

# **NYRx, the New York Medicaid Pharmacy Program**

## **OVERVIEW OF CONTENTS**

Electronic prior authorizations are now accepted by NYRx, the Medicaid Pharmacy Program via [CoverMyMeds®](#). Consider this alternative option as an effective and efficient way to request a PA other than by phone or by fax. For more information, contact NYRx Education & Outreach at [NYRxEO@primetherapeutics.com](mailto:NYRxEO@primetherapeutics.com)

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

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

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

**Note:** Not all drugs covered by NYRx are subject to programs included in this document. For a complete list of drugs covered by NYRx see the [Medicaid Pharmacy List of Reimbursable Drugs](#)

### **Clinical Drug Review Program (CDRP) (Page 61)**

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

### **Drug Utilization Review (DUR) Program (Pages 62–74)**

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

### **Medication Assisted Treatment (MAT) Formulary (Page 75)**

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

### **Brand Less Than Generic (BLTG) Program (Pages 76–77)**

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

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

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

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

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

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

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

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

## **Dose Optimization Program (Pages 79–83)**

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

## **Cost Optimization Program (Page 84)**

The Cost Optimization Program focuses on new formulations and dosages of older drug products that are disproportionately priced to other strengths of the same drug or similar drugs in the same drug class without any additional clinical benefit. This program can reduce prescription costs by encouraging the use of multiple or half of the lower cost strength, or choosing the lower cost formulation (e.g., tablets versus capsules), or choosing a lower cost therapeutic comparable drug in the same drug class.

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

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>I. Analgesics</b>		
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) <sup>CC</sup></b>		
<p>Celebrex<sup>®</sup>                      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</p>	<p>Arthrotec<sup>®</sup>                      Coxanto<sup>™</sup> <sup>MR</sup>                      Daypro<sup>®</sup>                      diclofenac epolamine patch                      diclofenac capsule                      diclofenac/misoprostol                      diclofenac potassium 25 mg tablet  <sup>MR</sup>                      diclofenac potassium tablet                      diclofenac potassium (gen                      Cambia<sup>®</sup>)                      diclofenac sodium ER                      diclofenac topical soln                      diflunisal                      Dolobid <sup>MR</sup>                      Elyxyb<sup>™</sup> <sup>F/Q/D</sup>                      etodolac                      etodolac ER                      Feldene<sup>®</sup>                      fenoprofen                      Fenopron<sup>™</sup> <sup>MR</sup>                      flurbiprofen                      ibuprofen 300 mg <sup>MR</sup>                      ibuprofen/famotidine (gen Duexis<sup>®</sup>)                      indomethacin ER                      indomethacin suspension                      ketoprofen                      ketoprofen ER                      ketorolac nasal spray (gen Sprix<sup>®</sup>)                      Kiprofen<sup>™</sup>                      meclofenamate                      mefenamic acid                      meloxicam capsule (gen Vivlodex<sup>®</sup>)  <sup>MR</sup></p>	<p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>PA required for patients utilizing two (2) or more NSAIDs concurrently.</li> </ul> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <ul style="list-style-type: none"> <li>Elyxyb<sup>™</sup> (celecoxib) – 4.8 mL bottle (120 mg) maximum quantity: 9 bottles / 30 days</li> </ul>

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<b>I. Analgesics</b>		
	Nalfon® Naprelan® naproxen susp naproxen CR naproxen EC naproxen-esomeprazole naproxen sodium oxaprozin oxaprozin capsule <b>MR</b> Relafen® DS <b>MR</b> tolmetin <b>MR</b> Vimovo®	
<b>Opioids – Long-Acting <b>CC</b></b>		
buprenorphine patch fentanyl patch (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg) morphine sulfate ER tablet	Belbuca® Butrans® ConZip® <b>ST</b> 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 <b>ST</b>	<b>CLINICAL CRITERIA (CC) *</b> <ul style="list-style-type: none"> <li>Limited to a total of 4 opioid prescriptions every 30 days; Exemption for diagnosis of cancer, hospice or palliative care, or sickle cell disease</li> <li>PA required for initiation of opioid therapy for patients on established opioid dependence therapy</li> <li>PA required for use if <math>\geq 90</math> MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting &gt; 7 days) PA required for initiation of long-acting opioid therapy in opioid-naïve patients.</li> <li>PA required for any additional long-acting opioid prescription for patients currently on long-acting opioid therapy.</li> <li>PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy</li> <li>PA required for any codeine- or tramadol-containing products in pts &lt; 12 years</li> </ul> <b>STEP THERAPY (ST)</b>

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

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<b>I. Analgesics</b>		
		<ul style="list-style-type: none"> <li>• <b>Tramadol ER (tramadol naïve patients):</b> Attempt treatment with IR formulations before the following ER formulations: ConZip®, tramadol ER</li> </ul> <p>*Exemption from requirements for diagnosis of cancer, sickle cell disease, or hospice or palliative care.</p>
<b>Opioids – Short-Acting <sup>CC</sup></b>		
butalbital/APAP/caffeine/codeine codeine codeine/APAP hydrocodone/APAP hydrocodone/ibuprofen hydromorphone tablets morphine IR oxycodone IR tablets, solution oxycodone/APAP tramadol tablet	butalbital compound/codeine butorphanol nasal spray dihydrocodeine/APAP/caffeine Dilaudid® hydromorphone solution levorphanol meperidine Nalocet® oxycodone IR capsules, concentrate oxycodone/APAP (Prolate) tablets oxymorphone pentazocine/naloxone Percocet® RoxyBond Roxicodone® Seglentis® tramadol solution tramadol 25mg, 75mg tablet tramadol/APAP	<p><b>CLINICAL CRITERIA (CC) *</b></p> <ul style="list-style-type: none"> <li>• Limited to a total of 4 opioid prescriptions every 30 days.</li> <li>• Initial prescription for opioid-naïve patients limited to a 7-day supply.</li> <li>• PA required for initiation of opioid therapy for patients on established opioid dependence therapy.</li> <li>• PA required for use if ≥ 90 MME of opioid per day for management of non-acute pain (&gt; 7 days)                             <ul style="list-style-type: none"> <li>– Exception for diagnosis of cancer or sickle cell disease, or hospice or palliative care programs</li> </ul> </li> <li>• PA is required for opioid-naïve patients for prescription requests ≥ 50 MME per day.</li> <li>• PA required for continuation of opioid therapy beyond an initial 7-day supply in patients established on gabapentin or pregabalin</li> <li>• PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy</li> <li>• PA required for any codeine- or tramadol-containing products in pts &lt; 12 years</li> </ul> <p><b>PA required for continuation of opioid therapy for &gt;7days for patients on established CNS stimulant therapy</b></p> <p><b>STEP THERAPY (ST)</b></p> <ul style="list-style-type: none"> <li>• For Non-opioid Pain management alternatives please visit: <a href="https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf">https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf</a></li> </ul> <p>*Exemptions from requirements for diagnosis of cancer, sickle cell disease, or hospice or palliative care</p>

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

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Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>II. Anti-Infectives</b>		
<b>Cephalosporins – Third Generation</b>		
cefdinir	cefixime cefpodoxime	
<b>Fluoroquinolones – Oral</b>		
Cipro <sup>®</sup> suspension <b>BLTG</b> ciprofloxacin tablet levofloxacin tablet moxifloxacin	Baxdela <sup>®</sup> Cipro <sup>®</sup> tablet ciprofloxacin suspension levofloxacin solution ofloxacin tablet	
<b>Hepatitis B Agents</b>		
adefovir dipivoxil Baraclude <sup>®</sup> solution entecavir lamivudine HBV	Baraclude <sup>®</sup> tablet Vemlidy <sup>®</sup>	
<b>Hepatitis C Agents – Direct Acting Antivirals</b>		
Mavyret <sup>™</sup> ribavirin sofosbuvir/velpatasvir (gen Epclusa <sup>®</sup> ) Vosevi <sup>®</sup>	Epclusa <sup>®</sup> Harvoni <sup>®</sup> ledipasvir/sofosbuvir (gen Harvoni <sup>®</sup> ) Sovaldi <sup>®</sup> Zepatier <sup>®</sup>	
<b>Tetracyclines</b>		
demeclocycline doxycycline hyclate minocycline capsule tetracycline capsule	Doryx <sup>®</sup> <b>ST</b> Doryx MPC <sup>®</sup> <b>ST</b> doxycycline hyclate DR <b>ST</b> doxycycline monohydrate minocycline tablet minocycline ER tablet Nuzyra <sup>™</sup> tetracycline 250 mg tablet <b>MR</b> tetracycline 500 mg tablet	<b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>Trial of doxycycline IR before progressing to doxycycline DR</li> </ul>

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

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<b>III. Cardiovascular</b>		
<b>Angiotensin Converting Enzyme Inhibitors (ACEIs)</b>		
benazepril enalapril lisinopril ramipril	Accupril® Altace® captopril enalapril (gen Epaned®) Epaned® fosinopril Lotensin® moexipril perindopril Qbrelis™ quinapril trandolapril Zestril®	
<b>ACE Inhibitor Combinations</b>		
benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ lisinopril/HCTZ Lotre® trandolapril/verapamil ER	Accuretic® fosinopril/HCTZ Lotensin HCT® quinapril/HCTZ Zestoretic®	
<b>Angiotensin Receptor Blockers (ARBs)</b>		
irbesartan losartan olmesartan telmisartan valsartan tablet	Arbli™ Atacand® Avapro® Benicar® <b>DO</b> candesartan Cozaar® Diovan® <b>DO</b> Edarbi® eprosartan	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul>

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Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>III. Cardiovascular</b>		
<b>ARBs Combinations</b>		
Exforge HCT® irbesartan/HCTZ losartan/HCTZ olmesartan/amlodipine olmesartan/HCTZ sacubitril/valsartan (gen Entresto®) telmisartan/HCTZ valsartan/amlodipine valsartan/amlodipine/HCTZ valsartan/HCTZ	Atacand HCT® Avalide® Azor® Benicar HCT® <b>DO</b> candesartan/HCTZ Diovan HCT® <b>DO</b> Edarbyclor® <b>DO</b> Entresto® Entresto® Sprinkle Exforge® <b>DO</b> Hyzaar® Micardis HCT® <b>DO</b> olmesartan/amlodipine/HCTZ telmisartan/amlodipine Tribenzor®	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul>
<b>Beta Blockers</b>		
atenolol carvedilol Hemangeol® labetalol metoprolol succ. XL metoprolol tartrate propranolol tablet propranolol ER	acebutolol betaxolol bisoprolol Bystolic® <b>DO</b> carvedilol ER Inderal LA® Inderal XL® InnoPran XL® Kaspargo™ Sprinkle Lopressor® nadolol <b>DO</b> nebivolol (gen Bystolic®) pindolol propranolol solution Tenormin® timolol	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul>

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Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>III. Cardiovascular</b>		
	Toprol XL <sup>®</sup> <a href="#">DO</a>	
<b>Beta Blockers / Diuretics</b>		
atenolol/chlorthalidone bisoprolol/HCTZ	metoprolol tartrate/ HCTZ Tenoretic <sup>®</sup>	
<b>Calcium Channel Blockers (Dihydropyridine)</b>		
amlodipine felodipine ER isradipine nicardipine HCl nifedipine nifedipine ER/SA	Katerzia <sup>™</sup> levamlodipine nisoldipine Norliqva <sup>®</sup> Norvasc <sup>®</sup> Procardia XL <sup>®</sup> Sular <sup>®</sup>	
<b>Cholesterol Absorption Inhibitors</b>		
cholestyramine cholestyramine light Colestid <sup>®</sup> tablet colestipol tablet ezetimibe	colesevelam Colestid granules, packet colestipol granules, packet Questran <sup>®</sup> Questran Light <sup>®</sup> Welchol <sup>®</sup> Zetia <sup>®</sup>	
<b>HMG-CoA Reductase Inhibitors (Statins)</b>		
atorvastatin lovastatin pravastatin rosuvastatin simvastatin	Altoprev <sup>®</sup> Atorvaliq <sup>®</sup> atorvastatin/amlodipine Caduet <sup>®</sup> Ezallor <sup>™</sup> Sprinkle ezetimibe/simvastatin fluvastatin fluvastatin ER Lescol XL <sup>®</sup> Lipitor <sup>®</sup> Livalo <sup>®</sup>	

