

Louisiana Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

- The PDL applies to **all** individuals enrolled in Louisiana Medicaid, including those covered by one of the managed care organizations (MCOs) and those in the Fee-for-Service (FFS) program
- The PDL is a list of over 100 therapeutic classes reviewed by the Pharmaceutical & Therapeutics (P&T) committee. With the exception of excluded drug classes listed in the provider manual, medications that are not included in this PDL are almost always covered without the requirement of prior authorization. **Examples: spironolactone, hydrochlorothiazide, amoxicillin suspension**
- To locate any medication on this list, you may use the keyboard shortcut **CTRL + F** to search.
- There is a mandatory generic substitution **unless** the brand is preferred, and the generic is non-preferred. When the brand is preferred and the generic is non-preferred, no special notations are required by the prescriber and the pharmacist enters “9” in the DAW field 408-D8.
- When the brand is non-preferred and the prescriber has determined it to be medically necessary, “Brand medically necessary” or “Brand necessary” must be written on the prescription in the prescriber’s handwriting or noted via an electronic prescription and the pharmacist enters “1” in the DAW field 408-D8. For more information, please refer to the [Provider Manual](#).
- Medications listed as non-preferred are available through the prior authorization process. Each Managed Care Organization (MCO) and Fee-for-Service (FFS) have their own prior authorization departments. All MCOs and FFS use the same [Prior Authorization Request Form](#).
- Some medications require a diagnosis code at the pharmacy to indicate the condition treated or to override a limit, such as quantity, patient age, or duration limit. These medications are found on the [Diagnosis Code List](#).
- New medications in classes reviewed by P&T will be added as non-preferred and require prior authorization until the next P&T committee meeting. Please refer to the following criteria: [New Drugs Introduced into the Market / Non-Preferred](#)
- This PDL/NPDL applies only to medications dispensed in the outpatient retail pharmacy setting.
- Requests for overrides to use a medication outside of established limits, such as diagnosis or quantity limits, can be made according to the: [Medically Necessary Policy](#)
- Any statement highlighted and underlined in blue is a hyperlink to more information.

DIABETIC SUPPLY LIST LINKS BY PLAN	Prior Authorization Information Phone Numbers for MCOs and FFS
AETNA AMERIHEALTH CARITAS LA HEALTHY BLUE LOUISIANA HEALTHCARE CONNECTIONS UNITEDHEALTHCARE	Aetna Better Health of Louisiana 1-855-242-0802 AmeriHealth Caritas Louisiana 1-800-684-5502 Healthy Blue 1-844-521-6942 Louisiana Healthcare Connections 1-888-929-3790 UnitedHealthcare 1-800-310-6826 Fee-for-Service (FFS) Louisiana Legacy Medicaid 1-866-730-4357
Click this Link to View Quantity Limits for Diabetic Test Strips and Lancets for FFS and All MCOs	

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
ACNE AGENTS, TOPICAL (1)	Clindamycin/Benzoyl Peroxide Gel (Generic for Benzaclin®)	Adapalene Cream (Generic; Differin®)
*Request Form *Criteria *POS Edits	Clindamycin/Benzoyl Peroxide Gel (Generic for Duac®)	Adapalene Gel (AG; Generic)
	Clindamycin Phosphate Gel (Generic)	Adapalene Gel Pump (AG; Generic; Differin®)
	Clindamycin Phosphate Lotion (Generic)	Adapalene Lotion (Differin®)
	Clindamycin Phosphate Medicated Swab (Generic)	Adapalene/Benzoyl Peroxide (Generic for Epiduo®)
	Clindamycin Phosphate Solution (Generic)	Adapalene/Benzoyl Peroxide Gel with Pump (AG; Generic; Epiduo Forte®)
	Erythromycin Gel (AG; Generic)	Azelaic Acid (Azelex®)
	Erythromycin Solution (Generic)	Clascoterone Cream (Winlevi®)
	Tretinoin Cream (Retin-A®)	Clindamycin/Benzoyl Peroxide Gel (Neuac®)
		Clindamycin/Benzoyl Peroxide Gel/Emollient Combo 94 (Neuac® Kit)
		Clindamycin/Benzoyl Peroxide Gel with Pump (Generic; Acanya®)
		Clindamycin /Benzoyl Peroxide Gel with Pump (Onexton®)
		Clindamycin/Benzoyl Peroxide Gel (BenzaClin®)
		Clindamycin/Benzoyl Peroxide Gel with Pump (Generic; BenzaClin®)
		Clindamycin Phosphate Gel (AG; Generic; Clindagel®)
		Clindamycin Phosphate Foam (Generic)
		Clindamycin Phosphate Lotion (Cleocin-T®)
		Clindamycin Phosphate/Skin Cleanser 19 (Clindacin® Pac Kit)
		Clindamycin/Tretinoin Gel (AG; Generic; Ziana®)
		Dapsone Gel, Gel with Pump (AG; Generic; Aczone®)
		Erythromycin Medicated Swab (Generic)
		Erythromycin/Benzoyl Peroxide Gel (Generic; Benzamycin®)
		Minocycline Topical Foam (Amzeeq™)
		Sulfacetamide Sodium Cleanser, Cleanser ER (Generic)
		Sulfacetamide Sodium Cleanser ER (Ovace® Plus)
		Sulfacetamide Sodium Cream ER (Ovace® Plus)
		Sulfacetamide Sodium Lotion (Ovace Plus®)
		Sulfacetamide Sodium Shampoo (Generic; Ovace® Plus)
		Sulfacetamide Sodium Suspension (Generic)
		Sulfacetamide Sodium Wash (Ovace® Plus)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
ACNE AGENTS, TOPICAL (1) Continued	(Preferred agents listed on page 1)	Sulfacetamide Sodium/Sulfur Wash (BP 10-1®) Sulfacetamide Sodium/Sulfur (Generic) Sulfacetamide Sodium/Sulfur (Avar®-e) Sulfacetamide Sodium/Sulfur Cleanser (Avar®) Sulfacetamide Sodium/Sulfur Cleanser (Avar® LS) Sulfacetamide Sodium/Sulfur Cleanser (Generic) Sulfacetamide Sodium/Sulfur/Cleanser 23 Kit (Generic; Sumaxin® CP Kit) Sulfacetamide Sodium/Sulfur Cream (Generic) Sulfacetamide Sodium/Sulfur Foam (SSS 10-5®) Sulfacetamide Sodium/Sulfur Lotion (Generic) Sulfacetamide Sodium/Sulfur Medicated Pads (Generic) Sulfacetamide Sodium/Sulfur Suspension (Generic) Sulfacetamide Sodium/Sulfur/Urea Cleanser (Generic) Tazarotene Foam (AG; Fabior®) Tazarotene Cream (AG; Generic; Tazorac®) Tazarotene Gel (Tazorac®) Tazarotene Lotion (Arazlo™) Tretinoin Lotion (Altreno®) Tretinoin Cream (Avita®) Tretinoin Cream (Generic) Tretinoin Gel (Generic; Atralin®) Tretinoin Gel (AG; Generic; Avita®) Tretinoin Gel (AG; Generic; Retin-A®) Tretinoin 0.06% Gel with Pump (Retin-A® Micro) Tretinoin 0.04% & 0.1% Gel (AG; Retin-A® Micro) Tretinoin 0.04% & 0.1% Gel with Pump (AG; Generic; Retin-A® Micro) Tretinoin 0.08% Pump (Retin-A® Micro) Tretinoin Cream (Tretin-X®) Tretinoin/Emollient 9/Skin Cleanser 1 (Tretin-X® Combo Pack) Trifarotene Cream (Aklief®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
ADD/ADHD (2)	Amphetamine Salt Combo ER Capsule (Adderall XR®)	Amphetamine ER Suspension (AG; Adzenys ER®)
Stimulants and Related Agents	Amphetamine Salt Combo Tablet (Generic; Adderall®)	Amphetamine ODT (Adzenys XR ODT®)
*Request Form *Criteria *POS Edits	Dexmethylphenidate ER Capsule (AG; Generic)	Amphetamine Salt Combo ER Capsule (AG; Generic)
	Dexmethylphenidate Tablet (AG; Generic)	Amphetamine Sulfate Tablet (Generic; Evekeo®)
	Dextroamphetamine Tablet (Generic)	Amphetamine Sulfate ODT (Evekeo® ODT)
	Atomoxetine Capsule (AG; Generic)	Amphetamine/Dextroamphetamine XR Capsule (Mydayis®)
	Guanfacine ER Tablet (Generic)	Armodafinil Tablet (AG; Generic; Nuvigil®)
	Lisdexamfetamine Capsule (Vyvanse®)	Atomoxetine Capsule (Strattera®)
	Lisdexamfetamine Chewable Tablet (Vyvanse®)	Clonidine ER Tablet (Generic)
	Methylphenidate CD Capsule (AG; Generic for Metadate CD®)	Dexmethylphenidate ER Capsule (Focalin XR®)
	Methylphenidate ER Capsule (Generic for Ritalin LA®)	Dexmethylphenidate Tablet (Focalin®)
	Methylphenidate ER Chewable (QuilliChew ER®)	Dextroamphetamine IR Tablet (Zenedi®)
	Methylphenidate ER Suspension (Quillivant XR®)	Dextroamphetamine Solution (Generic; ProCentra®)
	Methylphenidate ER Tablet (AG; Generic for Concerta®)	Dextroamphetamine Sulfate ER Capsule (Generic; Dexedrine® Spansule®)
	Methylphenidate IR Tablet (Generic)	Amphetamine Suspension (Dyanavel XR®)
	Methylphenidate Solution (Generic)	Guanfacine ER Tablet (Intuniv®)
	Modafinil Tablet (Generic)	Methamphetamine Tablet (Generic; Desoxyn®)
		Methylphenidate ER Capsule (Adhansia XR™)
		Methylphenidate ER Capsule (AG; Generic; Aptensio XR®)
		Methylphenidate ER Capsule (Jornay PM®, Ritalin LA®)
		Methylphenidate ER Tablet (Concerta®)
		Methylphenidate ER Tablet (Generic for Metadate ER)
		Methylphenidate ER Tablet 72 mg (Generic; Relexxii™)
		Methylphenidate IR Chewable Tablet (Generic)
		Methylphenidate IR Tablet (Ritalin®)
		Methylphenidate Transdermal Patch (Daytrana®)
		Methylphenidate Solution (Methylin®)
		Methylphenidate XR ODT (Cotempla XR ODT®)
		Modafinil Tablet (Provigil®)
		Pitolisant HCl Tablet (Wakix®)
		Serdexmethylphenidate/Dexmethylphenidate Capsule (Azstarys™)
		Solriamfetol HCl Tablet (Sunosi™)
		Viloxazine ER Capsule (Qelbree™)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
ALLERGY (3)	Cetirizine 1 mg/mL Solution OTC, Tablet OTC (Generic)	Cetirizine Capsule OTC, Chewable Tablet OTC, 5 mg/5mL Solution OTC (Generic)
Antihistamines – Minimally Sedating	Cetirizine Solution RX (1 mg/mL) (Generic)	Desloratadine Tablet (Generic; Clarinex®)
*Request Form *Criteria *POS Edits	Cetirizine-D Tablet OTC (Generic)	Desloratadine ODT (Generic)
	Levocetirizine Tablet OTC (Generic)	Desloratadine/Pseudoephedrine ER Tablet (Clarinex-D 12-Hour®)
	Levocetirizine Tablet (Generic)	Fexofenadine 60 mg Tablet OTC, 180 mg Tablet OTC (Generic)
	Loratadine ODT OTC, Solution OTC, Tablet OTC (Generic)	Fexofenadine-D 12-hour Tablet OTC (Generic)
	Loratadine-D Tablet OTC (Generic)	Levocetirizine Solution (Generic)
		Loratadine Chewable Tablet OTC (Generic)
ALLERGY (3)	Azelastine Nasal Spray (Generic for Astelin®)	Azelastine/Fluticasone Nasal Spray (AG; Generic; Dymista®)
Rhinitis Agents, Nasal	Azelastine Nasal Spray (AG; Generic for Astepro®)	Beclomethasone Nasal Spray (Beconase AQ®; Qnasl 40®; Qnasl 80®)
*Request Form *Criteria *POS Edits	Fluticasone Propionate Nasal Spray (Generic)	Ciclesonide Nasal Spray (Omnaris®; Zetonna®)
	Ipratropium Bromide Nasal Spray (Generic)	Flunisolide Nasal Spray (Generic)
		Fluticasone Propionate Nasal Spray (Xhance®)
		Mometasone Nasal Spray (Generic; Nasonex®)
		Mometasone Furoate Implant (Sinuva™)
		Olopatadine Nasal Spray (AG; Generic; Patanase®)
ALZHEIMER'S AGENTS (4)	Donepezil ODT, Tablet (Generic)	Aducanumab-avwa IV Solution (Aduhelm™)
Cholinesterase Inhibitors	Memantine Tablet (AG; Generic)	Donepezil Tablet (Aricept®)
*Request Form *Criteria *POS Edits *Aduhelm™ REQUEST FORM	Rivastigmine Transdermal Patch (AG; Generic)	Donepezil 23 mg Tablet (Generic)
		Galantamine Solution, Tablet (Generic)
		Galantamine ER Capsule (Generic)
		Memantine ER Capsule (AG; Generic; Namenda XR®)
		Memantine ER Capsule Dose Pack (Namenda XR® Titration Pack)
		Memantine Solution (Generic)
		Memantine Tablet (Namenda®)
		Memantine Tablet Dose Pack (AG; Namenda® Titration Pack)
		Memantine/Donepezil ER Capsule (Namzaric®, Namzaric® Titration Pack)
		Rivastigmine Capsule (Generic)
		Rivastigmine Transdermal Patch (Exelon®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
ANDROGENIC AGENTS (5)	Testosterone Transdermal System (Androderm®)	Testosterone Gel (Testim®)
*Request Form *Criteria *POS Edits	Testosterone Gel (AG for Vogelxo®; Generic for Vogelxo®)	Testosterone Gel Packet (Generic; Androgel®)
	Testosterone Gel Packet (AG for Vogelxo®)	Testosterone Gel Pump (Generic Axiron®)
	Testosterone Gel Pump (Generic for Androgel®)	Testosterone Gel Pump (Androgel®)
	Testosterone Gel Pump (AG for Vogelxo®)	Testosterone Gel Pump (Generic; Vogelxo®)
		Testosterone Gel Pump (AG; Generic; Fortesta®)
		Testosterone Nasal (Natesto®)
ANTHELMINTICS (6)	Albendazole Tablet (Generic)	Albendazole Tablet (Albenza®)
*Request Form *Criteria *POS Edits	Ivermectin Tablet (Generic)	Ivermectin Tablet (Stromectol®)
	Mebendazole Chewable Tablet (Emverm®)	Praziquantel Tablet (Biltricide®)
	Praziquantel Tablet (Generic)	
ANTI-ALLERGENS, ORAL (7)	NONE	Mixed Grass Allergen Extracts Sublingual Tablet (Oralair®)
*Request Form *Criteria *POS Edits		Peanut Allergen Titration Capsule (Palforzia®)
		Peanut Allergen Maintenance Sachet (Palforzia®)
ANTICONSULSANTS (8)	Brivaracetam Solution, Tablet (Briviact®)	Carbamazepine ER Capsule (Equetro®)
*Request Form *Criteria *POS Edits	Cannabidiol Solution (Epidiolex®)	Carbamazepine ER Capsule (Generic for Carbatrol®)
	Carbamazepine Chewable Tablet (Generic)	Carbamazepine ER Tablet (AG; Generic)
	Carbamazepine ER Capsule (Carbatrol®)	Carbamazepine Suspension (Generic; Tegretol®)
	Carbamazepine ER Tablet (Tegretol® XR)	Carbamazepine Tablet (Tegretol®)
	Carbamazepine Tablet (Generic)	Clobazam Film (Sympazan®)
	Cenobamate Daily Dose Pack, Tablet, Titration Pack (Xcopri®)	Clobazam Suspension, Tablet (Onfi®)
	Clobazam Suspension, Tablet (Generic)	Clonazepam Tablet (Klonopin®)
	Clonazepam ODT, Tablet (Generic)	Diazepam Rectal (AG)
	Diazepam Nasal Spray (Valtoco®)	Diazepam Rectal Device (AG)
	Diazepam Rectal (Diastat®)	Divalproex Sodium DR Tablet, ER Tablet (Depakote®; Depakote® ER)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
ANTICONVULSANTS (8) Continued	Diazepam Rectal Device (Diastat® AcuDia TM)	Divalproex Sodium DR Sprinkle (Generic)
	Divalproex ER Tablet (Generic)	Ethosuximide Capsule, Syrup (Zarontin®)
	Divalproex Sodium DR Sprinkle (Depakote® Sprinkles)	Felbamate Suspension (Felbatol®)
	Divalproex DR Tablet (Generic)	Fenfluramine Solution (Fintepla®)
	Eslicarbazepine Acetate Tablet (Aptiom®)	Lamotrigine Dispersible Tablet, ODT, Tablet (Lamictal®)
	Ethosuximide Capsule (AG; Generic)	Lamotrigine ODT Titration Kit, Tablet Starter Kit (Generic; Lamictal®)
	Ethosuximide Syrup (Generic)	Lamotrigine ER Tablet, Titration Kit (Lamictal® XR)
	Felbamate Suspension (Generic)	Levetiracetam ER Tablet (Keppra XR®)
	Felbamate Tablet (Generic; Felbatol®)	Levetiracetam Tablet for Oral Suspension (Spritam®)
	Lacosamide Solution, Tablet (Vimpat®)	Levetiracetam Solution, Tablet (Keppra®)
	Lamotrigine Dispersible Tablet, ER Tablet, ODT, Tablet (Generic)	Levetiracetam ER Tablet (Elepsia TM XR)
	Levetiracetam ER Tablet, Solution, Tablet (Generic)	Midazolam Nasal Spray (Nayzilam®)
	Methsuximide Capsule (Celontin®)	Oxcarbazepine Suspension (Generic)
	Oxcarbazepine Suspension (Trileptal®)	Oxcarbazepine Tablet (Trileptal®)
	Oxcarbazepine Tablet (Generic)	Phenytoin 100mg Capsule (Dilantin®)
	Oxcarbazepine XR Tablet (Oxtellar XR®)	Phenytoin Chewable Tablet (Dilantin® Infatabs®)
	Perampanel Suspension, Tablet (Fycompa®)	Phenytoin Sodium Capsule (Phenytek®)
	Phenobarbital Elixir, Tablet (Generic)	Phenytoin Suspension (Dilantin®)
	Phenytoin 100mg Capsule (Generic)	Primidone Tablet (Mysoline®)
	Phenytoin 30 mg Capsule (Dilantin®)	Rufinamide Suspension, Tablet (Generic)
	Phenytoin Chewable Tablet (Generic)	Tiagabine Tablet (Generic; Gabitril®)
	Phenytoin Sodium Capsule (Generic for Phenytek®)	Topiramate ER Capsule (Generic; Qudexy® XR)
	Phenytoin Suspension (AG; Generic)	Topiramate ER Capsule (Trokendi XR®)
	Primidone Tablet (Generic)	Topiramate Solution (Eprontia TM)
	Rufinamide Suspension, Tablet (Banzel®)	Topiramate Sprinkle, Tablet (Topamax®)
	Stiripentol Capsule, Powder Pack (Diacomit®)	Vigabatrin Powder Pack (Generic; Vigadrone®)
	Topiramate ER Capsule (AG for Qudexy® XR)	Vigabatrin Tablet (Generic)
	Topiramate Sprinkle, Tablet (Generic)	
	Valproic Acid Capsule, Solution (Generic)	
	Vigabatrin Powder Pack, Tablet (Sabril®)	
	Zonisamide Capsule (Generic)	

