UTAH DEPARTMENT OF HEALTH MEDICAID

PDL & Resources

(Preferred Drug List & Pharmacy Coverage Resources)

Effective July 1, 2020

Search Tip: Use the keyboard shortcut Ctrl+F to open the Find menu. Type a word/medication to find in the document.

UTAH DEPARTMENT OF HEALTH MEDICAID

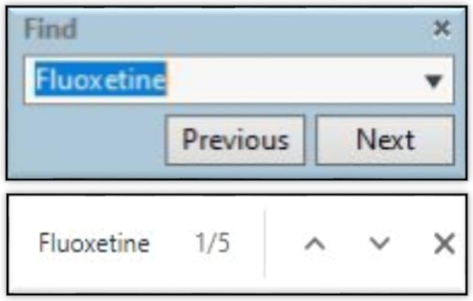
How to Navigate Resources

Headers and Classifications: Products are listed by Group, followed by Class/Sub-Class.

Medication/Product Group
Medication/Product Class
Medication/Product Sub-Class

Search Document:

- Open Find Menu, use the keyboard shortcut Ctrl+F (Command+F for Mac).



- Type a word/medication to find in document.

Note: Display format will vary depending upon browser/software used to view document.

- Select "Next" or Arrow Buttons to view multiple results.

Utah Medicaid Preferred Drug List - Effective July 1, 2020

- **Drugs Not Listed on PDL:** Are covered per the Pharmacy Provider Manual. Manuals can be found at https://medicaid.utah.gov/utah-medicaid-official-publications
- **Listed Drug Name:** When only the generic name is listed, this includes all generic strengths, dosage forms, and formulations for that drug and in that class. The same principle applies to brand name drugs. When the strength and/or dosage form is included in a name listing, this narrows the listing to those particular strengths and/or dosage forms. A comma may be used to delineate multiple strengths, dosage forms, or formulations.
- **Non-Preferred Products:** All Non-preferred products require an appropriate trial and failure of a preferred product with similar dosage form and use/indication. If a non-preferred strength/ dosage form is requested, the preferred strength/ dosage form must be tried before the non-preferred strength/ dosage form will be approved. Or the prescriber must demonstrate medical necessity for non-preferred. Additonal criteria found on Drug Class and Disease Specific PA Forms will also apply. Authorization Criteria can be found at https://medicaid.utah.gov/pharmacy/prior-authorization.
- **Non-Preferred Combination Products:** When the separate single ingredient products are preferred, those pmust be tried before the non-preferred product will be approved.
- **Non-Preferred Psychotropic Products - Dispense as Written (DAW):** 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 nonpreferred 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 nonpreferred 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.

- **Over-the-Counter (OTC) Products:** PDL listing is for legend drugs and do not include over-the-counter (OTC) products. A complete listing of covered OTC products is located in this document following the PDL.
- **Updates:** PDL changes will be posted monthly, changes effective in the posted month are highlighted in yellow. This may include changes to the status (preferred/non-preferred) or a change to the way the drug is listed. A date older than the release of a new form of a drug does not mean the newer form is excluded from that listing.

Analgesics

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Celecoxib	Preferred	Generic	09/01/15	2 capsules /day			
diclofenac gel	Preferred	Generic	11/01/19				
diclofenac Na DR 50, 75mg	Preferred	Generic	01/01/12				
diclofenac Na SR	Preferred	Generic	01/01/13				
diclofenac potassium	Preferred	Generic	07/01/12				
etodolac	Preferred	Generic	01/01/20				
Flector patch	Preferred	Brand	01/01/18			Flector	
flurbiprofen	Preferred	Generic	01/01/12				
ibuprofen	Preferred	Generic	09/28/09				
indomethacin [non-CR]	Preferred	Generic	01/01/12				

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
ketorolac tablet, solution	Preferred	Generic	09/28/09	4 units /day 20 units /180 days			Limits apply to oral, nasal, and injectable formulations.
ketorolac injectable	Medical Only	Generic	09/28/09	4 units /day 20 units /180 days			Covered under the medical benefit using the appropriate HCPCS code
meloxicam tablet	Preferred	Generic	09/28/09				
nabumetone	Preferred	Generic	09/28/09				
naproxen tablet, EC	Preferred	Generic	09/28/09				
Pennsaid	Preferred	Brand	01/01/18				
sulindac	Preferred	Generic	01/01/12				
Zipsor	Preferred	Brand	07/01/12				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Anjesco	Non Preferred	Brand	07/01/20		Medication Coverage Exception		
Celebrex	Non Preferred	Brand	09/01/15	2 capsules /day	Medication Coverage Exception		
Daypro	Non Preferred	Brand	02/01/16		Medication Coverage Exception		
diclofenac Na DR 25mg	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
diclofenac patch	Non Preferred	Generic	04/01/19		Medication Coverage Exception	Flector	
diclofenac solution	Non Preferred	Generic	05/30/14		Medication Coverage Exception		
diclofex DC	Non Preferred	Generic	10/01/17		Medication Coverage Exception		
etodolac ER	Non Preferred	Generic	05/30/14		Medication Coverage Exception		
Feldene	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Feldene	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
fenoprofen	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Indocin suppository	Non Preferred	Brand	09/01/18		Medication Coverage Exception		
Indocin suspension	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
indomethacin 20mg	Non Preferred	Generic	03/01/20		Medication Coverage Exception		
indomethacin CR	Non Preferred	Generic	01/01/12		Medication Coverage Exception		
ketoprofen, ER	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
ketorolac nasal	Non Preferred	Generic	06/01/20	4 units /day 20 units /180 days	Medication Coverage Exception		Limits apply to oral, nasal, and injectable formulations.
Licart	Non Preferred	Generic	06/01/20		Medication Coverage Exception		
meclofenamate	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
mefenamic acid	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Mobic	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Nalfon	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Naprelan	Non Preferred	Brand	08/01/17		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Naproxen Na	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
naproxen Na CR	Non Preferred	Generic	08/01/17		Medication Coverage Exception		
naproxen susp	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Oxaprozin	Non Preferred	Generic	02/01/16		Medication Coverage Exception		
piroxicam	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Qmiiz	Non Preferred	Brand	04/01/19		Medication Coverage Exception		
Relafen	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
Sprix	Non Preferred	Brand	06/01/20	4 units /day 20 units /180 days	Medication Coverage Exception		Limits apply to oral, nasal, and injectable formulations.
Tivorbex	Non Preferred	Brand	05/13/15		Medication Coverage Exception		
Tolmetin	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Vivlodex	Non Preferred	Brand	02/01/16		Medication Coverage Exception		
Zorvolex	Non Preferred	Brand	11/01/13		Medication Coverage Exception		

Short Acting Opioids

- **Cancer Pain:** The MED limit and quantity limit may be overridden if the prescriber writes Diagnosis Code (G89.3 Neoplasm related pain) for cancer related pain on the face of the prescription.
- **Children**: 18 years of age and younger, short-acting opioid prescriptions that exceed a 7 day supply require prior authorization.
- **Initial Fill**: 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 member in the past 60 days.
- **MME**: In addition to the drug-specific limits below, a Morphine Equivalents Daily (MED) limit for any combination of opioids is 90 MED.
- **Pregnancy:** Pregnant women, short-acting opioid prescriptions that exceed a 7 day supply require prior authorization.

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Actiq	Preferred	Brand	01/01/15	Cancer-related pain only		Actiq	
codeine solution	Preferred	Generic	01/01/15	90 MME & 1800 ml /30 days			
codeine tablet	Preferred	Generic	01/01/15	90 MME & 6 tablets /day			
hydromorphone liquid	Preferred	Generic	01/01/15	90 MME & 16 ml /day			
hydromorphone tablet	Preferred	Generic	01/01/15	90 MME & 3 tablets /day			
morphine tablet	Preferred	Generic	01/01/15	90 MME & 3 tablets /day			
morphine concentrate (10mg/ml)	Preferred	Generic	01/01/15	90 MME & 8 ml /day			
morphine concentrate (20mg/ml)	Preferred	Generic	01/01/15	90 MME & 4 ml /day			
oxycodone 20mg, 30mg	Preferred	Generic	01/01/15	90 MME & 3 tablets /day			
oxycodone 5mg, 7.5mg, 10mg, 15mg	Preferred	Generic	01/01/15	90 MME & 4 tablets /day			
oxycodone solution (1mg/ml)	Preferred	Generic	01/01/15	90 MME & 20 ml /day			
tramadol	Preferred	Generic	01/01/15	90 MME & 6 tablets /day			

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Abstral	Non Preferred	Brand	01/01/15	Cancer-related pain only	Opioid		
Dilaudid	Non Preferred	Brand	10/01/19	90 MME & 3 tablets /day	Opioid		
fentanyl lozenge	Non Preferred	Generic	01/01/15	Cancer-related pain only	Opioid	Actiq	
fentanyl tablet	Non Preferred	Generic	01/01/20	Cancer-related pain only	Opioid		
Fentora	Non Preferred	Brand	01/01/20	Cancer-related pain only	Opioid		
hydromorphone suppository	Non Preferred	Generic	09/01/18	90 MME & 16 ml /day	Opioid		
Lazanda	Non Preferred	Brand	01/01/15	Cancer-related pain only	Opioid		
meperidine solution	Non Preferred	Generic	01/01/15	90 MME & 8 ml /day	Opioid		
meperidine tablet	Non Preferred	Generic	01/01/15	90 MME & 1.8 tablets /day	Opioid		
morphine suppository	Non Preferred	Generic	01/01/15	90 MME & 3 suppository/day	Opioid		
Nucynta	Non Preferred	Brand	01/01/20	90 MME & 3 tablets /day	Opioid		
Opana	Non Preferred	Brand	08/01/17	90 MME & 3 tablets /day	Opioid		
Oxaydo	Non Preferred	Brand	10/01/15	90 MME & 3 tablets /day	Opioid		
oxycodone capsule 5mg	Non Preferred	Generic	10/01/19	90 MME & 4 capsules /day	Opioid		
oxycodone concentrate (20mg/ml)	Non Preferred	Generic	10/01/19	90 MME & 4 ml /day	Opioid		
oxymorphone	Non Preferred	Generic	08/01/17	90 MME & 3 tablets /day	Opioid		
Roxicodone 5mg, 15mg	Non Preferred	Brand	09/01/18	90 MME & 4 tablets /day	Opioid		
Roxicodone 30mg	Non Preferred	Brand	09/01/18	90 MME & 3 tablets /day	Opioid		
RoxyBond 5mg, 15mg	Non Preferred	Brand	07/01/18	90 MME & 4 tablets /day	Opioid		
RoxyBond 5mg, 30mg	Non Preferred	Brand	07/01/18	90 MME & 3 tablets /day	Opioid		
Ultram	Non Preferred	Brand	01/01/15	90 MME & 6 tablets /day	Opioid		
Long Acting Opioids							
• **Cancer Pain:** The MED limit and quantity limit may be overridden if the prescriber writes Diagnosis Code (G89.3 Neoplasm related pain) for cancer related pain on the face of the prescription.							
• **Benzodiazepine and Opioid Combination:** Concurrent prescriptions of long-acting opioids and benzodiazepines (filled within 45 days of each other) require prior authorization.							
• **MME**: In addition to the drug-specific limits below, a Morphine Equivalents Daily (MED) limit for any combination of opioids is 90 MED.							
• **Mutually Exclusive:** Methadone and Fentanyl are exclusive with each other and all other long acting opioids. All other opioids are not mutually exclusive with each other.							
• **Short before Long:** Short acting opioid fill (within 30 days) is required before initiation of long acting opioid therapy.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Butrans	Preferred	Brand	01/01/20	90 MME & 1 patch /7 days		Butrans	
fentanyl patch 12.5, 25, 50mcg	Preferred	Generic	01/01/19	90 MME & 1 patch /3 days			
fentanyl patch 75, 100mcg	Preferred	Generic	01/01/19	Cancer-related pain only			

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
morphine ER tablet	Preferred	Generic	01/01/14	15mg: 90 MME & 3 tablets /day >15mg: 90 MME & 2 tablets /day			
Nucynta ER	Preferred	Brand	10/01/17	90 MME & 2 tablets /day			
OxyContin	Preferred	Brand	01/01/20	90 MME & 2 tablets /day		Oxycontnin	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Arymo ER	Non Preferred	Brand	04/01/17	15mg: 90 MME & 3 tablets /day >15mg: 90 MME & 2 tablets /day	Opioid		
Belbuca	Non Preferred	Brand	01/01/16	90 MME & 2 films /day	Opioid		
buprenorphine patch	Non Preferred	Generic	10/30/14	90 MME & 1 patch /7 days	Opioid	Butrans	
Conzip ER	Non Preferred	Brand	08/18/14	90 MME & 1 tablet /day	Opioid		
Dolophine	Non Preferred	Brand	01/01/16	90 MME & 20mg /day	Methadone		
Duragesic patch	Non Preferred	Brand	01/01/11	90 MME & 1 patch /3 days	Opioid		
Embeda	Non Preferred	Brand	01/01/20	90 MME & 1 capsule /day	Opioid		
Exalgo	Non Preferred	Brand	01/01/15	90 MME & 1 tablet /day	Opioid		
fentanyl patch 37.5, 62.5, 87.5mcg	Non Preferred	Generic	09/28/09	90 MME & 1 patch /3 days	Opioid		
hydrocodone ER capsule	Non Preferred	Generic	01/01/20	90 MME & 1 capsule /day	Opioid		
hydromorphone ER	Non Preferred	Generic	01/01/15	90 MME & 1 tablet /day	Opioid		
Hysingla ER	Non Preferred	Brand	12/15/14	90 MME & 2 tablets /day	Opioid		
Kadian	Non Preferred	Brand	01/01/17	90 MME & 1 capsule /day	Opioid		
levorphano	Non Preferred	Generic	01/01/15	90 MME	Opioid		
methadone	Non Preferred	Generic	01/01/16	90 MME & 20mg /day	Methadone		
MorphaBond	Non Preferred	Brand	06/01/17	15mg: 90 MME & 3 tablets /day >15mg: 90 MME & 2 tablets /day	Opioid		
morphine beads ER capsule	Non Preferred	Generic	09/28/09	90 MME & 1 tablet/ day	Opioid		
MS Contin	Non Preferred	Brand	09/01/16	15mg: 90 MME & 3 tablets /day >15mg: 90 MME & 2 tablets /day	Opioid		
oxycodone ER	Non Preferred	Generic	01/01/20	90 MME & 2 tablets /day	Opioid	Oxycontin	
oxymorphone ER	Non Preferred	Generic	07/01/17	90 MME & 2 tablets /day	Opioid		
tramadol ER	Non Preferred	Generic	01/01/16	90 MME & 1 tablet /day	Opioid		
Xtampza ER	Non Preferred	Brand	06/01/16	90 MME & 2 tablets /day	Opioid		
Zohydro ER	Non Preferred	Brand	01/01/20	90 MME & 2 tablets /day	Opioid		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Opioid Combinations							
• **Cancer Pain:** The MED limit and quantity limit may be overridden if the prescriber writes Diagnosis Code (G89.3 Neoplasm related pain) for cancer related pain on the face of the prescription.							
• **Children**: 18 years of age and younger, short-acting opioid prescriptions that exceed a 7 day supply require prior authorization.							
• **Initial Fill**: 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 member in the past 60 days.							
• **MME**: In addition to the drug-specific limits below, a Morphine Equivalents Daily (MED) limit for any combination of opioids is 90 MED.							
• **Pregnancy:** Pregnant women, short-acting opioid prescriptions that exceed a 7 day supply require prior authorization.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
apap/codeine liquid	Preferred	Generic	05/01/17	90 MME & 15 ml /day			
apap/codeine tablet	Preferred	Generic	05/01/17	90 MME & 4 tablets /day			
benzhydrocodone/apap	Preferred	Generic	03/01/19	90 MME & 4 tablets /day			
hydrocodone/apap liquid	Preferred	Generic	05/01/17	90 MME & 60 ml /day			
hydrocodone/apap tablet	Preferred	Generic	05/01/17	90 MME & 4 tablets /day			
oxycodone/apap liquid	Preferred	Generic	05/01/17	90 MME & 20 ml /day			
oxycodone/apap tablet	Preferred	Generic	05/01/17	90 MME & 4 tablets /day			
pentazocine/naloxone	Preferred	Generic	08/01/18	90 MME & 4 tablets /day			
tramadol/apap	Preferred	Generic	05/01/17	90 MME & 4 tablets /day			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Apadaz	Non Preferred	Brand	03/01/19	90 MME & 4 tablets /day	Opioid		
dihydrocodeine/apap/caf	Non Preferred	Generic	01/01/19	90 MME & 4 tablets /day	Opioid		
hydrocodone/ibu	Non Preferred	Generic	05/01/17	90 MME & 4 tablets /day	Opioid		
Ibudone	Non Preferred	Brand	05/01/17	90 MME & 4 tablets /day	Opioid		
Lortab solution	Non Preferred	Brand	05/01/17	90 MME & 60 ml /day	Opioid		
Nalocet	Non Preferred	Brand	01/01/20	90 MME & 4 tablets /day	Opioid		
Norco	Non Preferred	Brand	05/01/17	90 MME & 4 tablets /day	Opioid		
oxycodone/apap 2.5/300mg	Non Preferred	Generic	03/01/20	90 MME & 4 tablets /day	Opioid		
oxycodone/asa	Non Preferred	Generic	05/01/17	90 MME & 4 tablets /day	Opioid		
oxycodone/ibu	Non Preferred	Generic	05/01/17	90 MME & 4 tablets /day	Opioid		
Percocet	Non Preferred	Brand	05/01/17	90 MME & 4 tablets /day	Opioid		
Primlev	Non Preferred	Brand	05/01/17	90 MME & 4 tablets /day	Opioid		
Prolate	Non Preferred	Brand	04/01/20	90 MME	Opioid		
Tylenol/codeine	Non Preferred	Brand	05/01/17	90 MME & 4 tablets /day	Opioid		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Ultracet	Non Preferred	Brand	05/01/17	90 MME & 4 tablets /day	Opioid		
Opioid Use Disorder Treatments							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
naltrexone tablet	Preferred	Generic	12/01/17	40 tablets /30 days			
Sublocade	Preferred	Brand	01/01/19				Must be dispensed directly to the provider, not the patient.
Suboxone Film	Preferred	Brand	01/01/12	24 mg & 3 Films /day		Suboxone	
Vivitrol	Preferred	Brand	01/01/18	1 unit /28 days			Must be dispensed directly to the provider, not the patient.
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Bunavail	Non Preferred	Brand	01/01/15	12.6 mg & 2 Films /day	Buprenorphine		
buprenorphine	Non Preferred	Generic	06/01/17	24 mg & 3 tablets /day	Buprenorphine		
buprenorphine/naloxone	Non Preferred	Generic	01/01/15	24 mg & 3 tablets or films /day	Buprenorphine	Suboxone Film	
Zubsolv	Non Preferred	Brand	01/01/17	17.1 mg & 2 tablets /day	Buprenorphine		
Androgens							
Topical Androgens							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Androderm	Preferred	Brand	01/01/19		Androgen	Androderm	
Androgel	Preferred	Brand	10/01/16		Androgen	Androgel	
Testim	Preferred	Brand	01/01/20		Androgen	Testim	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Fortesta	Non Preferred	Brand	06/01/12		Androgen		
Striant	Non Preferred	Brand	02/15/16		Androgen		
testosterone gel	Non Preferred	Generic	06/24/14		Androgen	Androgel	
testosterone solution	Non Preferred	Generic	06/24/14		Androgen		
Vogelxo	Non Preferred	Brand	06/09/14		Androgen		
Misc Androgens							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
danazol	Preferred	Generic	02/15/16		Androgen		
testosterone cypionate	Preferred	Generic	06/01/16		Androgen		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Anadrol-50	Non Preferred	Brand	06/01/12		Androgen		
Android	Non Preferred	Brand	01/01/13		Androgen		
Aveed	Non Preferred	Brand	03/17/14		Androgen		
Depo-Testosterone	Non Preferred	Brand	06/01/16		Androgen		
Jatenzo	Non Preferred	Brand	01/01/20		Androgen		
Methitest	Non Preferred	Brand	01/01/13		Androgen		
methyltestosterone	Non Preferred	Generic	02/15/16		Androgen		
Natesto	Non Preferred	Brand	07/01/20		Androgen		
oxandrolone	Non Preferred	Generic	01/01/13		Androgen		
testosterone enanthate	Non Preferred	Generic	12/01/18		Androgen		
Xyosted	Non Preferred	Brand	12/01/18		Androgen		
Antibiotics							
Aminoglycosides							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Kitabis Pak nebulizer	Preferred	Brand	01/01/16				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Arikayce	Non Preferred	Brand	11/01/18		Medication Coverage Exception		
Bethkis nebulizer	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Tobi nebulizer	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Tobi Podhaler capsule	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
tobramycin nebulizer	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
3rd Generation Cephalosporins							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
cefdinir	Preferred	Generic	02/01/10				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
cefixime	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
cefpodoxime	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Suprax	Non Preferred	Brand	01/01/19		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Quinolones							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Cipro suspension	Preferred	Brand	02/01/10			Cipro susp	
ciprofloxacin	Preferred	Generic	02/01/10				
levofloxacin	Preferred	Generic	02/01/16				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Avelox	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Baxdela	Non Preferred	Brand	10/01/17		Medication Coverage Exception		
Cipro tablet	Non Preferred	Brand	02/01/10		Medication Coverage Exception		
ciprofloxacin suspension	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Cipro susp	
Levaquin	Non Preferred	Brand	02/01/16		Medication Coverage Exception		
moxifloxacin	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
ofloxacin tablet	Non Preferred	Generic	02/01/10		Medication Coverage Exception		
Tetracyclines							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
doxycycline mono 50, 100mg capsule	Preferred	Generic	01/01/20				
doxycycline hyclate 50, 100mg	Preferred	Generic	01/01/20				
minocycline 50, 75, 100mg capsule	Preferred	Generic	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
demeclocycline	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Doryx	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
doxycycline (unless specified as preferred)	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Minocin	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
minocycline tablet	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Minolira	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Nuzyra	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Solodyn	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
tetracycline	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Vibramycin	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Ximino	Non Preferred	Brand	01/01/20		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Anticoagulants							
Oral							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Coumadin	Preferred	Brand	01/01/14				
Eliquis	Preferred	Brand	01/01/14				
Pradaxa	Preferred	Brand	01/01/14				
Xarelto	Preferred	Brand	01/01/13				
warfarin	Preferred	Generic	06/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Bevyxxa	Non Preferred	Brand	07/01/19		Medication Coverage Exception		
Savaysa	Non Preferred	Brand	01/20/15		Medication Coverage Exception		
Injectable							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
enoxaparin	Preferred	Generic	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Arixtra	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
fondaparinux	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Fragmin	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Lovenox	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Antidiabetics							
Short Acting Insulin							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Apidra vial	Preferred	Brand	01/01/17	60ml per /30 days			
Apidra Solostar	Preferred	Brand	01/01/17	60ml per /30 days			
Humalog U-100	Preferred	Brand	01/01/20	60ml per /30 days		Humalog	
Novolog vial	Preferred	Brand	02/01/10	60ml per /30 days		Novolog	
Novolog FlexPen	Preferred	Brand	02/01/10	60ml per /30 days		Novolog	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Admelog	Non Preferred	Brand	02/01/18	60ml per /30 days	Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Afrezza	Non Preferred	Brand	07/01/17	60ml per /30 days	Medication Coverage Exception		
Fiasp	Non Preferred	Brand	02/01/18	60ml per /30 days	Medication Coverage Exception		
Humalog U-200	Non Preferred	Brand	01/01/20	60ml per /30 days	Medication Coverage Exception		
Humulin-R	Non Preferred	Brand	01/01/17	60ml per /30 days	Medication Coverage Exception		
insulin aspart	Non Preferred	Generic	01/01/20	60ml per /30 days	Medication Coverage Exception	Novolog	
insulin lispro	Non Preferred	Generic	05/01/19	60ml per /30 days	Medication Coverage Exception	Humalog	
Lyumjev	Non Preferred	Brand	07/01/20	60ml per /30 days	Medication Coverage Exception		
Myxredlin	Non Preferred	Brand	09/01/19	60ml per /30 days	Medication Coverage Exception		
Novolin-R	Non Preferred	Brand	01/01/17	60ml per /30 days	Medication Coverage Exception		
Intermediate Acting Insulin							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Humulin-N pen	Preferred	Brand	01/01/20	60ml per /30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Humulin-N vial	Non Preferred	Brand	01/01/20	60ml per /30 days	Medication Coverage Exception		
Novolin-N	Non Preferred	Brand	01/01/20	60ml per /30 days	Medication Coverage Exception		
Long Acting Insulin							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Lantus vial	Preferred	Brand	01/01/17	60ml per /30 days			
Lantus Solostar	Preferred	Brand	01/01/17	60ml per /30 days			
Levemir	Preferred	Brand	09/28/09	60ml per /30 days			
Toujeo	Preferred	Brand	07/01/19	60ml per /30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Basaglar	Non Preferred	Brand	12/01/16	60ml per /30 days	Medication Coverage Exception		
Soliqua	Non Preferred	Brand	02/01/20	60ml per /30 days	Medication Coverage Exception		Trial and Failure of a preferred Long Acting Insulin AND a preferred GLP-1 Antagonist required.
Tresiba	Non Preferred	Brand	03/15/16	60ml per /30 days	Medication Coverage Exception		
Xultophy	Non Preferred	Brand	02/01/20	60ml per /30 days	Medication Coverage Exception		Trial and Failure of a preferred Long Acting Insulin AND a preferred GLP-1 Antagonist required.
Insulin Mixtures							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Humalog 50/50	Preferred	Brand	09/28/09	60ml per /30 days		Humalog	

