# Nevada Medicaid and Nevada Check Up Preferred Drug List (PDL)

**Effective January 1, 2018**

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<td>Gastrointestinal Agents</td>
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<td>Androgens</td>
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<td>Antidiabetic Agents</td>
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<td>Pituitary Hormones</td>
<td>16</td>
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**PDL Exception PA:** https://www.medicaid.nv.gov/Downloads/provider/FA-63.pdf

**Chapter 1200 PA Criteria:** https://dhcfp.nv.gov/
## Nevada Medicaid and Nevada Check Up Preferred Drug List (PDL)
**Effective January 1, 2018**

**Preferred Products** | **PA Criteria** | **Non-Preferred Products**
--- | --- | ---
### Analgesic/Miscellaneous
#### Neuropathic Pain/Fibromyalgia Agents
- **DULOXETINE** *
- **GABAPENTIN**
- **LYRICA®** *
- **SAVELLA®** *(Fibromyalgia only)*
  - * PA required
  - *No PA required for drugs in this class if ICD-10 - M79.1; M60.0-M60.9, M61.1.*
  - **CYMBALTA®** *
  - **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**
  - **BUTRANS®**
  - **EXALGO®**
  - **FENTANYL PATCH QL**
  - **KADIAN® QL**
  - **METHADONE**
  - **METHADOSE®**
  - **MS CONTIN® QL**
  - **NUCYNTA® ER**
  - **OPANA ER®**
  - **OXICODONE SR QL**
  - **OXYMORPHONE SR**
  - **XARTEMIS XR® QL**
  - **ZOHYDRO ER® QL**

#### Opiate Agonists - Abuse Deterrent
- **EMBEDA®**
- **HYSSINGLA ER®**
  - **OXYCONTIN® QL**
  - **XTAMPZA ER®**

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## Nevada Medicaid and Nevada Check Up Preferred Drug List (PDL)

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### Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) - Oral

<table>
<thead>
<tr>
<th>Preferred Products</th>
<th>PA Criteria</th>
<th>Non-Preferred Products</th>
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<tbody>
<tr>
<td>DICLOFENAC POTASSIUM</td>
<td>CAMBIA® POWDER</td>
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<tr>
<td>DICLOFENAC TAB DR</td>
<td>CELECOXIB CAP</td>
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<tr>
<td>FLURBIPROFEN TAB</td>
<td>DICLOFENAC SODIUM TAB ER</td>
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<tr>
<td>IBUPROFEN SUSP</td>
<td>DICLOFENAC W/ MISOPROSTOL TAB ER</td>
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<td>IBUPROFEN TAB</td>
<td>DUEXIS TAB</td>
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<tr>
<td>INDOMETHACIN CAP</td>
<td>ETODOLAC CAP</td>
<td></td>
</tr>
<tr>
<td>KETOROLAC TAB</td>
<td>ETODOLAC TAB</td>
<td></td>
</tr>
<tr>
<td>MELOXICAM TAB</td>
<td>ETODOLAC ER TAB</td>
<td></td>
</tr>
<tr>
<td>NABUMETONE TAB</td>
<td>INDOMETHACIN CAP ER</td>
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<tr>
<td>NAPROXEN SUSP</td>
<td>KETOPROFEN CAP</td>
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</tr>
<tr>
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<td>MEFENAM CAP</td>
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<td>PIROXICAM CAP</td>
<td>NAPRELAN TAB CR</td>
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<td>SULINDAC TAB</td>
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<td>OXAPROZIN TAB</td>
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<td>TIVORBEX CAP</td>
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<td>VIMOVO TAB</td>
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<td>ZIPSOR CAP</td>
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<td></td>
<td>ZORVOLEX CAP</td>
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### Antihistamines

#### H1 blockers

#### Non-Sedating H1 Blockers

<table>
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<tr>
<th>Preferred Products</th>
<th>PA Criteria</th>
<th>Non-Preferred Products</th>
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<td>CETIRIZINE D OTC</td>
<td>ALLEGRA®</td>
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<tr>
<td>CETIRIZINE OTC</td>
<td>CLARITIN®</td>
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</tr>
<tr>
<td>LORATADINE D OTC</td>
<td>CLARINEX®</td>
<td></td>
</tr>
<tr>
<td>LORATADINE OTC</td>
<td>DESLORATADINE</td>
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A two week trial of one of these drugs is required before a non-preferred drug will be authorized.