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
ANTIPSYCHOTIC AGENTS (9)	ORAL AGENTS	ORAL AGENTS
Antipsychotic Oral/Transdermal Agents	Aripiprazole Tablet (Generic)	Aripiprazole ODT, Solution (Generic)
*Request Form *Criteria *POS Edits ***Prior Use Requirement for Vraylar® and Latuda® - See POS Edits	Cariprazine Capsule, Therapy Pack (Vraylar®)***	Aripiprazole Tablet, Tablet with Sensor (Abilify®; Abilify® Mycite®)
	Chlorpromazine Oral Concentrate, Tablet (Generic)	Asenapine Sublingual Tablet (AG; Generic; Saphris®)
	Clozapine Tablet (AG; Generic)	Asenapine Transdermal Patch (Secuado®)
	Fluphenazine Tablet (Generic)	Brexipiprazole Tablet (Rexulti®)
	Haloperidol Tablet (Generic)	Clozapine ODT (AG; Generic)
	Haloperidol Lactate Oral Concentrate (Generic)	Clozapine Tablet (Clozaril®)
	Loxapine Capsule (Generic)	Clozapine Suspension (Versacloz®)
	Lurasidone Tablet (Latuda®)***	Fluphenazine Elixir/Solution (Generic)
	Olanzapine ODT, Tablet (Generic)	Iloperidone Tablet, Titration Pack (Fanapt®)
	Perphenazine Tablet (Generic)	Loxapine Inhalation (Adasuve®)
	Perphenazine/Amitriptyline Tablet (Generic)	Lumateperone Capsule (Caplyta™)
	Pimozide Tablet (Generic)	Molindone Tablet (Generic)
	Quetiapine ER Tablet (Generic)	Olanzapine Tablet, ODT (Zyprexa®; Zyprexa Zydis®)
	Quetiapine Tablet (Generic)	Olanzapine/Fluoxetine Capsule (Generic; Symbyax®)
	Risperidone Solution, Tablet (Generic)	Olanzapine/Samidorphan (Lybalvi™)
	Thioridazine Tablet (Generic)	Paliperidone ER Tablet (AG; Generic; Invega®)
	Thiothixene Capsule (Generic)	Pimavanserin Capsule, Tablet (Nuplazid®)
	Trifluoperazine Tablet (Generic)	Quetiapine ER Tablet, Tablet (Seroquel XR®; Seroquel®)
	Ziprasidone Capsule (Generic)	Risperidone ODT (Generic)
		Risperidone Solution, Tablet (Risperdal®)
		Ziprasidone Capsule (Geodon®)
ANTIPSYCHOTIC AGENTS (9)	INJECTABLE AGENTS	INJECTABLE AGENTS
Antipsychotic Injectable Agents	Aripiprazole Lauroxil (Aristada®; Aristada® Initio®)	Chlorpromazine Ampule (Generic)
*Request Form *Criteria *POS Edits	Aripiprazole Suspension ER (Abilify Maintena®)	Fluphenazine Vial (Generic)
	Fluphenazine Decanoate (Generic)	Haloperidol Decanoate Ampule (Haldol®)
	Haloperidol Decanoate, Lactate (Generic)	Olanzapine Solution (Generic; Zyprexa®)
	Paliperidone Syringe (Invega® Sustenna®; Invega® Trinza®)	Olanzapine Suspension (Zyprexa® Relprevv®)
	Risperidone ER Suspension (Intramuscular) (Risperdal® Consta®)	Paliperidone Syringe (Invega® Hafyera®)
	Risperidone ER Suspension (Subcutaneous) (Perseris®)	
	Ziprasidone Vial (Generic ; Geodon®)	