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Humalog 75/25	Preferred	Brand	09/28/09	60ml per /30 days		Humalog	
Humulin 70/30	Preferred	Brand	01/01/20	60ml per /30 days		Humulin	
Novolog 70/30	Preferred	Brand	02/01/10	60ml per /30 days		Novolog	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Novolin 70/30	Non Preferred	Brand	01/01/19	60ml per /30 days	Medication Coverage Exception		
insulin aspart protamine/aspart	Non Preferred	Generic	01/01/20	60ml per /30 days	Medication Coverage Exception	Novolog 70/30	
insulin lispro protamine/lispro	Non Preferred	Generic	05/01/20	60ml per /30 days	Medication Coverage Exception	Humalog 75/25	
Sulfonylureas							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
glimepiride	Preferred	Generic	07/01/14		90 Day Supply Required		
glipizide	Preferred	Generic	07/01/14		90 Day Supply Required		
glyburide	Preferred	Generic	05/15/16		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Amaryl	Non Preferred	Brand	07/01/14		Medication Coverage Exception		
Glucotrol	Non Preferred	Brand	07/01/14		Medication Coverage Exception		
Glynase	Non Preferred	Brand	07/01/14		Medication Coverage Exception		
tolazamide	Non Preferred	Generic	07/01/14		Medication Coverage Exception		
tolbutamide	Non Preferred	Generic	07/01/14		Medication Coverage Exception		
Sulfonylurea Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
glyburide/metformin	Preferred	Generic	07/01/14		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Duetact	Non Preferred	Brand	10/01/17		Medication Coverage Exception		
glipizide/metformin	Non Preferred	Generic	07/01/14		Medication Coverage Exception		
pioglitazone/glimepiride	Non Preferred	Generic	10/01/17		Medication Coverage Exception		
GLP-1 Agonists							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Bydureon, BCise	Preferred	Brand	02/01/20				
Ozempic	Preferred	Brand	02/01/20				
Victoza	Preferred	Brand	01/01/14				

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Adlyxin	Non Preferred	Brand	09/01/17		Medication Coverage Exception		
Byetta	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Rybelsus	Non Preferred	Brand	10/01/19		Rybelsus Prior Auth		
Soliqua	Non Preferred	Brand	02/01/20		Medication Coverage Exception		Trial and Failure of a preferred Long Acting Insulin AND a preferred GLP-1 Antagonist required.
Tanzeum	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Trulicity	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Xultophy	Non Preferred	Brand	02/01/20		Medication Coverage Exception		Trial and Failure of a preferred Long Acting Insulin AND a preferred GLP-1 Antagonist required.
DPP- 4 Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Januvia	Preferred	Brand	09/28/09				
Tradjenta	Preferred	Brand	11/01/16				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
alogliptin	Non Preferred	Generic	04/01/16		Medication Coverage Exception		
Nesina	Non Preferred	Brand	04/01/16		Medication Coverage Exception		
Onglyza	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
DPP- 4 Inhibitor Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Janumet	Preferred	Brand	11/01/16				
Janumet XR	Preferred	Brand	11/01/16				
Jentadueto	Preferred	Brand	01/01/20				
JentaduetoXR	Preferred	Brand	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
alogliptin/pioglitazone	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Oseni	
alogliptin/metformin	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Glyxambi	Non Preferred	Brand	02/11/15		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Jentadueto XR	Non Preferred	Brand	11/01/16		Medication Coverage Exception		
Kazano	Non Preferred	Brand	02/01/18		Medication Coverage Exception		
Kombiglyze XR	Non Preferred	Brand	01/01/19		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Oseni	Non Preferred	Brand	01/01/19		Medication Coverage Exception	Oseni	
Qtern	Non Preferred	Brand	12/01/17		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Steglujan	Non Preferred	Brand	02/01/18		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Trijardy XR	Non Preferred	Brand	04/01/20		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
SGLT-2 Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Farxiga	Preferred	Brand	01/01/18				
Jardiance	Preferred	Brand	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Invokana	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Steglatro	Non Preferred	Brand	02/01/18		Medication Coverage Exception		
SGLT-2 Inhibitor Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Synjardy	Preferred	Brand	01/01/18				
Synjardy XR	Preferred	Brand	01/01/18				
Xigduo	Preferred	Brand	01/01/18				
Xigduo XR	Preferred	Brand	01/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Glyxambi	Non Preferred	Brand	02/11/15		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Invokamet	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Invokamet XR	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Qtern	Non Preferred	Brand	12/01/17		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Segluromet	Non Preferred	Brand	03/01/18		Medication Coverage Exception		
Steglujan	Non Preferred	Brand	02/01/18		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Trijardy XR	Non Preferred	Brand	04/01/20		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Antifungals							
Oral							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Ancobon	Preferred	Brand	01/01/14			Ancobon	
clotrimazole lozenge	Preferred	Generic	10/01/11				
fluconazole	Preferred	Generic	10/01/11				
griseofulvin suspension	Preferred	Generic	01/01/13				
ketoconazole tablet	Preferred	Generic	01/15/12				
nystatin	Preferred	Generic	10/01/11				
terbinafine	Preferred	Generic	10/01/11				
voriconazole	Preferred	Generic	10/01/15				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Cresemba	Non Preferred	Brand	04/01/15		Medication Coverage Exception		
Diflucan	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
flucytosine	Non Preferred	Generic	08/01/16		Medication Coverage Exception	Ancobon	
griseofulvin tablet	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
itraconazole capsule	Non Preferred	Generic	04/01/13		Medication Coverage Exception		
itraconazole solution	Non Preferred	Generic	04/01/13		Medication Coverage Exception	Sporanox	
Noxafil	Non Preferred	Brand	08/01/19		Medication Coverage Exception		
Onmel	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Oravig	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
posaconazole	Non Preferred	Generic	08/01/19		Medication Coverage Exception		
Sporanox	Non Preferred	Brand	04/01/13		Medication Coverage Exception		
Tolsura	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Vfend	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Antihemophilia							
Factor VIII							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Advate	Preferred	Brand	10/01/18				
Adynovate	Preferred	Brand	10/01/18				
Koate, DVI	Preferred	Brand	10/01/18				

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Monoclate-P	Preferred	Brand	10/01/18				
Novoeight	Preferred	Brand	10/01/18				
Xyntha	Preferred	Brand	10/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Afstyla	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Eloctate	Non Preferred	Brand	10/01/18		Medication Coverage Exception		
Esperoct	Non Preferred	Brand	02/01/20		Medication Coverage Exception		
Helixate FS	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Hemofil M	Non Preferred	Brand	10/01/18		Medication Coverage Exception		
Jivi	Non Preferred	Brand	10/01/18		Medication Coverage Exception		
Kogenate FS	Non Preferred	Brand	10/01/18		Medication Coverage Exception		
Kovaltry	Non Preferred	Brand	10/01/18		Medication Coverage Exception		
Nuwiq	Non Preferred	Brand	10/01/18		Medication Coverage Exception		
Obizur	Non Preferred	Brand	07/01/20		Medication Coverage Exception		
Recombinate	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Factor VIII/von Willebrand Factor							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Alphanate	Preferred	Brand	01/01/19				
Humate P	Preferred	Brand	01/01/19				
Wilate	Preferred	Brand	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Vonvendi	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Factor IX							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Alphanine	Preferred	Brand	01/01/19				
Benefix	Preferred	Brand	01/01/19				
Feiba	Preferred	Brand	01/01/19				
Ixinity	Preferred	Brand	01/01/19				
Rixubis	Preferred	Brand	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Alprolix	Non Preferred	Brand	01/01/20		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Idelvion	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Mononine	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Profilnine	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Rebinyn	Non Preferred	Brand	01/01/19		Medication Coverage Exception		

Antihistamines

1st Generation

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
chlorpheniramine tablet	Preferred	Generic	01/01/18				
cyproheptadine	Preferred	Generic	07/01/14				
diphenhydramine	Preferred	Generic	07/01/14				
hydroxyzine HCl	Preferred	Generic	07/01/14				
hydroxyzine pam	Preferred	Generic	07/01/14				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
carbinoxamine	Non Preferred	Generic	07/01/14		Medication Coverage Exception		
chlorpheniramine SR	Non Preferred	Generic	10/01/19		Medication Coverage Exception		
chlorpheniramine syrup	Non Preferred	Generic	10/01/19		Medication Coverage Exception		
clemastine	Non Preferred	Generic	07/01/14		Medication Coverage Exception		
Ryclora	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
triprolidine	Non Preferred	Generic	12/01/17		Medication Coverage Exception		
Vistaril	Non Preferred	Brand	07/01/14		Medication Coverage Exception		

2nd Generation

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
cetirizine solution	Preferred	Generic	01/01/18				
cetirizine tablet	Preferred	Generic	01/01/18		90 Day Supply Required		
levocetirizine tablet	Preferred	Generic	01/01/19				
loratadine	Preferred	Generic	07/01/14		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
cetirizine chewable	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
Clarinex	Non Preferred	Brand	07/01/14		Medication Coverage Exception		
desloratadine	Non Preferred	Generic	07/01/14		Medication Coverage Exception		
levocetirizine solution	Non Preferred	Generic	01/01/19		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Anti-infectives (NOS)							
Amebicide & Antiprotozoal Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Flagyl 375mg	Preferred	Brand	01/01/15			Flagyl	
metronidazole 250, 500mg	Preferred	Generic	01/01/15				
tinidazole	Preferred	Generic	05/15/16				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Flagyl 250, 500mg	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
metronidazole 375mg	Non Preferred	Generic	01/01/15		Medication Coverage Exception		
Nebupent	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
paromomycin	Non Preferred	Generic	01/01/15		Medication Coverage Exception		
Solosec	Non Preferred	Brand	02/01/18		Medication Coverage Exception		
Antimalarials							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
hydroxychloroquine	Preferred	Generic	01/01/18				
primaquine	Preferred	Generic	01/01/16				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
atovaquone/proguanil	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
chloroquine	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Coartem	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Daraprim	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Krintafel	Non Preferred	Brand	02/01/19		Medication Coverage Exception		
Malarone	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
mefloquine	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Qualaquin	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
quinine	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Vaginal							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
AVC	Preferred	Brand	01/01/13				
clindamycin	Preferred	Generic	03/01/16				

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
clotrimazole	Preferred	Generic	01/01/18				
metronidazole vaginal	Preferred	Generic	04/18/13				
miconazole cream	Preferred	Generic	01/01/13				
miconazole 7	Preferred	Generic	10/01/11				
Vandazole	Preferred	Generic	01/01/13				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Cleocin	Non Preferred	Brand	03/01/16		Medication Coverage Exception		
Clindesse	Non Preferred	Brand	11/01/16		Medication Coverage Exception		
Gynazole-1	Non Preferred	Brand	10/01/11		Medication Coverage Exception		
Metrogel vaginal	Non Preferred	Brand	09/01/16		Medication Coverage Exception		
miconazole 1, 3 kit	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
Nuvessa	Non Preferred	Brand	03/06/15		Medication Coverage Exception		
terconazole	Non Preferred	Generic	10/01/11		Medication Coverage Exception		

Antivirals

Anti-Influenza - Oral

Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
oseltamivir	Preferred	Generic	01/01/20				
Relenza	Preferred	Brand	03/01/16				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Flumadine	Non Preferred	Brand	06/01/13		Medication Coverage Exception		
ribavirin	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
rimantadine	Non Preferred	Generic	06/01/13		Medication Coverage Exception		
Tamiflu	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Virazole	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Xofluza	Non Preferred	Brand	11/01/18		Medication Coverage Exception		

Antiretrovirals - Entry, Fusion Inhibitors

Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Selzentry	Preferred	Brand	07/01/17				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Fuzeon	Non Preferred	Brand	07/01/17		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Trogarzo	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
Antiretrovirals - Integrase Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Isentress	Preferred	Brand	07/01/17				
Tivicay	Preferred	Brand	07/01/17				
Antiretrovirals - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Edurant	Preferred	Brand	07/01/17				
Intelence	Preferred	Brand	07/01/17				
nevirapine	Preferred	Generic	07/01/17		90 Day Supply Required		
Sustiva	Preferred	Brand	07/01/17			Sustiva	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
efavirenz	Non Preferred	Generic	01/01/18		Medication Coverage Exception	Sustiva	
Pifeltro	Non Preferred	Brand	10/01/18		Medication Coverage Exception		
Rescriptor	Non Preferred	Brand	07/01/17		Medication Coverage Exception		
Viramune	Non Preferred	Brand	07/01/17		Medication Coverage Exception		
Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs)							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
abacavir tablet	Preferred	Generic	07/01/17		90 Day Supply Required		See NIH Guidelines
Emtriva	Preferred	Brand	07/01/17				See NIH Guidelines
lamivudine	Preferred	Generic	07/01/17				See NIH Guidelines
tenofovir disoproxil 300mg	Preferred	Generic	07/01/18				See NIH Guidelines
Viread 150mg, 200mg, 250mg, powder	Preferred	Brand	07/01/18				See NIH Guidelines
Ziagen solution	Preferred	Brand	07/01/17				See NIH Guidelines
zidovudine	Preferred	Generic	07/01/17		90 Day Supply Required		See NIH Guidelines
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
abacavir solution	Non Preferred	Generic	07/01/17		Medication Coverage Exception		See NIH Guidelines
Epivir	Non Preferred	Brand	07/01/17		Medication Coverage Exception		See NIH Guidelines
didanosine	Non Preferred	Generic	07/01/17		Medication Coverage Exception		See NIH Guidelines
Retrovir	Non Preferred	Brand	07/01/17		Medication Coverage Exception		See NIH Guidelines
stavudine	Non Preferred	Generic	07/01/17		Medication Coverage Exception		See NIH Guidelines

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Videx	Non Preferred	Brand	07/01/17		Medication Coverage Exception		See NIH Guidelines
Viread 300mg	Non Preferred	Generic	07/01/18		Medication Coverage Exception		See NIH Guidelines
Zerit	Non Preferred	Brand	07/01/17		Medication Coverage Exception		See NIH Guidelines
Ziagen tablet	Non Preferred	Brand	07/01/17		Medication Coverage Exception		See NIH Guidelines
Protease Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
atazanavir 200, 300mg	Preferred	Generic	01/01/20				
Norvir	Preferred	Brand	01/01/16			Norvir	
Prezista	Preferred	Brand	01/01/16				
Reyataz 150mg capsule	Preferred	Brand	01/01/20			Reyataz	
Reyataz powder	Preferred	Brand	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Aptivus	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
atazanavir 150mg	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Reyataz	
Crixivan	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
fosamprenavir	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Invirase	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Lexiva	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Reyataz 200, 300mg	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
ritonavir	Non Preferred	Generic	04/01/18		Medication Coverage Exception	Norvir	
Viracept	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Antiretrovirals- Combination Products							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
abacavir/lamivudine	Preferred	Generic	07/01/17				See NIH Guidelines
Atripla	Preferred	Brand	07/01/17				See NIH Guidelines
Biktarvy	Preferred	Brand	03/01/18				See NIH Guidelines
Cimduo	Preferred	Brand	05/01/18				See NIH Guidelines
Descovy	Preferred	Brand	07/01/17				See NIH Guidelines
Dovato	Preferred	Brand	05/01/19				See NIH Guidelines
Evotaz	Preferred	Brand	01/01/17				See NIH Guidelines
Genvoya	Preferred	Brand	07/01/17				See NIH Guidelines
Kaletra	Preferred	Brand	01/01/20			Kaletra	See NIH Guidelines

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
lamivudine/zidovudine	Preferred	Generic	07/01/17				See NIH Guidelines
Odefsey	Preferred	Brand	07/01/17				See NIH Guidelines
Prezcobix	Preferred	Brand	07/01/17				See NIH Guidelines
Symfi	Preferred	Brand	05/01/18				See NIH Guidelines
Symfi Lo	Preferred	Brand	05/01/18				See NIH Guidelines
Triumeq	Preferred	Brand	07/01/17				See NIH Guidelines
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
abacavir/lamivudine/zidovudine	Non Preferred	Generic	07/01/17		Medication Coverage Exception		See NIH Guidelines
Combivir	Non Preferred	Brand	07/01/17		Medication Coverage Exception		See NIH Guidelines
Complera	Non Preferred	Brand	07/01/17		Medication Coverage Exception		See NIH Guidelines
Delstrigo	Non Preferred	Brand	10/01/18		Medication Coverage Exception		See NIH Guidelines
Epzicom	Non Preferred	Brand	07/01/17		Medication Coverage Exception		See NIH Guidelines
Juluca	Non Preferred	Brand	12/01/17		Medication Coverage Exception		See NIH Guidelines
lopinavir/ritonavir	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Kaletra	See NIH Guidelines
Stribild	Non Preferred	Brand	07/01/17		Medication Coverage Exception		See NIH Guidelines
Symtuza	Non Preferred	Brand	08/01/18		Medication Coverage Exception		See NIH Guidelines
Trizivir	Non Preferred	Brand	07/01/17		Medication Coverage Exception		See NIH Guidelines
Truvada	Non Preferred	Brand	01/01/20		Medication Coverage Exception		See NIH Guidelines

Hepatitis C

Direct Acting Antivirals (DAAs)

Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Epclusa	Preferred	Brand	10/01/17		Hepatitis C	Epclusa	
Mavyret	Preferred	Brand	09/01/17		Hepatitis C		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Daklinza	Non Preferred	Brand	01/01/18		Hepatitis C		
Harvoni	Non Preferred	Brand	01/01/20		Hepatitis C	Harvoni	
sofosbuvir/ledipasvir	Non Preferred	Generic	01/01/20		Hepatitis C	Harvoni	
sofosbuvir/velpatasvir	Non Preferred	Generic	12/01/18		Hepatitis C	Epclusa	
Sovaldi	Non Preferred	Brand	01/01/18		Hepatitis C		
Vosevi	Non Preferred	Brand	08/01/17		Hepatitis C		
Zepatier	Non Preferred	Brand	01/01/20		Hepatitis C		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Herpes Simplex, Varicella Zoster, & Cytomegalovirus							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
acyclovir	Preferred	Generic	01/01/14				
valacyclovir	Preferred	Generic	01/01/14				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
famciclovir	Non Preferred	Generic	06/01/13		Medication Coverage Exception		
Prevymis	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Sitavig	Non Preferred	Brand	03/01/16		Medication Coverage Exception		
Valcyte	Non Preferred	Brand	06/01/13		Medication Coverage Exception		
valganciclovir	Non Preferred	Generic	06/01/13		Medication Coverage Exception		
Valtrex	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Zovirax	Non Preferred	Brand	06/01/13		Medication Coverage Exception		
Appetite Stimulants							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
megestrol	Preferred	Generic	01/01/15				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
dronabinol	Non Preferred	Generic	01/01/15		Medication Coverage Exception		Included in more than one PDL drug class
Marinol	Non Preferred	Brand	01/01/15		Medication Coverage Exception		Included in more than one PDL drug class
Megace suspension	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
Bile Acid Sequestrants							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
cholestyramine	Preferred	Generic	01/01/15				
colestipol	Preferred	Generic	01/01/15				
Welchol	Preferred	Brand	01/01/18			Welchol	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
colesevelam	Non Preferred	Generic	06/01/18		Medication Coverage Exception	Welchol	
Colestid	Non Preferred	Brand	01/01/15		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Questran	Non Preferred	Brand	01/01/15		Medication Coverage Exception		

Bone Density Regulators

Osteoporosis Agents

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
alendronate 5, 10, 35, 70mg	Preferred	Generic	10/01/09		84 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Actonel	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
alendronate 40mg	Non Preferred	Generic	10/01/09		Medication Coverage Exception		
Atelvia	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Binosto	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Boniva	Non Preferred	Brand	04/15/13		Medication Coverage Exception		
calcitonin	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Evenity	Non Preferred	Brand	05/01/19		Medication Coverage Exception		
Forteo	Non Preferred	Brand	03/01/16		Forteo		
Fosamax	Non Preferred	Brand	10/01/09		Medication Coverage Exception		
Fosamax-D	Non Preferred	Brand	10/01/09		Medication Coverage Exception		
ibandronate	Non Preferred	Generic	04/15/13		Medication Coverage Exception		
Miacalcin	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Prolia	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
risedronate	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
Tymlos	Non Preferred	Brand	06/01/17		Medication Coverage Exception		
Xgeva	Non Preferred	Brand	10/15/15		Medication Coverage Exception		

Cardiovascular

Antianginal Agents

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
isosorbide dinitrate	Preferred	Generic	01/01/16				
isosorbide mononitrate IR	Preferred	Generic	01/01/16				
isosorbide mononitrate ER	Preferred	Generic	01/01/16				
nitroglycerin patch	Preferred	Generic	01/01/18				
nitroglycerin sublingual	Preferred	Generic	01/01/20				

