

WYOMING MEDICAID
Preferred Drug List -Effective 5/28/09

Listed drugs are preferred. Drugs in the PDL classes that are not listed are non-preferred and require a PA. Drugs new to market are non-preferred until a clinical review has been completed. PA criteria will apply to both the pediatric population, as well as the adult population for those plans where PA/PDL limits are allowed.

Unless otherwise noted on the PDL, generic substitution is mandatory.

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA
ALLERGY MEDICATIONS	ANTIHISTAMINES, MINIMALLY SEDATING		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.
	cetirizine fexofenadine loratadine		
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
	cetirizine/pseudoephedrine loratadine/pseudoephedrine		
ANTIBIOTICS	BETA-LACTAMS / CLAVULANATE COMBO'S		
	AUGMENTIN XR		
ANALGESICS, NARCOTICS	LONG-ACTING NARCOTICS		Trial and failure of a preferred agent(s) greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.
	DURAGESIC* morphine sulfate		
ANGIOTENSIN MODULATORS	ACE INHIBITORS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.
	benazepril captopril enalapril fosinopril lisinopril moexipril quinapril ramipril trandolapril		
	ACE INHIBITORS AND DIURETICS		
	benazepril/HCTZ captopril/HCTZ enalapril/HCTZ lisinopril/HCTZ moexipril/HCTZ quinapril/HCTZ		
	ANGIOTENSIN RECEPTOR BLOCKERS		
	AVAPRO BENICAR COZAAR DIOVAN MICARDIS		
	ARBs AND DIURETICS		
	AVALIDE BENICAR-HCT DIOVAN-HCT HYZAAR MICARDIS-HCT		
	ARB COMBINATIONS		
	AZOR		
ANTIDEPRESSANTS	STEP 1		Naïve patients require a trial of one step 1 drug lasting 6 weeks prior to receiving approval for step 2 drug. Cymbalta, Lexapro and Pristiq are Tier-3 (non-preferred agents) . A trial of a step 2 drug for 6 weeks is required prior to approval of non-preferred agents. A drug trial is considered complete if the patient experiences a documented adverse reaction or intolerable side effect during the 6 week trial. Trazadone, buspirone, fluvoxamine, MAO inhibitors, TCA's, bupropion IR and venlafaxine IR do not require prior authorization but will not count towards
	bupropion SR citalopram fluoxetine paroxetine IR sertraline		
	STEP 2		
	EFFEXOR XR mirtazapine paroxetine CR WELLBUTRIN XL *		
ANTIVIRALS, ORAL	HERPES AGENTS		
	acyclovir famciclovir		

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	VALTREX		
CHOLESTEROL AGENTS	STATINS, LOW POTENCY		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.
	LESCOL/LESCOL XL lovastatin pravastatin		
	STATINS, HIGH POTENCY		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.
	LIPITOR simvastatin		
	STATIN COMBINATIONS		Trial and failure of a preferred agent greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.
	ADVICOR CADUET SIMCOR		
FIBRIC ACID DERIVATIVES			
	NIASPAN		
EAR	MISCELLANEOUS		
	CIPRODEX		
GASTROINTESTINAL	PROTON PUMP INHIBITORS		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.
	PREVACID PRILOSEC OTC * PROTONIX *		
GROWTH HORMONE	GROWTH HORMONE		PA is required for use outside of FDA-approved indications. Evaluation by an endocrinologist is preferred. Clinical evidence of improved growth will be required on a yearly basis to support ongoing utilization. Clinical evidence of need for growth hormone will be required for adult growth hormone deficiency and pediatric growth failure due to inadequate endogenous growth hormone. Trial and failure of a preferred agent within the last 12 months will be required for the following indications: Pediatric: Growth failure due to inadequate endogenous growth hormone, Prader-Willi syndrome, children born small for gestation. Turner syndrome. Adult: Replacement for those with growth hormone deficiency
		GENOTROPIN NUTROPIN	
INSOMNIA AGENTS	NON-BENZODIAZEPINES		Non-preferred products require a 14 day history of a preferred product in the last 365 days prior to approval for a non-preferred product. Rozerem is non-preferred without a history of substance abuse.
	LUNESTA zaleplon zolpidem		
MIGRAINE AGENTS	TRIPTANS		A documented trial and failure of ALL preferred products is required for PA approval of non-preferred products. Quantity limits apply.
	IMITREX * MAXALT/MLT RELPAX		
NSAIDS	NON-SELECTIVE		A trial and failure of 2 preferred agents each greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred NSAID.
	diclofenac etodolac fenoprofen flurbiprofen ibuprofen		

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	indomethacin ketorolac naproxen oxaprozin sulindac ketoprofen meclofenamate mefenamic acid meloxicam nabumetone tolmetin		
	COX 2 INHIBITORS		
		CELEBREX	Step through a preferred non-selective NSAID required prior to PA approval.
OVERACTIVE BLADDER AGENTS	OVERACTIVE BLADDER AGENTS		
	DETROL LA ENABLEX oxybutynin /ER SANCTURA / XR VESICARE		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. The patch will only be allowed if the patient has the inability to swallow.
PROSTATE AGENTS	5-ALPHA-REDUCTASE INHIBITORS		
	AVODART finasteride		
	ALPHA BLOCKERS		
	doxazosin terazosin		
SKELETAL MUSCLE RELAXANTS	MUSCLE RELAXANTS		
	baclofen cyclobenzaprine tizanidine		Trial and failure of a preferred agent greater than or equal to a 14 day supply in the last 12 months, along with a medical diagnosis of muscle spasticity will be required before approval can be given for a non-preferred agent.
SMOKING CESSATION	NICOTINE REPLACEMENT		
	nicotine gum, lozenges, and patches		
	OTHER		
	bupropion SR CHANTIX		Quantity limits apply. Generic bupropion SR needs to be an AB rated generic of Zyban.
TOPICAL AGENTS	IMMUNOMODULATORS		
	ELIDEL PROTOPIC		