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
ANTIVIRALS, ORAL (10)	Acyclovir Capsule, Suspension, Tablet (Generic)	Acyclovir Buccal Tablet (Sitavig®)
*Request Form *Criteria *POS Edits	Famciclovir Tablet (Generic)	Baloxavir Marboxil (Xofluza®)
	Oseltamivir Capsule, Suspension (Generic)	Oseltamivir Capsule, Suspension (Tamiflu®)
	Valacyclovir Tablet (Generic)	Rimantadine Tablet (Generic)
		Valacyclovir Caplet (Valtrex®)
		Zanamivir Inhalation Powder (Relenza® Diskhaler®)
ANXIOLYTICS (11)	Alprazolam Tablet (Generic)	Alprazolam ER Tablet (Generic; Xanax XR®)
*Request Form *Criteria *POS Edits	Buspirone Tablet (Generic)	Alprazolam Intensol Concentrate, ODT (Generic)
	Lorazepam Tablet (Generic)	Alprazolam Tablet (Xanax®)
		Chlordiazepoxide Capsule (Generic)
		Clorazepate Dipotassium Tablet (Generic)
		Diazepam Intensol Concentrate, Solution, Syringe, Tablet, Vial (Generic)
		Lorazepam ER Capsule (Loreev XR™)
		Lorazepam Intensol Concentrate (Generic)
		Lorazepam Tablet (Ativan®)
		Meprobamate Tablet (Generic)
		Oxazepam Capsule (Generic)
ASTHMA/COPD (12)	INHALATION	INHALATION
Bronchodilator, Anticholinergics (COPD) Inhalation	Ipratropium Inhalation Aerosol MDI (Atrovent HFA®)	Acclidinium Bromide/Formoterol Fumarate (Duaklir® Pressair®)
	Ipratropium Nebulizer Solution (Generic)	Acclidinium Bromide Inhalation Powder (Tudorza® Pressair®)
*Request Form *Criteria *POS Edits	Ipratropium/Albuterol Sulfate (Combivent® Respimat®)	Glycopyrrolate/Formoterol Fumarate (Bevespi Aerosphere®)
	Ipratropium/Albuterol Sulfate Nebulizer Solution (Generic)	Glycopyrrolate Inhalation Solution (Lonhala® Magnair®)
	Tiotropium Inhalation Powder (Spiriva® HandiHaler®)	Revefenacin Inhalation Solution (Yupelri®)
	Tiotropium/Olodaterol (Stiolto® Respimat®)	Tiotropium Bromide Inhalation Spray (Spiriva® Respimat®)
	Umeclidinium/Vilanterol Inhalation Powder (Anoro® Ellipta®)	Umeclidinium Inhalation Powder (Incruse® Ellipta®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
ASTHMA/COPD (12)	ORAL	ORAL
Bronchodilator, Anticholinergics (COPD) Oral	NONE	Roflumilast Tablet (Daliresp®)
*Request Form *Criteria *POS Edits		
ASTHMA/COPD (12)	INHALATION	INHALATION
Bronchodilator, Beta-Adrenergic Inhalation Agents	Albuterol Sulfate Nebulizer Solution 0.63 mg/3 mL (Generic)	Albuterol Sulfate MDI (Proventil HFA®)
	Albuterol Sulfate Nebulizer Solution 1.25 mg/3 mL (Generic)	Albuterol Sulfate MDI (Ventolin HFA®)
*Request Form *Criteria *POS Edits	Albuterol Sulfate Nebulizer Solution 2.5 mg/3 mL (Generic)	Albuterol Sulfate Inhalation Powder (ProAir® Digihaler™)
	Albuterol Sulfate Nebulizer Solution 100 mg/20 mL (Generic)	Albuterol Sulfate Inhalation Powder (ProAir® RespiClick®)
	Albuterol Sulfate Nebulizer Solution 2.5 mg/0.5 mL (Generic)	Arformoterol Inhalation Solution (AG; Generic; Brovana®)
	Albuterol Sulfate MDI (AG; Generic; ProAir HFA®)	Formoterol Inhalation Solution (AG; Generic; Perforomist®)
	Albuterol Sulfate MDI (AG; Generic for Proventil HFA®)	Levalbuterol Nebulizer Solution (Generic; Xopenex®)
	Albuterol Sulfate MDI (AG for Ventolin HFA®)	Levalbuterol Nebulizer Solution Concentrate (Generic; Xopenex®)
	Salmeterol Xinafoate (Serevent® Diskus®)	Levalbuterol MDI (AG; Xopenex HFA®)
		Olodaterol (Striverdi® Respimat®)
ASTHMA/COPD (12)	ORAL	ORAL
Bronchodilator, Beta-Adrenergic Oral Agents	Albuterol Sulfate Syrup (Generic)	Albuterol Sulfate ER Tablet (Generic)
*Request Form *Criteria *POS Edits		Albuterol Sulfate Tablet (Generic)
		Metaproterenol Sulfate Syrup (Generic)
		Terbutaline Sulfate Tablet (AG; Generic)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
ASTHMA/COPD (12)	Budesonide Respules 0.25 mg, 0.5 mg, 1 mg (Generic)	Beclomethasone Breath-Actuated HFA (QVAR® RediHaler®)
Glucocorticoids, Inhalation	Budesonide/Formoterol MDI (Symbicort®)	Budesonide DPI (Pulmicort® Flexhaler®)
*Request Form *Criteria *POS Edits	Fluticasone MDI (Flovent® HFA)	Budesonide Respules 0.25 mg, 0.5 mg, 1 mg (Pulmicort® Respules®)
	Fluticasone/Salmeterol DPI (Advair® Diskus®)	Budesonide/Formoterol Inhalation (AG for Symbicort®)
	Fluticasone/Salmeterol MDI (Advair HFA®)	Budesonide/Glycopyrrolate/Formoterol Inhalation (Breztri Aerosphere™)
	Mometasone Inhalation Powder (Asmanex® Twisthaler®)	Ciclesonide MDI (Alvesco®)
	Mometasone/Formoterol MDI (Dulera®)	Fluticasone Furoate Inhalation Powder (Arnuity Ellipta®)
		Fluticasone Propionate Inhalation Powder (Armonair® Digihaler™)
		Fluticasone Propionate Inhalation Powder (Flovent® Diskus®)
		Fluticasone/Salmeterol Inhalation Powder (AG; AirDuo® RespiClick®)
		Fluticasone/Salmeterol Inhalation Powder (AirDuo® Digihaler™)
		Fluticasone/Salmeterol DPI (AG; Generic for Advair Diskus®, Wixela Inhub®)
		Fluticasone/Vilanterol Inhalation Powder (Breo Ellipta®)
		Fluticasone/Umeclidinium/Vilanterol Inhalation Powder (Trelegy Ellipta®)
		Mometasone Furoate MDI (Asmanex HFA®)
ASTHMA/COPD (12)	Benralizumab Pen (Fasenra®)	Mepolizumab Auto-Injector (Nucala®)
Immunomodulators	Benralizumab Syringe (Fasenra®)	Mepolizumab Syringe (Nucala®)
*Request Form *Criteria *POS Edits	Omalizumab Syringe (Xolair®)	Mepolizumab Vial (Nucala®)
	Omalizumab Vial (Xolair®)	Reslizumab Vial (Cinqair®)
ASTHMA/COPD (12)	Montelukast Chewable Tablet (Generic)	Montelukast Chewable Tablet (Singulair®)
Leukotriene Modifiers	Montelukast Tablet (Generic)	Montelukast Granules (Generic; Singulair®)
*Request Form *Criteria *POS Edits		Montelukast Tablet (Singulair®)
		Zafirlukast Tablet (Generic; Accolate®)
		Zileuton ER Tablet (Generic)
		Zileuton Tablet (Zyflo®)
BOTULINUM TOXINS (13)	AbobotulinumtoxinA (Dysport®)	IncobotulinumtoxinA (Xeomin®)
*Request Form *Criteria *POS Edits	OnabotulinumtoxinA (Botox®)	RimabotulinumtoxinB (Myobloc®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
COLONY STIMULATING FACTORS (14)	Filgrastim Syringe, Vial (Neupogen®)	Filgrastim-aafi Syringe, Vial (Nivestym®)
*Request Form *Criteria *POS Edits	Pegfilgrastim-apgf Syringe (Nyvepria®)	Filgrastim-sndz Syringe (Zarxio®)
	Pegfilgrastim-jmdb Syringe (Fulphila®)	Pegfilgrastim Kit, Syringe (Neulasta®)
	Tbo-Filgrastim Vial (Granix®)	Pegfilgrastim-bmez Syringe (Ziextenzo®)
		Pegfilgrastim-cbqv Syringe (Udenyca®)
		Sargramostim Vial (Leukine®)
		Tbo-Filgrastim Injection Syringe (Granix®)
CYSTIC FIBROSIS, ORAL (15)	NONE	Elexacaftor/Tezacaftor/Ivacaftor Tablet (Trikafta®)
*Request Form *Criteria *POS Edits		Ivacaftor Packet, Tablet (Kalydeco®)
		Lumacaftor/Ivacaftor Packet, Tablet (Orkambi®)
		Mannitol Inhalation (Bronchitol®)
		Tezacaftor/Ivacaftor Tablet (Symdeko®)
DEPRESSION (16)	Bupropion HCl IR Tablet (Generic)	Brexanolone IV Solution (Zulresso™)
Antidepressants, Other	Bupropion HCl SR 12-Hour Tablet (Generic)	Bupropion HBr ER 24-Hour Tablet (Aplenzin®)
*Request Form *Criteria *POS Edits	Bupropion HCl XL 24-Hour Tablet (Generic)	Bupropion HCl SR 12-Hour (Wellbutrin SR®)
	Mirtazapine ODT (Generic)	Bupropion HCl XL (AG; Forfivo XL®)
	Mirtazapine Tablet (Generic)	Bupropion HCl XL 24-Hour (Wellbutrin XL®)
	Trazodone Tablet (Generic)	Desvenlafaxine ER (No Brand)
	Venlafaxine ER Capsule (Generic)	Desvenlafaxine Succinate ER Tablet (AG; Generic; Pristiq®)
	Venlafaxine IR Tablet (Generic)	Esketamine Nasal Spray (Spravato®)
		Isocarboxazid Tablet (Marplan®)
		Levomilnacipran ER Capsule, Titration Pack (Fetzima®)
		Mirtazapine ODT, Tablet (Remeron® ODT; Remeron®)
		Nefazodone Tablet (Generic)
		Phenelzine Tablet (Generic)
		Selegiline Transdermal Patch (Emsam®)
		Tranycypromine Sulfate Tablet (Generic)
		Venlafaxine ER Capsule (Effexor XR®)
		Venlafaxine ER Tablet (AG; Generic)
		Vilazodone Dose Pack, Tablet (Viibryd® Starter Pack; Viibryd®)
		Vortioxetine Tablet (Trintellix®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
DEPRESSION (16)	Citalopram Solution, Tablet (Generic)	Citalopram Tablet (Celexa®)
Selective Serotonin Reuptake Inhibitors (SSRIs) *Request Form *Criteria *POS Edits	Escitalopram Tablet (Generic)	Escitalopram Solution (Generic)
	Fluoxetine Capsule, Solution (Generic)	Escitalopram Tablet (Lexapro®)
	Fluvoxamine Maleate Tablet (Generic)	Fluoxetine Capsule (Prozac®)
	Paroxetine Tablet (Generic)	Fluoxetine Delayed Release Capsule, Tablet, 60mg Tablet (Generic)
	Sertraline Concentrate, Tablet (Generic)	Fluvoxamine Maleate ER Capsule (Generic)
		Paroxetine Suspension, Tablet (Paxil®)
		Paroxetine CR Tablet (AG; Generic; Paxil CR®)
		Paroxetine Mesylate Capsule (AG; Generic; Brisdelle®)
		Paroxetine Mesylate Tablet (Pexeva®)
		Sertraline Concentrate, Tablet (Zoloft®)
DERMATOLOGY (17)	Mupirocin Ointment (Generic)	Gentamicin Sulfate Cream, Ointment (Generic)
Antibiotics, Topical		Mupirocin Cream (Generic)
*Request Form		Mupirocin Ointment (Centany®; Centany® Kit)
*Criteria		Ozenoxacin Cream (Xepi®)
*POS Edits		
DERMATOLOGY (17)	Clotrimazole Rx Cream (Generic)	Benzoic Acid/ Salicylic Acid Ointment (Bensal HP®)
Antifungals, Topical	Clotrimazole Rx Solution (Generic)	Butenafine Cream (Mentax®)
*Request Form	Clotrimazole/Betamethasone Cream (Generic)	Ciclopirox Cream, Gel, 8% Solution (Generic)
*Criteria	Ketoconazole Cream (Generic)	Ciclopirox 0.77% Suspension (AG; Generic)
*POS Edits	Ketoconazole Shampoo Rx (Generic)	Ciclopirox Shampoo (Generic; Loprox®)
	Nystatin Cream (Generic)	Ciclopirox 8% Solution Treatment Kit (Generic)
	Nystatin Ointment (Generic)	Ciclopirox/Skin Cleanser No. 40 (Loprox® Kit)
	Nystatin Topical Powder (Generic)	Clotrimazole/Betamethasone Lotion (Generic)
	Nystatin/Triamcinolone Cream (Generic)	Econazole Nitrate Cream (Generic)
	Nystatin/Triamcinolone Ointment (Generic)	Econazole Nitrate Cream/Triamcinolone Acetonide Cream Kit (Triamazole®)
		Efinaconazole Solution (Jublia®)
		Ketoconazole Foam (AG; Generic)
		Luliconazole Cream (AG; Luzu®)
		Miconazole/Zinc Oxide/White Petrolatum (AG; Vusion®)
		Naftifine Cream (Generic)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
DERMATOLOGY (17)	(Preferred agents listed on page 12)	Naftifine Gel (Generic; Naftin®)
Antifungals, Topical		Oxiconazole Lotion (Oxistat®)
		Oxiconazole Cream (Generic; Oxistat®)
		Salicylic Acid (Bensal HP®)
		Sertaconazole Cream (Ertaczo®)
		Sulconazole Cream, Solution (AG; Exelderm®)
		Tavaborole Solution (Generic; Kerydin®)
DERMATOLOGY (17)	Permethrin Cream (Generic)	Crotamiton Cream, Lotion (Eurax®)
Antiparasitic Agents, Topical	Spinosad Suspension (Natroba®)	Crotamiton Lotion (Crotan®)
* Request Form * Criteria * POS Edits		Ivermectin Lotion (Generic; Sklice®)
		Lindane Shampoo (Generic)
		Malathion Lotion (Generic; Ovide®)
		Spinosad Suspension (Generic)
DERMATOLOGY (17)	Acitretin Capsule (AG; Generic)	Acitretin Capsule (Soriatane®)
Antipsoriatics, Oral		Methoxsalen Rapid Softgel (Generic)
* Request Form * Criteria * POS Edits		
DERMATOLOGY (17)	Calcipotriene Cream (Generic)	Calcipotriene Cream (Dovonex®)
