Revised: March 27, 2020

New York State Medicaid Fee-For-Service Pharmacy Programs

OVERVIEW OF CONTENTS

NYS Medicaid Fee-For-Service Preferred Drug List

PREFERRED DRUG LIST – TABLE OF CONTENTS

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Prescription		
diclofenac sodium ER diclofenac topical gel ibuprofen indomethacin ketorolac meloxicam (tablet) naproxen naproxen EC piroxicam sulindac	Arthrotec® Cambia® Celebrex® CC celecoxib CC Daypro® diclofenac epolamine (gen Flector) diclofenac/misoprostol diclofenac potassium diclofenac sodium diclofenac topical soln diflunisal Duexis® etodolac etodolac ER Feldene® fenoprofen Flector® patch flurbiprofen Indocin® indomethacin ER ketoprofen ketoprofen ER meclofenamate mefenamic acid Mobic® nabumetone Nalfon® Naprelan® naproxen CR naproxen sodium oxaprozin Pennsaid®	**CLINICAL CRITERIA (CC)** **Celebrex® (celecoxib)** – one of the following criteria will not require PA – Over the age of 65 years – Concurrent use of an anticoagulant agent – History of GI Bleed/Ulcer or Peptic Ulcer Disease

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
	Qmiiz ODT™ Relafen® DS Sprix® Tivorbex® tolmetin Vimovo® Vivlodex® Voltaren® Gel Zipsor® Zorvolex®	
Opioids – Long-Acting CC, F/Q/D		
Butrans® BLTG fentanyl patch (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg) morphine sulfate ER (tablet)	Arymo® ER Belbuca® buprenorphine patches Conzip® ST Duragesic® fentanyl patch (37.5 mcg, 62.5 mcg, 87.5 mcg) hydromorphone ER Hysingla® ER Kadian® Morphabond® ER morphine ER (capsule) (generic for Avinza) morphine ER (capsule) (generic for Kadian) MS Contin® Nucynta® ER ST oxycodone ER Oxycontin® oxymorphone ER tramadol ER ST Xtampza® ER	**CLINICAL CRITERIA (CC)** Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease PA required for initiation of opioid therapy for patients on established opioid dependence therapy PA required for initiation of long-acting opioid therapy in opioid-naïve patients. – Exception for diagnosis of cancer or sickle cell disease. PA required for any additional long-acting opioid prescription for patients currently on long-acting opioid therapy. – Exception for diagnosis of cancer or sickle cell disease. PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy PA required for any codeine- or tramadol-containing products in pts < 12yrs **STEP THERAPY (ST)** **Nucynta® ER (tapentadol ER):** Trial with tapentadol IR before tapentadol ER for patients who are naïve to a long-acting opioid **Tramadol ER (tramadol naïve patients):** Attempt treatment with IR formulations before the following ER formulations: Conzip®, tramadol ER **FREQUENCY/QUANTITY/DURATION (F/Q/D)** – Exemption for diagnosis of cancer or sickle cell disease Belbuca® (buprenorphine) – Maximum 2 (two) units per day Butrans® (buprenorphine) – Maximum 4 patches per 28 days Nucynta® ER (tapentadol ER): – Maximum 2 (two) units per day

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
		I. Analgesics
	Zohydro® ER	Nucynta® ER (tapentadol ER): – Maximum daily dose of tapentadol IR and tapentadol ER formulations if used in combination should not exceed 500mg/day Tramadol ER (Conzip®): – Maximum 30 tablets dispensed as a 30-day supply Zohydro® ER (hydrocodone ER): – Maximum 2 (two) units per day, 60 units per 30 days Hysingla® ER (hydrocodone ER): – Maximum 1 (one) unit per day; 30 units per 30 days Hydromorphone ER, oxymorphone ER: – Maximum 4 (four) units per day, 120 units per 30 days Oxycodone ER (Xtampza® ER): – Maximum 2 (two) units per day, 60 units per 30 days. Not to exceed a total daily dose of 160mg or its equivalent Fentanyl transdermal patch (Duragesic®): – Maximum 10 patches per 30 days; maximum 100mcg/hr (over a 72-hour dosing interval) Morphine ER (excluding MS Contin products): – Maximum 2 (two) units per day, 60 units per 30 days Morphine ER (MS Contin® & Arymo® ER 15mg, 30mg, 60mg only): – Maximum 3 (three) units per day, 90 units per 30 days Morphine ER (MS Contin® 100mg only): – Maximum 4 units per day, up to 3 times a day, maximum 120 units per 30 days Morphine ER (MS Contin® 200mg only): – Maximum 2 units per day, maximum 60 units per 30 days 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 *The quantity limits listed are systematically converted into Morphine Milligram Equivalents (MME) for the purpose of prospective drug utilization review/clinical editing.*

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
Opioids – Short-Acting [CC]		
butalbital / APAP / caffeine / codeine F/Q/D codeine F/Q/D codeine / APAP F/Q/D hydrocodone / APAP F/Q/D hydrocodone / ibuprofen F/Q/D Lortab® (elixir) F/Q/D morphine IR F/Q/D oxycodone / APAP F/Q/D tramadol	Apadaz® F/Q/D Benzhydrocone / APAP F/Q/D butalbital compound/ codeine F/Q/D butorphanol nasal spray dihydrocodeine / APAP / caffeine F/Q/D Dilaudid® F/Q/D Fiorinal® / codeine F/Q/D hydromorphone F/Q/D levorphanol meperidine Nalocet® Nucynta® ST, F/Q/D Opana® F/Q/D Oxaydo® oxycodone F/Q/D oxycodone / aspirin F/Q/D oxycodone / ibuprofen F/Q/D oxymorphone F/Q/D pentazocine / naloxone Percocet® F/Q/D Primlev® F/Q/D Roxicodone® F/Q/D tramadol / APAP F/Q/D Tylenol® / codeine #3 F/Q/D Tylenol® / codeine #4 F/Q/D	**CLINICAL CRITERIA (CC)** Limited to a total of four (4) opioid prescriptions every 30 days. – Exception for diagnosis of cancer or sickle cell disease Initial prescription for opioid-naïve patients limited to a 7-day supply. – Exception for diagnosis of cancer or sickle cell disease PA required for initiation of opioid therapy for patients on established opioid dependence therapy. PA is required for opioid-naïve patients for prescription requests ≥ 90 morphine milligram equivalent (MME) per day. PA required for continuation of opioid therapy beyond an initial 7-day supply in patients established on gabapentin or pregabalin PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy PA required for any codeine- or tramadol-containing products in pts < 12yrs **STEP THERAPY (ST)** **Nucynta® (tapentadol IR)** – Trial with tramadol and one (1) preferred opioid before tapentadol immediate-release (IR) **FREQUENCY/QUANTITY/DURATION (F/Q/D)** **Quantity Limits:** Apadaz® (benzhydrocodone/APAP): – Maximum 12 (twelve) units per day Nucynta® (tapentadol IR): – Maximum 6 (six) units per day; 180 units per 30 days Nucynta® (tapentadol IR): – Maximum daily dose of **tapentadol IR** and **tapentadol ER** formulations used in combination not to exceed 500mg/day **Morphine and congeners immediate-release (IR)** non-combination products (codeine, hydromorphone, morphine, oxycodone, oxymorphone): – Maximum 6 (six) units per day, 180 (one hundred eighty) units per 30 (thirty) days Additional/alternate parameters: To be applied to patients without a documented cancer or sickle cell diagnosis

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
		I. Analgesics
	Ultracet® F/Q/D Ultram®	**Morphine and congeners immediate-release (IR) combination** products maximum recommended: – acetaminophen (4 grams) – aspirin (4 grams) – ibuprofen (3.2 grams) – or the FDA-approved maximum opioid dosage as listed in the PI, whichever is less **Duration Limits:** 90 days for patients without a diagnosis of cancer or sickle-cell disease. 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 *The quantity limits listed are systematically converted into morphine milligram equivalents (MME) for the purpose of prospective drug utilization review/clinical editing.*

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

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
II. Anti-Infectives		
Fluoroquinolones – Oral		
ciprofloxacin (suspension, tablet) levofloxacin (tablet)	Baxdela® Cipro® (suspension, tablet) Levaquin® levofloxacin (solution) moxifloxacin ofloxacin (tablet)	
Hepatitis B Agents		
adefovir dipivoxil Baraclude® (solution) entecavir Epivir-HBV® (solution) lamivudine HBV	Baraclude® (tablet) Epivir-HBV® (tablet) Hepsera® Vemlidy®	
Hepatitis C Agents – Injectable F/Q/D		
Pegasys® PegIntron®	None	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** PA required for the initial 14 weeks therapy to determine appropriate duration of therapy based on genotype, prior treatment and response, presence of cirrhosis, and HIV-coinfection. Further documentation required for continuation of therapy at weeks 14 and 26. After 12 weeks of therapy obtain a quantitative HCV RNA. Continuation is supported if undetectable HCV RNA or at least a 2 log decrease compared to baseline. After 24 weeks of therapy obtain a HCV RNA. Continuation for genotype 1 and 4 is supported if undetectable HCV RNA. Maximum duration of 48 weeks for: – Treatment-naïve patients or prior relapsers with cirrhosis and HIV co-infection – Prior non-responders (including prior partial and null responders) with or without cirrhosis and with or without HIV co-infection

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
II. Anti-Infectives		
Hepatitis C Agents – Direct Acting Antivirals		
Mavyret™ CC, F/Q/D ribavirin sofosbuvir/velpatasvir CC, F/Q/D (gen Epclusa®) Vosevi® CC, F/Q/D	Epclusa® CC, F/Q/D Harvoni® CC, F/Q/D ledipasvir/sofosbuvir CC, F/Q/D (gen Harvoni®) Ribasphere® Sovaldi® CC, F/Q/D Viekira Pak® CC, F/Q/D Zepatier® CC, F/Q/D	**CLINICAL CRITERIA (CC)** Confirm diagnosis of FDA-approved or compendia-supported indication Require confirmation of patient readiness and adherence – Evaluation by using scales or assessment tools readily to determine a patient's readiness to initiate HCV treatment, specifically drug and alcohol abuse potential. Assessment tools are available to healthcare practitioners at: http://www.integration.samhsa.gov/clinical-practice/screening-tools OR https://prepc.org/. The Hepatitis C Worksheet with Clinical Criteria requirements can be accessed at: https://newyork.fhsc.com/providers/pdp_hepatitisc.asp
Tetracyclines		
demeclocycline doxycycline hyclate minocycline (capsule) tetracycline	Doryx® ST, F/Q/D Doryx MPC® ST, F/Q/D doxycycline hyclate DR ST, F/Q/D doxycycline monohydrate minocycline (tablet) minocycline ER Minolira ER™ Nuzyra™ 2 Oracea® Solodyn® Vibramycin® Ximino®	**STEP THERAPY (ST)** Trial of doxycycline IR before progressing to doxycycline DR **FREQUENCY/QUANTITY/DURATION (F/Q/D)** doxycycline DR (Doryx®): – Maximum 28 tablets/capsules per fill

