> <li>➤ See Dose Optimization Chart for affected drugs and strengths</li> </ul> <p><b><u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u></b></p> <ul style="list-style-type: none"> <li>➤ Quantity limits based on daily dosage as determined by FDA labeling</li> <li>➤ Quantity limits to include:             <ul style="list-style-type: none"> <li>▪ Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration)</li> <li>▪ Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days. Concerta 36mg and Cotelpla XR-ODT 25.9mg not to exceed 2 units daily.</li> </ul> </li> </ul>



# NYS Medicaid Fee-For-Service Preferred Drug List

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

# NYS Medicaid Fee-For-Service Preferred Drug List

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

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
<b>Selective Serotonin Reuptake Inhibitors (SSRIs)</b>		
citalopram escitalopram (tablet) fluoxetine (capsule, solution) paroxetine sertraline	Brisdelle® Celexa® escitalopram (soln) fluoxetine (tablet) fluoxetine DR weekly fluvoxamine <sup>CC</sup> fluvoxamine ER <sup>CC</sup> Lexapro® <sup>DO</sup> paroxetine 7.5mg	paroxetine CR Paxil® Paxil CR® Pexeva® Prozac® Sarafem® Trintellix™ <sup>DO</sup> Viibryd® <sup>DO</sup> Zoloft®
<p><b>DOSE OPTIMIZATION (DO)</b></p> <p>➤ See Dose Optimization Chart for affected strengths</p> <p><b>CLINICAL CRITERIA (CC)</b></p> <p>➤ Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA</p> <p>➤ Clinical editing to allow patients with a diagnosis of Obsessive Compulsive Disorder (OCD) to receive fluvoxamine and fluvoxamine ER without prior authorization</p>		
<b>Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)<sup>ST</sup></b>		
duloxetine 20mg, 30mg, 60mg (generic for Cymbalta®) venlafaxine venlafaxine ER <sup>DO</sup> (capsule)	Cymbalta® desvenlafaxine base ER desvenlafaxine fumarate ER desvenlafaxine succinate ER <sup>DO</sup> duloxetine 40mg (generic for Irenka™) Effexor XR® <sup>DO</sup> Fetzima® Irenka™ Khedezla™ Pristiq® <sup>DO</sup> Savella® venlafaxine ER (tablet)	<p><b>DOSE OPTIMIZATION (DO)</b></p> <p>➤ See Dose Optimization Chart for affected strengths</p> <p><b>STEP THERAPY (ST)</b></p> <p>➤ Trial of an SSRI prior to an SNRI*</p> <p>*Step therapy is not required for the following indications:</p> <ul style="list-style-type: none"> <li>▪ Chronic musculoskeletal pain (CMP)</li> <li>▪ Fibromyalgia (FM)</li> <li>▪ Diabetic peripheral neuropathy (DPN)* <ul style="list-style-type: none"> <li>❖ *duloxetine (Cymbalta® and Irenka™) – Requires a trial with a tricyclic antidepressant <b>OR</b> gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN)</li> </ul> </li> </ul>

# NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																																														
<b>Serotonin Receptor Agonists (Triptans)</b>																																																
rizatriptan <sup>F/Q/D</sup> sumatriptan <sup>F/Q/D</sup>	almotriptan <sup>F/Q/D</sup> Amerge <sup>®</sup> <sup>F/Q/D</sup> Axert <sup>®</sup> <sup>F/Q/D</sup> eletriptan <sup>F/Q/D</sup> Frova <sup>®</sup> <sup>F/Q/D</sup> frovatriptan <sup>F/Q/D</sup> Imitrex <sup>®</sup> <sup>F/Q/D</sup> Maxalt <sup>®</sup> <sup>F/Q/D</sup> Maxalt <sup>®</sup> MLT <sup>F/Q/D</sup> naratriptan <sup>F/Q/D</sup> Onzetra Xsail <sup>™</sup> <sup>F/Q/D</sup> Relpax <sup>®</sup> <sup>F/Q/D</sup> Sumavel <sup>®</sup> DosePro Treximet <sup>®</sup> <sup>F/Q/D</sup> Zembrace SymTouch <sup>™</sup> zolmitriptan <sup>F/Q/D</sup> Zomig <sup>®</sup> <sup>F/Q/D</sup> Zomig <sup>®</sup> ZMT <sup>F/Q/D</sup>	<table border="1"> <thead> <tr> <th colspan="2" data-bbox="1022 214 2049 248">FREQUENCY/QUANTITY/DURATION (F/Q/D)</th> </tr> </thead> <tbody> <tr> <td data-bbox="1087 253 1608 287">almotriptan</td> <td data-bbox="1608 253 2049 287">18 units every 30 days</td> </tr> <tr> <td data-bbox="1087 287 1608 321">Amerge<sup>®</sup></td> <td data-bbox="1608 287 2049 321"></td> </tr> <tr> <td data-bbox="1087 321 1608 355">Axert<sup>®</sup> 6.25mg</td> <td data-bbox="1608 321 2049 355"></td> </tr> <tr> <td data-bbox="1087 355 1608 389">Frova<sup>®</sup></td> <td data-bbox="1608 355 2049 389"></td> </tr> <tr> <td data-bbox="1087 389 1608 423">frovatriptan</td> <td data-bbox="1608 389 2049 423"></td> </tr> <tr> <td data-bbox="1087 423 1608 457">Imitrex<sup>®</sup> Nasal Spray</td> <td data-bbox="1608 423 2049 457"></td> </tr> <tr> <td data-bbox="1087 457 1608 492">Imitrex<sup>®</sup> tablets</td> <td data-bbox="1608 457 2049 492"></td> </tr> <tr> <td data-bbox="1087 492 1608 526">naratriptan</td> <td data-bbox="1608 492 2049 526"></td> </tr> <tr> <td data-bbox="1087 526 1608 560">Relpax<sup>®</sup> 20mg</td> <td data-bbox="1608 526 2049 560"></td> </tr> <tr> <td data-bbox="1087 560 1608 594">sumatriptan nasal spray</td> <td data-bbox="1608 560 2049 594"></td> </tr> <tr> <td data-bbox="1087 594 1608 628">sumatriptan tablets</td> <td data-bbox="1608 594 2049 628"></td> </tr> <tr> <td data-bbox="1087 628 1608 662">Treximet<sup>®</sup></td> <td data-bbox="1608 628 2049 662"></td> </tr> <tr> <td data-bbox="1087 662 1608 696">zolmitriptan (tablet, ODT) 2.5mg</td> <td data-bbox="1608 662 2049 696"></td> </tr> <tr> <td data-bbox="1087 696 1608 730">zolmitriptan (tablet, ODT) 5mg</td> <td data-bbox="1608 696 2049 730"></td> </tr> <tr> <td data-bbox="1087 730 1608 764">Zomig/Zomig<sup>®</sup> ZMT 2.5mg</td> <td data-bbox="1608 730 2049 764"></td> </tr> <tr> <td data-bbox="1087 764 1608 799">Zomig<sup>®</sup> /Zomig<sup>®</sup> ZMT 5mg</td> <td data-bbox="1608 764 2049 799"></td> </tr> <tr> <td data-bbox="1087 799 1608 833">Zomig<sup>®</sup> Nasal Spray</td> <td data-bbox="1608 799 2049 833"></td> </tr> <tr> <td data-bbox="1087 833 1608 867">Axert<sup>®</sup> 12.5mg</td> <td data-bbox="1608 833 2049 867">24 tablets every 30 days</td> </tr> <tr> <td data-bbox="1087 867 1608 901">Maxalt<sup>®</sup> /Maxalt MLT<sup>®</sup></td> <td data-bbox="1608 867 2049 901"></td> </tr> <tr> <td data-bbox="1087 901 1608 935">Relpax<sup>®</sup> 40mg</td> <td data-bbox="1608 901 2049 935"></td> </tr> <tr> <td data-bbox="1087 935 1608 969">rizatriptan (tablet, ODT)</td> <td data-bbox="1608 935 2049 969"></td> </tr> <tr> <td data-bbox="1087 969 1608 1003">Onzetra Xsail<sup>™</sup></td> <td data-bbox="1608 969 2049 1003">16 units (1 kit) every 30 days</td> </tr> </tbody> </table>	FREQUENCY/QUANTITY/DURATION (F/Q/D)		almotriptan	18 units every 30 days	Amerge <sup>®</sup>		Axert <sup>®</sup> 6.25mg		Frova <sup>®</sup>		frovatriptan		Imitrex <sup>®</sup> Nasal Spray		Imitrex <sup>®</sup> tablets		naratriptan		Relpax <sup>®</sup> 20mg		sumatriptan nasal spray		sumatriptan tablets		Treximet <sup>®</sup>		zolmitriptan (tablet, ODT) 2.5mg		zolmitriptan (tablet, ODT) 5mg		Zomig/Zomig <sup>®</sup> ZMT 2.5mg		Zomig <sup>®</sup> /Zomig <sup>®</sup> ZMT 5mg		Zomig <sup>®</sup> Nasal Spray		Axert <sup>®</sup> 12.5mg	24 tablets every 30 days	Maxalt <sup>®</sup> /Maxalt MLT <sup>®</sup>		Relpax <sup>®</sup> 40mg		rizatriptan (tablet, ODT)		Onzetra Xsail <sup>™</sup>	16 units (1 kit) every 30 days
FREQUENCY/QUANTITY/DURATION (F/Q/D)																																																
almotriptan	18 units every 30 days																																															
Amerge <sup>®</sup>																																																
Axert <sup>®</sup> 6.25mg																																																
Frova <sup>®</sup>																																																
frovatriptan																																																
Imitrex <sup>®</sup> Nasal Spray																																																
Imitrex <sup>®</sup> tablets																																																
naratriptan																																																
Relpax <sup>®</sup> 20mg																																																
sumatriptan nasal spray																																																
sumatriptan tablets																																																
Treximet <sup>®</sup>																																																
zolmitriptan (tablet, ODT) 2.5mg																																																
zolmitriptan (tablet, ODT) 5mg																																																
Zomig/Zomig <sup>®</sup> ZMT 2.5mg																																																
Zomig <sup>®</sup> /Zomig <sup>®</sup> ZMT 5mg																																																
Zomig <sup>®</sup> Nasal Spray																																																
Axert <sup>®</sup> 12.5mg	24 tablets every 30 days																																															
Maxalt <sup>®</sup> /Maxalt MLT <sup>®</sup>																																																
Relpax <sup>®</sup> 40mg																																																
rizatriptan (tablet, ODT)																																																
Onzetra Xsail <sup>™</sup>	16 units (1 kit) every 30 days																																															