Antipsoriatics, Topical	Calcipotriene Solution (Generic)	Calcipotriene Ointment (Generic)
* Request Form * Criteria * POS Edits		Calcipotriene Foam (AG; Sorilux®)
		Calcipotriene/Betamethasone Dipropionate Foam (Enstilar®)
		Calcipotriene/Betamethasone Dipropionate Ointment (AG; Generic; Taclonex®)
		Calcipotriene/Betamethasone Dipropionate Suspension (AG; Generic; Taclonex Scalp®)
		Calcitriol Ointment (Generic; Vectical®)
		Halobetasol/Tazarotene Lotion (Duobrii®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
DERMATOLOGY (17)	Acyclovir Ointment (Generic)	Acyclovir Cream (AG; Generic; Zovirax®)
Antiviral Agents, Topical		Acyclovir Ointment (Zovirax®)
*Request Form		Acyclovir/Hydrocortisone (Xerese®)
*Criteria		Penciclovir Cream (Denavir®)
*POS Edits		
DERMATOLOGY (17)	Crisaborole Ointment (Eucrisa®)	Dupilumab Pen (Dupixent®)
Atopic Dermatitis Immunomodulators	Pimecrolimus Cream (Elidel®)	Dupilumab Syringe (Dupixent®)
*Request Form		Pimecrolimus Cream (AG; Generic)
*Criteria		Ruxolitinib Cream (Opzelura™)
*POS Edits		Tacrolimus Ointment (AG; Generic; Protopic®)
		Tralokinumab-ldrm Injection (Adbry™)
DERMATOLOGY (17)	Ammonium Lactate Cream, Lotion (Generic)	Emollient Combination No. 10 (Biafine® Emulsion)
Emollients		Hyaluronic Acid/Grape Seed Extract/Vitamin C & E (Atopiclair®)
*Request Form		
*Criteria		
*POS Edits		
DERMATOLOGY (17)	Imiquimod 5% Cream Packet (Generic for Aldara®)	Imiquimod 5% Cream Packet (Aldara®)
Immunomodulators, Topical	Podofilox Gel (Condylox®)	Imiquimod (Generic; Zyclara®)
*Request Form		Podofilox Solution (Generic)
*Criteria		Sinecatechins (Veregen®)
*POS Edits		
DERMATOLOGY (17)	Hydrocortisone Cream (Generic)	Alclometasone Dipropionate Cream, Ointment (Generic)
Steroids, Topical	Hydrocortisone Lotion (Generic)	Desonide Cream, Lotion, Ointment (Generic)
Low Potency	Hydrocortisone Ointment (Generic)	Desonide Gel (Desonate®)
*Request Form		Fluocinolone Acetonide 0.01% Body Oil (Generic; Derma-Smoothe/FS®)
*Criteria		Fluocinolone Acetonide 0.01% Scalp Oil (Generic; Derma-Smoothe/FS®)
*POS Edits		Fluocinolone Acetonide Shampoo (Capex®)
		Hydrocortisone Solution (Texacort®)
		Hydrocortisone/Skin Cleanser No.25 (Aqua Glycolic HC®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
DERMATOLOGY (17)	Fluticasone Propionate Cream (Generic)	Betamethasone Valerate Foam (Generic)
Steroids, Topical	Fluticasone Propionate Ointment (Generic)	Clocortolone Pivalate Cream (AG; Cloderm®)
Medium Potency	Mometasone Furoate Cream (Generic)	Fluocinolone Acetonide Cream, Solution (Generic)
*Request Form *Criteria *POS Edits	Mometasone Furoate Ointment (Generic)	Fluocinolone Acetonide Ointment (Generic; Synalar®)
	Mometasone Furoate Solution (Generic)	Fluocinolone Acetonide/Emollient No. 65 Cream Kit, Ointment Kit (Synalar®)
		Fluocinolone Acetonide/Skin Cleanser No.28 Kit (Synalar® TS)
		Flurandrenolide Cream, Ointment (Generic)
		Flurandrenolide Lotion (AG; Generic)
		Fluticasone Propionate Lotion (Generic; Beser™)
		Fluticasone Propionate Lotion Kit (Beser™)
		Hydrocortisone Butyrate Cream, Lotion (AG; Generic)
		Hydrocortisone Butyrate Solution, Ointment (Generic)
		Hydrocortisone Butyrate/Emollient (AG; Generic)
		Hydrocortisone Probutate Cream (Pandel®)
		Hydrocortisone Valerate Cream, Ointment (Generic)
		Prednicarbate Cream; Ointment (Generic)
DERMATOLOGY (17)	Betamethasone Dipropionate/Propylene Glycol Cream (Generic)	Amcinonide Cream, Lotion (Generic)
Steroids, Topical	Betamethasone Valerate Cream (Generic)	Betamethasone Dipropionate Cream, Gel, Lotion, Ointment (Generic)
High Potency	Betamethasone Valerate Lotion (Generic)	Betamethasone Dipropionate/Propylene Glycol Lotion (Generic)
*Request Form *Criteria *POS Edits	Betamethasone Valerate Ointment (Generic)	Betamethasone Dipropionate/Propylene Glycol Ointment (Generic; Diprolene®)
	Triamcinolone Acetonide Cream (Generic)	Desoximetasone Cream, Gel, Ointment (Generic)
	Triamcinolone Acetonide Lotion (Generic)	Desoximetasone Spray (Generic; Topicort®)
	Triamcinolone Acetonide Ointment (Generic)	Diflorasone Diacetate Cream (Generic; Psorcon®)
		Diflorasone Diacetate Ointment (Generic)
		Fluocinonide Cream 0.05% (Generic)
		Fluocinonide Cream 0.1% (Generic; Vanos®)
		Fluocinonide Emollient, Gel, Ointment, Solution (Generic)
		Halcinonide Cream (AG; Generic; Halog®)
		Halcinonide Ointment, Solution (Halog®)
		Triamcinolone Acetonide Aerosol (Generic; Kenalog Aerosol®)
		Triamcinolone Acetonide Ointment (Trianex®)
		Triamcinolone Acetonide/Dimethicone/Silicone Kit (SanaDermRx)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
DERMATOLOGY (17)	Clobetasol Propionate Cream (Generic)	Clobetasol Propionate Cream (Temovate®)
Steroids, Topical	Clobetasol Propionate Emollient (Generic)	Clobetasol Propionate Foam (Generic; Olux®)
Very High Potency	Clobetasol Propionate Gel (Generic)	Clobetasol Propionate Emollient Foam (Generic; Tovet®)
*Request Form *Criteria *POS Edits	Clobetasol Propionate Ointment (Generic)	Clobetasol Propionate Emulsion Foam (AG; Generic; Olux-E®)
	Clobetasol Propionate Solution (Generic)	Clobetasol Propionate Kit (Tovet™ Kit)
	Halobetasol Propionate Cream (Generic)	Clobetasol Propionate Lotion (Generic)
	Halobetasol Propionate Ointment (Generic)	Clobetasol Propionate Shampoo (Generic; Clobex®; Clodan®)
		Clobetasol Propionate Spray (AG; Generic; Clobex®)
		Clobetasol/Skin Cleanser No. 28 (Clodan® Kit)
		Diflorasone Diacetate (Apexicon E®)
		Clobetasol Propionate Lotion (Impeklo®)
		Halobetasol Propionate Foam (AG; Lexette™)
		Halobetasol Propionate Lotion (Bryhali®)
		Halobetasol Propionate Lotion (Ultravate®)
DIABETES (18)	Acarbose (Generic)	Miglitol (Generic)
Alpha-Glucosidase Inhibitors		
*Request Form		
*Criteria		
*POS Edits		
DIABETES (18)	Dasiglucagon Auto-Injector (Zegalogue™)	Dasiglucagon Syringe (Zegalogue™)
Glucagon Agents	Glucagon Nasal (Baqsimi®)	Diazoxide Oral Suspension (Generic; Proglycem®)
*Request Form *Criteria *POS Edits	Glucagon, Human Recombinant Injection (Generic)	Glucagon Subcutaneous Pen, Syringe, Vial (Gvoke®)
	Glucagon, Human Recombinant Injection Emergency Kit (Lilly)	Glucagon Injection Emergency Kit (Fresenius Kabi)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
DIABETES (18)	Exenatide Microspheres ER Pen-Injector (Bydureon®)	Alogliptin Tablet (AG; Nesina®)
Hypoglycemics	Exenatide Solution Pens (Byetta®)	Alogliptin/Metformin Tablet (AG; Kazano®)
Incretin Mimetics/Enhancers	Dulaglutide Pen (Trulicity®)	Alogliptin/Pioglitazone Tablet (AG; Oseni®)
*Request Form *Criteria *POS Edits	Linagliptin Tablet (Tradjenta®)	Empagliflozin/Linagliptin/Metformin Tablet (Trijardy™ XR)
	Linagliptin/Metformin Tablet (Jentadueto®)	Exenatide Microspheres ER Auto-Injector (Bydureon BCise®)
	Liraglutide Pen (Victoza®)	Linagliptin/Empagliflozin (Glyxambi®) (See SGLT2 Criteria)
	Semaglutide Pen (Ozempic®)	Linagliptin/Metformin Tablet ER (Jentadueto XR®)
	Sitagliptin Tablet (Januvia®)	Liraglutide/Insulin Degludec (Xultophy®) (See Insulins & Related Agents Criteria)
	Sitagliptin/Metformin Tablet (Janumet®)	Lixisenatide Pen (Adlyxin®)
	Sitagliptin/Metformin Tablet ER (Janumet XR®)	Lixisenatide/ Insulin Glargine (Soliqua®) (See Insulins & Related Agents Criteria)
		Pramlintide Pen (SymlinPen®)
		Saxagliptin Tablet (Onglyza®)
		Saxagliptin/Dapagliflozin Tablet (Qtern®) (See SGLT2 Criteria)
		Saxagliptin/Metformin ER Tablet (Kombiglyze XR®)
		Semaglutide Tablet (Rybelsus®)
		Sitagliptin/Ertugliflozin Tablet (Steglujan®) (See SGLT2 Criteria)
DIABETES (18)	Insulin Aspart Cartridge, Pen, Vial (AG; Novolog®)	Insulin Aspart Cartridge, Pen, Vial (Fiasp® Penfill®; Fiasp® FlexTouch®; Fiasp®)
Hypoglycemics	Insulin Aspart Protamine/Insulin Aspart Vial (AG)	Insulin Aspart Protamine/Insulin Aspart Vial (Novolog Mix 70/30®)
Insulins & Related Agents	Insulin Aspart Protamine/Ins Aspart Pen (AG; Novolog Mix 70/30®)	Insulin Degludec Pen, Vial (Tresiba® FlexTouch®; Tresiba®)
*Request Form *Criteria *POS Edits	Insulin Detemir Pen, Vial (Levemir®)	Insulin Glargine U-100 (Basaglar® KwikPen®)
	Insulin Glargine Pen, Vial (Lantus® SoloStar®; Lantus®)	Insulin Glargine Pen, Vial (Semglee®)
	Insulin Vial OTC (Humulin® N; Humulin® R)	Insulin Glargine-yfgn Pen, Vial (Generic; Semglee®[yfgn])
	Insulin Regular 500 units/mL Pen, Vial (Humulin® R U-500)	Insulin Glargine Pen, 300 units/mL Pen (Toujeo Solostar®; Toujeo Max Solostar®)
	Insulin Isophane (NPH)/Insulin Regular Pen OTC (Humulin® 70/30)	Insulin Glulisine Pen, Vial (Apidra® SoloStar®; Apidra®)
	Insulin Isophane (NPH)/Insulin Regular Vial OTC (Humulin® 70/30)	Insulin Lispro Pen, Vial (Admelog® SoloStar®; Admelog®)
	Insulin Lispro (AG; Humalog® Junior KwikPen®)	Insulin Lispro 200 U/mL Pen (Humalog®)
	Insulin Lispro Cartridge (Humalog®)	Insulin Lispro-aabc 100 U/mL Pen, 200 U/mL Pen, 100 U/mL Vial (Lyumjev®)
	Insulin Lispro Pen, Vial (AG; Humalog®)	Insulin Isophane (NPH) Insulin Regular Pen OTC, Vial OTC (Novolin® 70/30)
	Insulin Lispro Protamine/Insulin Lispro KwikPen (AG)	Insulin Human Pen OTC, Vial OTC (Novolin® N; Novolin® R)
	Insulin Lispro Protamine/Insulin Lispro Pen, Vial (Humalog® Mix)	Insulin Human in 0.9% Sodium Chloride Piggyback IV (Myxredlin®)
		Insulin Human Inhalation Powder Cartridge (Afrezza®)
		Insulin Human Pen OTC (Humulin® N Kwikpen)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
DIABETES (18)	Nateglinide (Generic)	Repaglinide/Metformin (Generic)
Hypoglycemics	Repaglinide (Generic)	
Meglitinides		
*Request Form		
*Criteria		
*POS Edits		
DIABETES (18)	Canagliflozin Tablet (Invokana®)	Canagliflozin/Metformin ER Tablet (Invokamet® XR)
Hypoglycemics	Canagliflozin/Metformin Tablet (Invokamet®)	Empagliflozin/Metformin ER Tablet (Synjardy® XR)
Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	Dapagliflozin Tablet (Farxiga®)	Ertugliflozin Tablet (Steglatro®)
	Dapagliflozin/Metformin ER Tablet (Xigduo® XR)	Ertugliflozin/Metformin Tablet (Segluromet®)
*Request Form	Empagliflozin Tablet (Jardiance®)	
*Criteria	Empagliflozin/Metformin Tablet (Synjardy®)	
*POS Edits		
DIABETES (18)	Glimepiride (Generic)	Glimepiride (Amaryl®)
Hypoglycemics	Glipizide (Generic)	Glipizide ER (Glucotrol® XL)
Sulfonylureas	Glipizide ER (Generic)	Glyburide Micronized (Glynase®)
*Request Form	Glyburide (Generic)	
*Criteria	Glyburide Micronized (Generic)	
*POS Edits		
DIABETES (18)	Pioglitazone (Generic)	Pioglitazone (Actos®)
Hypoglycemics		Pioglitazone/Glimepiride (AG)
Thiazolidinediones (TZDs)		Pioglitazone/Metformin (Generic)
*Request Form		
*Criteria		
*POS Edits		
DIABETES (18)	Glipizide-Metformin (Generic)	Metformin ER (Generic for Fortamet™)
Metformins	Glyburide-Metformin (Generic)	Metformin ER (Generic; Glumetza™)
*Request Form	Metformin (Generic)	Metformin Solution (Generic; Riomet™)
*Criteria	Metformin ER (Generic for Glucophage® XR)	Metformin Oral Suspension (Riomet ER™)
*POS Edits		

