Revised: November 14, 2023

NYRx, the New York Medicaid Pharmacy Program

OVERVIEW OF CONTENTS

Preferred Drug Program (PDP) (Pages 4–58)

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.

NOTE: Not all drugs covered by NYRx are subject to programs included in this document. For a complete list of drugs covered by NYRx see the Medicaid Pharmacy List of Reimbursable Drugs

Clinical Drug Review Program (CDRP) (Page 59)

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 60–74)

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.

Medication Assisted Treatment (MAT) Formulary (Page 75)

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 77–79)

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.

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Mandatory Generic Drug Program (Page 80)

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 81–86)

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
I. Analgesics		
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)		
Celebrex® [1] celecoxib [1] diclofenac 1% topical gel diclofenac sodium oral ibuprofen Rx tablet, suspension ibuprofen OTC suspension indomethacin ketorolac meloxicam tablet nabumetone [1] naproxen tablet Pennsaid® BLTG, [1] piroxicam sulindac	Arthrotec® Daypro® diclofenac epolamine patch (gen Flector®) diclofenac capsule diclofenac/misoprostol diclofenac potassium diclofenac potassium (gen Cambia®) diclofenac sodium ER diclofenac topical soln (gen Pennsaid®) diflunisal Duexis® Elyxyb™ F/Q/D etodolac etodolac ER Feldene® fenoprofen Flector® patch flurbiprofen ibuprofen/famotidine (gen Duexis®) indomethacin ER ketoprofen ketoprofen ER ketorolac nasal spray (gen Sprix®) Licart™ meclofenamate mefenamic acid meloxicam capsule (gen Vivlodex®) Nalfon® Naprelan® naproxen susp	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Elyxyb™ (celecoxib) – 4.8 mL bottle (120 mg) maximum quantity: 9 / 30 days

1 = Preferred as of 12/14/2023
2 = Non-Preferred as of 12/14/2023

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
	naproxen CR naproxen EC naproxen-esomeprazole naproxen sodium oxaprozin Relafen® DS tolmetin Vimovo®	
Opioids – Long-Acting CC		
buprenorphine patch fentanyl patch (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg) morphine sulfate ER tablet	Belbuca® Butrans® ConZip® ST 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 (gen Avinza) morphine ER capsule (gen Kadian) MS Contin® Nucynta® ER ST oxycodone ER Oxycontin® oxymorphone ER tramadol ER ST Xtampza® ER	**CLINICAL CRITERIA (CC) *** • Limited to a total of 4 opioid prescriptions every 30 days; Exemption for diagnosis of cancer, hospice or palliatve care, or sickle cell disease • PA required for initiation of opioid therapy for patients on established opioid dependence therapy • PA required for use if ≥ 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting > 7 days) • PA required for initiation of long-acting opioid therapy in opioid-naïve patients. • PA required for any additional long-acting opioid prescription for patients currently on long-acting opioid therapy. • PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy • PA required for any codeine- or tramadol-containing products in pts < 12 years • PA required for initiation of opioid therapy for patients on established CNS stimulant therapy **STEP THERAPY (ST)** • **Nucynta® ER (tapentadol ER):** Trial with tapentadol IR before tapentadol ER for patients who are naïve to a long-acting opioid • **Tramadol ER (tramadol naïve patients):** Attempt treatment with IR formulations before the following ER formulations: ConZip®, tramadol ER

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
		*Exemption from requirements for diagnosis of cancer, sickle cell disease, or hospice or palliative care.
Opioids – Short-Acting CC		
butalbital/APAP/caffeine/codeine codeine codeine/APAP hydrocodone/APAP hydrocodone/ibuprofen hydromorphone tablets [1] morphine IR oxycodone IR tablets, solution [1] oxycodone/APAP tramadol tablet	butalbital compound/codeine butorphanol nasal spray dihydrocodeine/APAP/caffeine Dilaudid® hydromorphone solution levorphanol meperidine Nalocet® Nucynta® ST oxycodone IR capsules, concentrate oxycodone/APAP (Prolate) solution, tablets) oxymorphone pentazocine/naloxone Percocet® Roxicodone® Seglentis® tramadol solution tramadol/APAP	**CLINICAL CRITERIA (CC) *** • Limited to a total of 4 opioid prescriptions every 30 days. • Initial prescription for opioid-naïve patients limited to a 7-day supply. • PA required for initiation of opioid therapy for patients on established opioid dependence therapy. • PA required for use if ≥ 90 MME of opioid per day for management of non-acute pain (> 7 days) – Exception for diagnosis of cancer or sickle cell disease, or hospice or palliative care programs • PA is required for opioid-naïve patients for prescription requests ≥ 50 MME per day. • PA required for continuation of opioid therapy beyond an initial 7-day supply in patients established on gabapentin or pregabalin • PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy • PA required for any codeine- or tramadol-containing products in pts < 12 years • PA required for initiation of opioid therapy for patients on > 7 days established CNS stimulant therapy **STEP THERAPY (ST)** • **Nucynta® (tapentadol IR)** – Trial with tramadol and 1 preferred opioid before tapentadol immediate-release (IR) • For Non-opioid Pain management alternatives please visit: https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf *Exemptions from requirements for diagnosis of cancer, sickle cell disease, or hospice or palliative care

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NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
II. Anti-Infectives		
Antibiotics – Inhaled CC, F/Q/D		
Bethkis® BLTG Cayston® Kitabis® Pak BLTG TOBI Podhaler™ tobramycin (gen TOBI®) solution	TOBI® solution tobramycin (gen Bethkis®, Kitabis®) solution	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Aztreonam (Cayston) – 3 ampules (3 mL) per day – 84 ampules (84 mL) per 56-day regimen (28 days on, 28 days off) • Tobramycin inhalation solution (Bethkis, TOBI, Kitabis Pak) – 2 ampules (8 mL Bethkis, 10 mL TOBI, Kitabis Pak) per day – 56 ampules (224 mL Bethkis, 280 mL TOBI, Kitabis Pak) per 56 day regimen (28 days on-28 days off) • Tobramycin capsules with inhalation powder (TOBI Podhaler) – 8 capsules per day 224 capsules per 56-day regimen (28 days on-28 days off)
Anti-Fungals – Oral for Onychomycosis		
griseofulvin suspension, ultramicronized terbinafine tablet	griseofulvin tablet itraconazole itraconazole solution (gen Sporanox) Sporanox®	
Anti-Virals – Oral		
acyclovir valacyclovir	famciclovir Valtrex® Zovirax®	
Cephalosporins – Third Generation		
cefdinir	cefixime cefpodoxime Suprax®	
Fluoroquinolones – Oral		
ciprofloxacin suspension, tablet	Baxdela®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
II. Anti-Infectives		
levofloxacin tablet	Cipro® suspension, tablet levofloxacin solution moxifloxacin ofloxacin tablet	
Hepatitis B Agents		
adefovir dipivoxil Baraclude® solution entecavir Epivir-HBV® solution lamivudine HBV	Baraclude® tablet Epivir-HBV® tablet Hepsera® Vemlidy®	
Hepatitis C Agents – Direct Acting Antivirals		
Mavyret™ ribavirin sofosbuvir/velpatasvir (gen Epclusa®) Vosevi®	Epclusa® Harvoni® ledipasvir/sofosbuvir (gen Harvoni®) Sovaldi® Viekira Pak® Zepatier®	
Tetracyclines		
demeclocycline doxycycline hyclate minocycline capsule tetracycline	Doryx® ST, F/Q/D Doryx MPC® ST, F/Q/D doxycycline hyclate DR ST, F/Q/D doxycycline monohydrate minocycline tablet minocycline ER tablet Minolira ER™ Nuzyra™ Solodyn® Vibramycin®	**STEP THERAPY (ST)** • Trial of doxycycline IR before progressing to doxycycline DR **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • doxycycline DR (Doryx®): – Maximum 28 tablets/capsules per fill

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Angiotensin Receptor Blockers (ARBs)		
irbesartan losartan olmesartan telmisartan valsartan tablet	Atacand® Avapro® Benicar® DO candesartan Cozaar® Diovan® DO Edarbi® eprosartan Micardis® DO Valsartan solution	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths
Antianginals and Anti-Ischemics		
ranolazine	Aspruzyo Sprinkle™ Ranexa®	
ARBs Combinations		
Entresto® Exforge HCT® irbesartan/HCTZ losartan/HCTZ olmesartan/amlodipine olmesartan/HCTZ telmisartan/HCTZ valsartan/amlodipine valsartan/amlodipine/HCTZ valsartan/HCTZ	Atacand HCT® Avalide® Azor® Benicar HCT® DO candesartan/HCTZ Diovan HCT® DO Edarbyclor® DO Exforge® DO Hyzaar® Micardis HCT® DO olmesartan/amlodipine/HCTZ telmisartan/amlodipine Tribenzor®	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Beta Blockers		
atenolol carvedilol labetalol metoprolol succ. XL metoprolol tartrate propranolol tablet propranolol ER	acebutolol betaxolol bisoprolol Bystolic® DO carvedilol ER Coreg® Coreg CR® DO Corgard® Inderal LA® Inderal XL® InnoPran XL® Kapspargo™ Sprinkle Lopressor® nadolol DO nebivolol (gen Bystolic®) pindolol propranolol solution Tenormin® timolol Toprol XL® DO	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths
Beta Blockers / Diuretics		
atenolol/chlorthalidone bisoprolol/HCTZ propranolol/HCTZ	metoprolol tartrate/ HCTZ Tenoretic® Ziac®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Calcium Channel Blockers (Dihydropyridine)		
amlodipine felodipine ER isradipine nicardipine HCl nifedipine nifedipine ER/SA	Katerzia™ levamlodipine nisoldipine Norliqva® Norvasc® Procardia XL® Sular®	
Cholesterol Absorption Inhibitors		
cholestyramine cholestyramine light Colestid® tablet colestipol tablet ezetimibe	colesevelam Colestid granules, packet colestipol granules, packet Questran® Questran Light® Welchol® Zetia®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
HMG-CoA Reductase Inhibitors (Statins)		
atorvastatin lovastatin pravastatin rosuvastatin simvastatin	Altoprev® Atorvaliq® atorvastatin/amlodipine Caduet® Crestor® DO Ezallor™ Sprinkle ezetimibe/simvastatin fluvastatin fluvastatin ER Lescol XL® Lipitor® Livalo® Vytorin® Zocor® Zypitamag™	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths
Phosphodiesterase Type-5 (PDE-5) Inhibitors for PAH CC		
sildenafil tadalafil	Adcirca® Liqrev® Revatio® Tadliq®	**CLINICAL CRITERIA** • All prescriptions for **Adcirca®**, **tadalafil, Revatio®**, and **sildenafil** must have PA • Prescribers or their authorized agents are required to respond to a series of questions that identify prescriber, patient, and reason for prescribing drug • Please be prepared to fax clinical documentation upon request • Prescriptions can be written for a 30-day supply with up to 11 refills

