Revised: January 13, 2022

New York State Medicaid Fee-For-Service Pharmacy Programs

OVERVIEW OF CONTENTS

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)		
diclofenac 1% topical gel diclofenac sodium ibuprofen Rx (tablet) ibuprofen OTC (susp) indomethacin ketorolac meloxicam (tablet) naproxen (tablet) piroxicam sulindac	Arthrotec® Cambia® Celebrex® CC celecoxib CC Daypro® diclofenac epolamine (generic for Flector) diclofenac/misoprostol diclofenac potassium diclofenac sodium ER diclofenac topical soln diflunisal Duexis® etodolac etodolac ER Feldene® fenoprofen Flector® patch Flurbiprofen ibuprofen Rx (susp) ibuprofen/famotidine (gen Duexis®) Indocin® indomethacin ER ketoprofen ketoprofen ER ketorolac nasal spray (gen Sprix®) Licart™ meclofenamate mefenamic acid meloxicam (capsules) (gen Vivlodex®) Mobic® nabumetone	**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

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
	Nalfon® Naprelan® naproxen (susp) naproxen CR naproxen EC naproxen-esomeprazole naproxen sodium oxaprozin Pennsaid® Relafen® DS Sprix® Tivorbex® tolmetin Vimovo® Vivlodex® Voltaren® Gel Zipsor® Zorvolex®	
Opioids – Long-Acting CC, F/Q/D		
buprenorphine patches fentanyl patch (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg) morphine sulfate ER (tablet)	Arymo® ER Belbuca® Butrans® ConZip® ST Duragesic® fentanyl patch (37.5 mcg, 62.5 mcg, 87.5 mcg) hydrocodone ER hydrocodone ER (gen Hysingla ER) hydromorphone ER Hysingla® ER Kadian® MorphaBond® ER	**CLINICAL CRITERIA (CC) *** • Limited to a total of 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 use if ≥ 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting > 7 days) • PA required for initiation of long-acting opioid therapy in opioid-naïve patients. • PA required for any additional long-acting opioid prescription for patients currently on long-acting opioid therapy.

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
	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	• PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy • PA required for any codeine- or tramadol-containing products in pts < 12 yrs **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) *** • Belbuca® (buprenorphine) – Maximum 2 units per day • Butrans® (buprenorphine) – Maximum 4 patches per 28 days • Nucynta® ER (tapentadol ER): – Maximum 2 units per day • Nucynta® ER (tapentadol ER): – Maximum daily dose of tapentadol IR and tapentadol ER formulations if used in combination should not exceed 500mg/day • Tramadol ER (ConZip®): – Maximum 30 tablets dispensed as a 30-day supply • Zohydro® ER (hydrocodone ER): – Maximum 2 units per day, 60 units per 30 days • Hysingla® ER (hydrocodone ER): – Maximum 1 unit per day; 30 units per 30 days • Hydromorphone ER, oxymorphone ER: – Maximum 4 units per day, 120 units per 30 days • Oxycodone ER (Xtampza® ER): – Maximum 2 units per day, 60 units per 30 days. Not to exceed a total daily dose of 160 mg or its equivalent

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
		• Fentanyl transdermal patch (Duragesic®): – Maximum 10 patches per 30 days; maximum 100 mcg/hr (over a 72-hour dosing interval) • Morphine ER (excluding MS Contin products): – Maximum 2 units per day, 60 units per 30 days • Morphine ER (MS Contin® and Arymo® ER 15 mg, 30 mg, 60 mg only): – Maximum 3 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 • For Non-opioid Pain management alternatives please visit: https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf *The quantity limits listed are systematically converted into Morphine Milligram Equivalents (MME) for the purpose of prospective drug utilization review/clinical editing.* *Exemption from requirements for diagnosis of cancer, sickle cell disease, or hospice care.
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 tramadol F/Q/D	Apadaz® F/Q/D benzhydrocodone / APAP F/Q/D butalbital compound/ codeine F/Q/D butorphanol nasal spray dihydrocodeine / APAP / caffeine F/Q/D Dilaudid® F/Q/D Fiorinal® / codeine F/Q/D hydromorphone F/Q/D levorphanol meperidine Nalocet®	**CLINICAL CRITERIA (CC) *** • Limited to a total of 4 opioid prescriptions every 30 days. • Initial prescription for opioid-naïve patients limited to a 7-day supply. • PA required for initiation of opioid therapy for patients on established opioid dependence therapy. • PA required for use if ≥ 90 MME of opioid per day for management of non-acute pain (> 7 days) – Exception for diagnosis of cancer or sickle cell disease, or hospice program

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
	Nucynta® ST, F/Q/D Oxaydo® 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 Prolate® Qdolo® F/Q/D Roxicodone® F/Q/D tramadol / APAP F/Q/D Ultracet® F/Q/D Ultram®	• PA is required for opioid-naïve patients for prescription requests ≥ 50 MME per day. • PA required for continuation of opioid therapy beyond an initial 7-day supply in patients established on gabapentin or pregabalin • PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy • PA required for any codeine- or tramadol-containing products in pts < 12 yrs **STEP THERAPY (ST)** • **Nucynta® (tapentadol IR)** – Trial with tramadol and 1 preferred opioid before tapentadol immediate-release (IR) **FREQUENCY/QUANTITY/DURATION (F/Q/D)** **Quantity Limits:** • Apadaz® (benzhydrocodone/APAP): – Maximum 12 units per day • Nucynta® (tapentadol IR): – Maximum 6 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 • tramadol – Maximum 400 mg per day • **Morphine and congeners immediate-release (IR)** non-combination products (codeine, hydromorphone, morphine, oxycodone, oxymorphone): – Maximum 6 units per day, 180 units per 30 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)

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
		– 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. • For Non-opioid Pain management alternatives please visit: https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf The quantity limits listed are systematically converted into morphine milligram equivalents (MME) for the purpose of prospective drug utilization review/clinical editing. *Exemptions from requirements for diagnosis of cancer, sickle cell disease, or hospice care

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® BLTG Cayston® Kitabis® Pak BLTG TOBI Podhaler™	TOBI® (solution) tobramycin (generic for Bethkis®, Kitabis®, Tobi®) solution	**CLINICAL CRITERIA (CC)** Confirm diagnosis of FDA-approved or compendia-supported indication **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Aztreonam (Cayston) – 3 ampules (3 mL) per day – 84 ampules (84 mL) per 56 day regimen (28 days on, 28 days off) • Tobramycin inhalation solution (Bethkis, TOBI, Kitabis Pak) – 2 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 and ultramicronized) terbinafine (tablet)	griseofulvin (tablet) itraconazole itraconazole solution (generic for Sporanox) Sporanox®	
Anti-Virals – Oral		
acyclovir valacyclovir	famciclovir Valtrex® Zovirax®	
Cephalosporins – Third Generation		
cefdinir	cefixime cefpodoxime Suprax®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
II. Anti-Infectives		
Fluoroquinolones – Oral		
ciprofloxacin (suspension, tablet) levofloxacin (tablet)	Baxdela® Cipro® (suspension, tablet) levofloxacin (solution) moxifloxacin ofloxacin (tablet)	
Hepatitis B Agents		
adefovir dipivoxil Baraclude® (solution) entecavir Epivir-HBV® (solution) lamivudine HBV	Baraclude® (tablet) Epivir-HBV® (tablet) Hepsera® Vemlidy®	
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

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
II. Anti-Infectives		
Hepatitis C Agents – Direct Acting Antivirals		
Mavyret™ CC, F/Q/D ribavirin sofosbuvir/velpatasvir (generic for Epclusa®) CC, F/Q/D Vosevi® CC, F/Q/D	Epclusa® CC, F/Q/D Harvoni® CC, F/Q/D ledipasvir/sofosbuvir (generic for Harvoni®) CC, F/Q/D Sovaldi® CC, F/Q/D Viekira Pak® CC, F/Q/D Zepatier® CC, F/Q/D	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication • For patients being retreated 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: https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools OR https://prepc.org/. • The Hepatitis C Worksheet can be accessed at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_HepC.docx
Tetracyclines		
demeclocycline doxycycline hyclate minocycline (capsule) tetracycline	Doryx® ST, F/Q/D Doryx MPC® ST, F/Q/D doxycycline hyclate DR ST, F/Q/D doxycycline monohydrate minocycline (tablet) minocycline ER (gen Ximino®) Minolira ER™ Nuzyra™ Solodyn® Vibramycin® Ximino®	**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