### Anti-infective Agents

#### Aminoglycosides

#### Inhaled Aminoglycosides

<table>
<thead>
<tr>
<th>Preferred Products</th>
<th>PA Criteria</th>
<th>Non-Preferred Products</th>
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<tbody>
<tr>
<td>BETHKIS®</td>
<td>PEGASYS®</td>
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</tr>
<tr>
<td>KITABIS® PAK</td>
<td>PEGASYS® CONVENIENT PACK</td>
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<tr>
<td>TOBI PODHALER®</td>
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<td></td>
</tr>
<tr>
<td>TOBRAMYCIN NEBULIZER</td>
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### Antivirals

#### Alpha Interferons

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<thead>
<tr>
<th>Preferred Products</th>
<th>PA Criteria</th>
<th>Non-Preferred Products</th>
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<tr>
<td>PEGASYS®</td>
<td>PEGASYS® CONVENIENT PACK</td>
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<tr>
<td>PEGASYS®</td>
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### Additional Resources

- PDL Exception PA: [https://www.medicaid.nv.gov/Downloads/provider/FA-63.pdf](https://www.medicaid.nv.gov/Downloads/provider/FA-63.pdf)
- Chapter 1200 PA Criteria: [https://dhcfp.nv.gov/](https://dhcfp.nv.gov/)
### Nevada Medicaid and Nevada Check Up Preferred Drug List (PDL)
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#### Preferred Products

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<tr>
<th>Preferred Products</th>
<th>PA Criteria</th>
<th>Non-Preferred Products</th>
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</thead>
<tbody>
<tr>
<td>PEG-INTRON® and REDIPEN</td>
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### Anti-hepatitis Agents

#### Polymerase Inhibitors/Combination Products

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<tbody>
<tr>
<td>EPCLUSA®</td>
<td><a href="http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSMCh1200Packet6-11-15(1).pdf">PA required</a></td>
<td>DAKLINZA®</td>
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<tr>
<td>HARVONI®</td>
<td></td>
<td>OLYSIO®</td>
</tr>
<tr>
<td>SOVALDI®</td>
<td></td>
<td>TECHNIVIE®</td>
</tr>
<tr>
<td>ZEPATIER®</td>
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<td>VIEKIRA® PAK</td>
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#### Ribavirins

<table>
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<th>Non-Preferred Products</th>
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<tbody>
<tr>
<td>RIBAVIRIN</td>
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<td>RIBASPHERE RIBAPAK® MODERIBA® REBETOL®</td>
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### Anti-Herpetic Agents

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<tr>
<td>FAMVIR®</td>
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<td>VALCYCLOVIR</td>
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### Influenza Agents

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<tr>
<td>AMANTADINE</td>
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<td>OSELTAMIVIR CAP RAPIVAB</td>
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<td>TAMIFLU®</td>
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<td>RIMANTADINE</td>
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<td>RELENZA®</td>
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### Cephalosporins

#### Second-Generation Cephalosporins

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<td>CEFACLOR CAPS and SUSP</td>
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#### Third-Generation Cephalosporins

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<tr>
<td>CEFDINIR CAPS / SUSP</td>
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<td>CEFPODOXIME TABS and SUSP</td>
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### Macrolides

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<tbody>
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<td>AZITHROMYCIN TABS/SUSP</td>
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#### Chapter 1200 PA Criteria

**Preferred Products**

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<td>ERYTHROMYCIN BASE</td>
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<td>ERYTHROMYCIN</td>
<td>ZMAX®</td>
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<td>ESTOLATE</td>
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<td>ERYTHROMYCIN</td>
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<td>ETHYLSUCCINATE</td>
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<td>ERYTHROMYCIN</td>
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**Quinolones**

**Quinolones - 2nd Generation**

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<td>CIPROFLOXACIN TABS</td>
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<tr>
<td>CIPRO® SUSP</td>
<td>OFLOXACIN</td>
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**Quinolones - 3rd Generation**

<table>
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<tr>
<td>AVELOX®</td>
<td>LEVAQUIN®</td>
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<tr>
<td>AVELOX ABC PACK®</td>
<td>MOXFLOXACIN</td>
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<tr>
<td>LEVOFLOXACIN</td>
<td>BAXDELA®</td>
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**Autonomic Agents**

**Sympathomimetics**

**Self-Injectable Epinephrine**

<table>
<thead>
<tr>
<th>Self-Injectable Epinephrine</th>
<th>PA Criteria</th>
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<tr>
<td>EPINEPHRINE AUTO INJ</td>
<td>* PA required</td>
<td>ADRENACLICK® QL</td>
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<tr>
<td>EPINEPHRINE®</td>
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<td>AUVI-Q® *</td>
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**Biologic Response Modifiers**

