Revised: August 1, 2013

New York State Medicaid Fee-For-Service Pharmacy Programs

OVERVIEW OF CONTENTS

For more information on the NYS Medicaid Pharmacy Programs: http://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm
To contact the NYS Medicaid Pharmacy Clinical Call Center please call 1-877-309-9493
To download a copy of the Prior Authorization fax form go to https://newyork.fhsc.com/providers/PA_forms.asp

New York State Medicaid Fee-For-Service Pharmacy Programs

PREFERRED DRUG LIST – TABLE OF CONTENTS

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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 potassium	meloxicam	Anaprox®	ketoprofen SA	**CLINICAL CRITERIA (CC)** ➢ Celebrex – 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
diclofenac sodium	nabumetone	Anaprox® DS	meclofenamate	
diclofenac sodium XR	naproxen	Arthrotec®	mefenamic acid	
etodolac	naproxen EC	Cambia™	Mobic®	
flurbiprofen	naproxen sodium	Cataflam®	Nalfon®	
ibuprofen	oxaprozin	Celebrex® CC	Naprelan®	
indomethacin	piroxicam	Daypro®	Naprosyn®	
indomethacin SR	sulindac	diclofenac/misoprostol	Naprosyn® EC	
ketoprofen	Voltaren® Gel	diflunisal	Pennsaid®	
ketorolac		Duexis®	Ponstel®	
		etodolac ER	Sprix®	
		Feldene®	tolmetin	
		fenoprofen	Vimovo®	
		Flector® patch	Voltaren® XR	
		Indocin®	Zipsor®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Opioids – Long-Acting CC		
fentanyl patch F/Q/D Kadian® F/Q/D morphine sulfate SR (tablet) F/Q/D	Avinza® F/Q/D Butrans™ Conzip™ ST, F/Q/D Duragesic® F/Q/D Exalgo® F/Q/D morphine sulfate ER (capsule) F/Q/D MS Contin® F/Q/D Nucynta® ER ST, F/Q/D Opana ER® F/Q/D Oxycontin® F/Q/D oxymorphone ER F/Q/D Ryzolt® ST, F/Q/D tramadol ER ST, F/Q/D Ultram® ER ST, F/Q/D	**CLINICAL CRITERIA (CC)** ➢ Limited to a total of four (4) opioid prescriptions every 30 days **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 ➢ Ryzolt ➢ Ultram ER **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Nucynta ER (tapentadol ER) ➢ maximum 2 (two) units per day ➢ Nucynta ER ➢ maximum daily dose of tapentadol IR and tapentadol ER formulations if used in combination should not exceed 500mg/day ➢ Tramadol ER ➢ maximum 30 tablets dispensed as a 30 day supply Patients *without* documented cancer or sickle cell diagnosis for the following: ➢ Hydromorphone ER, oxymorphone ER: ➢ maximum 4 units per day, 120 units per 30 days ➢ Oxycodone CR: ➢ maximum 2 units per day, 60 units per 30 days. Not to exceed a total daily dose of 160 mg ➢ Fentanyl transdermal patch: ➢ maximum 10 patches per 30 days; maximum 100mcg/hr (over a 72 hour dosing interval) ➢ Morphine ER (excluding MS Contin products): ➢ maximum 2 units per day, 60 units per 30 days ➢ Morphine ER (MS Contin 15mg, 30mg, 60mg only): ➢ maximum 3 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

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NYS Medicaid Fee-For-Service Preferred Drug List

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Opioids – Short-Acting CC, F/Q/D		
butalbital/APAP/codeine F/Q/D codeine F/Q/D codeine/APAP F/Q/D hydrocodone/APAP F/Q/D hydrocodone/ibuprofen F/Q/D morphine IR F/Q/D oxycodone/APAP F/Q/D tramadol	butalbital compound/codeine F/Q/D butorphanol nasal spray Demerol® dihydrocodeine/APAP/ caffeine F/Q/D Dilaudid® F/Q/D Endodan® F/Q/D Fioricet®/codeine F/Q/D Fiorinal®/codeine F/Q/D hydromorphone F/Q/D Ibudone™ F/Q/D levorphanol Magnacet® F/Q/D meperidine Nucynta® ST, F/Q/D Opana® F/Q/D Oxecta® F/Q/D oxycodone F/Q/D oxycodone/ASA F/Q/D oxycodone/ibuprofen F/Q/D oxymorphone F/Q/D pentazocine/APAP F/Q/D pentazocine/naloxone Percocet® 2.5/325 mg F/Q/D Percodan® F/Q/D Primlev™ F/Q/D Reprexain™ F/Q/D Roxicet® (caplets, solution) F/Q/D Roxicodone® Rybix™ ODT Synalgos® DC F/Q/D tramadol/APAP F/Q/D Tylenol®/codeine #3 F/Q/D Tylenol®/codeine #4 F/Q/D Tylox® F/Q/D Ultracet® F/Q/D Ultram® Vicoprofen® F/Q/D Zamicet™ F/Q/D Zydone® F/Q/D	**CLINICAL CRITERIA (CC)** ➢ Limited to a total of four (4) opioid prescriptions every 30 days **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:** ➢ Nucynta® (tapentadol IR) ➢ maximum 6 (six) units per day; 180 units per 30 days ➢ Nucynta® ➢ 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 ➢ 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 ➢ Additional/alternate parameters: To be applied to patients without a documented cancer or sickle cell diagnosis **Duration Limits:** ➢ 90 days for patients without a diagnosis of cancer or sickle-cell disease. Excludes tramadol-containing products

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
II. ANTI-INFECTIVES		
Anti-Fungals – Oral for Onychomycosis		
Gris-PEG® griseofulvin (suspension) terbinafine (tablet)	Grifulvin V® (tablet) griseofulvin ultramicronized itraconazole Lamisil® (tablet) Sporanox®	
Anti-Virals – Oral		
acyclovir (capsule, suspension, tablet) Valtrex®	famciclovir Famvir® valacyclovir Zovirax® (capsule, suspension, tablet)	
Cephalosporins – Third Generation		
cefdinir cefpodoxime proxetil Suprax®	Cedax® cefditoren Spectracef®	
Fluoroquinolones – Oral		
Cipro® (suspension) ciprofloxacin (tablet) levofloxacin (tablet)	Avelox® Avelox ABC Pack® Cipro® (tablet) ciprofloxacin ER Factive® Levaquin® levofloxacin (solution) Noroxin® ofloxacin (tablet)	
Hepatitis B Agents		
Baraclude® Epivir-HBV® Hepsera® Tyzeka®	None	

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NYS Medicaid Fee-For-Service Preferred Drug List

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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. ➢ 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.

