

# NYRx, the New York Medicaid Pharmacy Program

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## OVERVIEW OF CONTENTS

### **[Preferred Drug Program \(PDP\) \(Pages 4–64\)](#)**

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

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

### **[Clinical Drug Review Program \(CDRP\) \(Page 65\)](#)**

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

### **[Drug Utilization Review \(DUR\) Program \(Pages 66–79\)](#)**

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

### **[Statewide Medication Assisted Treatment Formulary \(Page 80\)](#)**

A Single Statewide Medication Assisted Treatment (MAT) formulary was implemented on October 1, 2022, in accordance with §367-a (7)(e) of Social Services Law. The Single Statewide Medication Assisted Treatment formulary aligns coverage parameters across NYRx and Medicaid Managed Care. Prior authorization will not be required for medications used for the treatment of substance use disorder prescribed according to generally accepted national professional guidelines for the treatment of a substance use disorder.

### **[Brand Less Than Generic \(BLTG\) Program \(Pages 81–82\)](#)**

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

For more information on the NYS Medicaid Pharmacy Programs: [http://www.health.ny.gov/health\\_care/medicaid/program/pharmacy.htm](http://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm)

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

To download a copy of the Prior Authorization fax form go to [https://newyork.fhsc.com/providers/PA\\_forms.asp](https://newyork.fhsc.com/providers/PA_forms.asp)

Disclaimer: Branded generics are included with the single generic name listing; they are not listed as separate agents.

## **[NYRx, the Medicaid Pharmacy Program Preferred Drug List](#)**

### **[Mandatory Generic Drug Program \(Page 83\)](#)**

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

### **[Dose Optimization Program \(Pages 84–88\)](#)**

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.

# **NYRx, the Medicaid Pharmacy Program Preferred Drug List**

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>I. Analgesics</b>		
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</b>		
diclofenac 1% topical gel diclofenac sodium ibuprofen Rx (tablet) ibuprofen OTC (susp) indomethacin ketorolac meloxicam (tablet) naproxen (tablet) piroxicam sulindac	Arthrotec® Cambia® Celebrex® <sup>CC</sup> celecoxib <sup>CC</sup> Daypro® diclofenac epolamine (generic for Flector) diclofenac capsules (gen Zipsor®) diclofenac/misoprostol diclofenac potassium diclofenac sodium ER diclofenac topical soln diflunisal Duexis® Elyxyb™ <sup>F/Q/D</sup> 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®)	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>• <b>Celebrex® (celecoxib)</b> – one of the following criteria will not require PA                             <ul style="list-style-type: none"> <li>– Over the age of 65 years</li> <li>– Concurrent use of an anticoagulant agent</li> <li>– History of GI Bleed/Ulcer or Peptic Ulcer Disease</li> </ul> </li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>• Elyxyb™ (celecoxib) – 4.8 mL bottle (120 mg) maximum quantity: 9 / 30 days</li> </ul>

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<b>I. Analgesics</b>		
	Mobic® nabumetone Nalfon® Naprelan® naproxen (susp) naproxen CR naproxen EC naproxen-esomeprazole naproxen sodium oxaprozin Pennsaid® Relafen® DS Sprix® tolmetin Vimovo® Vivlodex® Zipsor® Zorvolex®	
<b>Opioids – Long-Acting <span style="color: red;">CC, F/Q/D</span></b>		
buprenorphine patches fentanyl patch (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg) morphine sulfate ER (tablet)	Belbuca® buprenorphine (gen Belbuca®) Butrans® ConZip® <sup>ST</sup> fentanyl patch (37.5 mcg, 62.5 mcg, 87.5 mcg) hydrocodone ER hydrocodone ER (gen Hysingla ER) hydromorphone ER Hysingla® ER morphine ER (capsule) (generic for Avinza) morphine ER (capsule) (generic for Kadian)	<b>CLINICAL CRITERIA (CC) *</b> <ul style="list-style-type: none"> <li>Limited to a total of 4 opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease</li> <li>PA required for initiation of opioid therapy for patients on established opioid dependence therapy</li> <li>PA required for use if <math>\geq 90</math> MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting &gt; 7 days)</li> <li>PA required for initiation of long-acting opioid therapy in opioid-naïve patients.</li> <li>PA required for any additional long-acting opioid prescription for patients currently on long-acting opioid therapy.</li> <li>PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy</li> </ul>

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

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<b>I. Analgesics</b>		
	<p>MS Contin®                      Nucynta® ER <sup>ST</sup>                      oxycodone ER                      Oxycontin®                      oxymorphone ER                      tramadol ER <sup>ST</sup>                      Xtampza® ER</p>	<ul style="list-style-type: none"> <li>• PA required for any codeine- or tramadol-containing products in pts &lt; 12 years</li> <li>• PA required for initiation of opioid therapy for patients on established CNS stimulant therapy</li> </ul> <p><b>STEP THERAPY (ST)</b></p> <ul style="list-style-type: none"> <li>• <b>Nucynta® ER (tapentadol ER):</b> Trial with tapentadol IR before tapentadol ER for patients who are naïve to a long-acting opioid</li> <li>• <b>Tramadol ER (tramadol naïve patients):</b> Attempt treatment with IR formulations before the following ER formulations: ConZip®, tramadol ER</li> </ul> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D) *</b></p> <ul style="list-style-type: none"> <li>• Belbuca® (buprenorphine)                             <ul style="list-style-type: none"> <li>– Maximum 2 units per day</li> </ul> </li> <li>• Butrans® (buprenorphine)                             <ul style="list-style-type: none"> <li>– Maximum 4 patches per 28 days</li> </ul> </li> <li>• Nucynta® ER (tapentadol ER):                             <ul style="list-style-type: none"> <li>– Maximum 2 units per day</li> </ul> </li> <li>• Nucynta® ER (tapentadol ER):                             <ul style="list-style-type: none"> <li>– Maximum daily dose of tapentadol IR and tapentadol ER formulations if used in combination should not exceed 500mg/day</li> </ul> </li> <li>• Tramadol ER (ConZip®):                             <ul style="list-style-type: none"> <li>– Maximum 30 tablets dispensed as a 30-day supply</li> </ul> </li> <li>• Zohydro® ER (hydrocodone ER):                             <ul style="list-style-type: none"> <li>– Maximum 2 units per day, 60 units per 30 days</li> </ul> </li> <li>• Hysingla® ER (hydrocodone ER):                             <ul style="list-style-type: none"> <li>– Maximum 1 unit per day; 30 units per 30 days</li> </ul> </li> <li>• Hydromorphone ER, oxymorphone ER:                             <ul style="list-style-type: none"> <li>– Maximum 4 units per day, 120 units per 30 days</li> </ul> </li> <li>• Oxycodone ER (Xtampza® ER):                             <ul style="list-style-type: none"> <li>– Maximum 2 units per day, 60 units per 30 days. Not to exceed a total daily dose of 160 mg or its equivalent</li> </ul> </li> </ul>

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<b>I. Analgesics</b>		
		<ul style="list-style-type: none"> <li>• Fentanyl transdermal patch (Duragesic®):                             <ul style="list-style-type: none"> <li>– Maximum 10 patches per 30 days; maximum 100 mcg/hr (over a 72-hour dosing interval)</li> </ul> </li> <li>• Morphine ER (excluding MS Contin products):                             <ul style="list-style-type: none"> <li>– Maximum 2 units per day, 60 units per 30 days</li> </ul> </li> <li>• Morphine ER (MS Contin® and Arymo® ER 15 mg, 30 mg, 60 mg only):                             <ul style="list-style-type: none"> <li>– Maximum 3 units per day, 90 units per 30 days</li> </ul> </li> <li>• Morphine ER (MS Contin® 100 mg only):                             <ul style="list-style-type: none"> <li>– Maximum 4 units per day, up to 3 times a day, maximum 120 units per 30 days</li> </ul> </li> <li>• Morphine ER (MS Contin® 200 mg only):                             <ul style="list-style-type: none"> <li>– Maximum 2 units per day, maximum 60 units per 30 days</li> </ul> </li> </ul> <p>For Non-opioid Pain management alternatives please visit:  <a href="https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf">https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf</a></p> <ul style="list-style-type: none"> <li>– The quantity limits listed are systematically converted into Morphine Milligram Equivalents (MME) for the purpose of prospective drug utilization review/clinical editing.</li> </ul> <p>*Exemption from requirements for diagnosis of cancer, sickle cell disease, or hospice care.</p>
<b>Opioids – Short-Acting <sup>CC</sup></b>		
butalbital / APAP / caffeine / codeine <sup>F/Q/D</sup> codeine <sup>F/Q/D</sup> codeine / APAP <sup>F/Q/D</sup> hydrocodone / APAP <sup>F/Q/D</sup> hydrocodone / ibuprofen <sup>F/Q/D</sup> Lortab® (elixir) <sup>F/Q/D</sup> morphine IR <sup>F/Q/D</sup> oxycodone / APAP <sup>F/Q/D</sup> tramadol tablet <sup>F/Q/D</sup>	Apadaz® <sup>F/Q/D</sup> benzhydrocodone / APAP <sup>F/Q/D</sup> butalbital compound/codeine <sup>F/Q/D</sup> butorphanol nasal spray dihydrocodeine / APAP / caffeine <sup>F/Q/D</sup> Dilaudid® <sup>F/Q/D</sup> hydromorphone <sup>F/Q/D</sup> levorphanol meperidine Nucynta® <sup>ST, F/Q/D</sup> Oxaydo®	<b>CLINICAL CRITERIA (CC) *</b> <ul style="list-style-type: none"> <li>• Limited to a total of 4 opioid prescriptions every 30 days.</li> <li>• Initial prescription for opioid-naïve patients limited to a 7-day supply.</li> <li>• PA required for initiation of opioid therapy for patients on established opioid dependence therapy.</li> <li>• PA required for use if ≥ 90 MME of opioid per day for management of non-acute pain (&gt; 7 days)                             <ul style="list-style-type: none"> <li>– Exception for diagnosis of cancer or sickle cell disease, or hospice program</li> </ul> </li> </ul>

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<b>I. Analgesics</b>		
	oxycodone <sup>F/Q/D</sup> oxycodone / aspirin <sup>F/Q/D</sup> oxycodone / ibuprofen <sup>F/Q/D</sup> oxymorphone <sup>F/Q/D</sup> pentazocine / naloxone Percocet <sup>®</sup> <sup>F/Q/D</sup> Roxicodone <sup>®</sup> <sup>F/Q/D</sup> Seglentis <sup>®</sup> tramadol solution tramadol / APAP <sup>F/Q/D</sup> Ultracet <sup>®</sup> <sup>F/Q/D</sup> Ultram <sup>®</sup>	<ul style="list-style-type: none"> <li>PA is required for opioid-naïve patients for prescription requests ≥ 50 MME per day.</li> <li>PA required for continuation of opioid therapy beyond an initial 7-day supply in patients established on gabapentin or pregabalin</li> <li>PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy</li> <li>PA required for any codeine- or tramadol-containing products in pts &lt; 12 years</li> <li>PA required for initiation of opioid therapy for patients on &gt;7 days established CNS stimulant therapy</li> </ul> <p><b>STEP THERAPY (ST)</b></p> <ul style="list-style-type: none"> <li><b>Nucynta<sup>®</sup> (tapentadol IR)</b> – Trial with tramadol and 1 preferred opioid before tapentadol immediate-release (IR)</li> </ul> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <p><b>Quantity Limits:</b></p> <ul style="list-style-type: none"> <li>Apadaz<sup>®</sup> (benzhydrocodone/APAP):                             <ul style="list-style-type: none"> <li>Maximum 12 units per day</li> </ul> </li> <li>Nucynta<sup>®</sup> (tapentadol IR):                             <ul style="list-style-type: none"> <li>Maximum 6 units per day; 180 units per 30 days</li> </ul> </li> <li>Nucynta<sup>®</sup> (tapentadol IR):                             <ul style="list-style-type: none"> <li>Maximum daily dose of <b>tapentadol IR</b> and <b>tapentadol ER</b> formulations used in combination not to exceed 500 mg/day</li> </ul> </li> <li>tramadol – Maximum 400 mg per day</li> <li><b>Morphine and congeners immediate-release (IR)</b> non-combination products (codeine, hydromorphone, morphine, oxycodone, oxymorphone):                             <ul style="list-style-type: none"> <li>Maximum 6 units per day, 180 units per 30 days</li> </ul> </li> </ul> <p>Additional/alternate parameters: To be applied to patients without a documented cancer or sickle cell diagnosis.</p>

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>I. Analgesics</b>		
		<ul style="list-style-type: none"> <li>• <b>Morphine and congeners immediate-release (IR) combination</b> products maximum recommended:               <ul style="list-style-type: none"> <li>– acetaminophen (4 grams)</li> <li>– aspirin (4 grams)</li> <li>– ibuprofen (3.2 grams)</li> <li>– or the FDA-approved maximum opioid dosage as listed in the PI, whichever is less</li> </ul> </li> </ul> <p><b>Duration Limits:</b></p> <ul style="list-style-type: none"> <li>• 90 days for patients without a diagnosis of cancer or sickle-cell disease.</li> <li>• For Non-opioid Pain management alternatives please visit:  <a href="https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf">https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf</a> </li> </ul> <p>The quantity limits listed are systematically converted into morphine milligram equivalents (MME) for the purpose of prospective drug utilization review/clinical editing.</p> <p>*Exemptions from requirements for diagnosis of cancer, sickle cell disease, or hospice care</p>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>II. Anti-Infectives</b>		
<b>Antibiotics – Inhaled <span style="color: red;">CC, F/Q/D</span></b>		
Bethkis® <span style="color: red;">BLTG</span> Cayston® Kitabis® Pak <span style="color: red;">BLTG</span> TOBI Podhaler™	TOBI® (solution) tobramycin (generic for Bethkis®, Kitabis®, Tobi®) solution	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Aztreonam (Cayston)               <ul style="list-style-type: none"> <li>3 ampules (3 mL) per day</li> <li>84 ampules (84 mL) per 56 day regimen (28 days on, 28 days off)</li> </ul> </li> <li>Tobramycin inhalation solution (Bethkis, TOBI, Kitabis Pak)               <ul style="list-style-type: none"> <li>2 ampules (8 mL Bethkis, 10 mL TOBI, Kitabis Pak) per day</li> <li>56 ampules (224 mL Bethkis, 280 mL TOBI, Kitabis Pak) per 56 day regimen (28 days on-28 days off)</li> </ul> </li> <li>Tobramycin capsules with inhalation powder (TOBI Podhaler)               <ul style="list-style-type: none"> <li>8 capsules per day 224 capsules per 56 day regimen (28 days on-28 days off)</li> </ul> </li> </ul>
<b>Anti-Fungals – Oral for Onychomycosis</b>		
griseofulvin (suspension and ultramicronized) terbinafine (tablet)	griseofulvin (tablet) itraconazole itraconazole solution (generic for Sporanox) Sporanox®	
<b>Anti-Virals – Oral</b>		
acyclovir valacyclovir	famciclovir Valtrex® Zovirax®	
<b>Cephalosporins – Third Generation</b>		
cefdinir	cefixime cefpodoxime Suprax®	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>II. Anti-Infectives</b>		
<b>Fluoroquinolones – Oral</b>		
ciprofloxacin (suspension, tablet) levofloxacin (tablet)	Baxdela® Cipro® (suspension, tablet) levofloxacin (solution) moxifloxacin ofloxacin (tablet)	
<b>Hepatitis B Agents</b>		
adefovir dipivoxil Baraclude® (solution) entecavir Epivir-HBV® (solution) lamivudine HBV	Baraclude® (tablet) Epivir-HBV® (tablet) Hepsera® Vemlidy®	
<b>Hepatitis C Agents – Direct Acting Antivirals</b>		
Mavyret™ <sup>CC, F/Q/D</sup> ribavirin sofosbuvir/velpatasvir (generic for Epclusa®) <sup>CC, F/Q/D</sup> Vosevi® <sup>CC, F/Q/D</sup>	Epclusa® <sup>CC, F/Q/D</sup> Harvoni® <sup>CC, F/Q/D</sup> ledipasvir/sofosbuvir (generic for Harvoni®) <sup>CC, F/Q/D</sup> Sovaldi® <sup>CC, F/Q/D</sup> Viekira Pak® <sup>CC, F/Q/D</sup> Zepatier® <sup>CC, F/Q/D</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>• For patients being retreated require confirmation of patient readiness and adherence <ul style="list-style-type: none"> <li>– Evaluation by using scales or assessment tools readily to determine a patient’s readiness to initiate HCV treatment, specifically drug and alcohol abuse potential. Assessment tools are available to healthcare practitioners at: <a href="https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools">https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools</a></li> <li>– OR <a href="https://prepc.org/">https://prepc.org/</a>.</li> </ul> </li> <li>• The optional Hepatitis C Worksheet can be accessed at: <a href="https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_HepC.docx">https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_HepC.docx</a></li> </ul>

