NYRx, the Medicaid Drug Program

OVERVIEW OF CONTENTS

Electronic prior authorizations are now accepted by NYRx, the Medicaid Drug 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

Preferred Drug Program (PDP) (Pages 4–61)

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 Drug 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 62)

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 63–75)

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 76)

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 77–78)

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 Drug Program: http://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm
To contact the NYRx Clinical Call Center please call 1-877-309-9493
To download a copy of the Prior Authorization fax form go to https://newyork.fhsc.com/providers/PA_forms.asp

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

NYRx, the Medicaid Drug Program Preferred Drug List

Mandatory Generic Drug Program (Page 79)

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 80–84)

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 85)

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 Drug Program Preferred Drug List

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Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
I. Analgesics		
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) CC		
Celebrex® celecoxib diclofenac 1% topical gel diclofenac sodium oral ibuprofen Rx tablet, suspension ibuprofen OTC suspension indomethacin capsule ketorolac meloxicam tablet nabumetone naproxen tablet piroxicam sulindac	Arthrotec® Coxanto™ MR Daypro® diclofenac epolamine patch diclofenac/misoprostol diclofenac potassium 25 mg capsule, tablet MR diclofenac potassium tablet diclofenac potassium (gen Cambia®) diclofenac sodium ER diclofenac topical solution diflunisal diflunisal 250 mg, 375 mg MR Elyxyb™ F/Q/D etodolac etodolac ER fenoprofen 200 mg, 300 mg, 400 mg capsule MR flurbiprofen MR ibuprofen 300 mg MR ibuprofen/famotidine (gen Duexis®) indomethacin ER indomethacin suspension MR ketoprofen ketoprofen 75 mg capsule MR ketoprofen ER MR meclofenamate mefenamic acid meloxicam capsule (gen Vivlodex®) MR Naprelan® MR naproxen suspension naproxen CR / ER MR	**CLINICAL CRITERIA (CC)** • PA required for patients utilizing two (2) or more NSAIDS concurrently. **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Elyxyb™ (celecoxib) – 4.8 mL bottle (120 mg) maximum quantity: 9 bottles / 30 days

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

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
I. Analgesics		
Opioids – Short-Acting [CC]		
butalbital/APAP/caffeine/codeine codeine codeine/APAP hydrocodone/APAP hydrocodone/ibuprofen hydromorphone tablet morphine IR oxycodone IR tablet, solution oxycodone/APAP tramadol tablet	butalbital compound/codeine butorphanol nasal spray dihydrocodeine/APAP/caffeine Dilaudid® hydromorphone solution levorphanol meperidine oxycodone IR capsule, concentrate oxycodone/APAP 2.5 mg, 5 mg, 7.5 mg, 10 mg/300 mg oxymorphone pentazocine/naloxone Percocet® RoxyBond Roxicodone® tapentadol (gen Nucynta®) tramadol solution tramadol 25mg, 75mg tablet tramadol/APAP	**CLINICAL CRITERIA (CC) *** • Limited to a total of 4 opioid prescriptions every 30 days. • Initial prescription for opioid-naïve patients limited to a 7-day supply. • PA required for initiation of opioid therapy for patients on established opioid dependence therapy. • PA required for use if ≥ 90 MME of opioid per day for management of non-acute pain (> 7 days) – Exception for diagnosis of cancer or sickle cell disease, or hospice or palliative care programs • PA is required for opioid-naïve patients for prescription requests ≥ 50 MME per day. • PA required for continuation of opioid therapy beyond an initial 7-day supply in patients established on gabapentin or pregabalin • PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy • PA required for any codeine- or tramadol-containing products in patients < 12 years • PA required for continuation of opioid therapy for > 7 days for patients on established CNS stimulant therapy **STEP THERAPY (ST)** • For Non-opioid Pain management alternatives please visit: https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf *Exemptions from requirements for diagnosis of cancer, sickle cell disease, or hospice or palliative care

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Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
II. Anti-Infectives		
Antibiotics – Inhaled CC, F/Q/D		
Bethkis® BLTG Kitabis® Pak BLTG tobramycin solution (gen TOBI®)	Cayston® 2 TOBI Podhaler™ 2 TOBI® solution tobramycin solution (gen Bethkis®, Kitabis®)	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Aztreonam (Cayston) – 3 ampules (3 mL) per day – 84 ampules (84 mL) per 56-day regimen (28 days on, 28 days off) • Tobramycin inhalation solution (Bethkis, TOBI, Kitabis Pak) – 2 ampules (8 mL Bethkis, 10 mL TOBI, Kitabis Pak) per day – 56 ampules (224 mL Bethkis, 280 mL TOBI, Kitabis Pak) per 56-day regimen (28 days on-28 days off) • Tobramycin capsules with inhalation powder (TOBI Podhaler) – 8 capsules per day 224 capsules per 56-day regimen (28 days on-28 days off)
Antibiotics – Vaginal F/Q/D		
Cleocin® ovules 1 metronidazole 1 Nuvessa® 1 Xaciato® 1	Cleocin® cream 2 clindamycin 2 Clindesse® 2 Vandazole® 2	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Cleocin ovules - 3 suppositories in 180 days. • metronidazole 0.75% gel - 140 grams in 180 days. • Nuvessa 1.3% gel - 5 grams in 180 days. • Xaciato - 8 grams in 180 days • clindamycin 2% cream - 120 grams in 365 days • Clindesse - 5 grams in 180 days.
Anti-Fungals – Oral for Onychomycosis		
griseofulvin suspension, ultramicrosize tablet terbinafine tablet	griseofulvin microsize tablet griseofulvin 165 mg ultramicrosize tablet MR	

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Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
II. Anti-Infectives		
	itraconazole itraconazole solution (gen Sporanox) Sporanox®	
Anti-Virals - COVID		
Paxlovid™		
Anti-Virals – Oral		
acyclovir famciclovir valacyclovir	Valtrex®	
Cephalosporins – Third Generation		
cefdinir	cefixime cefixime 400 mg tablet MR cefpodoxime	
Fluoroquinolones – Oral		
Cipro® suspension BLTG ciprofloxacin tablet levofloxacin tablet moxifloxacin	Baxdela® Cipro® tablet ciprofloxacin suspension levofloxacin solution ofloxacin tablet	
Hepatitis B Agents		
adefovir dipivoxil Baraclude® solution entecavir lamivudine HBV	Baraclude® tablet Vemlidy®	
Hepatitis C Agents – Direct Acting Antivirals		
Mavyret™ ribavirin sofosbuvir/velpatasvir (gen Epclusa®) Vosevi®	Epclusa® Harvoni® ledipasvir/sofosbuvir (gen Harvoni®) Sovaldi® Zepatier®	

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Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
II. Anti-Infectives		
Tetracyclines		
demeclocycline doxycycline hyclate minocycline capsule tetracycline capsule	Doryx® ST Doryx MPC® ST doxycycline hyclate 50 mg tablet MR Doxycycline hyclate 75 mg capsule MR doxycycline hyclate DR ST doxycycline monohydrate doxycycline monohydrate 75 mg, 150 mg capsule MR minocycline tablet minocycline ER tablet Nuzyra™ tetracycline 250 mg, 500 mg tablet MR	**STEP THERAPY (ST)** • Trial of doxycycline IR before progressing to doxycycline DR

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
III. Cardiovascular		
Angiotensin Converting Enzyme (ACE) Inhibitors		
benazepril enalapril lisinopril ramipril	Accupril® Altace® captopril enalapril solution (gen Epaned®) Epaned® fosinopril Lotensin® moexipril perindopril Qbrelis™ quinapril trandolapril Zestril®	

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Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
III. Cardiovascular		
ACE Inhibitor Combinations		
benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ lisinopril/HCTZ Lotrel® trandolapril/verapamil ER	Accuretic® fosinopril/HCTZ Lotensin HCT® quinapril/HCTZ Zestoretic®	
Angiotensin Receptor Blockers (ARBs)		
irbesartan losartan olmesartan telmisartan valsartan tablet	Arbli™ Atacand® Avapro® azilsartan (gen Edarbi®) Benicar® DO candesartan Cozaar® Diovan® DO Edarbi® eprosartan Micardis® DO valsartan solution	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths
ARBs Combinations		
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® DO candesartan/HCTZ Diovan HCT® DO Edarbyclor® DO Entresto® Entresto® Sprinkle Exforge® DO Hyzaar®	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths

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Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
III. Cardiovascular		
	Micardis HCT® DO olmesartan/amlodipine/HCTZ telmisartan/amlodipine Tribenzor® Widaplik™	
Beta Blockers		
atenolol carvedilol Hemangeol® labetalol metoprolol succ. XL metoprolol tartrate propranolol tablet propranolol ER	acebutolol betaxolol bisoprolol Bystolic® DO carvedilol ER Inderal LA® Inderal XL® InnoPran XL® Kapspargo™ Sprinkle Lopressor® Lopressor® 12.5 mg MR metoprolol tartrate 12.5 mg MR nadolol DO nebivolol (gen Bystolic®) pindolol propranolol solution Tenormin® timolol Toprol XL® DO	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths
Beta Blockers / Diuretics		
atenolol/chlorthalidone bisoprolol/HCTZ	metoprolol tartrate/ HCTZ Tenoretic®	
Calcium Channel Blockers (Dihydropyridine)		
amlodipine felodipine ER isradipine	Katerzia™ levamlodipine nisoldipine Norliqva®	

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Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
III. Cardiovascular		
nicardipine HCl nifedipine nifedipine ER/SA	Norvasc® Procardia XL® Sdamlo™ MR Sular®	
Cholesterol Absorption Inhibitors		
cholestyramine cholestyramine light Colestid® tablet colestipol tablet ezetimibe	colesevelam Colestid granules, packet colestipol granules, packet Welchol® Zetia®	
HMG-CoA Reductase Inhibitors (Statins)		
atorvastatin lovastatin pravastatin rosuvastatin simvastatin	Altoprev® Atorvaliq® atorvastatin/amlodipine Caduet® Crestor® DO ezetimibe/simvastatin fluvastatin fluvastatin ER Lescol XL® Lipitor® Livalo® pitavastatin (gen Livalo®) Vytorin® Zocor®	
Lipotropics, Other		
Praluent® 1 Repatha® 1	Lipfendra® Redemplo® 2 Tryngolza® 2	