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

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NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
zonisamide	Gabitril® Keppra® Keppra XR® Lamictal® tablet, chew, dosepak Lamictal® ODT tablet, dosepak Lamictal® XR DO tablet, dosepak lamotrigine dosepak lamotrigine ER lamotrigine ODT dosepak Lyrica® solution DO, F/Q/D Lyrica® CR F/Q/D, CC Motpoly XR Neurontin® F/Q/D, CC Onfi® ST, CC pregabalin solution DO, F/Q/D, CC pregabalin ER (gen Lyrica® CR) F/Q/D, CC Qudexy® XR CC rufinamide (gen Banzel®) Sabril® Spritam® Sympazan® film ST, CC Topamax® CC topiramate ER CC, DO (gen Qudexy® XR) topiramate ER CC (gen Trokendi XR®) Trokendi XR® CC, DO vigabatrin Vimpat® Xcopri® Zonisade™ Ztalmy®	• **Neurontin® (gabapentin) –** PA required for initiation of gabapentin at > 900 mg per day in patients currently on an opioid at > 50 MME per day • **Stiripentol (Diacomit®) –** Require diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form • **Topiramate IR/ER (Eprontia™, Qudexy® XR, Topamax®, Trokendi XR™)** – Require confirmation of FDA-approved, compendia-supported, or Medicaid covered diagnosis • **Onfi®/Sympazan® (clobazam):** – Require confirmation of FDA-approved or compendia-supported use – PA required for initiation of clobazam therapy in patients currently on opioid or oral buprenorphine therapy – PA required for any clobazam prescription in patients currently on benzodiazepine therapy **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **Eprontia™ (topiramate)** – Maximum quantity: 473 mL per month • **Lyrica®/Lyrica® CR (pregabalin)** – Maximum daily dose of IR: 600 mg per day, and ER: 660 mg per day • **Neurontin® (gabapentin)** – Maximum daily dose of 3,600 mg per day **STEP THERAPY (ST)** • **Onfi®/Sympazan® (clobazam)** – Requires a trial with an SSRI or SNRI for treatment of anxiety

NYRx, the Medicaid Pharmacy Program Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">IV. Central Nervous System</td></tr>
<tr><td colspan="3">Antimigraine Agents, Other ST, F/Q/D</td></tr>
<tr><td>Aimovig® 1
Ajovy®
Emgality®
Nurtec™ ODT
Ubrelvy™ 1</td><td>Emgality® 100mg syringe
Qulipta™
Reyvow™
Zavzpret™</td><td>STEP THERAPY (ST)
Acute treatment of migraine
• Trial of a product from the Antimigraine Agents-Triptan class
Prevention of migraine
• Trial of 2 FDA approved or compendia supported migraine prevention products from other drug classes
<table><tr><th>Agent</th><th>F/Q/D</th></tr><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>24 units/40 days</td></tr><tr><td>Qulipta</td><td>30 units/30 days</td></tr><tr><td>Zavzpret®</td><td>8 units/30 days</td></tr></table></td></tr>
<tr><td colspan="3">Antimigraine Agents – Triptans</td></tr>
<tr><td>rizatriptan F/Q/D
sumatriptan F/Q/D</td><td>almotriptan F/Q/D
eletriptan F/Q/D
Frova® F/Q/D
frovatriptan F/Q/D
Imitrex® F/Q/D
Maxalt® F/Q/D
Maxalt® MLT F/Q/D
naratriptan F/Q/D
Onzetra™ Xsail™ F/Q/D
Relpax®
sumatriptan-naproxen F/Q/D</td><td>FREQUENCY/QUANTITY/DURATION (F/Q/D)
<table><tr><th>Agent</th><th>F/Q/D</th></tr><tr><td>Onzetra™ Xsail™ 11 mg</td><td>16 units/30 days</td></tr><tr><td>almotriptan
eletriptan (Relpax®)
frovatriptan (Frova®)
naratriptan
rizatriptan (Maxalt®)
rizatriptan (Maxalt® MLT)
sumatriptan nasal spray (Imitrex®)</td><td>18 units/30 days</td></tr></table></td></tr>
</table>

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NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
	Tosymra™ F/Q/D Treximet® F/Q/D Zembrace™ SymTouch™ zolmitriptan F/Q/D Zomig® F/Q/D	sumatriptan (Imitrex®) sumatriptan-naproxen (Treximet®) Tosymra™ nasal spray zolmitriptan (Zomig®) Zomig® nasal spray
Antipsychotics – Injectable		
Abilify Asimtufii® 1 Abilify Maintena® Aristada® Aristada Initio® fluphenazine decanoate Haldol® decanoate haloperidol decanoate Invega Hafyera™ Invega Sustenna® Invega Trinza® Perseris™ Risperdal Consta® Uzedy™ 1 Zyprexa Relprevv®	N/A	
Antipsychotics – Second Generation CC, ST		
aripiprazole tablet DO asenapine (gen Saphris®) clozapine lurasidone (gen Latuda®) olanzapine tablet DO paliperidone ER F/Q/D, DO 1 quetiapine F/Q/D quetiapine ER F/Q/D, DO risperidone	Abilify® tablet DO Abilify MyCite® aripiprazole solution aripiprazole ODT Caplyta™ clozapine ODT Clozaril® Fanapt® Geodon®	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths **CLINICAL CRITERIA (CC)**

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NYRx, the Medicaid Pharmacy Program Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">IV. Central Nervous System</td></tr>
<tr><td>ziprasidone capsule</td><td>Invega® DO, F/Q/D
Latuda® DO
Lybalvi™
Nuplazid®
olanzapine ODT DO
Rexulti® DO
Risperdal®
Saphris®
Secuado® F/Q/D
Seroquel® F/Q/D
Seroquel XR® DO, F/Q/D
Versacloz®
Vraylar® DO
Zyprexa® DO
Zyprexa® Zydis</td><td>• Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA
• Prior authorization is required when an oral SGA is utilized above the highest MDD according to FDA labeling.
• Prior authorization is required for patients less than 21 years of age when there is concurrent use of 2 or more different oral antipsychotics for greater than 90 days.
• Prior authorization is required for patients 21 years of age or older when 3 or more different oral second-generation antipsychotics are used for more than 180 days.
• Confirm diagnosis of FDA-approved or compendia-supported indication
• PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below:
<table>
<tr><td>aripiprazole (Abilify®)</td><td>6 years</td></tr>
<tr><td>aripiprazole (Abilify MyCite®)</td><td>18 years</td></tr>
<tr><td>asenapine (Saphris®)</td><td>10 years</td></tr>
<tr><td>asenapine (Secuado®)</td><td>18 years</td></tr>
<tr><td>brexpiprazole (Rexulti®)</td><td>13 years</td></tr>
<tr><td>cariprazine (Vraylar®)</td><td>18 years</td></tr>
<tr><td>clozapine (Clozaril®, Versacloz®)</td><td>12 years</td></tr>
<tr><td>iloperidone (Fanapt®)</td><td>18 years</td></tr>
<tr><td>lumateperone (Caplyta™)</td><td>18 years</td></tr>
<tr><td>lurasidone HCl (Latuda®)</td><td>10 years</td></tr>
<tr><td>olanzapine (Zyprexa®)</td><td>10 years</td></tr>
<tr><td>paliperidone ER (Invega®)</td><td>12 years</td></tr>
<tr><td>pimavanserin (Nuplazid®)</td><td>18 years</td></tr>
<tr><td>quetiapine fum. (Seroquel®, Seroquel XR®)</td><td>10 years</td></tr>
<tr><td>risperidone (Risperdal®)</td><td>5 years</td></tr>
<tr><td>ziprasidone HCl (Geodon®)</td><td>10 years</td></tr>
</table>
</td></tr>
</table>

