WYOMING MEDICAID
Preferred Drug List (PDL) January 1, 2026

Drug classes not included on this list are not managed through a Preferred Drug List (PDL).
HOWEVER, THIS EXCLUSION IS NOT A GUARANTEE OF PAYMENT OR COVERAGE. Dosage limits and other requirements may apply.
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.
Yellow highlighted items below indicate new changes to the PDL. Red font indicates quantity/dosage limits apply. *Indicates BRAND is Preferred. May Use DAW 5.
Contact the OptumRx PA Helpdesk @ 877-207-1126 for prior authorization if client has primary insurance that will not cover the brand name medication.

Please refer to the Additional Therapeutic Criteria Chart, Dosage Limitation List (red font indicates quantity/dose limits apply), and Wyoming Medicaid Provider Manual for additional criteria.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT OptumRx WITH ANY QUESTIONS
ADDICTION	**BUPRENORPHINE COMBINATIONS**	buprenorphine/naloxone tablets SUBLOCADE SUBOXONE FILM*	Client must have a diagnosis of opioid dependence or abuse. This is not to be used for the treatment of chronic pain. Prior authorization will be required before any narcotic, benzodiazepine, or carisoprodol prescription will be allowed between fills. Prior authorization will be required before any short-acting stimulant prescription from any doctor other than the prescriber of buprenorphine or Suboxone, will be allowed between fills. Oral buprenorphine will be approved for clients with a documented allergy to naloxone. Please submit PA requests on the "Oral Buprenorphine/Naloxone or Oral Buprenorphine" PA form available at www.wymedicaid.org. Dosage limits apply Prior authorization will be required for doses >24mg	buprenorphine (oral) buprenorphine/naloxone film BRAND IS PREFERRED) ZUBSOLV
	NALOXONE		Kloxxado, naloxone products, and Narcan nasal spray will be limited to one fill per 180 days without prior authorization. Naloxone formulations available in quantities of 10ml will require prior authorization.	OPVEE REXTOVY ZIMHI
	KLOXXADO naloxone nasal spray NARCAN			
	NALTREXONE		Client must have a diagnosis of alcohol or opioid dependance. Prior authorization will be required before any narcotic, carisoprodol, or benzodiazepine prescription will be allowed between fills. Prior authorization will be required before a short-acting stimulant prescription from any doctor other than the prescriber of naltrexone or Vivitrol will be allowed between fills. *Topiramate requires 4 week trial and failure of naltrexone or acamprosate in AUD	topiramate*
	VIVITROL	naltrexone		
ALLERGY / ASTHMA / COPD	**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.	desloratadine CLARINEX RDT/SYRUP levocetirizine
	cetirizine fexofenadine loratadine			
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		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.	CLARINEX-D
	cetirizine/pseudoephedrine fexofenadine/pseudoephedrine loratadine/pseudoephedrine			
	ANTICHOLINERGIC BRONCHODILATORS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Spiriva 5 day STARTER package will be allowed one (1) time per recipient.	TIOTROPIUM BROM *(use brand)* TUDORZA YUPELRI
	ATROVENT HFA INCRUSE ELLIPTA ipratropium SPIRIVA HANDIHALER SPIRIVA RESPIMAT			
	ANTICHOLINERGIC COMBINATION AGENTS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. **Will also require the diagnosis of COPD.	BEVESPI DUAKLIR
	ANORO ELLIPTA** BREZTRI COMBIVENT STIOLTO TRELEGY			
	LEUKOTRIENE MODIFIERS		Trial and failure of preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	zafirlukast
	montelukast			
	LONG ACTING BRONCHODILATORS		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	BROVANA
	arformoterol SEREVENT STRIVERDI			
	NASAL ANTIHISTAMINES		Trial and failure of preferred agent greater than or equal to 90 days in the last 12 months will be required before approval can be given for a non-preferred agent.	azelastine 0.15% DYMISTA *(use separate agents)* olopatadine 0.6% RYALTRIS
	azelastine 0.1%			
	NASAL STEROIDS		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Budesonide will be approved for pregnancy.	DYMISTA *(use separate agents)* OMNARIS QNASL XHANCE ZETONNA
	budesonide flunisolide fluticasone mometasone			
	SHORT ACTING BRONCHODILATORS - INHALERS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Prior authorization will be required after a total of 12 albuterol inhalers are dispensed within 365 days. Minimum day supply of 16 days is required.	AIRSUPRA levalbuterol (BRAND IS PREFERRED) PROAIR DIGIHALER PROVENTIL HFA
	albuterol HFA PROAIR RESPICLICK VENTOLIN HFA XOPENEX HFA			
	STEROID INHALANTS		Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. *Fluticasone HFA and Asmanex HFA will be approved for pediatric clients 8 years of age or younger. Alvesco will be approved for a history of oral thrush with steroid inhalants.	AIRDUO DIGIHALER ALVESCO ARMONAIR ASMANEX HFA* fluticasone HFA* QVAR REDIHALER
	AIRDUO RESPICLICK ARNUITY ELLIPTA ASMANEX TWISTHALER budesonide suspension PULMICORT FLEXHALER			
	STEROID COMBINATION AGENTS		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. **Will also require the diagnosis of COPD or uncontrolled asthma. Advair 7 and 14-day STARTER package will be allowed one (1) time per recipient.	BREYNA fluticasone/vilanterol *(use preferred agent)* fluticasone/salmeterol 55-14/113-14/232-14 fluticasone/salmeterol 100-50/250-50/500-50 (BRAND IS PREFERRED) WIXELA
	ADVAIR (HFA, Diskus) BREO ELLIPTA** DULERA SYMBICORT* TRELEGY			
	EPINEPHRINE			AUVI-Q *(use preferred agent)* NEFFY
	epinephrine auto-injector pen EPI-PEN			
	EOSINOPHILIC ASTHMA AGENTS		Approval for these agents will require additional clinical criteria which can be found on the Additional Therapeutic Criteria Chart.	FASENRA NUCALA TEZSPIRE
		DUPIXENT XOLAIR		

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ARTHRITIS	IMMUNOMODULATORS ANKYLOSING SPONDYLITIS (AS)	adalimumab-fkjp ENBREL HADLIMA HUMIRA RINVOQ TALTZ	Client must have diagnosis of AS prior to approval of a preferred agent. To receive a non-preferred agent, client must have diagnosis of AS and 56-day trial and failure of two preferred agents **Cimzia will be allowed for clients that are pregnant or breast-feeding Quantity Limits apply for all diagnoses: Enbrel 25mg - limited to 10 per month Enbrel 50mg - limited to 5 per month Humira 20mg - limited to 10 per month Humira 40mg - limited to 5 per month	CIMZIA** COSENTYX REMICADE SIMPONI XELJANZ/XR
	JUVENILE IDIOPATHIC ARTHRITIS (JIA)	adalimumab-fkjp ENBREL HADLIMA HUMIRA	Client must have diagnosis of JIA prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of JIA and a 56-day trial and failure of both preferred agents.	ACTEMRA ILARIS ORENCIA XELJANZ/XR
	PSORIATIC ARTHRITIS (PA)	adalimumab-fkjp HADLIMA OTEZLA* HUMIRA OTEZLA* RINVOQ TALTZ	Client must have diagnosis of PA prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of PA and a 56-day trial and failure of two preferred agents. *Otezla starter pack is non-preferred **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** COSENTYX ORENCIA REMICADE SIMPONI SKYRIZI STELARA TREMFYA XELJANZ/XR
	RHEUMATOID ARTHRITIS (RA)	adalimumab-fkjp HADLIMA ENBREL HUMIRA RINVOQ	Client must have diagnosis of RA and a 56-day trial and failure of methotrexate prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of RA and a 56-day trial and failure of both preferred agents. *Cimzia will be allowed for clients that are pregnant or breast-feeding **See Dermatology criteria for Atopic Dermatitis approval	ACTEMRA CIMZIA* KEVZARA KINERET OLUMIANT ORENCIA REMICADE RITUXAN SIMPONI XELJANZ/XR
CONVULSIONS	INTERMITTENT, STEREOTYPIC SEIZURE EPISODES		*Nayzilam will be allowed for patients 12 years of age and older	
	diazepam gel NAYZILAM* VALTOCO			
	ORAL ANTICONVULSANTS		Preferred agents with clinical criteria will be limited to FDA approved indications related to seizures and epilepsy. Non-preferred agents require 30 day trial and failure of two preferred agents prior to approval. For indications not related to seizures and epilepsy, please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org. *Pregabalin will also be allowed for diagnoses of restless leg syndrome or anxiety **Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	APTIOM BRIVIACT clobazam** DIACOMIT** FINTEPLA** levetiracetam ER LIBERVANT OXTELLAR TROKENDI XR XCOPRI VIMPAT (tablets) zonisamide oral susp.