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Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>III. Cardiovascular</b>		
	pitavastatin (gen Livalo®) Vytorin® Zocor® Zypitamag™	
<b>Phosphodiesterase Type-5 (PDE-5) Inhibitors for PAH <sup>CC</sup></b>		
sildenafil tadalafil	Adcirca® Opsynvi® Revatio® Tadliq®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>PA is required for all drugs in this class</li> <li>Prescribers or their authorized agents are required to respond to a series of questions that identify prescriber, patient, and reason for prescribing drug</li> <li>Please be prepared to fax clinical documentation upon request</li> <li>Prescriptions can be written for a 30-day supply with up to 11 refills</li> </ul>
<b>Pulmonary Arterial Hypertension (PAH) Agents, Other</b>		
ambrisentan (gen Letairis) bosentan tablets (gen Tracleer®)	Adempas® bosentan tablets for susp (gen Tracleer®) Letairis® Opsumit® Orenitram® ER tablet, dosepack Tracleer® tablet for suspension, tablet Tyvaso® Uptravi® Winrevair™ Yutrepia™	
<b>Triglyceride Lowering Agents</b>		
fenofibrate tablet (gen Tricor®) fenofibrate capsule, tablet (gen Lofibra®) fenofibric acid capsule (gen Trilipix®) gemfibrozil icosapent <sup>F/Q/D</sup>	fenofibrate caps (gen Lipofen®) fenofibrate micronized capsule fenofibrate tablet (gen Fenoglide®) fenofibric acid tablet (gen Fibracor®) Fibracor® Lipofen® Lopid®	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>omega-3-acid ethyl esters (gen Lovaza®) and icosapent ethyl – Required dosage equal to 4 grams per day</li> </ul>

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Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>III. Cardiovascular</b>		
omega-3-acid ethyl esters (gen Lovaza®) <sup>F/Q/D</sup>	Tricor® Trilipix®	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>IV. Central Nervous System</b>		
<b>Alzheimer's Agents</b>		
donepezil 5 mg, 10 mg, ODT galantamine galantamine ER memantine Namenda® rivastigmine capsule, patch	Adlarity® Aricept® donepezil 23 mg Exelon® patch memantine ER memantine-donepezil ER (gen Namzaric®) Namenda XR® Namzaric® Zunveyl® DR	
<b>Anticonvulsants – Carbamazepine Derivatives</b>		
carbamazepine chewable Carbatrol® <span style="color: red;">BLTG</span> Equetro® oxcarbazepine Oxtellar XR® <span style="color: red;">DO, BLTG</span> Tegretol® suspension, tablet <span style="color: red;">BLTG</span> Tegretol XR® <span style="color: red;">BLTG</span>	Aptiom® <span style="color: red;">CC, DO</span> carbamazepine suspension carbamazepine tablet carbamazepine ER capsule carbamazepine XR tablet eslicarbazepine (gen Aptiom) <span style="color: red;">CC</span> oxcarbazepine ER (gen Oxtellar XR®) Trileptal® <span style="color: red;">CC</span>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA</li> </ul> <b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul>
<b>Anticonvulsants - Nasal</b>		
Nayzilam® Valtoco®		
<b>Anticonvulsants – Other</b>		
clobazam tablet <span style="color: red;">ST, CC</span> gabapentin capsule, solution, tablet <span style="color: red;">F/Q/D, CC</span> lacosamide tablet, solution lamotrigine tablet, chew levetiracetam levetiracetam ER	Banzel® Briviact® clobazam suspension <span style="color: red;">ST</span> Diacomit® <span style="color: red;">CC</span> Elepsia® XR Epidiolex® <span style="color: red;">CC</span> Eprontia™ <span style="color: red;">CC, F/Q/D</span>	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul> <b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA</li> <li><b>Cannabidiol extract (Epidiolex®)</b> – Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered</li> </ul>

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

# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>IV. Central Nervous System</b>		
Lyrica® capsule <span style="color: red;">DO, F/Q/D, CC</span> pregabalin capsule <span style="color: red;">F/Q/D, CC</span> tiagabine topiramate <span style="color: red;">CC</span> zonisamide	felbamate Felbatol® Fintepla® Fycompa® <span style="color: red;">DO</span> Gabarone™ <span style="color: red;">F/Q/D, CC, MR</span> Keppra® Keppra XR® Lamictal® tablet, chew, dosepak Lamictal® ODT tablet, dosepak Lamictal® XR <span style="color: red;">DO</span> tablet, dosepak lamotrigine dosepak lamotrigine ER lamotrigine ODT dosepak levetiracetam 250mg tablet for suspension (gen Spritam®) Lyrica® solution <span style="color: red;">F/Q/D, CC</span> Lyrica® CR <span style="color: red;">F/Q/D, CC</span> Motpoly XR Neurontin® <span style="color: red;">F/Q/D, CC</span> Onfi® <span style="color: red;">ST, CC</span> perampanel (gen Fycompa®) pregabalin solution <span style="color: red;">F/Q/D, CC</span> pregabalin ER (gen Lyrica® CR) <span style="color: red;">F/Q/D, CC</span> Qudexy® XR <span style="color: red;">CC, DO</span> rufinamide (gen Banzel®) Sabril® Spritam® Subvenite® suspension Sympazan® film <span style="color: red;">ST, CC</span> Topamax® <span style="color: red;">CC</span> topiramate 50mg Sprinkle <span style="color: red;">CC</span>	indication, or; Institutional Review Board (IRB) approval with signed consent form <ul style="list-style-type: none"> <li>• <b>Lyrica®/Lyrica® CR (pregabalin/pregabalin ER)</b> – PA required for the initiation of pregabalin at &gt; 150 mg per day in patients currently on an opioid at &gt; 50 MME per day</li> <li>• <b>Neurontin® (gabapentin)</b> – PA required for initiation of gabapentin at &gt; 900 mg per day in patients currently on an opioid at &gt; 50 MME per day</li> <li>• <b>Stiripentol (Diacomit®)</b> – Require diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form</li> <li>• <b>Topiramate IR/ER (Eprontia™, Qudexy® XR, Topamax®, Trokendi XR™)</b> – Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>• <b>Onfi®/Sympazan® (clobazam):</b> <ul style="list-style-type: none"> <li>– Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>– PA required for initiation of clobazam therapy in patients currently on opioid or oral buprenorphine therapy</li> <li>– PA required for any clobazam prescription in patients currently on benzodiazepine therapy</li> </ul> </li> <li>• <b>Vigafyde™ (vigabatrin):</b> <ul style="list-style-type: none"> <li>– Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> </ul> </li> </ul> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <ul style="list-style-type: none"> <li>• <b>Eprontia™ (topiramate)</b> – Maximum quantity: 473 mL per month</li> <li>• <b>Lyrica®/Lyrica® CR (pregabalin/pregabalin ER)</b> – Maximum daily dose of IR: 600 mg per day, and ER: 660 mg per day</li> <li>• <b>Neurontin® (gabapentin)</b> – Maximum daily dose of 3,600 mg per day</li> </ul>

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	topiramate ER <span style="color: red;">CC, DO</span> (gen Qudexy® XR) topiramate ER <span style="color: red;">CC, DO</span> (gen Trokendi XR®) topiramate soln <span style="color: red;">CC, F/Q/D</span> (gen Eprontia™) Trokendi XR® <span style="color: red;">CC, DO</span> vigabatrin Vigafyde™ <span style="color: red;">CC</span> Vimpat® Xcopri® Zonisade™ Ztalmy®	<b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>• <b>Onfi®/Sympazan® (clobazam)</b> – Requires a trial with an SSRI or SNRI for treatment of anxiety</li> </ul>																		
<b>Antimigraine Agents, Other <span style="color: red;">F/Q/D</span></b>																				
Aimovig® Ajovy® Emgality® 120 mg syringe, pen Qulipta® <span style="color: red;">ST</span> Ubrelvy™ <span style="color: red;">ST</span>	Emgality® 100mg syringe Nurtec® ODT <span style="color: red;">CC, ST</span> Reyvow™ <span style="color: red;">ST</span> Zavzpret™ <span style="color: red;">ST</span>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> </ul> <b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>• <b>Qulipta®</b> - Requires trial of a preferred monoclonal antibody</li> <li>• <b>Acute treatment of migraine</b> - Trial of a product from the Antimigraine Agents-Triptan class</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <table border="1" data-bbox="1052 1105 2007 1468"> <thead> <tr> <th data-bbox="1052 1105 1591 1149">Agent</th> <th data-bbox="1598 1105 2007 1149">F/Q/D</th> </tr> </thead> <tbody> <tr> <td data-bbox="1052 1154 1591 1190">Aimovig</td> <td data-bbox="1598 1154 2007 1190">1 syringe/30 days</td> </tr> <tr> <td data-bbox="1052 1195 1591 1230">Emgality 120 mg</td> <td data-bbox="1598 1195 2007 1230">2 syringes/30 days</td> </tr> <tr> <td data-bbox="1052 1235 1591 1271">Emgality 100 mg</td> <td data-bbox="1598 1235 2007 1271">3 syringes/30 days</td> </tr> <tr> <td data-bbox="1052 1276 1591 1312">Ajovy</td> <td data-bbox="1598 1276 2007 1312">3 syringes/90 days</td> </tr> <tr> <td data-bbox="1052 1317 1591 1352">Reyvow</td> <td data-bbox="1598 1317 2007 1352">8 units/30 days</td> </tr> <tr> <td data-bbox="1052 1357 1591 1393">Ubrelvy</td> <td data-bbox="1598 1357 2007 1393">16 units/30 days</td> </tr> <tr> <td data-bbox="1052 1398 1591 1433">Nurtec™ ODT</td> <td data-bbox="1598 1398 2007 1433">24 units/40 days</td> </tr> <tr> <td data-bbox="1052 1438 1591 1468">Qulipta</td> <td data-bbox="1598 1438 2007 1468">30 units/30 days</td> </tr> </tbody> </table>	Agent	F/Q/D	Aimovig	1 syringe/30 days	Emgality 120 mg	2 syringes/30 days	Emgality 100 mg	3 syringes/30 days	Ajovy	3 syringes/90 days	Reyvow	8 units/30 days	Ubrelvy	16 units/30 days	Nurtec™ ODT	24 units/40 days	Qulipta	30 units/30 days
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<b>IV. Central Nervous System</b>			
		Zavzpret®	8 units/30 days
<b>Antimigraine Agents – Triptans</b>			
rizatriptan <sup>F/Q/D</sup> sumatriptan <sup>F/Q/D</sup>	almotriptan <sup>F/Q/D</sup> eletriptan <sup>F/Q/D</sup> Frova® <sup>F/Q/D</sup> frovatriptan <sup>F/Q/D</sup> Imitrex® <sup>F/Q/D</sup> Maxalt® <sup>F/Q/D</sup> Maxalt® MLT <sup>F/Q/D</sup> naratriptan <sup>F/Q/D</sup> Relpax® <sup>F/Q/D</sup> sumatriptan-naproxen <sup>F/Q/D</sup> Symbravo® <sup>F/Q/D</sup> Tosymra™ <sup>F/Q/D</sup> Zembrace™ SymTouch™ zolmitriptan <sup>F/Q/D</sup> Zomig® <sup>F/Q/D</sup>	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b>	
		<b>Agent</b>	<b>F/Q/D</b>
		almotriptan eletriptan (Relpax®) frovatriptan (Frova®) naratriptan rizatriptan (Maxalt®) rizatriptan (Maxalt® MLT) sumatriptan nasal spray (Imitrex®) sumatriptan (Imitrex®) sumatriptan-naproxen Tosymra™ nasal spray zolmitriptan (Zomig®) zolmitriptan nasal spray (Zomig®)	18 units/30 days
		meloxicam/rizatriptan (Symbravo®)	9 units/30 days
<b>Antipsychotics – Injectable</b>			
Abilify Asimtufii® Abilify Maintena® Aristada® Aristada Initio® fluphenazine decanoate Haldol® decanoate haloperidol decanoate Invega Hafyera™ Invega Sustenna® Invega Trinza® Perseris™ Risperdal Consta® <sup>BLTG</sup> Uzedy™ Zyprexa Relprevv®	Erzofri® risperidone injection (gen Risperdal Consta®) Rykindo®		