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

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Angiotensin Receptor Blockers (ARBs)		
Diovan® DO losartan valsartan	Atacand® Avapro® Benicar® DO candesartan Cozaar® Edarbi® eprosartan irbesartan Micardis® DO olmesartan telmisartan	**DOSE OPTIMIZATION (DO)** See Dose Optimization Chart for affected drugs and strengths
Antianginals & Anti-Ischemics		
ranolazine	Ranexa®	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
ARBs Combinations		
Exforge HCT® losartan/ HCTZ valsartan/ amlodipine valsartan/ amlodipine / HCTZ valsartan/ HCTZ	Atacand HCT® Avalide® Azor® Benicar HCT® DO candesartan/ HCTZ Diovan HCT® DO Edarbyclor® DO Entresto® CC Exforge® DO Hyzaar® irbesartan/ HCTZ Micardis HCT® DO olmesartan/ amlodipine olmesartan/ amlodipine/ HCTZ olmesartan/ HCTZ telmisartan/ amlodipine telmisartan/ HCTZ Tribenzor® Twynsta®	**CLINICAL CRITERIA (CC)** PA is not required if patient has chronic symptomatic HFrEF (NYHA class II or III), can tolerate an ACE inhibitor or ARB, and transition to the non-preferred product is warranted to produce the desired health outcome **DOSE OPTIMIZATION (DO)** See Dose Optimization Chart for affected drugs and strengths

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

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Calcium Channel Blockers (Dihydropyridine)		
amlodipine felodipine ER isradipine nicardipine HCl nifedipine nifedipine ER/SA	Adalat® CC Katerzia™ nisoldipine Norvasc® Procardia® Procardia XL® Sular®	
Cholesterol Absorption Inhibitors		
cholestyramine cholestyramine light Colestid® (tablet) colestipol (tablet)	colesevelam Colestid (granules) colestipol (granules) ezetimibe Questran® Questran Light® Welchol® Zetia®	
Direct Renin Inhibitors ST		
aliskiren Tekturna® Tekturna HCT®	None	**STEP THERAPY (ST)** Trial of product containing either an ACE inhibitor or an ARB prior to initiating preferred DRI

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
HMG-CoA Reductase Inhibitors (Statins)		
atorvastatin lovastatin pravastatin rosuvastatin simvastatin	Altoprev® atorvastatin/amlodipine Caduet® Crestor® DO Ezallor™ Sprinkle ezetimibe/simvastatin fluvastatin fluvastatin ER Lescol XL® Lipitor® Livalo® Pravachol® Vytorin® Zocor® Zypitamag™	**DOSE OPTIMIZATION (DO)** See Dose Optimization Chart for affected drugs and strengths
Niacin Derivatives		
niacin ER	Niaspan® DO	**DOSE OPTIMIZATION (DO)** See Dose Optimization Chart for affected drugs and strengths
Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH CDRP		
sildenafil tadalafil (gen for Adcirca)	Adcirca® Revatio®	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** All prescriptions for **Adcirca®**, **tadalafil, Revatio®**, and **sildenafil** must have PA Prescribers 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 5 refills The **CDRP Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH Prescriber Worksheet**, located at https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PA_Worksheet_Prescribers_PDE-5_Inhibitors.docx, provides step-by-step assistance in completing the prior authorization process

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Pulmonary Arterial Hypertension (PAH) Agents, Other – Oral		
Letairis® BLTG Tracleer® BLTG tablet	Adempas® ambrisentan (gen Letairis) bosentan (gen Tracleer) Opsumit® Orenitram® ER Tracleer® tabs for suspension Uptravi®	
Triglyceride Lowering Agents		
gemfibrozil fenofibrate (48 mg, 145 mg) fenofibric acid	Antara® fenofibrate Fenoglide® Lipofen® Lopid® Lovaza® ST, F/Q/D omega-3 ethyl ester ST, F/Q/D Tricor® Triglide® Trilipix® Vascepa® ST, F/Q/D	**STEP THERAPY (ST)** **Lovaza® (omega-3-acid ethyl-esters)** and **Vascepa® (icosapent ethyl)** – Trial of fibric acid derivative OR niacin prior to treatment with omega-3-acid ethyl-esters **FREQUENCY/QUANTITY/DURATION (F/Q/D)** **Lovaza® (omega-3-acid ethyl-esters)** and **Vascepa® (icosapent ethyl)** – Required dosage equal to 4 (four) units per day

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Alzheimer's Agents		
donepezil 5mg, 10mg Exelon® BLTG (patch) galantamine galantamine ER memantine Namenda® rivastigmine (capsule)	Aricept® donepezil 23 mg memantine ER CC, ST Namenda XR® CC, ST Namzaric® CC, ST Razadyne® Razadyne ER® rivastigmine (patch)	**CLINICAL CRITERIA (CC)** **Memantine extended-release containing products(Namenda XR® and Namzaric®)** – Require confirmation of diagnosis of dementia or Alzheimer's disease **STEP THERAPY (ST)** **Memantine extended-release containing products (Namenda XR® and Namzaric®)** – Require trial with memantine immediate-release (Namenda®)
Anticonvulsants – Carbamazepine Derivatives CC		
carbamazepine (chewable, tablet) carbamazepine ER (capsule) carbamazepine XR (tablet) Equetro® oxcarbazepine Tegretol® BLTG (suspension)	Aptiom® carbamazepine (suspension) Carbatrol® Oxtellar XR® Tegretol® (tablet) Tegretol XR® Trileptal®	**CLINICAL CRITERIA (CC)** Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA
Anticonvulsants – Other CC		
clobazam (tablet) ST, 1 gabapentin (capsule, solution, tablet) F/Q/D lamotrigine (tablet, chew) levetiracetam levetiracetam ER Lyrica® (capsule) DO, ST, F/Q/D pregabalin (capsule) DO, ST, F/Q/D tiagabine topiramate zonisamide	Banzel® Briviact® clobazam (suspension) ST Diacomit® CC Epidiolex® felbamate Felbatol® Fycompa® Gabitril® Keppra® Keppra XR® Lamictal® (tablet, chew, dosepak) Lamictal® ODT (tablet, dosepak) Lamictal® XR (tablet, dosepak)	**DOSE OPTIMIZATION (DO)** See Dose Optimization Chart for affected drugs and strengths **CLINICAL CRITERIA (CC)** Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA **Cannabidiol extract (Epidiolex®)** – Confirm diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form **Lyrica®/Lyrica® CR (pregabalin)** – PA required for the initiation of pregabalin at > 150 mg per day in patients currently on an opioid at > 50 mme per day **Neurontin® (gabapentin) –** PA required for initiation of gabapentin at > 900 mg per day in patients currently on an opioid at > 50 mme per day

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
	lamotrigine (dosepak) [2] lamotrigine ER lamotrigine ODT (dosepak) Lyrica® (solution) DO, ST, F/Q/D Lyrica® CR ST, F/Q/D Neurontin® F/Q/D Onfi® ST pregabalin (solution) DO, ST, F/Q/D Qudexy® XR Sabril® Spritam® Sympazan® film ST Topamax® topiramate ER Trokendi XR® vigabatrin Vimpat®	**Stiripentol (Diacomit®) –** Require diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form **Topiramate IR/ER (Qudexy® XR, Topamax®, Trokendi XR™)** – Require confirmation of FDA-approved, compendia-supported, or Medicaid covered diagnosis **Onfi®/Sympazan® (clobazam):** – Require confirmation of FDA-approved or compendia-supported use – PA required for initiation of clobazam therapy in patients currently on opioid or oral buprenorphine therapy – PA required for any clobazam prescription in patients currently on benzodiazepine therapy **FREQUENCY/QUANTITY/DURATION (F/Q/D)** **Lyrica®/Lyrica® CR (pregabalin)** – Maximum daily dose of IR: 600 mg per day, and ER: 660 mg per day **Neurontin® (gabapentin)** – Maximum daily dose of 3,600 mg per day **STEP THERAPY (ST)** **Lyrica®/Lyrica® CR (pregabalin)** – Requires a trial with a tricyclic antidepressant OR gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN) **Onfi®/Sympazan® (clobazam)** – Requires a trial with an SSRI or SNRI for treatment of anxiety
Antimigraine Agents, Other ST, F/Q/D		
Emgality®	Aimovig® Ajovy®	Trial of two (2) FDA approved migraine prevention products prior to a calcitonin gene-related peptide (CGRP) receptor antagonist **FREQUENCY/QUANTITY/DURATION (F/Q/D)** **Erenumab (Aimovig®):** Maximum of one (1) prefilled autoinjector per thirty (30) days **Galcanezumab 100mg (Emgality®):** Maximum of three (3) prefilled syringes per thirty (30) days, 120mg: Maximum of two (2) prefilled syringes/autoinjectors per thirty (30) days **Fremanezumab (Ajovy®):** Maximum of three (3) prefilled syringes per ninety (90) days

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Antimigraine Agents - Triptans F/Q/D		
rizatriptan sumatriptan	almotriptan Amerge® eletriptan Frova® frovatriptan Imitrex® Maxalt® Maxalt® MLT naratriptan Onzetra™ Xsail™ Relpax® sumatriptan-naproxen Tosymra™ Treximet® Zembrace™ SymTouch™ zolmitriptan Zomig® Zomig® ZMT	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** almotriptan: 18 units every 30 days Amerge®: 18 units every 30 days Frova®: 18 units every 30 days frovatriptan: 18 units every 30 days Imitrex® Nasal Spray: 18 units every 30 days Imitrex® tablets: 18 units every 30 days naratriptan: 18 units every 30 days Relpax® 20mg: 18 units every 30 days sumatriptan nasal spray: 18 units every 30 days sumatriptan tablets: 18 units every 30 days Tosymra™: 18 units every 30 days Treximet® and generic: 18 units every 30 days zolmitriptan (tablet, ODT) 2.5mg: 18 units every 30 days zolmitriptan (tablet, ODT) 5mg: 18 units every 30 days Zomig/Zomig® ZMT 2.5mg: 18 units every 30 days Zomig® /Zomig® ZMT 5mg: 18 units every 30 days Zomig® Nasal Spray: 24 units every 30 days Zembrace™ SymTouch™: 24 tablets every 30 days Maxalt® /Maxalt MLT®: 24 tablets every 30 days Relpax® 40mg: 24 tablets every 30 days rizatriptan (tablet, ODT): 16 units (1 kit) every 30 days Onzetra™ Xsail™:

