Revised: May 17, 2018

New York State Medicaid Fee-For-Service Pharmacy Programs

OVERVIEW OF CONTENTS

For more information on the NYS Medicaid Pharmacy Programs: http://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm
To contact the NYS Medicaid Pharmacy Clinical Call Center please call 1-877-309-9493
To download a copy of the Prior Authorization fax form go to https://newyork.fhsc.com/providers/PA_forms.asp

NYS Medicaid Fee-For-Service Preferred Drug List

PREFERRED DRUG LIST – TABLE OF CONTENTS

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. ANALGESICS		
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Prescription		
diclofenac sodium XR ibuprofen indomethacin ketorolac meloxicam (tablet) naproxen naproxen EC piroxicam sulindac Voltaren® Gel	Anaprox® DS Arthrotec® Cambia® Celebrex® CC celecoxib CC Daypro® diclofenac / misoprostol diclofenac potassium diclofenac sodium diclofenac topical gel diclofenac topical soln diflunisal Duexis® etodolac etodolac ER Feldene® fenoprofen Flector® patch flurbiprofen Indocin® indomethacin SR ketoprofen ketoprofen SA meclofenamate mefenamic acid meloxicam (susp.) Mobic® nabumetone Nalfon® Naprelan® Naprosyn® Naprosyn® EC naproxen CR naproxen sodium oxaprozin Pennsaid® Tivorbex® tolmetin Vimovo® Vivlodex™ Zipsor® Zorvolex®	**CLINICAL CRITERIA (CC)** ➢ Celebrex® (celecoxib) – one of the following criteria will not require PA ▪ Over the age of 65 years ▪ Concurrent use of an anticoagulant agent ▪ History of GI Bleed/Ulcer or Peptic Ulcer Disease
Opioid Antagonists		
naloxone (syringe, vial) naltrexone Narcan® (nasal spray)		
Opioid Dependence Agents CC, F/Q/D		
buprenorphine Suboxone® (film)	Bunavail® buprenorphine/ naloxone (tablet) Zubsolv®	**CLINICAL CRITERIA (CC)** ➢ PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy **QUANTITY LIMIT:** ➢ Buprenorphine sublingual (SL): Six (6) tablets dispensed as a 2-day supply; not to exceed 24 mg per day ➢ Buprenorphine/ naloxone tablet and film (Bunavail™, Suboxone®, Zubsolv®): Three (3) sublingual tablets or films per day; maximum of 90 tablets or films dispensed as a 30-day supply, not to exceed 24 mg-6 mg of Suboxone, or its equivalent per day

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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

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Tetracyclines		
demeclocycline doxycycline hyclate minocycline (capsule) Morgidox® (capsule) tetracycline	Doryx® ST, F/Q/D Doryx MPC® ST, F/Q/D doxycycline hyclate DR ST, F/Q/D doxycycline monohydrate doxycycline monohydrate IR-DR minocycline (tablet) minocycline ER Oracea® Solodyn® Vibramycin® Ximino™ ER	**STEP THERAPY (ST)** ➢ Trial of doxycycline IR before progressing to doxycycline DR **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ doxycycline DR (Doryx®): ▪ Maximum 28 tablets/capsules per fill
III. CARDIOVASCULAR		
Angiotensin Converting Enzyme Inhibitors (ACEIs)		
benazepril enalapril lisinopril ramipril	Accupril® Altace® captopril Epaned™ fosinopril Lotensin® moexipril perindopril Prinivil® Qbrelis™ quinapril trandolapril Vasotec® Zestril®	
ACE Inhibitor Combinations		
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®	