	carbamazepine divalproex FELBAMATE fosphenytoin lacosamide (tablets) lamotrigine/XR levetiracetam oxcarbazepine phenytoin subvenite valproate/valproic acid VIMPAT (suspension) zonisamide	BANZEL (tablets only) clonazepam EPIDIOLEX FYCOMPA gabapentin pregabalin* topiramate/ER sprinkle caps		
CROHN'S	IMMUNOMODULATORS	adalimumab-fkjp HADLIMA HUMIRA RINVOQ	Client must have diagnosis of Crohn's prior to approval of the preferred agent. To receive a non-preferred agent, client must have a diagnosis of Crohn's and a 56-day trial and failure of the preferred agent. * Refer to Additional Therapeutics Clinical Criteria Chart for more info **Cimzia will be allowed for clients that are pregnant or breast-feeding	CIMZIA** ENTYVIO* REMICADE SKYRIZI STELARA TREMFYA TYSABRI (additional criteria applies)
DERMATOLOGY	BENZOYL PEROXIDE/CLINDAMYCIN COMBOs	clindamycin/benzoyl peroxide 1-5% clindamycyin/benzoyl peroxide 1.2-5% (Refrig)	Clients must be 12 to 20 years of age. Requires prior authorization for clients less than 12 years of age. Acne combinations are limited to clients under the age of 21.	ACANYA
	ISOTRETINOIN		Clients must be 12 to 20 years of age.	ABSORICA
	AMNESTEEM CLARAVIS isotretinoin ZENATANE			
	CORTICOSTEROIDS - STEP 1 AGENTS C=CREAM; G=GEL; L=LOTION; O=OINTMENT; S=SOLUTION			
	LOW POTENCY		Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days. *Cream, ointment, and lotion formulations of desonide are preferred.	PANDEL TEXACORT 2.5% (S)
	alclometasone desonide* fluocinolone 0.01% hydrocortisone butyrate 0.1% (C) hydrocortisone 1%, 2.5% (C,L,O)			
	MEDIUM POTENCY		Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	Clocortolone Pivalate flurandrenol fluticasone 0.05% (L) hydrocortisone butyrate 0.1% (O) triamcinolone 0.05% (O)
	betamethasone valerate desoximetasone 0.05%, 0.25% (C) fluocinolone 0.025% fluticasone 0.05% (C) mometasone SYNALAR 0.025% (C, O) triamcinolone 0.025%, 0.1%			
	HIGH POTENCY		Trial and failure of two preferred agents greater than or equal to 14 days in the last 90 days.	APEXICON 0.05% (C) amcinonide 0.1% (C,L,O) augmented betamethasone 0.05% (G,L,O) clobetasol 0.05% (L) desoximetasone 0.05%, 0.25% (G,O) diflorasone 0.05% (C) fluocinonide 0.1% (C) halcinonide 0.1% (C) HALOG 0.1% (O)
	betamethasone dipropionate clobetasol/E 0.05% (C,G,O,S) diflorasone 0.05% (O) fluocinonide flurandrenolide fluticasone 0.005% (O) halobetasol TOPICORT 0.025% (C) triamcinolone 0.5% ULTRAVATE 0.05% (C,O)			
	IMMUNOMODULATORS - STEP 2 AGENTS	tacrolimus	**To receive a step 2 agent:** Trial and failure of a preferred medium or high potency topical corticosteroid greater than or equal to a 21 day trial in the last 90 days. Exceptions will be made for application to the face and for clients age 12 and under, a trial and failure of a preferred low potency corticosteroid greater than or equal to a 21 day trial in the last 90 days will be required.	HYFTOR pimecrolimus (brand preferred)
	PHOSPHODIESTERASE 4 INHIBITOR - STEP 3 AGENT		**To receive a step 3 agent:** Trial and failure of a preferred step 2 agent (immunomodulator) greater than or equal to a 21 day trial within the last 30 days.	EUCRISA ZORYVE

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DERMATOLOGY (continued)	**ALOPECIA AREATA**		Non-preferred agents require 90-day trial and failure of a high potency steroid as well as a documented SALT score of >50%.	LITFULO OLUMIANT
	ATOPIC DERMATITIS	EBGLYSS DUPIXENT* RINVOQ	Dupixent requires member be at least 6 months of age or older, Adbry requires member be at least 12 years of age or older. No high-potency steroid trial will be necessary. For clients with >20% BSA, no immunomodulator trial and failure will be necessary for preferred agent(s). **Trial and failure of all criteria to receive a step 3 agent as defined above including medium/high potency topical corticosteroid, preferred step 2 immunomodulator AND 56-day trial and failure of a preferred biologic for Atopic Dermatitis in Step 3 will be required for approval of the non-preferred agents.	ADBRY CIBINQO** NEMLUVIO OPZELURA** ZORYVE
	PLAQUE PSORIASIS (PP)	adalimumab-fkjp ENBREL HADLIMA HUMIRA OTEZLA SOTYKTU* TALTZ ZORYVE***	Client must have diagnosis of PP prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of PP and a 56-day trial and failure of two of the preferred agents. *Sotyktu requires diagnosis of moderate to severe PP and 56 day trial and failure of Humira. **Cimzia will be allowed for clients that are pregnant or breast-feeding ***Zoryve will be allowed for PP after a 21-day trial and failure of a high-potency corticosteroid OR a mild-potency corticosteroid if using in intertriginous areas.	CIMZIA** COSENTYX ILUMYA REMICADE SKYRIZI STELARA TREMFYA
	SCABICIDES/PEDICULICIDES	permethrin VANALICE	Trial and failure of a preferred agent in the last 12 months.	malathion lotion NATROBA spinosad (BRAND IS PREFERRED)
	VITILIGO		Non-preferred agents require 90-day trial and failure of a medium or high potency steroid.	OPZELURA
DIABETES	**DIABETES AGENTS**			metformin SR 24H osm *(use preferred agent)* metformin SR 24H mod *(use preferred agent)*
	BIGUANIDES	metformin/ER		
	GLUCOSIDASE INHIBITORS	acarbose	Trial and failure of metformin and 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.	miglitol
	MEGLITINIDES	nateglinide	Trial and failure of metformin and 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.	repaglinide
	THIAZOLIDINEDIONES	pioglitazone	Trial and failure of metformin and 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.	ACTOPLUS MET *(use separate agents)*
	SULFONYLUREAS	glimepiride/ER glipizide/ER glyburide/ER	Trial and failure of metformin and 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.	
