



Division of Health Care Financing and Policy
Nevada Medicaid Preferred Drug List

Effective Oct. 1, 2015

	Preferred Products	PA Criteria	Non-Preferred Products
Analgesics			
Analgesic/Miscellaneous			
Neuropathic Pain Agents			
	CYMBALTA® GABAPENTIN LYRICA®	* PA Required	GRALISE® LIDODERM® * HORIZANT®
Tramadol and Related Drugs			
	TRAMADOL TRAMADOL/APAP		CONZIPR® NUCYNTA® RYZOLT® RYBIX® ODT TRAMADOL ER ULTRACET® ULTRAM® ULTRAM® ER
Opiate Agonists			
	MORPHINE SULFATE SA TABS (ALL GENERIC EXTENDED RELEASE) QL FENTANYL PATCH QL	PA Required for Fentanyl Patch General PA Form: https://www.medicaid.nv.gov/Downloads/provider/FA-59.pdf	AVINZA® QL BUTRANS® DOLOPHINE® DURAGESIC® PATCHES QL EMBEDA® EXALGO® HYSINGLA ER® KADIAN® QL METHADONE METHADOSE® MS CONTIN® QL NUCYNTA® ER OPANA ER® OXYCODONE SR QL OXYCONTIN® QL OXYMORPHONE SR XARTEMIS XR® QL ZOHYDRO ER® QL
Antihistamines			
H1 blockers			
Non-Sedating H1 Blockers			
	CETIRIZINE D OTC CETIRIZINE OTC LORATADINE D OTC LORATADINE OTC	A two week trial of one of these drugs is required before a non-preferred drug will be authorized.	ALLEGRA® CLARITIN® CLARINEX® DESLORATADINE FEXOFENADINE SEMPREX® XYZAL®

PDL Exception PA: <https://www.medicaid.nv.gov/Downloads/provider/FA-63.pdf>

Chapter 1200 PA Criteria: <http://dhcfp.nv.gov/>



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Antiinfective Agents			
Aminoglycosides			
Inhaled Aminoglycosides			
	BETHKIS® KITABIS® PAK TOBI PODHALER® TOBRAMYCIN NEBULIZER		
Antivirals			
Alpha Interferons			
	PEGASYS® PEGASYS® CONVENIENT PACK PEG-INTRON® and REDIPEN		
Anti-hepatitis Agents			
Polymerase Inhibitors/Combination Products			
	HARVONI® SOVALDI® VIEKIRA PAK®	PA Required http://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Resources/AdminSupport/Manuals/MSMCh1200Packet6-11-15(1).pdf https://www.medicaid.nv.gov/Downloads/provider/Pharmacy_Announcement_Viekira_2015-0721.pdf	
Protease Inhibitors			
	INCIVEK® VICTRELIS® OLYSIO®	PA Required https://www.medicaid.nv.gov/Downloads/provider/FA-75.pdf	
Ribavirins			
	RIBAVIRIN		RIBASPHERE RIBAPAK® MODERIBA® REBETOL®
Anti-Herpetic Agents			
	ACYCLOVIR FAMVIR® VALCYCLOVIR		
Influenza Agents			
	AMANTADINE TAMIFLU® RIMANTADINE RELENZA®		



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Cephalosporins				
Second-Generation Cephalosporins				
		CEFACLOR CAPS and SUSP CEFACLOR ER CEFUROXIME TABS and SUSP CEFPROZIL SUSP		CEFTIN® CECLOR® CECLOR CD® CEFZIL
Third-Generation Cephalosporins				
		CEFDINIR CAPS and SUSP CEFPODOXIME TABS and SUSP		CEDAX® CAPS and SUSP CEFDITOREN OMNICEF® SPECTRACEF® SUPRAX® VANTIN®
Macrolides				
		AZITHROMYCIN TABS/SUSP CLARITHROMYCIN TABS/SUSP ERYTHROMYCIN BASE ERYTHROMYCIN ESTOLATE ERYTHROMYCIN ETHYLSUCCINATE ERYTHROMYCIN STEARATE		BIAXIN® DIFICID® ZITHROMAX® ZMAX®
Quinolones				
Quinolones - 2nd Generation				
		CIPROFLOXACIN TABS CIPRO® SUSP		FLOXIN® OFLOXACIN
Quinolones - 3rd Generation				
		AVELOX® AVELOX ABC PACK® LEVOFLOXACIN		LEVAQUIN®
Autonomic Agents				
Sympathomimetics				
Self-Injectable Epinephrine				
		AUVI-Q® * EPINEPHRINE® EPIPEN® EPIPEN JR.®	* PA Required	ADRENALICK® QL