Additional Point-of-Sale (POS) Edits May Apply

Drugs highlighted in yellow indicate a new addition or a change in status

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
DIGESTIVE DISORDERS (19)	Meclizine Tablet (AG; Generic)	Amisulpride Vial (Barhemsys®)
Antiemetic/Antivertigo Agents	Metoclopramide Solution (Generic)	Aprepitant Capsule (Generic; Emend®)
*Request Form *Criteria *POS Edits	Metoclopramide Tablet (Generic)	Aprepitant Pack (Generic; Emend TriPack®)
	Metoclopramide Vial (Generic)	Aprepitant Powder for Oral Suspension Packet (Emend®)
	Ondansetron ODT (Generic)	Aprepitant Vial (Cinvanti®)
	Ondansetron Solution (Generic)	Dimenhydrinate Vial (Generic)
	Ondansetron Tablet (Generic)	Doxylamine/Pyridoxine Tablet (AG; Generic; Diclegis®)
	Ondansetron Vial (Generic)	Doxylamine/Pyridoxine Tablet (Bonjesta®)
	Prochlorperazine Tablet (Generic)	Dronabinol Oral (AG; Generic; Marinol®)
	Promethazine Ampule (Generic)	Fosaprepitant Dimeglumine Vial (AG; Generic; Emend®)
	Promethazine Rectal 12.5 mg (Generic)	Fosnetupitant/Palonosetron Vial (Akynzeo®)
	Promethazine Rectal 25 mg (Generic)	Granisetron Tablet, Vial (Generic)
	Promethazine Syrup (Generic)	Granisetron ER Syringe (Sustol®)
	Promethazine Tablet (Generic)	Granisetron Transdermal Patch (Sancuso®)
	Promethazine Vial (Generic)	Meclizine Tablet (Antivert®)
	Scopolamine Transdermal (Generic)	Metoclopramide Tablet (Reglan®)
		Metoclopramide Nasal (Gimoti®)
		Metoclopramide ODT, Syringe (Generic)
		Netupitant/Palonosetron HCl Capsule (Akynzeo®)
		Ondansetron Ampule, Syringe (Generic)
		Ondansetron Tablet (Zofran®)
		Ondansetron Oral Film (Zuplenz®)
		Palonosetron Vial (AG; Generic; Aloxi®)
		Prochlorperazine Rectal (Generic; Compro®)
		Prochlorperazine Vial (Generic)
		Promethazine Ampule, Vial (Phenergan®)
		Promethazine Suppository 50mg (Generic)
		Rolapitant Tablet (Varubi®)
		Scopolamine Transdermal (Transderm-Scop®)
		Trimethobenzamide Vial (Tigan®)
		Trimethobenzamide Capsule (Generic)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
DIGESTIVE DISORDERS (19)	Ursodiol 300 mg Capsule (Generic)	Chenodiol Tablet (Chenodal®)
Bile Acid Salts	Ursodiol Tablet (Generic)	Cholic Acid Capsule (Cholbam®)
*Request Form *Criteria *POS Edits		Maralixibat Solution (Livmarli™)
		Obeticholic Acid Tablet (Ocaliva®)
		Odevixibat Capsule, Pellet (Bylvay®)
		Ursodiol Capsule (Reltone®)
		Ursodiol Tablet (URSO 250®/URSO Forte®)
DIGESTIVE DISORDERS (19)	Famotidine Suspension (Generic)	Cimetidine Solution (Generic)
Histamine II Receptor Blockers	Famotidine Tablet (Generic)	Cimetidine Tablet (Generic)
*Request Form *Criteria *POS Edits		Famotidine Piggyback (Generic)
		Famotidine Tablet (Pepcid®)
		Famotidine Vial (Generic)
		Nizatidine Capsule (Generic)
		Nizatidine Solution (Generic)
DIGESTIVE DISORDERS (19)	Pancrelipase (Creon®)	Pancrelipase (Pancreaze®)
Pancreatic Enzymes	Pancrelipase (Zenpep®)	Pancrelipase (Pertzye®)
*Request Form *Criteria *POS Edits		Pancrelipase (Viokace®)
DIGESTIVE DISORDERS (19)	Esomeprazole Suspension (Nexium®)	Dexlansoprazole Capsule (Dexilant®)
Proton Pump Inhibitors	Lansoprazole Capsule (Generic)	Esomeprazole Capsule (AG; Generic; Nexium®)
*Request Form *Criteria *POS Edits	Omeprazole Capsule Rx (Generic)	Esomeprazole Suspension (Generic)
	Pantoprazole Tablet (Generic)	Lansoprazole Capsule (Prevacid®)
	Pantoprazole Suspension (Protonix®)	Lansoprazole ODT (Generic; Prevacid® SoluTab®)
		Omeprazole Granules for Suspension (Prilosec®)
		Omeprazole/Sodium Bicarbonate Rx Capsule, Packet (Generic; Zegerid®)
		Pantoprazole Suspension (Generic)
		Pantoprazole Tablet (Protonix®)
		Rabeprazole Tablet (Generic; AcipHex®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
DIGESTIVE DISORDERS (19)	Balsalazide Capsule (Generic)	Budesonide DR Rectal Foam (Uceris®)
Ulcerative Colitis Agents	Mesalamine ER Capsule (Apriso®)	Budesonide DR Tablet (AG; Generic; Uceris®)
* Request Form * Criteria * POS Edits	Mesalamine Suppositories (AG; Generic for Canasa®)	Mesalamine DR Tablet (Generic; Asacol HD®)
	Sulfasalazine Tablet (AG; Generic)	Mesalamine DR Capsule (AG; Generic; Delzicol®)
	Sulfasalazine DR Tablet (AG)	Mesalamine Enema (Rowasa®; SfRowasa®)
		Mesalamine Kit (Generic; Rowasa®)
		Mesalamine Rectal (Generic for sfRowasa®)
		Mesalamine DR Tablet MMX® (AG; Generic; Lialda®)
		Mesalamine ER Capsule (AG for Apriso®; Generic for Apriso®)
		Mesalamine ER Capsule (Pentasa®)
		Mesalamine Suppositories (Canasa®)
		Olsalazine Capsule (Dipentum®)
		Sulfasalazine DR Tablet, Tablet (Azulfidine EN-Tabs®; Azulfidine®)
ENZYME REPLACEMENTS (20)	NONE	Eliglustat Capsule (Cerdelga®)
* Request Form * Criteria * POS Edits		Imiglucerase 400 unit Vial (Cerezyme®)
		Miglustat Capsule (AG; Generic; Zavesca®)
		Taliglucerase alfa Vial (Elelyso®)
		Velaglucerase alfa 400 unit Vial (Vpriv®)
EPINEPHRINE, SELF-INJECTED (21)	Epinephrine 0.15 mg (AG; Generic for EpiPen Jr®)	Epinephrine 0.15 mg, 0.3 mg (EpiPen Jr®; EpiPen®)
* Request Form * Criteria * POS Edits	Epinephrine 0.3 mg (AG; Generic for EpiPen®)	Epinephrine 0.15 mg, 0.3 mg (AG for Adrenaclick®)
		Epinephrine Injection (Symjepi®)
GI MOTILITY, CHRONIC (22)	Linaclotide Capsule (Linzess®)	Alosetron Tablet (AG; Generic; Lotronex®)
* Request Form * Criteria * POS Edits	Lubiprostone Capsule (Amitiza®)	Eluxadoline Tablet (Viberzi®)
	Naloxegol Tablet (Movantik®)	Lubiprostone Capsule (AG for Amitiza®)
		Methylnaltrexone Syringe, Tablet, Vial (Relistor®)
		Naldemedine Tablet (Symproic®)
		Plecanatide Tablet (Trulance®)
		Prucalopride Tablet (Motegrity®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
GLUCOCORTICOIDS, ORAL (23)	Budesonide EC Capsules (Generic)	Budesonide ER Capsule (Ortikos™)
*Request Form *Criteria *POS Edits	Dexamethasone Tablet (Generic)	Deflazacort Suspension, Tablet (Emflaza®)
	Hydrocortisone Tablet (Generic)	Dexamethasone Tablet (Hemady®)
	Methylprednisolone Tablet Dose Pack (Generic)	Dexamethasone Tablet Therapy Pack (Taperdex®)
	Prednisolone Sodium Phosphate Solution (Generic)	Dexamethasone Elixir, Intensol Concentrate, Solution, Tablet Dose Pack (Generic)
	Prednisolone Solution (Generic)	Hydrocortisone Tablet (Cortef®)
	Prednisone Tablet (Generic)	Hydrocortisone Capsule (Alkindi® Sprinkle)
		Methylprednisolone Tablet, Dose Pack (Medrol®)
		Methylprednisolone Tablet 4 mg, 8 mg, 16 mg, 32 mg (Generic)
		Prednisolone Tablet, Tablet Dose Pack (Millipred®)
		Prednisolone Sodium Phosphate 10 mg/5 mL (Generic Millipred®)
		Prednisolone Sodium Phosphate 20 mg/5 mL (Generic Veripred®)
		Prednisolone Sodium Phosphate ODT (AG; Generic)
		Prednisone Delayed Release Tablet (Rayos®)
		Prednisone Intensol Concentrate, Solution, Tablet Dose Pack (Generic)
GOUT AGENTS (24)	Allopurinol Tablet (Generic)	Colchicine Capsule (AG; Mitigare®)
Antihyperuricemics	Colchicine Tablet (AG; Generic)	Colchicine Solution (Gloperba®)
*Request Form *Criteria *POS Edits	Probenecid Tablet (Generic)	Colchicine Tablet (Colcrys®)
	Probenecid/Colchicine Tablet (Generic)	Febuxostat Tablet (Generic; Uloric®)
		Pegloticase Intravenous (Krystexxa®)
GROWTH DEFICIENCY (25)	Somatropin Cartridge, Syringe (Genotropin®)	Lona pegsomatropin-tcgd (Skytrofa®)
Growth Hormones	Somatropin Pen (Norditropin® FlexPro®)	Somatropin Cartridge (Humatrope®)
*Request Form *Criteria *POS Edits		Somatropin Pen (Nutropin AQ® NuSpin®)
		Somatropin Cartridge, Vial (Omnitrope®)
		Somatropin Cartridge, Vial (Saizen®)
		Somatropin Vial (Serostim®)
		Somatropin Vial (Zomacton®)
		Somatropin Vial (Zorbtive®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
GROWTH FACTORS (26)	NONE	Mecasermin Subcutaneous (Increlex®)
*Request Form *Criteria *POS Edits		Tesamorelin Acetate Subcutaneous (Egrifta SV®)
		Vosoritide Vial (Voxzogo™)
H. PYLORI TREATMENT (27)	Bismuth Subcitrate Potassium/Metronidazole/Tetracycline (Pylera®)	Bismuth Subsalicylate/Metronidazole/Tetracycline (Helidac®)
*Request Form *Criteria *POS Edits		Lansoprazole/Amoxicillin/Clarithromycin (Generic Prevpac®)
		Omeprazole/Amoxicillin/Rifabutin (Talcia®)
		Omeprazole/Clarithromycin/Amoxicillin (Omeclamox-Pak®)
HEART DISEASE, HYPERLIPIDEMIA (28)	Apixaban Dose Pack, Tablet (Eliquis®)	Dalteparin Syringe (Fragmin®)
Anticoagulants	Dabigatran Capsule (Pradaxa®)	Dalteparin Vial (Fragmin®)
*Request Form *Criteria *POS Edits	Enoxaparin Syringe, Vial (AG; Generic)	Edoxaban Tablet (Savaysa®)
	Rivaroxaban Tablet (Xarelto®; Xarelto® Starter Pack)	Enoxaparin Syringe, Vial (Lovenox®)
	Warfarin Tablet (Generic)	Fondaparinux Syringe (Generic; Arixtra®)
		Rivaroxaban Suspension (Xarelto®)
HEART DISEASE, HYPERLIPIDEMIA (28)	Aspirin/Dipyridamole ER Capsule (AG; Generic)	Clopidogrel Tablet (Plavix®)
Anticoagulants	Clopidogrel Tablet (Generic)	Prasugrel Tablet (Effient®)
Platelet Aggregation Inhibitors	Dipyridamole Tablet (Generic)	Vorapaxar Tablet (Zontivity®)
*Request Form *Criteria *POS Edits	Prasugrel Tablet (Generic)	
	Ticagrelor Tablet (Brilinta®)	