	DIPEPTIDYL PEPTIDASE 4 (DPP-4) INHIBITORS	JANUVIA ONGLYZA TRADJENTA	Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial and failure of the preferred agent is required before approval can be given for a non-preferred agent.	alogliptin GLYXAMBI *(use separate preferred agents)* QTERN *(use separate preferred agents)* STEGLUJAN *(use separate preferred agents)*
	DPP-4 INHIBITOR COMBO AGENTS	JANUMET/XR JENTADUETO KOMBIGLYZE/XR	Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent. A 90 day trial of failure of the preferred agent is required before approval can be given for a non-preferred agent.	alogliptin/metformin alogliptin/pioglitazone *(use separate preferred agents)* JENTADUETO XR saxagliptin/metformin (BRAND IS PREFERRED) sitagliptin/metformin (BRAND IS PREFERRED)
	INCRETIN MIMETICS (GLP-1 RECEPTOR AGONISTS)	exenatide RYBELSUS TRULICITY VICTOZA	Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent unless ASCVD or risk factors are present, in which case the trial of metformin is waived. A 90 day trial of failure of the preferred agent is required before approval can be given for a non-preferred agent. Dosage Limits Apply: Ozempic: 2mg/week Victoza: 1.8mg/day	BYDUREON liraglutide *(use brand)* MOUNJARO OZEMPIC* SOLIQUA XULTOPHY *(use separate preferred agents)*
	SGLT2 INHIBITORS	FARXIGA JARDIANCE SYNJARDY XIGDUO XR	Trial and failure of metformin greater than or equal to a 90 day supply in the last 12 months will be required before approval can be given for a preferred agent unless there is a diagnosis of ASCVD, CKD, or heart failure, in which case the trial of metformin will be waived. A 90 day trial and failure of a preferred agent is required before approval can be given for a non-preferred agent.	GLYXAMBI *(use separate preferred agents)* QTERN *(use separate preferred agents)* INVOKAMET INVOKANA SEGLUROMET *(use separate preferred agents)* STEGLATRO STEGLUJAN *(use separate preferred agents)* SYNJARDY XR *(use separate preferred agents)* TRIJARDY XR *(use separate preferred agents)*
	FAST-ACTING INSULIN	HUMALOG HUMALOG 75/25 HUMALOG JR. HUMALOG MIX NOVOLOG MIX	Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently.	ADMELOG *(use preferred agent)* FIASP *(use preferred agent)* insulin lispro *(use preferred agents)* LYUMJEV
	LONG-ACTING INSULIN	LANTUS SOLOSTAR* LANTUS vial	Prior authorization will be required when using two different delivery forms of the same type of insulin concurrently.	BASAGLAR *(use preferred agent)* Insulin Glargine *(use preferred agent)* Insulin Degludec SOLIQUA TOUJEO *(use preferred agent)* TRESIBA* *(use preferred agent)* XULTOPHY *(use separate preferred agents)*
	DIABETIC METERS/TEST STRIPS	ACCU-CHEK GUIDE/STRIPS ACCU-CHEK GUIDE ME FREESTYLE (strips only) FREESTYLE FREEDOM FREESTYLE FREEDOM LITE FREESTYLE INSULINX FREESTYLE PRECISION NEO B FREESTYLE SIDEKICK II PRECISION XTRA	Quantity limits apply: Insulin Dependent Clients: 10 strips/day Non-Insulin Dependent Clients: 4 strips/day Clients are limited to 1 meter/365 days	ALL OTHER METERS AND TEST STRIPS ONE TOUCH ULTRA II ONE TOUCH ULTRA MINI ONE TOUCH ULTRA BLUE ONE TOUCH VERIO ONE TOUCH VERIO FLEX ONE TOUCH VERIO REFLECT ONE TOUCH VERIO IQ
	EXTERNAL DIABETIC DEVICES	OMNIPOD DASH OMNIPOD 5 OMNIPOD G5 FSL 2 PLUS G6		OMNIPOD GO
	CONTINUOUS BLOOD GLUCOSE MONITORS	DEXCOM G6 DEXCOM G7 FREESTYLE LIBRE FREESTYLE LIBRE 2 FREESTYLE LIBRE 3/PLUS	Prior authorization will be required to verify if the client is injecting insulin daily. Monitors will also be limited to the labeled age.	GUARDIAN MINIMED
	ACUTE HYPOGLYCEMIA AGENTS	BAQSIMI ZEGALOGUE (autoinjector)		GVOKE *(use preferred agent)*

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FIBROMYALGIA	**FIBROMYALGIA**		Trial and failure of a preferred agent greater than or equal to six (6) weeks in the last 12 months is required prior to approval of a non-preferred agent Clients will not be allowed to take gabapentin and pregabalin concurrently	pregabalin SAVELLA tablets *(savella titration pak will not be covered)*
	amitriptyline cyclobenzaprine duloxetine	gabapentin		
GASTROINTESTINAL	**BOWEL EVACUANTS**			GAVILYTE H *(use preferred agents)* POLY-PREP *(use preferred agents)* SUTAB
	CLENPIQ GAVILYTE G, N GOLYTELY PEG 3350 SOLUTION SUFLAVE SUPREP			
	CHRONIC IDIOPATHIC CONSTIPATION		Client must have a diagnosis of chronic idiopathic constipation to receive a preferred agent. To receive a non-preferred agent, the client must have a diagnosis of chronic idiopathic constipation and a 30-day trial and failure of a preferred agent within the last 12 months.	MOTEGRITY
		LINZESS lubiprostone		
	DIGESTIVE ENZYMES		Prior authorization required. *Pertzye will be preferred for members diagnosed with cystic fibrosis.	VIOKACE
	CREON ZENPEP	PERTZYE*		
	IRRITABLE BOWEL SYNDROME WITH CONSTIPATION		Client must have a diagnosis of Irritable Bowel Syndrome (IBS) with constipation.	
		LINZESS lubiprostone		
	MESALAMINE		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.	mesalamine DR tab 800mg, 1.2g mesalamine ER cap 0.375gm mesalamine sup 1000mg SFROWASA
	LIALDA* mesalamine 400mg DR capsule mesalamine enema PENTASA			
	OPIOID-INDUCED CONSTIPATION AGENTS		Client must have a diagnosis of opioid-induced constipation and a three (3) month trial and failure of a stool softener to receive the preferred agent. To receive the non-preferred agent, the client must have a diagnosis of opioid-induced constipation, a three (3) month trial and failure of a secretory agent, and a three (3) month trial and failure of the preferred agent. *Movantik will be approved for a diagnosis of cancer or for clients in hospice or palliative care.	MOVANTIK* SYMPROIC
		lubiprostone		
	PREGNANCY INDUCED NAUSEA/VOMITING			BONJESTA DICLEGIS
	doxylamine/pyridoxine			
	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.	amox/clarith/lanso pack DEXILANT dexlansoprazole esomeprazole omeprazole 20.6mg capsules omeprazole tablets omeprazole/sodium bicarbonate OMECLAMOX *(use separate agents)* PREVACID solutabs *(use preferred agents)* rabeprazole TALICIA *(use separate agents)* VIMOVO *(use separate agents)*
	lansoprazole capsules/ODT omeprazole capsules/ODT pantoprazole			
	POTASSIUM COMPETITIVE ACID REDUCERS		Voquezna will require trial and failure of two proton pump inhibitors twice daily at max dose for 30 days	VOQUEZNA
GOUT	**COLCHICINE**			MITIGARE *(use preferred agent)*
	colchicine (tablets)			
	XANTHINE OXIDASE AND URAT1 INHIBITORS		Trial and failure of the preferred agent greater than or equal to a 60 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	ULORIC*
	allopurinol			
HEMATOLOGY	**LOW MOLECULAR WEIGHT HEPARIN (LMWH)**		Prior authorization will be required for the 300mg/3ml strength.	FRAGMIN *(use preferred agent)* enoxaparin 300MG/3ML
	enoxaparin			
	DIRECT THROMBIN INHIBITOR		Client must have diagnosis of non-valvular atrial fibrillation and relative contraindication to warfarin for approval, treatment for deep vein thrombosis (DVT) or pulmonary embolism (PE), or for the reduction in the risk of recurrence of DVT and PE after initial therapy.	