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>II. Anti-Infectives</b>		
<b>Tetracyclines</b>		
demeclocycline doxycycline hyclate minocycline (capsule) tetracycline	Doryx <sup>®</sup> <i>ST, F/Q/D</i> Doryx MPC <sup>®</sup> <i>ST, F/Q/D</i> doxycycline hyclate DR <i>ST, F/Q/D</i> doxycycline monohydrate minocycline (tablet) minocycline ER (tablet) minocycline ER (gen Ximino <sup>®</sup> ) Minolira ER <sup>™</sup> Nuzyra <sup>™</sup> Solodyn <sup>®</sup> Vibramycin <sup>®</sup> Ximino <sup>®</sup>	<b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>Trial of doxycycline IR before progressing to doxycycline DR</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>doxycycline DR (Doryx<sup>®</sup>):               <ul style="list-style-type: none"> <li>Maximum 28 tablets/capsules per fill</li> </ul> </li> </ul>

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>III. Cardiovascular</b>		
<b>Angiotensin Converting Enzyme Inhibitors (ACEIs)</b>		
benazepril enalapril lisinopril ramipril	Accupril® Altace® Captopril Enalapril (gen Epaned®) Epaned® fosinopril Lotensin® moexipril perindopril Qbrelis™ quinapril trandolapril Vasotec® Zestril®	
<b>ACE Inhibitor Combinations</b>		
benazepril/ amlodipine benazepril/ HCTZ captopril/ HCTZ enalapril/ HCTZ lisinopril/ HCTZ Lotrel® trandolapril/verapamil ER	Accuretic® fosinopril/ HCTZ Lotensin HCT® quinapril/ HCTZ Vaseretic® Zestoretic®	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>III. Cardiovascular</b>		
<b>Angiotensin Receptor Blockers (ARBs)</b>		
Diovan® <sup>DO</sup> losartan valsartan tablets	Atacand® Avapro® Benicar® <sup>DO</sup> candesartan Cozaar® Edarbi® eprosartan irbesartan Micardis® <sup>DO</sup> olmesartan telmisartan	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul>
<b>Antianginals and Anti-Ischemics</b>		
ranolazine	Aspruzyo Sprinkle™ Ranexa®	
<b>ARBs Combinations</b>		
Entresto® Exforge HCT® losartan/ HCTZ valsartan/ amlodipine valsartan/ amlodipine / HCTZ valsartan/ HCTZ	Atacand HCT® Avalide® Azor® Benicar HCT® <sup>DO</sup> candesartan/ HCTZ Diovan HCT® <sup>DO</sup> Edarbyclor® <sup>DO</sup> Exforge® <sup>DO</sup> Hyzaar® irbesartan/ HCTZ Micardis HCT® <sup>DO</sup> olmesartan/ amlodipine olmesartan/ amlodipine/ HCTZ olmesartan/ HCTZ telmisartan/ amlodipine telmisartan/ HCTZ	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>III. Cardiovascular</b>		
Tribenzor®		
<b>Beta Blockers</b>		
atenolol carvedilol labetalol metoprolol succ. XL <sup>DO</sup> metoprolol tartrate propranolol (tablet)	acebutolol betaxolol bisoprolol Bystolic® <sup>DO</sup> carvedilol ER Coreg® Coreg CR® <sup>DO</sup> Corgard® Inderal LA® Inderal XL® InnoPran XL® Kaspargo™ Sprinkle Lopressor® nadolol <sup>DO</sup> nebivolol (generic Bystolic®) pindolol propranolol (solution) propranolol ER/SA Tenormin® timolol Toprol XL® <sup>DO</sup>	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul>
<b>Beta Blockers / Diuretics</b>		
atenolol/ chlorthalidone bisoprolol/ HCTZ propranolol/ HCTZ	metoprolol tartrate/ HCTZ Tenoretic® Ziac®	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>III. Cardiovascular</b>		
<b>Calcium Channel Blockers (Dihydropyridine)</b>		
amlodipine felodipine ER isradipine nicardipine HCl nifedipine nifedipine ER/SA	Adalat® CC Katerzia™ levamlodipine nisoldipine Norliqva® Norvasc® Procardia XL® Sular®	
<b>Cholesterol Absorption Inhibitors</b>		
cholestyramine cholestyramine light Colestid® (tablet) colestipol (tablet) ezetimibe	colesevelam Colestid (granules, packet) colestipol (granules, packet) Questran® Questran Light® Welchol® Zetia®	
<b>Direct Renin Inhibitors <sup>ST</sup></b>		
aliskiren Tekturna® Tekturna HCT®	None	<b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>• Trial of product containing either an ACE inhibitor or an ARB prior to initiating preferred DRI</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>III. Cardiovascular</b>		
<b>HMG-CoA Reductase Inhibitors (Statins)</b>		
atorvastatin lovastatin pravastatin rosuvastatin simvastatin	Altoprev® atorvastatin/amlodipine Caduet® Crestor® <sup>DO</sup> Ezallor™ Sprinkle ezetimibe/simvastatin fluvastatin fluvastatin ER Lescol XL® Lipitor® Livalo® Vytorin® Zocor® Zypitamag™	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul>
<b>Phosphodiesterase Type-5 (PDE-5) Inhibitors for PAH <sup>CC</sup></b>		
sildenafil tadalafil	Revatio® Tadliq®	<b>CLINICAL CRITERIA</b> <ul style="list-style-type: none"> <li>All prescriptions for <b>Adcirca®</b>, <b>tadalafil</b>, <b>Revatio®</b>, and <b>sildenafil</b> must have PA</li> <li>Prescribers or their authorized agents are required to respond to a series of questions that identify prescriber, patient, and reason for prescribing drug</li> <li>Please be prepared to fax clinical documentation upon request</li> <li>Prescriptions can be written for a 30-day supply with up to 11 refills</li> </ul>
<b>Pulmonary Arterial Hypertension (PAH) Agents, Other – Oral</b>		
ambrisentan (generic for Letairis) bosentan tablets (generic for Tracleer®)	Adempas® Letairis® Opsumit® Orenitram® ER Tracleer® tabs for suspension & tablets Uptravi®	

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>III. Cardiovascular</b>		
<b>Triglyceride Lowering Agents</b>		
fenofibrate tablet (generic Tricor®) fenofibrate caps (generic Lofibra®) fenofibric acid (generic Trilipix®) gemfibrozil omega-3 ethyl ester (generic Lovaza®) F/Q/D,	Antara® fenofibrate caps (gen Antara®) fenofibrate tabs (gen Fenoglide®) Fenoglide® icosapent (generic Vascepa®) F/Q/D Lipofen® Lopid® Lovaza® F/Q/D Tricor® Trilipix® Vascepa® F/Q/D	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>• Lovaza® (omega-3-acid ethyl-esters) and Vascepa® (icosapent ethyl) – Required dosage equal to 4 grams per day</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IV. Central Nervous System</b>		
<b>Alzheimer's Agents</b>		
donepezil 5mg, 10mg galantamine galantamine ER memantine Namenda® rivastigmine	Adlarity® Aricept® donepezil 23 mg Exelon® memantine ER <sup>CC, ST</sup> Namenda XR® <sup>CC, ST</sup> Namzaric® <sup>CC, ST</sup> Razadyne ER®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Memantine extended-release containing products (Namenda XR® and Namzaric®) – Require confirmation of diagnosis of dementia or Alzheimer's disease</li> </ul> <b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>Memantine extended-release containing products (Namenda XR® and Namzaric®) – Require trial with memantine immediate-release (Namenda®)</li> </ul>
<b>Anticonvulsants – Carbamazepine Derivatives</b>		
carbamazepine (chewable, tablet) carbamazepine ER (capsule) Equetro® oxcarbazepine (tablets) Tegretol® (suspension) <sup>BLTG</sup> Tegretol XR® <sup>CC, BLTG</sup> Trileptal® (suspension) <sup>CC, BLTG</sup>	Aptiom® <sup>CC, DO</sup> carbamazepine (suspension) <sup>CC</sup> carbamazepine XR (tablet) Carbatrol® <sup>CC</sup> oxcarbazepine (suspension) Oxtellar XR® <sup>CC, DO</sup> Tegretol® (tablet) <sup>CC</sup> Trileptal® (tablets) <sup>CC</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA</li> </ul> <b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul>
<b>Anticonvulsants – Other</b>		
clobazam (tablet) <sup>ST, CC</sup> gabapentin (capsule, solution, tablet) <sup>F/Q/D, CC</sup> lamotrigine (tablet, chew) levetiracetam levetiracetam ER Lyrica® (capsule) <sup>DO, ST, F/Q/D, CC</sup> pregabalin (capsule) <sup>DO, ST, F/Q/D, CC</sup> tiagabine topiramate <sup>CC</sup>	Banzel® Briviact® clobazam (suspension) <sup>ST</sup> Diacomit® <sup>CC</sup> Elevia® XR Epidiolex® <sup>CC</sup> Eprontia™ <sup>CC</sup> felbamate Felbatol® Fintepla®	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul> <b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA</li> <li><b>Cannabidiol extract (Epidiolex®)</b> – Confirm diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IV. Central Nervous System</b>		
zonisamide	Fycompa® <span style="color: red;">DO</span> Gabitril® Keppra® Keppra XR® lacosamide Lamictal® (tablet, chew, dosepak) Lamictal® ODT (tablet, dosepak) Lamictal® XR <span style="color: red;">DO</span> (tablet, dosepak) lamotrigine (dosepak) lamotrigine ER lamotrigine ODT (dosepak) Lyrica® (solution) <span style="color: red;">DO, ST, F/Q/D</span> Lyrica® CR <span style="color: red;">ST, F/Q/D, CC</span> Neurontin® <span style="color: red;">F/Q/D, CC</span> Onfi® <span style="color: red;">ST, CC</span> pregabalin (solution) <span style="color: red;">DO, ST, F/Q/D, CC</span> pregabalin ER (gen Lyrica® CR) <span style="color: red;">ST, F/Q/D, CC</span> Qudexy® XR <span style="color: red;">CC</span> rufinamide (gen Banzel®) Sabril® Spritam® Sympazan® film <span style="color: red;">ST, CC</span> Topamax® <span style="color: red;">CC</span> topiramate ER <span style="color: red;">CC, DO</span> Trokendi XR® <span style="color: red;">CC, DO</span> vigabatrin Vimpat® Xcopri® Zonisade™ Ztalmly®	<ul style="list-style-type: none"> <li><b>Lyrica®/Lyrica® CR (pregabalin)</b> – PA required for the initiation of pregabalin at &gt; 150 mg per day in patients currently on an opioid at &gt; 50 MME per day</li> <li><b>Neurontin® (gabapentin)</b> – PA required for initiation of gabapentin at &gt; 900 mg per day in patients currently on an opioid at &gt; 50 MME per day</li> <li><b>Stiripentol (Diacomit®)</b> – Require diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form</li> <li><b>Topiramate IR/ER (Eprontia™, Qudexy® XR, Topamax®, Trokendi XR™)</b> – Require confirmation of FDA-approved, compendia-supported, or Medicaid covered diagnosis</li> <li><b>Onfi®/Sympazan® (clobazam):</b> <ul style="list-style-type: none"> <li>– Require confirmation of FDA-approved or compendia-supported use</li> <li>– PA required for initiation of clobazam therapy in patients currently on opioid or oral buprenorphine therapy</li> <li>– PA required for any clobazam prescription in patients currently on benzodiazepine therapy</li> </ul> </li> </ul> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <ul style="list-style-type: none"> <li><b>Eprontia™ (topiramate)</b> – Maximum quantity: 473 mL per month</li> <li><b>Lyrica®/Lyrica® CR (pregabalin)</b> – Maximum daily dose of IR: 600 mg per day, and ER: 660 mg per day</li> <li><b>Neurontin® (gabapentin)</b> – Maximum daily dose of 3,600 mg per day</li> </ul> <p><b>STEP THERAPY (ST)</b></p> <ul style="list-style-type: none"> <li><b>Lyrica®/Lyrica® CR (pregabalin)</b> – Requires a trial with a tricyclic antidepressant OR gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN)</li> <li><b>Onfi®/Sympazan® (clobazam)</b> – Requires a trial with an SSRI or SNRI for treatment of anxiety</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																		
<b>IV. Central Nervous System</b>																				
<b>Antimigraine Agents, Other <span style="color: red;">ST, F/Q/D</span></b>																				
Ajovy® Emgality® Nurtec™ ODT	Aimovig® Emgality® 100mg syringe Qulipta™ Reyvow™ Ubrelvy™	<b>STEP THERAPY (ST)</b>  <b>Acute treatment of migraine</b> <ul style="list-style-type: none"> <li>Trial of a product from the Antimigraine Agents-Triptan class</li> </ul> <b>Prevention of migraine</b> <ul style="list-style-type: none"> <li>Trial of 2 FDA approved or compendia supported migraine prevention products from other drug classes</li> </ul> <table border="1" style="width: 100%; margin-top: 10px;"> <thead> <tr style="background-color: #D9E1F2;"> <th style="width: 70%;">Agent</th> <th style="width: 30%;">F/Q/D</th> </tr> </thead> <tbody> <tr> <td>Aimovig</td> <td>1 syringe/30 days</td> </tr> <tr> <td>Emgality 120 mg</td> <td>2 syringes/30 days</td> </tr> <tr> <td>Emgality 100 mg</td> <td>3 syringes/30 days</td> </tr> <tr> <td>Ajovy</td> <td>3 syringes/90 days</td> </tr> <tr> <td>Reyvow</td> <td>8 units/30 days</td> </tr> <tr> <td>Ubrelvy</td> <td>16 units/30 days</td> </tr> <tr> <td>Nurtec™ ODT</td> <td>18 units/30 days</td> </tr> <tr> <td>Qulipta</td> <td>30 units/30 days</td> </tr> </tbody> </table>	Agent	F/Q/D	Aimovig	1 syringe/30 days	Emgality 120 mg	2 syringes/30 days	Emgality 100 mg	3 syringes/30 days	Ajovy	3 syringes/90 days	Reyvow	8 units/30 days	Ubrelvy	16 units/30 days	Nurtec™ ODT	18 units/30 days	Qulipta	30 units/30 days
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Qulipta	30 units/30 days																			
<b>Antimigraine Agents – Triptans</b>																				
rizatriptan <span style="color: red;">F/Q/D</span> sumatriptan <span style="color: red;">F/Q/D</span>	almotriptan <span style="color: red;">F/Q/D</span> Amerge® eletriptan <span style="color: red;">F/Q/D</span> Frova® <span style="color: red;">F/Q/D</span> frovatriptan <span style="color: red;">F/Q/D</span> Imitrex® <span style="color: red;">F/Q/D</span> Maxalt® <span style="color: red;">F/Q/D</span> Maxalt® MLT <span style="color: red;">F/Q/D</span> naratriptan <span style="color: red;">F/Q/D</span> Onzeta™ Xsail™ <span style="color: red;">F/Q/D</span> Relpax® sumatriptan-naproxen <span style="color: red;">F/Q/D</span> Tosymra™ <span style="color: red;">F/Q/D</span>	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b>  <table border="1" style="width: 100%; margin-top: 10px;"> <thead> <tr style="background-color: #D9E1F2;"> <th style="width: 70%;">Agent</th> <th style="width: 30%;">F/Q/D</th> </tr> </thead> <tbody> <tr> <td>Onzeta™ Xsail™ 11 mg</td> <td>16 units / 30 days</td> </tr> <tr> <td>                     almotriptan                      eletriptan (Relpax®)                      frovatriptan (Frova®)                      naratriptan (Amerge®)                      rizatriptan (Maxalt®)                      rizatriptan (Maxalt® MLT)                      sumatriptan nasal spray (Imitrex®)                      sumatriptan (Imitrex®)                 </td> <td>18 units / 30 days</td> </tr> </tbody> </table>	Agent	F/Q/D	Onzeta™ Xsail™ 11 mg	16 units / 30 days	almotriptan eletriptan (Relpax®) frovatriptan (Frova®) naratriptan (Amerge®) rizatriptan (Maxalt®) rizatriptan (Maxalt® MLT) sumatriptan nasal spray (Imitrex®) sumatriptan (Imitrex®)	18 units / 30 days												
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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters	
<b>IV. Central Nervous System</b>			
	Treximet® <sup>F/Q/D</sup> Zembrace™ SymTouch™ zolmitriptan <sup>F/Q/D</sup> Zomig® <sup>F/Q/D</sup>	sumatriptan-naproxen (Treximet®) Tosymra™ nasal spray zolmitriptan (Zomig®) Zomig® nasal spray	
<b>Antipsychotics – Injectable</b>			
Abilify Maintena® Aristada® Aristada Initio® fluphenazine decanoate Haldol® decanoate haloperidol decanoate Invega Hafyera™ <sup>1</sup> Invega Sustenna® Invega Trinza® Perseris™ Risperdal Consta® Zyprexa Relprevv®	N/A		
<b>Antipsychotics – Second Generation <sup>CC, ST</sup></b>			
aripiprazole (tablet) <sup>DO</sup> asenapine (gen Saphris®) clozapine Latuda® <sup>DO</sup> olanzapine (tablet) <sup>DO</sup> quetiapine <sup>F/Q/D</sup> quetiapine ER <sup>F/Q/D, DO</sup> risperidone ziprasidone (capsules)	Abilify® (tablet) <sup>DO</sup> Abilify MyCite® aripiprazole (solution) aripiprazole ODT Caplyta™ clozapine ODT Clozaril® Fanapt® Geodon® Invega® <sup>DO, F/Q/D</sup> Lybalvi™	<b>DOSE OPTIMIZATION (DO)</b> • See Dose Optimization Chart for affected drugs and strengths <b>CLINICAL CRITERIA (CC)</b> • Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA • 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.	