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<tr><td colspan="3">IV. Central Nervous System</td></tr>
<tr><td colspan="3">Antipsychotics – Injectable</td></tr>
<tr><td>Abilify Maintena®
Aristada®
Aristada Initio®
fluphenazine decanoate
Haldol® decanoate
haloperidol decanoate
Invega Sustenna®
Invega Trinza®
Risperdal Consta®
Zyprexa Relprevv®</td><td>Perseris™</td><td></td></tr>
<tr><td colspan="3">Antipsychotics – Second Generation CC, ST, F/Q/D</td></tr>
<tr><td>aripiprazole (oral solution, tablet) DO
clozapine
Latuda® DO
olanzapine (tablet) DO
quetiapine F/Q/D
quetiapine ER F/Q/D
risperidone
Saphris®
ziprasidone</td><td>Abilify® (tablet) DO
aripiprazole ODT
clozapine ODT
Clozaril®
Fanapt®
FazaClo®
Geodon®
Invega® DO, F/Q/D
Nuplazid®
olanzapine ODT DO
paliperidone ER F/Q/D
Rexulti® DO
Risperdal®
Seroquel® F/Q/D
Seroquel XR® DO, F/Q/D
Versacloz®
Vraylar®
Zyprexa® DO</td><td>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
Prior authorization is required for patients less than 21 years of age when there is concurrent use of two or more different oral antipsychotics for greater than 90 days.
Prior authorization is required for patients 21 years of age or older when 3 or more different oral second generation antipsychotics are used for more than 180 days.
Confirm diagnosis of FDA-approved or compendia-supported indication
PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below:
<table>
<tr><td>aripiprazole (Abilify®)</td><td>6 years</td></tr>
<tr><td>asenapine (Saphris®)</td><td>10 years</td></tr>
<tr><td>brexpiprazole (Rexulti®)</td><td>18 years</td></tr>
<tr><td>cariprazine (Vraylar®)</td><td>18 years</td></tr>
</table></td></tr>
</table>

NYS Medicaid Fee-For-Service Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">IV. Central Nervous System</td></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>clozapine (Clozaril®, Fazaclo®, Versacloz®)</td><td>12 years</td></tr>
<tr><td>iloperidone (Fanapt®)</td><td>18 years</td></tr>
<tr><td>lurasidone HCl (Latuda®)</td><td>10 years</td></tr>
<tr><td>olanzapine (Zyprexa®)</td><td>10 years</td></tr>
<tr><td>paliperidone ER (Invega®)</td><td>12 years</td></tr>
<tr><td>pimavanserin (Nuplazid®)</td><td>18 years</td></tr>
<tr><td>quetiapine fum. (Seroquel®, Seroquel XR®)</td><td>10 years</td></tr>
<tr><td>risperidone (Risperdal®)</td><td>5 years</td></tr>
<tr><td>ziprasidone HCl (Geodon®)</td><td>10 years</td></tr>
</table>
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
Trial of risperidone prior to paliperidone (Invega®) therapy
FREQUENCY/QUANTITY/DURATION (F/Q/D)
paliperidone ER (Invega®) 1.5mg, 3mg, 9mg tablets: Maximum 1 (one) unit/day
paliperidone ER (Invega®) 6mg tablets: Maximum 2 (two) units/day
quetiapine/quetiapine ER (Seroquel®/Seroquel XR®): Minimum 100mg/day; maximum 800mg/day
quetiapine (Seroquel®): Maximum 3 (three) units per day, 90 units per 30 days
quetiapine ER (Seroquel XR®) 150mg, 200mg: 1 (one) unit/day, 30 units/30 days
quetiapine ER (Seroquel XR®) 50mg, 300mg, 400mg: 2 (two) units/day, 60 units/30 days</td></tr>
<tr><td colspan="3">Benzodiazepines – Rectal</td></tr>
<tr><td>diazepam (rectal gel)</td><td>Diastat® 2.5mg
Diastat® AcuDial™</td><td></td></tr>
</table>

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Central Nervous System (CNS) Stimulants CC, CDRP, F/Q/D		
amphetamine salt combo IR (generic for Adderall®) amphetamine salt combo ER DO (generic for Adderall XR®) Aptensio XR® Daytrana® dexmethylphenidate (generic for Focalin®) dextroamphetamine (tablet) Dyanavel XR® 1 Focalin XR® DO, BLTG methylphenidate tablet (generic for Ritalin®) Quillichew ER™ DO, 1 Quillivant XR® Vyvanse® (capsule, chewable) DO	Adderall XR® DO Adhansia XR™ Adzenys ER® Adzenys XR-ODT® amphetamine (generic for Evekeo®) armodafinil (generic for Nuvigil®) Concerta® DO Cotempla® XR-ODT™ Desoxyn® Dexedrine® dexmethylphenidate ER (generic for Focalin XR®) dextroamphetamine ER (generic for Dexedrine®) dextroamphetamine (solution) (generic for ProCentra®) Evekeo® Evekeo® ODT Focalin® Jornay PM™ Methamphetamine (generic for Desoxyn®) Methylin® methylphenidate chewable tablet) (generic for Methylin®) methylphenidate CD methylphenidate ER 72mg methylphenidate ER (generic Concerta®, Ritalin LA®, Metadate®) methylphenidate solution (generic for Methylin®) 2 modafinil DO (generic for Provigil®)	**CLINICAL CRITERIA (CC)** Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication for beneficiaries **less than 18 years of age**. – Prior authorization is required for initial prescriptions for stimulant therapy for beneficiaries **less than 3 years of age** – Require confirmation of diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent Patient-specific considerations for drug selection include treatment of excessive sleepiness associated with shift work sleep disorder, narcolepsy, or as an adjunct to standard treatment for obstructive sleep apnea. **CLINICAL DRUG REVIEW PROGRAM (CDRP)** **For patients 18 years of age and older**: Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication **DOSE OPTIMIZATION (DO)** See Dose Optimization Chart for affected drugs and strengths **FREQUENCY/QUANTITY/DURATION (F/Q/D)** Quantity limits based on daily dosage as determined by FDA labeling Quantity limits to include: – Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration) – Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days. Concerta 36mg and Cotempla XR-ODT 25.9mg, Adhansia XR 35mg & 45mg; not to exceed 2 units daily, Adhansia XR 25mg not to exceed 3 units daily. – Pitolisant (Wakix®): not to exceed 2 dosage units daily of the 17.8 mg tablets or 3 dosage units daily of the 4.45 mg tablets.

1 = Preferred as of 7/25/2019
2 = Non-Preferred as of 7/25/2019

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
	Mydayis™ Nuvigil® Procentra® Provigil® DO Ritalin® Ritalin LA® DO Sunosi™ Wakix® Zenzedi®	
Movement Disorder Agents CC		
Austedo® tetrabenazine	Ingrezza® Ingrezza® titration pack Xenazine®	**CLINICAL CRITERIA (CC)** Confirm diagnosis for an FDA-approved or compendia-supported indication
Multiple Sclerosis Agents		
Avonex® Betaseron® Copaxone® BLTG 20 mg/mL Gilenya® ST Rebif® Tecfidera® ST 1	Aubagio® ST Copaxone® 40 mg/mL Extavia® glatiramer Mavenclad® Mayzent® Plegridy® Vumerity™ ST	**STEP THERAPY (ST)** **Gilenya® (fingolimod)** and **Tecfidera® (dimethyl fumarate)** – requires a trial with a preferred injectable product **Aubagio® (teriflunomide)** and **Vumerity™ (diroximel)** – requires a trial with a preferred oral agent
Non-Ergot Dopamine Receptor Agonists		
pramipexole ropinirole	Mirapex® Mirapex ER® Neupro® pramipexole ER Requip XL® DO ropinirole ER	**DOSE OPTIMIZATION (DO)** See Dose Optimization Chart for affected strengths

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD) CC		
atomoxetine DO guanfacine ER DO	clonidine ER Intuniv® DO Strattera® DO	**CLINICAL CRITERIA (CC)** Confirm diagnosis for an FDA-approved or compendia-supported indication for beneficiaries < 18 years of age. Prior authorization is required for initial prescriptions for non-stimulant therapy for beneficiaries **less than 6 years of age** **DOSE OPTIMIZATION (DO)** See Dose Optimization Chart for affected strengths
Sedative Hypnotics/Sleep Agents F/Q/D		
estazolam CC flurazepam CC temazepam 15mg, 30mg CC zolpidem CC	Ambien® CC Ambien CR® CC Belsomra® doxepin (gen Silenor®) Edluar® CC eszopiclone Halcion® CC Intermezzo® CC Lunesta® DO ramelteon (gen Rozerem®) Restoril® CC Rozerem® Silenor® temazepam 7.5mg, 22.5mg CC triazolam CC zaleplon zolpidem (sublingual) CC zolpidem ER CC	**DOSE OPTIMIZATION (DO)** See Dose Optimization Chart for affected strengths **CLINICAL CRITERIA (CC)** **Zolpidem products**: Confirm dosage is consistent with FDA labeling for initial prescriptions **Benzodiazepine Agents (estazolam, flurazepam, Halcion®, Restoril®, temazepam, triazolam):** – Confirm diagnosis of FDA-approved or compendia-supported indication – PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy – PA required for any additional benzodiazepine prescription in patients currently on benzodiazepine therapy **FREQUENCY/QUANTITY/DURATION (F/Q/D)** Frequency and duration limits for the following products: – For **non-zaleplon** and **non-benzodiazepine** containing products: ❖ 30 dosage units per fill/1 dosage unit per day/30 days – For **zaleplon**-containing products: ❖ 60 dosage units per fill/2 dosage units per day/30 days Duration limit equivalent to the maximum recommended duration: – 180 days for immediate-release **zolpidem** (Ambien®, Edluar®, Intermezzo®) products

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
		– 180 days for **eszopiclone** and **ramelteon** (Rozerem®) products – 168 days for **zolpidem ER** (Ambien CR®) products – 90 days for **suvorexant** (Belsomra®) – 90 days for **doxepin** (Silenor®) – 30 days for **zaleplon** (Sonata®) products – 30 days for **benzodiazepine agents** (estazolam, flurazepam, Halcion®, Restoril®, temazepam, triazolam) for the treatment of insomnia Additional/Alternate parameters: – For patients naïve to non-benzodiazepine sedative hypnotics (NBSH): First-fill duration and quantity limit of 10 dosage units as a 10-day supply, except for zaleplon-containing products which the quantity limit is 20 dosage units as a 10-day supply
Selective Serotonin Reuptake Inhibitors (SSRIs)		
citalopram escitalopram (tablet) fluoxetine (capsule, solution) paroxetine sertraline	Brisdelle® Celexa® escitalopram (soln) fluoxetine (tablet) fluoxetine DR weekly fluvoxamine CC fluvoxamine ER CC Lexapro® DO paroxetine 7.5mg paroxetine CR Paxil® Paxil CR® Pexeva® Prozac® Sarafem® Trintellix® DO Viibryd® DO Zoloft®	**DOSE OPTIMIZATION (DO)** See Dose Optimization Chart for affected strengths **CLINICAL CRITERIA (CC)** Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA Clinical editing to allow patients with a diagnosis of Obsessive Compulsive Disorder (OCD) to receive fluvoxamine and fluvoxamine ER without prior authorization

