

# NYRx, the New York Medicaid Pharmacy Program

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## OVERVIEW OF CONTENTS

### **[Preferred Drug Program \(PDP\)](#) (Pages 4–60)**

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 61)**

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 62–74)**

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 76–77)**

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

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

To contact the NYRx Clinical Call Center please call 1-877-309-9493

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

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

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

### **Mandatory Generic Drug Program (Page 78)**

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 79–83)**

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

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

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>I. Analgesics</b>		
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</b>		
Celebrex® celecoxib diclofenac 1% topical gel diclofenac sodium oral ibuprofen Rx tablet, suspension ibuprofen OTC suspension indomethacin capsule ketorolac meloxicam tablet nabumetone naproxen tablet 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 diflunisal Duexis® Elyxyb™ <sup>F/Q/D</sup> etodolac etodolac ER Feldene® fenoprofen Flector® patch flurbiprofen ibuprofen/famotidine (gen Duexis®) indomethacin ER indomethacin suspension ketoprofen ketoprofen ER ketorolac nasal spray (gen Sprix®) Kiprofen™ Licart™ meclofenamate mefenamic acid meloxicam capsule (gen Vivlodex®) Nalfon® Naprelan®	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Elyxyb™ (celecoxib) – 4.8 mL bottle (120 mg) maximum quantity: 9 / 30 days</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>I. Analgesics</b>		
	naproxen susp naproxen CR naproxen EC naproxen-esomeprazole naproxen sodium oxaprozin Relafen® DS tolmetin Vimovo®	
<b>Opioids – Long-Acting <sup>CC</sup></b>		
buprenorphine patch fentanyl patch (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg) morphine sulfate ER tablet	Belbuca® Butrans® ConZip® <sup>ST</sup> fentanyl patch (37.5 mcg, 62.5 mcg, 87.5 mcg) hydrocodone ER hydrocodone ER (gen Hysingla ER) hydromorphone ER Hysingla® ER morphine ER capsule (gen Avinza) morphine ER capsule (gen Kadian) MS Contin® Nucynta® ER <sup>ST</sup> oxycodone ER Oxycontin® oxymorphone ER tramadol ER <sup>ST</sup> Xtampza® ER	<b>CLINICAL CRITERIA (CC) *</b> <ul style="list-style-type: none"> <li>Limited to a total of 4 opioid prescriptions every 30 days; Exemption for diagnosis of cancer, hospice or palliative care, or sickle cell disease</li> <li>PA required for initiation of opioid therapy for patients on established opioid dependence therapy</li> <li>PA required for use if ≥ 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting &gt; 7 days)</li> <li>PA required for initiation of long-acting opioid therapy in opioid-naïve patients.</li> <li>PA required for any additional long-acting opioid prescription for patients currently on long-acting opioid therapy.</li> <li>PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy</li> <li>PA required for any codeine- or tramadol-containing products in pts &lt; 12 years</li> </ul> <b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li><b>Nucynta® ER (tapentadol ER):</b> Trial with tapentadol IR before tapentadol ER for patients who are naïve to a long-acting opioid</li> <li><b>Tramadol ER (tramadol naïve patients):</b> Attempt treatment with IR formulations before the following ER formulations: ConZip®, tramadol ER</li> </ul> *Exemption 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

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<b>I. Analgesics</b>		
<b>Opioids – Short-Acting <sup>CC</sup></b>		
butalbital/APAP/caffeine/codeine codeine codeine/APAP hydrocodone/APAP hydrocodone/ibuprofen hydromorphone tablets morphine IR oxycodone IR tablets, solution oxycodone/APAP tramadol tablet	butalbital compound/codeine butorphanol nasal spray dihydrocodeine/APAP/caffeine Dilaudid® hydromorphone solution levorphanol meperidine Nalocet® Nucynta® <sup>ST</sup> oxycodone IR capsules, concentrate oxycodone/APAP (Prolate) solution, tablets) oxymorphone pentazocine/naloxone Percocet® Roxicodone® Seglentsis® tramadol solution tramadol 25mg tablet tramadol/APAP	<p><b>CLINICAL CRITERIA (CC) *</b></p> <ul style="list-style-type: none"> <li>Limited to a total of 4 opioid prescriptions every 30 days.</li> <li>Initial prescription for opioid-naïve patients limited to a 7-day supply.</li> <li>PA required for initiation of opioid therapy for patients on established opioid dependence therapy.</li> <li>PA required for use if <math>\geq 90</math> MME of opioid per day for management of non-acute pain (&gt; 7 days)                             <ul style="list-style-type: none"> <li>Exception for diagnosis of cancer or sickle cell disease, or hospice or palliative care programs</li> </ul> </li> <li>PA is required for opioid-naïve patients for prescription requests <math>\geq 50</math> MME per day.</li> <li>PA required for continuation of opioid therapy beyond an initial 7-day supply in patients established on gabapentin or pregabalin</li> <li>PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy</li> <li>PA required for any codeine- or tramadol-containing products in pts &lt; 12 years</li> </ul> <p><b>PA required for continuation of opioid therapy for &gt;7days for patients on established CNS stimulant therapy</b></p> <p><b>STEP THERAPY (ST)</b></p> <ul style="list-style-type: none"> <li><b>Nucynta® (tapentadol IR)</b> – Trial with tramadol and 1 preferred opioid before tapentadol immediate-release (IR)</li> <li>For Non-opioid Pain management alternatives please visit:  <a href="https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf">https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf</a> </li> </ul> <p>*Exemptions from requirements for diagnosis of cancer, sickle cell disease, or hospice or palliative care</p>

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>II. Anti-Infectives</b>		
	levofloxacin solution moxifloxacin ofloxacin tablet	
<b>Hepatitis B Agents</b>		
adefovir dipivoxil Baraclude® solution entecavir lamivudine HBV	Baraclude® tablet Hepsera® Vemlidy®	
<b>Hepatitis C Agents – Direct Acting Antivirals</b>		
Mavyret™ ribavirin sofosbuvir/velpatasvir (gen Eplusa®) Vosevi®	Epclusa® Harvoni® ledipasvir/sofosbuvir (gen Harvoni®) Sovaldi® Zepatier®	
<b>Tetracyclines</b>		
demeclocycline doxycycline hyclate minocycline capsule tetracycline capsule	Doryx® <sup>ST</sup> Doryx MPC® <sup>ST</sup> doxycycline hyclate DR <sup>ST</sup> doxycycline monohydrate minocycline tablet minocycline ER tablet Minolira ER™ Nuzyra™ Solodyn® Vibramycin®	<b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>• Trial of doxycycline IR before progressing to doxycycline DR</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

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

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>III. Cardiovascular</b>		
<b>Pulmonary Arterial Hypertension (PAH) Agents, Other – Oral</b>		
ambrisentan (gen Letairis) bosentan tablets (gen Tracleer®)	Adempas® Letairis® Opsumit® Orenitram® ER tablet, dosepack Tracleer® tablet for suspension, tablet Upravi®	
<b>Triglyceride Lowering Agents</b>		
fenofibrate tablet (gen Tricor®) fenofibrate capsule (gen Lofibra®) fenofibric acid capsule (gen Trilipix®) gemfibrozil omega-3 ethyl ester (gen Lovaza®) <sup>F/Q/D</sup> , Vascepa® <sup>F/Q/D</sup> , <u>BLTG</u>	fenofibrate caps (gen Lipofen®) fenofibrate micronized capsule fenofibrate tablet (gen Fenoglide®) fenofibric acid tablet (gen Fibracor®) Fenoglide® icosapent (gen Vascepa®) <sup>F/Q/D</sup> Lipofen® Lopid® Lovaza® <sup>F/Q/D</sup> Tricor® Trilipix®	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>• Lovaza® (omega-3-acid ethyl-esters) and Vascepa® (icosapent ethyl) – Required dosage equal to 4 grams per day</li> </ul>

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IV. Central Nervous System</b>		
<b>Alzheimer's Agents</b>		
donepezil 5 mg, 10 mg galantamine galantamine ER memantine Namenda® rivastigmine	Adlarity® Aricept® donepezil 23 mg Exelon® memantine ER Namenda XR® Namzaric®	
<b>Anticonvulsants – Carbamazepine Derivatives</b>		
carbamazepine chewable, tablet carbamazepine ER capsule Equetro® oxcarbazepine tablet Tegretol® suspension <span style="color: red;">BLTG</span> Tegretol XR® <span style="color: red;">BLTG</span> Trileptal® suspension <span style="color: red;">BLTG</span>	Aptiom® <span style="color: red;">CC, DO</span> carbamazepine suspension <span style="color: red;">CC</span> carbamazepine XR tablet Carbatrol® <span style="color: red;">CC</span> oxcarbazepine suspension Oxtellar XR® <span style="color: red;">CC, DO</span> Tegretol® tablet <span style="color: red;">CC</span> Trileptal® tablet <span style="color: red;">CC</span>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA</li> </ul> <b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul>
<b>Anticonvulsants – Other</b>		
clobazam tablet <span style="color: red;">ST, CC</span> gabapentin capsule, solution, tablet <span style="color: red;">F/Q/D, CC</span> lacosamide tablet, solution lamotrigine tablet, chew levetiracetam levetiracetam ER Lyrica® capsule <span style="color: red;">DO, F/Q/D, CC</span> pregabalin capsule <span style="color: red;">DO, F/Q/D, CC</span> tiagabine topiramate <span style="color: red;">CC</span>	Banzel® Briviact® clobazam suspension <span style="color: red;">ST</span> Diacomit® <span style="color: red;">CC</span> Elevia® XR Epidiolex® <span style="color: red;">CC</span> Eprontia™ <span style="color: red;">CC</span> felbamate Felbatol® Fintepla® Fycompa® <span style="color: red;">DO</span>	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul> <b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA</li> <li><b>Cannabidiol extract (Epidiolex®)</b> – Confirm diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form</li> <li><b>Lyrica®/Lyrica® CR (pregabalin)</b> – PA required for the initiation of pregabalin at &gt; 150 mg per day in patients currently on an opioid at &gt; 50 MME per day</li> </ul>

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Standard PA fax form: [https://newyork.fhsc.com/downloads/providers/NYRx\\_PDP\\_PA\\_Fax\\_Standardized.pdf](https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf)