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Hepatitis C Agents – Oral: Protease Inhibitors ST, F/Q/D		
Incivek® Victrelis®	None	**STEP THERAPY (ST)** ➢ **Incivek (telaprevir)** – step therapy assuring concomitant peginterferon and ribavirin therapy. ➢ **Victrelis (boceprevir)** – step therapy assuring four (4) consecutive weeks of peginterferon and ribavirin therapy immediately before initiation of boceprevir. **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Incivek (telaprevir): ➢ quantity limit: maximum 6 (six) units per day, 180 units per 30 days ➢ quantity limit: minimum 9 (nine) tablets per day for beneficiaries receiving efavirenz ➢ duration limit: Initially 56 days, pending results of quantitative HCV RNA testing after 4 weeks of treatment. ➢ maximum 12 consecutive weeks over beneficiary lifetime, pending results of quantitative HCV RNA testing ➢ Victrelis (boceprevir): ➢ quantity limit: maximum 12 units per day, 360 units per 30 days ➢ duration limit: Initially 84 days, pending results of quantitative HCV RNA testing after 4 and 8 weeks of boceprevir treatment (i.e. weeks 8 and 12 of triple therapy) ➢ subsequent limit of 84 days, pending results of quantitative HCV RNA testing after 20 weeks of boceprevir treatment (i.e. week 24 of triple therapy) ❖ maximum 44 consecutive weeks over beneficiary lifetime, pending results of quantitative HCV RNA testing if: o prior peginterferon/ribavirin non responder o compensated cirrhosis o maximum 32 consecutive weeks over beneficiary lifetime, pending results of quantitative HCV RNA testing for all other beneficiaries ➢ Click here for a copy of the Hepatitis C worksheet
Hepatitis C Agents – Oral: Ribavirins		
ribavirin	Copegus® Rebetol® Ribapak® Ribasphere™	

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Tetracyclines		
demeclocycline doxycycline hyclate 50 mg, 100 mg doxycycline monohydrate minocycline HCl Morgidox™ (capsule) tetracycline	Adoxa® Doryx® ST, F/Q/D doxycycline hyclate 20 mg doxycycline Hyclate DR ST, F/Q/D Dynacin® minocycline ER Oracea® Solodyn® Vibramycin®	**STEP THERAPY (ST)** ➢ trial of a more cost effective doxycycline IR before progressing to doxycycline DR **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ doxycycline DR: ➢ maximum 28 tablets/capsules per fill
III. CARDIOVASCULAR		
Angiotensin Converting Enzyme Inhibitors (ACEIs)		
benazepril captopril enalapril maleate lisinopril moexipril ramipril (capsule) trandolapril	Accupril® Aceon® Altace® fosinopril sodium Lotensin® Mavik® perindopril Prinivil® quinapril Univasc® Vasotec® Zestril®	
ACE Inhibitors / Calcium Channel Blockers		
benazepril/amlodipine Lotrel® Tarka® trandolapril/verapamil ER	None	
ACE Inhibitors / Diuretics		
benazepril/HCTZ captopril/HCTZ enalapril maleate/HCTZ lisinopril/HCTZ moexipril/HCTZ	Accuretic® fosinopril/HCTZ Lotensin HCT® quinapril/HCTZ Uniretic® Vaseretic® Zestoretic®	
Angiotensin Receptor Blockers (ARBs) ST		
Diovan® losartan	Atacand® Avapro® Benicar® Cozaar® Edarbi™ eprosartan irbesartan Micardis® Teveten®	**STEP THERAPY (ST)** ➢ trial of a product containing ACE inhibitor prior to preferred ARB ➢ trial containing either an ACE inhibitor or ARB prior preferred direct renin inhibitor (DRI)

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
ARBs / Calcium Channel Blockers ST				
Exforge®	Exforge HCT®	Azor®	Twynsta®	**STEP THERAPY (ST)** ➢ trial of product containing ACE Inhibitor prior to preferred ARB ➢ trial of product containing either ACE inhibitor or ARB prior to initiating DRI
		Tribenzor™		
ARBs / Diuretics ST				
Diovan HCT®	losartan/HCTZ	Atacand HCT®	irbesartan/HCTZ	**STEP THERAPY (ST)** ➢ trial of product containing ACE Inhibitor prior to preferred ARB ➢ trial of a product containing either an ACE inhibitor or an ARB prior to preferred DRI
		Avalide®	Micardis HCT®	
		Benicar HCT®	Teveten HCT®	
		candesartan/HCTZ	valsartan/HCTZ	
		Edarbyclor™		
		Hyzaar®		
Beta Blockers				
atenolol	metoprolol tartrate	acebutolol	metoprolol succinate XL	
carvedilol	propranolol	betaxolol	nadolol	
labetalol		bisoprolol	pindolol	
		Bystolic®	propranolol ER/SA	
		Coreg®	Sectral®	
		Coreg CR®	Tenormin®	
		Corgard®	timolol	
		Inderal LA®	Toprol XL®	
		InnoPran XL®	Trandate®	
		Kerlone®	Zebeta®	
		Levatol®	Ziac®	
		Lopressor®		
Beta Blockers / Diuretics				
atenolol/chlorthalidone		Corzide®		
bisoprolol/HCTZ		Dutoprol™		
propranolol/HCTZ		Lopressor HCT®		
		metoprolol tartrate/HCTZ		
		nadolol/bendroflumethiazide		
		Tenoretic®		
		Ziac®		

