

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>  
More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

Yellow shade signifies a new product being added as a new to market Non-Preferred product OR current coverage is being clarified

Orange shade signifies a significant change to the drug, category, or a clinical recommendation

Pink Shade signifies an Off-Cycle PDL move from Preferred to Non-Preferred or vice versa

Green shade signifies a Brand / Generic switch within the same category

Peach shade signifies categories that will be open for discussion even though there are no recommendations in that category

Purple shade signifies a product either no longer covered (rebatable) or no longer available from the manufacturer

**ALZHEIMER'S AGENTS**

Preferred	Non-Preferred
donepezil 5mg, 10mg tablet / ODT (generic for Aricept® / ODT)	Adlarity® Patch
Exelon® Patch	Aduhelm® Vial - <b>Clinical Criteria Apply</b>
memantine tablet / titration pack (generic for Namenda®)	Aricept® Tablet
rivastigmine capsule (generic for Exelon®)	donepezil 23mg tablet (generic for Aricept®)
	galantamine ER capsule / solution / tablet (generic for Razadyne® / ER)
	Leqembi® Vial - <b>Clinical Criteria Apply</b>
	memantine ER capsule / solution (generic for Namenda® XR / Solution)
	Namenda® Tablet / Titration Pack / XR Capsule / XR Titration Pack
	Namzaric® Capsule / Titration Pack
	rivastigmine (Transdermal) (generic for Exelon® Patch)

**ANALGESICS**

**OPIOID ANALGESICS**

**Long Acting Opioids**

**Clinical criteria apply to all drugs in this class**

Preferred	Non-Preferred
Butrans® Patch	Belbuca® (Buccal) Film
fentanyl patch 12mcg / 25mcg / 50mcg / 75mcg / 100mcg (generic for Duragesic®)	buprenorphine patch (generic for Butrans® Patch)
methadone concentrate / disks / intensol / tablets / solution	Conzip® Capsule
morphine sulfate ER tablet (generic for MS Contin®)	fentanyl patch (37.5, / 62.5 / 87.5mcg dosages) (generic for Duragesic®)
OxyContin® Tablet	hydrocodone ER capsule (generic for Zohydro® ER)
tramadol ER tablet (generic for Ultram ER®, Ryzolt®)	hydrocodone ER tablet (generic for Hysingla® ER)
Xtampza® ER Capsule	hydromorphone ER tablet (generic for Exalgo®)
	Hysingla® ER Tablet
	<b>Kadian® Capsule</b>
	morphine sulfate ER capsule (generic for Avinza®, Kadian®)
	MS Contin® Tablet
	Nucynta® ER Tablet
	oxycodone ER tablet (generic for OxyContin®)
	oxymorphone ER tablet
	tramadol ER capsule (generic for Conzip®)

**Remove Kadian® Capsule**

**Orally Disintegrating / Oral Spray Schedule II Opioids**

**Clinical criteria apply to all drugs in this class**

Preferred	Non-Preferred
Actiq® Lozenge	Dsuvia™ SL Tablet
	fentanyl citrate buccal tablet (generic for Fentora®)
	fentanyl citrate lozenge (generic for Actiq®)
	Fentora® Buccal Tablet

**Short Acting Schedule II Opioids**

**Clinical criteria apply to all drugs in this class**

Preferred	Non-Preferred
Endocet® Tablet (branded generic for Percocet®)	codeine sulfate tablet
hydrocodone-acetaminophen solution / tablet (generic for Hycet®, Lorcet®, Lortab®, Norco®, Vicodin®)	Dilaudid® Liquid / Tablet
hydrocodone-ibuprofen tablet (generic for Ibudone®, Reprexain®, Vicoprofen®)	hydromorphone solution / suppository (generic for Dilaudid®)
hydromorphone tablet (generic for Dilaudid®)	levorphanol tablet (generic for Levo-Dromoran®)
morphine solution / tablet (generic for MSIR®)	mepredine solution / tablet (generic for Demerol®)
oxycodone solution / tablet (generic for Roxicodone®)	morphine oral syringe
oxycodone-acetaminophen capsules (generic for Tylox®)	morphine suppositories (generic for Roxanol®)
oxycodone-acetaminophen tablets (generic for Percocet®)	Nalocet® Tablet
	Nucynta® Tablet
	oxycodone capsule (generic for OxyIR®)
	oxycodone concentrated solution (generic for Roxicodone® Intensol)
	oxycodone-acetaminophen solution
	oxymorphone tablet (generic for Opana®)
	Percocet® Tablet
	Prolate® Tablet / Solution
	Roxicodone® Tablet
	Roxybond® Tablet

**Short Acting Schedule III – IV Opioids / Analgesic Combinations**

**Clinical criteria apply to all drugs in this class**

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

Preferred	Non-Preferred
codeine-acetaminophen solution / tablet (generic for Tylenol with Codeine <sup>®</sup> )	Ascomp <sup>®</sup> Capsule (branded generic for Fiorinal with Codeine <sup>®</sup> )
tramadol tablet (generic for Ultram <sup>®</sup> )	butalbital compound with codeine capsule (generic for Fiorinal with Codeine <sup>®</sup> )
tramadol-acetaminophen tablet (generic for Ultracet <sup>®</sup> )	butalbital-caffeine-APAP with codeine tablet (generic for Fioricet with Codeine <sup>®</sup> )
	butorphanol spray (generic for Stadol <sup>®</sup> )
	dihydrocodeine-acetaminophen-caffeine tablet (generic for Panlor SS <sup>®</sup> )
	Fioricet with Codeine <sup>®</sup> Capsule
	pentazocine-naloxone tablet (generic for Talwin NX <sup>®</sup> )
	Seglentis <sup>®</sup> Tablet
	tramadol solution (generic for Qdolo <sup>®</sup> )
	tramadol tablet (25 mg)

**Add new to market product tramadol tablet (25 mg) as Non- Preferred**

NSAIDS	
Preferred	Non-Preferred
celecoxib capsule (generic for Celebrex <sup>®</sup> )	Arthrotec <sup>®</sup> Tablet
ibuprofen suspension / tablet (generic for Motrin <sup>®</sup> )	Celebrex <sup>®</sup> Capsule
indomethacin capsule (generic for Indocin <sup>®</sup> )	Daypro <sup>®</sup> Caplet
ketorolac tablet (generic for Toradol <sup>®</sup> )	diclofenac potassium capsule (generic for Zipsor <sup>®</sup> )
meloxicam tablet (generic for Mobic <sup>®</sup> )	diclofenac potassium tablet (generic for Cataflam <sup>®</sup> )
naproxen EC / DR tablet (generic for Naprosyn <sup>®</sup> EC)	diclofenac sodium tablet / ER tablet (generic for Voltaren <sup>®</sup> / XR)
naproxen tablet (generic for Naprosyn <sup>®</sup> )	diclofenac sodium-misoprostol tablet (generic for Arthrotec <sup>®</sup> )
sulindac tablet (generic for Clinoril <sup>®</sup> )	diffunisal tablet (generic for Dolobid <sup>®</sup> )
	Duexis <sup>®</sup> Tablet - <b>Trial and failure of only celecoxib required</b>
	etodolac capsule / tablet / ER tablet (generic for Lodine <sup>®</sup> / XL)
	Feldene <sup>®</sup> Capsule
	fenoprofen capsule/ tablet (generic for Nalfon <sup>®</sup> )
	flurbiprofen tablet (generic for Ansaid <sup>®</sup> )
	ibuprofen / famotidine tablet (generic for Duexis <sup>®</sup> ) <b>Trial and failure of only celecoxib required</b>
	indomethacin ER capsule (generic for Indocin SR <sup>®</sup> )
	indomethacin suppository
	ketoprofen capsule (generic for Orudis <sup>®</sup> )
	ketoprofen ER capsule (generic for Oruvail <sup>®</sup> )
	ketorolac tromethamine nasal spray (generic for Sprix <sup>®</sup> )
	Lofena <sup>™</sup> Tablet
	meclfenamate capsule (generic for Meclomen <sup>®</sup> )
	mefenamic acid capsule (generic for Ponstel <sup>®</sup> )
	meloxicam capsule (generic for Vivlodex <sup>®</sup> )
	Mobic <sup>®</sup> Tablet
	nabumetone tablet (generic for Relafen <sup>®</sup> )
	Nalfon <sup>®</sup> Capsule / Tablet
	Naprelan <sup>®</sup> Tablet
	naproxen sodium ER tablet (generic for Naprelan <sup>®</sup> )
	naproxen sodium tablet (generic for Anaprox <sup>®</sup> )
	naproxen suspension (generic for Naprosyn <sup>®</sup> )
	naproxen-esomeprazole tablet (generic for Vimovo <sup>®</sup> Tablet) - <b>Trial and failure of only celecoxib required</b>
	oxaprozin tablet (generic for DayPro <sup>®</sup> )
	piroxicam capsule (generic for Feldene <sup>®</sup> )
	Relafen <sup>™</sup> DS Tablet
	tolmetin tablet (generic for Tolectin <sup>®</sup> )
	Vimovo <sup>®</sup> Tablet - <b>Trial and failure of only celecoxib required</b>

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

NEUROPATHIC PAIN	
Preferred	Non-Preferred
duloxetine capsule (generic for Cymbalta®)	Cymbalta® Capsule
gabapentin capsule / solution / tablet (generic for Neurontin®)	DermacinRx™ Lidocaine Patch - <b>Clinical criteria apply</b>
lidocaine patch (generic for Lidoderm®) - <b>Clinical criteria apply</b>	Drizalma™ Sprinkle
pregabalin capsule / solution (generic for Lyrica®)	duloxetine capsule (generic for Irenka®)
	Gralise® Tablet
	Horizant® Tablet
	Lidocan® II / III (lidocaine) Patch
	Lidoderm® Patch - <b>Clinical criteria apply</b>
	Lyrica® Capsule / Solution / CR Tablet
	Neurontin® Capsule / Solution / Tablet
	pregabalin ER tablet (generic for Lyrica® CR)
	Quenza® Kit
	Savella® Tablet / Titration Pack
	Xvliderm™ Kit - <b>Clinical criteria apply</b>
	ZTLido™ Patch - <b>Clinical criteria apply</b>
<b>Add new to market products Lidocan™ II / III (lidocaine) Patch as Non-Preferred</b>	
ANTICONSULSANTS	
CARBAMAZEPINE DERIVATIVES	
<b>Patients with a diagnosis of seizure disorder are exempt from trial and failure criteria and may use any carbamazepine product.</b>	
Preferred	Non-Preferred
Aptiom® Tablet	Carbatrol® Capsule
carbamazepine chewable tablet (generic for Tegretol®)	carbamazepine suspension / tablet (generic for Tegretol®)
carbamazepine ER capsule (generic for Carbatrol®)	carbamazepine XR tablet (generic for Tegretol XR®)
Equetro® Capsule	Epitol® Tablet
oxcarbazepine suspension / tablet (generic for Trileptal®)	Trileptal® Tablet
Oxtellar® XR Tablet	
Tegretol® Suspension / Tablet / XR Tablet	
Trileptal® Suspension	
FIRST GENERATION	
<b>Patients with a diagnosis of seizure disorder are exempt from trial and failure criteria and may use any first generation product.</b>	
Preferred	Non-Preferred
Celontin® Kapsal	Depakote® ER Tablet / Sprinkle Capsule
Dilantin® Capsule / Infatab / Suspension	Depakote® Tablet
divalproex sprinkle capsule / ER tablet / tablet (generic for Depakote® / ER / Sprinkle)	felbamate tablet (generic for Felbatol®)
ethosuximide capsule / solution (generic for Zarontin®)	methsuximide capsule (generic for Celontin®)
felbamate suspension (generic for Felbatol®)	Mysoline® Tablet
Felbatol® Suspension / Tablet	Sezaby™ Vial
phenobarbital tablet / elixir / solution	Zarontin® Capsule / Solution
Phenytek® Capsule	
phenytoin chewable / extended capsules / infatab / suspension (generic for Dilantin®)	
phenytoin extended capsules (generic for Phenytek®)	
primidone Tablet (generic for Mysoline®)	
valproic acid capsule / solution (generic for Depakene®)	
<b>Remove Sezaby™ Vial</b>	
SECOND GENERATION	
<b>Patients with a diagnosis of seizure disorder are exempt from trial and failure criteria and may use any second generation product.</b>	
Preferred	Non-Preferred
Banzel® Suspension / Tablet	Banzel® Suspension
Briviact® Tablet / Solution	clonazepam ODT (generic for Klonopin® Wafer)
clobazam suspension / tablet (generic for Onfi®)	Elepsia™ XR Tablet
clonazepam tablet (generic for Klonopin®)	Keppra™ Tablet / Solution / XR Tablet
Diacomit® Capsule / Powder Pack	Klonopin® Tablet
Diastat® Acudial™ / Pedi System	Lamictal® Chewable / ODT / ODT Starter Kit / Starter Kit / Tablet / XR / XR Starter Kit
diazepam rectal / system (generic for Diastat® Accudial / Pedi System)	lamotrigine starter kits (generic for Lamictal®)
Epidiolex® Solution - <b>Clinical Criteria Apply</b>	Lyrica® Capsule / Solution
Eprontia™ Solution	Motoply XR™ (lacosamide extended release) Capsule
Fintepla® Solution	Neurontin® Capsule / Solution / Tablet
Fycompa® Tablet / Suspension	Onfi® Suspension / Tablet
gabapentin capsule / solution / tablet (generic for Neurontin®)	Quexy® XR Capsule
Gabitril® Tablet	rufinamide suspension / tablet (generic for Banzel®)
lacosamide solution / tablet (generic for Vimpat®)	Spritam® Tablet
lamotrigine chewable / tablet (generic for Lamictal®)	Sympazan® Film
lamotrigine ER tablet / ODT / ODT Starter Kit / Starter Kit (generic for Lamictal® XR / ODT)	Topamax® Sprinkle Capsule / Tablet
levetiracetam tablet / ER tablet / solution (generic for Keppra® / XR)	topiramate ER capsule (generic for Quexy®)
Nayzilam® Nasal Spray	topiramate ER capsule (generic for Trokendi XR®) - <b>Trial and Failure of Trokendi® XR Capsule Required for Coverage</b>
Rowepra™ Tablet	Trokendi® XR Capsule
rufinamide suspension (generic for Banzel®)	vigabatrin tablet (generic for Sabril®)
Sabril® Tablet / Powder Packet	Vigadrone® Powder Packet
Subvenite® Tablet / Tab Start Kit	Vigadrone® (vigabatrin) Tablet
tiagabine tablet (generic for Gabitril®)	Vimpat® Solution / Starter Kit / Tablet
topiramate sprinkle capsule / tablet (generic for Topamax®)	Zonisade™ Oral Suspension
Valtoco® Nasal Spray	Zialmy® Oral Suspension

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>  
More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

vigabatrin powder packet (generic for Sabril®)	
Xcopri® Tablet / Titration Pack	
zonisamide capsule (generic for Zonegran®)	
<b>Add new to market product Motoply XR™ (lacosamide extended release) Capsule as Non-Preferred</b> <b>Add Vigadrone® (vigabatrin) Tablet as Non-Preferred</b> <b>Brand-Generic Switch: move rufinamide suspension (generic for Banzel®) to Preferred and move Banzel® Suspension to Non-Preferred</b>	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.htm>  
More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

ANTI-INFECTIVES - SYSTEMIC	
ANTIBIOTICS	
Penicillins, Cephalosporins and Related	
Preferred	Non-Preferred
amoxicillin capsule / chewable / suspension / tablet (generic for Amoxil <sup>®</sup> , Trimox <sup>®</sup> )	amoxicillin-clavulanate chewable tablet (generic for Augmentin <sup>®</sup> )
amoxicillin-clavulanate suspension / tablet / XR tablet (generic for Augmentin <sup>®</sup> / XR)	Augmentin <sup>®</sup> Suspension / ES-600 / XR Tablet
ampicillin capsule / injection / vial	cefaclor capsule / suspension / ER tablet (generic for Ceclor <sup>®</sup> / CD)
ampicillin-sulbactam injection / vial	cefadroxil tablet (generic for Duricef <sup>®</sup> )
Bicillin <sup>®</sup> C-R injection	cefepodoxime suspension / tablet (generic for Vantin <sup>®</sup> )
cefadroxil capsule / suspension (generic for Duricef <sup>®</sup> )	Suprax <sup>®</sup> Capsule / Chewable / Suspension
cefdinir capsule / suspension (generic for Omnicel <sup>®</sup> )	
cefixime capsule / suspension (generic for Suprax <sup>®</sup> )	
cefprozil suspension / tablet (generic for Cefzil <sup>®</sup> )	
cefuroxime tablet (generic for Cefin <sup>®</sup> )	
cephalexin capsule / suspension / tablet (generic for Keflex <sup>®</sup> )	
dicloxacillin capsule	
nafcillin injection / vial	
oxacillin injection / vial	
penicillin G injection / vial	
penicillin V suspension / tablet	
piperacillin - tazobactam injection / vial	
Pfizerpen <sup>®</sup> injection / vial	
Unasyn <sup>®</sup> injection / vial	
Zosyn <sup>®</sup> injection / vial	
<b>Remove Suprax<sup>®</sup> Capsule / Chewable</b>	
Lincosamides and Oxazolidinones	
Preferred	Non-Preferred
clindamycin capsules / solution (generic for Cleocin <sup>®</sup> )	Cleocin <sup>®</sup> Capsules / Vial
linezolid suspension (oral) / tablet (generic for Zyvox <sup>®</sup> )	Cleocin <sup>®</sup> Pediatric Solution
	clindamycin injection (generic for Cleocin <sup>®</sup> )
	Lincocin <sup>®</sup> Vial
	lincomycin vial (generic for Lincocin <sup>®</sup> )
	linezolid IV solution (generic for Zyvox <sup>®</sup> )
	Sivextro <sup>®</sup> Tablet / Vial
	Synercid <sup>®</sup> Vial
	Zyvox <sup>®</sup> Tablet / IV Solution / Suspension
<b>No recommendations. Class open for comments.</b>	
Macrolides and Ketolides	
Preferred	Non-Preferred
azithromycin powder packet / suspension / tablet (generic for Zithromax <sup>®</sup> )	clarithromycin ER tablet (generic for Biaxin XL <sup>®</sup> )
clarithromycin suspension / tablet (generic for Biaxin <sup>®</sup> )	Eryped <sup>®</sup> 200/400 Suspension
E.E.S. <sup>®</sup> Filmtab / Suspension	Ery-Tab <sup>®</sup> Tablet
Erythrocin <sup>®</sup> Filmtab	Zithromax <sup>®</sup> Powder Packet / Suspension / Tablet / Tri-Pak / Z-Pak
erythromycin ES 200 mg and 400 mg suspension (generic for E.E.S. <sup>®</sup> Suspension, Eryped <sup>®</sup> )	
erythromycin EC capsule (generic for Eryc <sup>®</sup> )	
erythromycin filmtab	
erythromycin ES tablet (generic for E.E.S. <sup>®</sup> Filmtab)	
Nitroimidazoles (Gastrointestinal Antibiotics)	
Preferred	Non-Preferred
metronidazole tablet (generic for Flagyl <sup>®</sup> )	Aemcolo <sup>®</sup> DR Tablet
vancomycin capsule (generic for Vancocin <sup>®</sup> )	Difcid <sup>®</sup> Suspension / Tablet - <b>Trial and failure of only vancomycin is required for treatment of Clostridium difficile</b>
	Firvanq <sup>™</sup> Solution
	Flagyl <sup>®</sup> Capsule
	Likmez <sup>™</sup> (metronidazole) Suspension
	metronidazole capsule (generic for Flagyl <sup>®</sup> )
	neomycin tablet (generic for Mycifradin <sup>®</sup> )
	nitazoxanide tablet (generic for Alinia <sup>®</sup> Tablet)
	paromomycin capsule (generic for Humatin <sup>®</sup> )
	Solosec <sup>™</sup> Granules
	tinidazole tablet (generic for Tindamax <sup>®</sup> )
	Vancocin <sup>®</sup> Capsule
	vancomycin oral solution (generic for Firvanq <sup>™</sup> )
	Vowst <sup>™</sup> Capsule - <b>Clinical Criteria Apply</b>
	Xifaxan <sup>®</sup> Tablet - <b>Exemption for a diagnosis of Hepatic Encephalopathy</b>
<b>Add new to market product Likmez<sup>™</sup> (metronidazole) Suspension as Non-Preferred</b>	
Quinolones	
Preferred	Non-Preferred
Cipro <sup>®</sup> Suspension	Baxdela <sup>™</sup> Tablet
ciprofloxacin tablet (generic for Cipro <sup>®</sup> )	Cipro <sup>®</sup> Tablet
levofloxacin tablet (generic for Levaquin <sup>®</sup> )	ciprofloxacin suspension (generic for Cipro <sup>®</sup> )
moxifloxacin tablet (generic for Avelox <sup>®</sup> )	levofloxacin solution (generic for Levaquin <sup>®</sup> )