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Dilatrate SR	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Gonitro powder	Non Preferred	Brand	11/01/17		Medication Coverage Exception		
Isordil	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Minitran patch	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Nitro-Bid ointment	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Nitrostat	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Nitro-Dur patch	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
nitroglycerin lingual spray	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Nitrolingual	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Nitromist	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Ranexa	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
ranolazine	Non Preferred	Generic	10/01/19		Medication Coverage Exception		
Antihyperlipidemics							
HMG Co-A Reductase Inhibitors ("Statins")							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
atorvastatin	Preferred	Generic	11/01/12		90 Day Supply Required		
Crestor	Preferred	Brand	01/01/14			Crestor	
lovastatin	Preferred	Generic	09/28/09		90 Day Supply Required		
pravastatin	Preferred	Generic	09/28/09		90 Day Supply Required		
simvastatin	Preferred	Generic	09/28/09				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Altoprev	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Ezallor	Non Preferred	Brand	07/01/19		Medication Coverage Exception		
fluvastatin	Non Preferred	Generic	10/01/18		Medication Coverage Exception		
fluvastatin ER	Non Preferred	Generic	10/01/18		Medication Coverage Exception		
Lescol XL	Non Preferred	Brand	10/01/18		Medication Coverage Exception		
Lipitor	Non Preferred	Brand	11/01/12		Medication Coverage Exception		
Livalo	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Pravachol	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
rosuvastatin	Non Preferred	Generic	05/15/16		Medication Coverage Exception	Crestor	
Zocor	Non Preferred	Brand	01/01/13		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Zypitamag	Non Preferred	Brand	04/01/18		Medication Coverage Exception		
Cholesterol-Lowering Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Vytorin	Preferred	Brand	01/01/13			Vytorin	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
amlodipine/atorvastatin	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
Caduet	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
ezetimibe/simvastatin	Non Preferred	Generic	05/01/17		Medication Coverage Exception	Vytorin	
Nexlizet	Non Preferred	Brand	06/01/20		Medication Coverage Exception		
PCSK-9 Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Repatha	Preferred	Brand	01/01/20		PCSK9 Inhibitor		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Praluent	Non Preferred	Brand	01/01/20		PCSK9 Inhibitor		
Fibrates							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
fenofibrate 48, 50, 54, 145, 150, 160mg	Preferred	Generic	01/01/17				
gemfibrozil	Preferred	Generic	09/28/09				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
fenofibrate 40, 43, 67, 120, 130, 134, 200mg	Non Preferred	Generic	01/01/17		Medication Coverage Exception		
Antara	Non Preferred	Brand	01/01/12		Medication Coverage Exception		
choline fenofibrate	Non Preferred	Generic	01/01/17		Medication Coverage Exception		
fenofibrate micronized	Non Preferred	Generic	09/28/09		Medication Coverage Exception		
fenofibric acid	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Fenoglid	Non Preferred	Brand	07/01/15		Medication Coverage Exception		
Fibricor	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Lipofen	Non Preferred	Brand	05/14/14		Medication Coverage Exception		
Lopid	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Tricor	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
Triglide	Non Preferred	Brand	01/01/17		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Trilipix	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
Miscellaneous							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
ezetimibe	Preferred	Generic	01/01/20				
omega-3 acid ethyl esters	Preferred	Generic	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Juxtapid	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Lovaza	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Nexletol	Non Preferred	Brand	04/01/20		Medication Coverage Exception		
Vascepa	Non Preferred	Brand	11/01/15		Medication Coverage Exception		
Zetia	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Antihypertensives							
Alpha/Beta-Adrenergic Blocking Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
carvedilol	Preferred	Generic	09/28/09		90 day supply		
labetalol	Preferred	Generic	09/28/09		90 day supply		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
carvedilol ER	Non Preferred	Generic	12/01/17		Medication Coverage Exception	Coreg CR	
Coreg	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Coreg CR	Non Preferred	Brand	12/01/17		Medication Coverage Exception	Coreg CR	
Angiotensin Converting Enzyme (ACE) Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
benazepril	Preferred	Generic	09/28/09		90 Day Supply Required		
captopril	Preferred	Generic	09/28/09		90 Day Supply Required		
enalapril	Preferred	Generic	09/28/09		90 Day Supply Required		
fosinopril	Preferred	Generic	09/28/09		90 Day Supply Required		
lisinopril	Preferred	Generic	09/28/09		90 Day Supply Required		
quinapril	Preferred	Generic	09/28/09		90 Day Supply Required		
ramipril	Preferred	Generic	09/28/09		90 Day Supply Required		
trandolapril	Preferred	Generic	01/01/14		90 Day Supply Required		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Accupril	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Altace	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Epaned	Non Preferred	Brand	04/18/14		Medication Coverage Exception		
Lotensin	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
moexipril	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
perindopril	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
Prinivil	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Qbrelis	Non Preferred	Brand	09/01/16		Medication Coverage Exception		
Vasotec	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Zestril	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Angiotensin Converting Enzyme (ACE) Inhibitor Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
amlodipine/verapamil	Preferred	Generic	11/01/19				
benazepril/hydrochlorothiazide	Preferred	Generic	07/01/20				
captopril/hydrochlorothiazide	Preferred	Generic	09/28/09				
enalapril/hydrochlorothiazide	Preferred	Generic	09/28/09		90 Day Supply Required		
lisinopril/hydrochlorothiazide	Preferred	Generic	09/28/09		90 Day Supply Required		
quinapril/hydrochlorothiazide	Preferred	Generic	09/28/09				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Accuretic	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
fosinopril/hydrochlorothiazide	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Lotrel	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
moexipril/hydrochlorothiazide	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Prestalia	Non Preferred	Brand	09/01/19		Medication Coverage Exception		
Tarka	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
trandolapril/verapamil	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Vaseretic	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Zestoretic	Non Preferred	Brand	09/28/09		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Angiotensin Receptor Blockers (ARBs)							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Benicar	Preferred	Brand	01/01/19		90 Day Supply Required	Benicar	
Diovan	Preferred	Brand	01/01/19		90 Day Supply Required	Diovan	
Edarbi	Preferred	Brand	01/01/19				
irbesartan	Preferred	Generic	10/15/15				
losartan	Preferred	Generic	04/01/12				
Micardis	Preferred	Brand	01/01/19		90 Day Supply Required	Micardis	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Atacand	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
candesartan	Non Preferred	Generic	10/15/15		Medication Coverage Exception		
Avapro	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
Cozaar	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
eprosartan	Non Preferred	Generic	09/28/09		Medication Coverage Exception		
olmesartan	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Benicar	
telmisartan	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Micardis	
valsartan	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Diovan	
Angiotensin Receptor Blocker (ARB) + Thiazide Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Edarbyclor	Preferred	Brand	01/01/19				
irbesartan/hydrochlorothiazide	Preferred	Generic	01/01/14		90 Day Supply Required		
losartan/hydrochlorothiazide	Preferred	Generic	09/28/09				
Micardis HCT	Preferred	Brand	01/01/12			Micardis HCT	
olmesartan/hydrochlorothiazide	Preferred	Generic	08/01/17		90 Day Supply Required		
valsartan/hydrochlorothiazide	Preferred	Generic	10/15/15		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Atacand HCT	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Avalide	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Benicar HCT	Non Preferred	Brand	08/01/17		Medication Coverage Exception		
candesartan/hydrochlorothiazide	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
Diovan HCT	Non Preferred	Brand	10/15/15		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Hyzaar	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
telmisartan/hydrochlorothiazide	Non Preferred	Generic	01/01/14		Medication Coverage Exception	Micardis HCT	
Angiotensin Receptor Blocker (ARB) Combinations - Other							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
amlodipine/olmesartan	Preferred	Generic	08/01/17				
amlodipine/olmesartan/hydrochlorothiazide	Preferred	Generic	08/01/17				
amlodipine/valsartan	Preferred	Generic	01/01/19				
Entresto	Preferred	Brand	06/01/20				
Exforge HCT	Preferred	Brand	09/28/09			Exforge HCT	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
amlodipine/valsartan/hydrochlorothiazide	Non Preferred	Generic	03/01/16		Medication Coverage Exception	Exforge HCT	
Azor	Non Preferred	Generic	08/01/17		Medication Coverage Exception		
Exforge	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
telmisartan/amlodipine	Non Preferred	Generic	01/01/12		Medication Coverage Exception		
Tribenzor	Non Preferred	Brand	08/01/17		Medication Coverage Exception		
Twynsta	Non Preferred	Brand	01/01/12		Medication Coverage Exception		
Beta-Adrenergic Blocking Agents - Cardio Selective							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
atenolol	Preferred	Generic	09/28/09		90 Day Supply Required		
Bystolic	Preferred	Brand	01/01/19				
metoprolol succinate	Preferred	Generic	10/15/15		90 Day Supply Required		
metoprolol tartrate	Preferred	Generic	01/01/20		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
acebutolol	Non Preferred	Generic	08/01/17		Medication Coverage Exception		
betaxolol	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
bisoprolol	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
First-Atenol	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
First-Meto	Non Preferred	Brand	02/01/19		Medication Coverage Exception		
Kapspargo	Non Preferred	Brand	08/01/18		Medication Coverage Exception		
Lopressor	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Tenormin	Non Preferred	Brand	09/28/09		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Toprol XL	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
Beta-Adrenergic Blocking Agents - Cardio Nonselectiveve							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
nadolol	Preferred	Generic	10/15/15				
pindolol	Preferred	Generic	09/28/09				
propranolol SR	Preferred	Generic	03/01/16				
propranolol	Preferred	Generic	04/01/13		90 Day Supply Required		
sotalol AF	Preferred	Generic	01/01/19				
sotalol	Preferred	Generic	01/01/14		90 Day Supply Required		
timolol	Preferred	Generic	09/28/09				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Betapace	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Betapace AF	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Corgard	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
Hemangeol	Non Preferred	Brand	05/07/14		Medication Coverage Exception		
Inderal LA	Non Preferred	Brand	03/01/16		Medication Coverage Exception		
Inderal XL	Non Preferred	Brand	03/01/16		Medication Coverage Exception		
Innopran XL	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Sotylize	Non Preferred	Brand	02/19/15		Medication Coverage Exception		
Beta-Adrenergic Blocking Agent Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
atenolol/chlorthalidone	Preferred	Generic	09/28/09		90 Day Supply Required		
bisoprolol/hydrochlorothiazide	Preferred	Generic	09/28/09		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
nadolol/bendroflumethiazide	Non Preferred	Brand	11/01/16		Medication Coverage Exception		
metoprolol/hydrochlorothiazide	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Corzide	Non Preferred	Generic	11/01/16		Medication Coverage Exception		
propranolol/hydrochlorothiazide	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Tenoretic	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Ziac	Non Preferred	Brand	09/28/09		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Calcium Channel Blocking Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
amlodipine	Preferred	Generic	09/28/09		90 Day Supply Required		
diltiazem capsule	Preferred	Generic	09/28/09				
diltiazem solution	Preferred	Generic	09/28/09				
diltiazem tablet	Preferred	Generic	09/28/09				
felodipine ER	Preferred	Generic	09/28/09		90 Day Supply Required		
nifedipine	Preferred	Generic	01/01/14				
nifedipine ER	Preferred	Generic	01/01/14				
verapamil tablet	Preferred	Generic	09/28/09				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Adalat CC	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Calan	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Calan SR	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Cardizem	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Cardizem CD	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Cardizem LA	Non Preferred	Brand	03/01/16		Medication Coverage Exception		
diltiazem ER	Non Preferred	Generic	03/01/16		Medication Coverage Exception		
isradipine	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Katerzia	Non Preferred	Brand	08/01/19		Medication Coverage Exception		
nicardipine	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
nimodipine	Non Preferred	Generic	09/28/09		Medication Coverage Exception		
nisoldipine	Non Preferred	Generic	04/01/13		Medication Coverage Exception		
Norvasc	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Nymalize	Non Preferred	Brand	07/08/13		Medication Coverage Exception		
Procardia	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Procardia XL	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Sular	Non Preferred	Brand	04/01/13		Medication Coverage Exception		
Tiazac	Non Preferred	Brand	03/01/16		Medication Coverage Exception		
verapamil capsule	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
Verelan	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Verelan PM	Non Preferred	Brand	01/01/20		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Diuretics - Loop							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
bumetanide	Preferred	Generic	01/01/20				
furosemide	Preferred	Generic	01/01/16				
torsemide	Preferred	Generic	01/01/16		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Bumex	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Edecrin	Non Preferred	Brand	11/01/17		Medication Coverage Exception		
ethacrynic acid	Non Preferred	Generic	11/01/17		Medication Coverage Exception		
Lasix	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Diuretics - Thiazide							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
chlorothiazide	Preferred	Generic	12/01/16				
chlorthalidone	Preferred	Generic	01/01/20				
Diuril	Preferred	Generic	01/01/19				
hydrochlorothiazide	Preferred	Generic	01/01/16		90 Day Supply Required		
indapamide	Preferred	Generic	01/01/16		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
methyclothiazide	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
metolazone	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Microzide	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Diuretics - Potassium Sparing & Combination							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
amiloride	Preferred	Generic	01/01/19				
amiloride/hydrochlorothiazide	Preferred	Generic	01/01/16		90 Day Supply Required		
spironolactone	Preferred	Generic	01/01/16				
spironolactone/hydrochlorothiazide	Preferred	Generic	01/01/16				
triamterene/hydrochlorothiazide	Preferred	Generic	01/01/16		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Aldactazide	Non Preferred	Brand	01/01/16		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Aldactone	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
CaroSpir	Non Preferred	Brand	11/01/17		Medication Coverage Exception		
Dyazide	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
eplerenone	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Inspra	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Maxzide	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
triamterene	Non Preferred	Generic	09/01/19		Medication Coverage Exception		
Platelet Aggregation Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
clopidogrel 75mg	Preferred	Generic	06/01/12		90 Day Supply Required		
prasugrel	Preferred	Generic	07/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Brilinta	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
clopidogrel 300mg	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
dipyridamole	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
Effient	Non Preferred	Brand	07/01/18		Medication Coverage Exception		
Plavix	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Zontivity	Non Preferred	Brand	10/01/15		Medication Coverage Exception		
Platelet Aggregation Inhibitors-Miscellaneous, Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Aggrenox	Preferred	Brand	07/01/12				
asa/dipyridamole	Preferred	Generic	06/01/20				
cilostazol	Preferred	Generic	11/01/12				
pentoxifylline	Preferred	Generic	07/01/12				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Agrylin	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
anagrelide	Non Preferred	Generic	01/01/20		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Central Nervous System							
Antidementia Agents - Oral							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
donepezil 5, 10mg	Preferred	Generic	10/01/13		90 Day Supply Required		
donepezil orally disintegrating tablet	Preferred	Generic	01/01/19				
memantine tablet	Preferred	Generic	02/01/16		90 Day Supply Required		
rivastigmine capsule	Preferred	Generic	05/15/16				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Aricept	Non Preferred	Brand	01/15/13		Medication Coverage Exception		
donepezil 23mg	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
galantamine	Non Preferred	Generic	09/28/09		Medication Coverage Exception		
memantine solution	Non Preferred	Generic	03/15/16		Medication Coverage Exception		
memantine ER	Non Preferred	Generic	03/01/18		Medication Coverage Exception	Namenda XR	
Namenda tablet	Non Preferred	Brand	02/01/16		Medication Coverage Exception		
Namenda XR	Non Preferred	Brand	03/01/18		Medication Coverage Exception	Namenda XR	
Namzaric	Non Preferred	Brand	04/15/15		Medication Coverage Exception		
Razadyne	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Antidementia Agents - Topical							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Exelon	Preferred	Brand	09/28/09			Exelon	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
rivastigmine patch	Non Preferred	Generic	09/15/15		Medication Coverage Exception	Exelon	
Hypnotics - Benzodiazepines							
• **Cumulative limit:** 30 units in 30 days. Cumulative limits apply across all hypnotic classes.							
• **Benzodiazepine and Opioid Combination:** Concurrent prescriptions of long-acting opioids and benzodiazepines (filled within 45 days of each other) require prior authorization.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
flurazepam	Preferred	Generic	06/01/13	cumulative: 30 units /30 days			Benzo/Opioid Combo Requires PA
temazepam 15, 30mg	Preferred	Generic	06/01/13	cumulative: 30 units /30 days			Benzo/Opioid Combo Requires PA
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
estazolam	Non Preferred	Generic	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		Benzo/Opioid Combo Requires PA

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Halcion	Non Preferred	Brand	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		Benzo/Opioid Combo Requires PA
midazolam	Non Preferred	Generic	11/01/16	cumulative: 30 units /30 days	Medication Coverage Exception		Benzo/Opioid Combo Requires PA
Restoril	Non Preferred	Brand	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		Benzo/Opioid Combo Requires PA
temazepam 7.5, 22.5mg	Non Preferred	Generic	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		Benzo/Opioid Combo Requires PA
triazolam	Non Preferred	Generic	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		Benzo/Opioid Combo Requires PA
Hypnotics - Non Benzodiazepines, Non Barbiturates							
• **Cumulative limit:** 30 units in 30 days. Cumulative limits apply across all hypnotic classes.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
eszopiclone	Preferred	Generic	01/01/20	cumulative: 30 units /30 days			
Rozerem	Preferred	Brand	01/01/20	cumulative: 30 units /30 days		Rozerem	
Silenor	Preferred	Brand	01/01/20	cumulative: 30 units /30 days		Silenor	
zaleplon	Preferred	Generic	10/15/15	cumulative: 30 units /30 days			
zolpidem tablet	Preferred	Generic	01/01/20	cumulative: 30 units /30 days			
zolpidem CR	Preferred	Generic	01/01/20	cumulative: 30 units /30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Ambien	Non Preferred	Brand	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		
Ambien CR	Non Preferred	Brand	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		
Belsomra	Non Preferred	Brand	12/10/14	cumulative: 30 units /30 days	Medication Coverage Exception		
Dayvigo	Non Preferred	Brand	05/01/20	cumulative: 30 units /30 days	Medication Coverage Exception		
doxepin tablet	Non Preferred	Generic	01/01/20	cumulative: 30 units /30 days	Medication Coverage Exception	Silenor	
Edluar	Non Preferred	Brand	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		
Hetlioz	Non Preferred	Brand	03/17/14	cumulative: 30 units /30 days	Hetlioz		
Intermezzo	Non Preferred	Brand	11/01/18	cumulative: 30 units /30 days	Medication Coverage Exception		
Lunesta	Non Preferred	Brand	04/28/14	cumulative: 30 units /30 days	Medication Coverage Exception		
ramelteon	Non Preferred	Generic	08/01/19	cumulative: 30 units /30 days	Medication Coverage Exception	Rozerem	
zolpidem SL	Non Preferred	Brand	11/01/18	cumulative: 30 units /30 days	Medication Coverage Exception	Intermezzo	
Hypnotics - Barbiturates, Miscellanous							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
phenobarbital 15, 30, 60, 100mg	Preferred	Generic	06/01/13				
phenobarbital elixir	Preferred	Generic	06/01/13				

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Butisol	Non Preferred	Brand	11/01/17		Medication Coverage Exception		
phenobarb 16.2, 32.4, 64.8, 97.2mg	Non Preferred	Generic	06/01/13		Medication Coverage Exception		
Seconal	Non Preferred	Brand	06/01/13		Medication Coverage Exception		

Mental Health

Short Acting ADHD Stimulants

• **DAW:** 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. See Pg.3 Explanation for more information.

Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
amphetamine/dextroamphetamine table	Preferred	Generic	07/01/20	Min Age: 4 Years Old			
Focalin	Preferred	Brand	07/01/20	Min Age: 4 Years Old		Focalin	
Methylin (mph) solution	Preferred	Brand	07/01/20	Min Age: 4 Years Old			
methylphenidate solution	Preferred	Generic	07/01/20	Min Age: 4 Years Old			
methylphenidate tablet	Preferred	Generic	07/01/20	Min Age: 4 Years Old			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Adderall	Non Preferred	Brand	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
amphetamine sulfate tablet	Non Preferred	Generic	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception	Evekeo	
Desoxyn	Non Preferred	Brand	07/01/20	Min Age: 6 Years Old	Medication Coverage Exception	Desoxyn	
dextroamphetamine	Non Preferred	Generic	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
dextroamphetamine solution	Non Preferred	Generic	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
Dexedrine	Non Preferred	Brand	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
dexmethylphenidate	Non Preferred	Generic	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception	Focalin	
Evekeo	Non Preferred	Brand	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception	Evekeo	
Evekeo orally disintegrating tablet	Non Preferred	Brand	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
methamphetamine	Non Preferred	Brand	07/01/20	Min Age: 6 Years Old	Medication Coverage Exception	Desoxyn	
methylphenidate chewable	Non Preferred	Generic	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
Procentra	Non Preferred	Brand	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
Ritalin	Non Preferred	Brand	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
Zenzedi	Non Preferred	Brand	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Long Acting ADHD Stimulants							
• **DAW:** 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. See Pg.3 Explanation for more information.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
amphetamine/dextroamphetamine ER capsule	Preferred	Generic	07/01/20	Min Age: 4 Years Old			
Concerta	Preferred	Brand	07/01/20	Min Age: 4 Years Old		Concerta	
Dyanavel XR	Preferred	Brand	07/01/20	Min Age: 6 Years Old			
Focalin XR	Preferred	Brand	07/01/20	Min Age: 4 Years Old		Focalin XR	
Quillichew ER	Preferred	Brand	07/01/20	Min Age: 4 Years Old			
Quillivant suspension	Preferred	Brand	07/01/20	Min Age: 4 Years Old			
Vyvanse	Preferred	Brand	07/01/20	Min Age: 4 Years Old			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Adderall XR	Non Preferred	Brand	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
Adhansia XR	Non Preferred	Brand	07/01/20	Min Age: 6 Years Old	Medication Coverage Exception		
Adzenys XR	Non Preferred	Brand	07/01/20	Min Age: 6 Years Old	Medication Coverage Exception		
Adzenys XR orally disintegrating tablet	Non Preferred	Brand	07/01/20	Min Age: 6 Years Old	Medication Coverage Exception		
amphetamine ER suspension	Non Preferred	Generic	07/01/20	Min Age: 6 Years Old	Medication Coverage Exception		
Aptensio XR	Non Preferred	Brand	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
Cotempla XR orally disintegrating tablet	Non Preferred	Brand	07/01/20	Min Age: 6 Years Old	Medication Coverage Exception		
Daytrana	Non Preferred	Brand	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
Dexedrine Spansule	Non Preferred	Brand	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
dexmethylphenidate ER	Non Preferred	Generic	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception	Focalin XR	
dextroamphetamine ER	Non Preferred	Generic	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
Metadate CD	Non Preferred	Brand	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
Methylphenidate ER capsule	Non Preferred	Generic	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
Methylphenidate ER (osmotic release)	Non Preferred	Generic	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception	Concerta	
Methylphenidate ER (biphasic)	Non Preferred	Generic	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
Mydayis	Non Preferred	Brand	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
Relexxii	Non Preferred	Brand	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		
Ritalin LA	Non Preferred	Generic	07/01/20	Min Age: 4 Years Old	Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Anticonvulsants							
• **DAW:** 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. See Pg.3 Explanation for more information.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Aptiom	Preferred	Brand	01/01/17				
carbamazepine chewable	Preferred	Generic	01/01/17		90 Day Supply Required		
carbamazepine ER	Preferred	Generic	08/01/17				
Celontin	Preferred	Brand	01/01/17				
clobazam	Preferred	Generic	01/01/20				
clonazepam	Preferred	Generic	01/01/17	Cumulative limit: 120units/ 30days			
Diastat	Preferred	Brand	01/01/17			Diastat	
Dilantin 30mg	Preferred	Brand	01/01/17				
divalproex	Preferred	Brand	01/01/17		90 Day Supply Required		Included in more than one PDL drug class
ethosuximide	Preferred	Generic	06/01/19				
gabapentin	Preferred	Generic	10/01/16	3600mg /day			Pregabalin/ Gabapentin combo restricted
Gabitril	Preferred	Brand	01/01/18			Gabitril	
lamotrigine chewable	Preferred	Generic	11/01/16		90 Day Supply Required		
lamotrigine tablet	Preferred	Generic	11/01/16		90 Day Supply Required		
levetiracetam	Preferred	Generic	10/01/16				
Lyrica capsule	Preferred	Brand	01/01/19	600mg /day		Lyrica	Pregabalin/ Gabapentin Combo restricted
oxcarbazepine tablet	Preferred	Generic	10/01/16		90 Day Supply Required		
Peganone	Preferred	Brand	10/01/16				
phenytoin	Preferred	Generic	01/01/17				
primidone	Preferred	Generic	01/01/17				
Tegretol tablet	Preferred	Brand	01/01/17			Tegretol	
Tegretol solution	Preferred	Brand	01/01/17			Tegretol	
topiramate capsule	Preferred	Generic	01/01/19				Included in more than one PDL drug class
topiramate tablet	Preferred	Generic	01/01/19		90 Day Supply Required		Included in more than one PDL drug class
valproic acid	Preferred	Generic	01/01/17				
Valtoco	Preferred	Brand	05/01/20				
Vimpat	Preferred	Brand	10/01/16				
zonisamide	Preferred	Generic	10/01/16		90 Day Supply Required		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Banzel	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Briviact	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
carbamazepine tablet	Non Preferred	Generic	01/01/17		Medication Coverage Exception	Tegretol	
carbamazepine solution	Non Preferred	Generic	01/01/17		Medication Coverage Exception	Tegretol	
Carbatrol	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
clonazepam orally disintegrating tablet	Non Preferred	Generic	01/01/17		Medication Coverage Exception		
Depakene	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
Depakote	Non Preferred	Brand	01/01/17		Medication Coverage Exception		Included in more than one PDL drug class
Diacomit	Non Preferred	Brand	07/01/19		Medication Coverage Exception		
diazepam rectal	Non Preferred	Generic	01/01/17		Medication Coverage Exception	Diastat	
Dilantin 100mg	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
Dilantin chewable	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
Epidiolex	Non Preferred	Brand	01/01/19		Epidiolex Prior Auth Form		
Felbatol	Non Preferred	Brand	10/01/16		Medication Coverage Exception	Felbatol	
felbamate	Non Preferred	Generic	10/01/16		Medication Coverage Exception	Felbatol	
Fycompa	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Gralise	Non Preferred	Brand	09/01/18	3600mg /day	Medication Coverage Exception		Pregabalin/ Gabapentin combo restricted
Horizant	Non Preferred	Brand	09/01/18	3600mg /day	Medication Coverage Exception		Pregabalin/ Gabapentin combo restricted
Keppra	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Klonopin	Non Preferred	Brand	01/01/17	Cumulative limit: 120units /30days	Medication Coverage Exception		
Lamictal	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Lamictal orally disintegrating tablet	Non Preferred	Brand	10/01/16		Medication Coverage Exception	Lamictal orally disintegrating tablet	
Lamictal XR	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
lamotrigine orally disintegrating tablet	Non Preferred	Generic	10/01/16		Medication Coverage Exception	Lamictal orally disintegrating tablet	
lamotrigine ER	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Lyrica CR	Non Preferred	Brand	01/01/19	600mg /day	Medication Coverage Exception		Pregabalin/ Gabapentin combo restricted
Lyrica solution	Non Preferred	Brand	01/01/19	600mg /day	Medication Coverage Exception		Pregabalin/ Gabapentin combo restricted
Mysoline	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
Nayzilam	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
Neurontin	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Onfi	Non Preferred	Brand	11/01/18		Medication Coverage Exception		
oxcarbazepine suspension	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Oxtellar XR	Non Preferred	Brand	10/01/16		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Phenytek	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
pregabalin	Non Preferred	Generic	08/01/19	600mg /day	Medication Coverage Exception	Lyrica	Pregabalin/ Gabapentin combo restricted
Qudexy XR	Non Preferred	Brand	01/01/19		Medication Coverage Exception		Included in more than one PDL drug class
Sabril	Non Preferred	Brand	09/01/17		Medication Coverage Exception	Sabril	
Spritam	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Sympazan	Non Preferred	Brand	12/01/18		Medication Coverage Exception		
Tegretol XR	Non Preferred	Brand	08/01/17		Medication Coverage Exception		
tiagabine	Non Preferred	Generic	01/01/18		Medication Coverage Exception	Gabitril	
Topamax	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
topiramate ER	Non Preferred	Generic	01/01/19		Medication Coverage Exception		Included in more than one PDL drug class
Trileptal	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Trileptal suspension	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Trokendi XR	Non Preferred	Brand	10/01/16		Medication Coverage Exception		Included in more than one PDL drug class
Valtoco	Non Preferred	Brand	02/01/20		Medication Coverage Exception		
vigabatrin	Non Preferred	Generic	09/01/17		Medication Coverage Exception	Sabril	
Xcopri	Non Preferred	Brand	04/01/20		Medication Coverage Exception		
Zarontin	Non Preferred	Brand	06/01/19		Medication Coverage Exception		

Atypical Antipsychotics

- **Children under 20:** Utah Medicaid restricts the use of multiple antipsychotics in children under 20 years old.
- **Children under 6:** Prior Authorization is required for all antipsychotics prescribed to children under 6 years old.
- **DAW:** 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. See Pg.3 Explanation for more information.

Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Abilify Maintena	Preferred	Brand	10/01/16	age 4-11 years: 15mg /day age 12-17 years: 30mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
aripiprazole tablet	Preferred	Generic	01/01/18	age 4-11 years: 15mg /day age 12-17 years: 30mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
Aristada	Preferred	Brand	05/01/18	age 4-11 years: 15mg /day age 12-17 years: 30mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
clozapine tablet	Preferred	Generic	10/01/16	age 8-11 years: 300mg /day age 12-17 years: 600mg /day	Under 8 yrs/ limits exceeded Antipsychotics in Children		
Invega Sustenna	Preferred	Brand	05/01/18	age 12-17 years: 12mg /day	Under 12 yrs/ limits exceeded Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
Invega Trinza	Preferred	Brand	05/01/18	age 12-17 years: 12mg /day	Under 12 yrs/ limits exceeded Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
Latuda	Preferred	Brand	01/01/19	age 10-17 years: 80mg /day	Under 10 yrs/ limits exceeded Antipsychotics in Children		Step Therapy required; must fail another preferred agent first.

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
olanzapine orally disintegrating table	Preferred	Generic	01/01/20	age 4-5 years: 12.5mg /day age 6-17 years: 20mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
olanzapine	Preferred	Generic	10/01/16	age 4-5 years: 12.5mg /day age 6-17 years: 20mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
Perseris	Preferred	Brand	01/01/19	age 4-11 years: 3mg /day age 12-17 years: 6mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
quetiapine	Preferred	Generic	01/01/19	age 5-9 years: 400mg /day age 10-17 years: 800mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
quetiapine ER	Preferred	Generic	01/01/19	age 5-9 years: 400mg /day age 10-17 years: 800mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
risperidone solution	Preferred	Generic	01/01/18	age 4-11 years: 3mg /day age 12-17 years: 6mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
risperidone tablet	Preferred	Generic	01/01/18	age 4-11 years: 3mg /day age 12-17 years: 6mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
Saphris	Preferred	Brand	01/01/18	age 10-17 years: 20mg /day	Under 10 yrs/ limits exceeded Antipsychotics in Children		
ziprasidone	Preferred	Generic	01/01/18	age 10-17 years: 160mg /day	Under 10 yrs/ limits exceeded Antipsychotics in Children		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Abilify	Non Preferred	Brand	01/01/18	age 4-11 years: 15mg /day age 12-17 years: 30mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
Abilify Mycite	Non Preferred	Brand	07/01/20	age 4-11 years: 15mg /day age 12-17 years: 30mg /day	Abilify Mycite Prior Auth		
aripiprazole orally disintegrating tablet	Non Preferred	Generic	01/01/18	age 4-11 years: 15mg /day age 12-17 years: 30mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
aripiprazole solution	Non Preferred	Generic	01/01/18	age 4-11 years: 15mg /day age 12-17 years: 30mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
Caplyta	Non Preferred	Generic	02/01/20	Minimum Age: 18	Under 18 yrs Antipsychotics in Children		
clozapine orally disintegrating tablet	Non Preferred	Generic	10/01/16	age 8-11 years: 300mg /day age 12-17 years: 600mg /day	Under 8 yrs/ limits exceeded Antipsychotics in Children	Fazaclo	
Clozaril	Non Preferred	Brand	10/01/16	age 8-11 years: 300mg /day age 12-17 years: 600mg /day	Under 8 yrs/ limits exceeded Antipsychotics in Children		
Fanapt	Non Preferred	Brand	10/01/16	Minimum Age: 18	Under 18 yrs Antipsychotics in Children		
Fazaclo orally disintegrating tablet	Non Preferred	Brand	10/01/16	age 8-11 years: 300mg /day age 12-17 years: 600mg /day	Under 8 yrs/ limits exceeded Antipsychotics in Children	Fazaclo	
Geodon capsule	Non Preferred	Brand	01/01/18	age 10-17 years: 160mg /day	Under 10yrs/ limits exceeded Antipsychotics in Children		
Geodon injection	Non Preferred	Brand	04/01/20	age 10-17 years: 160mg /day	Under 10yrs/ limits exceeded Antipsychotics in Children		
Invega	Non Preferred	Brand	10/01/16	age 12-17 years: 12mg	Under 12yrs/ limits exceeded Antipsychotics in Children		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
olanzapine injection	Non Preferred	Generic	10/01/16	age 4-5 years: 12.5mg /day age 6-17 years: 20mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
paliperidone	Non Preferred	Generic	10/01/16	age 12-17 years: 12mg	Under 12yrs/ limits exceeded Antipsychotics in Children		
Rexulti	Non Preferred	Generic	10/01/16	Minimum Age: 18	Under 18 yrs Antipsychotics in Children		
Risperdal	Non Preferred	Brand	10/01/16	age 4-11 years: 3mg /day age 12-17 years: 6mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
risperidone injection	Non Preferred	Generic	10/01/16	age 4-11 years: 3mg /day age 12-17 years: 6mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
Risperdal Consta	Non Preferred	Brand	10/01/16	age 4-11 years: 3mg /day age 12-17 years: 6mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
risperidone orally disintegrating tablet	Non Preferred	Generic	10/01/16	age 4-11 years: 3mg /day age 12-17 years: 6mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
Secuado	Non Preferred	Brand	01/01/20	Minimum Age: 18	Under 18 yrs Antipsychotics in Children		
Seroquel	Non Preferred	Brand	10/01/16	age 5-9 years: 400mg /day age 10-17 years: 800mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
Seroquel XR	Non Preferred	Brand	10/01/16	age 5-9 years: 400mg /day age 10-17 years: 800mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
Versacloz	Non Preferred	Brand	10/01/16	age 8-11 years: 300mg /day age 12-17 years: 600mg /day	Under 8 yrs/ limits exceeded Antipsychotics in Children		
Vraylar	Non Preferred	Brand	01/01/19	Minimum Age: 18	Under 18yrs/ limits exceeded Antipsychotics in Children		
Ziprasidone injection	Non Preferred	Generic	04/01/20	age 10-17 years: 160mg /day	Under 10yrs/ limits exceeded Antipsychotics in Children		
Zyprexa Relprevv	Non Preferred	Brand	10/01/16	age 4-5 years: 12.5mg /day age 6-17 years: 20mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
Zyprexa	Non Preferred	Brand	10/01/16	age 4-5 years: 12.5mg /day age 6-17 years: 20mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
Zyprexa Zydis	Non Preferred	Brand	10/01/16	age 4-5 years: 12.5mg /day age 6-17 years: 20mg /day	Under 6 yrs/ limits exceeded Antipsychotics in Children		
Antidepressants - SSRI/SNRI							
• **DAW:** 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. See Pg.3 Explanation for more information.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
citalopram tablet	Preferred	Generic	02/01/17		90 Day Supply Required		
duloxetine 20, 30, 60mg	Preferred	Generic	10/01/16		90 Day Supply Required		
escitalopram tablet	Preferred	Generic	10/01/16		90 Day Supply Required		
fluoxetine capsule	Preferred	Generic	10/01/16		90 Day Supply Required		
fluoxetine solution	Preferred	Generic	10/01/16				

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
paroxetine [non-ER]	Preferred	Generic	10/01/16		90 Day Supply Required		
Savella	Preferred	Brand	01/01/18				
sertraline tablet	Preferred	Generic	10/01/16		90 Day Supply Required		
venlafaxine ER capsule	Preferred	Generic	10/01/16		90 Day Supply Required		
venlafaxine tablet [non-ER]	Preferred	Generic	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Brisdelle	Non Preferred	Brand	10/01/17		Medication Coverage Exception	Brisdelle	
Celexa	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
citalopram solution	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Cymbalta	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
desvenlafaxine	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Drizalma	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
duloxetine 40mg	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Effexor XR	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
escitalopram solution	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Fetzima	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
fluoxetine tablet	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
fluoxetine weekly	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
fluvoxamine	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
fluvoxamine ER	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Khedezla	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Lexapro	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
olanzapine/fluoxetine	Non Preferred	Generic	10/01/16		Medication Coverage Exception	Symbyax	
paroxetine 7.5mg	Non Preferred	Generic	10/01/17		Medication Coverage Exception	Brisdelle	
paroxetine ER	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Paxil CR	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Paxil tablet, suspension	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Pexeva	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Pristiq	Non Preferred	Brand	08/01/17		Medication Coverage Exception		
Prozac	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Sarafem	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
sertraline concentrate	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Symbyax	Non Preferred	Brand	10/01/16		Medication Coverage Exception	Symbyax	
venlafaxine ER tablet	Non Preferred	Generic	10/01/16		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Zoloft	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Antidepressants -TCAs							
• **DAW:** 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. See Pg.3 Explanation for more information.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
amitriptyline	Preferred	Generic	01/01/18				Included in more than one PDL drug class
doxepin capsule	Preferred	Generic	01/01/18	cumulative: 30 units /30 days			
imipramine HCl	Preferred	Generic	01/01/18				
nortriptyline capsule	Preferred	Generic	01/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
amitriptyline/chlordiazepoxide	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
amitriptyline/perphenazine	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
amoxapine	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
Anafranil	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
clomipramine	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
desipramine	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
imipramine pam	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
Norpramin	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
nortriptyline solution	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
Pamelor	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
protriptyline	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
Surmontil	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Tofranil	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
trimipramine	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Antidepressants -MAOIs							
• **DAW:** 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. See Pg.3 Explanation for more information.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Marplan	Preferred	Brand	01/01/18				
phenelzine	Preferred	Generic	01/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Emsam	Non Preferred	Brand	01/01/18		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Nardil	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
tranylcypromine	Non Preferred	Generic	03/01/19		Medication Coverage Exception		
Antidepressants - Miscellaneous							
• **DAW:** 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. See Pg.3 Explanation for more information.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
bupropion	Preferred	Generic	10/19/16				
bupropion SR	Preferred	Generic	10/19/16				
bupropion XL 150, 300mg	Preferred	Generic	10/19/16		90 Day Supply Required for 150mg		
mirtazapine 15, 30, 45mg	Preferred	Generic	10/01/16		90 Day Supply Required		
mirtazapine orally disintegrating tablet	Preferred	Generic	10/01/16				
trazodone 50, 100, 150mg	Preferred	Generic	10/01/16		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Aplenzin	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
bupropion 450mg ER	Non Preferred	Brand	10/01/18		Medication Coverage Exception	Forfivo XL	
Forfivo XL	Non Preferred	Brand	10/01/18		Medication Coverage Exception	Forfivo XL	
maprotiline	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
mirtazapine 7.5mg	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
nefazodone	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Remeron	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Remeron orally disintegrating tablet	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
trazodone 300mg	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Trintellix	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Viibryd	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Wellbutrin	Non Preferred	Brand	10/19/16		Medication Coverage Exception		
Zyban	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Anxiolytic Benzodiazepines							
• **DAW:** 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. See Pg.3 Explanation for more information.							
• **Cumulative limit:** 120 units in 30 days.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
alprazolam tablet	Preferred	Generic	01/01/17	Cumulative limit: 120units /30days			
chlordiazepoxide	Preferred	Generic	01/01/17	Cumulative limit: 120units /30days			