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

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																				
<b>IV. Central Nervous System</b>																						
<b>Antimigraine Agents, Other <span style="color: red;">ST, F/Q/D</span></b>																						
Aimovig® Ajovy® Emgality® Nurtec™ ODT Ubrelvy™	Emgality® 100mg syringe Qulipta™ Reyvow™ Zavzpret™	<b>STEP THERAPY (ST)</b> <b>Acute treatment of migraine</b> <ul style="list-style-type: none"> <li>Trial of a product from the Antimigraine Agents-Triptan class</li> </ul> <b>Prevention of migraine</b> <ul style="list-style-type: none"> <li>Trial of 2 FDA approved or compendia supported migraine prevention products from other drug classes</li> </ul> <table border="1" style="width: 100%; margin-top: 10px;"> <thead> <tr style="background-color: #D9E1F2;"> <th style="width: 60%;">Agent</th> <th style="width: 40%;">F/Q/D</th> </tr> </thead> <tbody> <tr><td>Aimovig</td><td>1 syringe/30 days</td></tr> <tr><td>Emgality 120 mg</td><td>2 syringes/30 days</td></tr> <tr><td>Emgality 100 mg</td><td>3 syringes/30 days</td></tr> <tr><td>Ajovy</td><td>3 syringes/90 days</td></tr> <tr><td>Reyvow</td><td>8 units/30 days</td></tr> <tr><td>Ubrelvy</td><td>16 units/30 days</td></tr> <tr><td>Nurtec™ ODT</td><td>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> </tbody> </table>	Agent	F/Q/D	Aimovig	1 syringe/30 days	Emgality 120 mg	2 syringes/30 days	Emgality 100 mg	3 syringes/30 days	Ajovy	3 syringes/90 days	Reyvow	8 units/30 days	Ubrelvy	16 units/30 days	Nurtec™ ODT	24 units/40 days	Qulipta	30 units/30 days	Zavzpret®	8 units/30 days
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<b>Antimigraine Agents – Triptans</b>																						
rizatriptan <span style="color: red;">F/Q/D</span> sumatriptan <span style="color: red;">F/Q/D</span>	almotriptan <span style="color: red;">F/Q/D</span> eletriptan <span style="color: red;">F/Q/D</span> Frova® <span style="color: red;">F/Q/D</span> frovatriptan <span style="color: red;">F/Q/D</span> Imitrex® <span style="color: red;">F/Q/D</span> Maxalt® <span style="color: red;">F/Q/D</span> Maxalt® MLT <span style="color: red;">F/Q/D</span> naratriptan <span style="color: red;">F/Q/D</span> Relpax® <span style="color: red;">F/Q/D</span> sumatriptan-naproxen <span style="color: red;">F/Q/D</span> Tosymra™ <span style="color: red;">F/Q/D</span>	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <table border="1" style="width: 100%; margin-top: 10px;"> <thead> <tr style="background-color: #D9E1F2;"> <th style="width: 60%;">Agent</th> <th style="width: 40%;">F/Q/D</th> </tr> </thead> <tbody> <tr> <td>                             almotriptan                              eletriptan (Relpax®)                              frovatriptan (Frova®)                              naratriptan                              rizatriptan (Maxalt®)                              rizatriptan (Maxalt® MLT)                              sumatriptan nasal spray (Imitrex®)                              sumatriptan (Imitrex®)                         </td> <td style="vertical-align: middle; text-align: center;">18 units/30 days</td> </tr> </tbody> </table>	Agent	F/Q/D	almotriptan eletriptan (Relpax®) frovatriptan (Frova®) naratriptan rizatriptan (Maxalt®) rizatriptan (Maxalt® MLT) sumatriptan nasal spray (Imitrex®) sumatriptan (Imitrex®)	18 units/30 days																
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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters	
<b>IV. Central Nervous System</b>			
	Zembrace™ SymTouch™ zolmitriptan <sup>F/Q/D</sup> Zomig® <sup>F/Q/D</sup>	sumatriptan-naproxen Tosymra™ nasal spray zolmitriptan (Zomig®) Zomig® nasal spray	
<b>Antipsychotics – Injectable</b>			
Abilify Asimtufii® Abilify Maintena® Aristada® Aristada Initio® fluphenazine decanoate Haldol® decanoate haloperidol decanoate Invega Hafyera™ Invega Sustenna® Invega Trinza® Perseris™ Risperdal Consta® <sup>BLTG</sup> Uzedy™ Zyprexa Relprevv®	risperidone injection (gen Risperdal Consta®) Rykindo®		
<b>Antipsychotics – Second Generation <sup>CC, ST</sup></b>			
aripiprazole tablet <sup>DO</sup> asenapine (gen Saphris®) clozapine lurasidone (gen Latuda®) olanzapine tablet <sup>DO</sup> paliperidone ER <sup>DO</sup> quetiapine <sup>F/Q/D</sup> quetiapine ER <sup>F/Q/D, DO</sup> risperidone	Abilify® tablet <sup>DO</sup> Abilify MyCite® aripiprazole solution aripiprazole ODT Caplyta™ clozapine ODT Clozaril® Fanapt® Geodon®	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul>	

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Standard PA fax form: [https://newyork.fhsc.com/downloads/providers/NYRx\\_PDP\\_PA\\_Fax\\_Standardized.pdf](https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf)

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																																
<b>IV. Central Nervous System</b>																																		
ziprasidone capsule	Invega® <span style="color: red;">DO</span> Latuda® <span style="color: red;">DO</span> Lybalvi™ Nuplazid® olanzapine ODT <span style="color: red;">DO</span> Rexulti® <span style="color: red;">DO</span> Risperdal® Saphris® Secuado® Seroquel® <span style="color: red;">F/Q/D</span> Seroquel XR® <span style="color: red;">DO, F/Q/D</span> Versacloz® Vraylar® <span style="color: red;">DO</span> Zyprexa® <span style="color: red;">DO</span> Zyprexa® Zydis	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA</li> <li>Prior authorization is required when an oral SGA is utilized above the highest MDD according to FDA labeling.</li> <li>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.</li> <li>Prior authorization is required for patients 21 years of age or older when 3 or more different oral second-generation antipsychotics are used for more than 180 days.</li> <li>PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below:                             <table border="1" style="margin-left: 20px; width: 100%;"> <tbody> <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> </tbody> </table> </li> </ul>	aripiprazole (Abilify®)	6 years	aripiprazole (Abilify MyCite®)	18 years	asenapine (Saphris®)	10 years	asenapine (Secuado®)	18 years	brexpiprazole (Rexulti®)	13 years	cariprazine (Vraylar®)	18 years	clozapine (Clozaril®, Versacloz®)	12 years	iloperidone (Fanapt®)	18 years	lumateperone (Caplyta™)	18 years	lurasidone HCl (Latuda®)	10 years	olanzapine (Zyprexa®)	10 years	paliperidone ER (Invega®)	12 years	pimavanserin (Nuplazid®)	18 years	quetiapine fum. (Seroquel®, Seroquel XR®)	10 years	risperidone (Risperdal®)	5 years	ziprasidone HCl (Geodon®)	10 years
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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IV. Central Nervous System</b>		
		<ul style="list-style-type: none"> <li>Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients &lt; 18 years of age</li> </ul> <p><b>STEP THERAPY (ST)</b></p> <ul style="list-style-type: none"> <li>For all Second Generation Antipsychotics used in the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is required</li> </ul> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <ul style="list-style-type: none"> <li><b>quetiapine/quetiapine ER (Seroquel®/Seroquel XR®):</b> Minimum 50 mg/day</li> <li><b>quetiapine (Seroquel®):</b> Maximum 3 units per day, 90 units per 30 days</li> <li><b>quetiapine ER (Seroquel XR®):</b> Maximum 150 mg, 1 unit/day, 30 units/30 days</li> <li><b>quetiapine ER (Seroquel XR®):</b> Maximum 50 mg, 2 units/day, 60 units/30 days</li> </ul>
<b>Central Nervous System (CNS) Stimulants <span style="color: red;">CC, F/Q/D</span></b>		
Adderall XR® <span style="color: red;">DO</span> amphetamine salt combo IR (gen Adderall®) amphetamine salt combo ER (gen Adderall XR®) <span style="color: red;">DO</span> Concerta® <span style="color: red;">DO</span> Daytrana® <span style="color: red;">BLTG</span> dexamethylphenidate (gen Focalin®) dexamethylphenidate ER <span style="color: red;">DO</span> (gen Focalin XR®) dextroamphetamine tablet lisdexamfetamine chewable tablet (gen Vyvanse® chew tablet) methylphenidate solution (gen Methylin®) methylphenidate tablet (gen Ritalin®)	Adzenys XR-ODT® amphetamine (gen Adzenys ER®) amphetamine (gen Evekeo®) Aptensio XR® armodafinil (gen Nuvigil®) Azstarys™ Cotelpla® XR-ODT™ Dexedrine® dextroamphetamine / amphetamine (gen Mydayis™) dextroamphetamine ER (gen Dexedrine®) dextroamphetamine solution (gen ProCentra®) dextroamphetamine tablet (gen Zenzedi®)	<p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved, compendia-supported and Medicaid covered indication</li> <li>Prior authorization is required for initial prescriptions for stimulant therapy for beneficiaries <b>less than 3 years of age</b></li> <li>Confirm diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent for beneficiaries <b>less than 18 years of age</b></li> <li>Patient-specific considerations for drug selection include treatment of narcolepsy, excessive daytime sleepiness, sleepiness associated with shift work sleep disorder, or sleepiness associated with obstructive sleep apnea.</li> <li>PA required for initiation of CNS Stimulant for patients currently on an opioid.</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IV. Central Nervous System</b>		
methylphenidate CD <span style="color: red;">DO</span> methylphenidate ER (gen Aptensio® XR) methylphenidate ER (gen Concerta®) methylphenidate ER (gen Metadate CD) Ritalin LA® <span style="color: red;">DO, BLTG</span> Vyvanse® capsule <span style="color: red;">DO, BLTG</span>	Dyanavel XR® Evekeo® Evekeo® ODT Focalin® Focalin XR® <span style="color: red;">DO</span> Jornay PM™ lisdexamfetamine capsule (gen Vyvanse®) 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®) <span style="color: red;">DO</span> Mydayis™ Nuvigil® ProCentra® Provigil® <span style="color: red;">DO</span> QuilliChew ER™ <span style="color: red;">DO</span> Quillivant XR® Relexxi® <span style="color: red;">F/Q/D</span> Ritalin® Sunosi™ Vyvanse® chewable tablet Wakix® Xelstry™ Zenzedi®	<ul style="list-style-type: none"> <li>PA required for initiation of CNS Stimulant for patients currently on a benzodiazepine</li> </ul> <p><b>DOSE OPTIMIZATION (DO)</b></p> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <ul style="list-style-type: none"> <li>Quantity limits based on daily dosage as determined by FDA labeling</li> </ul>

# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IV. Central Nervous System</b>		
<b>Movement Disorder Agents <sup>CC</sup></b>		
Austedo® Austedo® XR <sup>1</sup> Ingrezza® Ingrezza® titration pack tetrabenazine	Xenazine®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis for an FDA-approved or compendia-supported indication</li> </ul>
<b>Multiple Sclerosis Agents</b>		
Avonex® Copaxone® 20 mg/mL <sup>BLTG</sup> dimethyl fumarate DR Extavia® <sup>1</sup> fingolimod (gen Gilenya®) Kesimpta® <sup>1</sup> teriflunomide (gen Aubagio®)	Aubagio® Bafiertam™ Betaseron® <sup>2</sup> Copaxone® 40 mg/mL Gilenya® glatiramer Mavenclad® Mayzent® Plegridy® Ponvory™ <sup>F/Q/D</sup> Rebif® Rebif® Rebidose® Tascenso ODT™ Tecfidera® Vumerity® Zeposia® <sup>CC, ST</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li><b>Zeposia® (ozanimod):</b> Confirm diagnosis for FDA- or compendia-supported use</li> </ul> <b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li><b>Zeposia® (ozanimod):</b> For an indication of Ulcerative Colitis                             <ul style="list-style-type: none"> <li>Trial of a non-specific anti-inflammatory drug such as an aminosalicylate or immunosuppressant, or a disease-modifying anti-rheumatic drug (DMARD), and;</li> <li>Trial of a preferred systemic immunomodulator</li> </ul> </li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li><b>Ponvory™ (ponesimod) starter pack;</b> maximum quantity is 14, no refills</li> <li><b>Ponvory™ (ponesimod);</b> maintenance limited to a 30-day supply</li> </ul>
<b>Non-Ergot Dopamine Receptor Agonists</b>		
pramipexole ropinirole	Mirapex ER® Neupro® pramipexole ER ropinirole ER	