		PRADAXA		
	SELECTIVE FACTOR XA INHIBITOR		*To receive Xarelto 2.5mg, client must have a diagnosis of chronic coronary artery disease or peripheral artery disease with the need to reduce risk of major cardiovascular events	ELIQUIS (starter pack) SAVAYSA *(use preferred agent)*
	ELIQUIS (tablets) XARELTO (10/15/20mg, starter)	XARELTO 2.5mg*		
	CPTP DERIVATIVES		Client must have a diagnosis of acute coronary syndrome, history of myocardial infarction, or history of stroke and transient ischemic attack.	
		BRILINTA		
	PAR-1 ANTAGONIST		Client must have diagnosis of reduction of thrombotic cardiovascular events with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD). Must be used in conjunction with aspirin or clopidogrel.	
		ZONTIVITY		
	ANTIHEMOPHILIC FACTOR VIII			ALTUVIIIO KOVALTRY
	ADVATE ADYNOVATE AFSTYLA ELOCTATE ESPEROCT HEMOFIL M HEMLIBRA JIVI KOATE/KOATE-DVI KOGENATE FS/BIO-SET NOVOEIGHT NUWIQ OBIZUR RECOMBINATE XYNTHA/SOLOFUSE			
	COAGULATION FACTOR IX			
	ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY REBINYN RIXUBIS			
	ANTIHEMOPHILIC FACTOR/VWF			
	ALPHANATE HUMATE-P VONVENDI WILATE			
	ERYTHROPOIESIS STIMULATING AGENTS			ARANESP MIRCERA PROCRIT
	EPOGEN RETACRIT			
	ADDITIONAL HEMATOLOGICAL AGENTS		*Requires Sickle Cell Disease diagnosis **Additional criteria and diagnosis of beta-thalassemia required.	
	DROXIA* SIKLOS*	ZYNTEGLO**		

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT Optumrx WITH ANY QUESTIONS
HEPATITIS C	**DIRECT ACTING ANTIVIRALS**	sofosbuvir/velpatasvir MAVYRET	Limited to FDA approved indication. Prior authorization will be required prior to use of preferred agents. Please submit PA requests on the Hepatitis C PA form available at www.wymedicaid.org.	EPCLUSA *(use preferred agent)* HARVONI SOVALDI VOSEVI** ZEPATIER
HIDRADENITIS SUPPURATIVA	**IMMUNOMODULATORS**	HUMIRA	Humira will not be covered as a first line agent for the diagnosis for hidradenitis suppurativa.	COSENTYX
HORMONES	**GnRH ANTAGONISTS** MYFEMBREE ORIAHN ORILISSA		*Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements.	
	GROWTH HORMONE	GENOTROPIN NORDITROPIN SKYTROFA		HUMATROPE NGENLA SAIZEN SEROSTIM SOGROYA ZOMACTON
	TESTOSTERONE TOPICAL GELS	TESTIM GEL	Testosterone agents are only allowed for diagnosis of hypogonadism or insufficient testosterone production. *Other testosterone dosage form products will require a diagnosis of hypogonadism or insufficient testosterone production (not outlined on PDL).*	ANDRODERM *(use preferred agent)* FORTESTA *(use preferred agent)* JATENZO *(use preferred agent)* TESTOPEL *(use preferred agent)* testosterone gel *(use preferred agent)* testosterone solution *(use preferred agent)* XYOSTED *(use preferred agent)*
	THYROID HORMONES ARMOUR THYROID LEVOXYL levothyroxine (tablets) LEVO-T liothyronine SYNTHROID UNITHROID	ERMEZA	Ermeza will be covered with confirmed diagnosis of dysphagia.	THYQUIDITY TIROSINT
	CONTRACEPTIVES afirmelle altavera amethia amethyst apri ashlyna aubra/EQ aurovela 1-20/FE 1-20, 1-35 aviane ayuna azurette blisovi 1-20 FE, 1.5-30 FE bekyree beyaz camila camrese/LO chateal/EQ CHARLOTTE 24 FE chew cyred dasetta 1-35, 7/7/7 daysee deblitane deso/ethinyl estradiol drospir/ethinyl estradiol elinest emzahh enskyce errin estarylla falmina finzala FE chew gianvi hailey FE 1/20, 1/35 heather iclevia incassia introvale isibloom jaimiess jencycla jolessa juleber junel 1-20/FE, 1.5-30/FE kalliga kariva kelnor kurvelo larin 1-20/FE, 1.5-30/FE leena lessina levora lo loestrin loestrin FE loryna LOSEASONIQUE* low-ogestrel lutera marlissa melodetta mibelas FE chew microgestin 1-20/FE, 1.5-30/FE mili mono-linyah natazia NECON 0.5/35, 1/35, 1/50, 7/7/7, nikki nora-be noreth/ethinyl estradiol/FE chw noreth/ethinyl estradiol 1-20/FE norgest/ethinyl estradiol/LO norethindrone norlynda nylia nymyo			alyacen 1-35, 7/7/7 aranelle BALCOLTRA balziva briellyn drospir/ethinyl estradiol/levomefolate enpresse ethynodiol/ethinyl estradiol FALESSA KIT fayosim FEMLYV kaitlib FE chew layolis FE chew levonest levonorgest/ethinyl estradiol/LO (84-7) levonorgest/ethinyl estradiol 0.15- MERZEE MINASTRIN FE chew* NEXSTELLIS noreth/ethinyl estradiol/FE chew 0.8/25 nortrel OPILL PHEXXI philith rivelsa QUARTETTE SAFYRAL SLYND TAYSOFY TAYTULLA tilia FE tri-legest FE TRIVORA TWIRLA TYBLUME tydemy vyfemla wera wymzya FE chew XULANE ZAFEMY

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HORMONES; CONTRACEPTIVES ***(continued)***	ocella pimtrea portia previfem reclipsen safyral SEASONIQUE* setlakin sharobel simliya simpesse sprintec sronyx syeda tri-estarylla/LO tri-femynor tri-linyah tri-marzia LO tri-mili/LO tri-sprintec/LO tri-nymyo tri-vylibra velivet vestura vienva viorele volnea vylibra yasmin-28 YAZ zumandimine			
HYPERLIPIDEMIA	**BILE ACID SEQUESTRANT** cholestyramine/light colestipol		Trial and failure of ALL preferred agents greater than or equal to six (6) months in the last 12 months will be required before approval can be given for a non- preferred agent.	WELCHOL
	STATINS, LOW POTENCY lovastatin pravastatin		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. If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization. Prior authorization will be required for clients under the age of 10.	fluvastatin/ER
	STATINS, HIGH POTENCY atorvastatin rosuvastatin simvastatin		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. If client's current medication therapy is contraindicated with the preferred statin(s) due to a drug-drug interaction, a non-preferred agent may be obtained with a prior authorization. Prior authorization will be required for clients under the age of 10.	EZALLOR LIVALO ZYPITAMAG
	STATIN COMBINATIONS amlodipine/atorvastatin VYTORIN*		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. Prior authorization will be required for clients under the age of 10.	ezetimibe/simvastatin (BRAND IS PREFERRED)
	PCSK9-RELATED AGENTS	PRALUENT REPATHA	Client must have a diagnosis of homozygous familial hypercholesterolemia; have a diagnosis of heterozygous familial hypercholesterolemia or atherosclerotic cardiovascular disease AND not at goal with a maximum dose statin; or be intolerant to statin therapy. Approval for a non-preferred agent requires trial and failure of a preferred agent.	LEQVIO
	TRIGLYCERIDE LOWERING AGENTS fenofibrate gemfibrozil omega-3-acid		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.	fenofibric acid fenofibrate (43/50/120/130/150mg) icosapent LIPOFEN VASCEPA
HYPERTENSION/ CARDIOLOGY	**ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)** EDARBI irbesartan losartan olmesartan telmisartan valsartan		Non-preferred ARBs will require a history of ALL preferred ARBs before approval	candesartan eprosartan 600mg
	ARBs AND DIURETICS EDARBYCLOR irbesartan HCTZ losartan HCT olmesartan HCTZ valsartan HCTZ		Non-preferred ARB/diuretic combinations will require a history of ALL preferred	candesartan HCTZ telmisartan HCTZ
	ALPHA-BLOCKERS clonidine clonidine TD patches			
	COMBINATION PRODUCTS	ENTRESTO	Client must be greater than one year of age and have a diagnosis of Congestive Heart Failure (CHF) NYHA Class II-IV. Angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) will not be allowed in combination with Entresto.	ENTRESTO SPRINKLES VERQUVO
INFECTIOUS DISEASE	**ANTI-VIRALS**	PAXLOVID	Paxlovid requires COVID diagnosis. Product is limited to 1 dosepak per 30 days.	