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

ofloxacin tablet (generic for Floxin®)
--

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

Tetracycline Derivatives	
Preferred	Non-Preferred
doxycycline hyclate capsule / tablet (generic for Vibramycin <sup>®</sup> , Vibra-Tab <sup>®</sup> )	demeclocycline tablet (generic for Declomycin <sup>®</sup> )
doxycycline monohydrate 50mg, 100mg capsule (generic for Monodox <sup>®</sup> )	Doryx <sup>®</sup> DR / MPC Tablet
minocycline 50mg, 75mg, 100mg capsule (generic for Minocin <sup>®</sup> )	doxycycline hyclate DR tablet (generic for Doryx <sup>®</sup> DR)
	doxycycline monohydrate 75mg, 150mg capsule (generic for Monodox <sup>®</sup> , Adoxa <sup>®</sup> )
	doxycycline monohydrate 40mg IR-DR capsule (generic for Oracea <sup>®</sup> )
	doxycycline monohydrate 50mg, 75mg, 100mg, 150mg tablet
	doxycycline suspension (generic for Vibramycin <sup>®</sup> ) - <b>Exemption for patients &lt; 12 years of age</b>
	Lymepak <sup>™</sup> Tablet
	minocycline ER tablet (generic for Solodyn <sup>®</sup> ER) <b>Clinical justification and failure of doxycycline and minocycline required. Limited to a 12 week supply.</b>
	<b>minocycline ER capsule (Generic for Ximino<sup>™</sup> ER)</b>
	minocycline 50mg, 75mg, 100mg tablet
	Minolira <sup>™</sup> ER Tablet
	Morgidox <sup>®</sup> Capsule / Kit
	Nuzyra <sup>™</sup> Tablet
	Solodyn <sup>®</sup> ER Tablet - <b>Clinical justification and failure of doxycycline and minocycline required. Limited to a 12 week supply.</b>
	tetracycline capsule (generic for Sumycin <sup>®</sup> )
	Vibramycin <sup>®</sup> Capsule
<b>Remove minocycline ER capsule (Generic for Ximino<sup>™</sup> ER)</b>	
Antifungals	
Preferred	Non-Preferred
clotrimazole troche (generic for Mycelex <sup>®</sup> Troche)	Ancobon <sup>®</sup> Capsule
fluconazole suspension / tablet (generic for Diflucan <sup>®</sup> )	Brexafemme <sup>®</sup> Tablet
griseofulvin suspension (generic for Grifulvin V <sup>®</sup> )	Cresemba <sup>®</sup> Capsule
griseofulvin ultra tablet (generic for Gris-Peg <sup>®</sup> )	Diflucan <sup>®</sup> Suspension / Tablet
nystatin suspension (generic for Nilstat <sup>®</sup> )	flucytosine capsule (generic for Ancobon <sup>®</sup> )
nystatin tablet (generic for Mycostatin <sup>®</sup> )	griseofulvin micro tablets (generic for Grifulvin V <sup>®</sup> )
terbinafine tablet (generic for Lamisil <sup>®</sup> )	itraconazole capsule / solution (generic for Sporanox <sup>®</sup> )
	ketonazole tablet (generic for Nizoral <sup>®</sup> )
	Noxafil <sup>®</sup> Suspension / Tablet / DR Suspension Packet
	Oravig <sup>®</sup> Buccal Tablet
	posaconazole tablet / suspension (generic for Noxafil <sup>®</sup> )
	Sporanox <sup>®</sup> Capsule / Solution
	Tolsura <sup>™</sup> Capsule
	Vfend <sup>®</sup> Suspension / Tablet
	Vivjoa <sup>®</sup> Capsule - <b>Clinical Criteria Apply</b>
	voriconazole suspension / tablet (generic for Vfend <sup>®</sup> )
Antivirals (Hepatitis B Agents)	
Preferred	Non-Preferred
entecavir tablet (generic for Baraclude <sup>®</sup> )	adefovir tablet (generic for Hepsera <sup>®</sup> )
lamivudine HBV tablet (generic for EpiVir <sup>®</sup> HBV)	Baraclude <sup>®</sup> Solution / Tablet
tenofovir tablet (generic for Viread <sup>®</sup> )	EpiVir <sup>®</sup> HBV Tablet / Solution
Viread <sup>®</sup> Powder / Tablet	<b>Hepsera<sup>®</sup> Tablet</b>
	Vemlidy <sup>®</sup> tablet
<b>Remove Hepsera<sup>®</sup> Tablet</b>	
Antivirals (Hepatitis C Agents)	
Preferred	Non-Preferred
Pegasis <sup>®</sup> Syringe / Vial	
ribavirin capsule / tablet (generic for Copegus <sup>®</sup> , Rebetol <sup>®</sup> )	
<b>Clinical criteria apply to all drugs listed below</b>	
<b>Prior Approval Not Required for Mavyret<sup>®</sup> Tablet / Pellet Pack and sofosbuvir-velpatasvir tablet (generic for Epclusa<sup>®</sup>)</b>	
<b>All genotypes without cirrhosis</b>	Epclusa <sup>®</sup> Pellet Pack/ Tablet
Mavyret <sup>®</sup> Tablet (8 weeks of therapy)	Harvoni <sup>®</sup> Pellet Pack / Tablet
Mavyret <sup>®</sup> Pellet Pack	ledipasvir-sofosbuvir tablet (generic for Harvoni <sup>®</sup> )
sofosbuvir-velpatasvir tablet (generic for Epclusa <sup>®</sup> )	Sovaldi <sup>®</sup> Pellet Pack / Tablet
	<b>Viekira<sup>™</sup> Pak</b>
<b>All genotypes with compensated cirrhosis (Child Pugh-A)</b>	Zepatier <sup>®</sup> Tablet
Mavyret <sup>®</sup> Tablet (Up to 12 weeks of therapy)	
Mavyret <sup>®</sup> Pellet Pack	
sofosbuvir-velpatasvir tablet (generic for Epclusa <sup>®</sup> )	
<b>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.</b>	
Vosevi <sup>™</sup> Tablet	
<b>All genotypes with decompensated cirrhosis</b>	
sofosbuvir-velpatasvir tablet (generic for Epclusa <sup>®</sup> )	
<b>Remove Viekira<sup>™</sup> Pak</b>	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

Antivirals (Herpes Treatments)	
Preferred	Non-Preferred
acyclovir capsule / tablet / suspension (generic for Zovirax <sup>®</sup> )	Sitavig <sup>®</sup> Buccal Tablet
famciclovir tablet (generic for Famvir <sup>®</sup> )	Valtrex <sup>®</sup> Caplet
valacyclovir tablet (generic for Valtrex <sup>®</sup> )	
<b>No recommendations. Class open for comments.</b>	
Antivirals (Influenza)	
Preferred	Non-Preferred
oseltamivir phosphate capsule / suspension (generic for Tamiflu <sup>®</sup> )	amantadine tablet (generic for Symmetrel <sup>®</sup> )
rimantadine tablet (generic for Flumadine <sup>®</sup> )	Flumadine <sup>®</sup> Tablet
	Relenza <sup>®</sup> Diskhaler
	Tamiflu <sup>®</sup> Capsule / Suspension
	Xofluza <sup>™</sup> Tablet <b>Trial and failure of only one preferred drug required</b>
Antibiotics, Inhaled	
<b>Trial and failure of only one preferred drug required</b>	
Preferred	Non-Preferred
Kitabis <sup>™</sup> Pak (tobramycin inhalation solution)	Arikayce <sup>®</sup> Vial
Bethkis <sup>®</sup> (tobramycin inhalation solution)	Cayston <sup>®</sup> Solution
tobramycin inhalation solution (generic for Tobin <sup>™</sup> )	tobramycin inhalation pak (generic for Kitabis <sup>™</sup> )
	Tobi <sup>™</sup> Podhaler <sup>™</sup> / Solution
<b>BEHAVIORAL HEALTH</b>	
<b>ANTIDEPRESSANTS</b>	
Other	
Preferred	Non-Preferred
bupropion tablet / SR tablet / XL tablet (generic for Wellbutrin <sup>®</sup> Tablet / SR / XL)	Aplenzin <sup>®</sup> Tablet
desvenlafaxine ER tablet (generic for Pristiq <sup>®</sup> )	Auvelity <sup>®</sup> Tablet
duloxetine capsule (generic for Cymbalta <sup>®</sup> )	Bupropion XL tablet (generic for Forfivo <sup>®</sup> XL)
Effexor <sup>®</sup> XR Capsule	Cymbalta <sup>®</sup> Capsule
mirtazapine ODT / tablet (generic for Remeron <sup>®</sup> )	desvenlafaxine ER tablet (generic for Khedezla <sup>®</sup> )
Nardil <sup>®</sup> Tablet	duloxetine capsule (generic for Irenka <sup>®</sup> )
phenelzine tablet (generic for Nardil <sup>®</sup> )	Emsam <sup>®</sup> Patch
Pristiq <sup>®</sup> ER Tablet	Fetzima <sup>®</sup> Capsule / Titration Pak
tranylcypromine tablet (generic for Parnate <sup>®</sup> )	Forfivo <sup>®</sup> XL Tablet
trazodone tablet (generic for Desyrel <sup>®</sup> )	Marplan <sup>®</sup> Tablet
venlafaxine tablet / ER capsules (generic for Effexor <sup>®</sup> , Effexor <sup>®</sup> XR)	nefazodone tablet (generic for Serzone <sup>®</sup> )
vilazodone tablet (generic for Viibryd <sup>®</sup> )	Remeron <sup>®</sup> Soltab / Tablet
Viibryd <sup>®</sup> Tablet	Trintellix <sup>®</sup> Tablet
	venlafaxine besylate ER tablet
	venlafaxine ER tablet
	Viibryd <sup>®</sup> Starter Pack
	Viibryd <sup>®</sup> Tablet
	vilazodone tablet (generic for Viibryd <sup>®</sup> )
	Wellbutrin <sup>®</sup> SR / XL Tablet
	Zuruvae <sup>™</sup> (zuranolone) Capsule
<b>Add new to market product Zuruvae<sup>™</sup> (zuranolone) Capsule as Non-Preferred</b>	
<b>Brand-Generic Switch: move vilazodone tablet (generic for Viibryd<sup>®</sup>) to Preferred and move Viibryd<sup>®</sup> Tablet to Non-Preferred</b>	
Selective Serotonin Reuptake Inhibitor (SSRI)	
Preferred	Non-Preferred
citalopram solution / tablet (generic for Celexa <sup>®</sup> )	Celexa <sup>®</sup> Tablet
escitalopram tablet (generic for Lexapro <sup>®</sup> )	citalopram capsule
fluoxetine capsule / solution (generic for Prozac <sup>®</sup> )	escitalopram solution (generic for Lexapro <sup>®</sup> )
fluvoxamine tablet (generic for Luvox <sup>®</sup> )	fluoxetine DR capsules (generic for Prozac <sup>®</sup> Weekly)
paroxetine tablet (generic for Paxil <sup>®</sup> )	fluoxetine tablet (generic for Prozac <sup>®</sup> ) - <b>Exemption for children &lt; 18 years of age</b>
Paxil <sup>®</sup> Suspension	fluvoxamine ER capsule (generic for Luvox CR <sup>®</sup> )
sertraline concentrated solution / tablet (generic for Zoloft <sup>®</sup> )	Lexapro <sup>®</sup> Tablet
	paroxetine capsule (generic for Bridelle <sup>®</sup> )
	paroxetine suspension / CR tablet (generic for Paxil <sup>®</sup> / CR)
	Paxil <sup>®</sup> Tablet / CR Tablet
	Pexeva <sup>®</sup> Tablet
	Prozac <sup>®</sup> Pulvule
	sertraline capsule
	Zoloft <sup>®</sup> Solution / Tablet



North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

ANTHYPERKINESIS / ADHD	
Preferred	Non-Preferred
Adderall <sup>®</sup> Tablet ( <b>Generic Product Per FDA</b> )	Adhansia <sup>™</sup> XR Capsule
Adderall <sup>®</sup> XR Capsule	Adzenes <sup>®</sup> XR ODT
amphetamine salt combo tablet (generic for Adderall <sup>®</sup> )	amphetamine salt combo ER capsule (generic for Mydayis <sup>®</sup> )
amphetamine salt combo XR capsule (generic for Adderall <sup>®</sup> XR)	amphetamine sulfate tablet (generic for Evekeo <sup>®</sup> )
Aptensio <sup>®</sup> XR Capsule	Azstarys <sup>™</sup> Capsule
atomoxetine capsule (generic for Strattera <sup>®</sup> )	Cotempla <sup>™</sup> XR-ODT
clonidine ER tablet (generic for Kapvay <sup>®</sup> )	Desoxyn <sup>™</sup> Tablet
Concerta <sup>®</sup> Tablet	Dexedrine <sup>®</sup> Spansule <sup>®</sup>
Daytrana <sup>®</sup> Patch	dextroamphetamine ER capsule (generic for Dexedrine <sup>®</sup> Spansule <sup>®</sup> )
dexmethylphenidate tablet / ER capsule (generic for Focalin <sup>®</sup> / XR)	dextroamphetamine solution (generic for ProCentra <sup>®</sup> )
dextroamphetamine tablet (generic for Dexedrine <sup>®</sup> )	Dyanavel <sup>®</sup> XR Suspension - <b>Exemption for children &lt; 12 years of age</b>
guanfacine ER tablet (generic for Intuniv <sup>®</sup> )	Dyanavel <sup>®</sup> XR Tablet
Methylin <sup>®</sup> Solution	Evekeo <sup>®</sup> Tablet / Evekeo <sup>®</sup> ODT Tablet
methylphenidate ER tablet (generic for Concerta <sup>®</sup> )	Focalin <sup>®</sup> Tablet / XR Capsule
methylphenidate tablet / solution (generic for Methylin <sup>®</sup> , Ritalin <sup>®</sup> )	Intuniv <sup>®</sup> Tablet
Vyvanse <sup>®</sup> Capsule / Chewable Tablet	Jornay PM <sup>™</sup> Capsule
	lisdexamfetamine capsule / chewable tablet (generic for Vyvanse <sup>®</sup> )
	methamphetamine tablet (generic for Desoxyn <sup>™</sup> )
	methylphenidate CD capsule (generic for Metadate <sup>®</sup> CD)
	methylphenidate chewable (generic for Methylin <sup>®</sup> )
	methylphenidate ER capsule (generic for Aptensio <sup>®</sup> XR)
	methylphenidate ER tablet (45 mg and 63 mg) ( <b>Branded Product Per FDA</b> )
	methylphenidate LA capsule (generic for Ritalin <sup>®</sup> LA)
	methylphenidate patch (generic for Daytrana <sup>®</sup> )
	Mydayis <sup>®</sup> ER Capsule
	ProCentra <sup>®</sup> Solution
	Qelbree <sup>™</sup> Capsule
	Quillichew <sup>®</sup> ER Tablet - <b>Exemption for children &lt; 12 years of age</b>
	Quillivant <sup>®</sup> XR Suspension - <b>Exemption for children &lt; 12 years of age</b>
	Relexxii <sup>™</sup> ER Tablet
	Ritalin <sup>®</sup> LA Capsule
	Ritalin <sup>®</sup> Tablet
	Strattera <sup>®</sup> Capsule
	Xelstrym <sup>®</sup> Patch
	Zenzedi <sup>®</sup> Tablet

**Add new to market product amphetamine salt combo ER capsule (generic for Mydayis<sup>®</sup>) as Non-Preferred  
Remove Adhansia<sup>™</sup> XR Capsule**