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
		• Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients < 18 years of age **STEP THERAPY (ST)** • For all Second Generation Antipsychotics used in the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is required **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **asenapine (Secuado®)** 7.6 mg/24 hours • **lumateperone (Caplyta™)** 42 mg capsules: Maximum 1 unit/day • **paliperidone ER (Invega®)** 1.5 mg, 3 mg, 9 mg tablets: Maximum 1 unit/day • **paliperidone ER (Invega®)** 6 mg tablets: Maximum 2 units/day • **quetiapine/quetiapine ER (Seroquel®/Seroquel XR®):** Minimum 50 mg/day; maximum 800 mg/day • **quetiapine (Seroquel®):** Maximum 3 units per day, 90 units per 30 days • **quetiapine ER (Seroquel XR®)**: Maximum150 mg, 200 mg: 1 unit/day, 30 units/30 days • **quetiapine ER (Seroquel XR®):** Maximum 50 mg, 300 mg, 400 mg: 2 units/day, 60 units/30 days
Central Nervous System (CNS) Stimulants CC, F/Q/D		
Adderall XR® DO, 1 amphetamine salt combo IR (gen Adderall®) amphetamine salt combo ER (gen Adderall XR®) DO Concerta® DO Daytrana® BLTG dexmethylphenidate (gen Focalin®) dexmethylphenidate ER DO (gen Focalin XR®) dextroamphetamine tablet	Adzenys XR-ODT® amphetamine (gen Adzenys ER®) amphetamine (gen Evekeo®) Aptensio XR® armodafinil (gen Nuvigil®) Azstarys™ Cotempla® XR-ODT™ Desoxyn® Dexedrine® dextroamphetamine ER (gen Dexedrine®)	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved, compendia-supported and Medicaid covered indication • Prior authorization is required for initial prescriptions for stimulant therapy for beneficiaries **less than 3 years of age** • Confirm diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent for beneficiaries **less than 18 years of age** • 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.

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
methylphenidate solution (gen Methylin®) methylphenidate tablet (gen Ritalin®) methylphenidate CD DO, 1 methylphenidate ER (gen Aptensio® XR) methylphenidate ER (gen Concerta®) 1 methylphenidate ER (gen Metadate CD) 1 Ritalin LA® DO, BLTG, 1 Vyvanse® capsule, chewable DO	dextroamphetamine solution (gen ProCentra®) dextroamphetamine tablet (gen Zenzedi®) Dyanavel XR® Evekeo® Evekeo® ODT Focalin® Focalin XR® DO Jornay PM™ methamphetamine (gen Desoxyn®) Methylin® methylphenidate (gen Daytrana®) methylphenidate chewable tablet (gen Methylin®) methylphenidate ER 45 mg, 63 mg, 72 mg tablet methylphenidate ER (gen Ritalin LA®) modafinil (gen Provigil®) DO Mydayis™ Nuvigil® ProCentra® Provigil® DO QuilliChew ER™ DO Quillivant XR® Relexxii® Ritalin® Sunosi™ Wakix® Xelstrym™ Zenzedi®	• PA required for initiation of CNS Stimulant for patients currently on an opioid • PA required for initiation of CNS Stimulant for patients currently on a benzodiazepine **DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Quantity limits based on daily dosage as determined by FDA labeling • Quantity limits to include: – Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration) – Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days. Concerta 36mg and Cotempla XR-ODT 25.9 mg,; not to exceed 2 units daily – Azstarys; not to exceed 1 dosage unit per day – Pitolisant (Wakix®): not to exceed 2 dosage units daily of the 17.8 mg tablets or 3 dosage units daily of the 4.45 mg tablets.

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Movement Disorder Agents CC		
Austedo® Ingrezza® Ingrezza® titration pack tetrabenazine	Austedo® XR Xenazine®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis for an FDA-approved or compendia-supported indication
Multiple Sclerosis Agents		
Avonex® Betaseron® Copaxone® 20 mg/mL BLTG dimethyl fumarate DR fingolimod (gen Gilenya®) 1 teriflunomide (gen Aubagio®) 1	Aubagio® Bafiertam™ Copaxone® 40 mg/mL Extavia® Gilenya® glatiramer Kesimpta® Mavenclad® Mayzent® Plegridy® Ponvory™ F/Q/D Rebif® Rebif® Rebidose® Tascenso ODT™ Tecfidera® Vumerity® Zeposia® CC, ST	**CLINICAL CRITERIA (CC)** • **Zeposia® (ozanimod):** Confirm diagnosis for FDA- or compendia-supported use **STEP THERAPY (ST)** • **Zeposia® (ozanimod):** For an indication of Ulcerative Colitis – Trial of a non-specific anti-inflammatory drug such as an aminosalicylate or immunosuppressant, or a disease-modifying anti-rheumatic drug (DMARD), and; – Trial of a preferred systemic immunomodulator **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **Ponvory™ (ponesimod) starter pack**; maximum quantity is 14, no refills • **Ponvory™ (ponesimod)**; maintenance limited to a 30-day supply
Non-Ergot Dopamine Receptor Agonists		
pramipexole ropinirole	Kynmobi™ CC Mirapex ER® Neupro® pramipexole ER ropinirole ER	**CLINICAL CRITERIA (CC)** • **apomorphine (Kynmobi™)**: Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD) CC		
atomoxetine DO clonidine ER guanfacine ER DO	Intuniv® DO Qelbree™ Strattera® DO	**CLINICAL CRITERIA (CC)** • Confirm diagnosis for an FDA-approved or compendia-supported indication for beneficiaries < 18 years of age. • Prior authorization is required for initial prescriptions for non-stimulant therapy for beneficiaries **less than 6 years of age** **DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths
Sedative Hypnotics/Sleep Agents F/Q/D		
estazolam CC eszopiclone 1 ramelteon (gen Rozerem®) 1 temazepam 15 mg, 30 mg CC zolpidem tablet CC zolpidem ER CC, 1	Ambien® CC Ambien CR® CC Belsomra® Dayvigo™ Doral® CC doxepin (gen Silenor®) Edluar® CC flurazepam CC Halcion® CC Lunesta® DO quazepam CC (gen Doral®) Quviviq™ Restoril® CC Rozerem® Silenor® temazepam 7.5 mg, 22.5 mg CC triazolam CC zaleplon zolpidem sublingual, capsule CC	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **CLINICAL CRITERIA (CC)** • **Zolpidem products**: Confirm dosage is consistent with FDA labeling for initial prescriptions • **Benzodiazepine Agents** (estazolam, flurazepam, Halcion®, Restoril®, temazepam, triazolam): – Confirm diagnosis of FDA-approved or compendia-supported indication – PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy – PA required for any additional benzodiazepine prescription in patients currently on benzodiazepine therapy – PA required when greater than a 14-day supply of a benzodiazepine is prescribed for someone on a CNS stimulant **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Frequency and duration limits for the following products: – For non-zaleplon and non-benzodiazepine containing products: o 30 dosage units per fill/1 dosage unit per day/30 days – For zaleplon-containing products: o 60 dosage units per fill/2 dosage units per day/30 days

1 = Preferred as of 12/14/2023
2 = Non-Preferred as of 12/14/2023

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
		– Duration limit equivalent to the maximum recommended duration: o 180 days for immediate-release zolpidem (Ambien®, Edluar®) products o 180 days for eszopiclone and ramelteon (Rozerem®) products o 180 days for lemborexant (Dayvigo™) o 168 days for zolpidem ER (Ambien CR®) products o 90 days for daridorexant (Quviviq™) o 90 days for suvorexant (Belsomra®) o 90 days for doxepin (Silenor®) o 30 days for zaleplon (Sonata®) products o 30 days for benzodiazepine agents (estazolam, Halcion®, Restoril®, temazepam, triazolam) for the treatment of insomnia Additional/Alternate parameters: • For patients naïve to non-benzodiazepine sedative hypnotics (NBSH): First-fill duration and quantity limit of 10 dosage units as a 10-day supply, except for zaleplon-containing products which the quantity limit is 20 dosage units as a 10-day supply
Selective Serotonin Reuptake Inhibitors (SSRIs)		
citalopram tablet, solution escitalopram tablet fluoxetine capsule, solution paroxetine tablet sertraline tablet, concentrate Viibryd® DO, BLTG	Celexa® citalopram capsule escitalopram solution fluoxetine tablet fluoxetine DR weekly fluvoxamine CC fluvoxamine ER CC Lexapro® DO paroxetine capsule paroxetine CR paroxetine suspension Paxil® Paxil CR® Pexeva®	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **CLINICAL CRITERIA (CC)** • Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA • Clinical editing to allow patients with a diagnosis of Obsessive-Compulsive Disorder (OCD) to receive fluvoxamine and fluvoxamine ER without prior authorization

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
	Prozac® sertraline capsule Trintellix® DO vilazodone (gen Viibryd®) Zoloft®	
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)		
duloxetine 20 mg, 30 mg, 60 mg (gen Cymbalta®) venlafaxine venlafaxine ER capsule	Cymbalta® desvenlafaxine ER desvenlafaxine succinate ER DO Drizalma Sprinkle™ duloxetine 40 mg Effexor XR® DO Fetzima® Pristiq® DO Savella® venlafaxine ER tablet	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths

1 = Preferred as of 12/14/2023
2 = Non-Preferred as of 12/14/2023

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Acne Agents, Topical		
adapalene/benzoyl peroxide adapalene cream adapalene OTC gel Retin-A® cream CC, BLTG tazarotene cream CC tretinoin gel (gen Avita, Retin-A) CC	adapalene Rx gel, gel pump adapalene/benzoyl peroxide Altreno® CC Arazlo™ CC Atralin® CC Avita® CC clindamycin/tretinoin CC dapsone Fabior® CC Retin-A® gel CC Retin-A Micro® CC tazarotene foam (gen Fabior®) CC tazarotene gel CC tretinoin cream, gel CC (gen Atralin) tretinoin micro CC Winlevi® Ziana® CC	**CLINICAL CRITERIA** • Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication
Actinic Keratosis Agents		
diclofenac 3% gel fluorouracil solution fluorouracil 0.5% cream (gen Carac) fluorouracil 5% cream (gen Efudex cream) imiquimod (gen Aldara)	Carac® Efudex® imiquimod (gen Zyclara) Tolak® Zyclara®	
Antibiotics – Topical		
mupirocin ointment	Centany® mupirocin cream Xepi™	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Steroids, Topical – Medium Potency		
fluocinolone acetonide solution [1] fluticasone propionate cream, ointment [1] hydrocortisone valerate cream [1] mometasone furoate	Beser lotion betamethasone valerate foam clocortolone Cloderm® fluocinolone acetonide cream, ointment flurandrenolide fluticasone propionate lotion hydrocortisone butyrate cream, lotion, ointment, solution hydrocortisone valerate ointment Locoid® Locoid Lipocream® Luxiq® Pandel® prednicarbate Synalar®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Steroids, Topical – High Potency		
betamethasone dipropionate lotion, cream, ointment [1] betamethasone dipropionate augmented cream, ointment, lotion [1] betamethasone valerate cream, ointment fluocinonide cream, ointment, solution[1] triamcinolone acetonide	amcinonide ApexiCon-E® betamethasone dipropionate augmented gel betamethasone valerate lotion desoximetasone diflorasone Diprolene® fluocinonide 0.1% cream (gen Vanos®) fluocinonide gel, emollient halcinonide cream (gen Halog®) Halog® cream, solution, ointment Kenalog® Topicort® triamcinolone spray Vanos®	
Steroids, Topical – Very High Potency		
clobetasol cream, emollient, gel, ointment, solution halobetasol cream, ointment	Bryhali™ clobetasol foam, lotion, spray, shampoo Clobex® halobetasol foam Impeklo™ Lexette™ foam Olux® Olux-E® Temovate® Ultravate®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Anabolic Steroids – Topical CDRP, F/Q/D		
testosterone gel testosterone pump	Androderm® AndroGel® pump Fortesta® Testim® Vogelxo	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** • For diagnosis of hypogonadotropic or primary hypogonadism: – Requires documented low testosterone concentration with two tests prior to initiation of therapy. – Require documented testosterone therapeutic concentration to confirm response after initiation of therapy. • For diagnosis of delayed puberty: – Requires documentation that growth hormone deficiency has been ruled out prior to initiation of therapy. – The Anabolic Steroid fax form can be found at: https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PA_Worksheet_Prescribers_Anabolic_Steroids.pdf For diagnosis of gender dysphoria see cross-sex hormone coverage in the DUR section of this document **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Limitations for anabolic steroid products based on approved FDA labeled daily dosing and documented diagnosis: – Duration limit of 6 months for delayed puberty
Biguanides		
Glumetza® BLTG metformin HCl metformin ER (gen Glucophage XR®)	metformin solution (gen Riomet®) metformin 625mg tablets metformin ER DO (gen Fortamet®, Glumetza®) Riomet® Riomet ER™	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Bisphosphonates – Oral		
alendronate	Actonel® Atelvia® Boniva® Fosamax® Fosamax® Plus D ibandronate risedronate	
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors ST		
Glyxambi® Janumet® Janumet® XR Januvia® DO Jentadueto® Jentadueto® XR Kazano® BLTG Kombiglyze® XR BLTG Nesina® BLTG Onglyza® DO, BLTG Oseni® BLTG Tradjenta®	alogliptin alogliptin/metformin alogliptin/pioglitazone Qtern® saxagliptin (gen Onglyza®) saxagliptin/metformin (gen Kombiglyze® XR) Steglujan®	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **STEP THERAPY (ST)** • Requires a trial with metformin with or without insulin prior to DPP-4 Inhibitor therapy unless there is a documented contraindication.

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Glucagon Agents		
Baqsimi® glucagon vial glucagon HCl emergency kit (Fresenius) Gvoke® pen, syringe, vial Zegalogue® pen, syringe	glucagon emergency kit (Eli Lilly, Amphastar)	
Glucagon-like Peptide-1 (GLP-1) Agonists CC, ST		
Byetta® Ozempic® Trulicity® Victoza®	Adlyxin® Bydureon® BCise™ Mounjaro® Rybelsus® Soliqua® Xultophy®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication **STEP THERAPY (ST)** • Trial with metformin with or without insulin prior to initiating GLP-1 agonist therapy unless there is a contraindication, or the drug is being used for an FDA-approved Medicaid covered indication other than, or in addition to, Type 2 Diabetes.

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Glucocorticoids – Oral		
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 prednisolone tablet (gen Millipred®) prednisone intensol, solution Rayos® Uceris®	
Growth Hormones CC, CDRP		
Genotropin® Norditropin®	Humatrope® Ngenla™ Nutropin AQ® Omnitrope® Saizen® Skytrofa® Sogroya® Zomacton®	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** • Prescribers or their authorized agents may call or submit a fax request for a PA for beneficiaries 18 years of age or older **CLINICAL CRITERIA (CC)** • Patient-specific considerations for drug selection include concerns related to use of a non-preferred agent for FDA-approved indications that are not listed for a preferred agent. • Confirm diagnosis of FDA-approved or compendia-supported indication

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Insulin – Long-Acting		
insulin glargine solostar, vial (gen Lantus® Solostar®, vial) Lantus® Solostar®, vial Levemir®	Basaglar® Basaglar® Tempo™ insulin degludec vial, pen (gen Tresiba) insulin glargine-YFGN: vial, pen Rezvoglar™ Semglee®-YFGN: vial, pen Toujeo® Solostar® Toujeo® Max Solostar® Tresiba®	
Insulin – Mixes		
Humalog® 50/50 Mix: pen and vial Humalog® 75/25 Mix: vial insulin lispro 75/25 mix: pen (gen Humalog® Mix) insulin aspart prot/insulin aspart: vial, pen (gen Novolog)	Humalog® 75/25 mix: pen Novolog® Mix: vial, pen	
Insulin – Rapid-Acting		
Apidra® Humalog® Jr. 100 U/mL Kwikpen Humalog® 100 U/mL vial, pen, cartridge, Tempo™ insulin aspart (gen Novolog®) cartridge, vial, pen insulin lispro (gen Humalog® U100) vial, pen insulin lispro junior (gen Humalog® Jr.) Novolog® cartridge, vial, FlexPen	Admelog® Afrezza® Fiasp® Penfill, FlexTouch, Pumpcart Humalog® 200 U/mL Lyumjev® Lyumjev® Tempo™	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Pancreatic Enzymes		
Creon® Zenpep®	Pertzye® Viokace®	
Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors ST		
Farxiga® Invokamet® [1] Invokamet® XR [1] Invokana® Jardiance® Synjardy® [1] Synjardy® XR [1] Trijardy® XR [1] Xigduo® XR [1]	Inpefa™ Segluromet® Steglatro®	**STEP THERAPY (ST)** • Requires trial with metformin with or without insulin prior to initiating SGLT2 therapy unless there is a contraindication, or the drug is being used for an FDA-approved Medicaid covered indication other than, or in addition to, Type 2 Diabetes.
Thiazolidinediones (TZDs) ST		
pioglitazone	ACTOplus Met® Actos® DO Duetact® pioglitazone/glimepiride pioglitazone/metformin	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **STEP THERAPY (ST)** • Requires a trial with metformin with or without insulin prior to initiating TZD therapy unless there is a documented contraindication.

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VII. Gastrointestinal		
Anti-Emetics		
aprepitant pack Diclegis® CC, doxylamine succ/pyridoxine ondansetron ODT, solution, tablet	Akynzeo® Anzemet® aprepitant capsule Bonjesta® CC Emend® capsule, powder packet, TriPack granisetron tablet Sancuso®	**CLINICAL CRITERIA (CC)** • **Diclegis®** and **Bonjesta®:** Confirm diagnosis of FDA-approved or compendia-supported indication
Gastrointestinal Antibiotics		
metronidazole tablet neomycin vancomycin capsule, solution	Dificid® Firvanq® Flagyl® metronidazole capsule nitazoxanide paromomycin tinidazole Vancocin® Xifaxan® CC, ST, F/Q/D	**CLINICAL CRITERIA (CC)** • Xifaxan®: Confirm diagnosis of FDA-approved or compendia-supported indication **STEP THERAPY (ST)** • **Xifaxan®**: Requires trial of a fluoroquinolone antibiotic or azithromycin before Xifaxan® for treatment of Traveler's Diarrhea **QUANTITY LIMITS:** **Xifaxan®**: • Irritable bowel syndrome with diarrhea (550 mg tablets) – 42 tablets per 30 days (Dose = 550 mg three times a day for 14 days) – Maximum of 42 days' supply (126 units) per 365 days (3 rounds of therapy). • Small Intestine Bacterial Overgrowth (550mg tablets) - 42 tablets per 30 days (Dose = 550mg three times a day for 10-14 days); – Maximum of 28 days' supply (84 units) per 365 days (2 rounds of therapy).
Helicobacter pylori Agents		
Pylera® BLTG	bismuth/metronidazole/tetracycline (gen Pylera®) lansoprazole/amoxicillin/clarithromycin Omeclamox-Pak® Talicia®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VII. Gastrointestinal		
Proton Pump Inhibitors (PPIs) F/Q/D		
Dexilant® DO, BLTG esomeprazole magnesium Rx capsule lansoprazole Rx capsule omeprazole Rx pantoprazole tablet Protonix suspension BLTG rabeprazole Zegerid® Rx BLTG	Aciphex® dexlansoprazole (gen Dexilant) esomeprazole magnesium tablet OTC esomeprazole capsules OTC esomeprazole suspension Konvomep™ lansoprazole Rx ODT Nexium® RX DO omeprazole OTC omeprazole/sodium bicarbonate Rx omeprazole/sodium bicarbonate OTC pantoprazole suspension Prevacid® OTC Prevacid® Rx DO Prilosec® Rx Protonix® tablet	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Quantity limits: – Once daily dosing for: o GERD o erosive esophagitis o healing and maintenance of duodenal/gastric ulcers (including NSAID-induced) o prevention of NSAID-induced ulcers – Twice daily dosing for: o hypersecretory conditions o Barrett's esophagitis o H. pylori o refractory GERD • Duration limits: – 90 days for: o GERD – 365 days for: o Maintenance treatment of duodenal ulcers, or erosive esophagitis – 14 days for: o H. pylori