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)[ST]		
duloxetine 20mg, 30mg, 60mg (generic for Cymbalta®) venlafaxine venlafaxine ER [DO] (capsule)	Cymbalta® desvenlafaxine base ER desvenlafaxine fumarate ER desvenlafaxine succinate ER [DO] Drizalma Sprinkle™ duloxetine 40mg Effexor XR® [DO] Fetzima® Pristiq® [DO] Savella® venlafaxine ER (tablet)	**DOSE OPTIMIZATION (DO)** See Dose Optimization Chart for affected strengths **STEP THERAPY (ST)** Trial of an SSRI prior to an SNRI* *Step therapy is not required for the following indications: Chronic musculoskeletal pain (CMP) Fibromyalgia (FM) Diabetic peripheral neuropathy (DPN)* – *duloxetine (Cymbalta®) – Requires a trial with a tricyclic antidepressant **OR** gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN)

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Acne Agents – Prescription, Topical		
adapalene Retin-A® cream CC, BLTG tazarotene CC tretinoin gel CC	Aklief® CC Aczone® adapalene/benzoyl peroxide Altreno® Atralin® CC Avita® CC Azelex® clindamycin/ tretinoin dapsone Differin® Epiduo® Fabior® CC Retin-A® gel CC Retin-A Micro® CC Tazorac® CC tretinoin cream tretinoin micro CC Ziana® CC	**CLINICAL CRITERIA** Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication
Actinic Keratosis Agents		
diclofenac 3% gel F/Q/D fluorouracil (solution) fluorouracil 0.5% cream (generic for Carac) fluorouracil 5% cream (generic for Efudex cream) imiquimod (5% cream, 3.75% pump)	Aldara® Carac® Efudex® Picato Tolak® Zyclara®	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** **diclofenac 3% gel:** – Maximum 100 (one hundred) grams as a 90-day supply – Limited to one (1) prescription per year
Antibiotics – Topical		
mupirocin (ointment)	Centany® mupirocin (cream)	

NYS Medicaid Fee-For-Service Preferred Drug List

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

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Anti-Infectives – Topical		
clindamycin (solution) clindamycin/benzoyl peroxide (gen for Duac®) erythromycin (solution)	Acanya® BenzaClin® (gel, pump) Benzamycin® Cleocin T® clindamycin (foam, gel, lotion, pledget) clindamycin/benzoyl peroxide (gen for BenzaClin®) clindamycin/benzoyl peroxide (gen for Acanya®) Erygel® erythromycin (gel, pledget) erythromycin / benzoyl peroxide Evoclin® Neuac® Onexton®	
Anti-Virals – Topical		
docosanol (generic Abreva) Zovirax® BLTG (cream)	acyclovir (ointment, cream) Denavir® Sitavig® Xerese® Zovirax® (ointment)	
Immunomodulators – Topical CDRP		
Elidel® BLTG Protopic® BLTG	pimecrolimus tacrolimus	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** All prescriptions require prior authorization Refills on prescriptions are allowed

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Psoriasis Agents – Topical		
calcipotriene (cream, ointment, scalp solution)	calcipotriene / betamethasone dipropionate calcitriol (ointment) Dovonex® (cream) Duobrii™ Enstilar® Sorilux® Taclonex® Taclonex® Scalp® Vectical®	
Steroids, Topical – Low Potency		
hydrocortisone acetate OTC hydrocortisone acetate Rx hydrocortisone/ aloe vera OTC	Ala-Scalp® alclometasone Capex® Derma-Smoothe/FS® Desonate® desonide fluocinolone (oil) Texacort®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Steroids, Topical – Medium Potency		
mometasone furoate	Beser lotion betamethasone valerate (foam) clocortolone Cloderm® Cordran® Cutivate® Dermatop® Elocon® fluocinolone acetonide (cream, ointment, soln.) flurandrenolide fluticasone propionate hydrocortisone butyrate (cream, lotion, ointment, solution) hydrocortisone valerate Locoid® Locoid Lipocream® Luxiq® Pandel® prednicarbate Synalar®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Steroids, Topical – High Potency		
betamethasone dipropionate (cream, lotion) betamethasone valerate (cream, ointment) triamcinolone acetonide	amcinonide Apexicon-E® betamethasone dipropionate (gel, ointment) betamethasone dipropionate, augmented betamethasone valerate (lotion) desoximetasone diflorasone Diprolene® fluocinonide 0.1% cream (generic for Vanos®) fluocinonide (ointment, cream, gel, solution, emollient) halcinonide cream (gen Halog®) Halog® Kenalog® Psorcon® Sernivo® Topicort® triamcinolone spray Trianex® Vanos®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Steroids, Topical – Very High Potency		
clobetasol (cream, emollient, gel, ointment, solution) halobetasol (cream, ointment)	Bryhali™ clobetasol (foam, lotion, spray, shampoo) Clobex® halobetasol (foam) Lexette™ (foam) Olux® Olux-E® Temovate-E® Ultravate®	

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Alpha-Glucosidase Inhibitors ST		
acarbose Glyset® miglitol	Precose®	**STEP THERAPY (ST)** Requires a trial with metformin with or without insulin prior to initiating alpha-glucosidase inhibitor therapy, unless there is a documented contraindication.
Amylin Analogs ST		
Symlin®	None	**STEP THERAPY (ST)** Requires a trial with metformin with or without insulin prior to initiating amylin analogue therapy, unless there is a documented contraindication.

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Anabolic Steroids – Topical CDRP, F/Q/D		
Androgel® BLTG	Androderm® Fortesta® Testim® testosterone gel 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.docx **FREQUENCY/QUANTITY/DURATION (F/Q/D)** Limitations for anabolic steroid products based on approved FDA labeled daily dosing and documented diagnosis: – Duration limit of six (6) months for delayed puberty
Biguanides		
metformin HCl metformin ER (generic for Glucophage XR®)	Fortamet® Glucophage® Glucophage XR® Glumetza® metformin ER (generics for Fortamet®, Glumetza®) Riomet® (solution)	

NYS Medicaid Fee-For-Service Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">VI. Endocrine and Metabolic Agents</td></tr>
<tr><td colspan="3">Bisphosphonates – Oral F/Q/D</td></tr>
<tr><td>alendronate</td><td>Actonel®
Atelvia®
Boniva®
Fosamax®
Fosamax® Plus D
Ibandronate
risedronate</td><td>FREQUENCY/QUANTITY/DURATION (F/Q/D)
<table>
<tr><td>ibandronate sodium 150 mg (Boniva® 150 mg)</td><td rowspan="2">1 tablet every 28 days</td></tr>
<tr><td>risedronate sodium 150 mg (Actonel® 150 mg)</td></tr>
<tr><td>alendronate sodium 35 mg (Fosamax® 35 mg)</td><td rowspan="5">4 tablets every 28 days</td></tr>
<tr><td>alendronate sodium 70 mg (Fosamax® 70 mg, Binosto®)</td></tr>
<tr><td>alendronate sodium and cholecalciferol (Fosamax® Plus D)</td></tr>
<tr><td>risedronate sodium 35 mg (Actonel® 35 mg)</td></tr>
<tr><td>risedronate sodium 35 mg (Atelvia® 35 mg)</td></tr>
<tr><td>alendronate solution 70 mg/75 mL single-dose bottle</td><td>4 bottles every 28 days</td></tr>
</table></td></tr>
<tr><td colspan="3">Calcitonins – Intranasal</td></tr>
<tr><td>calcitonin-salmon</td><td></td><td></td></tr>
<tr><td colspan="3">Dipeptidyl Peptidase-4 (DPP-4) Inhibitors ST</td></tr>
<tr><td>Glyxambi®
Janumet®
Janumet® XR
Januvia® DO
Jentadueto®
Tradjenta®</td><td>Alogliptin
alogliptin / metformin
alogliptin / pioglitazone
Jentadueto® XR
Kazano®
Kombiglyze® XR
Nesina®
Onglyza® DO
Oseni®
Qtern®
Steglujan®</td><td>DOSE OPTIMIZATION (DO)
See Dose Optimization Chart for affected strengths
STEP THERAPY (ST)
Requires a trial with metformin with or without insulin prior to DPP-4 Inhibitor therapy, unless there is a documented contraindication.</td></tr>
</table>

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Glucagon-like Peptide-1 (GLP-1) Agonists ST		
Bydureon® Byetta® Victoza®	Adlyxin® Bydureon® BCise™ Ozempic® Rybelsus® Soliqua® Trulicity® Xultophy®	**STEP THERAPY (ST)** Requires a trial with metformin with or without insulin prior to a GLP-1 agonist. Prior authorization is required with lack of covered diagnosis in medical history.
Glucocorticoids – Oral		
dexamethasone (tablet) hydrocortisone methylprednisolone (dose-pack) prednisolone (solution) prednisone (dose-pack, tablet)	budesonide EC budesonide ER Cortef® cortisone dexamethasone (elixir, solution) dexamethasone intensol Dexpak® DXevo Emflaza® Entocort EC® Medrol® (dose-pack, tablet) methylprednisolone (4mg, 8mg 16mg, 32mg) Millipred® prednisolone ODT prednisone (intensol, solution) Rayos® TaperDex® Uceris®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Growth Hormones CC, CDRP		
Genotropin® Norditropin®	Humatrope® Nutropin AQ® 2 Omnitrope® Saizen® Zomacton® Zorbtive®	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** **Prescribers**, not authorized agents, are required to call for a PA for beneficiaries 21 years of age or older **CLINICAL CRITERIA (CC)** Patient-specific considerations for drug selection include concerns related to use of a non-preferred agent for FDA-approved indications that are not listed for a preferred agent. Confirm diagnosis of FDA-approved or compendia-supported indication
Insulin – Long-Acting		
Lantus® Levemir®	Basaglar® Toujeo® Solostar® Toujeo® Max Solostar® Tresiba®	
Insulin – Mixes		
Humalog® Mix Novolog® BLTG Mix	insulin aspart prot/insulin aspart (gen Novolog)	
Insulin – Rapid-Acting		
Apidra® Humalog® BLTG 100 U/mL Humalog® Jr 100U/mL Novolog® BLTG	Admelog® Afrezza® Fiasp® (Penfill, Flextouch) Humalog® 200 U/Ml insulin aspart (gen Novolog) insulin lispro (gen Humalog)	
Meglitinides ST		
nateglinide repaglinide	Prandin® repaglinide/ metformin Starlix®	**STEP THERAPY (ST)** Requires a trial with metformin with or without insulin prior to initiating meglitinide therapy, unless there is a documented contraindication.

