

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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 March 1, 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®) indomethacin capsule (generic for Indocin®)	Anaprox® Tablet / DS Tablet Arthrotec® Tablet

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

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®)	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 celecoxib capsule (generic for Celebrex®) - Clinical criteria apply	Non-Preferred Celebrex® Capsule - Clinical criteria apply Duexis® Tablet Vimovo®

ANALGESICS

NEUROPATHIC PAIN

Preferred duloxetine capsule (generic for Cymbalta®) gabapentin capsule / solution (generic for Neurontin®)	Non-Preferred Cymbalta® Capsule Gralise® Starter Pack / Tablet Horizant® Irenka® Capsule Lyrica® Capsule / Solution Neurontin® Capsule / Solution / Tablet Savella® Tablet / Titration Pack
--	---

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

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
 Onfi® Suspension / Tablet
 Potiga® Tablet

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

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
 Flagyl® Capsule / ER Tablet/ Tablet
 metronidazole capsule (generic for Flagyl® Capsule)

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

	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
--	---

Quinolones

Preferred	Non-Preferred
Avelox® Tablet Cipro® Suspension ciprofloxacin tablets (generic for Cipro®) levofloxacin tablet (generic for Levaquin® Tablet)	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®)

ANTI-INFECTIVES-SYSTEMIC

ANTIBIOTICS (Continued)

Tetracycline Derivatives

Preferred	Non-Preferred
doxycycline hyclate capsule / tablet (generic for Vibramycin®, Vibra-Tab®) doxycycline monohydrate 50mg, 100mg capsule (generic for Monodox®) minocycline capsule (generic for Minocin®)	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

Antifungals

Preferred	Non-Preferred
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®)	Ancobon® Capsule Cresemba® 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 Noxafil® Suspension / Tablet Onmel® Tablet Oravig® Buccal Tablet

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

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

Mavyret™ (8 weeks of therapy)

All genotypes with compensated cirrhosis (Child Pugh-A)

Mavyret™ (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)

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

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

All genotypes without cirrhosis

Mavyret™ (8 weeks of therapy)

All genotypes with compensated cirrhosis (Child Pugh-A)

Mavyret™ (12 weeks of therapy)

All genotypes with decompensated cirrhosis

Epclusa® Tablet in combination with ribavirin

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

North Carolina Division of Medical Assistance
North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
Effective March 1, 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>

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™

Herpes Treatments

Preferred

acyclovir capsule / tablet / suspension (generic for Zovirax®)
famciclovir tablet (generic for Famvir®)
valacyclovir tablet (generic for Valtrex®)

Non-Preferred

Famvir® Tablet
Sitavig® Buccal Tablet
Valtrex® Caplet
Zovirax® Capsule / Tablet / Suspension

Influenza

Preferred

amantadine capsule / solution (generic for Symmetrel®)
rimantadine tablet (generic for Flumadine®)
Tamiflu® Capsule / Suspension

Non-Preferred

amantadine tablet (generic for Symmetrel®)
oseltamivir phosphate
Relenza® Diskhaler

Antibiotics, Inhaled

Trial and failure of only one preferred drug required

Preferred

Kitabis™ Pak (tobramycin inhalation solution)
Bethkis® (tobramycin inhalation solution)

Non-Preferred

Cayston®
tobramycin solution / pak
Tobi®

BEHAVIORAL HEALTH

ANTIDEPRESSANTS

Other

Preferred

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)

Non-Preferred

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

BEHAVIORAL HEALTH

ANTIDEPRESSANTS (Continued)

Selective Serotonin Reuptake Inhibitor (SSRI)

Preferred

citalopram solution / tablet (generic for Celexa®)
escitalopram tablet (generic for Lexapro® Tablet)
fluoxetine capsule / solution (generic for Prozac®)
fluvoxamine tablet (generic for Luvox®)

Non-Preferred

Brisdelle® Capsule
Celexa® Tablet
escitalopram solution (generic for Lexapro® Solution)
fluoxetine DR capsules (generic for Prozac® Weekly)

