

Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

	Preferred Products	PA Criteria	Non-Preferred Products
<b>Analgesics</b>			
<b>Analgesic/Miscellaneous</b>			
<b>Neuropathic Pain/Fibromyalgia Agents</b>			
	DULOXETINE * GABAPENTIN LYRICA® * SAVELLA® * (Fibromyalgia only)	* PA required  <i>No PA required for drugs in this class if ICD-10 - M79.1; M60.0-M60.9, M61.1.</i>	CYMBALTA® * GRALISE® LIDODERM® * HORIZANT®
<b>Tramadol and Related Drugs</b>			
	TRAMADOL TRAMADOL/APAP		CONZIPR® NUCYNTA® RYZOLT® RYBIX® ODT TRAMADOL ER ULTRACET® ULTRAM® ULTRAM® ER
<b>Opiate Agonists</b>			
	MORPHINE SULFATE SA TABS (ALL GENERIC EXTENDED RELEASE) QL  FENTANYL PATCH QL	<b>PA required for Fentanyl Patch</b>  <b>General PA Form:</b> <a href="https://www.medicaid.nv.gov/Downloads/provider/FA-59.pdf">https://www.medicaid.nv.gov/Downloads/provider/FA-59.pdf</a>	AVINZA® QL BUTRANS® DOLOPHINE® DURAGESIC® PATCHES QL EXALGO® KADIAN® QL METHADONE METHADOSE® MS CONTIN® QL NUCYNTA® ER OPANA ER® OXYCODONE SR QL OXYMORPHONE SR XARTEMIS XR® QL ZOHYDRO ER® QL
<b>Opiate Agonists - Abuse Deterrent</b>			
	EMBEDA®		HYSINGLA ER® OXYCONTIN® QL

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

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

Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

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<b>Antihistamines</b>			
<b>H1 blockers</b>			
<b>Non-Sedating H1 Blockers</b>			
	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®
<b>Antiinfective Agents</b>			
<b>Aminoglycosides</b>			
<b>Inhaled Aminoglycosides</b>			
	BETHKIS® KITABIS® PAK TOBI PODHALER® TOBRAMYCIN NEBULIZER		
<b>Antivirals</b>			
<b>Alpha Interferons</b>			
	PEGASYS® PEGASYS® CONVENIENT PACK PEG-INTRON® and REDIPEN		
<b>Anti-hepatitis Agents</b>			
<b>Polymerase Inhibitors/Combination Products</b>			
	HARVONI® SOVALDI®  VIEKIRA PAK®	<b>PA required: (see below)</b> <a href="http://dhcfp.nv.gov/uploads/Files/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSMCh1200Packet6-11-15(1).pdf">http://dhcfp.nv.gov/uploads/Files/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSMCh1200Packet6-11-15(1).pdf</a> <a href="https://www.medicaid.nv.gov/Downloads/provider/Pharmacy%20Announcement%20Viekira%202015-0721.pdf">https://www.medicaid.nv.gov/Downloads/provider/Pharmacy Announcement Viekira 2015-0721.pdf</a>	
<b>Protease Inhibitors</b>			
	INCIVEK® VICTRELIS® OLYSIO®	<b>PA required</b> <a href="https://www.medicaid.nv.gov/Downloads/provider/FA-75.pdf">https://www.medicaid.nv.gov/Downloads/provider/FA-75.pdf</a>	

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Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