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Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
III. Cardiovascular		
Phosphodiesterase Type-5 (PDE-5) Inhibitors for PAH CC		
sildenafil tadalafil	Adcirca® Opsynvi® Revatio® Tadliq®	**CLINICAL CRITERIA (CC)** • PA is required for all drugs in this class • Prescribers or their authorized agents are required to respond to a series of questions that identify prescriber, patient, and reason for prescribing drug • Please be prepared to fax clinical documentation upon request • Prescriptions can be written for a 30-day supply with up to 11 refills
Pulmonary Arterial Hypertension (PAH) Agents, Other		
ambrisentan (gen Letairis) bosentan tablet (gen Tracleer®)	Adempas® bosentan tablet for suspension (gen Tracleer®) Letairis® macitentan (gen Opsumit®) Opsumit® Orenitram® ER tablet, dosepack Tracleer® tablet for suspension, tablet Tyvaso® Uptravi® Winrevair™ Yutrepia™	
Triglyceride Lowering Agents		
fenofibrate tablet (gen Tricor®) fenofibrate capsule, tablet (gen Lofibra®) fenofibric acid capsule (gen Trilipix®) gemfibrozil icosapent ethyl F/Q/D omega-3-acid ethyl esters (gen Lovaza®) F/Q/D	Fenofibrate 50 mg, 150 mg capsule (gen Lipofen®) MR fenofibrate micronized capsule fenofibrate 40 mg, 120 mg tablet (gen Fenoglide®) MR fenofibric acid tablet (gen Fibricor®) Fibricor® Lipofen® MR Lopid® Tricor®	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • omega-3-acid ethyl esters (gen Lovaza®) and icosapent ethyl – Required dosage equal to 4 grams per day

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Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
IV. Central Nervous System		
Alzheimer's Agents		
donepezil 5 mg, 10 mg, ODT galantamine galantamine ER memantine rivastigmine capsule, patch	Adlarity® Aricept® donepezil 23 mg Exelon® patch memantine ER memantine-donepezil ER (gen Namzaric®) Namenda XR® Namzaric® Zunveyl® DR	
Anticonvulsants – Carbamazepine Derivatives		
carbamazepine chewable Carbatrol® BLTG Equetro® oxcarbazepine Oxtellar XR® DO, BLTG Tegretol® suspension, tablet BLTG Tegretol XR® BLTG	Aptiom® CC, DO carbamazepine suspension carbamazepine tablet carbamazepine ER capsule carbamazepine XR tablet eslicarbazepine (gen Aptiom) CC oxcarbazepine ER (gen Oxtellar XR®) Trileptal® CC	**CLINICAL CRITERIA (CC)** • Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA **DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths
Anticonvulsants - Nasal		
Nayzilam® Valtoco®		
Anticonvulsants – Other		
clobazam tablet ST, CC gabapentin capsule, solution, tablet F/Q/D, CC lacosamide tablet, solution lamotrigine tablet, chew levetiracetam	Banzel® brivaracetam (gen Briviact®) Briviact® clobazam suspension ST, CC Diacomit® CC Elepsia® XR	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths **CLINICAL CRITERIA (CC)** • Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
IV. Central Nervous System		
levetiracetam ER Lyrica® capsule DO, F/Q/D, CC pregabalin capsule F/Q/D, CC tiagabine topiramate CC zonisamide	Epidiolex® CC Eprontia™ CC, F/Q/D felbamate Felbatol® Fintepla® Fycompa® DO gabapentin 100 mg, 400 mg tablet, 200 mg capsule F/Q/D, CC, MR Keppra® Keppra XR® Lamictal® tablet, chew, dosepak Lamictal® ODT tablet, dosepak Lamictal® XR tablet DO , dosepak lamotrigine dosepak lamotrigine ER lamotrigine ODT dosepak levetiracetam (gen Spritam®) Lyrica® solution F/Q/D, CC Lyrica® CR F/Q/D, CC Motpoly XR Neurontin® F/Q/D, CC Onfi® ST, CC perampanel (gen Fycompa®) pregabalin solution F/Q/D, CC pregabalin ER (gen Lyrica® CR) F/Q/D, CC Qudexy® XR CC, DO relgaabi MR rufinamide (gen Banzel®) Sabril® Spritam® Subvenite® suspension Sympazan® film ST, CC	• Diacomit® (stiripentol) – Require diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form • Epidiolex® (cannabidiol extract) – Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication, or; Institutional Review Board (IRB) approval with signed consent form • Lyrica®/Lyrica® CR (pregabalin/pregabalin ER) – PA required for the initiation of pregabalin at > 150 mg per day in patients currently on an opioid at > 50 MME per day • Neurontin® (gabapentin) – PA required for initiation of gabapentin at > 900 mg per day in patients currently on an opioid at > 50 MME per day • Onfi®/Sympazan® (clobazam): – Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication – PA required for initiation of clobazam therapy in patients currently on opioid or oral buprenorphine therapy – PA required for any clobazam prescription in patients currently on benzodiazepine therapy • Topiramate IR/ER (Eprontia™, Qudexy® XR, Topamax®, Trokendi XR™) – Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Vigafyde™ (vigabatrin): – Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Eprontia™ (topiramate) – Maximum quantity: 473 mL per month • Lyrica®/Lyrica® CR (pregabalin/pregabalin ER) – Maximum daily dose of IR: 600 mg per day, and ER: 660 mg per day • Neurontin® (gabapentin) – Maximum daily dose of 3,600 mg per day

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<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Coverage Parameters</th></tr>
<tr><td colspan="3">IV. Central Nervous System</td></tr>
<tr><td></td><td>Topamax® CC
topiramate 50mg Sprinkle CC
topiramate ER (gen Qudexy® XR) CC, DO
topiramate ER (gen Trokendi XR®) CC, DO
topiramate solution (gen Eprontia™) CC, F/Q/D
Trokendi XR® CC, DO
vigabatrin
Vigafyde™ CC
Vimpat®
Xcopri®
Zonisade™
Ztalmy®</td><td>STEP THERAPY (ST)
• Onfi®/Sympazan® (clobazam) – Requires a trial with an SSRI or SNRI for treatment of anxiety</td></tr>
<tr><td colspan="3">Antimigraine Agents, Other F/Q/D</td></tr>
<tr><td>Aimovig®
Ajovy®
Emgality® 120 mg syringe, pen
Qulipta® ST
Ubrelvy™ ST</td><td>Emgality® 100mg syringe
Nurtec® ODT CC, ST
Reyvow™ ST
Zavzpret™ ST</td><td>CLINICAL CRITERIA (CC)
• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication
STEP THERAPY (ST)
• Qulipta® (atogepant) - Requires trial of a preferred monoclonal antibody
• Acute treatment of migraine - Trial of a product from the Antimigraine Agents-Triptan class
FREQUENCY/QUANTITY/DURATION (F/Q/D)
<table>
<tr><th>Agent</th><th>F/Q/D</th></tr>
<tr><td>Aimovig</td><td>1 syringe/30 days</td></tr>
<tr><td>Emgality 120 mg</td><td>2 syringes/30 days</td></tr>
<tr><td>Emgality 100 mg</td><td>3 syringes/30 days</td></tr>
<tr><td>Ajovy</td><td>3 syringes/90 days</td></tr>
<tr><td>Reyvow</td><td>8 units/30 days</td></tr>
</table></td></tr>
</table>

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<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Coverage Parameters</th></tr>
<tr><td colspan="3">IV. Central Nervous System</td></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Ubrelvy</td><td>16 units/30 days</td></tr>
<tr><td>Nurtec™ ODT</td><td>24 units/40 days</td></tr>
<tr><td>Qulipta</td><td>30 units/30 days</td></tr>
<tr><td>Zavzpret®</td><td>6 units/30 days</td></tr>
</table>
</td></tr>
<tr><td colspan="3">Antimigraine Agents – Triptans</td></tr>
<tr><td>rizatriptan F/Q/D
sumatriptan F/Q/D</td><td>almotriptan F/Q/D
eletriptan F/Q/D
frovatriptan F/Q/D
Imitrex® F/Q/D
Maxalt® F/Q/D
Maxalt® MLT F/Q/D
naratriptan F/Q/D
Relpax® F/Q/D
sumatriptan-naproxen F/Q/D
Symbravo® F/Q/D
Tosymra™ F/Q/D
Zembrace™ SymTouch™
zolmitriptan F/Q/D
Zomig® F/Q/D</td><td>FREQUENCY/QUANTITY/DURATION (F/Q/D)
<table>
<tr><th>Agent</th><th>F/Q/D</th></tr>
<tr><td>almotriptan
eletriptan (Relpax®)
frovatriptan
naratriptan
rizatriptan (Maxalt®)
rizatriptan (Maxalt® MLT)
sumatriptan nasal spray (Imitrex®)
sumatriptan (Imitrex®)
sumatriptan-naproxen
Tosymra™ nasal spray
zolmitriptan (Zomig®)
zolmitriptan nasal spray (Zomig®)</td><td>18 units/30 days</td></tr>
<tr><td>meloxicam/rizatriptan (Symbravo®)</td><td>9 units/30 days</td></tr>
</table>
</td></tr>
<tr><td colspan="3">Antipsychotics – Injectable</td></tr>
<tr><td>Abilify Asimtufii®
Abilify Maintena®
Aristada®
Aristada Initio®
fluphenazine decanoate
haloperidol decanoate
Invega Hafyera™
Invega Sustenna®
Invega Trinza®
Perseris™
Risperdal Consta® BLTG</td><td>Erzofri®
risperidone injection (gen Risperdal Consta®)
Rykindo®</td><td></td></tr>
</table>