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

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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HMG-CoA Reductase Inhibitors (Statins)		
atorvastatin lovastatin pravastatin rosuvastatin simvastatin	Altoprev® atorvastatin/amlodipine Caduet® Crestor® DO ezetimibe/simvastatin fluvastatin fluvastatin ER Lescol XL® Lipitor® Livalo® Pravachol® Vytorin® Zocor®	**DOSE OPTIMIZATION (DO)** ➢ See *Dose Optimization Chart* for affected drugs and strengths
Niacin Derivatives		
niacin ER	Niaspan® DO	**DOSE OPTIMIZATION (DO)** ➢ See *Dose Optimization Chart* for affected drugs and strengths
Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH CDRP		
Adcirca® sildenafil	Revatio®	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** ➢ All prescriptions for Adcirca®, Revatio®, and sildenafil 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 CDRP Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH Prescriber Worksheet provides step-by-step assistance in completing the prior authorization process
Pulmonary Arterial Hypertension (PAH) Oral Agents, Other		
Letairis® Orenitram® Tracleer®	Adempas® Opsumit® Tracleer® tabs for suspension Uptravi®	
Triglyceride Lowering Agents		
gemfibrozil fenofibrate (48 mg, 145 mg) fenofibric acid	Antara® fenofibrate Fenoglide® Fibricor® Lipofen® Lopid® Lovaza® ST, F/Q/D omega-3 ethyl ester ST, F/Q/D Tricor® Triglide® Trilipix® Vascepa® ST, F/Q/D	**STEP THERAPY (ST)** ➢ Lovaza® (omega-3-acid ethyl-esters) and Vascepa® (icosapent ethyl) – Trial of fibric acid derivative OR niacin prior to treatment with omega-3-acid ethyl-esters **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Lovaza® (omega-3-acid ethyl-esters) and Vascepa® (icosapent ethyl) – Required dosage equal to 4 (four) units per day

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

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

aripiprazole (Abilify®)	6 years
asenapine (Saphris®)	10 years
brexpiprazole (Rexulti®)	18 years
cariprazine (Vraylar™)	18 years
clozapine (Clozaril®, Fazaclo®, Versacloz™)	12 years
iloperidone (Fanapt®)	18 years
lurasidone HCl (Latuda®)	10 years
olanzapine (Zyprexa®)	10 years
paliperidone ER (Invega®)	12 years
pimavanserin (Nuplazid™)	18 years
quetiapine fum. (Seroquel®, Seroquel XR®)	10 years
risperidone (Risperdal®)	5 years
ziprasidone HCl (Geodon®)	18 years

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

STEP THERAPY (ST)

➢ For all Second Generation Antipsychotics used in the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is required

➢ Trial of risperidone prior to paliperidone (Invega®) therapy

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

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

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

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

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

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

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

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

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Antipsychotics, Injectable		
Abilify Maintena® Aristada™ fluphenazine decanoate Haldol® decanoate haloperidol decanoate Invega Sustenna® Invega Trinza® Risperdal Consta® Zyprexa Relprevv™	None	
Benzodiazepines – Rectal		
Diastat® 2.5 mg Diastat® AcuDial™	diazepam (rectal gel)	
Carbamazepine Derivatives CC		
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®	**CLINICAL CRITERIA (CC)** ➢ Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Selective Serotonin Reuptake Inhibitors (SSRIs)			
citalopram escitalopram (tablet) fluoxetine (capsule, solution) paroxetine sertraline	Brisdelle® Celexa® escitalopram (soln) fluoxetine (tablet) fluoxetine DR weekly fluvoxamine CC fluvoxamine ER CC Lexapro® DO paroxetine 7.5 mg	paroxetine CR Paxil® Paxil CR® Pexeva® Prozac® Sarafem® Trintellix™ DO Viibryd® DO Zoloft®	**DOSE OPTIMIZATION (DO)** ➢ See *Dose Optimization Chart* for affected strengths **CLINICAL CRITERIA (CC)** ➢ Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA ➢ Clinical editing to allow patients with a diagnosis of Obsessive Compulsive Disorder (OCD) to receive fluvoxamine and fluvoxamine ER without prior authorization
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)ST			
duloxetine 20 mg, 30 mg, 60 mg (generic for Cymbalta®) venlafaxine venlafaxine ER DO (capsule)	Cymbalta® desvenlafaxine base ER desvenlafaxine fumarate ER desvenlafaxine succinate ER DO duloxetine 40 mg Effexor XR® DO Fetzima® Khedezla™ Pristiq® DO Savella® venlafaxine ER (tablet)		**DOSE OPTIMIZATION (DO)** ➢ See *Dose Optimization Chart* for affected strengths **STEP THERAPY (ST)** ➢ Trial of an SSRI prior to an SNRI* *Step therapy is not required for the following indications: ▪ Chronic musculoskeletal pain (CMP) ▪ Fibromyalgia (FM) ▪ Diabetic peripheral neuropathy (DPN)* ❖ *duloxetine (Cymbalta®) – Requires a trial with a tricyclic antidepressant **OR** gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN)

