Revised: March 20, 2025

NYRx, the New York Medicaid Pharmacy Program

OVERVIEW OF CONTENTS

For more information on NYRx, the Medicaid Pharmacy Program: 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

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 72)

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 73–77)

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

PREFERRED DRUG LIST – TABLE OF CONTENTS

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)		
Celebrex® 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 diclofenac capsule diclofenac/misoprostol diclofenac potassium diclofenac potassium (gen Cambia®) diclofenac sodium ER diclofenac topical soln diflunisal Dolobid Elyxyb™ F/Q/D etodolac etodolac ER Feldene® fenoprofen Fenopron™ flurbiprofen ibuprofen/famotidine (gen Duexis®) indomethacin ER indomethacin suspension ketoprofen ketoprofen ER ketorolac nasal spray (gen Sprix®) Kiprofen™ meclofenamate mefenamic acid meloxicam capsule (gen Vivlodex®) Nalfon® Naprelan® naproxen susp naproxen CR naproxen EC	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Elyxyb™ (celecoxib) – 4.8 mL bottle (120 mg) maximum quantity: 9 bottles / 30 days

1 = Preferred as of 2/6/2025
2 = Non-Preferred as of 2/6/2025

Standard PA fax form:
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
I. Analgesics		
	naproxen-esomeprazole naproxen sodium oxaprozin Relafen® DS tolmetin Vimovo®	
Opioids – Long-Acting CC		
buprenorphine patch fentanyl patch (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg) morphine sulfate ER tablet	Belbuca® Butrans® ConZip® ST fentanyl patch (37.5 mcg, 62.5 mcg, 87.5 mcg) hydrocodone ER hydrocodone ER (gen Hysingla ER) hydromorphone ER Hysingla® ER morphine ER capsule (gen Avinza) morphine ER capsule (gen Kadian) MS Contin® oxycodone ER Oxycontin® oxymorphone ER tramadol ER ST	**CLINICAL CRITERIA (CC) *** • Limited to a total of 4 opioid prescriptions every 30 days; Exemption for diagnosis of cancer, hospice or palliative care, or sickle cell disease • PA required for initiation of opioid therapy for patients on established opioid dependence therapy • PA required for use if ≥ 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting > 7 days) • PA required for initiation of long-acting opioid therapy in opioid-naïve patients. • PA required for any additional long-acting opioid prescription for patients currently on long-acting opioid therapy. • PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy • PA required for any codeine- or tramadol-containing products in pts < 12 years **STEP THERAPY (ST)** • **Tramadol ER (tramadol naïve patients):** Attempt treatment with IR formulations before the following ER formulations: ConZip®, tramadol ER *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

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
Opioids – Short-Acting CC		
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® oxycodone IR capsules, concentrate oxycodone/APAP (Prolate) solution, tablets oxymorphone pentazocine/naloxone Percocet® RoxyBond Roxicodone® Seglentis® tramadol solution tramadol 25mg, 75mg tablet tramadol/APAP	**CLINICAL CRITERIA (CC) *** • Limited to a total of 4 opioid prescriptions every 30 days. • Initial prescription for opioid-naïve patients limited to a 7-day supply. • PA required for initiation of opioid therapy for patients on established opioid dependence therapy. • PA required for use if ≥ 90 MME of opioid per day for management of non-acute pain (> 7 days) – Exception for diagnosis of cancer or sickle cell disease, or hospice or palliative care programs • PA is required for opioid-naïve patients for prescription requests ≥ 50 MME per day. • PA required for continuation of opioid therapy beyond an initial 7-day supply in patients established on gabapentin or pregabalin • PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy • PA required for any codeine- or tramadol-containing products in pts < 12 years **PA required for continuation of opioid therapy for >7days for patients on established CNS stimulant therapy** **STEP THERAPY (ST)** • For Non-opioid Pain management alternatives please visit: https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf *Exemptions from requirements for diagnosis of cancer, sickle cell disease, or hospice or palliative care

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

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II. Anti-Infectives		
	levofloxacin solution moxifloxacin ofloxacin tablet	
Hepatitis B Agents		
adefovir dipivoxil Baraclude® solution entecavir lamivudine HBV	Baraclude® tablet Vemlidy®	
Hepatitis C Agents – Direct Acting Antivirals		
Mavyret™ ribavirin sofosbuvir/velpatasvir (gen Epclusa®) Vosevi®	Epclusa® Harvoni® ledipasvir/sofosbuvir (gen Harvoni®) Sovaldi® Zepatier®	
Tetracyclines		
demeclocycline doxycycline hyclate minocycline capsule tetracycline capsule	Doryx® ST Doryx MPC® ST doxycycline hyclate DR ST doxycycline monohydrate minocycline tablet minocycline ER tablet Nuzyra™ Solodyn® tetracycline tablet	**STEP THERAPY (ST)** • Trial of doxycycline IR before progressing to doxycycline DR

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

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Beta Blockers		
atenolol carvedilol labetalol metoprolol succ. XL metoprolol tartrate propranolol tablet propranolol ER	acebutolol betaxolol bisoprolol Bystolic® DO carvedilol ER Inderal LA® Inderal XL® InnoPran XL® Kapspargo™ Sprinkle Lopressor® nadolol DO nebivolol (gen Bystolic®) pindolol propranolol solution Tenormin® timolol Toprol XL® DO	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths
Beta Blockers / Diuretics		
atenolol/chlorthalidone bisoprolol/HCTZ propranolol/HCTZ	metoprolol tartrate/ HCTZ Tenoretic®	
Calcium Channel Blockers (Dihydropyridine)		
amlodipine felodipine ER isradipine nicardipine HCl nifedipine nifedipine ER/SA	Katerzia™ levamlodipine nisoldipine Norliqva® Norvasc® Procardia XL® Sular®	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Cholesterol Absorption Inhibitors		
cholestyramine cholestyramine light Colestid® tablet colestipol tablet ezetimibe	colesevelam Colestid granules, packet colestipol granules, packet Questran® Questran Light® Welchol® Zetia®	
HMG-CoA Reductase Inhibitors (Statins)		
atorvastatin lovastatin pravastatin rosuvastatin simvastatin	Altoprev® Atorvaliq® atorvastatin/amlodipine Caduet® Ezallor™ Sprinkle ezetimibe/simvastatin FloLipid™ fluvastatin fluvastatin ER Lescol XL® Lipitor® Livalo® pitavastatin (gen Livalo®) Vytorin® Zocor® Zypitamag™	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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III. Cardiovascular		
Phosphodiesterase Type-5 (PDE-5) Inhibitors for PAH CC		
sildenafil tadalafil	Adcirca® Opsynvi® Revatio® Tadliq®	**CLINICAL CRITERIA** • All prescriptions for **Adcirca®**, **tadalafil, Revatio®**, and **sildenafil** must have PA • Prescribers or their authorized agents are required to respond to a series of questions that identify prescriber, patient, and reason for prescribing drug • Please be prepared to fax clinical documentation upon request • Prescriptions can be written for a 30-day supply with up to 11 refills
Pulmonary Arterial Hypertension (PAH) Agents, Other – Oral		
ambrisentan (gen Letairis) bosentan tablets (gen Tracleer®)	Adempas® Letairis® Opsumit® Orenitram® ER tablet, dosepack Tracleer® tablet for suspension, tablet Uptravi®	
Triglyceride Lowering Agents		
fenofibrate tablet (gen Tricor®) fenofibrate capsule (gen Lofibra®) fenofibric acid capsule (gen Trilipix®) gemfibrozil icosapent F/Q/D omega-3 ethyl ester (gen Lovaza®) F/Q/D	fenofibrate caps (gen Lipofen®) fenofibrate micronized capsule fenofibrate tablet (gen Fenoglide®) fenofibric acid tablet (gen Fibricor®) Fenoglide® Fibricor® Lipofen® Lopid® Lovaza® F/Q/D Tricor® Trilipix®	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Lovaza® (omega-3-acid ethyl-esters) and icosapent ethyl – Required dosage equal to 4 grams per day