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

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<b>IV. Central Nervous System</b>		
<b>Other Agents for Attention Deficit Hyperactivity Disorder (ADHD) <sup>CC</sup></b>		
atomoxetine <sup>DO</sup> clonidine ER guanfacine ER <sup>DO</sup>	Intuniv® <sup>DO</sup> Qelbree™ Strattera® <sup>DO</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis for an FDA-approved or compendia-supported indication for beneficiaries &lt; 18 years of age.</li> <li>Prior authorization is required for initial prescriptions for non-stimulant therapy for beneficiaries <b>less than 6 years of age</b></li> </ul> <b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul>
<b>Sedative Hypnotics/Sleep Agents <sup>F/Q/D</sup></b>		
estazolam <sup>CC</sup> eszopiclone ramelteon (gen Rozerem®) temazepam 15 mg, 30 mg <sup>CC</sup> zolpidem tablet <sup>CC</sup> zolpidem ER <sup>CC</sup>	Ambien® <sup>CC</sup> Ambien CR® <sup>CC</sup> Belsomra® Dayvigo™ Doral® <sup>CC</sup> doxepin Edluar® <sup>CC</sup> flurazepam <sup>CC</sup> Halcion® <sup>CC</sup> Lunesta® <sup>DO</sup> quazepam <sup>CC</sup> (gen Doral®) Quviviq™ Restoril® <sup>CC</sup> Rozerem® temazepam 7.5 mg, 22.5 mg <sup>CC</sup> triazolam <sup>CC</sup> zaleplon zolpidem sublingual, capsule <sup>CC</sup>	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul> <b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li><b>Zolpidem products:</b> Confirm dosage is consistent with FDA labeling for initial prescriptions</li> <li><b>Benzodiazepine Agents</b> (estazolam, flurazepam, Halcion®, Restoril®, temazepam, triazolam): <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy</li> <li>PA required for any additional benzodiazepine prescription in patients currently on benzodiazepine therapy</li> <li>PA required when greater than a 14-day supply of a benzodiazepine is prescribed for someone on a CNS stimulant</li> </ul> </li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Frequency and duration limits for the following products: <ul style="list-style-type: none"> <li>For non-zaleplon and non-benzodiazepine containing products: <ul style="list-style-type: none"> <li>30 dosage units per fill/1 dosage unit per day/30 days</li> </ul> </li> <li>For zaleplon-containing products: <ul style="list-style-type: none"> <li>60 dosage units per fill/2 dosage units per day/30 days</li> </ul> </li> </ul> </li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IV. Central Nervous System</b>		
		<ul style="list-style-type: none"> <li>– Duration limit equivalent to the maximum recommended duration:                             <ul style="list-style-type: none"> <li>o 180 days for immediate-release zolpidem (Ambien®, Edluar®) products</li> <li>o 180 days for eszopiclone and ramelteon (Rozerem®) products</li> <li>o 180 days for lemborexant (Dayvigo™)</li> <li>o 168 days for zolpidem ER (Ambien CR®) products</li> <li>o 90 days for daridorexant (Quviviq™)</li> <li>o 90 days for suvorexant (Belsomra®)</li> <li>o 90 days for doxepin</li> <li>o 30 days for zaleplon (Sonata®) products</li> <li>o 30 days for benzodiazepine agents (estazolam, Halcion®, Restoril®, temazepam, triazolam) for the treatment of insomnia</li> </ul> </li> </ul> <p>Additional/Alternate parameters:</p> <ul style="list-style-type: none"> <li>• For patients naïve to non-benzodiazepine sedative hypnotics (NBSH): First-fill duration and quantity limit of 10 dosage units as a 10-day supply, except for zaleplon-containing products which the quantity limit is 20 dosage units as a 10-day supply</li> </ul>
<b>Selective Serotonin Reuptake Inhibitors (SSRIs)</b>		
citalopram tablet, solution escitalopram tablet fluoxetine capsule, solution paroxetine tablet sertraline tablet, concentrate vilazodone (gen Viibryd®)	Celexa® citalopram capsule escitalopram solution fluoxetine tablet fluoxetine DR weekly fluvoxamine <sup>CC</sup> fluvoxamine ER <sup>CC</sup> Lexapro® <sup>DO</sup> paroxetine capsule paroxetine CR paroxetine suspension Paxil® Paxil CR® Pexeva®	<p><b>DOSE OPTIMIZATION (DO)</b></p> <ul style="list-style-type: none"> <li>• See Dose Optimization Chart for affected strengths</li> </ul> <p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>• Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA</li> <li>• Clinical editing to allow patients with a diagnosis of Obsessive-Compulsive Disorder (OCD) to receive fluvoxamine and fluvoxamine ER without prior authorization</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>V. Dermatologic Agents</b>		
<b>Acne Agents, Topical</b>		
adapalene/benzoyl peroxide (gen Epiduo®) adapalene cream adapalene OTC gel Retin-A® cream <sup>CC, BLTG</sup> tazarotene cream <sup>CC</sup> tretinoin gel (gen Avita, Retin-A) <sup>CC</sup>	adapalene Rx gel, gel pump adapalene/benzoyl peroxide (gen Epiduo® Forte) Altreno® <sup>CC</sup> Arazlo™ <sup>CC</sup> Atralin® <sup>CC</sup> Avita® <sup>CC</sup> Cabtreo™ clindamycin/tretinoin <sup>CC</sup> dapsone Fabior® <sup>CC</sup> Retin-A® gel <sup>CC</sup> Retin-A Micro® <sup>CC</sup> tazarotene foam (gen Fabior®) <sup>CC</sup> tazarotene gel <sup>CC</sup> tretinoin cream, gel <sup>CC</sup> (gen Atralin) tretinoin micro <sup>CC</sup> Winlevi® Ziana® <sup>CC</sup>	<b>CLINICAL CRITERIA</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication</li> </ul>
<b>Actinic Keratosis Agents</b>		
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) Zyclara®	
<b>Antibiotics – Topical</b>		
mupirocin ointment	Centany® mupirocin cream Xepi™	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>V. Dermatologic Agents</b>		
<b>Anti-Fungals – Topical</b>		
ciclopirox cream, suspension, shampoo ciclopirox 8% solution 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 Ciclodan® cream ciclopirox gel clotrimazole/betamethasone lotion econazole Ertaczo® Extina® Jublia® ketoconazole foam Loprox® cream, suspension luliconazole Luzu® miconazole/zinc/petrolatum (gen Vusion®) <sup>F/Q/D</sup> naftifine Naftin® oxiconazole Oxistat® tavaborole Vusion® <sup>F/Q/D</sup>	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b>  <ul style="list-style-type: none"> <li>• <b>Vusion® 50 gm ointment</b> –Maximum 100 grams in a 90-day time period</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>V. Dermatologic Agents</b>		
<b>Anti-Infectives – Topical</b>		
clindamycin solution, 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®) clindamycin/benzoyl peroxide (gen Onexton®) clindamycin/benzoyl peroxide (gen Acanya®) erythromycin swab erythromycin/benzoyl peroxide Evoclin® Neuac® Onexton®	
<b>Anti-Virals – Topical</b>		
acyclovir cream docosanol (gen Abreva)	acyclovir ointment Denavir® penciclovir (gen Denavir®) Xerese® Zovirax® cream, ointment	
<b>Immunomodulators – Topical <sup>CC</sup></b>		
Eucrisa® pimecrolimus tacrolimus	Elidel® Opzelura® Protopic®	<b>CLINICAL CRITERIA</b> <ul style="list-style-type: none"> <li>All prescriptions require prior authorization</li> <li>Refills on prescriptions are allowed</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>V. Dermatologic Agents</b>		
<b>Psoriasis Agents – Topical</b>		
calcipotriene cream, ointment, scalp solution	calcipotriene foam (gen Sorilux®) calcipotriene/betamethasone dipropionate (gen Taclonex®) calcitriol ointment (gen Vectical®) Duobrii™ Enstilar® Sorilux® Taclonex® Vtama® Zoryve™	
<b>Rosacea Agents</b>		
azelaic acid metronidazole cream, gel	Finacea® Ivermectin metronidazole gel pump, lotion Noritate® Rosadan®	
<b>Steroids, Topical – Low Potency</b>		
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
<b>V. Dermatologic Agents</b>		
<b>Steroids, Topical – Medium Potency</b>		
fluocinolone acetonide solution fluticasone propionate cream, ointment hydrocortisone valerate cream 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® Pandel® prednicarbate Synalar®	
<b>Steroids, Topical – High Potency</b>		
betamethasone dipropionate lotion, cream, ointment betamethasone dipropionate augmented cream, ointment, lotion betamethasone valerate cream, ointment fluocinonide cream, ointment, solution triamcinolone acetonide	ApexiCon-E® betamethasone dipropionate augmented gel betamethasone valerate lotion desoximetasone diflorasone Diprolene® fluocinonide gel, emollient halcinonide cream (gen Halog®) Halog® cream, solution, ointment Kenalog® Topicort® triamcinolone spray Vanos®	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Anabolic Steroids – Topical <span style="color: red;">CDRP, F/Q/D</span></b>		
testosterone gel packets (gen Vogelxo®) <sup>1</sup> testosterone pump	Androderm® AndroGel® pump Fortesta® Natesto® Testim® testosterone gel packets (gen AndroGel®) <sup>2</sup> Vogelxo®	<p><b>CLINICAL DRUG REVIEW PROGRAM (CDRP)</b></p> <ul style="list-style-type: none"> <li>• For diagnosis of hypogonadotropic or primary hypogonadism: <ul style="list-style-type: none"> <li>– Requires documented low testosterone concentration with two tests prior to initiation of therapy.</li> <li>– Requires documented testosterone therapeutic concentration to confirm response after initiation of therapy.</li> </ul> </li> <li>• For diagnosis of delayed puberty: <ul style="list-style-type: none"> <li>– Requires documentation that growth hormone deficiency has been ruled out prior to initiation of therapy.</li> </ul> </li> </ul> <p>The Anabolic Steroid fax form can be found at:  <a href="https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PA_Worksheet_Prescribers_Anabolic_Steroids.pdf">https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PA_Worksheet_Prescribers_Anabolic_Steroids.pdf</a></p> <p>For diagnosis of gender dysphoria, see Hormone Replacement Therapy for Treatment of Gender Dysphoria coverage in the <a href="#">DUR section</a> of this document</p> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <ul style="list-style-type: none"> <li>• Limitations for anabolic steroid products based on approved FDA labeled daily dosing and documented diagnosis: <ul style="list-style-type: none"> <li>– Duration limit of 6 months for delayed puberty</li> </ul> </li> </ul>
<b>Biguanides</b>		
glipizide/metformin glyburide/metformin Glumetza® <span style="color: red;">BLTG</span> metformin HCl metformin ER (gen Glucophage XR®)	metformin solution (gen Riomet®) metformin 625mg tablets metformin ER <span style="color: red;">DO</span> (gen Fortamet®, Glumetza®) Riomet® Riomet ER™	<p><b>DOSE OPTIMIZATION (DO)</b></p> <ul style="list-style-type: none"> <li>• See Dose Optimization Chart for affected strengths</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Bisphosphonates – Oral</b>		
alendronate	Actonel® Atelvia® Binosto® Fosamax® Fosamax® Plus D ibandronate risedronate	
<b>Dipeptidyl Peptidase-4 (DPP-4) Inhibitors</b>		
alogliptin alogliptin/metformin Glyxambi® Janumet® Janumet® XR Januvia® <span style="color: red;">DO</span> Jentadueto® Jentadueto® XR Kazano® Kombiglyze® XR <span style="color: red;">BLTG</span> Nesina® Onglyza® <span style="color: red;">DO, BLTG</span> Oseni® <span style="color: red;">BLTG</span> Tadjenta®	alogliptin/pioglitazone Qtern® saxagliptin (gen Onglyza®) saxagliptin/metformin (gen Kombiglyze® XR) sitagliptin (gen Zituvio™) Steglujan® Zituvio™	<b>DOSE OPTIMIZATION (DO)</b>  • See Dose Optimization Chart for affected strengths

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Glucagon Agents</b>		
Baqsimi® glucagon vial glucagon HCl emergency kit (Fresenius) Gvoke® pen, syringe, vial Zegalogue® pen, syringe	glucagon emergency kit (Eli Lilly, Amphastar)	
<b>Glucagon-like Peptide-1 (GLP-1) Agonists <sup>CC</sup></b>		
Byetta® Ozempic® Trulicity® Victoza®	Bydureon® BCise™ Mounjaro® Rybelsus® Soliqua® Xultophy®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Glucocorticoids – Oral</b>		
budesonide EC, DR dexamethasone tablet hydrocortisone methylprednisolone dose-pack prednisolone solution prednisone dose-pack, tablet	Agamree® Alkindi® Sprinkle budesonide ER Cortef® cortisone deflazacort (gen Emflaza®) dexamethasone elixir, solution dexamethasone intensol Emflaza® Eohilia™ Hemady™ Medrol® dose-pack, tablet methylprednisolone 4 mg, 8 mg, 16 mg, 32 mg Millipred® Millipred® DP prednisolone ODT prednisolone tablet (gen Millipred®) prednisone intensol, solution Rayos® TaperDex™ Uceris®	

