

North Carolina Division of Medical Assistance
North Carolina Medicaid and Health Choice Preferred Drug List (PDL)

Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.

Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.

In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.

Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:

www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html

More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

ALZHEIMER'S AGENTS

Preferred

donepezil 5mg, 10mg tablets / ODT (generic for Aricept® / ODT)
Exelon® Patch
memantine tablet / titration pack (generic for Namenda®)
Namenda® Solution
rivastigmine capsules (generic for Exelon®)

Non-Preferred

Aricept® ODT / Tablets
donepezil 23mg tablets (generic for Aricept®)
Exelon® Capsule
galantamine ER capsule / solution / tablet (generic for Razadyne® / ER)
memantine solution (oral) (generic for Namenda® Solution)
Namenda® Titration Pack / XR Capsule / XR Titration Pack
Namenda® Tablet
Namzaric™ Solution (Oral)
rivastigmine (Transderm) (generic for Exelon® Patch)
Razadyne® ER Capsule / Tablet

ANALGESICS

OPIOID ANALGESICS

Long Acting

Clinical criteria apply to all drugs in this class

Preferred

Butrans® Patch
Embeda® ER Capsule
fentanyl patch 12mcg / 25mcg / 50mcg / 75mcg / 100mcg (generic for Duragesic®)
morphine sulfate ER tablet (generic for MS Contin®)
OxyContin® Tablet

Non-Preferred

Arymo® ER
Avinza® Capsule
Belbuca (Buccal)
buprenorphine patch
Duragesic® Patch
Exalgo® Tablet
fentanyl patch (37.5 / 62.5 / 87.5mcg dosages)
hydromorphone ER tablet (generic for Exalgo®)
Hysingla® ER Tablet
Kadian® Capsule
morphine sulfate ER capsule (generic for Avinza®, Kadian®)
MorphaBond™ ER
MS Contin® Tablet
Nucynta® ER Tablet
oxycodone ER tablet (generic for OxyContin®)
oxymorphone ER tablet
Xartemis® XR Tablet
Xtampza® ER Capsule
Zohydro® Capsule

Orally Disintegrating / Oral Spray Schedule II Opioids

Clinical criteria apply to all drugs in this class

Preferred

Actiq® Lozenge

Non-Preferred

fentanyl citrate lozenge (generic for Actiq®)
Fentora® Buccal Tablet
Abstral® SL Tablet
Subsys® Spray

ANALGESICS

OPIOID ANALGESICS (Continued)

Short Acting Schedule II Opioids

Clinical criteria apply to all drugs in this class

Preferred

Endocet® Tablet (branded generic for Percocet®)
hydrocodone-acetaminophen solution / tablet (generic for Hycet®, Lorcet®, Lortab®, Norco®, Vicodin®)
hydrocodone-ibuprofen tablet (generic for Ibudone®, Reprexain®, Vicoprofen®)
hydromorphone tablet (generic for Dilaudid® Tablet)
morphine solution / tablet (generic for MSIR®)

Non-Preferred

codeine sulfate solution / tablet
Demerol® Tablet
Dilaudid® Liquid / Tablet
Endodan® Tablet (branded generic for Percodan®)
Hycet® Solution

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

oxycodone solution / tablet (generic for Roxicodone®) oxycodone-acetaminophen capsules (generic for Tylox®) oxycodone-acetaminophen tablets (generic for Percocet®) Xylon® (branded generic for Repraxin®)	hydromorphone solution / suppository (generic for Dilaudid®) Ibudone® Tablet Lazanda® Nasal Spray levorphanol tablet (generic for Levo-Dromoran®) Lorcet® Tablet / HD Tablet / Plus Tablet Lortab® Tablet meperidine solution / tablet (generic for Demerol®) Meperitab® tablet (branded generic for Demerol®) morphine suppositories (generic for Roxanol®) Norco® Tablet Nucynta® Tablet Opana® Tablet Oxecta® Tablet oxycodone/APAP suspension oxycodone-aspirin tablet (generic for Endodan®, Percodan®) oxycodone concentrated solution (generic for Roxicodone® Intensol) oxycodone-ibuprofen tablet (generic for Combunox®) oxymorphone tablet (generic for Opana®) oxycodone capsule (generic for OxyIR®) Percocet® Tablet Percodan® Tablet Primlev® Tablet Reprexain® Tablet Roxicet® Solution Roxicodone® Tablet Vicodin® Tablet / ES Tablet / HP Tablet Vicoprofen® Tablet Xodol® Tablet Zamicet® Solution
---	---

ANALGESICS

OPIOID ANALGESICS (Continued)

Short Acting Schedule III – IV Analgesic Combinations

Clinical criteria apply to all drugs in this class

Preferred	Non-Preferred
codeine-acetaminophen solution / tablet (generic for Tylenol with Codeine®) tramadol tablet (generic for Ultram®) tramadol-acetaminophen tablet (generic for Ultracet®)	Ascomp® Capsule (branded generic for Fiorinal with Codeine®) butalbital compound with codeine capsule (generic for Fiorinal with Codeine®) butalbital-caffeine-APAP with codeine tablet (generic for Fioricet with Codeine®) butorphanol spray (generic for Stadol®) Capital® with Codeine Suspension Conzip® Capsule dihydrocodeine-acetaminophen-caffeine tablet (generic for Panlor SS®) dihydrocodeine-aspirin-caffeine capsule (generic for Synalgos-DC®) Fioricet® with Codeine Capsule Fiorinal® with Codeine Capsule pentazocine-naloxone tablet (generic for Talwin NX®) Synalgos-DC® Capsule tramadol ER tablet (generic for Ultram ER®, Ryzolt®) Tylenol® with Codeine Tablet Ultracet® Tablet Ultram® Tablet / ER Tablet

ANALGESICS

NSAIDS

Preferred	Non-Preferred
ibuprofen suspension / tablet (generic for Motrin®)	Anaprox® Tablet / DS Tablet

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

indomethacin capsule (generic for Indocin®) ketorolac tablet (generic for Toradol®) meloxicam tablet (generic for Mobic Tablet®) naproxen EC tablet (generic for Naprosyn® EC) naproxen tablet (generic for Naprosyn® Tablet) sulindac tablet (generic for Clinoril®)	Arthrotec® Tablet DayPro® Caplet diclofenac potassium tablet (generic for Cataflam®) diclofenac sodium tablet / ER tablet (generic for Voltaren® / XR) diclofenac sodium-misoprostol tablet (generic for Arthrotec®) diflunisal tablet (generic for Dolobid®) EC-Naprosyn® Tablet etodolac capsule / tablet / ER tablet (generic for Lodine® / XL) Feldene® Capsule fenoprofen tablet (generic for Nalfon®) flurbiprofen tablet (generic for Ansaid®) Indocin® Suppository / Suspension indomethacin ER capsule (generic for Indocin SR®) Inflammacin® tablets ketoprofen capsule (generic for Orudis®) ketoprofen ER capsule (generic for Oruvail®) meclofenamate capsule (generic for Meclomen®) mefenamic acid capsule (generic for Ponstel®) Mobic® Tablet nabumetone tablet (generic for Relafen®) Nalfon® Capsule Naprelan® Tablet Naprosyn® Tablet Naprosyn® EC naproxen CR naproxen sodium ER tablet (generic for Naprelan®) naproxen sodium tablet (generic for Anaprox®) naproxen suspension (generic for Naprosyn® Suspension) oxaprozin tablet (generic for DayPro®) piroxicam capsule (generic for Feldene®) Ponstel® Kapseals Sprix® Nasal Spray Tivorbex® capsule tolmetin capsule / tablet (generic for Tolectin®) Vivlodex™ Voltaren® XR Tablet Zipsor® Capsule Zorvolex® Capsule meloxicam suspension (generic for Mobic® Oral Suspension) - Exemption for children < 12 years of age Mobic® Suspension
Preferred	Non-Preferred
celecoxib capsule (generic for Celebrex®) - Clinical criteria apply	Celebrex® Capsule - Clinical criteria apply Duexis® Tablet Vimovo®

ANALGESICS

NEUROPATHIC PAIN

<p style="text-align: center;">Preferred</p> duloxetine capsule (generic for Cymbalta®) gabapentin capsule / solution (generic for Neurontin®)	<p style="text-align: center;">Non-Preferred</p> Cymbalta® Capsule Gralise® Starter Pack / Tablet Horizant® Irenka® Capsule Lyrica® Capsule / Solution Neurontin® Capsule / Solution / Tablet
--	---

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Savella® Tablet / Titration Pack
 Dermacin RX® PHN PAK
 lidocaine patch (generic for Lidoderm®) - **Clinical criteria apply**
 Lidoderm® Patch - **Clinical criteria apply**
 Qutenza® Kit

ANTICONVULSANTS

CARBAMAZEPINE DERIVATIVES

Patients with a diagnosis of seizure disorder are exempt from trial and failure criteria and may use any carbamazepine product.

Preferred

Aptiom® Tablet
 carbamazepine chewable (generic for Tegretol®)
 carbamazepine ER capsule (generic for Carbatrol®)
 Equetro® Capsule
 oxcarbazepine tablet / suspension (generic for Trileptal®)
 Oxtellar® XR Tablet
 Tegretol® Suspension / Tablet / XR Tablet

Non-Preferred

Carbatrol® Capsule
 carbamazepine suspension / tablet (generic for Tegretol®)
 carbamazepine XR tablet (generic for Tegretol XR®)
 Epitol® Tablet
 Trileptal® Tablet / Suspension (oral)

FIRST GENERATION

Patients with a diagnosis of seizure disorder are exempt from trial and failure criteria and may use any first generation product.

Preferred

Celontin® Kapseal
 Depakene® Capsule / Solution
 Depakote® Tablet
 Dilantin® Capsule / Infatab / Suspension
 divalproex capsule/ sprinkle / ER tablet / tablet(generic for Depakote® / ER)
 ethosuximide capsule / solution (generic for Zarontin®)
 Mysoline® Tablet
 Peganone® Tablet
 phenobarbital
 Phenytek® Capsule
 phenytoin chewable / capsules / infatab / suspension (generic for Dilantin®)
 phenytoin extended capsules (generic for Phenytek®)
 Primidone® Tablet
 valproic acid capsule / solution (generic for Depakene®)
 Zarontin® Capsule / Solution

Non-Preferred

Depakote® ER Tablet / Sprinkle Capsule
 felbamate suspension / tablet (generic for Felbatol®)
 Felbatol® Suspension / Tablet
 Valproate Syrup (oral)

ANTICONVULSANTS

SECOND GENERATION

Patients with a diagnosis of seizure disorder are exempt from trial and failure criteria and may use any second generation product.

