Utah Medicaid Drug Criteria Limits

Effective June 1, 2020

Generic Name	Brand Name	Limit	Notes	Date
Analgesics				
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)				
COX-2 Inhibitors				
Cumulative limit of 60 units in 30 days.				
celecoxib	Celebrex	60		^
Non-Selective				
Ketorolac is limited to a 5 day supply with a max of 4 units per day. No more than one course may be filled per 180 days. This applies to oral, nasal, and injectable formulations.				
ketorolac	Sprix	20		06/01/20
Opioids				
Short Acting				
In addition to the drug-specific limits below, a Morphine Equivalents Daily (MED) limit for any combination of opioids and/or opioid/APAP combination products is 90 MED for members did not receive an opioid claim in the 90 days prior to the index date of January 1, 2019, or 120 MED for members who did have an opioid claim in the 90 days prior to the index date.				
CA (cancer pain): The MED limit and the drug-specific limit may be overridden if the prescriber writes a valid ICD code for cancer-related pain on the face of the prescription (G89.3 Neoplasm related pain).				
Initial prescriptions that exceed a 7 day supply or 3 day for dental providers require prior authorization. A prescription is considered "initial" if the drug has not been filled for the patient in the past 60 days. Subsequent prescriptions may be for a 30 day supply and do not require prior authorization if the quantity prescribed is less than or equal to the cumulative limit.				
For children 18 years of age and younger, and pregnant women, short-acting opioid prescriptions that exceed a 7 day supply require prior authorization. This limit may be overridden if the prescriber writes a valid ICD for cancer-related pain on the face of the prescription (G89.3 Neoplasm related pain).				
codeine sol		1,800ml	¶ Cancer related pain only.	01/01/19
codeine tab		180		01/01/19
fentanyl¶	all except patches	N/A		01/01/19
hydromorphone sol (1mg/ml)	Dilaudid sol	480ml		01/01/19
hydromorphone sup	Dilaudid sup	90		01/01/19
hydromorphone tab	Dilaudid tab	90		01/01/19
levorphanol		60		01/01/19
meperidine sol	Demerol sol	240ml		01/01/19
meperidine tab	Demerol tab	56		01/01/19
morphine con (10mg/ml)		240ml		01/01/19
morphine con (20mg/ml)		120ml		01/01/19
morphine sup		90		01/01/19
morphine tab		90		01/01/19
oxycodone 20mg, 30mg	RoxyBond	90		01/01/19
oxycodone 5mg, 7.5mg, 10mg, 15mg	Roxicodone, RoxyBond, Oxaydo	120		01/01/19
oxycodone con (20mg/ml)		120ml		01/01/19
oxycodone sol (1mg/ml)		600ml		01/01/19
oxymorphone	Opana	90		01/01/19
tapentadol	Nucynta	90		01/01/19
tramadol	Ultram	180		01/01/19