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
HEART DISEASE, HYPERLIPIDEMIA (28)	Benazepril (Generic)	Aliskiren (AG; Generic; Tekturna®)
Hypertension	Benazepril/HCTZ (Generic)	Aliskiren/HCTZ (Tekturna HCT®)
ACE Inhibitors & Direct Renin Inhibitors	Enalapril Tablet, Solution (Generic)	Azilsartan Medoxomil (Edarbi®)
*Request Form *Criteria *POS Edits	Enalapril/HCTZ (Generic)	Azilsartan/Chlorthalidone (Edarbyclor®)
	Fosinopril (Generic)	Candesartan (AG; Generic; Atacand®)
	Fosinopril/HCTZ (Generic)	Candesartan/HCTZ (AG; Generic; Atacand HCT®)
	Irbesartan (Generic)	Captopril (Generic)
	Irbesartan/HCTZ (Generic)	Captopril/HCTZ (Generic)
	Lisinopril (Generic)	Enalapril for Solution (Epaned®)
	Lisinopril/HCTZ (Generic)	Enalapril Tablet (Vasotec®)
	Losartan (Generic)	Enalapril/HCTZ (Vaseretic®)
	Losartan/HCTZ (Generic)	Eprosartan (Generic)
	Olmesartan (AG; Generic)	Irbesartan (Avapro®)
	Olmesartan/HCTZ (AG; Generic)	Irbesartan/HCTZ (Avalide®)
	Quinapril (Generic)	Lisinopril Solution (Qbrelis®)
	Quinapril/HCTZ (AG ; Generic)	Lisinopril (Zestril®)
	Ramipril (Generic)	Lisinopril/HCTZ (Zestoretic®)
	Sacubitril/Valsartan (Entresto®)	Losartan (Cozaar®)
	Valsartan (Generic)	Losartan/HCTZ (Hyzaar®)
	Valsartan/HCTZ (Generic)	Moexipril (Generic)
		Olmesartan (Benicar®)
		Olmesartan/HCTZ (Benicar HCT®)
		Perindopril (Generic)
		Quinapril (Accupril®)
		Ramipril (Altace®)
		Telmisartan (Generic; Micardis®)
		Telmisartan/HCTZ (Generic; Micardis HCT®)
		Trandolapril (Generic)
		Valsartan (Diovan®)
		Valsartan/HCTZ (Diovan HCT®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
HEART DISEASE, HYPERLIPIDEMIA (28)	Amlodipine/Benazepril (Generic)	Amlodipine/Benazepril (Lotrel®)
Hypertension	Amlodipine/Olmesartan (AG; Generic)	Amlodipine/Olmesartan (Azor®)
Angiotensin Modulators/Calcium Channel Blockers Combinations	Amlodipine/Valsartan (AG; Generic)	Amlodipine/Olmesartan/HCTZ (AG; Generic; Tribenzor®)
*Request Form *Criteria *POS Edits		Amlodipine/Valsartan (Exforge®)
		Amlodipine/Valsartan/HCTZ (Generic; Exforge HCT®)
		Telmisartan/Amlodipine (Generic)
		Trandolapril/Verapamil (Generic)
HEART DISEASE, HYPERLIPIDEMIA (28)	Acebutolol (Generic)	Atenolol (Tenormin®)
Hypertension	Atenolol (Generic)	Betaxolol (Generic)
Beta Blocker Agents	Atenolol/Chlorthalidone (Generic)	Carvedilol (Coreg®)
*Request Form *Criteria *POS Edits	Bisoprolol (Generic)	Carvedilol ER (AG; Generic; Coreg CR®)
	Bisoprolol/HCTZ (Generic)	Metoprolol/HCTZ (Generic)
	Carvedilol (Generic)	Metoprolol Succinate Capsule (Kaspargo Sprinkle®)
	Labetalol (Generic)	Metoprolol Succinate ER (Toprol XL®)
	Metoprolol Succinate ER (AG; Generic)	Metoprolol Tartrate (Lopressor®)
	Metoprolol Tartrate (Generic)	Nadolol (Corgard®)
	Nadolol (Generic)	Nebivolol (Bystolic®)
	Nebivolol (Generic)	Pindolol (Generic)
	Propranolol ER (AG; Generic)	Propranolol Oral Solution (Hemangeol®)
	Propranolol Solution (Generic)	Propranolol ER Capsule (Inderal XL®)
	Propranolol Tablet (Generic)	Propranolol ER Capsule (Innopran XL®)
	Sotalol (Generic)	Propranolol LA (Inderal LA®)
		Propranolol/HCTZ (Generic)
		Sotalol Solution (Sotylize®)
		Timolol Maleate (Generic)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
HEART DISEASE, HYPERLIPIDEMIA (28)	Amlodipine Tablet (Generic)	Amlodipine Tablet (Norvasc®)
Hypertension	Diltiazem ER Capsule (Generic)	Amlodipine Suspension (Katerzia™)
Calcium Channel Blockers	Diltiazem IR Tablet (Generic)	Diltiazem CD (Cardizem CD®; Cardizem CD® 360 mg; Tiazac®)
*Request Form *Criteria *POS Edits	Felodipine ER Tablet (Generic)	Diltiazem LA Tablet (AG; Cardizem LA®; Matzim LA®)
	Nifedipine ER Tablet (Generic)	Isradipine Capsule (Generic)
	Nifedipine IR Capsule (Generic)	Nicardipine Capsule (Generic)
	Verapamil ER Tablet (Generic)	Nifedipine ER Tablet (Procardia XL®)
	Verapamil IR Tablet (Generic)	Nimodipine Capsule (Generic)
		Nimodipine Oral Syringe , Solution (Nymalize®)
		Nisoldipine Tablet (Generic)
		Verapamil 360 mg Capsule (Generic)
		Verapamil ER PM Capsule (Generic; Verelan PM®)
		Verapamil ER Capsule (Generic; Verelan®)
		Verapamil ER Tablet (Calan® SR)
HEART DISEASE, HYPERLIPIDEMIA (28)	Cholestyramine/Sucrose Packet, Powder (Generic Questran®)	Alirocumab Subcutaneous Pen (Praluent®)
Lipotropics, Other	Colestipol Granules, Packet (Generic)	Bempedoic Acid Tablet (Nexleto™)
*Request Form *Criteria *POS Edits	Colestipol Tablet (Generic)	Bempedoic Acid and Ezetimibe Tablet (Nexlizet™)
	Ezetimibe (Generic)	Cholestyramine/Aspartame Packet, Powder (Generic)
	Fenofibrate Nanocrystallized Tablet (Generic Tricor® 48 mg)	Cholestyramine/Sucrose Packet, Powder (Questran®)
	Fenofibrate Nanocrystallized Tablet (Generic Tricor® 145 mg)	Colesevelam Powder Pack, Tablet (AG; Generic; Welchol®)
	Fenofibrate Capsule, Tablet (Generic for Lofibra®)	Colestipol Granules, Tablet (Colestid®)
	Gemfibrozil Tablet (AG; Generic)	Evinacumab-dgnb Vial (Evkeeza®)
	Niacin ER Tablet (Generic)	Evolocumab Auto-Injector (Repatha® SureClick®)
		Evolocumab Cartridge (Repatha® Pushtronex®)
		Evolocumab Prefilled Syringe (Repatha®)
		Ezetimibe (Zetia®)
		Fenofibrate Capsule Micronized (AG; Generic; Antara®)
		Fenofibrate Capsule (Generic; Lipofen®)
		Fenofibrate Tablet (AG; Generic; Fenoglide®)
		Fenofibrate Tablet Nanocrystallized Tablet (Tricor®)
		Fenofibric Acid Tablet (Generic for Fibracor®)
		Fenofibric Acid Choline Capsule (AG; Generic; Trilipix®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
HEART DISEASE, HYPERLIPIDEMIA (28)	(Preferred agents listed on page 26)	Gemfibrozil Tablet (Lopid®)
Lipotropics, Other		Icosapent Ethyl Capsule (Generic; Vascepa®)
		Inclisiran Syringe (Leqvio®)
		Lomitapide Capsule (Juxtapid®)
		Niacin ER Tablet (Niaspan®)
		Omega-3-acid Ethyl Esters Capsule (Generic; Lovaza®)
HEART DISEASE, HYPERLIPIDEMIA (28)	Ambrisentan Tablet (Generic)	Ambrisentan Tablet (Letairis®)
Pulmonary Arterial Hypertension (PAH)	Bosentan Tablet (Generic; Tracleer®)	Bosentan Suspension (Tracleer®)
* Request Form	Sildenafil Tablet (Generic for Revatio®)	Iloprost Inhalation Solution (Ventavis®)
* Criteria	Sildenafil Oral Suspension (Revatio®)	Macitentan Tablet (Opsumit®)
* POS Edits	Tadalafil Tablet (Generic for Adcirca®)	Riociguat Tablet (Adempas®)
		Selexipag Tablet, Dose Pack (Uptravi®)
		Sildenafil Oral Suspension (AG; Generic)
		Sildenafil Tablet (Revatio®)
		Tadalafil Tablet (Adcirca®)
		Treprostinil Inhalation Solution (Tyvaso®)
		Treprostinil ER Tablet (Orenitram ER®)
HEART DISEASE, HYPERLIPIDEMIA (28)	Atorvastatin Tablet (Generic)	Amlodipine/Atorvastatin Tablet (Generic; Caduet®)
Statins & Statin Combination Agents	Lovastatin Tablet (Generic)	Atorvastatin Tablet (Lipitor®)
* Request Form	Pravastatin Tablet (Generic)	Ezetimibe/Simvastatin Tablet (Generic; Vytorin®)
* Criteria	Rosuvastatin Tablet (Generic)	Fluvastatin Capsule (Generic)
* POS Edits	Simvastatin Tablet (Generic)	Fluvastatin ER Tablet (AG; Generic; Lescol XL®)
		Lovastatin ER Tablet (Altoprev®)
		Pitavastatin Tablet (Livalo®)
		Pitavastatin Tablet (Zypitamag®)
		Rosuvastatin Tablet (Crestor®)
		Rosuvastatin Capsule (Ezallor™ Sprinkle)
		Simvastatin Tablet (Zocor®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
HEART DISEASE, HYPERLIPIDEMIA (28)	Clonidine Patch (Generic; Catapres-TTS®)	Methyldopa/Hydrochlorothiazide Tablet (Generic)
Sympatholytics	Clonidine Tablet (Generic)	Methyldopate HCl (Intravenous)
* Request Form	Guanfacine Tablet (Generic)	
* Criteria	Methyldopa Tablet (Generic)	
* POS Edits		
HEART DISEASE, HYPERLIPIDEMIA (28)	Isosorbide Dinitrate Tablet (Generic)	Isosorbide Dinitrate Tablet (AG; Isordil®)
Vasodilators, Coronary	Isosorbide Dinitrate/Hydralazine Tablet (BiDil®)	Nitroglycerin Translingual Spray (AG; Generic; Nitrolingual®)
* Request Form	Isosorbide Mononitrate Tablet (Generic)	
* Criteria	Isosorbide Mononitrate SR Tablet (Generic)	Nitroglycerin Transdermal Patch (Nitro-Dur®)
* POS Edits	Nitroglycerin Sublingual Tablet (AG; Generic)	Nitroglycerin Sublingual Tablet (Nitrostat®)
	Nitroglycerin Transdermal Ointment (Nitro-Bid®)	Vericiguat (Verquvo®)
	Nitroglycerin Transdermal Patch (AG; Generic)	
HEMATOLOGIC AGENTS, HEMATOPOIETIC AGENTS (29)	Epoetin alfa-epbx Vial (Retacrit®)	Darbepoetin Syringe (Aranesp®)
	Epoetin alfa Vial (Epogen®)	Darbepoetin Vial (Aranesp®)
Erythropoietins		Epoetin alfa Vial (Procrit®)
* Request Form		Luspatercept-aamt Vial (Reblozyl®)
* Criteria		Methoxy Polyethylene Glycol-Epoetin Beta Syringe (Mircera®)
* POS Edits		
HEMODIALYSIS (30)	Calcium Acetate Capsule (Generic)	Calcium Acetate Tablet (Generic)
Phosphate Binders	Sevelamer Carbonate Tablet (Renvela®)	Calcium Acetate Solution (Phoslyra®)
* Request Form		Calcium Carbonate/Magnesium Carbonate/FA (MagneBind 400 Rx®)
* Criteria		Ferric Citrate Tablet (Auryxia®)
* POS Edits		Lanthanum Carbonate Chewable Tablet (Generic; Fosrenol®)
		Lanthanum Carbonate Powder Pack (Fosrenol®)
		Sevelamer Carbonate Tablet (AG; Generic)
		Sevelamer Carbonate Powder Pack (Generic; Renvela®)
		Sevelamer HCl Tablet (AG; Generic; RenaGel®)
		Sucroferric Oxyhydroxide Chewable Tablet (Velphoro®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
HEMOPHILIA TREATMENT (31)	Emicizumab-kxwh (Hemlibra®)	Anti-Inhibitor Coagulant Complex (Feiba NF®)
*Request Form *Criteria *POS Edits	Factor IX (Mononine® Kit)	Factor IX Complex (PCC) 3-Factor (Profilnine® SD)
	Factor IX Human Recombinant (BeneFIX® Kit)	Factor IX Human (AlphaNine SD®)
	Factor VIIa, Recombinant (NovoSeven® RT)	Factor IX Human Recomb, GlycoPEGylated (Rebinyn®)
	Factor VIII, B-Domain-Deleted (Xyntha® Kit)	Factor IX Human Recombinant (Ixinity®)
	Factor VIII, B-Domain-Deleted (Xyntha® Solofuse® Syringe Kit)	Factor IX Recombinant (Rixubis®)
	Factor VIII, B-Domain-Truncated (Novoeight®)	Factor IX Recombinant, Albumin Fusion (Idelvion®)
	Factor VIII, HEK B-Domain-Deleted (Nuwiq®)	Factor IX Recombinant, Fc Fusion Protein (Alprolix®)
	Factor VIII/VWF (Alphanate®)	Factor VIIa, (Recombinant)-jncw (Sevenfact®)
	Factor VIII/VWF (Humate-P® Kit)	Factor VIII, Full-Length (Advate®)
	Factor VIII/VWF (Wilate®)	Factor VIII (Kogenate FS®)
	Factor X (Coagadex®)	Factor VIII (Kovaltry®)
	Factor XIII Concentrate, Human (Corifact® Kit)	Factor VIII, Full-Length PEGylated (Adynovate®)
		Factor VIII, Human (Hemofil-M®)
		Factor VIII, Human Kit (Koate DVI®)
		Factor VIII, Human Vial (Koate DVI®)
		Factor VIII, Recombinant Glycopegylated-exei (Esperoct®)
		Factor VIII, Recombinant Porcine (Obizur®)
		Factor VIII, Recombinant (Recombinat®)
		Factor VIII, Recombinant, Fc Fusion (Eloctate®)
		Factor VIII, Recombinant, PEGylated-aucl (Jivi®)
		Factor VIII, Single-Chain, B-Domain Truncated (Afstyl®)
		Factor XIII A-Subunit, Recombinant (Tretten®)
		Von Willebrand Factor, Recombinant (Vonvendi®)
HEREDITARY ANGIOEDEMA (32)	C1 Esterase Inhibitor Subcutaneous (Haegarda®)	Berotralstat Hydrochloride (Orladeyo®)
*Request Form *Criteria *POS Edits	Icatibant Acetate Subcutaneous (Generic)	C1 Esterase Inhibitor Intravenous (Berinert®)
		C1 Esterase Inhibitor Intravenous (Cinryze®)
		C1 Esterase Inhibitor, Recombinant (Ruconest®)
		Ecaltantide Subcutaneous (Kalbitor®)
		Icatibant Acetate Subcutaneous (Firazyr®)
		Lanadelumab-flyo Subcutaneous (Takhzyro®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
HIV-AIDS (33)	Abacavir Solution, Tablet (Generic; Ziagen®)	NONE
*Request Form *Criteria *POS Edits	Abacavir/Lamivudine Tablet (Generic; Epzicom®)	
	Abacavir/Dolutegravir/Lamivudine Tablet (Triumeq®)	
	Abacavir/Lamivudine/Zidovudine Tablet (Generic; Trizivir®)	
	Atazanavir Capsule (Generic)	
	Atazanavir Capsule, Powder Pack (Reyataz®)	
	Atazanavir Sulfate/Cobicistat Tablet (Evotaz®)	
	Bictegravir/Emtricitabine/Tenofovir AF Tablet (Biktarvy®)	
	Cabotegravir (Apretude™)	
	Cabotegravir/Rilpivirine IM (Cabenuva®)	
	Cobicistat Tablet (Tybost®)	
	Darunavir Ethanolate Tablet, Suspension (Prezista®)	
	Darunavir/Cobicistat/Emtricitabine/Tenofovir AF (Symtuza®)	
	Darunavir/Cobicistat Tablet (Prezcobix®)	
	Didanosine Capsule DR (Generic)	
	Dolutegravir Sodium Suspension, Tablet (Tivicay PD®; Tivicay®)	
	Dolutegravir Sodium/Lamivudine Tablet (Dovato®)	
	Dolutegravir/Rilpivirine Tablet (Juluca®)	
	Doravirine Tablet (Pifeltro®)	
	Doravirine/Lamivudine/Tenofovir DF Tablet (Delstrigo®)	
	Efavirenz Capsule, Tablet (Generic; Sustiva®)	
	Efavirenz/Emtricitabine/Tenofovir DF Tablet (Generic; Atripla®)	
	Efavirenz/Lamivudine/Tenofovir DF Tablet (Generic; Symfi Lo®)	
	Efavirenz/Lamivudine/Tenofovir DF Tablet (Generic; Symfi®)	
	Elvitegravir/Cobicistat/Emtricitabine/Tenofovir AF (Genvoya®)	
	Elvitegravir/Cobicistat/Emtricitabine/Tenofovir DF (Stribild®)	
	Emtricitabine/Rilpivirine/Tenofovir DF Tablet (Complera®)	
	Emtricitabine/Rilpivirine/Tenofovir AF Tablet (Odefsey®)	
	Emtricitabine Capsule (Generic; Emtriva®)	
	Emtricitabine Solution (Emtriva®)	
	Emtricitabine/Tenofovir AF Tablet (Descovy®)	
	Emtricitabine/Tenofovir DF Tablet (Generic; Truvada®)	
	Enfuvirtide Vial (Fuzeon®)	