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

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IV. Central Nervous System		
	Keppra XR® Lamictal® tablet, chew, dosepak Lamictal® ODT tablet, dosepak Lamictal® XR DO tablet, dosepak lamotrigine dosepak lamotrigine ER lamotrigine ODT dosepak levetiracetam 250mg tablet for suspension (gen Spritam®) Lyrica® solution DO, F/Q/D Lyrica® CR F/Q/D, CC Motpoly XR Neurontin® F/Q/D, CC Onfi® ST, CC pregabalin solution DO, F/Q/D, CC pregabalin ER (gen Lyrica® CR) F/Q/D, CC Qudexy® XR CC rufinamide (gen Banzel®) Sabril® Spritam® Sympazan® film ST, CC Topamax® CC topiramate 50mg Sprinkle CC topiramate ER CC, DO (gen Qudexy® XR) topiramate ER CC (gen Trokendi XR®) Trokendi XR® CC, DO vigabatrin Vigafyde™ Vimpat® Xcopri® Zonisade™	• **Neurontin® (gabapentin) –** PA required for initiation of gabapentin at > 900 mg per day in patients currently on an opioid at > 50 MME per day • **Stiripentol (Diacomit®) –** Require diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form • **Topiramate IR/ER (Eprontia™, Qudexy® XR, Topamax®, Trokendi XR™)** – Require confirmation of FDA-approved, compendia-supported, or Medicaid covered diagnosis • **Onfi®/Sympazan® (clobazam):** – Require confirmation of FDA-approved or compendia-supported use – PA required for initiation of clobazam therapy in patients currently on opioid or oral buprenorphine therapy – PA required for any clobazam prescription in patients currently on benzodiazepine therapy **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **Eprontia™ (topiramate)** – Maximum quantity: 473 mL per month • **Lyrica®/Lyrica® CR (pregabalin)** – Maximum daily dose of IR: 600 mg per day, and ER: 660 mg per day • **Neurontin® (gabapentin)** – Maximum daily dose of 3,600 mg per day **STEP THERAPY (ST)** • **Onfi®/Sympazan® (clobazam)** – Requires a trial with an SSRI or SNRI for treatment of anxiety

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<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">IV. Central Nervous System</td></tr>
<tr><td></td><td>Ztalmy®</td><td></td></tr>
<tr><td colspan="3">Antimigraine Agents, Other F/Q/D</td></tr>
<tr><td>Aimovig®
Ajovy®
Emgality®
Nurtec™ ODT CC, ST
Ubrelvy™ ST</td><td>Emgality® 100mg syringe
Qulipta™
Reyvow™ ST
Zavzpret™ ST</td><td>CLINICAL CRITERIA (CC)
• Confirm diagnosis of FDA-approved or compendia-supported indication

STEP THERAPY (ST)
Acute treatment of migraine
• Trial of a product from the Antimigraine Agents-Triptan class
<table><tr><th>Agent</th><th>F/Q/D</th></tr><tr><td>Aimovig</td><td>1 syringe/30 days</td></tr><tr><td>Emgality 120 mg</td><td>2 syringes/30 days</td></tr><tr><td>Emgality 100 mg</td><td>3 syringes/30 days</td></tr><tr><td>Ajovy</td><td>3 syringes/90 days</td></tr><tr><td>Reyvow</td><td>8 units/30 days</td></tr><tr><td>Ubrelvy</td><td>16 units/30 days</td></tr><tr><td>Nurtec™ ODT</td><td>24 units/40 days</td></tr><tr><td>Qulipta</td><td>30 units/30 days</td></tr><tr><td>Zavzpret®</td><td>8 units/30 days</td></tr></table></td></tr>
<tr><td colspan="3">Antimigraine Agents – Triptans</td></tr>
<tr><td>rizatriptan F/Q/D
sumatriptan F/Q/D</td><td>almotriptan F/Q/D
eletriptan F/Q/D
Frova® F/Q/D
frovatriptan F/Q/D
Imitrex® F/Q/D
Maxalt® F/Q/D
Maxalt® MLT F/Q/D
naratriptan F/Q/D
Relpax® F/Q/D
sumatriptan-naproxen F/Q/D
Tosymra™ F/Q/D</td><td>FREQUENCY/QUANTITY/DURATION (F/Q/D)
<table><tr><th>Agent</th><th>F/Q/D</th></tr><tr><td>almotriptan
eletriptan (Relpax®)
frovatriptan (Frova®)
naratriptan
rizatriptan (Maxalt®)
rizatriptan (Maxalt® MLT)
sumatriptan nasal spray (Imitrex®)
sumatriptan (Imitrex®)</td><td>18 units/30 days</td></tr></table></td></tr>
</table>

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IV. Central Nervous System		
	Zembrace™ SymTouch™ zolmitriptan F/Q/D Zomig® F/Q/D	sumatriptan-naproxen Tosymra™ nasal spray zolmitriptan (Zomig®) Zomig® nasal spray
Antipsychotics – Injectable		
Abilify Asimtufii® Abilify Maintena® Aristada® Aristada Initio® fluphenazine decanoate Haldol® decanoate haloperidol decanoate Invega Hafyera™ Invega Sustenna® Invega Trinza® Perseris™ Risperdal Consta® BLTG Uzedy™ Zyprexa Relprevv®	Erzofri® risperidone injection (gen Risperdal Consta®) Rykindo®	
Antipsychotics – Second Generation CC, ST		
aripiprazole tablet DO asenapine (gen Saphris®) clozapine lurasidone (gen Latuda®) olanzapine tablet DO paliperidone ER DO quetiapine F/Q/D quetiapine ER F/Q/D, DO risperidone ziprasidone capsule	Abilify® tablet DO Abilify MyCite® aripiprazole solution aripiprazole ODT Caplyta™ clozapine ODT Clozaril® Cobenfy™ capsules, starter pack Fanapt® Geodon® Invega® DO Latuda® DO Lybalvi™	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths **CLINICAL CRITERIA (CC)**