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Biologic Response Modifiers			
Immunomodulators			
Disease-Modifying Antirheumatic Agents			
	ENBREL® HUMIRA®	Prior authorization is required for all drugs in this class https://www.medicaid.nv.gov/Downloads/provider/FA-61.pdf	ACTEMRA® CIMZIA® KINERET® REMICADE® SIMPONI® ORENCIA® STELARA®
Multiple Sclerosis Agents			
Injectable			
	AVONEX® AVONEX® ADMIN PACK BETASERON® COPAXONE® QL EXTAVIA® REBIF® QL TYSABRI®	<i>Trial of only one agent is required before moving to a non-preferred agent</i>	
Oral			
	AUBAGIO® GILENYA® TECFIDERA®		
Specific Symptomatic Treatment			
	AMPYRA® QL	PA required	
Cardiovascular Agents			
Antihypertensive Agents			
Angiotensin II Receptor Antagonists			
	DIOVAN® DIOVAN HCTZ® LOSARTAN LOSARTAN HCTZ		ATACAND® AVAPRO® BENICAR® EDARBI® EDARBYCLOR® EPROSARTAN IRBESARTAN MICARDIS® TELMISARTAN TEVETEN®



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Angiotensin-Converting Enzyme Inhibitors (ACE Inhibitors)			
	BENAZEPRIL BENAZEPRIL HCTZ CAPTOPRIL CAPTOPRIL HCTZ ENALAPRIL ENALAPRIL HCTZ EPANED® £ LISINOPRIL LISINOPRIL HCTZ RAMIPRIL	£ PREFERRED FOR AGES 10 AND UNDER ‡ NONPREFERRED FOR OVER 10 YEARS OLD	ACCURETIC® EPANED® ‡ FOSINOPRIL MAVIK® MOEXIPRIL QUINAPRIL QUINARETIC® TRANDOLAPRIL UNIVASC®
Beta-Blockers			
	ACEBUTOLOL ATENOLOL ATENOLOL/CHLORTH BETAXOLOL BISOPROLOL BISOPROLOL/HCTZ BYSTOLIC®* CARVEDILOL LABETALOL METOPROLOL (Regular Release) NADOLOL PINDOLOL PROPRANOLOL PROPRANOLOL/HCTZ SOTALOL TIMOLOL	*Restricted to-ICD-10 codes J40-J47	



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Calcium-Channel Blockers			
	AFEDITAB CR® AMLODIPINE CARTIA XT® DILTIA XT® DILTIAZEM ER DILTIAZEM HCL DYNACIRC CR® EXFORGE® EXFORGE HCT® FELODIPINE ER ISRADIPINE LOTREL® NICARDIPINE NIFEDIAC CC NIFEDICAL XL NIFEDIPINE ER NISOLDIPINE ER TAZTIA XT® VERAPAMIL VERAPAMIL ER		
Direct Renin Inhibitors			
	TEKAMLO® TEKURNA® TEKURNA HCT® VALTURNA®		AMTURNIDE®
Vasodilators			
Inhaled			
	VENTAVIS® TYVASO®		
Oral			
	ADCIRCA® LETAIRIS® SILDENAFIL TRACLEER®		ADEMPAS® OPSUMIT® ORENITRAM® REVATIO®
Antilipemics			
Bile Acid Sequestrants			
	COLESTIPOL CHOLESTYRAMINE WELCHOL®		QUESTRAN®
Cholesterol Absorption Inhibitors			
	ZETIA®		