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Pancreatic Enzymes		
Creon® Zenpep®	Pancreaze® Pertzye® Viokace®	
Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors ST		
Farxiga® Invokana® Jardiance®	Invokamet® Invokamet® XR Segluromet® Steglatro® Synjardy® Synjardy® XR Xigduo® XR	**STEP THERAPY (ST)** Requires a trial with metformin with or without insulin prior to initiating SGLT2 Inhibitor therapy, unless there is a documented contraindication.
Thiazolidinediones (TZDs) ST		
pioglitazone	Actoplus Met® Actoplus Met® XR DO Actos® DO Avandia® Duetact® pioglitazone / glimepiride pioglitazone / metformin	**DOSE OPTIMIZATION (DO)** See Dose Optimization Chart for affected strengths **STEP THERAPY (ST)** Requires a trial with metformin with or without insulin prior to initiating TZD therapy, unless there is a documented contraindication.

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VII. Gastrointestinal		
Anti-Emetics		
aprepitant pack Diclegis® CC, BLTG ondansetron (ODT, solution, tablet)	Akynzeo® Anzemet® aprepitant (capsule) Bonjesta® CC doxylamine succ/pyridoxine Emend® (capsule, powder packet, TriPack) granisetron (tablet) Sancuso® Varubi® Zofran® (ODT, solution, tablet) Zuplenz®	**CLINICAL CRITERIA (CC)** **Diclegis® & Bonjesta®:** Confirm diagnosis of FDA-approved or compendia-supported indication
Gastrointestinal Antibiotics		
metronidazole (tablet) neomycin vancomycin	Dificid® Firvanq® Flagyl® metronidazole (capsule) paromomycin tinidazole Vancocin® Xifaxan® CC, ST, F/Q/D	**CLINICAL CRITERIA (CC)** **Xifaxan®**: Confirm diagnosis of FDA-approved or compendia-supported indication **STEP THERAPY (ST)** **Xifaxan®:** Requires trial of a preferred fluoroquinolone antibiotic before rifaximin for treatment of Traveler's diarrhea **QUANTITY LIMITS:** **Xifaxan®:** – Traveler's diarrhea (200 mg tablet) – 9 (nine) tablets per 30 days (Dose = 200 mg three times a day for three days) – Hepatic encephalopathy (550 mg tablets) – 60 tablets per 30 days (Dose = 550 mg twice a day) – Irritable bowel syndrome with diarrhea (550 mg tablets) – 42 tablets per 30 days (Dose = 550 mg three times a day for 14 days) ❖ Maximum of 42 days' supply (126 units) per 365 (three rounds of therapy).

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VII. Gastrointestinal		
Gastrointestinal Preparatory Agents		
PEG 3350 powder PEG 3350/ electrolytes solution Rx	Clenpiq® Colyte® Gavilyte®-N Golytely® Moviprep® Nulytely® Osmoprep® PEG 3350 powder pack PEG 3350 with flavor packs Plenvu® Prepopik® Suprep®	
Helicobacter pylori Agents		
Pylera®	lansoprazole / amoxicillin / clarithromycin Omeclamox-Pak®	

NYS Medicaid Fee-For-Service Preferred Drug List

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

NYS Medicaid Fee-For-Service Preferred Drug List

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

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VIII. Hematological Agents		
Anticoagulants – Injectable F/Q/D		
enoxaparin sodium Fragmin® (vial)	Arixtra® CC fondaparinux CC Fragmin® (syringe) Lovenox®	**CLINICAL CRITERIA (CC)** For patients requiring >30 days of therapy: Require confirmation of FDA-approved or compendia-supported indication **Arixtra® (fondaparinux)** Clinical editing to allow patients with a diagnosis of Heparin Induced Thrombocytopenia (HIT) to receive therapy without prior authorization. **FREQUENCY/QUANTITY/DURATION (F/Q/D)** Duration Limit: No more than 30 days for members initiating therapy
Anticoagulants – Oral		
Coumadin® Eliquis® Pradaxa® warfarin Xarelto®	Bevyxxa® Savaysa® Xarelto® (dose pack)	
Colony Stimulating Factors		
Fulphila™ Neupogen® Udenyca®	Granix® Leukine® Neulasta® Nivestym™ Zarxio® Ziextenzo®	
Erythropoiesis Stimulating Agents (ESAs) CC		
Epogen® 1 Retacrit® 1	Aranesp® 2 Mircera® Procrit® 2	**CLINICAL CRITERIA (CC)** Confirm diagnosis for FDA- or compendia-supported uses

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VIII. Hematological Agents		
Platelet Inhibitors		
Aggrenox® BLTG Brilinta® clopidogrel dipyridamole	dipyridamole / aspirin Effient® Plavix® Prasugrel Zontivity®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IX. Immunologic Agents		
Immunomodulators – Systemic CC, ST		
Enbrel® products Cosentyx® Humira® products	Actemra® (subcutaneous) Benlysta® (subcutaneous) Cimzia® Ilumya® Kevzara® syringe, pen injector Kineret® Olumiant® Orencia® (subcutaneous) Otezla® Rinvoq™ ER Siliq™ Simponi® Skyrizi™ Stelara® Taltz® Tremfya® Xeljanz® Xeljanz® XR	**CLINICAL CRITERIA (CC)** Confirm diagnosis for FDA- or compendia-supported uses **STEP THERAPY (ST)** Trial of a disease-modifying anti-rheumatic drug (DMARD) prior to treatment with an immunomodulator Trial of a TNF inhibitor prior to treatment with Olumiant®
Immunosuppressives, Oral		
azathioprine Cellcept® (suspension) BLTG cyclosporine (softgel, capsule) cyclosporine modified (capsule, solution) mycophenolate mofetil (capsule, tablet) mycophenolic acid Rapamune® BLTG (solution) Sandimmune® (capsule) sirolimus (tablet) tacrolimus	Astagraf XL® Azasan® Cellcept® (capsule, tablet) Envarsus XR® Imuran® mycophenolate mofetil (suspension) Myfortic® Neoral® Prograf® Rapamune® (tablet) Sandimmune® (solution) sirolimus (solution) Zortress®	

NYS Medicaid Fee-For-Service Preferred Drug List

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

NYS Medicaid Fee-For-Service Preferred Drug List

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

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Alpha-2 Adrenergic Agonists (for Glaucoma) – Ophthalmic		
Alphagan P® BLTG brimonidine 0.2% Simbrinza®	apraclonidine brimonidine P 0.15% Iopidine®	
Antibiotics – Ophthalmic		
bacitracin / polymyxin B erythromycin gentamicin Natacyn® neomycin / gramicidin / polymyxin polymyxin / trimethoprim sulfacetamide (solution) tobramycin	Azasite® bacitracin Bleph®-10 neomycin / bacitracin / polymyxin Polytrim® sulfacetamide (ointment) Tobrex®	
Antibiotics/Steroid Combinations – Ophthalmic		
Blephamide® neomycin/ polymyxin / dexamethasone sulfacetamide / prednisolone TobraDex® ointment tobramycin / dexamethasone (suspension)	Maxitrol® neomycin / bacitracin / polymyxin / HC neomycin / polymyxin / HC Pred-G® TobraDex® ST TobraDex® suspension Zylet®	
Antihistamines – Ophthalmic		
Pazeo®	azelastine Bepreve® epinastine Lastacaft® olopatadine 0.1% olopatadine 0.2% Pataday® Patanol®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Anti-inflammatories/Immunomodulators – Ophthalmic CC, F/Q/D		
Restasis® Restasis MultiDose®	Cequa® Xiidra®	CLINICAL CRITERIA (CC) Diagnosis documentation required to justify utilization as a first line agent or attempt treatment with an artificial tear, gel or ointment. **FREQUENCY/QUANTITY/DURATION (F/Q/D)** Cequa®, Restasis®, Xiidra®: 60 vials dispensed as a 30-day supply; Restasis Multidose®: 5.5 mL dispensed as a 25-day supply
Beta Blockers – Ophthalmic		
betaxolol Betoptic S® carteolol Combigan® Istalol® levobunolol timolol maleate (gel, solution)	Timoptic® Timoptic® Ocudose® Timoptic-XE®	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Fluoroquinolones – Ophthalmic ST		
ciprofloxacin moxifloxacin ofloxacin	Besivance® Ciloxan® gatifloxacin levofloxacin Moxeza® Ocuflox® Vigamox® Zymaxid®	**STEP THERAPY (ST)** For patients 21 years or younger, attempt treatment with a non-fluoroquinolone ophthalmic antibiotic before progressing to the a fluoroquinolone ophthalmic product Examples of Non-Fluoroquinolone Ophthalmic Antibiotics – AK-Poly-Bac eye ointment – bacitracin-polymyxin eye ointment – erythromycin eye ointment – Gentak® (3 mg/gm eye ointment, 3 mg/mL eye drops) – gentamicin (3 mg/gm eye ointment, 3 mg/mL eye drops) – neomycin-polymyxin-gramicidin eye drops – polymyxin B-TMP eye drops – Romycin® eye ointment – sulfacetamide 10% eye drops – Sulfamide® 10% eye drops – tobramycin 0.3% eye drops – Tobrasol™ 0.3% eye drops
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Ophthalmic		
diclofenac flurbiprofen Ilevro® ketorolac	Acular® Acular LS® Acuvail® bromfenac BromSite® Nevanac® Prolensa®	

NYS Medicaid Fee-For-Service Preferred Drug List

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

NYS Medicaid Fee-For-Service Preferred Drug List

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

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XIV. Renal and Genitourinary		
Alpha Reductase Inhibitors for BPH		
finasteride	Avodart® dutasteride dutasteride / tamsulosin Jalyn® Proscar®	
Antihyperuricemics		
Allopurinol Mitigare® BLTG probenacid probenacid/colchicine	colchicine (tablet, capsule) Colcrys febuxostat Uloric® Zyloprim®	
Cystine Depleting Agents CC		
Cystagon®	Procysbi® ST	**CLINICAL CRITERIA (CC)** Confirm diagnosis of FDA-approved or compendia-supported indication **STEP THERAPY (ST)** Requires a trial with Cystagon immediate-release capsules
Phosphate Binders/Regulators		
calcium acetate Fosrenol® BLTG Renagel® BLTG	Auryxia™ lanthanum carbonate Phoslyra® Renvela® sevelamer carbonate (gen for Renvela) sevelamer HCL (gen for Renagel) Velphoro®	
Selective Alpha Adrenergic Blockers		
alfuzosin tamsulosin	Flomax Rapaflo® silodosin	