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
diazepam tablet	Preferred	Generic	01/01/17	Cumulative limit: 120units /30days			
lorazepam tablet	Preferred	Generic	01/01/17	Cumulative limit: 120units /30days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
alprazolam concentrate	Non Preferred	Generic	01/01/17	Cumulative limit: 120units /30days	Medication Coverage Exception		
alprazolam orally disintegrating tablet	Non Preferred	Generic	01/01/17	Cumulative limit: 120units /30days	Medication Coverage Exception		
Ativan	Non Preferred	Brand	01/01/17	Cumulative limit: 120units /30days	Medication Coverage Exception		
clorazepate	Non Preferred	Generic	01/01/17	Cumulative limit: 120units /30days	Medication Coverage Exception		
diazepam concentrate	Non Preferred	Generic	01/01/17	Cumulative limit: 120units /30days	Medication Coverage Exception		
diazepam solution	Non Preferred	Generic	01/01/17	Cumulative limit: 120units /30days	Medication Coverage Exception		
lorazepam concentrate	Non Preferred	Generic	01/01/17	Cumulative limit: 120units /30days	Medication Coverage Exception		
oxazepam	Non Preferred	Generic	01/01/17	Cumulative limit: 120units /30days	Medication Coverage Exception		
Tranxene	Non Preferred	Brand	01/01/17	Cumulative limit: 120units /30days	Medication Coverage Exception		
Xanax	Non Preferred	Brand	01/01/17	Cumulative limit: 120units /30days	Medication Coverage Exception		
Miscellaneous Mood Stabilizers							
• **DAW:** 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. See Pg.3 Explanation for more information.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
atomoxetine	Preferred	Generic	10/01/17				
lithium	Preferred	Generic	01/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Lithobid	Non Preferred	Brand	08/01/17		Medication Coverage Exception		
Strattera	Non Preferred	Brand	10/01/17		Medication Coverage Exception		
Contraceptives							
Low Dose and Mono-phasic - Oral							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
afirmelle	Preferred	Generic	11/01/19		84 Day Supply Required		
altavera	Preferred	Generic	01/01/12		84 Day Supply Required		
alyacen 1/35	Preferred	Generic	01/01/13		84 Day Supply Required		
apri	Preferred	Generic	01/01/14		84 Day Supply Required		
aubra	Preferred	Generic	05/05/15		84 Day Supply Required		
aviane	Preferred	Generic	03/15/16		84 Day Supply Required		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
ayuna	Preferred	Generic	07/01/19		84 Day Supply Required		
balziva	Preferred	Generic	01/01/20		84 Day Supply Required		
blisovi FE 1/20, 1.5/30	Preferred	Generic	11/01/16		84 Day Supply Required		
briellyn	Preferred	Generic	01/01/20		84 Day Supply Required		
chateal	Preferred	Generic	01/01/14		84 Day Supply Required		
cyclafem 1/35	Preferred	Generic	01/01/13		84 Day Supply Required		
cyred	Preferred	Generic	01/01/16		84 Day Supply Required		
dasetta	Preferred	Generic	01/01/13		84 Day Supply Required		
emoquette	Preferred	Generic	01/01/14		84 Day Supply Required		
enskyce	Preferred	Generic	01/01/14		84 Day Supply Required		
estarylla	Preferred	Generic	01/01/14		84 Day Supply Required		
falmina	Preferred	Generic	01/01/13		84 Day Supply Required		
femynor	Preferred	Generic	03/01/18		84 Day Supply Required		
isibloom	Preferred	Generic	07/01/18		84 Day Supply Required		
juleber	Preferred	Generic	05/15/16		84 Day Supply Required		
junel FE 1/20, 1.5/30	Preferred	Generic	01/01/16		84 Day Supply Required		
kalliga	Preferred	Generic	11/01/19		84 Day Supply Required		
kurvelo	Preferred	Generic	01/01/14		84 Day Supply Required		
larin FE 1/20, 1.5/30	Preferred	Generic	07/01/18		84 Day Supply Required		
larissia	Preferred	Generic	09/01/17		84 Day Supply Required		
lessina	Preferred	Generic	10/01/11		84 Day Supply Required		
levonorgestrel/ee	Preferred	Generic	01/01/16		84 Day Supply Required		
levora	Preferred	Generic	03/15/16		84 Day Supply Required		
lillow	Preferred	Generic	09/01/17		84 Day Supply Required		
loryna	Preferred	Generic	01/01/19		84 Day Supply Required		
lutera	Preferred	Generic	10/01/11		84 Day Supply Required		
marlissa	Preferred	Generic	01/01/13		84 Day Supply Required		
microgestin 1/20	Preferred	Generic	01/01/19		84 Day Supply Required		
microgestin FE	Preferred	Generic	03/15/16		84 Day Supply Required		
mili	Preferred	Generic	06/01/18		84 Day Supply Required		
mono-linyah	Preferred	Generic	04/01/13		84 Day Supply Required		
mononessa	Preferred	Generic	03/15/16		84 Day Supply Required		
norethindrone/ee, FE 1/20	Preferred	Generic	01/01/20		84 Day Supply Required		
norgestimate/ee	Preferred	Generic	01/01/13		84 Day Supply Required		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
ocella	Preferred	Generic	01/01/19		84 Day Supply Required		
orsythia	Preferred	Generic	01/01/13		84 Day Supply Required		
philith	Preferred	Generic	01/01/20		84 Day Supply Required		
pirmella 1/35	Preferred	Generic	01/01/20		84 Day Supply Required		
portia	Preferred	Generic	01/01/12		84 Day Supply Required		
previfem	Preferred	Generic	01/01/13		84 Day Supply Required		
reclipsen	Preferred	Generic	01/01/14		84 Day Supply Required		
sprintec	Preferred	Generic	10/01/11		84 Day Supply Required		
sronyx	Preferred	Generic	10/01/11		84 Day Supply Required		
syeda	Preferred	Generic	01/01/19		84 Day Supply Required		
tarina FE	Preferred	Generic	01/01/16		84 Day Supply Required		
vienva	Preferred	Generic	12/01/16		84 Day Supply Required		
vyfemla	Preferred	Generic	01/01/20		84 Day Supply Required		
vylibra	Preferred	Generic	03/01/18		84 Day Supply Required		
zarah	Preferred	Generic	01/01/20		84 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
aurovela, FE	Non Preferred	Generic	05/01/19		Medication Coverage Exception		
Balcoltra	Non Preferred	Brand	05/01/18		Medication Coverage Exception		
Beyaz	Non Preferred	Brand	08/01/17		Medication Coverage Exception		
blisovi 24 FE 1/20	Non Preferred	Generic	03/15/16		Medication Coverage Exception		
cryselle	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
desogestrel/ee	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
drospirenone/ee	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
drospirenone/ee/levomefolate	Non Preferred	Generic	11/01/19		Medication Coverage Exception		
elinest	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
ethynodiol/ee	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
FaLessa kit	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Generess FE chewable	Non Preferred	Brand	04/01/19		Medication Coverage Exception		
gianvi	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
gildess 1/20, 1.5/30	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
hailey, 24 FE	Non Preferred	Generic	09/01/19		Medication Coverage Exception		
jasmiel	Non Preferred	Generic	03/01/19		Medication Coverage Exception		
junel 1/20, 1.5/30, 24 FE 1/20	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
kaitlib	Non Preferred	Generic	10/01/18		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
kelnor	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
larin 1/20, 1.5/30, 24 FE 1/20	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
layolis	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Loestrin	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
low-ogestrel	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
lo-zumandimi	Non Preferred	Generic	11/01/19		Medication Coverage Exception		
melodetta 24 chewable	Non Preferred	Generic	10/01/17		Medication Coverage Exception		
mibelas 24 chw	Non Preferred	Generic	04/01/17		Medication Coverage Exception		
microgestin 1.5/30	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Minastrin 24 FE chewable	Non Preferred	Generic	11/01/19		Medication Coverage Exception		
necon 0.5/35	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
nikki	Non Preferred	Generic	08/04/14		Medication Coverage Exception		
norethindrone/ee FE chewable	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Norinyl 1/35	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
nortrel 0.5/35	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
nortrel 1/35	Non Preferred	Generic	02/01/19		Medication Coverage Exception		
Ogestrel	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Ortho-Novum 1/35	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Safyral	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
tarina FE 24	Non Preferred	Generic	04/01/19		Medication Coverage Exception		
Taytulla	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
tydemy	Non Preferred	Generic	04/01/18		Medication Coverage Exception		
wera	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
wymzya	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Yasmin	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Yaz	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
zenchent	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
zovia	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
zumandimi	Non Preferred	Generic	11/01/19		Medication Coverage Exception		
Bi-phasic - Oral							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
azurette	Preferred	Generic	01/01/18		84 Day Supply Required		
bekyree	Preferred	Generic	01/01/18		84 Day Supply Required		
desogestrel/ee	Preferred	Generic	01/01/18		84 Day Supply Required		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
pimtrea	Preferred	Generic	01/01/18		84 Day Supply Required		
volnea	Preferred	Generic	02/01/20		84 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
kariva	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Lo Loestrin	Non Preferred	Brand	01/01/12		Medication Coverage Exception		
Mircette	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
simliya	Non Preferred	Generic	05/01/19		Medication Coverage Exception		
viorele	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Tri-phasic/Multi-phasic - Oral							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
cyclafem 7/7/7	Preferred	Generic	01/01/13		84 Day Supply Required		
enpresse	Preferred	Generic	01/01/11		84 Day Supply Required		
leena	Preferred	Generic	01/01/19		84 Day Supply Required		
levonest	Preferred	Generic	01/01/13		84 Day Supply Required		
levonorgestrel/ee	Preferred	Generic	03/15/16		84 Day Supply Required		
myzilra	Preferred	Generic	01/01/13		84 Day Supply Required		
Natazia	Preferred	Brand	01/01/16		84 Day Supply Required		
norgestimate/ee	Preferred	Generic	01/01/16		84 Day Supply Required		
Ortho Tri-Cyclen, Lo	Preferred	Brand	01/01/18		84 Day Supply Required		
tri femynor	Preferred	Generic	06/01/17		84 Day Supply Required		
tri-estaryll, tri-lo-estaryll	Preferred	Generic	11/01/19		84 Day Supply Required		
tri-linyah	Preferred	Generic	04/01/13		84 Day Supply Required		
tri-marzia, tri-lo-marzia	Preferred	Generic	02/01/20		84 Day Supply Required		
tri-mili, tri-lo-mili	Preferred	Generic	07/01/19		84 Day Supply Required		
trinessa	Preferred	Generic	03/15/16		84 Day Supply Required		
tri-previfem	Preferred	Generic	01/01/13		84 Day Supply Required		
tri-sprintec, tri-lo-sprintec	Preferred	Generic	03/15/16		84 Day Supply Required		
trivora	Preferred	Generic	01/01/11		84 Day Supply Required		
tri-vylibra	Preferred	Generic	03/01/18		84 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
alyacen 7/7/7	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
aranelle	Non Preferred	Generic	10/01/11		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
caziant	Non Preferred	Generic	09/01/17		Medication Coverage Exception		
Cyclessa	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
dasetta 7/7/7	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Estrostep FE	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
necon 7/7/7	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
nortrel 7/7/7	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Ortho-Novum 7/7/7	Non Preferred	Brand	05/01/18		Medication Coverage Exception		
pirmella 7/7/7	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
simpesse	Non Preferred	Generic	11/01/19		Medication Coverage Exception		
tilia FE	Non Preferred	Generic	01/01/11		Medication Coverage Exception		
tri-legest FE	Non Preferred	Generic	01/01/11		Medication Coverage Exception		
velivet	Non Preferred	Generic	09/01/17		Medication Coverage Exception		
Extended Cycle - Oral							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
introvale	Preferred	Generic	01/01/18		91 Day Supply Required		
jolessa	Preferred	Generic	01/01/16		91 Day Supply Required		
Loseasonique	Preferred	Brand	01/01/13		91 Day Supply Required		
quasense	Preferred	Generic	01/01/16		91 Day Supply Required		
Seasonique	Preferred	Brand	01/01/13		91 Day Supply Required		
setlakin	Preferred	Generic	01/01/17		91 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
amethia, Lo	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
amethyst	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
ashlyna	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
camrese	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
camrese Lo	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
daysee	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
fayosim	Non Preferred	Generic	05/01/17		Medication Coverage Exception		
jaimiess, Lo	Non Preferred	Generic	02/01/20		Medication Coverage Exception		
levonorgestrel/ee	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Quartette	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
rivelsa	Non Preferred	Generic	05/01/17		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Cytokine Modulators							
Immunomodulators							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Cosentyx	Preferred	Brand	01/01/19				Step Therapy required; must fail another preferred agent first
Enbrel	Preferred	Brand	02/01/10				
Humira	Preferred	Brand	02/01/10				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Actemra	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Arcalyst	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Cimzia	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Ilaris	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Ilumya	Non Preferred	Brand	09/01/18		Medication Coverage Exception		
Inflectra	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Kevzara	Non Preferred	Brand	11/01/17		Medication Coverage Exception		
Kineret	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Olumiant	Non Preferred	Brand	07/01/18		Medication Coverage Exception		
Orencia	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Otezla	Non Preferred	Brand	04/02/14		Medication Coverage Exception		
Remicade	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Renflexis	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Rinvoq	Non Preferred	Brand	09/01/19		Medication Coverage Exception		
Siliq	Non Preferred	Brand	05/01/19		Medication Coverage Exception		
Simponi	Non Preferred	Brand	02/01/10		Medication Coverage Exception		
Skyrizi	Non Preferred	Brand	05/01/19		Medication Coverage Exception		
Stelara	Non Preferred	Brand	10/01/11		Medication Coverage Exception		
Taltz	Non Preferred	Brand	05/01/16		Medication Coverage Exception		
Tremfya	Non Preferred	Brand	05/01/19		Medication Coverage Exception		
Xeljanz	Non Preferred	Brand	09/15/14		Medication Coverage Exception		
Xeljanz XR	Non Preferred	Brand	09/15/14		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Dermatological							
Topical Acne Products - Antibiotics & Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
benzoyl peroxide/erythromycin	Preferred	Generic	01/01/13				
clindamycin lotion	Preferred	Generic	01/01/20				
clindamycin solution	Preferred	Generic	01/01/20				
clindamycin gel	Preferred	Generic	01/01/20				
clindamycin pad	Preferred	Generic	01/01/20				
clindamycin/benzoyl peroxide	Preferred	Generic	01/01/19				
Epiduo Forte	Preferred	Brand	01/01/14				
erythromycin 2% gel	Preferred	Generic	01/01/13				
erythromycin 2% solution	Preferred	Generic	01/01/13				
Evoclin	Preferred	Brand	01/01/14			Evoclin	
Onexton	Preferred	Brand	01/01/16				
Ziana	Preferred	Brand	01/01/13			Ziana	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Acanya	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Aczone	Non Preferred	Brand	11/01/17		Medication Coverage Exception		
adapalene/benzoyl peroxide gel	Non Preferred	Generic	08/01/17		Medication Coverage Exception		
Benzaclin	Non Preferred	Brand	09/01/18		Medication Coverage Exception		
Benzamycin	Non Preferred	Brand	08/01/11		Medication Coverage Exception		
Cleocin T gel	Non Preferred	Brand	08/01/11		Medication Coverage Exception		
Cleocin T lotion	Non Preferred	Brand	08/01/11		Medication Coverage Exception		
Clindacin kit	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Clindacin pad	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
clindamycin foam	Non Preferred	Brand	01/01/19		Medication Coverage Exception	Evoclin	
clindamycin/tretinoin	Non Preferred	Generic	08/01/17		Medication Coverage Exception	Ziana	
dapsone	Non Preferred	Generic	11/01/17		Medication Coverage Exception		
Duac	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
EryGel	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
erythromycin pad	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Klaron	Non Preferred	Brand	05/15/16		Medication Coverage Exception		
ss lotion	Non Preferred	Generic	01/01/18		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Zilxi	Non Preferred	Brand	07/01/20		Medication Coverage Exception		
Topical Acne Products - Retinoids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Differin	Preferred	Brand	01/01/19			Differin	
Retin-A	Preferred	Brand	01/01/14			Retin-A	
tazarotene	Preferred	Generic	11/01/18				
Tazorac 0.05% cream	Preferred	Brand	01/01/14				
Tazorac gel	Preferred	Brand	01/01/14				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
adapalene	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Differin	
Aklief	Non Preferred	Brand	07/01/20		Medication Coverage Exception		
Altreno	Non Preferred	Brand	05/01/19		Medication Coverage Exception		
Atralin	Non Preferred	Brand	11/01/17		Medication Coverage Exception		
Avita	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Fabior	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Retin-A Micro	Non Preferred	Brand	08/01/11		Medication Coverage Exception		
Tazorac 0.1% cream	Non Preferred	Brand	11/01/18		Medication Coverage Exception		
tretinoin	Non Preferred	Generic	01/01/14		Medication Coverage Exception	Retin-A	
Topical Acne Products - Miscellaneous							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Azelex	Preferred	Brand	01/01/14				
Finacea	Preferred	Brand	01/01/14			Finacea	
Mirvaso	Preferred	Brand	01/01/18				
ss/sulfur emulsion	Preferred	Generic	12/01/16				
ss/sulfur liquid	Preferred	Generic	12/01/16				
ss/sulfur suspension	Preferred	Generic	12/01/16				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
all washes	Non Preferred	all	08/01/11		Medication Coverage Exception		
azelaic acid gel	Non Preferred	Generic	12/01/18		Medication Coverage Exception	Finacea	
benzoyl peroxide gel	Non Preferred	all	11/01/19		Medication Coverage Exception		
Finacea foam	Non Preferred	Brand	10/01/15		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Ovace	Non Preferred	Brand	01/01/12		Medication Coverage Exception		
selenium sulfide	Non Preferred	Generic	04/01/12		Medication Coverage Exception		
ss gel	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
ss/sulfur cream	Non Preferred	Generic	12/01/16		Medication Coverage Exception		
ss/sulfur foam	Non Preferred	Generic	12/01/16		Medication Coverage Exception		
Sumadan XLT kit	Non Preferred	Brand	10/01/17		Medication Coverage Exception		
Sumaxin TS	Non Preferred	Brand	05/01/16		Medication Coverage Exception		
Oral Acne Products							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
myorisan	Preferred	Generic	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Absorica	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
amnesteem	Non Preferred	Generic	08/01/11		Medication Coverage Exception		
claravis	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
isotretinoin	Non Preferred	Generic	03/01/18		Medication Coverage Exception		
zenatane	Non Preferred	Generic	08/11/11		Medication Coverage Exception		
Topical Antifungals							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
butenafine	Preferred	Generic	12/01/17				
ciclopirox cream	Preferred	Generic	08/01/17				
ciclopirox gel	Preferred	Generic	08/01/17				
ciclopirox shampoo	Preferred	Generic	08/01/17				
ciclopirox suspension	Preferred	Generic	08/01/17				
clotrimazole cream	Preferred	Generic	01/01/20				
clotrimazole solution	Preferred	Generic	01/01/20				
Ertaczo	Preferred	Brand	01/01/14				
ketoconazole cream	Preferred	Generic	10/01/11				
ketoconazole shampoo	Preferred	Generic	10/01/11				
nystatin	Preferred	Generic	11/01/18				

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Alevazol	Non Preferred	Brand	06/01/20		Medication Coverage Exception		
ciclopirox solution	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
econazole	Non Preferred	Generic	04/01/13		Medication Coverage Exception		
Exelderm	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Extina	Non Preferred	Brand	10/01/11		Medication Coverage Exception		
Jublia	Non Preferred	Brand	09/15/14		Medication Coverage Exception		
Kerydin	Non Preferred	Brand	09/15/14		Medication Coverage Exception		
ketoconazole foam	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
Loprox	Non Preferred	Brand	08/01/17		Medication Coverage Exception		
luliconazole	Non Preferred	Generic	03/01/19		Medication Coverage Exception		
Luzu	Non Preferred	Brand	03/01/19		Medication Coverage Exception		
Mentax	Non Preferred	Brand	10/01/11		Medication Coverage Exception		
naftifine cream	Non Preferred	Generic	08/01/17		Medication Coverage Exception		
Naftin	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Nizoral	Non Preferred	Brand	10/01/11		Medication Coverage Exception		
oxiconazole	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
Oxistat	Non Preferred	Brand	10/01/11		Medication Coverage Exception		
Penlac	Non Preferred	Brand	10/01/11		Medication Coverage Exception		
sulconazole	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Exelderm	
Topical Antivirals							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Zovirax	Preferred	Brand	05/15/16			Zovirax	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
acyclovir	Non Preferred	Generic	03/01/19		Medication Coverage Exception	Zovirax	
Denavir	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Xerese	Non Preferred	Brand	06/01/13		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Very Potent - Corticosteroids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
betamethasone augmented cream	Preferred	Generic	10/01/13				
betamethasone dipropionate cream	Preferred	Generic	01/01/18				
betamethasone dipropionate lotion	Preferred	Generic	10/01/13				
clobetasol cream	Preferred	Generic	01/01/18				
clobetasol ointment	Preferred	Generic	01/01/18				
clobetasol solution	Preferred	Generic	01/01/18				
Clobex	Preferred	Brand	01/01/16			Clobex	
halobetasol cream	Preferred	Generic	11/01/19				
halobetasol ointment	Preferred	Generic	11/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Apexicon E	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
betamethasone augmented lotion	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
betamethasone augmented ointment	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
betamethasone dipropionate gel	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
betamethasone ointment	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
Bryhali	Non Preferred	Brand	12/01/18		Medication Coverage Exception		
clobetasol foam	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
clobetasol gel	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
clobetasol lotion	Non Preferred	Generic	01/01/18		Medication Coverage Exception	Clobex	
clobetasol shampoo	Non Preferred	Generic	01/01/18		Medication Coverage Exception	Clobex	
clobetasol spray	Non Preferred	Generic	01/01/18		Medication Coverage Exception	Clobex	
Cordran tape	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
diflorasone	Non Preferred	Generic	11/01/17		Medication Coverage Exception		
Diprolene	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
fluocinonide 0.1%	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
flurandrenolide	Non Preferred	Generic	03/01/17		Medication Coverage Exception		
halobetasol foam	Non Preferred	Generic	11/01/19		Medication Coverage Exception		
Lexette	Non Preferred	Brand	12/01/18		Medication Coverage Exception		
Olux	Non Preferred	Brand	06/01/16		Medication Coverage Exception		
Psorcon	Non Preferred	Brand	11/01/17		Medication Coverage Exception		
Sernivo	Non Preferred	Brand	11/01/16		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Temovate	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
Tovet	Non Preferred	Brand	07/01/20		Medication Coverage Exception		
Ultravate	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Vanos	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Potent - Corticosteroids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
fluocinonide 0.05% crean	Preferred	Generic	01/01/19				
fluocinonide 0.05% ointment	Preferred	Generic	01/01/19				
fluocinonide 0.05% solution	Preferred	Generic	01/01/19				
Halog	Preferred	Brand	01/01/20			Halog	
mometasone 0.1% ointment	Preferred	Generic	10/01/13				
triamcinolone 0.5%	Preferred	Generic	11/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
amcinonide	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
desoximetasone 0.25%	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
fluocinonide 0.05% gel	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
halcinonide	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Halog	
Topicort	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
Midstrength - Corticosteroids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
betamethasone val	Preferred	Generic	01/01/20				
fluocinolone 0.025% cream	Preferred	Generic	10/01/13				
fluocinolone 0.025% ointment	Preferred	Generic	10/01/13				
fluticasone cream	Preferred	Generic	01/01/20				
fluticasone lotion	Preferred	Generic	01/01/20				
fluticasone ointment	Preferred	Generic	01/01/20				
mometasone 0.1% cream	Preferred	Generic	10/01/13				
mometasone 0.1% solution	Preferred	Generic	10/01/13				
triamcinolone 0.1% cream	Preferred	Generic	10/01/13				
triamcinolone 0.1% lotion	Preferred	Generic	10/01/13				
triamcinolone 0.1% ointment	Preferred	Generic	10/01/13				
triamcinolone topical spray	Preferred	Generic	01/01/19				

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Beser	Non Preferred	Brand	07/01/20		Medication Coverage Exception		
clocortolone	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
Cloderm	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Cutivate	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
Dermatop	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
desoximetasone 0.05%	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
Elocon cream	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
fluocinolone solution	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
hydrocortisone val 0.2% cream	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
hydrocortisone val 0.2% ointment	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Kenalog spray	Non Preferred	Brand	04/01/20		Medication Coverage Exception		
Luxiq	Non Preferred	Brand	10/01/17		Medication Coverage Exception		
Pandel	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
prednicarbate	Non Preferred	Generic	01/01/15		Medication Coverage Exception		
Synalar 0.025% cream	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
Synalar 0.025% ointment	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
Topicort	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
triderm	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Mild - Corticosteroids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Capex	Preferred	Brand	10/01/13				
desonide	Preferred	Generic	11/01/16				
fluocinolone 0.01% cream	Preferred	Generic	01/01/16				
hydrocortisone 1% cream	Preferred	Generic	10/01/13				
hydrocortisone 1% ointment	Preferred	Generic	10/01/13				
hydrocortisone 2.5% cream	Preferred	Generic	10/01/13				
hydrocortisone 2.5% lotion	Preferred	Generic	10/01/13				
hydrocortisone 2.5% ointment	Preferred	Generic	10/01/13				
triamcinolone 0.025% cream	Preferred	Generic	10/01/13				
triamcinolone 0.025% lotion	Preferred	Generic	10/01/13				
triamcinolone 0.025% ointment	Preferred	Generic	10/01/13				

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Ala Scalp	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
alclometasone	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Desowen	Non Preferred	Brand	10/01/15		Medication Coverage Exception		
fluocinolone 0.01% oil	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
fluocinolone 0.01% solution	Non Preferred	Generic	11/01/19		Medication Coverage Exception		
hydrocortisone butyrate	Non Preferred	Generic	11/01/19		Medication Coverage Exception		
Locoid	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
MiCort-HC	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Synalar	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Texacort	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
Trianex	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
Steroid/Antifungal Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
clotrimazole/betamethasone cream	Preferred	Generic	12/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
clotrimazole/betamethasone lotion	Non Preferred	Generic	12/01/19		Medication Coverage Exception		
nystatin/triamcinolone	Non Preferred	Generic	01/01/17		Medication Coverage Exception		
Topical - Immunomodulating Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
pimecrolimus	Preferred	Generic	01/01/20				
Protopic	Preferred	Brand	01/01/19			Protopic	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Elidel	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Eucrisa	Non Preferred	Brand	09/01/18		Medication Coverage Exception		
tacrolimus	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Protopic	
Local Anesthetic Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
lidocaine cream	Preferred	Generic	01/01/15	60 grams /30 days			
lidocaine gel	Preferred	Generic	01/01/15	60 grams /30 days			

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
lidocaine ointment	Preferred	Generic	01/01/15	60 grams /30 days			
lidocaine solution	Preferred	Generic	01/01/15	60 grams /30 days			
lidocaine/hydrocortisone rectal cream	Preferred	Generic	01/01/15	60 grams /30 days			
lidocaine/prilocaine	Preferred	Generic	11/01/16	60 grams /30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Epifoam	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
lidocaine lotion	Non Preferred	Generic	05/01/18	60 grams /30 days	Medication Coverage Exception		
lidocaine patch	Non Preferred	Generic	03/01/16	90 patches /30 days	Lidocaine Topical Patch PA Form		
lidocaine 3.88%	Non Preferred	Brand	11/01/16	60 grams /30 days	Medication Coverage Exception		
lidocaine/hydrocortisone rectal gel	Non Preferred	Generic	01/01/15	60 grams /30 days	Medication Coverage Exception		
Lidoderm	Non Preferred	Brand	03/01/16	90 patches /30 days	Lidocaine Topical Patch PA Form		
Lidotral	Non Preferred	Brand	11/01/16	60 grams /30 days	Medication Coverage Exception		
Pliaglis	Non Preferred	Brand	11/01/18	60 grams /30 days	Medication Coverage Exception		
Proctofoam	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
Synera	Non Preferred	Brand	01/01/15	5 patches /30 days	Medication Coverage Exception		
Ztlido	Non Preferred	Brand	02/01/19	60 grams /30 days	Lidocaine Topical Patch PA Form		
Scabicides/Pediculicides							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Natroba	Preferred	Brand	01/01/15			Natroba	
permethrin	Preferred	Generic	01/01/15				
Vanalice	Preferred	Brand	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
crotamiton	Non Preferred	Brand	11/01/18		Medication Coverage Exception		
Elimite	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
Eurax	Non Preferred	Brand	11/01/18		Medication Coverage Exception		
lindane	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
malathion	Non Preferred	Generic	01/01/15		Medication Coverage Exception		
Ovide	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
Sklice	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
spinosad	Non Preferred	Generic	01/01/15		Medication Coverage Exception	Natroba	