INJECTABLE ANTIPSYCHOTICS	
Injectable Long Acting	
Preferred	Non-Preferred
Abilify Maintena <sup>®</sup> Syringe / Vial	
Abilify Asimtufii <sup>®</sup> Syringe Kit	
Aristada <sup>®</sup> / Initio <sup>™</sup> Syringe	
fluphenazine decanoate vial (generic for Prolixin decanoate <sup>®</sup> )	
Haldol <sup>®</sup> decanoate Ampule	
haloperidol decanoate ampule / vial (generic for Haldol decanoate <sup>®</sup> )	
Invenga <sup>®</sup> Hafyera Prefilled Syringe Kit	
Invenga <sup>®</sup> Sustenna Prefilled Syringe	
Invenga <sup>®</sup> Trinza Syringe	
Perseris <sup>®</sup> Syringe	
Risperdal <sup>®</sup> Consta Vial	
risperidone ER vial (generic for Risperdal <sup>®</sup> Consta)	
Rykindo <sup>®</sup> Vial / Vial Kit	
Uzedy <sup>™</sup> Syringe Kit	
Zyprexa <sup>®</sup> Relprevv <sup>™</sup> Vial Kit	

**Add new to market product risperidone ER vial (generic for Risperdal<sup>®</sup> Consta) as Preferred**

ATYPICAL ANTIPSYCHOTICS	
Oral / Topical	
<b>Trial and failure of only one preferred drug required</b>	
Preferred	Non-Preferred
aripiprazole Tablet / Solution (generic for Abilify <sup>®</sup> )	Abilify <sup>®</sup> Tablet / Abilify <sup>®</sup> MyCite <sup>®</sup> Tablet
clozapine tablet (generic for Clozaril <sup>®</sup> )	aripiprazole ODT (generic for Abilify <sup>®</sup> Discmelt <sup>®</sup> )
Invenga <sup>™</sup> Tablet	asenapine SL tablet (generic for Saphris <sup>®</sup> SL)
lurasidone tablet (generic for Latuda <sup>®</sup> )	Caplyta <sup>™</sup> Capsule
olanzapine ODT / tablet (generic for Zyprexa <sup>®</sup> )	clozapine ODT (generic for FazaClo <sup>®</sup> )
paliperidone ER tablet (generic for Invega <sup>®</sup> )	Clozaril <sup>®</sup> Tablet
quetiapine tablet / ER tablet (generic for Serquel <sup>®</sup> / XR)	Fanap <sup>®</sup> Tablet / Titration Pack
risperidone ODT / solution / tablet (generic for Risperdal <sup>®</sup> )	Geodon <sup>®</sup> Capsule
Saphris <sup>®</sup> SL Tablet	Invenga <sup>™</sup> Tablet
Symbyax <sup>®</sup> Capsule	Latuda <sup>®</sup> Tablet
Vraylar <sup>®</sup> Capsule - <b>Trial and Failure of 1 Preferred Atypical Antipsychotic required except for adjunct treatment of MDD</b>	Lybalvi <sup>™</sup> Tablet

North Carolina Division of Health Benefits  
 North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

ziprasidone capsule (generic for Geodon <sup>®</sup> )	olanzapine-fluoxetine capsule (generic for Symbyax <sup>®</sup> )
	paliperidone ER tablet (generic for Invega <sup>®</sup> )
	Rexulti <sup>®</sup> Tablet
	Rexulti <sup>®</sup> (brexipiprazole) 7-Day / 14-Day Titration Pack
	Risperdal <sup>®</sup> Solution / Tablet
	Secuado <sup>®</sup> Patch
	Seroquel <sup>®</sup> Tablet / XR Tablet / XR Sample Kit
	Versacloz <sup>®</sup> Suspension
	Zyprexa <sup>®</sup> Tablet / Zydys <sup>®</sup> Tablet

**Add new to market product Rexulti (brexipiprazole) <sup>®</sup> 7-Day / 14-Day Titration Pack as Non-Preferred**  
**Brand-Generic Switch: move paliperidone ER tablet (generic for Invega<sup>®</sup>) to Preferred and move Invega<sup>®</sup> Tablet to Non-Preferred**

North Carolina Division of Health Benefits  
 North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

CARDIOVASCULAR	
ACE INHIBITORS	
Preferred	Non-Preferred
benazepril tablet (generic for Lotensin <sup>®</sup> )	Accupril <sup>®</sup> Tablet
enalapril tablet (generic for Vasotec <sup>®</sup> )	Altace <sup>®</sup> Capsule
lisinopril tablet (generic for Prinivil <sup>®</sup> and Zestril <sup>®</sup> )	captopril tablet (generic for Capoten <sup>®</sup> )
ramipril capsule (generic for Altace <sup>®</sup> )	enalapril solution (generic for Epaned <sup>®</sup> ) - <b>Exemption for children &lt; 12 years of age</b>
	Epaned <sup>®</sup> Solution - <b>Exemption for children &lt; 12 years of age</b>
	fosinopril tablet (generic for Monopril <sup>®</sup> )
	Lotensin <sup>®</sup> Tablet
	moexipril tablet (generic for Univasc <sup>®</sup> )
	Qbrelis <sup>®</sup> Solution - <b>Exemption for children &lt; 12 years of age</b>
	perindopril tablet (generic for Aceon <sup>®</sup> )
	quinapril tablet (generic for Accupril <sup>®</sup> )
	trandolapril tablet (generic for Mavik <sup>®</sup> )
	Vasotec <sup>®</sup> Tablet
	Zestril <sup>®</sup> Tablet
ACE INHIBITOR / CALCIUM CHANNEL BLOCKER COMBINATIONS	
Preferred	Non-Preferred
amlodipine-benazepril capsule (generic for Lotrel <sup>®</sup> )	Lotrel <sup>®</sup> Capsule
	trandolapril-verapamil ER tablet (generic for Tarka <sup>®</sup> )
ACE INHIBITOR / DIURETIC COMBINATIONS	
Preferred	Non-Preferred
enalapril-HCTZ tablet (generic for Vaseretic <sup>®</sup> )	Accuretic <sup>®</sup> Tablet
lisinopril-HCTZ tablet (generic for Prinzide <sup>®</sup> , Zestoretic <sup>®</sup> )	benazepril-HCTZ tablet (generic for Lotensin <sup>®</sup> HCT)
	captopril-HCTZ tablet (generic for Capozide <sup>®</sup> )
	fosinopril-HCTZ tablet (generic for Monopril <sup>®</sup> HCT)
	Lotensin <sup>®</sup> HCT Tablet
	quinapril-HCTZ tablet (generic for Accuretic <sup>®</sup> , Quinaretic <sup>®</sup> )
	Vaseretic <sup>®</sup> Tablet
	Zestoretic <sup>®</sup> Tablet
<b>No recommendations. Class open for comments.</b>	
ANGIOTENSIN II RECEPTOR BLOCKERS	
Preferred	Non-Preferred
irbesartan tablet (generic for Avapro <sup>®</sup> )	Atacand <sup>®</sup> Tablet
losartan tablet (generic for Cozaar <sup>®</sup> )	Avapro <sup>®</sup> Tablet
olmesartan tablet (generic for Benicar <sup>®</sup> )	Benicar <sup>®</sup> Tablet
valsartan tablet (generic for Diovan <sup>®</sup> )	candesartan tablet (generic for Atacand <sup>®</sup> )
	Cozaar <sup>®</sup> Tablet
	Diovan <sup>®</sup> Tablet
	Edarbi <sup>®</sup> Tablet
	eprosartan tablet (generic for Teveten <sup>®</sup> )
	Micardis <sup>®</sup> Tablet
	telmisartan tablet (generic for Micardis <sup>®</sup> )
	valsartan oral solution
ANGIOTENSIN II RECEPTOR BLOCKER COMBINATIONS	
Preferred	Non-Preferred
amlodipine-olmesartan tablet (generic for Azor <sup>®</sup> )	Azor <sup>®</sup> Tablet
amlodipine-valsartan tablet (generic for Exforge <sup>®</sup> )	Exforge <sup>®</sup> Tablet / HCT Tablet
amlodipine-valsartan-HCTZ tablet (generic for Exforge <sup>®</sup> HCT)	telmisartan-amlodipine tablet (generic for Twynsta <sup>®</sup> )
olmesartan-amlodipine-HCTZ tablet (generic for Tribenzor <sup>®</sup> )	Tribenzor <sup>®</sup> Tablet
<b>No recommendations. Class open for comments.</b>	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

ANGIOTENSIN II RECEPTOR BLOCKER DIURETIC COMBINATIONS	
Preferred	Non-Preferred
irbesartan-HCTZ tablet (generic for Avalide <sup>®</sup> )	Atacand <sup>®</sup> HCT Tablet
losartan-HCTZ tablet (generic for Hyzaar <sup>®</sup> )	Avalide <sup>®</sup> Tablet
olmesartan-HCTZ tablet (generic for Benicar <sup>®</sup> HCT)	Benicar <sup>®</sup> HCT Tablet
valsartan-HCTZ tablet (generic for Diovan <sup>®</sup> HCT)	candesartan-HCTZ tablet (generic for Atacand <sup>®</sup> HCT)
	Diovan <sup>®</sup> HCT Tablet
	Edarbyclor <sup>®</sup> Tablet
	Hyzaar <sup>®</sup> Tablet
	Micardis <sup>®</sup> HCT Tablet
	telmisartan-HCTZ tablet (generic for Micardis <sup>®</sup> HCT)
<b>No recommendations. Class open for comments.</b>	
ANGIOTENSIN II RECEPTOR / NEPRILYSIN BLOCKER COMBINATIONS	
Preferred	Non-Preferred
Entresto <sup>®</sup> Tablet	
<b>No recommendations. Class open for comments.</b>	
ANTI-ARRHYTHMICS	
Preferred	Non-Preferred
amiodarone tablet (generic for Cordarone <sup>®</sup> )	Multaq <sup>®</sup> Tablet
disopyramide capsule (generic for Norpace <sup>®</sup> )	Norpace <sup>®</sup> Capsule / CR Capsule
dofetilide capsule (generic for Tikosyn <sup>®</sup> )	Pacerone <sup>®</sup> Tablet
flecainide tablet (generic for Tambocor <sup>®</sup> )	quinidine gluconate ER tablet (generic for Quinaglute DuraTabs <sup>®</sup> )
mexiletine capsule (generic for Mexitil <sup>®</sup> )	Rythmol SR <sup>®</sup> Capsule
propafenone tablet (generic for Rythmol <sup>®</sup> )	Tikosyn <sup>®</sup> Capsule
propafenone SR capsule (generic for Rythmol SR <sup>®</sup> )	
quinidine sulfate tablet (generic for Quinidex <sup>®</sup> Tablet)	
<b>No recommendations. Class open for comments.</b>	
BETA BLOCKERS	
Preferred	Non-Preferred
atenolol tablet (generic for Tenormin <sup>®</sup> )	acebutolol capsule (generic for Sectral <sup>®</sup> )
carvedilol tablet (generic for Coreg <sup>®</sup> )	Betapace <sup>®</sup> Tablet / AF Tablet
labetalol tablet (generic for Trandate <sup>®</sup> )	betaxolol tablet (generic for Kerlone <sup>®</sup> )
metoprolol succinate XL tablet (generic for Toprol XL <sup>®</sup> )	bisoprolol tablet (generic for Zebeta <sup>®</sup> )
metoprolol tartrate tablet (generic for Lopressor <sup>®</sup> )	Bystolic <sup>®</sup> Tablet
propranolol solution / tablet / ER capsule (generic for Inderal <sup>®</sup> )	carvedilol ER capsule (generic for Coreg <sup>®</sup> CR Capsule)
Sorine <sup>®</sup> Tablet	Coreg <sup>®</sup> Tablet / CR Capsule
sotalol tablet / AF tablet (generic for Betapace <sup>®</sup> / AF, Sorine <sup>®</sup> )	Corgard <sup>®</sup> Tablet
	Hemangeol <sup>®</sup> Solution - <b>Exemption for diagnosis of infantile hemangioma</b>
	Inderal <sup>®</sup> LA Capsule / XL Capsule
	Innopran <sup>®</sup> XL Capsule
	Kapsargo <sup>™</sup> Sprinkle - <b>Exemption for children &lt; 12 years of age</b>
	Lopressor <sup>®</sup> Tablet
	nadolol tablet (generic for Corgard <sup>®</sup> )
	nebivolol tablet (generic for Bystolic <sup>®</sup> )
	pindolol tablet (generic for Visken <sup>®</sup> )
	Sotylize <sup>®</sup> Solution
	Tenormin <sup>®</sup> Tablet
	timolol tablet (generic for Blocadren <sup>®</sup> )
	Toprol XL <sup>®</sup> Tablet
<b>No recommendations. Class open for comments.</b>	
BETA BLOCKER DIURETIC COMBINATIONS	
Preferred	Non-Preferred
atenolol-chlorthalidone tablet (generic for Tenoretic <sup>®</sup> )	metoprolol-HCTZ tablet (generic for Lopressor <sup>®</sup> HCT)
bisoprolol-HCTZ tablet (generic for Ziac <sup>®</sup> )	propranolol-HCTZ tablet (generic for Inderide <sup>®</sup> )
	Tenoretic <sup>®</sup> Tablet
	Ziac <sup>™</sup> Tablet
<b>No recommendations. Class open for comments.</b>	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

BILE ACID SEQUESTRANTS	
Preferred	Non-Preferred
cholestyramine packet / powder / light packet / light powder (generic for Questran® / Questran® Light)	colesevelam packet / tablet (generic for Welchol®)
colestipol tablet (generic for Colestid® Tablet)	Colestid® Granules / Tablet
	colestipol granules (generic for Colestid®)
	Prevalite® Packet / Powder
	Questran® Light Powder / Packet / Powder
	Welchol® Packet / Tablet

**No recommendations. Class open for comments.**

CHOLESTEROL LOWERING AGENTS	
Preferred	Non-Preferred
atorvastatin tablet (generic for Lipitor®)	Altoprev® Tablet
ezetimibe (generic for Zetia®)	amlodipine-atorvastatin tablet (generic for Caduet®)
lovastatin tablet (generic for Mevacor®)	Atorvaliq® Suspension
pravastatin tablet (generic for Pravachol®)	Caduet® Tablet
rosuvastatin tablet (generic for Crestor®)	Crestor® Tablet
simvastatin tablet (generic for Zocor®)	Ezallor™ Capsule
	ezetimibe-simvastatin (generic for Vytorin®)
	fluvastatin capsule / ER tablet (generic for Lescol® / XL)
	Juxtapid® Capsule - <b>Clinical criteria apply</b>
	Lescol® XL Tablet
	Lipitor® Tablet
	Livalo® Tablet
	Nexleto® Tablet - <b>Clinical criteria apply</b>
	Nexlizet® Tablet - <b>Clinical criteria apply</b>
	<b>pitavastatin tablet (generic for Livalo®)</b>
	Vytorin® Tablet
	Zetia® Tablet
	Zocor® Tablet
	Zypitamag™ Tablet

**Add new to market product pitavastatin tablet (generic for Livalo®) as Non-Preferred**

CORONARY VASODILATORS	
Preferred	Non-Preferred
isosorbide dinitrate tablet (generic for Isordil® Titradose®, IsoDitrate®, et.al.)	Gonitro® Sublingual Powder
isosorbide mononitrate tablet / ER tablet (generic for Ismo®, Monoket®, Imdur®)	Isordil® Tablet / Titradose® Tablet
Minitran® Patch	Nitro-Bid® Ointment
nitroglycerin patch / spray / SL tablet (generic for Nitro-Dur®, Minitran®, Nitrostat®, et. al)	Nitro-Dur® Patch
Nitrostat® SL Tablet	Nitrolingual® Spray
	Verquvo™ Tablet

DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKERS	
Preferred	Non-Preferred
amlodipine tablet (generic for Norvasc®)	felodipine ER tablet (generic for Plendil®)
nifedipine capsule (generic for Procardia®)	isradipine capsule (generic for Dynacirc®)
nifedipine ER tablet (generic for Adalat CC® / Procardia XL®)	Katerzia™ Suspension - <b>Exemption for children &lt; 12 years of age</b>
	levamlodipine tablet (generic for Conjupri®)
	nicardipine capsule (generic for Cardene®)
	nimodipine capsule (generic for Nimotop®)
	nisoldipine ER tablet (generic for Sular®)
	Norliqva® Solution
	Norvasc® Tablet
	Nymalize® Solution
	Procardia® XL Tablet
	Sular® Tablet

DIRECT RENIN INHIBITOR	
Preferred	Non-Preferred
Tekturna® Tablet	aliskiren tablet (generic for Tekturna® Tablet)
Tekturna® HCT Tablet	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