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Calcium Channel Blockers (Dihydropyridine)				
Afeditab CR®	nicardipine HCl	Adalat CC®	Procardia®	
amlodipine	Nifediac CC®	Cardene SR®	Procardia XL®	
DynaCirc CR®	Nifedical XL®	nisoldipine	Sular®	
felodipine ER	nifedipine	Norvasc®		
isradipine	nifedipine ER/SA			
Cholesterol Absorption Inhibitors				
cholestyramine	colestipol (tablet)	Colestid (granules)	Questran Light®	
cholestyramine light	Prevalite®	colestipol (granules)	Welchol™	
Colestid® (tablet)		Questran®	Zetia®	
Direct Renin Inhibitors ST				
Tekturna®	Tekturna HCT®	Amturnide™	Valturna®	**STEP THERAPY (ST)** ➢ trial of product containing ACE Inhibitor prior to preferred ARB ➢ trial of product containing either an ACE inhibitor or an ARB prior to initiating preferred DRI
		Tekamlo™		
Endothelin Receptor Antagonists for Pulmonary Arterial Hypertension (PAH)				
Letairis®	Tracleer®	None		
HMG-CoA Reductase Inhibitors (Statins)				
atorvastatin	Simcor®	Advicor®	Lipitor®	
lovastatin	simvastatin	Altoprev®	Liptruzet™	
pravastatin		atorvastatin/amlodipine	Livalo®	
		Caduet®	Mevacor®	
		Crestor®	Pravachol®	
		fluvastatin	Vytorin®	
		Lescol®	Zocor®	
		Lescol XL®		
Niacin Derivatives				
Niaspan®		None		

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Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH CDRP				
Adcirca®	sildenafil	Revatio®		**CLINICAL DRUG REVIEW PROGRAM (CDRP)** ➢ all prescriptions for Adcirca® , 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 and Instructions provides step-by-step assistance in completing the prior authorization process
Triglyceride Lowering Agents				
gemfibrozil Tricor®	Trilipix®	Antara® fenofibrate fenofibric acid Fibricor® Lipofen®	Lofibra® Lopid® Lovaza® ST, F/Q/D Triglide® 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
IV. CENTRAL NERVOUS SYSTEM				
Alzheimer's Agents				
donepezil Exelon® (patch, solution) galantamine	galantamine ER Namenda® rivastigmine	Aricept® Exelon® (capsule) Namenda XR™	Razadyne® Razadyne ER®	
Anticonvulsants – Second Generation				
Felbatol® gabapentin Gabitril® (2mg, 4mg) lamotrigine levetiracetam	levetiracetam ER Lyrica® ST Topiragen™ CC topiramate CC, Vimpat® zonisamide	Banzel® CC,2 felbamate CC,2 Gabitril® (12mg, 16mg) Keppra® CC,2 Keppra XR® CC,2 Lamictal® CC,2 Lamictal® XR™ CC,2 lamotrigine ER	Neurontin® CC,2 Potiga™ Sabril® CC,2 tiagabine Topamax® CC,2 Zonegran® CC,2	**CLINICAL CRITERIA (CC)** ➢ Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA ➢ Topiramate (Topamax®) – Require confirmation of FDA approved, compendia supported, or Medicaid covered diagnosis **STEP THERAPY (ST)** ➢ Lyrica® (pregabalin) - Requires a trial with a tricyclic antidepressant **OR** gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN)

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Antipsychotics – Second Generation[CC]				
clozapine	risperidone	Abilify®	Latuda®	**CLINICAL CRITERIA (CC)** ➢ clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA ➢ **Abilify® - PA is not required when prescribed for treatment of bipolar disorder or schizophrenia as verified by Medicaid claims information** ➢ PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below:
Fanapt™	Saphris®	clozapine ODT[CC]	olanzapine ODT	
olanzapine (tablet)	Seroquel XR® F/Q/D	Clozaril®	Risperdal®	
quetiapine F/Q/D	ziprasidone	FazaClo®	Seroquel® F/Q/D	
		Geodon®	Zyprexa®	
		Invega® ST, F/Q/D		

aripiprazole (Abilify®)	6 years
asenapine (Saphris®)	18 years
clozapine (Clozaril®, Fazaclo®)	12 years
iloperidone (Fanapt®)	18 years
lurasidone HCl (Latuda®)	18 years
olanzapine (Zyprexa®)	10 years
paliperidone (Invega®)	12 years
quetiapine Fum. (Seroquel®)	10 years
risperidone (Risperdal®)	5 years
ziprasidone HCl (Geodon®)	18 years

➢ Require confirmation of FDA approved, compendia supported, or Medicaid covered diagnosis for initial prescriptions for beneficiaries between minimum age as indicated above and 18 years of age.

STEP THERAPY (ST)

➢ trial of risperidone prior to paliperidone (Invega®) therapy

FREQUENCY/QUANTITY/DURATION (F/Q/D)

➢ Invega® 1.5mg, 3mg, 9mg tablets
  ➢ maximum 1 (one) unit per day
➢ Invega® 6mg tablets
  ➢ maximum 2 (two) units per day
➢ quetiapine/quetiapine extended-release (Seroquel®/Seroquel XR®)
  ➢ minimum 100mg/day; maximum 800mg/day
➢ quetiapine (Seroquel®)
  ➢ maximum 3 (three) units per day, 90 units per 30 days
➢ Seroquel XR® (150mg and 200mg)
  ➢ 1 (one) unit per day, 30 units per 30 days
➢ Seroquel XR® (50mg, 300mg and 400mg)
  ➢ 2 (two) units per day, 60 units per 30 days

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Benzodiazepines – Rectal		
Diastat® 2.5mg Diastat® AcuDial™	diazepam (rectal gel)	
Carbamazepine Derivatives		
carbamazepine (chewable, tablet) Carbatrol® Epitol® Equetro® oxcarbazepine (tablet) Tegretol® (chewable, suspension) Tegretol XR® Trileptal® (suspension)	carbamazepine (suspension) CC,2 carbamazepine ER (capsule) carbamazepine XR (tablet) CC,2 oxcarbazepine (suspension) Oxtellar XR™ Tegretol® (tablet) CC,2 Trileptal® (tablet) CC,2	**CLINICAL CRITERIA (CC)** ➢ clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA