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

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<b>IV. Central Nervous System</b>																												
<b>Antipsychotics – Second Generation <span style="color: red;">CC, ST</span></b>																												
aripiprazole tablet <span style="color: red;">DO</span> asenapine (gen Saphris <sup>®</sup> ) clozapine lurasidone (gen Latuda <sup>®</sup> ) olanzapine tablet <span style="color: red;">DO</span> olanzapine ODT <span style="color: red;">DO</span> paliperidone ER <span style="color: red;">DO</span> quetiapine <span style="color: red;">F/Q/D</span> quetiapine ER <span style="color: red;">F/Q/D, DO</span> risperidone tablet, solution Vraylar <sup>®</sup> <span style="color: red;">DO</span> ziprasidone capsule	Abilify <sup>®</sup> tablet <span style="color: red;">DO</span> aripiprazole solution aripiprazole ODT Caplyta <sup>™</sup> clozapine ODT Clozaril <sup>®</sup> Cobenfy <sup>™</sup> capsules, starter pack Fanapt <sup>®</sup> Geodon <sup>®</sup> Invega <sup>®</sup> <span style="color: red;">DO</span> Latuda <sup>®</sup> <span style="color: red;">DO</span> Lybalvi <sup>®</sup> Nuplazid <sup>®</sup> olanzapine / fluoxetine Opipza <sup>™</sup> Rexulti <sup>®</sup> <span style="color: red;">DO</span> Risperdal <sup>®</sup> risperidone ODT Saphris <sup>®</sup> Secuado <sup>®</sup> Seroquel <sup>®</sup> <span style="color: red;">F/Q/D</span> Seroquel XR <sup>®</sup> <span style="color: red;">DO, F/Q/D</span> Versacloz <sup>®</sup> Zyprexa <sup>®</sup> <span style="color: red;">DO</span> Zyprexa <sup>®</sup> Zydis	<p><b>DOSE OPTIMIZATION (DO)</b></p> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected drugs and strengths</li> </ul> <p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA</li> <li>PA is required when an oral SGA is utilized above the highest MDD according to FDA labeling.</li> <li>PA is required for patients less than 21 years of age when there is concurrent use of 2 or more different oral antipsychotics for greater than 90 days.</li> <li>PA is required for patients 21 years of age or older when 3 or more different oral second-generation antipsychotics are used for more than 180 days.</li> <li>PA is required for initial prescription for patients younger than the drug-specific minimum age as indicated below:</li> </ul> <table border="1" data-bbox="1123 961 2009 1448"> <tbody> <tr> <td>aripiprazole (Abilify<sup>®</sup>, Opipza<sup>™</sup>)</td> <td>6 years</td> </tr> <tr> <td>asenapine (Saphris<sup>®</sup>)</td> <td>10 years</td> </tr> <tr> <td>asenapine (Secuado<sup>®</sup>)</td> <td>18 years</td> </tr> <tr> <td>brexpiprazole (Rexulti<sup>®</sup>)</td> <td>13 years</td> </tr> <tr> <td>cariprazine (Vraylar<sup>®</sup>)</td> <td>10 years</td> </tr> <tr> <td>clozapine (Clozaril<sup>®</sup>, Versacloz<sup>®</sup>)</td> <td>12 years</td> </tr> <tr> <td>iloperidone (Fanapt<sup>®</sup>)</td> <td>18 years</td> </tr> <tr> <td>lumateperone (Caplyta<sup>™</sup>)</td> <td>18 years</td> </tr> <tr> <td>lurasidone HCl (Latuda<sup>®</sup>)</td> <td>10 years</td> </tr> <tr> <td>olanzapine (Zyprexa<sup>®</sup>)</td> <td>10 years</td> </tr> <tr> <td>olanzapine / fluoxetine (Symbyax<sup>®</sup>)</td> <td>10 years</td> </tr> <tr> <td>olanzapine / samidorphan (Lybalvi<sup>®</sup>)</td> <td>18 years</td> </tr> <tr> <td>paliperidone ER (Invega<sup>®</sup>)</td> <td>12 years</td> </tr> </tbody> </table>	aripiprazole (Abilify <sup>®</sup> , Opipza <sup>™</sup> )	6 years	asenapine (Saphris <sup>®</sup> )	10 years	asenapine (Secuado <sup>®</sup> )	18 years	brexpiprazole (Rexulti <sup>®</sup> )	13 years	cariprazine (Vraylar <sup>®</sup> )	10 years	clozapine (Clozaril <sup>®</sup> , Versacloz <sup>®</sup> )	12 years	iloperidone (Fanapt <sup>®</sup> )	18 years	lumateperone (Caplyta <sup>™</sup> )	18 years	lurasidone HCl (Latuda <sup>®</sup> )	10 years	olanzapine (Zyprexa <sup>®</sup> )	10 years	olanzapine / fluoxetine (Symbyax <sup>®</sup> )	10 years	olanzapine / samidorphan (Lybalvi <sup>®</sup> )	18 years	paliperidone ER (Invega <sup>®</sup> )	12 years
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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters										
<b>IV. Central Nervous System</b>												
		<table border="1" data-bbox="1125 266 2007 451"> <tr> <td>pimavanserin (Nuplazid®)</td> <td>18 years</td> </tr> <tr> <td>quetiapine fum. (Seroquel®, Seroquel XR®)</td> <td>10 years</td> </tr> <tr> <td>risperidone (Risperdal®)</td> <td>5 years</td> </tr> <tr> <td>xanomeline-trospium (Cobenfy™)</td> <td>18 years</td> </tr> <tr> <td>ziprasidone HCl (Geodon®)</td> <td>10 years</td> </tr> </table> <ul data-bbox="1054 457 2007 558" style="list-style-type: none"> <li>• Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients &lt; 18 years of age</li> </ul> <p data-bbox="1054 597 1339 626"><b>STEP THERAPY (ST)</b></p> <ul data-bbox="1054 636 2007 971" style="list-style-type: none"> <li>• For all Second Generation Antipsychotics used in the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is required</li> <li>• 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</li> <li>• Vraylar®: for indications other than MDD, trial of a preferred generic is required</li> </ul> <p data-bbox="1054 1010 1663 1039"><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <ul data-bbox="1054 1049 2007 1253" style="list-style-type: none"> <li>• <b>quetiapine/quetiapine ER (Seroquel®/Seroquel XR®):</b> Minimum 50 mg/day</li> <li>• <b>quetiapine (Seroquel®):</b> Maximum 3 units per day, 90 units per 30 days</li> <li>• <b>quetiapine ER (Seroquel XR®):</b> 50mg, maximum 2 units/day, 60 units/30 days</li> </ul>	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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<b>Central Nervous System (CNS) Stimulants <span style="color: red;">CC, F/Q/D</span></b>												
amphetamine salt combo IR (gen Adderall®)	Adderall XR® <span style="color: red;">DO</span> Adzenys XR-ODT® amphetamine ER ODT (gen Adzenys XR-ODT®)	<b>CLINICAL CRITERIA (CC)</b> <ul data-bbox="1054 1390 2007 1455" style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> </ul>										

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<b>IV. Central Nervous System</b>		
<p>amphetamine salt combo ER (gen Adderall XR®) <b>DO</b></p> <p>dexmethylphenidate (gen Focalin®)</p> <p>dexmethylphenidate ER <b>DO</b> (gen Focalin XR®)</p> <p>dextroamphetamine tablet</p> <p>lisdexamfetamine chewable tablet (gen Vyvanse® chew tablet)</p> <p>methylphenidate solution (gen Methylin®)</p> <p>methylphenidate tablet (gen Ritalin®)</p> <p>methylphenidate CD <b>DO</b></p> <p>methylphenidate ER (gen Aptensio XR)</p> <p>methylphenidate ER (gen Concerta®)</p> <p>methylphenidate ER (gen Metadate CD)</p> <p>methylphenidate ER (gen Ritalin LA®)</p> <p>Ritalin LA® <b>DO</b></p> <p>Vyvanse® capsule <b>DO, BLTG</b></p>	<p>amphetamine (gen Evekeo®)</p> <p>Aptensio XR®</p> <p>armodafinil (gen Nuvigil®)</p> <p>Azstarys™</p> <p>Concerta® <b>DO</b></p> <p>Cotempla® XR-ODT™</p> <p>Dexedrine®</p> <p>dextroamphetamine / amphetamine (gen Mydayis™)</p> <p>dextroamphetamine ER (gen Dexedrine®)</p> <p>dextroamphetamine solution (gen ProCentra®)</p> <p>dextroamphetamine tablet (gen Zenzedi®)</p> <p>Dyanavel XR®</p> <p>Evekeo®</p> <p>Evekeo® ODT</p> <p>Focalin®</p> <p>Focalin XR® <b>DO</b></p> <p>Jornay PM™</p> <p>lisdexamfetamine capsule (gen Vyvanse®)</p> <p>methamphetamine (gen Desoxyn®)</p> <p>Methylin®</p> <p>methylphenidate (gen Daytrana®)</p> <p>methylphenidate chewable tablet (gen Methylin®)</p> <p>methylphenidate ER 45 mg, 63 mg, 72 mg tablet</p> <p>modafinil (gen Provigil®) <b>DO</b></p> <p>Mydayis™</p> <p>Nuvigil®</p> <p>ProCentra®</p> <p>Provigil® <b>DO</b></p>	<ul style="list-style-type: none"> <li>• PA is required for initial prescriptions for stimulant therapy for patients <b>less than 3 years of age</b></li> <li>• Confirm diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent for patients <b>less than 18 years of age</b></li> <li>• Patient-specific considerations for drug selection include treatment of narcolepsy, excessive daytime sleepiness, sleepiness associated with shift work sleep disorder, or sleepiness associated with obstructive sleep apnea.</li> <li>• PA required for initiation of CNS Stimulant for patients currently on an opioid</li> <li>• PA required for initiation of CNS Stimulant for patients currently on a benzodiazepine</li> </ul> <p><b>DOSE OPTIMIZATION (DO)</b></p> <ul style="list-style-type: none"> <li>• See Dose Optimization Chart for affected drugs and strengths</li> </ul> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <ul style="list-style-type: none"> <li>• Quantity limits based on daily dosage as determined by FDA labeling</li> </ul>

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<b>IV. Central Nervous System</b>		
	QuilliChew ER™ <sup>DO</sup> Quillivant XR® Relexxii® Ritalin® Sunosi™ Vyvanse® chewable tablet Wakix® Xelstry™ Zenzedi®	
<b>Movement Disorder Agents <sup>CC</sup></b>		
Austedo® Austedo® XR Austedo® XR titration pack Ingrezza® Ingrezza® Sprinkle Ingrezza® titration pack tetrabenazine	Xenazine®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of an FDA-approved or compendia-supported indication and Medicaid covered indication</li> </ul>

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>IV. Central Nervous System</b>		
<b>Multiple Sclerosis Agents</b>		
Avonex® Copaxone® 20 mg/mL <span style="color: red;">BLTG</span> dimethyl fumarate DR fingolimod (gen Gilenya®) Kesimpta® teriflunomide (gen Aubagio®)	Aubagio® Bafiertam™ Betaseron® cladribine (gen Mavenclad®) Copaxone® 40 mg/mL Gilenya® glatiramer Mavenclad® Mayzent® Plegridy® Ponvory™ <span style="color: red;">F/Q/D</span> Rebif® Rebif® Rebidose® Tascenso ODT™ Tecfidera® Vumerity® Zeposia® <span style="color: red;">CC, ST</span>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>• <b>Zeposia® (ozanimod):</b> Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> </ul> <b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>• <b>Zeposia® (ozanimod):</b> For an indication of Ulcerative Colitis               <ul style="list-style-type: none"> <li>- Trial of a non-specific anti-inflammatory drug such as an aminosalicylate or immunosuppressant, or a non-biologic disease-modifying anti-rheumatic drug (DMARD), and;</li> <li>- Trial of a preferred systemic immunomodulator</li> </ul> </li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>• <b>Ponvory™ (ponesimod) starter pack;</b> maximum quantity is 14, no refills</li> <li>• <b>Ponvory™ (ponesimod);</b> maintenance limited to a 30-day supply</li> </ul>
<b>Non-Ergot Dopamine Receptor Agonists</b>		
pramipexole ropinirole	Neupro® pramipexole ER ropinirole ER	
<b>Other Agents for Attention Deficit Hyperactivity Disorder (ADHD) <span style="color: red;">CC</span></b>		
atomoxetine <span style="color: red;">DO</span> clonidine ER guanfacine ER <span style="color: red;">DO</span>	Intuniv® <span style="color: red;">DO</span> Onyda™ XR Qelbree™ Strattera® <span style="color: red;">DO</span>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>• Confirm diagnosis of an FDA-approved or compendia-supported indication for patients &lt; 18 years of age.</li> <li>• PA is required for initial prescriptions for non-stimulant therapy for patients <b>less than 6 years of age</b></li> </ul> <b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>• See Dose Optimization Chart for affected strengths</li> </ul>
<b>Sedative Hypnotics/Sleep Agents <span style="color: red;">F/Q/D</span></b>		
estazolam <span style="color: red;">CC</span>	Ambien® <span style="color: red;">CC</span>	<b>CLINICAL CRITERIA (CC)</b>