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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IV. Central Nervous System		
	Nuplazid® olanzapine ODT DO olanzapine / fluoxetine Opipza™ Rexulti® DO Risperdal® Saphris® Secuado® Seroquel® F/Q/D Seroquel XR® DO, F/Q/D Versacloz® Vraylar® DO Zyprexa® DO Zyprexa® Zydis	• Confirm diagnosis of FDA-approved or compendia-supported indication • Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA • Prior authorization is required when an oral SGA is utilized above the highest MDD according to FDA labeling. • Prior authorization is required for patients less than 21 years of age when there is concurrent use of 2 or more different oral antipsychotics for greater than 90 days. • Prior authorization is required for patients 21 years of age or older when 3 or more different oral second-generation antipsychotics are used for more than 180 days. • PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below:

aripiprazole (Abilify®, Opipza™)	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
olanzapine / fluoxetine (Symbyax®)	10 years
paliperidone ER (Invega®)	12 years
pimavanserin (Nuplazid®)	18 years
quetiapine fum. (Seroquel®, Seroquel XR®)	10 years
risperidone (Risperdal®)	5 years
xanomeline-trospium (Cobenfy™)	18 years
ziprasidone HCl (Geodon®)	10 years

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
		• Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients < 18 years of age **STEP THERAPY (ST)** • For all Second Generation Antipsychotics used in the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is required • olanzapine / fluoxetine: 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 **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **quetiapine/quetiapine ER (Seroquel®/Seroquel XR®):** Minimum 50 mg/day • **quetiapine (Seroquel®):** Maximum 3 units per day, 90 units per 30 days • **quetiapine ER (Seroquel XR®):** 50mg, maximum 2 units/day, 60 units/30 days
Central Nervous System (CNS) Stimulants CC, F/Q/D		
amphetamine salt combo IR (gen Adderall®) amphetamine salt combo ER (gen Adderall XR®) DO Daytrana® BLTG dexmethylphenidate (gen Focalin®) dexmethylphenidate ER DO (gen Focalin XR®) dextroamphetamine tablet lisdexamfetamine chewable tablet (gen Vyvanse® chew tablet) methylphenidate solution (gen Methylin®)	Adderall XR® DO Adzenys XR-ODT® amphetamine (gen Adzenys ER®) amphetamine (gen Evekeo®) Aptensio XR® armodafinil (gen Nuvigil®) Azstarys™ Concerta® DO Cotempla® XR-ODT™ Dexedrine® dextroamphetamine / amphetamine (gen Mydayis™)	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved, compendia-supported and Medicaid covered indication • Prior authorization is required for initial prescriptions for stimulant therapy for beneficiaries **less than 3 years of age** • Confirm diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent for beneficiaries **less than 18 years of age** • Patient-specific considerations for drug selection include treatment of narcolepsy, excessive daytime sleepiness, sleepiness associated with shift work sleep disorder, or sleepiness associated with obstructive sleep apnea.

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
methylphenidate tablet (gen Ritalin®) methylphenidate CD DO methylphenidate ER (gen Aptensio® XR) methylphenidate ER (gen Concerta®) methylphenidate ER (gen Metadate CD) methylphenidate ER (gen Ritalin LA®) Ritalin LA® DO Vyvanse® capsule DO, BLTG	dextroamphetamine ER (gen Dexedrine®) dextroamphetamine solution (gen ProCentra®) dextroamphetamine tablet (gen Zenzedi®) Dyanavel XR® Evekeo® Evekeo® ODT Focalin® Focalin XR® DO 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 modafinil (gen Provigil®) DO Mydayis™ Nuvigil® ProCentra® Provigil® DO QuilliChew ER™ DO Quillivant XR® Relexxii® F/Q/D Ritalin® Sunosi™ Vyvanse® chewable tablet Wakix® Xelstrym™ Zenzedi®	• PA required for initiation of CNS Stimulant for patients currently on an opioid • PA required for initiation of CNS Stimulant for patients currently on a benzodiazepine **DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Quantity limits based on daily dosage as determined by FDA labeling

1 = Preferred as of 2/6/2025
2 = Non-Preferred as of 2/6/2025

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Acne Agents, Topical		
adapalene/benzoyl peroxide (gen Epiduo®) adapalene cream adapalene OTC gel Retin-A® cream CC, BLTG tazarotene cream CC tretinoin gel (Retin-A) CC	adapalene Rx gel, gel pump adapalene/benzoyl peroxide (gen Epiduo® Forte) Aklief® Altreno® CC Arazlo™ CC Atralin® CC Cabtreo™ clindamycin/tretinoin CC dapsone Differin® cream, gel pump, lotion, OTC gel Epiduo® Forte gel pump Fabior® CC Klaron® Ovace® Plus Retin-A® gel CC Retin-A Micro® CC SSS® cream, foam sulfacetamide sulfacetamide-sulfur tazarotene foam (gen Fabior®) CC tazarotene gel CC tretinoin cream, gel CC (gen Atralin) tretinoin micro CC Twyneo® Winlevi® Ziana® CC ZMA® Clear	**CLINICAL CRITERIA** • Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Actinic Keratosis Agents		
diclofenac 3% gel fluorouracil solution fluorouracil 0.5% cream (gen Carac) fluorouracil 5% cream (gen Efudex cream) imiquimod (gen Aldara)	Carac® Efudex® imiquimod (gen Zyclara) Zyclara®	
Antibiotics – Topical		
mupirocin ointment	Centany® mupirocin cream Xepi™	
Anti-Fungals – Topical		
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	butenafine Ciclodan® cream ciclopirox gel clotrimazole/betamethasone lotion econazole Extina® Jublia® ketoconazole foam Loprox® cream, suspension luliconazole Luzu® miconazole/zinc/petrolatum (gen Vusion®) F/Q/D naftifine Naftin® oxiconazole Oxistat® tavaborole Vusion® F/Q/D	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **Vusion® 50 gm ointment** –Maximum 100 grams in a 90-day time period

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Anti-Infectives – Topical		
clindamycin solution, gel, lotion, swab clindamycin/benzoyl peroxide (gen Duac®) erythromycin solution, gel	Acanya® Benzamycin® Cleocin T® Clindagel® clindamycin phos gel (gen Clindagel®) clindamycin foam clindamycin/benzoyl peroxide (gen BenzaClin®) clindamycin/benzoyl peroxide (gen Onexton®) clindamycin/benzoyl peroxide (gen Acanya®) erythromycin swab erythromycin/benzoyl peroxide Evoclin® Neuac® Onexton®	
Anti-Virals – Topical		
acyclovir cream docosanol (gen Abreva)	acyclovir ointment Denavir® penciclovir (gen Denavir®) Xerese® Zovirax® cream, ointment	
Immunomodulators – Topical CC		
Eucrisa® pimecrolimus tacrolimus	Elidel® Opzelura®	**CLINICAL CRITERIA** • Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Psoriasis Agents – Topical		
calcipotriene cream, ointment, scalp solution	calcipotriene foam (gen Sorilux®) calcipotriene/betamethasone dipropionate (gen Taclonex®) calcitriol ointment (gen Vectical®) Duobrii™ Enstilar® Sorilux® Taclonex® Vectical® Vtama® Zoryve™	
Rosacea Agents, Topical CC		
azelaic acid metronidazole cream, gel	Epsolay® Finacea® ivermectin Metrocream® Metrogel® metronidazole gel pump, lotion Noritate® Rosadan® Soolantra®	**CLINICAL CRITERIA** • Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication
Steroids, Topical – Low Potency		
hydrocortisone acetate OTC hydrocortisone acetate Rx	alclometasone Capex® shampoo Derma-Smoothe/FS® desonide fluocinolone oil hydrocortisone 2.5% soln (gen Texacort®) Texacort®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. Dermatologic Agents		
Steroids, Topical – Medium Potency		
fluocinolone acetonide solution fluticasone propionate cream, ointment hydrocortisone valerate cream mometasone furoate	Beser lotion betamethasone valerate foam clocortolone fluocinolone acetonide cream, ointment flurandrenolide fluticasone propionate lotion hydrocortisone butyrate cream, lotion, ointment, solution hydrocortisone valerate ointment Locoid® Locoid Lipocream® Pandel® prednicarbate Synalar®	
Steroids, Topical – High Potency		
betamethasone dipropionate lotion, cream, ointment betamethasone dipropionate augmented cream, ointment, lotion betamethasone valerate cream, ointment fluocinonide cream, ointment, solution triamcinolone acetonide	amcinonide cream ApexiCon-E® betamethasone dipropionate augmented gel betamethasone valerate lotion desoximetasone diflorasone Diprolene® fluocinonide gel, emollient halcinonide cream, solution (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
V. Dermatologic Agents		
Steroids, Topical – Very High Potency		
clobetasol cream, emollient, gel, ointment, solution halobetasol cream, ointment	Bryhali™ clobetasol foam, lotion, spray, shampoo Clobex® halobetasol foam Olux® Ultravate®	