1 = Preferred as of 10/22/2026
2 = Non-Preferred as of 10/22/2026

Standard PA fax form:
https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
IV. Central Nervous System		
Uzedy™ Zyprexa Relprevv®		
Antipsychotics – Second Generation CC, ST		
aripiprazole tablet DO asenapine (gen Saphris®) clozapine lurasidone (gen Latuda®) olanzapine tablet DO olanzapine ODT DO paliperidone ER DO quetiapine F/Q/D quetiapine ER F/Q/D, DO risperidone tablet, solution Vraylar® DO ziprasidone capsule	Abilify® tablet DO aripiprazole solution aripiprazole ODT Caplyta™ clozapine ODT Clozaril® Cobenfy™ capsule, starter pack Fanapt® Geodon® Invega® DO Latuda® DO Lybalvi® Nuplazid® olanzapine / fluoxetine Opipza™ Rexulti® DO Risperdal® risperidone ODT Saphris® Secuado® Seroquel® F/Q/D Seroquel XR® DO, F/Q/D Versacloz® Zyprexa® Zyprexa® Zydis DO	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths **CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA • PA is required when an oral SGA is utilized above the highest MDD according to FDA labeling. • 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. • 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. • PA is required for initial prescription for patients younger than the drug-specific minimum age as indicated below: aripiprazole (Abilify®, Opipza™) 6 years asenapine (Saphris®) 10 years asenapine (Secuado®) 18 years brexpiprazole (Rexulti®) 13 years cariprazine (Vraylar®) 10 years clozapine (Clozaril®, Versacloz®) 12 years iloperidone (Fanapt®) 18 years lumateperone (Caplyta™) 18 years lurasidone HCl (Latuda®) 10 years olanzapine (Zyprexa®) 10 years olanzapine / fluoxetine (Symbyax®) 10 years olanzapine / samidorphan (Lybalvi®) 18 years

NYRx, the Medicaid Drug Program Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Coverage Parameters</th></tr>
<tr><td colspan="3">IV. Central Nervous System</td></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>paliperidone ER (Invega®)</td><td>12 years</td></tr>
<tr><td>pimavanserin (Nuplazid®)</td><td>18 years</td></tr>
<tr><td>quetiapine fum. (Seroquel®, Seroquel XR®)</td><td>10 years</td></tr>
<tr><td>risperidone (Risperdal®)</td><td>5 years</td></tr>
<tr><td>xanomeline-trospium (Cobenfy™)</td><td>18 years</td></tr>
<tr><td>ziprasidone HCl (Geodon®)</td><td>10 years</td></tr>
</table>
• Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients < 18 years of age

STEP THERAPY (ST)
• For all Second Generation Antipsychotics used in the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is required
• olanzapine / fluoxetine: When prescribing for the treatment of major depressive disorder (MDD) in the absence of other psychiatric comorbidities, trial with at least one different antidepressant agent is required
• Vraylar®: for indications other than MDD, trial of a preferred generic is required

FREQUENCY/QUANTITY/DURATION (F/Q/D)
• quetiapine/quetiapine ER (Seroquel®/Seroquel XR®): Minimum 50 mg/day
• quetiapine (Seroquel®): Maximum 3 units/day, 90 units/30 days
• quetiapine ER (Seroquel XR®): 50mg tablets: maximum 2 units/day, 60 units/30 days</td></tr>
<tr><td colspan="3">Central Nervous System (CNS) Stimulants CC, F/Q/D</td></tr>
<tr><td>amphetamine salt combo IR (gen Adderall®)</td><td>Adderall XR® DO
Adzenys XR-ODT®
amphetamine ER ODT (gen Adzenys XR-ODT®)</td><td>CLINICAL CRITERIA (CC)
• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication</td></tr>
</table>

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
IV. Central Nervous System		
amphetamine salt combo ER (gen Adderall XR®) DO dexmethylphenidate (gen Focalin®) dexmethylphenidate ER (gen Focalin XR®) DO dextroamphetamine tablet (gen Dexedrine®) lisdexamfetamine chewable tablet (gen Vyvanse® chew tablet) methylphenidate solution (gen Methylin®) methylphenidate tablet (gen Ritalin®) methylphenidate CD DO methylphenidate ER (gen Aptensio® XR) methylphenidate ER (gen Concerta®) methylphenidate ER (gen Metadate CD) methylphenidate ER (gen Ritalin LA®) Ritalin LA® DO Vyvanse® capsule DO, BLTG	amphetamine sulfate Aptensio XR® armodafinil (gen Nuvigil®) Arynta™ MR Azstarys™ Concerta® DO Cotempla® XR-ODT™ Dexedrine® dextroamphetamine / amphetamine (gen Mydayis™) dextroamphetamine ER (gen Dexedrine®) dextroamphetamine solution dextroamphetamine tablet Dyanavel XR® Focalin® Focalin XR® DO Jornay PM™ lisdexamfetamine capsule (gen Vyvanse®) methamphetamine (gen Desoxyn®) Methylin® methylphenidate (gen Daytrana®) methylphenidate chewable tablet (gen Methylin®) methylphenidate ER 45 mg, 63 mg, 72 mg tablet methylphenidate ER ODT (gen Cotempla® XR-ODT™) modafinil (gen Provigil®) DO Mydayis™ Nuvigil® Provigil® DO QuilliChew ER™ DO Quillivant XR®	• PA is required for initial prescriptions for stimulant therapy for patients **less than 3 years of age** • Confirm diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent for patients **less than 18 years of age** • Patient-specific considerations for drug selection include treatment of narcolepsy, excessive daytime sleepiness, sleepiness associated with shift work sleep disorder, or sleepiness associated with obstructive sleep apnea. • PA required for initiation of CNS Stimulant for patients currently on an opioid • PA required for initiation of CNS Stimulant for patients currently on a benzodiazepine **DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Quantity limits based on daily dosage as determined by FDA labeling

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
IV. Central Nervous System		
	Relexxii® Ritalin® Sunosi™ Vyvanse® chewable tablet Wakix® Xelstrym™	
Movement Disorder Agents CC		
Austedo® Austedo® XR Austedo® XR titration pack Ingrezza® Ingrezza® Sprinkle Ingrezza® titration pack tetrabenazine	Xenazine®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of an FDA-approved or compendia-supported indication and Medicaid covered indication

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
IV. Central Nervous System		
Multiple Sclerosis Agents		
Avonex® Copaxone® 20 mg/mL BLTG 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™ F/Q/D Rebif® Rebif® Rebidose® Tascenso ODT™ Tecfidera® Vumerity® Zeposia® CC, ST	**CLINICAL CRITERIA (CC)** • Zeposia® (ozanimod): Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication **STEP THERAPY (ST)** • Zeposia® (ozanimod): For an indication of Ulcerative Colitis – Trial of a non-specific anti-inflammatory drug such as an aminosalicylate or immunosuppressant, or a non-biologic disease-modifying anti-rheumatic drug (DMARD), and; – Trial of a preferred systemic immunomodulator **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Ponvory™ (ponesimod) starter pack; maximum quantity is 14, no refills • Ponvory™ (ponesimod); maintenance limited to a 30-day supply
Non-Ergot Dopamine Receptor Agonists		
pramipexole ropinirole	Neupro® pramipexole ER ropinirole ER	

NYRx, the Medicaid Drug Program Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Coverage Parameters</th></tr>
<tr><td colspan="3">IV. Central Nervous System</td></tr>
<tr><td colspan="3">Other Agents for Attention Deficit Hyperactivity Disorder (ADHD) CC</td></tr>
<tr><td>atomoxetine capsules DO
clonidine ER
guanfacine ER DO</td><td>atomoxetine solution (gen Atoncy™) MR
Atoncy™, MR
Intuniv® DO
Onyda™ XR
Qelbree®
Strattera® DO</td><td>CLINICAL CRITERIA (CC)
• Confirm diagnosis of an FDA-approved or compendia-supported indication for patients < 18 years of age.
• PA is required for initial prescriptions for non-stimulant therapy for patients less than 6 years of age

DOSE OPTIMIZATION (DO)
• See Dose Optimization Chart for affected drugs and strengths</td></tr>
<tr><td colspan="3">Sedative Hypnotics/Sleep Agents F/Q/D</td></tr>
<tr><td>estazolam CC
eszopiclone
ramelteon (gen Rozerem®)
temazepam 15 mg, 30 mg CC
zaleplon
zolpidem tablet CC
zolpidem ER CC</td><td>Ambien® CC
Ambien CR® CC
Belsomra®
Dayvigo™
Doral® CC
doxepin
Edluar® CC
flurazepam CC
quazepam (gen Doral®) CC
Quviviq™
Restoril® CC
Rozerem®
temazepam 7.5 mg, 22.5 mg CC
triazolam CC
zolpidem sublingual, capsule CC</td><td>CLINICAL CRITERIA (CC)
• Zolpidem products: Confirm dosage is consistent with FDA labeling for initial prescriptions
• Benzodiazepine Agents (estazolam, Doral®, flurazepam, quazepam, Restoril®, temazepam, triazolam):
– Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication
– PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy
– PA required for any additional benzodiazepine prescription in patients currently on benzodiazepine therapy
– PA required when greater than a 14-day supply of a benzodiazepine is prescribed for someone on a CNS stimulant
FREQUENCY/QUANTITY/DURATION (F/Q/D)
• Frequency and duration limits for the following products:
<table>
<tr><th>Agent</th><th>Quantity Limit</th></tr>
<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>
<tr><th>Agent</th><th>Duration Limit</th></tr>
</table>
</td></tr>
</table>

NYRx, the Medicaid Drug Program Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th colspan="2">Coverage Parameters</th></tr>
<tr><td colspan="4">IV. Central Nervous System</td></tr>
<tr><td rowspan="4"></td><td rowspan="4"></td><td>estazolam*; flurazepam*; quazepam (Doral®)*; temazepam (Restoril)*; triazolam*; zaleplon

*For the treatment of insomnia</td><td>30 days</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>
<tr><td colspan="2">Additional/Alternate parameters:
• For patients naïve to non-benzodiazepine sedative hypnotics (NBSH): First-fill duration and quantity limit of 10 dosage units as a 10-day supply, except for zaleplon-containing products which the quantity limit is 20 dosage units as a 10-day supply</td></tr>
<tr><td colspan="4">Selective Serotonin Reuptake Inhibitors (SSRIs)</td></tr>
<tr><td>citalopram tablet, solution
escitalopram tablet
fluoxetine capsule, solution
paroxetine tablet
sertraline tablet, concentrate
vilazodone (gen Viibryd®)</td><td>Celexa®
citalopram capsule MR
escitalopram solution
Escitalopram 15 mg MR
fluoxetine tablet
fluoxetine DR weekly
fluvoxamine CC
fluvoxamine ER CC
Lexapro® DO
paroxetine capsule
paroxetine CR
paroxetine suspension
Paxil®
Paxil CR®
Prozac®</td><td colspan="2">DOSE OPTIMIZATION (DO)
• See Dose Optimization Chart for affected drugs and strengths
CLINICAL CRITERIA (CC)
• Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA
• Clinical editing to allow patients with a diagnosis of Obsessive-Compulsive Disorder (OCD) to receive fluvoxamine and fluvoxamine ER without PA</td></tr>
</table>