ENDOTHELIN RECEPTOR ANTAGONISTS	
Covered for diagnosis of Pulmonary Arterial Hypertension only	
Preferred	Non-Preferred
ambrisentan tablet (generic for Letairis® Tablet)	bosentan tablet (generic for Tracleer® Tablet)
Tracleer® Tablet	Letairis® Tablet
	Opsumit® Tablet
	Tracleer® Suspension
INHALED PROSTACYCLIN ANALOGS	
Preferred	Non-Preferred
Tyvaso® Refill Kit / Solution / Starter Kit	Tyvaso® DPI
Ventavis® Solution	
NIACIN DERIVATIVES	
Preferred	Non-Preferred
niacin ER tablet (generic for Niaspan®)	
NITRATE COMBINATION	
Preferred	Non-Preferred
Bidil® Tablet	isosorbide dinit/hydralazine tablet (generic for Bidil®)
NON-DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKERS	
Preferred	Non-Preferred
Cartia XT® Capsule (branded generic for Cardizem CD®)	Calan SR® Caplet
Dilt XR® Capsule (branded generic for Dilacor XR®)	Cardizem CD® Capsule
diltiazem ER 24 hour capsule (generic for Dilacor XR®, Tiazac®)	Cardizem® Tablet / LA Tablet
diltiazem tablet / CD capsule / ER 12 hour capsule (generic for Cardizem® / CD / SR)	diltiazem LA tablet (generic for Cardizem LA®)
Taztia XT® Capsule (branded generic for Tiazac®)	Matzim® LA Tablet (generic for Cardizem LA®)
Tiadyt® ER Capsule	Tiazac® Capsule
verapamil tablet / ER tablet (generic for Calan® / SR)	verapamil 360 mg capsule
	verapamil ER capsule / PM capsule (generic for Verelan® / Verelan® PM)
	Verelan® Capsule / Verelan® PM Capsule
ORAL PULMONARY HYPERTENSION	
Covered for diagnosis of Pulmonary Arterial Hypertension (all) and Chronic Thromboembolic Pulmonary Hypertension- Adempas® only	
Preferred	Non-Preferred
Alysq® Tablet (branded generic for tadalafil)	Adcirca® Tablet
sildenafil tablet (generic for Revatio®)	Adempas® Tablet
tadalafil tablet (generic for Adcirca®)	Liqreiv® Suspension
	Orenitram® ER Tablet / Titration Kit
	Revatio® Suspension / Tablet <b>Exemption for children &lt; 12 years of age for Suspension ONLY</b>
	sildenafil suspension (generic for Revatio®) <b>Exemption for children &lt; 12 years of age</b>
	Tadliq® Suspension
	Upravi® Tablet / Titration Pack
PLATELET INHIBITORS	
Preferred	Non-Preferred
Brilinta® Tablet	aspirin/dipyridamole ER capsule (generic for Aggrenox®)
clopidogrel tablet (generic for Plavix®)	aspirin-omeprazole DR tablet
dipyridamole tablet (generic for Persantine®)	Effient® Tablet
prasugrel tablet (generic for Effient® Tablet)	Plavix® Tablet
ANTIANGINAL & ANTI-ISCHEMIC	
Preferred	Non-Preferred
ranolazine ER tablet (generic for Ranexa® Tablet)	Aspruzo™ Sprinkle
	Ranexa® Tablet
SYMPATHOLYTICS AND COMBINATIONS	
Preferred	Non-Preferred
Catapres® TTS Patch	clonidine ER tablet (generic for Nexiclon™ XR)
clonidine tablet / patch (generic for Catapres® / TTS)	methyldopa-HCTZ tablet (generic for Aldoril®)
guanfacine tablet (generic for Tenex®)	methyldopa vial (generic for Aldomet®)
methyldopa tablet (generic for Aldomet®)	
Remove Catapres® TTS Patch	
TRIGLYCERIDE LOWERING AGENTS	
Preferred	Non-Preferred
fenofibrate tablet (generic for Tricor®)	Antara® Capsule
gemfibrozil tablet (generic for Lopid®)	fenofibrate capsule / tablet (generic for Antara®, Lofibra®, Fenoglide®, et. al)
omega-3 acid ethyl esters capsule (generic for Lovaza®)	fenofibric acid tablet (generic for Fibricor®, Trilipix®)
Vascepa® Capsule	Fenoglide® Tablet
	icosapent ethyl capsule (generic for Vascepa®)
	Lipofen® Capsule
	Lopid® Tablet
	Lovaza® Capsule
	Tricor® Tablet
	Trilipix® Capsule
CARDIOVASCULAR, OTHER	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

Preferred	Non-Preferred
Camzyos <sup>®</sup> Capsule - <b>Clinical Criteria Apply</b>	

**CENTRAL NERVOUS SYSTEM**

ANTIMIGRAINE AGENTS

**Quantity limits apply to all triptans**

Preferred	Non-Preferred
rizatriptan tablet / ODT (generic for Maxalt <sup>®</sup> )	almotriptan tablet (generic for Axert <sup>®</sup> )
sumatriptan nasal spray / tablet / vial (generic for Imitrex <sup>®</sup> )	diclofenac potassium powder packet (generic for Cambia <sup>®</sup> ) - <b>Trial and failure of 2 preferred NSAIDs, in addition to trial and failure of 2 preferred triptans in the Antimigraine Agents class required for coverage</b>
	eletriptan tablet (generic for Relpax <sup>®</sup> )
	Elyxib <sup>™</sup> Solution - <b>Trial and failure of 2 preferred NSAIDs, in addition to trial and failure of 2 preferred triptans in the Antimigraine Agents class required for coverage</b>
	Prova <sup>®</sup> Tablet
	frovatriptan tablet (generic for Frova <sup>®</sup> )
	Imitrex <sup>®</sup> Cartridge / Nasal Spray / Pen / Tablet
	Maxalt <sup>®</sup> Tablet / MLT Tablet
	naratriptan tablet (generic for Amerge <sup>®</sup> )
	<del>Onzetra<sup>™</sup> Xsail<sup>™</sup> Nasal Powder</del>
	Relpax <sup>®</sup> Tablet
	Reyvow <sup>™</sup> Tablet
	sumatriptan injection kit / refill / syringe (generic for Imitrex <sup>®</sup> )
	sumatriptan/naproxen tablet (generic for Treximet <sup>®</sup> )
	Tosymra <sup>™</sup> Nasal Spray
	<del>Treximet<sup>®</sup> Tablet</del>
	Zembrace <sup>®</sup> SymTouch <sup>®</sup>
	zolmitriptan nasal spray / ODT / tablet (generic for Zomig <sup>®</sup> )
	Zomig <sup>®</sup> Nasal Spray / Tablet / ZMT <sup>®</sup> Tablet

**Remove Onzetra<sup>™</sup> Xsail<sup>™</sup> Nasal Powder and Treximet<sup>®</sup> Tablet**

ANTIMIGRAINE AGENTS

CGRP Blockers/Modulators PREVENTATIVE

**Clinical criteria apply to all drugs in this class**

Preferred	Non-Preferred
Aimovig <sup>®</sup> Autoinjector	Qulipta <sup>®</sup> Tablet
Ajovy <sup>®</sup> Autoinjector / Syringe	Vyepti <sup>®</sup> Vial
Emgality <sup>®</sup> Pen / Syringe	
Nurtec <sup>®</sup> ODT	

ANTIMIGRAINE AGENTS

CGRP Blockers/Modulators ACUTE TREATMENT

**Clinical criteria apply to all drugs in this class**

Preferred	Non-Preferred
Nurtec <sup>®</sup> ODT	Zavzpret <sup>™</sup> Nasal Spray
Ubrovelvy <sup>®</sup> Tablet	

ANTI-NARCOLEPSY

**Clinical criteria apply to all drugs in this class**

Preferred	Non-Preferred
Nuvigil <sup>®</sup> Tablet	armodafinil tablet (generic for Nuvigil <sup>®</sup> )
Provigil <sup>®</sup> Tablet	modafinil tablet (generic for Provigil <sup>®</sup> )
	Sunosi <sup>™</sup> Tablet
	Wakix <sup>®</sup> Tablet

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

ANTIPARKINSON AND RESTLESS LEG SYNDROME AGENTS		
Preferred		Non-Preferred
amantadine capsule / solution (generic for Symmetrel®)	Apokyn® Cartridge	
benztropine tablet (generic for Cogentin®)	apomorphine cartridge (generic for Apokyn®)	
bromocriptine capsule / tablet (generic for Parlodel®)	Azilect® Tablet	
carbidopa-levodopa ODT (generic for Parcopa®)	carbidopa tablet (generic for Lodosyn®)	
carbidopa-levodopa tablet / ER tablet (generic for Sinemet® / CR)	carbidopa-levodopa-entacapone tablet (generic for Stalevo®)	
pramipexole tablet (generic for Mirapex®)	Comtan® Tablet	
ropinirole tablet (generic for Requip®)	Dhivy Tablet™	
selegiline capsule / tablet (generic for Emsam®)	Duopa® Suspension	
trihexphenidyl elixir / tablet (generic for Artane®)	entacapone tablet (generic for Comtan®)	
	Gocovri® Capsule - <b>Clinical criteria apply</b>	
	Horizant® Tablet	
	Inbrija™ Inhalation	
	Kynmobi™ Titration Kit	
	Lodosyn® Tablet	
	Mirapex® ER Tablet	
	Neupro® Patch	
	Nourianz™ Tablet	
	Ongentys® Capsule	
	Osmolex ER™ Tablet - <b>Clinical criteria apply</b>	
	Parlodel® Capsule / Tablet	
	pramipexole ER tablet (generic for Mirapex ER®)	
	rasagiline tablet (generic for Azilect®)	
	ropinirole ER tablet (generic for Requip XL®)	
	Rytary® ER Capsule	
	Sinemet® Tablet	
	Stalevo® Tablet	
	Tasmar® Tablet	
	tolcapone tablet (generic for Tasmar®)	
	Xadago® Tablet	
	Zelapar® ODT	
MULTIPLE SCLEROSIS		
Injectable		
Preferred		Non-Preferred
Avonex® Pack / Pen / Syringe	Briumvi™ Vial	
Betaseron® Kit / Vial	Extavia® Kit / Vial	
Copaxone® Syringe	glatiramer syringe (generic for Copaxone® Syringe)	
Kesimpta® Pen	Glatopa® Syringe	
Rebif® Rebidose® / Titration Pack / Syringe	Lemrada® Vial	
	Ocrevus® Vial - <b>Diagnosis of Primary Progressive MS (PPMS) bypasses requirement for 2 preferred agents</b>	
	Plegridy® Pen / Pen Starter Pack / Syringe / Syringe Starter Pack	
	Tysabri® Vial	
MULTIPLE SCLEROSIS		
Oral		
Preferred		Non-Preferred
dalfampridine ER tablet (generic for Ampyra®)	Ampyra® Tablet	
dimethyl fumarate DR capsule / starter pack (generic for Tecfidera® Capsule / Starter Pack)	Aubagio® Tablet	
fingolimod capsule (generic for Gilenya®)	Bafiertam™ Capsule	
teriflunomide tablet (generic for Aubagio®)	Gilenya® Capsule	
	Mavenclad® Tablet	
	Mayzent® Starter Pack / Tablet	
	Ponvory™ Starter Pack / Tablet	
	Tascenso ODT™	
	Tecfidera® Capsule / Starter Pack	
	Vumerity™ Capsule	
	Zeposia® Starter Pack / Capsule	
AMYOTROPHIC LATERAL SCLEROSIS (ALS) AGENTS		
Preferred		Non-Preferred
riluzole tablet (generic for Riutek®)	Exservan™ Oral Film	
	<b>Qalsody™ Vial</b>	
	Tiglutik® Suspension	
	Radicava® ORS® Suspension / ORS® Starter Kit Suspension / Bag	
	Relyvrio™ Powder Packet	
Remove Qalsody™ Vial		
SEDATIVE HYPNOTICS		
Quantity limits apply to all sedative hypnotics		
Preferred		Non-Preferred
eszopiclone tablet (generic for Lunesta®)	Ambien® Tablet / CR Tablet	
flurazepam capsule (generic for Dalmane®)	Belsomra® Tablet	
ramelteon tablet (generic for Rozerem® Tablet)	Dayvigo™ Tablet	
temazepam 15mg, 30mg capsule (generic for Restoril®)	Doral® Tablet	
zaleplon capsule (generic for Sonata®)	doxepin tablet (generic for Silenor®)	
zolpidem tablet (generic for Ambien®)	Eduar® SL Tablet	



North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

	estazolam tablet (generic for Prosom <sup>®</sup> )
	Halcion <sup>®</sup> Tablet
	Hetlioz <sup>®</sup> Capsule / LQ Suspension - <b>Clinical criteria apply</b>
	Lunesta <sup>®</sup> Tablet
	quazepam tablet (generic for Doral <sup>®</sup> )
	Quviviq <sup>™</sup> Tablet
	Restoril <sup>®</sup> Capsule
	Rozerem <sup>®</sup> Tablet
	<b>Silenor<sup>®</sup> Tablet</b>
	tasimelteon capsule (generic for Hetlioz <sup>®</sup> ) - <b>Trial and Failure of Hetlioz<sup>®</sup> Capsule Required for Coverage</b>
	temazepam 7.5, 22.5 mg capsule (generic for Restoril <sup>®</sup> )
	triazolam tablet (generic for Halcion <sup>®</sup> )
	zolpidem capsule
	zolpidem ER tablet (generic for Ambien <sup>®</sup> CR)
	zolpidem SL tablet (generic for Intermezzo <sup>®</sup> )
<b>Remove Silenor<sup>®</sup> Tablet</b>	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>  
More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

SMOKING CESSATION	
Preferred	Non-Preferred
bupropion SR tablet (generic for Zyban®)	Nicotrol® Inhaler / NS Nasal Spray
Chantix® Tablet / Starting Box / Continuation Month Box - <b>Quantity limited to 6 months per 12 months</b>	
nicotine gum / lozenge (buccal) / patch	
varenicline starting month box (generic for Chantix®) - <b>Quantity limited to 6 months per 12 months</b>	
varenicline tablet (generic for Chantix®) <b>Quantity limited to 6 months per 12 months. Only rebate eligible versions are covered.</b>	
ENDOCRINOLOGY	
GROWTH HORMONE	
<b>Clinical criteria apply to all drugs in this class</b>	
<b>Prior Approval Not Required for Use of Serostim® in AIDS Wasting Syndrome</b>	
Preferred	Non-Preferred
Genotropin® Cartridge / MiniQuick®	Humatrope® Cartridge
Norditropin® Flexpro®	Ngenla® Pen
	Nutropin® AQ NuSpin®
	Omnitrope® Cartridge / Vial
	Saizen® Vial
	Serostim® Vial
	Skytrofa® Cartridge - <b>Exemption for children &lt;18 years of age</b>
	Sogroya® Pen
	Zomacton® Vial
	Zorbtive® Vial
<b>Remove Zorbtive® Vial</b>	
HYPOGLYCEMICS - INJECTABLE	
Rapid Acting Insulin	
<b>Trial and failure of only one preferred drug required</b>	
Preferred	Non-Preferred
Humalog® U-100 Cartridge	Admelog® SoloStar® / Vial
Humalog® U-100 Junior KwikPen®	Afrezza® Inhalation Powder
Humalog® U-100 KwikPen® / Vial	Apidra® SoloStar® / Vial
insulin aspart U-100 FlexPen® / vial (generic for Novolog®)	Fiasp® FlexTouch® / Penfill® / PumpCart® / Vial
insulin lispro U-100 Junior KwikPen® (generic for Humalog® Junior)	Humalog® U-200 KwikPen® / U-400-Tempo-Pen™
insulin lispro U-100 KwikPen® / vial (generic for Humalog®)	insulin aspart U-100 cartridge (generic for Novolog®)
Novolog® U-100 Cartridge / FlexPen® / Vial	Lyumjev™ U-100 KwikPen® / U-200 KwikPen® / Vial / U-400-Tempo-Pen™
<b>Remove Humalog® Tempo Pen™ and Lyumjev™ Tempo Pen™</b>	
Short Acting Insulin	
<b>Trial and failure of only one preferred drug required</b>	
Preferred	Non-Preferred
Humulin® R Vial	Myxredlin™ Injection
Humulin® R U-500 KwikPen® / U500 Vial	Novolin® R Vial / ReliOn® R Vial
	Novolin R FlexPen®
Intermediate Acting Insulin	
Preferred	Non-Preferred
Humulin® N Vial	Humulin® N KwikPen®
	Novolin® N FlexPen® / ReliOn® N FlexPen®
	Novolin® N Vial / ReliOn® N Vial
Long Acting Insulin	
<b>Trial and failure of only one preferred drug required</b>	
Preferred	Non-Preferred
insulin glargine vial / SoloStar® (authorized biologic for Lantus)	Basaglar® U-100 KwikPen® / U-400-Tempo-Pen™
Lantus® SoloStar® / Vial	insulin degludec pen / vial (generic for Tresiba®)
Levemir® / FlexPen® / FlexTouch® / Vial	<b>insulin glargine SoloStar® / Max SoloStar® (generic for Toujeo®)</b>
	insulin glargine-yfgn pen / vial (generic for Semglee™ yfgn)
	Rezvoglar™ Kwikpen®
	Semglee™ yfgn Pen / Vial
	Toujeo® SoloStar® / Max SoloStar®
	Tresiba® FlexTouch® / Vial
<b>Add new to market product insulin glargine SoloStar® / Max SoloStar® (generic for Toujeo®) as Non-Preferred</b>	
<b>Remove Basaglar® Tempo Pen™</b>	
Premixed Rapid Combination Insulin	
Preferred	Non-Preferred
Humalog® 50/50 Mix KwikPen® / Vial	insulin lispro protamine 75/25 KwikPen® (generic for Humalog® 75/25 Mix)
Humalog® 75/25 Mix KwikPen® / Vial	Novolog® Mix 70/30 Vial
insulin aspart protamine-aspart 70/30 U-100 FlexPen® / vial (generic for Novolog® Mix 70/30)	
Novolog® Mix 70/30 FlexPen®	
Premixed 70/30 Combination Insulin	
Preferred	Non-Preferred
Humulin® 70/30 KwikPen® / Vial	Novolin® 70/30 FlexPen® / Vial / ReliOn® 70/30 Vial

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

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	Non-Preferred
Symlin <sup>®</sup> Pen Injector	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.htm>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

GLP-1 Receptor Agonists and Combinations	
Clinical criteria apply to all drugs in this class	
Preferred	Non-Preferred
Byetta <sup>®</sup> Pen	Adlyxin <sup>®</sup> Pen
Trulicity <sup>®</sup> Pen	Bydureon <sup>®</sup> BCise <sup>™</sup>
Victoza <sup>®</sup> Pen	Rybelsus <sup>®</sup> Tablet
Ozempic <sup>®</sup> Pen	Soliqua <sup>®</sup> Pen
	Xultophy <sup>®</sup> Pen
	Mounjaro <sup>™</sup> Pen
<b>Remove Adlyxin<sup>®</sup> Pen</b>	
HYPOGLYCEMICS - ORAL	
2nd Generation Sulfonylureas	
Preferred	Non-Preferred
glimepiride tablet (generic for Amaryl <sup>®</sup> )	
glipizide tablet / ER tablet (generic for Glucotrol <sup>®</sup> / XL)	
Glucotrol <sup>®</sup> XL Tablet	
glyburide micronized tablet (generic for Micronase <sup>®</sup> , Glynase <sup>®</sup> )	
glyburide tablet (generic for Diabeta <sup>®</sup> )	
Glynase <sup>®</sup> Tablet	
Alpha-Glucosidase Inhibitors	
Preferred	Non-Preferred
acarbose tablet (generic for Precose <sup>®</sup> )	miglitol tablet (generic for Glyset <sup>®</sup> )
	Precose <sup>®</sup> Tablet
Biguanides and Combinations	
Preferred	Non-Preferred
glipizide-metformin tablet (generic for Metaglip <sup>®</sup> )	Glumetza <sup>®</sup> Tablet <b>** requires documentation as to why the beneficiary cannot use preferred long acting metformin product</b>
glyburide-metformin tablet (generic for Glucovance <sup>®</sup> )	metformin solution (generic for Riomet <sup>®</sup> Solution) <b>Exemption for children &lt; 12 years of age</b>
metformin tablet / ER tablet (generic for Glucophage <sup>®</sup> / ER)	metformin tablet (625 mg)
	metformin ER tablet (generic for Fortamet <sup>®</sup> )
	metformin ER tablet (generic for Glumetza <sup>®</sup> )
	Riomet <sup>®</sup> Solution / ER Suspension
DPP-IV Inhibitors and Combinations	
<b>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 or Combination</b>	
Preferred	Non-Preferred
Janumet <sup>®</sup> Tablet / XR Tablet	alogliptin tablet (generic for Nesina <sup>®</sup> )
Januvia <sup>®</sup> Tablet	alogliptin-metformin tablet (generic for Kazano <sup>®</sup> )
Jentadueto <sup>®</sup> Tablet / XR Tablet	alogliptin-pioglitazone tablet (generic for Oseni <sup>®</sup> )
Onglyza <sup>®</sup> Tablet	Glyxambi <sup>®</sup> Tablet
saxagliptin tablet (generic for Onglyza <sup>®</sup> )	Kazano <sup>®</sup> Tablet
Tradjenta <sup>®</sup> Tablet	Kombiglyze <sup>®</sup> XR Tablet
	Nesina <sup>®</sup> Tablet
	Oseni <sup>®</sup> Tablet
	Qtern <sup>®</sup> Tablet
	saxagliptin-metformin ER tablet (generic for Kombiglyze <sup>®</sup> XR)
	Stegljua <sup>™</sup> Tablet
	Trijardy <sup>®</sup> XR Tablet
	Zituvio <sup>™</sup> (sitagliptin) Tablet
<b>Add new to market product Zituvio<sup>™</sup> (sitagliptin) Tablet as Non-Preferred</b>	
Meglitinides	
Preferred	Non-Preferred
nateglinide tablet (generic for Starlix <sup>®</sup> )	
repaglinide tablet (generic for Prandin <sup>®</sup> )	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