	QUINOLONES ciprofloxacin levofloxacin ofloxacin			moxifloxacin *(use preferred agents)*
	DOXYCYCLINE doxycycline			DORYX *(use preferred agent)*
	MINOCYCLINE minocycline/ER			minocycline 65mg and 115mg ER *(use preferred agent)* SOLODYN *(use preferred agent)*
	INHALED TOBRAMYCIN KITABIS		*Tobi Podhaler requires a 28 day trial of a preferred agent, as well as 28 days off of that same preferred agent prior to approval. Minimum day supply of 56 days is required	BETHKIS inhaled tobramycin TOBI PODHALER *(use preferred agent)*

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INFECTIOUS DISEASE (continued)	**ANTI-RETROVIRALS**		*Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org for specific requirements. **Rukobia approval requires documentation of multi-drug resistance defined as failure of two medications from different classes.	CABENUVA EMCITRABINE/RILPIVIRINE/TENOFOVIR JULUCA NORVIR RUKOBIA** STRIBILD (use separate agents) SUNLENCA SYMTUZA (use separate preferred agents)
	APRETUDE BIKTARVY CIMDUO COMPLERA DELSTRIGO DOVATO EVOTAZ GENVOYA ODEFSEY PIFELTRO PREZCOBIX ritonavir tablets SYMFI/LO TRIUMEQ TROGARZO	DESCOVY* TRUVADA*		
INFLAMMATION	**NSAIDs**		Trial and failure of two (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 agent. Dosing and quantity limits apply for ketorolac (limit 5days/34 days; max dose 40mg/day for oral tablets).	CALDOLOR *(use preferred agent)* diclofenac 1.3% patch (BRAND IS PREFERRED) diclofenac 1.5% soln. diclofenac 3% gel fenoprofen mefenamic acid NEOPROFEN *(use preferred agent)*
	celecoxib diclofenac *tablets* etodolac FLECTOR* flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meclofenamate meloxicam nabumetone naproxen oxaprozin piroxicam sulindac			
	ORAL CORTICOSTEROIDS			CELESTONE *(use preferred agent)* EMFLAZA
	budesonide cortisone acetate dexamethasone/intensol hydrocortisone methylprednisolone prednisolone prednisone			
INSOMNIA	**NON-BENZODIAZEPINES**		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. Prior Authorization will be required for clients under the age of 18 *Quviviq requires trial and failure of two preferred agents with different mechanisms of action **Rozerem is non-preferred without a history of substance abuse Prior authorization will be required when a client is taking more than one insomnia agent concurrently. Dosage limits apply: zaleplon: 30mg/day zolpidem: 15mg/day	EDLUAR *(additional criteria applies)* DAYVIGO QUVIVIQ* ROZEREM** zolpidem sublingual *(additional criteria applies)*
	BELSOMRA eszopiclone zaleplon zolpidem zolpidem ER			
MASH (Metabolic-Associated Steatohepatitis)	**APPROVED AGENTS**		*Wegovy will require diagnosis of MASH. Please consult the Additional Therapeutics Clinical Criteria chart for more information regarding cardiovascular disease criteria.	REZDIFFRA
		WEGOVY*		
MENTAL HEALTH	**ALZHEIMER'S AGENTS**		Client must have a diagnosis of dementia.	donepezil 23mg *(use preferred agent)* memantine ER NAMZARIC *(use separate agents)* rivastigmine capsules/patches
		donepezil/ODT galantamine/ER memantine tablets/solution		
	ANTIDEPRESSANTS **NORADRENERGIC/SPECIFIC SEROTONERGICS (NaSS)**		Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks WITHIN THE LAST 2 YEARS will be required before approval can be given for a non-preferred agent. One of the trials of preferred agents must be in the same class (NaSS, NDRI, SSRI, or SNRI) as the requested non-preferred agent.	**NaSS** mirtazapine rapid dissolve tablets *(use preferred agent)*
	mirtazapine tablets			
	NOREPINEPHRINE/DOPAMINE REUPTAKE INHIBITORS (NDRI)			**NDRI**
	bupropion ER/SR/XL			APLENZIN AUVELITY **FORFIVO XL***
	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)		Trazodone, buspirone, fluvoxamine, MAO inhibitors, TCA's, bupropion IR, and venlafaxine IR do not require prior authorization but **will not count** towards meeting preferred therapy requirements.	**SSRI**
	citalopram escitalopram fluoxetine capsules paroxetine IR/CR sertraline			BUCAPSOL citalopram capsules fluoxetine tablets VIIBRYD
	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS (SNRI)		Clients will not be allowed to be on more than one antidepressant, including fluvoxamine, bupropion IR, and venlafaxine IR, at one time with the exception of mirtazapine or bupropion with a SSRI or SNRI. ***Trintellix requires trial and failure of two preferred agents in any class Clients five (5) years of age and younger will require prior authorization before approval. Dosage limits apply: bupropion ER/SR/XL: 450mg/day citalopram < 60 years of age: 60mg/day citalopram > 60 years of age: 30mg/day escitalopram: 30mg/day fluoxetine < 18 years of age: 90mg/day fluoxetine > 18 years of age: 120mg/day mirtazapine: 67.5mg/day paroxetine IR/CR < 18 years of age: 75mg/day paroxetine IR > 18 years of age: 90mg/day paroxetine CR > 18 years of age: 112.5mg/day sertraline: 300mg/day venlafaxine ER: 337.5mg/day	**SNRI** desvenlafaxine FETZIMA venlafaxine ER tablets *(use preferred agent)*
	duloxetine venlafaxine ER capsules			
				OTHER TRINTELLIX***

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MENTAL HEALTH (continued)	**ATYPICAL ANTIPSYCHOTICS** ABILIFY MAINTENA ABILIFY ASIMTUFII aripiprazole tab/solution/ODT ARISTADA asenapine FANAPT** paliperidone INVEGA HAFYERA INVEGA SUSTENNA INVEGA TRINZA lurasidone** olanzapine PERSERIS quetiapine* quetiapine ER RISPERDAL CONSTA risperidone UZEDY VRAYLAR ziprasidone ziprasidone		*Quetiapine doses less than 100mg will require prior authorization without a diagnosis of mood disorder or major depressive disorder. For titration doses, contact the OptumRx Pharmacy Help Desk for an override. **Clients nine (9) years of age and younger will require a prior authorization to receive approval of lurasidone and asenapine. Clients eighteen (18) years of age and younger will require a prior authorization to receive approval of Fanapt. ***Rexulti approval for MDD treatment requires concurrent antidepressant therapy as well as a trial and failure of aripiprazole or other preferred atypical antipsychotic indicated for adjunct MDD treatment. Trial and failure of two (2) preferred agents greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent unless otherwise specified. Prior authorization will be required for any client five (5) years of age or younger, or for any client taking both an injectable and oral dosage form of the same medication concurrently. Dosage limits apply: aripiprazole <13 years of age: 15mg/day; ≥13 years of age: 30mg/day