Preferred

clonazepam tablet (generic for Klonopin®)
 Diastat® Accudial / Pedi System
 gabapentin capsule / solution (generic for Neurontin®)
 Gabitril® Tablet
 lamotrigine chewable / tablet (generic for Lamictal®)
 levetiracetam tablet / ER tablet / solution (generic for Keppra® / XR)
 Topiragen® Tablet (branded generic for Topamax®)
 topiramate sprinkle capsule / tablet (generic for Topamax®)
 zonisamide capsule (generic for Zonegran®)

Non-Preferred

Banzel® Suspension / Tablet
 Briviact® Tablet and Solution
 clonazepam ODT (generic for Klonopin® Wafer)
 diazepam rectal / system (generic for Diastat® Accudial / Pedi System)
 Fycompa® Tablet / Kit/Suspension
 gabapentin tablet (generic for Neurontin® Tablet)
 Gralise® Starter Pack / Tablet
 Keppra® Tablet / Solution / XR Tablet
 Klonopin® Tablet
 Lamictal® Chewable / ODT / Starter Kit / Tablet / XR / XR Starter Kit / Tablet
 lamotrigine starter kits (generic for Lamictal®)
 lamotrigine ER tablet / ODT (generic for Lamictal® XR / ODT)
 Lyrica® Capsule / Solution
 Neurontin® Capsule / Solution / Tablet

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Onfi® Suspension / Tablet
 Potiga® Tablet
 Qudexy® XR Capsule
 Sabril® Powder Packet / Tablet
 Spritam® Tablet
 tiagabine tablet (generic for Gabitril®)
 Topamax® Sprinkle Capsule / Tablet
 topiramate ER capsule (generic for Qudexy®)
 Trokendi® XR Capsule
 Vimpat® Solution / Starter Kit / Tablet
 Zonegran® Capsule

ANTI-INFECTIVES-SYSTEMIC

ANTIBIOTICS

Cephalosporins and Related

Preferred

amoxicillin capsule / chewable / suspension / tablet (generic for Amoxil®, Trimox®)
 amoxicillin-clavulanate chewable / suspension / tablet / XR tablet (generic for Augmentin® /XR)
 cefadroxil capsule / suspension (generic for Duricef®)
 cefdinir capsule / suspension (generic for Omnicef®)
 cefpodoxime suspension / tablet (generic for Vantin®)
 cefprozil suspension / tablet (generic for Cefzil®)
 Ceftin® Suspension / Tablet
 cefuroxime tablet (generic for Ceftin®)
 cephalixin capsule / suspension / tablet (generic for Keflex®)
 Suprax® Capsule / Chewable / Suspension/ Tablet

Non-Preferred

Augmentin® Suspension / Tablet / XR Tablet
 Cedax® Capsule / Suspension
 cefaclor capsule / suspension / ER tablet (generic for Ceclor® / CD)
 cefadroxil tablet (generic for Duricef®)
 cefixime suspension
 ceftibuten capsule / suspension (generic for Cedax®)
 Keflex® Capsule

Lincosamides and Oxazolidinones

Preferred

Cleocin® Granules
 clindamycin capsules / solution (generic for Cleocin®)
 linezolid Tablet (generic for Zyvox®)
 linezolid suspension (generic for Zyvox®)

Non-Preferred

Cleocin® Capsules / Injection
 clindamycin injection (generic for Cleocin® Injection)
 Lincocin® Vial
 lincomycin injection (generic for Lincocin Vial®)
 linezolid IV solution (generic for Zyvox®)
 Sivextro® Tablet / Vial
 Synercid® Vial
 Zyvox® Tablet / IV Solution / Suspension

ANTI-INFECTIVES-SYSTEMIC

ANTIBIOTICS (Continued)

Macrolides and Ketolides

Preferred

azithromycin powder packet / suspension / tablet (generic for Zithromax®)
 clarithromycin suspension / tablet (generic for Biaxin®)
 E.E.S.® Granules / Filmtab
 Eryped® Suspension
 Erythrocin® Filmtab
 erythromycin EC capsule (generic for Ery-C®)
 erythromycin filmtab
 erythromycin es 200mg suspension (generic for E.E.S.® Suspension)
 erythromycin es tablet (E.E.S® Filmtab)

Non-Preferred

Biaxin® Suspension / Tablet
 clarithromycin ER tablet (generic for Biaxin XL®)
 Ery-Tab® Tablet
 Ketek® Tablet
 PCE® Tablet
 Zithromax® Powder Packet / Suspension / Tablet / Tri-Pak / Z-Pak
 Zmax® Suspension

Nitromidazoles

Preferred

metronidazole tablet (generic for Flagyl® Tablet)
 vancomycin capsule (generic for Vancocin®)

Non-Preferred

Alinia® Suspension / Tablet
 Difucid® Tablet

North Carolina Division of Medical Assistance
North Carolina Medicaid and Health Choice Preferred Drug List (PDL)

Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.

Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.

In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.

Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:

www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html

More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

	<p>Flagyl® Capsule / ER Tablet/ Tablet metronidazole capsule (generic for Flagyl® Capsule) neomycin tablet (generic for Mycifradin®) paromomycin capsule (generic for Humatin®) Tindamax® Tablet tinidazole tablet (generic for Tindamax®) Vancocin® Capsule Xifaxan® Tablet - Exemption for a diagnosis of Hepatic Encephalopathy</p>
--	--

Quinolones

Preferred	Non-Preferred
<p>Avelox® Tablet Cipro® Suspension ciprofloxacin tablets (generic for Cipro®) levofloxacin tablet (generic for Levaquin® Tablet)</p>	<p>Avelox® ABC Pack Cipro® Tablet / XR Tablet ciprofloxacin ER tablet / suspension (generic for Cipro® XR / Suspension) Levaquin® Solution / Tablet levofloxacin solution (generic for Levaquin® Solution) moxifloxacin tablet (generic for Avelox®) ofloxacin tablet (generic for Floxin®)</p>

ANTI-INFECTIVES-SYSTEMIC

ANTIBIOTICS (Continued)

Tetracycline Derivatives

Preferred	Non-Preferred
<p>doxycycline hyclate capsule / tablet (generic for Vibramycin®, Vibra-Tab®) doxycycline monohydrate 50mg, 100mg capsule (generic for Monodox®) minocycline capsule (generic for Minocin®)</p>	<p>Adoxa® Capsule demeclocycline tablet (generic for Declomycin®) Doryx® DR Tablet Doryx ® MPC Tablet doxycycline hyclate DR tablet (generic for Doryx DR®) doxycycline monohydrate 75mg, 150mg capsule (generic for Monodox®, Adoxa®) doxycycline monohydrate 40mg capsules (generic for Oracea® Capsules) doxycycline monohydrate tablets (generic for Adoxa®) minocycline ER tablet (generic for Solodyn® ER) minocycline tablet (generic for Dynacin®) Morgidox® Capsule / Kit Oracea® Capsule Solodyn® ER Tablet - Clinical justification and failure of doxycycline and minocycline required. Limited to 12 week supply. tetracycline capsule (generic for Sumycin®) Vibramycin® Capsules doxycycline suspension (generic for Vibramycin Suspension®) - Exemption for patients < 12 years of age Vibramycin® Suspension / Syrup</p>

Antifungals

Preferred	Non-Preferred
<p>clotrimazole troche (generic for Mycelex Troche®) fluconazole suspension / tablet (generic for Diflucan®) griseofulvin suspension (generic for Grifulvin V®) griseofulvin ultra tablets (generic for Gris-Peg®) nystatin suspension (generic for Nilstat® Suspension) nystatin tablet (generic for Mycostatin®) terbinafine tablet (generic for Lamisil®)</p>	<p>Ancobon® Capsule Cresamba® Capsule Diflucan® Suspension / Tablet flucytosine capsule (generic for Ancobon®) griseofulvin micro tablets (generic for Grifulvin V®) Gris-Peg® Tablet itraconazole capsule (generic for Sporanox®) ketoconazole tablet (generic for Nizoral®) Lamisil® Granules Packet / Tablet</p>

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Noxafil® Suspension / Tablet
 Onmel® Tablet
 Oravig® Buccal Tablet
 Sporanox® Capsule / Solution
 Vfend® Suspension / Tablet
 voriconazole suspension / tablet (generic for Vfend®)

ANTIVIRALS

Hepatitis B Agents

Preferred

Baraclude® Solution / Suspension
 entecavir tablet (generic for Baraclude®)
 Epivir® HBV Solution
 Hepsera® Tablet
 lamivudine HBV tablet (generic for Epivir® HBV)
 Tyzeka® Tablet
 Viread® Powder / Tablet

Non-Preferred

adefovir tablet (generic for Hepsera®)
 Baraclude® Tablet
 Epivir® HBV Tablet
 Vemlidy® tablet

ANTI-INFECTIVES-SYSTEMIC

ANTIVIRALS (Continued)

Hepatitis C Agents

Preferred

Copegus® Tablet
 Moderiba® Dosepack (branded generic for Ribasphere® Ribapak)
 Moderiba® Tablet (branded generic for Copegus®)
 Pegasys® Proclick / Syringe
 ribavirin capsule / tablet (generic for Copegus®, Rebetol®)

Non-Preferred

Pegasys® Vial
 Ribasphere® Ribapak
 Ribasphere® Capsule / Tablet (branded generic for Rebetrol)

**Clinical criteria apply to all drugs in this class
 November 1, 2017- April 30, 2018**

All genotypes without cirrhosis

Mayvret™ (8 weeks of therapy)

All genotypes with compensated cirrhosis (Child Pugh-A)

Mayvret™ (12 weeks of therapy)

All genotypes with decompensated cirrhosis (Child-Pugh B and C)

Epclusa® Tablet in combination with ribavirin

All genotypes previously treated with an HCV regimen containing an NS5A inhibitor or genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor.

Vosevi™

Harvoni® Tablet (for completion of therapy initiated prior to November 1, 2017)

**Clinical criteria apply to all drugs in this class
 May 1, 2018 and after**

All genotypes without cirrhosis

Mayvret™ (8 weeks of therapy)

All genotypes with compensated cirrhosis (Child Pugh-A)

Mayvret™ (12 weeks of therapy)

Daklinza® Tablet (for genotype 3) - **must request Sovaldi® in addition to Daklinza® with a separate PA**
 Harvoni® Tablet
 Olysio® Capsule
 Sovaldi® Tablet
 Technivie™ Dose Pack (for genotype 4)
 Viekira™ Pak
 Viekira™ XR Tablet
 Zepatier® Tablet

Daklinza® Tablet (for genotype 3) - **must request Sovaldi® in addition to Daklinza® with a separate PA**
 Harvoni® Tablet
 Olysio® Capsule
 Sovaldi® Tablet
 Technivie™ Dose Pack (for genotype 4)
 Viekira™ Pak

North Carolina Division of Medical Assistance
North Carolina Medicaid and Health Choice Preferred Drug List (PDL)

Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.

Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.

In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.

Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:

www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html

More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

<p><u>All genotypes with decompensated cirrhosis</u> Epclusa® Tablet in combination with ribavirin</p> <p><u>All genotypes previously treated with an HCV regimen containing an NS5A inhibitor or genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor.</u> Vosevi™</p>	<p>Viekira™ XR Tablet Zepatier® Tablet</p>
--	--

Herpes Treatments

Preferred	Non-Preferred
<p>acyclovir capsule / tablet / suspension (generic for Zovirax®) famciclovir tablet (generic for Famvir®) valacyclovir tablet (generic for Valtrex®)</p>	<p>Famvir® Tablet Sitavig® Buccal Tablet Valtrex® Caplet Zovirax® Capsule / Tablet / Suspension</p>

Influenza

Preferred	Non-Preferred
<p>amantadine capsule / solution (generic for Symmetrel®) rimantadine tablet (generic for Flumadine®) Tamiflu® Capsule / Suspension</p>	<p>amantadine tablet (generic for Symmetrel®) oseltamivir phosphate Relenza® Diskhaler</p>

Antibiotics, Inhaled

Trial and failure of only one preferred drug required

Preferred	Non-Preferred
<p>Kitabis™ Pak (tobramycin inhalation solution) Bethkis® (tobramycin inhalation solution)</p>	<p>Cayston® tobramycin solution / pak Tobi®</p>

BEHAVIORAL HEALTH

ANTIDEPRESSANTS

Other

Preferred	Non-Preferred
<p>bupropion tablet / SR tablet / XL tablet (generic for Wellbutrin® / SR / XL) duloxetine capsule (generic for Cymbalta®) maprotiline tablet (generic for Ludiomil®) mirtazapine ODT / tablet (generic for Remeron®) Parnate® Tablet phenelzine tablet (generic for Nardil®) tranylcypromine tablet (generic for Parnate®) trazodone tablet (generic for Desyrel®) venlafaxine tablet / ER capsules (generic for Effexor®, Effexor® XR)</p>	<p>Aplenzin® Tablet Trintellix® Tablet Cymbalta® Capsule desvenlafaxine ER tablet (generic for Khedezla®) Effexor® XR Capsules Emsam® Patch Fetzima® Capsule / Titration Pak Forfivo® XL Tablet Khedezla® Marplan® Nardil® Tablet nefazodone tablet (generic for Serzone®) Oleptro® ER Tablet Pristiq® ER Tablet Remeron® Solutab / Tablet Savella® Tablet / Titration Pack venlafaxine ER tablets (generic for Effexor® ER) Viibryd® Starter Pack / Tablet Wellbutrin® Tablet / SR Tablet / XR Tablet</p>

BEHAVIORAL HEALTH

ANTIDEPRESSANTS (Continued)

Selective Serotonin Reuptake Inhibitor (SSRI)