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
<b>V. DERMATOLOGIC AGENTS</b>		
<b>Acne Agents – Prescription, Topical</b>		
adapalene Retin-A <sup>®</sup> cream <sup>CC</sup> tazarotene <sup>CC</sup> tretinoin <sup>CC</sup> gel	Aczone <sup>®</sup> adapalene/benzoyl peroxide Atralin <sup>®</sup> <sup>CC</sup> Avita <sup>®</sup> <sup>CC</sup> Azelex <sup>®</sup> clindamycin/ tretinoin dapsons Differin <sup>®</sup>	Epiduo <sup>®</sup> Fabior <sup>®</sup> <sup>CC</sup> Retin-A <sup>®</sup> gel <sup>CC</sup> Retin-A Micro <sup>®</sup> <sup>CC</sup> Tazorac <sup>®</sup> <sup>CC</sup> tretinoin cream tretinoin micro <sup>CC</sup> Veltin <sup>®</sup> <sup>CC</sup> Ziana <sup>®</sup> <sup>CC</sup>
<b>Agents for Actinic Keratosis</b>		
diclofenac 3% gel <sup>F/Q/D</sup> fluorouracil (solution) fluorouracil 0.5% cream (generic for Carac) fluorouracil 5% cream (generic for Efudex cream) imiquimod	Aldara <sup>®</sup> Carac <sup>®</sup> Efudex <sup>®</sup> Picato Solaraze <sup>®</sup> <sup>F/Q/D</sup> Tolak <sup>™</sup> Zyclara <sup>®</sup>	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>➤ Solaraze<sup>®</sup> / diclofenac 3% gel: <ul style="list-style-type: none"> <li>▪ Maximum 100 (one hundred) grams as a 90-day supply</li> <li>▪ Limited to one (1) prescription per year</li> </ul> </li> </ul>
<b>Antibiotics – Topical</b>		
mupirocin (ointment)	Altabax <sup>®</sup> Bactroban <sup>®</sup> Bactroban Nasal <sup>®</sup> <sup>CC</sup>	Centany <sup>®</sup> mupirocin (cream)
<b>Anti-Fungals – Topical</b>		
ciclopirox (cream, suspension) clotrimazole OTC clotrimazole / betamethasone (cream) miconazole OTC Nyamyc <sup>™</sup> nystatin (cream, ointment, powder) Nystop <sup>®</sup> terbinafine OTC tolnaftate OTC	Alevazol OTC Ciclodan <sup>®</sup> (cream) ciclopirox (gel) clotrimazole / betamethasone (lotion) clotrimazole Rx econazole Ertaczo <sup>®</sup> Exelderm <sup>®</sup> Extina <sup>®</sup> ketoconazole Lamisil <sup>®</sup> OTC (spray) Lotrisone <sup>®</sup> Luzu <sup>®</sup> Mentax <sup>®</sup> naftifine Naftin <sup>®</sup> nystatin/ triamcinolone oxiconazole Oxistat <sup>®</sup> Vusion <sup>®</sup> <sup>F/Q/D</sup>	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>➤ Vusion<sup>®</sup> 50 gm ointment – Maximum 100 (one hundred) grams in a 90-day time period</li> </ul>