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VIII. Hematological Agents		
Anticoagulants – Injectable F/Q/D		
enoxaparin sodium Fragmin® vial	Arixtra® CC fondaparinux CC Fragmin® syringe Lovenox®	**CLINICAL CRITERIA (CC)** • For patients requiring > 30 days of therapy: Require confirmation of FDA-approved or compendia-supported indication • **Arixtra® (fondaparinux)** Clinical editing to allow patients with a diagnosis of Heparin Induced Thrombocytopenia (HIT) to receive therapy without prior authorization. **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Duration Limit: No more than 30 days for members initiating therapy
Anticoagulants – Oral		
Eliquis® Pradaxa® capsule BLTG warfarin Xarelto® tablet DO	dabigatran (gen Pradaxa®) Pradaxa® pellet pack Savaysa® Xarelto® dose pack, suspension	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths
Colony Stimulating Factors		
Neupogen® Nyvepria™	Fylnetra® Fulphila™ Granix® Leukine® Neulasta® Nivestym™ Releuko™ Rolvedon® Stimufend® Udenyca® Zarxio® Ziextenzo®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VIII. Hematological Agents		
Erythropoiesis Stimulating Agents (ESAs) [CC]		
Aranesp® Epogen® Retacrit®	Jesduvroq Mircera® Procrit®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis for FDA- or compendia-supported uses
Hemophilia Agents – Factor VIII		
Advate® Adynovate® Afstyla® Eloctate® Esperoct® Hemofil® M Humate-P® Jivi® Koate® Kogenate® FS Kovaltry® Novoeight® Nuwiq® Obizur® Recombinate™ Xyntha® Xyntha® Solofuse	Altuviiio™	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VIII. Hematological Agents		
Hemophilia Agents – Factor IX		
AlphaNine® SD Alprolix® BeneFIX® Idelvion® Ixinity® Profilnine® Rebinyn® Rixubis®	N/A	
Hemophilia Agents – Other		
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	
Platelet Inhibitors		
Brilinta® clopidogrel dipyridamole dipyridamole/aspirin	Effient® Plavix® prasugrel	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IX. Immunologic Agents		
Immunomodulators – Systemic CC, ST		
Cosentyx® Dupixent® Enbrel® Fasenra® Humira® Nucala® Xolair®	Actemra® subcutaneous adalimumab-FKJP (gen Hulio®) adalimumab-ADAZ (gen Hyrimoz®) adalimumab-ADBM (gen Cyltezo®) Adbry™ Amjevita™ Cibinqo™ Cimzia® Cyltezo® (adalimumab-ADMB) Hadlima™ Hulio® (adalimumab-FKJP) Hyrimoz® (adalimumab-ADAZ) Idacio® Ilumya® Kevzara® Kineret® Olumiant® Orencia® subcutaneous Otezla® Rinvoq™ ER Siliq™ Simponi® Skyrizi® Skyrizi® On-Body Sotyktu™ Stelara® Taltz® Tezspire® pen Tremfya® Xeljanz®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis for FDA- or compendia-supported uses **STEP THERAPY (ST)** For indications not specified below • Trial of a non-specific anti-inflammatory drug such as an aminosalicylate or immunosuppressant, or a disease-modifying anti-rheumatic drug (DMARD) • Trial of a TNF inhibitor prior to treatment with a JAK inhibitor **INDICATION-SPECIFIC REQUIREMENTS:** • Asthma: – history and concurrent use of a corticosteroid • Nasal polyps: – history and concurrent use of an intranasal corticosteroid • Atopic dermatitis: – Trial with a topical prescription product for a duration of at least 3 months. – For JAK inhibitors: Trial of topical prescription product and systemic product for a combined duration of at least 6 months.

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
X. Miscellaneous Agents		
Progestins (for Cachexia)		
megestrol acetate suspension	megestrol 625 mg/5 mL suspension	
Epinephrine – Self-injected		
EpiPen® BLTG EpiPen Jr.® BLTG	Auvi-Q® (0.1mg) epinephrine (gen Adrenaclick®) epinephrine (gen EpiPen®) epinephrine (gen EpiPen Jr.®) Symjepi®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XI. Musculoskeletal Agents		
Skeletal Muscle Relaxants		
baclofen tablet chlorzoxazone 500 mg cyclobenzaprine 5 mg, 10 mg tablet dantrolene methocarbamol orphenadrine ER tizanidine tablet	Amrix® baclofen solution F/Q/D baclofen (gen Fleqsuvy™) carisoprodol ST, F/Q/D carisoprodol compound ST, F/Q/D carisoprodol compound/codeine CC, ST, F/Q/D chlorzoxazone (gen Lorzone) 375 mg, 750 mg cyclobenzaprine 7.5 mg cyclobenzaprine ER capsule (gen Amrix) Dantrium® Fexmid® Fleqsuvy™ Lorzone® Lyvispah™ metaxalone orphenadrine-aspirin-caffeine Soma® ST, F/Q/D Soma® 250 ST, F/Q/D tizanidine capsule Zanaflex®	**CLINICAL CRITERIA (CC)** For carisoprodol/codeine products: • Limited to a total of 4 opioid prescriptions every 30 days; exemption for diagnosis of cancer or sickle cell disease • Medical necessity rationale for opioid therapy is required for patients on established opioid dependence therapy • PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy • PA required for any codeine containing products in patients < 12 years **STEP THERAPY (ST)** • Trial with 1 preferred analgesic and 2 preferred skeletal muscle relaxants prior to use of **carisoprodol** containing products: – carisoprodol – carisoprodol/ASA – carisoprodol/ASA/codeine – Soma® **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Maximum 84 cumulative units per a year • Baclofen solution – Maximum 946 mL per 30 days • **Carisoprodol** – Maximum 4 units per day, 21-day supply • **Carisoprodol combinations** – Maximum 8 units per day, 21-day supply (not to exceed the 84 cumulative units per year limit)