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters																
<b>IV. Central Nervous System</b>																		
eszopiclone ramelteon (gen Rozerem®) temazepam 15 mg, 30 mg <span style="color: red;">CC</span> zaleplon zolpidem tablet <span style="color: red;">CC</span> zolpidem ER <span style="color: red;">CC</span>	Ambien CR® <span style="color: red;">CC</span> Belsomra® Dayvigo™ Doral® <span style="color: red;">CC</span> doxepin Edluar® <span style="color: red;">CC</span> flurazepam <span style="color: red;">CC</span> Halcion® <span style="color: red;">CC</span> quazepam <span style="color: red;">CC</span> (gen Doral®) Quviviq™ Restoril® <span style="color: red;">CC</span> Rozerem® temazepam 7.5 mg, 22.5 mg <span style="color: red;">CC</span> triazolam <span style="color: red;">CC</span> zolpidem sublingual, capsule <span style="color: red;">CC</span>	<ul style="list-style-type: none"> <li>• <b>Zolpidem products:</b> Confirm dosage is consistent with FDA labeling for initial prescriptions</li> <li>• <b>Benzodiazepine Agents</b> (estazolam, Doral®, flurazepam, Halcion®, quazepam, Restoril®, temazepam, triazolam):                             <ul style="list-style-type: none"> <li>– Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>– PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy</li> <li>– PA required for any additional benzodiazepine prescription in patients currently on benzodiazepine therapy</li> <li>– PA required when greater than a 14-day supply of a benzodiazepine is prescribed for someone on a CNS stimulant</li> </ul> </li> </ul> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <ul style="list-style-type: none"> <li>• Frequency and duration limits for the following products:</li> </ul> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #008080; color: white;">Agent</th> <th style="background-color: #008080; color: white;">Quantity Limit</th> </tr> </thead> <tbody> <tr> <td>Non-zaleplon and non-benzodiazepine containing products</td> <td>30 units/30 days</td> </tr> <tr> <td>Zaleplon containing products</td> <td>60 units/30 days</td> </tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #008080; color: white;">Agent</th> <th style="background-color: #008080; color: white;">Duration Limit</th> </tr> </thead> <tbody> <tr> <td>estazolam*; flurazepam*; quazepam (Doral®)*; temazepam (Restoril)*; triazolam (Halcion)*; zaleplon</td> <td>30 days</td> </tr> <tr> <td colspan="2">*For the treatment of insomnia</td> </tr> <tr> <td>daridorexant (Quviviq™); suvorexant (Belsomra®); doxepin</td> <td>90 days</td> </tr> <tr> <td>eszopiclone (Lunesta); ramelteon (Rozerem®); (lemborexant) Dayvigo™; zolpidem IR; zolpidem ER (Ambien, Ambien CR, Edular) sublingual, capsule, tablet</td> <td>180 days</td> </tr> </tbody> </table>	Agent	Quantity Limit	Non-zaleplon and non-benzodiazepine containing products	30 units/30 days	Zaleplon containing products	60 units/30 days	Agent	Duration Limit	estazolam*; flurazepam*; quazepam (Doral®)*; temazepam (Restoril)*; triazolam (Halcion)*; zaleplon	30 days	*For the treatment of insomnia		daridorexant (Quviviq™); suvorexant (Belsomra®); doxepin	90 days	eszopiclone (Lunesta); ramelteon (Rozerem®); (lemborexant) Dayvigo™; zolpidem IR; zolpidem ER (Ambien, Ambien CR, Edular) sublingual, capsule, tablet	180 days
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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>IV. Central Nervous System</b>		
		<p><b>Additional/Alternate parameters:</b></p> <ul style="list-style-type: none"> <li>For patients naïve to non-benzodiazepine sedative hypnotics (NBSH): First-fill duration and quantity limit of 10 dosage units as a 10-day supply, except for zaleplon-containing products which the quantity limit is 20 dosage units as a 10-day supply</li> </ul>
<b>Selective Serotonin Reuptake Inhibitors (SSRIs)</b>		
citalopram tablet, solution escitalopram tablet fluoxetine capsule, solution paroxetine tablet sertraline tablet, concentrate vilazodone (gen Viibryd®)	Celexa® citalopram capsule escitalopram solution escitalopram 15 mg <span style="color: red;">MR</span> fluoxetine tablet fluoxetine DR weekly fluvoxamine <span style="color: red;">CC</span> fluvoxamine ER <span style="color: red;">CC</span> Lexapro® <span style="color: red;">DO</span> paroxetine capsule paroxetine CR paroxetine suspension Paxil® Paxil CR® Prozac® sertraline capsule Trintellix® <span style="color: red;">DO</span> Viibryd® <span style="color: red;">DO</span> Zoloft®	<p><b>DOSE OPTIMIZATION (DO)</b></p> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul> <p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA</li> <li>Clinical editing to allow patients with a diagnosis of Obsessive-Compulsive Disorder (OCD) to receive fluvoxamine and fluvoxamine ER without PA</li> </ul>

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>V. Dermatologic Agents</b>		
<b>Acne Agents, Topical</b>		
adapalene/benzoyl peroxide (gen Epiduo®) adapalene cream adapalene OTC gel tazarotene cream 0.1% <span style="color: red;">CC</span> tretinoin cream, gel (gen Retin-A) <span style="color: red;">CC</span>	adapalene Rx gel, gel pump adapalene/benzoyl peroxide (gen Epiduo® Forte) Akliel® clindamycin/tretinoin <span style="color: red;">CC</span> dapsone Differin® cream, gel pump, lotion, OTC gel Epiduo® Forte gel pump Fabior® <span style="color: red;">CC</span> sulfacetamide tazarotene cream 0.05% <span style="color: red;">CC</span> tazarotene foam (gen Fabior®) <span style="color: red;">CC</span> tazarotene gel <span style="color: red;">CC</span> tretinoin gel <span style="color: red;">CC</span> (gen Atralin) tretinoin micro <span style="color: red;">CC</span> Twyneo® Winlevi®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> </ul>
<b>Actinic Keratosis Agents</b>		
diclofenac 3% gel fluorouracil solution fluorouracil 0.5% cream (gen Carac) fluorouracil 5% cream (gen Efudex cream) imiquimod (gen Aldara)	imiquimod (gen Zyclara)	
<b>Antibiotics – Topical</b>		
mupirocin ointment	Centany® mupirocin cream Xepi™	

# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>V. Dermatologic Agents</b>		
<b>Anti-Fungals – Topical</b>		
ciclopirox cream, suspension, shampoo ciclopirox 8% solution clotrimazole OTC clotrimazole Rx clotrimazole/betamethasone cream ketoconazole cream ketoconazole 2% shampoo miconazole OTC nystatin cream, ointment, powder nystatin/triamcinolone terbinafine OTC tolnaftate OTC	butenafine Ciclodan® cream ciclopirox gel clotrimazole/betamethasone lotion econazole cream econazole foam <sup>MR</sup> Ertaczo® Extina® ketoconazole foam Loprox® cream, suspension miconazole/zinc/petrolatum (gen Vusion®) <sup>F/Q/D</sup> naftifine Naftin® oxiconazole Oxistat® tavaborole Vusion® <sup>F/Q/D</sup>	<b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>• <b>Vusion® 50 gm ointment</b> –Maximum 100 grams in a 90-day time period</li> </ul>

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>V. Dermatologic Agents</b>		
<b>Anti-Infectives – Topical</b>		
clindamycin phosphate 1% solution, gel, lotion, swab (gen Cleocin T <sup>®</sup> ) clindamycin phosphate/benzoyl peroxide gel 1.2%-5% (gen Duac <sup>®</sup> ) erythromycin 2% solution, gel	Cleocin T <sup>®</sup> 1% lotion clindamycin phosphate foam 1% (gen Evoclin <sup>®</sup> ) clindamycin phosphate gel 1% (gen Clindagel <sup>®</sup> ) clindamycin phosphate/benzoyl peroxide gel 1%-5% (gen BenzaClin <sup>®</sup> ) clindamycin/benzoyl peroxide gel pump 1.2%-3.75% (gen Onexton <sup>®</sup> ) clindamycin/benzoyl peroxide gel pump 1.2%-2.5% (gen Acanya <sup>®</sup> ) erythromycin swab 2% erythromycin/benzoyl peroxide gel 3%-5% (gen Benzamycin <sup>®</sup> ) Evoclin <sup>®</sup> 1% foam	
<b>Anti-Virals – Topical</b>		
acyclovir cream docosanol (gen Abreva)	acyclovir ointment Denavir <sup>®</sup> penciclovir (gen Denavir <sup>®</sup> )	
<b>Immunomodulators &amp; Related Agents – Topical <sup>CC</sup></b>		
Eucrisa <sup>®</sup> pimecrolimus tacrolimus	Anzupgo <sup>®</sup> Opzelura <sup>®</sup> Vtama <sup>®</sup> Zoryve <sup>®</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>Plaque psoriasis – Trial of a Preferred agent from the Psoriasis Agents, Topical class</li> </ul>

# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>V. Dermatologic Agents</b>		
<b>Psoriasis Agents – Topical</b>		
calcipotriene cream, ointment, scalp solution	calcipotriene foam (gen Sorilux®) calcipotriene/betamethasone dipropionate (gen Taclonex®) calcitriol ointment (gen Vectical®) Enstilar® Sorilux® Taclonex® Vectical®	
<b>Rosacea Agents, Topical <sup>CC</sup></b>		
azelaic acid metronidazole cream, gel	Epsolay® Finacea® ivermectin Metrocream® Metrogel® metronidazole gel pump, lotion Soolantra®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> </ul>
<b>Steroids, Topical – Low Potency</b>		
hydrocortisone acetate OTC hydrocortisone acetate Rx	alclometasone Capex® shampoo Derma-Smoothe/FS® desonide fluocinolone oil hydrocortisone 2.5% soln <sup>MR</sup>	

# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>V. Dermatologic Agents</b>		
<b>Steroids, Topical – Medium Potency</b>		
fluocinolone acetonide solution fluticasone propionate cream, ointment hydrocortisone valerate cream mometasone furoate	Beser lotion betamethasone valerate foam clocortolone fluocinolone acetonide cream, ointment flurandrenolide fluticasone propionate lotion hydrocortisone butyrate cream, lotion, ointment, solution hydrocortisone valerate ointment Pandel® prednicarbate ointment Synalar®	
<b>Steroids, Topical – High Potency</b>		
betamethasone dipropionate lotion, cream, ointment betamethasone dipropionate augmented cream betamethasone valerate cream, ointment fluocinonide cream, ointment, solution triamcinolone acetonide	amcinonide cream <span style="color: red;">MR</span> ApexiCon-E® betamethasone dipropionate augmented gel, ointment, lotion betamethasone valerate lotion clobetasol 0.025% cream desoximetasone diflorasone Diprolene® fluocinonide gel, emollient halcinonide cream halcinonide 0.1% solution (gen Halog®) <span style="color: red;">MR</span> Halog® cream, solution, ointment Kenalog® Topicort® triamcinolone spray	