# NYS Medicaid Fee-For-Service Preferred Drug List

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

# NYS Medicaid Fee-For-Service Preferred Drug List

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

# NYS Medicaid Fee-For-Service Preferred Drug List

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



# NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs	Prior Authorization/Coverage Parameters	
<b>Biguanides</b>				
metformin HCl metformin ER (generic for Glucophage XR®)		Fortamet® Glucophage® Glucophage XR® Glumetza® metformin ER (generics for Fortamet®, Glumetza®) Riomet® (solution)		
<b>Bisphosphonates – Oral <span style="color: red;">F/Q/D</span></b>				
alendronate		Actonel® Atelvia® Binosto® Boniva® Fosamax® Fosamax® Plus D Ibandronate risedronate	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b>	
			ibandronate sodium 150 mg (Boniva® 150 mg)	1 tablet every 28 days
			risedronate sodium 150 mg (Actonel® 150 mg)	
			alendronate sodium 35 mg (Fosamax® 35 mg)	4 tablets every 28 days
			alendronate sodium 70 mg (Fosamax® 70 mg, Binosto)	
			alendronate sodium and cholecalciferol (Fosamax® Plus D)	
			risedronate sodium 35 mg (Actonel® 35 mg)	
			risedronate sodium 35 mg (Atelvia® 35 mg)	
			alendronate solution 70 mg/75 mL single-dose bottle	4 bottles every 28 days
<b>Calcitonins – Intranasal</b>				
calcitonin-salmon	Miacalcin®			
<b>Dipeptidyl Peptidase-4 (DPP-4) Inhibitors <span style="color: red;">ST</span></b>				
Janumet® Janumet® XR Januvia® <span style="color: red;">DO</span>	Jentadueto® Jentadueto® XR Tradjenta®	alogliptin alogliptin / metformin alogliptin / pioglitazone Glyxambi® Kazano™ Kombiglyze® XR Nesina™ Onglyza® <span style="color: red;">DO</span> Oseni™ Qtern®	<b>DOSE OPTIMIZATION (DO)</b> ➤ See Dose Optimization Chart for affected strengths <b>STEP THERAPY (ST)</b> ➤ Requires a trial with metformin with or without insulin prior to DPP-4 Inhibitor 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
<b>Glucagon-like Peptide-1 (GLP-1) Agonists <sup>ST</sup></b>				
Bydureon® Byetta® Victoza®	Adlyxin™ Bydureon® BCise™ Soliqua™ Tanzeum® Trulicity®	Xultophy®		<b><u>STEP THERAPY (ST)</u></b> ➤ Requires a trial with metformin with or without insulin prior to a GLP-1 agonist. ➤ Prior authorization is required with lack of covered diagnosis in medical history.
<b>Glucocorticoids – Oral</b>				
dexamethasone (tablet) hydrocortisone methylprednisolone (dose-pack) prednisolone (solution) prednisone (dose-pack, tablet)	budesonide EC Cortef® cortisone <sup>2</sup> dexamethasone (elixir, solution <sup>2</sup> ) dexamethasone intensol Dexpak® Emflaza™ Entocort EC® Medrol® (dose-pack, tablet) methylprednisolone (4mg <sup>2</sup> , 8mg <sup>2</sup> 16mg, 32mg <sup>2</sup> ) Millipred® Orapred® ODT prednisolone ODT prednisone (intensol, solution <sup>2</sup> ) Rayos® Uceris® Veripred®			
<b>Growth Hormones <sup>CC, CDRP</sup></b>				
Genotropin® Norditropin®	Nutropin AQ®	Humatrope® Omnitrope® Saizen®	Zomacton® Zorbitive®	<b><u>CLINICAL DRUG REVIEW PROGRAM (CDRP)</u></b> ➤ <b>Prescribers</b> , not authorized agents, are required to call for a PA for beneficiaries 21 years of age or older <b><u>CLINICAL CRITERIA (CC)</u></b> ➤ 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. ➤ Confirm diagnosis of FDA-approved or compendia-supported indication
<b>Insulin – Long-Acting</b>				
Lantus®	Levemir®	Basaglar® Toujeo®	Tresiba®	

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
<b>Insulin – Mixes</b>				
Humalog® Mix	Novolog® Mix	None		
<b>Insulin – Rapid-Acting</b>				
Apidra®	Novolog®	Afrezza®		
Humalog® 100 U/mL		Humalog® 200 U/mL		
Humalog® Jr 100U/mL				
<b>Meglitinides <sup>ST</sup></b>				
nateglinide	repaglinide	Prandin®	repaglinide/ metformin Starlix®	<b>STEP THERAPY (ST)</b> ➤ Requires a trial with metformin with or without insulin prior to initiating meglitinide therapy, unless there is a documented contraindication.
<b>Pancreatic Enzymes</b>				
Creon®	Zenpep®	Pancreaze®	Viokace®	
pancrelipase		Pertzye®		
<b>Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors <sup>ST</sup></b>				
Farxiga™		Invokamet®	Jardiance®	<b>STEP THERAPY (ST)</b> ➤ Requires a trial with metformin with or without insulin prior to initiating SGLT2 Inhibitor therapy, unless there is a documented contraindication.
Invokana®		Invokamet® XR	Synjardy® Synjardy® XR Xigduo® XR	
<b>Thiazolidinediones (TZDs) <sup>ST</sup></b>				
pioglitazone		Actoplus Met® Actoplus Met® XR <sup>DO</sup> Actos® <sup>DO</sup> Avandia® Duetact® pioglitazone / glimepiride pioglitazone / metformin		<b>DOSE OPTIMIZATION (DO)</b> ➤ See Dose Optimization Chart for affected strengths <b>STEP THERAPY (ST)</b> ➤ Requires a trial with metformin with or without insulin prior to initiating TZD therapy, unless there is a documented contraindication.

# NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VII. GASTROINTESTINAL</b>		
<b>Anti-Emetics</b>		
Diclegis® <sup>CC 1</sup> Emend Pack® <sup>1</sup> ondansetron (ODT, solution, tablet)	Akynzeo® <sup>2</sup> Anzemet® aprepitant (capsule, pack) <sup>2</sup> Emend® (capsule, powder packet) <sup>2</sup> granisetron (tablet) Sancuso® Varubi® <sup>2</sup> Zofran® (ODT, solution, tablet) Zuplenz®	<b><u>CLINICAL CRITERIA (CC)</u></b> ➤ <u>Diclegis®</u> : Confirm diagnosis of FDA-approved or compendia-supported indication
<b>Gastrointestinal Antibiotics</b>		
metronidazole (tablet) neomycin vancomycin	Alinia® Dificid® Flagyl® Flagyl® ER metronidazole (capsule) paromomycin Tindamax® tinidazole Vancocin® Xifaxan® <sup>CC, ST, F/Q/D</sup>	<b><u>CLINICAL CRITERIA (CC)</u></b> ➤ <u>Xifaxan®</u> : Confirm diagnosis of FDA-approved or compendia-supported indication <b><u>STEP THERAPY (ST)</u></b> ➤ <u>Xifaxan®</u> : Requires trial of a preferred fluoroquinolone antibiotic before rifaximin for treatment of Traveler's diarrhea <b><u>QUANTITY LIMITS:</u></b> ➤ <u>Xifaxan®</u> : <ul style="list-style-type: none"> <li>▪ Traveler's diarrhea (200 mg tablet) – 9 (nine) tablets per 30 days (Dose = 200 mg three times a day for three days)</li> <li>▪ Hepatic encephalopathy (550 mg tablets) – 60 tablets per 30 days (Dose = 550 mg twice a day)</li> <li>▪ Irritable bowel syndrome with diarrhea (550 mg tablets) – 42 tablets per 30 days (Dose = 550 mg three times a day for 14 days)</li> </ul> ❖ Maximum of 42 days' supply (126 units) per 365 (three rounds of therapy).