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Serotonin Receptor Agonists (Triptans)		
rizatriptan F/Q/D sumatriptan F/Q/D	almotriptan F/Q/D Amerge® F/Q/D Axert® F/Q/D eletriptan F/Q/D Frova® F/Q/D frovatriptan F/Q/D Imitrex® F/Q/D Maxalt® F/Q/D Maxalt® MLT F/Q/D naratriptan F/Q/D Onzetra Xsail™ F/Q/D Relpax® F/Q/D sumatriptan-naproxen F/Q/D Treximet® F/Q/D Zembrace SymTouch™ zolmitriptan F/Q/D Zomig® F/Q/D Zomig® ZMT F/Q/D	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** almotriptan; Amerge®; Axert® 6.25 mg; Frova®; frovatriptan; Imitrex® Nasal Spray; Imitrex® tablets; naratriptan; Relpax® 20 mg; sumatriptan nasal spray; sumatriptan tablets; Treximet® and generic; zolmitriptan (tablet, ODT) 2.5 mg; zolmitriptan (tablet, ODT) 5 mg; Zomig/Zomig® ZMT 2.5 mg; Zomig® /Zomig® ZMT 5 mg; Zomig® Nasal Spray — 18 units every 30 days Axert® 12.5 mg; Maxalt® /Maxalt MLT®; Relpax® 40 mg; rizatriptan (tablet, ODT) — 24 tablets every 30 days Onzetra Xsail™ — 16 units (1 kit) every 30 days

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VII. GASTROINTESTINAL		
Anti-Emetics		
aprepitant pack Diclegis® CC 1 ondansetron (ODT, solution, tablet)	Akynzeo® 2 Anzemet® aprepitant (capsule) 2 Bonjesta® CC Emend® (capsule2, powder packet2, TriPack) granisetron (tablet) Sancuso® Varubi® 2 Zofran® (ODT, solution, tablet) Zuplenz®	**CLINICAL CRITERIA (CC)** ➢ Diclegis®/Bonjesta®: Confirm diagnosis of FDA-approved or compendia-supported indication
Gastrointestinal Antibiotics		
metronidazole (tablet) neomycin vancomycin	Alinia® Dificid® Flagyl® metronidazole (capsule) paromomycin Tindamax® tinidazole Vancocin® Xifaxan® CC, ST, F/Q/D	**CLINICAL CRITERIA (CC)** ➢ Xifaxan®: Confirm diagnosis of FDA-approved or compendia-supported indication **STEP THERAPY (ST)** ➢ Xifaxan®: Requires trial of a preferred fluoroquinolone antibiotic before rifaximin for treatment of Traveler's diarrhea **QUANTITY LIMITS:** ➢ Xifaxan®: ▪ Traveler's diarrhea (200 mg tablet) – 9 (nine) tablets per 30 days (Dose = 200 mg three times a day for three days) ▪ Hepatic encephalopathy (550 mg tablets) – 60 tablets per 30 days (Dose = 550 mg twice a day) ▪ Irritable bowel syndrome with diarrhea (550 mg tablets) – 42 tablets per 30 days (Dose = 550 mg three times a day for 14 days) ❖ Maximum of 42 days' supply (126 units) per 365 (three rounds of therapy).
Gastrointestinal Preparatory Agents		
Clearlax® Gavilax® Gavilyte®-C Gavilyte®-G Glycolax® Miralax® OTC PEG 3350 powder OTC PEG 3350/ electrolytes solution Rx	Clenpiq™ Colyte® Gavilyte®-N Golytely® Moviprep® Nulytely® Osmoprep® PEG 3350 powder pack OTC PEG 3350 with flavor packs Prepopik® Suprep® Trilyte®	
Helicobacter pylori Agents		
lansoprazole / amoxicillin / clarithromycin	Omeclamox-Pak®	