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Growth Hormones <span style="color: red;">CC, CDRP</span></b>		
Genotropin® Norditropin®	Humatrope® Ngenla™ Nutropin AQ® Omnitrope® Saizen® Skytrofa® Sogroya® Zomacton®	<b>CLINICAL DRUG REVIEW PROGRAM (CDRP)</b> <ul style="list-style-type: none"> <li>Prescribers or their authorized agents may call or submit a fax request for a PA for beneficiaries 18 years of age or older</li> </ul> <b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Patient-specific considerations for drug selection include concerns related to use of a non-preferred agent for FDA-approved indications that are not listed for a preferred agent.</li> <li>Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
<b>Insulin – Long-Acting</b>		
insulin glargine solostar, vial (gen Lantus® Solostar®, vial) Lantus® Solostar®, vial Levemir®	Basaglar® Basaglar® Tempo™ insulin degludec vial, pen (gen Tresiba) insulin glargine max solostar (gen Toujeo® Max Solostar®) insulin glargine solostar (gen Toujeo® Solostar®) insulin glargine-YFGN: vial, pen Rezvoglar™ Semglee®-YFGN: vial, pen Toujeo® Solostar® Toujeo® Max Solostar® Tresiba®	
<b>Insulin – Mixes</b>		
Humalog® 50/50 Mix: pen and vial Humalog® 75/25 Mix: vial insulin lispro 75/25 mix: pen (gen Humalog® Mix) insulin aspart prot/insulin aspart: vial, pen (gen Novolog)	Humalog® 75/25 mix: pen Novolog® Mix: vial, pen	

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Insulin – Rapid-Acting</b>		
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, vial Humalog® 200 U/mL Lyumjev® Lyumjev® Tempo™	
<b>Pancreatic Enzymes</b>		
Creon® Zenpep®	Pertzye® Viokace®	
<b>Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors</b>		
Farxiga® <span style="color: red;">BLTG</span> Invokamet® Invokamet® XR Invokana® Jardiance® Synjardy® Synjardy® XR Trijardy® XR Xigduo® XR <span style="color: red;">BLTG</span>	dapagliflozin (gen Farxiga®) dapagliflozin/metformin (gen Xigduo® XR) Inpefa™ Segluromet® Steglatro®	
<b>Thiazolidinediones (TZDs)</b>		
pioglitazone	ACTOplus Met® Actos® <span style="color: red;">DO</span> Duetact® pioglitazone/glimepiride pioglitazone/metformin	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul>

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VII. Gastrointestinal</b>		
<b>Anti-Emetics</b>		
aprepitant pack Diclegis <sup>®</sup> <b>CC</b> doxylamine succ/pyridoxine (gen Diclegis <sup>®</sup> ) <b>CC</b> ondansetron ODT, solution, tablet	Akynzeo <sup>®</sup> Anzemet <sup>®</sup> aprepitant capsule Bonjesta <sup>®</sup> <b>CC</b> Emend <sup>®</sup> capsule, powder packet, TriPack granisetron tablet Sancuso <sup>®</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>• <b>doxylamine succ/pyridoxine (Diclegis<sup>®</sup>, Bonjesta<sup>®</sup>):</b> Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
<b>Gastrointestinal Antibiotics</b>		
metronidazole tablet neomycin vancomycin capsule, solution	Difucid <sup>®</sup> Firvanq <sup>®</sup> Flagyl <sup>®</sup> Likmez <sup>™</sup> metronidazole capsule nitazoxanide paromomycin tinidazole Vancocin <sup>®</sup> Xifaxan <sup>®</sup> <b>CC, ST, F/Q/D</b>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>• <b>Xifaxan<sup>®</sup>:</b> Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul> <b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>• <b>Xifaxan<sup>®</sup>:</b> Requires trial of a fluoroquinolone antibiotic or azithromycin before Xifaxan<sup>®</sup> for treatment of Traveler’s Diarrhea</li> </ul> <b>QUANTITY LIMITS:</b> <b>Xifaxan<sup>®</sup>:</b> <ul style="list-style-type: none"> <li>• Irritable bowel syndrome with diarrhea (550 mg tablets) – 42 tablets per 30 days (Dose = 550 mg three times a day for 14 days)                             <ul style="list-style-type: none"> <li>– Maximum of 42 days’ supply (126 units) per 365 days (3 rounds of therapy).</li> </ul> </li> <li>• Small Intestine Bacterial Overgrowth (550mg tablets) - 42 tablets per 30 days (Dose = 550mg three times a day for 10-14 days);                             <ul style="list-style-type: none"> <li>– Maximum of 28 days’ supply (84 units) per 365 days (2 rounds of therapy).</li> </ul> </li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VII. Gastrointestinal</b>		
<b>Helicobacter pylori Agents</b>		
Pylera® <span style="color: red;">BLTG</span>	bismuth/metronidazole/tetracycline (gen Pylera®) lansoprazole/amoxicillin/clarithromycin Omeclamox-Pak® Talicia® Voquezna® Dual Pak Voquezna® Triple Pak	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VII. Gastrointestinal</b>		
<b>Proton Pump Inhibitors (PPIs) <sup>F/Q/D</sup></b>		
esomeprazole magnesium Rx capsule lansoprazole capsule, OTC solutab omeprazole Rx pantoprazole tablet Protonix suspension <sup>BLTG</sup> rabeprazole Zegerid® Rx <sup>BLTG</sup>	Aciphex® dexlansoprazole (gen Dexilant®) Dexilant® <sup>DO, 2</sup> esomeprazole magnesium tablet OTC esomeprazole capsules OTC esomeprazole suspension Konvomep™ lansoprazole Rx solutab Nexium® RX <sup>DO</sup> omeprazole OTC omeprazole/sodium bicarbonate Rx pantoprazole suspension Prevacid® OTC Prevacid® Rx <sup>DO</sup> Prilosec® Rx Protonix® tablet	<p><b>DOSE OPTIMIZATION (DO)</b></p> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <ul style="list-style-type: none"> <li>Quantity limits:                             <ul style="list-style-type: none"> <li>Once daily dosing for:                                     <ul style="list-style-type: none"> <li>GERD</li> <li>erosive esophagitis</li> <li>healing and maintenance of duodenal/gastric ulcers (including NSAID-induced)</li> <li>prevention of NSAID-induced ulcers</li> </ul> </li> <li>Twice daily dosing for:                                     <ul style="list-style-type: none"> <li>hypersecretory conditions</li> <li>Barrett's esophagitis</li> <li>H. pylori</li> <li>refractory GERD</li> </ul> </li> </ul> </li> <li>Duration limits:                             <ul style="list-style-type: none"> <li>90 days for:                                     <ul style="list-style-type: none"> <li>GERD</li> </ul> </li> <li>365 days for:                                     <ul style="list-style-type: none"> <li>Maintenance treatment of duodenal ulcers, or erosive esophagitis</li> </ul> </li> <li>14 days for:                                     <ul style="list-style-type: none"> <li>H. pylori</li> </ul> </li> </ul> </li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VII. Gastrointestinal</b>		
<b>Sulfasalazine Derivatives</b>		
Apriso® <small>BLTG</small> Lialda® <small>BLTG</small> Pentasa® <small>BLTG</small> sulfasalazine DR sulfasalazine IR	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	

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>VIII. Hematological Agents</b>		
<b>Anticoagulants – Injectable <span style="color: red;">F/Q/D</span></b>		
enoxaparin sodium Fragmin® vial	Arixtra® <span style="color: red;">CC</span> fondaparinux <span style="color: red;">CC</span> Fragmin® syringe Lovenox®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>For patients requiring &gt; 30 days of therapy: Require confirmation of FDA-approved or compendia-supported indication</li> <li><b>Arixtra® (fondaparinux)</b> Clinical editing to allow patients with a diagnosis of Heparin Induced Thrombocytopenia (HIT) to receive therapy without prior authorization.</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Duration Limit: No more than 30 days for members initiating therapy</li> </ul>
<b>Anticoagulants – Oral</b>		
Eliquis® Pradaxa® capsule <span style="color: red;">BLTG</span> warfarin Xarelto® tablet <span style="color: red;">DO</span>	dabigatran (gen Pradaxa®) Pradaxa® pellet pack Savaysa® Xarelto® dose pack, suspension	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul>
<b>Colony Stimulating Factors</b>		
Neupogen® 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
<b>VIII. Hematological Agents</b>		
<b>Erythropoiesis Stimulating Agents (ESAs) <sup>CC</sup></b>		
Aranesp <sup>®</sup> Epogen <sup>®</sup> Retacrit <sup>®</sup>	Mircera <sup>®</sup> Procrit <sup>®</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis for FDA- or compendia-supported uses</li> </ul>
<b>Hemophilia Agents – Factor VIII</b>		
Advate <sup>®</sup> Adynovate <sup>®</sup> Afstyla <sup>®</sup> Altuviiio <sup>TM1</sup> Eloctate <sup>®</sup> Esperoct <sup>®</sup> Hemofil <sup>®</sup> M Humate-P <sup>®</sup> Jivi <sup>®</sup> Koate <sup>®</sup> Kogenate <sup>®</sup> FS Kovaltry <sup>®</sup> Novoeight <sup>®</sup> Nuwiq <sup>®</sup> Obizur <sup>®</sup> Recombinate <sup>TM</sup> Xyntha <sup>®</sup> Xyntha <sup>®</sup> Solofuse		