Utah Medicaid Drug Criteria Limits

Effective June 1, 2020

Generic Name	Brand Name	Limit	Notes	Date
Long Acting				
Fentanyl is mutually exclusive with Methadone and all other long acting opioids. Methadone is mutually exclusive with Fentanyl and all other long acting opioids. All other opioids are not mutually exclusive with each other.				
In addition to the drug-specific limits below, a Morphine Equivalents Daily (MED) limit for any combination of opioids and/or opioid/APAP combination products is 90 MED for members did not receive an opioid claim in the 90 days prior to the index date of January 1, 2019, or 120 MED for members who did have an opioid claim in the 90 days prior to the index date.				
Concurrent prescriptions of long-acting opioid medications and benzodiazepines require a prior authorization. Long acting opioid and benzodiazepine prescriptions are considered concurrent if filled within 45 days of each other.				
CA (cancer pain): The MED limit and the drug-specific limit may be overridden if the prescriber writes a valid ICD code for cancer-related pain on the face of the prescription (G89.3 Neoplasm related pain).				
buprenorphine buccal	Belbuca	60	¶ Cancer related pain only for 75mcg and 100mcg strengths.	01/01/19
buprenorphine patch	Butrans	4		01/01/19
fentanyl patch¶	Duragesic	10		01/01/19
hydrocodone ER	Hysingla ER, Zohydro ER	60		01/01/19
hydromorphone ER	Exalgo	30		01/01/19
methadone	Dolophine	20mg/day		01/01/19
morphine beads ER cap		30		01/01/19
morphine ER cap	Kadian	30		01/01/19
morphine ER tab >15mg	Arymo ER, MorphaBond, MS Contin	60		01/01/19
morphine ER tab 15mg	Arymo ER, MorphaBond, MS Contin	90		01/01/19
morphine/naltrexone	Embeda	30		01/01/19
oxycodone ER	OxyContin, Xtampza ER	60		01/01/19
oxymorphone ER		60		01/01/19
tapentadol ER	Nucynta ER	60		01/01/19
tramadol ER	Conzip ER, Ultram ER	30		01/01/19
Opioid Combinations				
In addition to the drug-specific limits below, a Morphine Equivalents Daily (MED) limit for any combination of opioids and/or opioid/APAP combination products is 90 MED for members did not receive an opioid claim in the 90 days prior to the index date of January 1, 2019, or 120 MED for members who did have an opioid claim in the 90 days prior to the index date.				
CA (cancer pain): The MED limit and the drug-specific limit may be overridden if the prescriber writes a valid ICD code for cancer-related pain on the face of the prescription (G89.3 Neoplasm related pain).				
Initial prescriptions that exceed a 7 day supply or 3 day for dental providers require prior authorization. A prescription is considered "initial" if the drug has not been filled for the patient in the past 60 days. Subsequent prescriptions may be for a 30 day supply and do not require prior authorization if the quantity prescribed is less than or equal to the cumulative limit.				
benzhydrocodone/apap (all strengths)	Apadaz	120		03/01/19
carisoprodol/asa/codeine		30		01/01/19
codeine/apap liq	Capital/codeine	450ml		01/01/19
codeine/apap tab	Tylenol/codeine	120		01/01/19
dihydrocodeine/apap/caf	Dvorah, Panlor	120		01/01/19
hydrocodone/apap 10/300mg/15ml sol	Lortab sol	1,800ml		01/01/19
hydrocodone/apap 10/325mg/15ml sol	Zamicet	1,800ml		01/01/19
hydrocodone/apap 7.5/325mg/15ml sol		1,800ml		01/01/19
hydrocodone/apap tab (all strengths)	Norco, Xodol	120		01/01/19
hydrocodone/ibu	Ibudone, Reprexain, Xylon	120		01/01/19
oxycodone/apap sol		600ml		01/01/19
oxycodone/apap tab (all strengths)	Percocet, Primlev	120		01/01/19
oxycodone/asa		120		01/01/19
oxycodone/ibu		120		01/01/19
pentazocine/naloxone		120		01/01/19
tramadol/apap	Ultracet	120		01/01/19

Utah Medicaid Drug Criteria Limits

Effective June 1, 2020

Generic Name	Brand Name	Limit	Notes	Date
Opioid Use Disorder Treatments				
Maximum daily limits for buprenorphine containing products are as follows and apply to both the brand and generic formulations. The limit for naltrexone tablets is the limit per 30 days. The limit for naltrexone IM suspension is the limit per 28 days.				
buprenorphine SL tab		3		01/30/17
buprenorphine/naloxone buccal film 2.1/0.3mg	Bunavail	2		01/30/17
buprenorphine/naloxone buccal film 4.2/0.7mg	Bunavail	2		01/30/17
buprenorphine/naloxone buccal film 6.3/1mg	Bunavail	2		01/30/17
buprenorphine/naloxone SL film 12/3mg	Suboxone	2		01/30/17
buprenorphine/naloxone SL film 2/0.5mg	Suboxone	3		01/30/17
buprenorphine/naloxone SL film 4/1mg	Suboxone	3		01/30/17
buprenorphine/naloxone SL film 8/2mg	Suboxone	3		01/30/17
buprenorphine/naloxone tab 0.7/0.18mg	Zubsolv	2		01/30/17
buprenorphine/naloxone tab 1.4/0.36mg	Zubsolv	2		01/30/17
buprenorphine/naloxone tab 11.4/2.9mg	Zubsolv	1		01/30/17
buprenorphine/naloxone tab 2.9/0.71mg	Zubsolv	2		01/30/17
buprenorphine/naloxone tab 5.7/1.4mg	Zubsolv	2		01/30/17
buprenorphine/naloxone tab 8.6/2.1mg	Zubsolv	2		01/30/17
naltrexone IM susp	Vivitrol	1		09/01/19
naltrexone tab		40		01/30/17