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	Ribavirins		
	RIBAVIRIN		RIBASPHERE RIBAPAK® MODERIBA® REBETOL®
	<b>Anti-Herpetic Agents</b>		
	ACYCLOVIR FAMVIR® VALCYCLOVIR		
	<b>Infuenza Agents</b>		
	AMANTADINE TAMIFLU® RIMANTADINE RELENZA®		
	<b>Cephalosporins</b>		
	<b>Second-Generation Cephalosporins</b>		
	CEFACLOR CAPS and SUSP CEFACLOR ER CEFUROXIME TABS and SUSP  CEFPROZIL SUSP		CEFTIN® CECLOR® CECLOR CD® CEFZIL
	<b>Third-Generation Cephalosporins</b>		
	CEFDINIR CAPS and SUSP CEFPODOXIME TABS and SUSP		CEDAX® CAPS and SUSP CEFDITOREN OMNICEF® SPECTRACEF® SUPRAX® VANTIN®
	<b>Macrolides</b>		
	AZITHROMYCIN TABS/SUSP  CLARITHROMYCIN TABS/SUSP ERYTHROMYCIN BASE ERYTHROMYCIN ESTOLATE ERYTHROMYCIN ETHYLSUCCINATE ERYTHROMYCIN STEARATE		BIAXIN® DIFICID® ZITHROMAX® ZMAX®
	<b>Quinolones</b>		
	<b>Quinolones - 2nd Generation</b>		
	CIPROFLOXACIN TABS CIPRO® SUSP		FLOXIN® OFLOXACIN

Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

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<b>Quinolones - 3rd Generation</b>			
	AVELOX® AVELOX ABC PACK® LEVOFLOXACIN		LEVAQUIN®
<b>Autonomic Agents</b>			
<b>Sympathomimetics</b>			
<b>Self-Injectable Epinephrine</b>			
	AUVI-Q® * EPINEPHRINE® EPIPEN® EPIPEN JR.®	* PA required	ADRENACLICK® QL
<b>Biologic Response Modifiers</b>			
<b>Immunomodulators</b>			
<b>Disease-Modifying Antirheumatic Agents</b>			
	ENBREL® HUMIRA®	Prior authorization is required for all drugs in this class  <a href="https://www.medicaid.nv.gov/Downloads/provider/FA-61.pdf">https://www.medicaid.nv.gov/Downloads/provider/FA-61.pdf</a>	ACTEMRA® CIMZIA® COSENTYX® KINERET® REMICADE® SIMPONI® ORENCIA® STELARA®
<b>Multiple Sclerosis Agents</b>			
<b>Injectable</b>			
	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>	GLATOPA® LEMTRADA® PLEGRIDY®
<b>Oral</b>			
	AUBAGIO® TECFIDERA®		GILENYA®
<b>Specific Symptomatic Treatment</b>			
	AMPYRA® QL	PA required	

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Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

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<b>Cardiovascular Agents</b>			
<b>Antihypertensive Agents</b>			
<b>Angiotensin II Receptor Antagonists</b>			
	DIOVAN® DIOVAN HCTZ® LOSARTAN LOSARTAN HCTZ		ATACAND® AVAPRO® BENICAR® EDARBI® EDARBYCLOR® EPROSARTAN IRBESARTAN MICARDIS® TELMISARTAN TEVETEN®
<b>Angiotensin-Converting Enzyme Inhibitors (ACE Inhibitors)</b>			
	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®
<b>Beta-Blockers</b>			
	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-J48	SOTYLIZE®

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Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

	Preferred Products	PA Criteria	Non-Preferred Products
<b>Calcium-Channel Blockers</b>			
	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		
<b>Direct Renin Inhibitors</b>			
	TEKAMLO® TEKURNA® TEKURNA HCT® VALTURNA®		AMTURNIDE®
<b>Vasodilators</b>			
	Inhaled		
	VENTAVIS® TYVASO®		
	Oral		
	LETAIRIS® ORENITRAM® SILDENAFIL TRACLEER®		ADCIRCA® ADEMPAS® OPSUMIT® REVATIO®
<b>Antilipemics</b>			
<b>Bile Acid Sequestrants</b>			
	COLESTIPOL CHOLESTYRAMINE WELCHOL®		QUESTRAN®
<b>Cholesterol Absorption Inhibitors</b>			
	ZETIA®		

Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

	Preferred Products	PA Criteria	Non-Preferred Products
<b>Fibric Acid Derivatives</b>			
	FENOFIBRATE FENOFIBRIC GEMFIBROZIL LIPOFEN®		ANTARA® FENOGLIDE® FIBRICOR® LOFIBRA® TRICOR® TRIGLIDE® TRILIPIX®
<b>HMG-CoA Reductase Inhibitors (Statins)</b>			
	ATORVASTATIN CRESTOR® QL FLUVASTATIN LOVASTATIN PRAVASTATIN SIMVASTATIN		ADVICOR® ALTOPREV® AMLODIPINE/ATORVASTATIN  CADUET® LESCOL® LESCOL XL® LIPITOR® LIPTRUZET® LIVALO® MEVACOR® PRAVACHOL® SIMCOR® VYTORIN® ZOCOR®
<b>Niacin Agents</b>			
	NIASPAN® (Brand only) NIACIN ER (ALL GENERICS)		NIACOR®
<b>Omega-3 Fatty Acids</b>			
	LOVAZA® VASCEPA®		OMEGA-3-ACID OMTRYG®
<b>Dermatological Agents</b>			
<b>Antipsoriatic Agents</b>			
<b>Topical Vitamin D Analogs</b>			
	CALCIPOTRIENE		CALCITENE® DOVONEX® CREAM SORILUX® TACLONEX® VECTICAL®

Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

	Preferred Products	PA Criteria	Non-Preferred Products
<b>Topical Analgesics</b>			
	LIDOCAINE LIDOCAINE HC LIDOCAINE VISCOUS VOLTAREN® GEL		EMLA® FLECTOR® LIDODERM® QL LIDAMANTLE® PENNSAID®
<b>Topical Antiinfectives</b>			
<b>Acne Agents: Topical, Benzoyl Peroxide, Antibiotics and Combination Products</b>			
	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
<b>Impetigo Agents: Topical</b>			
	MUPIROCIN OINT		ALTABAX® CENTANY® MUPIROCIN CREAM
<b>Topical Antifungals (onychomycosis)</b>			
	CICLOPIROX SOLN TERBINAFINE TABS	PA required	JUBLIA® KERYDIN® PENLAC® ITRACONAZOLE
<b>Topical Antivirals</b>			
	ABREVA® DENA VIR® ZOVIRAX®, OINTMENT		
<b>Topical Scabicides</b>			
	NATROBA® * NIX® PERMETHRIN RID® SKLICE®	* PA required	EURAX® LINDANE MALATHION OVIDE® ULESFIA®
<b>Topical Antiinflammatory Agents</b>			
<b>Immunomodulators: Topical</b>			
	ELIDEL® QL PROTOPIC® QL	Prior authorization is required for all drugs in this class	



Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

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<b>Topical Antineoplastics</b>			
<b>Topical Retinoids</b>			
	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®
<b>Electrolytic and Renal Agents</b>			
<b>Phosphate Binding Agents</b>			
	CALCIUM ACETATE ELIPHOS® FOSRENOL® RENAGEL® RENVELA®		AURYXIA® PHOSLO® PHOSLYRA® SEVELAMER CARBONATE VELPHORO®
<b>Gastrointestinal Agents</b>			
<b>Antiemetics</b>			
<b>Miscellaneous</b>			
	Diclegis® Emend®		
<b>Serotonin-receptor antagonists/Combo</b>			
	GRANISETRON QL ONDANSETRON QL	PA required for all medication in this class	AKYNZEO® ANZEMET® QL KYTRIL® QL SANCUSO® ZOFRAN® QL ZUPLENZ® QL
<b>Antilulcer Agents</b>			
<b>H2 blockers</b>			
	FAMOTIDINE RANITIDINE RANITIDINE SYRUP*	*PA not required for < 12 years	
<b>Proton Pump Inhibitors (PPIs)</b>			
	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®

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Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