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>IX. Immunologic Agents</b>		
<b>Immunomodulators – Systemic <span style="color: red;">CC, ST</span></b>		
<p>Cosentyx® Dupixent® Enbrel® Fasenra® Humira® Nucala® Xolair®</p>	<p>Abrilada™ (adalimumab-AFZB) Actemra® subcutaneous adalimumab-AACF (gen Idacio®) adalimumab-FKJP (gen Hulio®) adalimumab-ADAZ (gen Hyrimoz®) adalimumab-ADBM (gen Cyltezo®)Adbry™ Amjevita™ Bimzelx® Cibinqo™ Cimzia® Cyltezo® (adalimumab-ADMB) Entyvio pen® Hadlima™ Hulio® (adalimumab-FKJP) Hyrimoz® (adalimumab-ADAZ) Idacio® Ilumya® Kevzara® Kineret® Olumiant® Omvoh™ pen Orencia® subcutaneous Otezla® Rinvoq™ ER Siliq™ Simlandi® Simponi® Skyrizi® Skyrizi® On-Body</p>	<p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>Confirm diagnosis for FDA- or compendia-supported uses</li> </ul> <p><b>STEP THERAPY (ST)</b> For indications not specified below</p> <ul style="list-style-type: none"> <li>Trial of a non-specific anti-inflammatory drug such as an aminosalicylate or immunosuppressant, or a disease-modifying anti-rheumatic drug (DMARD)</li> <li>Trial of a TNF inhibitor prior to treatment with a JAK inhibitor</li> </ul> <p><b>INDICATION-SPECIFIC REQUIREMENTS:</b></p> <ul style="list-style-type: none"> <li>Asthma:             <ul style="list-style-type: none"> <li>history and concurrent use of a corticosteroid</li> </ul> </li> <li>Nasal polyps:             <ul style="list-style-type: none"> <li>history and concurrent use of an intranasal corticosteroid</li> </ul> </li> <li>Atopic dermatitis:             <ul style="list-style-type: none"> <li>Trial with a topical prescription product for a duration of at least 3 months.</li> <li>For JAK inhibitors: Trial of topical prescription product and systemic product for a combined duration of at least 6 months.</li> </ul> </li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XI. Musculoskeletal Agents</b>		
<b>Skeletal Muscle Relaxants</b>		
baclofen tablet chlorzoxazone 500 mg cyclobenzaprine 5 mg, 10 mg tablet dantrolene methocarbamol orphenadrine ER tizanidine tablet	Amrix® baclofen 15mg tablet baclofen solution baclofen suspension (gen Fleqsuvy™) carisoprodol <sup>ST, F/Q/D</sup> carisoprodol compound <sup>ST, F/Q/D</sup> carisoprodol compound/codeine <sup>CC, ST, F/Q/D</sup> chlorzoxazone (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® <sup>ST, F/Q/D</sup> Soma® 250 <sup>ST, F/Q/D</sup> tizanidine capsule Zanaflex®	<b>CLINICAL CRITERIA (CC)</b> For carisoprodol/codeine products: <ul style="list-style-type: none"> <li>Limited to a total of 4 opioid prescriptions every 30 days; exemption for diagnosis of cancer or sickle cell disease</li> <li>Medical necessity rationale for opioid therapy is required for patients on established opioid dependence therapy</li> <li>PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy</li> <li>PA required for any codeine containing products in patients &lt; 12 years</li> </ul> <b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>Trial with 1 analgesic and 2 skeletal muscle relaxants prior to use of <b>carisoprodol</b> containing products</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li><b>Carisoprodol</b> – Maximum 4 units per day, 21-day supply</li> <li><b>Carisoprodol combinations</b> – Maximum 8 units per day, 21-day supply (not to exceed the 84 cumulative units per year limit)</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XII. Ophthalmics</b>		
<b>Alpha-2 Adrenergic Agonists (for Glaucoma) – Ophthalmic</b>		
Alphagan P® 0.1% <span style="color: red;">BLTG</span> Alphagan P® 0.15% <span style="color: red;">BLTG</span> brimonidine 0.2% Simbrinza®	apraclonidine brimonidine 0.1% (gen Alphagan P®) brimonidine 0.15% (gen Alphagan P®) lopidine®	
<b>Antibiotics – Ophthalmic</b>		
bacitracin/polymyxin B erythromycin gentamicin Natacyn® neomycin/gramicidin/polymyxin polymyxin/trimethoprim sulfacetamide solution tobramycin	Azasite® bacitracin neomycin/bacitracin/polymyxin sulfacetamide ointment Tobrex®	
<b>Antibiotics/Steroid Combinations – Ophthalmic</b>		
neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TobraDex® ointment tobramycin/dexamethasone suspension	Maxitrol® neomycin / bacitracin/polymyxin /HC neomycin/polymyxin/HC TobraDex® ST Zylet®	
<b>Antihistamines – Ophthalmic</b>		
azelastine ketotifen OTC olopatadine OTC	bepotastine (gen Bepreve®) Bepreve® epinastine Lastacaft® olopatadine Rx Pataday® Zaditor® OTC Zerviate™	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XII. Ophthalmics</b>		
<b>Anti-inflammatories/Immunomodulators – Ophthalmic <sup>CC</sup></b>		
Eysuvis <sup>®</sup> <sup>F/Q/D</sup> Restasis <sup>®</sup> <sup>BLTG</sup> Restasis MultiDose <sup>®</sup> Xiidra <sup>®</sup>	Cequa <sup>®</sup> cyclosporine (gen Restasis <sup>®</sup> ) Miebo <sup>™</sup> Tyrvaya <sup>™</sup> Verkazia <sup>®</sup> Vevye <sup>®</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Diagnosis documentation required to justify utilization as a first line agent or attempt treatment with an artificial tear, gel, or ointment.</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Eysuvis<sup>®</sup> max duration: 2 weeks</li> </ul>
<b>Beta Blockers – Ophthalmic</b>		
betaxolol Betoptic S <sup>®</sup> carteolol Combigan <sup>®</sup> <sup>BLTG</sup> Istalol <sup>®</sup> <sup>BLTG</sup> levobunolol timolol maleate gel	Betimol <sup>®</sup> brimonidine/timolol (gen Combigan <sup>®</sup> ) timolol maleate (gen Timoptic <sup>®</sup> Ocudose <sup>®</sup> ) timolol maleate solution (gen Istalol <sup>®</sup> ) Timoptic <sup>®</sup> Ocudose <sup>®</sup>	
<b>Fluoroquinolones – Ophthalmic</b>		
ciprofloxacin moxifloxacin (gen Vigamox <sup>®</sup> ) ofloxacin	Besivance <sup>®</sup> Ciloxan <sup>®</sup> gatifloxacin moxifloxacin (gen Moxeza <sup>®</sup> ) Ocuflox <sup>®</sup> Vigamox <sup>®</sup>	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XII. Ophthalmics</b>		
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) – Ophthalmic</b>		
diclofenac flurbiprofen ketorolac ketorolac LS	Acular® Acular LS® Acuvail® bromfenac BromSite® Ilevro® <sup>2</sup> Nevanac® Prolensa®	
<b>Prostaglandin Agonists – Ophthalmic</b>		
latanoprost	bimatoprost Iyuzeh™ Lumigan® Rocklatan™ tafluprost (gen Zioptan®) Travatan Z® travoprost (gen Travatan Z®) Xalatan® Xelpros™ Vyzulta™ Zioptan®	

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XIII. Otics</b>		
<b>Fluoroquinolones – Otic</b>		
Cipro HC® 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
<b>XIV. Renal and Genitourinary</b>		
<b>Alpha Reductase Inhibitors for BPH</b>		
finasteride	Avodart® dutasteride dutasteride/tamsulosin Entadfi™ Proscar®	
<b>Antihyperuricemics</b>		
allopurinol 100 mg, 300 mg colchicine tablet febuxostat probenecid probenecid/colchicine	allopurinol 200 mg colchicine capsule Colcrys Gloperba® Mitigare® Uloric® Zyloprim®	
<b>Cystine Depleting Agents <sup>CC</sup></b>		
Cystagon®	Procysbi® <sup>ST</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
<b>Electrolyte Depleters</b>		
Lokelma® sodium polystyrene Veltassa®		
<b>Phosphate Binders/Regulators</b>		
calcium acetate Renvela® tablet, powder pack <sup>BLTG</sup> sevelamer HCl (gen Renagel)	Auryxia™ Fosrenol® lanthanum carbonate sevelamer carbonate powder, tablet (gen Renvela) Velphoro® Xphozah®	

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XIV. Renal and Genitourinary</b>		
<b>Selective Alpha Adrenergic Blockers</b>		
alfuzosin tamsulosin	Flomax® Rapaflo® silodosin	
<b>Urinary Tract Antispasmodics</b>		
fesoterodine ER (gen Toviaz®) oxybutynin oxybutynin ER <span style="color: red;">DO</span> solifenacin Toviaz® <span style="color: red;">DO</span>	darifenacin Detrol® Detrol LA® <span style="color: red;">DO</span> flavoxate Gelnique® Gemtesa® Myrbetriq® <span style="color: red;">DO</span> Myrbetriq® solution <span style="color: red;">F/Q/D</span> Oxytrol® tolterodine tolterodine ER trospium trospium ER Vesicare® <span style="color: red;">DO</span> Vesicare® LS	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Myrbetriq® solution; limited to a 30-day supply</li> </ul>
<b>Urea Cycle Disorders</b>		
Buphenyl® powder, tablet Carbaglu® <span style="color: red;">BLTG</span> Olpruva™ Pheburane® Ravicti® sodium phenylbutyrate powder, tablet (gen Buphenyl®)	carglumic acid	

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XIV. Renal and Genitourinary</b>		
<b>Uterine Disorder Treatments <sup>F/Q/D</sup></b>		
Myfembree® OriaHnn® Orilissa®		<b>LIFETIME QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>• 24 months cumulative use</li> </ul>

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XV. Respiratory</b>		
<b>Anticholinergics / COPD Agents</b>		
Anoro Ellipta® Atrovent HFA® Bevespi® Aerosphere® Combivent Respimat® Incruse Ellipta® ipratropium ipratropium / albuterol roflumilast (gen Daliresp®) Spiriva® HandiHaler® <sup>BLTG</sup> Spiriva Respimat® Stiolto Respimat® Trelegy Ellipta® Tudorza Pressair®	Breztri™ Aerosphere Daliresp® Duaklir® Pressair tiotropium (gen Spiriva® Handihaler®) Yupelri®	
<b>Antihistamines – Intranasal</b>		
azelastine olopatadine	Patanase®	
<b>Antihistamines – Second Generation</b>		
cetirizine OTC tablet cetirizine OTC syrup/solution 1 mg/ 1 mL fexofenadine OTC tablet levocetirizine tablet	cetirizine OTC chewable cetirizine OTC syrup/solution 5 mg/5 mL cetirizine-D OTC Clarinet® Clarinet-D®	

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Standard PA fax form: [https://newyork.fhsc.com/downloads/providers/NYRx\\_PDP\\_PA\\_Fax\\_Standardized.pdf](https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf)

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																
<b>XV. Respiratory</b>																		
loratadine OTC	desloratadine (gen Clarinex®) levocetirizine solution loratadine-D OTC																	
<b>Beta2 Adrenergic Agents – Inhaled Long-Acting <span style="color: red;">CC, F/Q/D</span></b>																		
arformoterol (gen Brovana®) formoterol (gen Perforomist®) Serevent Diskus®	Brovana® Perforomist® Striverdi Respimat®	<p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA- or compendia-supported age as indicated:</li> </ul> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Brovana® / arformoterol</td> <td style="width: 20%;">≥ 18 years</td> </tr> <tr> <td>Perforomist® / formoterol</td> <td>≥ 18 years</td> </tr> <tr> <td>Serevent Diskus®</td> <td>≥ 4 years</td> </tr> <tr> <td>Striverdi Respimat®</td> <td>≥ 18 years</td> </tr> </table> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> Maximum units per 30 days</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Brovana® / arformoterol</td> <td>60 units (1 carton of 60 vials or 120 mL)</td> </tr> <tr> <td>Perforomist® / formoterol</td> <td>60 units (1 carton of 60 vials or 120 mL)</td> </tr> <tr> <td>Serevent Diskus®</td> <td>1 diskus (60 blisters)</td> </tr> <tr> <td>Striverdi Respimat®</td> <td>1 unit (one cartridge and one Respimat inhaler)</td> </tr> </table>	Brovana® / arformoterol	≥ 18 years	Perforomist® / formoterol	≥ 18 years	Serevent Diskus®	≥ 4 years	Striverdi Respimat®	≥ 18 years	Brovana® / arformoterol	60 units (1 carton of 60 vials or 120 mL)	Perforomist® / formoterol	60 units (1 carton of 60 vials or 120 mL)	Serevent Diskus®	1 diskus (60 blisters)	Striverdi Respimat®	1 unit (one cartridge and one Respimat inhaler)
Brovana® / arformoterol	≥ 18 years																	
Perforomist® / formoterol	≥ 18 years																	
Serevent Diskus®	≥ 4 years																	
Striverdi Respimat®	≥ 18 years																	
Brovana® / arformoterol	60 units (1 carton of 60 vials or 120 mL)																	
Perforomist® / formoterol	60 units (1 carton of 60 vials or 120 mL)																	
Serevent Diskus®	1 diskus (60 blisters)																	
Striverdi Respimat®	1 unit (one cartridge and one Respimat inhaler)																	
<b>Beta2 Adrenergic Agents – Inhaled Short-Acting</b>																		
albuterol nebulizer solution albuterol HFA (gen ProAir® HFA, Proventil HFA®) ProAir® Digihaler™ ProAir® RespiClick Ventolin HFA® <span style="color: red;">BLTG</span> Xopenex HFA® <span style="color: red;">BLTG</span>	Airsupra™ albuterol HFA (gen Ventolin HFA®) levalbuterol solution levalbuterol HFA																	
<b>Corticosteroids – Inhaled</b>																		
Alvesco® Arnuity Ellipta®	ArmonAir® Digihaler® Asmanex® HFA																	