Antidiabetics

Generic Name	Brand Name	Limit	Notes	Date
Insulin				
Rapid Acting				
Prescriptions are limited to 60 ml per month. Higher doses may be overridden with a prior authorization if the prescriber verifies the medical necessity of the higher dose.				
insulin aspart	Fiasp, Novolog	60ml		^
insulin glulisine	Apidra	60ml		^
insulin lispro	Admelog, Humalog	60ml		^
insulin regular	Humulin R, Novolin R	60ml		^
Intermediate Acting				
Prescriptions are limited to 60 ml per month. Higher doses may be overridden with a prior authorization if the prescriber verifies the medical necessity of the higher dose.				
insulin NPH	Humulin-N/Novolin-N	60ml		^
Long Acting				
Prescriptions are limited to 60 ml per month. Higher doses may be overridden with a prior authorization if the prescriber verifies the medical necessity of the higher dose.				
insulin degludec	Tresiba	60ml		^
insulin detemir	Levemir	60ml		^
insulin glargine	Basaglar, Lantus, Toujeo	60ml		^
Mixtures				
Prescriptions are limited to 60 ml per month. Higher doses may be overridden with a prior authorization if the prescriber verifies the medical necessity of the higher dose.				
insulin degludec/liraglutide	Xultophy	60ml		^
insulin glargine/lixisenatide	Soliqua	60ml		^
insulin lispro/lispro protamine	Humalog 50/50, 75/25	60ml		^
insulin NPH/regular	Humulin 70/30, Novolin 70/30	60ml		^