**Immunomodulators**

**Targeted Immunomodulators**

<table>
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<th>Targeted Immunomodulators</th>
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<th>Non-Preferred Products</th>
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<tr>
<td>CIMZIA®</td>
<td>Prior authorization is required for all drugs in this class</td>
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</tr>
<tr>
<td>COSENTYX®</td>
<td>ACTEMRA®</td>
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<td>ENBREL®</td>
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<td>HUMIRA®</td>
<td>ILARIS®</td>
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<tr>
<td>KINERET®</td>
<td>INFLECTRA®</td>
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<td>ORENCIA®</td>
<td>KEVZARA®</td>
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<td>OTEZLA®</td>
<td>REMICADE®</td>
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<td>SIMPONI®</td>
<td>RENFLEXIS®</td>
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<td>XELJANZ®</td>
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<td>STELARA®</td>
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<td>TALTZ®</td>
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<td>TREMFYA®</td>
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**Multiple Sclerosis Agents**

**Injectable**

<table>
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<tr>
<th>Injectable</th>
<th>PA Criteria</th>
<th>Non-Preferred Products</th>
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<td>AVONEX®</td>
<td>Trial of only one agent is required before moving to a non-preferred agent</td>
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<tr>
<td>AVONEX® ADMIN PACK</td>
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<tr>
<td>BETASERON®</td>
<td>GLATOPA®</td>
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<td>COPAXONE® QL</td>
<td>LEMTRADA®</td>
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<td>EXTAVIA®</td>
<td>PLEGRIDY®</td>
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<td>OCREVUS®</td>
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<td>REBIF® QL</td>
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<td>TYSABRI®</td>
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<table>
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<tr>
<th>Preferred Products</th>
<th>PA Criteria</th>
<th>Non-Preferred Products</th>
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<td><strong>Oral</strong></td>
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<td>AUBAGIO®</td>
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<td>GILENYA®</td>
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<td>TECFIDERA®</td>
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<tr>
<td><strong>Specific Symptomatic Treatment</strong></td>
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</tr>
<tr>
<td>AMPYRA® QL</td>
<td>PA required</td>
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<td><strong>Cardiovascular Agents</strong></td>
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</tr>
<tr>
<td><strong>Angiotensin II Receptor Antagonists</strong></td>
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<td></td>
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<tr>
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PDL Exception PA: https://www.medicaid.nv.gov/Downloads/provider/FA-63.pdf
Chapter 1200 PA Criteria: https://dhcfp.nv.gov/
Nevada Medicaid and Nevada Check Up Preferred Drug List (PDL)
Effective January 1, 2018

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<th>PA Criteria</th>
<th>Non-Preferred Products</th>
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<td>ISRADIPI NE</td>
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**Vasodilators**

**Inhaled**

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**Oral**

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# Nevada Medicaid and Nevada Check Up Preferred Drug List (PDL)

**Effective January 1, 2018**

## Preferred Products

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

Chapter 1200 PA Criteria: https://dhcfp.nv.gov/
### Preferred Products

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### Topical Analgesics

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### Topical Anti-infectives

#### Acne Agents: Topical, Benzoyl Peroxide, Antibiotics and Combination Products

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#### Impetigo Agents: Topical

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#### Topical Antifungals (onychomycosis)

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<td>ZUPLENZ® QL</td>
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# Nevada Medicaid and Nevada Check Up Preferred Drug List (PDL)
## Effective January 1, 2018

### Preferred Products | PA Criteria | Non-Preferred Products
---|---|---
#### 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®
- ESOMEPRAZOLE
- LANSOPRAZOLE
- OMEPRAZOLE OTC TABS
- PREVACID®
- PRILOSEC®
- PRILOSEC® OTC TABS
- PROTONIX®

#### Functional Gastrointestinal Disorder Drugs (New)
- AMITIZA® *
- LINZESS®
  * PA required for Opioid Induced Constipation
- MOVANTIK® *
- RELISTOR® *

#### Gastrointestinal Anti-inflammatory Agents
- APRISO®
- ASACOL HD®
- ASACOL®SUPP
- BALSALAZIDE®
- CANASA®
- DELZICOL®
- LIALDA®
- MESALAMINE ENEMA SUSP
- PENTASA®
- SULFASALAZINE DR
- SULFASALAZINE IR
- COLAZAL®
- GIAZO®
- MESALAMINE (GEN LIALDA)
- MESALAMINE (GEN ASACOL HD)