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
<b>Gastrointestinal Preparatory Agents</b>		
Clearlax® Gavilax® Gavilyte®-C Gavilyte®-G Glycolax® Miralax® OTC PEG 3350 powder OTC PEG 3350/ electrolytes solution Rx	Colyte® Gavilyte®-N Golytely® Moviprep® Nulytely® Osmoprep® PEG 3350 powder pack OTC PEG 3350 with flavor packs Prepopik® Suprep® Trilyte®	
<b>Helicobacter pylori Agents</b>		
lansoprazole / amoxicillin / clarithromycin Pylera®	Omeclamox-Pak® Prevpac®	

# NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
<b>Proton Pump Inhibitors (PPIs) <sup>F/Q/D</sup></b>				
omeprazole Rx pantoprazole		Aciphex® Dexilant™ <sup>DO</sup> esomeprazole magnesium (generic for Nexium) esomeprazole strontium lansoprazole Rx (capsule, ODT) Nexium® RX <sup>DO</sup> omeprazole OTC omeprazole/ sodium bicarbonate Rx Prevacid® OTC Prevacid® Rx <sup>DO</sup> Prilosec® Rx Protonix® rabeprazole Zegerid®		<p><b><u>DOSE OPTIMIZATION (DO)</u></b></p> <ul style="list-style-type: none"> <li>➤ See Dose Optimization Chart for affected strengths</li> </ul> <p><b><u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u></b></p> <ul style="list-style-type: none"> <li>➤ <b>Quantity limits:</b> <ul style="list-style-type: none"> <li>▪ Once daily dosing for:                             <ul style="list-style-type: none"> <li>❖ GERD</li> <li>❖ erosive esophagitis</li> <li>❖ healing and maintenance of duodenal/gastric ulcers (including NSAID-induced)</li> <li>❖ prevention of NSAID-induced ulcers</li> </ul> </li> <li>▪ Twice daily dosing for:                             <ul style="list-style-type: none"> <li>❖ hypersecretory conditions</li> <li>❖ Barrett's esophagitis</li> <li>❖ H. pylori</li> <li>❖ refractory GERD</li> </ul> </li> </ul> </li> <li>➤ <b>Duration limits:</b> <ul style="list-style-type: none"> <li>▪ 90 days for:                             <ul style="list-style-type: none"> <li>❖ GERD</li> </ul> </li> <li>▪ 365 days for:                             <ul style="list-style-type: none"> <li>❖ Maintenance treatment of duodenal ulcers, or erosive esophagitis</li> </ul> </li> <li>▪ 14 days for:                             <ul style="list-style-type: none"> <li>❖ H. pylori</li> </ul> </li> </ul> </li> </ul>
<b>Sulfasalazine Derivatives</b>				
Apriso® Delzico® Dipentum® sulfasalazine DR/EC	sulfasalazine IR Sulfazine Sulfazine EC	Asacol HD® Azulfidine® Azulfidine Entab® balsalazide	Colazal® Giazo® Lialda® mesalamine DR (gen for Lialda) mesalamine DR 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
<b>VIII. HEMATOLOGICAL AGENTS</b>				
<b>Anticoagulants – Injectable <sup>CC F/Q/D</sup></b>				
enoxaparin sodium	Fragmin <sup>®</sup>	Arixtra <sup>®</sup> <sup>CC</sup> fondaparinux <sup>CC</sup>	Lovenox <sup>®</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>➤ For patients requiring &gt;30 days of therapy: Require confirmation of FDA-approved or compendia-supported indication</li> <li>➤ Arixtra<sup>®</sup> (fondaparinux) Clinical editing to allow patients with a diagnosis of Heparin Induced Thrombocytopenia (HIT) to receive therapy without prior authorization.</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>➤ Duration Limit: No more than 30 days for members initiating therapy</li> </ul>
<b>Anticoagulants – Oral</b>				
Coumadin <sup>®</sup> Eliquis <sup>®</sup> Jantoven <sup>®</sup> Pradaxa <sup>®</sup>	warfarin Xarelto <sup>®</sup>	Savaysa <sup>®</sup> Xarelto <sup>®</sup> (dose pack)		
<b>Erythropoiesis Stimulating Agents (ESAs) <sup>CC</sup></b>				
Aranesp <sup>®</sup>	Procrit <sup>®</sup>	Epogen <sup>®</sup>	Mircera <sup>®</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>➤ Confirm diagnosis for FDA- or compendia-supported uses</li> </ul>
<b>Platelet Inhibitors</b>				
Aggrenox <sup>®</sup> Brilinta <sup>®</sup> clopidogrel dipyridamole		dipyridamole / aspirin Durlaza <sup>®</sup> Effient <sup>®</sup> Plavix <sup>®</sup> prasugrel ticlopidine Yosprala <sup>™</sup> Zontivity <sup>®</sup>		

# NYS Medicaid Fee-For-Service Preferred Drug List

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



# NYS Medicaid Fee-For-Service Preferred Drug List

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

# NYS Medicaid Fee-For-Service Preferred Drug List

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

# NYS Medicaid Fee-For-Service Preferred Drug List

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

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

# NYS Medicaid Fee-For-Service Preferred Drug List

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

# NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																								
<b>Beta<sub>2</sub> Adrenergic Agents – Inhaled Long-Acting <span style="color: red;">CC, F/Q/D</span></b>																										
Foradil® Perforomist® Serevent Diskus®	Arcapta Neohaler® Brovana® Striverdi Respimat®	<p><b>CLINICAL CRITERIA (CC)</b></p> <p>PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA- or compendia-supported age as indicated:</p> <table border="1" data-bbox="1094 321 1982 565"> <tr> <td>Arcapta Neohaler®</td> <td>≥18 years</td> </tr> <tr> <td>Brovana®</td> <td>≥18 years</td> </tr> <tr> <td>Foradil®</td> <td>≥ 5 years</td> </tr> <tr> <td>Perforomist®</td> <td>≥18 years</td> </tr> <tr> <td>Serevent Diskus®</td> <td>≥4 years</td> </tr> <tr> <td>Striverdi Respimat®</td> <td>≥18 years</td> </tr> </table> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <p><b>Maximum units per 30 days</b></p> <table border="1" data-bbox="1087 659 1986 898"> <tr> <td>Arcapta Neohaler®</td> <td>30 units (1 box of 30 unit dose capsules)</td> </tr> <tr> <td>Brovana®</td> <td>60 units (1 carton of 60 vials or 120 mL)</td> </tr> <tr> <td>Foradil®</td> <td>60 units (1 box of 60 unit dose capsules)</td> </tr> <tr> <td>Perforomist®</td> <td>60 units (1 carton of 60 vials or 120 mL)</td> </tr> <tr> <td>Serevent Diskus®</td> <td>1 diskus (60 blisters)</td> </tr> <tr> <td>Striverdi Respimat®</td> <td>1 unit (one cartridge and one Respimat inhaler)</td> </tr> </table>	Arcapta Neohaler®	≥18 years	Brovana®	≥18 years	Foradil®	≥ 5 years	Perforomist®	≥18 years	Serevent Diskus®	≥4 years	Striverdi Respimat®	≥18 years	Arcapta Neohaler®	30 units (1 box of 30 unit dose capsules)	Brovana®	60 units (1 carton of 60 vials or 120 mL)	Foradil®	60 units (1 box of 60 unit dose capsules)	Perforomist®	60 units (1 carton of 60 vials or 120 mL)	Serevent Diskus®	1 diskus (60 blisters)	Striverdi Respimat®	1 unit (one cartridge and one Respimat inhaler)
Arcapta Neohaler®	≥18 years																									
Brovana®	≥18 years																									
Foradil®	≥ 5 years																									
Perforomist®	≥18 years																									
Serevent Diskus®	≥4 years																									
Striverdi Respimat®	≥18 years																									
Arcapta Neohaler®	30 units (1 box of 30 unit dose capsules)																									
Brovana®	60 units (1 carton of 60 vials or 120 mL)																									
Foradil®	60 units (1 box of 60 unit dose capsules)																									
Perforomist®	60 units (1 carton of 60 vials or 120 mL)																									
Serevent Diskus®	1 diskus (60 blisters)																									
Striverdi Respimat®	1 unit (one cartridge and one Respimat inhaler)																									
<b>Beta<sub>2</sub> Adrenergic Agents – Inhaled Short-Acting</b>																										
albuterol Proventil HFA® ProAir HFA®	levalbuterol (solution) Ventolin HFA® levalbuterol HFA Xopenex® (solution) ProAir® RespiClick Xopenex HFA®																									