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Beta Blockers – Ophthalmic		
betaxolol Betoptic S® carteolol Combigan® Istalol® levobunolol timolol maleate (gel, solution)	Betagan® Timoptic® Timoptic® in Ocudose® Timoptic-XE®	
Fluoroquinolones – Ophthalmic ST		
ciprofloxacin ofloxacin Vigamox®	Besivance® Ciloxan® gatifloxacin levofloxacin Moxeza® moxifloxacin Ocuflox® Zymaxid®	**STEP THERAPY (ST)** ➢ 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 ▪ AK-Poly-Bac eye ointment ▪ bacitracin-polymyxin eye ointment ▪ erythromycin eye ointment ▪ Gentak (3 mg/gm eye ointment, 3 mg/mL eye drops) ▪ gentamicin (3 mg/gm eye ointment, 3 mg/mL eye drops) ▪ neomycin-polymyxin-gramicidin eye drops ▪ polymyxin B-TMP eye drops ▪ Romycin eye ointment ▪ sulfacetamide 10% eye drops ▪ Sulfamide 10% eye drops ▪ tobramycin 0.3% eye drops ▪ Tobrasol 0.3% eye drops
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Ophthalmic		
diclofenac flurbiprofen Ilevro® [1] ketorolac	Acular® Acular LS® Acuvail® bromfenac BromSite™ Nevanac® Prolensa®	
Prostaglandin Agonists – Ophthalmic		
latanoprost	bimatoprost Lumigan® Travatan Z® travoprost Xalatan® Vyzulta™ Zioptan®	

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Xanthine Oxidase Inhibitors		
allopurinol	Duzallo® Uloric® Zyloprim®	
XV. RESPIRATORY		
Anticholinergics / COPD Agents		
Atrovent HFA® Combivent Respimat® ipratropium ipratropium / albuterol Spiriva® Stiolto Respimat®	Anoro Ellipta® Bevespi Aerosphere™ Daliresp® Incruse Ellipta® Lonhala™ Magnair™ Seebri Neohaler® Spiriva Respimat® Trelegy Ellipta® Tudorza Pressair® Utibron Neohaler®	
Antihistamines – Intranasal		
azelastine olopatadine	Astepro® Patanase®	
Antihistamines – Second Generation		
cetirizine OTC (tablet) cetirizine OTC (syrup/solution 1 mg/1 mL) fexofenadine OTC (suspension) levocetirizine (tablet) loratadine OTC	cetirizine OTC (chewable) cetirizine OTC (syrup/solution 5 mg/5 mL) cetirizine-D OTC Clarinex® CC Clarinex-D® OTC desloratadine fexofenadine OTC (tablet) levocetirizine (solution) loratadine-D OTC Semprex-D Xyzal® OTC CC	**CLINICAL CRITERIA (CC)** ➢ No prior authorization required for patients less than 24 months of age
Beta$_2$ Adrenergic Agents – Inhaled Long-Acting CC, F/Q/D		
Perforomist® Serevent Diskus®	Arcapta Neohaler® Brovana® Striverdi Respimat®	**CLINICAL CRITERIA (CC)** PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA- or compendia-supported age as indicated: Arcapta Neohaler® ≥18 years Brovana® ≥18 years Perforomist® ≥18 years Serevent Diskus® ≥4 years Striverdi Respimat® ≥18 years **FREQUENCY/QUANTITY/DURATION (F/Q/D)** **Maximum units per 30 days** Arcapta Neohaler® 30 units (1 box of 30 unit dose capsules) Brovana® 60 units (1 carton of 60 vials or 120 mL) Perforomist® 60 units (1 carton of 60 vials or 120 mL) Serevent Diskus® 1 diskus (60 blisters) Striverdi Respimat® 1 unit (one cartridge and one Respimat inhaler)

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NYS Medicaid Fee-For-Service Preferred Drug List

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

Aerospan® 80 mcg	2 inhalers every 30 days
Alvesco® 80 mcg	1 inhaler every 30 days
Alvesco® 160 mcg	1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use.
ArmonAir™ RespiClick® 55 mcg, 113 mcg	1 inhaler every do days
ArmonAir™ RespiClick® 232 mcg	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® 50 mcg, 100 mcg	1 diskus every 30 days
Flovent Diskus® 250 mcg	1 diskus every 15 days. Up to 1 diskus every 7 days with previous oral corticosteroid use.
Flovent HFA® 44 mcg, 110 mcg	1 inhaler every 30 days
Flovent HFA® 220 mcg	1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use.
Pulmicort 90 mcg	1 inhaler every 30 days
Pulmicort 180 mcg	1 inhaler every 15 days
QVAR® 40 mcg	1 inhaler every 25 days
QVAR® 80 mcg	1 inhaler every 12 days
QVAR® Redihaler™ 40 mcg	1 inhaler every 30 days
QVAR® Redihaler™ 80 mcg	1 inhaler every 15 days