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

**Clinical criteria apply to all drugs in this class**

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

Farxiga <sup>®</sup> Tablet	dapagliflozin tablet (generic for Farxiga <sup>®</sup> )
Invokana <sup>®</sup> Tablet	dapagliflozin / metformin ER tablet (generic for Xigduo <sup>®</sup> XR)
Jardiance <sup>®</sup> Tablet	Inpefa <sup>™</sup> Tablet
Synjardy <sup>®</sup> Tablet	Invokamet <sup>®</sup> Tablet / XR Tablet
	Segluromet <sup>™</sup> Tablet
	Steglatro <sup>™</sup> Tablet
	Synjardy <sup>®</sup> XR Tablet
	Xigduo <sup>®</sup> XR Tablet

**Add new to market products dapagliflozin tablet (generic for Farxiga<sup>®</sup>) and dapagliflozin / metformin ER tablet (generic for Xigduo<sup>®</sup> XR) as Non-Preferred**

Thiazolidinediones and Combinations

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

pioglitazone tablet (generic for Actos <sup>®</sup> )	ActoPlus Met <sup>®</sup> Tablet
	Actos <sup>®</sup> Tablet
	Duetact <sup>®</sup> Tablet
	pioglitazone-glimepiride tablet (generic for Duetact <sup>®</sup> )
	pioglitazone-metformin tablet (generic for ActoPlus Met <sup>®</sup> )

**GASTROINTESTINAL**

ANTIEMETIC-ANTIVERTIGO AGENTS

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

aprepitant capsule / pack (generic for Emend <sup>®</sup> ) - <b>Clinical criteria apply</b>	Akynzeo <sup>®</sup> Capsule / Vial
Diclegis <sup>®</sup> Tablet	Antivert <sup>®</sup> Tablet / Chewable Tablet
dimenhydrinate vial (generic for Dramamine <sup>®</sup> )	Anzemet <sup>®</sup> Tablet
meclizine tablet (generic for Antivert <sup>®</sup> )	Aponvie <sup>™</sup> Vial
metoclopramide solution / tablet (generic for Reglan <sup>®</sup> )	Barhensys <sup>®</sup> Vial
ondansetron ODT / solution / tablet (generic for Zofran <sup>®</sup> )	Bonjesta <sup>®</sup> Tablet
prochlorperazine tablet (generic for Compazine <sup>®</sup> )	Cinvanti <sup>®</sup> Vial
<b>Promethegan<sup>®</sup> (promethazine) Suppository (12.5 mg and 25 mg)</b>	Compro <sup>®</sup> Suppository
promethazine syrup / suppository (12.5 mg and 25 mg) / tablet / ampule / vial (generic for Phenergan <sup>®</sup> )	doxylamine-pyridoxine tablet (generic for Diclegis <sup>®</sup> Tablet)
Transderm-Scop <sup>®</sup> Patch	dronabinol capsule (generic for Marinol <sup>®</sup> )
	Emend <sup>®</sup> Capsule / Powder Packet / Trifold Pack - <b>Clinical criteria apply</b>
	Emend <sup>®</sup> Vial
	fosaprepitant vial (generic for Emend <sup>®</sup> )
	Gimoti <sup>™</sup> Nasal Spray
	granisetron vial / tablet (generic for Kytril <sup>®</sup> )
	Marinol <sup>®</sup> Capsule
	metoclopramide ODT / vial
	ondansetron vial
	palonosetron injection (generic for Aloxi <sup>®</sup> )
	Phenergan <sup>®</sup> Ampule / Vial
	prochlorperazine vial / suppository (generic for Compazine <sup>®</sup> )
	<b>Promethegan<sup>®</sup> Suppository (50 mg)</b>
	promethazine 50 mg suppository (generic for Phenergan <sup>®</sup> )
	Reglan <sup>®</sup> Tablet
	Sancuso <sup>®</sup> Patch
	scopolamine patch (generic for Transderm-Scop <sup>®</sup> )
	Sustol <sup>®</sup> Syringe
	Tigan <sup>®</sup> Vial
	trimethobenzamide capsule (generic for Tigan <sup>®</sup> )

**Add Promethegan<sup>®</sup> (promethazine) Suppository (12.5 mg and 25 mg) as Preferred and Promethegan Suppository (50 mg) as Non-Preferred**

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

BILE ACID SALTS	
Trial and failure of only one preferred drug required	
Preferred	Non-Preferred
ursodiol capsule (generic for Actigall®)	Bylvay™ Capsule / Pellet - <b>Exemption for diagnosis of PFIC</b>
ursodiol tablet (generic for Urso®)	Chenodal® Tablet
	Cholbam® Capsule
	Livmarli® Oral Solution
	Ocaliva® Tablet
	Reltone™ Capsule
	Urso® Tablet / Urso® Forte Tablet
H. PYLORI COMBINATIONS	
Preferred	Non-Preferred
Pylera® Capsule	bismuth / metronidazole / tetracycline capsule (generic for Pylera®)
	lansoprazole-amoxicillin-clarithromycin pack (generic for Prevpac®)
	Omeclamox-Pak® Combo Pack
	Talicia® Capsule
	Voquezna® (vonoprazan) Tablet / Dual Pak (vonaprazan / amoxicillin) / Triple Pak (vonaprazan / amoxicillin / clarithromycin)
<b>Add new to market product Voquezna® (vonoprazan) Tablet / Dual Pak (vonaprazan / amoxicillin) / Triple Pak (vonaprazan / amoxicillin / clarithromycin) as Non-Preferred</b>	
HISTAMINE-2 RECEPTOR ANTAGONISTS	
Preferred	Non-Preferred
famotidine tablet / suspension (generic for Pepcid®)	cimetidine solution / tablet (generic for Tagamet®)
	nizatidine capsule (generic for Axid®)
	Pepcid® Tablet
<b>Remove cimetidine solution (generic for Tagamet®)</b>	
PANCREATIC ENZYMES	
Preferred	Non-Preferred
Creon® Capsule	Pertzye® Capsule
Zenpep® Capsule	Viokase® Tablet
PROGESTINS USED FOR CACHEXIA	
Preferred	Non-Preferred
megestrol suspension / tablet (generic for Megace®)	megestrol ES suspension (generic for Megace® ES)
PROTON PUMP INHIBITORS	
Preferred	Non-Preferred
Dexilant® Capsule	<b>Exemption for children &lt; 12 years of age</b>
esomeprazole magnesium capsule (generic for Nexium® Rx )	Aciphex® Tablet
lansoprazole capsule (generic for Prevacid® Rx)	dexlansoprazole capsules (generic for Dexilant®)
Nexium® Rx Packet	esomeprazole magnesium OTC capsule / tablet (generic for Nexium® OTC )
omeprazole Rx capsule (generic for Prilosec® Rx)	esomeprazole magnesium packet (generic for Nexium® Rx Packet)
pantoprazole tablet (generic for Protonix®)	Konvomep™ Suspension
Protonix® Suspension	lansoprazole capsule (generic for Prevacid® OTC)
	lansoprazole ODT (generic for Prevacid® SoluTab™)
	Nexium® Rx Capsule
	omeprazole-sodium bicarbonate capsule / packet (generic for Zegerid® Rx / OTC)
	omeprazole OTC capsule / ODT / tablet (generic for Prilosec® OTC)
	pantoprazole suspension (generic for Protonix®)
	Prevacid® Rx / OTC Capsule / Solutab
	Prilosec® Rx Suspension
	Protonix® Tablet
	rabeprazole tablet (generic for Aciphex®)
	Zegerid® Rx / Capsule / Packet

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.htm>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

SELECTIVE CONSTIPATION AGENTS	
Preferred	Non-Preferred
Amitiza <sup>®</sup> Capsule	alosetron tablet (generic for Lotronex <sup>®</sup> )
Linzess <sup>®</sup> Capsule	lksrela <sup>®</sup> Tablet
	Lotronex <sup>®</sup> Tablet
	lubiprostone capsule (generic for Amitiza <sup>®</sup> )
	Motegrity <sup>™</sup> Tablet
	Movantik <sup>®</sup> Tablet
	Relistor <sup>®</sup> Syringe / Vial / Tablet <b>Clinical Criteria Apply</b>
	Symproic <sup>®</sup> Tablet
	Trulance <sup>®</sup> Tablet
	Viberzi <sup>®</sup> Tablet - <b>Exemption for Irritable Bowel Syndrome with Diarrhea (IBS-D)</b>
ULCERATIVE COLITIS	
Oral	
Preferred	Non-Preferred
Apriso <sup>®</sup> Capsule	Asacol <sup>®</sup> HD Tablet
balsalazide capsule (generic for Colazal <sup>®</sup> )	Azulfidine <sup>®</sup> Entab / Tablet
Lialda <sup>®</sup> Tablet	budesonide ER tablet (generic for Uceris <sup>®</sup> )
sulfasalazine IR / DR tablet (generic for Azulfidine <sup>®</sup> / Entab)	Colazal <sup>®</sup> Capsule
	Delzicol <sup>®</sup> Capsule
	Dipentum <sup>®</sup> Capsule
	mesalamine DR capsule (generic for Delzicol <sup>®</sup> , Asacol <sup>®</sup> HD, Lialda <sup>®</sup> )
	mesalamine ER capsule (generic for Apriso <sup>®</sup> , Pentasa <sup>®</sup> )
	Pentasa <sup>®</sup> Capsule
	Uceris <sup>®</sup> Tablet
ULCERATIVE COLITIS	
Rectal	
<b>Trial and failure of only one preferred drug required</b>	
Preferred	Non-Preferred
mesalamine enema (generic for Rowasa <sup>®</sup> )	budesonide rectal foam
mesalamine suppository (generic for Canasa <sup>®</sup> )	Canasa <sup>®</sup> Suppository
	mesalamine kit (generic for Rowasa <sup>®</sup> )
	Rowasa <sup>®</sup> Kit
	SF Rowasa <sup>®</sup> Enema
	Uceris <sup>®</sup> Rectal Foam
ELECTROLYTE DEPLETERS (KIDNEY DISEASE)	
Preferred	Non-Preferred
calcium acetate capsule (generic for PhosLo <sup>®</sup> )	Auryxia <sup>®</sup> Tablet
calcium acetate tablet (generic for Eliphos <sup>®</sup> )	Fosrenol <sup>®</sup> Chewable Tablet / Powder Pack
Renvela <sup>®</sup> Powder Pack / Tablet	lanthanum carbonate chewable tablet (generic for Fosrenol <sup>®</sup> )
	MagneBind <sup>®</sup> 400 Rx Tablet
	<b>Phoslyra<sup>®</sup> Solution</b>
	Renagel <sup>®</sup> Tablet
	sevelamer carbonate powder pack / tablet (generic for Renvela <sup>®</sup> )
	sevelamer hydrochloride tablet (generic for Renagel <sup>®</sup> )
	Velphoro <sup>®</sup> Chewable
	<b>Xphozah<sup>®</sup> (tenapanor) Tablet</b>
<b>Add new to market product Xphozah<sup>®</sup> (tenapanor) Tablet as Non-Preferred</b> <b>Remove Phoslyra<sup>®</sup> Solution</b>	
GENITOURINARY / RENAL	
BENIGN PROSTATIC HYPERPLASIA TREATMENTS	
Preferred	Non-Preferred
alfuzosin ER tablet (generic for Uroxatral <sup>®</sup> )	Avodart <sup>®</sup> Softgel
doxazosin tablet (generic for Cardura <sup>®</sup> )	Cardura <sup>®</sup> Tablet / XL Tablet
dutasteride capsule (generic Avodart <sup>®</sup> )	Cialis <sup>®</sup> Tablet ( <b>2.5mg and 5mg strengths only</b> ) <b>Clinical criteria apply</b>
finasteride tablet (generic for Proscar <sup>®</sup> )	dutasteride / tamsulosin capsule (generic for Jalyn <sup>®</sup> )
tamsulosin capsule (generic for Flomax <sup>®</sup> )	Entadfi <sup>™</sup> Capsule
terazosin capsule (generic for Hytrin <sup>®</sup> )	Flomax <sup>®</sup> Capsule
	Jalyn <sup>®</sup> Capsule
	Proscar <sup>®</sup> Tablet
	Rapaflo <sup>®</sup> Capsule
	silodosin capsule (generic for Rapaflo <sup>®</sup> )
	tadalafil tablet (generic for Cialis <sup>®</sup> ) ( <b>2.5mg and 5mg strengths only</b> ) <b>Clinical criteria apply</b>

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>  
More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

URINARY ANTISPASMODICS	
Preferred	Non-Preferred
oxybutynin syrup / tablet / ER tablet (generic for Ditropan® / XL)	darifenacin ER tablet (generic for Enablex®)
oxybutynin solution (generic for Ditropan®)	Detrol® Tablet / LA Capsule
solifenacin tablet (generic for Vesicare®)	Ditropan® XL Tablet
Toviaz® Tablet	fesoterodine ER tablet (generic for Toviaz®)
	flavoxate tablet (generic for Urispas®)
	Gelnique® Gel Sachets
	Gemtesa® Tablet - <b>Exemption in patients with a diagnosis of dementia or mild cognitive impairment</b>
	Myrbetriq® (mirabegron) Granules / ER Tablet - <b>Exemption in patients with a diagnosis of dementia or mild cognitive impairment</b>
	oxybutynin tablet (2.5 mg)
	Oxytrol® Patch
	tolterodine tablet / ER capsule (generic for Detrol® / LA)
	tropium tablet / ER capsule (generic for Sanctura® / XR)
	Vesicare® LS Suspension / Tablet
<b>Add oxybutynin solution (generic for Ditropan®) as Preferred Remove Ditropan® XL Tablet</b>	
GOUT	
Preferred	Non-Preferred
allopurinol tablet (generic for Zyloprim®)	allopurinol tablet (200 mg)
colchicine tablet (generic for Colcrys®)	colchicine capsule (generic for Mitigare®)
probenecid tablet (generic for Benemid®)	Colcrys® Tablet
probenecid-colchicine tablet (generic for Col-Benemid®)	febuxostat tablet (generic for Uloric® Tablet)
	Gloperba® Solution
	Krystexxa® Vial
	Mitigare® (branded colchicine 0.6mg) Capsules
	Uloric® Tablet
	Zyloprim® Tablet
HEMATOLOGIC	
ANTICOAGULANTS	
Injectable	
Preferred	Non-Preferred
enoxaparin syringe / vial (generic for Lovenox®)	Arixtra® Syringe
Fragmin® Syringe / Vial	fondaparinux syringe (generic for Arixtra®)
	Lovenox® Syringe / Vial
Oral	
Preferred	Non-Preferred
Eliquis® Tablet / Starter Dose Pack	dabigatran capsule (generic for Pradaxa® Capsule)
Jantoven® (branded generic for Coumadin®)	Pradaxa® Pellet Pack
Pradaxa® Capsule	Savaysa® Tablet
warfarin tablet (generic for Coumadin®)	Xarelto® Suspension
Xarelto® Starter Pack / Tablet	
COLONY STIMULATING FACTORS	
Preferred	Non-Preferred
Neupogen® Vial / Syringe	Fulphila™ Syringe
Nyvepria™ Syringe	Fylmetra® Syringe
Udenyca® Autoinjector / Syringe	Granix® Safe Syringe / Syringe / Vial
	Leukine® Vial
	Neulasta® Syringe / Kit
	Nivestym™ Syringe / Vial
	Releuko® Syringe / Vial
	Rolvedon™ Syringe
	Stimufend® Syringe
	Udenyca® (pegfilgrastim-cbqv) On-Body
	Zarxio® Syringe
	Zixtenzo® Syringe
<b>Add new to market product Udenyca® (pegfilgrastim-cbqv) On-Body as Non-Preferred</b>	
HEMATOPOIETIC AGENTS	
Clinical criteria apply to all drugs in this class	
Preferred	Non-Preferred
Aranesp® Syringe / Vial	Jesduvroq® Tablet
Epogen® Vial	Mircera® Syringe
Retacrit® Vial	Procrit® Vial
	Reblozyl® Vial
THROMBOPOIESIS STIMULATING AGENTS	
Preferred	Non-Preferred
Nplate® Vial	Tavalisse™ Tablet
Promacta® Suspension / Tablet	
OPHTHALMIC	