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Fibric Acid Derivatives				
		FENOFIBRATE FENOFIBRIC GEMFIBROZIL LIPOFEN®		ANTARA® FENOGLIDE® FIBRICOR® LOFIBRA® TRICOR® TRIGLIDE® TRILIPIX®
HMG-CoA Reductase Inhibitors (Statins)				
		ATORVASTATIN CRESTOR® QL FLUVASTATIN LOVASTATIN PRAVASTATIN SIMVASTATIN		ADVICOR® ALTOPREV® AMLODIPINE/ATORVASTATIN CADUET® LESCOL® LESCOL XL® LIPITOR® LIPTRUZET® LIVALO® MEVACOR® PRAVACHOL® SIMCOR® VYTORIN® ZOCOR®
Niacin Agents				
		NIASPAN® (Brand only) NIACIN ER (ALL GENERICS)		NIACOR®
Dermatological Agents				
Antipsoriatic Agents				
Topical Vitamin D Analogs				
		CALCIPOTRIENE		CALCITENE® DOVONEX® CREAM SORILUX® TACLONEX® VECTICAL®
Topical Analgesics				
		LIDOCAINE LIDOCAINE HC LIDOCAINE VISCOUS VOLTAREN® GEL		EMLA® FLECTOR® LIDODERM® QL LIDAMANTLE® PENNSAID®



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Topical Antiinfectives			
Acne Agents: Topical, Benzoyl Peroxide, Antibiotics and Combination Products			
	AZELEX® 20% cream BENZACLIN® BENZOYL PEROXIDE (2.5, 5 and 10% only) CLINDAMYCIN ERYTHROMYCIN/BENZOYL PEROXIDE SODIUM SULFACETAMIDE	PA required if over 21 years old	ACANYA DUAC CS® ERYTHROMYCIN CLINDAMYCIN/BENZOYL PEROXIDE GEL SODIUM SULFACETAMIDE/SULFUR
Impetigo Agents: Topical			
	MUPIROCIN OINT		ALTABAX® CENTANY® MUPIROCIN CREAM
Topical Antifungals (onychomycosis)			
	CICLOPIROX SOLN TERBINAFINE TABS	PA Required	
Topical Antivirals			
	ABREVA® DENA VIR® ZOVIRAX®, OINTMENT		
Topical Scabicides			
	NATROBA® * NIX® PERMETHRIN RID® SKLICE®	* PA Required	EURAX® LINDANE MALATHION OVIDE® ULESFIA®
Topical Antiinflammatory Agents			
Immunomodulators: Topical			
	ELIDEL® QL PROTOPIC® QL	Prior authorization is required for all drugs in this class	
Topical Antineoplastics			
Topical Retinoids			
	RETIN-A MICRO®(Pump and Tube) TAZORAC® ZIANA®	Payable only for recipients up to age 21.	ADAPALENE GEL AND CREAM ATRALIN® AVITA® DIFFERIN® EPIDUO® TRETINOIN TRETIN-X® VELTIN®



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Electrolytic and Renal Agents			
Phosphate Binding Agents			
	CALCIUM ACETATE ELIPHOS® FOSRENOL® RENAGEL® RENVELA®		PHOSLO® PHOSLYRA® SEVELAMER CARBONATE VELPHORO®
Gastrointestinal Agents			
Antiemetics			
Serotonin-receptor antagonists/Combo			
	GRANISETRON QL ONDANSETRON QL	PA Required for all	AKYNZEO® ANZEMET® QL KYTRIL® QL SANCUSO® ZOFRAN® QL ZUPLENZ® QL
Ant ulcer Agents			
H2 blockers			
	FAMOTIDINE RANITIDINE RANITIDINE SYRUP*	*PA not required for < 12 years	
Proton Pump Inhibitors (PPIs)			
	NEXIUM® CAPSULES NEXIUM® POWDER FOR SUSP* PANTOPRAZOLE	PA required if exceeding 1 per day *for children ≤ 12 yrs.	ACIPHEX® DEXILANT® LANSOPRAZOLE OMEPRAZOLE OTC TABS PREVACID® PRILOSEC® PRILOSEC® OTC TABS PROTONIX®
Gastrointestinal Antiinflammatory Agents			
	ASACOL® SUPP BALSALAZIDE® CANASA® DELZICOL® MESALAMINE ENEMA SUSP PENTASA® SULFASALAZINE DR SULFASALAZINE IR		APRISO® ASACOL HD® COLAZAL® GIAZO® LIALDA®