asenapine: 20mg/day ABILIFY MAINTENA: 400mg per 26 days ARISTADA 441/662/882mg: 1 injection per 28 days; 1064mg: 1 injection per 56 days ARISTADA INITIO: 1 injection per 365 days FANAPT: 24mg/day INVEGA HAFYERA: 1 injection per 6 months INVEGA SUSTENNA: 1 injection per 28 days INVEGA TRINZA: 1 injection per 84 days lurasidone 10-17 years of age: 80mg/day; >17 years of age: 160mg/day olanzapine <13 years of age: 10mg/day; ≥13 years of age: 20mg/day paliperidone: 12mg/day PERSERIS: 1 injection per 28 days quetiapine <13 years of age: 400mg/day; 13-17 years of age: 600mg/day; >17 years of age: 800mg/day risperidone <10 years of age: 3mg/day; 10-17 years of age: 6mg/day; >17 years of age: 16mg/day RISPERDAL CONSTA: 2 injections per 28 days ziprasidone ≤17 years of age: 120mg/day; >17 years of age: 200mg/day	ABILIFY MYCITE *(use preferred agent)* CAPLYTA GEODON 20MG INJ LYBALVI *(additional criteria applies)* NUPLAZID olanzapine 10mg Inj SAPHRIS *(use preferred agent)* SECUADO REXULTI*** RYKINDO ZYPREXA RELPREVV
	SPECIAL ATYPICAL ANTIPSYCHOTICS clozapine/ODT		Dosage limits apply: 900mg/day	VERSACLOZ Suspension *(use preferred agent)*
	AMPHETAMINES **LONG ACTING AMPHETAMINES** ADDERALL XR* amphetamine salts combo XR dextroamphetamine CR caps VYVANSE CAPSULES** **IMMEDIATE RELEASE AMPHETAMINES** amphetamine salts combo dextroamphetamine tablets		Clients over the age of 17 must have a diagnosis for ADD, ADHD (see ADD/ADHD criteria below), narcolepsy, obstructive sleep apnea, shift work sleep disturbance, MS fatigue (see MS Fatigue criteria below), or refractory depression (see refractory depression criteria below). For clients over the age of 17, they must meet the DSM-5 criteria for diagnosis of ADHD. These criteria include: • Five or more symptoms of inattention, present for at least 6 months, inappropriate for developmental level. OR • Five or more symptoms of hyperactivity and impulsivity, present for at least 6 months, to an extent that is disruptive and inappropriate for developmental level. AND • Symptoms must be present in two or more settings (home, school or work); • There must be clear evidence that the symptoms interfere or reduce the quality of social, school or work functioning; and • The symptoms must not be better explained by another mental disorder. Diagnosis of MS fatigue will require a fatigue severity scale score of 5.0, a 60-day trial of amantadine and discontinuation of medications that may contribute to drowsiness and fatigue. Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant. **Vyvanse will be approved for the diagnosis of binge-eating disorder for clients 18 years of age and older. Authorizations will be approved for 12 weeks. After initiation a one-year prior authorization of Vyvanse for this diagnosis will require additional documentation prior to approval. Claims will require Prior Authorization if client is under the age of 4, or has a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use. Trial and failure of two (2) preferred agents (each from a different class: methylphenidate and amphetamine) greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent. Two or more long-acting agents will not be allowed concurrently. Dosage limits apply: amphetamine salts combo XR: 60mg/day amphetamine salts combo: 60mg/day amphetamine salts combo (narcolepsy): 90mg/day DAYTRANA: 45mg/9 hour patch/day dextroamphetamine: 90mg/day dextroamphetamine CR: 90mg/day dexmethylphenidate: 30mg/day FOCALIN XR < 13 years of age: 45mg/day FOCALIN XR > 13 years of age: 60mg/day JORNAY PM: 100mg/day methylin/methylphenidate/ER: 90mg/day VYVANSE: 105mg/day	**AMPHETAMINES** ADZENYS XR ODT DYANAVEL XR EVEKEO/ODT MYDAYIS PROCENTRA VYVANSE CHEWABLES ZENZEDI 2.5 AND 7.5MG TABLETS **METHYLPHENIDATES** APTENSIO XR AZSTARYS COTEMPLA XR DAYTRANA FOCALIN XR JORNAY PM methylphenidate ER osmotic release (BRAND IS PREFERRED) methylphenidate ER/CR/SR capsules (METADATE CD/RITALIN LA, APTENSIO XR) RELEXXII QUILLICHEW ER QUILLIVANT
	METHYLPHENIDATES **LONG ACTING METHYLPHENIDATES** CONCERTA* dexmethylphenidate ER methylphenidate ER tablets **IMMEDIATE RELEASE METHYLPHENIDATES** dexmethylphenidate methylphenidate chewables methylphenidate solution methylphenidate tablets			

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MENTAL HEALTH continued	SELECTIVE ALPHA-ADRENERGIC AGONIST		Client must must have a diagnosis of ADD or ADHD. Prior authorization will be required for clients under the age of 4.	ONYDA XR
	clonidine, clonidine ER guanfacine, guanfacine ER			
	SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR		Atomoxetine: Clients must have a diagnosis for ADD, ADHD, narcolepsy, obstructive sleep apnea, shift work sleep disturbance, or refractory depression (see refractory depression criteria below). Diagnosis of refractory depression will require a 6-week trial and failure of an antidepressant (monotherapy) and continued concomitant use of an antidepressant with the stimulant. Prior Authorization required for clients under the age of 4. Claims will require Prior Authorization if clients have a history of the following: glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, untreated hyperthyroidism, substance abuse, or current MAO inhibitor use. Qelbree: Clients must have a 30-day trial and failure of a preferred non-stimulant OR trial and failure of two preferred ADHD agents. Approval will be limited to a max dose of 400mg in clients 6-17 years of age, and 600mg for clients 18 years of age or older. Dosage limits apply: atomoxetine: 100mg/day	
		atomoxetine QELBREE		
MIGRAINE	MIGRAINE PROPHYLAXIS STEP 1 AGENTS		Trial and failure of both an anticonvulsant and a beta blocker (Step 1 agents) greater than or equal to three (3) months will be required before approval can be given for the step 2 agents. Concurrent use of Botox will not be approved. Nurtec will be limited to 16 tabs/30 days.	NURTEC
	beta blockers	divalproex topiramate		
	STEP 2 AGENTS		*Starting dose will be limited to 70mg **Approval for non-preferred agents requires trial and failure of a preferred agent along with the trial and failures described with Step 1 Agents' criteria above.	QULIPTA**
		AIMOVIG* AJOVY EMGALITY		
	ACUTE MIGRAINE TREATMENT STEP 1 AGENTS		Trial and failure of two preferred agents will be required for approval of a non- preferred agent.	almotriptan ELYXYB Sumatriptan-Naproxen Sodium TOSYMRA (use preferred agent) ZEMBRACE (use preferred agent) ZAVZPRET zolmitriptan