North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

ALLERGIC CONJUNCTIVITIS AGENTS	
Preferred	Non-Preferred
cromolyn sodium drops (generic for Cromol <sup>®</sup> )	Alocril <sup>®</sup> Drops
olopatadine drops (generic for Pataday <sup>®</sup> , Patanol <sup>®</sup> )	Alomide <sup>®</sup> Drops
	Alrex <sup>®</sup> Drops
	azelastine drops (generic for Optivar <sup>®</sup> )
	bepotastine drops (generic for Bepreve <sup>®</sup> )
	Bepreve <sup>®</sup> Drops
	epinastine drops (generic for Elestat <sup>®</sup> )
	Zerviate <sup>™</sup> Drops
ANTIBIOTICS	
Preferred	Non-Preferred
bacitracin-polymyxin ointment (generic for Polysporin <sup>®</sup> )	Azasite <sup>®</sup> Drops
ciprofloxacin solution drops (generic for Ciloxan <sup>®</sup> )	bacitracin ointment (generic for AK-Tracin <sup>®</sup> )
erythromycin ointment (generic for Ilotycin <sup>®</sup> )	Besivance <sup>®</sup> Suspension
gentamicin drops (generic for Garamycin <sup>®</sup> )	Ciloxan <sup>®</sup> Drops / Ointment
moxifloxacin ophthalmic solution (generic for Vigamox <sup>®</sup> )	gatifloxacin drops (generic for Zymaxid <sup>®</sup> )
ofloxacin drops (generic for Ocuflax <sup>®</sup> )	moxifloxacin ophthalmic solution (generic for Moxeza <sup>®</sup> )
Polycin <sup>®</sup> Ointment (branded generic for Polysporin <sup>®</sup> )	Natacyn <sup>®</sup> Drops
polymyxin-trimethoprim drops (generic for Polytrim <sup>®</sup> )	neomycin-bacitracin-polymyxin ointment (generic for Neosporin <sup>®</sup> Ophthalmic Ointment)
sulfacetamide drops (generic for Bleph-10 <sup>®</sup> )	neomycin-polymyxin-gramicidin drops (generic for Neosporin <sup>®</sup> Ophthalmic Drops)
tobramycin drops (generic for Tobrex <sup>®</sup> )	Neo-Polycin <sup>®</sup> Ointment (branded generic for Neosporin <sup>®</sup> Ophthalmic Ointment)
	Ocuflax <sup>®</sup> Drops
	sulfacetamide ointment (generic for Cetamide <sup>®</sup> )
	Tobrex <sup>®</sup> Ointment / Drops
	Vigamox <sup>®</sup> Drops
	Zymaxid <sup>®</sup> Drops
<b>Remove Ciloxan<sup>®</sup> Drops and Tobrex<sup>®</sup> Drops</b>	
ANTIBIOTICS-STEROID COMBINATIONS	
Preferred	Non-Preferred
neomycin-polymyxin-dexamethasone drops / ointment (generic for Maxitrol <sup>®</sup> )	Maxitrol <sup>®</sup> Drops / Ointment
Tobradex <sup>®</sup> Drops / Ointment	Neo-Polycin <sup>®</sup> HC (branded generic for Cortisporin <sup>®</sup> )
tobramycin-dexamethasone suspension (generic for Tobradex <sup>®</sup> )	neomycin-bacitracin-polymyxin-HC ointment (generic for Cortisporin <sup>®</sup> )
	neomycin-polymyxin-HC drops / ointment (generic for Ocutricin <sup>®</sup> )
	sulfacetamide-prednisolone drops (generic for Vasocidin <sup>®</sup> )
	Tobradex <sup>®</sup> ST Drops
	Zylet <sup>®</sup> Drops
<b>Remove neomycin-polymyxin-HC ointment (generic for Ocutricin<sup>®</sup>)</b>	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

ANTI-INFLAMMATORY	
Preferred	Non-Preferred
dexamethasone drops (generic for Decadron®)	Acular® Drops / LS Solution
diclofenac drops (generic for Voltaren®)	Acuvail® Solution
difluprednate drops (generic for Durezol®)	<b>bromfenac 0.07% drops (generic for Prolensa®)</b>
Flarex® Drops	bromfenac drops (generic for Xibrom®)
fluorometholone drops (generic for FML®)	Bromsite™ Solution
flurbiprofen drops (generic for Ocufen®)	Dextenza® Insert
ketorolac solution (generic for Acular® / LS)	Dexycu™ Vial
Lotemax® Drops	Durezol® Drops
Nevanac® Droptainer	<b>FML® Forte Drops / S.O.P. Ointment / Liquifilm® Drops</b>
Pred Mild® Drops	Ilevro® Drops
prednisolone acetate drops (generic for Pred Forte®)	Iluvien® Implant
	Inveltys™ Drops
	Lotemax® Gel / SM Gel / Ointment
	loteprednol drops / gel (generic for Lotemax®)
	<b>loteprednol 0.2% drops (generic for Alrex®)</b>
	Maxidex® Drops
	Ozurdex® Implant
	Pred Forte™ Drops
	prednisolone sodium phosphate drops (generic for Inflammase Forte®)
	Prolensa® Drops
	Retisert® Implant
	Triessence® Vial
	Xipere™ (Intraocular)
	Yutiq™ Implant
<b>Add new to market products bromfenac 0.07% drops (generic for Prolensa®) and loteprednol 0.2% drops (generic for Alrex®) as Non-Preferred</b> <b>Remove FML® S.O.P. Ointment</b>	
ANTI-INFLAMMATORY / IMMUNOMODULATOR	
Preferred	Non-Preferred
Eysuvis™ Drops	Cequa™ Drops
Restasis® Drops / Restasis® Multidose™ Drops	cyclosporine emulsion (generic for Restasis®)
Xiidra® Drops	Miebo™ Drops
	Tyrvaya® Nasal Spray
	Verkazia® Eye Emulsion - <b>Exemption in patients with vernal keratoconjunctivitis (VKC)</b>
	<b>Veveye® (cyclosporine) Drops</b>
<b>Add new to market product Veveye® (cyclosporine) Drops as Non-Preferred</b>	
ALPHA 2 ADRENERGIC AGENTS	
Preferred	Non-Preferred
Alphagan® P Drops	apraclonidine drops (generic for Iopidine®)
brimonidine drops (generic for Alphagan®)	brimonidine P drops (generic for Alphagan® P)
	Iopidine® Drops
BETA BLOCKER AGENTS / COMBINATIONS	
Preferred	Non-Preferred
Combigan® Drops	betaxolol drops (generic for Betoptic®)
timolol drops / GFS gel-solution (generic for Timoptic® / Timoptic XE®)	Betimol® Drops
	Betoptic® S Drops
	brimonidine tartrate / timolol drops (generic for Combigan®)
	carteolol drops (generic for Ocupress®)
	Istalol® Drops
	levobunolol drops (generic for Betagan®)
	timolol drop (generic for Istalol® Drops)
	timolol maleate drop (generic for Timoptic® Oculose® Drops)
	Timoptic® Drops / Oculose® Drops / XE® Solution

North Carolina Division of Health Benefits  
 North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

CARBONIC ANHYDRASE INHIBITORS / COMBINATIONS	
Preferred	Non-Preferred
dorzolamide drops (generic for Trusopt®)	Azopt® Drops
dorzolamide-timolol drops (generic for Cosopt®)	brinzolamide drops (generic for Azopt® Drops)
Simbrinza® Drops	Cosopt® Drops / PF Drops
	dorzolamide-timolol PF drops (generic for Cosopt® PF)
PROSTAGLANDIN AGONISTS	
Preferred	Non-Preferred
latanoprost drops (generic for Xalatan®)	bimatoprost drops (generic for Lumigan® Drops)
Travatan® Z Drops	Durysta® Implant (intracameral)
	Iyuzeh™ Drops
	Lumigan® Drops
	tafluprost drops (generic for Zioptan®)
	travoprost drops (generic for Travatan® Z)
	Vyzulta® Drops
	Xalatan® Drops
	Xelpros® Drops
	Zioptan® Drops
RHO KINASE MODIFIERS / COMBINATIONS	
Preferred	Non-Preferred
Rhopressa® Drops	
Rocklatan® Drops	
OSTEOPOROSIS	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS	
Preferred	Non-Preferred
alendronate tablet (generic for Fosamax®)	Actonel® Tablet
raloxifene tablet (generic for Evista®)	alendronate solution (generic for Fosamax® Solution)
	Atelvia® Tablet
	<b>Binosto® (alendronate sodium) Effervescent Tablet</b>
	<b>Boniva® Tablet</b>
	calcitonin salmon nasal spray (generic for Miacalcin®)
	Evenity™ Syringe
	Evista® Tablet
	Forteo® Pen
	Fosamax® Tablet / Plus D Tablet
	ibandronate tablet (generic for Boniva®)
	Prolia® Syringe
	risedronate tablet (generic for Actonel®)
	<b>risedronate DR tablet (generic for Atelvia®)</b>
	teriparatide pen (generic for Forteo®)
	Tymlos® Pen
<b>Add Binosto® (alendronate sodium) Effervescent Tablet and risedronate DR tablet (generic for Atelvia®) as Non-Preferred</b> <b>Remove Boniva® Tablet</b>	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

OTIC	
ANTIBIOTICS	
Preferred	Non-Preferred
Ciprodex <sup>®</sup> Suspension	Cipro <sup>®</sup> HC Suspension
ciprofloxacin-dexamethasone suspension (generic for Ciprodex <sup>®</sup> )	ciprofloxacin solution (generic for Cetraxal <sup>®</sup> )
neomycin-polymyxin-hydrocortisone solution / suspension (generic for Cortisporin <sup>®</sup> )	ciprofloxacin-fluocinolone drops (generic for Otovel <sup>®</sup> )
ofloxacin drops (generic for Floxin <sup>®</sup> )	Cortisporin-TC <sup>®</sup> Suspension
	Otovel <sup>®</sup> Drops
ANTI-INFECTIVES AND ANESTHETICS	
Preferred	Non-Preferred
acetic acid solution (generic for Vosol <sup>®</sup> )	acetic acid-hydrocortisone solution (generic for Vosol <sup>®</sup> HC)
ANTI-INFLAMMATORY	
Preferred	Non-Preferred
Dermotic <sup>®</sup> Oil	Flac <sup>®</sup> Otic Oil
	fluocinolone 0.01% oil (generic for Dermotic <sup>®</sup> )
RESPIRATORY	
BETA-ADRENERGIC HANDHELD, LONG ACTING	
Preferred	Non-Preferred
Serevent <sup>®</sup> Diskus <sup>®</sup>	Striverdi <sup>®</sup> Respimat <sup>®</sup> Inhalation Spray
BETA-ADRENERGIC HANDHELD, SHORT ACTING	
Preferred	Non-Preferred
<b>ProAir<sup>®</sup> (albuterol sulfate) HFA inhaler</b>	albuterol HFA inhaler (generic for Proair <sup>®</sup> HFA Inhaler / Proventil <sup>®</sup> HFA Inhaler / Ventolin <sup>®</sup> HFA Inhaler)
Ventolin <sup>®</sup> HFA Inhaler	levalbuterol HFA inhaler (generic for Xopenex <sup>®</sup> HFA Inhaler)
Xopenex <sup>®</sup> HFA Inhaler	Proair <sup>®</sup> Digihaler <sup>™</sup>
	Proair <sup>®</sup> RespiClick <sup>®</sup>
	Proventil <sup>®</sup> HFA Inhaler
Add ProAir <sup>®</sup> (albuterol sulfate) HFA inhaler as Preferred	
BETA-ADRENERGIC, NEBULIZERS	
Trial and failure of only one preferred drug required	
Preferred	Non-Preferred
albuterol 0.63mg / 3ml solution (generic for Accuneb <sup>®</sup> )	arformoterol solution (generic for Brovana <sup>®</sup> )
albuterol 1.25mg / 3ml solution (generic for Accuneb <sup>®</sup> )	Brovana <sup>®</sup> Solution
albuterol sulfate 2.5mg / 0.5ml solution	formoterol solution (generic for Perforomist <sup>®</sup> )
albuterol sulfate 2.5mg / 3ml solution	levalbuterol solution / concentrate solution (generic for Xopenex <sup>®</sup> / Concentrate )
	Perforomist <sup>®</sup> Solution
BETA-ADRENERGIC, ORAL	
Preferred	Non-Preferred
albuterol tablets (generic for Proventil <sup>®</sup> Repetabs)	albuterol ER tablets (generic for VoSpire <sup>®</sup> ER)
albuterol syrup (generic for Ventolin <sup>®</sup> Syrup)	
terbutaline tablet (generic for Brethine <sup>®</sup> )	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

ORALLY INHALED ANTICHOLINERGICS / COPD AGENTS	
Preferred	Non-Preferred
Anoro <sup>®</sup> Ellipta <sup>®</sup> Inhaler	Bevespi <sup>®</sup> Aerosphere <sup>®</sup>
Atrovent <sup>®</sup> HFA Inhaler	Daliresp <sup>®</sup> Tablet
Combivent <sup>®</sup> Respimat <sup>®</sup> Inhalation Spray	Duaklir <sup>®</sup> Pressair <sup>®</sup>
Incruse <sup>®</sup> Ellipta <sup>®</sup> Inhaler	tiotropium inhaler (generic for Spiriva <sup>®</sup> Handihaler <sup>®</sup> )
ipratropium nebulizer solution (generic for Atrovent <sup>®</sup> )	Tudorza <sup>®</sup> Pressair <sup>®</sup> Inhaler
ipratropium / albuterol solution (generic for Duoneb <sup>®</sup> )	Yupelri <sup>™</sup> Solution
roflumilast tablet (generic for Daliresp <sup>®</sup> )	
Spiriva <sup>®</sup> Handihaler <sup>®</sup> / Respimat <sup>®</sup> Inhalation Spray	
Stiolto <sup>®</sup> Respimat <sup>®</sup> Inhalation Spray	
INHALED CORTICOSTEROIDS	
Preferred	Non-Preferred
budesonide suspension 0.25mg, 0.5mg, 1mg (generic for Pulmicort <sup>®</sup> Respules)	Alvesco <sup>®</sup> Inhaler
Flovent <sup>®</sup> Diskus / HFA Inhaler	ArmonAi <sup>™</sup> DigiHaler <sup>™</sup>
fluticasone propionate HFA / diskus (generic for Flovent <sup>®</sup> HFA / Diskus)	Arnuity <sup>®</sup> Ellipta <sup>®</sup> Inhaler
	Asmanex <sup>®</sup> HFA Inhaler / Twisthaler <sup>®</sup>
	Pulmicort <sup>®</sup> Flexhaler
	Pulmicort <sup>®</sup> Respules 0.25mg, 0.5mg, 1mg
	QVAR <sup>®</sup> ReditHaler <sup>™</sup>
INHALED CORTICOSTEROID COMBINATIONS	
Preferred	Non-Preferred
Advair <sup>®</sup> Diskus <sup>®</sup>	AirDuo <sup>®</sup> DigiHaler <sup>™</sup> / RespiClick <sup>®</sup>
Advair <sup>®</sup> HFA Inhaler	AirSupra <sup>™</sup> Inhaler
Dulera <sup>®</sup> Inhaler	Breo <sup>®</sup> Ellipta <sup>®</sup>
Symbicort <sup>®</sup> Inhaler	Breyna <sup>™</sup> Inhaler
	Breztri <sup>™</sup> Aerosphere <sup>™</sup>
	budesonide / formoterol inhalation (generic for Symbicort <sup>®</sup> )
	fluticasone / salmeterol HFA inhaler (generic for Advair <sup>®</sup> HFA)
	fluticasone / salmeterol inhalation (generic for Advair <sup>®</sup> Diskus <sup>®</sup> )
	fluticasone / salmeterol inhalation (generic for AirDuo <sup>®</sup> )
	fluticasone / vilanterol inhalation (generic for Breo <sup>®</sup> Ellipta <sup>®</sup> )
	Trelegy <sup>®</sup> Ellipta <sup>®</sup>
	Wixela <sup>™</sup> Inhub <sup>™</sup>
INTRANASAL RHINITIS AGENTS	
Preferred	Non-Preferred
azelastine spray (generic for Astelin <sup>®</sup> )	<b>Exemption for steroids applies to children &lt; 4 years of age</b>
Dymista <sup>®</sup> Nasal Spray	azelastine nasal spray (generic for Astepro <sup>®</sup> )
fluticasone spray (generic for Flonase <sup>®</sup> )	azelastine-fluticasone nasal spray (generic for Dymista <sup>®</sup> )
ipratropium spray (generic for Atrovent <sup>®</sup> Nasal)	Beconase <sup>®</sup> AQ Nasal Spray
olopatadine nasal spray (generic for Patanase <sup>®</sup> )	flunisolide nasal spray (generic for Nasalide <sup>®</sup> )
	mometasone nasal spray (generic for Nasonex <sup>®</sup> )
	Omnaris <sup>®</sup> Nasal Spray
	Patanase <sup>®</sup> Nasal Spray
	QNasal <sup>®</sup> Nasal Spray / Children's Spray
	Ryvaltris <sup>®</sup> Nasal Spray
	Sinuva <sup>™</sup> Implant
	Xhance <sup>™</sup> Nasal Spray
	Zetonna <sup>®</sup> Nasal Spray
LEUKOTRIENE MODIFIERS	
Preferred	Non-Preferred
montelukast chewable / tablet (generic for Singulair <sup>®</sup> )	Accolate <sup>®</sup> Tablet
	montelukast granules (generic for Singulair <sup>®</sup> )
	Singulair <sup>®</sup> Chewable / Granules / Tablet
	zafirlukast tablet (generic for Accolate <sup>®</sup> )
	zileuton tablet (generic for Zyllo <sup>®</sup> )
	Zyflo <sup>®</sup> FilmTab

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>  
More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