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																											
<b>XV. Respiratory</b>																													
Asmanex® Twisthaler fluticasone HFA Pulmicort® Flexhaler	fluticasone DISKUS QVAR RediHaler®																												
<b>Corticosteroid/Beta2 Adrenergic Agent (Long-Acting) Combinations – Inhaled <span style="color: red;">CC, F/Q/D</span></b>																													
Advair Diskus® <span style="color: red;">BLTG</span> Advair HFA® <span style="color: red;">BLTG</span> Dulera® Symbicort® <span style="color: red;">BLTG</span>	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®)	<p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA-or compendia-supported age as indicated:</li> </ul> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Advair Diskus®</td><td style="text-align: right;">≥ 4 years</td></tr> <tr><td>Advair HFA®</td><td style="text-align: right;">≥ 12 years</td></tr> <tr><td>AirDuo™ RespiClick®</td><td style="text-align: right;">&gt; 12 years</td></tr> <tr><td>Dulera® 100 mcg and 200 mcg</td><td style="text-align: right;">≥ 12 years</td></tr> <tr><td>Dulera® 50 mcg</td><td style="text-align: right;">≥ 4 years</td></tr> <tr><td>fluticasone-salmeterol</td><td style="text-align: right;">≥ 4 years</td></tr> <tr><td>budesonide-formoterol (Symbicort®) 80/4.5 mcg</td><td style="text-align: right;">≥ 4 years</td></tr> <tr><td>budesonide-formoterol (Symbicort®) 160/4.5 mcg</td><td style="text-align: right;">≥ 12 years</td></tr> <tr><td>fluticasone/vilanterol (Breo Ellipta®)</td><td style="text-align: right;">≥ 18 years</td></tr> </table> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Advair Diskus®</td><td rowspan="4" style="text-align: center; vertical-align: middle;">One inhaler/diskus every 30 days</td></tr> <tr><td>Advair HFA®</td></tr> <tr><td>AirDuo™ RespiClick®</td></tr> <tr><td>fluticasone-salmeterol</td></tr> <tr><td>fluticasone/vilanterol (Breo Ellipta®)</td><td rowspan="3" style="text-align: center; vertical-align: middle;">Up to 8 inhalers every 180 days</td></tr> <tr><td>Budesonide/formoterol (Symbicort®)</td></tr> <tr><td>Dulera®</td></tr> </table>	Advair Diskus®	≥ 4 years	Advair HFA®	≥ 12 years	AirDuo™ RespiClick®	> 12 years	Dulera® 100 mcg and 200 mcg	≥ 12 years	Dulera® 50 mcg	≥ 4 years	fluticasone-salmeterol	≥ 4 years	budesonide-formoterol (Symbicort®) 80/4.5 mcg	≥ 4 years	budesonide-formoterol (Symbicort®) 160/4.5 mcg	≥ 12 years	fluticasone/vilanterol (Breo Ellipta®)	≥ 18 years	Advair Diskus®	One inhaler/diskus every 30 days	Advair HFA®	AirDuo™ RespiClick®	fluticasone-salmeterol	fluticasone/vilanterol (Breo Ellipta®)	Up to 8 inhalers every 180 days	Budesonide/formoterol (Symbicort®)	Dulera®
Advair Diskus®	≥ 4 years																												
Advair HFA®	≥ 12 years																												
AirDuo™ RespiClick®	> 12 years																												
Dulera® 100 mcg and 200 mcg	≥ 12 years																												
Dulera® 50 mcg	≥ 4 years																												
fluticasone-salmeterol	≥ 4 years																												
budesonide-formoterol (Symbicort®) 80/4.5 mcg	≥ 4 years																												
budesonide-formoterol (Symbicort®) 160/4.5 mcg	≥ 12 years																												
fluticasone/vilanterol (Breo Ellipta®)	≥ 18 years																												
Advair Diskus®	One inhaler/diskus every 30 days																												
Advair HFA®																													
AirDuo™ RespiClick®																													
fluticasone-salmeterol																													
fluticasone/vilanterol (Breo Ellipta®)	Up to 8 inhalers every 180 days																												
Budesonide/formoterol (Symbicort®)																													
Dulera®																													

1 = Preferred as of 8/1/2024  
2 = Non-Preferred as of 8/1/2024

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
<b>XV. Respiratory</b>		
<b>Corticosteroids – Intranasal</b>		
budesonide OTC Dymista® <sup>BLTG</sup> fluticasone fluticasone OTC Nasonex® OTC Omnaris® triamcinolone OTC Zetonna®	azelastine-fluticasone (gen Dymista®) Beconase AQ® <sup>CC</sup> flunisolide mometasone Rx, OTC QNASL® <sup>CC</sup> Ryaltris® Xhance™	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Clinical consideration in regard to drug interactions will be given to patients with HIV/AIDs diagnosis or antiretroviral therapy in history</li> </ul>
<b>Leukotriene Modifiers</b>		
montelukast tablet, chew tab	Accolate® montelukast granules Singulair® zafirlukast	

1 = Preferred as of 8/1/2024  
 2 = Non-Preferred as of 8/1/2024

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

### NYS Medicaid NYRx Clinical Drug Review Program (CDRP)

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

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

#### Prior Authorization

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

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

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

- [fentanyl mucosal agents](https://newyork.fhsc.com/providers/CDRP_fentanyl_mucosal_agents.asp): [https://newyork.fhsc.com/providers/CDRP\\_fentanyl\\_mucosal\\_agents.asp](https://newyork.fhsc.com/providers/CDRP_fentanyl_mucosal_agents.asp)
- [palivizumab \(Synagis®\)](https://newyork.fhsc.com/providers/CDRP_synagis.asp): [https://newyork.fhsc.com/providers/CDRP\\_synagis.asp](https://newyork.fhsc.com/providers/CDRP_synagis.asp)
- [sodium oxybate products \(Xyrem®, Xywav™\)](https://newyork.fhsc.com/providers/CDRP_xyrem.asp): [https://newyork.fhsc.com/providers/CDRP\\_xyrem.asp](https://newyork.fhsc.com/providers/CDRP_xyrem.asp)
- [somatropin \(Serostim®\)](https://newyork.fhsc.com/providers/CDRP_serostim.asp): [https://newyork.fhsc.com/providers/CDRP\\_serostim.asp](https://newyork.fhsc.com/providers/CDRP_serostim.asp)

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

- [Anabolic Steroids](https://newyork.fhsc.com/providers/CDRP_anabolic_steroids.asp): [https://newyork.fhsc.com/providers/CDRP\\_anabolic\\_steroids.asp](https://newyork.fhsc.com/providers/CDRP_anabolic_steroids.asp)
- [Growth Hormones for 18 years and older](https://newyork.fhsc.com/providers/CDRP_growth_hormones.asp): [https://newyork.fhsc.com/providers/CDRP\\_growth\\_hormones.asp](https://newyork.fhsc.com/providers/CDRP_growth_hormones.asp)

## NYS Medicaid NYRx Drug Utilization Review (DUR) Program

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

For additional Step Therapy and Frequency/Quantity/Duration parameters for drugs and drug classes that are also included on the Preferred Drug List (PDL), please see pages 3 through 60.

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Corticotropin (Acthar®, Cortrophin®)	<p>Requires trial of first-line therapy for all FDA-approved indications, other than infantile spasms.</p> <p><b>Note:</b> It is first line therapy for infantile spasms in children less than 2 years of age – step therapy not required.</p>	<p><b>QUANTITY LIMITS:</b></p> <ul style="list-style-type: none"> <li>• Infantile spasms – 30 mL (six 5 mL vials)</li> <li>• Multiple sclerosis – 35 mL (seven 5 mL vials)</li> </ul> <p><b>DURATION LIMITS:</b></p> <ul style="list-style-type: none"> <li>• Infantile spasms – 4 weeks; indicated for &lt; 2 years of age</li> <li>• Multiple sclerosis – 5 weeks</li> <li>• Rheumatic disorders – 5 weeks</li> <li>• Dermatologic conditions – 5 weeks</li> <li>• Allergic states (serum sickness) – 5 weeks</li> </ul>	<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>• Not covered for diagnostic purposes</li> </ul>

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

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
<p>Anabolic Steroids – Injectable</p> <ul style="list-style-type: none"> <li>testosterone cypionate (Depo-Testosterone®)</li> <li>testosterone enanthate (Xyosted®)*</li> </ul> <hr/> <p>Anabolic Steroids – Oral</p> <ul style="list-style-type: none"> <li>testosterone undecanoate (Jatenzo®, Tlando®)</li> <li>methyltestosterone (Methitest®)</li> <li>oxandrolone</li> </ul>		<ul style="list-style-type: none"> <li>Limitations for anabolic steroid products is based on approved FDA labeled daily dosing and documented diagnosis not to exceed a 90-day supply (30-day supply for oxandrolone):</li> <li>Xyosted® is limited to no more than 3 boxes for 90 days (1 box per 30 days)</li> <li>Initial duration limit of 3 months (for all products except oxandrolone), requiring documented follow-up monitoring for response and/or adverse effects before continuing treatment</li> <li>Duration limit of 6 months for delayed puberty</li> <li>Duration limit of 1 month for all uses of oxandrolone products</li> </ul>	<p>*for additional parameters, see Hormone Replacement Therapy for Treatment of Gender Dysphoria section below.</p>
<p>Anti-Diarrheal Agents</p> <ul style="list-style-type: none"> <li>alosetron (Lotronex®)</li> <li>crofelemer (Mytesi®)</li> <li>eluxadoline (Viberzi®)</li> <li>telotristat (Xermelo®)</li> </ul>	<ul style="list-style-type: none"> <li>Irritable Bowel Syndrome w/Diarrhea <ul style="list-style-type: none"> <li>Trial of eluxadoline and rifaximin prior to alosetron.</li> </ul> </li> <li>Symptomatic relief of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy <ul style="list-style-type: none"> <li>Trial with an alternative anti-diarrheal agent.</li> </ul> </li> <li>Carcinoid Syndrome <ul style="list-style-type: none"> <li>Trial with and concurrent use with a somatostatin analog</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>Confirmation of FDA-approved or compendia-supported indication.</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anti-Fungals, Topical – for Onychomycosis <ul style="list-style-type: none"> <li>• ciclopirox 8% solution</li> <li>• efinaconazole (Jublia®)</li> <li>• tavaborole</li> </ul>	<ul style="list-style-type: none"> <li>• Trial with an oral antifungal agent* prior to use of ciclopirox 8% solution</li> </ul> *terbinafine (Lamisil®) tablets; griseofulvin (Gris PEG®) oral suspension, ultramicronized tablets micronized tablets; itraconazole (Sporanox®,) tablets, oral solution <ul style="list-style-type: none"> <li>• Trial with ciclopirox 8% solution prior to the use of other topical antifungals [efinaconazole (Jublia®) or tavaborole]</li> </ul>		