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Anabolic Steroids – Topical <b>CDRP, F/Q/D</b></b>		
testosterone gel packets (gen Vogelxo®) testosterone gel pump (gen AndroGel)	AndroGel® pump Natesto® Testim® testosterone gel packets (gen AndroGel®) testosterone pump Vogelxo®	<p><b>CLINICAL DRUG REVIEW PROGRAM (CDRP)</b></p> <ul style="list-style-type: none"> <li>For diagnosis of hypogonadotropic or primary hypogonadism: <ul style="list-style-type: none"> <li>Requires documented low testosterone concentration with two tests prior to initiation of therapy.</li> <li>Require documented testosterone therapeutic concentration to confirm response after initiation of therapy.</li> </ul> </li> <li>For diagnosis of delayed puberty: <ul style="list-style-type: none"> <li>Requires documentation that growth hormone deficiency has been ruled out prior to initiation of therapy.</li> </ul> </li> </ul> <p>The Anabolic Steroid fax form can be found at:  <a href="https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PA_Worksheets_Prescribers_Anabolic_Steroids.pdf">https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PA_Worksheets_Prescribers_Anabolic_Steroids.pdf</a>  For diagnosis of gender dysphoria, see Hormone Replacement Therapy for Treatment of Gender Dysphoria coverage in the <a href="#">DUR section</a> of this document</p> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <ul style="list-style-type: none"> <li>Limitations for anabolic steroid products based on approved FDA labeled daily dosing and documented diagnosis: <ul style="list-style-type: none"> <li>Duration limit of 6 months for delayed puberty</li> </ul> </li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Biguanides</b>		
glipizide/metformin glyburide/metformin metformin HCl metformin ER (gen Glucophage XR®)	metformin solution (gen Riomet®) metformin 625 mg, 750 mg <sup>MR</sup> metformin ER <sup>DO</sup> (gen Fortamet®, Glumetza®) Riomet®	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul>
<b>Bisphosphonates – Oral</b>		
alendronate	Actonel® Atelvia® Binosto® Fosamax® Fosamax® Plus D ibandronate risedronate	
<b>Dipeptidyl Peptidase-4 (DPP-4) Inhibitors <sup>CC</sup></b>		
alogliptin alogliptin/metformin Glyxambi® Janumet® Janumet® XR Januvia® <sup>DO</sup> Jentadueto® Jentadueto® XR Kazano® Nesina® Tradjenta®	alogliptin/pioglitazone (gen Oseni®) Brynovin® Qtern® saxagliptin (gen Onglyza®) saxagliptin/metformin sitagliptin (gen Zituvio™) sitagliptin/metformin (gen Zituvimet) Steglujan® Zituvimet Zituvimet XR Zituvio™	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>PA required for patients utilizing a DPP-4 and GLP-1 concurrently</li> </ul> <b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul>

# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Glucagon Agents</b>		
Baqsimi® glucagon vial glucagon HCl emergency kit (Fresenius, Amphastar) Zegalogue® pen, syringe	glucagon emergency kit (Mylan) Gvoke® pen, syringe, vial	
<b>Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists – Type 2 Diabetes <span style="color: red;">CC</span></b>		
exenatide Ozempic® Trulicity® Victoza® <span style="color: red;">BLTG</span>	Bydureon® BCise™ Byetta® liraglutide (gen Victoza®) Mounjaro® Rybelsus® Soliqua® Xultophy®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>PA required for patients utilizing a GLP-1 and DPP-IV concurrently</li> </ul>

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

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Growth Hormones <sup>CC</sup></b>		
Genotropin <sup>®</sup> Norditropin <sup>®</sup>	Humatrope <sup>®</sup> Ngenla <sup>™</sup> Nutropin AQ <sup>®</sup> NuSpin Omnitrope <sup>®</sup> Skytrofa <sup>®</sup> Sogroya <sup>®</sup> Zomacton <sup>®</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>For Diagnosis of Growth Hormone Deficiency (GHD) or Short for Gestational Age (SGA):                             <ul style="list-style-type: none"> <li>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)</li> </ul> </li> <li>Continuation of GH treatment, documentation of a recommended GHD laboratory test annually (e.g., IGF-1 test) and documentation of positive treatment response</li> </ul>
<b>Insulin – Long-Acting</b>		
insulin glargine solostar, vial (gen Lantus <sup>®</sup> Solostar <sup>®</sup> , vial) insulin glargine-YFGN Lantus <sup>®</sup> Solostar <sup>®</sup> , vial	Basaglar <sup>®</sup> Basaglar <sup>®</sup> Tempo <sup>™</sup> insulin degludec vial, pen (gen Tresiba) insulin glargine max solostar (gen Toujeo <sup>®</sup> Max Solostar <sup>®</sup> ) insulin glargine solostar (gen Toujeo <sup>®</sup> Solostar <sup>®</sup> ) Levemir <sup>®</sup> Rezvoglar <sup>™</sup> Semglee <sup>®</sup> -YFGN: vial, pen Toujeo <sup>®</sup> Solostar <sup>®</sup> Toujeo <sup>®</sup> Max Solostar <sup>®</sup> Tresiba <sup>®</sup>	
<b>Insulin – Mixes</b>		
Humalog <sup>®</sup> 50/50 Mix: pen insulin lispro 75/25 mix: pen (gen Humalog <sup>®</sup> Mix) insulin aspart prot/insulin aspart: vial, pen (gen Novolog)	Humalog <sup>®</sup> 75/25 mix: pen, vial Novolog <sup>®</sup> Mix: vial, pen	

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Insulin – Rapid-Acting</b>		
insulin aspart (gen Novolog®) cartridge, vial, pen insulin lispro (gen Humalog® U100) vial, pen insulin lispro junior (gen Humalog® Jr.)	Admelog® Afrezza® Apidra® Fiasp® Penfill, FlexTouch, Pumpcart, vial Humalog® Jr. 100 U/mL Kwikpen Humalog® 100 U/mL vial, pen, cartridge, Tempo™ Humalog® 200 U/mL Kirsty™ Lyumjev® Lyumjev® Tempo™ Merilog™ Solostar, vial Novolog® cartridge, vial, FlexPen	
<b>Pancreatic Enzymes</b>		
Creon® Zenpep®	Pertzye® Viokace®	
<b>Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors</b>		
Farxiga® <b>BLTG</b> Jardiance® Synjardy® Synjardy® XR Trijardy® XR Xigduo® XR <b>BLTG</b>	dapagliflozin (gen Farxiga®) dapagliflozin/metformin (gen Xigduo® XR) Inpefa™ Invokamet® Invokamet® XR Invokana® Segluromet® Steglatro®	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>VI. Endocrine and Metabolic Agents</b>		
<b>Thiazolidinediones (TZDs)</b>		
pioglitazone	ACTOplus Met® Actos® <span style="color: red;">DO</span> Duetact® pioglitazone/glimepiride pioglitazone/metformin	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul>

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>VII. Gastrointestinal</b>		
<b>Anti-Emetics</b>		
aprepitant pack Diclegis® <span style="color: red;">CC</span> doxylamine succ/pyridoxine (gen Diclegis®) <span style="color: red;">CC</span> ondansetron ODT, solution, tablet	Akynzeo® Anzemet® aprepitant capsule Bonjesta® <span style="color: red;">CC</span> Emend® capsule, powder packet, TriPack granisetron tablet Sancuso®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li><b>doxylamine succ/pyridoxine (Diclegis®, Bonjesta®):</b> Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> </ul>
<b>Gastrointestinal Antibiotics</b>		
metronidazole tablet neomycin vancomycin capsule, solution	Difucid® fidaxomicin (gen Difucid®) Firvanq® Flagyl® Likmez™ metronidazole capsule metronidazole 125 mg tablet nitazoxanide paromomycin tinidazole Vancocin®	

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>VII. Gastrointestinal</b>		
<b>Proton Pump (PPI)/Acid Secretion Inhibitors <span style="color: red;">F/Q/D</span></b>		
esomeprazole magnesium Rx capsule lansoprazole capsule (Rx, OTC) lansoprazole OTC solutab omeprazole Rx pantoprazole tablet Protonix suspension <span style="color: red;">BLTG</span> rabeprazole	dexlansoprazole (gen Dexilant®) Dexilant® <span style="color: red;">DO</span> esomeprazole magnesium tablet OTC esomeprazole capsules OTC esomeprazole suspension esomeprazole DR packets Konvomep™ lansoprazole Rx solutab Nexium® Rx <span style="color: red;">DO</span> omeprazole OTC omeprazole/sodium bicarbonate Rx pantoprazole suspension Prevacid® OTC Prevacid® Rx <span style="color: red;">DO</span> Prilosec® Rx Protonix® tablet Voquezna® <span style="color: red;">ST</span>	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul> <b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>Trial of 2 PPIs at maximally tolerated doses prior to the use of a Potassium Competitive Acid Blocker (PCAB).</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Quantity limits:               <ul style="list-style-type: none"> <li>Once daily dosing for:                   <ul style="list-style-type: none"> <li>GERD</li> <li>erosive esophagitis</li> <li>healing and maintenance of duodenal/gastric ulcers (including NSAID-induced)</li> <li>prevention of NSAID-induced ulcers</li> </ul> </li> <li>Twice daily dosing for:                   <ul style="list-style-type: none"> <li>hypersecretory conditions</li> <li>Barrett's esophagitis</li> <li>H. pylori</li> <li>refractory GERD</li> </ul> </li> </ul> </li> <li>Duration limits:               <ul style="list-style-type: none"> <li>90 days for:                   <ul style="list-style-type: none"> <li>GERD</li> </ul> </li> <li>365 days for:                   <ul style="list-style-type: none"> <li>Maintenance treatment of duodenal ulcers, or erosive esophagitis</li> </ul> </li> <li>14 days for:                   <ul style="list-style-type: none"> <li>H. pylori</li> </ul> </li> </ul> </li> </ul>

# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>VII. Gastrointestinal</b>		
<b>Sulfasalazine Derivatives</b>		
mesalamine DR (gen Lialda®) mesalamine ER (gen Apriso®) Pentasa® <span style="color: red;">BLTG</span> sulfasalazine DR sulfasalazine IR	Azulfidine® Azulfidine Entab® balsalazide Delzicol® Dipentum® Lialda® mesalamine DR (gen Delzicol®) mesalamine ER (gen Pentasa®) mesalamine DR	

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>VIII. Hematological Agents</b>		
<b>Anticoagulants – Injectable <span style="color: red;">F/Q/D</span></b>		
enoxaparin sodium Fragmin <sup>®</sup> vial	Arixtra <sup>®</sup> <span style="color: red;">CC</span> fondaparinux <span style="color: red;">CC</span> Fragmin <sup>®</sup> syringe Lovenox <sup>®</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>For patients requiring &gt; 30 days of therapy: Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li><b>Arixtra<sup>®</sup> (fondaparinux)</b> Clinical editing to allow patients with a diagnosis of Heparin Induced Thrombocytopenia (HIT) to receive therapy without a PA.</li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Duration Limit: No more than 30 days for patients initiating therapy</li> </ul>
<b>Anticoagulants – Oral</b>		
dabigatran capsule Eliquis <sup>®</sup> warfarin Xarelto <sup>®</sup> tablet <span style="color: red;">DO</span> Xarelto <sup>®</sup> 2.5 mg tablet <span style="color: red;">BLTG</span>	Eliquis <sup>®</sup> sprinkle, packets Pradaxa <sup>®</sup> pellet pack, capsule rivaroxaban tablet, suspension (gen Xarelto <sup>®</sup> ) Savaysa <sup>®</sup> Xarelto <sup>®</sup> dose pack, suspension	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul>
<b>Colony Stimulating Factors</b>		
Fulphila <sup>®</sup> Neupogen <sup>®</sup>	Fylnetra <sup>®</sup> Granix <sup>®</sup> Leukine <sup>®</sup> Neulasta <sup>®</sup> Nivestym <sup>™</sup> Nypozi <sup>®</sup> Nyvepria <sup>™</sup> Releuko <sup>™</sup> Rolvedon <sup>®</sup> Stimufend <sup>®</sup> Udenyca <sup>®</sup> Zarxio <sup>®</sup> Ziextenzo <sup>®</sup>	

# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>VIII. Hematological Agents</b>		
<b>Erythropoiesis Stimulating Agents (ESAs) <sup>CC</sup></b>		
Aranesp® Epogen® Retacrit®	Mircera® Procrit®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> </ul>
<b>Hemophilia Agents – Factor VIII</b>		
Advate® Adynovate® Afstyla® Altuviiiio™ Eloctate® Esperoct® Hemofil® M Humate-P® Jivi® Koate® Kogenate® FS Kovaltry® Novoeight® Nuwiq® Obizur® Recombinate™ Xyntha® Xyntha® Solofuse		