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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New York State Medicaid Fee-For-Service Pharmacy Programs

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

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

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

Prior Authorization

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

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

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

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

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

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

For more information on the NYS Medicaid Pharmacy Programs: http://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm
To contact the NYS Medicaid Pharmacy Clinical Call Center please call 1-877-309-9493
To download a copy of the Prior Authorization fax form go to https://newyork.fhsc.com/providers/PA_forms.asp

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

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

For additional Step Therapy and Frequency/Quantity/Duration parameters for drugs and drug classes that are also included on the Preferred Drug List (PDL), please see pages 3 through 40.

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

FDA Indication	First line Therapy
Multiple Sclerosis (MS) exacerbations	Corticosteroid or plasmapheresis
Polymyositis/ dermatomyositis	Corticosteroid
Idiopathic nephrotic syndrome	ACE Inhibitor, diuretic, corticosteroid (and for refractory patients: an immunosuppressive)
Systemic lupus erythematosus (SLE)	Corticosteroid, antimalarial, or cytotoxic/immunosuppressive agent
Nephrotic syndrome due to SLE	Immunosuppressive, corticosteroid, or ACE Inhibitor
Rheumatic disorders (specifically: psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis)	Corticosteroid, topical retinoid, biologic disease-modifying antirheumatic drugs (DMARD), non-biologic DMARD, or a non-steroidal anti-inflammatory drug (NSAID)
Dermatologic diseases (specifically Stevens-Johnson syndrome and erythema multiforme)	Corticosteroid or analgesic
Allergic states (specifically serum sickness)	Topical or oral corticosteroid, antihistamine, or NSAID
Ophthalmic diseases (keratitis, iritis, iridocyclitis, diffuse posterior uveitis/choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation)	Analgesic, anti-infective agent, and agents to reduce inflammation, such as NSAIDs and steroids
Respiratory diseases (systemic sarcoidosis)	Oral corticosteroid or an immunosuppressive.

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Amoxicillin ER (Moxatag®)	Prescribers should attempt treatment with an immediate-release amoxicillin first before progressing to extended-release amoxicillin	**QUANTITY LIMIT:** ➢ Equal to 10 tablets per fill	
Anabolic Steroids – Injectable ➢ Depo-Testosterone® ➢ testosterone cypionate* ➢ testosterone enanthate *for additional parameters, see *Cross-Sex Hormones* section below. Anabolic Steroids – Oral ➢ Anadrol-50® ➢ Android® ➢ Androxy™ ➢ Methitest® ➢ Oxandrin® ➢ oxandrolone ➢ Testred®		Limitations for anabolic steroid products is based on approved FDA labeled daily dosing and documented diagnosis not to exceed a 90-day supply (30-day supply for oxandrolone): ➢ Initial duration limit of 3 months (for all products except oxandrolone), requiring documented follow-up monitoring for response and/or adverse effects before continuing treatment ➢ Duration limit of 6 months for delayed puberty ➢ Duration limit of 1 month for all uses of oxandrolone products	
Anti-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) ▪ terbinafine (Lamisil®) tablets; griseofulvin (Gris PEG®) oral suspension, ultramicronized tablets micronized tablets; itraconazole (Sporanox®, Onmel™) tablets, oral solution ➢ Trial with ciclopirox 8% solution prior to the use of other topical antifungals [efinaconazole (Jublia) or tavaborole (Kerydin)]		
Anti-Retroviral (ARV) Interventions		**QUANTITY LIMITS:** ➢ Limit ARV active ingredient duplication ➢ Limit ARV utilization to a maximum of five products concurrently - excluding boosting with ritonavir (dose limit 600 mg or less) or cobicistat ➢ Limit Protease Inhibitor utilization to a maximum of two products concurrently ➢ Limit Integrase inhibitor utilization to a maximum of one product concurrently	➢ Require confirmation of FDA-approved or compendia-supported use ➢ Point of service edit for contraindicated antiretroviral / non-antiretroviral combinations ➢ Point of service edit for contraindicated antiretroviral / antiretroviral combinations
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	**QUANTITY LIMITS:** Crisaborole (Eucrisa) ➢ 100 gm/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®)		**QUANTITY LIMIT:** ➢ 2 (two) 15 gram tubes in a lifetime	