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
IV. Central Nervous System		
	sertraline capsule MR Trintellix® DO Viibryd® DO Zoloft®	
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)		
duloxetine 20 mg, 30 mg, 60 mg (gen Cymbalta®) venlafaxine venlafaxine ER capsule	Cymbalta® Desvenlafaxine ER MR desvenlafaxine succinate ER DO Drizalma Sprinkle™ duloxetine 40 mg Duloxetine 80 mg, 90 mg, 120 mg capsule MR Effexor XR® DO Fetzima® milnacipran (gen Savella) Pristiq® DO Savella® Venlafaxine besylate ER MR venlafaxine ER tablet	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
V. Dermatologic Agents		
Acne Agents, Topical		
adapalene/benzoyl peroxide (gen Epiduo®) adapalene cream adapalene OTC gel tazarotene cream 0.1% CC tretinoin cream, gel (gen Retin-A) CC	adapalene Rx gel, gel pump adapalene/benzoyl peroxide (gen Epiduo® Forte) Aklief® clindamycin/tretinoin CC, MR dapsone Differin® cream, gel pump, lotion, OTC gel Epiduo® Forte gel pump Fabior® CC, MR sulfacetamide tazarotene cream 0.05% CC tazarotene foam (gen Fabior®) CC, MR tazarotene gel CC, MR tretinoin gel (gen Atralin) CC tretinoin micro CC, MR Twyneo® Winlevi®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication
Actinic Keratosis Agents		
diclofenac 3% gel fluorouracil solution fluorouracil 0.5% cream (gen Carac) fluorouracil 5% cream (gen Efudex cream) imiquimod (gen Aldara)	imiquimod (gen Zyclara)	
Antibiotics – Topical		
mupirocin ointment	Centany® mupirocin cream Xepi™	

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
V. Dermatologic Agents		
Anti-Fungals – Topical		
ciclopirox cream, suspension, shampoo ciclopirox 8% solution clotrimazole OTC clotrimazole Rx clotrimazole/betamethasone cream ketoconazole cream ketoconazole 2% shampoo miconazole OTC nystatin cream, ointment, powder nystatin/triamcinolone terbinafine OTC tolnaftate OTC	butenafine ciclopirox gel clotrimazole/betamethasone lotion econazole cream econazole foam MR Ertaczo® MR Extina® ketoconazole foam Loprox® cream, suspension miconazole/zinc/petrolatum (gen Vusion®) F/Q/D naftifine Naftin® oxiconazole Oxistat® tavaborole Vusion® F/Q/D	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Vusion® (miconazole/zinc/petrolatum) 50 gm ointment – Maximum 100 grams in a 90-day time period

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
V. Dermatologic Agents		
Anti-Infectives – Topical		
clindamycin phosphate 1% solution, gel, lotion, swab (gen Cleocin T®) clindamycin phosphate/benzoyl peroxide gel 1.2%-5% (gen Duac®) erythromycin 2% solution, gel	Cleocin T® 1% lotion clindamycin phosphate 1% foam (gen Evoclin®) MR clindamycin phosphate gel 1% (gen Clindagel®) MR clindamycin phosphate/benzoyl peroxide gel 1%-5% (gen BenzaClin®) clindamycin phosphate/benzoyl peroxide gel pump (gen Onexton®) MR clindamycin/benzoyl peroxide gel pump 1.2%-2.5% (gen Acanya®) erythromycin swab 2% erythromycin/benzoyl peroxide gel 3%-5% (gen Benzamycin®)	
Anti-Virals – Topical		
acyclovir cream docosanol (gen Abreva)	acyclovir ointment Denavir® penciclovir (gen Denavir®)	

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
V. Dermatologic Agents		
Immunomodulators & Related Agents – Topical CC, ST		
Eucrisa® pimecrolimus tacrolimus Vtama® 1	Adquey® Anzupgo® Opzelura® Zoryve®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication **STEP THERAPY (ST)** • Atopic Dermatitis: – Trial of a medium, high, or very high potency preferred topical corticosteroid – PA is required when a systemic immunomodulator and a topical JAK inhibitor are used concurrently • Vtama (tapinarof): For an indication of Plaque Psoriasis – Trial of a preferred product in the Psoriasis Agents - Topical class
Psoriasis Agents – Topical		
calcipotriene cream, ointment, scalp solution	calcipotriene foam (gen Sorilux®) calcipotriene/betamethasone dipropionate (gen Taclonex®) calcitriol ointment (gen Vectical®) Enstilar® Sorilux® Taclonex® Vectical®	
Rosacea Agents, Topical CC		
azelaic acid metronidazole cream, gel	Epsolay® Finacea® ivermectin Metrocream® Metrogel® metronidazole gel pump, lotion Soolantra®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication

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2 = Non-Preferred as of 10/22/2026

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NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
V. Dermatologic Agents		
Steroids, Topical – Low Potency F/Q/D		
hydrocortisone acetate OTC hydrocortisone acetate Rx	alclometasone Capex® shampoo Derma-Smoothe/FS® desonide fluocinolone oil hydrocortisone 2.5% solution MR	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • 360 grams/year, or; 12 claims/year
Steroids, Topical – Medium Potency F/Q/D		
fluocinolone acetonide solution fluticasone propionate cream, ointment hydrocortisone valerate cream mometasone furoate	betamethasone valerate foam clocortolone fluocinolone acetonide cream, ointment flurandrenolide fluticasone propionate lotion hydrocortisone butyrate cream, lotion, ointment, solution hydrocortisone valerate ointment Pandel® Synalar®	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • 360 grams/year, or; 12 claims/year

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
V. Dermatologic Agents		
Steroids, Topical – High Potency F/Q/D		
betamethasone dipropionate lotion, cream, ointment betamethasone dipropionate augmented cream betamethasone valerate cream, ointment fluocinonide cream, ointment, solution triamcinolone acetonide	amcinonide cream, oinment MR betamethasone dipropionate augmented ointment, lotion betamethasone dipropionate gel betamethasone valerate lotion clobetasol 0.025% cream MR desoximetasone diflorasone ointment diflorasone cream MR Diprolene® fluocinonide gel, emollient halcinonide cream, solution (gen Halog®) MR Halog® cream, solution MR Kenalog® spray MR triamcinolone spray MR	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • 360 grams/year, or; 12 claims/year
Steroids, Topical – Very High Potency CC, F/Q/D		
clobetasol cream, emollient, gel, ointment, solution halobetasol cream, ointment	clobetasol foam, lotion, spray, shampoo Clobex® halobetasol foam MR halobetasol lotion (gen Ultravate®) MR Olux® Ultravate® MR	**CLINICAL CRITERIA (CC)** • PA required for age < 12 years **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • 240 grams/year or; 6 claims/year

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
VI. Endocrine and Metabolic Agents		
Anabolic Steroids – Topical CDRP, F/Q/D		
testosterone gel packets (gen Vogelxo®) testosterone gel pump (gen Androgel)	AndroGel® pump Natesto® Testim® testosterone gel packets (gen AndroGel®) testosterone pump Vogelxo®	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** • For diagnosis of hypogonadotropic or primary hypogonadism: – Requires documented low testosterone concentration with two tests prior to initiation of therapy. – Require documented testosterone therapeutic concentration to confirm response after initiation of therapy. • For diagnosis of delayed puberty: – Requires documentation that growth hormone deficiency has been ruled out prior to initiation of therapy. The Anabolic Steroid fax form can be found at: https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PA_Worksheet_Prescribers_Anabolic_Steroids.pdf For diagnosis of gender dysphoria, see Hormone Replacement Therapy for Treatment of Gender Dysphoria coverage in the DUR section of this document **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Limitations for anabolic steroid products based on approved FDA labeled daily dosing and documented diagnosis: – Duration limit of 6 months for delayed puberty
Biguanides		
glipizide/metformin glyburide/metformin metformin HCl metformin ER (gen Glucophage XR®)	metformin solution (gen Riomet®) metformin 625 mg, 750 mg MR metformin ER (gen Fortamet®, Glumetza®) DO Riomet®	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
VI. Endocrine and Metabolic Agents		
Bisphosphonates – Oral		
alendronate	Actonel® Atelvia® Binosto® Fosamax® Fosamax® Plus D ibandronate risedronate	
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors CC		
alogliptin alogliptin/metformin Glyxambi® Janumet® BLTG Janumet® XR BLTG Januvia® DQ, BLTG Jentadueto® Jentadueto® XR Kazano® Nesina® Tradjenta®	alogliptin/pioglitazone (gen Oseni®) Brynovin® dapagliflozin/saxagliptin (gen Qtern®) saxagliptin (gen Onglyza®) saxagliptin/metformin sitagliptin (gen Januvia®) sitagliptin (gen Zituvio™) sitagliptin/metformin (gen Janumet®) sitagliptin/metformin (gen Zituvimet) sitagliptin/metformin ER (gen Janumet® XR) sitagliptin/metformin ER (gen Zituvimet XR) Steglujan® Zituvimet Zituvimet XR Zituvio™	**CLINICAL CRITERIA (CC)** • PA required for patients utilizing a DPP-4 and GLP-1 concurrently **DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
VI. Endocrine and Metabolic Agents		
Glucagon Agents		
Baqsimi® glucagon HCl emergency kit [1] glucagon vial Gvoke® pen, syringe, vial [1] Zegalogue® pen, syringe		
Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists – Type 2 Diabetes [CC]		
exenatide Ozempic® pen Trulicity® Victoza® BLTG	liraglutide (gen Victoza®) Mounjaro® Ozempic® tablets Rybelsus® Soliqua® Xultophy®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • PA required for patients utilizing a GLP-1 and DPP-IV concurrently

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
VI. Endocrine and Metabolic Agents		
Glucocorticoids – Oral		
budesonide EC, DR dexamethasone tablet hydrocortisone methylprednisolone dose-pack prednisolone solution prednisone dose-pack, tablet	Agamree® Alkindi® Sprinkle budesonide ER Cortef® cortisone deflazacort dexamethasone elixir, solution dexamethasone intensol dexamethasone 0.25 mg tablet MR Emflaza® Eohilia™ Hemady™ Khindivi® Medrol® dose-pack, tablet methylprednisolone 4 mg, 8 mg, 16 mg, 32 mg Millipred® DP prednisolone ODT prednisolone tablet prednisone DR MR prednisone intensol, solution	