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
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® Tarka® trandolapril/verapamil ER	Accuretic® fosinopril/ HCTZ Lotensin HCT® quinapril/ HCTZ Vaseretic® Zestoretic®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
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
Antianginals and Anti-Ischemics		
ranolazine	Ranexa®	
ARBs Combinations		
Entresto® Exforge HCT® losartan/ HCTZ valsartan/ amlodipine valsartan/ amlodipine / HCTZ valsartan/ HCTZ	Atacand HCT® Avalide® Azor® Benicar HCT® DO candesartan/ HCTZ Diovan HCT® DO Edarbyclor® DO Exforge® DO Hyzaar® irbesartan/ HCTZ Micardis HCT® DO olmesartan/ amlodipine olmesartan/ amlodipine/ HCTZ olmesartan/ HCTZ telmisartan/ amlodipine telmisartan/ HCTZ Tribenzor®	**DOSE OPTIMIZATION (DO)** • 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
III. Cardiovascular		
Beta Blockers		
atenolol carvedilol labetalol metoprolol succ. XL DO metoprolol tartrate propranolol (tablet)	acebutolol betaxolol bisoprolol Bystolic® DO carvedilol ER Coreg® Coreg CR® DO Corgard® Inderal LA® Inderal XL® InnoPran XL® Kapspargo™ Sprinkle Lopressor® nadolol DO nebivolol (generic Bystolic®) 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	metoprolol tartrate/ HCTZ nadolol/ bendroflumethiazide Tenoretic® Ziac®	**DOSE OPTIMIZATION (DO)** • 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
III. Cardiovascular		
Calcium Channel Blockers (Dihydropyridine)		
amlodipine felodipine ER isradipine nicardipine HCl nifedipine nifedipine ER/SA	Adalat® CC Katerzia™ nisoldipine Norvasc® Procardia® Procardia XL® Sular®	
Cholesterol Absorption Inhibitors		
cholestyramine cholestyramine light Colestid® (tablet) colestipol (tablet)	colesevelam Colestid (granules, packet) colestipol (granules, packet) ezetimibe Questran® Questran Light® Welchol® Zetia®	
Direct Renin Inhibitors ST		
aliskiren Tekturna® Tekturna HCT®	None	**STEP THERAPY (ST)** • 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
III. Cardiovascular		
HMG-CoA Reductase Inhibitors (Statins)		
atorvastatin lovastatin pravastatin rosuvastatin simvastatin	Altoprev® atorvastatin/amlodipine Caduet® Crestor® DO Ezallor™ Sprinkle ezetimibe/simvastatin fluvastatin fluvastatin ER Lescol XL® Lipitor® Livalo® Pravachol® Vytorin® Zocor® Zypitamag™	**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 CC		
sildenafil tadalafil	Revatio®	**CLINICAL CRITERIA** • All prescriptions for **Adcirca®**, **tadalafil, Revatio®**, and **sildenafil** must have PA • Prescribers or their authorized agents 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 11 refills

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Pulmonary Arterial Hypertension (PAH) Agents, Other – Oral		
ambrisentan (generic for Letairis) bosentan tablets (generic for Tracleer®)	Adempas® Letairis® Opsumit® Orenitram® ER Tracleer® tabs for suspension & tablets Uptravi®	
Triglyceride Lowering Agents		
gemfibrozil fenofibrate tablet (generic Tricor®) fenofibrate caps (generic Lofibra®) fenofibric acid (generic Trilipix®) omega-3 ethyl ester (generic Lovaza®) F/Q/D,	Antara® Fenoglide® icosapent (generic Vascepa®) F/Q/D Lipofen® Lopid® Lovaza® F/Q/D Tricor® Trilipix® Vascepa® F/Q/D	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Lovaza® (omega-3-acid ethyl-esters) and Vascepa® (icosapent ethyl) – Required dosage equal to 4 grams per day

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Alzheimer's Agents		
donepezil 5mg, 10mg Exelon® (patch) BLTG galantamine galantamine ER memantine Namenda® rivastigmine (capsule)	Aricept® donepezil 23 mg memantine ER CC, ST Namenda XR® CC, ST Namzaric® CC, ST Razadyne ER® rivastigmine (patch)	**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 – Carbamazepine Derivatives		
carbamazepine (chewable, tablet) carbamazepine ER (capsule) carbamazepine XR (tablet) Equetro® oxcarbazepine Tegretol® (suspension) BLTG	Aptiom® CC carbamazepine (suspension) CC Carbatrol® CC Oxtellar XR® CC Tegretol® (tablet) CC Tegretol XR® CC Trileptal® CC	**CLINICAL CRITERIA (CC)** • Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA
Anticonvulsants – Other		
clobazam (tablet) ST, CC gabapentin (capsule, solution, tablet) F/Q/D, CC lamotrigine (tablet, chew) levetiracetam levetiracetam ER Lyrica® (capsule) DO, ST, F/Q/D, CC pregabalin (capsule) DO, ST, F/Q/D, CC tiagabine topiramate CC zonisamide	Banzel® Briviact® clobazam (suspension) ST Diacomit® CC Elepsia® XR Epidiolex® CC felbamate Felbatol® Fintepla® Fycompa® Gabitril® Keppra®	**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 • **Cannabidiol extract (Epidiolex®)** – Confirm diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form • **Lyrica®/Lyrica® CR (pregabalin)** – PA required for the initiation of pregabalin at > 150 mg per day in patients currently on an opioid at > 50 MME per day

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
	Keppra XR® Lamictal® (tablet, chew, dosepak) Lamictal® ODT (tablet, dosepak) Lamictal® XR (tablet, dosepak) lamotrigine (dosepak) lamotrigine ER lamotrigine ODT (dosepak) Lyrica® (solution) DO, ST, F/Q/D Lyrica® CR ST, F/Q/D, CC Neurontin® F/Q/D, CC Onfi® ST, CC pregabalin (solution) DO, ST, F/Q/D, CC pregabalin ER (gen Lyrica® CR) ST, F/Q/D, CC rufinamide (gen Banzel®) Qudexy® XR CC Sabril® Spritam® Sympazan® film ST, CC Topamax® CC topiramate ER CC Trokendi XR® CC vigabatrin Vimpat® Xcopri®	• **Neurontin® (gabapentin) –** PA required for initiation of gabapentin at > 900 mg per day in patients currently on an opioid at > 50 MME per day • **Stiripentol (Diacomit®) –** Require diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form • **Topiramate IR/ER (Qudexy® XR, Topamax®, Trokendi XR™)** – Require confirmation of FDA-approved, compendia-supported, or Medicaid covered diagnosis • **Onfi®/Sympazan® (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)** • **Lyrica®/Lyrica® CR (pregabalin)** – Maximum daily dose of IR: 600 mg per day, and ER: 660 mg per day • **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®/Sympazan® (clobazam)** – Requires a trial with an SSRI or SNRI for treatment of anxiety

NYS Medicaid Fee-For-Service Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">IV. Central Nervous System</td></tr>
<tr><td colspan="3">Antimigraine Agents, Other ST, F/Q/D</td></tr>
<tr><td>Ajovy®
Emgality®</td><td>Aimovig®
Emgality® 100mg syringe</td><td>Trial of 2 FDA approved migraine prevention products prior to a calcitonin gene-related peptide (CGRP) receptor antagonist
FREQUENCY/QUANTITY/DURATION (F/Q/D)
• Erenumab (Aimovig®): Maximum of 1 prefilled autoinjector per 30 days
• Galcanezumab 100mg (Emgality®): Maximum of 3 prefilled syringes per 30 days, 120 mg: Maximum of 2 prefilled syringes/autoinjectors per 30 days
• Fremanezumab (Ajovy®): Maximum of 3 prefilled syringes per ninety (90) days</td></tr>
<tr><td colspan="3">Antimigraine Agents – Acute Treatment F/Q/D</td></tr>
<tr><td>rizatriptan
sumatriptan</td><td>almotriptan
Amerge®
eletriptan
Frova®
frovatriptan
Imitrex®
Maxalt®
Maxalt® MLT
naratriptan
Nurtec™ ODT
Onzetra™ Xsail™
Relpax®
Reyvow™
sumatriptan-naproxen
Tosymra™
Treximet®
Ubrelvy™
Zembrace™ SymTouch™
zolmitriptan
Zomig®
Zomig® ZMT</td><td>FREQUENCY/QUANTITY/DURATION (F/Q/D)
<table>
<tr><th>Agent</th><th>F/Q/D</th></tr>
<tr><td>Reyvow™ 50 mg, 100 mg</td><td>8 units / 30 days</td></tr>
<tr><td>Nurtec™ ODT 75 mg
Onzetra™ Xsail™ 11 mg
Ubrelvy™ 50 mg, 100 mg</td><td>16 units / 30 days</td></tr>
<tr><td>almotriptan
eletriptan (Relpax®) 20 mg
eletriptan (Relpax®) 40 mg
frovatriptan (Frova®) 2.5 mg
naratriptan (Amerge®) 1 mg, 2.5 mg
rizatriptan (Maxalt®) 5 mg, 10 mg tablets
rizatriptan (Maxalt® MLT) 5 mg, 10 mg ODT
sumatriptan nasal spray (Imitrex®) 5 mg, 20 mg
sumatriptan (Imitrex®) 25 mg, 50 mg, 100 mg tablets
sumatriptan-naproxen (Treximet®) 85–500 mg
Tosymra™ nasal spray 10 mg
zolmitriptan (Zomig®) 2.5 mg, 5 mg tablets,
zolmitriptan (Zomig® ZMT) 2.5 mg, 5 mg ODT
Zomig® nasal spray 2.5 mg, 5 mg</td><td>18 units / 30 days</td></tr>
</table></td></tr>
</table>