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

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Dextromethorphan / quinidine (Nuedexta®)		**QUANTITY LIMIT:** ➢ Two (2) capsules per day; 60 units per 30 days **DURATION LIMIT:** ➢ 90 days of therapy	For patients ≥ 18 years of age: Confirm diagnosis of FDA-approved or compendia-supported indication
Diabetic Test Strips		**QUANTITY LIMIT:** ➢ 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 https://newyork.fhsc.com/providers/diabeticsupplies.asp
Dronabinol (Marinol®, Syndros)	➢ Step therapy for beneficiaries with HIV/AIDS, or cancer, AND eating disorder: trial with megestrol acetate suspension prior to dronabinol ➢ 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) ➢ Subsys® (sublingual spray)		**QUANTITY LIMIT:** Abstral, Actiq, Fentora 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 **DURATION LIMIT:** ➢ 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	Requires a trial of a long-acting opioid prior to initiation for the management of chronic non-cancer pain	**QUANTITY LIMIT:** ➢ 12 units per day, 360 units per 30 days ➢ Exemption for diagnosis of cancer or sickle cell disease	➢ Confirm diagnosis of chronic non-cancer pain ➢ Limited to a total of four (4) opioid prescriptions every 30 days; exemption for diagnosis of cancer or sickle cell disease ➢ PA required for initiation of methadone for patients on established opioid dependence therapy ➢ PA required for methadone prescriptions for patients currently on long-acting opioid therapy. Exemption for diagnosis of cancer or sickle cell disease ➢ PA required for initiation of long-acting opioid therapy in opioid-naïve patients. Exemption for diagnosis of cancer or sickle cell disease ➢ PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy
Metozolv® ODT (metoclopramide)	Requires a trial with conventional metoclopramide before metoclopramide orally disintegrating tablet (ODT), except with diagnosis of diabetes mellitus	**QUANTITY LIMIT:** ➢ 4 units per day, 120 units per 30 days **DURATION LIMIT:** ➢ 90 days	
Metreleptin (Myalept®)			Confirm diagnosis of FDA-approved or compendia-supported indication
Olanzapine / Fluoxetine (Symbyax®)	When prescribing for the treatment of major depressive disorder (MDD) in the absence of other psychiatric comorbidities, trial with at least one different antidepressant agent is required		PA is required for the initial prescription for beneficiaries younger than 18 years
Oral Pollen/Allergen Extracts (Grastek®, Oralair®, Ragwitek®)	Trial with a preferred intranasal corticosteroid		Confirm diagnosis for the FDA-approved indication of Pollen-induced allergic rhinitis confirmed by positive skin or in vitro testing for pollen-specific IgE antibodies
Pubertal Suppressants ➢ goserelin acetate ➢ leuprolide acetate ➢ nafarelin acetate			➢ Confirm diagnosis of FDA-approved or compendia-supported indication Refer to the January 2017 Medicaid Update Article for Transgender Related Care and Services Update

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Pulmonary Fibrosis Agents ➢ Ofev® ➢ Esbriet®			Confirm diagnosis of FDA-approved or compendia-supported indication
Pyrimethamine (Daraprim®)			Confirmation of FDA-approved or compendia-supported indications Require concurrent utilization of leucovorin
Quinine		**QUANTITY AND DURATION LIMITS:** ➢ Maximum 42 capsules as a 7-day supply ➢ limited to 1 prescription per year	
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®)		**QUANTITY LIMIT:** ➢ 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	**QUANTITY LIMIT:** ➢ One unit per 30-day period **LIFETIME QUANTITY LIMIT:** ➢ 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.