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Anabolic Steroids – Topical CDRP, F/Q/D		
testosterone gel packets (gen Vogelxo®) testosterone gel pump (gen Androgel)	AndroGel® pump Natesto® Testim® testosterone gel packets (gen AndroGel®) testosterone pump Vogelxo®	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** • For diagnosis of hypogonadotropic or primary hypogonadism: – Requires documented low testosterone concentration with two tests prior to initiation of therapy. – Require documented testosterone therapeutic concentration to confirm response after initiation of therapy. • For diagnosis of delayed puberty: – Requires documentation that growth hormone deficiency has been ruled out prior to initiation of therapy. The Anabolic Steroid fax form can be found at: https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PA_Worksheet_Prescribers_Anabolic_Steroids.pdf For diagnosis of gender dysphoria, see Hormone Replacement Therapy for Treatment of Gender Dysphoria coverage in the DUR section of this document **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Limitations for anabolic steroid products based on approved FDA labeled daily dosing and documented diagnosis: – Duration limit of 6 months for delayed puberty

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Biguanides		
glipizide/metformin glyburide/metformin Glumetza® BLTG metformin HCl metformin ER (gen Glucophage XR®)	metformin solution (gen Riomet®) metformin 625mg, 750mg tablets metformin ER DO (gen Fortamet®, Glumetza®) Riomet®	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths
Bisphosphonates – Oral		
alendronate	Actonel® Atelvia® Binosto® Fosamax® Fosamax® Plus D ibandronate risedronate	
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors		
alogliptin alogliptin/metformin Glyxambi® Janumet® Janumet® XR Januvia® DO Jentadueto® Jentadueto® XR Kazano® Nesina® Onglyza® DO, BLTG Oseni® BLTG Tradjenta®	alogliptin/pioglitazone Qtern® saxagliptin (gen Onglyza®) saxagliptin/metformin sitagliptin (gen Zituvio™) Steglujan® Zituvimet Zituvimet XR Zituvio™	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Glucagon Agents		
Baqsimi® glucagon vial glucagon HCl emergency kit (Fresenius) Gvoke® pen, syringe, vial Zegalogue® pen, syringe	glucagon emergency kit (Eli Lilly, Amphastar)	
Glucagon-like Peptide-1 (GLP-1) Agonists CC		
Byetta® Ozempic® Trulicity® Victoza® BLTG	Bydureon® BCise™ liraglutide (gen Victoza®) Mounjaro® Rybelsus® Soliqua® Xultophy®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Glucocorticoids – Oral		
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®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Growth Hormones CC		
Genotropin® Norditropin®	Humatrope® Ngenla™ Nutropin AQ® NuSpin Omnitrope® Skytrofa® Sogroya® Zomacton®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication • For Diagnosis of Growth Hormone Deficiency (GHD) or Short for Gestational Age (SGA): ○ Prior to initiating growth hormone treatment, documentation of a recommended GHD diagnostic and / or laboratory test (e.g., provocative test and / or IGF-1 test) • Continuation of GH treatment, documentation of a recommended GHD laboratory test annually (e.g., IGF-1 test) and documentation of positive treatment response
Insulin – Long-Acting		
insulin glargine solostar, vial (gen Lantus® Solostar®, vial) insulin glargine-YFGN 1 Lantus® Solostar®, vial	Basaglar® Basaglar® Tempo™ insulin degludec vial, pen (gen Tresiba) insulin glargine max solostar (gen Toujeo® Max Solostar®) insulin glargine solostar (gen Toujeo® Solostar®) Levemir® 2 Rezvoglar™ Semglee®-YFGN: vial, pen Toujeo® Solostar® Toujeo® Max Solostar® Tresiba®	
Insulin – Mixes		
Humalog® 50/50 Mix: pen insulin lispro 75/25 mix: pen (gen Humalog® Mix) insulin aspart prot/insulin aspart: vial, pen (gen Novolog)	Humalog® 75/25 mix: pen, vial Novolog® Mix: vial, pen	

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2 = Non-Preferred as of 2/6/2025

Standard PA fax form:
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
VI. Endocrine and Metabolic Agents		
Insulin – Rapid-Acting		
Apidra® insulin aspart (gen Novolog®) cartridge, vial, pen insulin lispro (gen Humalog® U100) vial, pen insulin lispro junior (gen Humalog® Jr.)	Admelog® Afrezza® Fiasp® Penfill, FlexTouch, Pumpcart, vial Humalog® Jr. 100 U/mL Kwikpen Humalog® 100 U/mL vial, pen, cartridge, Tempo™ Humalog® 200 U/mL Lyumjev® Lyumjev® Tempo™ Novolog® cartridge, vial, FlexPen	
Pancreatic Enzymes		
Creon® Zenpep®	Pertzye® Viokace®	
Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors		
Farxiga® BLTG Jardiance® Synjardy® Synjardy® XR Trijardy® XR Xigduo® XR BLTG	dapagliflozin (gen Farxiga®) dapagliflozin/metformin (gen Xigduo® XR) Inpefa™ Invokamet® 2 Invokamet® XR 2 Invokana® 2 Segluromet® Steglatro®	
Thiazolidinediones (TZDs)		
pioglitazone	ACTOplus Met® Actos® DO Duetact® pioglitazone/glimepiride pioglitazone/metformin	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths

1 = Preferred as of 2/6/2025
2 = Non-Preferred as of 2/6/2025

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IX. Immunologic Agents		
Immunomodulators – Systemic CC, ST		
Cosentyx® Dupixent® Enbrel® Fasenra® Humira® Nucala® Xolair®	Abrilada™ (adalimumab-AFZB) Actemra® subcutaneous adalimumab-AACF (gen Idacio®) adalimumab-AATY (gen Yuflyma®) adalimumab-ADAZ (gen Hyrimoz®) adalimumab-ADBM (gen Cyltezo®) adalimumab-FKJP (gen Hulio®) adalimumab-RYVK (gen Simlandi®) adalimumab-RYVK Adbry™ Amjevita™ Bimzelx® Cibinqo™ Cimzia® Cyltezo® (adalimumab-ADMB) Ebglyss™ Entyvio pen® Hadlima™ Hulio® (adalimumab-FKJP) Hyrimoz® (adalimumab-ADAZ) Idacio® Ilumya® Kevzara® Kineret® Nemluvio® Olumiant® Omvoh™ Orencia® subcutaneous Otezla® Rinvoq™ ER Rinvoq® LQ Selarsdi™	**CLINICAL CRITERIA (CC)** • Confirm diagnosis for FDA- or compendia-supported uses **STEP THERAPY (ST)** For indications not specified below • Trial of a non-specific anti-inflammatory drug such as an aminosalicylate or immunosuppressant, or a disease-modifying anti-rheumatic drug (DMARD) • Trial of a TNF inhibitor prior to treatment with a JAK inhibitor **INDICATION-SPECIFIC REQUIREMENTS:** • Asthma: – history and concurrent use of a corticosteroid • Nasal polyps: – history and concurrent use of an intranasal corticosteroid • Atopic dermatitis: – Trial with a topical prescription product for a duration of at least 3 months. – For JAK inhibitors: Trial of topical prescription product and systemic product for a combined duration of at least 6 months. • COPD: – History and concurrent use of a long acting beta agonist (LABA) + long acting muscarinic agonist (LAMA) + inhaled corticosteroid (ICS)

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IX. Immunologic Agents		
	Siliq™ Simlandi® Simponi® Skyrizi® Skyrizi® On-Body Sotyktu™ Spevigo® Stelara® Steqeyma® Taltz® Tezspire® pen Tremfya® Tyenne® Velsipity™ Xeljanz® Xeljanz® XR Yesintek™ Yuflyma® Yusimry™ Zymfentra™	
Immunosuppressives, Oral		

azathioprine
CellCept® suspension BLTG
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™ CC, F/Q/D
	mycophenolate mofetil suspension
	Myfortic®
	Myhibbin™
	Neoral®
	Prograf®
		CLINICAL CRITERIA (CC)
		• Lupkynis™ (voclosporin):
		  • Confirm diagnosis for FDA- or compendia-supported uses
		  • Confirm concurrent therapy with mycophenolate
		FREQUENCY/QUANTITY/DURATION (F/Q/D)
		• Lupkynis™ limited to 30-day supply

1 = Preferred as of 2/6/2025
2 = Non-Preferred as of 2/6/2025

Standard PA fax form:
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
IX. Immunologic Agents		
	Sandimmune® capsule, solution Zortress®	

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XI. Musculoskeletal Agents		
Skeletal Muscle Relaxants		
baclofen tablet chlorzoxazone 500 mg cyclobenzaprine 5 mg, 10 mg tablet dantrolene methocarbamol orphenadrine ER tizanidine tablet	Amrix® baclofen 15mg tablet baclofen solution baclofen suspension (gen Fleqsuvy™) carisoprodol ST, F/Q/D carisoprodol compound ST, F/Q/D carisoprodol compound/codeine CC, ST, F/Q/D chlorzoxazone (gen Lorzone) 375 mg, 750 mg cyclobenzaprine 7.5 mg cyclobenzaprine ER capsule (gen Amrix) Dantrium® Fexmid® Fleqsuvy™ Lorzone® Lyvispah™ metaxalone orphenadrine-aspirin-caffeine Soma® ST, F/Q/D Soma® 250 ST, F/Q/D Tanlor® tizanidine capsule Zanaflex®	**CLINICAL CRITERIA (CC)** For carisoprodol/codeine products: • Limited to a total of 4 opioid prescriptions every 30 days; exemption for diagnosis of cancer or sickle cell disease • Medical necessity rationale for opioid therapy is required for patients on established opioid dependence therapy • PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy • PA required for any codeine containing products in patients < 12 years **STEP THERAPY (ST)** • Trial with 1 analgesic and 2 skeletal muscle relaxants prior to use of **carisoprodol** containing products **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **Carisoprodol** – Maximum 4 units per day, 21-day supply • **Carisoprodol combinations** – Maximum 8 units per day, 21-day supply (not to exceed the 84 cumulative units per year limit)

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Alpha-2 Adrenergic Agonists (for Glaucoma) – Ophthalmic		
Alphagan P® 0.1% BLTG Alphagan P® 0.15% BLTG brimonidine 0.2% Simbrinza®	apraclonidine brimonidine 0.1% (gen Alphagan P®) brimonidine 0.15% (gen Alphagan P®) Iopidine®	
Antibiotics – Ophthalmic		
bacitracin/polymyxin B erythromycin gentamicin Natacyn® neomycin/gramicidin/polymyxin polymyxin/trimethoprim sulfacetamide solution tobramycin	Azasite® bacitracin neomycin/bacitracin/polymyxin sulfacetamide ointment Tobrex®	
Antibiotics/Steroid Combinations – Ophthalmic		
neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TobraDex® ointment tobramycin/dexamethasone suspension	Maxitrol® neomycin / bacitracin/polymyxin /HC neomycin/polymyxin/HC TobraDex® ST Zylet®	
Antihistamines – Ophthalmic		
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
XII. Ophthalmics		
Anti-inflammatories/Immunomodulators – Ophthalmic CC		
Eysuvis® Restasis® BLTG Restasis MultiDose® Xiidra®	Cequa® cyclosporine (gen Restasis®) Miebo™ Tyrvaya™ Verkazia® Vevye®	**CLINICAL CRITERIA (CC)** • Diagnosis documentation required to justify utilization as a first line agent or attempt treatment with an artificial tear, gel, or ointment.
Beta Blockers – Ophthalmic		
betaxolol Betoptic S® carteolol Combigan® BLTG Istalol® BLTG levobunolol timolol maleate gel	Betimol® brimonidine/timolol (gen Combigan®) timolol 0.5% (gen Betimol®) timolol maleate (gen Timoptic® Ocudose®) timolol maleate solution (gen Istalol®) Timoptic® Ocudose®	
Fluoroquinolones – Ophthalmic		
ciprofloxacin moxifloxacin (gen Vigamox®) ofloxacin	Besivance® Ciloxan® gatifloxacin moxifloxacin (gen Moxeza®) Ocuflox® Vigamox®	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Ophthalmic		
diclofenac flurbiprofen ketorolac ketorolac LS	Acular® Acular LS® Acuvail® bromfenac BromSite® Ilevro® Nevanac® Prolensa®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XIV. Renal and Genitourinary		
Alpha Reductase Inhibitors for BPH		
finasteride	Avodart® dutasteride dutasteride/tamsulosin Proscar®	
Antihyperuricemics		
allopurinol 100 mg, 300 mg colchicine tablet febuxostat probenecid probenecid/colchicine	allopurinol 200 mg colchicine capsule Colcrys Gloperba® Mitigare® Uloric® Zyloprim®	
Cystine Depleting Agents CC		
Cystagon®	Procysbi®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication
Electrolyte Depleters		
Lokelma® sodium polystyrene Veltassa®		
Phosphate Binders/Regulators		
calcium acetate sevelamer carbonate powder, tablet (gen Renvela)	Auryxia™ Fosrenol® lanthanum carbonate Renvela® tablet, powder pack sevelamer HCl (gen Renagel) Velphoro® Xphozah®	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XIV. Renal and Genitourinary		
Selective Alpha Adrenergic Blockers		
alfuzosin tamsulosin	Flomax® Rapaflo® silodosin	
Urinary Tract Antispasmodics		
fesoterodine ER (gen Toviaz®) Myrbetriq® DO, BLTG oxybutynin oxybutynin ER DO solifenacin Toviaz® DO	darifenacin Detrol® Detrol LA® DO flavoxate Gemtesa® mirabegron (gen Myrbetriq®) Myrbetriq® solution F/Q/D Oxytrol® tolterodine tolterodine ER trospium trospium ER Vesicare® DO Vesicare® LS	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Myrbetriq® solution; limited to a 30-day supply
Urea Cycle Disorders		
Buphenyl® powder, tablet Carbaglu® BLTG Olpruva™ Pheburane® Ravicti® sodium phenylbutyrate powder, tablet (gen Buphenyl®)	carglumic acid	
Uterine Disorder Treatments F/Q/D		
Myfembree® Oriahnn® Orilissa®		**LIFETIME QUANTITY LIMIT:** • 24 months cumulative use

NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

NYRx, the Medicaid Pharmacy Program Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">XV. Respiratory</td></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Brovana® / arformoterol</td><td>≥ 18 years</td></tr>
<tr><td>Perforomist® / formoterol</td><td>≥ 18 years</td></tr>
<tr><td>Serevent Diskus®</td><td>≥ 4 years</td></tr>
<tr><td>Striverdi Respimat®</td><td>≥ 18 years</td></tr>
</table>
FREQUENCY/QUANTITY/DURATION (F/Q/D)
Maximum units per 30 days
<table>
<tr><td>Brovana® / arformoterol</td><td>60 units (1 carton of 60 vials or 120 mL)</td></tr>
<tr><td>Perforomist® / formoterol</td><td>60 units (1 carton of 60 vials or 120 mL)</td></tr>
<tr><td>Serevent Diskus®</td><td>1 diskus (60 blisters)</td></tr>
<tr><td>Striverdi Respimat®</td><td>1 unit (one cartridge and one Respimat inhaler)</td></tr>
</table>
</td></tr>
<tr><td colspan="3">Beta2 Adrenergic Agents – Inhaled Short-Acting</td></tr>
<tr><td>albuterol nebulizer solution
albuterol HFA (gen ProAir® HFA)
ProAir® Digihaler™
ProAir® RespiClick
Ventolin HFA® BLTG
Xopenex HFA® BLTG</td><td>Airsupra™
albuterol HFA (gen Ventolin HFA®)
levalbuterol solution
levalbuterol HFA</td><td></td></tr>
<tr><td colspan="3">Corticosteroids – Inhaled</td></tr>
<tr><td>Alvesco®
Arnuity Ellipta®
Asmanex® Twisthaler
fluticasone HFA
Pulmicort® Flexhaler</td><td>ArmonAir® Digihaler®
Asmanex® HFA
fluticasone DISKUS
QVAR RediHaler®</td><td></td></tr>
</table>

NYRx, the Medicaid Pharmacy Program Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">XV. Respiratory</td></tr>
<tr><td colspan="3">Corticosteroid/Beta2 Adrenergic Agent (Long-Acting) Combinations – Inhaled CC, F/Q/D</td></tr>
<tr><td>Advair Diskus® BLTG
Advair HFA® BLTG
Dulera®
Symbicort® BLTG</td><td>AirDuo® Digihaler®
AirDuo™ RespiClick®
Breo Ellipta®
budesonide/formoterol (gen Symbicort)
fluticasone-salmeterol (gen AirDuo™ RespiClick®)
fluticasone-salmeterol (gen Advair Diskus®)
fluticasone-salmeterol (gen Advair HFA™)
fluticasone-vilanterol (gen Breo Ellipta®)</td><td>CLINICAL CRITERIA (CC)
• PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA-or compendia-supported age as indicated:
<table><tr><td>Advair Diskus®</td><td>≥ 4 years</td></tr><tr><td>Advair HFA®</td><td>≥ 12 years</td></tr><tr><td>AirDuo™ RespiClick®</td><td>> 12 years</td></tr><tr><td>Dulera® 100 mcg and 200 mcg</td><td>≥ 12 years</td></tr><tr><td>Dulera® 50 mcg</td><td>≥ 4 years</td></tr><tr><td>fluticasone-salmeterol</td><td>≥ 4 years</td></tr><tr><td>budesonide-formoterol (Symbicort®) 80/4.5 mcg</td><td>≥ 4 years</td></tr><tr><td>budesonide-formoterol (Symbicort®) 160/4.5 mcg</td><td>≥ 12 years</td></tr><tr><td>fluticasone/vilanterol (Breo Ellipta®)</td><td>≥ 18 years</td></tr></table>FREQUENCY/QUANTITY/DURATION (F/Q/D)
<table><tr><td>Advair Diskus®</td><td rowspan="5">One inhaler/diskus every 30 days</td></tr><tr><td>Advair HFA®</td></tr><tr><td>AirDuo™ RespiClick®</td></tr><tr><td>fluticasone-salmeterol</td></tr><tr><td>fluticasone/vilanterol (Breo Ellipta®)</td></tr><tr><td>Budesonide/formoterol (Symbicort®)</td><td rowspan="2">Up to 8 inhalers every 180 days</td></tr><tr><td>Dulera®</td></tr></table></td></tr>
<tr><td colspan="3">Corticosteroids – Intranasal</td></tr>
<tr><td>budesonide OTC
Dymista® BLTG
fluticasone
fluticasone OTC
Nasonex® OTC
Omnaris®
triamcinolone OTC
Zetonna®</td><td>azelastine-fluticasone (gen Dymista®)
flunisolide
mometasone Rx, OTC
QNASL® CC
Ryaltris®
Xhance™</td><td>CLINICAL CRITERIA (CC)
• Clinical consideration in regard to drug interactions will be given to patients with HIV/AIDs diagnosis or antiretroviral therapy in history</td></tr>
</table>

1 = Preferred as of 2/6/2025
2 = Non-Preferred as of 2/6/2025

Standard PA fax form:
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
XV. Respiratory		
Leukotriene Modifiers		
montelukast tablet, chew tab	Accolate® montelukast granules Singulair® zafirlukast	

NYRx, the Medicaid Pharmacy Program Preferred Drug List

NYS Medicaid NYRx Clinical Drug Review Program (CDRP)

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

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

Prior Authorization

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

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

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

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

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

- Anabolic Steroids: https://newyork.fhsc.com/providers/CDRP_anabolic_steroids.asp

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 58.

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

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

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anabolic Steroids – Injectable • testosterone cypionate (Depo-Testosterone®, Azmiro™) • testosterone enanthate (Xyosted®)* Anabolic Steroids – Oral • testosterone undecanoate (Jatenzo®, Tlando®, Undecatrex) • methyltestosterone (Methitest®) oxandrolone		• Limitations for anabolic steroid products is based on approved FDA labeled daily dosing and documented diagnosis not to exceed a 90-day supply (30-day supply for oxandrolone): • Xyosted® is limited to no more than 3 boxes for 90 days (1 box per 30 days) • Initial duration limit of 3 months (for all products except oxandrolone), requiring documented follow-up monitoring for response and/or adverse effects before continuing treatment • Duration limit of 6 months for delayed puberty • Duration limit of 1 month for all uses of oxandrolone products	*for additional parameters, see Hormone Replacement Therapy for Treatment of Gender Dysphoria section below.
Anti-Diarrheal Agents • alosetron (Lotronex®) • crofelemer (Mytesi®) • eluxadoline (Viberzi®) •	• Irritable Bowel Syndrome w/Diarrhea – Trial of eluxadoline and rifaximin prior to alosetron. • Symptomatic relief of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy – Trial with an alternative anti-diarrheal agent. • Carcinoid Syndrome – Trial with and concurrent use with a somatostatin analog		• Confirmation of FDA-approved or compendia-supported indication.