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																																										
<b>Corticosteroids – Inhaled <span style="color: red;">F/Q/D</span></b>																																												
Asmanex® Flovent Diskus® Flovent HFA® Pulmicort® Flexhaler QVAR®	Aerospan® Alvesco® ArmonAir™ Respiclick® Arnuity Ellipta® Asmanex® HFA	<table border="1"> <thead> <tr> <th colspan="2" data-bbox="1026 215 2045 248">FREQUENCY/QUANTITY/DURATION (F/Q/D)</th> </tr> </thead> <tbody> <tr> <td data-bbox="1075 256 1409 289">Aerospan® 80 mcg</td> <td data-bbox="1409 256 1997 289">2 inhalers every 30 days</td> </tr> <tr> <td data-bbox="1075 297 1409 329">Alvesco® 80 mcg</td> <td data-bbox="1409 297 1997 329">1 inhaler every 30 days</td> </tr> <tr> <td data-bbox="1075 337 1409 394">Alvesco® 160 mcg</td> <td data-bbox="1409 337 1997 394">1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use.</td> </tr> <tr> <td data-bbox="1075 402 1409 459">ArmonAir™ Respiclick® 55mcg, 113mcg</td> <td data-bbox="1409 402 1997 459">1 inhaler every do days</td> </tr> <tr> <td data-bbox="1075 467 1409 524">ArmonAir™ Respiclick® 232mcg</td> <td data-bbox="1409 467 1997 524">1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use</td> </tr> <tr> <td data-bbox="1075 532 1409 565">Arnuity Ellipta</td> <td data-bbox="1409 532 1997 565">1 inhaler every 30 days</td> </tr> <tr> <td data-bbox="1075 573 1409 605">Asmanex® 110 mcg</td> <td data-bbox="1409 573 1997 605">1 inhaler every 30 days</td> </tr> <tr> <td data-bbox="1075 613 1409 646">Asmanex® 220 mcg (30 units)</td> <td data-bbox="1409 613 1997 646">1 inhaler every 30 days</td> </tr> <tr> <td data-bbox="1075 654 1409 743">Asmanex® 220 mcg (60 units)</td> <td data-bbox="1409 654 1997 743">1 inhaler every 30 days Up to 1 inhaler every 15 days with previous oral corticosteroid use.</td> </tr> <tr> <td data-bbox="1075 751 1409 816">Asmanex® 220 mcg (120 units)</td> <td data-bbox="1409 751 1997 816">1 inhaler every 60 days. Up to 1 inhaler every 30 days with previous oral corticosteroid use.</td> </tr> <tr> <td data-bbox="1075 824 1409 857">Asmanex® HFA 100 mcg</td> <td data-bbox="1409 824 1997 857">1 inhaler every 30 days</td> </tr> <tr> <td data-bbox="1075 865 1409 898">Asmanex® HFA 200 mcg</td> <td data-bbox="1409 865 1997 898">1 inhaler every 30 days</td> </tr> <tr> <td data-bbox="1075 906 1409 963">Flovent Diskus® 50mcg, 100 mcg</td> <td data-bbox="1409 906 1997 963">1 diskus every 30 days</td> </tr> <tr> <td data-bbox="1075 971 1409 1027">Flovent Diskus® 250mcg</td> <td data-bbox="1409 971 1997 1027">1 diskus every 15 days. Up to 1 diskus every 7 days with previous oral corticosteroid use.</td> </tr> <tr> <td data-bbox="1075 1036 1409 1068">Flovent HFA® 44mcg, 110 mcg</td> <td data-bbox="1409 1036 1997 1068">1 inhaler every 30 days</td> </tr> <tr> <td data-bbox="1075 1076 1409 1133">Flovent HFA® 220mcg</td> <td data-bbox="1409 1076 1997 1133">1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use.</td> </tr> <tr> <td data-bbox="1075 1141 1409 1174">Pulmicort 90mcg</td> <td data-bbox="1409 1141 1997 1174">1 inhaler every 30 days</td> </tr> <tr> <td data-bbox="1075 1182 1409 1214">Pulmicort 180mcg</td> <td data-bbox="1409 1182 1997 1214">1 inhaler every 15 days</td> </tr> <tr> <td data-bbox="1075 1222 1409 1255">QVAR® 40mcg</td> <td data-bbox="1409 1222 1997 1255">1 inhaler every 25 days</td> </tr> <tr> <td data-bbox="1075 1263 1409 1295">QVAR® 80mcg</td> <td data-bbox="1409 1263 1997 1295">1 inhaler every 12 days</td> </tr> </tbody> </table>	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 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
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 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																																											