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Gastrointestinal Enzymes			
	CREON® ZENPEP®		PANCREAZE® PANCRELIPASE PERTZYE® ULTRESA® VIOKACE®
Genitourinary Agents			
Benign Prostatic Hyperplasia (BPH) Agents			
5-Alpha Reductase Inhibitors			
	AVODART® FINASTERIDE		JALYN® PROSCAR®
Alpha-Blockers			
	DOXAZOSIN TAMSULOSIN TERAZOSIN		ALFUZOSIN CARDURA® FLOMAX® MINIPRESS® PRAZOSIN RAPAFLO® UROXATRAL®
Bladder Antispasmodics			
	OXYBUTYNIN TABS/SYRUP/ER SANCTURA XR® TOVIAZ® VESICARE®		DETROL® DETROL LA® DITROPAN XL® ENABLEX® FLAVOXATE GELNIQUE® OXYTROL® SANCTURA® TOLTERODINE TROSPIMUM
Hematological Agents			
Anticoagulants			
Oral			
	COUMADIN® ELIQUIS® * JANTOVEN® PRADAXA® * QL WARFARIN XARELTO® *	* No PA required if approved Dx code transmitted on claim: I48.0-I48.9; I26.0- I26.9; O08.2; O88.0-O88.9; Z86.711; I80.0-I80.9; I82.0- I82.9	
Injectable			
	ARIXTRA® ENOXAPARIN FRAGMIN®		FONDAPARINUX INNOHEP® LOVENOX®



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Colony Stimulating Factors			
	ARANESP® QL PROCRIT® QL	PA Required Quantity Limit	EPOGEN® QL OMONTYS® QL
Platelet Inhibitors			
	AGGRENOX® ANAGRELIDE ASPIRIN BRILINTA® * QL CILOSTAZOL® CLOPIDOGREL DIPYRIDAMOLE TICLOPIDINE	* PA Required	EFFIENT® * QL PLAVIX® ZONTIVITY®
Hormones and Hormone Modifiers			
Androgens			
	ANDROGEL® ANDRODERM®	PA Required PA Form: https://www.medicaid.nv.gov/Downloads/provider/FA-72.pdf	AXIRON® FORTESTA® STRIANT® TESTIM® TESTOSTERONE GEL VOGELXO®
Antidiabetic Agents			
Alpha-Glucosidase Inhibitors/Amylin analogs/Misc.			
	ACARBOSE (Precose®) GLYSET® PRECOSE® SYMLIN® (PA required)		CYCLOSET®
Biguanides			
	FORTAMET® GLUCOPHAGE® GLUCOPHAGE XR® METFORMIN EXT-REL (Glucophage XR®) GLUMETZA® METFORMIN (Glucophage®) RIOMET®		



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Dipeptidyl Peptidase-4 Inhibitors			
	JANUMET® JANUMET XR® JANUVIA® JENTADUETO® JUVISYNC® KOMBIGLYZE XR® ONGLYZA® TRADJENTA®		KAZANO® NESINA® OSENI®
Incretin Mimetics			
	BYDUREON® * BYETTA® * VICTOZA® *	* PA Required	TANZEUM® TRULICITY®
Insulins (Vials and Pens)			
	APIDRA® HUMALOG® HUMULIN® LANTUS® LEVEMIR® NOVOLIN® NOVOLOG®		
Meglitinides			
	NATEGLINIDE (Starlix®) PRANDIMET® PRANDIN® STARLIX®		
Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors			
	FARXIGA® INVOKANA®		INVOKAMET® JARDIANCE® XIGDUO XR®



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Sulfonylureas			
	AMARYL® CHLORPROPAMIDE DIABETA® GLIMEPIRIDE (Amaryl®) GLIPIZIDE (Glucotrol®) GLUCOTROL® GLUCOVANCE® GLIPIZIDE EXT-REL (Glucotrol XL®) GLIPIZIDE/METFORMIN (Metaglip®) GLYBURIDE MICRONIZED (Glynase®) GLYBURIDE/METFORMIN (Glucoavance®) GLUCOTROL XL® GLYBURIDE (Diabeta®) GLYNASE® METAGLIP® TOLAZAMIDE TOLBUTAMIDE		
Thiazolidinediones			
	ACTOPLUS MET XR® ACTOS® ACTOPLUS MET® AVANDAMET® AVANDARYL® AVANDIA® DUETACT®		
Pituitary Hormones			
Growth hormone modifiers			
	GENOTROPIN® NORDITROPIN®	PA Required for entire class https://www.medicaid.nv.gov/Downloads/provider/FA-67.pdf	HUMATROPE® NUTROPIN AQ® OMNITROPE® NUTROPIN® SAIZEN® SEROSTIM® SOMAVERT® TEV-TROPIN® ZORBTIVE®
Progestins for Cachexia			
	MEGESTROL ACETATE, SUSP		MEGACE ES®