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Preferred	Non-Preferred
citalopram solution / tablet (generic for Celexa®) escitalopram tablet (generic for Lexapro® Tablet) fluoxetine capsule / solution (generic for Prozac®) fluvoxamine tablet (generic for Luvox®) paroxetine tablet (generic for Paxil®) sertraline concentrated solution / tablet (generic for Zoloft®)	Brisdelle® Capsule Celexa® Tablet escitalopram solution (generic for Lexapro® Solution) fluoxetine DR capsules (generic for Prozac® Weekly) fluoxetine tablet (generic for Prozac®) - Exemption for children < 12 years of age fluvoxamine ER capsule (generic for Luvox CR®) Lexapro® Solution / Tablet paroxetine CR tablet (generic for Paxil CR®) Paxil® Suspension / Tablet / CR Tablet Pexeva® Tablet Prozac® Pulvule / Weekly Capsule Sarafem® Tablet Zoloft® Solution / Tablet

ANTIHYPERKINESIS/ ADHD

Preferred	Non-Preferred
Aptensio® XR Adderall® XR Capsule amphetamine salt combo tablets (generic for Adderall®) atomoxetine capsule Daytrana® Patch dextroamphetamine tablet (generic for Dexedrine®) Focalin® Tablet / XR Capsule guanfacine ER tablet (generic for Intuniv®) Kapvay® Tablet Methylin® Solution methylphenidate tablets (generic for Methylin®, Ritalin®) Quillichew® ER Oral Quillivant® XR Suspension Ritalin® Tablet Vyvanse® Capsule / Chewable Tablet	Adderall® Tablet (GENERIC PRODUCT PER FDA) Adzenys® XR ODT amphetamine salt combo XR capsules (generic for Adderall XR) clonidine ER tablet (generic for Kapvay®) Concerta® Tablet Dexedrine® Tablet / Spansules dexamethylphenidate tablet / ER capsules (generic for Focalin® / XR) Desoxyn® Tablet dextroamphetamine solution (generic for ProCentra®) dextroamphetamine ER capsule (generic for Dexedrine® Spansules) Dyanavel® XR Evekeo® Tablet Intuniv® Tablet methamphetamine tablet (generic for Desoxyn®) Methylin® Chewable methylphenidate CD capsules (generic for Metadate® CD) methylphenidate chewable / solution (generic for Methylin®) methylphenidate ER tablets methylphenidate LA capsules (generic for Ritalin® LA) ProCentra® Solution Ritalin® LA Capsule Strattera® Capsule Zenzedi® Tablet

ATYPICAL ANTIPSYCHOTICS

Injectable Long Acting

Trial and failure of only one preferred drug required

Preferred	Non-Preferred
Abilify Maintena® Syringe / Vial fluphenazine decanoate vial (generic for Prolixin decanoate®) Haldol® decanoate Ampule haloperidol decanoate ampule / vial (generic for Haldol decanoate®) Invega® Sustenna Prefilled Syringe / Trinza Syringe Risperdal® Consta Syringe Zyprexa® Relprevv Vial Kit	Aristada® Syringe

BEHAVIORAL HEALTH

ATYPICAL ANTIPSYCHOTICS

Oral

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Trial and failure of only one preferred drug required

Preferred	Non-Preferred
Abilify® Discmelt aripiprazole Tablet / Solution (generic for Abilify®) clozapine ODT (generic for FazaClo®) clozapine tablet (generic for Clozaril®) Invega® Tablet Latuda® Tablet olanzapine ODT / tablet (generic for Zyprexa®) quetiapine tablet (generic for Seroquel®) quetiapine ER tablet (generic for Seroquel® XR Tablet) risperidone ODT / solution/tablet (generic for Risperdal®) Saphris® SL Tablet Symbyax® Capsule ziprasidone capsule (generic for Geodon®)	Abilify® Tablet aripiprazole ODT (generic for Abilify®) Clozaril® Tablet Fanapt® Titration Pack Fanapt® Tablet FazaClo® ODT Geodon® Capsule Nuplazid® Tablet olanzapine-fluoxetine (generic for Symbyax®) paliperidone (generic for Invega® Tablet) Risperdal® Solution / Tablet / M-Tab ODT Rexulti® Tablet Seroquel® Tablet Seroquel® XR Tablet / XR Sample Kit Versacloz® Suspension Vraylar® Capsule Zyprexa® Tablet / Zydis Tablet

CARDIOVASCULAR

ACE INHIBITORS

Preferred	Non-Preferred
benazepril tablet (generic for Lotensin®) enalapril tablet (generic for Vasotec®) lisinopril tablet (generic for Prinivil® and Zestril®) ramipril capsule (generic for Altace®)	Aceon® Accupril® Tablet Altace® Capsule captopril tablet (generic for Capoten®) Epaned® Solution - Exemption for children < 12 years of age fosinopril tablet (generic for Monopril®) Lotensin® Tablet Mavik® Tablet moexipril tablet (generic for Univasc®) Qbrelis® Solution - Exemption for children < 12 years of age perindopril tablet (generic for Aceon®) Prinivil® Tablet quinapril tablet (generic for Accupril®) trandolapril tablet (generic for Mavik®) Univasc® Tablet Vasotec® Tablet Zestril® Tablet

ACE INHIBITOR CALCIUM CHANNEL BLOCKER COMBINATIONS

Preferred	Non-Preferred
amlodipine-benazepril capsule (generic for Lotrel®)	Lotrel® Capsule Tarka® ER Tablet trandolapril-verapamil ER tablet (generic for Tarka®)

ACE INHIBITOR DIURETIC COMBINATIONS

Preferred	Non-Preferred
enalapril-HCTZ tablet (generic for Vaseretic®) lisinopril-HCTZ tablet (generic for Prinzide®, Zestoretic®)	Accuretic® Tablet benazepril-HCTZ tablet (generic for Lotensin® HCT) captopril-HCTZ tablet (generic for Capozide®) fosinopril-HCTZ tablet (generic for Monopril® HCT) Lotensin® HCT Tablet moexipril-HCTZ tablet (generic for Uniretic®) quinapril-HCTZ tablet (generic for Accuretic®, Quinaretic®)

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

	Vaseretic® Tablet Zestoretic® Tablet
CARDIOVASCULAR	
ANGIOTENSIN II RECEPTOR BLOCKERS	
Requires trial and failure of an ACE Inhibitor unless contraindicated or documented adverse event when using a either a preferred or non-preferred Angiotensin II Receptor Blocker	
Preferred	Non-Preferred
Diovan® Tablet losartan tablet (generic for Cozaar®)	Atacand® Tablet Avapro® Tablet Benicar® Tablet candesartan tablet (generic for Atacand®) Cozaar® Tablet Edarbi® Tablet eprosartan tablet (generic for Teveten®) irbesartan tablet (generic for Avapro®) Micardis® Tablet telmisartan tablet (generic for Micardis®) valsartan tablet (generic for Diovan®)
ANGIOTENSIN II RECEPTOR BLOCKER COMBINATIONS	
Requires trial and failure of an ACE Inhibitor unless contraindicated or documented adverse event when using a either a preferred or non-preferred Angiotensin II Receptor Blocker Combination	
Preferred	Non-Preferred
Exforge® Tablet Exforge® HCT Tablet	amlodipine/olmesartan tablet (generic for Azor®) amlodipine-valsartan tablet (generic for Exforge®) amlodipine-valsartan-HCTZ tablet (generic for Exforge® HCT) Azor® Tablet Prestalia® telmisartan-amlodipine tablet (generic for Twynsta®) Tribenzor® Tablet Twynsta® Tablet
ANGIOTENSIN II RECEPTOR BLOCKER DIURETIC COMBINATIONS	
Requires trial and failure of an ACE Inhibitor unless contraindicated or documented adverse event when using a either a preferred or non-preferred Angiotensin II Receptor Blocker Diuretic Combination	
Preferred	Non-Preferred
losartan-HCTZ tablet (generic for Hyzaar®) valsartan-HCTZ tablet (generic for Diovan® HCT)	Atacand® HCT Tablet Avalide® Tablet Benicar® HCT Tablet candesartan-HCTZ tablet (generic for Atacand® HCT) Diovan® HCT Tablet Edarbyclor® Tablet Hyzaar® Tablet irbesartan-HCTZ tablet (generic for Avalide®) Micardis® HCT Tablet telmisartan-HCTZ tablet (generic for Micardis® HCT) Teveten® HCT Tablet
ANGIOTENSIN II RECEPTOR-NEPRILYSIN BLOCKER COMBINATIONS	
Preferred	Non-Preferred
Entresto® Clinical Criteria Apply	

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

ANTI-ARRHYTHMICS

Preferred

amiodarone tablet (generic for Cordarone®)
 disopyramide capsule (generic for Norpace®)
 flecainide tablet (generic for Tambocor®)
 mexiletine capsule (generic for Mexitil®)
 propafenone tablet (generic for Rythmol®)
 quinidine sulfate tablet / ER tablet (generic for Quinidex® Extentabs / Tablet)
 Rythmol SR® Capsule

Non-Preferred

Cordarone® Tablet
 dofetilide capsule (generic for Tikosyn®)
 Multaq® Tablet
 Norpace® Capsule / CR Capsule
 Pacerone® Tablet
 propafenone SR capsule (generic for Rythmol SR®)
 quinidine gluconate tablet (generic for Quinaglute DuraTabs®)
 Rythmol® Tablet
 Tikosyn® Capsule

CARDIOVASCULAR

BETA BLOCKERS

Preferred

atenolol tablet (generic for Tenormin®)
 carvedilol tablet (generic for Coreg®)
 labetalol tablet (generic for Trandate®)
 metoprolol succinate XL tablet (generic for Toprol XL®)
 metoprolol tartrate tablet (generic for Lopressor®)
 propranolol solution / tablet / ER capsule (generic for Inderal®)
 Sorine® Tablet
 sotalol AF tablet / tablet (generic for Betapace® / AF, Sorine®)

Non-Preferred

acebutolol capsule (generic for Sectral®)
 Betapace® AF Tablet / Tablet
 betaxolol tablet (generic for Kerlone®)
 bisoprolol tablet (generic for Zebeta®)
 Bystolic® Tablet
 Coreg® Tablet / CR Capsule
 Corgard® Tablet
 Hemangeol® Solution
 Inderal® LA Capsule / XL Capsule
 Innopran® XL Capsule
 Levatol® Tablet
 Lopressor® Tablet
 nadolol tablet (generic for Corgard®)
 pindolol tablet (generic for Visken®)
 Sectral® Capsule
 Sotylize® Solution
 Tenormin® Tablet
 timolol tablet (generic for Blocadren®)
 Toprol XL® Tablet
 Trandate® Tablet
 Zebeta® Tablet

BETA BLOCKER DIURETIC COMBINATION

Preferred

atenolol-chlorthalidone tablet (generic for Tenoretic®)
 bisoprolol-HCTZ tablet (generic for Ziac®)

Non-Preferred

Corzide® Tablet
 Dutoprol® Tablet
 Lopressor® HCT Tablet
 metoprolol-HCTZ tablet (generic for Lopressor® HCT)
 propranolol-HCTZ tablet (generic for Inderide®)
 nadolol-bendroflumethiazide (generic for Corzide®)
 Tenoretic® Tablet
 Ziac® Tablet

BILE ACID SEQUESTRANTS

Preferred

cholestyramine light packet / light powder / packet / powder (generic for Questran® / Light)
 colestipol tablet (generic for Colestid® Tablet)

Non-Preferred

colestipol granules (generic for Colestid® Granules)
 Colestid® Granules / Tablet
 Prevalite® Packet / Powder
 Questran® Light Powder / Packet / Powder

North Carolina Division of Medical Assistance
North Carolina Medicaid and Health Choice Preferred Drug List (PDL)

Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.

Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.

In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.

Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:

www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html

More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Welchol® Packet / Tablet

CARDIOVASCULAR

CHOLESTEROL LOWERING AGENTS

Preferred

atorvastatin tablet (generic for Lipitor®)
lovastatin tablet (generic for Mevacor®)
pravastatin tablet (generic for Pravachol®)
simvastatin tablet (generic for Zocor®)
rosuvastatin tablet (generic for Crestor®)
Zetia® Tablet (used as an adjunctive to statin therapy)

Non-Preferred

Altoprev® Tablet
amlodipine-atorvastatin tablet (generic for Caduet®)
Caduet® Tablet
Crestor® Tablet
ezetimibe (generic for Zetia®)
fluvastatin capsule / ER tablet (generic for Lescol® / XL)
Lescol® Capsule / XL Tablet
Lipitor® Tablet
Livalo® Tablet
Pravachol® Tablet
Vytorin® Tablet
Zocor® Tablet

Juxtapid® Capsule - **Clinical criteria apply**
Kynamro® Syringe - **Clinical criteria apply**

CORONARY VASODILATORS

Preferred

isosorbide dinitrate tablet / ER (generic for Isordil Titradose®, IsoDitrate®, et.al.)
isosorbide mononitrate tablet / ER tablet (generic for Ismo®, Monoket®, Imdur®)
Minitran® Patch
nitroglycerin ER capsules / patches / spray / sublingual (generic for Nitro-Dur®, Minitran®, Nitrostat®, Nitrolingual®, Nitromist®)
Nitrostat® SL Tablet

Non-Preferred

Dilatrate® SR Capsule
Gonitro® Sublingual Powder
Isordil® Tablet / Titradose Tablet
Nitro-Bid® Ointment
Nitro-Dur® Patch
Nitrolingual® Spray
Nitromist® Spray

DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKERS

Preferred

Afedintab CR® Tablet (branded generic for Adalat CC®)
amlodipine tablet (generic for Norvasc®)
Nifedical® XL Tablet (branded generic for Procardia XL®)
nifedipine capsule (generic for Procardia®)
nifedipine ER tablet (generic for Adalat CC® / Procardia XL®)

Non-Preferred

Adalat® CC Tablet
felodipine ER tablet (generic for Plendil®)
isradipine capsule (generic for Dynacirc®)
nicardipine capsule (generic for Cardene®)
nimodipine capsule (generic for Nimotop®)
nisoldipine ER tablet (generic for Sular®)
Norvasc® Tablet
Nymalize® Solution
Procardia® Capsule / XL Tablet
Sular® Tablet

DIRECT RENIN INHIBITOR

Requires trial and failure of an ACE Inhibitor unless contraindicated or documented adverse event when using either a preferred or non-preferred Direct Renin Inhibitor

Preferred

Tekturna® HCT Tablet
Tekturna® Tablet

Non-Preferred

ENDOTHELIN RECEPTOR ANTAGONISTS

Preferred

Letairis® Tablet
Tracleer® Tablet

Non-Preferred

Opsumit® Tablet

North Carolina Division of Medical Assistance
North Carolina Medicaid and Health Choice Preferred Drug List (PDL)

Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.

Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.

In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.

Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:

www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html

More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

CARDIOVASCULAR	
INHALED PROSTACYCLIN ANALOGS	
Preferred	
Tyvaso® Refill Kit / Solution / Starter Kit Ventavis® Solution	Non-Preferred
NIACIN DERIVATIVES	
Preferred	
niacin ER tablet (generic for Niaspan®)	Non-Preferred
	Niacor® Tablet Niaspan® ER Tablet
NITRATE COMBINATION	
Preferred	
Bidil® Tablet	Non-Preferred
NON-DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKERS	
Preferred	
Calan® Tablet Cartia XT® Capsule (branded generic for Cardizem CD®) Dilt XR® Capsule (branded generic for Dilacor XR®) diltiazem ER 24 hour capsule (generic for Dilacor XR®, Tiazac®) diltiazem tablet / CD capsules / ER 12 hour capsule (generic for Cardizem® / CD / SR) Taztia XT® Capsule (branded generic for Tiazac®) verapamil tablet / ER tablet (generic for Calan® / SR)	Non-Preferred
	Calan SR® Caplet Cardizem CD® Capsule Cardizem® LA Tablet Cardizem® Tablet diltiazem LA tablet (generic for Cardizem LA®) Matzim® LA Tablet (generic for Cardizem LA®) Tiazac® Capsule verapamil 360 mg capsule verapamil ER capsules (generic for Verelan®) verapamil PM capsule (generic for Verelan PM®) Verelan® Capsule Verelan® PM Capsule
ORAL PULMONARY HYPERTENSION	
Preferred	
Adcirca® Tablet sildenafil (generic for Revatio®) tablet	Non-Preferred
	Adempas® Tablet Orenitram® ER Tablet Revatio® Suspension / Tablet Uptravi® Tablet
PLATELET INHIBITORS	
Preferred	
Aggrenox® Capsule Brilinta® Tablet clopidogrel tablet (generic for Plavix®) dipyridamole tablet (generic for Persantine®) Effient® Tablet	Non-Preferred
	aspirin/dipyridamole ER capsule (generic for Aggrenox®) Durlaza® Capsule Persantine® Tablet Plavix® Tablet prasugrel tablelet (generic for Effient® Tablet) ticlopidine tablet (generic for Ticlid®) Yosprala® Tablet Zontivity® Tablet
ANTIANGINAL & ANTI-ISCHEMIC	
Preferred	
Ranexa® Tablet	Non-Preferred
CARDIOVASCULAR	

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

SYMPATHOLYTICS AND COMBINATIONS

Preferred

Catapres®-TTS Patch
 clonidine tablets (generic for Catapres®)
 guanfacine tablet (generic for Tenex®)
 methyl dopa tablet (generic for Aldomet®)

Non-Preferred

Catapres® Tablet
 clonidine patches (generic for Catapres®-TTS)
 Clorpres® Tablet (branded generic for Combipres®)
 methyl dopa-HCTZ tablet (generic for Aldoril®)
 methyl dopate injection (generic for Aldomet® Injection)
 reserpine tablet (generic for Serpalan®)
 Tenex® Tablet

TRIGLYCERIDE LOWERING AGENTS

Preferred

fenofibrate tablet (Tricor®)
 fenofibric acid capsule / tablet (Trilipix®)
 gemfibrozil tablet (generic for Lopid®)

Non-Preferred

Antara® Capsule
 fenofibrate capsule / tablet (generic for Antara®, Lofibra®, Fieor®)
 fenofibrate tablet (generic for Fenoglide®)
 fenofibric acid capsule / tablet (generic for Fibracor®, Trilipix®)
 Fenoglide® Tablet
 Fibracor® Tablet
 Lipofen® Capsule
 Lofibra® Capsule / Tablet
 Lopid® Tablet
 Lovaza® Capsule - **Exemption for patients with triglycerides ≥ 500mg/dl**
 omega-3 acid ethyl esters capsule (generic for Lovaza®) - **Exemption for patients with triglycerides ≥ 500mg/dl**
 Tricor® Tablet
 Triglide® Tablet
 Trilipix® Capsule
 Vascepa® Capsule

CENTRAL NERVOUS SYSTEM

ANTIMIGRAINE AGENTS

Quantity limits apply to all triptans

Preferred

rizatriptan ODT (generic for Maxalt MLT®)
 rizatriptan tablet (generic for Maxalt®)
 sumatriptan nasal spray / syringe / tablet/ vial (generic for Imitrex®)

Non-Preferred

Alsuma® Auto-Injection
 almotriptan tablet (generic for Axert®)
 Amerge® Tablet
 Axert® Tablet
 Cambia® Powder Packet
 frovatriptan tablet (generic for Frova®)
 Frova® Tablet
 Imitrex® Cartridges / Nasal Spray / Pen / Tablet / Vial
 Maxalt® Tablet / MLT Tablet
 Migranow® Kit
 naratriptan tablet (generic for Amerge®)
 Onzetra Xsail Nasal Powder®
 Relpax® Tablet
 sumatriptan kit / refill/ injection (generic for Imitrex®)
 Sumavel DosePro® Syringe
 Treximet® Tablet
 Zembrace® SymTouch®
 zolmitriptan ODT / tablet (generic for Zomig®)
 Zomig® Nasal Spray / Tablet / ZMT Tablet

ANTINARCOLEPSY

Clinical criteria apply to all drugs in this class

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Preferred	
Nuvigil® Tablet Provigil® Tablet	Non-Preferred armodafinil tablet (generic for Nuvigil®) modafinil tablet (generic for Provigil®)

CENTRAL NERVOUS SYSTEM
ANTIPARKINSON AND RESTLESS LEG SYNDROME AGENTS

Preferred	Non-Preferred
benzotropine tablet (generic for Cogentin®) bromocriptine tablet (generic for Parlodel®) carbidopa-levodopa ODT (generic for Parcopa®) carbidopa-levodopa tablet / ER tablet (generic for Sinemet® / CR) pramipexole tablet (generic for Mirapex®) ropinirole tablet (generic for Requip®) selegiline capsule / tablet (generic for Emsam®) trihexyphenidyl elixir / tablet (generic for Artane®)	Azilect® Tablet carbidopa tablet (generic for Lodosyn®) carbidopa-levodopa-entacapone tablet (generic for Stalevo®) Comtan® Tablet Duopa® Suspension entacapone tablet (generic for Comtan®) Horizant® Lodosyn® Tablet Mirapex® Tablet / ER Tablet Neupro® Patch Parlodel® Capsule / Tablet pramipexole ER tablet (generic for Mirapex ER®) rasagiline (generic for Azilect®) Requip® Tablet / XL Tablet ropinirole ER tablet (generic for Requip XL®) Rytary® ER Capsule Sinemet® Tablet / CR Tablet Stalevo® Tablet Tasmar® Tablet tolcapone tablet (generic for Tasmar®) Xadago® Zelapar® ODT

MULTIPLE SCLEROSIS

Preferred	Non-Preferred
Avonex® Pack / Pen / Syringe Betaseron® Kit / Vial Copaxone® Syringe Gilenya® Capsule Rebif® Ribidose / Titration Pack / Syringe Tecfidera® Capsule / Starter Pack	Ampyra® Tablet Aubagio® Tablet Extavia® Kit / Vial Glatopa® Syringe Lemtrada® Vial Plegridy® Pen / Pen Starter Pack / Syringe / Syringe Starter Pack Zinbryta® Injection Ocrevus®

SEDATIVE HYPNOTICS

Quantity limits apply to all sedative hypnotics

Preferred	Non-Preferred
flurazepam capsule (generic for Dalmane®) temazepam 15mg, 30mg capsule (generic for Restoril®) zolpidem tablet (generic for Ambien®)	Ambien® Tablet / CR Tablet Belsomra® Tablet Edluar® SL Tablet estazolam tablet (generic for Prosom®) eszopiclone tablet (generic for Lunesta®) Halcion® Tablet Hetlioz® Capsule Intermezzo® SL Tablet Lunesta® Tablet Restoril® Capsule

North Carolina Division of Medical Assistance
North Carolina Medicaid and Health Choice Preferred Drug List (PDL)

Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.

Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.

In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.

Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:

www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html

More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

	Rozerem® Tablet Silenor® Tablet Sonata® Capsule temazepam 7.5, 22.5 mg capsule (generic for Restoril®) triazolam tablet (generic for Halcion®) zaleplon capsule (generic for Sonata®) zolpidem ER tablet (generic for Ambien® CR) zolpidem SL tablet (generic for Intermezzo®) zolpimist oral spray
--	---

CENTRAL NERVOUS SYSTEM

SMOKING CESSATION

Preferred

Buproban® Tablet (branded generic for Zyban®)
 bupropion SR tablet (generic for Zyban®)
 Chantix® Tablet / Starting Box / Continuation Month Box - **Quantity limited to 6 months per 12 months**
 Nicorelief® Gum
 nicotine gum / lozenge / patch

Non-Preferred

Nicoderm® CQ Patch
 Nicotrol® Inhaler / NS Spray
 Nicorette® Gum / Lozenge (Buccal)
 Zyban® SR Tablet

ENDOCRINOLOGY

GROWTH HORMONE

Clinical criteria apply to all drugs in this class

Preferred

Genotropin® Cartridge / Miniquick
 Norditropin® Flexpro / Nordiflex
 Serostim® Vial

Non-Preferred

Humatrope® Cartridge / Vial
 Nutropin® AQ Pen / Nuspin
 Omnitrope® Cartridge / Vial
 Saizen® Click-Easy Cartridge / Vial
 TevTropin® Vial
 Zomacton® Vial
 Zorbtive® Vial

HYPOGLYCEMICS - INJECTABLE

Rapid Acting Insulin

Preferred

Humalog® Vial
 Novolog® Cartridge / Flexpen / Vial

Non-Preferred

Humalog® Kwikpen
 Afrezza® Inhalation Powder
 Apidra® Solostar / Vial
 Humalog® Cartridge