NYRx, the Medicaid Drug Program Preferred Drug List

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

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
VI. Endocrine and Metabolic Agents		
Insulin – Rapid-Acting		
Humalog® 100 U/mL vial, pen, cartridge [1] Humalog® Jr. 100 U/mL Kwikpen [1] insulin lispro vial, pen (gen Humalog® U100) insulin lispro junior (gen Humalog® Jr.)	Admelog® Afrezza® Apidra® Fiasp® Penfill, FlexTouch, Pumpcart, vial Humalog® 100 U/mL Tempo Humalog® 200 U/mL insulin aspart cartridge, vial, pen (gen Novolog®) [2] Kirsty™ Lyumjev® Lyumjev® Tempo™ Merilog™ Solostar, vial Novolog® cartridge, FlexPen, vial	
Pancreatic Enzymes		
Creon® Zenpep®	Pertzye® Viokace®	
Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors		
dapagliflozin (gen Farxiga®) Jardiance® Synjardy® Synjardy® XR Trijardy® XR Xigduo® XR BLTG	dapagliflozin/metformin (gen Xigduo® XR) Farxiga® Inpefa™ Invokamet® Invokamet® XR Invokana® Segluromet® Steglatro®	

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
VI. Endocrine and Metabolic Agents		
Thiazolidinediones (TZDs)		
pioglitazone	ACTOplus Met® Actos® DO Duetact® pioglitazone/glimepiride pioglitazone/metformin	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
VII. Gastrointestinal		
Anti-Emetics		
aprepitant pack Diclegis® CC doxylamine succ/pyridoxine (gen Diclegis®) CC ondansetron ODT, solution, tablet	Akynzeo® aprepitant capsule Bonjesta® CC Emend® capsule, powder packet, TriPack granisetron solution MR granisetron tablet Sancuso®	**CLINICAL CRITERIA (CC)** • doxylamine succ/pyridoxine (Diclegis®, Bonjesta®): Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication
Gastrointestinal Antibiotics		
metronidazole tablet neomycin vancomycin capsule, solution	Dificid® fidaxomicin (gen Dificid®) Firvanq® Likmez™ metronidazole capsule metronidazole 125 mg tablet nitazoxanide tinidazole Vancocin®	

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
VII. Gastrointestinal		
Helicobacter pylori Agents		
Pylera® BLTG	bismuth/metronidazole/tetracycline (gen Pylera®) lansoprazole/amoxicillin/clarithromycin Omeclamox-Pak® Talicia® Voquezna® Dual Pak Voquezna® Triple Pak	

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
VII. Gastrointestinal		
Proton Pump (PPI)/Acid Secretion Inhibitors F/Q/D		
esomeprazole magnesium Rx capsule lansoprazole capsule (Rx, OTC) lansoprazole OTC solutab omeprazole Rx pantoprazole tablet Protonix suspension BLTG rabeprazole	dexlansoprazole (gen Dexilant®) Dexilant® DO esomeprazole magnesium tablet OTC esomeprazole capsule OTC esomeprazole suspension esomeprazole DR packets Konvomep™ lansoprazole Rx solutab Nexium® Rx DO omeprazole OTC omeprazole/sodium bicarbonate capsule Rx omeprazole/sodium bicarbonate packet MR pantoprazole suspension Prevacid® OTC Prevacid® Rx DO Prilosec® Rx Protonix® tablet Voquezna® ST	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths **STEP THERAPY (ST)** • Trial of 2 PPIs at maximally tolerated doses prior to the use of a Potassium Competitive Acid Blocker (PCAB). **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Quantity limits: – Once daily dosing for: o GERD o erosive esophagitis o healing and maintenance of duodenal/gastric ulcers (including NSAID-induced) o prevention of NSAID-induced ulcers – Twice daily dosing for: o hypersecretory conditions o Barrett's esophagitis o H. pylori o refractory GERD • Duration limits: – 90 days for: o GERD – 365 days for: o Maintenance treatment of duodenal ulcers, or erosive esophagitis – 14 days for: o H. pylori

NYRx, the Medicaid Drug Program Preferred Drug List

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

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
VIII. Hematological Agents		
Anticoagulants – Injectable F/Q/D		
enoxaparin sodium Fragmin® vial	Arixtra® CC fondaparinux CC Fragmin® syringe Lovenox®	**CLINICAL CRITERIA (CC)** • For patients requiring > 30 days of therapy: Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Arixtra® (fondaparinux): Clinical editing to allow patients with a diagnosis of Heparin Induced Thrombocytopenia (HIT) to receive therapy without a PA. **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Duration Limit: No more than 30 days for patients initiating therapy
Anticoagulants – Oral		
dabigatran capsule Eliquis® warfarin Xarelto® tablet DO Xarelto® 2.5 mg tablet BLTG	Eliquis® sprinkle, packets Pradaxa® pellet pack, capsule rivaroxaban tablet, suspension (gen Xarelto®) Savaysa® Xarelto® dose pack, suspension	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
VIII. Hematological Agents		
Colony Stimulating Factors		
Fulphila® Neupogen®	Armlupeg™ Filkri™ Fylnetra® Granix® Leukine® Neulasta® Nivestym™ Nypozi® Nyvepria™ Releuko™ Rolvedon® Stimufend® Udenyca® Zarxio® Ziextenzo®	
Erythropoiesis Stimulating Agents (ESAs) CC		
Aranesp® Epogen® Retacrit®	Mircera® Procrit®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication

NYRx, the Medicaid Drug Program Preferred Drug List

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

NYRx, the Medicaid Drug Program Preferred Drug List

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

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
IX. Immunologic Agents		
Immunomodulators – Systemic CC, ST		
Interleukin (IL) Inhibitors		**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • PA is required when a systemic immunomodulator and a topical JAK inhibitor are used concurrently **STEP THERAPY (ST)** • Trial of a TNF inhibitor prior to treatment with a JAK inhibitor **INDICATION-SPECIFIC STEP THERAPY REQUIREMENTS:** • Asthma: – History and concurrent use of a corticosteroid • Atopic Dermatitis: – Trial of a medium, high, or very high potency preferred topical corticosteroid or a preferred topical immunomodulator – JAK inhibitors: Trial of a medium, high, or very high potency preferred topical corticosteroid and a preferred systemic immunomodulator • COPD: • History and concurrent use of a long-acting beta agonist (LABA) + long-acting muscarinic agonist (LAMA) + inhaled corticosteroid (ICS) • Nasal polyps: – History and concurrent use of an intranasal corticosteroid • Ankylosing Spondylitis, Crohn's Disease, Ulcerative Colitis: – No step therapy required • Indications not mentioned above: – Trial of a non-specific anti-inflammatory drug such as an aminosalicylate or immunosuppressant, or a non-biologic disease-modifying anti-rheumatic drug (DMARD)
Adbry™ 1 Dupixent® Ebglyss™ Fasenra® Starjemza™ 1 Taltz® 1 Tyenne® 1	Actemra® SQ Avtozma® Bimzelx® Cosentyx® 2 Icotyde™ Ilaris® Ilumya® Imuldosa® Kevzara® Kineret® Nemluvio® Nucala® 2 Omvoh™ SQ Otulfi™ Pyzchiva® Selarsdi™ Skyrizi® Skyrizi® On-Body Spevigo® Stelara® Steqeyma® Tremfya® ustekinumab Yesintek™	
Janus kinase (JAK) Inhibitors		
	Cibinqo™ Olumiant® Rinvoq™ ER Rinvoq® LQ tofacitinib (gen Xeljanz®)	

1 = Preferred as of 10/22/2026
2 = Non-Preferred as of 10/22/2026

Standard PA fax form:
https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
IX. Immunologic Agents		
	tofacitinib ER (gen Xeljanz® XR) Xeljanz® Xeljanz® XR	
Tumor Necrosis Factor (TNF) Inhibitors		
adalimumab (Boehringer Ingelheim) Hadlima™ 1	Abrilada™ adalimumab Amjevita™ Cyltezo® Cimzia® Enbrel® 2 Hulio® Humira® 2 Hyrimoz® Idacio® Simlandi® Simponi® Yuflyma® Yusimry™ Zymfentra™	
Miscellaneous		
Orencia® SQ 1 Otezla® 1 Tezspire® pen 1 Xolair®	Entyvio® SQ Omlyclo® Otezla XR™ Rhapsido® Sotyktu™ Velsipity™	
Immunosuppressives, Oral		
azathioprine cyclosporine softgel, capsule cyclosporine modified capsule, solution mycophenolic acid	Astagraf XL® azathioprine 75 mg, 100 mg MR CellCept® capsule, tablet, suspension Envarsus XR®	**CLINICAL CRITERIA (CC)** • Lupkynis™ (voclosporin): - Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication - Confirm concurrent therapy with mycophenolate

1 = Preferred as of 10/22/2026
2 = Non-Preferred as of 10/22/2026

Standard PA fax form:
https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
IX. Immunologic Agents		
mycophenolate mofetil capsule, tablet, suspension sirolimus solution, tablet tacrolimus	everolimus (gen Zortress®) Imuran® Lupkynis™ CC, F/Q/D Myfortic® Myhibbin™ Neoral® Prograf® Sandimmune® capsule, solution Zortress®	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Lupkynis™ limited to 30-day supply

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

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
XI. Musculoskeletal Agents		
Skeletal Muscle Relaxants		
baclofen tablet chlorzoxazone 500 mg F/Q/D cyclobenzaprine 5 mg, 10 mg tablet F/Q/D dantrolene methocarbamol F/Q/D orphenadrine ER F/Q/D tizanidine tablet F/Q/D	Amrix® F/Q/D Atmeksi® F/Q/D, MR baclofen 15 mg tablet MR baclofen solution MR baclofen suspension (gen Fleqsuvy™) carisoprodol ST, F/Q/D chlorzoxazone F/Q/D chlorzoxazone 250 mg F/Q/D, MR cyclobenzaprine 7.5 mg F/Q/D cyclobenzaprine ER capsule (gen Amrix) F/Q/D Dantrium® Fleqsuvy™ Lyvispah™ metaxalone F/Q/D metaxalone 640 mg tablet F/Q/D, MR methocarbamol 1000 mg F/Q/D, MR Ontralfy™ F/Q/D, MR orphenadrine-aspirin-caffeine F/Q/D, MR Ozobax® MR Ozobax® DS MR Soma® ST, F/Q/D tizanidine capsule F/Q/D tizanidine 8 mg capsule F/Q/D, MR Tonmya™ F/Q/D, MR Zanaflex® F/Q/D	**STEP THERAPY (ST)** • Trial with 1 analgesic and 2 skeletal muscle relaxants prior to use of carisoprodol **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • 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 • Carisoprodol: Maximum 4 units per day, 28-day supply