Utah Medicaid Drug Criteria Limits

Effective June 1, 2020

Generic Name	Brand Name	Limit	Notes	Date
Central Nervous System				
Hypnotics				
Benzodiazepines				
Cumulative limit of 30 units in 30 days. Cumulative limits apply across all hypnotic classes.				
Concurrent prescriptions of opioid medications and benzodiazepines require a prior authorization. Opioid and benzodiazepine prescriptions are considered concurrent if filled within 45 days of each other.				
estazolam		30		^
flurazepam		30		^
midazolam		30		^
temazepam	Restoril	30		^
triazolam	Halcion	30		^
Non Benzodiazepines, Non Barbiturates				
Cumulative limit of 30 units in 30 days. Cumulative limits apply across all hypnotic classes.				
doxepin	Silenor	30		^
eszopiclone	Lunesta	30		^
lemborexant	Dayvigo	30		05/01/20
ramelteon	Rozerem	30		^
suvorexant	Belsomra	30		^
tasimelteon	Hetlioz	30		^
zaleplon	Sonata	30		^
zolpidem SL	Edluar, Intermezzo	30		^
zolpidem, CR	Ambien, CR	30		^
Mental Health				
Anticonvulsants				
Cumulative limit of 120 units in 30 days for clonazepam.				
Dose limit (mg/day) for gabapentin and pregabalin. Gabapentin and pregabalin may not be filled concurrently.				
clonazepam	Klonopin	120		^
gabapentin	Gralise, Horizant, Neurontin	3600mg		04/01/20
pregabalin	Lyrica	600mg		04/01/20
Antipsychotics				
Dose limit (mg/day) for specified ages. For ages younger than those specified, the drug is restricted. If no age is listed, the drug is not covered in children younger than 18 years. A prior authorization will be required for all antipsychotic medications prescribed for children under 6 years of age.				
aripiprazole (age 4-11 years)	Abilify	15mg		10/01/19
aripiprazole (age 12-17 years)	Abilify	30mg		10/01/19
asenapine (age 10-17 years)	Saphris	20mg		10/01/19
brexpiprazole	Rexulti	0mg		10/01/19
cariprazine	Vraylar	0mg		10/01/19
clozapine (age 8-11 years)	Clozaril, Fazaclo, Versacloz	300mg		10/01/19
clozapine (age 12-17 years)	Clozaril, Fazaclo, Versacloz	600mg		10/01/19
iloperidone	Fanapt	0mg		10/01/19
lurasidone (age 13-17 years)	Latuda	80mg		10/01/19
olanzapine (age 4-6 years)	Zyprexa	12.5mg		10/01/19
olanzapine (age 7-17 years)	Zyprexa	20mg		10/01/19
paliperidone (age 12-17 years)	Invega	12mg		10/01/19
quetiapine (age 5-9 years)	Seroquel	400mg		10/01/19
quetiapine (age 10-17 years)	Seroquel	800mg		10/01/19
risperidone (age 4-11 years)	Risperdal	3mg		10/01/19
risperidone (age 12-17 years)	Risperdal	6mg		10/01/19
ziprasidone (age 10-17 years)	Geodon	160mg		10/01/19

Utah Medicaid Drug Criteria Limits

Effective June 1, 2020

Generic Name	Brand Name	Limit	Notes	Date
Anxiolytic Benzodiazepines				
Cumulative limit of 120 units in 30 days.				
Concurrent prescriptions of long-acting opioid medications and benzodiazepines require a prior authorization. Long acting opioid and benzodiazepine prescriptions are considered concurrent if filled within 45 days of each other.				
alprazolam	Xanax	120		^
chlordiazepoxide		120		^
clorazepate	Tranxene	120		^
diazepam		120		^
lorazepam	Ativan	120		^
oxazepam		120		^
Smoking Deterrents				
Minimum patient age in years (unless otherwise specified).				
nicotine replacement products		12		^
varenicline	Chantix	16		04/01/19
Contraceptives				
Oral				
Emergency				
Cumulative limit of 2 kits per month.				
ulipristal	Ella	2		^
levonorgestrel	Plan B, others	4		^
Dermatological				
Local Anesthetic Agents				
Limit per 30 days.				
lidocaine patch	Lidoderm	90	¶ This includes all lidocaine containing combinations.	^
lidocaine/tetracaine patch 70/70mg	Synera	5		^
lidocaine¶ oint, sol, gel, crm, lot		60g		^
Diagnostic Products				
Diabetic Test Supplies				
Limit of 200 strips per 30 days.				
Abbott Products				
Freestyle Test Strips		200		^
Precision Test Strips		200		^
Trividia/True Metrix				
TrueTrack Test Strips		200		^
True Metrix Test Strips		200		^
Gastrointestinal (GI)				
Antidiarrheals				
Antiperistaltic Agents				
Cumulative limit of 180 tablets in 30 days.				
diphenoxylate/atropine	Lomotil	180		^
loperamide		180		^
Laxatives				
Osmotic Laxatives				
Cumulative limit of 1054g in 30 days.				
PEG-3350		1054		^
Hematopoietics				
Hematopoietic Growth Factors				
Cumulative limit of 30 units in 30 days.				
eltrombopag	Promacta	30		11/01/18