		Preferred Products	PA Criteria	Non-Preferred Products
<b>Gastrointestinal Anti-inflammatory Agents</b>				
		ASACOL® SUPP BALSALAZIDE® CANASA® DELZICOL® MESALAMINE ENEMA SUSP PENTASA® SULFASALAZINE DR SULFASALAZINE IR		APRISO® ASACOL HD® COLAZAL® GIAZO® LIALDA®
<b>Gastrointestinal Enzymes</b>				
		CREON® ZENPEP®		PANCREAZE® PANCRELIPASE PERTZYE® ULTRESA® VIOKACE®
<b>Genitourinary Agents</b>				
<b>Benign Prostatic Hyperplasia (BPH) Agents</b>				
<b>5-Alpha Reductase Inhibitors</b>				
		AVODART® FINASTERIDE		JALYN® PROSCAR®
<b>Alpha-Blockers</b>				
		DOXAZOSIN TAMSULOSIN TERAZOSIN		ALFUZOSIN CARDURA® FLOMAX® MINIPRESS® PRAZOSIN RAPAFLO® UROXATRAL®
<b>Bladder Antispasmodics</b>				
		OXYBUTYNIN TABS/SYRUP/ER SANCTURA XR® TOVIAZ® VESICARE®		DETROL® DETROL LA® DITROPAN XL® ENABLEX® FLAVOXATE GELNIQUE® OXYTROL® SANCTURA® TOLTERODINE TROSPIMUM

Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

		Preferred Products	PA Criteria	Non-Preferred Products
<b>Hematological Agents</b>				
<b>Anticoagulants</b>				
<b>Oral</b>				
		COUMADIN® ELIQUIS® * JANTOVEN® PRADAXA® * QL WARFARIN XARELTO® *	* No PA required if approved Dx code transmitted on claim	SAVAYSA®
<b>Injectable</b>				
		ARIXTRA® ENOXAPARIN FRAGMIN®		FONDAPARINUX INNOHEP® LOVENOX®
<b>Colony Stimulating Factors</b>				
		ARANESP® QL PROCRT® QL	PA required Quantity Limit	EPOGEN® QL OMONTYS® QL
<b>Platelet Inhibitors</b>				
		AGGRENOX® ANAGRELIDE ASPIRIN BRILINTA® * QL CILOSTAZOL® CLOPIDOGREL DIPYRIDAMOLE TICLOPIDINE	* PA required	EFFIENT® * QL PLAVIX® ZONTIVITY®
<b>Hormones and Hormone Modifiers</b>				
<b>Androgens</b>				
		ANDROGEL® ANDRODERM®	PA required PA Form: <a href="https://www.medicaid.nv.gov/Downloads/provider/FA-72.pdf">https://www.medicaid.nv.gov/Downloads/provider/FA-72.pdf</a>	AXIRON® FORTESTA® NATESTO® STRIANT® TESTIM® TESTOSTERONE GEL VOGELXO®
<b>Antidiabetic Agents</b>				
<b>Alpha-Glucosidase Inhibitors/Amylin analogs/Misc.</b>				
		ACARBOSE (Precose®) GLYSET® PRECOSE® SYMLIN® (PA required)		CYCLOSET®

Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

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	<b>Biguanides</b>		
	FORTAMET® GLUCOPHAGE® GLUCOPHAGE XR® METFORMIN EXT-REL (Glucophage XR®) GLUMETZA® METFORMIN (Glucophage®) RIOMET®		
	<b>Dipeptidyl Peptidase-4 Inhibitors</b>		
	JANUMET® JANUMET XR® JANUVIA® JENTADUETO® JUVISYNC® KOMBIGLYZE XR® ONGLYZA® TRADJENTA®		KAZANO® NESINA® OSENI®
	<b>Incretin Mimetics</b>		
	BYDUREON® * BYETTA® * VICTOZA® *	* PA required	TANZEUM® TRULICITY®
	<b>Insulins (Vials, Pens and Inhaled)</b>		
	APIDRA® HUMALOG® HUMULIN® LANTUS® LEVEMIR® NOVOLIN® NOVOLOG®		AFREZZA® HUMALOG® U-200 TOUJEO SOLO® 300 IU/ML
	<b>Meglitinides</b>		
	NATEGLINIDE (Starlix®) PRANDIMET® PRANDIN® STARLIX®		
	<b>Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors</b>		
	FARXIGA® INVOKAMET® INVOKANA® XIGDUO XR®		GLYXAMBI® JARDIANCE® SYNJARDY®

Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

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<b>Sulfonylureas</b>			
	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		
<b>Thiazolidinediones</b>			
	ACTOPLUS MET XR® ACTOS® ACTOPLUS MET® AVANDAMET® AVANDARYL® AVANDIA® DUETACT®		
<b>Pituitary Hormones</b>			
<b>Growth hormone modifiers</b>			
	GENOTROPIN® NORDITROPIN®	<b>PA required for entire class</b>  <a href="https://www.medicaid.nv.gov/Downloads/provider/FA-67.pdf">https://www.medicaid.nv.gov/Downloads/provider/FA-67.pdf</a>	HUMATROPE® NUTROPIN AQ® OMNITROPE® NUTROPIN® SAIZEN® SEROSTIM® SOMAVERT® TEV-TROPIN® ZORBTIVE®
<b>Progestins for Cachexia</b>			
	MEGESTROL ACETATE, SUSP		MEGACE ES®

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Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

		Preferred Products	PA Criteria	Non-Preferred Products
<b>Musculoskeletal Agents</b>				
<b>Antigout Agents</b>				
		ALLOPURINOL		
<b>Bone Resorption Inhibitors</b>				
<b>Bisphosphonates</b>				
		ALENDRONATE TABS FOSAMAX PLUS D®		ACTONEL® ALENDRONATE SOLUTION ATELVIA® BINOSTO® BONIVA® DIDRONEL® ETIDRONATE IBANDRONATE SKELID®
<b>Nasal Calcitonins</b>				
		MIACALCIN®		
<b>Restless Leg Syndrome Agents</b>				
		PRAMIPEXOLE REQUIP XL ROPINIROLE		HORIZANT® MIRAPEX® MIRAPEX® ER REQUIP
<b>Skeletal Muscle Relaxants</b>				
		BACLOFEN CHLORZOXAZONE CYCLOBENZAPRINE DANTROLENE METHOCARBAMOL METHOCARBAMOL/ASPIRIN  ORPHENADRINE CITRATE ORPHENADRINE COMPOUND  TIZANIDINE		
<b>Neurological Agents</b>				
<b>Alzheimers Agents</b>				
		DONEPEZIL DONEPEZIL ODT EXELON® PATCH EXELON® SOLN NAMENDA® TABS NAMENDA® XR TABS RIVASTIGMINE CAPS		ARICEPT® 23mg ARICEPT® GALANTAMINE GALANTAMINE ER RAZADYNE® RAZADYNE® ER

Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

	Preferred Products	PA Criteria	Non-Preferred Products
<b>Anticonvulsants</b>			
	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®

Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

	Preferred Products	PA Criteria	Non-Preferred Products
	<b>Barbiturates</b>		
	LUMINAL® MEBARAL® MEPHOBARBITAL SOLFOTON® PHENOBARBITAL MYSOLINE® PRIMIDONE	PA required for members under 18 years old	
	<b>Benzodiazepines</b>		
	CLONAZEPAM CLORAZEPATE DIASTAT® DIAZEPAM DIAZEPAM rectal soln KLONOPIN® TRANXENE T-TAB® VALIUM®	PA required for members under 18 years old	ONFI®
	<b>Hydantoins</b>		
	CEREBYX® DILANTIN® ETHOTOIN FOSPHENYTOIN PEGANONE® PHENYTEK® PHENYTOIN PRODUCTS	PA required for members under 18 years old	
	<b>Anti-Migraine Agents</b>		
	<b>Serotonin-Receptor Agonists</b>		
	RELPAX® RIZATRIPTAN ODT SUMATRIPTAN NASAL SPRAY  SUMATRIPTAN INJECTION SUMATRIPTAN TABLET	PA required for exceeding Quantity Limit	AMERGE®  AXERT® FROVA® IMITREX® MAXALT® TABS MAXALT® MLT NARATRIPTAN SUMAVEL® TREXIMET® ZECUITY® TRANSDERMAL ZOMIG® ZOMIG® ZMT



Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

	Preferred Products	PA Criteria	Non-Preferred Products
<b>Antiparkinsonian Agents</b>			
<b>Non-ergot Dopamine Agonists</b>			
	PRAMIPEXOLE ROPINIROLE ROPINIROLE ER		MIRAPEX® MIRAPEX® ER NEUPRO® REQUIP® REQUIP XL®
<b>Ophthalmic Agents</b>			
<b>Antiglaucoma Agents</b>			
<b>Carbonic Anhydrase Inhibitors/Beta-Blockers</b>			
	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®
<b>Ophthalmic Prostaglandins</b>			
	LATANOPROST TRAVATAN® TRAVATAN Z® ZIOPTAN®		LUMIGAN® XALATAN®
<b>Ophthalmic Antihistamines</b>			
	ALAWAY® BEPREVE® PATADAY® ZADITOR OTC®		ELESTAT® EMADINE® LASTACRAFT® OPTIVAR® PATANOL®
<b>Ophthalmic Antiinfectives</b>			
<b>Ophthalmic Macrolides</b>			
	ERYTHROMYCIN OINTMENT		
<b>Ophthalmic Quinolones</b>			
	BESIVANCE® CIPROFLOXACIN MOXEZA® OFLOXACIN® VIGAMOX®		CILOXAN® ZYMAXID®

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

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

Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

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

Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

	Preferred Products	PA Criteria	Non-Preferred Products
<b>Psychotropic Agents</b>			
<b>ADHD Agents</b>			
	ADDERALL XR® AMPHETAMINE SALT COMBO IR DEXMETHYLPHENIDATE DEXTROAMPHETAMINE SA TAB DEXTROAMPHETAMINE TAB DEXTROSTAT® FOCALIN XR® INTUNIV® METADATE CD® METHYLIN® METHYLIN ER® METHYLPHENIDATE METHYLPHENIDATE ER (All forms generic extended release) METHYLPHENIDATE SOL PROCENTRA® QUILLIVANT® XR SUSP RITALIN LA® STRATTERA® VYVANSE®	<b>PA required for entire class</b>  <b>Children's Form:</b> <a href="https://www.medicaid.nv.gov/Downloads/provider/FA-69.pdf">https://www.medicaid.nv.gov/Downloads/provider/FA-69.pdf</a>  <b>Adult Form:</b> <a href="https://www.medicaid.nv.gov/Downloads/provider/FA-68.pdf">https://www.medicaid.nv.gov/Downloads/provider/FA-68.pdf</a>	ADDERALL® AMPHETAMINE SALT COMBO XR CONCERTA® DAYTRANA® DESOXYN® DEXEDRINE® DEXTROAMPHETAMINE SOLUTION FOCALIN® KAPVAY® METADATE ER® RITALIN®
<b>Antidepressants</b>			
	<b>Other</b> BUPROPION BUPROPION SR BUPROPION XL CYMBALTA® (PA not required for certain ICD-10) 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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Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

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<b>Selective Serotonin Reuptake Inhibitors (SSRIs)</b>			
	CITALOPRAM ESCITALOPRAM FLUOXETINE PAROXETINE PEXEVA® SERTRALINE	PA required for members under 18 years old	CELEXA® FLUVOXAMINE QL LEXAPRO® LUVOX® PAXIL® PROZAC® SARAFEM® ZOLOFT®
<b>Antipsychotics</b>			
<b>Atypical Antipsychotics</b>			
	ABILIFY® CLOZAPINE FANAPT® LATUDA® OLANZAPINE QUETIAPINE RISPERIDONE SAPHRIS® SEROQUEL XR® ZIPRASIDONE	PA required for Ages under 18 years old  PA Form: <a href="https://www.medicaid.nv.gov/Downloads/provider/FA-70.pdf">https://www.medicaid.nv.gov/Downloads/provider/FA-70.pdf</a>	CLOZARIL® FAZACLO® GEODON® INVEGA® RISPERDAL® SEROQUEL® ZYPREXA®
<b>Anxiolytics, Sedatives, and Hypnotics</b>			
	ESTAZOLAM FLURAZEPAM ROZEREM® * TEMAZEPAM TRIAZOLAM ZOLPIDEM	*(PA not required for ICD-10 code G47.0 and F51.0)  PA required for members under 18 years old	AMBIEN® AMBIEN CR® BELSOMRA® DORAL® ESZOPICLONE EDLUAR® HETLIOZ® INTERMEZZO® LUNESTA® SILENOR® SOMNOTE® SONATA® ZALEPLON ZOLPIDEM CR ZOLPIMIST®
<b>Psychostimulants</b>			
<b>Narcolepsy Agents</b>			
	Provigil® *	*(No PA required for ICD-10 code G47.4)	MODAFINIL NUVIGIL® XYREM®