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Musculoskeletal Agents			
Antigout Agents			
	ALLOPURINOL		
Bone Resorption Inhibitors			
Bisphosphonates			
	ALENDRONATE TABS FOSAMAX PLUS D®		ACTONEL® ALENDRONATE SOLUTION ATELVIA® BINOSTO® BONIVA® DIDRONEL® ETIDRONATE IBANDRONATE SKELID®
Nasal Calcitonins			
	MIACALCIN®		
RESTLESS LEG SYNDROME AGENTS			
	PRAMIPEXOLE REQUIP XL ROPINIROLE		HORIZANT® MIRAPEX® MIRAPEX® ER REQUIP
Skeletal Muscle Relaxants			
	BACLOFEN CHLORZOXAZONE CYCLOBENZAPRINE DANTROLENE METHOCARBAMOL METHOCARBAMOL/ASPIRIN ORPHENADRINE CITRATE ORPHENADRINE COMPOUND TIZANIDINE		
Neurological Agents			
Alzheimers Agents			
	DONEPEZIL DONEPEZIL ODT EXELON® PATCH EXELON® SOLN NAMENDA® TABS NAMENDA® XR TABS RIVASTIGMINE CAPS		ARICEPT® 23mg ARICEPT® GALANTAMINE GALANTAMINE ER RAZADYNE® RAZADYNE® ER



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Anticonvulsants		
BANZEL® CARBAMAZEPINE CARBAMAZEPINE XR CARBATROL ER® CELONTIN® DEPAKENE® DEPAKOTE ER® DEPAKOTE® DIVALPROEX SODIUM DIVALPROEX SODIUM ER EPITOL® ETHOSUXIMIDE FELBATOL® GABAPENTIN GABITRIL® KEPPRA® KEPPRA XR® LAMACTAL ODT® LAMACTAL XR® LAMICTAL® LAMOTRIGINE LEVETIRACETAM LYRICA® NEURONTIN® OXCARBAZEPINE SABRIL® STAVZOR® DR TEGRETOL® TEGRETOL XR® TOPAMAX® TOPIRAGEN® TOPIRAMATE (IR AND ER) TRILEPTAL® VALPROATE ACID VIMPAT® ZARONTIN® ZONEGRAN® ZONISAMIDE	PA Required for members under 18 years old	APTIOM® FYCOMPA® OXTELLAR XR® POTIGA® QUDEXY XR® TROKENDI XR®



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Barbiturates			
	LUMINAL® MEBARAL® MEPHOBARBITAL SOLFOTON® PHENOBARBITAL MYSOLINE® PRIMIDONE	PA Required for members under 18 years old	
Benzodiazepines			
	CLONAZEPAM CLORAZEPATE DIASTAT® DIAZEPAM DIAZEPAM rectal soln KLONOPIN® TRANXENE T-TAB® VALIUM®	PA Required for members under 18 years old	ONFI®
Hydantoins			
	CEREBYX® DILANTIN® ETHOTOIN FOSPHENYTOIN PEGANONE® PHENYTEK® PHENYTOIN PRODUCTS	PA Required for members under 18 years old	
Anti-Migraine Agents			
Serotonin-Receptor Agonists			
	RELPAK® SUMATRIPTAN NASAL SPRAY SUMATRIPTAN INJECTION SUMATRIPTAN TABLET ZOMIG® ZMT	PA Required for exceeding Quantity Limit	AMERGE® AXERT® FROVA® IMITREX® MAXALT® TABS MAXALT® MLT NARATRIPTAN SUMAVEL® TREXIMET® ZOMIG®
Antiparkinsonian Agents			
Non-ergot Dopamine Agonists			
	PRAMIPEXOLE ROPINIROLE ROPINIROLE ER		MIRAPEX® MIRAPEX® ER NEUPRO® REQUIP® REQUIP XL®