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
HIV-AIDS (33) Continued	Etravirine Tablet (Generic; Intelence®)	NONE
	Fosamprenavir Tablet (Generic; Lexiva®)	
	Fosamprenavir Suspension (Lexiva®)	
	Fostemsavir Tromethamine Tablet (Rukobia®)	
	Ibalizumab-uiyk Vial (Trogarzo®)	
	Lamivudine Solution, Tablet (Generic; Epivir®)	
	Lamivudine/Tenofovir DF Tablet (Cimduo®)	
	Lamivudine/Tenofovir DF Tablet (Temixys®)	
	Lamivudine/Zidovudine Tablet (Generic; Combivir®)	
	Lopinavir/Ritonavir Solution (Generic; Kaletra®)	
	Lopinavir/Ritonavir Tablet (Generic; Kaletra®)	
	Maraviroc Solution (Selzentry®)	
	Maraviroc Tablet (Generic; Selzentry®)	
	Nelfinavir Mesylate Tablet (Viracept®)	
	Nevirapine ER Tablet (Generic; Viramune XR®)	
	Nevirapine Suspension (Generic; Viramune®)	
	Nevirapine Tablet (Generic)	
	Raltegravir Potassium Chewable, Powder Pack, Tablet (Isentress®)	
	Raltegravir Potassium Tablet (Isentress HD®)	
	Rilpivirine HCl Tablet (Edurant®)	
	Ritonavir Powder Pack, Solution (Norvir®)	
	Ritonavir Tablet (Generic; Norvir®)	
	Saquinavir Mesylate Tablet (Invirase®)	
	Stavudine Capsule (Generic)	
	Tenofovir Disoproxil Fumarate Tablet (Generic)	
	Tenofovir Disoproxil Fumarate Powder, Tablet (Viread®)	
	Tipranavir Capsule (Aptivus®)	
	Zidovudine Syrup (Generic; Retrovir®)	
	Zidovudine Capsule, Tablet (Generic)	

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
IDIOPATHIC PULMONARY FIBROSIS (34)	Nintedanib Capsule (Ofev®)	Pirfenidone Capsule, Tablet (Esbriet®)
*Request Form *Criteria *POS Edits		
IMMUNE GLOBULINS (IG) (35)	Cytomegalovirus IG IV [(Human) Cytogam®]	NONE
*Request Form *Criteria *POS Edits	Hepatitis B IG Syringe [(Human) HyperHEP B® S/D] Hepatitis B IG Vial [(Human) HyperHEP B® S/D] Hepatitis B IG Intravenous [(Human) HepaGam B®] IG Infusion [(Human) Hyqvia®] IG Injection [(Human) Gammaked™] IG Injection [(Human) Gamunex®-C] IG Intravenous [(Human) Flebogamma® DIF] IG Intravenous [(Human) Gammagard Liquid] IG Intravenous [(Human) Gammagard S/D] IG Intravenous [(Human) Gammaplex®] IG Intravenous [(Human) Octagam®] IG Intravenous [(Human) Privigen®] IG Intravenous [(Human) Cuvitru®] IG Intravenous [(Human-slra) Asceniv™] IG Intravenous [(Human-ifas) Panzyga®] IG Subcutaneous [(Human-hipp) Cutaquig®] IG Subcutaneous [(Human-klhw) Xembify®] IG Subcutaneous Syringe [(Human) Hizentra®] IG Subcutaneous Vial [(Human) Hizentra®] IG Vial [(Human) GamaSTAN®] IG Vial [(Human) GamaSTAN® S/D] Rabies IG Vial [(Human) HyperRAB®] Rabies IG [(Human) Kedrab™] Varicella Zoster IG [(Human) Varizig®]	

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)	
IMMUNOSUPPRESSIVES, ORAL (36)	Azathioprine Tablet (Generic)	Avacopan Capsule (Tavneos™)	
*Request Form *Criteria *POS Edits	Cyclosporine Capsule – MODIFIED 25 mg, 100 mg	Azathioprine (Azasan®; Imuran®)	
	Mycophenolate Mofetil Capsule (Generic)	Belumosudil Tablet (Rezurock™)	
	Mycophenolate Mofetil Tablet (Generic)	Cyclosporine Capsule 25 mg, 100 mg (Generic; Sandimmune®)	
	Mycophenolic Acid as Mycophenolate Sodium (Generic)	Cyclosporine Capsule – MODIFIED (Neoral®)	
	Sirolimus Solution (Rapamune®)	Cyclosporine Softgel – MODIFIED 50 mg	
	Sirolimus Tablet (Rapamune®)	Cyclosporine Solution – MODIFIED (Generic; Neoral®)	
	Tacrolimus Capsule (Generic)	Cyclosporine Solution (Sandimmune®)	
		Everolimus Tablet (Generic; Zortress®)	
		Mycophenolate Mofetil Capsule (CellCept®)	
		Mycophenolate Mofetil Suspension (CellCept®)	
		Mycophenolate Mofetil Tablet (CellCept®)	
		Mycophenolate Mofetil Suspension (Generic)	
		Mycophenolic Acid as Mycophenolate Sodium (Myfortic®)	
		Sirolimus Solution (Generic)	
		Sirolimus Tablet (AG; Generic)	
		Tacrolimus Capsule (Prograf®)	
		Tacrolimus Granule Packet (Prograf®)	
		Tacrolimus ER Capsule (Astagraf® XL)	
		Tacrolimus ER Tablet (Envarsus® XR)	
INFECTIOUS DISORDERS (37)	Amoxicillin/Clavulanate Suspension (Generic)	Amoxicillin/Clavulanate ER Tablet (Generic)	
Antibiotics	Amoxicillin/Clavulanate Tablet (Generic)	Amoxicillin/Clavulanate Chewable Tablet (Generic)	
Cephalosporin and Related Antibiotics	Cefadroxil Capsule (Generic)	Cefaclor Capsule, ER Tablet, Suspension (Generic)	
*Request Form *Criteria *POS Edits	Cefdinir Capsule (Generic)	Cefadroxil Suspension, Tablet (Generic)	
	Cefdinir Suspension (Generic)	Cefixime Capsule (AG; Generic; Suprax®)	
	Cefprozil Suspension (Generic)	Cefixime Chewable Tablet (Suprax®)	
	Cefprozil Tablet (Generic)	Cefixime Suspension (Generic; Suprax®)	
	Cefuroxime Tablet (Generic)	Cefpodoxime Proxetil Suspension, Tablet (Generic)	
	Cephalexin Capsule (Generic)	Cephalexin Capsule (Keflex®)	
	Cephalexin Suspension (Generic)	Cephalexin Tablet (Generic)	

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
INFECTIOUS DISORDERS (37)	Ciprofloxacin Tablet (Generic)	Ciprofloxacin Suspension (Generic; Cipro®)
Antibiotics	Levofloxacin Tablet (Generic)	Ciprofloxacin Tablet (Cipro®)
Fluoroquinolones		Delafloxacin Tablet (Baxdela®)
* Request Form * Criteria * POS Edits		Levofloxacin Solution (Generic)
		Moxifloxacin Tablet (Generic)
		Ofloxacin Tablet (Generic)
INFECTIOUS DISORDERS (37)	Metronidazole Tablet (Generic)	Fidaxomicin Suspension, Tablet (Dificid®)
Antibiotics	Neomycin Tablet (Generic)	Metronidazole Capsule (Generic)
Gastrointestinal Antibiotics	Tinidazole (Generic)	Metronidazole Tablet (Flagyl®)
* Request Form * Criteria * POS Edits	Vancomycin HCl Capsule (AG; Generic)	Nitazoxanide Tablet (AG; Generic)
		Paromomycin (Generic)
		Rifaximin (Xifaxan®)
		Secnidazole Oral Granules (Solosec™)
		Vancomycin HCl Capsule (Vancocin®)
		Vancomycin Solution (Generic; Firvanq®)
INFECTIOUS DISORDERS (37)	Tobramycin Solution (Bethkis®)	Amikacin Inhalation Suspension (Arikayce®)
Antibiotics	Tobramycin Solution (AG for Tobi®; Generic for Tobi®)	Aztreonam Solution (Cayston®)
Inhaled Antibiotics		Tobramycin Solution (AG; Generic for Bethkis®)
* Request Form * Criteria * POS Edits		Tobramycin Solution (Tobi®)
		Tobramycin (Tobi Podhaler®)
		Tobramycin Inhalation Solution Pak (AG ; Kitabis Pak®)
INFECTIOUS DISORDERS (37)	Clindamycin Capsule (Generic)	Clindamycin Capsule (Cleocin®)
Antibiotics	Clindamycin Palmitate Solution (Generic)	Clindamycin Palmitate Solution (Cleocin®)
Lincosamides		Clindamycin Phosphate in D5W Piggyback Injection (Generic)
* Request Form * Criteria * POS Edits		Clindamycin Phosphate Injection Vial (Generic; Cleocin®)
		Clindamycin in 0.9% Sodium Chloride Piggyback Intravenous (Generic)
		Lincomycin HCl Vial (Generic; Lincocin®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
INFECTIOUS DISORDERS (37)	Azithromycin Packet (AG)	Azithromycin Packet, Suspension, Tablet (Zithromax®)
Antibiotics	Azithromycin Suspension, Tablet (Generic)	Clarithromycin ER Tablet, Suspension (Generic)
Macrolides - Ketolides	Clarithromycin Tablet (Generic)	Erythromycin Base Tablet (Generic)
*Request Form *Criteria *POS Edits	Erythromycin Base DR Capsule, DR Tablet (Generic)	Erythromycin Base DR Tablet (Ery-Tab®)
		Erythromycin Ethyl Succinate Suspension (AG; E.E.S.® 200; EryPed® 200)
		Erythromycin Ethyl Succinate Suspension (AG; Generic; EryPed® 400)
		Erythromycin Ethyl Succinate Tablet (E.E.S. ® 400)
		Erythromycin Stearate Filmtab (Erythrocin®)
INFECTIOUS DISORDERS (37)	Nitrofurantoin Macrocrystals Capsule (AG ; Generic)	Nitrofurantoin Macrocrystals Capsule 25 mg, 50 mg (Macrochantin®)
Antibiotics	Nitrofurantoin Monohydrate Macrocrystals Capsule (Generic)	Nitrofurantoin Monohydrate Macrocrystals Capsule 100 mg (Macrobid®)
Nitrofurantoin Derivatives		Nitrofurantoin Suspension (AG; Generic)
*Request Form *Criteria *POS Edits		
INFECTIOUS DISORDERS (37)	Linezolid Tablet (AG; Generic)	Linezolid IV (AG; Generic; Zyvox®)
Antibiotics		Linezolid Suspension (AG; Generic; Zyvox®)
Oxazolidinones		Linezolid Tablet (Zyvox®)
*Request Form *Criteria *POS Edits		Tedizolid IV (Sivextro®)
		Tedizolid Tablet (Sivextro®)
INFECTIOUS DISORDERS (37)	NONE	Lefamulin Acetate Tablet, Vial (Xenleta®)
Antibiotics		
Pleuromutins		
*Request Form *Criteria *POS Edits		
INFECTIOUS DISORDERS (37)	NONE	Quinupristin/Dalfopristin Vial (Synercid®)
Antibiotics		
Streptogramins		
*Request Form *Criteria *POS Edits		