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Central Nervous System (CNS) Stimulants CDRP,F/Q/D		
Adderall® Adderall XR® dexmethylphenidate dextroamphetamine Focalin XR® Metadate ER® Methylin® methylphenidate methylphenidate ER (generic for Concerta) methylphenidate SR 10 mg, 20 mg (tablet) Vyvanse®	amphetamine salt combo extended-release amphetamine salt combo immediate-release Concerta® Daytrana® Desoxyn® Dexedrine Spansule® dextroamphetamine SR Focalin® Metadate CD® methamphetamine methylphenidate CD (generic for Metadate CD) methylphenidate ER (generic for Ritalin LA) modafinil Nuvigil® CC Procentra® Provigil® CC Quillivant XR™ Ritalin® Ritalin LA® Ritalin SR®	**CLINICAL CRITERIA (CC)** ➢ patient-specific considerations for drug selection include treatment of excessive sleepiness associated with shift work sleep disorder or as an adjunct to standard treatment for obstructive sleep apnea. **CLINICAL DRUG REVIEW PROGRAM (CDRP)** ➢ For patients 18 years of age and older: ➢ Require confirmation of FDA approved, compendia supported, or Medicaid covered diagnosis ➢ Click here for a copy of the CNS Stimulant for patients 18 years and older worksheet **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ quantity limits based on daily dosage as determined by FDA labeling ➢ quantity limits for patients less than 18 years of age 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 ➢ quantity limits for patients 18 years of age and older to include: ➢ Short-acting CNS stimulants, not to exceed 3 dosage units daily with maximum of 30 days ➢ Long-acting CNS stimulants, not to exceed 1 dosage unit daily with maximum of 30 days ➢ For patients 18 years of age and older: a 90 day supply may be obtained with confirmation of FDA approved, Compendia supported or Medicaid covered diagnosis
Multiple Sclerosis Agents		
Avonex® Copaxone® Betaseron® Rebif®	Aubagio® Gilenya™ Extavia® Tecfidera™	
Non-Ergot Dopamine Receptor Agonists		
pramipexole ropinirole	Mirapex® Requip® Mirapex ER® Requip® XL™ Neupro® ropinirole ER	
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)		
Intuniv™ Strattera®	Kapvay™ 2	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Sedative Hypnotics/Sleep Agents		
chloral hydrate estazolam flurazepam temazepam 15 mg, 30 mg zolpidem F/Q/D	Ambien® F/Q/D Ambien CR® F/Q/D Doral® Edluar™ F/Q/D Halcion® Intermezzo® F/Q/D Lunesta® F/Q/D Restoril® Rozerem® F/Q/D Silenor® Somnote® Sonata® F/Q/D temazepam 7.5 mg, 22.5 mg triazolam zaleplon F/Q/D zolpidem ER F/Q/D Zolpimist™ F/Q/D	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Frequency and duration limits for the following products: ➢ for non-zaleplon 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: ➢ 360 days for immediate-release zolpidem products ➢ 180 days for eszopiclone and ramelteon products ➢ 168 days for ER zolpidem products ➢ 30 days for zaleplon products 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 fluoxetine 10 mg, 20 mg, 40 mg fluvoxamine paroxetine sertraline	Celexa® fluoxetine 60 mg fluoxetine weekly Lexapro® Luvox CR® paroxetine CR Paxil® Paxil CR® Pexeva® Prozac® Sarafem® Viibryd™ Zoloft®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) ST		
Cymbalta® venlafaxine venlafaxine ER (capsule)	Desvenlafaxine Effexor XR® Pristiq Savella® venlafaxine ER (tablet)	**STEP THERAPY (ST)** ➢ trial of an SSRI prior to an SNRI ➢ ST is not required for the following indications: ❖ Chronic musculoskeletal pain (CMP) ❖ Diabetic peripheral neuropathy (DPN) ❖ Fibromyalgia (FM) ➢ Cymbalta® (duloxetine) - Requires a trial with a tricyclic antidepressant **OR** gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN)
Serotonin Receptor Agonists (Triptans)		
Maxalt-MLT® F/Q/D rizatriptan (tablet) F/Q/D sumatriptan F/Q/D	Amerge® F/Q/D Axert® F/Q/D Frova® F/Q/D Imitrex® F/Q/D Maxalt® F/Q/D naratriptan F/Q/D Relpax® F/Q/D rizatriptan ODT F/Q/D Sumavel® DosePro™ Treximet® F/Q/D Zomig® F/Q/D	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** Amerge®: 18 units every 30 days Axert® 6.25mg: 18 units every 30 days Frova®: 18 units every 30 days Imitrex® tablets: 18 units every 30 days Imitrex® Nasal Spray: 18 units every 30 days naratriptan: 18 units every 30 days Relpax® 20mg: 18 units every 30 days sumatriptan tablets: 18 units every 30 days Treximet®: 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: 18 units every 30 days Axert® 12.5mg: 24 tablets every 30 days Maxalt® /Maxalt MLT®: 24 tablets every 30 days Relpax® 40mg: 24 tablets every 30 days rizatriptan (tablet, ODT): 24 tablets every 30 days