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Alpha-2 Adrenergic Agonists (for Glaucoma) – Ophthalmic		
Alphagan P® 0.1% Alphagan P® 0.15% BLTG brimonidine 0.2% Simbrinza®	apraclonidine brimonidine P 0.15% Iopidine®	
Antibiotics – Ophthalmic		
bacitracin/polymyxin B erythromycin gentamicin Natacyn® neomycin/gramicidin/polymyxin polymyxin/trimethoprim sulfacetamide solution tobramycin	Azasite® bacitracin neomycin/bacitracin/polymyxin Polytrim® sulfacetamide ointment Tobrex®	
Antibiotics/Steroid Combinations – Ophthalmic		
Blephamide® neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TobraDex® ointment tobramycin/dexamethasone suspension	Maxitrol® neomycin / bacitracin/polymyxin /HC neomycin/polymyxin/HC Pred-G® TobraDex® ST TobraDex® suspension Zylet®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Antihistamines – Ophthalmic		
azelastine ketotifen OTC olopatadine OTC	bepotastine (gen Bepreve®) Bepreve® epinastine Lastacaft® olopatadine Rx Pataday® Zaditor® OTC Zerviate™	
Anti-inflammatories/Immunomodulators – Ophthalmic CC		
Restasis® BLTG Restasis MultiDose® Xiidra®	Cequa® cyclosporine (gen Restasis®) Miebo™ Tyrvaya™ Verkazia®	**CLINICAL CRITERIA (CC)** • Diagnosis documentation required to justify utilization as a first line agent or attempt treatment with an artificial tear, gel, or ointment.
Beta Blockers – Ophthalmic		
betaxolol Betoptic S® carteolol Combigan® BLTG Istalol® levobunolol timolol maleate solution (gen Istalol®) timolol maleate gel	Betimol® brimonidine/timolol (gen Combigan®) timolol maleate (gen Timoptic® Ocudose®) Timoptic® Ocudose®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Fluoroquinolones – Ophthalmic ST		
ciprofloxacin moxifloxacin (gen Vigamox®) ofloxacin	Besivance® Ciloxan® gatifloxacin levofloxacin moxifloxacin (gen Moxeza®) Ocuflox® Vigamox® Zymaxid®	**STEP THERAPY (ST)** • For patients 21 years or younger, attempt treatment with a non-fluoroquinolone ophthalmic antibiotic before progressing to a fluoroquinolone ophthalmic product • Examples of Non-Fluoroquinolone Ophthalmic Antibiotics – AK-Poly-Bac eye ointment – bacitracin-polymyxin eye ointment – erythromycin eye ointment – Gentak® (3 mg/gm eye ointment, 3 mg/mL eye drops) – gentamicin (3 mg/gm eye ointment, 3 mg/mL eye drops) – neomycin-polymyxin-gramicidin eye drops – polymyxin B-TMP eye drops – Romycin® eye ointment – sulfacetamide 10% eye drops – Sulfamide® 10% eye drops – tobramycin 0.3% eye drops – Tobrasol™ 0.3% eye drops
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Ophthalmic		
diclofenac flurbiprofen Ilevro® ketorolac ketorolac LS	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
XII. Ophthalmics		
Prostaglandin Agonists – Ophthalmic		
latanoprost	bimatoprost Iyuzeh™ Lumigan® Rocklatan™ tafluprost (gen Zioptan®) Travatan Z® travoprost (gen Travatan Z®) Xalatan® Xelpros™ Vyzulta™ Zioptan®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XIV. Renal and Genitourinary		
Alpha Reductase Inhibitors for BPH		
finasteride	Avodart® dutasteride dutasteride/tamsulosin Entadfi™ Jalyn® Proscar®	
Antihyperuricemics		
allopurinol 100 mg, 300 mg colchicine tablet febuxostat probenecid probenecid/colchicine	allopurinol 200 mg colchicine capsule Colcrys Gloperba® Mitigare® Uloric® Zyloprim®	
Cystine Depleting Agents CC		
Cystagon®	Procysbi® ST	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication **STEP THERAPY (ST)** • Requires a trial with Cystagon immediate-release capsules
Phosphate Binders/Regulators		
calcium acetate Renvela® tablet, powder pack BLTG sevelamer HCl (gen Renagel)	Auryxia™ Fosrenol® lanthanum carbonate Phoslyra® sevelamer carbonate powder, tablet (gen Renvela) Velphoro®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XV. Respiratory		
Anticholinergics / COPD Agents		
Anoro Ellipta® Atrovent HFA® Bevespi® Aerosphere® Combivent Respimat® Incruse Ellipta® ipratropium ipratropium / albuterol roflumilast (gen Daliresp®) Spiriva® HandiHaler® BLTG Spiriva Respimat® Stiolto Respimat® Trelegy Ellipta® Tudorza Pressair®	Breztri™ Aerosphere Daliresp® Duaklir® Pressair Lonhala® Magnair® tiotropium (gen Spiriva® Handihaler®) Yupelri®	
Antihistamines – Intranasal		
azelastine olopatadine	Patanase®	
Antihistamines – Second Generation		
cetirizine OTC tablet cetirizine OTC syrup/solution 1mg/ 1mL fexofenadine OTC tablet levocetirizine tablet loratadine OTC	cetirizine OTC chewable cetirizine OTC syrup/solution 5 mg/5 mL cetirizine-D OTC Clarinex® Clarinex-D® desloratadine (gen Clarinex®) levocetirizine solution loratadine-D OTC	
Beta2 Adrenergic Agents – Inhaled Long-Acting CC, F/Q/D		
arformoterol (gen Brovana®) formoterol (gen Perforomist®) Serevent Diskus®	Brovana® Perforomist® Striverdi Respimat®	**CLINICAL CRITERIA (CC)** PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA- or compendia-supported age as indicated:

NYRx, the Medicaid Pharmacy Program Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">XV. Respiratory</td></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Brovana® / arformoterol</td><td>≥ 18 years</td></tr>
<tr><td>Perforomist® / formoterol</td><td>≥ 18 years</td></tr>
<tr><td>Serevent Diskus®</td><td>≥ 4 years</td></tr>
<tr><td>Striverdi Respimat®</td><td>≥ 18 years</td></tr>
</table>
FREQUENCY/QUANTITY/DURATION (F/Q/D)
Maximum units per 30 days
<table>
<tr><td>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>
</td></tr>
<tr><td colspan="3">Beta2 Adrenergic Agents – Inhaled Short-Acting</td></tr>
<tr><td>albuterol nebulizer solution
albuterol HFA (gen ProAir® HFA, Proventil HFA®) [1]
ProAir® Digihaler™ [1]
ProAir® RespiClick [1]
Proventil HFA® [1]
Ventolin HFA® BLTG
Xopenex HFA® BLTG, [1]</td><td>Airsupra™
albuterol HFA (gen Ventolin HFA®)
levalbuterol solution
levalbuterol HFA</td><td></td></tr>
<tr><td colspan="3">Corticosteroids – Inhaled</td></tr>
<tr><td>Alvesco® [1]
Arnuity Ellipta® [1]
Asmanex® Twisthaler
Flovent Diskus®
Flovent HFA® BLTG
Pulmicort® Flexhaler</td><td>ArmonAir® Digihaler®
Asmanex® HFA
fluticasone HFA (gen Flovent® HFA)
QVAR RediHaler®</td><td></td></tr>
</table>

NYRx, the Medicaid Pharmacy Program Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">XV. Respiratory</td></tr>
<tr><td colspan="3">Corticosteroid/Beta2 Adrenergic Agent (Long-Acting) Combinations – Inhaled CC, F/Q/D</td></tr>
<tr><td>Advair Diskus® BLTG
Dulera®
Symbicort® BLTG</td><td>Advair HFA®
AirDuo® Digihaler®
AirDuo™ RespiClick®
Breo Ellipta®
budesonide/formoterol (gen Symbicort)
fluticasone-salmeterol (gen AirDuo™ RespiClick®)
fluticasone-salmeterol (gen Advair Diskus®)
fluticasone-salmeterol (gen Advair HFA™)
fluticasone-vilanterol (gen Breo Ellipta®)</td><td>CLINICAL CRITERIA (CC)
• PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA-or compendia-supported age as indicated:
<table>
<tr><td>Advair Diskus®</td><td>≥ 4 years</td></tr>
<tr><td>Advair HFA®</td><td>≥ 12 years</td></tr>
<tr><td>AirDuo™ RespiClick® & Digihaler®</td><td>> 12 years</td></tr>
<tr><td>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>
FREQUENCY/QUANTITY/DURATION (F/Q/D)
<table>
<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® & Digihaler®</td></tr>
<tr><td>fluticasone-salmeterol</td></tr>
<tr><td>fluticasone/vilanterol (Breo Ellipta®)</td></tr>
<tr><td>Budesonide/formoterol (Symbicort®)</td><td rowspan="2">Up to 8 inhalers every 180 days</td></tr>
<tr><td>Dulera®</td></tr>
</table></td></tr>
</table>

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XV. Respiratory		
Corticosteroids – Intranasal		
budesonide OTC Dymista® BLTG, 1 fluticasone fluticasone OTC Nasonex® OTC Omnaris® 1 triamcinolone OTC Zetonna® 1	azelastine-fluticasone (gen Dymista®) Beconase AQ® CC flunisolide mometasone QNASL® CC Ryaltris® Xhance™	**CLINICAL CRITERIA (CC)** • Clinical consideration in regard to drug interactions will be given to patients with HIV/AIDs diagnosis or antiretroviral therapy in history
Leukotriene Modifiers		
montelukast tablet, chew tab	Accolate® montelukast granules Singulair® zafirlukast	

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.

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

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

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

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

NYS Medicaid 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, Cortrophin®)	Requires trial of first-line therapy for all FDA-approved indications, other than infantile spasms. **Note**: It is first line therapy for infantile spasms in children less than 2 years of age – step therapy not required.	**QUANTITY LIMITS:** • Infantile spasms – 30 mL (six 5 mL vials) • Multiple sclerosis – 35 mL (seven 5 mL vials) **DURATION LIMITS:** • Infantile spasms – 4 weeks; indicated for < 2 years of age • Multiple sclerosis – 5 weeks • Rheumatic disorders – 5 weeks • Dermatologic conditions – 5 weeks • Allergic states (serum sickness) – 5 weeks	• Confirm diagnosis of FDA-approved or compendia-supported indication • Not covered for diagnostic purposes

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

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anabolic Steroids – Injectable • Depo-Testosterone® • testosterone cypionate • testosterone enanthate (Xyosted®)* Anabolic Steroids – Oral • Jatenzo® • Methitest® • Oxandrolone • Tlando®		• Limitations for anabolic steroid products is based on approved FDA labeled daily dosing and documented diagnosis not to exceed a 90-day supply (30-day supply for oxandrolone): • Xyosted® is limited to no more than 3 boxes for 90 days (1 box per 30 days) • Initial duration limit of 3 months (for all products except oxandrolone), requiring documented follow-up monitoring for response and/or adverse effects before continuing treatment • Duration limit of 6 months for delayed puberty • Duration limit of 1 month for all uses of oxandrolone products	*for additional parameters, see Cross-Sex Hormones section below.
Anti-Diabetic agents (not on the PDL) • acarbose (Precose®) • glimepiride • glipizide (Glucotrol XL®) • glyburide • glyburide, micronized • miglitol • nateglinide • pramlintide (Symlin®) • repaglinide • repaglinide/metformin	• Requires a trial with metformin with or without insulin prior to initiating other antidiabetic agents unless there is a documented contraindication. • Clinical editing to allow patients with a diagnosis of gestational diabetes to receive glyburide without a trial of metformin first.		