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XIV. Renal and Genitourinary		
Urinary Tract Antispasmodics		
oxybutynin solifenacin Toviaz® DO	darifenacin Detrol® Detrol LA® DO Ditropan XL® Enablex® DO flavoxate Gelnique® Myrbetriq® DO oxybutynin ER DO Oxytrol® tolterodine tolterodine ER trospium trospium ER Vesicare® DO	**DOSE OPTIMIZATION (DO)** See Dose Optimization Chart for affected strengths

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XV. Respiratory		
Anticholinergics / COPD Agents		
Atrovent HFA® Bevespi® Aerosphere® Combivent Respimat® ipratropium ipratropium / albuterol Spiriva® Stiolto Respimat® Tudorza Pressair® [1]	Anoro Ellipta® Daliresp® Duaklir® Pressair Incruse Ellipta® Lonhala® Magnair® Seebri Neohaler® Spiriva Respimat® Trelegy Ellipta® Utibron Neohaler® Yupelri®	
Antihistamines – Intranasal		
azelastine olopatadine	Patanase®	
Antihistamines – Second Generation		
cetirizine OTC (tablet) cetirizine OTC (syrup/solution 1mg/ 1mL) fexofenadine OTC (suspension) levocetirizine (tablet) loratadine OTC	cetirizine OTC (chewable) cetirizine OTC (syrup/solution 5mg/ 5mL) cetirizine-D OTC Clarinex® [CC] Clarinex-D® OTC desloratadine fexofenadine OTC (tablet) levocetirizine (solution) loratadine-D OTC Semprex-D	**CLINICAL CRITERIA (CC)** No prior authorization required for patients less than 24 months of age

NYS Medicaid Fee-For-Service Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">XV. Respiratory</td></tr>
<tr><td colspan="3">Beta2 Adrenergic Agents – Inhaled Long-Acting CC, F/Q/D</td></tr>
<tr><td>Perforomist®
Serevent Diskus®</td><td>Arcapta Neohaler®
Brovana®
Striverdi Respimat®</td><td>CLINICAL CRITERIA (CC)
PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA- or compendia-supported age as indicated:
<table><tr><td>Arcapta Neohaler®</td><td>≥18 years</td></tr><tr><td>Brovana®</td><td>≥18 years</td></tr><tr><td>Perforomist®</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>Arcapta Neohaler®</td><td>30 units (1 box of 30 unit dose capsules)</td></tr><tr><td>Brovana®</td><td>60 units (1 carton of 60 vials or 120 mL)</td></tr><tr><td>Perforomist®</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
ProAir HFA® BLTG</td><td>albuterol HFA
levalbuterol (solution)
levalbuterol HFA
ProAir® Digihaler™
ProAir® RespiClick
Proventil HFA®
Ventolin HFA®
Xopenex® (solution)
Xopenex HFA®</td><td></td></tr>
</table>

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XV. Respiratory		
Corticosteroids – Inhaled F/Q/D		
Asmanex® Flovent Diskus® Flovent HFA® Pulmicort® Flexhaler	Alvesco® Arnuity Ellipta® Asmanex® HFA QVAR® Redihaler™	**FREQUENCY/QUANTITY/DURATION (F/Q/D)**

Alvesco® 80 mcg	1 inhaler every 30 days
Alvesco® 160 mcg	1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use.
Arnuity Ellipta	1 inhaler every 30 days
Asmanex® 110 mcg	1 inhaler every 30 days
Asmanex® 220 mcg (30 units)	1 inhaler every 30 days
Asmanex® 220 mcg (60 units)	1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use.
Asmanex® 220 mcg (120 units)	1 inhaler every 60 days. Up to 1 inhaler every 30 days with previous oral corticosteroid use.
Asmanex® HFA 100 mcg	1 inhaler every 30 days
Asmanex® HFA 200 mcg	1 inhaler every 30 days
Flovent Diskus® 50mcg, 100 mcg	1 diskus every 30 days
Flovent Diskus® 250mcg	1 diskus every 15 days. Up to 1 diskus every 7 days with previous oral corticosteroid use.
Flovent HFA® 44mcg, 110 mcg	1 inhaler every 30 days
Flovent HFA® 220mcg	1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use.
Pulmicort 90mcg	1 inhaler every 30 days
Pulmicort 180mcg	1 inhaler every 15 days
QVAR® Redihaler™ 40mcg	1 inhaler every 30 days
QVAR® Redihaler™ 80mcg	1 inhaler every 15 days

NYS Medicaid Fee-For-Service Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">XV. Respiratory</td></tr>
<tr><td colspan="3">Corticosteroid/Beta2 Adrenergic Agent (Long-Acting) Combinations – Inhaled CC, F/Q/D</td></tr>
<tr><td>Dulera®
fluticasone-salmeterol (gen for Advair Diskus®)
Symbicort® BLTG</td><td>Advair Diskus®
Advair HFA®
AirDuo™ RespiClick®
Breo Ellipta®
budesonide/formoterol (gen Symbicort)
fluticasone-salmeterol (gen for AirDuo™ RespiClick®)</td><td>CLINICAL CRITERIA (CC)
PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA-or compendia-supported age as indicated:
<table><tr><td>Advair Diskus®</td><td>≥4 years</td></tr><tr><td>Advair HFA®</td><td>≥12 years</td></tr><tr><td>AirDuo™ RespiClick®</td><td>>12 years</td></tr><tr><td>Breo Ellipta®</td><td>≥18 years</td></tr><tr><td>Dulera®</td><td>≥12 years</td></tr><tr><td>fluticasone-salmeterol</td><td>>12 years</td></tr><tr><td>Symbicort® 80/4.5 mcg</td><td>≥6 years</td></tr><tr><td>Symbicort® 160/4.5 mcg</td><td>≥12 years</td></tr></table>FREQUENCY/QUANTITY/DURATION (F/Q/D)
<table><tr><td>Advair Diskus®</td><td rowspan="8">One (1) inhaler/diskus every 30 days</td></tr><tr><td>Advair HFA®</td></tr><tr><td>AirDuo™ RespiClick®</td></tr><tr><td>Breo Ellipta™</td></tr><tr><td>Dulera®</td></tr><tr><td>fluticasone-salmeterol</td></tr><tr><td>Symbicort®</td></tr></table></td></tr>
</table>

NYS Medicaid Fee-For-Service Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">XV. Respiratory</td></tr>
<tr><td colspan="3">Corticosteroids – Intranasal F/Q/D</td></tr>
<tr><td>fluticasone</td><td>Beconase AQ® CC
budesonide
Dymista®
flunisolide
mometasone
Nasonex®
Omnaris®
QNASL® CC
Xhance™
Zetonna®</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
FREQUENCY/QUANTITY/DURATION (F/Q/D)
<table>
<tr><td>flunisolide</td><td>One (1) inhaler every 12 days</td></tr>
<tr><td>budesonide
mometasone
Nasonex®
Xhance™</td><td>One (1) inhaler every 15 days</td></tr>
<tr><td>Beconase AQ®</td><td>One (1) inhaler every 22 days</td></tr>
<tr><td>Dymista™
fluticasone
Omnaris®
QNASL®
Zetonna™</td><td>One (1) inhaler every 30 days</td></tr>
</table></td></tr>
<tr><td colspan="3">Leukotriene Modifiers</td></tr>
<tr><td>montelukast (tablets, chew tabs) ST</td><td>Accolate®
montelukast (granules)
Singulair® ST
zafirlukast</td><td>STEP THERAPY (ST)
For non-asthmatic patients, trial of intranasal corticosteroid or a 2nd generation oral antihistamine before montelukast (Singulair®)</td></tr>
</table>

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XVI. SUBSTANCE USE DISORDER AGENTS		
Opioid Antagonists		
naloxone (syringe, vial) naltrexone Narcan® (nasal spray)	None	
Opioid Dependence Agents – Injectable		
Vivitrol® Sublocade™	None	
Opioid Dependence Agents – Oral/Transmucosal CC, F/Q/D		
buprenorphine Suboxone® BLTG (film)	Bunavail® buprenorphine/ naloxone (tablet, film) Zubsolv®	**CLINICAL CRITERIA (CC)** PA required for initiation of opioid therapy for patients on established opioid dependence therapy **QUANTITY LIMIT:** **buprenorphine sublingual (SL):** Six (6) tablets dispensed as a 2-day supply; not to exceed 24 mg per day **buprenorphine/ naloxone tablet and film (Bunavail™, Suboxone®, Zubsolv®** up to 5.7mg/1.4mg strength); Three (3) sublingual tablets or films per day; maximum of 90 tablets or films dispensed as a 30-day supply, not to exceed 24 mg-6 mg of Suboxone, or its equivalent per day **buprenorphine/naloxone tablet (Zubsolv®** 8.6mg/2.1mg strength): Maximum of 60 tablets dispensed as a 30 day supply **buprenorphine/naloxone tablet (Zubsolv®** 11.4mg/2.9mg strength): Maximum of 30 tablets dispensed as a 30 day supply

NYS Medicaid Fee-For-Service Clinical Drug Review Program (CDRP)

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

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

Prior Authorization

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

Fax requests for prior authorization are not permitted. Each CDRP drug has specific clinical information that must be provided to the clinical call center before prior authorization will be issued. Prescribers may be asked to fax that information. Clinical guidelines for the CDRP as well as prior authorization worksheets are available online at https://newyork.fhsc.com/providers/CDRP_about.asp.