Utah Medicaid Drug Criteria Limits

Effective June 1, 2020

Generic Name	Brand Name	Limit	Notes	Date
Migraine Agents				
Serotonin 5-HT$_1$ Receptor Agonists				
Cumulative limit of 9 dosage units per 30 days - all forms count towards this limit.				
almotriptan	Axert	9		^
butorphanol nasal spray		2.5ml		08/01/19
diclofenac packets	Cambia	9		^
eletriptan	Relpax	9		^
frovatriptan	Frova	9		^
naratriptan	Amerge	9		^
rizatriptan	Maxalt	9		^
sumatriptan inj	Imitrex inj, Sumavel, Zembrace	9		^
sumatriptan powder	Onzetra	9		^
sumatriptan spray	Imitrex spray	9		^
sumatriptan tab	Imitrex tab	9		^
zolmitriptan	Zomig	9		^
Butalbital Containing Products				
Cumulative limit of 20 dosage units per 30 days. Restricted to patients age 18 and older.				
but/apap	Allzital	20		10/01/19
but/apap/caf	Fioricet, Esgic	20		10/01/19
but/apap/caf/codeine		20		10/01/19
but/asa/caf	Fiorinal	20		10/01/19
but/asa/caf/codeine	Fiorinal/codeine	20		10/01/19
Muscle Relaxants				
Antispasmodic Agents				
Cumulative limits specific to each agent (per maximum FDA-approved doses).				
carisoprodol	Soma	120		^
carisoprodol/asa		30		^
chlorzoxazone	Lorzone	120		^
cyclobenzaprine	Amrix, Fexmid	90		^
metaxalone	Skelaxin	120		^
methocarbamol	Robaxin	180		^
orphenadrine		60		^
orphenadrine/asa/caf	Norgesic Forte	60		05/01/19
Antispasticity Agents				
Cumulative limits specific to each agent (per maximum FDA-approved doses).				
dantrolene	Dantrium	90		^
tizanidine	Zanaflex	90		^
Nasal				
Corticosteroids				
The cumulative number of inhalers in any 30-day period is limited for a Medicaid member. When there are more than two sizes or strengths for a given product, the limit is based on the largest size or strength. The limits are stated below represent the number of inhalers that may be filled per 30 days.				
beclomethasone	Beconase AQ	2		^
beclomethasone	Qnasl	1		^
ciclesonide	Omnaris	1		^
ciclesonide	Zetonna	1		^
flunisolide		2		^
fluticasone furoate	Veramyst	1		^
fluticasone propionate		1		^
mometasone	Nasonex	1		^

Drugs Requiring Prior Authorization

Effective June 1, 2020

Generic Name	Brand Name	Notes	Date
Special PA Forms			
PA Forms that are not specific to a drug or drug class			
Antipsychotics in Children			04/21/20
Exception to 3 Month Supply			10/07/19
Hemophilia Additional Nursing Visits			03/28/19
Medication Coverage Exception Request			11/20/19
New to Market Drugs			03/28/19
Drug Class PA Forms			
PA Forms that are for a disease state or drug class			
Androgens			01/13/20
Antiemetics			11/20/19
Anti-vascular Endothelial Growth Factor Therapy[J]			01/13/20
Botulinum Toxins[J]			01/13/20
Buprenorphine Single and Combo Agents (oral)			01/01/20
CAR-T cell Therapy[Q]			03/28/19
CGRP Antagonists			03/31/20
Cystic Fibrosis Gene Therapies			01/13/20
Growth Hormone			03/28/19
Growth Hormone AIDS			03/28/19
Hepatitis C			03/09/20
Opioid and Opioid Benzodiazepine Combination			01/13/20
PAMORAs			03/28/19
PCSK9 Inhibitors			11/07/19
Pulmonary Arterial Hypertension (PAH)			11/20/19