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anti-Diarrheal Agents • alosetron (Lotronex®) • crofelemer (Mytesi®) • eluxadoline (Viberzi®) • telotristat (Xermelo®)	• Irritable Bowel Syndrome w/Diarrhea – Trial of eluxadoline and rifaximin prior to alosetron. • Symptomatic relief of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy – Trial with an alternative anti-diarrheal agent. • Carcinoid Syndrome – Trial with and concurrent use with a somatostatin analog		• Confirmation of FDA-approved or compendia-supported indication.
Anti-Fungals, Topical – for Onychomycosis • ciclopirox 8% solution • Jublia® • tavaborole (Kerydin®)	• Trial with an oral antifungal agent* prior to use of ciclopirox 8% solution *terbinafine (Lamisil®) tablets; griseofulvin (Gris PEG®) oral suspension, ultramicronized tablets micronized tablets; itraconazole (Sporanox®,) tablets, oral solution • Trial with ciclopirox 8% solution prior to the use of other topical antifungals [efinaconazole (Jublia®) or tavaborole (Kerydin®)]		

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anti-Retroviral (ARV) Interventions		**QUANTITY LIMITS:** • Limit ARV active ingredient duplication • Limit ARV utilization to a maximum of five products concurrently - excluding boosting with ritonavir (dose limit 600 mg or less) or cobicistat • Limit Protease Inhibitor utilization to a maximum of two products concurrently • Limit Integrase inhibitor utilization to a maximum of one product concurrently • Limit non-nucleoside reverse transcriptase inhibitor utilization to a maximum of 1 product concurrently • Limit coformulated and copackaged complete ARV regimens listed in Appendix A to a maximum of 1 product concurrently with no additional ARVs.	Require confirmation of FDA-approved or compendia-supported use • Point-of-service edit for antiretroviral / antiretroviral combinations to be avoided: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_reference_Antiretroviral_Antiretroviral_Drug2Drug_Interactions.pdf
Benlysta® (belimumab)	• Trial of a disease-modifying anti-rheumatic drug (DMARD) prior to treatment with an immunomodulator		• Confirm diagnosis of FDA-approved or compendia-supported indication
biotin			• Confirm diagnosis of FDA-approved or compendia-supported indication

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Atopic Dermatitis Agents • crisaborole (Eucrisa®) • ruxolitinib (Opzelura™)	• Trial with a medium or high potency prescription topical steroid within the last 3 months	**QUANTITY LIMITS:** • 100 gm/30 days (crisaborole) • 240 gm/30 days (ruxolitinib)	• Confirm diagnosis of FDA-approved or compendia-supported indication • ruxolitinib: age 12 years +
Benzodiazepine agents – oral • alprazolam (Xanax®, Xanax® XR) • chlordiazepoxide • chlordiazepoxide/amitriptyline • clonazepam (Klonopin®) • clorazepate • diazepam (Valium®) • lorazepam (Ativan®, Lorazepam Intensol®, Loreev XR™) • oxazepam	Generalized Anxiety Disorder (GAD) or Social Anxiety Disorder (SAD) • Require trial with a Selective-Serotonin Reuptake Inhibitor (SSRI) or a Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) prior to initial benzodiazepine prescription • Panic Disorder requires concurrent therapy with an antidepressant (SSRI, SNRI, or Tricyclic antidepressant [TCA]). Skeletal muscle spasms • Require trial with a skeletal muscle relaxant prior to a benzodiazepine	**DURATION LIMIT:** • For Insomnia: 30 consecutive days • For Panic Disorder: 30 consecutive days	• Require confirmation of FDA-approved or compendia-supported use • PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy • PA required for any additional oral benzodiazepine prescription in patients currently on benzodiazepine therapy • PA required when greater than a 14-day supply of a benzodiazepine is prescribed for someone on a CNS stimulant
Constipation Agents • linaclotide (Linzess®) • lubiprostone (Amitiza®) • methylnaltrexone (Relistor®) • naldemedine (Symproic®) • naloxegol (Movantik®) • plecanatide (Trulance®) • prucalopride (Motegrity™) • tenapanor (Ibsrela®)	Opioid Induced Constipation (OIC) and Chronic Idiopathic Constipation (CIC) • Trial with an osmotic laxative, a stimulant laxative, and a stool softener prior to use. Irritable Bowel Syndrome w/ Constipation (IBS-C) • Trial with a bulking agent and an osmotic laxative within 89 days of use.	**QUANTITY LIMIT:** • linaclotide, naldemedine, naloxegol, plecanatide: 1 tablet/day • lubiprostone: 2 capsules/day • methylnaltrexone: 1 vial or syringe/day, 4 kits/28 days • prucalopride: 2 mg/day max; 1 tablet per day • tenapanor 2 tablets/day	• Confirmation of FDA-approved or compendia-supported indication.

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Cross-Sex Hormones • conjugated estrogens • estradiol • testosterone cypionate • testosterone enanthate (Xyosted™) • testosterone gel 1.62% (AndroGel®)* • testosterone patch (Androderm)*			• Confirm diagnosis of FDA-approved or compendia-supported indication • For diagnosis of gender dysphoria please refer to October 2023 edition of the Medicaid Update: *Subject to Anabolic Steroids – Topical PDL class criteria
dextromethorphan / quinidine (Nuedexta®)		**QUANTITY LIMIT:** • 2 capsules per day; 60 units per 30 days **DURATION LIMIT:** • 90 days of therapy	For patients ≥ 18 years of age: • Confirm diagnosis of FDA-approved or compendia-supported indication
Diabetic Test Strips		**QUANTITY LIMIT:** • Type I DM – max 300 test strips per 30-day supply • Type II DM – max 100 test strips per 30-day supply	• Preferred diabetic supply program https://newyork.fhsc.com/providers/diabeticsupplies.asp
Direct Renin Inhibitors • aliskiren • Tekturna® • Tekturna® HCT	Trial of product containing either an ACE inhibitor or an ARB prior to initiating preferred DRI		

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
dronabinol (Marinol®)	Step therapy for beneficiaries with HIV/AIDS, or cancer, AND eating disorder: • Trial with megestrol acetate suspension prior to dronabinol Step therapy for beneficiaries with diagnosis of cancer and nausea/vomiting: • Trial with a NYS Medicaid-preferred 5-HT3 receptor antagonist prior to dronabinol		• Confirm diagnosis of FDA-approved or compendia-supported indication
risdiplam (Evrysdi®)			• Confirm diagnosis of FDA-approved indication • Confirm absence of advanced disease

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

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

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Lipid Lowering Agents: • alirocumab (Praluent®) • evolocumab (Repatha®) • lomitapide (Juxtapid®) • bempedoic acid (Nexletol™) • bempedoic acid/ezetimibe (Nexlizet™)	• Require trial of an HMG-CoA Reductase Inhibitors (statin) at maximum tolerated dosage		• Confirm diagnosis of FDA-approved or compendia-supported indication **PCSK-9 Inhibitors** (alirocumab [Praluent®], evolocumab [Repatha®]) and **ACL inhibitors** (Bempedoic acid [Nexletol], Bempedoic acid/ezetimibe [Nexlizet]): • Require concurrent statin therapy
Methadone	• Requires a trial of a long-acting opioid prior to initiation for the management of chronic non-cancer pain	**QUANTITY LIMIT:** • 12 units per day, 360 units per 30 days • Exemption for diagnosis of cancer, hospice care, or sickle cell disease	• Confirm diagnosis of chronic non-cancer pain • Limited to a total of 4 opioid prescriptions every 30 days; • PA required for initiation of methadone for patients on established opioid dependence therapy • PA required for methadone prescriptions for patients currently on long-acting opioid therapy. • PA required for initiation of long-acting opioid therapy in opioid-naïve patients. • PA required for use if > 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting > 7 days). PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy • Exemption for diagnosis of cancer, sickle cell, or hospice care

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Metoclopramide nasal spray (Gimoti™)			• Metoclopramide nasal spray confirm diagnosis of diabetes
olanzapine / fluoxetine (Symbyax®)	• When prescribing for the treatment of major depressive disorder (MDD) in the absence of other psychiatric comorbidities, trial with at least one different antidepressant agent is required		• PA is required for the initial prescription for beneficiaries younger than 10 years
Ovulation Enhancing Drugs • bromocriptine • clomiphene • letrozole • tamoxifen			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Refer to https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-06.htm#ovulation
Oxazolidinone Antibiotics • linezolid (Zyvox®) • tedizolid (Sivextro®)			• Please be prepared to respond to a series of questions that identify the prescriber, the patient, and the reason for prescribing this drug. • Please be prepared to fax clinical documentation upon request.
Pubertal Suppressants • goserelin acetate • leuprolide acetate • nafarelin acetate			• Confirm diagnosis of FDA-approved or compendia-supported indication • Refer to https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender for Transgender Related Care and Services Update

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Rosacea Agents • azelaic acid (Finacea®) * • brimonidine gel pump • ivermectin • oxymetazoline HCl (Rhofade®) • doxycycline	• Trial with topical metronidazole product. *does not apply to azelaic acid (Finacea®)		• Confirmation of FDA-approved or compendia-supported indication *does not apply to azelaic acid (Finacea®)

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Spravato® (esketamine)	• Treatment Resistant Depression: trial of at least two oral antidepressants		• Confirm diagnosis of FDA approved indication for patients ≥18 years of age • Confirm concurrent use of an FDA approved antidepressant • 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). • 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: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_Spravato.docx
tasimelteon (Hetlioz®,Hetlioz® LQ)		**QUANTITY LIMIT:** • One unit per day; 30 units per 30 days	• Confirm diagnosis of FDA-approved or compendia-supported indication

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Parathyroid Hormone Analogs • teriparatide (Forteo®) • Tymlos®	• Requires a trial with a preferred oral bisphosphonate	**QUANTITY LIMIT:** • One unit per 30-day period **LIFETIME QUANTITY LIMIT:** • 25 months' cumulative use of a PTH analog	
Topical Compounded Prescriptions			• Confirm diagnosis of FDA-approved or compendia-supported indication • For non-opioid pain management alternatives please visit: https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf
Uterine Disorder Agents • Oriahnn® • Myfembree®		**QUANTITY LIMIT:** • 28 days per 30-day period **LIFETIME QUANTITY LIMIT:** • 24 months cumulative use	