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Agents for Actinic Keratosis		
Carac® Efudex® Fluoroplex® fluorouracil Solaraze® F/Q/D	None	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Solaraze® ➢ Maximum 100 (one hundred) grams as a 90 day supply ➢ Limited to one (1) prescription per year
Antibiotics – Topical		
Altabax® Bactroban® (cream) mupirocin (ointment)	Bactroban® (ointment) Bactroban Nasal® (ointment) CC Centany™ (ointment) mupirocin (cream)	**CLINICAL CRITERIA** ➢ Bactroban Nasal® ointment – Patient-specific considerations for drug selection include concerns related to use for the eradication of nasal colonization with methicillin-resistant Staphylococcus aureus (MRSA) in a patient greater than 12 years of age.
Anti-Fungals – Topical		
clotrimazole OTC Lamisil AT® miconazole OTC Nyamyc™ nystatin (cream, ointment, powder) nystatin/triamcinolone Nystop® Pedi-Dri® terbinafine OTC tolnaftate OTC	Ciclodan® ST ciclopirox (cream, gel, suspension) ST clotrimazole/ betamethasone ST clotrimazole Rx ST econazole ST Ertaczo® ST Exelderm® ST Extina® ST ketoconazole ST Ketodan™ ST Loprox® ST Lotrisone ST Mentax® ST Naftin® ST Oxistat® ST Vusion® F/Q/D Xolegel® ST	**STEP THERAPY (ST)** ➢ trial of a preferred product (of comparable coverage) before using a non-preferred product **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Vusion® 50 gm ointment - Maximum 100 (one hundred) grams in a 90 day time period
Anti-Virals – Topical		
Abreva® Zovirax® (ointment)	acyclovir ointment Denavir® Xerese™ Zovirax® (cream)	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Immunomodulators – Topical CDRP		
Elidel® Protopic®	None	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** ➢ all prescriptions require prior authorization ➢ refills on prescriptions are allowed ➢ Click here for CDRP Topical Immunomodulators Prescriber Worksheet and Instructions
Psoriasis Agents – Topical		
calcipotriene (ointment, scalp solution) Dovonex® (cream)	calcipotriene (cream) Calcitrene™ (ointment) calcitriol (ointment) Dovonex® (scalp solution) Sorilux® Taclonex® Taclonex® Scalp® Vectical™	
Steroids, Topical – Low Potency		
hydrocortisone acetate OTC hydrocortisone acetate Rx hydrocortisone/aloe vera	alclometasone ST Derma-Smoothe/FS® ST Desonate® ST desonide ST fluocinolone (oil) ST Texacort® ST Verdeso™ ST	**STEP THERAPY (ST)** ➢ trial of preferred product (of comparable potency) before using non-preferred product.
Steroids, Topical – Medium Potency		
hydrocortisone butyrate (ointment, solution) hydrocortisone valerate mometasone furoate	Cloderm® ST Cordran® ST Cutivate® ST Dermatop® ST Elocon® ST fluocinolone (cream, ointment, solution) ST fluticasone propionate ST hydrocortisone butyrate (cream) ST Luxiq® ST Pandel® ST prednicarbate ST Synalar® ST	**STEP THERAPY (ST)** ➢ trial of preferred product (of comparable potency) before using non-preferred product

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Steroids, Topical – High Potency		
amcinonide fluocinonide fluocinonide emollient fluocinonide-E triamcinolone acetonide	Apexicon-E® ST Beta-Val® ST betamethasone dipropionate ST betamethasone dipropionate, augmented ST betamethasone valerate ST desoximetasone ST diflorasone ST Diprolene® ST Diprolene® AF ST Halog® ST Kenalog® ST Topicort® ST Trianex® ST Vanos™ ST	**STEP THERAPY (ST)** ➢ trial of preferred product (of comparable potency) before using non-preferred product
Steroids, Topical – Very High Potency		
clobetasol (cream, gel, ointment, solution) halobetasol	clobetasol (foam, lotion) ST Clobex® ST Cormax® ST Olux® ST Olux-E® ST Temovate® ST Temovate-E® ST Ultravate® ST	**STEP THERAPY (ST)** ➢ trial of preferred product (of comparable potency) before using non-preferred product.
VI. ENDOCRINE AND METABOLIC AGENTS		
Amylin Analogs ST		
Symlin®	None	**STEP THERAPY (ST)** ➢ Requires a trial with metformin with or without insulin prior to initiating other antidiabetic agents, unless there is a documented contraindication.

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Anabolic Steroids – Topical CDRP, F/Q/D		
Androderm® Testim® Androgel®	Axiron® Fortesta™	**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. ➢ Click here for a copy of the Anabolic Steroid worksheet **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 – Duration limit of one (1) month for all used of oxandrolone products
Biguanides		
metformin HCl metformin ER (generic for Glucophage XR)	Fortamet® Glucophage® Glucophage XR® Glumetza® metformin ER (generic for Fortamet) Riomet® (solution)	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Bisphosphonates – Oral F/Q/D		
alendronate	Actonel® Atelvia® Binosto™ Boniva® Fosamax® Fosamax® Plus D ibandronate	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** Actonel® 150mg — 1 tablet every 28 days Boniva® 150mg — 1 tablet every 28 days ibandronate sodium 150 mg — 1 tablet every 28 days Actonel® 35 mg — 4 tablets every 28 days alendronate sodium 35 mg — 4 tablets every 28 days alendronate sodium 70 mg — 4 tablets every 28 days Atelvia® 35 mg — 4 tablets every 28 days Fosamax® 35 mg — 4 tablets every 28 days Fosamax® 70mg — 4 tablets every 28 days Fosamax® Plus D — 4 tablets every 28 days alendronate solution 70mg/75ml single-dose bottle — 4 bottles every 28 days
Calcitonins – Intranasal		
calcitonin-salmon Miacalcin®	Fortical®	
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors ST		
Janumet® Janumet® XR Januvia® Jentadueto™ Kombiglyze XR™ Onglyza® Tradjenta™	Juvisync™ Kazano™ Nesina™ Oseni™	**STEP THERAPY (ST)** ➢ Requires a trial with metformin with or without insulin prior to initiating other antidiabetic agents, unless there is a documented contraindication.
Glucagon-like Peptide-1 (GLP-1) Agonists ST		
Byetta®	Bydureon™ Victoza®	**STEP THERAPY (ST)** ➢ Requires a trial with metformin plus another oral antidiabetic agent prior to a GLP-1 agonist. ➢ Prior authorization is required with lack of covered diagnosis in medical history.