#### Gastrointestinal Enzymes
- CREON®
- ZENPEP®
- PANCREAZE®
- PANCRELIPASE
- PERTZYE®
- ULTRESA®
- VIOKACE®

#### Genitourinary Agents
**Benign Prostatic Hyperplasia (BPH) Agents**
- AVODART®
- FINASTERIDE
- DUTASTERIDE/TAMSULOSIN
- JALYN®
- PROSCAR®

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PDL Exception PA: https://www.medicaid.nv.gov/Downloads/provider/FA-63.pdf  
Chapter 1200 PA Criteria: https://dhcfp.nv.gov/
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<tr>
<th>Preferred Products</th>
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# Nevada Medicaid and Nevada Check Up Preferred Drug List (PDL)
## Effective January 1, 2018

**Preferred Products** | **PA Criteria** | **Non-Preferred Products**
--- | --- | ---
CILOSTAZOL® |  | ZONTIVITY®
CLOPIDOGREL |  | YOSPRALA®
DIPYRIDAMOLE |  |  

### Hormones and Hormone Modifiers

#### Androgens

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### Antidiabetic Agents

#### Alpha-Glucosidase Inhibitors/Amylin analogs/Misc.

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#### Biguanides

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PDL Exception PA: [https://www.medicaid.nv.gov/Downloads/provider/FA-63.pdf](https://www.medicaid.nv.gov/Downloads/provider/FA-63.pdf)
Chapter 1200 PA Criteria: [https://dhcfp.nv.gov/](https://dhcfp.nv.gov/)
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# Nevada Medicaid and Nevada Check Up Preferred Drug List (PDL)

**Effective January 1, 2018**

### Preferred Products

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PDL Exception PA: https://www.medicaid.nv.gov/Downloads/provider/FA-63.pdf
Chapter 1200 PA Criteria: https://dhcfp.nv.gov/
### Preferred Products

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PDL Exception PA: https://www.medicaid.nv.gov/Downloads/provider/FA-63.pdf
Chapter 1200 PA Criteria: https://dhcfp.nv.gov/
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- ETHOTOIN
- FOSPHENYTOIN
- PEGANONE®
- PHENYTEK®
- PHENYTOIN PRODUCTS

### PA Criteria

**Anti-Migraine Agents**

#### Serotonin-Receptor Agonists

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### Ophthalmic Agents

#### Antiglaucoma Agents

#### Carbonic Anhydrase Inhibitors/Beta-Blockers

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## Preferred Products

### Ophthalmic Prostaglandins

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### Ophthalmic Anti-infectives

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<tr>
<td>VYVANSE®</td>
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### Antidepressants

#### Other

<table>
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<tr>
<th>Product</th>
<th>PA Criteria</th>
<th>Non-Preferred Products</th>
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<tbody>
<tr>
<td>BUPROPION</td>
<td>PA required for members under 18 years old</td>
<td>APLENZIN®</td>
</tr>
<tr>
<td>BUPROPION SR</td>
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<td>BRINTELLIX®</td>
</tr>
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<td>BUPROPION XL</td>
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<td>CYMBALTA® *</td>
</tr>
<tr>
<td>DULOXETINE *</td>
<td></td>
<td>DESVENLAFAXINE FUMARATE</td>
</tr>
<tr>
<td>MIRTAZAPINE</td>
<td></td>
<td>EFFEXOR® (ALL FORMS)</td>
</tr>
<tr>
<td>MIRTAZAPINE RAPID TABS</td>
<td></td>
<td>FETZIMA®</td>
</tr>
<tr>
<td>PRISTIQ®</td>
<td></td>
<td>FORFIVO XL®</td>
</tr>
<tr>
<td>TRAZODONE</td>
<td></td>
<td>KHEDEZLA®</td>
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<tr>
<td>VENLAFAXINE (ALL FORMS)</td>
<td></td>
<td>VIIBRYD®</td>
</tr>
<tr>
<td>MIRTAZAPINE RAPID TABS</td>
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<td>WELLBUTRIN®</td>
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#### Selective Serotonin Reuptake Inhibitors (SSRIs)