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																								
<b>Corticosteroid/Beta<sub>2</sub> Adrenergic Agent (Long-Acting) Combinations – Inhaled <span style="color: red;">CC, F/Q/D</span></b>																											
Advair Diskus <sup>®</sup>	Dulera <sup>®</sup> Symbicort <sup>®</sup>	Advair HFA <sup>®</sup> AirDuo™ RespiClick <sup>®</sup> Breo Ellipta <sup>®</sup> fluticasone-salmeterol (gen for AirDuo™ RespiClick <sup>®</sup> )	<p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA- or compendia-supported age as indicated:</li> </ul> <table border="1"> <tr><td>Advair Diskus<sup>®</sup></td><td>≥4 years</td></tr> <tr><td>Advair HFA<sup>®</sup></td><td>≥12 years</td></tr> <tr><td>AirDuo™ RespiClick<sup>®</sup></td><td>≥12 years</td></tr> <tr><td>Breo Ellipta™</td><td>≥18 years</td></tr> <tr><td>Dulera<sup>®</sup></td><td>≥12 years</td></tr> <tr><td>fluticasone-salmeterol</td><td>≥12 years</td></tr> <tr><td>Symbicort<sup>®</sup> 80/4.5 mcg</td><td>≥6 years</td></tr> <tr><td>Symbicort<sup>®</sup> 160/4.5 mcg</td><td>≥12 years</td></tr> </table> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <table border="1"> <tr><td>Advair Diskus<sup>®</sup></td><td rowspan="7">One (1) inhaler/diskus every 30 days</td></tr> <tr><td>Advair HFA<sup>®</sup></td></tr> <tr><td>AirDuo™ RespiClick<sup>®</sup></td></tr> <tr><td>Breo Ellipta™</td></tr> <tr><td>Dulera<sup>®</sup></td></tr> <tr><td>fluticasone-salmeterol</td></tr> <tr><td>Symbicort<sup>®</sup></td></tr> </table>	Advair Diskus <sup>®</sup>	≥4 years	Advair HFA <sup>®</sup>	≥12 years	AirDuo™ RespiClick <sup>®</sup>	≥12 years	Breo Ellipta™	≥18 years	Dulera <sup>®</sup>	≥12 years	fluticasone-salmeterol	≥12 years	Symbicort <sup>®</sup> 80/4.5 mcg	≥6 years	Symbicort <sup>®</sup> 160/4.5 mcg	≥12 years	Advair Diskus <sup>®</sup>	One (1) inhaler/diskus every 30 days	Advair HFA <sup>®</sup>	AirDuo™ RespiClick <sup>®</sup>	Breo Ellipta™	Dulera <sup>®</sup>	fluticasone-salmeterol	Symbicort <sup>®</sup>
Advair Diskus <sup>®</sup>	≥4 years																										
Advair HFA <sup>®</sup>	≥12 years																										
AirDuo™ RespiClick <sup>®</sup>	≥12 years																										
Breo Ellipta™	≥18 years																										
Dulera <sup>®</sup>	≥12 years																										
fluticasone-salmeterol	≥12 years																										
Symbicort <sup>®</sup> 80/4.5 mcg	≥6 years																										
Symbicort <sup>®</sup> 160/4.5 mcg	≥12 years																										
Advair Diskus <sup>®</sup>	One (1) inhaler/diskus every 30 days																										
Advair HFA <sup>®</sup>																											
AirDuo™ RespiClick <sup>®</sup>																											
Breo Ellipta™																											
Dulera <sup>®</sup>																											
fluticasone-salmeterol																											
Symbicort <sup>®</sup>																											
<b>Corticosteroids – Intranasal <span style="color: red;">F/Q/D</span></b>																											
fluticasone		Beconase AQ <sup>®</sup> <span style="color: red;">CC</span> QNASL <sup>®</sup> <span style="color: red;">CC</span> budesonide                      Veramyst <sup>®</sup> Dymista <sup>®</sup> Zetonna <sup>®</sup> flunisolide mometasone Nasonex <sup>®</sup> Omnaris <sup>®</sup>	<p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>Clinical consideration in regard to drug interactions will be given to patients with HIV/AIDs diagnosis or antiretroviral therapy in history</li> </ul> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <table border="1"> <tr><td>flunisolide</td><td>One (1) inhaler every 12 days</td></tr> <tr><td>budesonide mometasone Nasonex<sup>®</sup></td><td>One (1) inhaler every 15 days</td></tr> <tr><td>Beconase AQ<sup>®</sup></td><td>One (1) inhaler every 22 days</td></tr> <tr><td>Dymista™ fluticasone Nasacort AQ<sup>®</sup> Omnaris<sup>®</sup> QNASL<sup>®</sup> Veramyst<sup>®</sup> Zetonna™</td><td>One (1) inhaler every 30 days</td></tr> </table>	flunisolide	One (1) inhaler every 12 days	budesonide mometasone Nasonex <sup>®</sup>	One (1) inhaler every 15 days	Beconase AQ <sup>®</sup>	One (1) inhaler every 22 days	Dymista™ fluticasone Nasacort AQ <sup>®</sup> Omnaris <sup>®</sup> QNASL <sup>®</sup> Veramyst <sup>®</sup> Zetonna™	One (1) inhaler every 30 days																
flunisolide	One (1) inhaler every 12 days																										
budesonide mometasone Nasonex <sup>®</sup>	One (1) inhaler every 15 days																										
Beconase AQ <sup>®</sup>	One (1) inhaler every 22 days																										
Dymista™ fluticasone Nasacort AQ <sup>®</sup> Omnaris <sup>®</sup> QNASL <sup>®</sup> Veramyst <sup>®</sup> Zetonna™	One (1) inhaler every 30 days																										
<b>Leukotriene Modifiers</b>																											
montelukast <span style="color: red;">ST</span> zafirlukast	Accolate <sup>®</sup> Singulair <sup>®</sup> <span style="color: red;">ST</span>		<p><b>STEP THERAPY (ST)</b></p> <ul style="list-style-type: none"> <li>For non-asthmatic patients, trial of intranasal corticosteroid or a 2nd generation oral antihistamine before montelukast (Singulair<sup>®</sup>)</li> </ul>																								

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](http://newyork.fhsc.com/providers/CDRP_forms.asp).

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

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

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](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](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)	<p>Requires trial of first-line therapy for all FDA-approved indications, other than infantile spasms.</p> <p><b>Note:</b> Acthar is first line therapy for infantile spasms in children less than 2 years of age – step therapy not required.</p>	<p><b>QUANTITY LIMITS:</b></p> <ul style="list-style-type: none"> <li>➤ Infantile spasms – 30 mL (six 5 mL vials)</li> <li>➤ Multiple sclerosis – 35 mL (seven 5 mL vials)</li> </ul> <p><b>DURATION LIMITS:</b></p> <ul style="list-style-type: none"> <li>➤ Infantile spasms – 4 weeks; indicated for &lt; 2 years of age</li> <li>➤ Multiple sclerosis – 5 weeks</li> <li>➤ Rheumatic disorders – 5 weeks</li> <li>➤ Dermatologic conditions – 5 weeks</li> <li>➤ Allergic states (serum sickness) – 5 weeks</li> </ul>	<p>Confirm diagnosis of FDA-approved or compendia-supported indication</p> <p>Not covered for diagnostic purposes</p>
	<b>FDA Indication</b>	<b>First line Therapy</b>	
	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	<b>QUANTITY LIMIT:</b> ➤ Equal to 10 tablets per fill	
Anabolic Steroids – Injectable ➤ Depo-Testosterone® ➤ testosterone cypionate* ➤ testosterone enanthate  *for additional parameters, see Cross-Sex Hormones section below.		Limitations for anabolic steroid products is based on approved FDA labeled daily dosing and documented diagnosis not to exceed a 90-day supply (30-day supply for oxandrolone): ➤ Initial duration limit of 3 months (for all products except oxandrolone), requiring documented follow-up monitoring for response and/or adverse effects before continuing treatment ➤ Duration limit of 6 months for delayed puberty ➤ Duration limit of 1 month for all uses of oxandrolone products	
Anabolic Steroids – Oral ➤ Anadrol-50® ➤ Android® ➤ Androxy™ ➤ Methitest® ➤ Oxandrin® ➤ oxandrolone ➤ Testred®			
Anti-Diabetic agents (not on the PDL) ➤ chlorpropamide ➤ glimepiride ➤ glipizide (Glucotrol®, Glucotrol XL®) ➤ glyburide (DiaBeta®, Glynase®) ➤ glyburide, micronized ➤ tolazamide ➤ tolbutamide	➤ Requires a trial with metformin with or without insulin prior to initiating other antidiabetic agents, unless there is a documented contraindication. ➤ Clinical editing to allow patients with a diagnosis of gestational diabetes to receive glyburide without a trial of metformin first.		
Anti-Diarrheal Agents ➤ alosetron (Lotronex) ➤ crofelemer (Mytesi) ➤ eluxadoline (Viberzi) ➤ telotristat (Xermelo)	Irritable Bowel Syndrome w/Diarrhea ➤ Trial of eluxadoline and rifaximin prior to alosetron.  Symptomatic relief of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy ➤ Trial with an alternative anti-diarrheal agent.  Carcinoid Syndrome ➤ 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 ➤ ciclopirox 8% solution ➤ Jublia® ➤ Kerydin® ➤ Penlac®	➤ Trial with an oral antifungal agent* prior to use of ciclopirox 8% solution (Penlac) <ul style="list-style-type: none"> <li>▪ terbinafine (Lamisil®) tablets; griseofulvin (Gris PEG®) oral suspension, ultramicrozoned tablets; itraconazole (Sporanox®, Onmel™) tablets, oral solution</li> </ul> ➤ Trial with ciclopirox 8% solution prior to the use of other topical antifungals [efinaconazole (Jublia) or tavaborole (Kerydin)]		
Anti-Retroviral (ARV) Interventions		<b>QUANTITY LIMITS:</b> <ul style="list-style-type: none"> <li>➤ Limit ARV active ingredient duplication</li> <li>➤ Limit ARV utilization to a maximum of five products concurrently - excluding boosting with ritonavir (dose limit 600 mg or less) or cobicistat</li> <li>➤ Limit Protease Inhibitor utilization to a maximum of two products concurrently</li> <li>➤ Limit Integrase inhibitor utilization to a maximum of one product concurrently</li> </ul>	<ul style="list-style-type: none"> <li>➤ Require confirmation of FDA-approved or compendia-supported use</li> <li>➤ <a href="#">Point of service edit for contraindicated antiretroviral / non-antiretroviral combinations</a></li> <li>➤ <a href="#">Point of service edit for contraindicated antiretroviral / antiretroviral combinations</a></li> </ul>
Atopic Dermatitis Agents ➤ crisaborole (Eucrisa™) ➤ dupilumab (Dupixent®)	Crisaborole (Eucrisa) ➤ Trial with a medium or high potency prescription topical steroid within the last 3 months  Dupilumab (Dupixent) ➤ 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	<b>QUANTITY LIMITS:</b> Crisaborole (Eucrisa) ➤ 100GM/30 days Dupilumab (Dupixent) ➤ 4 syringes for first 30 days followed by 2 syringes/30 days.	Confirm diagnosis of FDA-approved or compendia-supported indication
Becaplermin (Regranex®)		<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>➤ 2 (two) 15 gram tubes in a lifetime</li> </ul>	