	frovatriptan naratriptan RELPAX* sumatriptan rizatriptan		Rizatriptan will be limited to clients 6 years of age or older Quantity limits apply: naratriptan 1mg: 25 tabs/34 days naratriptan 2.5mg: 10 tabs/34 days RELPAX 20mg: 20 tabs/34 days RELPAX 40mg: 14 tabs/34 days rizatriptan 5mg: 27 doses/34 days rizatriptan 10mg: 14 doses/34 days sumatriptan vials: 2 vials/34 days sumatriptan nasal 20mg: 6 bottles/34 days; 5mg: 12 bottles/34 days sumatriptan 25mg: 41 tabs/34 days sumatriptan 50mg: 20 tabs/34 days sumatriptan 100mg: 10 tabs/34 days	
	STEP 2 AGENTS		Trial and failure of two triptan agents required for Step 2 Agent approval Trial and failure of two preferred triptan agents AND Nurtec OR Ubrelvy will be required for approval of a non-preferred agent. Quantity limits apply: NURTEC 75mg: limited to 8 tabs/30 days REYVOW: 200mg/day or 1 tab/day, 4 tab/30 days	REYVOW
		NURTEC UBRELVY		
MOVEMENT DISORDERS	VMAT 2 INHIBITORS		Quantity limits apply: AUSTEDO: limited to 4 tabs/day INGREZZA: limited to 4 tabs/day *Please refer to the Additional Therapeutic Criteria chart at www.wymedicaid.org	INGREZZA (sprinkles)
	AUSTEDO/XR* INGREZZA* TETRABENAZINE			
MULTIPLE SCLEROSIS	MS AGENTS		Gilenya, Kesimpta, Lemtrada, Ocrevus, and Tysabri will be approved for highly active disease, please refer to the ATCC for additional information. Trial and failure of two preferred agents for at least 56 days (each from a separate class) will be required before approval can be given for a non-preferred agent. For Mavenclad, in addition to the above criteria, approval will be granted on a case- by-case basis.	AUBAGIO AVONEX BAFIERTAM BRIUMVI glatiramer (BRAND IS PREFERRED) GLATOPA (use preferred agent) MAVENCLAD MAYZENT PLEGRIDY PONVORY TECFIDERA VUMERITY ZEPOSIA
	BETASERON COPAXONE 20MG/ML* dimethyl fumarate REBIF teriflunomide	GILENYA KESIMPTA LEMTRADA OCREVUS TYSABRI		
NARCOLEPSY	STIMULANTS		Modafinil and Nuvigil: Client must be > 16 years of age. Client must have a diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, Multiple Sclerosis (MS) Fatigue, or ADD/ADHD with a concurrent diagnosis of substance abuse.	
		modafinil NUVIGIL*		
	NON-STIMULANTS		Diagnosis of MS will require a fatigue severity scale score of 5.0, a 60 day trial of amantadine AND discontinuation of medications that may contribute to drowsiness or fatigue. Clients will not be allowed to take two or more agents in this class concurrently	SUNOSI WAKIX XYREM
NEUROPATHIC PAIN	GABAPENTIN		Clients will not be allowed to take gabapentin and pregabalin concurrently Prior authorizations for perioperative pain will be approved for gabapentin OR pregabalin for less than or equal to 14 day supplies	
		gabapentin pregabalin		
	TOPICAL LIDOCAINE			ZTLIDO
	Lidocaine Patches			
	ADDITIONAL AGENTS		Trial and failure of a tricyclic antidepressant greater than or equal to a 12 week supply AND trial and failure of gabapentin at a dose of 3600mg per day OR pregabalin for greater than or equal to a 12 week supply in the last 12 months will be required before approval can be given for a non-preferred agent.	carbamazepine imipramine (capsules) oxcarbazepine valproic acid
	amitriptyline desipramine imipramine (tablets) nortriptyline			
OBSTRUCTIVE SLEEP APNEA	GLP-1 Agonists		Client must have diagnosis of moderate to severe obstructive sleep apnea. Will be approved for obese adults with an AHI (Apnea-Hypopnea Index) of greater than 15. Prior authorization will be required again at 6 months to show at least 5% weight loss as evidenced by sleep study within the prior 12 months. Prior authorization will be required again at 12 months to demonstrate improvement in obstructive sleep apnea.	
		ZEPBOUND		

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OPHTHALMICS	**OP. -ANTI-ALLERGICS**		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent. Alomide and Alocril will be approved for pregnancy. Alomide will be approved for children under the age of 3.	ALOCRIL ALOMIDE bepotastine epinastine ZERVIATE
	ALREX azelastine BEPREVE* cromolyn 0.4%			
	OP. -ANTIBIOTICS- QUINOLONES		Trial and failure of a preferred agent greater than or equal to 5 days in the last 12 months will be required before approval can be given for a non-preferred agent.	gatifloxacin ZYMAXID
	ciprofloxacin BESIVANCE gentamIcin moxifloxacin 0.5% ofloxacin tobramycin			
	OP. -ANTI-INFLAMMATORY		Trial and failure of ALL preferred agents each greater than or equal to 5 day supply in the last 12 months will be required before approval can be given for a non- preferred agent.	ACULAR/LS/PF *(use preferred agent)* ACUVAIL bromfenac 0.9% BROMSITE DUREZOL ILEVRO INVELTYS LOTEMAX SM loteprednol 0.5% (BRAND IS PREFERRED) PROLENSA
	flurbiprofen diclofenac LOTEMAX* ketorolac NEVANAC			
	OP. -BETA-BLOCKERS		Trial and failure of three (3) preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non- preferred agent. *Betoptic S will be approved for those with heart and lung conditions.	BETIMOL BETOPTIC S*
	betaxolol carteolol levobunolol timolol			
	OP. -CARBONIC ANHYDRASE INHIBITOR		Trial and failure of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	brinzolamide (BRAND IS PREFERRED)
	AZOPT dorzolamide			
	OP. -COMBO PRODUCTS			dorzolamide/timolol (BRAND IS PREFERRED)
	COMBIGAN* ROCKLATAN SIMBRINZA			
	OP. -DRY EYE AGENTS		Trial and failure of the preferred agent greater than or equal to 12 weeks will be required before approval can be given for the non-preferred agent.	CEQUA cyclosporine (BRAND IS PREFERRED) EYSUVIS MIEBO RESTASIS MULTIDOSE (see preferred) TYRVAYA
	RESTASIS* XIIDRA			
	OP. -PROSTAGLANDINS		Trial and failure of ALL preferred agents each greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non- preferred agent.	bimatoprost IYUZEH tafluprost
	latanoprost LUMIGAN TRAVATAN Z XALATAN ZIOPTAN			
	OP. -RHO KINASE INHIBITOR			
	RHOPRESSA			
	OP. -SYMPATHOMIMETICS		Trial of a preferred agent greater than or equal to 30 days in the last 12 months will be required before approval can be given for a non-preferred agent.	brimonidine 0.15% (BRAND IS PREFERRED)
	ALPHAGAN P 0.1% ALPHAGAN P 0.15%* brimonidine 0.2%			
OSTEOPOROSIS	**BISPHOSPHONATES**		Trial and failure of a preferred agent greater than or equal to 12 months will be required before approval can be given for a non-preferred agent. Fosamax liquid will be approved for clients that have difficulty swallowing. **Evinity will only be allowed for a maximum of 12 months of treatment, will not be allowed with any concurrent osteoporosis treatment, and will be limited to approved indication ***Will be limited to 2 years of use	EVENITY** FORTEO*** FOSAMAX-D TYMLOS***