NYRx, the Medicaid Drug Program Preferred Drug List

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

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
XII. Ophthalmics		
Anti-inflammatories/Immunomodulators – Ophthalmic CC		
Eysuvis® Restasis® BLTG Restasis MultiDose® Xiidra®	Cequa® cyclosporine (gen Restasis®) Miebo™ Tryptyr® Tyrvaya™ Verkazia® Vevye®	**CLINICAL CRITERIA (CC)** • Diagnosis documentation required to justify utilization as a first line agent or attempt treatment with an artificial tear, gel, or ointment.
Beta Blockers – Ophthalmic		
betaxolol Betoptic S® carteolol Combigan® BLTG Istalol® BLTG levobunolol timolol maleate gel	Betimol® brimonidine/timolol (gen Combigan®) timolol 0.5% (gen Betimol®) timolol maleate (gen Timoptic® Ocudose®) timolol maleate solution (gen Istalol®) Timoptic® Ocudose®	
Fluoroquinolones – Ophthalmic		
ciprofloxacin moxifloxacin (gen Vigamox®) ofloxacin	besifloxacin (gen Besivance®) Besivance® Ciloxan® Gatifloxacin levofloxacin moxifloxacin (gen Moxeza®) Ocuflox® Vigamox®	

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
XII. Ophthalmics		
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Ophthalmic		
Acular LS® BLTG diclofenac flurbiprofen ketorolac	Acular® Acuvail® bromfenac BromSite® Ilevro® ketorolac LS Nevanac® Prolensa®	
Prostaglandin Agonists – Ophthalmic		
latanoprost Rocklatan® ST Rhopressa® ST	bimatoprost (gen Lumigan®) Iyuzeh™ Lumigan® tafluprost (gen Zioptan®) Travatan Z® travoprost (gen Travatan Z®) Xalatan® Vyzulta™ Zioptan® Zolymbus™	**STEP THERAPY (ST)** • For Rhopressa® and Rocklatan®: Trial of a preferred generic product is required.

NYRx, the Medicaid Drug Program Preferred Drug List

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

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
XIV. Renal and Genitourinary		
Alpha Reductase Inhibitors for BPH		
dutasteride finasteride	dutasteride/tamsulosin Proscar®	
Antihyperuricemics		
allopurinol 100 mg, 300 mg colchicine tablet febuxostat probenecid probenecid/colchicine	allopurinol 200 mg MR colchicine capsule MR Colcrys Gloperba® Mitigare® MR Uloric® Zyloprim®	
Cystine Depleting Agents CC		
Cystagon®	Procysbi®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication
Electrolyte Depleters		
Lokelma® sodium polystyrene Veltassa®		

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
XIV. Renal and Genitourinary		
Phosphate Binders/Regulators CC ****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.****		
calcium acetate sevelamer carbonate powder, tablet (gen Renvela)	Auryxia™ ferric citrate 210 mg tablet (gen Auryxia™) Fosrenol® lanthanum carbonate Renvela® tablet, powder pack sevelamer HCl (gen Renagel) Velphoro® Xphozah®	**CLINICAL CRITERIA (CC)** • For patients not on dialysis, confirm diagnosis of FDA approved or compendia-supported and Medicaid covered indication
Selective Alpha Adrenergic Blockers		
alfuzosin tamsulosin	Rapaflo® silodosin	

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
XIV. Renal and Genitourinary		
Urinary Tract Antispasmodics		
fesoterodine ER (gen Toviaz®) Myrbetriq® DO, BLTG oxybutynin oxybutynin ER DO solifenacin	darifenacin flavoxate Gemtesa® mirabegron tablet, suspension (gen Myrbetriq®) Myrbetriq® suspension oxybutynin 2.5 mg tablet Oxytrol® tolterodine tolterodine ER Toviaz® DO trospium trospium ER Vesicare® DO Vesicare® LS	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
XIV. Renal and Genitourinary		
Urea Cycle Disorders		
Buphenyl® powder, tablet Carbaglu® BLTG glycerol phenylbutyrate (gen Ravicti®) Olpruva™ Pheburane® sodium phenylbutyrate powder, tablet (gen Buphenyl®)	carglumic acid Ravicti®	
Uterine Disorder Treatments F/Q/D		
Myfembree® Oriahnn® Orilissa®		**LIFETIME QUANTITY LIMIT:** • Myfembree®, Oriahnn®, Orilissa® 150 mg: maximum of 24 months cumulative use • Orilissa® 200 mg: maximum of 6 months cumulative use

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
XV. Respiratory		
COPD Agents		
Anoro Ellipta® BLTG Atrovent HFA® BLTG Combivent Respimat® Incruse Ellipta® BLTG ipratropium ipratropium / albuterol roflumilast (gen Daliresp®) Spiriva® HandiHaler® BLTG Spiriva Respimat® Stiolto Respimat® Tudorza Pressair®	Bevespi® Aerosphere® Breztri™ Aerosphere CC, ST Daliresp® Duaklir® Pressair ipratropium HFA (gen Atrovent HFA®) Ohtuvayre™ tiotropium (gen Spiriva® Handihaler®) Trelegy Ellipta® CC, ST umeclidinium (gen Incruse Ellipta®) umeclidinium/vilanterol (gen Anoro Ellipta®) Yupelri®	**CLINICAL CRITERIA (CC)** Breztri Aerosphere™ 160 mcg/ 18 mcg/ 4.8 mcg: • PA required for patients under FDA or compendia-supported age 12. Trelegy Ellipta®: • PA required for patients under FDA or compendia-supported age 18. **STEP THERAPY (ST)** Asthma Indication – Non-Preferred Agent • Trial of a preferred agent in the Corticosteroid/Beta2 Adrenergic Agent (Long-Acting) Combinations – Inhaled drug class required.
Antihistamines – Intranasal		
azelastine olopatadine		
Antihistamines – Second Generation		
cetirizine OTC syrup/solution, tablet fexofenadine OTC tablet levocetirizine tablet loratadine OTC syrup/solution, tablet	cetirizine OTC chewable cetirizine-D OTC Clarinex® Clarinex-D® desloratadine tablet desloratadine solution MR levocetirizine solution loratadine-D OTC	

NYRx, the Medicaid Drug Program Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Coverage Parameters</th></tr>
<tr><td colspan="3">XV. Respiratory</td></tr>
<tr><td colspan="3">Beta2 Adrenergic Agents – Inhaled Long-Acting CC, F/Q/D</td></tr>
<tr><td>arformoterol (gen Brovana®)
formoterol (gen Perforomist®)
Serevent Diskus®</td><td>Perforomist®
Striverdi Respimat®</td><td>CLINICAL CRITERIA (CC)
• PA is required for all new long-acting beta agonist prescriptions for patients under FDA- or compendia-supported age as indicated:
<table><tr><th colspan="2">FDA / Compendia-Supported Age</th></tr><tr><td>arformoterol</td><td>≥ 18 years</td></tr><tr><td>Perforomist® / formoterol</td><td>≥ 18 years</td></tr><tr><td>Serevent Diskus®</td><td>≥ 4 years</td></tr><tr><td>Striverdi Respimat®</td><td>≥ 18 years</td></tr></table>
FREQUENCY/QUANTITY/DURATION (F/Q/D)
Maximum units per 30 days
<table><tr><td>arformoterol</td><td>60 units (1 carton of 60 vials or 120 mL)</td></tr><tr><td>Perforomist® / formoterol</td><td>60 units (1 carton of 60 vials or 120 mL)</td></tr><tr><td>Serevent Diskus®</td><td>1 diskus (60 blisters)</td></tr><tr><td>Striverdi Respimat®</td><td>1 unit (one cartridge and one Respimat inhaler)</td></tr></table></td></tr>
<tr><td colspan="3">Beta2 Adrenergic Agents – Inhaled Short-Acting</td></tr>
<tr><td>albuterol nebulizer solution
albuterol HFA (gen ProAir® HFA, Proventil® HFA)
levalbuterol HFA
ProAir® RespiClick
Ventolin HFA® BLTG</td><td>Airsupra™
albuterol HFA (gen Ventolin HFA®)
levalbuterol solution
Xopenex HFA®</td><td></td></tr>
<tr><td colspan="3">Corticosteroids – Inhaled</td></tr>
<tr><td>Alvesco®
Arnuity Ellipta® BLTG
Asmanex® Twisthaler
fluticasone HFA</td><td>Asmanex® HFA
beclomethasone HFA (gen Qvar®)
fluticasone DISKUS
fluticasone ellipta (gen Arnuity Ellipta®)
QVAR RediHaler®</td><td></td></tr>
</table>