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>IX. Immunologic Agents</b>		
<b>Immunomodulators – Systemic <span style="color: red;">CC, ST</span></b>		
<b>Interleukin Inhibitors</b>		<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> </ul> <b>STEP THERAPY (ST)</b> For indications not specified below <ul style="list-style-type: none"> <li>Trial of a non-specific anti-inflammatory drug such as an aminosalicylate or immunosuppressant, or a non-biologic disease-modifying anti-rheumatic drug (DMARD)</li> <li>Trial of a TNF inhibitor prior to treatment with a JAK inhibitor</li> </ul> <b>INDICATION-SPECIFIC REQUIREMENTS:</b> <ul style="list-style-type: none"> <li><b>Asthma:</b> <ul style="list-style-type: none"> <li>history and concurrent use of a corticosteroid</li> </ul> </li> <li><b>Nasal polyps:</b> <ul style="list-style-type: none"> <li>history and concurrent use of an intranasal corticosteroid</li> </ul> </li> <li><b>Atopic dermatitis:</b> <ul style="list-style-type: none"> <li>Trial with a topical prescription product for a duration of at least 3 months.</li> <li>For JAK inhibitors: Trial of topical prescription product and systemic product for a combined duration of at least 6 months.</li> </ul> </li> <li><b>COPD:</b> <ul style="list-style-type: none"> <li>History and concurrent use of a long acting beta agonist (LABA) + long acting muscarinic agonist (LAMA) + inhaled corticosteroid (ICS)</li> </ul> </li> </ul>
Cosentyx® Dupixent® Ebglyss™ <sup>1</sup> Fasenna® Nucala®	Actemra® SQ Adbry™ Bimzelx® Ilumya® Imuldosa® Kevzara® Kineret® Nemluvio® Omvoh™ SQ Otulfi™ Pyszchiva® Selarsdi™ Skyrizi® Skyrizi® On-Body Spevigo® Starjemza™ Stelara® Steqeyma® Taltz® Tremfya®Tyenne® ustekinumab Yesintek™	
<b>JAK Inhibitors</b>		
	Cibinqo™ Olumiant® Rinvoq™ ER Rinvoq® LQ Xeljanz® Xeljanz® XR	

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>IX. Immunologic Agents</b>		
<b>TNF Inhibitors</b>		
adalimumab (Boehringer Ingelheim) <sup>1</sup> Enbrel <sup>®</sup> Humira <sup>®</sup>	Abrilada™ adalimumab Amjevita™ Cyltezo <sup>®</sup> Cimzia <sup>®</sup> Hadlima™ Hulio <sup>®</sup> Hyrimoz <sup>®</sup> Idacio <sup>®</sup> Simlandi <sup>®</sup> Simponi <sup>®</sup> Yuflyma <sup>®</sup> Yusimry™ Zymfentra™	
<b>Miscellaneous</b>		
Xolair <sup>®</sup>	Entyvio <sup>®</sup> SQ Orencia <sup>®</sup> SQ Otezla <sup>®</sup> Otezla XR™ Sotyktu™ Tezspire <sup>®</sup> pen Velsipity™	
<b>Immunosuppressives, Oral</b>		
azathioprine cyclosporine softgel, capsule cyclosporine modified capsule, solution mycophenolic acid mycophenolate mofetil capsule, tablet, suspension Rapamune <sup>®</sup> solution	Astagraf XL <sup>®</sup> CellCept <sup>®</sup> capsule, tablet, suspension Envarsus XR <sup>®</sup> everolimus (gen Zortress <sup>®</sup> ) Imuran <sup>®</sup> Lupkynis™ CC, F/Q/D Myfortic <sup>®</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Lupkynis™ (voclosporin):                             <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>Confirm concurrent therapy with mycophenolate</li> </ul> </li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>Lupkynis™ limited to 30-day supply</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>IX. Immunologic Agents</b>		
Rapamune® tablet sirolimus solution, tablet tacrolimus	Myhibbin™ Neoral® Prograf® Sandimmune® capsule, solution Zortress®	

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

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>XI. Musculoskeletal Agents</b>		
<b>Skeletal Muscle Relaxants</b>		
baclofen tablet chlorzoxazone 500 mg cyclobenzaprine 5 mg, 10 mg tablet dantrolene methocarbamol orphenadrine ER tizanidine tablet	Amrix® baclofen 15mg tablet baclofen solution baclofen suspension (gen Fleqsuvy™) carisoprodol <b>ST, F/Q/D</b> chlorzoxazone (gen Lorzone) 375 mg, 750 mg chlorzoxazone 250 mg tablet <b>MR</b> cyclobenzaprine 7.5 mg cyclobenzaprine ER capsule (gen Amrix) Dantrium® Fexmid® Fleqsuvy™ Lorzone® Lyvispah™ metaxalone metaxalone 640 mg tablet <b>MR</b> methocarbamol 1000mg orphenadrine-aspirin-caffeine Ozobax® Ozobax® DS Soma® <b>ST, F/Q/D</b> Tanlor® tizanidine capsule Tonmya™ <b>MR</b> Zanaflex® 8 mg <b>MR</b> Zanaflex®	<b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>• Trial with 1 analgesic and 2 skeletal muscle relaxants prior to use of <b>carisoprodol</b></li> </ul> <b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> <ul style="list-style-type: none"> <li>• <b>Carisoprodol</b> – Maximum 4 units per day, 28-day supply</li> <li>• PA is required for a quantity exceeding a 14-day supply and up to one (1) refill for initial fill of an antispasmodic skeletal muscle relaxant</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

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

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>XII. Ophthalmics</b>		
<b>Anti-inflammatories/Immunomodulators – Ophthalmic <sup>CC</sup></b>		
Eysuvis <sup>®</sup> Restasis <sup>®</sup> <sup>BLTG</sup> Restasis MultiDose <sup>®</sup> Xiidra <sup>®</sup>	Cequa <sup>®</sup> cyclosporine (gen Restasis <sup>®</sup> ) Miebo <sup>™</sup> Tryptyr <sup>®</sup> Tyrvaya <sup>™</sup> Verkazia <sup>®</sup> Vevye <sup>®</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Diagnosis documentation required to justify utilization as a first line agent or attempt treatment with an artificial tear, gel, or ointment.</li> </ul>
<b>Beta Blockers – Ophthalmic</b>		
betaxolol Betoptic S <sup>®</sup> carteolol Combigan <sup>®</sup> <sup>BLTG</sup> Istalol <sup>®</sup> <sup>BLTG</sup> levobunolol timolol maleate gel	Betimol <sup>®</sup> brimonidine/timolol (gen Combigan <sup>®</sup> ) timolol 0.5% (gen Betimol <sup>®</sup> ) timolol maleate (gen Timoptic <sup>®</sup> Ocudose <sup>®</sup> ) timolol maleate solution (gen Istalol <sup>®</sup> ) Timoptic <sup>®</sup> Ocudose <sup>®</sup>	
<b>Fluoroquinolones – Ophthalmic</b>		
ciprofloxacin moxifloxacin (gen Vigamox <sup>®</sup> ) ofloxacin	Besivance <sup>®</sup> Ciloxan <sup>®</sup> Gatifloxacin levofloxacin moxifloxacin (gen Moxeza <sup>®</sup> ) Ocuflox <sup>®</sup> Vigamox <sup>®</sup>	

# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>XII. Ophthalmics</b>		
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) – Ophthalmic</b>		
Acular LS <sup>®</sup> <b>BLTG</b> diclofenac flurbiprofen ketorolac	Acular <sup>®</sup> Acuvail <sup>®</sup> bromfenac BromSite <sup>®</sup> Ilevro <sup>®</sup> ketorolac LS Nevanac <sup>®</sup> Prolensa <sup>®</sup>	
<b>Prostaglandin Agonists – Ophthalmic</b>		
latanoprost Rocklatan <sup>®</sup> <b>ST</b> Rhopressa <sup>®</sup> <b>ST</b>	bimatoprost Iyuzeh <sup>™</sup> Lumigan <sup>®</sup> tafluprost (gen Zioptan <sup>®</sup> ) Travatan Z <sup>®</sup> travoprost (gen Travatan Z <sup>®</sup> ) Xalatan <sup>®</sup> Xelpros <sup>®</sup> Vyzulta <sup>™</sup> Zioptan <sup>®</sup>	<b>STEP THERAPY (ST)</b> <ul style="list-style-type: none"> <li>For Rhopressa<sup>®</sup> and Rocklatan<sup>®</sup>: Trial of a preferred generic product is required.</li> </ul>

1 = Preferred as of 2/19/2026  
 2 = Non-Preferred as of 2/19/2026

# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>XIII. Otics</b>		
<b>Fluoroquinolones – Otic</b>		
Cipro HC® <b>BLTG</b> ciprofloxacin/dexamethasone (gen Ciprodex®) ofloxacin	ciprofloxacin ciprofloxacin/hydrocortisone (gen Cipro HC®) ciprofloxacin/fluocinolone (gen Otovel™)	

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>XIV. Renal and Genitourinary</b>		
<b>Alpha Reductase Inhibitors for BPH</b>		
dutasteride finasteride	dutasteride/tamsulosin Proscar®	
<b>Antihyperuricemics</b>		
allopurinol 100 mg, 300 mg colchicine tablet febuxostat probenecid probenecid/colchicine	allopurinol 200 mg colchicine capsule Colcrys Gloperba® Mitigare® Uloric® Zyloprim®	
<b>Cystine Depleting Agents <sup>CC</sup></b>		
Cystagon®	Procysbi®	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> </ul>
<b>Electrolyte Depleters</b>		
Lokelma® sodium polystyrene Veltassa®		

# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>XIV. Renal and Genitourinary</b>		
<b>Phosphate Binders/Regulators <sup>CC</sup></b> <b>**Effective 1/1/2026, Phosphate Binders/Regulators will no longer be covered by NYRx when used for dialysis. Phosphate Binders/Regulators will be covered as part of the dialysis rate.**</b>		
calcium acetate sevelamer carbonate powder, tablet (gen Renvela)	Auryxia <sup>™</sup> ferric citrate 210 mg tablet (gen Auryxia <sup>™</sup> ) Fosrenol <sup>®</sup> lanthanum carbonate Renvela <sup>®</sup> tablet, powder pack sevelamer HCl (gen Renagel) Velphoro <sup>®</sup> Xphozah <sup>®</sup>	<b>CLINICAL CRITERIA (CC)</b> <ul style="list-style-type: none"> <li>For patients not on dialysis, confirm diagnosis of FDA approved or compendia-supported and Medicaid covered indication</li> </ul>
<b>Selective Alpha Adrenergic Blockers</b>		
alfuzosin tamsulosin	Flomax <sup>®</sup> Rapaflo <sup>®</sup> silodosin	

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>XIV. Renal and Genitourinary</b>		
<b>Urinary Tract Antispasmodics</b>		
fesoterodine ER (gen Toviaz®) Myrbetriq® <span style="color: red;">DO</span> , <span style="color: red;">BLTG</span> oxybutynin oxybutynin ER <span style="color: red;">DO</span> solifenacin	darifenacin Detrol® Detrol LA® <span style="color: red;">DO</span> flavoxate Gemtesa® mirabegron (gen Myrbetriq®) Myrbetriq® solution oxybutynin 2.5 mg tablets Oxytrol® tolterodine tolterodine ER Toviaz® <span style="color: red;">DO</span> trospium trospium ER Vesicare® <span style="color: red;">DO</span> Vesicare® LS	<b>DOSE OPTIMIZATION (DO)</b> <ul style="list-style-type: none"> <li>See Dose Optimization Chart for affected strengths</li> </ul>

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>XIV. Renal and Genitourinary</b>		
<b>Urea Cycle Disorders</b>		
Buphenyl <sup>®</sup> powder, tablet Carbaglu <sup>®</sup> <b>BLTG</b> Olpruva <sup>™</sup> Pheburane <sup>®</sup> Ravicti <sup>®</sup> <b>BLTG</b> sodium phenylbutyrate powder, tablet (gen Buphenyl <sup>®</sup> )	carglumic acid glycerol phenylbutyrate (gen Ravicti <sup>®</sup> )	
<b>Uterine Disorder Treatments <sup>F/Q/D</sup></b>		
Myfembree <sup>®</sup> Oria <sup>®</sup> Orilissa <sup>®</sup>		<b>LIFETIME QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>• Myfembree<sup>®</sup>, Oria<sup>®</sup>, Orilissa<sup>®</sup> 150 mg: maximum of 24 months cumulative use</li> <li>• Orilissa<sup>®</sup> 200 mg: maximum of 6 months cumulative use</li> </ul>

## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>XV. Respiratory</b>		
<b>COPD Agents</b>		
Anoro Ellipta® <span style="color: red;">BLTG</span> Atrovent HFA® Combivent Respimat® Incruse Ellipta® ipratropium ipratropium / albuterol roflumilast (gen Daliresp®) Spiriva® HandiHaler® <span style="color: red;">BLTG</span> Spiriva Respimat® Stiolto Respimat® Tudorza Pressair®	Bevespi® Aerosphere® Breztri™ Aerosphere Daliresp® Duaklir® Pressair Ohtuvayre™ tiotropium (gen Spiriva® Handihaler®) Trelegy Ellipta® umeclidinium/vilanterol (gen Anoro Ellipta®) Yupelri®	
<b>Antihistamines – Intranasal</b>		
azelastine olopatadine		
<b>Antihistamines – Second Generation</b>		
cetirizine OTC syrup/solution, tablet fexofenadine OTC tablet levocetirizine tablet loratadine OTC syrup/solution, tablet	cetirizine OTC chewable cetirizine-D OTC Clarinetx® Clarinetx-D® desloratadine levocetirizine solution loratadine-D OTC	

# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters																		
<b>XV. Respiratory</b>																				
<b>Beta2 Adrenergic Agents – Inhaled Long-Acting <span style="color: red;">CC, F/Q/D</span></b>																				
arformoterol (gen Brovana®) formoterol (gen Perforomist®) Serevent Diskus®	Perforomist® Striverdi Respimat®	<p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>PA is required for all new long-acting beta agonist prescriptions for patients under FDA- or compendia-supported age as indicated:</li> </ul> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;">FDA / Compendia-Supported Age</th> </tr> </thead> <tbody> <tr> <td>arformoterol</td> <td style="text-align: center;">≥ 18 years</td> </tr> <tr> <td>Perforomist® / formoterol</td> <td style="text-align: center;">≥ 18 years</td> </tr> <tr> <td>Serevent Diskus®</td> <td style="text-align: center;">≥ 4 years</td> </tr> <tr> <td>Striverdi Respimat®</td> <td style="text-align: center;">≥ 18 years</td> </tr> </tbody> </table> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b> Maximum units per 30 days</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td>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> </tbody> </table>	FDA / Compendia-Supported Age		arformoterol	≥ 18 years	Perforomist® / formoterol	≥ 18 years	Serevent Diskus®	≥ 4 years	Striverdi Respimat®	≥ 18 years	arformoterol	60 units (1 carton of 60 vials or 120 mL)	Perforomist® / formoterol	60 units (1 carton of 60 vials or 120 mL)	Serevent Diskus®	1 diskus (60 blisters)	Striverdi Respimat®	1 unit (one cartridge and one Respimat inhaler)
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Striverdi Respimat®	1 unit (one cartridge and one Respimat inhaler)																			
<b>Beta2 Adrenergic Agents – Inhaled Short-Acting</b>																				
albuterol nebulizer solution albuterol HFA (gen ProAir® HFA, Proventil® HFA) levalbuterol HFA ProAir® Digihaler™ ProAir® RespiClick Ventolin HFA® <span style="color: red;">BLTG</span>	Airsupra™ albuterol HFA (gen Ventolin HFA®) levalbuterol solution Xopenex HFA®																			
<b>Corticosteroids – Inhaled</b>																				
Alvesco® Arnuity Ellipta® <span style="color: red;">BLTG</span> Asmanex® Twisthaler	ArmonAir® Digihaler® Asmanex® HFA fluticasone DISKUS																			

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# NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters																													
<b>XV. Respiratory</b>																															
fluticasone HFA Pulmicort® Flexhaler	fluticasone ellipta (gen Arnuity Ellipta®) QVAR RediHaler®																														
<b>Corticosteroid/Beta2 Adrenergic Agent (Long-Acting) Combinations – Inhaled <span style="color: red;">CC, F/Q/D</span></b>																															
Advair Diskus® <span style="color: red;">BLTG</span> Advair HFA® <span style="color: red;">BLTG</span> Dulera® Symbicort® <span style="color: red;">BLTG</span>	AirDuo® Digihaler® AirDuo™ RespiClick® Breo Ellipta® budesonide/formoterol (gen Symbicort) fluticasone-salmeterol (gen AirDuo™ RespiClick®) fluticasone-salmeterol (gen Advair Diskus®) fluticasone-salmeterol (gen Advair HFA™) fluticasone-vilanterol (gen Breo Ellipta®)	<p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>PA is required for all new long-acting beta agonist prescriptions for patients under FDA- or compendia-supported age as indicated:</li> </ul> <table border="1" data-bbox="1071 535 1984 941"> <thead> <tr> <th colspan="2" data-bbox="1071 535 1984 576">FDA / Compendia-Supported Age</th> </tr> </thead> <tbody> <tr> <td data-bbox="1071 576 1711 617">Advair Diskus®</td> <td data-bbox="1711 576 1984 617">≥ 4 years</td> </tr> <tr> <td data-bbox="1071 617 1711 657">Advair HFA®</td> <td data-bbox="1711 617 1984 657">≥ 12 years</td> </tr> <tr> <td data-bbox="1071 657 1711 698">AirDuo™ RespiClick®</td> <td data-bbox="1711 657 1984 698">&gt; 12 years</td> </tr> <tr> <td data-bbox="1071 698 1711 738">Dulera® 100 mcg and 200 mcg</td> <td data-bbox="1711 698 1984 738">≥ 12 years</td> </tr> <tr> <td data-bbox="1071 738 1711 779">Dulera® 50 mcg</td> <td data-bbox="1711 738 1984 779">≥ 4 years</td> </tr> <tr> <td data-bbox="1071 779 1711 820">fluticasone-salmeterol</td> <td data-bbox="1711 779 1984 820">&gt; 4 years</td> </tr> <tr> <td data-bbox="1071 820 1711 860">budesonide-formoterol (Symbicort®) 80/4.5 mcg</td> <td data-bbox="1711 820 1984 860">≥ 4 years</td> </tr> <tr> <td data-bbox="1071 860 1711 901">budesonide-formoterol (Symbicort®) 160/4.5 mcg</td> <td data-bbox="1711 860 1984 901">≥ 12 years</td> </tr> <tr> <td data-bbox="1071 901 1711 941">fluticasone/vilanterol (Breo Ellipta®)</td> <td data-bbox="1711 901 1984 941">≥ 18 years</td> </tr> </tbody> </table> <p><b>FREQUENCY/QUANTITY/DURATION (F/Q/D)</b></p> <table border="1" data-bbox="1071 982 1984 1258"> <tbody> <tr> <td data-bbox="1071 982 1711 1023">Advair Diskus®</td> <td data-bbox="1711 982 1984 1185" rowspan="5">One inhaler/diskus every 30 days</td> </tr> <tr> <td data-bbox="1071 1023 1711 1063">Advair HFA®</td> </tr> <tr> <td data-bbox="1071 1063 1711 1104">AirDuo™ RespiClick®</td> </tr> <tr> <td data-bbox="1071 1104 1711 1144">fluticasone-salmeterol</td> </tr> <tr> <td data-bbox="1071 1144 1711 1185">fluticasone/vilanterol (Breo Ellipta®)</td> </tr> <tr> <td data-bbox="1071 1185 1711 1226">Budesonide/formoterol (Symbicort®)</td> <td data-bbox="1711 1185 1984 1258" rowspan="2">Up to 8 inhalers every 180 days</td> </tr> <tr> <td data-bbox="1071 1226 1711 1258">Dulera®</td> </tr> </tbody> </table>	FDA / Compendia-Supported Age		Advair Diskus®	≥ 4 years	Advair HFA®	≥ 12 years	AirDuo™ RespiClick®	> 12 years	Dulera® 100 mcg and 200 mcg	≥ 12 years	Dulera® 50 mcg	≥ 4 years	fluticasone-salmeterol	> 4 years	budesonide-formoterol (Symbicort®) 80/4.5 mcg	≥ 4 years	budesonide-formoterol (Symbicort®) 160/4.5 mcg	≥ 12 years	fluticasone/vilanterol (Breo Ellipta®)	≥ 18 years	Advair Diskus®	One inhaler/diskus every 30 days	Advair HFA®	AirDuo™ RespiClick®	fluticasone-salmeterol	fluticasone/vilanterol (Breo Ellipta®)	Budesonide/formoterol (Symbicort®)	Up to 8 inhalers every 180 days	Dulera®
FDA / Compendia-Supported Age																															
Advair Diskus®	≥ 4 years																														
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AirDuo™ RespiClick®	> 12 years																														
Dulera® 100 mcg and 200 mcg	≥ 12 years																														
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fluticasone-salmeterol	> 4 years																														
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Advair Diskus®	One inhaler/diskus every 30 days																														
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fluticasone/vilanterol (Breo Ellipta®)																															
Budesonide/formoterol (Symbicort®)	Up to 8 inhalers every 180 days																														
Dulera®																															
<b>Corticosteroids – Intranasal</b>																															
budesonide OTC fluticasone fluticasone OTC Nasonex® OTC	azelastine-fluticasone (gen Dymista®) Dymista® flunisolide mometasone Rx, OTC	<p><b>CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>Clinical consideration in regard to drug interactions will be given to patients with HIV/AIDS diagnosis or antiretroviral therapy in history</li> </ul>																													

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## NYRx, the Medicaid Pharmacy Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
<b>XV. Respiratory</b>		
Omnaris® triamcinolone OTC Zetonna®	QNASL® <sup>CC</sup> Ryaltris® Xhance™	
<b>Leukotriene Modifiers</b>		
montelukast tablet, chew tab	Accolate® montelukast granules Singulair® zafirlukast zileuton ER	

# **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 a PA 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 PA 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 PA worksheets are available online at

[https://newyork.fhsc.com/providers/CDRP\\_about.asp](https://newyork.fhsc.com/providers/CDRP_about.asp).

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

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

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

- [Anabolic Steroids: https://newyork.fhsc.com/providers/CDRP\\_anabolic\\_steroids.asp](https://newyork.fhsc.com/providers/CDRP_anabolic_steroids.asp)

## 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 4 through 57.

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Corticotropin (Acthar <sup>®</sup> , Cortrophin <sup>®</sup> )	<p>Requires trial of first-line therapy for all FDA-approved indications, other than infantile spasms.</p> <p><b>Note:</b> It is first line therapy for infantile spasms in children less than 2 years of age – step therapy not required.</p>	<p><b>QUANTITY LIMITS:</b></p> <ul style="list-style-type: none"> <li>• Infantile spasms – 30 mL (six 5 mL vials)</li> <li>• Multiple sclerosis – 35 mL (seven 5 mL vials)</li> <li>• Multiple sclerosis - 40 u/0.5mL and 80 u/mL Selfject = 21 syringes</li> </ul> <p><b>DURATION LIMITS:</b></p> <ul style="list-style-type: none"> <li>• Infantile spasms – 4 weeks; indicated for &lt; 2 years of age</li> <li>• Multiple sclerosis – 5 weeks</li> <li>• Rheumatic disorders – 5 weeks</li> <li>• Dermatologic conditions – 5 weeks</li> <li>• Allergic states (serum sickness) – 5 weeks</li> </ul>	<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>• Not covered for diagnostic purposes</li> </ul>