	alendronate ibandronate risedronate			
	NASAL CALCITONIN			
	calcitonin-salmon			
OTIC	**ANTIBIOTIC/STEROID COMBINATION**			ciprofloxacin 0.2% *(use preferred agent)* CIPRO HC *(use preferred agent)* CORTISPORIN-TC *(use preferred agent)* FLUOCINOLONE ACET OIL 0.01% *(use preferred agent)*
	ciprofloxacin/dexamethasone Neo/Poly/HC suspension/solution ofloxacin tobramycin/dexamethasone			
OVERACTIVE BLADDER	**OVERACTIVE BLADDER AGENTS**		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. Oxytrol will be approved for clients that have an inability to swallow.	darifenacin GELNIQUE GEL 10% GEMTESA mirabegron (BRAND IS PREFERRED) OXYTROL DIS tolterodine/ER TOVIAZ trospium
	MYRBETRIQ oxybutynin /ER solifenacin			
PAIN	**LONG-ACTING C-IIs**		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. C-IIIs and C-IVs that are not included on the PDL and are available without prior authorization with the exception of Butrans (generic substitution is mandatory). Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid. Fentanyl: 50mcg, 1 strength at a time, 1 patch every 3 days Hydromorphone ER: 30mg/day Hysingla ER: 120mg/day Methadone: Limited to 3 tablets per day Morphine ER: 90mg/day Oxycontin: 80mg/day Oxymorphone: 40mg/day Clients will be limited to one long-acting narcotic at a time.	fentanyl patches hydrocodone ER hydromorphone ER HYSINGLA ER METHADONE morphine ER capsules *(use preferred agents)* oxymorphone ER OXYCONTIN
	morphine ER tablets			

WYOMING MEDICAID
Preferred Drug List (PDL) January 1, 2026

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THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT OptumRx WITH ANY QUESTIONS
PAIN continued	**SHORT-ACTING C-IIs**		Trial and failure of three (3) preferred agents greater than or equal to a 6 day supply in the last 90 days will be required before approval can be given for a non-preferred agent. Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid. All short-acting narcotics, after 42 days of consecutive use of any combination of short-acting narcotics, will be limited to **4 tablets** per day (liquids have specific dosing limits per medication - please refer to dosage limitation chart at www.wymedicaid.org) Clients will be limited to one short-acting narcotic at a time	levorphanol oxymorphone ROXYBOND
	codeine sulfate hydrocodone/APAP hydrocodone/IBU hydromorphone meperidine morphine oxycodone oxycodone/APAP			
	C-III/C-V AGENTS		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. Quantity and dosage limits apply (max 8 tabs/day). Concurrent therapy with a benzodiazepine and a narcotic medication or with duplicate benzodiazepines is not covered by Wyoming Medicaid. A single medication will continue to be allowed to process unless another benzodiazepine (or narcotic) is billed to Wyoming Medicaid.	BELBUCA tramadol/apap tramadol ER capsules/tablets
	BUTRANS tramadol			
PARKINSON'S DISEASE	**SHORT-ACTING AGENTS**			
	amantadine benztropine tablets carbidopa/levodopa pramipexole ropinirole			
	LONG-ACTING AGENTS		**Non-preferred Parkinson's agents will require a 30 day trial and failure of 2 preferred medications including at least one short-acting agent and one long-acting agent *Neupro will be approved for clients with difficulty swallowing	APOKYN benztropine injectables GOCOVRI INBRIJA NEUPRO* ONGENTYS pramipexole ER XADAGO
	ropinirole ER RYTARY			
PHOSPHATE BINDERS	**PHOSPHATE BINDERS**		Prior authorization required for non-preferred agents.	AURYXIA lanthanum sevelamer VELPHORO
	calcium acetate			
PROSTATE	**5-ALPHA-REDUCTASE INHIBITORS**		Trial and failure of a preferred agent greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	dutasteride dutasteride/tamsulosin *(use separate agents)*
	finasteride			
	ALPHA BLOCKERS		Trial and failure of a preferred agent greater than or equal to a 30 day supply in the last 12 months will be required before approval can be given for a non-preferred agent.	alfuzosin dutasteride/tamsulosin *(use separate agents)* silodosin
	doxazosin tamsulosin terazosin			
PULMONARY ANTIHYPERTENSIVES	**5-ALPHA-REDUCTASE INHIBITORS**		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	OPSYNVI REVATIO (suspension)
		ALYQ sildenafil suspension sildenafil (A/B rated generics)		
	ENDOTHELIN RECEPTOR ANTAGONISTS		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	bosentan (BRAND IS PREFERRED) OPSUMIT *(use preferred agent)* TRACLEER TABS FOR ORAL SUSP *(use preferred agent)* WINREVAIR
		LETAIRIS TRACLEER TABS*		
	GUANYLATE CYCLASE INHIBITORS		Prior authorization required.	ADEMPAS *(use preferred agent)*
	PROSTACYCLINE VASODILATORS		Prior authorization required. Client must have a diagnosis of pulmonary hypertension.	
		ORENITRAM		
	PROSTACYCLINE RECEPTOR AGONIST		Prior authorization required.	UPTRAVI *(use preferred agent)*
RESTLESS LEG SYNDROME	**RESTLESS LEG SYNDROME**		Client must have a diagnosis of Restless Leg Syndrome (RLS). Trial and failure of gabapentin greater than or equal to 60 days and a trial and failure of a dopamine agonist greater than or equal to 60 days in the last 12 months will be required before approval can be given for a non-preferred agent. *Neupro will be approved for clients with difficulty swallowing or for clients with a diagnosis of Parkinson's Disease. Clients will not be allowed to take gabapentin and pregabalin concurrently	HORIZANT NEUPRO*
	pramipexole ropinirole	gabapentin pregabalin		
SKELETAL MUSCLE RELAXANTS	**MUSCLE RELAXANTS**		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. Cyclobenzaprine will require a prior authorization for clients concurrently taking a tricylic antidepressant. Carisoprodol is limited to 84 tabs/365 days	carisoprodol chlorzoxazone cyclobenzaprine ER LYVISPAH metaxalone methocarbamol orphenadrine tizanidine capsules *(use preferred agent)*
	baclofen (5, 10, 20mg tablets) cyclobenzaprine tizanidine tablets			
ULCERATIVE COLITIS	**IMMUNOMODULATORS**		Client must have diagnosis of UC prior to approval of a preferred agent. To receive a non-preferred agent, client must have a diagnosis of UC and a 56-day trial and failure of the preferred agent. * Refer to Additional Therapeutics Clinical Criteria Chart for more information	ENTYVIO* REMICADE SIMPONI SKYRIZI STELARA TREMFYA XELJANZ/XR
		adalimumab-fkjp HADLIMA HUMIRA RINVOQ		
UVEITIS	**IMMUNOMODULATORS**		Client must have diagnosis of non-infectious intermediate, posterior, or panuveitis	
		adalimumab-fkjp HADLIMA HUMIRA		