Drugs Requiring Prior Authorization

Effective June 1, 2020

Generic Name	Brand Name	Notes	Date
Individual Drug PA Forms			
PA Forms that are for a specific drug			
agalsidase beta[J]	Fabrazyme		03/28/19
alitretinoin	Panretin		10/16/19
alpha-1 proteinase inhibitor[J]	Aralast		03/28/19
alpha-1 proteinase inhibitor[J]	Prolastin, Zemaira		03/28/19
aripiprazole with sensor	Abilify MyCite		03/28/19
armodafinil, modafinil, pitolisant, solriamfetol	Nuvigil, Provigil, Sunosi, Wakix		01/13/20
avatrombopag	Doptelet		03/28/19
bedaquiline	Sirturo		03/28/19
benralizumab	Fasenra		03/28/19
binimetinib	Mektovi		03/28/19
brantuximab vedotin	Adcetris		03/28/19
brexanolone	Zulresso		10/23/19
burosumab	Crysvita		03/28/19
cannabidiol	Epidiolex		06/03/19
cladribine tab	Mavenclad		10/24/19
deflazacort	Emflaza		03/28/19
desmopressin	Nocdurna		11/20/19
dextromethorphan/quinidine	Nuedexta		03/28/19
dupilumab	Dupixent		10/30/19
elagolix	Orilissa		11/20/19
emicizumab	Hemlibra		03/28/19
encorafenib	Braftovi		03/28/19
esketamine	Spravato		05/18/20
eteplirsen[J]	Exondys 51		03/28/19
fluocinolone (intravitreal)	Iluvien, Retisert, Yutiq		11/20/19
glycopyrronium	Qbrexza		03/28/19
hydroxyprogesterone caproate	Makena		01/13/20
inotersen	Tegsedi		03/28/19
laronidase[J]	Aldurazyme		03/28/19
lidocaine patch	Lidoderm, ZTLido		01/13/20
lofexidine	Lucemyra		03/28/19
tadalafil	Cialis		05/18/20
methadone			03/28/19
mifepristone	Mifeprex		05/13/19
mixed pollens allergen extract	Oralair		03/28/19
nurinersen	Spinraza		09/23/19
ocrelizumab[J]	Ocrevus		03/28/19
omalizumab[J]	Xolair		12/24/19
onasemnogene abeparvovec	Zolgensma		09/23/19
opthalmic cyclosporine	Restasis, Cequa		03/28/19
palivizumab	Synagis		03/28/19
patisiran[J]	Onpattro		03/28/19

Drugs Requiring Prior Authorization

Effective June 1, 2020

Generic Name	Brand Name	Notes	Date
pegademase bovine[J]	Adagen		03/28/19
pegloticase[J]	Krystexxa		03/28/19
phenylbutyrate (glycerol)	Ravicti		03/28/19
phenylbutyrate (sodium)	Buphenyl		03/28/19
ragweed pollen allergen extract	Ragwitek		03/28/19
rifaximin	Xifaxan		02/11/20
sodium oxybate	Xyrem		11/07/19
sorafenib	Nexavar		03/28/19
sunitinib	Sutent		03/28/19
tasimelteon	Hetlioz		08/08/19
teriparatide	Forteo		03/28/19
vestronidase alfa	Mepsevii		03/28/19
voretigene neparvovec[J]	Luxturna		03/28/19

Explanations

Drugs with Criteria and Limits

Many drugs in the Medicaid pharmacy program do not require a Prior Authorization (PA), but are still subject to restrictions that are outlined in the Medicaid Pharmacy Services Manual and the Medicaid Physician Services Manual. This section serves as a quick reference for the specific policies that govern coverage of these drugs.

In accordance with the Utah Medicaid Provider Manual for Pharmacy Services, SECTION 3, Chapter 5, Limitations, some drugs are limited by a quantity in any thirty-day (30) period. The limits listed are those approved by the Medicaid Drug Utilization Review (DUR) Board. Prescribers who feel that a patient has specific needs that exceed the limits may submit a prior authorization request using the Quantity Override Request form that is available online.

All medications remain subject to all other requirements of the Utah Medicaid Pharmacy Program, as described in the Utah Medicaid Manual for Pharmacy Services.

Unless otherwise stated in this attachment, limits apply to both the brand-name and generic formulations of the listed drugs.

Unless otherwide noted, listed limits are for a one month (30 days) supply. The per day limit for a drug is equal to 1/30th of the monthly limit.