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Diagnostic Products							
Diabetic Glucose Meters							
• **Nursing Home Members -** Diabetic test supplies are not covered for members in a nursing home.							
• **DME -** Non-preferred products must be billed through DME.							
Preferred Product	**Status**	**Covered NDCs**					
Abbott	Preferred	99073-0711-43, 99073-0709-14, 99073-0708-05, 57599-8814-01, 57599-5175-01					
True Metrix	Preferred	56151-1490-02, 56151-1470-02, 56151-0888-80					
Non Preferred Product	**Status**	**Additional Note**					
All other Glucose Meters	Non Preferred	Must be billed through DME.					
Diabetic Testing Strips							
• **Nursing Home Members -** Diabetic test supplies are not covered for members in a nursing home.							
• **DME -** Non-preferred products must be billed through DME.							
Preferred Product	**Status**	**Limits**	**Covered NDCs**				
Freestyle Test Strips	Preferred	200 strips /30 days	99073-0120-50, 99073-0121-01, 99073-0708-22, 99073-0708-27, 99073-0712-27, 99073-0712-31				
Precision Test Strips	Preferred	200 strips /30 days	57599-9728-04, 57599-9877-05				
True Metrix Test Strips	Preferred	200 strips /30 days	56151-1460-01, 56151-1460-04				
TrueTrack Test Strips	Preferred	200 strips /30 days	56151-0810-01, 56151-0850-50				
Non Preferred Product	**Status**	**Additional Note**					
All other diabetic test strips	Non Preferred	Must be billed through DME.					
Diabetic Testing Lancets							
• **Nursing Home Members -** Diabetic test supplies are not covered for members in a nursing home.							
• **DME -** Non-preferred products must be billed through DME.							
Preferred Product	**Status**	**Limits**	**Covered NDCs**				
Unilet Lancets	Preferred	200 units /30 days	08470-0565-01, 08470-0575-01, 08470-0585-01				
Non Preferred Product	**Status**	**Additional Note**					
All other lancets	Non Preferred	Must be billed through DME.					
Epinephrine							
Injection Devicess							
Preferred Drugs	**Status**	**Limits**	**Covered NDCs**				
Mylan epinephrine	Preferred	Generic N 43101	49502-0102-01, 4950-20102-02, 49502-0101-01, 49502-0101-02				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Adrenaclick	Non Preferred	Brand	01/01/15		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
epinephrine	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
EpiPen	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Symjepi	Non Preferred	Brand	08/01/19		Medication Coverage Exception		
Estrogens							
Oral Single Ingredient							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
estradiol	Preferred	Generic	10/01/11				
Premarin	Preferred	Brand	01/01/17				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Estrace	Non Preferred	Brand	10/01/11		Medication Coverage Exception		
estropipate	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
Menest	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Oral Combination							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Angeliq	Preferred	Brand	01/01/19				
Premphase	Preferred	Brand	01/01/17				
Prempro	Preferred	Brand	10/01/11				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Activella	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
amabelz	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
Duavee	Non Preferred	Brand	11/01/16		Medication Coverage Exception		
estradiol/norethindrone	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
FemHRT	Non Preferred	Brand	12/01/16		Medication Coverage Exception		
fyavolv	Non Preferred	Generic	11/01/16		Medication Coverage Exception		
jevantique	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
jinteli	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
lopreeza	Non Preferred	Generic	05/01/19		Medication Coverage Exception		
mimvey	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
mimvey lo	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
Prefest	Non Preferred	Brand	10/01/11		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Topical & Miscellaneous							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Climara Pro	Preferred	Brand	01/01/16				
Combipatch patch	Preferred	Brand	01/01/14				
Divigel	Preferred	Brand	01/01/16				
Elestrin gel	Preferred	Brand	01/01/18				
Evamist spray	Preferred	Brand	01/01/19				
Menostar	Preferred	Brand	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Alora patch	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Climara patch	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
estradiol patch	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
Minivelle patch	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Vivelle-DOT patch	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Vaginal							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Estring	Preferred	Brand	01/01/20		90 Day Supply Required		
Femring	Preferred	Brand	01/02/20		90 Day Supply Required		
Premarin cream	Preferred	Brand	10/01/11				
Vagifem	Preferred	Brand	01/01/17			Vagifem	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Estrace	Non Preferred	Brand	02/01/18		Medication Coverage Exception		
estradiol cream	Non Preferred	Generic	02/01/18		Medication Coverage Exception		
estradiol vaginal tablet	Non Preferred	Generic	01/01/17		Medication Coverage Exception	Vagifem	
Gastrointestinal (GI)							
Antiemetics - Anticholinergics							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
meclizine	Preferred	Generic	11/01/16				
prochlorperazine tablet	Preferred	Generic	01/01/15				
promethazine	Preferred	Generic	01/01/15				

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Tigan capsule	Preferred	Brand	01/01/15			Tigan	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Bonjesta	Non Preferred	Brand	04/01/18		Antiemetics Prior Auth		
Compro suppository	Non Preferred	Brand	01/01/15		Antiemetics Prior Auth		
doxylamine/pyridoxine	Non Preferred	Generic	07/01/19		Antiemetics Prior Auth	Diclegis	
dimenhydrinate injection	Non Preferred	Generic	01/01/15		Antiemetics Prior Auth		
Diclegis	Non Preferred	Brand	07/01/19		Antiemetics Prior Auth	Diclegis	
Phenergan	Non Preferred	Brand	01/01/15		Antiemetics Prior Auth		
prochlorperazine injection	Non Preferred	Generic	01/01/15		Antiemetics Prior Auth		
prochlorperazine suppository	Non Preferred	Generic	01/01/15		Antiemetics Prior Auth		
scopolamine	Non Preferred	Generic	06/01/16		Antiemetics Prior Auth		
Tigan injection	Non Preferred	Brand	01/01/15		Antiemetics Prior Auth		
Transderm-SC	Non Preferred	Brand	06/01/16		Antiemetics Prior Auth		
trimethobenzamide capsule	Non Preferred	Generic	01/01/15		Antiemetics Prior Auth	Tigan	
Antiemetics - Miscellaneous							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Emend capsule	Preferred	Brand	11/01/19			Emend	
Emend oral suspension	Preferred	Brand	11/01/19				
ondansetron	Preferred	Generic	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Akynzeo	Non Preferred	Brand	10/15/15		Antiemetics Prior Auth		
Aloxi	Non Preferred	Brand	11/01/19		Antiemetics Prior Auth		
Anzemet	Non Preferred	Brand	09/30/09		Antiemetics Prior Auth		
aprepitant	Non Preferred	Generic	01/01/19		Antiemetics Prior Auth	Emend	
Cesamet	Non Preferred	Brand	01/01/15		Antiemetics Prior Auth		
Cinvanti	Non Preferred	Brand	10/01/19		Antiemetics Prior Auth		
dronabinol	Non Preferred	Generic	01/01/15		Antiemetics Prior Auth		Included in more than one PDL drug class
Emend solution	Non Preferred	Brand	09/01/19		Antiemetics Prior Auth		
fosaprepitant	Non Preferred	Generic	09/01/19		Antiemetics Prior Auth		
granisetron	Non Preferred	Generic	01/01/13		Antiemetics Prior Auth		
Marinol	Non Preferred	Brand	01/01/15		Antiemetics Prior Auth		Included in more than one PDL drug class
palonosetron	Non Preferred	Generic	11/01/19		Antiemetics Prior Auth		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Sancuso	Non Preferred	Brand	04/01/12		Antiemetics Prior Auth		
Sustol	Non Preferred	Brand	11/01/18		Antiemetics Prior Auth		
Varubi	Non Preferred	Brand	10/15/15		Antiemetics Prior Auth		
Zofran	Non Preferred	Brand	09/30/09		Antiemetics Prior Auth		
Zuplenz	Non Preferred	Brand	04/01/12		Antiemetics Prior Auth		
Bowel Evacuant Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Colyte	Preferred	Brand	01/01/18				
gavilyte-c	Preferred	Generic	01/01/18				
gavilyte-g	Preferred	Generic	01/01/18				
gavilyte-n	Preferred	Generic	01/01/18				
Golytely	Preferred	Brand	01/01/16				
Moviprep	Preferred	Brand	01/01/16				
Nulytely	Preferred	Brand	01/01/16				
PEG-3350/electrolytes	Preferred	Generic	01/01/18	Cumulative limit: 1054g /30 days			
trilyte	Preferred	Generic	01/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Clenpiq	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
gavilyte-h	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Plenvu	Non Preferred	Brand	09/01/18		Medication Coverage Exception		
Poly-Prep kit	Non Preferred	Brand	10/01/17		Medication Coverage Exception		
Prepopik	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Suprep	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
PAMORAs							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Movantik	Preferred	Brand	01/01/20		PAMORA		
Relistor inject	Preferred	Brand	01/01/19		PAMORA		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Relistor tablet	Non Preferred	Brand	01/01/19		PAMORA		
Symproic	Non Preferred	Brand	11/01/17		PAMORA		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Oral - Inflammatory Bowel Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Apriso	Preferred	Brand	01/01/20			Apriso	
Asacol	Preferred	Brand	01/01/19			Asacol	
balsalazide	Preferred	Generic	07/01/14				
Dipentum	Preferred	Brand	01/01/19				
Lialda	Preferred	Brand	01/01/18			Lialda	
Pentasa	Preferred	Brand	01/01/17				
sulfasalazine	Preferred	Generic	07/01/14				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Azulfidine	Non Preferred	Brand	07/01/14		Medication Coverage Exception		
Colazal	Non Preferred	Brand	07/01/14		Medication Coverage Exception		
Delzicol	Non Preferred	Brand	06/01/19		Medication Coverage Exception	Delzicol	
Giazo	Non Preferred	Brand	07/01/14		Medication Coverage Exception		
mesalamine capsule	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Apriso	
mesalamine tablet	Non Preferred	Generic	01/01/18		Medication Coverage Exception	Lialda	
mesalamine DR tablet	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Asacol	
mesalamine DR capsule	Non Preferred	Generic	06/01/19		Medication Coverage Exception	Delzicol	
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
SfRowasa enema	Preferred	Brand	01/01/20			SfRowasa	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Canasa	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
mesalamine enema	Non Preferred	Generic	01/01/20		Medication Coverage Exception	SfRowasa	
mesalamine kit	Non Preferred	Generic	07/01/14		Medication Coverage Exception		
mesalamine suppository	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Rowasa	Non Preferred	Brand	07/01/14		Medication Coverage Exception		
Irritable Bowel Syndrome Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Amitiza	Preferred	Brand	01/01/18				
Linzess	Preferred	Brand	01/01/16				

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Lotronex	Preferred	Brand	01/01/18			Lotronex	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
alosetron	Non Preferred	Generic	01/01/18		Medication Coverage Exception	Lotronex	
Trulance	Non Preferred	Brand	03/01/17		Medication Coverage Exception		
Viberzi	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Pancreatic Enzymes							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Creon	Preferred	Brand	08/01/11				
Zenpep	Preferred	Brand	08/01/11				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Pancreaze	Non Preferred	Brand	01/01/12		Medication Coverage Exception		
Pertzye	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Viokace	Non Preferred	Brand	12/01/17		Medication Coverage Exception		
Phosphate Binders							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
calcium acetate	Preferred	Generic	10/15/15				
Eliphos	Preferred	Brand	07/01/14				
Fosrenol	Preferred	Brand	01/01/19			Fosrenol	
Phoslyra solution	Preferred	Brand	07/01/14				
Renagel	Preferred	Brand	07/01/14			Renagel	
sevelamer carbonate powder	Preferred	Generic	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Auryxia	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
lanthanum	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Fosrenol	
Renvela	Non Preferred	Brand	01/01/20		Medication Coverage Exception	Renvela	
Renvela powder	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
sevelamer HCl	Non Preferred	Generic	03/01/19		Medication Coverage Exception	Renagel	
sevelamer carbonate tablet	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Renvela	
Velphoro	Non Preferred	Brand	07/01/14		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Proton Pump Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Dexilant	Preferred	Brand	01/01/18				
esomeprazole mag	Preferred	Generic	04/01/18				
Nexium granules	Preferred	Brand	06/01/18	Members under 12 years old or Members with a feeding tube.			
omeprazole	Preferred	Generic	01/01/19		90 Day Supply Required		
pantoprazole	Preferred	Generic	01/01/13		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Aciphex	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
esomeprazole str	Non Preferred	Generic	04/01/18		Medication Coverage Exception		
lansoprazole capsule	Non Preferred	Generic	02/01/10		Medication Coverage Exception		
lansoprazole Solutabs	Non Preferred	Generic	02/01/10	Members under 12 years old or Members with a feeding tube.	Medication Coverage Exception	Prevacid	
Nexium capsule	Non Preferred	Brand	04/01/18		Medication Coverage Exception		
omeprazole/sodium bicarbonate	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
Prevacid capsule	Non Preferred	Brand	02/01/10		Medication Coverage Exception		
Prevacid Solutabs	Non Preferred	Brand	02/01/10	Members under 12 years old or Members with a feeding tube.	Medication Coverage Exception	Prevacid	
Prilosec	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Protonix	Non Preferred	Brand	06/01/18		Medication Coverage Exception		
rabeprazole	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Yosprala	Non Preferred	Brand	08/01/19		Medication Coverage Exception		
Zegerid	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Gout							
Acute Gout							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Mitigare	Preferred	Brand	01/01/19			Mitigare	
probenecid/colchicine	Preferred	Generic	01/01/19				

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
colchicine capsule	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Mitigare	
colchicine tablet	Non Preferred	Generic	07/01/17		Medication Coverage Exception		
Colcrys	Non Preferred	Brand	07/01/17		Medication Coverage Exception		
Chronic Gout							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
allopurinol	Preferred	Generic	07/01/17			3-Month	
probenecid	Preferred	Generic	07/01/17				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
febuxostat	Non Preferred	Generic	08/01/19		Medication Coverage Exception	Uloric	
Uloric	Non Preferred	Brand	08/01/19		Medication Coverage Exception	Uloric	
Zyloprim	Non Preferred	Brand	07/01/17		Medication Coverage Exception		
Growth Hormone							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Genotropin	Preferred	Brand	10/01/10		Growth Hormone		
Norditropin	Preferred	Brand	01/01/14		Growth Hormone		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Humatrope	Non Preferred	Brand	01/01/15		Growth Hormone		
Nutropin	Non Preferred	Brand	01/01/13		Growth Hormone		
Omnitrope	Non Preferred	Brand	01/01/13		Growth Hormone		
Saizen	Non Preferred	Brand	11/01/19		Growth Hormone		
Saizenprep	Non Preferred	Brand	11/01/19		Growth Hormone		
Serostim	Non Preferred	Brand	10/01/10		Growth Hormone		
Zomacton	Non Preferred	Brand	11/01/16		Growth Hormone		
Zorbtive	Non Preferred	Brand	01/01/13		Growth Hormone		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Hematopoietics							
Erythropoiesis Stimulating Agents (ESAs)							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Aranesp	Preferred	Brand	01/01/18				
Epogen	Preferred	Brand	01/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Procrit	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Retacrit	Non Preferred	Brand	06/01/18		Medication Coverage Exception		
Immune Globulin							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Gamastan	Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Gamastan S/D	Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Gammagard	Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Gammagard S/D	Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Gamunex-C	Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Asceniv	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Bivigam	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Cutaquig	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Cuvitru	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Flebogamma	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Gammaked	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Gammaplex	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Hizentra	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Hyqvia	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Octagam	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Panzyga	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Privigen	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Xembify	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Prenatal Vitamins							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Citranatal 90 DHA	Preferred	Brand	01/01/15	Member must be pregnant			
Citranatal Assure	Preferred	Brand	01/01/17	Member must be pregnant			
Citranatal Bloom	Preferred	Brand	01/01/19	Member must be pregnant			
Citranatal DHA	Preferred	Brand	01/01/17	Member must be pregnant			
Citranatal Harmony	Preferred	Brand	01/01/15	Member must be pregnant			
Concept DHA	Preferred	Brand	01/01/15	Member must be pregnant			
Select-OB+DHA	Preferred	Brand	01/01/18	Member must be pregnant			
Vitafol Fe+	Preferred	Brand	01/01/17	Member must be pregnant			
Vitafol Gummies	Preferred	Brand	01/01/19	Member must be pregnant			
Vitafol One	Preferred	Brand	01/01/18	Member must be pregnant			
Vitafol Ultra	Preferred	Brand	01/01/17	Member must be pregnant			
Vitafol-OB+DHA	Preferred	Brand	04/01/17	Member must be pregnant			
ALL OTHER Prenatal with DHA/Folate	Preferred	Generic	01/01/16	Member must be pregnant			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
C-Nate DHA	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
C-Nate DHA	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
Enbrace HR	Non Preferred	Brand	11/01/19	Member must be pregnant	Medication Coverage Exception		
Extra-Virt plus DHA	Non Preferred	Brand	01/01/18	Member must be pregnant	Medication Coverage Exception		
Nestabs One	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
OB Complete, Gold, Petite, DHA	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
PNV -DHA -Omega	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
Prenaissance	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
Prenatal DHA Pak	Non Preferred	Brand	03/01/18	Member must be pregnant	Medication Coverage Exception		
Prenate DHA	Non Preferred	Brand	01/01/15	Member must be pregnant	Medication Coverage Exception		
Prenate Enhance	Non Preferred	Brand	01/01/18	Member must be pregnant	Medication Coverage Exception		
Prenate Essential	Non Preferred	Brand	01/01/15	Member must be pregnant	Medication Coverage Exception		
Prenate Mini	Non Preferred	Brand	01/01/16	Member must be pregnant	Medication Coverage Exception		
Prenate Pixie	Non Preferred	Brand	01/01/15	Member must be pregnant	Medication Coverage Exception		
Prenate Restore	Non Preferred	Brand	01/01/17	Member must be pregnant	Medication Coverage Exception		
Provida DHA	Non Preferred	Brand	01/01/15	Member must be pregnant	Medication Coverage Exception		
Relnate DHA	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Taron-Prex	Non Preferred	Brand	01/01/20	Member must be pregnant	Medication Coverage Exception		
Tricare, DHA	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
Tristart DHA, One	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
Vinate DHA	Non Preferred	Brand	01/01/15	Member must be pregnant	Medication Coverage Exception		
Virt -Select, -Nate	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
Virtprex	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
VP -CH, -DHA, -Heme, -Plus	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
Zatean -PN	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
ALL NON-DHA/Folate products	Non Preferred	Generic	01/01/16	Member must be pregnant	Medication Coverage Exception		

Muscle Relaxants

Antispasmodic Agents

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
chlorzoxazone	Preferred	Generic	09/28/09	4 tablets /day			
cyclobenzaprine 5, 10mg	Preferred	Generic	09/28/09	3 tablets /day			
cyclobenzaprine ER	Preferred	Generic	01/01/20	3 capsules /day			
methocarbamol	Preferred	Generic	01/01/19	6 tablets /day			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Amrix	Non Preferred	Brand	09/28/09	3 capsules /day	Medication Coverage Exception		
carisoprodol	Non Preferred	Generic	01/01/14	4 tablets /day	Medication Coverage Exception		
carisoprodol/asa	Non Preferred	Generic	09/28/09	1 tablet /day	Medication Coverage Exception		
carisoprodol/asa/codeine	Non Preferred	Generic	09/28/09	1 tablet /day	Medication Coverage Exception		
cyclobenzaprine 7.5mg	Non Preferred	Generic	01/01/14	3 tablets /day	Medication Coverage Exception		
Fexmid	Non Preferred	Brand	01/01/14	3 tablets /day	Medication Coverage Exception		
Lorzone	Non Preferred	Brand	01/01/14	4 tablets /day	Medication Coverage Exception		
metaxalone	Non Preferred	Generic	01/01/16	4 tablets /day	Medication Coverage Exception		
orphenadrine	Non Preferred	Generic	09/28/09	2 tablets /day	Medication Coverage Exception		
Robaxin	Non Preferred	Brand	01/01/19	6 tablets /day	Medication Coverage Exception		
Skelaxin	Non Preferred	Brand	01/01/16	4 tablets /day	Medication Coverage Exception		
Soma	Non Preferred	Brand	01/01/14	4 tablets /day	Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Antispasticity Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
baclofen	Preferred	Generic	09/28/09				
tizanidine tablet	Preferred	Generic	10/15/15	3 tablets /day			Tablets are Preferred
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Dantrium	Non Preferred	Brand	01/01/13	3 tablets /day	Medication Coverage Exception		
dantrolene	Non Preferred	Generic	01/01/13	3 tablets /day	Medication Coverage Exception		
Ozobax	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
tizanidine capsule	Non Preferred	Generic	10/15/15	3 tablets /day	Medication Coverage Exception		Tablets are Preferred
Zanaflex	Non Preferred	Brand	09/28/09	3 tablets or capsules /day	Medication Coverage Exception		
Nasal							
Antihistamines							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Astepro	Preferred	Brand	01/01/19			Astepro	
azelastine 0.1%	Preferred	Generic	01/01/19				
Dymista	Preferred	Brand	01/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
azelastine 0.15%	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Astepro	
Azenase Pak	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
olopatadine	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Patanase	Non Preferred	Brand	11/01/18		Medication Coverage Exception		
Ticanase Pak	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Corticosteroids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Beconase AQ	Preferred	Brand	01/01/13				
fluticasone	Preferred	Generic	10/01/09				
mometasone	Preferred	Generic	11/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
flunisolide	Non Preferred	Generic	01/01/19		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Nasonex	Non Preferred	Brand	11/01/18		Medication Coverage Exception		
Omnaris	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Qnasl	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Sinuva	Non Preferred	Brand	06/01/20		Medication Coverage Exception		
Xhance	Non Preferred	Brand	12/01/18		Medication Coverage Exception		
Zetonna	Non Preferred	Brand	01/01/20		Medication Coverage Exception		