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

- becaplermin gel (Regranex®): https://newyork.fhsc.com/providers/CDRP_regranex.asp
- HIV-1 Pre-Exposure Prophylaxis (PrEP) agents (Descovy®, Truvada®): https://newyork.fhsc.com/providers/CDRP_PReP_agents.asp
- fentanyl mucosal agents: https://newyork.fhsc.com/providers/CDRP_fentanyl_mucosal_agents.asp
- lidocaine patch (Lidoderm®, ZTLido™): https://newyork.fhsc.com/providers/CDRP_lidoderm.asp
- oxazolidinone antibiotics (Sivextro™, Zyvox®): https://newyork.fhsc.com/providers/CDRP_oxazolidinone_antibiotics.asp
- palivizumab (Synagis®): https://newyork.fhsc.com/providers/CDRP_synagis.asp
- sodium oxybate (Xyrem®): https://newyork.fhsc.com/providers/CDRP_xyrem.asp
- somatropin (Serostim®): https://newyork.fhsc.com/providers/CDRP_serostim.asp

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

- Anabolic Steroids: https://newyork.fhsc.com/providers/CDRP_anabolic_steroids.asp
- Central Nervous System (CNS) Stimulants for 18 years and older: https://newyork.fhsc.com/providers/CDRP_cns_stimulants.asp
- Growth Hormones for 21 years and older: https://newyork.fhsc.com/providers/CDRP_growth_hormones.asp
- Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH: https://newyork.fhsc.com/providers/CDRP_PDE-5.asp
- Topical Immunomodulators: https://newyork.fhsc.com/providers/CDRP_topical_immunomodulators.asp

NYS Medicaid Fee-For-Service Drug Utilization Review (DUR) Program

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

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

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

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Acthar® (ACTH injectable) 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.
Amoxicillin ER (Moxatag®)	Prescribers should attempt treatment with an immediate-release amoxicillin first before progressing to extended-release amoxicillin	**QUANTITY LIMIT:** Equal to 10 tablets per fill	

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anabolic Steroids – Injectable Depo-Testosterone® testosterone cypionate* testosterone enanthate Xyosted® *for additional parameters, see Cross-Sex Hormones section below. Anabolic Steroids – Oral Anadrol-50® Android® Androxy™ Methitest® Oxandrin® oxandrolone Testred®		• Limitations for anabolic steroid products is based on approved FDA labeled daily dosing and documented diagnosis not to exceed a 90-day supply (30-day supply for oxandrolone): • Xyosted® is limited to no more than 3 boxes for 90 days (1 box per 30 days) • Initial duration limit of 3 months (for all products except oxandrolone), requiring documented follow-up monitoring for response and/or adverse effects before continuing treatment • Duration limit of 6 months for delayed puberty • Duration limit of 1 month for all uses of oxandrolone products	
Anti-Diabetic agents (not on the PDL) chlorpropamide glimepiride glipizide (Glucotrol®, Glucotrol XL®) glyburide (DiaBeta®, Glynase®) glyburide, micronized tolazamide tolbutamide	• Requires a trial with metformin with or without insulin prior to initiating other antidiabetic agents, unless there is a documented contraindication. • Clinical editing to allow patients with a diagnosis of gestational diabetes to receive glyburide without a trial of metformin first.		

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anti-Diarrheal Agents alosetron (Lotronex®) crofelemer (Mytesi®) eluxadoline (Viberzi®) telotristat (Xermelo®)	• Irritable Bowel Syndrome w/Diarrhea • Trial of eluxadoline and rifaximin prior to alosetron. • Symptomatic relief of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy • Trial with an alternative anti-diarrheal agent. Carcinoid Syndrome • Trial with and concurrent use with a somatostatin analog		• Confirmation of FDA-approved or compendia-supported indication.

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anti-Fungals, Topical – for Onychomycosis ciclopirox 8% solution Jublia® Kerydin® Penlac®	• Trial with an oral antifungal agent* prior to use of ciclopirox 8% solution (Penlac®) • terbinafine (Lamisil®) tablets; griseofulvin (Gris PEG®) oral suspension, ultramicronized tablets micronized tablets; itraconazole (Sporanox®, Onmel®) tablets, oral solution • Trial with ciclopirox 8% solution prior to the use of other topical antifungals [efinaconazole (Jublia®) or tavaborole (Kerydin®)]		
Anti-Malarials chloroquine hydroxychloroquine			Confirm FDA approved or compendia supported use.
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	• Require confirmation of FDA-approved or compendia-supported use • Point-of-service edit for antiretroviral / non-antiretroviral combinations to be avoided: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_reference_Antiretroviral_NonAntretroviral_Drug2Drug_Interactions.pdf • 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

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
crisaborole (Eucrisa®)	Atopic Dermatitis • Trial with a medium or high potency prescription topical steroid within the last 3 months	**QUANTITY LIMITS:** • 100GM/30 days	Confirm diagnosis of FDA-approved or compendia-supported indication
dupilumab (Dupixent®)	Atopic Dermatitis • Trial with a medium or high potency prescription topical steroid AND one other topical prescription agent other than a steroid (within a different class) indicated for atopic dermatitis for a combined duration of at least 6 months prior Asthma • History and concurrent use of a corticosteroid Chronic rhinosinusitis with nasal polyposis • History and concurrent use of intranasal steroids	**QUANTITY LIMITS:** **Atopic Dermatitis** • Dupixent® 300mg, 4 syringes for first 30 days followed by 2 syringes/30 days. **Asthma** • Dupixent® 200mg or 300mg, 4 syringes for first 30 days followed by 2 syringes/30 days. **Chronic rhinosinusitis with nasal polyposis** • 300mg, 2 syringes/30 days	Confirm diagnosis of FDA-approved or compendia-supported indication
Becaplermin (Regranex®)		**QUANTITY LIMIT:** 2 (two) 15 gram tubes in a lifetime	

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Benzodiazepine agents – oral alprazolam (Niravam™, Xanax®, Xanax® XR) chlordiazepoxide (Librium®) chlordiazepoxide/amitriptyline (Limbitrol®) clonazepam (Klonopin®) clorazepate (Tranxene®, Tranxene T-Tab®) diazepam (Valium®) lorazepam (Ativan®, Lorazepam Intensol®) oxazepam (Serax®)	Generalized Anxiety Disorder (GAD) or Social Anxiety Disorder (SAD) • Require trial with a Selective-Serotonin Reuptake Inhibitor (SSRI) or a Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) prior to initial benzodiazepine prescription • Panic Disorder requires concurrent therapy with an antidepressant (SSRI, SNRI, or Tricyclic antidepressant [TCA]). Skeletal muscle spasms • Require trial with a skeletal muscle relaxant prior to a benzodiazepine	**DURATION LIMIT:** For Insomnia: 30 consecutive days For Panic Disorder: 30 consecutive days	• Require confirmation of FDA-approved or compendia-supported use • PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy • PA required for any additional oral benzodiazepine prescription in patients currently on benzodiazepine therapy
Constipation Agents linaclotide (Linzess®) lubiprostone (Amitiza®) methylnaltrexone (Relistor®) naldemedine (Symproic®) naloxegol (Movantik®) plecanatide (Trulance®) prucalopride (Motegrity™) tegaserod (Zelnorm™)	Opioid Induced Constipation (OIC) & Chronic Idiopathic Constipation (CIC) • Trial with an osmotic laxative, a stimulant laxative and a stool softener prior to use. Irritable Bowel Syndrome w/ Constipation (IBS-C) • Trial with a bulking agent and an osmotic laxative within 89 days of use.	**QUANTITY LIMIT:** linaclotide, naldemedine, naloxegol, plecanatide: 1 tablet/day; 30 tablets/month lubiprostone: 2 capsules/day; 60 capsules/month methylnaltrexone: 1 vial or syringe/day; 30/month; 4 kits/28 days; 90 tablets/30 days prucalopride: 2mg/day max; 1 tablet per day; 30/month. If CrCl <30mL/min, then reduce dose to 1mg/day max; 1 tablet per day; 30/month. tegaserod: 2 tablets/day; 60 tabs/30 days	Confirmation of FDA-approved or compendia-supported indication.

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Cross-Sex Hormones conjugated estrogensestradiol testosterone cypionate			• Confirm diagnosis of FDA-approved or compendia-supported indication Refer to: https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender for Transgender Related Care and Services Update
Cystic fibrosis agents ivacaftor (Kalydeco®) ivacaftor / lumacaftor (Orkambi®) ivacaftor / tezacaftor (Symdeko®) ivacaftor/ tezacaftor / elexacaftor (Trikafta™)			• Confirm diagnosis of FDA-approved or compendia-supported indication • Genetic testing required to verify appropriate mutations
Dextromethorphan / quinidine (Nuedexta®)		**QUANTITY LIMIT:** Two (2) capsules per day; 60 units per 30 days **DURATION LIMIT:** 90 days of therapy	For patients ≥ 18 years of age: • Confirm diagnosis of FDA-approved or compendia-supported indication
Diabetic Test Strips		**QUANTITY LIMIT:** Type I DM – max 300 test strips per 30-day supply Type II DM – max 100 test strips per 30-day supply	Preferred diabetic supply program https://newyork.fhsc.com/providers/diabeticsupplies.asp

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Dronabinol (Marinol®)	Step therapy for beneficiaries with HIV/AIDS, or cancer, AND eating disorder: • Trial with megestrol acetate suspension prior to dronabinol Step therapy for beneficiaries with diagnosis of cancer and nausea/vomiting: • Trial with a NYS Medicaid-preferred 5-HT3 receptor antagonist prior to dronabinol		Confirm diagnosis of FDA-approved or compendia-supported indication
Fentanyl Transmucosal Agents Abstral® (sublingual tablet) Actiq® (lozenge) Fentora® (buccal tablet) Lazanda® (nasal spray)		**QUANTITY LIMIT:** Abstral®, Actiq®, Fentora®, and 4 units per day, 120 units per 30 days Lazanda®: 5 mL (1 bottle) per day, 150 mL (5 bottles) per 30 days **DURATION LIMIT:** 90 days Quantity and duration limits are not applicable to patients with a documented cancer or sickle cell diagnosis	• Limited to a total of four (4) opioid prescriptions every 30 days; exemption for diagnosis of cancer or sickle cell disease • For opioid-naïve patients - limited to a 7 days' supply for all initial opioid prescriptions, exemption for diagnosis of cancer or sickle cell disease • PA required for initiation of opioid therapy for patients on established opioid dependence therapy • PA is required for initiation of opioid therapy in patients currently on benzodiazepine therapy
Lipid Lowering Agents – Proprotein Convertase Subtilisin Kexin 9 (PCSK9) Inhibitors alirocumab (Praluent®) evolocumab (Repatha®)	Require trial of a HMG-CoA Reductase Inhibitors (statin) at maximum tolerated dosage		• Confirm diagnosis of FDA-approved or compendia-supported indication • Require concurrent statin therapy
Lipid Lowering Agents – Triglyceride transfer protein inhibitors: lomitapide (Juxtapid®) mipomersen (Kynamro®)	Requires trial with high intensity statin therapy		Confirm diagnosis of FDA-approved or compendia-supported indication

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
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 or sickle cell disease	• Confirm diagnosis of chronic non-cancer pain • Limited to a total of four (4) opioid prescriptions every 30 days; exemption for diagnosis of cancer or sickle cell disease • 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. Exemption for diagnosis of cancer or sickle cell disease • PA required for initiation of long-acting opioid therapy in opioid-naïve patients. Exemption for diagnosis of cancer or sickle cell disease • PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy
Metozolv® ODT (metoclopramide)	Requires a trial with conventional metoclopramide before metoclopramide orally disintegrating tablet (ODT), except with diagnosis of diabetes mellitus	**QUANTITY LIMIT:** 4 units per day, 120 units per 30 days **DURATION LIMIT:** 90 days	