LOW SEDATING ANTIHISTAMINES	
Preferred	Non-Preferred
cetirizine OTC syrup 1mg/1ml (generic for Zyrtec® OTC Syrup)	cetirizine chewable tablet OTC (generic for Zyrtec® OTC Tablet)
cetirizine Rx syrup (generic for Zyrtec® Syrup)	cetirizine OTC syrup 5mg/5ml (generic for Zyrtec® OTC Syrup)
cetirizine tablets OTC (generic for Zyrtec® OTC Tablet)	cetirizine OTC softgel
levocetirizine OTC tablet (generic for Xyzal® OTC Tablet)	Clarinetix® Tablet - <b>Exemption for children &lt; 2 years of age</b>
levocetirizine Rx tablet (generic for Xyzal® Rx Tablet)	desloratadine ODT / Tablet (generic for Clarinetix®) - <b>Exemption for children &lt; 2 years of age</b>
loratadine tablet OTC (generic for Claritin® OTC)	fexofenadine OTC suspension / OTC tablet (generic for Allegra® OTC)
	levocetirizine Rx solution (generic for Xyzal® Rx Solution)
	loratadine OTC chewable ODT / solution (generic for Claritin® OTC)
LOW SEDATING ANTIHISTAMINE COMBINATIONS	
<b>Quantity limit of 102 days supply per 12 months apply to all drugs in this class</b>	
Preferred	Non-Preferred
loratadine-D OTC tablet (generic for Claritin-D® OTC)	cetirizine-D OTC tablet (generic for Zyrtec-D® OTC)
	Clarinetix-D® Tablet
	fexofenadine-D 12 Hour OTC Tablet (generic for Allegra-D® 12 Hour OTC)
	fexofenadine-pseudoephedrine ER 24 hour tablet (generic for Allegra-D® 24 hour)
FIRST GENERATION ANTIHISTAMINES	
Preferred	Non-Preferred
carbinoxamine solution	carbinoxamine tablet
cycloheptadine syrup / tablet	clemastine tablet
hydroxyzine capsule / solution / tablet	Karbinal™ ER Suspension - <b>Trial and failure of immediate release carbinoxamine solution and cetirizine syrup required for coverage</b>
	RyClora™ Solution
	RyVent™ Tablet
	Vistari® Capsule
TOPICALS	
ACNE AGENTS	
Preferred	Non-Preferred
adapalene / benzoyl peroxide (generic for Epiduo® Forte)	Acanya® Gel Pump
adapalene / benzoyl peroxide (generic for Epiduo® Gel)	adapalene gel pump (generic for Differin®)
adapalene cream / gel (generic for Differin®)	Altreno® Lotion (Topical)
azelaic acid gel (generic for Finacea®)	Arazlo™ Lotion
<b>BP® 10-1 Wash / Cleansing Wash</b>	Atralin® Gel
clindamycin phosphate pledgets / solution (generic for Cleocin-T®)	Avar® Cleanser / LS Cleanser
clindamycin-benzoyl peroxide gel (generic for Duac®)	Avar-E® Emollient Cream / Green Emollient Cream / LS Cream
erythromycin gel (generic for Emcin®, Erycette®, EryGel®, et. al.)	Avita® Cream
erythromycin solution (generic for Emcin®, EryDerm®, EryMax®, et. al.)	Benzamycin® Gel
erythromycin-benzoyl peroxide gel (generic for Benzamycin®)	<b>BP® 10-1 Wash / Cleansing Wash</b>
Finacea® Gel	Cabtree® (clindamycin / adapalene / benzoyl peroxide) Gel
Retin-A® Cream / Gel	Cleocin® T Lotion
Retin-A® Micro Gel	Clindacin® ETZ.Pledget / Kit / P Foam / P Pledgets / PAC Kit
	Clindagel® Gel
	clindamycin / tretinoin (generic for Veltin®)
	clindamycin phosphate foam (generic for Evoclin®)
	clindamycin phosphate gel / lotion (generic for Cleocin-T®, Clindagel®)
	clindamycin-benzoyl peroxide gel (generic for Neua®)
	clindamycin-benzoyl peroxide gel / pump (generic for Benzacilin®)
	clindamycin-benzoyl peroxide pump (generic for Acanya®)
	<b>clindamycin-benzoyl peroxide pump (generic for Onexton®)</b>
	dapsone gel / gel pump (generic for Aczone® Gel)
	Ery® Pads
	Erygel® Gel
	Evoclin® Foam
	Fabior® Foam
	Finacea® Foam
	Klaron® Lotion
	Neua® Gel / Kit
	Onexton® Gel / Gel Pump
	Ovace® Plus Cleansing Cream / Gel / Lotion / Shampoo / Wash
	<b>Promiseb® Topical Cream</b>
	Retin-A® Micro Pump Gel
	Rosula® Cloths / Wash
	sodium sulfacetamide cleanser / cream (generic for Avar® / LS)
	sodium sulfacetamide lotion (generic for Klaron®)
	sodium sulfacetamide shampoo, wash (generic for Ovace® / Plus)
	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 Sumaxin®)
	SSS® 10-5 Cream / Foam
	sulfacetamide-sulfur 9-4% cleanser (generic for Zencia™)
	sulfacetamide-sulfur cream (generic for Avar® E, SSS® 10-5)
	Sumadan® Kit / XLT Kit
	<b>Sumadan® Wash</b>
	Sumaxin® Cleansing Pads / CP Kit / TS Topical Suspension / Wash
	tazarotene cream / foam / gel (generic for Tazorac®, Fabior®)
	tretinoin cream / gel (generic for Retin-A®)

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

	tretinoin microsphere gel / microsphere gel pump (generic for Retin-A® Micro)
	Tretin-X™ Combo Pack / Cream
	Winlevi® Cream
	Ziana® Gel
	Zma Clear™ Cleanser

**Add new to market Cabtreo™ (clindamycin / adapalene / benzoyl peroxide) Gel and clindamycin-benzoyl peroxide pump (generic for Onexton®) as Non-Preferred**  
**Add Sumadan® (sodium sulfacetamide-sulfur) Wash as Non-Preferred**  
**Move BP® 10-1 Wash / Cleansing Wash from Preferred to Non-Preferred**  
**Remove Promiseb® Topical Cream, sodium sulfacetamide-sulfur kit (generic for Sumadan®), Tretin-X™ Combo Pack / Cream**

**ANDROGENIC AGENTS**

Preferred	Non-Preferred
AndroGel® Pump	Androderm® Patch
testosterone gel pump (generic for AndroGel®)	AndroGel® Packet
	Fortesta® Gel Pump
	Natesto® Nasal Gel
	Testim® Gel
	testosterone gel / packet (generic for Testim®, Vogelxo®)
	testosterone gel pump (generic for Fortesta®, Axiron®)
	testosterone packet (generic for AndroGel®)
	Vogelxo® Gel / Packet / Pump

**NSAIDS**

Preferred	Non-Preferred
diclofenac topical gel (generic for Voltaren® Gel)	diclofenac epolamine patch (generic for Flector®)
	diclofenac solution / pump (generic for Pennsaid®)
	Flector® Patch
	Licart™ Patch
	Pennsaid® Solution Packet / Pump

**ANTIBIOTICS**

Preferred	Non-Preferred
gentamicin cream / ointment (generic for Garamycin®)	Centany® AT Ointment Kit / Ointment
mupirocin ointment (generic for Bactroban®)	mupirocin cream (generic for Bactroban®)
	Xepi™ Cream

**ANTIBIOTICS - VAGINAL**

Preferred	Non-Preferred
Cleocin® Vaginal Ovules	Cleocin® Vaginal Cream
Clindesse® Vaginal Cream	clindamycin vaginal cream (generic for Cleocin® Vaginal Cream)
metronidazole vaginal gel (generic for Metrogel® Vaginal Gel)	Metrogel® Vaginal Gel
NuVessa® Vaginal Gel	Vandazole™ Vaginal Gel
	Xaciato® Vaginal Gel

**ANTIFUNGALS**

Preferred	Non-Preferred
ciclopirox cream / solution (generic for Loprox®, Penlac®)	Bensal HP® Ointment
clotrimazole Rx cream (generic for Lotrimin® Rx)	Ciclodan® Cream / Cream Kit / Kit / Solution
clotrimazole-betamethasone cream (generic for Lotrisone®)	ciclopirox gel / shampoo / suspension (generic for Loprox®)
ketoconazole cream / shampoo (generic for Nizoral®)	ciclopirox treatment kit (generic for Ciclodan®)
<b>Klayesta® (nystatin) Powder (branded generic for Nystop®)</b>	clotrimazole Rx solution (generic for Lotrimin® Rx)
Nyamy® Powder (branded generic for Nystop®)	clotrimazole-betamethasone lotion (generic for Lotrisone®)
nystatin cream / ointment / powder (generic for Mycostatin®, Nystop®)	econazole cream (generic for Spectazole®)
Nystop® Powder	Ertaczo® Cream
	Extina® Foam
	Jublia® Topical Solution
	ketoconazole foam (generic for Extina®)
	Ketodan® Foam / Foam Kit
	Loprox® Shampoo / Suspension / Cream / Kit
	luliconazole cream (generic for Luzu®)
	Luzu® Cream
	miconazole / zinc oxide / petrolatum ointment (generic for Vusion®) - <b>Clinical criteria apply</b>
	naftifine cream / gel (generic for Naftin®)
	Naftin® Gel
	nystatin-triamcinolone cream / ointment (generic for Mycolog II®)
	oxiconazole cream (generic for Oxistat®)
	Oxistat® Lotion
	salicylic acid ointment (generic for Bensal HP®)
	tavaborole topical solution (generic for Kerydin®)
	Triamazole™ (triamcinolone ointment / econazole cream) Combo Pack
	Vusion® Ointment - <b>Clinical criteria apply</b>

**Add Klayesta® (nystatin) Powder as Preferred**  
**Remove Loprox® Shampoo**

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

ANTIPARASITICS		
Trial and failure of only one preferred drug required		
Preferred		Non-Preferred
Natroba <sup>®</sup> Topical Suspension	Crotan <sup>™</sup> Lotion	
permethrin cream (generic for Elimite <sup>®</sup> )	Eurax <sup>®</sup> Cream / Lotion	
	ivermectin lotion (generic for Sklice <sup>®</sup> )	
	lindane shampoo	
	malathion lotion (generic for Ovide <sup>®</sup> )	
	Ovide <sup>®</sup> Lotion	
	Sklice <sup>®</sup> Lotion	
	spinosad topical suspension (generic for Natroba <sup>®</sup> )	
<b>Remove ivermectin lotion (generic for Sklice<sup>®</sup>)</b>		
ANTIVIRAL		
Preferred		Non-Preferred
acyclovir ointment (generic for Zovirax <sup>®</sup> )	acyclovir cream (generic for Zovirax <sup>®</sup> )	
Zovirax <sup>®</sup> Cream	Denavir <sup>®</sup> Cream	
	peniclovir cream (generic for Denavir <sup>®</sup> )	
	Xerese <sup>®</sup> Cream	
	Zovirax <sup>®</sup> Ointment	
IMMUNOMODULATORS		
Atopic Dermatitis		
Clinical criteria apply to all drugs in this class		
Preferred		Non-Preferred
Adbry <sup>®</sup> Syringe	Opzelura <sup>™</sup> Cream	
Dupixent <sup>®</sup> Pen / Syringe	pimecrolimus cream (generic for Elidel <sup>®</sup> )	
Elidel <sup>®</sup> Cream	Zoryve <sup>®</sup> (roflumilast) Foam	
Eucriisa <sup>®</sup> 2% Ointment		
Protopic <sup>®</sup> Ointment		
tacrolimus ointment (generic for Protopic <sup>®</sup> )		
<b>Add new to market product Zoryve<sup>®</sup> (roflumilast) Foam as Non-Preferred</b>		
Imidazoquinolinamines		
Preferred		Non-Preferred
imiquimod cream packet (generic for Aldara <sup>®</sup> )	Condylox <sup>®</sup> Gel	
	Hyftor <sup>™</sup> Gel	
	imiquimod cream / cream pump (generic for Zyclara <sup>®</sup> )	
	podofilox gel (generic for Condylox <sup>®</sup> )	
	podofilox solution (generic for Condylox <sup>®</sup> )	
	Veregen <sup>®</sup> Ointment	
	Zyclara <sup>®</sup> Cream / Cream Pump	
<b>Add new to market product podofilox gel (generic for Condylox<sup>®</sup>) as Non-Preferred</b>		
PSORIASIS		
Preferred		Non-Preferred
calcipotriene cream / solution (generic for Dovonex <sup>®</sup> )	calcipotriene ointment / foam (generic for Dovonex <sup>®</sup> , Sorilux <sup>®</sup> )	
	calcipotriene-betamethasone suspension / ointment (generic for Talconex <sup>®</sup> )	
	calcitriol ointment (generic for Vectical <sup>®</sup> )	
	Duobrii <sup>™</sup> Lotion	
	Enstilar <sup>®</sup> Foam	
	Sorilux <sup>®</sup> Foam	
	Taclonex <sup>®</sup> Ointment / Suspension	
	Vitama <sup>®</sup> Cream	
	Zoryve <sup>®</sup> Cream	
ROSACEA AGENTS		
Preferred		Non-Preferred
azelaic acid gel (generic for Finacea <sup>®</sup> )	brimonidine gel pump (generic for Mirvaso <sup>®</sup> )	
Finacea <sup>®</sup> Gel	Finacea <sup>®</sup> Foam	
metronidazole cream (generic for MetroCream <sup>®</sup> )	ivermectin cream (generic for Soolantra <sup>®</sup> )	
metronidazole gel / pump (generic for MetroGel <sup>®</sup> )	metronidazole lotion (generic for MetroLotion <sup>®</sup> )	
Rosadan <sup>®</sup> Cream / Gel	Noritate <sup>®</sup> Cream	
	Rhofade <sup>®</sup> Cream	
	Rosadan <sup>®</sup> Kit	



North Carolina Division of Health Benefits  
 North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

STEROIDS	
Low Potency	
Preferred	Non-Preferred
DermaSmoothe <sup>®</sup> FS Scalp and Body Oil	alclometasone dipropionate cream / ointment (generic for Aclovate <sup>®</sup> )
desonide cream / ointment (generic for DesOwen <sup>®</sup> )	Aqua Glycolic <sup>®</sup> HC Kit
hydrocortisone cream / lotion / ointment (generic for Hytone <sup>®</sup> )	desonide lotion (generic for DesOwen <sup>®</sup> Lotion)
	fluocinolone body / scalp oil (generic for DermaSmoothe <sup>®</sup> FS Scalp / Body Oil)
	Hydroxym <sup>™</sup> Gel
	Texacort <sup>®</sup> Solution
Medium Potency	
Preferred	Non-Preferred
fluticasone cream / ointment (generic for Cutivate <sup>®</sup> )	Beser <sup>™</sup> Lotion / Kit
mometasone cream / ointment / solution (generic for Elocon <sup>®</sup> )	clocortolone cream / pump (generic for Cloderm <sup>®</sup> )
	Cloderm <sup>®</sup> Cream / Pump
	fluocinolone cream / ointment / solution (generic for Synalar <sup>®</sup> )
	flurandrenolide cream / lotion / ointment (generic for Cordran <sup>®</sup> )
	fluticasone lotion (generic for Cutivate <sup>®</sup> Lotion)
	hydrocortisone butyrate cream / lipid cream / lotion / ointment / solution (generic for Locoid <sup>®</sup> )
	hydrocortisone valerate cream / ointment (generic for Westcort <sup>®</sup> )
	Locoid <sup>®</sup> Lipocream / Lotion
	Luxiq <sup>®</sup> Foam
	Pandel <sup>®</sup> Cream
	prednicarbate cream / ointment (generic for Dermatop <sup>®</sup> )
	Synalar <sup>®</sup> Cream / Ointment / Kit / Solution / TS Kit
<b>Remove Luxiq<sup>®</sup> Foam</b>	
High Potency	
Preferred	Non-Preferred
betamethasone valerate cream / ointment (generic for Valisone <sup>®</sup> )	amcinonide cream (generic for Cyclocort <sup>®</sup> )
fluocinonide ointment / solution (generic for Lidex <sup>®</sup> )	betamethasone dipropionate augmented cream / gel / lotion / ointment (generic for Diprolene <sup>®</sup> )
triamcinolone acetonide cream / lotion / ointment (generic for Kenalog <sup>®</sup> )	betamethasone dipropionate cream / lotion / ointment (generic for Diprosone <sup>®</sup> )
	betamethasone valerate foam / lotion (generic for Valisone <sup>®</sup> )
	desoximetasone cream / gel / ointment / spray (generic for Topicort <sup>®</sup> )
	diflorasone cream / ointment (generic for Florone <sup>®</sup> )
	Diprolene <sup>®</sup> Ointment
	fluocinonide cream / emollient cream / gel (generic for Lidex <sup>®</sup> / Lidex <sup>®</sup> E)
	halcinonide cream (generic for Halog <sup>®</sup> )
	Halog <sup>®</sup> Cream / Ointment / Solution
	Kenalog <sup>®</sup> Spray
	Sanaderm <sup>®</sup> Rx Solution
	Topicort <sup>®</sup> Cream / Gel / Ointment / Spray
	triamcinolone spray (generic for Kenalog <sup>®</sup> )
	Vanos <sup>®</sup> Cream
<b>Remove Sanaderm<sup>®</sup> Rx Solution</b>	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

Very High Potency	
Preferred	Non-Preferred
clobetasol cream / emollient cream / gel / ointment (generic for Temovate®)	ApexiCon® E Cream
clobetasol solution (generic for Cormax®)	Bryhali™ Lotion
halobetasol propionate cream / ointment (generic for Ultravate®)	clobetasol foam / emollient foam / emulsion foam (generic for Olux® / Olux-E®)
clobetasol shampoo (generic for Clobex®)	clobetasol lotion / spray (generic for Clobex®)
	Clodan® Kit / Shampoo
	halobetasol propionate foam (generic for Lexette®)
	Impeklo™ Lotion
	Lexette® Foam
	Olux® Foam / E-Foam
	Temovate® Cream / Ointment
	Tovet™ Foam / Foam Kit
	Ultravate® Lotion
<b>Remove Olux® E-Foam and Temovate® Cream</b>	
MISCELLANEOUS	
IMMUNOMODULATORS, ASTHMA	
<b>Clinical criteria apply to all drugs in this class</b>	
Preferred	Non-Preferred
Fasenra® Pen / Syringe	Cinqair® Vial
Xolair® Syringe	Nucala® Syringe / Vial / Autoinjector
	Tezspire® Pen / Syringe - <b>Exemption for non-allergic, non-eosinophilic severe asthma</b>
	Xolair® Vial
ANTIPSORIATICS, ORAL	
Preferred	Non-Preferred
acitretin (generic for Soriatane®)	methoxsalen rapid (generic for Oxsoalene-Ultra®)
EPINEPHRINE, SELF INJECTED	
<b>Quantity limits apply to all drugs in this class</b>	
Preferred	Non-Preferred
Epi-Pen® Auto Injector / 2-Pak / Jr. Auto Injector / Jr. 2-Pak	Auvi-Q® Auto Injector
epinephrine auto injector (generic for Epi-Pen® / Epi-Pen® Jr.)	epinephrine auto injector (generic for AdrenaClick®)
	Symjepi™ Syringe
ESTROGEN AGENTS, COMBINATIONS	
Preferred	Non-Preferred
Activella® Tablet	Bijuva® Capsule
Amabelz™ Tablet	Prefest® Tablet
estradiol/norethindrone tablet (generic for Activella®)	
Fyavolv™ Tablet	
Jimteli® (branded generic for FemHRT®)	
Mimvey® / Lo (branded generic for Activella®)	
norethindrone-ethinyl estradiol (generic for FemHRT®)	
Premphase® Tablet	
Prempo® Tablet	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