Neurological

Parkinson - COMT Inhibitors & Combinations

Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
amantadine	Preferred	Generic	01/01/14				
carbidopa/levodopa	Preferred	Generic	01/01/14		90 Day Supply Required		
carbidopa/levodopa ER	Preferred	Generic	01/01/14				
Duopa	Preferred	Brand	01/01/20				
entacapone	Preferred	Generic	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
carbidopa	Non Preferred	Generic	11/01/16		Medication Coverage Exception		
carbidopa/levodopa orally disintegrating tablet	Non Preferred	Generic	10/01/09		Medication Coverage Exception		
carbidopa/levodopa/entacapone	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
Comtan	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Gocovri	Non Preferred	Brand	10/01/17		Medication Coverage Exception		
Inbrija	Non Preferred	Brand	03/01/19		Medication Coverage Exception		
Lodosyn	Non Preferred	Brand	11/01/16		Medication Coverage Exception		
Northera	Non Preferred	Brand	08/15/14		Medication Coverage Exception		
Osmolex ER	Non Preferred	Brand	06/01/18		Medication Coverage Exception		
Rytary	Non Preferred	Brand	10/01/15		Medication Coverage Exception		
Sinemet	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Sinemet CR	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Stalevo	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Tasmar	Non Preferred	Brand	10/01/09		Medication Coverage Exception		
tolcapone	Non Preferred	Generic	10/01/09		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Parkinson - MAO Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Azilect	Preferred	Brand	01/01/19			Azilect	
selegiline	Preferred	Generic	02/01/10				
Zelapar	Preferred	Brand	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
rasagiline	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Azilect	
Xadago	Non Preferred	Brand	06/01/17		Medication Coverage Exception		
Parkinson - Non-ergot Derived Dopamine Receptor Agonists and Others							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
pramipexole	Preferred	Generic	12/02/11		90 Day Supply Required		
ropinirole	Preferred	Generic	10/01/09		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Kynmobi	Non Preferred	Brand	07/01/20		Medication Coverage Exception		
Mirapex	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Mirapex ER	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Mirapex ER	
Neupro patch	Non Preferred	Brand	10/01/09		Medication Coverage Exception		
Nourianz	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
Nuplazid	Non Preferred	Brand	06/01/17		Medication Coverage Exception		
pramipexole ER	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Mirapex ER	
Requip, XL	Non Preferred	Brand	10/01/09		Medication Coverage Exception		
ropinirole ER	Non Preferred	Generic	10/01/09		Medication Coverage Exception		
Migraine - Abortive Therapy							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Nurtec	Preferred	Brand	06/01/20	Cumulative 9 units /30 days	CGRP Prior Auth		
Relpax	Preferred	Brand	01/01/13	Cumulative 9 units /30 days		Relpax	
rizatriptan	Preferred	Generic	01/01/17	Cumulative 9 units /30 days			
sumatriptan tablet	Preferred	Generic	01/01/13	Cumulative 9 units /30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
almotriptan	Non Preferred	Generic	01/01/13	Cumulative 9 units /30 days	Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Amerge	Non Preferred	Brand	01/01/13	Cumulative 9 units /30 days	Medication Coverage Exception		
but/apap/caf/codeine	Non Preferred	Generic	05/01/17	20 tablets or capsules /30 days	Medication Coverage Exception		
but/asa/caf/codeine	Non Preferred	Brand	05/01/17	20 tablets or capsules /30 days	Medication Coverage Exception		
butorphanol nasal spray	Non Preferred	Generic	08/01/19	2.5ml /30 days	Medication Coverage Exception		
Cafergot	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Cambia	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
dhe spray	Non Preferred	Generic	12/01/17		Medication Coverage Exception		
eletriptan	Non Preferred	Generic	09/01/17	Cumulative 9 units /30 days	Medication Coverage Exception	Relpax	
Ergomar	Non Preferred	Brand	05/01/18		Medication Coverage Exception		
ergotamine/caf	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Fiorinal/codeine	Non Preferred	Brand	05/01/17	20 tablets/caps /30 days	Medication Coverage Exception		
Frova	Non Preferred	Brand	04/01/16	Cumulative 9 units /30 days	Medication Coverage Exception		
frovatriptan	Non Preferred	Generic	04/01/16	Cumulative 9 units /30 days	Medication Coverage Exception		
Imitrex injection	Non Preferred	Brand	01/01/17	Cumulative 9 units /30 days	Medication Coverage Exception		
Imitrex spray	Non Preferred	Brand	01/01/17	Cumulative 9 units /30 days	Medication Coverage Exception		
Imitrex tablet	Non Preferred	Brand	01/01/12	Cumulative 9 units /30 days	Medication Coverage Exception		
Maxalt	Non Preferred	Brand	01/01/14	Cumulative 9 units /30 days	Medication Coverage Exception		
Migergot	Non Preferred	Brand	06/01/20		Medication Coverage Exception		
Migranal spray	Non Preferred	Brand	12/01/17		Medication Coverage Exception		
naratriptan	Non Preferred	Generic	01/01/13	Cumulative 9 units /30 days	Medication Coverage Exception		
Onzetra	Non Preferred	Brand	05/01/16	Cumulative 9 units /30 days	Medication Coverage Exception		
Reyvow	Non Preferred	Brand	02/01/20		Reyvow Prior Auth		
sumatriptan injection	Non Preferred	Generic	01/01/17	Cumulative 9 units /30 days	Medication Coverage Exception		
sumatriptan spray	Non Preferred	Generic	01/01/17	Cumulative 9 units /30 days	Medication Coverage Exception		
sumatriptan/naproxen	Non Preferred	Generic	09/28/09	Cumulative 9 units /30 days	Medication Coverage Exception	Treximet	
Tosymra	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
Treximet	Non Preferred	Brand	09/28/09	Cumulative 9 units /30 days	Medication Coverage Exception	Treximet	
Ubrelvy	Non Preferred	Brand	02/01/20	Cumulative 9 units /30 days	CGRP Prior Auth		
Zembrace	Non Preferred	Brand	04/01/16	Cumulative 9 units /30 days	Medication Coverage Exception		
zolmitriptan	Non Preferred	Generic	06/01/13	Cumulative 9 units /30 days	Medication Coverage Exception		
Zomig	Non Preferred	Brand	06/01/13	Cumulative 9 units /30 days	Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Migraine - Prophylactic Therapy							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required PA Form/ Mandatory 3-Month**	**Brand Required**	**Additional Note**
Aimovig	Preferred	Brand	01/01/20		CGRP Prior Auth		
amitriptyline	Preferred	Generic	01/01/18				Included in more than one PDL drug class
divalproex	Preferred	Generic	01/01/17		90 Day Supply Required		Included in more than one PDL drug class
propranolol SR	Preferred	Generic	03/01/16				Included in more than one PDL drug class
propranolol	Preferred	Generic	04/01/13		90 Day Supply Required		Included in more than one PDL drug class
timolol	Preferred	Generic	09/28/09				Included in more than one PDL drug class
topiramate capsule	Preferred	Generic	01/01/19				Included in more than one PDL drug class
topiramate tablet	Preferred	Generic	01/01/19		90 Day Supply Required		Included in more than one PDL drug class
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Ajovy	Non Preferred	Brand	01/01/19		CGRP Prior Auth		
Botox	Non Preferred	Brand	01/01/19		Botox Prior Auth		Covered under the medical benefit using the appropriate HCPCS code
Depakote	Non Preferred	Brand	01/01/17		Medication Coverage Exception		Included in more than one PDL drug class
Emgality	Non Preferred	Brand	01/01/19		CGRP Prior Auth		
Inderal LA	Non Preferred	Brand	03/01/16		Medication Coverage Exception		Included in more than one PDL drug class
Inderal XL	Non Preferred	Brand	03/01/16		Medication Coverage Exception		Included in more than one PDL drug class
Innopran XL	Non Preferred	Brand	09/28/09		Medication Coverage Exception		Included in more than one PDL drug class
Qudexy XR	Non Preferred	Brand	01/01/19		Medication Coverage Exception		Included in more than one PDL drug class
Trokendi XR	Non Preferred	Brand	10/01/16		Medication Coverage Exception		Included in more than one PDL drug class
topiramate ER	Non Preferred	Generic	01/01/19		Medication Coverage Exception		Included in more than one PDL drug class
Vyepti	Non Preferred	Brand	04/01/20		CGRP Prior Auth		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Movement Disorder Treatments - VMAT-2 Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Austedo	Preferred	Brand	01/01/19				Step Therapy required; must fail another preferred agent first
tetrabenazine	Preferred	Generic	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Ingrezza	Non Preferred	Brand	07/01/18		Medication Coverage Exception		
Xenazine	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Multiple Sclerosis Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Avonex	Preferred	Brand	02/01/10				
Betaseron	Preferred	Brand	01/01/16				
Copaxone 20mg	Preferred	Brand	09/28/09			Copaxone	
Gilenya	Preferred	Brand	01/01/18				Step Therapy required; must fail another preferred agent first
Vumerity	Preferred	Brand	12/01/19				Step Therapy required; must fail another preferred agent first
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Ampyra	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Aubagio	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Copaxone 40mg	Non Preferred	Brand	05/30/14		Medication Coverage Exception	Copaxone	
dalfampridine	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Extavia	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
glatiramer	Non Preferred	Generic	07/01/15		Medication Coverage Exception	Copaxone	
Mavenclad	Non Preferred	Brand	05/01/19		Mavenclad Prior Auth		
Mayzent	Non Preferred	Brand	04/01/19		Medication Coverage Exception		
Plegridy	Non Preferred	Brand	05/01/19		Medication Coverage Exception		
Rebif	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
Tecfidera	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Therapies for Spinal Muscular Atrophy							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Spinraza	Preferred	Brand	10/01/19		Spinraza PA		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Zolgensma	Preferred	Brand	10/01/19		Zolgensma PA		

Ophthalmics

Anti-Glaucoma - Alpha Adrenergics

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Alphagan P 0.1%	Preferred	Brand	01/01/14				
Alphagan P 0.15%	Preferred	Brand	01/01/13			Alphagan	
brimonidine 0.2%	Preferred	Generic	10/01/10				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
apraclonidine	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
brimonidine 0.15%	Non Preferred	Generic	10/01/10		Medication Coverage Exception	Alphagan	
Iopidine	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Simbrinza	Non Preferred	Brand	01/01/20		Medication Coverage Exception		

Anti-Glaucoma - Beta Blockers

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Betoptic-S	Preferred	Brand	01/01/19				
Combigan	Preferred	Brand	01/01/19				
dorzolamide/timolol	Preferred	Generic	01/01/20				
levobunolol	Preferred	Generic	04/01/16				
timolol	Preferred	Generic	04/01/16				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
betaxolol	Non Preferred	Generic	04/01/16		Medication Coverage Exception		
carteolol	Non Preferred	Generic	04/01/16		Medication Coverage Exception		
Cosopt	Non Preferred	Brand	02/01/19		Medication Coverage Exception		
Cosopt PF	Non Preferred	Brand	02/01/19		Medication Coverage Exception		
dorzolamide/timolol PF	Non Preferred	Generic	02/01/19		Medication Coverage Exception		
Istalol	Non Preferred	Brand	01/01/20		Medication Coverage Exception	Istalol	
latanoprost/timolol	Non Preferred	Generic	07/01/18		Medication Coverage Exception		
timolol gel	Non Preferred	Generic	04/01/16		Medication Coverage Exception		
timolol once daily	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Istalol	
timolol PF	Non Preferred	Generic	04/01/16		Medication Coverage Exception		
Timoptic	Non Preferred	Brand	04/01/16		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Timoptic Occudose	Non Preferred	Brand	04/01/16		Medication Coverage Exception		
Timoptic-XE	Non Preferred	Brand	04/01/16		Medication Coverage Exception		
Anti-Glaucoma - Prostaglandins							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
latanoprost	Preferred	Generic	12/02/11				
Lumigan	Preferred	Brand	01/01/19				
Travatan Z	Preferred	Brand	01/01/12			Travatan Z	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
bimatoprost	Non Preferred	Generic	05/06/15		Medication Coverage Exception		
Vyzulta	Non Preferred	Brand	12/01/17		Medication Coverage Exception		
Xalatan	Non Preferred	Brand	12/02/11		Medication Coverage Exception		
travoprost	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Travatan Z	
Xelpros	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Zioptan	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Ophthalmic - Antibiotics - Quinolones							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Besivance	Preferred	Brand	01/01/18				
ciprofloxacin	Preferred	Generic	06/01/12				
Moxeza	Preferred	Brand	01/01/13				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Ciloxan	Non Preferred	Brand	11/01/16		Medication Coverage Exception		
gatifloxacin	Non Preferred	Generic	11/01/19		Medication Coverage Exception		
levofloxacin	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
moxifloxacin	Non Preferred	Generic	08/01/17		Medication Coverage Exception		
Ocuflox	Non Preferred	Brand	06/01/12		Medication Coverage Exception		
ofloxacin	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
Vigamox	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Zymaxid	Non Preferred	Brand	11/01/19		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Ophthalmic - Antibiotics - Non Quinolones							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
erythromycin ointment	Preferred	Generic	12/01/17				
gentamicin drops	Preferred	Generic	06/01/12				
poly/trimethoprim	Preferred	Generic	06/01/12				
ss drops	Preferred	Generic	12/01/17				
tobramycin drops	Preferred	Generic	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Azasite	Non Preferred	Brand	06/01/12		Medication Coverage Exception		
bac	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
bac/poly B	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Bleph-10	Non Preferred	Brand	12/01/17		Medication Coverage Exception		
Gentak ointment	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
neomycin/bac/poly	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
neomycin/poly/gramicidin	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Polytrim	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
ss ointment	Non Preferred	Generic	12/01/17		Medication Coverage Exception		
Tobrex drops	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Tobrex ointment	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Ophthalmic - Antihistamines							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Alomide	Preferred	Brand	01/01/14				
Bepreve	Preferred	Brand	01/01/18				
cromolyn	Preferred	Generic	01/01/14				
Lastacaft	Preferred	Brand	01/01/18				
Pazeo	Preferred	Brand	01/01/17				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Alocril	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
azelastine	Non Preferred	Generic	10/01/10		Medication Coverage Exception		
epinastine	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
olopatadine	Non Preferred	Generic	01/01/16		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Pataday	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Patanol	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
Zerviate	Non Preferred	Brand	05/01/20		Medication Coverage Exception		
Ophthalmic - Anti-Inflammatory - Corticosteroids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Alrex	Preferred	Brand	06/01/12				
Flarex	Preferred	Brand	06/01/12				
fluorometholone	Preferred	Generic	06/01/12				
FML Forte	Preferred	Brand	01/01/18				
FML ointment	Preferred	Brand	01/01/18				
Lotemax drops	Preferred	Brand	06/01/19			Lotemax	
Maxidex	Preferred	Brand	06/01/12				
Pred Mild	Preferred	Brand	06/01/12				
prednisolone acetate	Preferred	Generic	07/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
dexamethasone sodium phosphate	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Durezol	Non Preferred	Brand	06/01/12		Medication Coverage Exception		
FML liquifilm	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Inveltys	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Lotemax gel	Non Preferred	Brand	06/01/12		Medication Coverage Exception		
Lotemax ointment	Non Preferred	Brand	06/01/12		Medication Coverage Exception		
loteprednol 0.5% suspension	Non Preferred	Generic	06/01/19		Medication Coverage Exception	Lotemax	
Omnipred	Non Preferred	Brand	07/01/19		Medication Coverage Exception		
Pred Forte	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
prednisolone sodium phosphate	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
Ophthalmic - Anti-Inflammatory - NSAIDs							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Acuvail	Preferred	Brand	06/01/12				
diclofenac	Preferred	Generic	06/01/12				
ketorolac 0.5%	Preferred	Generic	01/01/19				

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Acular	Non Preferred	Brand	06/01/12		Medication Coverage Exception		
Acular LS	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
bromfenac	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Bromsite	Non Preferred	Brand	11/01/16		Medication Coverage Exception		
flurbiprofen	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Ilevro	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
ketorolac 0.4%	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Nevanac	Non Preferred	Brand	06/01/12		Medication Coverage Exception		
Prolensa	Non Preferred	Brand	04/16/13		Medication Coverage Exception		
Ophthalmic - Anti-Inflammatory - Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Blephamide drops	Preferred	Brand	06/01/12				
neomycin/poly/dexamethasone	Preferred	Generic	06/01/12				
Pred-G, S.O.P.	Preferred	Brand	01/01/18				
Tobradex [0.3/0.1% drops]	Preferred	Brand	01/01/13			Tobradex	
Tobradex ointment	Preferred	Brand	01/01/16				
Zylet	Preferred	Brand	12/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Blephamide S.O.P. ointment	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Maxitrol	Non Preferred	Brand	12/01/18		Medication Coverage Exception		
neomycin/poly/bac/hc	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
neomycin/poly/hc	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
ss/prednisolone drops	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
Tobradex ST	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
tobramycin/dexamethasone	Non Preferred	Generic	06/01/12		Medication Coverage Exception	Tobradex	
Otics							
Otic - Antibiotics							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
ciprofloxacin otic solution 0.2%	Preferred	Generic	01/01/16				
ofloxacin otic drops	Preferred	Generic	01/01/19				

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Floxin otic	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Otic - Antibiotic Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Cipro HC	Preferred	Brand	10/01/13				
CiproDex	Preferred	Brand	01/01/14				
Coly-Mycin suspension	Preferred	Brand	11/01/15				
Cortisporin TC	Preferred	Brand	11/01/19				
neomycin/poly/hc suspension	Preferred	Generic	11/01/15				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
ciprofloxacin/fluocinolone	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Otovel	
Otovel	Non Preferred	Brand	01/01/20		Medication Coverage Exception	Otovel	
neomycin/poly/hc solution	Non Preferred	Generic	11/01/15		Medication Coverage Exception		
Prostatic Hypertrophy Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
alfuzosin	Preferred	Generic	01/01/14				
doxazosin	Preferred	Generic	10/01/11		90 Day Supply Required		
dutasteride	Preferred	Generic	01/01/18		90 Day Supply Required		
finasteride	Preferred	Generic	10/01/11		90 Day Supply Required		
prazosin	Preferred	Generic	12/01/18				
Rapaflo	Preferred	Brand	01/01/18			Rapaflo	
tamsulosin	Preferred	Generic	01/01/12		90 Day Supply Required		
terazosin	Preferred	Generic	10/01/11		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Avodart	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Cardura	Non Preferred	Brand	04/01/12		Medication Coverage Exception		
Cardura XL	Non Preferred	Brand	04/01/12		Medication Coverage Exception		
Cialis 5mg	Non Preferred	Brand	06/01/20		Cialis Prior Auth form		
dutasteride/tamsulosin	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
Flomax	Non Preferred	Brand	10/01/11		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Jalyn	Non Preferred	Brand	10/01/11		Medication Coverage Exception		
Minipress	Non Preferred	Brand	12/01/18		Medication Coverage Exception		
Proscar	Non Preferred	Brand	10/01/11		Medication Coverage Exception		
silodosin	Non Preferred	Generic	12/01/18		Medication Coverage Exception	Rapaflo	
tadalafil 5mg	Non Preferred	Generic	06/01/20		Cialis Prior Auth form		

Pulmonary Hypertension (PAH)

Endothelin Antagonists

Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Letairis	Preferred	Brand	01/01/12		Pulmonary Arterial HTN	Letairis	
Tracleer	Preferred	Brand	06/01/19		Pulmonary Arterial HTN	Tracleer	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
ambrisentan	Non Preferred	Generic	05/01/19		Pulmonary Arterial HTN	Letairis	
bosentan	Non Preferred	Generic	06/01/19		Pulmonary Arterial HTN	Tracleer	
Opsumit	Non Preferred	Brand	10/01/13		Pulmonary Arterial HTN		

Phosphodiesterase-5 Enzyme (PDE-5) Inhibitors

Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
sildenafil	Preferred	Generic	09/01/13		Pulmonary Arterial HTN		
tadalafil	Preferred	Generic	01/01/20		Pulmonary Arterial HTN		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Adcirca	Non Preferred	Brand	01/01/20		Pulmonary Arterial HTN		
Revatio	Non Preferred	Brand	09/01/13		Pulmonary Arterial HTN		

Prostacyclins

Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
epoprostenol	Preferred	Generic	06/01/12		Pulmonary Arterial HTN		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Flolan	Non Preferred	Brand	06/01/12		Pulmonary Arterial HTN		
Orenitram	Non Preferred	Brand	04/02/14		Pulmonary Arterial HTN		
Remodulin	Non Preferred	Brand	10/01/19		Pulmonary Arterial HTN	Remodulin	
treprostinil	Non Preferred	Brand	10/01/19		Pulmonary Arterial HTN	Remodulin	

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Tyvaso	Non Preferred	Brand	06/01/12		Pulmonary Arterial HTN		
Uptravi	Non Preferred	Brand	01/15/16		Pulmonary Arterial HTN		
Veletri	Non Preferred	Brand	06/01/12		Pulmonary Arterial HTN		
Ventavis	Non Preferred	Brand	01/01/14		Pulmonary Arterial HTN		

Respiratory

Asthma & COPD - Anticholinergics

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Atrovent HFA	Preferred	Brand	04/01/12				
ipratropium	Preferred	Generic	04/01/12				
Spiriva	Preferred	Brand	01/01/20				
Yupelri	Preferred	Brand	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Incruse Ellipta	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
Lonhala Magnair	Non Preferred	Brand	03/01/18		Medication Coverage Exception		
Seebri Neohaler	Non Preferred	Brand	09/01/17		Medication Coverage Exception		
Tudorza Pressair	Non Preferred	Brand	01/01/20		Medication Coverage Exception		

Asthma & COPD - Short Acting Beta Agonists (SABA)

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
albuterol nebulizer	Preferred	Generic	01/01/13				
levalbuterol nebulizer	Preferred	Generic	05/15/16				
ProAir HFA	Preferred	Brand	01/01/20			Brand Required	
ProAir RespiClick	Preferred	Brand	01/01/20				
Proventil HFA	Preferred	Brand	05/01/20			Brand Required	
Ventolin HFA	Preferred	Brand	05/01/20			Brand Required	
Xopenex HFA	Preferred	Brand	01/01/12			Xopenex	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
albuterol HFA	Non Preferred	Generic	05/01/19		Medication Coverage Exception	Brand Required	
levalbuterol HFA	Non Preferred	Generic	12/01/16		Medication Coverage Exception	Xopenex	
ProAir Digihaler	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
Xopenex nebulizer	Non Preferred	Brand	05/15/16		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Asthma & COPD - Long Acting Beta Agonists (LABA)							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Arcapta	Preferred	Brand	01/01/20				
Serevent Diskus	Preferred	Brand	09/28/09				
Striverdi	Preferred	Brand	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Brovana	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Perforomist	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Asthma & COPD - Corticosteroids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Arnuity Ellipta	Preferred	Brand	01/01/19				
Flovent Diskus	Preferred	Brand	06/28/11				
Flovent HFA	Preferred	Brand	06/28/11		90 Day Supply Required		
Pulmicort 0.25mg/2ml, 0.5mg/2ml	Preferred	Brand	01/01/13			Pulmicort	
Pulmicort Flexhaler	Preferred	Brand	01/01/13				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Alvesco	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Asmanex	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
Asmanex Twisthaler 220	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
budesonide ampules	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Pulmicort 1mg/2ml	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Qvar	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Asthma & COPD - Leukotriene Receptor Antagonists							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
montelukast chewable	Preferred	Generic	01/01/13				
montelukast tablet	Preferred	Generic	01/01/13				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Accolate	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
montelukast granules	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Singulair	Non Preferred	Brand	01/01/13		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
zafirlukast	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
zileuton CR	Non Preferred	Generic	10/15/15		Medication Coverage Exception		
Zyflo CR	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
Asthma & COPD - Oral Beta Agonists							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
albuterol syrup	Preferred	Generic	01/01/19				
metaproterenol	Preferred	Generic	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
albuterol tablet	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
albuterol ER tablet	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
terbutaline	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Asthma & COPD - Combination Products							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Advair	Preferred	Brand	06/01/19			Advair	
Dulera	Preferred	Brand	05/23/11				
ipratropium/albuterol	Preferred	Generic	01/01/14				
Symbicort	Preferred	Brand	01/01/13				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
AirDuo	Non Preferred	Brand	09/01/19		Medication Coverage Exception	AirDuo	
Breo Ellipta	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
budesonide/formoterol	Non Preferred	Generic	07/01/20		Medication Coverage Exception	Symbicort	
Combivent	Non Preferred	Brand	04/01/13		Medication Coverage Exception		
fluticasone/salmeterol	Non Preferred	Generic	09/01/19		Medication Coverage Exception	Advair	
fluticasone/salmeterol	Non Preferred	Generic	05/01/17		Medication Coverage Exception	AirDuo	
Asthma & COPD - LABA/LAMA Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Anoro Ellipta	Preferred	Brand	09/01/17				
Bevespi	Preferred	Brand	01/01/18				