Drugs Requiring Prior Authorization

Certain drugs that are covered by the Medicaid program may require the patient and prescriber to meet specific criteria and demonstrate medical necessity in order to receive the requested medication. Detailed information regarding prior approval criteria for individual medications and classes of medications is provided in this attachment.

Please note that prior authorization for a medication is Medicaid member specific and product specific. Prior authorization cannot be transferred to another product, nor to another strength of a product that has been approved. The prior authorization also cannot be transferred to another Medicaid member.

To initiate a prior authorization request, the prescriber must obtain the most current criteria sheet from the Medicaid Pharmacy

Services Website at https://medicaid.utah.gov/pharmacy/prior-authorization and gather all of the records that are requested in the criteria set for the medication being prescribed. The requests can be faxed to (855) 828-4992. The criteria sheet must be completely and legibly filled out and must be accompanied by all requested information. Incomplete or illegible requests will be returned to the prescriber without being processed by Medicaid and may result in denial.

Drugs Requiring Diagnosis Codes

Utah Medicaid pharmacy claims requiring a diagnosis code will require a current valid ICD-10 code.

Cumulative limits on narcotic analgesics are waived for the current treatment of cancer-related pain. The prescriber must provide an appropriate current diagnosis code for cancer on prescriptions for these drugs.

When prescribing an opioid for cancer-related pain, the prescriber is responsible to provide a valid ICD code for cancer-related pain (G89.3 Neoplasm related pain) on the face of prescription. The current diagnosis code may be hand-written by the prescriber on the prescription or computer generated by prescribing software. Pharmacy providers may also obtain a current diagnosis code verbally from a prescriber, and note the date, time, and name of the prescriber's representative providing the current diagnosis code on the original hard-copy prescription. The dispensing pharmacist must enter that current diagnosis code into the appropriate diagnoses field when processing a claim.

If a pharmacy fills an opioid analgesic prescription that does not comply with the requirements above, funds paid by Medicaid will be recovered through post-payment review.

Many of the drugs and classes listed in this document are also on the Preferred Drug List (PDL). Any drugs or classes listed herein are also subject to the limitations of the PDL if they are listed in the current version of the PDL. See https://medicaid.utah.gov/pharmacy/preferred-drug-list.

Psychotropic Medication Classes on the Utah Medicaid Preferred Drug List

Utah Medicaid has psychotropic drugs on the Preferred Drug List (PDL). For the purposes of the Preferred Drug List, psychotropic medications are defined as atypical antipsychotics, anti-depressants, anti-convulsants/mood stabilizers, anti-anxiety medications, and attention deficit hyperactivity disorder (ADHD) stimulants.

Explanations

Non-preferred psychotropic medication classes listed on the PDL may bypass the non-preferred drug prior authorization if a prescriber writes “dispense as written” on a prescription and the pharmacy submits a Dispense As Written (DAW) Code of “1” on the claim.

The prescriber is expected to provide services of quality that meet professionally recognized standards of care and can be substantiated by records including evidence of medical necessity.

Note: In accordance with UCA 58-17b-606 (4) and (5), the DAW Code will not allow claims for the brand-name version of multisource drugs to bypass the prior authorization requirement, even if the brand-name version of the drug is listed as non-preferred and the prescriber writes “dispense as written” on the prescription. If the brand-name version is preferred over the generic formulation due to cost, the non-preferred brand-name drug may bypass the prior authorization requirement instead of the generic formulation.