ESTROGEN AGENTS, ORAL / TRANSDERMAL	
Preferred	Non-Preferred
Climara <sup>®</sup> Pro Patch	Climara <sup>®</sup> Patch
CombiPatch <sup>®</sup> Patch	Divigel <sup>®</sup> Gel Packet
estradiol patch (generic for Climara <sup>®</sup> , Menostar <sup>®</sup> , Vivelle-Dot <sup>®</sup> )	Doti <sup>™</sup> Patch
estradiol tablet (generic for Estrace <sup>®</sup> )	Duavee <sup>®</sup> Tablet
Evamist <sup>®</sup> Spray	Elestrin <sup>®</sup> Gel
Menest <sup>®</sup> Tablet	Estrace <sup>®</sup> Tablet
Premarin <sup>®</sup> Tablet	estradiol gel packet (generic for Divigel <sup>®</sup> )
	Lyllana <sup>™</sup> Patch
	Menostar <sup>®</sup> Patch
	Minivelle <sup>®</sup> Patch
	Veozah <sup>™</sup> Tablet
	Vivelle-Dot <sup>®</sup> Patch

**Remove Veozah<sup>™</sup> Tablet**

ESTROGEN AGENTS, VAGINAL PREPARATIONS	
Preferred	Non-Preferred
Estring <sup>®</sup> Vaginal Ring	Estrace <sup>®</sup> Cream
Premarin <sup>®</sup> Vaginal Cream	estradiol vaginal cream / tablet (generic for Estrace <sup>®</sup> )
Vagifem <sup>®</sup> Vaginal Tablet	Femring <sup>®</sup> Vaginal Ring
	Imvexxy <sup>®</sup> Vaginal Inserts
	Yuvafem <sup>®</sup> Vaginal Tablet

GLUCOCORTICOID STEROIDS, ORAL	
Preferred	Non-Preferred
budesonide EC capsule (generic for Entocort <sup>®</sup> EC)	Alkindi <sup>™</sup> Sprinkle Capsule
dexamethasone elixir / tablet (generic for Decadron <sup>®</sup> )	Cortef <sup>®</sup> Tablet
dexamethasone solution (generic for Concedix <sup>®</sup> )	cortisone tablet (generic for Patisono <sup>®</sup> )
<b>Emlaza<sup>®</sup> Tablet - Clinical criteria apply</b>	dexamethasone tablet dosepack / Intensol <sup>®</sup> Drops
hydrocortisone tablet (generic for Cortef <sup>®</sup> )	<b>Emlaza<sup>®</sup> Suspension / Tablet - Clinical criteria apply</b>
methylprednisolone 4mg dosepack / tablet (generic for Medrol <sup>®</sup> )	Hemady <sup>™</sup> Tablet
prednisolone sodium phosphate solution (generic for PediaPred <sup>®</sup> , OraPred <sup>®</sup> , Veripred <sup>®</sup> )	Medrol <sup>™</sup> Dose Pack / Tablet
prednisolone solution (generic for Prelone <sup>®</sup> , Millipred <sup>®</sup> )	methylprednisolone 8mg / 16mg / 32mg / tablet (generic for Medrol <sup>®</sup> )
prednisone dose pack (generic for Sterapred <sup>®</sup> )	Millipred <sup>™</sup> Dose Pack / Tablet
prednisone solution / tablet (generic for Deltasone <sup>®</sup> )	<b>Ortikos<sup>™</sup> Capsule</b>
	prednisolone ODT (generic for Orapred <sup>®</sup> ODT)
	prednisolone tablet
	Prednisone Intensol <sup>®</sup> Concentrated Solution
	Rayos <sup>®</sup> Tablet
	Taperdex <sup>®</sup> Tablet
	Tarpevo <sup>™</sup> Capsule - <b>Exemption for diagnosis of IgA nephropathy</b>

**Move Emlaza<sup>®</sup> Tablet from Non-Preferred to Preferred**  
**Remove Ortikos<sup>™</sup> Capsule**

CYTOKINE AND CAM ANTAGONISTS (previously listed as Immunomodulators, Systemic)	
<b>Clinical criteria apply to all drugs in this class</b>	
<b>Trial and failure of only one Preferred drug required</b>	

Preferred	Non-Preferred
Cosentyx <sup>®</sup> Sensoready <sup>®</sup> Pen / UnoReady <sup>®</sup> Pen / Syringe	<b>Abrilada<sup>™</sup> (adalimumab-afzb) Pen / Syringe</b>
Enbrel <sup>®</sup> Mini Cartridge / Sureclick <sup>®</sup> Syringe / Syringe / Vial	Actemra <sup>®</sup> ACTPen <sup>™</sup> / Syringe / Vial
Humira <sup>®</sup> Crohn's Starter Pack / Ped. Crohn's Starter Pack / Pen / Psoriasis Starter Pack / Syringe	<b>adalimumab-aacr Pen</b>
infliximab vial (generic for Remicade <sup>®</sup> )	adalimumab-adaz Pen / Syringe
	adalimumab-adbm Pen / Psoriasis-UV Pen / Crohn's Pen / Syringe
	adalimumab-ikjp Pen / Syringe
	Amjevita <sup>™</sup> Syringe / Autoinjector
	Arcalyst <sup>®</sup> SQ Syringe
	Avsola <sup>™</sup> Vial
	<b>Bimzelx<sup>™</sup> (bimekizumab-bkzx) Autoinjector / Syringe</b>
	Cibinqo <sup>™</sup> Tablet
	Cimzia <sup>®</sup> Starter Kit / Syringe Kit / Vial Kit
	<b>Cosentyx<sup>®</sup> (secukinumab) Vial</b>
	Cyltezo <sup>™</sup> Syringe / Crohn's-UC-HS Pen / Psoriasis Pen / Pen
	Enspryng <sup>™</sup> Syringe
	Entyvio <sup>®</sup> Vial
	<b>Entyvio<sup>®</sup> (vedolizumab) Pen</b>
	Hadlima <sup>™</sup> Syringe / PushTouch
	Hyrimoz <sup>™</sup> Pen / Crohn's-UC Pen / Ped. Crohn's Pen / Syringe / Psoriasis Pen
	Hulio <sup>™</sup> Pen / Syringe
	Idacio <sup>®</sup> Pen / Psoriasis Pen / Crohn's-UC Pen / Syringe
	Ilaris <sup>®</sup> Vial
	Ilumya <sup>®</sup> Syringe
	Inflectra <sup>™</sup> Vial
	Kevzara <sup>®</sup> Syringe / Pen
	Kineret <sup>®</sup> Syringe - <b>Exemption for diagnosis of Neonatal Onset Multi-System Inflammatory Disease</b>
	Olumiant <sup>®</sup> Tablet
	<b>Omvoht<sup>™</sup> (mirikizumab-mrkz) Pen / Vial</b>

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>  
More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

	Orencia® Clickjet® / Syringe / Vial
	Otezla® Starter Pack / Tablet
	Remicade® Vial
	Renflexis™ Vial
	Rinvoq™ ER Tablet
	Siliq® Syringe
	Simponi® Pen / Syringe / Aria® Vial
	Skyrizi® On-Body / Vial / Pen / Syringe
	Sotyktu® Tablet
	Spevigo® (spesolimab-sbzo) Vial
	Stelara® Syringe / Vial
	Taltz® Auto-injector / Syringe
	Tremfya® Syringe / Injector
	Uplizna® Vial
	Velsipity® (etrasimod) Tablet
	Xeljanz® Tablet / Solution / XR Tablet
	Yuflyma® Syringe / Autoinjector
	Yuflyma® (adalimumab-aaty) Crohn's-UC-HS Autoinjector
	Yusimry™ Pen

**Add new to market products (Humira biosimilars) as Non-Preferred: Abrilada™ (adalimumab-afzb) Pen / Syringe, adalimumab-aacf Pen, Yuflyma® (adalimumab-aaty) Crohn's-UC-HS Autoinjector**

**Add the following new to market products as Non-Preferred: Bimzelx® (bimekizumab-bkzx) Autoinjector / Syringe, Cosentyx® (secukinumab) Vial, Entyvio® (vedolizumab) Pen, Omvoh™ (mirikizumab-mrkz) Pen / Vial, Velsipity® (etrasimod) Tablet**

IMMUNOSUPPRESSANTS	
Preferred	Non-Preferred
Astagraf® XL Capsule	
Azasan® Tablet	
azathioprine tablet (generic for Imuran®)	
Cellcept® Capsule / Suspension / Tablet	
cyclosporine capsule (generic for Sandimmune®)	
cyclosporine modified capsule / solution (generic for Gengraf®, Neoral®)	
Envarsus® XR Tablet	
everolimus tablet (generic for Zortress® Tablet)	
Gengraf® Capsule / Solution	
Imuran® Tablet	
mycophenolate capsule / suspension / tablet (generic for Cellcept®)	
mycophenolic acid tablet (generic for Myfortic®)	
Myfortic® Tablet	
Neoral® Capsule / Solution	
Prograf® Capsule / Granule Packet	
Rapamune® Solution / Tablet	
Rezurock™ Tablet	
Sandimmune® Capsule / Solution	
sirolimus tablet / solution (generic for Rapamune®)	
tacrolimus capsule (generic for Hecoria®, Prograf®)	
Tavneos® Capsule	
Zortress® Tablet	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.htm>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

MOVEMENT DISORDERS	
Clinical criteria apply to all drugs in this class	
Preferred	Non-Preferred
Austedo <sup>®</sup> Tablet	Xenazine <sup>®</sup> Tablet
Austedo <sup>®</sup> XR Tablet	
Austedo <sup>®</sup> XR (deutetrabenazine) Titration Kit	
Ingrezza <sup>®</sup> Capsule / Initiation Pack	
tetrabenazine tablet	
<b>Add Austedo<sup>®</sup> XR (deutetrabenazine) Titration Kit as Preferred</b>	
HEREDITARY ANGIOEDEMA (HAE) PROPHYLAXIS AGENTS	
Clinical criteria apply to all drugs in this class	
Preferred	Non-Preferred
Haegarda <sup>®</sup> Vial	Cinryze <sup>®</sup> Vial
Orladeyo <sup>®</sup> Capsule	Takhzyro <sup>®</sup> Vial / Syringe
HEREDITARY ANGIOEDEMA (HAE) TREATMENT AGENTS	
Clinical criteria apply to all drugs in this class	
Preferred	Non-Preferred
Beriner <sup>®</sup> Vial / Kit	Firazyr <sup>®</sup> Syringe
icatibant syringe (generic for Firazyr <sup>®</sup> )	Ruconest <sup>®</sup> Vial
Kalbitor <sup>®</sup> Vial	
Sajazir <sup>™</sup> Syringe (branded generic for icatibant)	
OPIOID ANTAGONISTS	
Preferred	Non-Preferred
Kloxxado <sup>™</sup> Nasal Spray	
LifEMS <sup>™</sup> naloxone Syringe Kit	
naloxone nasal spray (OTC)	
naloxone syringe / spray / vial (generic for Narcan <sup>®</sup> )	
naltrexone tablet	
Narcan <sup>®</sup> Nasal Spray (OTC)	
Opvee <sup>®</sup> Nasal Spray	
Vivitrol <sup>®</sup> Vial / Diluent	
Zimhi <sup>™</sup> Syringe	
OPIOID DEPENDENCE	
Clinical criteria apply to all drugs in this class	
Trial and failure of Suboxone <sup>®</sup> SL film or buprenorphine-naloxone SL tablet (generic Suboxone <sup>®</sup> ) required for coverage of non-preferred options	
For coverage of Sublocade <sup>®</sup> - 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
Brixadi <sup>™</sup> Weekly Syringe / Monthly Syringe	buprenorphine SL tablet (generic for Subutex <sup>®</sup> )
buprenorphine-naloxone SL tablet (generic for Suboxone <sup>®</sup> )	buprenorphine-naloxone SL film (generic for Suboxone <sup>®</sup> )
Suboxone <sup>®</sup> SL Film	Lucemyra <sup>®</sup> Tablet - <b>Exemption for diagnosis of opioid withdrawal symptoms</b>
Sublocade <sup>®</sup> Syringe	Zubsolv <sup>®</sup> Tablet SL
SKELETAL MUSCLE RELAXANTS	
Preferred	Non-Preferred
baclofen tablet (generic for Lioresal <sup>®</sup> )	Amrix <sup>®</sup> ER Capsule
cyclobenzaprine tablet (generic for Flexeril <sup>®</sup> )	baclofen oral solution
methocarbamol tablet (generic for Robaxin <sup>®</sup> )	baclofen suspension (generic for Fleqsuvy <sup>™</sup> )
tizanidine tablet (generic for Zanaflex <sup>®</sup> )	chlorzoxazone tablet (generic for Parafon Forte <sup>®</sup> )
	cyclobenzaprine ER capsule (generic for Amrix <sup>®</sup> ER)
	Dantrium <sup>®</sup> Capsule / Vial
	dantrolene sodium capsule (generic for Dantrium <sup>®</sup> )
	Fexmid <sup>®</sup> Tablet
	Fleqsuvy <sup>™</sup> Suspension
	Lorzone <sup>®</sup> Tablet
	Lyvispah <sup>®</sup> Granule Packet
	metaxalone tablet (generic for Skelaxin <sup>®</sup> )
	Norgesic <sup>™</sup> Tablet / Forte Tablet
	orphenadrine / aspirin / caffeine tablet (generic for Norgesic <sup>™</sup> )
	orphenadrine citrate tablet / vial (generic for Norflex <sup>®</sup> )
	Orphengestic <sup>®</sup> Forte Tablet
	Robaxin <sup>®</sup> Vial
	Skelaxin <sup>®</sup> Tablet
	tizanidine capsules (generic for Zanaflex <sup>®</sup> )
	Zanaflex <sup>®</sup> Capsule / Tablet
<b>Remove Skelaxin<sup>®</sup> Tablet</b>	
DISPOSABLE INSULIN DELIVERY DEVICES	
Preferred	Non-Preferred
Omnipod 5 <sup>®</sup>	
Omnipod 5 <sup>®</sup> Kit	
Omnipod DASH <sup>®</sup>	
Omnipod DASH <sup>®</sup> Kit	

North Carolina Division of Health Benefits  
North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>

More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

Omnipod GO™

Remove Omnipod GO™

North Carolina Division of Health Benefits  
 North Carolina Medicaid Preferred Drug List (PDL)

**Effective DATE: Draft for April 11, 2024 Meeting**

Trial and failure of two Preferred drugs are required unless only one Preferred option is listed or is 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. **New to market products typically default to Non-Preferred status until reviewed by the PDL Panel. These drugs are listed as TO BE REVIEWED.** Drugs requiring prior authorization, clinical criteria and prior authorization request forms can be found at: <https://www.nctracks.nc.gov/content/public/providers/pharmacy.html>  
 More information on the PDL can be found at: <https://medicaid.ncdhhs.gov/providers/programs-services/prescription-drugs/outpatient-pharmacy-services>

**DIABETIC CONTINUOUS GLUCOSE MONITOR SUPPLIES**

**Clinical criteria apply to all items in this class**

Continuous Glucose Monitor Transmitters / Receivers / Readers

Preferred	Non-Preferred
Dexcom G6 <sup>®</sup> Transmitter / Receiver	Freestyle Libre <sup>™</sup> 14 day Reader
Dexcom G7 <sup>®</sup> Transmitter / Receiver	
Freestyle Libre <sup>™</sup> 2 Reader	
Freestyle Libre <sup>™</sup> 3 Reader	

**Off cycle change: Add new to market product Freestyle Libre<sup>™</sup> 3 Reader as Preferred  
 Remove Dexcom G7<sup>®</sup> Transmitter**

Continuous Glucose Monitor Sensors

Preferred	Non-Preferred
Freestyle Libre <sup>™</sup> 2 Sensor	Freestyle Libre <sup>™</sup> 14 day Sensor
Freestyle Libre <sup>™</sup> 3 Sensor	
Dexcom G6 <sup>®</sup> Sensor 3 Pack	
Dexcom G7 <sup>®</sup> Sensor	

**DIABETIC SUPPLIES**

N.C. Medicaid only covers, at point of sale, the designated preferred products listed below for blood glucose meters, diabetic test strips, control solutions, lancets, and lancing devices for Medicaid-primary recipients (dually eligible and third-party recipients are not affected). These products are covered under the Outpatient Pharmacy Program and can be submitted to the pharmacy point-of-sale system with a prescription. Diabetic supplies, including other brands, can also be submitted under Durable Medical Equipment using the NDC and HCPCS code. Beneficiaries are allowed 1 covered meter every 2 years (730 days). For questions or assistance regarding diabetic supplies for Medicaid Direct members, please call the NC Tracks call center at 1-800-688-6696. **\*All blood glucose meters are billed using the NC Medicaid Free BIN Meter program. BIN 610524, PCN 1016, Group 40026479, ID 066499643.\***

Meters	Lancing Devices
ACCU-CHEK <sup>®</sup> Guide Retail care kit * (see above for billing)	ACCU-CHEK <sup>®</sup> Softclix lancing device kit (Black)
ACCU-CHEK <sup>®</sup> Guide Me Retail care kit * (see above for billing)	ACCU-CHEK <sup>®</sup> Fastclix lancing device kit
Test Strips	Control Solutions
ACCU-CHEK <sup>®</sup> AVIVA PLUS 50 ct test strips	ACCU-CHEK <sup>®</sup> Aviva glucose control solution (2 levels)
ACCU-CHEK <sup>®</sup> SMARTVIEW 50 ct test strips	ACCU-CHEK <sup>®</sup> SmartView glucose control solution (1 level)
ACCU-CHEK <sup>®</sup> Guide 50 ct test strips	ACCU-CHEK <sup>®</sup> Guide 2-Level control solution (2-levels)
ACCU-CHEK <sup>®</sup> Guide 100 ct test strips	
Lancets	
ACCU-CHEK <sup>®</sup> Softclix 100 ct Lancets	
ACCU-CHEK <sup>®</sup> Fastclix 102 ct Lancets	