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

paroxetine tablet (generic for Paxil®) sertraline concentrated solution / tablet (generic for Zoloft®)	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 Concerta® Tablet 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®) 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

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	Abilify® Tablet aripiprazole ODT (generic for Abilify®) Clozaril® Tablet Fanapt® Titration Pack Fanapt® Tablet

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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.ncdhs.gov/dma/pharmacy/index.htm>

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®) ziprasidone capsule (generic for Geodon®)	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®) 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 either a preferred or non-preferred Angiotensin II Receptor Blocker

Preferred	Non-Preferred
-----------	---------------

North Carolina Division of Medical Assistance
North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
Effective March 1, 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>

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	

ANTI-ARRHYTHMICS

Preferred	Non-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	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

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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

BETA BLOCKERS

Preferred	Non-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®)	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	Non-Preferred
atenolol-chlorthalidone tablet (generic for Tenoretic®) bisoprolol-HCTZ tablet (generic for Ziac®)	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	Non-Preferred
cholestyramine light packet / light powder / packet / powder (generic for Questran® / Light) colestipol tablet (generic for Colestid® Tablet)	colestipol granules (generic for Colestid® Granules) Colestid® Granules / Tablet Prevalite® Packet / Powder Questran® Light Powder / Packet / Powder Welchol® Packet / Tablet

CARDIOVASCULAR

CHOLESTEROL LOWERING AGENTS

Preferred	Non-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)	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

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

	Vytorin® Tablet Zocor® Tablet Juxtapid® Capsule - Clinical criteria apply Kynamro® Syringe - Clinical criteria apply
--	---

CORONARY VASODILATORS

Preferred	Non-Preferred
isosorbide dinitrate tablet / ER (generic for Isordil Titrados®e, 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	Dilatrate® SR Capsule Gonitro® Sublingual Powder Isordil® Tablet / Titrados®e Tablet Nitro-Bid® Ointment Nitro-Dur® Patch Nitrolingual® Spray Nitromist® Spray

DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKERS

Preferred	Non-Preferred
Afeditab 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®)	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 a either a preferred or non-preferred Direct Renin Inhibitor

Preferred	Non-Preferred
Tekturna® HCT Tablet Tekturna® Tablet	

ENDOTHELIN RECEPTOR ANTAGONISTS

Preferred	Non-Preferred
Letairis® Tablet Tracleer® Tablet	Opsumit® Tablet

CARDIOVASCULAR

INHALED PROSTACYCLIN ANALOGS

Preferred	Non-Preferred
Tyvaso® Refill Kit / Solution / Starter Kit Ventavis® Solution	

NIACIN DERIVATIVES

Preferred	Non-Preferred
niacin ER tablet (generic for Niaspan®)	Niacor® Tablet Niaspan® ER Tablet

NITRATE COMBINATION

Preferred	Non-Preferred
Bidil® Tablet	

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

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
 Upravi® 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

SYMPATHOLYTICS AND COMBINATIONS

Preferred

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

Non-Preferred

Catapres® Tablet
 clonidine patches (generic for Catapres®-TTS)
 Clorpres® Tablet (branded generic for Combipres®)
 methyldopa-HCTZ tablet (generic for Aldoril®)
 methyldopate 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®, ~~Tricor®~~)
 fenofibrate tablet (generic for Fenoglide®)
 fenofibric acid capsule / tablet (generic for Fibricor®, ~~Trilipix®~~)
 Fenoglide® Tablet
 Fibricor® Tablet

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

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

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

benztropine 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®)

Non-Preferred

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

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

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

Avonex® Pack / Pen / Syringe
 Betaseron® Kit / Vial
 Copaxone® Syringe
 Gilenya® Capsule
 Rebif® Ribidose / Titration Pack / Syringe
 Tecfidera® Capsule / Starter Pack