Short Acting Insulin

Preferred

Humulin® R Vial

Non-Preferred

Humulin R-U500 Kwikpen®
 Novolin® R Vial / Relion Vial

Intermediate Acting Insulin

Preferred

Humulin® N Vial

Non-Preferred

Humulin® N Pen
 Novolin® N Vial / Relion Vial

Long Acting Insulin

Preferred

Trial and failure of only one preferred drug required

Lantus® Solostar / Vial
 Levemir® FlexTouch / FlexPen / Vial

Non-Preferred

Basaglar Kwikpen®
 Tresiba® Flextouch
 Toujeo® Solostar

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Premixed Rapid Combination Insulin	
Preferred	
Humalog® Mix 50/50 Kwikpen Humalog® Mix 75/25 Kwikpen Humalog® Mix 75/25 Vial Novolog® Mix 70/30 Flexpen / Vial	Non-Preferred
Premixed 70/30 Combination Insulin	
Preferred	
Humulin® 70/30 Vial	Non-Preferred
	Humulin® 70/30 Pen Novolin® 70/30 Vial / Relion Vial
ENDOCRINOLOGY	
HYPOGLYCEMICS - INJECTABLE (continued)	
Amylin Analogs	
Requires trial and failure or insufficient response to metformin containing product unless contraindicated or documented adverse event when using either a preferred or non-preferred Amylin Analog	
Preferred	
Symlin® Pen Injector	Non-Preferred
GLP-1 Receptor Agonists and Combinations	
Requires trial and failure or insufficient response to metformin containing products unless contraindicated or documented adverse event when using either a preferred or a non-preferred GLP-1 Receptor Agonist and Combination	
Preferred	
Byetta® Pen Bydureon® Pen / Vial Tanzeum® Pen Injector	Non-Preferred
	Continuation of therapy requires documentation that clinical goals have been met Adlyxin® Injection Soliqua® Injection Trulicity® Pen Victoza® Pen Xultophy® Injection
HYPOGLYCEMICS - ORAL	
2nd Generation Sulfonylureas	
Preferred	
Amaryl® Tablet Diabeta® Tablet glimepiride tablet (generic for Amaryl®) glipizide tablet / ER tablet (generic for Glucotrol® / XL) Glucotrol® Tablet / XL Tablet glyburide micronized tablet (generic for Micronase®, Glynase®) glyburide tablet (generic for Diabeta®) Glynase® Tablet	Non-Preferred
Alpha-Glucosidase Inhibitors	
Preferred	
acarbose tablet (generic for Precose®) Glyset® Tablet	Non-Preferred
	miglitol tablet (generic for Glyset®) Precose® Tablet
Biguanides and Combinations	
Preferred	
glipizide-metformin tablet (generic for Metaglip®)	Non-Preferred

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

glyburide-metformin tablet (generic for Glucovance®) metformin tablet / ER tablet (generic for Glucophage® / ER)	Fortamet® Tablet Glucophage® Tablet / ER Tablet Glucovance® Tablet Glumetza® Tablet ** requires documentation as to why the beneficiary cannot use preferred long acting metformin product metformin ER tablet (generic for Fortamet®) metformin ER tablet (generic for Glumetza®) Riomet® Solution
---	--

DPP-IV Inhibitors and Combinations

Requires trial and failure or insufficient response to metformin containing products unless contraindicated or documented adverse event when using either a preferred or a non-preferred DPP-IV Inhibitor and Combination

Preferred	Non-Preferred
Janumet® Tablet Janumet® XR Tablet Januvia® Tablet Jentadueto® Tablet Tradjenta® Tablet	alogliptin tablet (generic for Nesina®) alogliptin-metformin tablet (generic for Kazano®) alogliptin-pioglitazone tablet (generic for Orseni®) Glyxambi® Tablet Jentadueto® XR Tablet Kazano® Tablet Kombiglyze® XR Tablet Nesina® Tablet Onglyza® Tablet Oseni® Tablet

ENDOCRINOLOGY

HYPOGLYCEMICS - ORAL (continued)

Meglitinides

Preferred	Non-Preferred
nateglinide tablet (generic for Starlix®) repaglinide tablet (generic for Prandin®)	Prandin® Tablet Starlix® Tablet repaglinide-metformin tablet (generic for Prandimet®)

Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitor and Combinations

Requires trial and failure or insufficient response to metformin containing products unless contraindicated or documented adverse event when using either a preferred or a non-preferred SGLT2 Inhibitor and Combination

Preferred	Non-Preferred
Farxiga® Tablet Jardiance® Tablet	Invokamet® Tablet / XR Tablet Invokana® Tablet Invokana® Tablet Synjardy® Tablet / XR Tablet Xigduo® XR Tablet

Thiazolidinediones and Combinations

Preferred	Non-Preferred
pioglitazone tablet (generic for Actos®)	ActoPlus Met® Tablet / XR Tablet Actos® Tablet Avandamet® Tablet Avandaryl® Tablet Avandia® Tablet Duetact® Tablet pioglitazone-glimepiride tablet (generic for Duetact®) pioglitazone-metformin tablet (generic for ActoPlus Met®)

GASTROINTESTINAL

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

ANTIEMETIC-ANTIVERTIGO AGENTS	
Preferred	Non-Preferred
dimenhydrinate vial (generic for Dramamine®) meclizine tablet (generic for Antivert®) metoclopramide / solution / tablet (generic for Reglan®) ondansetron ODT / solution / tablet (generic for Zofran®) prochlorperazine tablet (generic for Compazine®) promethazine syrup / tablet (generic for Phenergan®) Transderm-Scop® Patch Emend® Capsule - Clinical criteria apply	Akynzeo® Capsule Anzemet® Tablet / Vial Cesamet® Capsule dronabinol capsule (generic for Marinol®) granisetron tablets (generic for Kytril®) Marinol® Capsule metoclopramide ODT (generic for Metozolv®) metoclopramide ODT (generic for Reglan®) Metozolv® ODT Sancuso® patch scopolamine patch Sustol® Injection trimethobenzamide capsule (generic for Tigan®) Varubi® Tablet Zofran® Solution / ODT / Tablet Zuplenz® Soluble Film aprepitant capsule/pack (generic for Emend®) - Clinical criteria apply Emend® Powder Packet - Clinical criteria apply Emend® Trifold Pack - Clinical criteria apply Diclegis® Tablet - Exemption for diagnosis of pregnancy
BILE ACID SALTS	
Preferred	Non-Preferred
ursodiol tablet (generic for Urso®)	Actigall® Capsule Chenodal® Tablet Cholbam® Capsule Ocaliva® Tablet Urso® Tablet / Urso® Forte Tablet ursodiol capsule (generic for Actigall®)
GASTROINTESTINAL	
H. PYLORI COMBINATIONS	
Preferred	Non-Preferred
Pylera® Capsule	lansoprazole-amoxicillin-clarithromycin pack (generic for Prevpac®) Omeclamox-Pak® Combo Pack Prevpac® Patient Pack
HISTAMINE-2 RECEPTOR ANTAGONISTS	
Preferred	Non-Preferred
famotidine tablet / suspension (generic for Pepcid®) ranitidine capsule / syrup / tablet (generic for Zantac®)	cimetidine solution / tablet (generic for Tagamet®) nizatidine capsule / solution (generic for Axid®) Pepcid® Tablet / Suspension Zantac® Tablet
PANCREATIC ENZYMES	
Preferred	Non-Preferred
Creon® Capsule pancrelipase capsule (generic for Pancrease®) Zenpep® Capsule	Pancreaze® Capsule Pertzye® Capsule Ultresa® Capsule Viokase® Tablet
PROGESTINS USED FOR CACHEXIA	
Preferred	

North Carolina Division of Medical Assistance
North Carolina Medicaid and Health Choice Preferred Drug List (PDL)

Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.

Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.

In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.

Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:

www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html

More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

megestrol suspension / tablet (generic for Megace®)	Non-Preferred Megace® Suspension / ES Suspension megestrol ES suspension (generic for Megace® ES)
---	--

PROTON PUMP INHIBITORS

Preferred	Non-Preferred
Nexium® RX / Capsule / Packet omeprazole RX capsule (generic for Prilosec® RX) pantoprazole tablet (generic for Protonix®) Protonix® Suspension	Exemption for children < 12 years of age Aciphex® Sprinkle Capsules / Tablets Dexilant® Capsule esomeprazole capsule (generic for Nexium® RX / OTC) lansoprazole capsule (generic for Prevacid® RX / OTC) omeprazole OTC capsule / tablet (generic for Prilosec® OTC) omeprazole sodium bicarbonate capsule (generic for Zegerid® RX / OTC) Prevacid® RX / OTC Capsule / Solutab Prilosec® RX Capsule / Suspension Protonix® Tablet rabeprazole tablet (generic for Aciphex®) Zegerid® RX / Capsule / Packet

SELECTIVE CONSTIPATION AGENTS

Preferred	Non-Preferred
Amitiza® Capsule Linzess® Capsule Movantik® Tablet	alosetron tablet (generic for Lotronex® Tablet) Lotronex® Tablet Relistor® Syringe / Vial / Oral Tablet Trulance® Viberzi® Tablet - Exemption for Irritable Bowel Syndrome with Diarrhea (IBS-D)

GASTROINTESTINAL

ULCERATIVE COLITIS

Oral

Preferred	Non-Preferred
Apriso® Capsule balsalazide capsule (generic for Colazal®) sulfasalazine DR tablet (generic for Azulfidine® Entab) sulfasalazine IR tablet (generic for Azulfidine®) Sulfazine® (branded generic for Azulfidine®)	Asacol® HD Tablet Azulfidine® Entab / Tablet Colazal® Capsule Delzicol® Capsule Dipentum® Capsule Giazo® Tablet Lialda® Tablet mesalamine tablet (generic for Asacol® HD) Pentasa® Capsule Uceris® TabletA

Rectal

Trial and failure of only one preferred drug required

Preferred	Non-Preferred
Canasa® Suppository mesalamine enema (generic for Rowasa® Enema)	mesalamine kit (generic for Rowasa® Kit) Rowasa® Kit SFRowasa® Enema Uceris® Rectal Foam

BENIGN PROSTATIC HYPERPLASIA TREATMENTS

Preferred	Non-Preferred
alfuzosin ER tablet (generic for Uroxatral®) doxazosin tablet (generic for Cardura®) dutasteride capsule (generic Avodart®) finasteride tablet (generic for Proscar®) tamsulosin capsule (generic for Flomax®)	Avodart® Softgel Cardura® Tablet / XL Tablet dutasteride/ tamsulosin capsule (generic Jalyn capsule®) Flomax® Capsule

North Carolina Division of Medical Assistance
North Carolina Medicaid and Health Choice Preferred Drug List (PDL)

Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.

Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.

In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.

Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:

www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html

More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

terazosin capsule (generic for Hytrin®)	Jalyn® Capsule Proscar® Tablet Rapaflo® Capsule Uroxatral® Tablet Cialis® Tablet - Clinical criteria apply
ELECTROLYTE DEPLETERS	
Preferred	Non-Preferred
calcium acetate capsule (generic for PhosLo®) calcium acetate tablet (generic for Eliphos®) Eliphos® Tablet Renagel® Tablet Renvela® Powder Pack	Auryxia® Tablet Fosrenol® Chewable Fosrenol® Powder Pack Magnebind® 400 RX Tablet PhosLo® Gelcap / Solution Phoslyra® Solution Renvela® Tablet sevelamer tablet / powder pack (generic for Renvela®) Velphoro® Chewable
GENTOURINARY/RENAL	
URINARY ANTISPASMODICS	
Preferred	Non-Preferred
oxybutynin syrup / tablet (generic for Ditropan®) Toviaz® Tablet Vesicare® Tablet	darifenacin er tablet (generic for Enablex®) Detrol® Tablet / LA Capsule Ditropan® XL Tablet Enablex® Tablet flavoxate tablet (generic for Urispas®) Gelnique® Gel / Gel Sachets Myrbetriq® Tablet oxybutynin ER tablet (generic for Ditropan XL®) Oxytrol® Patch tolterodine tablet / ER capsule (generic for Detrol® / LA) trospium tablet / ER capsule (generic for Sanctura® / XR)
GOUT	
Preferred	Non-Preferred
allopurinol tablet (generic for Zyloprim®) colchicine capsule (generic for Mitigare®) probenecid tablet (generic for Benemid®) probenecid-colchicine tablet (generic for Col-Benemid®)	colchicine tablet (generic for Colcrys®) Colcrys® Tablet Mitigare® Capsule Uloric® Tablet Zyloprim® Tablet Zurampic® Tablet
HEMATOLOGIC	
ANTICOAGULANTS	
Injectable	
Preferred	Non-Preferred
Fragmin® Syringe / Vial Lovenox® Syringe / Vial	Arixtra® Syringe enoxaparin syringe / vial (generic for Lovenox®) fondaparinux syringe (generic for Arixtra®)
Oral	
Preferred	Non-Preferred
Coumadin® Tablet Eliquis® Tablet Jantoven® (branded generic for Coumadin®) Pradaxa® Capsule	

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Savaysa® Tablet warfarin tablet (generic for Coumadin®) Xarelto® Starter Pack / Tablet	
HEMATOPOIETIC AGENTS	
Clinical criteria apply to all drugs in this class	
Preferred	
Aranesp® Syringe / Vial Procrit® Vial	Non-Preferred
	Epogen® Vial Mircera® Syringe
THROMBOPOIESIS STIMULATING AGENTS	
Preferred	
Nplate® Vial Promacta® Tablet	Non-Preferred
OPHTHALMIC	
ALLERGIC CONJUNCTIVITIS AGENTS	
Preferred	
cromolyn sodium drops (generic for Crolom®) olopatadine drops (AG generic for Patanol®)	Non-Preferred
	Alocril® Drops Alomide® Drops Alrex® Drops azelastine drops (generic for Optivar®) Bepreve® Drops Elestat® Drops Emadine® Drops epinastine drops (generic for Elestat®) Lastacaft® Drops olopatadine drops (generic for Pataday®) Optivar® Drops Patanol® Drops Pataday® Drops Pazeo® Drops
ANTIBIOTICS	
Preferred	
Azasite® Drops AK-Poly-Bac® Ointment (branded generic for Polysporin®) bacitracin-polymyxin ointment (generic for Polysporin®) ciprofloxacin solution drops (generic for Ciloxan®) erythromycin ointment (generic for Ilotycin®) Gentak® Ointment (branded generic for Garamycin®) gentamicin drops / ointment (generic for Garamycin®) Moxeza® Drops neomycin-bacitracin-polymyxin ointment (generic for Neosporin® Ophthalmic Ointment) Neo-Polycin® (branded generic for Neosporin® Ophthalmic Ointment) neomycin-polymyxin-gramicidin drops (generic for Neosporin® Ophthalmic Drops) ofloxacin drops (generic for Ocuflox®) Polycin® Ointment (branded generic for Polysporin®) polymyxin-trimethoprim drops (generic for Polytrim®) sulfacetamide drops (generic for Bleph-10®) tobramycin drops (generic for Tobrex®) Vigamox® Drops	Non-Preferred
	bacitracin ointment (generic for AK-Tracin®) Besivance® Suspension Bleph-10® Drops Ciloxan® Drops / Ointment Garamycin® Drops gatifloxacin drops (generic for Zymaxid®) Ilotycin® Ointment levofloxacin drops (generic for Quixin®) moxifloxacin ophthalmic solution Natacyn® Drops Neosporin® Drops Ocuflox® Drops Polytrim® Drops sulfacetamide ointment (generic for Cetamide®) Tobrex® Ointment/ Drops Zymaxid® Drops
ANTIBIOTICS-STEROID COMBINATIONS	
Preferred	
neomycin-polymyxin-dexamethasone drops / ointment (generic for Maxitrol®)	Non-Preferred

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Tobradex® Drops / Ointment	Blephamide® Drops / S.O.P. Ointment Maxitrol® Drops / Ointment Neo-Polycin® HC (branded generic for Cortisporin®) neomycin-bacitracin-polymyxin-HC ointment (generic for Cortisporin®) neomycin-polymyxin-HC drops / ointment (generic for Ocucricin®) Pred-G® S.O.P. Ointment / Suspension sulfacetamide-prednisolone drops (generic for Vasocidin®) Tobradex® ST Drops tobramycin-dexamethasone suspension (generic for Tobradex® Suspension) Zylet® Drops
OPHTHALMIC	
ANTI INFLAMMATORY	
Preferred	Non-Preferred
dexamethasone drops (generic for Decadron®) diclofenac drops (generic for Voltaren®) Durezol® Drops Flarex® Drops fluorometholone drops (generic for FML®) flurbiprofen drops (generic for Ocufen®) FML® Forte Drops / S.O.P. Ointment ketorolac solution (generic for Acular® / LS) Lotemax® Drops Maxidex® Drops Pred Mild® Drops prednisolone acetate drops (generic for Pred Forte®) prednisolone sodium phosphate drops (generic for Inflamase Forte®)	Acular® Drops / LS Solution Acuvail® Solution bromfenac drops (generic for Xibrom®) FML® Liquifilm Drops Ilevro® Drops Iluvien® Implant Lotemax® Gel / Ointment Nevanac® Droptainer Ocufen® Drops Omnipred® Drops Ozurdex® Implant Pred Forte® Drops Prolensa® Drops Retisert® Implant Triesence® Vial Vexol® Drops
ANTI INFLAMMATORY/IMMUNOMODULATOR	
Preferred	Non-Preferred
Restasis® Restasis® (multidose)	Xiidra®
Alpha 2 Adrenergic Agents	
Preferred	Non-Preferred
Alphagan® P Drops brimonidine drops (generic for Alphagan®)	apraclonidine drops (generic for Iopidine®) brimonidine P drops (generic for Alphagan® P) Iopidine® Drops
Beta Blocker Agents	
Preferred	Non-Preferred
carteolol drops (generic for Ocupress®) Combigan® Drops Istalol® Drops levobunolol drops (generic for Betagan®) timolol drops / GFS gel-solution / gel-solution (generic for Timoptic® / Timoptic XE®)	betaxolol drops (generic for Betoptic®) Betagan® Drops Betimol® Drops Betoptic® S Drops metipranolol drops (generic for OptiPranolol®) Timoptic® Drops / Ocudose Drops / XE Solution
Carbonic Anhydrase Inhibitors	
Preferred	Non-Preferred
Azopt® Drops dorzolamide drops (generic for Trusopt®) dorzolamide-timolol drops (generic for Cosopt®)	Cosopt® Drops / PF Drops Trusopt® Drops

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Simbrinza® Drops		
Prostaglandin Agonists		
Preferred		
latanoprost drops (generic for Xalatan®) Travatan® Z Drops	Non-Preferred	
	bimatoprost (generic for Lumigan® Drops) Lumigan® Drops travoprost drops (generic for Travatan®) Xalatan® Drops Zioptan® Drops	
OSTEOPOROSIS		
BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
Preferred		
alendronate tablet (generic for Fosamax®) Evista® Tablet Fortical® Nasal Spray	Non-Preferred	
	Actonel® Tablet alendronate solution (generic for Fosamax® Solution) Atelvia® Tablet Binosto® Effervescent Tablet Boniva® Tablet calcitonin salmon nasal spray (generic for Miacalcin®) etidronate tablet (generic for Didronel®) Forteo® Pen Injection Fosamax® Tablet / Plus D Tablet ibandronate tablet (generic for Boniva®) Miacalcin® Nasal Spray Prolia® Syringe raloxifene tablet (generic for Evista®) risedronate tablet (generic for Actonel®) Tymlos™	
OTIC		
ANTIBIOTICS		
Preferred		
Ciprodex® Suspension neomycin-polymyxin-hydrocortisone solution / suspension (generic for Cortisporin®)	Non-Preferred	
	Cipro® HC Suspension ciprofloxacin solution (generic for Cetraxal®) Coly-Mycin® S Drops Cortisporin-TC® Suspension ofloxacin drops (generic for Floxin®) Otiprio® Suspension Otovel® Drops	
ANTI-INFECTIVES AND ANESTHETICS		
Preferred		
acetic acid solution (generic for Vosol®) acetic acid-aluminum drops (generic for Domeboro®) antipyrine-benzocaine drops (generic for Auralgan®) Auroguard® Solution (branded generic for Auralgan®)	Non-Preferred	
	Acetasol HC® Drops (branded generic for Vosol® HC) acetic acid-hydrocortisone solution (generic for Vosol® HC) Otic Care® Solution Oto-End 10® Drops Otozin® Ear Drops Pinnacaine® Otic Drops	
RESPIRATORY		
BETA-ADRENERGIC HANDHELD, LONG ACTING		
Preferred		
Serevent® Diskus	Non-Preferred	
	Arcapta® Neohaler Striverdi® Respimat Inhalation Spray	

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

BETA-ADRENERGIC HANDHELD, SHORT ACTING	
<p style="text-align: center;">Preferred</p> Proair® HFA Inhaler Proventil® HFA Inhaler	<p style="text-align: center;">Non-Preferred</p> Proair Respiclick® Ventolin® HFA Inhaler Xopenex® HFA Inhaler
BETA-ADRENERGIC NEBULIZERS	
<p style="text-align: center;">Preferred</p> albuterol 0.63mg/3ml solution (generic for Accuneb®) albuterol 1.25mg/3ml solution (generic for Accuneb®) albuterol sulfate 2.5mg/0.5ml solution albuterol sulfate 2.5mg/3ml solution albuterol sulfate 5mg/ml solution	<p style="text-align: center;">Non-Preferred</p> Brovana® Solution levalbuterol solution / concentrate solution (generic for Xopenex® / Concentrate) Perforomist® Solution Xopenex® Solution / Concentrate Solution
RESPIRATORY	
BETA-ADRENERGIC - ORAL	
<p style="text-align: center;">Preferred</p> albuterol tablets (generic for Proventil® Repetabs) albuterol syrup (generic for Ventolin® Syrup) metaproterenol syrup (generic for Alupent® Syrup) terbutaline tablet (generic for Brethine®)	<p style="text-align: center;">Non-Preferred</p> albuterol ER tablets (generic for VoSpire® ER) metaproterenol tablet (generic for Alupent® Tablet) VoSpire® ER Tablet
COPD AGENTS	
<p style="text-align: center;">Preferred</p>	<p style="text-align: center;">Non-Preferred</p>
Trial and failure of Spiriva® only required to obtain a non-preferred drug in this class	
Atrovent® HFA Inhaler ipratropium nebulizer solution (generic for Atrovent® Nebulizer Solution) ipratropium-albuterol solution (generic for Duoneb®) Spiriva® Handihaler Stiolto® Respimat Inhalation Spray	<p style="text-align: center;">Non-Preferred</p> Anoro® Elipta Inhaler Bevespi ® Aerosphere Combivent® Respimat Inhalation Spray Daliresp® Tablet Incruse® Elipta Inhaler Seebri® Neohaler Spiriva® Respimat Inhalation Spray 2.5mcg Tudorza® Pressair Inhaler Utibron® Neohaler Spiriva Respimat Inhalation Spray 1.25mcg **Exemption from trial and failure of preferred drugs for Spiriva® Respimat 1.25mcg when used for Asthma, but must be used concurrently with an inhaled corticosteroid or inhaled corticosteroid/beta agonist combination**
CORTICOSTEROIDS	
Clinical criteria apply to all drugs in this class	
<p style="text-align: center;">Preferred</p> Pulmicort® Respules 0.25mg, 0.5mg, 1mg QVAR® Inhaler	<p style="text-align: center;">Non-Preferred</p> Aerospan® Inhaler Alvesco® Inhaler Arnuity Elipta® Inhaler Asmanex® HFA Inhaler Asmanex® Twisthaler budesonide suspension (generic for Pulmicort® Respules) Flovent® Diskus / HFA Inhaler Pulmicort® Flexhaler
CORTICOSTEROID COMBINATION	
Clinical criteria apply to all drugs in this class	
<p style="text-align: center;">Preferred</p> Advair® Diskus Dulera® Inhaler	<p style="text-align: center;">Non-Preferred</p> Advair® HFA Inhaler

North Carolina Division of Medical Assistance
North Carolina Medicaid and Health Choice Preferred Drug List (PDL)

Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.

Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.

In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.

Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:

www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html

More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Symbicort® Inhaler	Breo Elipta® AirDuo® fluticasone/salmeterol (generic for AirDuo®)
INTRANASAL RHINITIS AGENTS	
Preferred	Non-Preferred
azelastine spray (generic for Astepro®) azelastine spray (generic for Astelin®) fluticasone spray (generic for Flonase®) ipratropium spray (generic for Atrovent® Nasal) Patanase® Nasal Spray	<p style="text-align: center;">Exemption for steroids applies to children < 4 years of age</p> Astepro® Nasal Spray Astelin® Nasal Spray Atrovent® Spray Beconase® AQ spray budesonide nasal spray (generic for Rhinocort® Aqua) Dymista® Nasal Spray Flonase® Nasal Spray (RX ONLY) flunisolide spray (generic for Nasalide®) mometasone nasal spray (generic for Nasonex®) Nasonex® Nasal Spray olopatadine nasal spray(generic for Patanase®) Omnaris® Nasal Spray QNasl® Nasal Spray / Children's Spray Rhinocort® Aqua Nasal Spray Ticanase nasal spray triamcinolone nasal spray (generic for Nasacort® AQ) Veramyst® Nasal Spray Zetonna® Nasal Spray
RESPIRATORY	
LEUKOTRIENE MODIFIERS	
Preferred	Non-Preferred
montelukast chewable / granules / tablet (generic for Singulair®) zafirlukast tablet (generic for Accolate®)	Accolate® Tablet Singulair® Chewable / Granules / Tablet Zyflo® CR Tablet / Filmtab zileuton
LOW SEDATING ANTIHISTAMINES	
Preferred	Non-Preferred
cetirizine tablets OTC (generic for Zyrtec® OTC Tablets) cetirizine RX syrup (generic for Zyrtec® Syrup) loratadine tablet OTC (generic for Claritin® OTC)	cetirizine OTC syrup 1mg/1ml (generic for Zyrtec OTC® Syrup) cetirizine OTC syrup 5mg/5ml (generic for Zyrtec® OTC Syrup) Clarinex® Syrup / Tablet - Exemption for children < 2 years of age Claritin® Tablet desloratadine ODT / Tablet (generic for Clarinex®) fexofenadine 60mg, 180 mg tablet (generic for Allegra®) fexofenadine OTC suspension / tablet (generic for Allegra® OTC) levocetirizine solution / tablet (generic for Xyzal®) loratadine OTC ODT / solution (generic for Claritin® OTC) Xyzal® Solution / Tablet
LOW SEDATING ANTIHISTAMINE COMBINATION	
Quantity limit of 102 days supply per 12 months apply to all drugs in this class	
Preferred	Non-Preferred
loratadine-D OTC tablet (generic for Claritin-D® OTC)	cetirizine-D OTC tablet (generic for Zyrtec-D® OTC) Clarinex-D® Tablet fexofenadine-D 12 Hour OTC Tablet (generic for Allegra-D® 12 Hour OTC) Semprex-D® Capsule
TOPICALS	
ACNE AGENTS	

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Preferred

Azelex® Cream
 Benzaclin® Gel / Gel Pump
 clindamycin phosphate pledgets / solution (generic for Cleocin-T®)
 Differin® Cream / Gel / Gel Pump / Lotion
 Retin-A® Cream / Gel

Non-Preferred

Acne Clearing System
 Acanya® Gel Pump
 Aczone® Gel
 adapalene cream / gel / gel pump (generic for Differin®)
 Atralin® Gel
 Avar® Cleanser / Cleansing Pads / LS Cleanser / LS Cleansing Pads
 Avar-E® Emollient Cream / Green Emollient Cream / LS Cream
 Avita® Cream / Gel
 Benzamycin® Gel / Pak Gel
 Benzefoam Ultra
 Benzepro® Creamy Wash / Emollient Foam / Foam / Foaming Cloths
 benzoyl peroxide cleanser / wash / foam / gel / kit / towlette (generic for Benzac®, et. al)
 BP® 10-1 Wash / Cleansing Wash
 Cleocin® T Gel / Lotion / Pledgets / Solution
 Clindacin® ETZ Pledget / Kit / P Pledgets / PAC Kit
 clindamycin phosphate gel / lotion (generic for Cleocin-T®)
 clindamycin phosphate foam (generic for Evoclin®)
 clindamycin-benzoyl peroxide gel (generic for Benzaclin®, Duac®, Neucac®)
 clindamycin/benzoyl peroxide with pump (generic for Benzaclin®)
 clindamycin/tretinoin (generic for Veltin®)
 Duac® Gel
 Epiduo® Gel / Gel Pump/ Forte
 Ery® Pads
 Erygel® Gel
 erythromycin gel / pledgets / solution (generic for Emcin®, Erycette®, EryDerm®, EryGel®, EryMax®, A/T/S®, T-Stat®)
 erythromycin-benzoyl peroxide gel (generic for Benzamycin®)
 Evoclin® Foam
 Fabior® Foam
 Inova® (4/1, 8/2)
 Klaron® Lotion
 Neucac® Gel / Kit
 Onexton® Gel / Gel Pump
 Ovace® Plus Cleansing Gel / Plus Cream / Plus Lotion / Plus Shampoo / Wash
 Promiseb® Complete
 Retin-A® / Micro Gel / Micro Pump Gel
 Rosula® Cloths / Wash
 Seb-Prev® Wash
 sodium sulfacetamide shampoo, wash (generic for Ovace® / Plus)
 sodium sulfacetamide cleanser / cream (generic for Avar® / LS)
 sodium sulfacetamide lotion (generic for Klaron®)
 sodium sulfacetamide sulfur cleanser / cloth (generic for Rosula®)
 sodium sulfacetamide sulfur kit / wash (generic for Sumadan®)
 sodium sulfacetamide sulfur lotion / suspension (generic for Novacet®, Plexion®, Zetacet®)
 sodium sulfacetamide sulfur pad / suspension / wash (generic for Suamxin®)
 SSS® 10-5 Cream / Foam
 sulfacetamide sulfur cream (generic for Avar® E, SSS® 10-5)
 Sulfacleanse® Suspension
 Sumadan® Kit / Wash / XLT Kit
 Sumaxin® Cleansing Pads / CP Kit / TS Topical Suspension / Wash
 tazarotene cream
 Tazorac® Cream / Gel
 tretinoin microsphere gel / gel pump (generic for Retin-A® Micro)
 tretinoin cream / gel (generic for Retin-A®)
 Veltin® Gel

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

	Virti-Sulf® Emollient Cream Ziana® Gel
TOPICALS	
ANDROGENIC AGENTS	
Preferred	
Androgel® Packet / Pump	Non-Preferred
	Androderm® Patch Axiron® Actuation Solution Fortesta® Gel Pump Natesto® Nasal Testim® Gel testosterone gel (generic for Testim, Vogelxo®) testosterone gel packet / pump (generic for Androgel, Vogelxo®) testosterone gel pump (generic for Fortesta®) Vogelxo® Gel / Gel Packet / Gel Pump
NSAIDS	
Preferred	
Voltaren Gel®	Non-Preferred
	diclofenac solution (generic for Pennsaid®) diclofenac topical gel (generic for Voltaren® Gel) Flector® Patch Pennsaid® Pump / Solution Pennsaid® Packet Klofensaid® II Vopac® MDS Xrylix®
ANTIBIOTIC	
Preferred	
Bactroban® Cream gentamicin cream / ointment (generic for Garamycin®) mupirocin ointment (generic for Bactroban® Ointment)	Non-Preferred
	Altanax® Ointment Bactroban® Ointment / Nasal Ointment Centany® AT Ointment Kit / Ointment mupirocin cream (generic for Bactroban® Cream)
ANTIBIOTIC - VAGINAL	
Preferred	
Cleocin® Vaginal Ovules Clindese® Vaginal Cream clindamycin vaginal cream (generic for Cleocin® Vaginal Cream) metronidazole vaginal gel (generic for Metrogel® Vaginal Gel) Vandazole® Vaginal Gel	Non-Preferred
	Cleocin® Vaginal Cream Nuversa® Vaginal Gel Metrogel® Vaginal Gel
TOPICALS	
ANTIFUNGAL	
Preferred	
ciclopirox cream (generic for Loprox® Cream) ciclopirox solution (generic for Penlac® Solution) clotrimazole RX cream (generic for Lotrimin® RX) clotrimazole-betamethasone cream (generic for Lotrisone® cream) ketoconazole cream / shampoo (generic for Nizoral®) Nyamyc® Powder (branded generic for Nystop®) nystatin cream / ointment / powder (generic for Mycostatin®, Nystop®) Nystop® Powder	Non-Preferred
	Bensal HP® Ciclodan® Cream / Cream Kit / Kit / Solution ciclopirox gel / shampoo / suspension (generic for Loprox®) ciclopirox treatment kit (generic for Ciclodan® Kit) clotrimazole-betamethasone lotion (generic for Lotrisone® lotion) clotrimazole RX solution (generic for Lotrimin® RX) CNL® 8 Nail Kit Dermacin® RX Therazole PAK econazole cream (generic for Spectazole®) Ertaczo® Cream Exelderm® Cream / Solution

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

	Extina® Foam Jublia® Topical Solution Kerydin® Topical Solution ketoconazole foam (generic for Extina® Foam) Loprox® suspension/cream/kit Loprox® Shampoo Lotrisone® Cream Luzu® Cream Mentax® Cream naftifine cream / gel (generic for Naftin® Cream / Gel) Naftin® Cream / Gel Nizoral® Shampoo nystatin-triamcinolone cream / ointment (generic for Mycolog II®) oxiconazole cream (generic for Oxistat®) Oxistat® Cream / Lotion Pediaderm AF® Kit Penlac® Solution Vusion® Ointment - Clinical criteria apply Xolegel® Gel
--	--

ANTIPARASITICS

Trial and failure of only one preferred drug required

Preferred	Non-Preferred
Eurax® Cream Natroba® Topical Suspension permethrin cream (generic for Elimite®) Sklice® Lotion	Elimite® Cream Eurax® Lotion lindane lotion / shampoo malathion lotion (generic for Ovide®) Ovide® Lotion spinosad topical suspension (generic for Natroba®) Ulesfia®

ANTIVIRAL

Preferred	Non-Preferred
Zovirax® Cream	acyclovir ointment/ AG (generic for Zovirax® Ointment) Denavir® Cream Xerese® Cream Zovirax® Ointment

IMMUNOMODULATORS

Atopic Dermatitis

Clinical criteria apply to all drugs in this class

Preferred	Non-Preferred
Elidel® Cream Eucrisa 2%® Ointment	Protopic® Ointment tacrolimus ointment (generic Protopic®) Dupixent®

Imidazoquinolinamines

Preferred	Non-Preferred
imiquimod cream packet (generic for Aldara®)	Aldara® Cream Zyclara® Cream / Cream Pump

TOPICALS

PSORIASIS

Preferred	Non-Preferred
calcipotriene cream / ointment / solution (generic for Dovonex®)	calcipotriene-betamethasone ointment (generic for Talconex®) Calcitrene® Ointment (branded generic for Dovonex®)

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

	calcitriol ointment (generic for Vectical®) Dovonex® Cream Enstilar® Foam Sorilux® Foam Taclonex® Ointment / Suspension Vectical® Ointment
--	---

ROSACEA AGENTS

Preferred	Non-Preferred
MetroGel® MetroCream® MetroLotion®	Finacea® Gel metronidazole gel (generic for MetroGel®) Mirvaso® Gel metronidazole cream (generic for MetroCream®) metronidazole lotion (generic for MetroLotion®) Noritate® Cream Rosadan® Cream / Gel / Kit Soolantra® Cream Rhofade®

STEROIDS

Low Potency

Preferred	Non-Preferred
alclometasone dipropionate cream / ointment (generic for Aclovate®) DermaSmoothe® FS Scalp and Body Oil hydrocortisone cream / gel/ lotion / ointment (generic for Hytone®) hydrocortisone in absorbbase	Aqua Glycolic® HC Kit Capex® Shampoo Desonate® Gel desonide cream / ointment (generic for DesOwen®) - Exemption for children < 12 years of age desonide lotion (generic for DesOwen® Lotion) DesOwen® Lotion fluocinolone body / scalp oil (generic for Derma-Smoothe® FS Scalp / Body Oil) Micort-HC Cream Pediaderm® HC Kit / TA Kit Texacort® Solution