1 = Preferred as of 10/28/2021
2 = Non-Preferred as of 10/28/2021

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Antipsychotics – Injectable		
Abilify Maintena® Aristada® Aristada Initio® fluphenazine decanoate Haldol® decanoate haloperidol decanoate Invega Sustenna® Invega Trinza® Perseris™ 1 Risperdal Consta® Zyprexa Relprevv®	Invega Hafyera™ CC	**CLINICAL CRITERIA (CC)** paliperidone (Invega Hafyera™) – Requires a trial of either Invega Sustenna® in the last 4 months, or Invega Trinza® in the last 3 months. Minimum age is 18 years.
Antipsychotics – Second Generation CC, ST, F/Q/D		
aripiprazole (tablet) DO asenapine (gen Saphris®) clozapine Latuda® DO olanzapine (tablet) DO quetiapine F/Q/D quetiapine ER F/Q/D risperidone ziprasidone (capsules)	Abilify® (tablet) DO Abilify MyCite® aripiprazole (solution) aripiprazole ODT Caplyta™ clozapine ODT Clozaril® Fanapt® Geodon® Invega® DO, F/Q/D Lybalvi™ Nuplazid® olanzapine ODT DO paliperidone ER F/Q/D Rexulti® DO Risperdal® Saphris® Secuado® F/Q/D Seroquel® F/Q/D	**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 • Prior authorization is required when an oral SGA is utilized above the highest MDD according to FDA labeling. • Prior authorization is required for patients less than 21 years of age when there is concurrent use of 2 or more different oral antipsychotics for greater than 90 days. • Prior authorization is required for patients 21 years of age or older when 3 or more different oral second generation antipsychotics are used for more than 180 days. • 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 aripiprazole (Abilify MyCite®) – 18 years

1 = Preferred as of 10/28/2021
2 = Non-Preferred as of 10/28/2021

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
	Seroquel XR® DO, F/Q/D Versacloz® Vraylar® Zyprexa® DO Zyprexa® Zydis	asenapine (Saphris®) 10 years Asenapine (Secuado®) 18 years brexpiprazole (Rexulti®) 18 years cariprazine (Vraylar®) 18 years clozapine (Clozaril®, Versacloz®) 12 years iloperidone (Fanapt®) 18 years lumateperone (Caplyta™) 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®) 10 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 **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **asenapine (Secuado®)** 7.6 mg/24 hours • **lumateperone (Caplyta™)** 42 mg capsules: Maximum 1 unit/day • **paliperidone ER (Invega®)** 1.5 mg, 3 mg, 9 mg tablets: Maximum 1 unit/day • **paliperidone ER (Invega®)** 6 mg tablets: Maximum 2 units/day • **quetiapine/quetiapine ER (Seroquel®/Seroquel XR®):** Minimum 100 mg/day; maximum 800 mg/day • **quetiapine (Seroquel®):** Maximum 3 units per day, 90 units per 30 days • **quetiapine ER (Seroquel XR®)** 150 mg, 200 mg: 1 unit/day, 30 units/30 days

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
		• **quetiapine ER (Seroquel XR®)** 50 mg, 300 mg, 400 mg: 2 units/day, 60 units/30 days
Benzodiazepines – Rectal		
diazepam (rectal gel)	Diastat® 2.5 mg Diastat® AcuDial™	
Central Nervous System (CNS) Stimulants CC, F/Q/D		
amphetamine salt combo IR (generic for Adderall®) amphetamine salt combo ER (generic for Adderall XR®) DO Concerta® DO, BLTG Daytrana® dexmethylphenidate (generic for Focalin®) dexmethylphenidate ER (generic for Focalin XR®) dextroamphetamine (tablet) methylphenidate solution (generic for Methylin®) methylphenidate tablet (generic for Ritalin®) methylphenidate ER (generic for Aptensio® XR) Vyvanse® (capsule, chewable) DO	Adderall XR® DO Adhansia XR™ Adzenys ER® Adzenys XR-ODT® amphetamine (generic for Adzenys ER®) amphetamine (generic for Evekeo®) Aptensio XR® armodafinil (generic for Nuvigil®) Azstarys™ Cotempla® XR-ODT™ Desoxyn® Dexedrine® dextroamphetamine ER (generic for Dexedrine®) dextroamphetamine (solution) (generic for ProCentra®) Dyanavel XR® Evekeo® Evekeo® ODT Focalin® Focalin XR® DO Jornay PM™ methamphetamine (generic for Desoxyn®) Methylin®	**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, narcolepsy, or as an adjunct to standard treatment for obstructive sleep apnea. • 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 36mg and Cotempla XR-ODT 25.9 mg, Adhansia XR 35 mg and 45 mg; not to exceed 2 units daily, Adhansia XR 25 mg not to exceed 3 units daily.

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
	methylphenidate chewable tablet (generic for Methylin®) methylphenidate CD methylphenidate ER 72 mg methylphenidate ER (generic Concerta®, Ritalin LA®, Metadate®) modafinil (generic for Provigil®) DO Mydayis™ Nuvigil® ProCentra® Provigil® DO QuilliChew ER™ DO Quillivant XR® Ritalin® Ritalin LA® DO Sunosi™ Wakix® Zenzedi®	– Azstarys; not to exceed 1 dosage unit per day – Pitolisant (Wakix®): not to exceed 2 dosage units daily of the 17.8 mg tablets or 3 dosage units daily of the 4.45 mg tablets.
Movement Disorder Agents CC		
Austedo® tetrabenazine	Ingrezza® Ingrezza® titration pack Xenazine®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis for an FDA-approved or compendia-supported indication

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Multiple Sclerosis Agents		
Avonex® Betaseron® Copaxone® 20 mg/mL BLTG Tecfidera® BLTG	Aubagio® Bafiertam™ Copaxone® 40 mg/mL dimethyl fumarate DR Extavia® Gilenya® 2 glatiramer Kesimpta® Mavenclad® Mayzent® Plegridy® Ponvory™ F/Q/D Rebif® Vumerity® Zeposia®	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **Ponvory™ (ponesimod) starter pack**; maximum quantity is 14, no refills • **Ponvory™ (ponesimod);** maintenance limited to a 30 day supply
Non-Ergot Dopamine Receptor Agonists		
pramipexole ropinirole	Kynmobi™ CC Mirapex ER® Neupro® pramipexole ER ropinirole ER	**CLINICAL CRITERIA (CC)** • **apomorphine (Kynmobi™)**: Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication **DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD) CC		
atomoxetine DO guanfacine ER DO	clonidine ER Intuniv® DO Qelbree™ 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

1 = Preferred as of 10/28/2021
2 = Non-Preferred as of 10/28/2021

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
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® Dayvigo™ doxepin (generic for Silenor®) Edluar® CC eszopiclone Halcion® CC Lunesta® DO ramelteon (generic for Rozerem®) Restoril® CC Rozerem® Silenor® temazepam 7.5 mg, 22.5 mg CC triazolam CC zaleplon zolpidem (sublingual) CC zolpidem ER 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®) products – 180 days for **eszopiclone** and **ramelteon** (Rozerem®) products – 180 days for lemborexant (Dayvigo™) – 168 days for **zolpidem ER** (Ambien CR®) products – 90 days for **suvorexant** (Belsomra®) – 90 days for **doxepin** (Silenor®) – 30 days for **zaleplon** (Sonata®) products

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
		– 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
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® 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

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)[ST]		
duloxetine 20 mg, 30 mg, 60 mg (generic for Cymbalta®) venlafaxine venlafaxine ER (capsule) [DO]	Cymbalta® desvenlafaxine ER desvenlafaxine succinate ER [DO] Drizalma Sprinkle™ duloxetine 40 mg Effexor XR® [DO] Fetzima® 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)

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Acne Agents, Topical		
adapalene/benzoyl peroxide (generic for Epiduo) adapalene cream Differin® OTC (1% gel) Retin-A® cream CC, BLTG Tazarotene cream CC tretinoin gel (generic Avita, Retin-A) CC	Aklief® CC Aczone® adapalene (Rx gel, gel pump) Altreno® CC Amzeeq™ F/Q/D Arazlo™ CC Atralin® CC Avita® CC clindamycin / tretinoin CC dapsone Differin® (Rx gel, solution, lotion, cream) Epiduo® Fabior® CC Retin-A® gel CC Retin-A Micro® CC tazarotene foam (generic Fabior®) CC Tazorac® CC tretinoin cream, gel CC (generic Atralin) tretinoin micro CC Winlevi® Ziana® CC	**CLINICAL CRITERIA** • Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Frequency and duration limits for the following products: • **Amzeeq™ (minocycline)** – maximum quantity is 30 grams per month
Actinic Keratosis Agents		
Diclofenac 3% gel CC fluorouracil (solution) fluorouracil 0.5% cream (generic Carac) fluorouracil 5% cream (generic Efudex cream) imiquimod (generic Aldara)	Aldara® Carac® Efudex® imiquimod (generic Zyclara) 2 Picato Tolak® Zyclara®	**CLINICAL CRITERIA** • diclofenac 3% gel: confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication

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2 = Non-Preferred as of 10/28/2021

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Antibiotics – Topical		
mupirocin (ointment)	Centany® mupirocin (cream) Xepi™	
Anti-Fungals – Topical		
ciclopirox (cream, suspension) clotrimazole OTC clotrimazole / betamethasone (cream) miconazole OTC nystatin (cream, ointment, powder) terbinafine OTC tolnaftate OTC	Alevazol OTC Ciclodan® (cream) ciclopirox (gel, shampoo) clotrimazole / betamethasone (lotion) clotrimazole Rx econazole Ertaczo® Exelderm® Extina® ketoconazole ketoconazole 2% shampoo Lamisil® OTC (spray) Loprox® shampoo luliconazole Luzu® Mentax® naftifine Naftin® nystatin/ triamcinolone oxiconazole Oxistat® Vusion® F/Q/D	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **Vusion® 50 gm ointment** – Maximum 100 grams in a 90-day time period

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2 = Non-Preferred as of 10/28/2021

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Anti-Infectives – Topical		
clindamycin (solution) clindamycin/benzoyl peroxide (generic for Duac®) erythromycin (solution)	Acanya® BenzaClin® (gel, pump) Benzamycin® Cleocin T® clindamycin (foam, gel, lotion, pledget) clindamycin/benzoyl peroxide (generic for BenzaClin®) clindamycin/benzoyl peroxide (generic for Acanya®) Erygel® erythromycin (gel, pledget) erythromycin / benzoyl peroxide Evoclin® Neuac® Onexton®	
Anti-Virals – Topical		
docosanol (generic Abreva) Zovirax® (cream) BLTG	acyclovir (ointment, cream) Denavir® Sitavig® Xerese® Zovirax® (ointment)	
Immunomodulators – Topical CC		
pimecrolimus tacrolimus	Elidel® Protopic®	**CLINICAL CRITERIA** • All prescriptions require prior authorization • Refills on prescriptions are allowed

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Psoriasis Agents – Topical		
calcipotriene (cream, ointment, scalp solution)	calcipotriene (generic Sorilux®) calcipotriene / betamethasone dipropionate (generic Taclonex®) calcitriol (ointment) Dovonex® (cream) Duobrii™ Enstilar® Sorilux® Taclonex® Taclonex® Scalp® Vectical®	
Steroids, Topical – Low Potency		
hydrocortisone acetate OTC hydrocortisone acetate Rx	alclometasone Capex® Derma-Smoothe/FS® Desonate® desonide fluocinolone (oil) Texacort®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Steroids, Topical – Medium Potency		
mometasone furoate	Beser lotion betamethasone valerate (foam) clocortolone Cloderm® Cutivate® fluocinolone acetonide (cream, ointment, soln.) flurandrenolide fluticasone propionate hydrocortisone butyrate (cream, lotion, ointment, solution) hydrocortisone valerate Locoid® Locoid Lipocream® Luxiq® Pandel® prednicarbate Synalar®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Steroids, Topical – High Potency		
betamethasone dipropionate (lotion) betamethasone valerate (cream, ointment) triamcinolone acetonide	amcinonide ApexiCon-E® betamethasone dipropionate (gel, ointment, cream) betamethasone dipropionate, augmented betamethasone valerate (lotion) desoximetasone diflorasone Diprolene® fluocinonide 0.1% cream (generic for Vanos®) fluocinonide (ointment, cream, gel, solution, emollient) halcinonide cream (generic for Halog®) Halog® (cream, solution, ointment) Kenalog® Topicort® triamcinolone spray Trianex® Vanos®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Steroids, Topical – Very High Potency		
clobetasol (cream, emollient, gel, ointment, solution) halobetasol (cream, ointment)	Bryhali™ clobetasol (foam, lotion, spray, shampoo) Clobex® halobetasol (foam) Impeklo™ Lexette™ (foam) Olux® Olux-E® Temovate-E® Ultravate®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Alpha-Glucosidase Inhibitors ST		
acarbose miglitol	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® BLTG	Androderm® Fortesta® 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. – 1.62% gel only: For diagnosis of gender dysphoria please refer to July 2020 edition of the Medicaid Update; https://www.health.ny.gov/health_care/medicaid/program/update/2020/no12_2020-07.htm#transgender • The Anabolic Steroid fax form can be found at: https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PA_Worksheet_Prescribers_Anabolic_Steroids.docx **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Limitations for anabolic steroid products based on approved FDA labeled daily dosing and documented diagnosis: – Duration limit of 6 months for delayed puberty

NYS Medicaid Fee-For-Service Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">VI. Endocrine and Metabolic Agents</td></tr>
<tr><td colspan="3">Biguanides</td></tr>
<tr><td>metformin HCl
metformin ER (generic for Glucophage XR®)</td><td>Fortamet®
Glucophage XR®
Glumetza®
metformin solution (generic Riomet®)
metformin ER (generic for Fortamet®, Glumetza®)
Riomet®
Riomet ER™</td><td></td></tr>
<tr><td colspan="3">Bisphosphonates – Oral F/Q/D</td></tr>
<tr><td>alendronate</td><td>Actonel®
Atelvia®
Boniva®
Fosamax®
Fosamax® Plus D
Ibandronate
risedronate</td><td>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) — 1 tablet every 28 days
alendronate sodium 35 mg (Fosamax® 35 mg) — 4 tablets every 28 days
alendronate sodium 70 mg (Fosamax® 70 mg, Binosto®) — 4 tablets every 28 days
alendronate sodium and cholecalciferol (Fosamax® Plus D) — 4 tablets every 28 days
risedronate sodium 35 mg (Actonel® 35 mg) — 4 tablets every 28 days
risedronate sodium 35 mg (Atelvia® 35 mg) — 4 tablets every 28 days
alendronate solution 70 mg/75 mL single-dose bottle — 4 bottles every 28 days</td></tr>
<tr><td colspan="3">Calcitonins – Intranasal</td></tr>
<tr><td>calcitonin-salmon</td><td></td><td></td></tr>
</table>

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors ST		
Glyxambi® Janumet® Janumet® XR Januvia® DO Jentadueto® Tradjenta®	alogliptin alogliptin / metformin alogliptin / pioglitazone Jentadueto® XR 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		
Byetta® Trulicity® Victoza®	Adlyxin® Bydureon® BCise™ Ozempic® Rybelsus® Soliqua® 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.

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Glucocorticoids – Oral		
dexamethasone (tablet) Entocort EC® 1, BLTG hydrocortisone methylprednisolone (dose-pack) prednisolone (solution) prednisone (dose-pack, tablet)	Alkindi® Sprinkle budesonide EC budesonide ER Cortef® cortisone dexamethasone (elixir, solution) dexamethasone intensol Emflaza® Hemady™ Medrol® (dose-pack, tablet) methylprednisolone (4 mg, 8 mg 16 mg, 32 mg) Millipred® Ortikos™ prednisolone ODT prednisone (intensol, solution) Rayos® TaperDex® Uceris®	
Growth Hormones CC, CDRP		
Genotropin® Norditropin®	Humatrope® Nutropin AQ® Omnitrope® Saizen® Skytrofa® Zomacton® Zorbtive®	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** • Prescribers or their authorized agents may call or submit a fax request for a PA for beneficiaries 18 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

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Insulin – Long-Acting		
Lantus® Levemir®	Basaglar® Semglee® Toujeo® Solostar® Toujeo® Max Solostar® Tresiba®	
Insulin – Mixes		
Humalog® 50/50 Mix: pen and vial Humalog® 75/25 Mix: vial insulin lispro 75/25 mix: pen (generic for Humalog® Mix) insulin aspart prot/insulin aspart vial (generic for Novolog) Novolog® Mix: pen BLTG	Humalog® 75/25 mix: pen insulin aspart prot/insulin aspart pen (generic for Novolog®) Novolog® 70/30 Mix: vial	
Insulin – Rapid-Acting		
Apidra® Humalog® 100 U/mL pen BLTG insulin aspart (generic Novolog®) cartridge insulin aspart (generic Novolog®) vial insulin lispro vial (generic Humalog® U100) insulin lispro junior (generic Humalog® Jr.) Novolog® Flexpen BLTG	Admelog® Afrezza® Fiasp® (Penfill, FlexTouch) Humalog® 200 U/mL Humalog® Jr. 100 U/mL Humalog® 100 U/mL vial insulin aspart (generic Novolog®) pen insulin lispro (generic Humalog®) pen Lyumjev™ Novolog® cartridge, vial	
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.