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																															
<b>IV. Central Nervous System</b>																																	
<p>Nuplazid®                      olanzapine ODT <span style="color: red;">DO</span>                      paliperidone ER <span style="color: red;">F/Q/D, DO</span>                      Rexulti® <span style="color: red;">DO</span>                      Risperdal®                      Saphris®                      Secuado® <span style="color: red;">F/Q/D</span>                      Seroquel® <span style="color: red;">F/Q/D</span>                      Seroquel XR® <span style="color: red;">DO, F/Q/D</span>                      Versacloz®                      Vraylar® <span style="color: red;">DO</span>                      Zyprexa® <span style="color: red;">DO</span>                      Zyprexa® Zydis</p>	<ul style="list-style-type: none"> <li>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.</li> <li>Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below:</li> </ul> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tbody> <tr><td>aripiprazole (Abilify®)</td><td style="text-align: center;">6 years</td></tr> <tr><td>aripiprazole (Abilify MyCite®)</td><td style="text-align: center;">18 years</td></tr> <tr><td>asenapine (Saphris®)</td><td style="text-align: center;">10 years</td></tr> <tr><td>Asenapine (Secuado®)</td><td style="text-align: center;">18 years</td></tr> <tr><td>brexpiprazole (Rexulti®)</td><td style="text-align: center;">13 years</td></tr> <tr><td>cariprazine (Vraylar®)</td><td style="text-align: center;">18 years</td></tr> <tr><td>clozapine (Clozaril®, Versacloz®)</td><td style="text-align: center;">12 years</td></tr> <tr><td>iloperidone (Fanapt®)</td><td style="text-align: center;">18 years</td></tr> <tr><td>lumateperone (Caplyta™)</td><td style="text-align: center;">18 years</td></tr> <tr><td>lurasidone HCl (Latuda®)</td><td style="text-align: center;">10 years</td></tr> <tr><td>olanzapine (Zyprexa®)</td><td style="text-align: center;">10 years</td></tr> <tr><td>paliperidone ER (Invega®)</td><td style="text-align: center;">12 years</td></tr> <tr><td>pimavanserin (Nuplazid®)</td><td style="text-align: center;">18 years</td></tr> <tr><td>quetiapine fum. (Seroquel®, Seroquel XR®)</td><td style="text-align: center;">10 years</td></tr> <tr><td>risperidone (Risperdal®)</td><td style="text-align: center;">5 years</td></tr> <tr><td>ziprasidone HCl (Geodon®)</td><td style="text-align: center;">10 years</td></tr> </tbody> </table> <ul style="list-style-type: none"> <li>Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients &lt; 18 years of age</li> </ul> <p><b>STEP THERAPY (ST)</b></p> <ul style="list-style-type: none"> <li>For all Second Generation Antipsychotics used in the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is required</li> </ul>	aripiprazole (Abilify®)	6 years	aripiprazole (Abilify MyCite®)	18 years	asenapine (Saphris®)	10 years	Asenapine (Secuado®)	18 years	brexpiprazole (Rexulti®)	13 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
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<b>IV. Central Nervous System</b>		
		<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li><b>asenapine (Secuado®)</b> 7.6 mg/24 hours</li> <li><b>lumateperone (Caplyta™)</b> 42 mg capsules: Maximum 1 unit/day</li> <li><b>paliperidone ER (Invega®)</b> 1.5 mg, 3 mg, 9 mg tablets: Maximum 1 unit/day</li> <li><b>paliperidone ER (Invega®)</b> 6 mg tablets: Maximum 2 units/day</li> <li><b>quetiapine/quetiapine ER (Seroquel®/Seroquel XR®)</b>: Minimum 100 mg/day; maximum 800 mg/day</li> <li><b>quetiapine (Seroquel®)</b>: Maximum 3 units per day, 90 units per 30 days</li> <li><b>quetiapine ER (Seroquel XR®)</b> 150 mg, 200 mg: 1 unit/day, 30 units/30 days</li> <li><b>quetiapine ER (Seroquel XR®)</b> 50 mg, 300 mg, 400 mg: 2 units/day, 60 units/30 days</li> </ul>
<b>Central Nervous System (CNS) Stimulants <span style="color: red;">CC, F/Q/D</span></b>		
amphetamine salt combo IR (generic for Adderall®) amphetamine salt combo ER (generic for Adderall XR®) <span style="color: red;">DO</span> Concerta® <span style="color: red;">DO, BLTG</span> Daytrana® <span style="color: red;">BLTG</span> dexamethylphenidate (generic for Focalin®) dexamethylphenidate ER <span style="color: red;">DO</span> (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) <span style="color: red;">DO</span>	Adderall XR® <span style="color: red;">DO</span> Adhansia XR™ 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®) dextroamphetamine tablet (generic for Zenzedi®) Dyanavel XR® Evekeo® Evekeo® ODT	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved, compendia supported and Medicaid covered indication</li> <li>Prior authorization is required for initial prescriptions for stimulant therapy for beneficiaries <b>less than 3 years of age</b></li> <li>Confirm diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent for beneficiaries <b>less than 18 years of age</b></li> <li>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.</li> <li>PA required for initiation of CNS Stimulant for patients currently on an opioid</li> <li>PA required for initiation of CNS Stimulant for patients currently on a benzodiazepine</li> </ul> <b>DOSE OPTIMIZATION (DO)</b>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IV. Central Nervous System</b>		
	Focalin® Focalin XR® <span style="color: red;">DO</span> Jornay PM™ methamphetamine (generic for Desoxyn®) Methylin® methylphenidate (gen Daytrana®) methylphenidate chewable tablet (generic for Methylin®) methylphenidate CD <span style="color: red;">DO</span> methylphenidate ER 72 mg methylphenidate ER (generic Concerta®, Ritalin LA®, Metadate®) modafinil (generic for Provigil®) <span style="color: red;">DO</span> Mydayis™ Nuvigil® ProCentra® Provigil® <span style="color: red;">DO</span> QuilliChew ER™ <span style="color: red;">DO</span> Quillivant XR® Ritalin® Ritalin LA® <span style="color: red;">DO</span> Sunosi™ Wakix® Zenedi®	<ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Quantity limits based on daily dosage as determined by FDA labeling</li> <li>Quantity limits to include:               <ul style="list-style-type: none"> <li>Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration)</li> <li>Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days. Concerta 36mg and 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.</li> <li>Azstarys; not to exceed 1 dosage unit per day</li> <li>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.</li> </ul> </li> </ul>
<b>Movement Disorder Agents <span style="color: red;">CC</span></b>		
Austedo® Ingrezza® Ingrezza® titration pack tetrabenazine	Xenazine®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis for an FDA-approved or compendia-supported indication</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IV. Central Nervous System</b>		
<b>Multiple Sclerosis Agents</b>		
Avonex® Betaseron® Copaxone® 20 mg/mL <span style="color: red;">BLTG</span> dimethyl fumarate DR	Aubagio® Bafiertam™ Copaxone® 40 mg/mL Extavia® Gilenya® glatiramer Kesimpta® Mavenclad® Mayzent® Plegridy® Ponvory™ <span style="color: red;">F/Q/D</span> Rebif® Rebif® Rebidose® Tecfidera® Vumerity® Zeposia®	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>• <b>Ponvory™ (ponesimod) starter pack</b>; maximum quantity is 14, no refills</li> <li>• <b>Ponvory™ (ponesimod)</b>; maintenance limited to a 30 day supply</li> </ul>
<b>Non-Ergot Dopamine Receptor Agonists</b>		
pramipexole ropinirole	Kynmobi™ <span style="color: red;">CC</span> Mirapex ER® Neupro® pramipexole ER ropinirole ER	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>• <b>apomorphine (Kynmobi™)</b>: Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication</li> </ul>
<b>Other Agents for Attention Deficit Hyperactivity Disorder (ADHD) <span style="color: red;">CC</span></b>		
atomoxetine <span style="color: red;">DO</span> clonidine ER <sup>1</sup> guanfacine ER <span style="color: red;">DO</span>	Intuniv® <span style="color: red;">DO</span> Qelbree™ Strattera® <span style="color: red;">DO</span>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>• Confirm diagnosis for an FDA-approved or compendia-supported indication for beneficiaries &lt; 18 years of age.</li> <li>• Prior authorization is required for initial prescriptions for non-stimulant therapy for beneficiaries <b>less than 6 years of age</b></li> </ul> <b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>• See Dose Optimization Chart for affected strengths</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IV. Central Nervous System</b>		
<b>Sedative Hypnotics/Sleep Agents <span style="color: red;">F/Q/D</span></b>		
<p>estazolam <span style="color: red;">CC</span>                      flurazepam <span style="color: red;">CC</span>                      temazepam 15 mg, 30 mg <span style="color: red;">CC</span>                      zolpidem <span style="color: red;">CC</span></p>	<p>Ambien® <span style="color: red;">CC</span>                      Ambien CR® <span style="color: red;">CC</span>                      Belsomra®                      Dayvigo™                      doxepin (generic for Silenor®)                      Edluar® <span style="color: red;">CC</span>                      eszopiclone                      Halcion® <span style="color: red;">CC</span>                      Lunesta®                      Quviviq™                      ramelteon (generic for Rozerem®)                      Restoril® <span style="color: red;">CC</span>                      Rozerem®                      Silenor®                      temazepam 7.5 mg, 22.5 mg <span style="color: red;">CC</span>                      triazolam <span style="color: red;">CC</span>                      zaleplon                      zolpidem (sublingual) <span style="color: red;">CC</span>                      zolpidem ER <span style="color: red;">CC</span></p>	<p><b>DOSE OPTIMIZATION (DO)</b></p> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul> <p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li><b>Zolpidem products:</b> Confirm dosage is consistent with FDA labeling for initial prescriptions</li> <li><b>Benzodiazepine Agents</b> (estazolam, flurazepam, Halcion®, Restoril®, temazepam, triazolam):                             <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy</li> <li>PA required for any additional benzodiazepine prescription in patients currently on benzodiazepine therapy</li> <li>PA required when greater than a 14-day supply of a benzodiazepine is prescribed for someone on a CNS stimulant</li> </ul> </li> </ul> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <ul style="list-style-type: none"> <li>Frequency and duration limits for the following products:                             <ul style="list-style-type: none"> <li>For <b>non-zaleplon</b> and <b>non-benzodiazepine</b> containing products:                                     <ul style="list-style-type: none"> <li>30 dosage units per fill/1 dosage unit per day/30 days</li> </ul> </li> <li>For <b>zaleplon</b>-containing products:                                     <ul style="list-style-type: none"> <li>60 dosage units per fill/2 dosage units per day/30 days</li> </ul> </li> <li>Duration limit equivalent to the maximum recommended duration:                                     <ul style="list-style-type: none"> <li>180 days for immediate-release <b>zolpidem</b> (Ambien®, Edluar®) products</li> <li>180 days for <b>eszopiclone</b> and <b>ramelteon</b> (Rozerem®) products</li> <li>180 days for lemborexant (Dayvigo™)</li> <li>168 days for <b>zolpidem ER</b> (Ambien CR®) products</li> <li>90 days for daridorexant (Quviviq™)</li> <li>90 days for <b>suvorexant</b> (Belsomra®)</li> </ul> </li> </ul> </li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IV. Central Nervous System</b>		
		<ul style="list-style-type: none"> <li>o 90 days for <b>doxepin</b> (Silenor®)</li> <li>o 30 days for zaleplon (Sonata®) products</li> <li>o 30 days for benzodiazepine agents (estazolam, flurazepam, Halcion®, Restoril®, temazepam, triazolam) for the treatment of insomnia</li> </ul> <p>Additional/Alternate parameters:</p> <ul style="list-style-type: none"> <li>• For patients naïve to non-benzodiazepine sedative hypnotics (NBSH): First-fill duration and quantity limit of 10 dosage units as a 10-day supply, except for zaleplon-containing products which the quantity limit is 20 dosage units as a 10-day supply</li> </ul>
<b>Selective Serotonin Reuptake Inhibitors (SSRIs)</b>		
Citalopram (tablet) escitalopram (tablet) fluoxetine (capsule, solution) paroxetine (tablets) sertraline tablets	Brisdelle® Celexa® citalopram (capsules) escitalopram (soln) fluoxetine (tablet) fluoxetine DR weekly fluvoxamine <sup>CC</sup> fluvoxamine ER <sup>CC</sup> Lexapro® <sup>DO</sup> paroxetine (capsules) paroxetine CR paroxetine suspension Paxil® Paxil CR® Pexeva® Prozac® sertraline capsules Trintellix® <sup>DO</sup> Viibryd® <sup>DO</sup> vilazodone (gen Viibryd®) Zoloft®	<p><b>DOSE OPTIMIZATION (DO)</b></p> <ul style="list-style-type: none"> <li>• See Dose Optimization Chart for affected strengths</li> </ul> <p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>• Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA</li> <li>• Clinical editing to allow patients with a diagnosis of Obsessive-Compulsive Disorder (OCD) to receive fluvoxamine and fluvoxamine ER without prior authorization</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IV. Central Nervous System</b>		
<b>Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)</b>		
duloxetine 20 mg, 30 mg, 60 mg (generic for Cymbalta®) venlafaxine venlafaxine ER (capsule) <span style="color: red;">DO</span>	Cymbalta® desvenlafaxine ER desvenlafaxine succinate ER <span style="color: red;">DO</span> Drizalma Sprinkle™ duloxetine 40 mg Effexor XR® <span style="color: red;">DO</span> Fetzima® Pristiq® <span style="color: red;">DO</span> Savella® venlafaxine ER (tablet)	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>V. Dermatologic Agents</b>		
<b>Acne Agents, Topical</b>		
adapalene/benzoyl peroxide (generic for Epiduo) adapalene cream Differin® OTC (1% gel) Retin-A® cream <sup>CC, BLTG</sup> tazarotene cream <sup>CC</sup> tretinoin gel (generic Avita, Retin-A) <sup>CC</sup>	adapalene (gel, gel pump) adapalene/benzoyl peroxide (gen Epiduo® Forte) Akliel® <sup>CC</sup> Altreno® <sup>CC</sup> Amzeeq™ <sup>F/Q/D</sup> Arazlo™ <sup>CC</sup> Atralin® <sup>CC</sup> Avita® <sup>CC</sup> clindamycin / tretinoin <sup>CC</sup> dapsone Differin® (Rx gel, solution, lotion, cream) Epiduo® Forte Fabior® <sup>CC</sup> Retin-A® gel <sup>CC</sup> Retin-A Micro® <sup>CC</sup> tazarotene foam (generic Fabior®) <sup>CC</sup> tazarotene gel <sup>CC</sup> tretinoin cream, gel <sup>CC</sup> (generic Atralin) tretinoin micro <sup>CC</sup> Twyneo® <sup>F/Q/D, CC</sup> Winlevi® Ziana® <sup>CC</sup>	<b>CLINICAL CRITERIA</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication</li> <li>FREQUENCY/QUANTITY/DURATION (F/Q/D) <b>Amzeeq™ (minocycline), Twyneo® (tretinoin/benzoyl peroxide)</b> – maximum quantity is 30 grams per month</li> </ul>
<b>Actinic Keratosis Agents</b>		
diclofenac 3% gel <sup>CC</sup> fluorouracil (solution) fluorouracil 0.5% cream (generic Carac) fluorouracil 5% cream (generic Efudex cream) imiquimod (generic Aldara)	Aldara® Carac® Efudex® imiquimod (generic Zyclara) Tolak® Zyclara®	<b>CLINICAL CRITERIA</b> <ul style="list-style-type: none"> <li>diclofenac 3% gel: confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>V. Dermatologic Agents</b>		
<b>Antibiotics – Topical</b>		
mupirocin (ointment)	Centany® mupirocin (cream) Xepi™	
<b>Anti-Fungals – Topical</b>		
ciclopirox (cream, suspension) clotrimazole OTC clotrimazole / betamethasone (cream) ketoconazole cream ketoconazole 2% shampoo 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 foam Loprox® shampoo luliconazole Luzu® Mentax® miconazole/zinc/petrolatum (gen Vusion®) <sup>F/Q/D</sup> naftifine Naftin® nystatin/ triamcinolone oxiconazole Oxistat® sulconazole (gen Exelderm®) Vusion® <sup>F/Q/D</sup>	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b>  <ul style="list-style-type: none"> <li><b>Vusion® 50 gm ointment</b> – Maximum 100 grams in a 90-day time period</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>V. Dermatologic Agents</b>		
<b>Anti-Infectives – Topical</b>		
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®	
<b>Anti-Virals – Topical</b>		
acyclovir cream docosanol (generic Abreva)	acyclovir (ointment) Denavir® Sitavig® Xerese® Zovirax® (cream, ointment)	
<b>Immunomodulators – Topical <sup>CC</sup></b>		
pimecrolimus tacrolimus	Elidel® Protopic®	<b>CLINICAL CRITERIA</b> <ul style="list-style-type: none"> <li>All prescriptions require prior authorization</li> <li>Refills on prescriptions are allowed</li> </ul>



## NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>V. Dermatologic Agents</b>		
<b>Steroids, Topical – High Potency</b>		
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®	

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>V. Dermatologic Agents</b>		
<b>Steroids, Topical – Very High Potency</b>		
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® Ultravate®	

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Anabolic Steroids – Topical <span style="color: red;">CDRP, F/Q/D</span></b>		
testosterone gel testosterone pump	Androderm® AndroGel® pump Fortesta® Testim® Vogelxo	<p><b>CLINICAL DRUG REVIEW PROGRAM (CDRP)</b></p> <ul style="list-style-type: none"> <li>• For diagnosis of hypogonadotropic or primary hypogonadism:               <ul style="list-style-type: none"> <li>– Requires documented low testosterone concentration with two tests prior to initiation of therapy.</li> <li>– Require documented testosterone therapeutic concentration to confirm response after initiation of therapy.</li> </ul> </li> <li>• For diagnosis of delayed puberty:               <ul style="list-style-type: none"> <li>– Requires documentation that growth hormone deficiency has been ruled out prior to initiation of therapy.</li> <li>– 1.62% gel only: For diagnosis of gender dysphoria please refer to <a href="https://www.health.ny.gov/health_care/medicaid/program/update/2020/no12_2020-07.htm#transgender">July 2020 edition of the Medicaid Update</a>; <a href="https://www.health.ny.gov/health_care/medicaid/program/update/2020/no12_2020-07.htm#transgender">https://www.health.ny.gov/health_care/medicaid/program/update/2020/no12_2020-07.htm#transgender</a></li> </ul> </li> <li>• The Anabolic Steroid fax form can be found at: <a href="https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PA_Worksheet_Prescribers_Anabolic_Steroids.docx">https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PA_Worksheet_Prescribers_Anabolic_Steroids.docx</a></li> </ul> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <ul style="list-style-type: none"> <li>• Limitations for anabolic steroid products based on approved FDA labeled daily dosing and documented diagnosis:               <ul style="list-style-type: none"> <li>– Duration limit of 6 months for delayed puberty</li> </ul> </li> </ul>
<b>Biguanides</b>		
metformin HCl metformin ER (generic for Glucophage XR®)	Glumetza® metformin solution (generic Riomet®) metformin ER <sup>DQ</sup> (generic for Fortamet®, Glumetza®) Riomet® Riomet ER™	<p><b>DOSE OPTIMIZATION (DO)</b></p> <ul style="list-style-type: none"> <li>• See Dose Optimization Chart for affected strengths</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters	
<b>VI. Endocrine and Metabolic Agents</b>			
<b>Bisphosphonates – Oral <span style="color: red;">F/Q/D</span></b>			
alendronate	Actonel® Atelvia® Boniva® Fosamax® Fosamax® Plus D ibandronate risedronate	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b>	
		ibandronate sodium 150 mg (Boniva® 150 mg)	1 tablet every 28 days
		risedronate sodium 150 mg (Actonel® 150 mg)	
		alendronate sodium 35 mg (Fosamax® 35 mg)	4 tablets every 28 days
		alendronate sodium 70 mg (Fosamax® 70 mg, Binosto®)	
		alendronate sodium and cholecalciferol (Fosamax® Plus D)	
		risedronate sodium 35 mg (Actonel® 35 mg)	
		risedronate sodium 35 mg (Atelvia® 35 mg)	
		alendronate solution 70 mg/75 mL single-dose bottle	4 bottles every 28 days
<b>Dipeptidyl Peptidase-4 (DPP-4) Inhibitors <span style="color: red;">ST</span></b>			
Glyxambi® Janumet® Janumet® XR Januvia® <span style="color: red;">DO</span> Jentadueto® Kazano® <span style="color: red;">BLTG</span> Nesina® <span style="color: red;">BLTG</span> Tradjenta®	alogliptin alogliptin / metformin alogliptin / pioglitazone Jentadueto® XR Kombiglyze® XR Onglyza® <span style="color: red;">DO</span> Oseni® Qtern® Steglujan®	<b>DOSE OPTIMIZATION (DO)</b>	
		<ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul>	
		<b>STEP THERAPY (ST)</b>	
		<ul style="list-style-type: none"> <li>Requires a trial with metformin with or without insulin prior to DPP-4 Inhibitor therapy unless there is a documented contraindication.</li> </ul>	

1 = Preferred as of 11/17/2022  
2 = Non-Preferred as of 11/17/2022

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Glucagon Agents</b>		
glucagon vial <sup>1</sup> glucagon HCl emergency kit <sup>1</sup> (Fresenius) Zegalogue® <sup>1</sup> (pen, syringe)	Baqsimi® <sup>2</sup> glucagon emergency kit <sup>2</sup> (Eli Lilly, Amphastar) GVOKE® <sup>2</sup> (pen, syringe, vial)	
<b>Glucagon-like Peptide-1 (GLP-1) Agonists <sup>CC, ST</sup></b>		
Byetta® Ozempic® Trulicity® Victoza®	Adlyxin® Bydureon® BCise™ Mounjaro™ Rybelsus® Soliqua® Xultophy®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication</li> </ul> <b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>Requires a trial with metformin with or without insulin prior to a GLP-1 agonist</li> </ul>
<b>Glucocorticoids – Oral</b>		
budesonide EC, DR dexamethasone (tablet) hydrocortisone methylprednisolone (dose-pack) prednisolone (solution) prednisone (dose-pack, tablet)	Alkindi® Sprinkle 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® Millipred® DP Ortikos™ prednisolone ODT prednisone (intensol, solution) Rayos® Uceris®	

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Growth Hormones</b> <small>CC, CDRP</small>		
Genotropin® Norditropin®	Humatrope® Nutropin AQ® Omnitrope® Saizen® Skytrofa® Zomacton® Zorbtive®	<b>CLINICAL DRUG REVIEW PROGRAM (CDRP)</b> <ul style="list-style-type: none"> <li>Prescribers or their authorized agents may call or submit a fax request for a PA for beneficiaries 18 years of age or older</li> </ul> <b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>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.</li> <li>Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
<b>Insulin – Long-Acting</b>		
insulin glargine solostar, vial (gen Lantus® Solostar®, vial) Levemir®	Basaglar® insulin degludec vial, pen (gen Tresiba) insulin glargine-YFGN: vial, pen Lantus® Solostar®, vial Semglee® Semglee®-YFGN: vial, pen Toujeo® Solostar® Toujeo® Max Solostar® Tresiba®	
<b>Insulin – Mixes</b>		
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, pen (generic for Novolog)	Humalog® 75/25 mix: pen Novolog® Mix: vial, pen	



## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Insulin – Rapid-Acting</b>		
Apidra® insulin aspart (generic Novolog®) cartridge, vial, pen insulin lispro (generic Humalog® U100) vial, pen insulin lispro junior (generic Humalog® Jr.)	Admelog® Afrezza® Fiasp® (Penfill, FlexTouch) Humalog® 200 U/mL Humalog® Jr. 100 U/mL Humalog® 100 U/mL vial, pen Lyumjev™ Novolog® cartridge, vial, FlexPen	
<b>Meglitinides <sup>ST</sup></b>		
nateglinide repaglinide	repaglinide/ metformin	<b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>Requires a trial with metformin with or without insulin prior to initiating meglitinide therapy unless there is a documented contraindication.</li> </ul>
<b>Pancreatic Enzymes</b>		
Creon® Zenpep®	Pancreaze® Pertzye® Viokace®	
<b>Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors <sup>ST</sup></b>		
Farxiga® Invokana® Jardiance®	Invokamet® Invokamet® XR Segluromet® Steglatro® Synjardy® Synjardy® XR Trijardy® XR Xigduo® XR	<b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>Requires a trial with metformin with or without insulin prior to initiating SGLT2 Inhibitor therapy unless there is a documented contraindication.</li> <li>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.</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Thiazolidinediones (TZDs) <sup>ST</sup></b>		
pioglitazone	ACTOplus Met® Actos® <sup>DO</sup> Duetact® pioglitazone / glimepiride pioglitazone / metformin	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul> <b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>Requires a trial with metformin with or without insulin prior to initiating TZD therapy unless there is a documented contraindication.</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VII. Gastrointestinal</b>		
<b>Anti-Emetics</b>		
aprepitant pack doxylamine succ/pyridoxine ondansetron (ODT, solution, tablet)	Akynzeo® Anzemet® aprepitant (capsule) Bonjesta® <sup>CC</sup> Diclegis® <sup>CC</sup> Emend® (capsule, powder packet, TriPack) granisetron (tablet) Sancuso®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>• <b>Diclegis®</b> and <b>Bonjesta®</b>: Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
<b>Gastrointestinal Antibiotics</b>		
Firvanq® <sup>BLTG</sup> metronidazole (tablet) neomycin vancomycin (capsule)	Difucid® Flagyl® metronidazole (capsule) nitazoxanide paromomycin tinidazole Vancocin® vancomycin (solution) Xifaxan® <sup>CC, ST, F/Q/D</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>• <b>Xifaxan®</b>: Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul> <b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>• <b>Xifaxan®</b>: Requires trial of a preferred fluoroquinolone antibiotic before rifaximin for treatment of Traveler's diarrhea</li> </ul> <b>QUANTITY LIMITS:</b> <ul style="list-style-type: none"> <li>• <b>Xifaxan®</b>:               <ul style="list-style-type: none"> <li>– Traveler's diarrhea (200 mg tablet) – 9 tablets per 30 days (Dose = 200 mg 3 times a day for 3 days)</li> <li>– Hepatic encephalopathy (550 mg tablets) – 60 tablets per 30 days (Dose = 550 mg twice a day)</li> <li>– Irritable bowel syndrome with diarrhea (550 mg tablets) – 42 tablets per 30 days (Dose = 550 mg three times a day for 14 days)                   <ul style="list-style-type: none"> <li>o Maximum of 42 days' supply (126 units) per 365 (3 rounds of therapy).</li> </ul> </li> </ul> </li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VII. Gastrointestinal</b>		
<b>Helicobacter pylori Agents</b>		
Pylera®	lansoprazole / amoxicillin / clarithromycin Omeclamox-Pak® Talicia®	
<b>Proton Pump Inhibitors (PPIs) <sup>F/Q/D</sup></b>		
omeprazole Rx pantoprazole tablet Zegerid® <sup>BLTG</sup>	Aciphex® Dexilant® <sup>DO</sup> dexlansoprazole (gen Dexilant) esomeprazole magnesium Rx, OTC (generic for Nexium) lansoprazole Rx (capsule, ODT) Nexium® RX <sup>DO</sup> omeprazole OTC omeprazole / sodium bicarbonate Rx omeprazole / sodium bicarbonate OTC pantoprazole suspension Prevacid® OTC Prevacid® Rx <sup>DO</sup> Prilosec® Rx Protonix® rabeprazole	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Quantity limits: <ul style="list-style-type: none"> <li>Once daily dosing for: <ul style="list-style-type: none"> <li>GERD</li> <li>erosive esophagitis</li> <li>healing and maintenance of duodenal/gastric ulcers (including NSAID-induced)</li> <li>prevention of NSAID-induced ulcers</li> </ul> </li> <li>Twice daily dosing for: <ul style="list-style-type: none"> <li>hypersecretory conditions</li> <li>Barrett's esophagitis</li> <li>H. pylori</li> <li>refractory GERD</li> </ul> </li> </ul> </li> <li>Duration limits: <ul style="list-style-type: none"> <li>90 days for: <ul style="list-style-type: none"> <li>GERD</li> </ul> </li> <li>365 days for: <ul style="list-style-type: none"> <li>Maintenance treatment of duodenal ulcers, or erosive esophagitis</li> </ul> </li> <li>14 days for: <ul style="list-style-type: none"> <li>H. pylori</li> </ul> </li> </ul> </li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VII. Gastrointestinal</b>		
<b>Sulfasalazine Derivatives</b>		
Apriso® <a href="#">BLTG</a> Lialda® <a href="#">BLTG</a> Pentasa® <a href="#">BLTG</a> 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 ER (generic for Pentasa®) mesalamine DR	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VIII. Hematological Agents</b>		
<b>Anticoagulants – Injectable <sup>F/Q/D</sup></b>		
enoxaparin sodium Fragmin <sup>®</sup> (vial)	Arixtra <sup>®</sup> <sup>CC</sup> fondaparinux <sup>CC</sup> Fragmin <sup>®</sup> (syringe) Lovenox <sup>®</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>For patients requiring &gt; 30 days of therapy: Require confirmation of FDA-approved or compendia-supported indication</li> <li><b>Arixtra<sup>®</sup> (fondaparinux)</b> Clinical editing to allow patients with a diagnosis of Heparin Induced Thrombocytopenia (HIT) to receive therapy without prior authorization.</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Duration Limit: No more than 30 days for members initiating therapy</li> </ul>
<b>Anticoagulants – Oral</b>		
Eliquis <sup>®</sup> Pradaxa <sup>®</sup> <sup>BLTG</sup> warfarin Xarelto <sup>®</sup> (10 mg) <sup>DO</sup>	dabigatran (generic Pradaxa <sup>®</sup> ) Savaysa <sup>®</sup> Xarelto <sup>®</sup> (dose pack, suspension)	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul>
<b>Colony Stimulating Factors</b>		
Neupogen <sup>®</sup> Nyvepria <sup>™</sup>	Fulphila <sup>™</sup> Granix <sup>®</sup> Leukine <sup>®</sup> Neulasta <sup>®</sup> Nivestym <sup>™</sup> Releuko <sup>™</sup> Udenyca <sup>®</sup> Zarxio <sup>®</sup> Ziextenzo <sup>®</sup>	
<b>Erythropoiesis Stimulating Agents (ESAs) <sup>CC</sup></b>		
Epogen <sup>®</sup> Retacrit <sup>®</sup>	Aranesp <sup>®</sup> Mircera <sup>®</sup> Procrit <sup>®</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis for FDA- or compendia-supported uses</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VIII. Hematological Agents</b>		
<b>Hemophilia Agents – Factor VIII</b>		
Advate® Adynovate® Afstyla® Eloctate® Esperoct® Hemofil® M Humate-P® Jivi® Koate® Kogenate® FS Kovaltry® Novoeight® Nuwiq® Obizur® Recombinate™ Xyntha® Xyntha® Solofuse	N/A	
<b>Hemophilia Agents – Factor IX</b>		
AlphaNine® SD Alprolix® BeneFIX® Idelvion® Ixinity® Profilnine® Rebinyn® Rixubis®	N/A	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VIII. Hematological Agents</b>		
<b>Hemophilia Agents – Other</b>		
Alphanate® (von Willebrand factor / Factor VIII) Coagadex® (Factor X) Corifact® (Factor XIII) Feiba® NF (activated prothrombin complex) Hemlibra® (emicizumab-kxwh) Novoseven® RT (Factor VIIa) Sevenfact® (Factor VIIa-jncw) Tretten® (Factor XIII) Vonvendi® (von Willebrand factor) Wilate® (von Willebrand factor / Factor VIII)	N/A	
<b>Platelet Inhibitors</b>		
Brilinta® clopidogrel dipyridamole dipyridamole / aspirin	Effient® Plavix® prasugrel Zontivity®	



## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IX. Immunologic Agents</b>		
<b>Immunomodulators – Systemic <span style="color: red;">CC, ST</span></b>		
<p>Cosentyx® Dupixent® Enbrel® Fasenra® Humira® Nucala® Xolair®</p>	<p>Actemra® (subcutaneous) Adbry™ Cibinqo™ Cimzia® Ilumya® Kevzara® Kineret® Olumiant® Orencia® (subcutaneous) Otezla® Rinvoq™ ER Siliq™ Simponi® Skyrizi™ Sotyktu™ Stelara® Taltz® Tremfya® Xeljanz® Xeljanz® XR</p>	<p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>Confirm diagnosis for FDA- or compendia-supported uses</li> </ul> <p><b>STEP THERAPY (ST)</b></p> <ul style="list-style-type: none"> <li>Trial of a disease-modifying anti-rheumatic drug (DMARD) prior to treatment with an immunomodulator for <b>indications not specified below</b></li> <li>Trial of a TNF inhibitor prior to treatment with a JAK inhibitor for <b>indications not specified below</b></li> </ul> <p><b>INDICATION-SPECIFIC REQUIREMENTS:</b></p> <ul style="list-style-type: none"> <li>Asthma:             <ul style="list-style-type: none"> <li>history and concurrent use of a corticosteroid</li> </ul> </li> <li>Nasal polyps:             <ul style="list-style-type: none"> <li>history and concurrent use of an intranasal corticosteroid</li> </ul> </li> <li>Atopic dermatitis:             <ul style="list-style-type: none"> <li>Trial with a topical prescription product for a duration of at least 3 months.</li> <li>For JAK inhibitors: Trial of topical prescription product and systemic product for a combined duration of at least 6 months.</li> </ul> </li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IX. Immunologic Agents</b>		
<b>Immunosuppressives, Oral</b>		
azathioprine CellCept® (suspension) <b>BLTG</b> cyclosporine (softgel, capsule) cyclosporine modified (capsule, solution) mycophenolate mofetil (capsule, tablet) Rapamune® (solution) <b>BLTG</b> sirolimus (tablet) tacrolimus	Astagraf XL® Azasan® CellCept® (capsule, tablet) Envarsus XR® everolimus (gen Zortress®) Imuran® Lupkynis™ <b>CC, ST, F/Q/D</b> mycophenolic acid mycophenolate mofetil (suspension) Myfortic® Neoral® Prograf® Rapamune® (tablet) Sandimmune® (solution, capsule) sirolimus (solution) Zortress®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Lupkynis™ (voclosporin) – Confirm diagnosis for FDA- or compendia-supported uses</li> </ul> <b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>Trial of mycophenolate prior to Lupkynis™</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Lupkynis™ limited to 30-day supply</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>X. Miscellaneous Agents</b>		
<b>Progestins (for Cachexia)</b>		
megestrol acetate (suspension)	megestrol 625 mg/5 mL (suspension)	
<b>Epinephrine – Self-injected</b>		
EpiPen® <a href="#">BLTG</a> EpiPen Jr.® <a href="#">BLTG</a>	epinephrine (generic for Adrenaclick®) epinephrine (generic for EpiPen®) epinephrine (generic for EpiPen Jr.®) Symjepi®	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XI. Musculoskeletal Agents</b>		
<b>Skeletal Muscle Relaxants</b>		
baclofen (tablet) chlorzoxazone 500 mg cyclobenzaprine 5 mg, 10 mg (tablet) dantrolene methocarbamol orphenadrine ER tizanidine (tablet)	Amrix® baclofen (solution) <sup>F/Q/D</sup> carisoprodol <sup>ST, F/Q/D</sup> carisoprodol compound <sup>ST, F/Q/D</sup> carisoprodol compound / codeine <sup>CC, ST, F/Q/D</sup> chlorzoxazone (generic for Lorzone) 375 mg, 750 mg cyclobenzaprine 7.5 mg cyclobenzaprine ER (generic for Amrix) capsule Dantrium® Fexmid® Fleqsuvy™ Lorzone® Lyvispah™ metaxalone Norgesic® Forte Skelaxin® Soma® <sup>ST, F/Q/D</sup> Soma® 250 <sup>ST, F/Q/D</sup> tizanidine (capsule) Zanaflex®	<b>CLINICAL CRITERIA (CC)</b> For carisoprodol/codeine products: <ul style="list-style-type: none"> <li>Limited to a total of 4 opioid prescriptions every 30 days; exemption for diagnosis of cancer or sickle cell disease</li> <li>Medical necessity rationale for opioid therapy is required for patients on established opioid dependence therapy</li> <li>PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy</li> <li>PA required for any codeine containing products in patients &lt; 12 years</li> </ul> <b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>Trial with 1 preferred analgesic and 2 preferred skeletal muscle relaxants prior to use of <b>carisoprodol</b> containing products:               <ul style="list-style-type: none"> <li>– carisoprodol</li> <li>– carisoprodol/ASA</li> <li>– carisoprodol/ASA/codeine</li> <li>– Soma®</li> </ul> </li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Maximum 84 cumulative units per a year</li> <li>Baclofen solution – Maximum 946 mL per 30 days</li> <li><b>Carisoprodol</b> – Maximum 4 units per day, 21-day supply</li> <li><b>Carisoprodol combinations</b> – Maximum 8 units per day, 21-day supply (not to exceed the 84 cumulative units per year limit)</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XII. Ophthalmics</b>		
<b>Alpha-2 Adrenergic Agonists (for Glaucoma) – Ophthalmic</b>		
Alphagan P® 0.1% Alphagan P® 0.15% <a href="#">BLIG</a> brimonidine 0.2% Simbrinza®	apraclonidine brimonidine P 0.15% lopidine®	
<b>Antibiotics – Ophthalmic</b>		
bacitracin / polymyxin B erythromycin gentamicin Natacyn® neomycin / gramicidin / polymyxin polymyxin / trimethoprim sulfacetamide (solution) tobramycin	Azasisite® bacitracin Bleph®-10 neomycin / bacitracin / polymyxin Polytrim® sulfacetamide (ointment) Tobrex®	
<b>Antibiotics/Steroid Combinations – Ophthalmic</b>		
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®	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XII. Ophthalmics</b>		
<b>Antihistamines – Ophthalmic</b>		
olopatadine OTC	azelastine bepotastine (gen Bepreve®) Bepreve® epinastine ketotifen OTC Lastacaft® olopatadine Rx Pataday® Zaditor® OTC Zerviate™	
<b>Anti-inflammatories/Immunomodulators – Ophthalmic <span style="color: red;">CC, F/Q/D</span></b>		
Restasis® <span style="color: red;">BLTG</span> Restasis MultiDose® Xiidra®	Cequa® cyclosporine (gen Restasis®) Tyrvaya™	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Diagnosis documentation required to justify utilization as a first line agent or attempt treatment with an artificial tear, gel, or ointment.</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Cequa®, Restasis®, Xiidra®: 60 vials dispensed as a 30-day supply;</li> <li>Restasis Multidose®: 5.5 mL dispensed as a 25-day supply</li> </ul>
<b>Beta Blockers – Ophthalmic</b>		
betaxolol Betoptic S® carteolol Combigan® <span style="color: red;">BLTG</span> Istalol® levobunolol timolol maleate solution (gen Istalol®) timolol maleate gel (gen Timoptic-XE®)	Betimol® brimonidine / timolol (gen Combigan®) timolol maleate (gen Timoptic® and Timoptic® Ocudose®) Timoptic® Timoptic® Ocudose® Timoptic-XE®	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XII. Ophthalmics</b>		
<b>Fluoroquinolones – Ophthalmic <sup>ST</sup></b>		
ciprofloxacin moxifloxacin (gen Vigamox®) ofloxacin	Besivance® Ciloxan® gatifloxacin levofloxacin Moxeza® moxifloxacin (gen Moxeza®) Ocuflax® Vigamox® Zymaxid®	<b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>• For patients 21 years or younger, attempt treatment with a non-fluoroquinolone ophthalmic antibiotic before progressing to a fluoroquinolone ophthalmic product</li> <li>• Examples of Non-Fluoroquinolone Ophthalmic Antibiotics               <ul style="list-style-type: none"> <li>– AK-Poly-Bac eye ointment</li> <li>– bacitracin-polymyxin eye ointment</li> <li>– erythromycin eye ointment</li> <li>– Gentak® (3 mg/gm eye ointment, 3 mg/mL eye drops)</li> <li>– gentamicin (3 mg/gm eye ointment, 3 mg/mL eye drops)</li> <li>– neomycin-polymyxin-gramicidin eye drops</li> <li>– polymyxin B-TMP eye drops</li> <li>– Romycin® eye ointment</li> <li>– sulfacetamide 10% eye drops</li> <li>– Sulfamide® 10% eye drops</li> <li>– tobramycin 0.3% eye drops</li> <li>– Tobrasol™ 0.3% eye drops</li> </ul> </li> </ul>
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) – Ophthalmic</b>		
diclofenac flurbiprofen Ilevro® ketorolac	Acular® Acular LS® Acuvail® bromfenac BromSite® Nevanac® Prolensa®	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XIII. Otics</b>		
<b>Fluoroquinolones – Otic</b>		
Cipro HC® Ciprodex® <span style="color: red;">BLTG</span> ofloxacin	ciprofloxacin ciprofloxacin/dexamethasone (generic for Ciprodex®) ciprofloxacin/fluocinolone (generic for Otovel™) Otovel™	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XIV. Renal and Genitourinary</b>		
<b>Alpha Reductase Inhibitors for BPH</b>		
finasteride	Avodart® dutasteride dutasteride / tamsulosin Entadfi™ Jalyn® Proscar®	
<b>Antihyperuricemics</b>		
allopurinol colchicine (tablet) febuxostat probenecid probenecid/colchicine	colchicine (capsule) Colcrys Gloperba® Mitigare® Uloric® Zyloprim®	
<b>Cystine Depleting Agents <sup>CC</sup></b>		
Cystagon®	Procysbi® <sup>ST</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul> <b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>Requires a trial with Cystagon immediate-release capsules</li> </ul>
<b>Phosphate Binders/Regulators</b>		
calcium acetate Renvela® tablets <sup>BLTG</sup> sevelamer HCl (generic for Renagel)	Auryxia™ Fosrenol® lanthanum carbonate Phoslyra® sevelamer carbonate powder and tablets (generic for Renvela) Velphoro®	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XIV. Renal and Genitourinary</b>		
<b>Selective Alpha Adrenergic Blockers</b>		
alfuzosin tamsulosin	Flomax® Rapaflo® silodosin	
<b>Urinary Tract Antispasmodics</b>		
fesoterodine ER (gen Toviaz®) oxybutynin solifenacin	darifenacin Detrol® Detrol LA® <sup>DO</sup> Ditropan XL® flavoxate Gelnique® Gemtesa® Myrbetriq® <sup>DO</sup> Myrbetriq® solution <sup>F/Q/D</sup> oxybutynin ER <sup>DO</sup> Oxytrol® tolterodine tolterodine ER Toviaz® <sup>DO</sup> trospium trospium ER Vesicare® <sup>DO</sup>	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Myrbetriq® solution; limited to a 30-day supply</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XV. Respiratory</b>		
<b>Anticholinergics / COPD Agents</b>		
Anoro Ellipta® Atrovent HFA® Bevespi® Aerosphere® Combivent Respimat® ipratropium ipratropium / albuterol Spiriva® Spiriva Respimat® Stiolto Respimat®	Breztri™ Aerosphere Daliresp® Duaklir® Pressair Incruse Ellipta® Lonhala® Magnair® Trelegy Ellipta® Tudorza Pressair® Yupelri®	
<b>Antihistamines – Intranasal</b>		
azelastine olopatadine	Patanase®	
<b>Antihistamines – Second Generation</b>		
cetirizine OTC (tablet) cetirizine OTC (syrup/solution 1mg/ 1mL) levocetirizine (tablet) loratadine OTC	cetirizine OTC (chewable) cetirizine OTC (syrup/solution 5 mg/5 mL) cetirizine-D OTC Clarinex® <sup>CC</sup> Clarinex-D® OTC desloratadine fexofenadine OTC (tablet) levocetirizine (solution) loratadine-D OTC	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>No prior authorization required for patients less than 24 months of age</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																
<b>XV. Respiratory</b>																		
<b>Beta2 Adrenergic Agents – Inhaled Long-Acting <span style="color: red;">CC, F/Q/D</span></b>																		
formoterol (generic Perforomist®) Serevent Diskus®	arformoterol (generic Brovana®) Brovana® Perforomist® Striverdi Respimat®	<p><b>CLINICAL CRITERIA (CC)</b> PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA- or compendia-supported age as indicated:</p> <table border="1"> <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> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> Maximum units per 30 days</p> <table border="1"> <tr> <td>Brovana® / arformoterol</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>	Brovana® / arformoterol	≥ 18 years	Perforomist® / formoterol	≥ 18 years	Serevent Diskus®	≥ 4 years	Striverdi Respimat®	≥ 18 years	Brovana® / arformoterol	60 units (1 carton of 60 vials or 120 mL)	Perforomist® / formoterol	60 units (1 carton of 60 vials or 120 mL)	Serevent Diskus®	1 diskus (60 blisters)	Striverdi Respimat®	1 unit (one cartridge and one Respimat inhaler)
Brovana® / arformoterol	≥ 18 years																	
Perforomist® / formoterol	≥ 18 years																	
Serevent Diskus®	≥ 4 years																	
Striverdi Respimat®	≥ 18 years																	
Brovana® / arformoterol	60 units (1 carton of 60 vials or 120 mL)																	
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Serevent Diskus®	1 diskus (60 blisters)																	
Striverdi Respimat®	1 unit (one cartridge and one Respimat inhaler)																	
<b>Beta2 Adrenergic Agents – Inhaled Short-Acting</b>																		
albuterol nebulizer solution Ventolin HFA® <span style="color: red;">BLTG</span>	albuterol HFA levalbuterol (solution) levalbuterol HFA ProAir® Digihaler™ ProAir® RespiClick Proventil HFA® Xopenex® (solution) Xopenex HFA®																	
<b>Corticosteroids – Inhaled <span style="color: red;">F/Q/D</span></b>																		
Asmanex® Flovent Diskus® Flovent HFA® <span style="color: red;">BLTG</span> Pulmicort® Flexhaler	Alvesco® ArmonAir® Digihaler® Arnuity Ellipta® Asmanex® HFA fluticasone HFA (gen Flovent® HFA) QVAR RediHaler®	<p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <table border="1"> <tr> <td>Alvesco® 80 mcg</td> <td>1 inhaler every 30 days</td> </tr> <tr> <td>Alvesco® 160 mcg</td> <td>1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use.</td> </tr> <tr> <td>ArmonAir® Digihaler®</td> <td>1 inhaler every 30 days</td> </tr> </table>	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										
Alvesco® 80 mcg	1 inhaler every 30 days																	
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ArmonAir® Digihaler®	1 inhaler every 30 days																	