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

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

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

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

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

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

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

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Imcivree™ (setmelanotide)			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>• Please be prepared to respond to a series of questions that identify the prescriber, the patient, and the reason for prescribing this drug.</li> <li>• Please be prepared to fax clinical documentation upon request.</li> </ul> <p>The Imcivree fax form can be found at:  <a href="https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_Imcivree.pdf">https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_Imcivree.pdf</a></p>
ivermectin (oral)			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> </ul>
Lidocaine patches <ul style="list-style-type: none"> <li>• lidocaine 5% patch (Lidoderm®)</li> <li>• lidocaine 1.8% patch (ZTLido™)</li> </ul>	<ul style="list-style-type: none"> <li>• Trial of an alternate first line agent to treat diagnosis</li> </ul>	<ul style="list-style-type: none"> <li>• Maximum 3 patches per day</li> <li>• Prescriptions can be written for a 30-day supply with up to 2 refills</li> </ul>	<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
methadone	<ul style="list-style-type: none"> <li>Requires a trial of a long-acting opioid prior to initiation for the management of chronic non-cancer pain</li> </ul>	<p><b>QUANTITY LIMIT:</b></p> <ul style="list-style-type: none"> <li>12 units per day, 360 units per 30 days</li> <li>Exemption for diagnosis of cancer, hospice care, or sickle cell disease</li> </ul>	<ul style="list-style-type: none"> <li>Confirm diagnosis of chronic non-cancer pain</li> <li>Limited to a total of 4 opioid prescriptions every 30 days;</li> <li>PA required for initiation of methadone for patients on established opioid dependence therapy</li> <li>PA required for methadone prescriptions for patients currently on long-acting opioid therapy.</li> <li>PA required for initiation of long-acting opioid therapy in opioid-naïve patients.</li> <li>PA required for use if &gt; 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting &gt; 7 days).</li> <li>PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy</li> <li>Exemption for diagnosis of cancer, sickle cell, or hospice care</li> </ul>
metoclopramide nasal spray (Gimoti™)			<ul style="list-style-type: none"> <li>Metoclopramide nasal spray confirm diagnosis of diabetes</li> </ul>

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Ovulation Enhancing Drugs <ul style="list-style-type: none"> <li>• bromocriptine</li> <li>• clomiphene</li> <li>• letrozole</li> <li>• tamoxifen</li> </ul>			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>• Refer to <a href="https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-06.htm#ovulation">https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-06.htm#ovulation</a></li> </ul>
Oxazolidinone Antibiotics <ul style="list-style-type: none"> <li>• linezolid (Zyvox®)</li> <li>• tedizolid (Sivextro®)</li> </ul>			<ul style="list-style-type: none"> <li>• Please be prepared to respond to a series of questions that identify the prescriber, the patient, and the reason for prescribing this drug.</li> <li>• Please be prepared to fax clinical documentation upon request.</li> </ul> <p>The Oxazolidinone Antibiotics fax form can be found at: <a href="https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_oxazolidinone_antibiotic.pdf">https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_oxazolidinone_antibiotic.pdf</a></p>
Pubertal Suppressants <ul style="list-style-type: none"> <li>• leuprolide acetate (Lupron Depot-PED®, Eligard®, Fensolvi®, Lupron Depot®)</li> <li>• nafarelin acetate (Synarel®)</li> <li>• triptorelin (Triptodur®)</li> </ul>			<ul style="list-style-type: none"> <li>• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>• Refer to <a href="https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender">https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender</a> for Transgender Related Care and Services Update</li> </ul>

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

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
tasimelteon (Hetlioz <sup>®</sup> , Hetlioz <sup>®</sup> LQ)		<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>One unit per day; 30 units per 30 days</li> </ul>	<ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> </ul>
Parathyroid Hormone Analogs <ul style="list-style-type: none"> <li>teriparatide (Forteo<sup>®</sup>, Bonsity<sup>®</sup>)</li> <li>abaloparatide (Tymlos<sup>®</sup>)</li> </ul>	<ul style="list-style-type: none"> <li>Requires a trial with a preferred oral bisphosphonate</li> </ul>	<b>QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>One unit per 28-day period</li> </ul> <b>LIFETIME QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>25 months' cumulative use of a PTH analog</li> </ul>	
Topical Compounded Prescriptions			<ul style="list-style-type: none"> <li>Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</li> <li>For non-opioid pain management alternatives please visit: <a href="https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf">https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf</a></li> </ul>
semaglutide (Wegovy <sup>®</sup> )		<b>LIFETIME QUANTITY LIMIT:</b> <ul style="list-style-type: none"> <li>Two treatment attempts per lifetime</li> </ul>	<ul style="list-style-type: none"> <li>Confirm diagnosis of cardiovascular disease</li> <li>Confirm patient BMI of <math>\geq 40\text{kg/m}^2</math></li> <li>Confirm patient is participating in lifestyle modifications that support cardiovascular health</li> </ul>

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

## Medication Assisted Treatment (MAT) Formulary

Medication Assisted Treatment (MAT) Formulary	
**Prior authorization will not be required for medications used for the treatment of substance use disorder when prescribed according to generally accepted national professional guidelines for the treatment of a substance use disorder. **	
Drugs	Coverage Parameters
<b>Opioid Antagonists</b>	
Kloxxado™ naloxone (syringe, vial, nasal spray) naloxone (nasal spray) OTC naltrexone Narcan® (nasal spray) Narcan® OTC Opvee® Rextovy® Zimhi™	
<b>Opioid Dependence Agents – Injectable</b>	
Brixadi™ Sublocade™ Vivitrol®	
<b>Opioid Dependence Agents – Oral/Transmucosal <span style="color: red;">F/Q/D</span></b>	
buprenorphine (tablet) buprenorphine/naloxone (tablet) buprenorphine/naloxone (film) Suboxone® (film) Zubsolv®	<p><b>QUANTITY LIMIT:</b></p> <ul style="list-style-type: none"> <li>• <b>buprenorphine sublingual (SL):</b> Eight tablets dispensed as a 2-day supply; not to exceed 32 mg per day</li> <li>• <b>buprenorphine / naloxone tablet and film (Suboxone® 2mg/0.5mg, Zubsolv® 1.4mg/0.36mg, 0.7mg/0.18mg strength; Up to 12 sublingual tablets or films per day.</b></li> <li>• <b>buprenorphine/naloxone tablet and film (Suboxone® up to 4mg/1mg and 8mg/2mg strength, Zubsolv® 2.9mg/0.71mg and 5.7mg/1.4mg strength; Four sublingual tablets or films per day; maximum of 120 tablets or films dispensed as a 30-day supply, not to exceed 32 mg-8 mg of Suboxone®, or its equivalent per day</b></li> <li>• <b>buprenorphine/naloxone tablet: Suboxone® 12mg/3mg, Zubsolv® 8.6 mg/2.1 mg and Zubsolv® 11.4 mg/2.9 mg strength: Maximum of 60 tablets dispensed as a 30-day supply</b></li> </ul> <p><b>RELATED CLINICAL CRITERIA (CC)</b></p> <ul style="list-style-type: none"> <li>• PA required for initiation of <b>opioid therapy</b> for patients established on opioid dependence therapy</li> <li>• PA required for initiation of a <b>CNS stimulant</b> for patients established on opioid dependence therapy</li> </ul>

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

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

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

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

### Effective February 19, 2026:

- Cipro HC will be **added** to the program
- Daytrana<sup>®</sup>, Exelon<sup>®</sup> patch, Jynarque<sup>®</sup>, Motegrity<sup>®</sup>, Nexavar<sup>®</sup> Trileptal<sup>®</sup> suspension and Votrient<sup>®</sup> will be **removed** from the program

List of Brand Name Drugs included in this program**		
Acular LS <sup>®</sup>	Copaxone <sup>®</sup> 20 mg SQ	Ravicti <sup>®</sup>
Advair Diskus <sup>®</sup>	Depakote <sup>®</sup> Sprinkle	Restasis <sup>®</sup>
Advair HFA <sup>®</sup>	EpiPen	Risperdal Consta <sup>®</sup>
Alphagan P <sup>®</sup> 0.15%	EpiPen Jr	Spiriva <sup>®</sup> Handihaler <sup>®</sup>
Alphagan P <sup>®</sup> 0.1%	Farxiga <sup>®</sup>	Symbicort <sup>®</sup>
Anoro Ellipta <sup>®</sup>	Forteo <sup>®</sup>	Tegretol <sup>®</sup> suspension
Arnuity Ellipta <sup>®</sup>	Istalol <sup>®</sup>	Tegretol <sup>®</sup> tablet
Azopt <sup>™</sup>	Kitabis <sup>®</sup> Pak	Tegretol <sup>®</sup> XR
Bethkis <sup>®</sup>	Myrbetriq <sup>®</sup>	Ventolin <sup>®</sup> HFA
Carbaglu <sup>®</sup>	Oxtellar XR <sup>®</sup>	Victoza <sup>®</sup>
Carbatrol <sup>®</sup>	Pentasa <sup>®</sup>	Vyvanse <sup>®</sup> capsules
<b>Cipro HC</b>	Promacta <sup>®</sup> tablets	Xarelto <sup>®</sup> 2.5 mg tablet
Cipro <sup>®</sup> oral suspension	Protonix <sup>®</sup> suspension	Xigduo <sup>®</sup> XR
Combigan <sup>®</sup>	Pylera <sup>®</sup>	Zavesca <sup>®</sup>
Complera <sup>®</sup>		

\*\*List is subject to change

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

## Important Billing Information

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

## NYS Medicaid NYRx Mandatory Generic Drug Program

State law excludes Medicaid coverage of brand name drugs that have a Federal Food and Drug Administration (FDA) approved A-rated generic equivalent unless a PA 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 PA 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®, Levoxy®)	

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

## NYS Medicaid NYRx Dose Optimization Program

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

### Dose Optimization Chart

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

Brand Name	Dose Optimization Limitations		
<b>CENTRAL NERVOUS SYSTEM</b>			
<b>Anticonvulsants</b>			
Aptiom® 200 mg, 400 mg	1 daily	Tablet	
Fycompa® 4 mg, 6 mg	1 daily	Tablet	
topiramate ER 100 mg (Qudexy® XR, Trokendi XR®)	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	Capsule	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
Qudexy® XR 100 mg	1 daily	Capsule	
Lyrica® 225 mg and 300 mg	2 daily	Capsule	
Trokendi XR® 100 mg	1 daily	Capsule	
<b>Antiparkinson Agents</b>			
Azilect® 0.5 mg	1 daily	Tablet	
<b>Antipsychotics – Second Generation</b>			
Abilify® 2 mg	4 daily	Tablet	In case of dose titration for these medications, the Department will allow for multiday dosing (up to 2 doses/daily) for titration purposes for three months
Abilify® 5 mg, 10 mg, 15 mg	1 daily	Tablet	
aripiprazole 5 mg, 10 mg, 15 mg	1 daily	Tablet	
Invega® 1.5 mg, 3 mg	1 daily	Tablet	
Latuda® 20 mg, 40 mg, 60 mg	1 daily	Tablet	
olanzapine 5 mg, 10 mg	1 daily	Tablet	
olanzapine ODT 5 mg, 10 mg	1 daily	Tablet	
paliperidone er 1.5 mg, 3 mg	1 daily	Tablet	
quetiapine fumarate er 200 mg, 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® Zydys 5 mg, 10 mg	1 daily	Tablet	

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

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

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

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

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

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

## NYRx Cost Optimization Program (Cost-Op)

In December 2025, NYRx, the Medicaid Pharmacy program initiated a cost optimization program. This program focuses on new formulations and dosages of older drug products that are disproportionately priced to other strengths of the same drug or similar drugs in the same drug class without any additional clinical benefit. Prescribers are encouraged to achieve the desired dose by using multiple or half of the lower cost strength or choosing the lower cost formulation (e.g., tablets versus capsules), or choosing a lower cost therapeutic comparable drug in the same drug class. If a prescriber has determined that one of these drugs is the only appropriate treatment for a Medicaid member, they may submit a letter of medical necessity and supporting documentation to the Department. The letter must accompany patient chart notes and peer reviewed medical literature that supports the use of the requested drug unit strength or dosage form. This information should be sent to [NYRx@health.ny.gov](mailto:NYRx@health.ny.gov). A review will be conducted once all the listed information is received.

Drugs in the Cost-Op program that are also included in another NYRx, Medicaid pharmacy program will be identified with a “MR” after the drug. For example, Ibuprofen 300mg <sup>MR</sup>.

Additional information and the current list of drugs in the Cost-op program can be found at [https://www.emedny.org/info/NYRx\\_Cost\\_Optimization\\_Program.pdf](https://www.emedny.org/info/NYRx_Cost_Optimization_Program.pdf).

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 PA, please call the 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 PA to be obtained.