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Growth Hormones CC, CDRP				
Genotropin® Norditropin®[1]	Nutropin® Nutropin AQ®	Humatrope® Omnitrope® Saizen®	Tev-Tropin® Zorbtive®	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** ➢ prescriptions for enrollees that are 21 years of age or older require PA under the CDRP ➢ prescribers, not authorized agents, are required to call the clinical call center toll free number 1-877-309-9493 and respond to a series of questions that identify prescriber, patient and reason for prescribing a drug in this class for enrollees 21 years of age or older ➢ refills on prescriptions are allowed ➢ refer to the Preferred Drug Program web page and review list of preferred and non- preferred drugs when prescribing for enrollees under the age of 21 ➢ Click here for a copy of the CDRP Growth Hormone Prescriber Fax Form and Instructions **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. ➢ appropriate diagnosis is required for all Growth Hormones, regardless of age or preferred status.
Insulin – Long-Acting				
Lantus®	Levemir	None		
Insulin – Mixes				
Humalog® Mix	Novolog® Mix	None		
Insulin – Rapid-Acting				
Apidra® Humalog®	Novolog®	None		
Pancreatic Enzymes				
Creon® pancrelipase	Zenpep®	Pancreaze® Pertzye™	Ultresa™ Viokace	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Thiazolidinediones (TZDs)[ST]		
Duetact® pioglitazone pioglitazone/ metformin	Actoplus Met® Actoplus Met® XR Actos® Avandamet® Avandaryl® Avandia® pioglitazone/ glimepiride	**STEP THERAPY (ST)** ➢ Requires a trial with metformin with or without insulin prior to initiating other antidiabetic agents, unless there is a documented contraindication.
VII. GASTROINTESTINAL		
Anti-Emetics		
ondansetron (ODT, solution, tablet)	Anzemet® granisetron (tablet) Sancuso® Zofran® (ODT, solution, tablet)	
Helicobacter pylori Agents		
Helidac® Prevpac® Pylera®	Omeclamox-Pak®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Proton Pump Inhibitors (PPIs) F/Q/D		
omeprazole Rx pantoprazole Prilosec® OTC	Aciphex® Dexilant™ lansoprazole Rx (capsule, ODT) Nexium® omeprazole OTC omeprazole/sodium bicarbonate Rx Prevacid® OTC Prevacid® Rx Prilosec® Rx Protonix®	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Quantity limits: ➢ Once daily dosing (30 units every 30 days) for: ❖ GERD, ❖ erosive esophagitis, ❖ healing and maintenance of duodenal/gastric ulcers (including NSAID-induced), ❖ prevention of NSAID-induced ulcers ➢ Twice daily dosing (60 units every 30 days) for: ❖ hypersecretory conditions, ❖ Barrett's esophagitis, ❖ H. pylori, ❖ refractory GERD ➢ Duration limits: ➢ 60 days for: ❖ Mild/moderate GERD, ❖ acute healing of duodenal/gastric ulcers (including NSAID-induced) ➢ 365 days for: ❖ Maintenance treatment of duodenal ulcers ➢ 14 days for: ❖ H. pylori
Sulfasalazine Derivatives		
Apriso® Asacol® Dipentum® sulfasalazine DR/EC sulfasalazine IR sulfazine sulfazine EC	Asacol HD® Azulfidine® Azulfidine Entab® balsalazide Colazal® Delzicol™ Giazo™ Lialda® Pentasa®	
VIII. HEMATOLOGICAL AGENTS		
Anticoagulants – Injectable		
fondaparinux Fragmin® Lovenox®	Arixtra® enoxaparin sodium Innohep®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Anticoagulants – Oral				
Coumadin®	Pradaxa®	Eliquis®		
Jantoven®	warfarin	Xarelto®		
Erythropoiesis Stimulating Agents (ESAs)				
Aranesp®	Procrit®	Epogen®		
Platelet Inhibitors				
Aggrenox®	dipyridamole	Brilinta™	Plavix®	
clopidogrel	Effient®	Persantine®	ticlopidine	
IX. IMMUNOLOGIC AGENTS				
Immunomodulators – Systemic				
Enbrel®	Humira®	Cimzia®	Simponi™	
		Kineret®	Xeljanz®	
		Orencia® (subcutaneous)		
X. MISCELLANEOUS				
Progestins (for Cachexia)				
megestrol acetate (suspension)		Megace® (suspension)	Megace ES®	

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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 cyclobenzaprine 5mg, 10mg dantrolene methocarbamol orphenadrine orphenadrine compound orphenadrine compound forte tizanidine (tablet)	Amrix® carisoprodol ST, F/Q/D carisoprodol compound ST, F/Q/D carisoprodol compound - codeine ST, F/Q/D cyclobenzaprine 7.5 mg Dantrium® Fexmid® Lorzone™ metaxalone Parafon Forte® DSC Robaxin® Skelaxin® Soma® ST, F/Q/D Soma® 250 ST, F/Q/D tizanidine (capsule) Zanaflex®	**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 (twenty-one) day supply (not to exceed the 84 cumulative units per year limit)
XII. OPHTHALMICS		
Alpha-2 Adrenergic Agonists (for Glaucoma) – Ophthalmic		
Alphagan P® 0.1%,0.15% brimonidine 0.2%	apraclonidine brimonidine 0.15%	Iopidine® Simbrinza™
Antibiotics – Ophthalmic		
bacitracin/polymyxin B erythromycin gentamicin Natacyn® neomycin/gramicidin/polymyxin polymyxin/trimethoprim sulfacetamide (solution) tobramycin	Azasite® bacitracin Bleph®-10 Garamycin® neomycin/bacitracin/polymyxin Neosporin® Polytrim® sulfacetamide (ointment) Tobrex®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Antibiotics/Steroids – Ophthalmic		
Blephamide® Maxitrol® (ointment) neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TobraDex® (ointment, suspension)	Maxitrol® (suspension) neomycin/bacitracin/polymyxin/hydrocortisone neomycin/polymyxin/hydrocortisone Pred-G® TobraDex® ST tobramycin/dexamethasone Zylet™	
Antihistamines – Ophthalmic		
Pataday®	azelastine Bepreve® Elestat® Emadine® epinastine Lastacaft™ Optivar® Patanol®	
Beta Blockers – Ophthalmic		
betaxolol Betimol® Betoptic S® carteolol Combigan® Istalol® levobunolol metipranolol timolol maleate (gel, solution)	Betagan® Optipranolol® Timoptic® Timoptic® in Ocudose® Timoptic-XE®	
Fluoroquinolones – Ophthalmic ST		
ciprofloxacin ofloxacin Vigamox®	Besivance™ Ciloxan® levofloxacin Moxeza™ Ocuflox® Zymar® Zymaxid™	**STEP THERAPY (ST)** ➢ for patients 21 yrs or younger, attempt treatment with a non-fluoroquinolone ophthalmic antibiotic before progressing to the following products: ➢ Besivance® ➢ Ciloxan® ➢ ciprofloxacin ➢ levofloxacin ➢ Moxeza® ➢ Ocuflox® ➢ ofloxacin ➢ Vigamox® ➢ Zymaxid®