NYRx, the Medicaid Drug Program Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Coverage Parameters</th></tr>
<tr><td colspan="3">XV. Respiratory</td></tr>
<tr><td colspan="3">Corticosteroid/Beta2 Adrenergic Agent (Long-Acting) Combinations – Inhaled CC, F/Q/D</td></tr>
<tr><td>Advair Diskus® BLTG
Advair HFA® BLTG
Dulera®
Symbicort® BLTG</td><td>Breo Ellipta®
budesonide/formoterol (gen Symbicort)
fluticasone-salmeterol (gen AirDuo™ RespiClick®)
fluticasone-salmeterol (gen Advair Diskus®)
fluticasone-salmeterol (gen Advair HFA™)
fluticasone-vilanterol (gen Breo Ellipta®)</td><td>CLINICAL CRITERIA (CC)
• PA is required for all new long-acting beta agonist prescriptions for patients under FDA- or compendia-supported age as indicated:
<table><tr><th colspan="2">FDA / Compendia-Supported Age</th></tr><tr><td>Advair Diskus® 100/50 mcg</td><td>≥ 4 years</td></tr><tr><td>Advair Diskus® 250/50 mcg, 500/50 mcg</td><td>≥ 12 years</td></tr><tr><td>Advair HFA®</td><td>≥ 12 years</td></tr><tr><td>Dulera® 50 mcg</td><td>≥ 4 years</td></tr><tr><td>Dulera® 100 mcg, 200 mcg</td><td>≥ 12 years</td></tr><tr><td>budesonide-formoterol (Symbicort®) 80/4.5 mcg</td><td>≥ 4 years</td></tr><tr><td>budesonide-formoterol (Symbicort®) 160/4.5 mcg</td><td>≥ 12 years</td></tr><tr><td>fluticasone/vilanterol (Breo Ellipta®) 50/25 mcg</td><td>≥ 5 years</td></tr><tr><td>fluticasone/vilanterol (Breo Ellipta®) 100/25 mcg</td><td>≥ 12 years</td></tr><tr><td>fluticasone/vilanterol (Breo Ellipta®) 200/25 mcg</td><td>≥ 18 years</td></tr></table>FREQUENCY/QUANTITY/DURATION (F/Q/D)
<table><tr><td>Advair Diskus®</td><td rowspan="4">One device every 30 days</td></tr><tr><td>Advair HFA®</td></tr><tr><td>fluticasone-salmeterol</td></tr><tr><td>fluticasone/vilanterol (Breo Ellipta®)</td></tr><tr><td>budesonide/formoterol (Symbicort®)</td><td>Up to 8 inhalers every 180 days</td></tr><tr><td>Dulera®</td><td></td></tr></table></td></tr>
<tr><td colspan="3">Corticosteroids – Intranasal</td></tr>
<tr><td>budesonide OTC
fluticasone
fluticasone OTC
mometasone Rx
Omnaris®
triamcinolone OTC</td><td>azelastine-fluticasone (gen Dymista®)
Dymista®
flunisolide
mometasone OTC
Nasonex® OTC
QNASL® CC
Ryaltris®
Xhance™</td><td>CLINICAL CRITERIA (CC)
• Clinical consideration in regard to drug interactions will be given to patients with HIV/AIDs diagnosis or antiretroviral therapy in history</td></tr>
</table>

NYRx, the Medicaid Drug Program Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
XV. Respiratory		
Leukotriene Modifiers		
montelukast tablet, chew tab	Accolate® montelukast granules Singulair® zafirlukast zileuton ER	

NYRx, the Medicaid Drug 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.

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

- sodium oxybate products (Xyrem®, Xywav™): https://newyork.fhsc.com/providers/CDRP_xyrem.asp

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

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

NYS Medicaid NYRx Drug Utilization Review (DUR) Program

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

For additional Step Therapy and Frequency/Quantity/Duration parameters for drugs and drug classes that are also included on the Preferred Drug List (PDL), please see pages 4 through 57.

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Corticotropin (Acthar®, Cortrophin®)	Requires trial of first-line therapy for all FDA-approved indications, other than infantile spasms. **Note**: It is first line therapy for infantile spasms in children less than 2 years of age – step therapy not required.	**QUANTITY LIMITS:** • Infantile spasms – 30 mL (six 5 mL vials) • Multiple sclerosis – 35 mL (seven 5 mL vials) • Multiple sclerosis - 40 u/0.5mL and 80 u/mL Selfject = 21 syringes **DURATION LIMITS:** • Infantile spasms – 4 weeks; indicated for < 2 years of age • Multiple sclerosis – 5 weeks • Rheumatic disorders – 5 weeks • Dermatologic conditions – 5 weeks • Allergic states (serum sickness) – 5 weeks	• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Not covered for diagnostic purposes

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

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

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

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
biotin			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication
Benzodiazepine agents – oral • alprazolam (Xanax®, Xanax® XR) • chlordiazepoxide • chlordiazepoxide/amitriptyline • clonazepam (Klonopin®) • clorazepate • diazepam (Valium®) • lorazepam (Ativan®, Loreev XR™) • oxazepam	Generalized Anxiety Disorder (GAD) or Social Anxiety Disorder (SAD) • Require trial with a Selective-Serotonin Reuptake Inhibitor (SSRI) or a Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) prior to initial benzodiazepine prescription • Panic Disorder requires concurrent therapy with an antidepressant (SSRI, SNRI, or Tricyclic antidepressant [TCA]). Skeletal muscle spasms • Require trial with a skeletal muscle relaxant prior to a benzodiazepine	**DURATION LIMIT:** • For Insomnia: 30 consecutive days • For Panic Disorder: 90 consecutive days	• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy • PA required for any additional oral benzodiazepine prescription in patients currently on benzodiazepine therapy • PA required when greater than a 14-day supply of a benzodiazepine is prescribed for someone on a CNS stimulant
Butalbital-Containing Agents* *See Opioids – Short-Acting class for butalbital with codeine products	• Trial of a non-steroidal anti-inflammatory drug (NSAID), acetaminophen, or aspirin prior to initiation of therapy	**QUANTITY LIMIT:** Tablets/Capsules • 30 tablets/capsules per fill • 60 tablets/capsules per month Solution • 450 mL per fill • 900 mL per month	

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Constipation Agents • linaclotide (Linzess®) • lubiprostone (Amitiza®) • naldemedine (Symproic®) • naloxegol (Movantik®) • prucalopride (Motegrity™) • tenapanor (Ibsrela®)	Opioid Induced Constipation (OIC) and Chronic Idiopathic Constipation (CIC) • Trial with an osmotic laxative, a stimulant laxative, and a stool softener prior to use. Irritable Bowel Syndrome w/ Constipation (IBS-C) • Trial with a bulking agent and an osmotic laxative within 89 days of use.	**QUANTITY LIMIT:** • linaclotide, naldemedine, naloxegol, prucalopride: 1 tablet/day • lubiprostone: 2 capsules/day • tenapanor: 2 tablets/day	• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication.
doxepin cream (Zonalon®, Prudoxin®)		**QUANTITY LIMIT:** • 45 grams/month; 180 grams/year	• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication.
Hormone Replacement Therapy for Treatment of Gender Dysphoria • conjugated estrogens • estradiol • testosterone cypionate (Azmiro™) • testosterone enanthate (Xyosted™) • testosterone gel 1.62% (AndroGel®)* • testosterone patch*			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • For diagnosis of gender dysphoria please refer to October 2023 edition of the Medicaid Update: https://www.health.ny.gov/health_care/medicaid/program/update/2023/no15_2023-10.htm#hormones *Subject to Anabolic Steroids – Topical PDL class criteria
dextromethorphan / quinidine (Nuedexta®) BLTG		**QUANTITY LIMIT:** • 2 capsules per day; 60 units per 30 days **DURATION LIMIT:** • 90 days of therapy	For patients ≥ 18 years of age: • Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Diabetic Test Strips		• Preferred diabetic supply program https://newyork.fhsc.com/providers/diabeticsupplies.asp	
diazoxide choline (Vykat™ XR)			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication
dronabinol (Marinol®)	Step therapy for patients with HIV/AIDS, or cancer, AND eating disorder: • Trial with megestrol acetate suspension prior to dronabinol Step therapy for patients with diagnosis of cancer and nausea/vomiting: • Trial with a NYS Medicaid-preferred 5-HT3 receptor antagonist prior to dronabinol		• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication
Ergotamine Derivatives • dihydroergotamine autoinjector (Brekiya®) • dihydroergotamine nasal spray • ergotamine sublingual tablet MR	• Trial of triptan and either a non-steroidal anti-inflammatory drug (NSAID) or acetaminophen prior to initiation of therapy		
Neurokinin Receptor Antagonists • elinzanetant (Lynkuet®) • fezolinetant (Veozah®)	• Trial of one hormone replacement therapy regimen unless otherwise contraindicated		
risdiplam (Evrysdi®)			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Confirm absence of advanced disease

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
HIV PrEP (Pre-Exposure Prophylaxis Agents): • cabotegravir (Apretude) • emtricitabine/tenofovir disoproxil fumarate (Truvada®) • emtricitabine/tenofovir alafenamide (Descovy®) • lenacapavir (Yeztugo®)			• Oral PrEP: Confirm negative HIV test every 3 months. • Injectable PrEP: Confirm negative HIV test prior to initiation and as directed in the FDA package label, and when clinically appropriate.
Imcivree™ (setmelanotide)			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Please be prepared to respond to a series of questions that identify the prescriber, the patient, and the reason for prescribing this drug. • Please be prepared to fax clinical documentation upon request. The Imcivree fax form can be found at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_Imcivree.pdf
ivermectin (oral)			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication
Lidocaine patches • lidocaine 5% patch (Lidoderm®) • lidocaine 1.8% patch (ZTLido™)	• Trial of an alternate first line agent to treat diagnosis	• Maximum 3 patches per day • Prescriptions can be written for a 30-day supply with up to 2 refills	• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
doxecitine/doxribtimine (Kygevvi®)			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Confirm symptom onset prior to age 12
methadone	• Requires a trial of a long-acting opioid prior to initiation for the management of chronic non-cancer pain	**QUANTITY LIMIT:** • 12 units per day, 360 units per 30 days • Exemption for diagnosis of cancer, hospice care, or sickle cell disease	• Confirm diagnosis of chronic non-cancer pain • Limited to a total of 4 opioid prescriptions every 30 days; • PA required for initiation of methadone for patients on established opioid dependence therapy • PA required for methadone prescriptions for patients currently on long-acting opioid therapy. • PA required for initiation of long-acting opioid therapy in opioid-naïve patients. • PA required for use if > 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting > 7 days). • PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy • Exemption for diagnosis of cancer, sickle cell, or hospice care
metoclopramide nasal spray (Gimoti™)			• Metoclopramide nasal spray confirm diagnosis of diabetes

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Ovulation Enhancing Drugs • bromocriptine • clomiphene • letrozole • tamoxifen			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Refer to https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-06.htm#ovulation
Oxazolidinone Antibiotics • linezolid (Zyvox®) • tedizolid (Sivextro®)			• Please be prepared to respond to a series of questions that identify the prescriber, the patient, and the reason for prescribing this drug. • Please be prepared to fax clinical documentation upon request. The Oxazolidinone Antibiotics fax form can be found at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_oxazolidinone_antibiotic.pdf
Pubertal Suppressants • leuprolide acetate (Lupron Depot-PED®, Eligard®, Fensolvi®, Lupron Depot®) • nafarelin acetate (Synarel®) • triptorelin (Triptodur®)			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Refer to https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender for Transgender Related Care and Services Update