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Division of Health Care Financing and Policy  
**Nevada Medicaid Preferred Drug List**  
 Effective Feb. 22, 2016

	Preferred Products	PA Criteria	Non-Preferred Products
<b>Respiratory Agents</b>			
<b>Nasal Antihistamines</b>			
	ASTEPRO® DYMISTA® PATANASE®		AZELASTINE
<b>Respiratory Antiinflammatory Agents</b>			
<b>Leukotriene Receptor Antagonists</b>			
	MONTELUKAST ZAFIRLUKAST		ACCOLATE® SINGULAIR®
<b>Respiratory Corticosteroids</b>			
	AEROSPAN HFA® ASMANEX® BUDESONIDE NEBS* FLOVENT DISKUS® QL FLOVENT HFA® QL PULMICORT FLEXHALER® QVAR®	*No PA required if < 4 years old	ALVESCO® ARNUITY ELLIPTA® PULMICORT RESPULES®*
<b>Nasal Corticosteroids</b>			
	FLUTICASONE NASONEX®		BECONASE AQ® FLONASE® FLUNISOLIDE NASACORT AQ® OMNARIS® QNASL® RHINOCORT AQUA® TRIAMCINOLONE ACETONIDE  VERAMYST® ZETONNA®
<b>Phosphodiesterase Type 4 Inhibitors</b>			
	DALIRESP® QL	PA required	
<b>Respiratory Antimuscarinics</b>			
	COMBIVENT RESPIMAT® IPRATROPIUM/ALBUTEROL NEBS QL IPRATROPIUM NEBS SPIRIVA®	Only one agent per 30 days is allowed	INCRUSE ELLIPTA® SPIRIVA RESPIMAT® TUDORZA®
<b>Respiratory Beta-Agonists</b>			
<b>Long-Acting Respiratory Beta-Agonist</b>			
	ARCAPTA NEOHALER® FORADIL® SEREVENT DISKUS® QL		BROVANA® PERFORMIST NEBULIZER® STRIVERDI RESPIMAT®

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Effective Feb. 22, 2016

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<b>Short-Acting Respiratory Beta-Agonist</b>			
	ALBUTEROL NEB/SOLN PROVENTIL® HFA PROAIR® HFA XOPENEX® HFA* QL XOPENEX® Solution* QL	* PA required	MAXAIR AUTOHALER® VENTOLIN HFA® LEVALBUTEROL
<b>Respiratory Corticosteroid/Long-Acting Beta-Agonist Combinations</b>			
	ADVAIR DISKUS® ADVAIR HFA® DULERA® SYMBICORT®		BREO ELLIPTA®
<b>Respiratory Long-Acting Antimuscarinic/Long-Acting Beta-Agonist Combinations</b>			
	ANORO ELLIPTA® STIOLTO RESPIMAT®		
<b>Toxicology Agents</b>			
<b>Antidotes</b>			
<b>Opiate Antagonists</b>			
	EVZIO® NALOXONE NARCAN® NASAL SPRAY <b>NEW</b>		
<b>Substance Abuse Agents</b>			
<b>Mixed Opiate Agonists/Antagonists</b>			
	BUNAVAIL® SUBOXONE® ZUBSOLV®	PA required for class	BUPRENORPHINE/NALOXON E