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Fibromyalgia agents			
	CYMBALTA® LYRICA® SAVELLA®	No PA required for drugs in this class if ICD-10 code = M79.1, M60.0-M60.9, M61.1, M79.7	
Ophthalmic Agents			
Antiglaucoma Agents			
Carbonic Anhydrase Inhibitors/Beta-Blockers			
	ALPHAGAN P® AZOPT® BETAXOLOL BETOPTIC S® BRIMONIDINE CARTEOLOL COMBIGAN® DORZOLAM DORZOLAM / TIMOLOL LEVOBUNOLOL METIPRANOLOL SIMBRINZA® TIMOLOL DROPS/ GEL SOLN		ALPHAGAN® BETAGAN® BETOPTIC® COSOPT® COSOPT PF® OCUPRESS® OPTIPRANOLOL® TIMOPTIC® TIMOPTIC XE® TRUSOPT®
Ophthalmic Prostaglandins			
	LATANOPROST TRAVATAN® TRAVATAN Z® ZIOPTAN®		LUMIGAN® XALATAN®
Ophthalmic Antihistamines			
	ALAWAY® BEPREVE® PATADAY® ZADITOR OTC®		ELESTAT® EMADINE® LASTACRAFT® OPTIVAR® PATANOL®
Ophthalmic Antiinfectives			
Ophthalmic Macrolides			
	ERYTHROMYCIN OINTMENT		
Ophthalmic Quinolones			
	BESIVANCE® CIPROFLOXACIN MOXEZA® OFLOXACIN® VIGAMOX®		CILOXAN® ZYMADIX®



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Ophthalmic Antiinflammatory Agents			
Ophthalmic Corticosteroids			
	ALREX® DEXAMETHASONE DUREZOL® FLUOROMETHOLONE LOTEMAX® PREDNISOLONE		FLAREX® FML® FML FORTE® MAXIDEX® OMNIPRED® PRED FORTE® PRED MILD® VEXOL®
Ophthalmic Nonsteroidal Antiinflammatory Drugs (NSAIDs)			
	ACULAR® ACULAR LS® ACULAR PF® DICLOFENAC FLURBIPROFEN NEVANAC®		ACUVAIL® BROMDAY® BROMFENAC® ILEVRO® PROLENSA®
Otic Agents			
Otic Antiinfectives			
Otic Quinolones			
	CIPRODEX® OFLOXACIN		



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Psychotropic Agents			
ADHD Agents			
	AMPHETAMINE SALT COMBO XR AMPHETAMINE SALT COMBO DEXMETHYLPHENIDATE DEXTROAMPHETAMINE SA DEXTROAMPHETAMINE TAB DEXTROSTAT® FOCALIN XR® INTUNIV® METADATE CD® METHYLIN® METHYLIN ER® METHYLPHENIDATE METHYLPHENIDATE ER (All forms generic extended release) METHYLPHENIDATE SOL QUILLIVANT® XR SUSP RITALIN LA® STRATTERA® VYVANSE®	PA Required for entire class Adult Form: https://www.medicaid.nv.gov/Downloads/provider/FA-68.pdf Children's Form: https://www.medicaid.nv.gov/Downloads/provider/FA-69.pdf * No PA required for ICD-10 codes G47.1 and G47.4	ADDERALL® ADDERALL XR® CONCERTA® DAYTRANA® DESOXYN® DEXEDRINE® FOCALIN® KAPVAY® MODAFINIL NUVIGIL® METADATE ER® PROVIGIL®* PROCENTRA® RITALIN®
Antidepressants			
	Other BUPROPION BUPROPION SR BUPROPION XL CYMBALTA® (PA not required for-certain ICD-10 codes. Refer to Fibromyalgia agents on page 17) MIRTAZAPINE MIRTAZAPINE RAPID TABS PRISTIQ® TRAZODONE VENLAFAXINE (ALL FORMS)	PA Required for members under 18 years old	APLENZIN® BRINTELLIX® DULOXETINE DESVENLAFAXINE FUMARATE EFFEXOR® (ALL FORMS) FETZIMA® FORFIVO XL® KHEDEZLA® VIIBRYD® WELLBUTRIN®