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Ophthalmic				
diclofenac	ketorolac	Acular®	Ilevro™	
flurbiprofen		Acular LS®	Nevanac®	
		Acuvail®	Ocufen®	
		Bromday™	Prolensa™	
		bromfenac	Voltaren®	
Prostaglandin Agonists – Ophthalmic				
latanoprost		Lumigan®	travoprost	
		Rescula®	Xalatan®	
		Travatan Z®	Zioptan™	
XIII. OTICS				
Fluoroquinolones – Otic				
Ciprodex®	ofloxacin	Cipro HC®		
XIV. RENAL AND GENITOURINARY				
Alpha Reductase Inhibitors for BPH				
Avodart®	finasteride	Jalyn™	Proscar®	
Phosphate Binders/Regulators				
calcium acetate	Renagel®	Phoslo®	Renvela® (oral powder)	
Eliphos™	Renvela® (tablet)	Phoslyra™		
Fosrenol®				
Selective Alpha Adrenergic Blockers				
alfuzosin	tamsulosin	Flomax	Uroxatral®	
		Rapaflo™		
Urinary Tract Antispasmodics				
oxybutynin	Toviaz™	Detrol®	oxybutynin ER	
Oxytrol®	Vesicare®	Detrol LA®	Sanctura®	
Sanctura XR®		Ditropan XL®	tolterodine	
		Enablex®	trospium	
		Gelnique™	trospium ER	
		Myrbetriq™		

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Xanthine Oxidase Inhibitors		
allopurinol	Uloric® Zyloprim®	
XV. RESPIRATORY		
Anticholinergics – Inhaled/COPD Agents		
Atrovent HFA® Combivent® ipratropium ipratropium/albuterol Spiriva®	Combivent® Respimat® Daliresp® Duoneb® Tudorza™ Pressair™	
Antihistamines – Intranasal		
Astelin® Astepro™ Patanase®	azelastine	
Antihistamines – Second Generation		
cetirizine Rx (syrup) OTC cetirizine (tablet, syrup) OTC loratadine (tablet, syrup)	Allegra® CC Allegra-D® Clarinex® CC Clarinex-D® desloratadine fexofenadine fexofenadine-D levocetirizine OTC cetirizine-D OTC loratadine-D Xyzal® CC	**CLINICAL CRITERIA (CC)** ➢ no PA required for patients less than 24 months of age

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Beta$_2$ Adrenergic Agents – Inhaled Long-Acting CC,F/Q/D				
Foradil®	Serevent Diskus®	Arcapta™	Perforomist®	**CLINICAL CRITERIA (CC)** PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA or compendia supported age as indicated: Arcapta™ ≥18 years Brovana® ≥18 years Foradil® ≥ 5 years Perforomist® ≥18 years Serevent® ≥4 years **FREQUENCY/QUANTITY/DURATION (F/Q/D)** **Maximum units per 30 days** Arcapta™ 30 units (1 box of 30 unit dose capsules) Brovana® 60 units (1 carton of 60 vials or 120 mL) Foradil® 60 units (1 box of 60 unit dose capsules) Perforomist® 60 units (1 carton of 60 vials or 120 mL) Serevent® 1 diskus (60 blisters)
		Brovana®		
Beta$_2$ Adrenergic Agents – Inhaled Short-Acting				
albuterol	ProAir HFA®	Accuneb®	Xopenex® (solution)	
Maxair Autohaler®	Proventil HFA®	levalbuterol (solution)	Xopenex HFA®	
		Ventolin HFA®		

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Corticosteroids – Inhaled F/Q/D				
Asmanex®	Flovent HFA®	Alvesco®	Pulmicort® (Flexhaler) CC	**CLINICAL CRITERIA** ➢ patient-specific considerations for drug selection include concerns related to pregnancy **FREQUENCY/QUANTITY/DURATION (F/Q/D)**
Flovent Diskus®	QVAR®			

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.
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.
Flovent Diskus® 50mcg	1 diskus every 30 days
Flovent Diskus® 100mcg	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	1 inhaler every 30 days
Flovent HFA® 110mcg	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® 40mcg	1 inhaler every 25 days
QVAR® 80mcg	1 inhaler every 12 days

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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">Corticosteroid/Beta$_2$ Adrenergic Agent (Long-Acting) Combinations – Inhaled CC,F/Q/D</td></tr>
<tr><td>Advair Diskus®
Advair HFA®
Dulera®
Symbicort®</td><td>None</td><td><u>CLINICAL CRITERIA (CC)</u>
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>Dulera®</td><td>≥12 years</td></tr><tr><td>Symbicort®</td><td>≥12 years</td></tr></table><u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u>
<table><tr><td>Advair Diskus®</td><td rowspan="4">One (1) inhaler/diskus every 30 days</td></tr><tr><td>Advair HFA®</td></tr><tr><td>Dulera®</td></tr><tr><td>Symbicort®</td></tr></table></td></tr>
</table>

1 = Preferred as of 02/21/2013
2 = Non-preferred as of 02/21/2013

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Corticosteroids – Intranasal F/Q/D		
Nasacort AQ®	Beconase AQ® Dymista™ Flonase® flunisolide fluticasone Nasonex® Omnaris® QNASL™ Rhinocort Aqua® triamcinolone Veramyst® Zetonna™	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** Beconase AQ® — One (1) inhaler every 22 days flunisolide — One (1) inhaler every 25 days Dymista™ — One (1) inhaler every 30 days Flonase fluticasone Nasacort AQ® Nasonex® Omnaris® QNASL® Rhinocort Aqua® triamcinolone Veramyst® Zetonna™
Leukotriene Modifiers		
Accolate® montelukast (chewable, tablet) ST Singulair® (granules) ST	montelukast (granules) ST Singulair® (chewable, tablet) ST zafirlukast	**STEP THERAPY (ST)** ➢ For non-asthmatic patients, trial of intranasal corticosteroid or a 2nd generation oral antihistamine before montelukast.

1 = Preferred as of 02/21/2013
2 = Non-preferred as of 02/21/2013

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 http://newyork.fhsc.com/providers/CDRP_forms.asp.

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

- becaplermin gel (Regranex®)
- emtricitabine/tenofovir (Truvada®)
- fentanyl mucosal agents
- lidocaine patch (Lidoderm®)
- linezolid (Zyvox®)
- palivizumab (Synagis®)
- sodium oxybate (Xyrem®)
- somatropin (Serostim®)

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

- Anabolic Steroids
- Central Nervous System (CNS) Stimulants for 18 years and older
- Growth Hormones for 21 years and older
- Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH
- Topical Immunomodulators

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 31.