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anti-Retroviral (ARV) Interventions		<p><b>QUANTITY LIMITS:</b></p> <ul style="list-style-type: none"> <li>• Limit ARV active ingredient duplication</li> <li>• Limit ARV utilization to a maximum of five products concurrently - excluding boosting with ritonavir (dose limit 600 mg or less) or cobicistat</li> <li>• Limit Protease Inhibitor utilization to a maximum of two products concurrently</li> <li>• Limit Integrase inhibitor utilization to a maximum of one product concurrently</li> <li>• Limit non-nucleoside reverse transcriptase inhibitor utilization to a maximum of 1 product concurrently</li> <li>• Limit ARV booster utilization to 1 product concurrently</li> <li>• Limit co-formulated and co-packaged complete ARV regimens listed in Appendix A to a maximum of 1 product concurrently with no additional ARVs.</li> </ul>	<ul style="list-style-type: none"> <li>• Require confirmation of FDA-approved or compendia-supported use</li> <li>• Point-of-service edit for antiretroviral / antiretroviral combinations to be avoided: <a href="https://newyork.fhsc.com/downloads/providers/NYRx_PDP_reference_Antiretroviral_Antiretroviral_Drug2Drug_Interactions.pdf">https://newyork.fhsc.com/downloads/providers/NYRx_PDP_reference_Antiretroviral_Antiretroviral_Drug2Drug_Interactions.pdf</a></li> </ul>
belimumab (Benlysta®)	<ul style="list-style-type: none"> <li>• Trial of a disease-modifying anti-rheumatic drug (DMARD) prior to treatment with an immunomodulator</li> </ul>		<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
biotin			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Atopic Dermatitis Agents <ul style="list-style-type: none"> <li>crisaborole (Eucrisa®)</li> <li>ruxolitinib (Opzelura™)</li> </ul>	<ul style="list-style-type: none"> <li>Trial with a medium or high potency prescription topical steroid within the last 3 months</li> </ul>	<b>QUANTITY LIMITS:</b> <ul style="list-style-type: none"> <li>100 gm/30 days (crisaborole)</li> <li>240 gm/30 days (ruxolitinib)</li> </ul>	<ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported Medicaid covered indication</li> <li>ruxolitinib: age 12 years +</li> </ul>
Benzodiazepine agents – oral <ul style="list-style-type: none"> <li>alprazolam (Xanax®, Xanax® XR)</li> <li>chlordiazepoxide</li> <li>chlordiazepoxide/amitriptyline</li> <li>clonazepam (Klonopin®)</li> <li>clorazepate</li> <li>diazepam (Valium®)</li> <li>lorazepam (Ativan®, Lorazepam IntensoI®, Loreev XR™)</li> <li>oxazepam</li> </ul>	Generalized Anxiety Disorder (GAD) or Social Anxiety Disorder (SAD) <ul style="list-style-type: none"> <li>Require trial with a Selective-Serotonin Reuptake Inhibitor (SSRI) or a Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) prior to initial benzodiazepine prescription</li> <li>Panic Disorder requires concurrent therapy with an antidepressant (SSRI, SNRI, or Tricyclic antidepressant [TCA]).</li> </ul> Skeletal muscle spasms <ul style="list-style-type: none"> <li>Require trial with a skeletal muscle relaxant prior to a benzodiazepine</li> </ul>	<b>DURATION LIMIT:</b> <ul style="list-style-type: none"> <li>For Insomnia: 30 consecutive days</li> <li>For Panic Disorder: 30 consecutive days</li> </ul>	<ul style="list-style-type: none"> <li>Require confirmation of FDA-approved or compendia-supported use</li> <li>PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy</li> <li>PA required for any additional oral benzodiazepine prescription in patients currently on benzodiazepine therapy</li> <li>PA required when greater than a 14-day supply of a benzodiazepine is prescribed for someone on a CNS stimulant</li> </ul>
Constipation Agents <ul style="list-style-type: none"> <li>linaclotide (Linzess®)</li> <li>lubiprostone (Amitiza®)</li> <li>methylnaltrexone (Relistor®)</li> <li>naldemedine (Symproic®)</li> <li>naloxegol (Movantik®)</li> <li>plecanatide (Trulance®)</li> <li>prucalopride (Motegrity™)</li> <li>tenapanor (Ibsrela®)</li> </ul>	Opioid Induced Constipation (OIC) and Chronic Idiopathic Constipation (CIC) <ul style="list-style-type: none"> <li>Trial with an osmotic laxative, a stimulant laxative, and a stool softener prior to use.</li> </ul> Irritable Bowel Syndrome w/ Constipation (IBS-C) <ul style="list-style-type: none"> <li>Trial with a bulking agent and an osmotic laxative within 89 days of use.</li> </ul>	<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>linaclotide, naldemedine, naloxegol, plecanatide: 1 tablet/day</li> <li>lubiprostone: 2 capsules/day</li> <li>methylnaltrexone: 1 vial or syringe/day, 4 kits/28 days</li> <li>prucalopride: 2 mg/day max; 1 tablet per day</li> <li>tenapanor 2 tablets/day</li> </ul>	<ul style="list-style-type: none"> <li>Confirmation of FDA-approved or compendia-supported indication.</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Hormone Replacement Therapy for Treatment of Gender Dysphoria <ul style="list-style-type: none"> <li>• conjugated estrogens</li> <li>• estradiol</li> <li>• testosterone cypionate</li> <li>• testosterone enanthate (Xyosted™)</li> <li>• testosterone gel 1.62% (AndroGel®)*</li> <li>• testosterone patch (Androderm)*</li> </ul>			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>• For diagnosis of gender dysphoria please refer to October 2023 edition of the Medicaid Update:                  <a href="https://www.health.ny.gov/health_care/medicaid/program/update/2023/no15_2023-10.htm#hormones">https://www.health.ny.gov/health_care/medicaid/program/update/2023/no15_2023-10.htm#hormones</a> </li> </ul> <p>*Subject to Anabolic Steroids – Topical PDL class criteria</p>
dextromethorphan / quinidine (Nuedexta®)		<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>• 2 capsules per day; 60 units per 30 days</li> </ul> <b>DURATION LIMIT:</b> <ul style="list-style-type: none"> <li>• 90 days of therapy</li> </ul>	For patients ≥ 18 years of age: <ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
Diabetic Test Strips		<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>• Type I DM – max 300 test strips per 30-day supply</li> <li>• Type II DM – max 100 test strips per 30-day supply</li> </ul>	<ul style="list-style-type: none"> <li>• Preferred diabetic supply program                  <a href="https://newyork.fhsc.com/providers/diabeticsupplies.asp">https://newyork.fhsc.com/providers/diabeticsupplies.asp</a> </li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
dronabinol (Marinol®)	<p>Step therapy for beneficiaries with HIV/AIDS, or cancer, AND eating disorder:</p> <ul style="list-style-type: none"> <li>• Trial with megestrol acetate suspension prior to dronabinol</li> </ul> <p>Step therapy for beneficiaries with diagnosis of cancer and nausea/vomiting:</p> <ul style="list-style-type: none"> <li>• Trial with a NYS Medicaid-preferred 5-HT3 receptor antagonist prior to dronabinol</li> </ul>		<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>
risdiplam (Evrysdi®)			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved indication</li> <li>• Confirm absence of advanced disease</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Fentanyl Transmucosal Agents <ul style="list-style-type: none"> <li>• fentanyl (lozenge)</li> <li>• fentanyl (Fentora®) (buccal tablet)</li> </ul>		<b>QUANTITY LIMIT:</b> fentanyl lozenge, Fentora®: <ul style="list-style-type: none"> <li>• 4 units per day, 120 units per 30 days</li> </ul> <b>DURATION LIMIT:</b> <ul style="list-style-type: none"> <li>• 90 days</li> <li>• Exemption for diagnosis of cancer, sickle cell disease, or hospice care</li> </ul>	<ul style="list-style-type: none"> <li>• Confirm diagnosis</li> <li>• Limited to a total of 4 opioid prescriptions every 30 days;</li> <li>• For opioid-naïve patients: limited to a 7 days' supply for all initial opioid prescriptions,</li> <li>• PA required for use if &gt; 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting &gt; 7 days).</li> <li>• PA required for initiation of opioid therapy for patients on established opioid dependence therapy</li> <li>• PA is required for initiation of opioid therapy in patients currently on benzodiazepine therapy</li> <li>• Exemption for diagnosis of cancer, sickle cell, or hospice care</li> </ul>
HIV PrEP (Pre-Exposure Prophylaxis Agents): <ul style="list-style-type: none"> <li>• cabotegravir (Apretude)</li> <li>• emtricitabine/tenofovir disoproxil fumarate (Truvada®)</li> <li>• emtricitabine/tenofovir alafenamide (Descovy®)</li> </ul>			<ul style="list-style-type: none"> <li>• Confirmation of negative HIV test every 3 months</li> </ul>
ivermectin (oral)			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Lidocaine patches <ul style="list-style-type: none"> <li>lidocaine (Lidoderm®, ZTLido™)</li> </ul>			<ul style="list-style-type: none"> <li>Prescribers, or their authorized agents, are required to respond to a series of questions that identify the prescriber, the patient, and the reason for prescribing this drug.</li> <li>Prescriptions can be written for a 30-day supply with up to 2 refills</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
methadone	<ul style="list-style-type: none"> <li>Requires a trial of a long-acting opioid prior to initiation for the management of chronic non-cancer pain</li> </ul>	<p><b>QUANTITY LIMIT:</b></p> <ul style="list-style-type: none"> <li>12 units per day, 360 units per 30 days</li> <li>Exemption for diagnosis of cancer, hospice care, or sickle cell disease</li> </ul>	<ul style="list-style-type: none"> <li>Confirm diagnosis of chronic non-cancer pain</li> <li>Limited to a total of 4 opioid prescriptions every 30 days;</li> <li>PA required for initiation of methadone for patients on established opioid dependence therapy</li> <li>PA required for methadone prescriptions for patients currently on long-acting opioid therapy.</li> <li>PA required for initiation of long-acting opioid therapy in opioid-naïve patients.</li> <li>PA required for use if &gt; 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting &gt; 7 days). PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy</li> <li>Exemption for diagnosis of cancer, sickle cell, or hospice care</li> </ul>
metoclopramide nasal spray (Gimoti™)			<ul style="list-style-type: none"> <li>Metoclopramide nasal spray confirm diagnosis of diabetes</li> </ul>
olanzapine / fluoxetine (Symbyax®)	<ul style="list-style-type: none"> <li>When prescribing for the treatment of major depressive disorder (MDD) in the absence of other psychiatric comorbidities, trial with at least one different antidepressant agent is required</li> </ul>		<ul style="list-style-type: none"> <li>PA is required for the initial prescription for beneficiaries younger than 10 years</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Ovulation Enhancing Drugs <ul style="list-style-type: none"> <li>• bromocriptine</li> <li>• clomiphene</li> <li>• letrozole</li> <li>• tamoxifen</li> </ul>			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>• Refer to <a href="https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-06.htm#ovulation">https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-06.htm#ovulation</a></li> </ul>
Oxazolidinone Antibiotics <ul style="list-style-type: none"> <li>• linezolid (Zyvox®)</li> <li>• tedizolid (Sivextro®)</li> </ul>			<ul style="list-style-type: none"> <li>• Please be prepared to respond to a series of questions that identify the prescriber, the patient, and the reason for prescribing this drug.</li> <li>• Please be prepared to fax clinical documentation upon request.</li> </ul>
Pubertal Suppressants <ul style="list-style-type: none"> <li>• leuprolide acetate (Lupron®, Lupron Depot-PED®, Eligard®, Fensolvi®, Lupron Depot®)</li> <li>• nafarelin acetate (Synarel®)</li> <li>• triptorelin (Triptodur®)</li> </ul>			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>• Refer to <a href="https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender">https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender</a> for Transgender Related Care and Services Update</li> </ul>
Rosacea Agents <ul style="list-style-type: none"> <li>• brimonidine gel pump</li> <li>• oxymetazoline HCl (Rhofade®)</li> <li>• doxycycline</li> </ul>	<ul style="list-style-type: none"> <li>• Trial with topical metronidazole product.</li> </ul> *does not apply to azelaic acid (Finacea®)		<ul style="list-style-type: none"> <li>• Confirmation of FDA-approved or compendia-supported indication</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
esketamine (Spravato®)	<ul style="list-style-type: none"> <li>Treatment Resistant Depression: trial of at least two oral antidepressants</li> </ul>		<ul style="list-style-type: none"> <li>Confirm diagnosis of FDA approved indication for patients ≥18 years of age</li> <li>Confirm concurrent use of an FDA approved antidepressant</li> <li>Before initiating esketamine nasal spray (Spravato), prescribers must attest that they have obtained a baseline score using a validated clinical assessment tool for depression (e.g., HAMD17, QIDS-C16C, MADRS).</li> <li>After the initiation of esketamine nasal spray (Spravato) therapy, every six months prescribers must attest that esketamine nasal spray (Spravato) has resulted in an improvement of depressive symptoms (from baseline) using the same baseline clinical assessment tool for depression (e.g., HAMD17, QIDS-C16C, MADRS).The esketamine worksheet can be accessed at: <a href="https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_Spravato.docx">https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_Spravato.docx</a></li> </ul>
tasimelteon (Hetlioz®, Hetlioz® LQ)		<p><b>QUANTITY LIMIT:</b></p> <ul style="list-style-type: none"> <li>One unit per day; 30 units per 30 days</li> </ul>	<ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Parathyroid Hormone Analogs <ul style="list-style-type: none"> <li>• teriparatide (Forteo®)</li> <li>• abaloparatide (Tymlos®)</li> </ul>	<ul style="list-style-type: none"> <li>• Requires a trial with a preferred oral bisphosphonate</li> </ul>	<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>• One unit per 30-day period</li> </ul> <b>LIFETIME QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>• 25 months' cumulative use of a PTH analog</li> </ul>	
Topical Compounded Prescriptions			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>• For non-opioid pain management alternatives please visit: <a href="https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf">https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf</a></li> </ul>
Zoryve® foam			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication</li> <li>• Minimum age: 9 years</li> </ul>