Non-Preferred

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

flurazepam capsule (generic for Dalmane®)
 temazepam 15mg, 30mg capsule (generic for Restoril®)
 zolpidem tablet (generic for Ambien®)

Non-Preferred

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
 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

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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.ncdhs.gov/dma/pharmacy/index.htm>

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

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

Non-Preferred

Trial and failure of only one preferred drug required

Basaglar Kwikpen®
 Tresiba® Flextouch
 Toujeo® Solostar

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

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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.ncdhs.gov/dma/pharmacy/index.htm>

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	Non-Preferred
Byetta® Pen Bydureon® Pen / Vial Tanzeum® Pen Injector	<p style="text-align: center;">Continuation of therapy requires documentation that clinical goals have been met</p> Adlyxin® Injection Soliqua® Injection Trulicity® Pen Victoza® Pen Xultophy® Injection

HYPOGLYCEMICS - ORAL

2nd Generation Sulfonylureas

Preferred	Non-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	

Alpha-Glucosidase Inhibitors

Preferred	Non-Preferred
acarbose tablet (generic for Precose®) Glyset® Tablet	miglitol tablet (generic for Glyset®) Precose® Tablet

Biguanides and Combinations

Preferred	Non-Preferred
glipizide-metformin tablet (generic for Metaglip®) 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

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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
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

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

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

	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	Non-Preferred
megestrol suspension / tablet (generic for Megace®)	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	<p style="text-align: center; color: red;">Exemption for children < 12 years of age</p> 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

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

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 Giazol® 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®) terazosin capsule (generic for Hytrin®)	Avodart® Softgel Cardura® Tablet / XL Tablet dutasteride/ tamsulosin capsule (generic Jalyn capsule®) Flomax® Capsule 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

GENITOURINARY/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)

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

trospium tablet / ER capsule (generic for Sanctura® / XR)

GOUT

Preferred

allopurinol tablet (generic for Zyloprim®)
 colchicine capsule (generic for Mitigare®)
 probenecid tablet (generic for Benemid®)
 probenecid-colchicine tablet (generic for Col-Benemid®)

Non-Preferred

colchicine tablet (generic for Colcrys®)
 Colcrys® Tablet
 Mitigare® Capsule
 Uloric® Tablet
 Zyloprim® Tablet
 Zurampic® Tablet

HEMATOLOGIC

ANTICOAGULANTS

Injectable

Preferred

Fragmin® Syringe / Vial
 Lovenox® Syringe / Vial

Non-Preferred

Arixtra® Syringe
 enoxaparin syringe / vial (generic for Lovenox®)
 fondaparinux syringe (generic for Arixtra®)

Oral

Preferred

Coumadin® Tablet
 Eliquis® Tablet
 Jantoven® (branded generic for Coumadin®)
 Pradaxa® Capsule
 Savaysa® Tablet
 warfarin tablet (generic for Coumadin®)
 Xarelto® Starter Pack / Tablet

Non-Preferred

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
 Alex® 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

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

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®)
 Tobradex® Drops / Ointment

Non-Preferred

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 Ocutricin®)
 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

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 Inflammase Forte®)

Non-Preferred

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

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

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®) Simbrinza® Drops	Cosopt® Drops / PF Drops Trusopt® Drops

Prostaglandin Agonists

Preferred	Non-Preferred
latanoprost drops (generic for Xalatan®) Travatan® Z Drops	bimatoprost (generic for Lumigan® Drops) Lumigan® Drops travoprost drops (generic for Travatan®) Xalatan® Drops Zioptan® Drops

OSTEOPOROSIS

BONE RESORPTION SUPPRESSION AND RELATED AGENTS

Preferred	Non-Preferred
alendronate tablet (generic for Fosamax®) Evista® Tablet Fortical® Nasal Spray	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	Non-Preferred
Ciprodex® Suspension	Cipro® HC Suspension

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

neomycin-polymyxin-hydrocortisone solution / suspension (generic for Cortisporin®)	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	Non-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®)	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	Non-Preferred
Serevent® Diskus	Arcapta® Neohaler Striverdi® Respimat Inhalation Spray