Utah Medicaid Preferred Drug List Footnotes

Last Modified October 1, 2019

Symbols and Footnotes		
*	Clinical PA required	PA Critera Forms
**	Clinical PA required in some cases - see specific PA criteria for details	
⁂	Non-preferred on PDL; must fail a preferred agent first	
†	Brand Required Over Generic	Refer to Brand Over Generic (BOG) reference in the Resource Library
‡	Quantity Limits Apply	Drug Criteria and Limits Attachment to the Pharmacy Manual
#	Listed on the 3 Month supply list	Utah Medicaid 3 Month Supply Medication List
##	Must be dispensed directly to the provider, not the patient	
^	Added to reference before dates were tracked	
^^	Part of more than one PDL drug class	
¶	Indicates that additional pertinent information can be found in the center area between preferred and non-preferred drugs	
J	Covered under the medical benefit using the appropriate J code	
Q	Covered under the medical benefit using the appropriate Q code	
§	Step Therapy required; must fail another preferred agent first	
§§	Pursuant to HB 437, passed during the 2016 General Session, Utah Medicaid began placing psychotropic drugs on the Preferred Drug List (PDL) effective July 1, 2016. For the purposes of the Preferred Drug List, psychotropic medications are defined as atypical antipsychotics, anti-depressants, anti-convulsants/mood stabilizers, anti-anxiety medications, and attention deficit hyperactivity disorder (ADHD) stimulants. Non-preferred psychotropic medication classes listed on the PDL may bypass the non-preferred drug prior authorization if a prescriber writes “dispense as written” on a prescription and the pharmacy submits a Dispense As Written (DAW) Code of “1” on the claim. Note: In accordance with UCA 58-17b-606 (4) and (5), the DAW Code will not allow claims for the brand-name version of multisource drugs to bypass the prior authorization requirement, even if the brand-name version of the drug is listed as non-preferred and the prescriber writes “dispense as written” on the prescription. An exception to this is in the case that a brand-name drug is listed on the Brand Over Generic reference; in that case, the DAW Code will only override the brand-name drug. Note: In order for a prescription to be eligible for the pharmacy to submit the DAW Code of “1” to bypass the edit for a non-preferred medication the prescriber must write “dispense as written” on the physical prescription. Check boxes or pre-printed forms that include “dispense as written” are not acceptable substitutes for the prescriber writing “dispense as written” on the prescription. Electronic prescriptions must state “dispense as written” as either a note or as part of the prescription drug order to satisfy this requirement. Verbal orders that include “dispense as written” must be reduced to writing on the prescription by the pharmacist accepting the verbal order and documented in the member’s medical record.	
***	The following meter NDCs are covered through Medicaid: Abbott 99073-0711-43 99073-0709-14 99073-0708-05 57599-8814-01 57599-5175-01 Abbott meters may also be billed to the manufacturer using the following: RxBIN: 610020 Group number: 99992432 ID: ERXUTMED Free for Medicaid members Diabetic test supplies are not covered for Nursing Home clients. Non-preferred products must be billed through DME.	True Metrix 56151-1490-02 56151-1470-02 56151-0888-80

Utah Medicaid Drug Criteria Limits Key

Last Modified January 1, 2020

Key

Selected Abbreviations

Drug Name		Dosage Form	
amph	amphetamine	aug	augmented
apap	acetaminophen	cap	capsule
asa	aspirin	chw	chewable
bac	bacitracin	con	concentrate
but	butalbital	crm	cream
caf	caffeine	emul	emulsion
damph	dextroamphetamine	inj	injection
dhe	dihydroergotamine	liq	liquid
ee	ethinyl estradiol	lot	lotion
hc	hydrocortisone	loz	lozenge
hctz	hydrochlorothiazide	neb	nebulization solution
ibu	ibuprofen	ODT	orally disintegrating tablet
mph	methylphenidate	oint	ointment
poly	polymyxin	shmp	shampoo
sa	sulfacetamide	SL	sublingual
ss	sodium sulfacetamide	sol	solution
		sup	suppository
		susp	suspension
		syp	syrup
		tab	tablet
Brand/Generic		**Salt Form**	
B	Brand	buty	butyrate
BG	Both Brand and Generic	dip	dipropionate
G	Generic	Fe	iron
		Fl	fluoride
		HCl	hydrochloride
		mag	magnesium
		Na	sodium
		$NaHCO_3$	sodium bicarbonate
		$NaPO_4$	sodium phosphate
		pam	pamoate
		str	Strontium