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Benzodiazepine agents – oral <ul style="list-style-type: none"> <li>➤ alprazolam (Niravam™, Xanax®, Xanax® XR)</li> <li>➤ clordiazepoxide (Librium®)</li> <li>➤ clordiazepoxide/amitriptyline (Limbitrol®)</li> <li>➤ clonazepam (Klonopin®)</li> <li>➤ clorazepate (Tranxene®, Tranxene T-Tab®)</li> <li>➤ diazepam (Valium®)</li> <li>➤ lorazepam (Ativan®, Lorazepam Intenso!®)</li> <li>➤ oxazepam (Serax®)</li> </ul>	<ul style="list-style-type: none"> <li>➤ 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</li> <li>➤ For diagnosis of Panic Disorder: Require concurrent therapy with an antidepressant (SSRI, SNRI, or Tricyclic antidepressant [TCA]).</li> <li>➤ For diagnosis of skeletal muscle spasms: Require trial with a skeletal muscle relaxant prior to a benzodiazepine</li> </ul>	<b>DURATION LIMIT:</b> <ul style="list-style-type: none"> <li>➤ For Insomnia: 30 consecutive days</li> <li>➤ For Panic Disorder: 30 consecutive days</li> </ul>	<ul style="list-style-type: none"> <li>➤ Require confirmation of FDA-approved or compendia-supported use</li> <li>➤ PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy</li> <li>➤ PA required for any additional oral benzodiazepine prescription in patients currently on benzodiazepine therapy</li> </ul>
Constipation Agents <ul style="list-style-type: none"> <li>➤ linaclotide (Linzess)</li> <li>➤ lubiprostone (Amitiza)</li> <li>➤ methylnaltrexone (Relistor)</li> <li>➤ naloxegol (Movantik)</li> <li>➤ plecanatide (Trulance)</li> </ul>	Opioid Induced Constipation (OIC) & Chronic Idiopathic Constipation (CIC) <ul style="list-style-type: none"> <li>➤ Trial with an osmotic laxative, a stimulant laxative and a stool softener prior to use.</li> </ul> Irritable Bowel Syndrome w/ Constipation (IBS-C) <ul style="list-style-type: none"> <li>➤ Trial with a bulking agent and an osmotic laxative within 89 days of use.</li> </ul>	<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>➤ lubiprostone: 2 capsules/day; 60 capsules/month</li> <li>➤ methylnaltrexone: 1 vial or syringe/day; 30/month; 4 kits/28 days; 90 tablets/30 days</li> <li>➤ naloxegol: 1 tablet/day; 30 tablets/month</li> <li>➤ plecanatide: 1 tablet/day; 30 tablets/month</li> </ul>	Confirmation of FDA-approved or compendia-supported indication.
Cross-Sex Hormones <ul style="list-style-type: none"> <li>➤ conjugated estrogens</li> <li>➤ estradiol</li> <li>➤ testosterone cypionate</li> </ul>			<ul style="list-style-type: none"> <li>➤ Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul> Refer to: <a href="https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender">https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender</a> for Transgender Related Care and Services Update
<ul style="list-style-type: none"> <li>➤ cyclosporine ophthalmic emulsion (Restasis®, Restasis MultiDose™)</li> <li>➤ lifitegrast ophthalmic solution (Xiidra™)</li> </ul>	Diagnosis documentation required to justify utilization as a first line agent or attempt treatment with an artificial tear, gel or ointment	<b>QUANTITY LIMIT:</b> Restasis, Xiidra: <ul style="list-style-type: none"> <li>➤ 60 vials dispensed as a 30-day supply;</li> </ul> Restasis Multidose: <ul style="list-style-type: none"> <li>➤ 5.5 mL dispensed as a 25-day supply</li> </ul>	
Cystic fibrosis agents <ul style="list-style-type: none"> <li>➤ ivacaftor (Kalydeco™)</li> <li>➤ ivacaftor / lumacaftor (Orkambi™)</li> </ul>			<ul style="list-style-type: none"> <li>➤ Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>➤ Genetic testing required to verify appropriate mutations</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Dextromethorphan / quinidine (Nuedexta®)		<b>QUANTITY LIMIT:</b> ➤ Two (2) capsules per day; 60 units per 30 days <b>DURATION LIMIT:</b> ➤ 90 days of therapy	For patients ≥ 18 years of age: Confirm diagnosis of FDA-approved or compendia-supported indication
Diabetic Test Strips		<b>QUANTITY LIMIT:</b> ➤ Type I DM – max 300 test strips per 30-day supply ➤ Type II DM – max 100 test strips per 30-day supply	Preferred diabetic supply program <a href="https://newyork.fhsc.com/providers/diabeticsupplies.asp">https://newyork.fhsc.com/providers/diabeticsupplies.asp</a>
Dronabinol (Marinol®, Syndros)	➤ Step therapy for beneficiaries with HIV/AIDS, or cancer, AND eating disorder: trial with megestrol acetate suspension prior to dronabinol ➤ Step therapy for beneficiaries with diagnosis of cancer and nausea/vomiting: trial with a NYS Medicaid-preferred 5-HT3 receptor antagonist prior to dronabinol		Confirm diagnosis of FDA-approved or compendia-supported indication
Fentanyl Transmucosal Agents ➤ Abstral® (sublingual tablet) ➤ Actiq® (lozenge) ➤ Fentora® (buccal tablet) ➤ Lazanda® (nasal spray) ➤ Onsolis® (buccal film) ➤ Subsys® (sublingual spray)		<b>QUANTITY LIMIT:</b> Abstral, Actiq, Fentora, Onsolis, and Subsys: ➤ 4 units per day, 120 units per 30 days Lazanda: ➤ 5 mL (1 bottle) per day, 150 mL (5 bottles) per 30 days <b>DURATION LIMIT:</b> ➤ 90 days ➤ 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 ➤ For opioid-naïve patients - limited to a 15 days' supply for all initial opioid prescriptions, exemption for diagnosis of cancer or sickle cell disease ➤ PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy ➤ PA is required for initiation of opioid therapy in patients currently on benzodiazepine therapy
Lipid Lowering Agents – Proprotein Convertase Subtilisin Kexin 9 (PCSK9) Inhibitors ➤ alirocumab (Praluent™) ➤ evolocumab (Repatha™)	Require trial of a HMG-CoA Reductase Inhibitors (Statin) at maximum tolerated dosage		Confirm diagnosis of FDA-approved or compendia-supported indication  Require concurrent statin therapy
Lipid Lowering Agents – Triglyceride transfer protein inhibitors: ➤ lomitapide (Juxtapid®) ➤ mipomersen (Kynamro®)	Requires trial with high intensity statin therapy		Confirm diagnosis of FDA-approved or compendia-supported indication