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

Medication Assisted Treatment (MAT) Formulary

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 05/05/2022

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**
Opioid Antagonists	
Kloxxado™ naloxone (syringe, vial, nasal spray) naloxone (nasal spray) OTC naltrexone Narcan® (nasal spray) Narcan® OTC Opvee® Zimhi™*	n/a
Opioid Dependence Agents – Injectable	
Brixadi™ Vivitrol® Sublocade™	n/a
Opioid Dependence Agents – Oral/Transmucosal F/Q/D	
buprenorphine (tablet) buprenorphine/naloxone (tablet) Suboxone® (film) buprenorphine/naloxone (film) Zubsolv®	**QUANTITY LIMIT:** • **buprenorphine sublingual (SL):** Six tablets dispensed as a 2-day supply; not to exceed 24 mg per day • **buprenorphine/ naloxone tablet and film (Suboxone®, Zubsolv®**) up to 5.7 mg/1.4 mg strength); Three sublingual tablets or films per day; maximum of 90 tablets or films dispensed as a 30-day supply, not to exceed 24 mg-6 mg of Suboxone, or its equivalent per day • **buprenorphine/naloxone tablet (Zubsolv® 8.6 mg/2.1 mg strength):** Maximum of 60 tablets dispensed as a 30-day supply • **buprenorphine/naloxone tablet (Zubsolv® 11.4 mg/2.9 mg strength):** Maximum of 30 tablets dispensed as a 30-day supply **RELATED CLINICAL CRITERIA (CC)** • PA required for initiation of **opioid therapy** for patients on established opioid dependence therapy

	• PA required for initiation of a **CNS stimulant** for patients established on opioid dependence therapy **

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 December 14, 2023:

- Dymista®, Pennsaid®, Ritalin LA® and Xopenex HFA® will be **added** to the program
- Concerta®, Ciprodex® will be **removed** from the program

List of Brand Name Drugs included in this program**		
Advair Diskus®	Glumetza®	Rapamune® solution
Alphagan P® 0.15%	Kazano®	Renvela® tablet, and powder pack
Amitiza®	Kitabis® Pak	Restasis®
Apriso®	Kombiglyze® XR	Retin-A® cream
Azopt™	Lialda®	**Ritalin LA®**
Bethkis®	Nesina®	Spiriva® Handihaler®
CellCept® suspension	Nexavar®	Symbicort®
Combigan®	NuvaRing®	Tegretol® suspension
Copaxone® 20 mg SQ	Onglyza®	Tegretol® XR
Daytrana®	Oseni®	Trileptal® suspension
Depakote® Sprinkle	**Pennsaid®**	Vascepa®
Dexilant®	Pentasa®	Ventolin® HFA
Dymista®	Pradaxa®	Viibryd®
EpiPen	Protonix® suspension	**Xopenex HFA®**
EpiPen, Jr	Pylera®	Zegerid® Rx
Flovent® HFA		

**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 an NCPDP reject response of "22" which means missing/invalid DAW code if other DAW codes are submitted. The only exception to this is DAW code 1 and "*Brand Medically Necessary"* on the prescription.
- For more information on the Brand Less Than Generic (BLTG) Program, please refer to https://newyork.fhsc.com/providers/bltgp_about.asp

NYS Medicaid 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, provide step-by-step assistance in completing the prior authorization process.
- The prescriber must write "DAW and Brand Medically Necessary" on the face of the prescription.
- The call line 1-877-309-9493 is in operation 24 hours a day, seven days a week.

Exempt Drugs

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

Exempt Drugs	
Clozaril®	Neoral®
Dilantin®	Sandimmune®
Gengraf®	Tegretol®
Lanoxin®	Zarontin®
Levothyroxine Sodium (Unithroid®, Synthroid®, Levoxyl®)	

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

NYS Medicaid 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		
CARDIOVASCULAR			
Angiotensin Receptor Blockers (ARBs)			
Benicar® 20 mg	1 daily	Tablet	
Micardis® 20 mg, 40 mg	1 daily	Tablet	
Diovan® 40 mg, 80 mg, 160 mg	1 daily	Tablet	
Antiarrhythmics			
Amiodarone 100 mg	1 daily	Tablet	In case of dose titration for these medications, the department will allow for multiday dosing (up to 2 doses daily) for loading dose for 30 days
ARBs Combinations			
Exforge® 5–160mg	1 daily	Tablet	
ARBs/Diuretics			
Benicar® HCT 20–12.5 mg	1 daily	Tablet	
Diovan® HCT 80–12.5 mg, 160–12.5 mg	1 daily	Tablet	
Edarbyclor® 40–12.5 mg	1 daily	Tablet	
Micardis® HCT 40–12.5 mg, 80–12.5 mg	1 daily	Tablet	
Beta Blockers			
Bystolic® 2.5 mg, 5 mg, 10 mg	1 daily	Tablet	
Coreg® CR 20 mg, 40 mg	1 daily	Tablet	
nadolol 40 mg	1 daily	Tablet	
Toprol® XL 25 mg, 50 mg, 100 mg	1 daily	Tablet	

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

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

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Antipsychotics – Second Generation			
Abilify® 2 mg	4 daily	Tablet	
Abilify® 5 mg, 10 mg, 15 mg	1 daily	Tablet	In case of dose titration for these medications, the Department will allow for multiday dosing (up to 2 doses/daily) for titration purposes for three months
aripiprazole 5 mg, 10 mg, 15 mg	1 daily	Tablet	
Invega® 1.5 mg, 3 mg	1 daily	Tablet	
Latuda® 20 mg, 40 mg, 60 mg	1 daily	Tablet	
olanzapine 5 mg, 10 mg	1 daily	Tablet	
olanzapine ODT 5 mg, 10 mg	1 daily	Tablet	
paliperidone er 1.5 mg, 3 mg	1 daily	Tablet	
quetiapine fumarate er 200 mg	1 daily	Tablet	
Rexulti® 0.25 mg, 0.5 mg, 1 mg, 2 mg	1 daily	Tablet	
Seroquel® XR 150 mg, 200 mg	1 daily	Tablet	
Symbyax® 3–25 mg, 6–25 mg, 12–25 mg	1 daily	Capsule	
Vraylar® 1.5 mg, 3 mg	1 daily	Capsule	
Zyprexa® Zydis 5 mg, 10 mg	1 daily	Tablet	
CNS Stimulants			
Adderall® XR 5 mg, 10 mg, 15 mg	1 daily	Capsule	
amphetamine salt combo ER 5 mg, 10 mg, 15 mg	1 daily	Capsule	
Concerta® ER 18 mg, 27 mg	1 daily	Tablet	
dexmethylphenidate ER 10 mg, 20 mg (Focalin XR generic)	1 daily	Capsule	
Focalin® XR 5 mg, 10 mg, 15 mg, 20 mg	1 daily	Capsule	
methylphenidate CD 10 mg, 20 mg	1 daily	Capsule	
methylphenidate er 18 mg (Concerta® generic)	1 daily	Tablet	
methylphenidate la 20 mg (Ritalin® LA generic)	1 daily	Capsule	
modafinil 100 mg	1 daily	Tablet	
Provigil® 100 mg	1 daily	Tablet	
QuilliChew® ER 20 mg	1 daily	Tablet	
Ritalin® LA 10 mg, 20 mg	1 daily	Capsule	

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Vyvanse® 10 mg, 20 mg, 30 mg, 40 mg	1 daily	Capsule	
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)			
guanfacine ER 1 mg, 2 mg	1 daily	Tablet	
atomoxetine 40 mg	1 daily	Capsule	
Intuniv® 1 mg, 2 mg	1 daily	Tablet	
Strattera® 40 mg	1 daily	Capsule	
Sedative Hypnotics			
Lunesta® 1 mg	1 daily	Tablet	
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)			
Effexor® XR 37.5 mg, 75 mg, 150 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.
desvenlafaxine succinate ER (Pristiq® ER 50 mg)	1 daily	Tablet	
Selective Serotonin Reuptake Inhibitors (SSRIs)			
Lexapro® 5 mg, 10 mg	1 daily	Tablet	In the case of dose titration for these once daily medications, the Department will allow for multiday dosing (up to 2 doses/daily) for titration purposes for three months.
Trintellix® 5 mg, 10 mg	1 daily	Tablet	
Viibryd® 10 mg, 20 mg	1 daily	Tablet	
Miscellaneous Antidepressants			
bupropion xl 150 mg	1 daily	Tablet	In case of dose titration for these medications, the Department will allow for multiday dosing (up to 2 doses/daily) for titration purposes for three months
mirtazapine 7.5 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
ENDOCRINE AND METABOLIC			
Biguanides			
metformin ER 500 mg (Glumetza ER, Fortamet ER generic)	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
ENDOCRINE AND METABOLIC			
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors			
Januvia® 25 mg, 50 mg	1 daily	Tablet	
Onglyza® 2.5 mg	1 daily	Tablet	
Thiazolidinediones (TZDs)			
Actos® 15 mg	1 daily	Tablet	

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

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

Brand Name	Dose Optimization Limitations		
RENAL AND GENITOURINARY			
Urinary Tract Antispasmodics			
Detrol® LA 2 mg	1 daily	Capsule	
Myrbetriq® 25 mg	1 daily	Tablet	
oxybutynin chloride ER 5 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
RENAL AND GENITOURINARY			
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 72-hour emergency supply of the drug prescribed to allow time for the prior authorization to be obtained.