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Pancreatic Enzymes		
Creon® Zenpep®	Pancreaze® Pertzye® Viokace®	
Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors ST		
Farxiga® ST Invokana® Jardiance® ST	Invokamet® Invokamet® XR Segluromet® Steglatro® Synjardy® Synjardy® XR Trijardy® 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. • Farxiga® (dapagliflozin), Jardiance® (empagliflozin) – Requires a trial with metformin with or without insulin prior to initiating SGLT2 Inhibitor therapy, unless there is a documented contraindication or drug is being used for an FDA-approved indication other than Type 2 Diabetes or related.
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.

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VII. Gastrointestinal		
Anti-Emetics		
aprepitant pack doxylamine succ/pyridoxine ondansetron (ODT, solution, tablet)	Akynzeo® aprepitant (capsule) Bonjesta® CC Diclegis® CC Emend® (capsule, powder packet, TriPack) granisetron (tablet) Sancuso® Zofran® (ODT, solution, tablet)	**CLINICAL CRITERIA (CC)** • **Diclegis®** and **Bonjesta®:** Confirm diagnosis of FDA-approved or compendia-supported indication
Gastrointestinal Antibiotics		
Firvanq® BLTG metronidazole (tablet) neomycin vancomycin (capsule)	Dificid® Flagyl® metronidazole (capsule) nitazoxanide paromomycin tinidazole Vancocin® vancomycin (solution) 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 tablets per 30 days (Dose = 200 mg 3 times a day for 3 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 (3 rounds of therapy).

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VII. Gastrointestinal		
Helicobacter pylori Agents		
Pylera®	Helidac™ lansoprazole / amoxicillin / clarithromycin Omeclamox-Pak® Talicia®	
Proton Pump Inhibitors (PPIs) F/Q/D		
omeprazole Rx pantoprazole tablet	Aciphex® Dexilant® DO esomeprazole magnesium (generic for Nexium) esomeprazole strontium lansoprazole Rx (capsule, ODT) Nexium® RX DO omeprazole OTC omeprazole/ sodium bicarbonate Rx pantoprazole suspension 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

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VII. Gastrointestinal		
Sulfasalazine Derivatives		
Apriso® BLTG Lialda® BLTG Pentasa® sulfasalazine DR sulfasalazine IR	Asacol HD® Azulfidine® Azulfidine Entab® balsalazide Colazal® Delzicol® Dipentum® mesalamine DR (generic for Delzicol®) mesalamine DR (generic for Lialda®) mesalamine ER (generic for Apriso®) mesalamine DR	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VIII. Hematological Agents		
Anticoagulants – Injectable F/Q/D		
enoxaparin sodium Fragmin® (vial)	Arixtra® CC fondaparinux CC Fragmin® (syringe) 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		
Eliquis® Pradaxa® warfarin Xarelto® (10 mg) DO	Savaysa® Xarelto® (dose pack)	
Colony Stimulating Factors		
Neupogen® Nyvepria™	Fulphila™ Granix® Leukine® Neulasta® Nivestym™ Udenyca® Zarxio® Ziextenzo®	
Erythropoiesis Stimulating Agents (ESAs) CC		
Epogen® Retacrit®	Aranesp® Mircera® Procrit®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis for FDA- or compendia-supported uses

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VIII. Hematological Agents		
Platelet Inhibitors		
Brilinta® clopidogrel dipyridamole dipyridamole / aspirin	Effient® Plavix® prasugrel Zontivity®	

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IX. Immunologic Agents		
Immunomodulators – Systemic CC, ST		
Cosentyx® Enbrel® Humira®	Actemra® (subcutaneous) Benlysta® (subcutaneous) Cimzia® Ilumya® Kevzara® Kineret® Olumiant® Orencia® (subcutaneous) Otezla® Rinvoq™ ER Siliq™ Simponi® Skyrizi™ 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 • Trial of a TNF inhibitor prior to treatment with Olumiant®

1 = Preferred as of 10/28/2021
2 = Non-Preferred as of 10/28/2021

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IX. Immunologic Agents		
Immunosuppressives, Oral		
azathioprine CellCept® (suspension) BLTG cyclosporine (softgel, capsule) cyclosporine modified (capsule, solution) mycophenolate mofetil (capsule, tablet) Rapamune® (solution) BLTG sirolimus (tablet) tacrolimus	Astagraf XL® Azasan® CellCept® (capsule, tablet) Envarsus XR® everolimus (gen Zortress®) Imuran® Lupkynis™ CC, ST, F/Q/D mycophenolic acid mycophenolate mofetil (suspension) Myfortic® Neoral® Prograf® Rapamune® (tablet) Sandimmune® (solution, capsule) sirolimus (solution) Zortress®	**CLINICAL CRITERIA (CC)** • Lupkynis™ (voclosporin) - Confirm diagnosis for FDA- or compendia-supported uses **STEP THERAPY (ST)** • Trial of mycophenolate prior to Lupkynis™ **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Lupkynis™ limited to 30 day supply

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
X. Miscellaneous Agents		
Progestins (for Cachexia)		
megestrol acetate (suspension)	megestrol 625 mg/5 mL (suspension)	
Epinephrine - Self-injected		
epinephrine (generic for EpiPen®) epinephrine (generic for EpiPen Jr.®)	epinephrine (generic for Adrenaclick®) EpiPen® EpiPen Jr.® Symjepi®	

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 500 mg cyclobenzaprine 5 mg, 10 mg (tablet) 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 chlorzoxazone (generic for Lorzone) 375 mg, 750 mg cyclobenzaprine 7.5 mg cyclobenzaprine ER (generic for Amrix) capsule Dantrium® Fexmid® Lorzone® metaxalone Norgesic® Forte Ozobax™ 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 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 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 < 12 yrs **STEP THERAPY (ST)** • Trial with 1 preferred analgesic and 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 units per day, 21-day supply • **Carisoprodol combinations** – Maximum 8 units per day, 21-day supply (not to exceed the 84 cumulative units per year limit)

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Alpha-2 Adrenergic Agonists (for Glaucoma) – Ophthalmic		
Alphagan P® 0.1% Alphagan P® 0.15% BLTG 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 tobramycin / dexamethasone (suspension)	Maxitrol® neomycin / bacitracin / polymyxin / HC neomycin / polymyxin / HC Pred-G® TobraDex® ST TobraDex® suspension Zylet®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Antihistamines – Ophthalmic		
Pataday®	azelastine bepotastine (gen Bepreve®) Bepreve® epinastine ketotifen OTC Lastacaft® olopatadine 0.1% olopatadine 0.2% Zaditor® OTC Zerviate™	
Anti-inflammatories/Immunomodulators – Ophthalmic CC, F/Q/D		
Restasis® Restasis MultiDose® Xiidra®	Cequa®	**CLINICAL CRITERIA (CC)** • Diagnosis documentation required to justify utilization as a first line agent or attempt treatment with an artificial tear, gel or ointment. **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Cequa®, Restasis®, Xiidra®: 60 vials dispensed as a 30-day supply; • Restasis Multidose®: 5.5 mL dispensed as a 25-day supply
Beta Blockers – Ophthalmic		
betaxolol Betoptic S® carteolol Combigan® Istalol® levobunolol timolol maleate (gel, solution)	Betimol® Timoptic® Timoptic® Ocudose® Timoptic-XE®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Fluoroquinolones – Ophthalmic ST		
ciprofloxacin moxifloxacin ofloxacin	Besivance® Ciloxan® gatifloxacin levofloxacin Moxeza® Ocuflox® Vigamox® Zymaxid®	**STEP THERAPY (ST)** • For patients 21 years or younger, attempt treatment with a non-fluoroquinolone ophthalmic antibiotic before progressing to 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® ketorolac	Acular® Acular LS® Acuvail® bromfenac BromSite® Nevanac® Prolensa®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Prostaglandin Agonists – Ophthalmic		
latanoprost	bimatoprost Lumigan® Rocklatan™ Travatan Z® travoprost (generic for Travatan Z®) Xalatan® Xelpros™ Vyzulta™ Zioptan®	