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Metreleptin (Myalept®)			Confirm diagnosis of FDA-approved or compendia-supported indication
Olanzapine / Fluoxetine (Symbyax®)	When prescribing for the treatment of major depressive disorder (MDD) in the absence of other psychiatric comorbidities, trial with at least one different antidepressant agent is required		PA is required for the initial prescription for beneficiaries younger than 18 years
Oral Pollen/Allergen Extracts Oralair®	Trial with a preferred intranasal corticosteroid		Confirm diagnosis for the FDA-approved indication of Pollen-induced allergic rhinitis confirmed by positive skin or in vitro testing for pollen-specific IgE antibodies
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
Pubertal Suppressants goserelin acetate leuprolide acetate nafarelin acetate			Confirm diagnosis of FDA-approved or compendia-supported indication Refer to https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender for Transgender Related Care and Services Update
Pulmonary Fibrosis Agents Ofev® Esbriet®			Confirm diagnosis of FDA-approved or compendia-supported indication
Pyrimethamine (Daraprim®)			Confirmation of FDA-approved or compendia-supported indications Require concurrent utilization of leucovorin

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Quinine		**QUANTITY AND DURATION LIMITS:** Maximum 42 capsules as a 7-day supply; limited to 1 prescription per year	
Rosacea Agents azelaic acid (Finacea®) brimonidine (Mirvaso®) ivermectin (Soolantra®) oxymetazoline HCL (Rhofade®) doxycycline (Oracea®)	Trial with topical metronidazole product.		Confirmation of FDA-approved or compendia-supported indication
Tasimelteon (Hetlioz®)		**QUANTITY LIMIT:** One unit per day; 30 units per 30 days	Confirm diagnosis of FDA-approved or compendia-supported indication
Parathyroid Hormone Analogs Forteo® Tymlos®	Requires a trial with a preferred oral bisphosphonate	**QUANTITY LIMIT:** One unit per 30-day period **LIFETIME QUANTITY LIMIT:** 25 months' cumulative use of a PTH analog	
Topical Compounded Prescriptions			Confirm diagnosis of FDA-approved or compendia-supported indication For non-opioid pain management alternatives please visit: https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf

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

NYS Medicaid Fee-For-Service Brand Less Than Generic (BLTG) Program

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

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

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

Effective February 27, 2020:

- Apriso® and Novolog® will be **added** to the program
- No products will be **removed** from the program

List of Brand Name Drugs included in this program**		
Aggrenox®	Focalin® XR	Rapamune® solution
Alphagan P® 0.15%	Fosrenol® Chew tablets	Renagel®
Androgel®	Humalog U100 vial & Kwikpen	Retin-A® cream
Apriso®	Letairis®	Sensipar®
Butrans®	Lexiva® tablets	Suboxone® film
Catapres-TTS®	Mitigare®	Symbicort®
CellCept® suspension	Norvir® tablets	Tegretol® suspension
Copaxone® 20mg SQ	**Novolog®**	Tracleer® Tablet
Diclegis®	NuvaRing®	Transderm Scop®
Elidel®	Proair® HFA	Xeloda®
Exelon® patch	Protopic®	Zovirax® cream

**List is subject to change

Please keep in mind that drugs in this program may be subject to prior authorization requirements of other pharmacy programs; again 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 a 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 Fee-For-Service Mandatory Generic Drug Program

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

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

Prior Authorization Process

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

Exempt Drugs

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

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

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

NYS Medicaid Fee-For-Service Dose Optimization Program

On November 14, 2013, the Medicaid Fee-for-Service 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® 20mg	1 daily	Tablet	
Micardis® 20mg, 40mg	1 daily	Tablet	
Diovan® 40mg, 80mg, 160mg	1 daily	Tablet	
Antiarrythmics			
Amiodarone 100 mg	1 daily	Tablet	In case of dose titration for these medications, the department will allow for multi-day dosing (up to 2 doses daily) for loading dose for 30 days
ARBs/Calcium Channel Blockers			
Exforge® 5–160mg	1 daily	Tablet	
ARBs/Diuretics			
Benicar® HCT 20–12.5mg	1 daily	Tablet	
Diovan® HCT 80–12.5mg, 160–12.5mg	1 daily	Tablet	
Edarbyclor® 40–12.5mg	1 daily	Tablet	
Micardis® HCT 40–12.5mg, 80–12.5mg	1 daily	Tablet	
Beta Blockers			
Bystolic® 2.5mg, 5mg, 10mg	1 daily	Tablet	
Coreg® CR 20mg,40mg	1 daily	Tablet	
metoprolol succinate 25mg, 50mg, 100mg	1 daily	Tablet	
nadolol 40mg	1 daily	Tablet	
Toprol® XL 25mg, 50mg, 100mg	1 daily	Tablet	
HMG Co A Reductase Inhibitors			
Crestor® 5mg, 10mg, 20mg	1 daily	Tablet	
Niacin Derivatives			
Niaspan® 500mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Anticonvulsants			
Aptiom® 200 mg, 400 mg	1 daily	Tablet	
Fycompa® 400 mg, 600 mg	1 daily	Tablet	
topiramate ER 100 mg	1 daily	Capsule	
Lamictal XR® 50 mg	1 daily	Tablet	In case of dose titration for these medications, the department will allow for multi-day dosing (up to 2 doses daily) for titration purposes for 90 days
Oxtellar XR® 300 mg	1 daily	Tablet	In case of dose titration for these medications, the department will allow for multi-day dosing (up to 2 doses daily) for titration purposes for 90 days
Anticonvulsants, Other			
Lyrica® 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg	3 daily	Tablet	Electronic bypass for diagnosis of seizure disorder identified in medical claims data. In case of dose titration for these medications, the department will allow for multi-day dosing (up to 2 doses daily) for titration purposes for 3 months
Lyrica® 225 mg and 300 mg	2 daily	Tablet	
Trokendi XR® 100 mg	1 daily	Tablet	
Antiparkinson Agents			
Azilect® 0.5mg	1 daily	Tablet	
Antipsychotics – Second Generation			
Abilify® 2mg	4 daily	Tablet	
Abilify® 5mg, 10mg, 15mg	1 daily	Tablet	In case of dose titration for these medications, the Department will allow for multi-day dosing (up to 2 doses/daily) for titration purposes for three months
aripiprazole 5mg, 10mg, 15mg	1 daily	Tablet	
Invega® 1.5mg, 3mg	1 daily	Tablet	
Latuda® 20mg, 40mg, 60mg	1 daily	Tablet	
olanzapine 5mg, 10mg	1 daily	Tablet	
olanzapine ODT 5mg, 10mg	1 daily	Tablet	
paliperidone er 1.5mg, 3mg	1 daily	Tablet	
quetiapine fumarate er 200mg	1 daily	Tablet	
Rexulti® 0.25mg, 0.5mg, 1mg, 2mg	1 daily	Tablet	
Seroquel® XR 150mg, 200mg	1 daily	Tablet	
Symbyax® 3–25mg, 6–25mg, 12–25mg	1 daily	Capsule	
Vraylar® 1.5mg, 3mg	1 daily	Capsule	
Zyprexa® Zydis 5mg, 10mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
CNS Stimulants			
Adderall® XR 5mg, 10mg, 15mg	1 daily	Capsule	
amphetamine salt combo ER 5mg, 10mg, 15mg	1 daily	Capsule	
Concerta® ER 18mg, 27mg	1 daily	Tablet	
dexmethylphenidate er 10mg, 20mg (Focalin XR generic)	1 daily	Capsule	
Focalin® XR 5mg, 10mg, 15mg, 20mg	1 daily	Capsule	
methylphenidate CD 10mg, 20mg	1 daily	Capsule	
methylphenidate er 18mg (Concerta® generic)	1 daily	Tablet	
methylphenidate la 20mg (Ritalin® LA generic)	1 daily	Capusle	
modafinil 100mg	1 daily	Tablet	
Provigil® 100mg	1 daily	Tablet	
Quillichew® ER 20mg	1 daily	Tablet	
Ritalin® LA 10mg, 20mg	1 daily	Capsule	
Vyvanse® 10mg, 20mg, 30mg, 40mg	1 daily	Capsule	
Non-Ergot Dopamine Receptor Agonists			
Requip® XL 2mg, 6mg	1 daily	Tablet	
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)			
guanfacine ER 1mg, 2mg	1 daily	Tablet	
atomoxetine 40mg	1 daily	Capsule	
Intuniv® 1mg, 2mg	1 daily	Tablet	
Strattera® 40mg	1 daily	Capsule	
Sedative Hypnotics			
Lunesta® 1mg	1 daily	Tablet	
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)			
Effexor® XR 37.5mg, 75mg	1 daily	Capsule	In the case of dose titration for these medications, the Department will allow for multi-day dosing (up to 2 doses/daily) for titration purposes for three months.
Pristiq® ER 50mg	1 daily	Tablet	
venlafaxine ER 37.5mg, 75mg	1 daily	Capsule	
Selective Serotonin Reuptake Inhibitors (SSRIs)			
Lexapro® 5mg, 10mg	1 daily	Tablet	In the case of dose titration for these once daily medications, the Department will allow for multi-day dosing (up to 2 doses/daily) for titration purposes for three months.
Trintellix® 5mg, 10mg	1 daily	Tablet	
Viibryd® 10mg, 20mg	1 daily	Tablet	

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

Brand Name	Dose Optimization Limitations		
ENDOCRINE AND METABOLIC			
Biguanides			
metformin ER 500mg (Glumetza ER, Fortamet ER generic)	1 daily	Tablet	
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors			
Januvia® 25mg, 50mg	1 daily	Tablet	
Onglyza® 2.5mg	1 daily	Tablet	
Thiazolidinediones (TZDs)			
Actos® 15mg	1 daily	Tablet	
Actoplus Met® XR 15–1000mg	1 daily	Tablet	

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

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

Brand Name	Dose Optimization Limitations		
RENAL AND GENITOURINARY			
Urinary Tract Antispasmodics			
Detrol® LA 2mg	1 daily	Capsule	
Enablex® 7.5mg	1 daily	Tablet	
Myrbetriq® 25mg	1 daily	Tablet	
oxybutynin chloride ER 5mg	1 daily	Tablet	
Toviaz® ER 4mg	1 daily	Tablet	
VESIcare® 5mg	1 daily	Tablet	

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

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

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

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