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

# Medication Assisted Treatment (MAT) Formulary

Effective 05/05/2022

**Medication Assisted Treatment (MAT) Formulary**

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

Drugs	Coverage Parameters
<b>Opioid Antagonists</b>	
Kloxxado™ naloxone (syringe, vial, nasal spray) naloxone (nasal spray) OTC naltrexone Narcan® (nasal spray) Narcan® OTC Opvee® RiVive™ Zimhi™	N/A
<b>Opioid Dependence Agents – Injectable</b>	
Brixadi™ Vivitrol® Sublocade™	N/A
<b>Opioid Dependence Agents – Oral/Transmucosal <sup>F/Q/D</sup></b>	
buprenorphine (tablet) buprenorphine/naloxone (tablet) Suboxone® (film) buprenorphine/naloxone (film) Zubsolv®	<p><b>QUANTITY LIMIT:</b></p> <ul style="list-style-type: none"> <li>• <b>buprenorphine sublingual (SL):</b> Eight tablets dispensed as a 2-day supply; not to exceed 32 mg per day</li> <li>• <b>buprenorphine / naloxone tablet and film (Suboxone® 2mg/0.5mg, Zubsolv® 1.4mg/0.36mg, 0.7mg/0.18mg strength; Up to 12 sublingual tablets or films per day.</b></li> <li>• <b>buprenorphine/naloxone tablet and film (Suboxone® up to 4mg/1mg and 8mg/2mg strength, Zubsolv® 2.9mg/0.71mg and 5.7mg/1/4mg strength; Four sublingual tablets or films per day; maximum of 120 tablets or films dispensed as a 30-day supply, not to exceed 32 mg-8 mg of Suboxone®, or its equivalent per day</b></li> <li>• <b>buprenorphine/naloxone tablet: Suboxone® 12mg/3mg, Zubsolv® 8.6 mg/2.1 mg and Zubsolv® 11.4 mg/2.9 mg strength: Maximum of 60 tablets dispensed as a 30-day supply</b></li> </ul> <p><b>RELATED CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>• PA required for initiation of <b>opioid therapy</b> for patients on established opioid dependence therapy</li> <li>• PA required for initiation of a <b>CNS stimulant</b> for patients established on opioid dependence therapy **</li> </ul>

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

On April 26, 2010, NYRx, the Medicaid Pharmacy Program, implemented a new cost-containment initiative, which promotes the use of certain multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent.

In conformance with State Education Law, which intends that patients receive the lower cost alternative, brand name drugs included in this program:

- Do not require “Dispense as Written” (DAW) or “Brand Medically Necessary” on the prescription
- Have a generic copayment
- Are paid at the Brand Name Drug reimbursement rate or usual and customary price, whichever is lower (SMAC/FUL are not applied)
- Do not require a new prescription if the drug is removed from this program

### Effective August 1, 2024:

- No products will be **added** to the program
- Dexilant® will be **removed** from the program

List of Brand Name Drugs included in this program**		
Advair Diskus®	Farxiga®	Restasis®
Advair HFA®	Glumetza®	Retin-A® cream
Alphagan P® 0.15%	Istalol®	Risperdal Consta®
Alphagan P® 0.1%	Kitabis® Pak	Ritalin LA®
Apriso®	Kombiglyze® XR	Spiriva® Handihaler®
Azopt™	Lialda®	Symbicort®
Bethkis®	Nascobal®	Tegretol® suspension
Carbaglu®	Nexavar®	Tegretol® XR
CellCept® suspension	NuvaRing®	Trileptal® suspension
Combigan®	Onglyza®	Vascepa®
Copaxone® 20 mg SQ	Oseni®	Ventolin® HFA
Daytrana®	Pentasa®	Votrient®
Depakote® Sprinkle	Pradaxa®	Vyvanse® capsules
Dymista®	Protonix® suspension	Xigduo® XR
EpiPen	Pylera®	Xopenex HFA®
EpiPen, Jr	Renvela® tablet, and powder pack	Zegerid® Rx

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

## NYS Medicaid NYRx Mandatory Generic Drug Program

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

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

### Prior Authorization Process

- Prescribers, or an agent of the prescriber, must call the prior authorization line at 1-877-309-9493 and respond to a series of questions that identify the prescriber, the patient, and the reason for prescribing this drug. The Mandatory Generic Program Prescriber Worksheet and Instructions, located at [https://newyork.fhsc.com/providers/MGDP\\_forms.asp](https://newyork.fhsc.com/providers/MGDP_forms.asp), provide step-by-step assistance in completing the prior authorization process.
- The prescriber must write “DAW and Brand Medically Necessary” on the face of the prescription.
- The call line 1-877-309-9493 is in operation 24 hours a day, seven days a week.

### Exempt Drugs

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

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

For more information on the Mandatory Generic Program, please refer to [https://newyork.fhsc.com/providers/MGDP\\_about.asp](https://newyork.fhsc.com/providers/MGDP_about.asp).

## NYS Medicaid NYRx Dose Optimization Program

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

### Dose Optimization Chart

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

Brand Name	Dose Optimization Limitations		
<b>CENTRAL NERVOUS SYSTEM</b>			
<b>Anticonvulsants</b>			
Aptiom® 200 mg, 400 mg	1 daily	Tablet	
Fycompa® 4 mg, 6 mg	1 daily	Tablet	
topiramate ER 100 mg	1 daily	Capsule	
Lamictal XR® 50 mg	1 daily	Tablet	In case of dose titration for these medications, the department will allow for multiday dosing (up to 2 doses daily) for titration purposes for 90 days
Oxtellar XR® 300 mg	1 daily	Tablet	In case of dose titration for these medications, the department will allow for multiday dosing (up to 2 doses daily) for titration purposes for 90 days
Lyrica® 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg	3 daily	Tablet	Electronic bypass for diagnosis of seizure disorder identified in medical claims data. In case of dose titration for these medications, the department will allow for multiday dosing (up to 2 doses daily) for titration purposes for 3 months
Lyrica® 225 mg and 300 mg	2 daily	Tablet	
Trokendi XR® 100 mg	1 daily	Tablet	
<b>Antiparkinson Agents</b>			
Azilect® 0.5 mg	1 daily	Tablet	
<b>Antipsychotics – Second Generation</b>			
Abilify® 2 mg	4 daily	Tablet	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
Abilify® 5 mg, 10 mg, 15 mg	1 daily	Tablet	
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	

Brand Name	Dose Optimization Limitations		
<b>CENTRAL NERVOUS SYSTEM</b>			
Vraylar® 1.5 mg, 3 mg	1 daily	Capsule	
Zyprexa® Zydis 5 mg, 10 mg	1 daily	Tablet	
<b>CNS Stimulants</b>			
Adderall® XR 5 mg, 10 mg, 15 mg	1 daily	Capsule	
amphetamine salt combo ER 5 mg, 10 mg, 15 mg	1 daily	Capsule	
Concerta® ER 18 mg, 27 mg	1 daily	Tablet	
dexmethylphenidate ER 10 mg, 20 mg (Focalin XR generic)	1 daily	Capsule	
Focalin® XR 5 mg, 10 mg, 15 mg, 20 mg	1 daily	Capsule	
methylphenidate CD 10 mg, 20 mg	1 daily	Capsule	
methylphenidate er 18 mg (Concerta® generic)	1 daily	Tablet	
methylphenidate la 20 mg (Ritalin® LA generic)	1 daily	Capsule	
modafinil 100 mg	1 daily	Tablet	
Provigil® 100 mg	1 daily	Tablet	
QuilliChew® ER 20 mg	1 daily	Tablet	
Ritalin® LA 10 mg, 20 mg	1 daily	Capsule	
Vyvanse® 10 mg, 20 mg, 30 mg, 40 mg	1 daily	Capsule	
<b>Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)</b>			
guanfacine ER 1 mg, 2 mg	1 daily	Tablet	
atomoxetine 40 mg	1 daily	Capsule	
Intuniv® 1 mg, 2 mg	1 daily	Tablet	
Strattera® 40 mg	1 daily	Capsule	
<b>Sedative Hypnotics</b>			
Lunesta® 1 mg	1 daily	Tablet	
<b>Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)</b>			
Effexor® XR 37.5 mg, 75 mg, 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	

Brand Name	Dose Optimization Limitations		
<b>CENTRAL NERVOUS SYSTEM</b>			
<b>Selective Serotonin Reuptake Inhibitors (SSRIs)</b>			
Lexapro® 5 mg, 10 mg	1 daily	Tablet	In the case of dose titration for these once daily medications, the Department will allow for multiday dosing (up to 2 doses/daily) for titration purposes for three months.
Trintellix® 5 mg, 10 mg	1 daily	Tablet	
Viibryd® 10 mg, 20 mg	1 daily	Tablet	
<b>Miscellaneous Antidepressants</b>			
bupropion xl 150 mg	1 daily	Tablet	In case of dose titration for these medications, the Department will allow for multiday dosing (up to 2 doses/daily) for titration purposes for three months
mirtazapine 7.5 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
<b>ENDOCRINE AND METABOLIC</b>			
<b>Biguanides</b>			
metformin ER 500 mg (Glumetza ER, Fortamet ER generic)	1 daily	Tablet	
<b>Dipeptidyl Peptidase-4 (DPP-4) Inhibitors</b>			
Januvia® 25 mg, 50 mg	1 daily	Tablet	
Onglyza® 2.5 mg	1 daily	Tablet	
<b>Thiazolidinediones (TZDs)</b>			
Actos® 15 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
<b>GASTROINTESTINAL</b>			
<b>Proton Pump Inhibitors</b>			
Dexilant® 30 mg	1 daily	Capsule	
Nexium® 5 mg, 10 mg, 20 mg	1 daily	Packet	
Nexium® 20 mg	1 daily	Capsule	

Brand Name	Dose Optimization Limitations		
<b>GASTROINTESTINAL</b>			
Prevacid® DR 15 mg	1 daily	Capsule	

Brand Name	Dose Optimization Limitations		
<b>HEMATOLOGICAL</b>			
<b>Anticoagulants - Oral</b>			
Xarelto® 10 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
<b>RENAL AND GENITOURINARY</b>			
<b>Urinary Tract Antispasmodics</b>			
Detrol® LA 2 mg	1 daily	Capsule	
Myrbetriq® 25 mg	1 daily	Tablet	
oxybutynin chloride ER 5 mg	1 daily	Tablet	
Toviaz® ER 4 mg	1 daily	Tablet	
VESIcare® 5 mg	1 daily	Tablet	

PA requirements are not dependent on the date a prescription is written. New prescriptions and refills on existing prescriptions require PA even if the prescription was written before the date the drug was determined to require PA.

To obtain a prior authorization (PA), please call the prior authorization Clinical Call Center at 1-877-309-9493. The Clinical Call Center is available 24 hours per day, 7 days per week with pharmacy technicians and pharmacists who will work with you, or your agent, to quickly obtain PA.

Medicaid enrolled prescribers with an active e-PACES account can initiate PA requests through the web-based application PAXpress®. The website for PAXpress is <https://paxpress.nypa.hidinc.com>.

When, in the judgment of the prescriber or the pharmacist, an emergency condition exists, the prescriber or pharmacist can call the Clinical Call center and obtain authorization for a 72-hour emergency supply of the drug prescribed to allow time for the prior authorization to be obtained.