Utah Medicaid Preferred Drug List - Effective July 1, 2020

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Duaklir	Non Preferred	Brand	02/01/20		Medication Coverage Exception		
Stiolto Respimat	Non Preferred	Brand	09/01/17		Medication Coverage Exception		
Trelegy Ellipta	Non Preferred	Brand	11/01/17		Medication Coverage Exception		
Utibron	Non Preferred	Brand	09/01/17		Medication Coverage Exception		
Urinary							
Short Acting Antispasmodics							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
bethanechol	Preferred	Generic	01/01/20				
oxybutynin	Preferred	Generic	09/28/09				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Detrol	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
flavoxate	Non Preferred	Generic	09/28/09		Medication Coverage Exception		
tolterodine	Non Preferred	Generic	09/28/09		Medication Coverage Exception		
trospium	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
Urecholine	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Long Acting Antispasmodics							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
oxybutynin ER	Preferred	Generic	02/01/10				
Oxytrol Rx	Preferred	Brand	01/01/19				
Toviaz	Preferred	Brand	09/28/09				
Vesicare	Preferred	Brand	09/28/09			Vesicare	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
darifenacin	Non Preferred	Generic	04/01/16		Medication Coverage Exception		
Detrol LA	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Ditropan XL	Non Preferred	Brand	01/01/12		Medication Coverage Exception		
Enablex	Non Preferred	Brand	04/01/16		Medication Coverage Exception		
Gelnique	Non Preferred	Brand	05/01/17		Medication Coverage Exception		
Myrbetriq	Non Preferred	Brand	05/09/13		Medication Coverage Exception		
solifenacin	Non Preferred	Generic	05/01/19		Medication Coverage Exception	Vesicare	

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
tolterodine ER	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
trospium ER	Non Preferred	Generic	10/01/13		Medication Coverage Exception		

Vitamin D Analogs

Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
calcitriol capsule	Preferred	Generic	01/01/18				
Rocaltrol solution	Preferred	Brand	01/01/18			Rocaltrol	
vitamin D	Preferred	Generic	01/01/15				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
calcitriol solution	Non Preferred	Generic	01/01/18		Medication Coverage Exception	Rocaltrol	
doxercalciferol	Non Preferred	Generic	01/01/15		Medication Coverage Exception		
Drisdol	Non Preferred	Brand	11/01/16		Medication Coverage Exception		
Hectorol	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
paricalcitol	Non Preferred	Generic	01/01/15		Medication Coverage Exception		
Rocaltrol capsule	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Zemplar	Non Preferred	Brand	01/01/15		Medication Coverage Exception		

Utah Medicaid Covered Over-the-Counter Drugs - Effective July 1, 2020

Anti-Fungals

Drugs	Last Update	Limits	Mandatory 3-Month	Additional Note
clotrimazole 1% vaginal cream	04/01/17			
miconazole 2% vaginal cream	04/01/17			
miconazole 4% vaginal cream	04/01/17			

1st Generation Antihistamines

Drugs	Last Update	Limits	Mandatory 3-Month	Additional Note
chlorpheniramine 4mg tablet	04/01/17			
diphenhydramine 12.5mg/5ml liquid	04/01/17			
diphenhydramine 25mg capsule	04/01/17			
diphenhydramine 25mg tablet	04/01/17			
diphenhydramine 50mg capsule	04/01/17			

2nd Generation Antihistamines

Drugs	Last Update	Limits	Mandatory 3-Month	Additional Note
cetirizine 10 mg tablet	04/01/17			
cetirizine 5mg tablet	04/01/17			
cetirizine 5mg/5ml solution	04/01/17			
loratadine 10mg tablet	04/01/17			
loratadine 5mg chewable tablet	04/01/17			
loratadine 5mg/5ml solution	04/01/17			

Contraceptives

Emergency

Drugs	Last Update	Limits	**Covered Generic Products** (Brand Plan B is not covered)
levonorgestrel 1.5 mg tablet	04/01/17	4 tablets per 30 days	Aftera, Econtra, FallBack, My Choice, My Way, New Day, Opcicon, Option 2,Take Action

Non-Emergency

Products	Last Update	Limits	Mandatory 3-Month	Additional Note
condoms - male	04/01/17			
condoms - female	04/01/17			

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Dermatological

Corticosteroids

Drugs	Last Update	Limits	Mandatory 3-Month	Additional Note
hydrocortisone 0.5% cream	04/01/17			
hydrocortisone 0.5% ointment	04/01/17			
hydrocortisone 1% cream	04/01/17			
hydrocortisone 1% ointment	04/01/17			

Anti-Lice

Drugs	Last Update	Limits	Mandatory 3-Month	Additional Note
permethrin 1% liquid	04/01/17			
permethrin 1% lotion	04/01/17			
pyrethrins/piperonyl butoxide 0.33%/4% shampoo	04/01/17			
Vanalice 0.3-3.5% gel	01/01/20			

Fever Reducers and Pain Relievers

Acetaminophen

Drugs	Last Update	Limits	Mandatory 3-Month	Additional Note
acetaminophen 160mg/5ml liquid	04/01/17			
acetaminophen 160mg/5ml suspension	04/01/17			
acetaminophen 160mg/5ml solution	04/01/17			
acetaminophen 120mg suppository	04/01/17			
acetaminophen 325mg suppository	04/01/17			
acetaminophen 650mg suppository	04/01/17			
acetaminophen 160mg chewable tablet	04/01/17			
acetaminophen 160mg dispersible tablet	04/01/17			
acetaminophen 325mg tablet	04/01/17			
acetaminophen 500mg capsule	04/01/17			
acetaminophen 500mg tablet	04/01/17			
acetaminophen 650mg tablet	04/01/17			

Utah Medicaid Covered Over-the-Counter Drugs - Effective July 1, 2020

Aspirin				
Drugs	**Last Update**	**Limits**	**Mandatory 3-Month**	**Additional Note**
aspirin 81mg tablet	04/01/17			
aspirin 81mg chewable tablet	04/01/17		90 Day Supply Required	
aspirin 81mg oral disintegrating tablet	04/01/17			
aspirin 81mg enteric coated tablet	04/01/17		90 Day Supply Required	
aspirin 325mg enteric coated tablet	04/01/17			
aspirin 325mg tablet	04/01/17			
Non-Steroidal Anti-Inflammatorys (NSAIDs)				
Drugs	**Last Update**	**Limits**	**Mandatory 3-Month**	**Additional Note**
ibuprofen 100mg/5ml suspension	04/01/17			
ibuprofen 50mg/1.25ml suspension	04/01/17			
ibuprofen 100mg chewable tablet	01/01/19			
ibuprofen 200mg tablet	04/01/17			
naproxen Na 220mg tablet	04/01/17			

Gastrointestinal (GI)

Anti-Diarrheals				
Drugs	**Last Update**	**Limits**	**Mandatory 3-Month**	**Additional Note**
loperamide 2mg capsule	04/01/17			
loperamide 2mg tablet	04/01/17			
loperamide 1mg/7.5ml suspension	04/01/17			
loperamide 1mg/5ml suspension	04/01/17			
Laxatives - Bulk				
Drugs	**Last Update**	**Limits**	**Mandatory 3-Month**	**Additional Note**
psyllium	04/01/17			
Laxatives - Osmotic				
Drugs	**Last Update**	**Limits**	**Mandatory 3-Month**	**Additional Note**
polyethylene glycol 3350 powder	04/01/17	1054g per 30 days		

Utah Medicaid Covered Over-the-Counter Drugs - Effective July 1, 2020

Laxatives - Saline				
Drugs	**Last Update**	**Limits**	**Mandatory 3-Month**	**Additional Note**
mag hydroxide 400mg/ml suspension	11/01/18			
Laxatives - Surfactant				
Drugs	**Last Update**	**Limits**	**Mandatory 3-Month**	**Additional Note**
docusate calcium 240mg capsules	04/01/17			
docusate Na 100mg capsules	01/01/19		90 Day Supply Required	
docusate Na 200mg capsules	01/01/19		90 Day Supply Required	
docusate Na 50mg/5ml liquid	04/01/17			
Laxatives - Stimulant				
Drugs	**Last Update**	**Limits**	**Mandatory 3-Month**	**Additional Note**
bisacodyl 10mg suppository	04/01/17			
bisacodyl EC 5mg tablets	04/01/17			
sennosides 8.6mg tablets	01/01/19			
sennosides/docusate 8.5/50mg tablets	01/01/19			
Ulcer Drugs - Antacids				
Drugs	**Last Update**	**Limits**	**Mandatory 3-Month**	**Additional Note**
aluminum hydroxide/mag carbonate 160/104mg chewable	04/01/17			
aluminum hydroxide/mag carbonate 95/358mg/15ml suspension	04/01/17			
aluminum hydroxide/mag hydroxide/simethicone 200/200/25mg chewable	04/01/17			
aluminum hydroxide/mag hydroxide/simethicone 200/200/20mg/5ml susp	04/01/17			
aluminum hydroxide/mag hydroxide/simethicone 400/400/40mg/5ml susp	04/01/17			
calcium carbonate 1000mg chewable	04/01/17			
Ulcer Drugs - Stomach Acid Reducers				
Drugs	**Last Update**	**Limits**	**Mandatory 3-Month**	**Additional Note**
famotidine 20mg tablet	04/01/17			

Utah Medicaid Covered Over-the-Counter Drugs - Effective July 1, 2020

Smoking Deterrents				
Drugs	**Last Update**	**Limits**	**Mandatory 3-Month**	**Additional Note**
nicotine 2mg gum	04/01/17			
nicotine 4mg gum	04/01/17			
nicotine 2mg lozenge	04/01/17			
nicotine 4mg lozenge	04/01/17			
nicotine 7mg/24hr patch	04/01/17			
nicotine 14mg/24hr patch	04/01/17			
nicotine 21mg/24hr patch	04/01/17			
Supplements				
Iron				
ferrous gluconate 325mg (36mg elemental Fe) tablet	04/01/17			
ferrous sulfate drops 75 mg/ml (15 mg/ml elemental Fe) liquid	04/01/17			
ferrous sulfate 220mg/5ml (44mg/5ml elemental Fe) liquid	04/01/17			
ferrous sulfate 325mg (65mg elemental fe) tablet	01/01/19			
ferrous sulfate CR 325mg (65mg elemental fe) tablet	04/01/17			

Utah Medicaid Additional Drugs that Require Brand Over Generic - Effective July 1, 2020

• **Policy:** Drugs listed on this list or on the PDL as preferred, are exceptions to Utah Medicaid's Mandatory Generic Drug Policy.

Preferred Brand Name Drugs	Non-Preferred Generic Drugs	Last Update	Limits	Prior Auth Required	Mandatory 3-Month	Additional Note
Bicnu	carmustine	10/01/18				
Biltricide	praziquantel	Not Available				
Buphenyl	sodium phenylbutyrate	Not Available				
Carafate suspension	sucralfate suspension	06/01/19				
Cellcept suspension	mycophenolate suspension	Not Available				
Dovonex cream	calcipotriene cream	Not Available				
Fareston	toremifene	02/01/19				
Glyset	miglitol	Not Available				
Hepsera	adefovir	Not Available				
Mephyton	phytonadione	11/01/18				
Methergine tablet	methylergonovine	Not Available				
Mycamine	micafungin	05/01/20				
Niaspan	niacin ER	Not Available				
Nuvaring	etonogestrel/ee vaginal ring	02/01/20				
Oracea	doxycycline 40mg	Not Available				
Rapamune solution	sirolimus solution	02/01/19				
Sensipar	cinacalcet	Not Available				
Soolantra	ivermectin 1% cream	11/01/19				
Sorilux foam	calcipotrien foam	Not Available				
Syprine	trientine	Not Available				
Taclonex ointment	calcipotriene-betameth dip ointment	Not Available				
Tarceva	erlotinib	06/01/19				
Tekturna	aliskiren	04/01/19				
Uceris tablet	budesonide tablet	03/01/19				
Urocit-K 5, 10	potassium citrate 5, 10mEq	01/01/19				
Valstar	valrubicin	05/01/19				
Xeloda	capecitabine	Not Available				
Zavesca	miglustat	02/01/19				
Zortress	everolimus	Not Available				
Zyclara	imiquimod 3.75%	09/01/18				
Zytiga	abiraterone	12/01/18				

Utah Medicaid Additional Drugs that Require 3 Month Supply - Effective July 1, 2020

• **Policy:** Utah Medicaid has instituted a mandatory 3 month supply for maintenance medications, following a two-month window for dose titration and stabilization.

• **Copays:** For a 3 month supply, Utah Medicaid fee for service members who are subject to cost-sharing will pay a single copay**.**

• **Day Supply:** 3 Month supply is defined as a 90 day supply. Exceptions to this are hormonal contraceptives. For continuous cycle contraceptives it is defined as 91 days; for all other hormonal contraceptives it is defined as 84 days.

• **Dispensing Fees:** Pharmacies will receive a single dispensing fee on prescriptions filled for a 3 Month supply.

• **Exemptions:** Mandatory three month policy applies to most members. Exemptions from this program as determined based on the member Category of Aid. Note: The mandatory 3 Month policy does not apply to Indian Health Service providers, or Medicaid members receiving long term services and supports in nursing facilities, intermediate care facilities, or home and community based waiver programs. While not mandatory, 3 Month supply fills remains optional for these groups.

• **Exceptions**: Requests for exceptions may be submitted by the prescriber through Prior Authorization.

Drugs	Strength(s)	Status	Type	Last Update
amiodarone hydrochloride	200mg	Mandatory Generic Policy Applies	Generic	08/01/18
amlodipine/benazepril	2.5/10mg, 5/10mg, 5/20mg, 5/40mg, 10/20mg, 10/40mg	Mandatory Generic Policy Applies	Generic	08/01/18
anastrozole	1mg, 2mg	Mandatory Generic Policy Applies	Generic	08/01/18
aspirin chew & EC tablet	81mg	Mandatory Generic Policy Applies	Generic	07/01/16
clonidine tablet	0.1mg, 0.2mg, 0.3mg	Mandatory Generic Policy Applies	Generic	07/01/16
contraceptives	barruer,injectable, progestin only, transdermal, vaginal	Mandatory Generic Policy Applies	Brand/ Generic	05/01/19
dapsone tablet	25mg, 100mg	Mandatory Generic Policy Applies	Generic	08/01/18
dicyclomine	20mg	Mandatory Generic Policy Applies	Generic	07/01/16
docusate Na	100mg, 250mg	Mandatory Generic Policy Applies	Generic	07/01/16
ferrous sulfate	325mg	Mandatory Generic Policy Applies	Generic	07/01/16
folic acid	1mg	Mandatory Generic Policy Applies	Generic	07/01/16
isoniazid 100mg	100mg, 300mg	Mandatory Generic Policy Applies	Generic	08/01/18
isoniazid syrup	50mg/5ml	Mandatory Generic Policy Applies	Generic	08/01/18
letrozole	2.5mg	Mandatory Generic Policy Applies	Generic	07/01/16
medroxyprogesterone	2.5mg, 5mg, 10mg	Mandatory Generic Policy Applies	Generic	08/01/18
metformin	500mg, 850mg, 1000mg	Mandatory Generic Policy Applies	Generic	07/01/16
metformin ER	500mg, 750mg	Mandatory Generic Policy Applies	Generic	07/01/16
pediatric vitamins	ADC, multi- w/o Fl & Fe	Mandatory Generic Policy Applies	Brand/ Generic	05/01/19
Prempro	0.3/1.5mg, 0.45/1.5mg, 0.625/2.5mg, 0.625/5mg	Mandatory Generic Policy Applies	Brand	08/01/18
tamoxifen	10mg, 20mg	Mandatory Generic Policy Applies	Generic	08/01/18
trihexylphenidyl	2mg, 5mg	Mandatory Generic Policy Applies	Generic	02/01/18

Utah Medicaid Additional Drug Limits - Effective July 1, 2020

Central Nervous System - Smoking Deterrents				
Generic Name Drugs	**Brand Name Drugs**	**Last Update**	**Limits**	**Additional Note**
Nicotine Replacement Products	All	Not Available	12 years and older	
Varenicline	Chantix	04/01/19	16 years and older	

Emergency Contraceptives				
Generic Name Drugs	**Brand Name Drugs**	**Last Update**	**Limits**	**Additional Note**
Ulipristal	Ella	Not Available	2 kits /30 days	

Gastrointestinal (GI) - Antidiarrheals				
Generic Name Drugs	**Brand Name Drugs**	**Last Update**	**Limits**	**Additional Note**
diphenoxylate/atropine	Lomotil	Not Available	Cumulative limit: 180 tab /30 days	
loperamide		Not Available	Cumulative limit: 180 tab /30 days	

Hematopoietic Growth Factors				
Generic Name Drugs	**Brand Name Drugs**	**Last Update**	**Limits**	**Additional Note**
eltrombopag	Promacta	11/01/18	Cumulative limit: 30 tab /30 days	

Migraine Agents				
Generic Name Drugs	**Brand Name Drugs**	**Last Update**	**Limits**	**Additional Note**
butalbital/apap	Allzital	10/01/19	Cumulative limit: 20 units /30 days	Restricted to members age 18 and older.
butalbital/apap/caf	Fioricet, Esgic	10/01/19	Cumulative limit: 20 units /30 days	Restricted to members age 18 and older.
butalbital/apap/caf/codeine		10/01/19	Cumulative limit: 20 units /30 days	Restricted to members age 18 and older.
butalbital/asa/caf	Fiorinal	10/01/19	Cumulative limit: 20 units /30 days	Restricted to members age 18 and older.
butalbital/asa/caf/codeine	Fiorinal/codeine	10/01/19	Cumulative limit: 20 units /30 days	Restricted to members age 18 and older.

Utah Medicaid Prior Authorizations - Effective July 1, 2020

• **Pharmacy Prior Authorization Forms:** Can be found on the Utah Medicaid website. https://medicaid.utah.gov/pharmacy/prior-authorization

• **Submission:** Fax completed and signed form along with documentation, including chart notes, letter of medical necessity and laboratory results to 855-828-4992.

Non Drug Specific PA Forms

Form	Notes	Last Update
Exception to 3 Month Supply		10/07/19
Medication Coverage Exception Request	Incorporates Brand Name, Combination Products, Continuation of Therapy, Dosing Kits, Non-Preferred Medications, Off-Label Use, Quantity Limit Exceptions, Step Therapy, or an other non specific requests.	07/01/20
New to Market Drug		07/01/20

Drug Class or Disease Specific PA Forms

• **Policy:** Non-Preferred products, per Utah Medicaid's PDL, require trial and failure of a preferred product or the prescriber must demonstrate medical necessity for non-preferred.

Form	Drug Name(s)	Notes	Last Update
ADHD Stimulant			07/01/20
Androgen			01/13/20
Antiemetic			07/01/20
Antipsychotics in Children			07/01/20
Anti-vascular Endothelial Growth Factor Therapy	Avastin, Beovu, Cyramza, Eylea, Lucentis, Macugen, Mvasi, Zaltrap, Zirabev	Covered under the medical benefit using appropriate HCPCS code	07/01/20
Botulinum Toxin		Covered under the medical benefit using appropriate HCPCS code	01/13/20
Buprenorphine & Buprenorphine/Naloxone			06/04/20
CAR-T cell Therapy		Covered under the medical benefit using appropriate HCPCS code	03/28/19
CGRP Antagonist			07/01/20
Cystic Fibrosis Gene Therapy			01/13/20
Growth Hormone			07/01/20
Hepatitis C			01/13/20
HER- 2 Therapy	Enhertu, Herceptin, Herzuma, Kadcyla, Kanjinti, Ogivri, Tukysa	Covered under the medical benefit using appropriate HCPCS code	07/01/20
Immunoglobulin Therapy			07/01/20
Opioid and Opioid Benzodiazepine Combination			01/13/20
PAMORAs			07/01/20
PCSK9 Inhibitors			07/01/20
Pulmonary Arterial Hypertension (PAH)			06/04/20

Drug Specific PA Forms

Brand Name	Generic Name	Notes	Last Update
Adagen	pegademase bovine		03/28/19
Adcetris	brentuximab vedotin		03/28/19

Utah Medicaid Prior Authorizations - Effective July 1, 2020

Drug Specific PA Forms continued			
Brand Name	**Generic Name**	**Notes**	**Last Update**
Aldurazyme	laronidase		03/28/19
Aralast	alpha1 proteinase inhibitor		03/28/19
Ayvakit	avapritinib		06/08/20
Braftovi, Mektovi	encorafenib and binimetinib		03/28/19
Cialis	tadalafil		05/18/20
Crysvita	burosumab-twza		03/28/19
Doptelet	avatrombopag		03/28/19
Dupixent	dupilumab		10/30/19
Emflaza	deflazacort		07/01/20
Exondys 51, Vyondys 53	eteplirsen and golodirsen		01/13/20
Fabrazyme	agalsidase beta		03/28/19
Fasenra	benralizumab		03/28/19
Hemlibra	emicizumab		03/28/19
Iluvien, Yutiq, Retisert	fluocinolone acetonide intravitreal implant		11/20/19
Isturisa	osilodostat		07/01/20
Makena	Compounded Hydroxyprogesterone Caproate/17-p		01/13/20
Krystexxa	Pegloticase		03/28/19
Lidoderm, ZTlido	lidocaine patch		06/04/20
Lucemyra	lofesidine hydrochloride		07/01/20
Lupron	leuprolide acetate, subcutaneous		07/01/20
Luxturna	voretigene neparvovec-rzyl		03/28/19
Mepsevii	vestronidase alfa-vjbk		03/28/19
Methadone	Methadone	Treatment of chronic pain only	07/01/20
Mifeprex	mifepristone		05/13/19
Nexavar	sorafenib		03/28/19
Nocdurna	desmopressin acetate sublingual tablets		11/20/19
Nuedexta	dextromethorphan/quinidine		07/01/20
Nuvigil, Provigil, Sunosi, Wakix	armodafinil, modafinil, solriamfetol, pitolisant		01/13/20
Ocrevus	ocrelizumab		03/28/19
Onpattro, Tegsedi	patisiran, inotersen		03/28/19
Oralair	Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens Allergen Extract		03/28/19
Orilissa	elagolix		07/01/20
Panrentin	Alitretinoin Topical Gel 0.1%		10/16/19
Prolastin, Zemaira	alpha1-proteinase inhibitor		03/28/19
Qbrexza	glycopyrronium		07/01/20
Ravicti, Buphenyl	glycerol phenylbutyrate, sodium phenylbutyrate		03/28/19
Restasis, Cequa	Ophthalmic Cyclosporine		07/01/20
Reyvow	lasmiditan		07/01/20
Rybelsus	semaglutide		07/01/20
Sirturo	bedaquiline		07/01/20

Utah Medicaid Prior Authorizations - Effective July 1, 2020

Drug Specific PA Forms continued			
Brand Name	**Generic Name**	**Notes**	**Last Update**
Spravato	esketamine nasal spray		06/09/20
Sutent	sunitinib		07/01/20
Synagis	Palivizumab		07/01/20
Tepezza	teprotumumab		06/09/20
Xifaxan	rifaximin		02/11/20
Xolair	omalizumab		12/24/19
Xyrem	sodium oxybate		11/07/19
Zulresso	brexanolone	Covered under the medical benefit using appropriate HCPCS code	10/23/19