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 ➢ Multlple sclerosis – 5 weeks ➢ Rheumatic disorders – 5 weeks ➢ Dermatologic conditions – 5 weeks ➢ Allergic states (serum sickness) – 5 weeks	Confirm diagnosis for Medicaid covered uses. Medicaid Fee-For-Service benefit does not cover for diagnostic purposes.

FDA Indication	First line Therapy
Multiple Sclerosis (MS) exacerbations	Corticosteroid or plasmapheresis
Polymyositis/ dermatomyositis	Corticosteroid
Idiopathic nephrotic syndrome	ACE Inhibitor, diuretic, corticosteroid (and for refractory patients: an immunosuppressive)
Systemic lupus erythematosus (SLE)	Corticosteroid, antimalarial, or cytotoxic/immunosuppressive agent
Nephrotic syndrome due to SLE	Immumosuppressive, corticosteroid, or ACE Inhibitor
Rheumatic disorders (specifically: psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis)	Corticosteroid, topical retinoid, biologic disease-modifying antirheumatic drugs (DMARD), non-biologic DMARD, or a non-steroidal anti-inflammatory drug (NSAID)
Dermatologic diseases (specifically Stevens-Johnson syndrome and erythema multiforme)	Corticosteroid or analgesic
Allergic states (specifically serum sickness)	Topical or oral corticosteroid, antihistamine, or NSAID
Ophthalmic diseases (keratitis, iritis, iridocyclitis, diffuse posterior uveitis/choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation)	Analgesic, anti-infective agent, and agents to reduce inflammation, such as NSAIDs and steroids
Respiratory diseases (systemic sarcoidosis)	Oral costicosteroid or an imunosuppressive.

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Amitiza® (lubiprostone)	Step therapy with trials of both a bulking-agent and an osmotic laxative prior (defined as within 89 days) to lubiprostone	**DURATION LIMIT:** ➢ 30 days with 2 refills/prescription	
Anabolic Steroids – Oral ➢ Anadrol-50® ➢ Android® ➢ Androxy™ ➢ Methitest® ➢ Oxandrin® ➢ oxandrolone ➢ Testred® Anabolic Steroids – Injectable ➢ Depo-Testosterone® ➢ Testosterone cypionate ➢ Testosterone enanthate		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): ➢ 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-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	
Antidiabetic agents ➢ acarbose (Precose®) ➢ acetohexamide ➢ canagliflozin (Invokana™) ➢ chlorpropamide ➢ glimepiride ➢ glyburide (Diabeta®, Glynase®) ➢ glyburide, micronized ➢ miglitol (Glyset®) ➢ nateglinide (Starlix®) ➢ repaglinide (Prandin®) ➢ tolazamide ➢ tolbutamide	Requires a trial with metformin with or without insulin prior to initiating other antidiabetic agents, unless there is a documented contraindication.		

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Buprenorphine sublingual (SL)		**QUANTITY LIMIT:** ➢ 6 tablets dispensed as a 2-day supply	
Fentanyl transmucosal agents		**QUANTITY LIMIT:** ➢ 4 units per day, 120 units per 30 days	Quantity limit not applicable to patients with a documented cancer or sickle cell diagnosis
Forteo® (teriparatide)	Requires a trial with a preferred oral bisphosphonate prior to teriparatide.	**QUANTITY LIMIT:** ➢ one unit (2.4 mL) per 30-day period **LIFETIME QUANTITY LIMIT:** ➢ 25 months of 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	
Methadone		**QUANTITY LIMIT:** ➢ 12 units per day, 360 units per 30 days	Quantity limit not applicable to patients with a documented cancer or sickle cell diagnosis
Marinol® (dronabinol)	➢ 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 for Medicaid covered uses as follows: ▪ HIV/AIDS or Cancer and eating disorder ▪ Cancer and nausea/vomiting
Moxatag® (amoxicillin)	Prescribers should attempt treatment with a more cost effective immediate-release amoxicillin first before progressing to extended-release amoxicillin	**QUANTITY LIMIT:** ➢ Equal to 10 tablets per fill	
Quinine		**QUANTITY AND DURATION LIMITS:** ➢ Maximum 42 capsules as a 7-day supply ➢ limited to 1 prescription per year	
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)
Restasis®	Diagnosis documentation required to justify utilization as a first line agent or attempt treatment with an artificial tear, gel or ointment	**QUANTITY LIMIT:** ➢ 60 vials dispensed as a 30-day supply	
Suboxone® sublingual (SL) Tablet and Film		**QUANTITY LIMIT:** ➢ 3 sublingual tablets or films per day; maximum of 90 tablets or films dispensed as a 30-day supply	
Symbyax® (olanzapine/fluoxetine)			PA is required for the initial prescription for beneficiaries younger than 18 years
Xifaxan® (rifaximin)	Traveler's diarrhea: Requires trial of a preferred fluoroquinolone antibiotic before rifaximin	**QUANTITY LIMITS:** ➢ 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)	Requires confirmation of diagnosis of Traveler's diarrhea or hepatic encephalopathy

For more information on DUR Program, please refer to http://nyhealth.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
- Do not require a new prescription if the drug is removed from this program

Catapres TTS will be removed (due to market availability) from the Program.

Effective August 14, 2013

- **Depakote sprinkle, Dovonex cream, Marinol and Prograf 1mg capsule will be added** to the Program.

Current list of Brand name drugs included in this program* (*Updated 7/31/2013*):

Accolate	Diovan HCT	Marinol	Tegretol XR
Adderall & Adderall XR	Dovonex cream	Maxalt MLT	Tobradex
Alphagan P 0.15%	Duetact	Nasacort AQ	Tricor
Astelin	Epivir	Prograf 1mg capsule	Trileptal suspension
Bactroban cream	Felbatol	Pulmicort Respules	Valtrex
Carbatrol	Gabitril 2mg, 4mg	Sanctura XR	Vancocin
Combivir	Gris-PEG	Singulair granules	Ziagen tablet
Depakote sprinkle	Kadian	Symbyax	Zovirax ointment
Diastat	Lovenox	Tegretol suspension	

* 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

- Prescription claims submitted to the Medicaid program do not require the submission of Dispense As Written/Product Selection Code of '1';
- Pharmacies can submit any valid NCPDP field (408-D8) value

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 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:

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.