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XIII. Otics		
Fluoroquinolones – Otic		
Cipro HC® Ciprodex® BLTG ofloxacin	Ciprofloxacin ciprofloxacin/dexamethasone (generic for Ciprodex®) ciprofloxacin/fluocinolone (generic for Otovel™) Otovel™	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XIV. Renal and Genitourinary		
Alpha Reductase Inhibitors for BPH		
finasteride	Avodart® dutasteride dutasteride / tamsulosin Jalyn® Proscar®	
Antihyperuricemics		
allopurinol colchicine (tablet) probenecid probenecid/colchicine	colchicine (capsule) Colcrys febuxostat Gloperba® Mitigare® Uloric® Zyloprim®	
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 Renagel® 1, BLTG Renvela® tablets 1, BLTG	Auryxia™ Fosrenol® lanthanum carbonate Phoslyra® sevelamer carbonate powder and tablets[2] (generic for Renvela) sevelamer HCl (generic for Renagel) Velphoro®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XIV. Renal and Genitourinary		
Selective Alpha Adrenergic Blockers		
alfuzosin tamsulosin	Flomax® Rapaflo® silodosin	
Urinary Tract Antispasmodics		
oxybutynin solifenacin Toviaz® DO	darifenacin Detrol® Detrol LA® DO Ditropan XL® flavoxate Gelnique® Gemtesa® Myrbetriq® DO Myrbetriq® solution F/Q/D oxybutynin ER DO Oxytrol® tolterodine tolterodine ER trospium trospium ER Vesicare® DO	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Myrbetriq® solution; limited to a 30-day supply

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XV. Respiratory		
Anticholinergics / COPD Agents		
Anoro Ellipta® [1] Atrovent HFA® Bevespi® Aerosphere® Combivent Respimat® ipratropium ipratropium / albuterol Spiriva® Stiolto Respimat® Tudorza Pressair®	Breztri™ Aerosphere Daliresp® Duaklir® Pressair Incruse Ellipta® Lonhala® Magnair® Seebri Neohaler® Spiriva Respimat® Trelegy Ellipta® Utibron Neohaler® Yupelri®	
Antihistamines – Intranasal		
azelastine olopatadine	Patanase®	
Antihistamines – Second Generation		
cetirizine OTC (tablet) cetirizine OTC (syrup/solution 1mg/ 1mL) fexofenadine OTC (suspension) levocetirizine (tablet) loratadine OTC	cetirizine OTC (chewable) cetirizine OTC (syrup/solution 5 mg/5 mL) cetirizine-D OTC Clarinex® [CC] Clarinex-D® OTC desloratadine fexofenadine OTC (tablet) levocetirizine (solution) loratadine-D OTC	**CLINICAL CRITERIA (CC)** • No prior authorization required for patients less than 24 months of age

1 = Preferred as of 10/28/2021
2 = Non-Preferred as of 10/28/2021

NYS Medicaid Fee-For-Service Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">XV. Respiratory</td></tr>
<tr><td colspan="3">Beta2 Adrenergic Agents – Inhaled Long-Acting CC, F/Q/D</td></tr>
<tr><td>formoterol (generic Perforomist®)
Serevent Diskus®</td><td>Arcapta Neohaler®
arformoterol (generic Brovana)
Brovana®
Perforomist®
Striverdi Respimat®</td><td>CLINICAL CRITERIA (CC)
PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA- or compendia-supported age as indicated:
<table>
<tr><td>Arcapta Neohaler®</td><td>≥ 18 years</td></tr>
<tr><td>Brovana® / arformoterol</td><td>≥ 18 years</td></tr>
<tr><td>Perforomist® / formoterol</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>
FREQUENCY/QUANTITY/DURATION (F/Q/D)
Maximum units per 30 days
<table>
<tr><td>Arcapta Neohaler®</td><td>30 units (1 box of 30 unit dose capsules)</td></tr>
<tr><td>Brovana® / aformoterol</td><td>60 units (1 carton of 60 vials or 120 mL)</td></tr>
<tr><td>Perforomist® / formoterol</td><td>60 units (1 carton of 60 vials or 120 mL)</td></tr>
<tr><td>Serevent Diskus®</td><td>1 diskus (60 blisters)</td></tr>
<tr><td>Striverdi Respimat®</td><td>1 unit (one cartridge and one Respimat inhaler)</td></tr>
</table></td></tr>
<tr><td colspan="3">Beta2 Adrenergic Agents – Inhaled Short-Acting</td></tr>
<tr><td>albuterol HFA
albuterol nebulizer solution</td><td>levalbuterol (solution)
levalbuterol HFA
ProAir® Digihaler™
ProAir® RespiClick
ProAir HFA®
Proventil HFA®
Ventolin HFA®
Xopenex® (solution)
Xopenex HFA®</td><td></td></tr>
</table>

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XV. Respiratory		
Corticosteroids – Inhaled F/Q/D		
Asmanex® Flovent Diskus® Flovent HFA® Pulmicort® Flexhaler	Alvesco® ArmonAir® Digihaler® Arnuity Ellipta® Asmanex® HFA QVAR RediHaler®	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** 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® Digihaler®: 1 inhaler every 30 days 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® RediHaler™ 40 mcg: 1 inhaler every 30 days QVAR® RediHaler™ 80 mcg: 1 inhaler every 15 days

NYS Medicaid Fee-For-Service Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">XV. Respiratory</td></tr>
<tr><td colspan="3">Corticosteroid/Beta2 Adrenergic Agent (Long-Acting) Combinations – Inhaled CC, F/Q/D</td></tr>
<tr><td>Advair Diskus® BLTG
Dulera®
Symbicort® BLTG</td><td>Advair HFA®
AirDuo® Digihaler®
AirDuo™ RespiClick®
Breo Ellipta®
budesonide/formoterol (generic for Symbicort)
fluticasone-salmeterol (generic for AirDuo™ RespiClick®)
fluticasone-salmeterol (generic for Advair Diskus®)</td><td>CLINICAL CRITERIA (CC)
• PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA-or compendia-supported age as indicated:
<table><tr><td>Advair Diskus®</td><td>≥ 4 years</td></tr><tr><td>Advair HFA®</td><td>≥ 12 years</td></tr><tr><td>AirDuo™ RespiClick® & Digihaler®</td><td>> 12 years</td></tr><tr><td>Breo Ellipta®</td><td>≥ 18 years</td></tr><tr><td>Dulera® 100 mcg and 200 mcg</td><td>≥ 12 years</td></tr><tr><td>Dulera® 50 mcg</td><td>≥ 5 years</td></tr><tr><td>fluticasone-salmeterol</td><td>> 12 years</td></tr><tr><td>Symbicort® 80/4.5 mcg</td><td>≥ 6 years</td></tr><tr><td>Symbicort® 160/4.5 mcg</td><td>≥ 12 years</td></tr></table>FREQUENCY/QUANTITY/DURATION (F/Q/D)
<table><tr><td>Advair Diskus®</td><td rowspan="8">One inhaler/diskus every 30 days</td></tr><tr><td>Advair HFA®</td></tr><tr><td>AirDuo™ RespiClick® & Digihaler®</td></tr><tr><td>Breo Ellipta™</td></tr><tr><td>Dulera®</td></tr><tr><td>fluticasone-salmeterol</td></tr><tr><td>Symbicort®</td></tr></table></td></tr>
</table>

NYS Medicaid Fee-For-Service Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">XV. Respiratory</td></tr>
<tr><td colspan="3">Corticosteroids – Intranasal F/Q/D</td></tr>
<tr><td>fluticasone</td><td>Beconase AQ® CC
Dymista®
flunisolide
mometasone
Nasonex®
Omnaris®
QNASL® CC
Xhance™
Zetonna®</td><td>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)
<table>
<tr><td>flunisolide</td><td>1 inhaler every 12 days</td></tr>
<tr><td>mometasone
Nasonex®
Xhance™</td><td>1 inhaler every 15 days</td></tr>
<tr><td>Beconase AQ®</td><td>1 inhaler every 22 days</td></tr>
<tr><td>Dymista™
fluticasone
Omnaris®
QNASL®
Zetonna™</td><td>1 inhaler every 30 days</td></tr>
</table></td></tr>
<tr><td colspan="3">Immunomodulators, Asthma CC, F/Q/D</td></tr>
<tr><td>Dupixent®
Fasenra®
Nucala®
Xolair®</td><td>None</td><td>CLINICAL CRITERIA (CC)
• Confirm FDA or compendia-supported indication
STEP THERAPY (ST)
• Dupixent®, Fasenra®, and Nucala® – history and concurrent use of a corticosteroid when used for asthma.
• Xolair® – history of a corticosteroid when used for asthma
• Dupixent®, Nucala®, and Xolair® – history and concurrent use of intranasal corticosteroid when used for nasal polyps
• 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, when used for atopic dermatitis</td></tr>
</table>

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XV. Respiratory		
		QUANTITY LIMITS: • Dupixent® 200 mg or 300 mg, 4 syringes for first 30 days followed by 2 syringes/30 days. • Fasenra® 30 mg, 1 syringe or autoinjector/4 weeks • Nucala® 100 mg, 3 syringes, vials or autoinjectors/4 weeks • Xolair® 75 mg, 2 syringes/4 weeks, 150 mg, 8 syringes or vials/4 weeks
Leukotriene Modifiers		
montelukast (tablets, chew tabs) ST	Accolate® montelukast (granules) Singulair® ST zafirlukast	**STEP THERAPY (ST)** • For non-asthmatic patients, trial of intranasal corticosteroid or a 2nd generation oral antihistamine before montelukast (Singulair®)