BETA-ADRENERGIC HANDHELD, SHORT ACTING

Preferred	Non-Preferred
Proair® HFA Inhaler Proventil® HFA Inhaler	Proair Respiclick® Ventolin® HFA Inhaler Xopenex® HFA Inhaler

BETA-ADRENERGIC NEBULIZERS

Preferred	Non-Preferred
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	Brovana® Solution levalbuterol solution / concentrate solution (generic for Xopenex® / Concentrate) Perforomist® Solution Xopenex® Solution / Concentrate Solution

RESPIRATORY

BETA-ADRENERGIC - ORAL

Preferred	Non-Preferred
albuterol tablets (generic for Proventil® Repetabs) albuterol syrup (generic for Ventolin® Syrup) metaproterenol syrup (generic for Alupent® Syrup) terbutaline tablet (generic for Brethine®)	albuterol ER tablets (generic for VoSpire® ER) metaproterenol tablet (generic for Alupent® Tablet) VoSpire® ER Tablet

COPD AGENTS

Preferred	Non-Preferred
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	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

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

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

Preferred

Flovent® HFA Inhaler
 Pulmicort® Respules 0.25mg, 0.5mg, 1mg
 QVAR® Inhaler (discontinued)

Non-Preferred

Aerospan® Inhaler
 Alvesco® Inhaler
 Arnuity Elipta® Inhaler
 Asmanex® HFA Inhaler
 Asmanex® Twisthaler
 budesonide suspension (generic for Pulmicort® Respules)
 Flovent® Diskus
 Pulmicort® Flexhaler
 QVAR® RediHaler™

CORTICOSTEROID COMBINATION

Clinical criteria apply to all drugs in this class

Preferred

Advair® Diskus
 Dulera® Inhaler
 Symbicort® Inhaler

Non-Preferred

Advair® HFA Inhaler
 Breo Elipta®
 AirDuo®
 fluticasone/salmeterol (generic for AirDuo®)

INTRANASAL RHINITIS AGENTS

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

Non-Preferred

Exemption for steroids applies to children < 4 years of age

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

montelukast chewable / granules / tablet (generic for Singulair®)
 zafirlukast tablet (generic for Accolate®)

Non-Preferred

Accolate® Tablet
 Singulair® Chewable / Granules / Tablet
 Zyflo® CR Tablet / Filmtab
 zileuton

LOW SEDATING ANTIHISTAMINES

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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
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

Preferred	Non-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	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®, Neuac®) 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 Neuac® Gel / Kit Onexton® Gel / Gel Pump Ovace® Plus Cleansing Gel / Plus Cream / Plus Lotion / Plus Shampoo / Wash

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

	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 Virti-Sulf® Emollient Cream Ziana® Gel
--	--

TOPICALS

ANDROGENIC AGENTS

Preferred	Non-Preferred
Androgel® Packet / Pump	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	Non-Preferred
Voltaren Gel®	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	Non-Preferred
Bactroban® Cream gentamicin cream / ointment (generic for Garamycin®) mupirocin ointment (generic for Bactroban® Ointment)	Altabax® Ointment Bactroban® Ointment / Nasal Ointment Centany® AT Ointment Kit / Ointment mupirocin cream (generic for Bactroban® Cream)

ANTIBIOTIC - VAGINAL

Preferred	Non-Preferred
------------------	----------------------

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

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	Cleocin® Vaginal Cream Nuvessa® Vaginal Gel Metrogel® Vaginal Gel
---	---

TOPICALS

ANTIFUNGAL

Preferred	Non-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	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 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 Pediaerm 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

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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

Atopic Dermatitis

Clinical criteria apply to all drugs in this class

Preferred

Elidel® Cream
 Eucrisa 2%® Ointment

Non-Preferred

Protopic® Ointment
 tacrolimus ointment (generic Protopic®)
 Dupixent®

Imidazoquinolinamines

Preferred

imiquimod cream packet (generic for Aldara®)