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Methadone		<p><b>QUANTITY LIMIT:</b></p> <ul style="list-style-type: none"> <li>➤ 12 units per day, 360 units per 30 days</li> <li>➤ Exemption for diagnosis of cancer or sickle cell disease</li> </ul>	<ul style="list-style-type: none"> <li>➤ Limited to a total of four (4) opioid prescriptions every 30 days; exemption for diagnosis of cancer or sickle cell disease</li> <li>➤ PA required for initiation of methadone for patients on established buprenorphine opioid dependence therapy</li> <li>➤ PA required for methadone prescriptions for patients currently on long-acting opioid therapy. Exemption for diagnosis of cancer or sickle cell disease</li> <li>➤ PA required for initiation of long-acting opioid therapy in opioid-naïve patients. Exemption for diagnosis of cancer or sickle cell disease</li> <li>➤ PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy</li> </ul>
Metozolv <sup>®</sup> ODT (metoclopramide)	Requires a trial with conventional metoclopramide before metoclopramide orally disintegrating tablet (ODT), except with diagnosis of diabetes mellitus	<p><b>QUANTITY LIMIT:</b></p> <ul style="list-style-type: none"> <li>➤ 4 units per day, 120 units per 30 days</li> </ul> <p><b>DURATION LIMIT:</b></p> <ul style="list-style-type: none"> <li>➤ 90 days</li> </ul>	
Mentreleptin (Myalept <sup>®</sup> )			Confirm diagnosis of FDA-approved or compendia-supported indication
Olanzapine / Fluoxetine (Symbyax <sup>®</sup> )	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 <sup>®</sup> , Oralair <sup>®</sup> , Ragwitek <sup>®</sup> )	Trial with a preferred intranasal corticosteroid		Confirm diagnosis for the FDA-approved indication of Pollen-induced allergic rhinitis confirmed by positive skin or in vitro testing for pollen-specific IgE antibodies
Pubertal Suppressants <ul style="list-style-type: none"> <li>➤ goserelin acetate</li> <li>➤ leuprolide acetate</li> <li>➤ nafarelin acetate</li> </ul>			<ul style="list-style-type: none"> <li>➤ Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul> Refer to the <a href="#">January 2017 Medicaid Update Article</a> for Transgender Related Care and Services Update

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Pulmonary Fibrosis Agents ➤ Ofev® ➤ Esbriet®			Confirm diagnosis of FDA-approved or compendia-supported indication
Pyrimethamine (Daraprim®)			Confirmation of FDA-approved or compendia-supported indications Require concurrent utilization of leucovorin
Quinine		<b>QUANTITY AND DURATION LIMITS:</b> ➤ Maximum 42 capsules as a 7-day supply ➤ limited to 1 prescription per year	
Rosacea Agents ➤ azelaic acid (Finacea®) ➤ brimonidine (Mirvaso®) ➤ ivermectin (Soolantra®) ➤ oxymetazoline HCL (Rhofade™) ➤ doxycycline (Oracea®)	Trial with topical metronidazole product.		Confirmation of FDA-approved or compendia-supported indication
Tasimelteon (Hetlioz®)		<b>QUANTITY LIMIT:</b> ➤ One unit per day; 30 units per 30 days	Confirm diagnosis of FDA-approved or compendia-supported indication
Parathyroid Hormone Analogs ➤ Forteo ➤ Tymlos	Requires a trial with a preferred oral bisphosphonate	<b>QUANTITY LIMIT:</b> ➤ One unit per 30-day period  <b>LIFETIME QUANTITY LIMIT:</b> ➤ 25 months' cumulative use of a PTH analog	
Vesicular monoamine transport 2 inhibitors ➤ Austedo® ➤ Xenazine® ➤ 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](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 20ml SQ	Pataday	Xeloda
Diastat	Protopic	Xenazine
Edecrin	Pulmicort Respules 1mg	Zyflo CR
Emend Tripack	Retin-A cream	
Exelon patch	<b>Reyataz capsules</b>	
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](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](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](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		
<b>CARDIOVASCULAR</b>			
<b>Angiotensin Receptor Blockers (ARBs)</b>			
Benicar 20mg	1 daily	Tablet	
Micardis 20mg, 40mg	1 daily	Tablet	
Diovan 40mg, 80mg, 160mg	1 daily	Tablet	
<b>ARBs/ Calcium Channel Blockers</b>			
Exforge 5–160mg	1 daily	Tablet	
<b>ARBs/ Diuretics</b>			
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	
<b>Beta Blockers</b>			
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	
<b>HMG Co A Reductase Inhibitors</b>			
Crestor 5mg, 10mg, 20mg	1 daily	Tablet	
<b>Niacin Derivatives</b>			
Niaspan 500mg	1 daily	Tablet	
<b>Anticonvulsants – Second Generation</b>			
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		
<b>CENTRAL NERVOUS SYSTEM</b>			
<b>Antiparkinson Agents</b>			
Azilect 0.5mg	1 daily	Tablet	
<b>Antipsychotics – Second Generation</b>			
Abilify 2mg	4 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.
Abilify 5mg, 10mg, 15mg	1 daily	Tablet	
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	
<b>CNS Stimulants</b>			
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	
Metadate 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	
<b>Non-Ergot Dopamine Receptor Agonists</b>			
Requip XL 2mg, 4mg, 6mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
<b>CENTRAL NERVOUS SYSTEM</b>			
<b>Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)</b>			
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	
<b>Sedative Hypnotics</b>			
Lunesta 1mg	1 daily	Tablet	
<b>Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)</b>			
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	
<b>Selective Serotonin Reuptake Inhibitors (SSRIs)</b>			
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	
<b>ENDOCRINE AND METABOLIC</b>			
<b>Dipeptidyl Peptidase-4 (DPP-4) Inhibitors</b>			
Januvia 25mg, 50mg	1 daily	Tablet	
Onglyza 2.5mg	1 daily	Tablet	
<b>Thiazolidinediones (TZDs)</b>			
Actos 15mg	1 daily	Tablet	
ACTOplus Met XR 15–1000mg	1 daily	Tablet	
<b>GASTROINTESTINAL</b>			
<b>Proton Pump Inhibitors</b>			
Dexilant 30mg	1 daily	Capsule	
Nexium 20mg	1 daily	Capsule	
Prevacid DR 15mg	1 daily	Capsule	

Brand Name	Dose Optimization Limitations		
<b>RENAL AND GENITOURINARY</b>			
<b>Urinary Tract Antispasmodics</b>			
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>.