Medium Potency

Preferred	Non-Preferred
fluticasone cream / ointment (generic for Cutivate®) mometasone cream / ointment / solution (generic for Elocon®)	clocortolone cream / pump (generic for Cloderm®) Cloderm® Cream / Pump Cordran® Tape Cutivate® Cream / Lotion Dermatop® Cream / Emollient Cream / Ointment Elocon® Cream / Lotion / Ointment fluocinolone cream / ointment / solution (generic for Synalar®) flurandrenolide cream/lotion (generic for Cordran® SP cream and Cordran® lotion) flurandrenolide ointment (generic for Cordran® ointment) fluticasone lotion (generic for Cutivate® Lotion) hydrocortisone butyrate cream / lipid cream / ointment / solution (generic for Locoid®) hydrocortisone valerate cream / ointment (generic for Westcort®) Locoid® Lotion Luxiq® Foam Pandel® Cream prednicarbate cream / ointment (generic for Dermatop®) Synalar® Cream / Ointment / Kit / Solution / TS Kit

TOPICALS

STEROIDS (Continued)

High Potency

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Preferred	
betamethasone valerate cream / lotion / ointment (generic for Valisone®) fluocinonide-solution (generic for Lidex® / Lidex® E) triamcinolone acetonide cream / lotion / ointment (generic for Kenalog®)	Non-Preferred
	amcinonide cream / lotion / ointment (generic for Cyclocort®) betamethasone dipropionate augmented cream / gel / lotion / ointment (generic for Diprolene®) betamethasone dipropionate cream / lotion / ointment (generic for Diprosone®) betamethasone valerate foam (generic for Valisone®) desoximetasone cream / gel / ointment (generic for Topicort®) diflorasone cream / ointment (generic for Florone®) Diprolene® Lotion / Ointment / AF Cream fluocinonide cream / emollient cream / gel (generic for Lidex® / Lidex® E) fluocinonide ointment (generic for Lidex® Ointment) Halog® Cream / Ointment Kenalog® Spray Sernivo® Spray Dermacin Silapak® Dermacin RX Silazone® Sanaderm®RX Solution Silazone®II Topicort® Cream / Gel / Ointment / Spray / LP triamcinolone spray (generic for Kenalog® Spray) Trianex® Ointment Vanos® Cream Vanos® Cream Ellzia®
Very High Potency	
Preferred	
clobetasol cream / emollient cream / gel / ointment (generic for Temovate®) clobetasol solution (generic for Cormax®) halobetasol propionate cream / ointment (generic for Ultravate®)	Non-Preferred
	Apexicon E® Cream clobetasol foam / emulsion foam (generic for Olux® / Olux-E®) clobetasol lotion / shampoo (generic for Clobex®) clobetasol spray (generic for Clobex® spray) Clobex® Lotion / Shampoo / Spray Clodan® Kit / Shampoo Olux® Foam / E-Foam Temovate® Cream / Emollient Cream / Ointment Ultravate® Cream / Ointment / X Cream Combo Pack / X Ointment Combo Pack Ultravate® Lotion
MISCELLANEOUS	
ANTIPSORIATICS, ORAL	
Preferred	
Acitretin (generic for Soriatane®)	Non-Preferred
	8-MOP® Methoxsalen Rapid (generic for Oxsoralen-Ultra®) Oxsoralen-Ultra® Soriatane® Soriatane®
EPINEPHRINE, SELF INJECTED	
Preferred	
epinephrine auto injector / JR (generic for Epi-Pen® Auto Injector / JR Auto Injector)	Non-Preferred
	Adrenaclick® Auto Injector Auvi-Q® Auto Injector epinephrine auto injector (generic for Adrenaclick®) Epi-Pen® Auto Injector / JR Auto Injector
ESTROGEN AGENTS, COMBINATIONS	
Preferred	

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

Activella® Tablet estradiol/norethindrone tablet (generic for Activella®) FemHRT® Tablet Jinteli® (branded generic for FemHRT®) Mimvey® / Lo (branded generic for Activella®) norethindrone-ethinyl estradiol (generic for FemHRT®) Prefest® Tablet Premphase® Tablet Prempro® Tablet	Non-Preferred Lopreeza® Tablet
PROGESTATIONAL AGENTS	
Preferred	Non-Preferred
Makena® (hydroxyprogesterone caproate injection) Compounded 17 P	
MISCELLANEOUS	
ESTROGEN AGENTS, ORAL/TRANSDERMAL	
Preferred	Non-Preferred
Cenestin® Tablet Climara® Patch / Pro Patch CombiPatch® Enjuvia® Tablet Estrace® Tablet estradiol patch (generic for Climara®, Menostar®) estradiol tablet (generic for Estrace®) estropipate tablet (generic for Ogen®) Evamist® Spray Menest® Tablet Premarin® Tablet Vivelle-Dot® Patch	Alora® Patch Divigel® Gel Packet Duavee® Tablet Elestrin® Gel estradiol patch (generic for Vivelle-Dot®) Menostar® Patch Mini-Velle® Patch
ESTROGEN AGENTS, VAGINAL PREPARATIONS	
Preferred	Non-Preferred
Estring® Vaginal Ring Premarin® Vaginal Cream Vagifem® Vaginal Tablet	Estrace® Cream estradiol vaginal tablet Femring® Vaginal Ring Yuvaferm® Intrarosa®
GLUCOCORTICOID STEROIDS, ORAL	
Preferred	Non-Preferred
budesonide EC capsule (generic for Entocort® EC) dexamethasone elixir / tablet (generic for Decadron®) dexamethasone solution (generic for Concedix®) hydrocortisone tablet (generic for Cortef®) methylprednisolone 4mg dosepack / tablet (generic for Medrol®) Orapred® ODT prednisolone sodium phosphate solution (generic for PediaPred®, OraPred®, Veripred®) prednisolone solution (generic for Prelone®, Millipred®) prednisone dose pack (generic for Sterapred®) prednisone solution / tablet (generic for Deltasone®)	Cortef® Tablet cortisone tablet (generic for Patisone®) Dexamethasone Intensol® Drops Dexpak® Tablet Emflaza® Entocort® EC Capsule Medrol® Dose Pack / Tablet methylprednisolone 8mg / 16mg / 32mg / tablet (generic for Medrol®) Millipred® Dose Pack / Tablet / Solution PediaPred® Solution prednisolone ODT (generic for Orapred® ODT) Prednisone Intensol® Concentrated Solution Rayos® Tablet Veripred® Solution

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

IMMUNOMODULATORS, SYSTEMIC

Clinical criteria apply to all drugs in this class

Trial and failure of only one preferred drug required

Preferred

Enbrel® Kit / Sureclick Syringe / Syringe
 Humira® Crohn's Starter Pack / Pediatric Crohn's Starter Pack / Pen / Psoriasis Starter Pack / Syringe

Non-Preferred

Actemra® Syringe / Vial
 Arcalyst® SQ Syringe
 Cimzia® Starter Kit / Syringe Kit / Vial Kit
 Cosentyx® Pen / Syringe
 Entyvio® Vial
 Ilaris® Injection
 Inflectra™ Vial
 Kevzara®
 Orencia® SQ Syringe / Clickjet
 Orencia® Vial
 Otezla® Starter Pack / Tablet
 Remicade® Injection
 Renflexis™ Injection
 Simponi® Aria Vial / Pen Injector / Syringe
 Stelara® Syringe
 Taltz® Auto-injector/syringe
 Xeljanz® Tablet/ Xeljanz®XR
 Siliq®
 Kineret® Syringe - **Exemption for diagnosis of Neonatal Onset: Multi-System Inflammatory Disease**

MISCELLANEOUS

IMMUNOSUPPRESSANTS

Preferred

Astagraf® XL Capsule
 Azasan® Tablet
 azathioprine tablet (generic for Imuran®)
 Cellcept® Capsule / Suspension / Tablet
 cyclosporine capsule / solution (generic for Sandimmune®)
 cyclosporine modified capsule / solution (generic for Gengraf®, Neoral®)
 Envarsus® XR Tablet
 Gengraf® Capsule / Solution
 Hecoria® Capsule
 Imuran® Tablet
 mycophenolate capsule / suspension / tablet (generic for Cellcept®)
 mycophenolic acid tablet (generic for Myfortic®)
 Myfortic® Tablet
 Neoral® Capsule / Solution
 Prograf® Capsule
 Rapamune® Solution / Tablet
 Sandimmune® Capsule / Solution
 sirolimus tablet (generic for Rapamune®)
 tacrolimus capsule (generic for Hecoria®, Prograf®)
 Zortress® Tablet

Non-Preferred

OPIOID ANTAGONIST

Preferred

naloxone ampule / syringe / vial (generic for Narcan®)
 naltrexone (oral)
 Narcan® Nasal Spray
 Vivitrol®

Non-Preferred

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.
 Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.
 In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.
 Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:
www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html
 More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>

OPIOID DEPENDENCE	
Clinical criteria apply to all drugs in this class	
Preferred	Non-Preferred
Suboxone® SL Film	Bunavail® Film buprenorphine sl tablet (generic for Subutex®) buprenorphine-naloxone sl tablet (generic for Suboxone®) Zubsolv® Tablet SL
SKELETAL MUSCLE RELAXANTS	
Preferred	Non-Preferred
baclofen tablet (generic for Lioresal®) chlorzoxazone tablet (generic for Parafon Forte®) cyclobenzaprine tablet (generic for Flexeril®) methocarbamol tablet (generic for Robaxin®) tizanidine tablet (generic for Zanaflex® Tablet)	Amrix® ER Capsule Dantrium® Capsule / Vial dantrolene sodium capsule (generic for Dantrium®) Fexmid® Tablet Lorzone® Tablet metaxalone tablet (generic for Skelaxin®) orphenadrine citrate ampule / tablet / vial (generic for Norflex®) Parafon® Forte Caplet Robaxin® Tablet / Vial Skelaxin® Tablet tizanidine capsules (generic for Zanaflex® Capsule) Zanaflex® Capsule / Tablet
DIABETIC SUPPLIES	
Roche Diagnostics Corporation is N.C. Medicaid's designated preferred manufacturer for glucose meters, diabetic test strips, control solutions, lancets, and lancing devices for Medicaid-primary recipients and Health Choice-primary recipients (dually eligible and third-party recipients are not affected). These products are covered under the Outpatient Pharmacy Program and can be submitted under the pharmacy point-of-sale system with a prescription. Diabetic supplies can also be submitted under Durable Medical Equipment using the NDC and HCPCS code. For questions or assistance regarding diabetic supplies, please call the Division of Medical Assistance at 919-855-4310 (DME), 919-855-4300 (Pharmacy) or Roche Diagnostics Corporation at 1-877-906-8969.	
Meters	Lancing Devices
ACCU-CHEK® Aviva Plus care kit ACCU-CHEK® Compact Plus care kit ACCU-CHEK® Nano SmartView care kit ACCU-CHEK® Guide Retail care kit	ACCU-CHEK® Softclix lancing device kit (Blue) ACCU-CHEK® Softclix lancing device kit (Black) ACCU-CHEK® Multiclix lancing device kit
Test Strips	Control Solutions
ACCU-CHEK® AVIVA 50 ct test strips ACCU-CHEK® AVIVA PLUS 50 ct test strips ACCU-CHEK® SMARTVIEW 50 ct test strips ACCU-CHEK® COMPACT Plus 51 ct test strips ACCU-CHEK® Guide 50 ct test strips	ACCU-CHEK® Fastclix lancing device kit ACCU-CHEK® Aviva glucose control solution (2 levels) ACCU-CHEK® Compact blue glucose control solution (2 levels) ACCU-CHEK® Compact Plus clear glucose control solution (2 levels) ACCU-CHEK® SmartView glucose control solution (1 level) ACCU-CHEK® Guide 2-Level control solution (2-levels)
Lancets	
ACCU-CHEK® Multiclix 102 ct Lancets ACCU-CHEK® Softclix 100 ct Lancets ACCU-CHEK® Fastclix 102 ct Lancets	

North Carolina Division of Medical Assistance
North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
Effective January 5, 2018

Trial and failure of two preferred drugs are required unless otherwise indicated.

Not all therapeutic drug classes are included on the PDL. All drugs in the classes not included are considered preferred.

In addition to trial and failure criteria, clinical criteria (indicated in **RED**) may also apply.

Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at:

www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html

More information on the PDL can be found at: <http://www.ncdhhs.gov/dma/pharmacy/index.htm>