Non-Preferred

Aldara® Cream
 Zyclara® Cream / Cream Pump

TOPICALS

PSORIASIS

Preferred

calcipotriene cream / ointment / solution (generic for Dovonex®)

Non-Preferred

calcipotriene-betamethasone ointment (generic for Talconex®)
 Calcitrene® Ointment (branded generic for Dovonex®)
 calcitriol ointment (generic for Vectical®)
 Dovonex® Cream
 Enstilar® Foam
 Sorilux® Foam
 Taclonex® Ointment / Suspension
 Vectical® Ointment

ROSACEA AGENTS

Preferred

MetroGel®
 MetroCream®
 MetroLotion®

Non-Preferred

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

alclometasone dipropionate cream / ointment (generic for Aclovate®)
 DermaSmoothe® FS Scalp and Body Oil
 hydrocortisone cream / gel/ lotion / ointment (generic for Hytone®)
 hydrocortisone in absorbable

Non-Preferred

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

fluticasone cream / ointment (generic for Cutivate®)
 mometasone cream / ointment / solution (generic for Elocon®)

Non-Preferred

clocortolone cream / pump (generic for Cloderm®)
 Cloderm® Cream / Pump

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

	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

Preferred	Non-Preferred
betamethasone valerate cream / lotion / ointment (generic for Valisone®) fluocinonide-solution (generic for Lidex® / Lidex® E) triamcinolone acetonide cream / lotion / ointment (generic for Kenalog®)	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	Non-Preferred
clobetasol cream / emollient cream / gel / ointment (generic for Temovate®) clobetasol solution (generic for Cormax®) halobetasol propionate cream / ointment (generic for Ultravate®)	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

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

MISCELLANEOUS

ANTIPSORIATICS, ORAL

Preferred	Non-Preferred
Acitretin (generic for Soriatane®)	8-MOP® Methoxsalen Rapid (generic for OxSORALEN-ULTRA®) OxSORALEN-ULTRA® Soriatane® Soriatane®

EPINEPHRINE, SELF INJECTED

Preferred	Non-Preferred
epinephrine auto injector / JR (generic for Epi-Pen® Auto Injector / JR Auto Injector)	AdrenaClick® Auto Injector Auvi-Q® Auto Injector epinephrine auto injector (generic for AdrenaClick®) Epi-Pen® Auto Injector / JR Auto Injector

ESTROGEN AGENTS, COMBINATIONS

Preferred	Non-Preferred
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	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 Yuvafem®

North Carolina Division of Medical Assistance
 North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
 Effective March 1, 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>

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

IMMUNOMODULATORS, SYSTEMIC

Clinical criteria apply to all drugs in this class

Trial and failure of only one preferred drug required

Preferred	Non-Preferred
Enbrel® Kit / Sureclick Syringe / Syringe Humira® Crohn's Starter Pack / Pediatric Crohn's Starter Pack / Pen / Psoriasis Starter Pack / Syringe	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	Non-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®)	

North Carolina Division of Medical Assistance
North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
Effective March 1, 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>

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	
--	--

OPIOID ANTAGONIST

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

OPIOID DEPENDENCE

Clinical criteria apply to all drugs in this class
Trial and failure of only one preferred required
For coverage of Sublocade- must have diagnosis of moderate to severe opioid use disorder and have initiated treatment with a transmucosal buprenorphine-containing product followed by a dose adjustment period for a minimum of seven days.

Preferred	Non-Preferred
Suboxone® SL Film Sublocade™	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® Fastclix lancing device kit

North Carolina Division of Medical Assistance
North Carolina Medicaid and Health Choice Preferred Drug List (PDL)
Effective March 1, 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>

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

Lancets

ACCU-CHEK® Multiclix 102 ct Lancets
ACCU-CHEK® Softclix 100 ct Lancets
ACCU-CHEK® Fastclix 102 ct Lancets

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)