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

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
bulevirtide-gmod (Hepcludex®)			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Prescriber must attest to clinical improvement with continued therapy.
tasimelteon (Hetlioz®,Hetlioz® LQ)		**QUANTITY LIMIT:** • One unit per day; 30 units per 30 days	• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication
Parathyroid Hormone Analogs • teriparatide (Forteo® BLTG, Bonsity®) • abaloparatide (Tymlos®)	• Requires a trial with a preferred oral bisphosphonate	**QUANTITY LIMIT:** Forteo®, Bonsity®: • One unit per 28-day period Tymlos®: • One unit per 30-day period **LIFETIME QUANTITY LIMIT:** • 25 months' cumulative use of a PTH analog	
pyrimethamine (Daraprim®)			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Confirm concurrent utilization with leucovorin
somatropin (Serostim®)			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication The Serostim® fax form can be found at: https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PA_worksheet_Prescribers_Serostim.pdf

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Topical Compounded Prescriptions			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • For non-opioid pain management alternatives please visit: https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf
semaglutide (Wegovy®)		**LIFETIME QUANTITY LIMIT:** • Two treatment attempts per lifetime	• Confirm diagnosis of cardiovascular disease • Confirm patient BMI of ≥ 40kg/m2 • Confirm patient is participating in lifestyle modifications that support cardiovascular health
tirzepatide (Zepbound®)		**LIFETIME QUANTITY LIMIT:** • Two treatment attempts per lifetime	• Confirm diagnosis of obstructive sleep apnea (OSA) • Confirm patient BMI of ≥ 40kg/m2 • Confirm patient is participating in lifestyle modifications

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

Medication Assisted Treatment (MAT) Formulary

Medication Assisted Treatment (MAT) Formulary **Prior authorization will not be required for medications used for the treatment of substance use disorder when prescribed according to generally accepted national professional guidelines for the treatment of a substance use disorder. **	
Drugs	**Coverage Parameters**
Opioid Antagonists	
Kloxxado™ naloxone (syringe, vial, nasal spray) naloxone (nasal spray) OTC naltrexone Narcan® (nasal spray) Narcan® OTC Opvee® Rextovy® Zimhi™	
Opioid Dependence Agents – Injectable	
Brixadi™ Sublocade™ Vivitrol®	
Opioid Dependence Agents – Oral/Transmucosal F/Q/D	
buprenorphine (tablet) buprenorphine/naloxone (tablet) buprenorphine/naloxone (film) Suboxone® (film) Zubsolv®	**QUANTITY LIMIT:** • **buprenorphine sublingual (SL):** Eight tablets dispensed as a 2-day supply; not to exceed 32 mg per day • **buprenorphine / naloxone tablet and film** (**Suboxone®** 2mg/0.5mg, **Zubsolv®** 1.4mg/0.36mg, 0.7mg/0.18mg strength; Up to 12 sublingual tablets or films per day. • **buprenorphine/naloxone tablet and film (Suboxone®** up to 4mg/1mg and 8mg/2mg strength, **Zubsolv®** 2.9mg/0.71mg and 5.7mg/1.4mg strength; Four sublingual tablets or films per day; maximum of 120 tablets or films dispensed as a 30-day supply, not to exceed 32 mg-8 mg of Suboxone®, or its equivalent per day • **buprenorphine/naloxone tablet: Suboxone®** 12mg/3mg**, Zubsolv®** 8.6 mg/2.1 mg and **Zubsolv®** 11.4 mg/2.9 mg strength: Maximum of 60 tablets dispensed as a 30-day supply **RELATED CLINICAL CRITERIA (CC)** • PA required for initiation of **opioid therapy** for patients established on opioid dependence therapy • PA required for initiation of a **CNS stimulant** for patients established on opioid dependence therapy

NYS Medicaid NYRx Brand Less Than Generic (BLTG) Program

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

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

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

Effective October 22, 2026:

- Janumet® XR, Nexiclon™ XR, and Nuedexta®, will be **added** to the program
- No products will be **removed** from the program

List of Brand Name Drugs included in this program**		
Acular LS®	Depakote® Sprinkle	Protonix® suspension
Advair Diskus®	Edurant®	Pylera®
Advair HFA®	Endometrin®	Restasis®
Alphagan P® 0.15%	EpiPen	Risperdal Consta®
Alphagan P® 0.1%	EpiPen Jr	Spiriva® Handihaler®
Anoro Ellipta®	Forteo®	Symbicort®
Arnuity Ellipta®	Incruse Ellipta®	Tegretol® suspension
Atrovent HFA®	Istalol®	Tegretol® tablet
Azopt™	Janumet®	Tegretol® XR
Bethkis®	**Janumet® XR**	Ventolin® HFA
Bosulif® tablet	Januvia®	Victoza®
Carbaglu®	Kitabis® Pak	Vyvanse® capsule
Carbatrol®	Myrbetriq® tablet	Xarelto® 2.5 mg tablet
Cipro HC	**Nexiclon XR™**	Xigduo® XR
Cipro® oral suspension	**Nuedexta®**	Xyrem®
Combigan®	Oxtellar XR®	Zavesca®
Complera®	Pentasa®	
Copaxone® 20 mg SQ	Premarin® tablet	

**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

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®, Levoxyl®)	

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

NYS Medicaid NYRx Dose Optimization Program

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

Dose Optimization Chart

Brand Name	Dose Optimization Limitations		
CARDIOVASCULAR			
Angiotensin Receptor Blockers (ARBs)			
Benicar® 20 mg	1 daily	Tablet	
Micardis® 20 mg, 40 mg	1 daily	Tablet	
Diovan® 40 mg, 80 mg, 160 mg	1 daily	Tablet	
Antiarrhythmics			
Amiodarone 100 mg	1 daily	Tablet	NYRx will allow two doses per day for up to 90 days for dose titration.
ARBs Combinations			
Exforge® 5–160mg	1 daily	Tablet	
ARBs/Diuretics			
Benicar® HCT 20–12.5 mg	1 daily	Tablet	
Diovan® HCT 80–12.5 mg, 160–12.5 mg	1 daily	Tablet	
Edarbyclor® 40–12.5 mg	1 daily	Tablet	
Micardis® HCT 40–12.5 mg, 80–12.5 mg	1 daily	Tablet	
Beta Blockers			
Bystolic® 2.5 mg, 5 mg, 10 mg	1 daily	Tablet	
nadolol 40 mg	1 daily	Tablet	
Toprol® XL 25 mg, 50 mg, 100 mg	1 daily	Tablet	
HMG-CoA Reductase Inhibitors (Statins)			
Crestor® 5 mg, 10 mg, 20 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Anticonvulsants			
Aptiom® 200 mg, 400 mg	1 daily	Tablet	
Fycompa® 4 mg, 6 mg	1 daily	Tablet	
topiramate ER 100 mg (Qudexy® XR, Trokendi XR®)	1 daily	Capsule	
Lamictal XR® 50 mg	1 daily	Tablet	NYRx will allow two doses per day for up to 90 days for dose titration.
Oxtellar XR® 300 mg	1 daily	Tablet	NYRx will allow two doses per day for up to 90 days for dose titration.
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. NYRx will allow two doses per day for up to 90 days for dose titration.
Qudexy® XR 100 mg	1 daily	Capsule	
Lyrica® 225 mg and 300 mg	2 daily	Capsule	
Trokendi XR® 100 mg	1 daily	Capsule	
Antiparkinson Agents			
Azilect® 0.5 mg	1 daily	Tablet	
Antipsychotics – Second Generation			
Abilify® 2 mg	4 daily	Tablet	
Abilify® 5 mg, 10 mg, 15 mg	1 daily	Tablet	NYRx will allow two doses per day for up to 90 days for dose titration.
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, 0.5 mg, 0.75 mg	1 daily	Capsule	
Zyprexa® Zydis 5 mg, 10 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
CNS Stimulants			
Adderall® XR 5 mg, 10 mg, 15 mg	1 daily	Capsule	
amphetamine salt combo ER 5 mg, 10 mg, 15 mg	1 daily	Capsule	
Concerta® ER 18 mg, 27 mg	1 daily	Tablet	
dexmethylphenidate ER 10 mg, 20 mg (Focalin XR generic)	1 daily	Capsule	
Focalin® XR 5 mg, 10 mg, 15 mg, 20 mg	1 daily	Capsule	
methylphenidate CD 10 mg, 20 mg	1 daily	Capsule	
methylphenidate er 18 mg (Concerta® generic)	1 daily	Tablet	
methylphenidate la 20 mg (Ritalin® LA generic)	1 daily	Capsule	
modafinil 100 mg	1 daily	Tablet	
Provigil® 100 mg	1 daily	Tablet	
QuilliChew® ER 20 mg	1 daily	Tablet	
Ritalin® LA 10 mg, 20 mg	1 daily	Capsule	
Vyvanse® 10 mg, 20 mg, 30 mg, 40 mg	1 daily	Capsule	
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)			
guanfacine ER 1 mg, 2 mg	1 daily	Tablet	
atomoxetine 40 mg	1 daily	Capsule	
Intuniv® 1 mg, 2 mg	1 daily	Tablet	
Strattera® 40 mg	1 daily	Capsule	
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)			
Effexor® XR 37.5 mg, 75 mg	1 daily	Capsule	NYRx will allow two doses per day for up to 90 days for dose titration.
desvenlafaxine succinate ER (Pristiq® ER 50 mg)	1 daily	Tablet	
Selective Serotonin Reuptake Inhibitors (SSRIs)			
Lexapro® 5 mg, 10 mg	1 daily	Tablet	NYRx will allow two doses per day for up to 90 days for dose titration.
Trintellix® 5 mg, 10 mg	1 daily	Tablet	
Viibryd® 10 mg, 20 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Miscellaneous Antidepressants			
mirtazapine 7.5 mg	1 daily	Tablet	NYRx will allow two doses per day for up to 90 days for dose titration.

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

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

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

Brand Name	Dose Optimization Limitations		
RENAL AND GENITOURINARY			
Urinary Tract Antispasmodics			
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. All required documents must be sent by fax at (518) 473-5508. 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 MR.

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.

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.