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<tr>
<th>Product</th>
<th>PA Criteria</th>
<th>Non-Preferred Products</th>
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<tbody>
<tr>
<td>CITALOPRAM</td>
<td>PA required for members under 18 years old</td>
<td>CELEXA®</td>
</tr>
<tr>
<td>ESCITALOPRAM</td>
<td></td>
<td>FLUOXAMINE QL</td>
</tr>
<tr>
<td>FLUOXETINE</td>
<td></td>
<td>LEXAPRO®</td>
</tr>
<tr>
<td>PAROXETINE</td>
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<td>LUVOX®</td>
</tr>
<tr>
<td>PEXEVA®</td>
<td></td>
<td>PAXIL®</td>
</tr>
<tr>
<td>SERTRALINE</td>
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<td>PROZAC®</td>
</tr>
<tr>
<td>CITALOPRAM</td>
<td></td>
<td>SARAFEM®</td>
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<tr>
<td>ESCITALOPRAM</td>
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<td>ZOLOFT®</td>
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### Antipsychotics

#### Atypical Antipsychotics - Oral

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<th>Product</th>
<th>PA Criteria</th>
<th>Non-Preferred Products</th>
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<tbody>
<tr>
<td>ARIPIPRAZOLE</td>
<td>PA required for Ages under 18 years old</td>
<td>ABILIFY®</td>
</tr>
<tr>
<td>CLOZAPINE</td>
<td></td>
<td>CLOZARIL®</td>
</tr>
<tr>
<td>FANAPT®</td>
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<td>FAZACLO®</td>
</tr>
<tr>
<td>LATUDA®</td>
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<td>GEODON®</td>
</tr>
<tr>
<td>NUPLAZID®* Preferred for ICD-10 code G31.83</td>
<td></td>
<td>INVEGA®</td>
</tr>
<tr>
<td>OLANZAPINE</td>
<td></td>
<td>PALIPERIDONE</td>
</tr>
<tr>
<td>QUETIAPINE</td>
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</table>

**PA Forms:**

- [https://www.medicaid.nv.gov/Downloads/provider/FA-70A.pdf](https://www.medicaid.nv.gov/Downloads/provider/FA-70A.pdf) (ages 0-5)

---

**PDL Exception PA:** [https://www.medicaid.nv.gov/Downloads/provider/FA-63.pdf](https://www.medicaid.nv.gov/Downloads/provider/FA-63.pdf)

**Chapter 1200 PA Criteria:** [https://dhcfp.nv.gov/](https://dhcfp.nv.gov/)
<table>
<thead>
<tr>
<th>Preferred Products</th>
<th>PA Criteria</th>
<th>Non-Preferred Products</th>
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<tbody>
<tr>
<td>QUETIAPINE XR</td>
<td><a href="https://www.medicaid.nv.gov/Downloads/provider/FA-70B.pdf">https://www.medicaid.nv.gov/Downloads/provider/FA-70B.pdf</a> (ages 6-18)</td>
<td>RISPERDAL®</td>
</tr>
<tr>
<td>REXULTI®</td>
<td><em>(No PA required Parkinson’s related psychosis ICD code on claim)</em></td>
<td>SEROQUEL®</td>
</tr>
<tr>
<td>RISPERIDONE</td>
<td></td>
<td>SEROQUEL XR®</td>
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<tr>
<td>SAPHRIS®</td>
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<td>ZYPREXA®</td>
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<tr>
<td>VRAYLAR®</td>
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<tr>
<td>ZIPRASIDONE</td>
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</tbody>
</table>

### Anxiolytics, Sedatives, and Hypnotics

- ESTAZOLAM
- FLURAZEPAM
- ROZEREM®
- TEMAZEPAM
- TRIAZOLAM
- ZALEPLON
- ZOLPIDEM

No PA required if approved diagnosis code transmitted on claim (All agents in this class)

PA required for members under 18 years old

- AMBIEN®
- AMBIEN CR®
- BELSOMRA®
- DORAL®
- ESZOPICLONE
- EDLUAR®
- HETLIOZ®
- INTERMEZZO®
- LUNESTA®
- SILENOR®
- SOMNOTE®
- SONATA®
- ZOLPIDEM CR
- ZOLPIMIST®

### Psychostimulants

#### Narcolepsy Agents

- Provigil® *

* (No PA required for ICD-10 code G47.4)

- MODAFINIL
- NUVIGIL®
- XYREM®

### Respiratory Agents

#### Nasal Antihistamines

- DYMISTA®
- PATANASE®

- ASTEPRO®
- AZELASTINE
- OLOPATADINE

#### Respiratory Anti-inflammatory Agents

### Leukotriene Receptor Antagonists

<table>
<thead>
<tr>
<th>MONTELUKAST</th>
<th>ZAFIRLUKAST</th>
<th>ZYFLO®</th>
<th>ZYFLO CR®</th>
<th>ACCOLATE®</th>
<th>SINGULAIR®</th>
<th>ZILEUTON ER</th>
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</thead>
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# Nevada Medicaid and Nevada Check Up Preferred Drug List (PDL)
Effective January 1, 2018