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

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

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Hormone Replacement Therapy for Treatment of Gender Dysphoria • conjugated estrogens • estradiol • testosterone cypionate (Azmiro™) • testosterone enanthate (Xyosted™) • testosterone gel 1.62% (AndroGel®)* • testosterone patch*			• Confirm diagnosis of FDA-approved or compendia-supported indication • For diagnosis of gender dysphoria please refer to October 2023 edition of the Medicaid Update: https://www.health.ny.gov/health_care/medicaid/program/update/2023/no15_2023-10.htm#hormones *Subject to Anabolic Steroids – Topical PDL class criteria
dextromethorphan / quinidine (Nuedexta®)		**QUANTITY LIMIT:** • 2 capsules per day; 60 units per 30 days **DURATION LIMIT:** • 90 days of therapy	For patients ≥ 18 years of age: • Confirm diagnosis of FDA-approved or compendia-supported indication
Diabetic Test Strips		**QUANTITY LIMIT:** • Type I DM – max 300 test strips per 30-day supply • Type II DM – max 100 test strips per 30-day supply	• Preferred diabetic supply program https://newyork.fhsc.com/providers/diabeticsupplies.asp
dronabinol (Marinol®)	Step therapy for beneficiaries with HIV/AIDS, or cancer, AND eating disorder: • Trial with megestrol acetate suspension prior to dronabinol Step therapy for beneficiaries with diagnosis of cancer and nausea/vomiting: • Trial with a NYS Medicaid-preferred 5-HT3 receptor antagonist prior to dronabinol		• Confirm diagnosis of FDA-approved or compendia-supported indication

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
risdiplam (Evrysdi®)			• Confirm diagnosis of FDA-approved indication • Confirm absence of advanced disease
Fentanyl Transmucosal Agents • fentanyl (lozenge) • fentanyl (Fentora®) (buccal tablet)		**QUANTITY LIMIT:** fentanyl lozenge, Fentora®: • 4 units per day, 120 units per 30 days **DURATION LIMIT:** • 90 days • Exemption for diagnosis of cancer, sickle cell disease, or hospice care	• Confirm diagnosis • Limited to a total of 4 opioid prescriptions every 30 days; • For opioid-naïve patients: limited to a 7 days' supply for all initial opioid prescriptions, • PA required for use if > 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting > 7 days). • PA required for initiation of opioid therapy for patients on established opioid dependence therapy • PA is required for initiation of opioid therapy in patients currently on benzodiazepine therapy • Exemption for diagnosis of cancer, sickle cell, or hospice care
HIV PrEP (Pre-Exposure Prophylaxis Agents): • cabotegravir (Apretude) • emtricitabine/tenofovir disoproxil fumarate (Truvada®) • emtricitabine/tenofovir alafenamide (Descovy®)			• Confirmation of negative HIV test every 3 months

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Imcivree™ (setmelanotide)			• Confirm diagnosis of FDA approved or compendia supported indication. • Please be prepared to respond to a series of questions that identify the prescriber, the patient, and the reason for prescribing this drug. • Please be prepared to fax clinical documentation upon request. The Imcivree fax form can be found at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_Imcivree.pdf
ivermectin (oral)			• Confirm diagnosis of FDA-approved or compendia-supported indication
Lidocaine patches • lidocaine (Lidoderm®, ZTLido™)			• Prescribers, or their authorized agents, are required to respond to a series of questions that identify the prescriber, the patient, and the reason for prescribing this drug. • Prescriptions can be written for a 30-day supply with up to 2 refills

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
methadone	• Requires a trial of a long-acting opioid prior to initiation for the management of chronic non-cancer pain	**QUANTITY LIMIT:** • 12 units per day, 360 units per 30 days • Exemption for diagnosis of cancer, hospice care, or sickle cell disease	• Confirm diagnosis of chronic non-cancer pain • Limited to a total of 4 opioid prescriptions every 30 days; • PA required for initiation of methadone for patients on established opioid dependence therapy • PA required for methadone prescriptions for patients currently on long-acting opioid therapy. • PA required for initiation of long-acting opioid therapy in opioid-naïve patients. • PA required for use if > 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting > 7 days). PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy • Exemption for diagnosis of cancer, sickle cell, or hospice care
metoclopramide nasal spray (Gimoti™)			• Metoclopramide nasal spray confirm diagnosis of diabetes
Ovulation Enhancing Drugs • bromocriptine • clomiphene • letrozole • tamoxifen			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Refer to https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-06.htm#ovulation

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Oxazolidinone Antibiotics • linezolid (Zyvox®) • tedizolid (Sivextro®)			• Please be prepared to respond to a series of questions that identify the prescriber, the patient, and the reason for prescribing this drug. • Please be prepared to fax clinical documentation upon request.
Pubertal Suppressants • leuprolide acetate (Lupron Depot-PED®, Eligard®, Fensolvi®, Lupron Depot®) • nafarelin acetate (Synarel®) • triptorelin (Triptodur®)			• Confirm diagnosis of FDA-approved or compendia-supported indication • Refer to https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender for Transgender Related Care and Services Update

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
esketamine (Spravato®)	• Treatment Resistant Depression: trial of at least two oral antidepressants		• Confirm diagnosis of FDA approved indication for patients ≥18 years of age • Before initiating esketamine nasal spray (Spravato), prescribers must attest that they have obtained a baseline score using a validated clinical assessment tool for depression (e.g., HAMD17, QIDS-C16C, MADRS). • After the initiation of esketamine nasal spray (Spravato) therapy, every six months prescribers must attest that esketamine nasal spray (Spravato) has resulted in an improvement of depressive symptoms (from baseline) using the same baseline clinical assessment tool for depression (e.g., HAMD17, QIDS-C16C, MADRS).The esketamine worksheet can be accessed at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_Spravato.docx
tasimelteon (Hetlioz®,Hetlioz® LQ)		**QUANTITY LIMIT:** • One unit per day; 30 units per 30 days	• Confirm diagnosis of FDA-approved or compendia-supported indication

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Parathyroid Hormone Analogs • teriparatide (Forteo®) • abaloparatide (Tymlos®)	• Requires a trial with a preferred oral bisphosphonate	**QUANTITY LIMIT:** • One unit per 30-day period **LIFETIME QUANTITY LIMIT:** • 25 months' cumulative use of a PTH analog	
Topical Compounded Prescriptions			• Confirm diagnosis of FDA-approved or compendia-supported indication • For non-opioid pain management alternatives please visit: https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf
Zoryve®			• Confirm diagnosis of FDA-approved or compendia-supported indication • Minimum age: 9 years (foam) • Minimum age: 6 years (cream) with diagnosis of atopic dermatitis