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Selective Serotonin Reuptake Inhibitors (SSRIs)			
	CITALOPRAM ESCITALOPRAM FLUOXETINE PAROXETINE PEXEVA® SERTRALINE	PA Required for members under 18 years old	CELEXA® FLUVOXAMINE QL LEXAPRO® LUVOX® PAXIL® PROZAC® SARAFEM® ZOLOFT®
Antipsychotics			
Atypical Antipsychotics			
	ABILIFY® CLOZAPINE FANAPT® LATUDA® OLANZAPINE QUETIAPINE RISPERIDONE SAPHRIS® SEROQUEL XR® ZIPRASIDONE	PA Required for Ages under 18 years old PA Form: https://www.medicaid.nv.gov/Downloads/provider/FA-70.pdf	CLOZARIL® FAZACLO® GEODON® INVEGA® RISPERDAL® SEROQUEL® ZYPREXA®
Anxiolytics, Sedatives, and Hypnotics			
	ESTAZOLAM FLURAZEPAM ROZEREM® * TEMAZEPAM TRIAZOLAM ZOLPIDEM	*PA not required for ICD-10 codes G47.0 and F51.0 PA Required for members under 18 years old	AMBIEN® AMBIEN CR® DORAL® EDLUAR® INTERMEZZO® LUNESTA® SILENOR® SOMNOTE® SONATA® ZALEPLON ZOLPIDEM CR ZOLPIMIST®
Respiratory Agents			
Nasal Antihistamines			
	ASTEPRO® DYMISTA® PATANASE®		AZELASTINE
Respiratory Antiinflammatory Agents			
Leukotriene Receptor Antagonists			
	MONTELUKAST ZAFIRLUKAST		ACCOLATE® SINGULAIR®



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Respiratory Corticosteroids			
	ASMANEX® BUDESONIDE NEBS* FLOVENT DISKUS® QL FLOVENT HFA® QL PULMICORT FLEXHALER® PULMICORT RESPULES®* QVAR®	*No PA required if < 4 years old	AEROSPAN HFA® ALVESCO® ARNUITY ELLIPTA®
Nasal Corticosteroids			
	FLUTICASONE NASONEX®		BECONASE AQ® FLONASE® FLUNISOLIDE NASACORT AQ® OMNARIS® QNASL® RHINOCORT AQUA® TRIAMCINOLONE ACETONIDE VERAMYST® ZETONNA®
Phosphodiesterase Type 4 Inhibitors			
	DALIRESP® QL	PA Required	
Respiratory Antimuscarinics			
	ANORO ELLIPTA® COMBIVENT RESPIMAT® IPRATROPIUM/ALBUTEROL NEBS QL IPRATROPIUM NEBS SPIRIVA®	Only one agent per 30 days is allowed	INCRUSE ELLIPTA® SPIRIVA RESPIMAT® TUDORZA®
Respiratory Beta-Agonists			
Long-Acting Respiratory Beta-Agonist			
	ARCAPTA NEOHALER® FORADIL® SEREVENT DISKUS® QL		BROVANA® PERFORMIST® SOLUTION FOR INHALATION STRIVERDI RESPIMAT®
Short-Acting Respiratory Beta-Agonist			
	ALBUTEROL NEB/SOLN PROVENTIL® HFA PROAIR® HFA XOPENEX® HFA* QL XOPENEX® Solution* QL	* PA required	MAXAIR AUTOHALER® VENTOLIN HFA® LEVALBUTEROL



Division of Health Care Financing and Policy
Nevada Medicaid Preferred Drug List

Effective Oct. 1, 2015

	Preferred Products	PA Criteria	Non-Preferred Products
Respiratory Corticosteroid/Long-Acting Beta-Agonist Combinations			
	ADVAIR DISKUS® ADVAIR HFA® DULERA® SYMBICORT®		BREO ELLIPTA®
Toxicology Agents			
Antidotes			
Opiate Antagonists			
	EVZIO® NALOXONE	* Injectable can be used intranasally with nasal atomizer	
Substance Abuse Agents			
Mixed Opiate Agonists/Antagonists			
	BUNAVAIL® SUBOXONE®	PA Required for class	BUPRENORPHINE/NALOXONE ZUBSOLV®