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 May 17, 2018:

- Norvir tablets and Sustiva tablets will be **added** to the program
- Emend TriPack and Edecrin will be **removed** from the program

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

***List is subject to change*

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

IMPORTANT BILLING INFORMATION

Prescription claims submitted to the Medicaid program **DO NOT require** the submission of Dispense As Written/Product Selection Code of '1':

- Pharmacies can submit any valid NCPDP field (408-D8) value https://www.emedny.org/HIPAA/5010/transactions/NCPDP_D.0_Companion_Guide.pdf
- For more information on the Brand Less Than Generic (BLTG) Program, please refer to https://newyork.fhsc.com/providers/bltgp_about.asp

NYS Medicaid Fee-For-Service Mandatory Generic Drug Program

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

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

Prior Authorization Process

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

Exempt Drugs

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

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

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

NYS Medicaid Fee-For-Service Dose Optimization Program

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

Dose Optimization Chart

Brand Name	Dose Optimization Limitations		
CARDIOVASCULAR			
Angiotensin Receptor Blockers (ARBs)			
Benicar 20 mg	1 daily	Tablet	
Micardis 20 mg, 40 mg	1 daily	Tablet	
Diovan 40 mg, 80 mg, 160 mg	1 daily	Tablet	
ARBs/ Calcium Channel Blockers			
Exforge 5–160 mg	1 daily	Tablet	
ARBs/ Diuretics			
Benicar HCT 20–12.5 mg	1 daily	Tablet	
Diovan HCT 80–12.5 mg, 160–12.5 mg	1 daily	Tablet	
Edarbyclor 40–12.5 mg	1 daily	Tablet	
Micardis HCT 40–12.5 mg, 80–12.5 mg	1 daily	Tablet	
Beta Blockers			
Bystolic 2.5 mg, 5 mg, 10 mg	1 daily	Tablet	
Coreg CR 20 mg,40 mg	1 daily	Tablet	
nadolol 40 mg	1 daily	Tablet	
Toprol XL 25 mg, 50 mg, 100 mg	1 daily	Tablet	
HMG Co A Reductase Inhibitors			
Crestor 5 mg, 1 0mg, 20 mg	1 daily	Tablet	
Niacin Derivatives			
Niaspan 500 mg	1 daily	Tablet	
Anticonvulsants – Second Generation			
Lyrica 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg	3 daily	Capsule	Electronic bypass for diagnosis of seizure disorder identified in medical claims data.
Lyrica 225 mg and 300 mg	2 daily	Capsule	

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

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)			
guanfacine ER 1 mg, 2 mg, 3 mg, 4 mg	1 daily	Tablet	
atomoxetine 40 mg	1 daily	Capsule	
Intuniv 1 mg, 2 mg	1 daily	Tablet	
Strattera 40 mg	1 daily	Capsule	
Sedative Hypnotics			
Lunesta 1 mg	1 daily	Tablet	
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)			
Effexor XR 37.5 mg, 75 mg	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 50 mg	1 daily	Tablet	
Trintellix 5 mg, 10 mg	1 daily	Tablet	
venlafaxine ER 37.5 mg, 75 mg	1 daily	Capsule	
Selective Serotonin Reuptake Inhibitors (SSRIs)			
Lexapro 5 mg, 10 mg	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 10 mg, 20 mg	1 daily	Tablet	
ENDOCRINE AND METABOLIC			
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors			
Januvia 25 mg, 50 mg	1 daily	Tablet	
Onglyza 2.5 mg	1 daily	Tablet	
Thiazolidinediones (TZDs)			
Actos 15 mg	1 daily	Tablet	
ACTOplus Met XR 15–1000 mg	1 daily	Tablet	
GASTROINTESTINAL			
Proton Pump Inhibitors			
Dexilant 30 mg	1 daily	Capsule	
Nexium 20 mg	1 daily	Capsule	
Prevacid DR 15 mg	1 daily	Capsule	

Brand Name	Dose Optimization Limitations		
RENAL AND GENITOURINARY			
Urinary Tract Antispasmodics			
Detrol LA 2 mg	1 daily	Capsule	
Enablex 7.5 mg	1 daily	Tablet	
Myrbetriq 25 mg	1 daily	Tablet	
oxybutynin chloride ER 5 mg	1 daily	Tablet	
Toviaz ER 4 mg	1 daily	Tablet	
Vesicare 5 mg	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.