1 = Preferred as of 11/17/2022

2 = Non-Preferred as of 11/17/2022

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																														
<b>XV. Respiratory</b>																																
		<table border="1"> <tr> <td>Arnuity Ellipta</td> <td>1 inhaler every 30 days</td> </tr> <tr> <td>Asmanex® 110 mcg</td> <td>1 inhaler every 30 days</td> </tr> <tr> <td>Asmanex® 220 mcg (30 units)</td> <td>1 inhaler every 30 days</td> </tr> <tr> <td>Asmanex® 220 mcg (60 units)</td> <td>1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use.</td> </tr> <tr> <td>Asmanex® 220 mcg (120 units)</td> <td>1 inhaler every 60 days. Up to 1 inhaler every 30 days with previous oral corticosteroid use.</td> </tr> <tr> <td>Asmanex® HFA 100 mcg</td> <td>1 inhaler every 30 days</td> </tr> <tr> <td>Asmanex® HFA 200 mcg</td> <td>1 inhaler every 30 days</td> </tr> <tr> <td>Flovent Diskus® 50 mcg, 100 mcg</td> <td>1 diskus every 30 days</td> </tr> <tr> <td>Flovent Diskus® 250 mcg</td> <td>1 diskus every 15 days. Up to 1 diskus every 7 days with previous oral corticosteroid use.</td> </tr> <tr> <td>Flovent HFA® 44 mcg, 110 mcg</td> <td>1 inhaler every 30 days</td> </tr> <tr> <td>Flovent HFA® 220 mcg</td> <td>1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use.</td> </tr> <tr> <td>Pulmicort 90 mcg</td> <td>1 inhaler every 30 days</td> </tr> <tr> <td>Pulmicort 180 mcg</td> <td>1 inhaler every 15 days</td> </tr> <tr> <td>QVAR® RediHaler™ 40 mcg</td> <td>1 inhaler every 30 days</td> </tr> <tr> <td>QVAR® RediHaler™ 80 mcg</td> <td>1 inhaler every 15 days</td> </tr> </table>	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
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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																												
<b>XV. Respiratory</b>																														
<b>Corticosteroid/Beta2 Adrenergic Agent (Long-Acting) Combinations – Inhaled <span style="color: red;">CC, F/Q/D</span></b>																														
Advair Diskus® <span style="color: red;">BLTG</span> Dulera® Symbicort® <span style="color: red;">BLTG</span>	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®) fluticasone-vilanterol (generic for Breo Ellipta®)	<p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA-or compendia-supported age as indicated:</li> </ul> <table border="1" data-bbox="1073 451 2003 833"> <tr> <td>Advair Diskus®</td> <td>≥ 4 years</td> </tr> <tr> <td>Advair HFA®</td> <td>≥ 12 years</td> </tr> <tr> <td>AirDuo™ RespiClick® &amp; Digihaler®</td> <td>&gt; 12 years</td> </tr> <tr> <td>Dulera® 100 mcg and 200 mcg</td> <td>≥ 12 years</td> </tr> <tr> <td>Dulera® 50 mcg</td> <td>≥ 4 years</td> </tr> <tr> <td>fluticasone-salmeterol</td> <td>≥ 4 years</td> </tr> <tr> <td>budesonide-formoterol (Symbicort®) 80/4.5 mcg</td> <td>≥ 4 years</td> </tr> <tr> <td>budesonide-formoterol (Symbicort®) 160/4.5 mcg</td> <td>≥ 12 years</td> </tr> <tr> <td>fluticasone/vilanterol (Breo Ellipta®)</td> <td>≥ 18 years</td> </tr> </table> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <table border="1" data-bbox="1073 878 2003 1291"> <tr> <td>Advair Diskus®</td> <td rowspan="5">One inhaler/diskus every 30 days</td> </tr> <tr> <td>Advair HFA®</td> </tr> <tr> <td>AirDuo™ RespiClick® &amp; Digihaler®</td> </tr> <tr> <td>fluticasone-salmeterol</td> </tr> <tr> <td>fluticasone/vilanterol (Breo Ellipta®)</td> </tr> <tr> <td>Budesonide/formoterol (Symbicort®)</td> <td>Up to 8 inhalers every 180 days</td> </tr> <tr> <td>Dulera®</td> <td></td> </tr> </table>	Advair Diskus®	≥ 4 years	Advair HFA®	≥ 12 years	AirDuo™ RespiClick® & Digihaler®	> 12 years	Dulera® 100 mcg and 200 mcg	≥ 12 years	Dulera® 50 mcg	≥ 4 years	fluticasone-salmeterol	≥ 4 years	budesonide-formoterol (Symbicort®) 80/4.5 mcg	≥ 4 years	budesonide-formoterol (Symbicort®) 160/4.5 mcg	≥ 12 years	fluticasone/vilanterol (Breo Ellipta®)	≥ 18 years	Advair Diskus®	One inhaler/diskus every 30 days	Advair HFA®	AirDuo™ RespiClick® & Digihaler®	fluticasone-salmeterol	fluticasone/vilanterol (Breo Ellipta®)	Budesonide/formoterol (Symbicort®)	Up to 8 inhalers every 180 days	Dulera®	
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Advair HFA®	≥ 12 years																													
AirDuo™ RespiClick® & Digihaler®	> 12 years																													
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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters								
<b>XV. Respiratory</b>										
<b>Corticosteroids – Intranasal <span style="color: red;">F/Q/D</span></b>										
fluticasone	Beconase AQ <sup>®</sup> <span style="color: red;">CC</span> Dymista <sup>®</sup> flunisolide mometasone Omnaris <sup>®</sup> QNASL <sup>®</sup> <span style="color: red;">CC</span> Ryaltris <sup>®</sup> Xhance <sup>™</sup> Zetonna <sup>®</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Clinical consideration in regard to drug interactions will be given to patients with HIV/AIDs diagnosis or antiretroviral therapy in history</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">flunisolide</td> <td style="padding: 2px;">1 inhaler every 12 days</td> </tr> <tr> <td style="padding: 2px;">mometasone Xhance<sup>™</sup></td> <td style="padding: 2px;">1 inhaler every 15 days</td> </tr> <tr> <td style="padding: 2px;">Beconase AQ<sup>®</sup></td> <td style="padding: 2px;">1 inhaler every 22 days</td> </tr> <tr> <td style="padding: 2px;">Dymista<sup>™</sup> fluticasone Omnaris<sup>®</sup> QNASL<sup>®</sup> Zetonna<sup>™</sup></td> <td style="padding: 2px;">1 inhaler every 30 days</td> </tr> </table>	flunisolide	1 inhaler every 12 days	mometasone Xhance <sup>™</sup>	1 inhaler every 15 days	Beconase AQ <sup>®</sup>	1 inhaler every 22 days	Dymista <sup>™</sup> fluticasone Omnaris <sup>®</sup> QNASL <sup>®</sup> Zetonna <sup>™</sup>	1 inhaler every 30 days
flunisolide	1 inhaler every 12 days									
mometasone Xhance <sup>™</sup>	1 inhaler every 15 days									
Beconase AQ <sup>®</sup>	1 inhaler every 22 days									
Dymista <sup>™</sup> fluticasone Omnaris <sup>®</sup> QNASL <sup>®</sup> Zetonna <sup>™</sup>	1 inhaler every 30 days									
<b>Leukotriene Modifiers</b>										
montelukast (tablets, chew tabs) <span style="color: red;">ST</span>	Accolate <sup>®</sup> montelukast (granules) Singulair <sup>®</sup> <span style="color: red;">ST</span> zafirlukast	<b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>For non-asthmatic patients, trial of intranasal corticosteroid or a 2nd generation oral antihistamine before montelukast (Singulair<sup>®</sup>)</li> </ul>								



## NYRx, the Medicaid Pharmacy Program Preferred Drug List

### NYS Medicaid NYRx 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](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): [https://newyork.fhsc.com/providers/CDRP\\_fentanyl\\_mucosal\\_agents.asp](https://newyork.fhsc.com/providers/CDRP_fentanyl_mucosal_agents.asp)
- [palivizumab \(Synagis®\)](https://newyork.fhsc.com/providers/CDRP_synagis.asp): [https://newyork.fhsc.com/providers/CDRP\\_synagis.asp](https://newyork.fhsc.com/providers/CDRP_synagis.asp)
- [sodium oxybate products \(Xyrem®, Xywav™\)](https://newyork.fhsc.com/providers/CDRP_xyrem.asp): [https://newyork.fhsc.com/providers/CDRP\\_xyrem.asp](https://newyork.fhsc.com/providers/CDRP_xyrem.asp)
- [somatropin \(Serostim®\)](https://newyork.fhsc.com/providers/CDRP_serostim.asp): [https://newyork.fhsc.com/providers/CDRP\\_serostim.asp](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): [https://newyork.fhsc.com/providers/CDRP\\_anabolic\\_steroids.asp](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): [https://newyork.fhsc.com/providers/CDRP\\_growth\\_hormones.asp](https://newyork.fhsc.com/providers/CDRP_growth_hormones.asp)