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XVI. Medication Assisted Treatment Agents		
Opioid Antagonists		
naloxone (syringe, vial) naltrexone Narcan® (nasal spray)	Kloxxado™	
Opioid Dependence Agents – Injectable		
Vivitrol® Sublocade™	None	
Opioid Dependence Agents – Oral/Transmucosal CC, F/Q/D		
buprenorphine buprenorphine / naloxone (tablet)¥ Suboxone® (film) BLTG	buprenorphine / naloxone (film) Zubsolv®	**CLINICAL CRITERIA (CC)** • PA required for initiation of opioid therapy for patients on established opioid dependence therapy **QUANTITY LIMIT:** • **buprenorphine sublingual (SL):** Six tablets dispensed as a 2-day supply; not to exceed 24 mg per day • **buprenorphine/ naloxone tablet and film (Suboxone®, Zubsolv®** up to 5.7 mg/1.4 mg strength); Three 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 • **buprenorphine/naloxone tablet (Zubsolv®** 8.6 mg/2.1 mg strength): Maximum of 60 tablets dispensed as a 30-day supply • **buprenorphine/naloxone tablet (Zubsolv®** 11.4 mg/2.9 mg strength): Maximum of 30 tablets dispensed as a 30-day supply

¥NOTE: Effective date of change is 10/01/2021

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. For some drugs subject to the CDRP, only prescribers, not their authorized agents, can initiate the prior authorization process.

Please be prepared to respond to a series of questions that identify prescriber, patient, and reason for prescribing drug, and to fax clinical documentation upon request. Clinical guidelines for the CDRP as well as prior authorization worksheets are available online at https://newyork.fhsc.com/providers/CDRP_about.asp.

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

- fentanyl mucosal agents: https://newyork.fhsc.com/providers/CDRP_fentanyl_mucosal_agents.asp
- palivizumab (Synagis®): https://newyork.fhsc.com/providers/CDRP_synagis.asp
- sodium oxybate products (Xyrem®, Xywav™): https://newyork.fhsc.com/providers/CDRP_xyrem.asp
- somatropin (Serostim®): https://newyork.fhsc.com/providers/CDRP_serostim.asp

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

- Anabolic Steroids: https://newyork.fhsc.com/providers/CDRP_anabolic_steroids.asp
- Growth Hormones for 18 years and older: https://newyork.fhsc.com/providers/CDRP_growth_hormones.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 60.

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

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

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anabolic Steroids – Injectable • Depo-Testosterone® • testosterone cypionate* • testosterone enanthate • Xyosted® Anabolic Steroids – Oral • Anadrol-50® • Android® • Jatenzo® • Methitest® • 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): • Xyosted® is limited to no more than 3 boxes for 90 days (1 box per 30 days) • 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	*for additional parameters, see Cross-Sex Hormones section below.
Anti-Diabetic agents (not on the PDL) • chlorpropamide • glimepiride • glipizide (Glucotrol®, Glucotrol XL®) • glyburide (Glynase®) • glyburide, micronized • tolazamide • tolbutamide	• Requires a trial with metformin with or without insulin prior to initiating other antidiabetic agents, unless there is a documented contraindication. • Clinical editing to allow patients with a diagnosis of gestational diabetes to receive glyburide without a trial of metformin first.		

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
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.
Anti-Fungals, Topical – for Onychomycosis • ciclopirox 8% solution • Jublia® • tavaborole (Kerydin®)	• Trial with an oral antifungal agent* prior to use of ciclopirox 8% solution *terbinafine (Lamisil®) tablets; griseofulvin (Gris PEG®) oral suspension, ultramicronized tablets micronized tablets; itraconazole (Sporanox®,) tablets, oral solution • Trial with ciclopirox 8% solution prior to the use of other topical antifungals [efinaconazole (Jublia®) or tavaborole (Kerydin®)]		
Anti-Malarials chloroquine hydroxychloroquine			• Confirm FDA approved or Compendia supported use

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
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 antiretroviral / non-antiretroviral combinations to be avoided: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_reference_Antiretroviral_NonAntiretroviral_Drug2Drug_Interactions.pdf • Point-of-service edit for antiretroviral / antiretroviral combinations to be avoided: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_reference_Antiretroviral_Antiretroviral_Drug2Drug_Interactions.pdf
biotin			• Confirm diagnosis of FDA-approved or compendia-supported indication
Atopic Dermatitis Agents crisaborole (Eucrisa®) ruxolitinib (Opzelura™)	• Trial with a medium or high potency prescription topical steroid within the last 3 months	**QUANTITY LIMITS:** • 100 GM/30 days (crisaborole) • 240 GM/30 days (ruxolitinib)	• Confirm diagnosis of FDA-approved or compendia-supported indication • ruxolitinib: age 12 years +

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®, Loreev XR™) • oxazepam	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 • Panic Disorder requires concurrent therapy with an antidepressant (SSRI, SNRI, or Tricyclic antidepressant [TCA]). 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®) • prucalopride (Motegrity™) • tegaserod (Zelnorm™)	Opioid Induced Constipation (OIC) and 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 • prucalopride: 2 mg/day max; 1 tablet per day; 30/month. • If CrCl < 30 mL/min, then reduce dose to 1 mg/day max; 1 tablet per day; 30/month. • tegaserod: 2 tablets/day; 60 tabs/30 days	• 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)
Cross-Sex Hormones • conjugated estrogens estradiol • testosterone cypionate • testosterone enanthate (Xyosted™) • testosterone gel 1.62% (Androgel®)* • testosterone patch* *Subject to Anabolic Steroids – Topical PDL class criteria			• Confirm diagnosis of FDA-approved or compendia-supported indication • For diagnosis of gender dysphoria please refer to July 2020 edition of the Medicaid Update: https://www.health.ny.gov/health_care/medicaid/program/update/2020/no12_2020-07.htm#transgender
Cystic fibrosis agents • ivacaftor (Kalydeco®) • ivacaftor / lumacaftor (Orkambi®) • ivacaftor / tezacaftor (Symdeko®) • ivacaftor/ tezacaftor / elexacaftor (Trikafta™)			• Confirm diagnosis of FDA-approved or compendia-supported indication • Genetic testing required to verify appropriate mutations
dextromethorphan / quinidine (Nuedexta®)		**QUANTITY LIMIT:** • 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

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
dronabinol (Marinol®)	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 • Actiq® (lozenge) • Fentora® (buccal tablet)		**QUANTITY LIMIT:** Actiq®, Fentora®: • 4 units per day, 120 units per 30 days **DURATION LIMIT:** • 90 days • Exemption for diagnosis of cancer, sickle cell disease, or hospice care	• Limited to a total of 4 opioid prescriptions every 30 days; • For opioid-naïve patients: limited to a 7 days' supply for all initial opioid prescriptions, • PA required for use if > 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting > 7 days). • PA required for initiation of opioid therapy for patients on established opioid dependence therapy • PA is required for initiation of opioid therapy in patients currently on benzodiazepine therapy • Exemption for diagnosis of cancer, sickle cell, or hospice care

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
HIV PrEP (Pre-Exposure Prophylaxis Agents): ▪ emtricitabine/tenofovir disoproxil fumarate (Truvada®) ▪ emtricitabine/tenofovir alafenamide (Descovy®)			• Prescribers or authorized agents are required to respond to a series of questions that identify the prescriber, the patient and the reason for prescribing an HIV-1 PrEP agent. • Prescribers or authorized agents must indicate whether the HIV-1 PrEP agent has been prescribed for HIV pre-exposure prophylaxis (PrEP) or treatment of HIV/AIDS. If the agent has been prescribed for prophylaxis, the date of last negative HIV test must also be provided.
Ivermectin (oral)			• Confirm diagnosis of FDA-approved or compendia-supported indication
Lidocaine patches • Lidoderm® • ZTLido™			• Prescribers, or their authorized agents, are required to respond to a series of questions that identify the prescriber, the patient and the reason for prescribing this drug. • Prescriptions can be written for a 30-day supply with up to 2 refills

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Lipid Lowering Agents: • alirocumab (Praluent®) • evolocumab (Repatha®) • lomitapide (Juxtapid®) • bempedoic acid (Nexletol™) • bempedoic acid/ezetimibe (Nexlizet™)	• Require trial of a HMG-CoA Reductase Inhibitors (statin) at maximum tolerated dosage		• Confirm diagnosis of FDA-approved or compendia-supported indication **PCSK-9 Inhibitors** (alirocumab [Praluent®], evolocumab [Repatha®]) and **ACL inhibitors** (Bempedoic acid [Nexletol], Bempedoic acid/ ezetimibe [Nexlizet]): • Require concurrent statin therapy
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, hospice care, or sickle cell disease	• Confirm diagnosis of chronic non-cancer pain • Limited to a total of 4 opioid prescriptions every 30 days; • 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. • PA required for initiation of long-acting opioid therapy in opioid-naïve patients. • PA required for use if > 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting > 7 days). PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy • Exemption for diagnosis of cancer, sickle cell, or hospice care