<table>
<thead>
<tr>
<th>Preferred Products</th>
<th>PA Criteria</th>
<th>Non-Preferred Products</th>
</tr>
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<tbody>
<tr>
<td><strong>Respiratory Corticosteroids</strong></td>
<td>*No PA required if &lt; 4 years old</td>
<td>ALVESCO® AEROSPAN HFA® BUDESONIDE NEBS*</td>
</tr>
<tr>
<td>ARNUITY ELLIPTA®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASMANEX®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FLOVENT DISKUS® QL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FLOVENT HFA® QL</td>
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<td></td>
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<tr>
<td>PULMICORT FLEXHALER®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PULMICORT RESPULES®*</td>
<td></td>
<td></td>
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<tr>
<td>QVAR®</td>
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<tr>
<td><strong>Nasal Corticosteroids</strong></td>
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<td>BECONASE AQ® FLONASE® FLUNISOLIDE NASACORT AQ® OMNARIS® QNAR® RHINOCORT AQUA® TRIAMCINOLONE ACETONIDE VERAMYST® ZETONNA®</td>
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<tr>
<td>FLUTICASONE</td>
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<tr>
<td>NASONEX®</td>
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<tr>
<td><strong>Phosphodiesterase Type 4 Inhibitors</strong></td>
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<td></td>
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<tr>
<td>DALIRESP® QL</td>
<td>PA required</td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory Antimuscarinics</strong></td>
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<tr>
<td>ATROVENT®</td>
<td>Only one agent per 30 days is allowed</td>
<td>INCRUSE ELLIPTA® SEEBRI NEOHALER® SPIRIVA RESPIMAT® TUDORZA®</td>
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<tr>
<td>COMBIVENT RESPIMAT®</td>
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<tr>
<td>IPRATROPIUM/ALBUTEROL NEBS QL</td>
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<tr>
<td>IPRATROPIUM NEBS SPIRIVA®</td>
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<tr>
<td><strong>Respiratory Beta-Agonists</strong></td>
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<tr>
<td><strong>Long-Acting Respiratory Beta-Agonist</strong></td>
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<tr>
<td>FORADIL®</td>
<td></td>
<td>ARCAPTA NEOHALER® BROVANA® PERFOROMIST NEBULIZER®</td>
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<tr>
<td>SEREVENT DISKUS® QL</td>
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<td>STRIVERDI RESPIMAT®</td>
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<tr>
<td><strong>Short-Acting Respiratory Beta-Agonist</strong></td>
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<tr>
<td>ALBUTEROL NEB/SOLN LEVALBUTEROL* NEBS PROVENTIL® HFA XOPENEX® HFA* QL</td>
<td>* PA required</td>
<td>LEVALBUTEROL* HFA PROAIR® HFA PROAIR RESPICLICK® VENTOLIN HFA® XOPENEX® Solution* QL</td>
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<td>ADVAIR DISKUS®</td>
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<td>AIRDUO® BREO ELLIPTA®</td>
</tr>
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<td>ADVAIR HFA®</td>
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### Preferred Products

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<th>PA Criteria</th>
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<tbody>
<tr>
<td>DULERA®</td>
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<td>FLUTICASONE PROPIONATE/SALMETEROL</td>
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<td>SYMBICORT®</td>
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**Respiratory Long-Acting Antimuscarinic/Long-Acting Beta-Agonist Combinations**

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<th>Preferred Products</th>
<th>PA Criteria</th>
<th>Non-Preferred Products</th>
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<tbody>
<tr>
<td>ANORO ELLIPTA®</td>
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<td>UTIBRON NEOHALER®</td>
</tr>
<tr>
<td>STIOLTO RESPIMAT®</td>
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### Toxicology Agents

#### Antidotes

**Opiate Antagonists**

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<th>Preferred Products</th>
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<tr>
<td>NALOXONE</td>
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<tr>
<td>NARCAN® NASAL SPRAY</td>
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**Substance Abuse Agents**

**Mixed Opiate Agonists/Antagonists**

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<tbody>
<tr>
<td>BUNAVAIL®</td>
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<td>BUPRENORPHINE /NALOXONE</td>
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<tr>
<td>SUBOXONE®</td>
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</tr>
<tr>
<td>ZUBSOLV®</td>
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