## NYS Medicaid NYRx 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)
Corticotropin (Acthar®) (ACTH injectable)	<p>Requires trial of first-line therapy for all FDA-approved indications, other than infantile spasms.</p> <p><b>Note:</b> Acthar is first line therapy for infantile spasms in children less than 2 years of age – step therapy not required.</p>	<p><b>QUANTITY LIMITS:</b></p> <ul style="list-style-type: none"> <li>• Infantile spasms – 30 mL (six 5 mL vials)</li> <li>• Multiple sclerosis – 35 mL (seven 5 mL vials)</li> </ul> <p><b>DURATION LIMITS:</b></p> <ul style="list-style-type: none"> <li>• Infantile spasms – 4 weeks; indicated for &lt; 2 years of age</li> <li>• Multiple sclerosis – 5 weeks</li> <li>• Rheumatic disorders – 5 weeks</li> <li>• Dermatologic conditions – 5 weeks</li> <li>• Allergic states (serum sickness) – 5 weeks</li> </ul>	<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>• Not covered for diagnostic purposes</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Corticotropin (Acthar®) (ACTH injectable) <i>continued</i>		<b>FDA Indication</b>	<b>First line Therapy</b>
		<ul style="list-style-type: none"> <li>• Multiple Sclerosis (MS) exacerbations</li> <li>• Polymyositis/ dermatomyositis</li> <li>• Idiopathic nephrotic syndrome</li> <li>• Systemic lupus erythematosus (SLE)</li> <li>• Nephrotic syndrome due to SLE</li> <li>• Rheumatic disorders (specifically: psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis)</li> <li>• Dermatologic diseases (specifically Stevens-Johnson syndrome and erythema multiforme)</li> <li>• Allergic states (specifically serum sickness)</li> <li>• Ophthalmic diseases (keratitis, iritis, iridocyclitis, diffuse posterior uveitis/choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation)</li> <li>• Respiratory diseases (systemic sarcoidosis)</li> </ul>	<ul style="list-style-type: none"> <li>• Corticosteroid or plasmapheresis</li> <li>• Corticosteroid</li> <li>• ACE Inhibitor, diuretic, corticosteroid (and for refractory patients: an immunosuppressive)</li> <li>• Corticosteroid, antimalarial, or cytotoxic/immunosuppressive agent</li> <li>• Immunosuppressive, corticosteroid, or ACE Inhibitor</li> <li>• Corticosteroid, topical retinoid, biologic disease-modifying antirheumatic drugs (DMARD), non-biologic DMARD, or a non-steroidal anti-inflammatory drug (NSAID)</li> <li>• Corticosteroid or analgesic</li> <li>• Topical or oral corticosteroid, antihistamine, or NSAID</li> <li>• Analgesic, anti-infective agent, and agents to reduce inflammation, such as NSAIDs and steroids</li> <li>• Oral corticosteroid or an immunosuppressive.</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Alpha Glucosidase Inhibitors <ul style="list-style-type: none"> <li>• acarbose (Precose®)</li> <li>• miglitol</li> </ul>	<ul style="list-style-type: none"> <li>• Requires a trial with metformin with or without insulin prior to initiating alpha-glucosidase inhibitor therapy unless there is a documented contraindication.</li> </ul>		
Anabolic Steroids – Injectable <ul style="list-style-type: none"> <li>• Depo-Testosterone®</li> <li>• testosterone cypionate*</li> <li>• testosterone enanthate</li> <li>• Xyosted®</li> </ul>		<ul style="list-style-type: none"> <li>• 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):</li> <li>• Xyosted® is limited to no more than 3 boxes for 90 days (1 box per 30 days)</li> <li>• 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</li> <li>• Duration limit of 6 months for delayed puberty</li> <li>• Duration limit of 1 month for all uses of oxandrolone products</li> </ul>	*for additional parameters, see Cross-Sex Hormones section below.
Anabolic Steroids – Oral <ul style="list-style-type: none"> <li>• Jatenzo®</li> <li>• Methitest®</li> <li>• Oxandrolone</li> <li>• Tlando®</li> </ul>			
Anti-Diabetic agents (not on the PDL) <ul style="list-style-type: none"> <li>• chlorpropamide</li> <li>• glimepiride</li> <li>• glipizide (Glucotrol®, Glucotrol XL®)</li> <li>• glyburide (Glynase®)</li> <li>• glyburide, micronized</li> <li>• tolazamide</li> <li>• tolbutamide</li> </ul>	<ul style="list-style-type: none"> <li>• Requires a trial with metformin with or without insulin prior to initiating other antidiabetic agents unless there is a documented contraindication.</li> <li>• Clinical editing to allow patients with a diagnosis of gestational diabetes to receive glyburide without a trial of metformin first.</li> </ul>		

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anti-Diarrheal Agents <ul style="list-style-type: none"> <li>• alosetron (Lotronex®)</li> <li>• crofelemer (Mytesi®)</li> <li>• eluxadoline (Viberzi®)</li> <li>• telotristat (Xermelo®)</li> </ul>	<ul style="list-style-type: none"> <li>• Irritable Bowel Syndrome w/Diarrhea               <ul style="list-style-type: none"> <li>– Trial of eluxadoline and rifaximin prior to alosetron.</li> </ul> </li> <li>• Symptomatic relief of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy               <ul style="list-style-type: none"> <li>– Trial with an alternative anti-diarrheal agent.</li> </ul> </li> <li>• Carcinoid Syndrome               <ul style="list-style-type: none"> <li>– Trial with and concurrent use with a somatostatin analog</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>• Confirmation of FDA-approved or compendia-supported indication.</li> </ul>
Anti-Fungals, Topical – for Onychomycosis <ul style="list-style-type: none"> <li>• ciclopirox 8% solution</li> <li>• Jublia®</li> <li>• tavaborole (Kerydin®)</li> </ul>	<ul style="list-style-type: none"> <li>• Trial with an oral antifungal agent* prior to use of ciclopirox 8% solution               <ul style="list-style-type: none"> <li>*terbinafine (Lamisil®) tablets; griseofulvin (Gris PEG®) oral suspension, ultramicronized tablets micronized tablets; itraconazole (Sporanox®,) tablets, oral solution</li> </ul> </li> <li>• Trial with ciclopirox 8% solution prior to the use of other topical antifungals [efinaconazole (Jublia®) or tavaborole (Kerydin®)]</li> </ul>		
Anti-Malarials chloroquine hydroxychloroquine			<ul style="list-style-type: none"> <li>• Confirm FDA approved or Compendia supported use</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anti-Retroviral (ARV) Interventions		<b>QUANTITY LIMITS:</b> <ul style="list-style-type: none"> <li>• Limit ARV active ingredient duplication</li> <li>• Limit ARV utilization to a maximum of five products concurrently - excluding boosting with ritonavir (dose limit 600 mg or less) or cobicistat</li> <li>• Limit Protease Inhibitor utilization to a maximum of two products concurrently</li> <li>• Limit Integrase inhibitor utilization to a maximum of one product concurrently</li> </ul>	<ul style="list-style-type: none"> <li>• Require confirmation of FDA-approved or compendia-supported use</li> <li>• Point-of-service edit for antiretroviral / non-antiretroviral combinations to be avoided: <a href="https://newyork.fhsc.com/downloads/providers/NYRx_PDP_reference_Antiretroviral_NonAntiretroviral_Drug2Drug_Interactions.pdf">https://newyork.fhsc.com/downloads/providers/NYRx_PDP_reference_Antiretroviral_NonAntiretroviral_Drug2Drug_Interactions.pdf</a></li> <li>• Point-of-service edit for antiretroviral / antiretroviral combinations to be avoided: <a href="https://newyork.fhsc.com/downloads/providers/NYRx_PDP_reference_Antiretroviral_Antiretroviral_Drug2Drug_Interactions.pdf">https://newyork.fhsc.com/downloads/providers/NYRx_PDP_reference_Antiretroviral_Antiretroviral_Drug2Drug_Interactions.pdf</a></li> </ul>
Benlysta® (belimumab)	<ul style="list-style-type: none"> <li>• Trial of a disease-modifying anti-rheumatic drug (DMARD) prior to treatment with an immunomodulator</li> </ul>		<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
biotin			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
Atopic Dermatitis Agents <ul style="list-style-type: none"> <li>• crisaborole (Eucrisa®)</li> <li>• ruxolitinib (Opzelura™)</li> </ul>	<ul style="list-style-type: none"> <li>• Trial with a medium or high potency prescription topical steroid within the last 3 months</li> </ul>	<b>QUANTITY LIMITS:</b> <ul style="list-style-type: none"> <li>• 100 gm/30 days (crisaborole)</li> <li>• 240 gm/30 days (ruxolitinib)</li> </ul>	<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>• ruxolitinib: age 12 years +</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Benzodiazepine agents – oral <ul style="list-style-type: none"> <li>• alprazolam (Niravam™, Xanax®, Xanax® XR)</li> <li>• clordiazepoxide (Librium®)</li> <li>• clordiazepoxide/amitriptyline (Limbitrol®)</li> <li>• clonazepam (Klonopin®)</li> <li>• clorazepate (Tranxene®, Tranxene T-Tab®)</li> <li>• diazepam (Valium®)</li> <li>• lorazepam (Ativan®, Lorazepam Intensol®, Loreev XR™)</li> <li>• oxazepam</li> </ul>	Generalized Anxiety Disorder (GAD) or Social Anxiety Disorder (SAD) <ul style="list-style-type: none"> <li>• Require trial with a Selective-Serotonin Reuptake Inhibitor (SSRI) or a Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) prior to initial benzodiazepine prescription</li> <li>• Panic Disorder requires concurrent therapy with an antidepressant (SSRI, SNRI, or Tricyclic antidepressant [TCA]).</li> </ul> Skeletal muscle spasms <ul style="list-style-type: none"> <li>• Require trial with a skeletal muscle relaxant prior to a benzodiazepine</li> </ul>	<b>DURATION LIMIT:</b> <ul style="list-style-type: none"> <li>• For Insomnia: 30 consecutive days</li> <li>• For Panic Disorder: 30 consecutive days</li> </ul>	<ul style="list-style-type: none"> <li>• Require confirmation of FDA-approved or compendia-supported use</li> <li>• PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy</li> <li>• PA required for any additional oral benzodiazepine prescription in patients currently on benzodiazepine therapy</li> <li>• PA required when greater than a 14-day supply of a benzodiazepine is prescribed for someone on a CNS stimulant</li> </ul>
Constipation Agents <ul style="list-style-type: none"> <li>• linaclotide (Linzess®)</li> <li>• lubiprostone (Amitiza®)</li> <li>• methylnaltrexone (Relistor®)</li> <li>• naldemedine (Symproic®)</li> <li>• naloxegol (Movantik®)</li> <li>• plecanatide (Trulance®)</li> <li>• prucalopride (Motegrity™)</li> <li>• tenapanor (Ibsrela®)</li> </ul>	Opioid Induced Constipation (OIC) and Chronic Idiopathic Constipation (CIC) <ul style="list-style-type: none"> <li>• Trial with an osmotic laxative, a stimulant laxative and a stool softener prior to use.</li> </ul> Irritable Bowel Syndrome w/ Constipation (IBS-C) <ul style="list-style-type: none"> <li>• Trial with a bulking agent and an osmotic laxative within 89 days of use.</li> </ul>	<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>• linaclotide, naldemedine, naloxegol, plecanatide: 1 tablet/day; 30 tablets/month</li> <li>• lubiprostone: 2 capsules/day; 60 capsules/month</li> <li>• methylnaltrexone: 1 vial or syringe/day; 30/month; 4 kits/28 days; 90 tablets/30 days</li> <li>• prucalopride: 2 mg/day max; 1 tablet per day; 30/month.</li> <li>• tenapanor 2 tablets/day; 60 tabs/30 days</li> </ul>	<ul style="list-style-type: none"> <li>• Confirmation of FDA-approved or compendia-supported indication.</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Cross-Sex Hormones <ul style="list-style-type: none"> <li>• conjugated estrogens estradiol</li> <li>• testosterone cypionate</li> <li>• testosterone enanthate (Xyosted™)</li> <li>• testosterone gel 1.62% (AndroGel®)*</li> <li>• testosterone patch*</li> </ul> *Subject to Anabolic Steroids – Topical PDL class criteria			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>• For diagnosis of gender dysphoria please refer to July 2020 edition of the Medicaid Update: <a href="https://www.health.ny.gov/health_care/medicaid/program/update/2020/no12_2020-07.htm#transgender">https://www.health.ny.gov/health_care/medicaid/program/update/2020/no12_2020-07.htm#transgender</a></li> </ul>
Cystic fibrosis agents <ul style="list-style-type: none"> <li>• ivacaftor (Kalydeco®)</li> <li>• ivacaftor / lumacaftor (Orkambi®)</li> <li>• ivacaftor / tezacaftor (Symdeko®)</li> <li>• ivacaftor/ tezacaftor / elexacaftor (Trikafta™)</li> </ul>			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>• Genetic testing required to verify appropriate mutations</li> </ul>
dextromethorphan / quinidine (Nuedexta®)		<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>• 2 capsules per day; 60 units per 30 days</li> </ul> <b>DURATION LIMIT:</b> <ul style="list-style-type: none"> <li>• 90 days of therapy</li> </ul>	For patients ≥ 18 years of age: <ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
Diabetic Test Strips		<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>• Type I DM – max 300 test strips per 30-day supply</li> <li>• Type II DM – max 100 test strips per 30-day supply</li> </ul>	<ul style="list-style-type: none"> <li>• Preferred diabetic supply program <a href="https://newyork.fhsc.com/providers/diabeticsupplies.asp">https://newyork.fhsc.com/providers/diabeticsupplies.asp</a></li> </ul>



Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
dronabinol (Marinol®)	<p>Step therapy for beneficiaries with HIV/AIDS, or cancer, AND eating disorder:</p> <ul style="list-style-type: none"> <li>• Trial with megestrol acetate suspension prior to dronabinol</li> </ul> <p>Step therapy for beneficiaries with diagnosis of cancer and nausea/vomiting:</p> <ul style="list-style-type: none"> <li>• Trial with a NYS Medicaid-preferred 5-HT3 receptor antagonist prior to dronabinol</li> </ul>		<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
<p>Fentanyl Transmucosal Agents</p> <ul style="list-style-type: none"> <li>• Actiq® (lozenge)</li> <li>• Fentora® (buccal tablet)</li> </ul>		<p><b>QUANTITY LIMIT:</b> Actiq®, Fentora®:</p> <ul style="list-style-type: none"> <li>• 4 units per day, 120 units per 30 days</li> </ul> <p><b>DURATION LIMIT:</b></p> <ul style="list-style-type: none"> <li>• 90 days</li> <li>• Exemption for diagnosis of cancer, sickle cell disease, or hospice care</li> </ul>	<ul style="list-style-type: none"> <li>• Limited to a total of 4 opioid prescriptions every 30 days;</li> <li>• For opioid-naïve patients: limited to a 7 days' supply for all initial opioid prescriptions,</li> <li>• PA required for use if &gt; 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting &gt; 7 days).</li> <li>• PA required for initiation of opioid therapy for patients on established opioid dependence therapy</li> <li>• PA is required for initiation of opioid therapy in patients currently on benzodiazepine therapy</li> <li>• Exemption for diagnosis of cancer, sickle cell, or hospice care</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
HIV PrEP (Pre-Exposure Prophylaxis Agents): <ul style="list-style-type: none"> <li>• emtricitabine/tenofovir disoproxil fumarate (Truvada®)</li> <li>• emtricitabine/tenofovir alafenamide (Descovy®)</li> </ul>			<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul>
Ivermectin (oral)			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
Lidocaine patches <ul style="list-style-type: none"> <li>• Lidoderm®</li> <li>• ZTLido™</li> </ul>			<ul style="list-style-type: none"> <li>• 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.</li> <li>• Prescriptions can be written for a 30-day supply with up to 2 refills</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Lipid Lowering Agents: <ul style="list-style-type: none"> <li>• alirocumab (Praluent®)</li> <li>• evolocumab (Repatha®)</li> <li>• lomitapide (Juxtapid®)</li> <li>• bempedoic acid (Nexletol™)</li> <li>• bempedoic acid/ezetimibe (Nexlizet™)</li> </ul>	<ul style="list-style-type: none"> <li>• Require trial of an HMG-CoA Reductase Inhibitors (statin) at maximum tolerated dosage</li> </ul>		<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>• <b>PCSK-9 Inhibitors</b> (alirocumab [Praluent®], evolocumab [Repatha®]) and <b>ACL inhibitors</b> (Bempedoic acid [Nexletol], Bempedoic acid/ezetimibe [Nexlizet]):</li> <li>• Require concurrent statin therapy</li> </ul>
Methadone	<ul style="list-style-type: none"> <li>• Requires a trial of a long-acting opioid prior to initiation for the management of chronic non-cancer pain</li> </ul>	<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>• 12 units per day, 360 units per 30 days</li> <li>• Exemption for diagnosis of cancer, hospice care, or sickle cell disease</li> </ul>	<ul style="list-style-type: none"> <li>• Confirm diagnosis of chronic non-cancer pain</li> <li>• Limited to a total of 4 opioid prescriptions every 30 days;</li> <li>• PA required for initiation of methadone for patients on established opioid dependence therapy</li> <li>• PA required for methadone prescriptions for patients currently on long-acting opioid therapy.</li> <li>• PA required for initiation of long-acting opioid therapy in opioid-naïve patients.</li> <li>• PA required for use if &gt; 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting &gt; 7 days). PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy</li> <li>• Exemption for diagnosis of cancer, sickle cell, or hospice care</li> </ul>

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™)	<ul style="list-style-type: none"> <li>• ODT formulation requires a trial with conventional tablet except with a diagnosis of diabetes mellitus</li> </ul>	<p><b>Quantity Limit</b></p> <ul style="list-style-type: none"> <li>• Tablet and ODT 4 units per day, 120 units per 30 days</li> <li>• Nasal spray 4 sprays per day, 1 bottle (9.8 mL) per 4 weeks</li> </ul> <p><b>Duration Limit</b></p> <ul style="list-style-type: none"> <li>• Tablet, ODT tablet 90 days</li> <li>• Nasal spray 8 weeks</li> </ul>	<ul style="list-style-type: none"> <li>• Metoclopramide nasal spray confirm diagnosis of diabetes</li> </ul>
metreleptin (Myalept®)			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
olanzapine / fluoxetine (Symbyax®)	<ul style="list-style-type: none"> <li>• 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</li> </ul>		<ul style="list-style-type: none"> <li>• PA is required for the initial prescription for beneficiaries younger than 10 years</li> </ul>
Oral Pollen/Allergen Extracts <ul style="list-style-type: none"> <li>• Oralair®</li> </ul>	<ul style="list-style-type: none"> <li>• Trial with a preferred intranasal corticosteroid</li> </ul>		<ul style="list-style-type: none"> <li>• 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</li> </ul>
Ovulation Enhancing Drugs <ul style="list-style-type: none"> <li>• bromocriptine</li> <li>• clomiphene</li> <li>• letrozole</li> <li>• tamoxifen</li> </ul>			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>• Refer to <a href="https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-06.htm#ovulation">https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-06.htm#ovulation</a></li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Oxazolidinone Antibiotics <ul style="list-style-type: none"> <li>• linezolid (Zyvox®)</li> <li>• tedizolid (Sivextro®)</li> </ul>			<ul style="list-style-type: none"> <li>• Please be prepared to respond to a series of questions that identify the prescriber, the patient, and the reason for prescribing this drug.</li> <li>• Please be prepared to fax clinical documentation upon request.</li> </ul>
Pubertal Suppressants <ul style="list-style-type: none"> <li>• goserelin acetate</li> <li>• leuprolide acetate</li> <li>• nafarelin acetate</li> </ul>			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>• Refer to <a href="https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender">https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender</a> for Transgender Related Care and Services Update</li> </ul>
pyrimethamine (Daraprim®)			<ul style="list-style-type: none"> <li>• Confirmation of FDA-approved or compendia-supported indications</li> <li>• Require concurrent utilization of leucovorin</li> </ul>
quinine		<b>QUANTITY AND DURATION LIMITS:</b> <ul style="list-style-type: none"> <li>• Maximum 42 capsules as a 7-day supply; limited to 1 prescription per year</li> </ul>	
Rosacea Agents <ul style="list-style-type: none"> <li>• azelaic acid (Finacea®)</li> <li>• brimonidine (Mirvaso®)</li> <li>• benzoyl peroxide (Epsolay®)</li> <li>• ivermectin (Soolantra®)</li> <li>• oxymetazoline HCl (Rhofade®)</li> <li>• minocycline (Zilxi™)</li> <li>• doxycycline (Oracea®)</li> </ul>	<ul style="list-style-type: none"> <li>• Trial with topical metronidazole product.</li> </ul>		<ul style="list-style-type: none"> <li>• Confirmation of FDA-approved or compendia-supported indication</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Spravato® (esketamine)	<ul style="list-style-type: none"> <li>Treatment Resistant Depression: trial of at least two oral antidepressants</li> </ul>		<ul style="list-style-type: none"> <li>Confirm diagnosis of FDA approved indication for patients ≥18 years of age</li> <li>Confirm concurrent use of an FDA approved antidepressant</li> <li>Before initiating esketamine nasal spray (Spravato), prescribers must attest that they have obtained a baseline score using a validated clinical assessment tool for depression (e.g., HAMD17, QIDS-C16C, MADRS).</li> <li>After the initiation of esketamine nasal spray (Spravato) therapy, every six months prescribers must attest that esketamine nasal spray (Spravato) has resulted in an improvement of depressive symptoms (from baseline) using the same baseline clinical assessment tool for depression (e.g., HAMD17, QIDS-C16C, MADRS). The esketamine worksheet can be accessed at: <a href="https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_Spravato.docx">https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_Spravato.docx</a></li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Symlin® (pramlintide)	<ul style="list-style-type: none"> <li>Requires a trial with metformin with or without insulin prior to initiating amylin analogue therapy, unless there is a documented contraindication</li> </ul>		
tasimelteon (Hetlioz®)		<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>One unit per day; 30 units per 30 days</li> </ul>	<ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
Parathyroid Hormone Analogs <ul style="list-style-type: none"> <li>teriparatide (Forteo®)</li> <li>Tymlos®</li> </ul>	<ul style="list-style-type: none"> <li>Requires a trial with a preferred oral bisphosphonate</li> </ul>	<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>One unit per 30-day period</li> </ul> <b>LIFETIME QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>25 months' cumulative use of a PTH analog</li> </ul>	
Topical Compounded Prescriptions			<ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>For non-opioid pain management alternatives please visit: <a href="https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf">https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf</a></li> </ul>
Uterine Disorder Agents <ul style="list-style-type: none"> <li>Oriahnn®</li> <li>Myfembree®</li> </ul>		<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>28 days per 30-day period</li> </ul> <b>LIFETIME QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>24 months cumulative use</li> </ul>	

For more information on DUR Program, please refer to [https://www.health.ny.gov/health\\_care/medicaid/program/dur/index.htm](https://www.health.ny.gov/health_care/medicaid/program/dur/index.htm).

## Statewide Medication Assisted Treatment (MAT) Formulary

A Single Statewide Medication Assisted Treatment (MAT) formulary was implemented on October 1, 2022, in accordance with §367-a (7)(e) of Social Services Law. The Single Statewide Medication Assisted Treatment formulary aligns coverage parameters across NYRx and Medicaid Managed Care.

Prior authorization will not be required for medications used for the treatment of substance use disorder prescribed according to generally accepted national professional guidelines for the treatment of a substance use disorder.

Effective 03/22/2022

Single Statewide Medication Assisted Treatment (MAT) Formulary	
**Prior authorization will not be required when prescribed according to generally accepted national professional guidelines for the treatment of a substance use disorder.**	
Drugs	Coverage Parameters
<b>Opioid Antagonists</b>	
naloxone (syringe, vial) naltrexone Narcan® (nasal spray) naloxone nasal spray Kloxxado™ Zimhi™*	n/a
<b>Opioid Dependence Agents – Injectable</b>	
Vivitrol® Sublocade™	n/a
<b>Opioid Dependence Agents – Oral/Transmucosal<sup>F/Q/D</sup></b>	
Buprenorphine (tablet) buprenorphine / naloxone (tablet) Suboxone® (film) buprenorphine / naloxone (film) Zubsolv®	<p><b>QUANTITY LIMIT:</b></p> <ul style="list-style-type: none"> <li>• <b>buprenorphine sublingual (SL):</b> Six tablets dispensed as a 2-day supply; not to exceed 24 mg per day</li> <li>• <b>buprenorphine/ naloxone tablet and film (Suboxone®, Zubsolv®)</b> up to 5.7mg/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</li> <li>• <b>buprenorphine/naloxone tablet (Zubsolv® 8.6 mg/2.1 mg strength):</b> Maximum of 60 tablets dispensed as a 30-day supply</li> <li>• <b>buprenorphine/naloxone tablet (Zubsolv® 11.4 mg/2.9 mg strength):</b> Maximum of 30 tablets dispensed as a 30-day supply</li> </ul> <p><b>RELATED CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>• PA required for initiation of <b>opioid therapy</b> for patients on established opioid dependence therapy</li> <li>• PA required for initiation of a <b>CNS stimulant</b> for patients established on opioid dependence therapy **</li> </ul>



## NYS Medicaid NYRx Brand Less Than Generic (BLTG) Program

On April 26, 2010, NYRx, the Medicaid Pharmacy Program, 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 November 17, 2022:

- Zegerid® will be **added** to the program
- Exelon® patch, Lantus® Solostar® and vial will be **removed** from the program

List of Brand Name Drugs included in this program**		
Advair Diskus®	EpiPen	Renvela® tablets
Alphagan P® 0.15%	EpiPen, Jr	Restasis®
Amitiza®	Firvanq®	Retin-A® cream
Apriso®	Flovent® HFA	Symbicort®
Azopt™	Kazano®	Tegretol® XR
Bethkis®	Kitabis® Pak	Tegretol® suspension
CellCept® suspension	Lialda®	Trileptal® suspension
Ciprodex®	Nesina®	Ventolin® HFA
Combigan®	Nexavar®	<b>Zegerid®</b>
Concerta®	NuvaRing®	
Copaxone® 20 mg SQ	Pentasa®	
Daytrana®	Pradaxa®	
Depakote® Sprinkle	Rapamune® solution	

\*\*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, 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](https://newyork.fhsc.com/providers/bltgp_about.asp)

## NYS Medicaid NYRx 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](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](https://newyork.fhsc.com/providers/MGDP_about.asp).

## NYS Medicaid NYRx Dose Optimization Program

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

### Dose Optimization Chart

Brand Name	Dose Optimization Limitations		
<b>CARDIOVASCULAR</b>			
<b>Angiotensin Receptor Blockers (ARBs)</b>			
Benicar® 20 mg	1 daily	Tablet	
Micardis® 20 mg, 40 mg	1 daily	Tablet	
Diovan® 40 mg, 80 mg, 160 mg	1 daily	Tablet	
<b>Antiarrhythmics</b>			
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
<b>ARBs Combinations</b>			
Exforge® 5–160mg	1 daily	Tablet	
<b>ARBs/Diuretics</b>			
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	
<b>Beta Blockers</b>			
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		
<b>CARDIOVASCULAR</b>			
<b>HMG Co A Reductase Inhibitors</b>			
Crestor® 5 mg, 10 mg, 20 mg	1 daily	Tablet	
<b>Niacin Derivatives</b>			
Niaspan® 500 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
<b>CENTRAL NERVOUS SYSTEM</b>			
<b>Anticonvulsants</b>			
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
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	
<b>Antiparkinson Agents</b>			
Azilect® 0.5 mg	1 daily	Tablet	
<b>Antipsychotics – Second Generation</b>			
Abilify® 2 mg	4 daily	Tablet	
Abilify® 5 mg, 10 mg, 15 mg	1 daily	Tablet	
aripiprazole 5 mg, 10 mg, 15 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
<b>CENTRAL NERVOUS SYSTEM</b>			
Invega® 1.5 mg, 3 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
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	
<b>CNS Stimulants</b>			
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	
<b>Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)</b>			
guanfacine ER 1 mg, 2 mg	1 daily	Tablet	
atomoxetine 40 mg	1 daily	Capsule	
Intuniv® 1 mg, 2 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
<b>CENTRAL NERVOUS SYSTEM</b>			
Strattera® 40 mg	1 daily	Capsule	
<b>Sedative Hypnotics</b>			
Lunesta® 1 mg	1 daily	Tablet	
<b>Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)</b>			
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	
<b>Selective Serotonin Reuptake Inhibitors (SSRIs)</b>			
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	
<b>Miscellaneous Antidepressants</b>			
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		
<b>ENDOCRINE AND METABOLIC</b>			
<b>Biguanides</b>			
metformin ER 500 mg (Glumetza ER, Fortamet ER generic)	1 daily	Tablet	
<b>Dipeptidyl Peptidase-4 (DPP-4) Inhibitors</b>			
Januvia® 25 mg, 50 mg	1 daily	Tablet	
Onglyza® 2.5 mg	1 daily	Tablet	
<b>Thiazolidinediones (TZDs)</b>			
Actos® 15 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
<b>GASTROINTESTINAL</b>			
<b>Proton Pump Inhibitors</b>			
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		
<b>HEMATOLOGICAL</b>			
<b>Anticoagulants - Oral</b>			
Xarelto® 10 mg	1 daily	Capsule	

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