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Metoclopramide (tablet, ODT) Metoclopramide nasal spray (Gimoti™)	• ODT formulation requires a trial with conventional tablet except with a diagnosis of diabetes mellitus	**Quantity Limit** • Tablet and ODT 4units per day, 120 units per 30 days • Nasal spray 4 sprays per day, 1 bottle (9.8ml) per 4 weeks **Duration Limit** • Tablet, ODT tablet 90days • Nasal spray 8 weeks	• Metoclopramide nasal spray confirm diagnosis of diabetes
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 10 years
Oral Pollen/Allergen Extracts • Oralair®	• 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
Ovulation Enhancing Drugs • bromocriptine • clomiphene • letrozole • tamoxifen			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Refer to https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-06.htm#ovulation

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Oxazolidinone Antibiotics ▪ linezolid (Zyvox®) ▪ tedizolid (Sivextro®)			• Please be prepared to respond to a series of questions that identify the prescriber, the patient and the reason for prescribing this drug. • Please be prepared to fax clinical documentation upon request.
Pubertal Suppressants • goserelin acetate • leuprolide acetate • nafarelin acetate			• 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
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	

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Rosacea Agents • azelaic acid (Finacea®) • brimonidine (Mirvaso®) • ivermectin (Soolantra®) • oxymetazoline HCl (Rhofade®) • minocycline (Zilxi™) • 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 • teriparatide (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	
Topical Compounded Prescriptions			• Confirm diagnosis of FDA-approved or compendia-supported indication • For non-opioid pain management alternatives please visit: https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf
Uterine Disorder Agents • Oriahnn® • Myfembree®		**QUANTITY LIMIT:** • 28 days per 30-day period **LIFETIME QUANTITY LIMIT:** • 24 months cumulative use	

For more information on DUR Program, please refer to https://www.health.ny.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 January 13, 2022:

- Afinitor® tablets will be **added** to the program
- Diclegis®, Focalin® XR, Humalog® vial, ProAir® HFA, and Tracleer™ tablets, will be **removed** from the program

List of Brand Name Drugs included in this program**		
Advair Diskus®	Depakote® Sprinkle	Retin-A® cream
Afinitor® tablets	Entocort EC®	Suboxone® film
Alphagan P® 0.15%	Exelon® patch	Symbicort®
Amitiza®	Firvanq®	Tecfidera®
Androgel® pump & packets	Humalog® U100 KwikPen	Tegretol® suspension
Apriso®	Kitabis® Pak	Xeloda®
Azopt™	Lialda®	Zovirax® cream
Bethkis®	Novolog® 100u/mL FlexPen	
Catapres-TTS®	Novolog® Mix 70/30 FlexPen	
CellCept® suspension	NuvaRing®	
Ciprodex®	Rapamune® solution	
Concerta®	Renagel®	
Copaxone® 20 mg SQ	Renvela® tablets	

**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

- Pursuant to this program prescription claims submitted to the Medicaid program **do not require** the submission of Dispense as Written/Product Selection Code of '1'; **Pharmacies should submit DAW code 9** (Substitution Allowed by Prescriber but Plan Requests Brand)**.** Pharmacies will receive a NCPDP reject response of "22" which means missing/invalid DAW code if other DAW codes are submitted. The only exception to this is DAW code 1 and "*Brand Medically Necessary"* on the prescription.
- 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, located at https://newyork.fhsc.com/providers/MGDP_forms.asp, 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®	Neoral®
Dilantin®	Sandimmune®
Gengraf®	Tegretol®
Lanoxin®	Zarontin®
Levothyroxine Sodium (Unithroid®, Synthroid®, Levoxyl®)	

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	
Antiarrhythmics			
Amiodarone 100 mg	1 daily	Tablet	In case of dose titration for these medications, the department will allow for multiday dosing (up to 2 doses daily) for loading dose for 30 days
ARBs/Calcium Channel Blockers			
Exforge® 5–160mg	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	
metoprolol succinate 25 mg, 50 mg, 100 mg	1 daily	Tablet	
nadolol 40 mg	1 daily	Tablet	
Toprol® XL 25 mg, 50 mg, 100 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
CARDIOVASCULAR			
HMG Co A Reductase Inhibitors			
Crestor® 5 mg, 10 mg, 20 mg	1 daily	Tablet	
Niacin Derivatives			
Niaspan® 500 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Anticonvulsants			
Aptiom® 200 mg, 400 mg	1 daily	Tablet	
Fycompa® 4 mg, 6 mg	1 daily	Tablet	
topiramate ER 100 mg	1 daily	Capsule	
Lamictal XR® 50 mg	1 daily	Tablet	In case of dose titration for these medications, the department will allow for multiday dosing (up to 2 doses daily) for titration purposes for 90 days
Oxtellar XR® 300 mg	1 daily	Tablet	In case of dose titration for these medications, the department will allow for multiday dosing (up to 2 doses daily) for titration purposes for 90 days
Anticonvulsants, Other			
Lyrica® 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg	3 daily	Tablet	Electronic bypass for diagnosis of seizure disorder identified in medical claims data. In case of dose titration for these medications, the department will allow for multiday dosing (up to 2 doses daily) for titration purposes for 3 months
Lyrica® 225 mg and 300 mg	2 daily	Tablet	
Trokendi XR® 100 mg	1 daily	Tablet	
Antiparkinson Agents			
Azilect® 0.5 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Antipsychotics – Second Generation			
Abilify® 2 mg	4 daily	Tablet	
Abilify® 5 mg, 10 mg, 15 mg	1 daily	Tablet	In case of dose titration for these medications, the Department will allow for multiday 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, 10 mg	1 daily	Tablet	
olanzapine ODT 5 mg, 10 mg	1 daily	Tablet	
paliperidone er 1.5 mg, 3 mg	1 daily	Tablet	
quetiapine fumarate er 200 mg	1 daily	Tablet	
Rexulti® 0.25 mg, 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	
Vraylar® 1.5 mg, 3 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	
amphetamine salt combo ER 5 mg, 10 mg, 15 mg	1 daily	Capsule	
Concerta® ER 18 mg, 27 mg	1 daily	Tablet	
dexmethylphenidate ER 10 mg, 20 mg (Focalin XR generic)	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	
methylphenidate er 18 mg (Concerta® generic)	1 daily	Tablet	
methylphenidate la 20 mg (Ritalin® LA generic)	1 daily	Capsule	
modafinil 100 mg	1 daily	Tablet	
Provigil® 100 mg	1 daily	Tablet	
QuilliChew® ER 20 mg	1 daily	Tablet	
Ritalin® LA 10 mg, 20 mg	1 daily	Capsule	
Vyvanse® 10 mg, 20 mg, 30 mg, 40 mg	1 daily	Capsule	

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)			
guanfacine ER 1 mg, 2 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 multiday dosing (up to 2 doses/daily) for titration purposes for three months.
Pristiq® ER 50 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 multiday dosing (up to 2 doses/daily) for titration purposes for three months.
Trintellix® 5 mg, 10 mg	1 daily	Tablet	
Viibryd® 10 mg, 20 mg	1 daily	Tablet	
Miscellaneous Antidepressants			
bupropion xl 150 mg	1 daily	Tablet	In case of dose titration for these medications, the Department will allow for multiday dosing (up to 2 doses/daily) for titration purposes for three months
mirtazapine 7.5 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
ENDOCRINE AND METABOLIC			
Biguanides			
metformin ER 500 mg (Glumetza ER, Fortamet ER generic)	1 daily	Tablet	
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors			
Januvia® 25 mg, 50 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
ENDOCRINE AND METABOLIC			
Onglyza® 2.5 mg	1 daily	Tablet	
Thiazolidinediones (TZDs)			
Actos® 15 mg	1 daily	Tablet	
Actoplus Met® XR 15–1000 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
GASTROINTESTINAL			
Proton Pump Inhibitors			
Dexilant® 30 mg	1 daily	Capsule	
Nexium® 5 mg, 10 mg, 20 mg	1 daily	Packet	
Nexium® 20 mg	1 daily	Capsule	
Prevacid® DR 15 mg	1 daily	Capsule	

Brand Name	Dose Optimization Limitations		
HEMATOLOGICAL			
Anticoagulants - Oral			
Xarelto® 10 mg	1 daily	Capsule	

Brand Name	Dose Optimization Limitations		
RENAL AND GENITOURINARY			
Urinary Tract Antispasmodics			
Detrol® LA 2 mg	1 daily	Capsule	
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.

When, in the judgment of the prescriber or the pharmacist, an emergency condition exists, the prescriber or pharmacist can call the Clinical Call center and obtain authorization for a seventy-two hour emergency supply of the drug prescribed to allow time for the prior authorization to be obtained.