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

Medication Assisted Treatment (MAT) Formulary

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**
Opioid Antagonists	
Kloxxado™ naloxone (syringe, vial, nasal spray) naloxone (nasal spray) OTC naltrexone Narcan® (nasal spray) Narcan® OTC Opvee® Rextovy® Zimhi™*	n/a
Opioid Dependence Agents – Injectable	
Brixadi™ Sublocade™ Vivitrol®	n/a
Opioid Dependence Agents – Oral/Transmucosal F/Q/D	
buprenorphine (tablet) buprenorphine/naloxone (tablet) buprenorphine/naloxone (film) Suboxone® (film) Zubsolv®	**QUANTITY LIMIT:** • **buprenorphine sublingual (SL):** Eight tablets dispensed as a 2-day supply; not to exceed 32 mg per day • **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. • **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 • **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 **RELATED CLINICAL CRITERIA (CC)** • PA required for initiation of **opioid therapy** for patients on established opioid dependence therapy • PA required for initiation of a **CNS stimulant** for patients established on opioid dependence therapy **

NYS Medicaid NYRx Brand Less Than Generic (BLTG) Program

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

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

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

Effective March 20, 2025:

- No agents will be **added** to the program
- Ritalin LA® and Zegerid® Rx will be **removed** from the program

List of Brand Name Drugs included in this program**		
Advair Diskus®	Forteo®	Sandostatin LAR®
Advair HFA®	Glumetza®	Spiriva® Handihaler®
Alphagan P® 0.15%	Istalol®	Sprycel®
Alphagan P® 0.1%	Kitabis® Pak	Symbicort®
Apriso®	Myrbetriq®	Tegretol® suspension
Azopt™	Nexavar®	Tegretol® XR
Bethkis®	NuvaRing®	Trileptal® suspension
Carbaglu®	Onglyza®	Ventolin® HFA
CellCept® suspension	Oseni®	Victoza®
Combigan®	Pentasa®	Votrient®
Copaxone® 20 mg SQ	Pradaxa®	Vyvanse® capsules
Daytrana®	Protonix® suspension	Xigduo® XR
Depakote® Sprinkle	Pylera®	Xopenex HFA®
Dymista®	Restasis®	Zavesca®
EpiPen	Retin-A® cream	
EpiPen, Jr	Risperdal Consta®	
Farxiga®		

**List is subject to change

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

Important Billing Information

- Pursuant to this program, prescription claims submitted to the Medicaid program **do not require** the submission of Dispense as Written/Product Selection Code of '1'; **Pharmacies should submit DAW code 9** (Substitution Allowed by Prescriber but Plan Requests Brand)**.** Pharmacies will receive an NCPDP reject response of "22" which means missing/invalid DAW code if other DAW codes are submitted. The only exception to this is DAW code 1 and "*Brand Medically Necessary"* on the prescription*.*
- For more information on the Brand Less Than Generic (BLTG) Program, please refer to https://newyork.fhsc.com/providers/bltgp_about.asp

NYS Medicaid NYRx Mandatory Generic Drug Program

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

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

Prior Authorization Process

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

Exempt Drugs

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

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

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

NYS Medicaid NYRx Dose Optimization Program

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

Dose Optimization Chart

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

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Anticonvulsants			
Aptiom® 200 mg, 400 mg	1 daily	Tablet	
Fycompa® 4 mg, 6 mg	1 daily	Tablet	
topiramate ER 100 mg	1 daily	Capsule	
Lamictal XR® 50 mg	1 daily	Tablet	In case of dose titration for these medications, the department will allow for multiday dosing (up to 2 doses daily) for titration purposes for 90 days
Oxtellar XR® 300 mg	1 daily	Tablet	In case of dose titration for these medications, the department will allow for multiday dosing (up to 2 doses daily) for titration purposes for 90 days
Lyrica® 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg	3 daily	Tablet	Electronic bypass for diagnosis of seizure disorder identified in medical claims data. In case of dose titration for these medications, the department will allow for multiday dosing (up to 2 doses daily) for titration purposes for 3 months
Lyrica® 225 mg and 300 mg	2 daily	Tablet	
Trokendi XR® 100 mg	1 daily	Tablet	
Antiparkinson Agents			
Azilect® 0.5 mg	1 daily	Tablet	
Antipsychotics – Second Generation			
Abilify® 2 mg	4 daily	Tablet	
Abilify® 5 mg, 10 mg, 15 mg	1 daily	Tablet	In case of dose titration for these medications, the Department will allow for multiday dosing (up to 2 doses/daily) for titration purposes for three months
aripiprazole 5 mg, 10 mg, 15 mg	1 daily	Tablet	
Invega® 1.5 mg, 3 mg	1 daily	Tablet	
Latuda® 20 mg, 40 mg, 60 mg	1 daily	Tablet	
olanzapine 5 mg, 10 mg	1 daily	Tablet	
olanzapine ODT 5 mg, 10 mg	1 daily	Tablet	
paliperidone er 1.5 mg, 3 mg	1 daily	Tablet	
quetiapine fumarate er 200 mg, 150 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	
Vraylar® 1.5 mg, 3 mg	1 daily	Capsule	
Zyprexa® Zydis 5 mg, 10 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
CNS Stimulants			
Adderall® XR 5 mg, 10 mg, 15 mg	1 daily	Capsule	
amphetamine salt combo ER 5 mg, 10 mg, 15 mg	1 daily	Capsule	
Concerta® ER 18 mg, 27 mg	1 daily	Tablet	
dexmethylphenidate ER 10 mg, 20 mg (Focalin XR generic)	1 daily	Capsule	
Focalin® XR 5 mg, 10 mg, 15 mg, 20 mg	1 daily	Capsule	
methylphenidate CD 10 mg, 20 mg	1 daily	Capsule	
methylphenidate er 18 mg (Concerta® generic)	1 daily	Tablet	
methylphenidate la 20 mg (Ritalin® LA generic)	1 daily	Capsule	
modafinil 100 mg	1 daily	Tablet	
Provigil® 100 mg	1 daily	Tablet	
QuilliChew® ER 20 mg	1 daily	Tablet	
Ritalin® LA 10 mg, 20 mg	1 daily	Capsule	
Vyvanse® 10 mg, 20 mg, 30 mg, 40 mg	1 daily	Capsule	
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)			
guanfacine ER 1 mg, 2 mg	1 daily	Tablet	
atomoxetine 40 mg	1 daily	Capsule	
Intuniv® 1 mg, 2 mg	1 daily	Tablet	
Strattera® 40 mg	1 daily	Capsule	
Sedative Hypnotics			
Lunesta® 1 mg	1 daily	Tablet	
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)			
Effexor® XR 37.5 mg, 75 mg, 150 mg	1 daily	Capsule	In the case of dose titration for these medications, the Department will allow for multiday dosing (up to 2 doses/daily) for titration purposes for three months.
desvenlafaxine succinate ER (Pristiq® ER 50 mg)	1 daily	Tablet	
Selective Serotonin Reuptake Inhibitors (SSRIs)			
Lexapro® 5 mg, 10 mg	1 daily	Tablet	
Trintellix® 5 mg, 10 mg	1 daily	Tablet	

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

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

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

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

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

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

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

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

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