Division of Health Care Financing and Policy

Nevada Medicaid Preferred Drug List

Effective Sept. 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®

Category	Preferred Products	PA Criteria	Non-Preferred Products
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®	**PA Required** http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSMCh1200Packet6-11-15(1).pdf	
	VIEKIRA PAK®	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	
Ribavrins			
	RIBAVIRIN		RIBASPHERE RIBAPAK® MODERIBA® REBETOL®
Anti-Herpetic Agents			
	ACYCLOVIR FAMVIR® VALCYCLOVIR		
Influenza Agents			
	AMANTADINE TAMIFLU® RIMANTADINE RELENZA®		

			Preferred Products	PA Criteria	Non-Preferred Products
	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	ADRENACLICK® QL
Biologic Response Modifiers					
	Immunomodulators				
		Disease-Modifying Antirheumatic Agents			
			ENBREL® HUMIRA®	Prior authorization is required for all drugs in this	ACTEMRA® CIMZIA®

			Preferred Products	PA Criteria	Non-Preferred Products
				class https://www.medicaid.nv.gov/Downloads/provider/FA-61.pdf	KINERET® REMICADE® SIMPONI® ORENCIA® STELARA®
	Multiple Sclerosis Agents				
		Injectable			
			AVONEX® AVONEX® ADMIN PACK BETASERON® COPAXONE® QL EXTAVIA® REBIF® QL TYSABRI®	*Trial of only one agent is required before moving to a non-preferred agent*	
		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®
		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 ǂ NONPREFERRED FOR OVER 10 YEARS OLD	ACCURETIC® EPANED® ǂ FOSINOPRIL MAVIK® MOEXIPRIL QUINAPRIL QUINARETIC® TRANDOLAPRIL UNIVASC®

			Preferred Products	PA Criteria	Non-Preferred Products
		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-9 codes 490-496	
		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® TEKTURNA® TEKTURNA HCT® VALTURNA®		AMTURNIDE®

			Preferred Products	PA Criteria	Non-Preferred Products
		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®		
		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®

			Preferred Products	PA Criteria	Non-Preferred Products
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®
	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® DENAVIR® ZOVIRAX®, OINTMENT		
		Topical Scabicides			
			NATROBA® * NIX® PERMETHRIN RID® SKLICE®	* PA Required	EURAX® LINDANE MALATHION OVIDE® ULESFIA®
	Topical Antiinflammatory Agents				
		Immunomodulators: Topical			
			ELIDEL® QL	Prior authorization is	

			Preferred Products	PA Criteria	Non-Preferred Products
			PROTOPIC® QL	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®
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
	Antiulcer 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®

			Preferred Products	PA Criteria	Non-Preferred Products
	Gastrointestinal Antiinflammatory Agents				
			ASACOL®SUPP BALSALAZIDE® CANASA® DELZICOL® MESALAMINE ENEMA SUSP PENTASA® SULFASALAZINE DR SULFASALAZINE IR		APRISO® ASACOL HD® COLAZAL® GIAZO® LIALDA ®
	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 TROSPIUM
Hematological Agents					
	Anticoagulants				
		Oral			
			COUMADIN® ELIQUIS® *	* No PA required if approved Dx code transmitted on claim	

			Preferred Products	PA Criteria	Non-Preferred Products
			JANTOVEN® PRADAXA® * QL WARFARIN XARELTO ® *		
		Injectable			
			ARIXTRA® ENOXAPARIN FRAGMIN®		FONDAPARINUX INNOHEP® LOVENOX®
	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®		

			Preferred Products	PA Criteria	Non-Preferred Products
		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®
		Sulfonylureas			
			AMARYL® CHLORPROPAMIDE DIABETA® GLIMEPIRIDE (Amaryl®) GLIPIZIDE (Glucotrol®) GLUCOTROL® GLUCOVANCE® GLIPIZIDE EXT-REL (Glucotrol XL®) GLIPIZIDE/METFORMIN (Metaglip®) GLYBURIDE MICRONIZED (Glynase®)		

			Preferred Products	PA Criteria	Non-Preferred Products
			GLYBURIDE/METFORMIN (Glucovance®) 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®
Musculoskeletal Agents					
	Antigout Agents				
			ALLOPURINOL		
	Bone Resorption Inhibitors				
		Bisphosphonates			
			ALENDRONATE TABS FOSAMAX PLUS D®		ACTONEL® ALENDRONATE SOLUTION ATELVIA® BINOSTO® BONIVA® DIDRONEL® ETIDRONATE IBANDRONATE SKELID®

			Preferred Products	PA Criteria	Non-Preferred Products
		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
	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®	PA Required for members under 18 years old	APTIOM® FYCOMPA® OXTELLAR XR® POTIGA® QUDEXY XR® TROKENDI XR®

			Preferred Products	PA Criteria	Non-Preferred Products
			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		
		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®	PA Required for members under 18 years old	

			Preferred Products	PA Criteria	Non-Preferred Products
			PHENYTEK® PHENYTOIN PRODUCTS		
	Anti-Migraine Agents				
		Serotonin-Receptor Agonists			
			RELPAX® 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®
	Fibromyalgia agents				
			CYMBALTA® LYRICA® SAVELLA®	*No PA required for drugs in this class if ICD-9 code=729.1.*	
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®		LUMIGAN® XALATAN®

			Preferred Products	PA Criteria	Non-Preferred Products
			TRAVATAN Z® ZIOPTAN®		
	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® ZYMAXID®
	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		
Psychotropic Agents					
	ADHD Agents				
			AMPHETAMINE SALT COMBO XR	**PA Required for entire class**	ADDERALL® ADDERALL XR®

			Preferred Products	PA Criteria	Non-Preferred Products
			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®	**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-9 codes 347.00, 347.01, 347.10, 347.11, 780.53 and 780.57)	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 ICD-9 code 729.1 or 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®
		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				

			Preferred Products	PA Criteria	Non-Preferred Products
		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-9 code 307.42) 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®
		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®

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