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
INFECTIOUS DISORDERS (37)	Doxycycline Hyclate Capsule (Generic)	Demeclocycline (Generic)
Antibiotics	Doxycycline Hyclate Tablet (Generic)	Doxycycline Calcium Syrup (Vibramycin®)
Tetracyclines	Doxycycline Monohydrate 50 mg Capsule (AG; Generic)	Doxycycline Hyclate DR Tablet (Doryx® MPC)
*Request Form *Criteria *POS Edits	Doxycycline Monohydrate 100 mg Capsule (AG; Generic)	Doxycycline Hyclate DR Tablet (AG; Generic; Doryx®)
	Doxycycline Monohydrate Tablet (Generic)	Doxycycline Hyclate Capsule/Skin Cleanser (Morgidox® Kit)
	Minocycline Capsule (Generic)	Doxycycline Monohydrate 40 mg DR Capsule (AG; Oracea®)
		Doxycycline Monohydrate Capsule 75 mg (AG; Generic)
		Doxycycline Monohydrate Capsule 150 mg (Generic)
		Doxycycline Monohydrate Suspension (Generic)
		Minocycline ER Capsule (AG; Ximino®)
		Minocycline ER Tablet (MinoLira®)
		Minocycline ER Tablet (Generic; Solodyn®)
		Minocycline Tablet (Generic)
		Omadacycline Tosylate Tablet (Nuzyra®)
		Tetracycline (Generic)
INFECTIOUS DISORDERS (37)	Clindamycin Vaginal Cream (Clindesse®)	Clindamycin Vaginal Cream (Generic; Cleocin®)
Antibiotics	Metronidazole Vaginal Gel (Nuversa®)	Clindamycin Vaginal Ovules (Cleocin®)
Vaginal	Metronidazole Vaginal Gel (Generic for MetroGel-Vaginal®)	Metronidazole Vaginal Gel (MetroGel-Vaginal®)
*Request Form *Criteria *POS Edits		Metronidazole Vaginal Gel (Vandazole®)
INFECTIOUS DISORDERS (37)	Clotrimazole Troche (Generic)	Fluconazole Suspension, Tablet (Diflucan®)
Antifungals	Fluconazole Suspension (Generic)	Flucytosine Capsule (AG; Generic)
Antifungals, Oral	Fluconazole Tablet (Generic)	Griseofulvin Tablet, Ultramicrosize Tablet (Generic)
*Request Form *Criteria *POS Edits	Griseofulvin Suspension (Generic)	Ibexafungerp Citrate (Brexafemme™)
	Nystatin Suspension (Generic)	Isavuconazonium Capsule (Cresamba®)
	Nystatin Tablet (Generic)	Itraconazole Capsule, Solution (Generic; Sporanox®)
	Terbinafine Tablet (Generic)	Itraconazole Capsule (Tolsura®)
		Ketoconazole Tablet (Generic)
		Miconazole Buccal Tablet (Oravig®)
		Posaconazole Suspension (Noxafil®)
		Posaconazole Tablet (AG; Generic; Noxafil®)
		Voriconazole Suspension, Tablet (Generic; Vfend®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
INFECTIOUS DISORDERS (37)	Sofosbuvir/Velpatasvir (AG for Epclusa®)	Elbasvir/Grazoprevir (Zepatier®)
Hepatitis C Agents		Glecaprevir/Pibrentasvir Pellet Pack, Tablet (Mavyret®)
Direct Acting Antiviral Agents		Ledipasvir/Sofosbuvir Tablet (AG; Harvoni®)
*Request Form *Hepatitis C DAA Criteria *Hepatitis C DAA Worksheet *Patient Treatment Agreement *POS Edits		Ledipasvir/Sofosbuvir Pellet Pack (Harvoni®)
		Ombitasvir/Paritaprevir/Ritonavir/Dasabuvir (Viekira Pak®)
		Sofosbuvir Tablet, Pellet Pack (Sovaldi®)
		Sofosbuvir/Velpatasvir (Epclusa®)
		Sofosbuvir/Velpatasvir/Voxilaprevir (Vosevi®)
INFECTIOUS DISORDERS (37)	Peginterferon alfa 2a Syringe (Pegasys®)	Ribavirin Capsule (Generic)
Hepatitis C Agents	Peginterferon alfa 2a Vial (Pegasys®)	
Not Direct Acting Antiviral Agents	Ribavirin Tablet (Generic)	
*Request Form *Criteria *POS Edits		
LUPUS IMMUNOMODULATORS (38)	NONE	Anifrolumab-fnia Vial (Saphnelo®)
*Request Form *Criteria *POS Edits		Belimumab Auto-Injector, Syringe, Vial (Benlysta®)
		Voclosporin (Lupkynis®)
METHOTREXATE (39)	Methotrexate PF Vial	Methotrexate Auto-Injector (Otrexup®)
*Request Form *Criteria *POS Edits	Methotrexate Tablet	Methotrexate Auto-Injector (Rasuvo®)
	Methotrexate Vial	Methotrexate Solution (Xatmep®)
		Methotrexate PF Syringe (RediTrex®)
		Methotrexate Tablet (Trexall™)
MOVEMENT DISORDERS (40)	Deutetrabenazine Tablet (Austedo®)	Tetrabenazine Tablet (Xenazine®)
*Request Form *Criteria *POS Edits	Tetrabenazine Tablet (Generic)	Valbenazine Capsule Initiation Pack (Ingrezza®)
	Valbenazine Capsule (Ingrezza®)	

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
MULTIPLE SCLEROSIS (41)	Dalfampridine ER Tablet (AG; Generic)	Alemtuzumab Vial (Lemtrada®)
Multiple Sclerosis Agents	Dimethyl Fumarate DR Capsule (AG; Generic)	Cladribine Tablet (Mavenclad®)
Immunomodulatory Agents	Dimethyl Fumarate DR Starter Pack (Generic)	Dalfampridine ER Tablet (Ampyra®)
*Request Form *Criteria *POS Edits	Fingolimod Capsule (Gilenya®)	Dimethyl Fumarate Capsule, Starter Pack (Tecfidera®)
	Glatiramer Acetate Syringe 20mg, 40mg (Copaxone®)	Diroximel Fumarate Capsule (Vumerity®)
	Interferon β-1a Pen Kit (Avonex® Pen)	Glatiramer Acetate Syringe (Generic)
	Interferon β-1b Kit (Betaseron®)	Interferon β-1a Auto-Injector, Titration Pack (Rebif® Rebidos®)
	Interferon β-1a Syringe, Syringe Kit (Avonex®)	Interferon β-1a Syringe, Titration Pack (Rebif®)
	Interferon β-1a Vial Kit (Avonex®)	Interferon β-1b Kit, Vial (Extavia®)
	Ofatumumab Pen (Kesimpta®)	Monomethyl Fumarate Capsule DR (Bafiertam®)
		Natalizumab Vial (Tysabri®)
		Ocrelizumab Vial (Ocrevus®)
		Ozanimod Capsule, Starter Kit, Starter Pack (Zeposia®)
		Peginterferon β -1a IM, Subcutaneous (Plegridy®)
		Ponesimod Starter Pack, Tablet (Ponvory®)
		Siponimod Dose Pack, Tablet (Mayzent®)
		Teriflunomide Tablet (Aubagio®)
ONCOLOGY (42)	Anastrozole Tablet (Generic)	Abemaciclib Tablet (Verzenio®)
Oral – Breast	Capecitabine Tablet (Generic)	Alpelisib Tablet (Piqray®)
*Request Form *Criteria *POS Edits	Cyclophosphamide Capsule, Tablet (Generic)	Anastrozole Tablet (Arimidex®)
	Exemestane Tablet (Generic)	Capecitabine Tablet (Xeloda®)
	Letrozole Tablet (Generic)	Exemestane Tablet (Aromasin®)
	Palbociclib Capsule (Ibrance®)	Fulvestrant Syringe (AG; Generic; Faslodex®)
	Palbociclib Tablet (Ibrance®)	Lapatinib Ditosylate Tablet (Generic; Tykerb®)
	Tamoxifen Citrate Tablet (Generic)	Letrozole Tablet (Femara®)
		Neratinib Maleate Tablet (Nerlynx®)
		Ribociclib Succinate Tablet (Kisqali®)
		Ribociclib Succinate/Letrozole Tablet (Kisqali/Femara Kit®)
		Talazoparib Capsule (Talzenna®)
		Tamoxifen Citrate Solution (Soltamox®)
		Toremifene Citrate Tablet (Generic; Fareston®)
		Tucatinib Tablet (Tukysa™)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
ONCOLOGY (42)	Busulfan Tablet (Myleran®)	Acalabrutinib Capsule (Calquence®)
Oral – Hematologic	Chlorambucil Tablet (Leukeran®)	Asciminib Tablet (Scemblix®)
*Request Form *Criteria *POS Edits	Dasatinib Tablet (Sprycel®)	Azacitidine Tablet (Onureg™)
	Hydroxyurea Capsule (Generic)	Bosutinib Tablet (Bosulif®)
	Ibrutinib Capsule (Imbruvica®)	Decitabine/Cedazuridine Tablet (Inqovi®)
	Ibrutinib Tablet (Imbruvica®)	Duvelisib Capsule (Copiktra®)
	Imatinib Mesylate Tablet (Generic)	Enasidenib Mesylate Tablet (Idhifa®)
	Lenalidomide Capsule (Revlimid®)	Fedratinib Capsule (Inrebic®)
	Melphalan Tablet (Generic)	Gilterinib Tablet (Xospata®)
	Mercaptopurine Tablet (Generic)	Glasdegib Tablet (Daurismo®)
	Procarbazine HCl Capsule (Matulane®)	Hydroxyurea Capsule (Hydrea®)
	Ruxolitinib Phosphate Tablet (Jakafi®)	Idelalisib Tablet (Zydelig®)
	Tretinoin Capsule (Generic)	Imatinib Mesylate Tablet (Gleevec®)
	Venetoclax Tablet (Venclexta®)	Ivosidenib Tablet (Tibsovo®)
	Venetoclax Starting Pack Tablet (Venclexta®)	Ixazomib Citrate Capsule (Ninlaro®)
		Melphalan Tablet (Alkeran®)
		Mercaptopurine Suspension (Purixan®)
		Midostaurin Capsule (Rydapt®)
		Nilotinib HCl Capsule (Tasigna®)
		Panobinostat Lactate Capsule (Farydak®)
		Pomalidomide Capsule (Pomalyst®)
		Ponatinib HCl Tablet (Iclusig®)
		Selinexor Tablet (Xpovio®)
		Thalidomide Capsule (Thalomid®)
		Thioguanine Tablet (Tabloid®)
		Umbralisib Tosylate Tablet (Ukoniq™)
		Vorinostat Capsule (Zolinza®)
		Zanubrutinib Capsule (Brukinsa™)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
ONCOLOGY (42)	Afatinib Dimaleate Tablet (Gilotrif®)	Brigatinib Tablet (Alunbrig®)
Oral – Lung	Alectinib HCl Capsule (Alecensa®)	Capmatinib Tablet (Tabrecta™)
*Request Form *Criteria *POS Edits	Crizotinib Capsule (Xalkori®)	Ceritinib Tablet (Zykadia®)
	Osimertinib Mesylate Tablet (Tagrisso®)	Dacomitinib Tablet (Vizimpro®)
	Topotecan HCl Capsule (Hycamtin®)	Entrectinib Capsule (Rozlytrek®)
		Erlotinib HCl Tablet (Generic; Tarceva®)
		Gefitinib Tablet (Iressa®)
		Lorlatinib Tablet (Lorbrena®)
		Mobocertinib Capsule (Exkivity®)
		Pralsetinib Capsule (Gavreto™)
		Selpercatinib Capsule (Retevmo™)
		Sotorasib Tablet (Lumakras™)
		Tepotinib HCl Tablet (Tepmetko®)
ONCOLOGY (42)	Niraparib Tosylate Capsule (Zejula®)	Avapritinib Tablet (Ayvakit™)
Oral – Other	Selumetinib Capsule (Koselugo™)	Cabozantinib S-Malate Capsule (Cometriq®)
*Request Form *Criteria *POS Edits	Temozolomide Capsule (AG; Generic)	Erdaftinib Tablet (Balversa™)
		Infagratinib Phosphate Capsule (Truseltiq™)
		Larotrectinib Capsule (Vitrakvi®)
		Larotrectinib Solution (Vitrakvi®)
		Olaparib Tablet (Lynparza®)
		Pemigatinib Tablet (Pemazyre®)
		Pexidartinib Capsule (Turalio®)
		Regorafenib Tablet (Stivarga®)
		Ripretinib Tablet (Qinlock™)
		Rucaparib Camsylate Tablet (Rubraca®)
		Tazemetostat Tablet (Tazverik™)
		Temozolomide Capsule (Temodar®)
		Trifluridine/Tipiracil HCl Tablet (Lonsurf®)
		Vandetanib Tablet (Caprelsa®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
ONCOLOGY (42)	Abiraterone Acetate Tablet (Generic for Zytiga®)	Abiraterone Acetate Tablet (Zytiga®)
Oral – Prostate	Bicalutamide Tablet (Generic)	Abiraterone Acetate, Submicronized Tablet (Yonsa®)
*Request Form *Criteria *POS Edits	Enzalutamide Capsule, Tablet (Xtandi®)	Apalutamide Tablet (Erleada®)
	Flutamide Capsule (Generic)	Bicalutamide Tablet (Casodex®)
		Darolutamide Tablet (Nubeqa®)
		Estramustine Phosphate Sodium Capsule (Emcyt®)
		Nilutamide Tablet (AG; Generic)
		Relugolix Tablet (Orgovyx®)
ONCOLOGY (42)	Axitinib Tablet (Inlyta®)	Belzutifan Tablet (Welireg™)
Oral - Renal Cell	Everolimus Tablet (Afinitor®)	Cabozantinib S-Malate Tablet (Cabometyx®)
*Request Form *Criteria *POS Edits	Lenvatinib Mesylate Capsule (Lenvima®)	Everolimus Soluble Tablet (Afinitor Disperz®)
	Pazopanib HCl Tablet (Votrient®)	Everolimus Tablet (Generic for Afinitor®)
	Sorafenib Tosylate Tablet (Nexavar®)	Tivozanib HCl Capsule (Fotivda™)
	Sunitinib Malate Capsule (Generic; Sutent®)	
ONCOLOGY (42)	Cobimetinib Fumarate Tablet (Cotellic®)	Binimetinib Tablet (Mektovi®)
Oral - Skin	Dabrafenib Mesylate Capsule (Tafinlar®)	Encorafenib Capsule (Braftovi®)
*Request Form *Criteria *POS Edits	Sonidegib Phosphate Capsule (Odomzo®)	Vismodegib Capsule (Erivedge®)
	Trametinib Dimethyl Sulfoxide Tablet (Mekinist®)	
	Vemurafenib Tablet (Zelboraf®)	
OPHTHALMIC DISORDERS (43)	Azelastine HCl Solution (Generic)	Alcaftadine Solution (Lastacaft®)
Allergic Conjunctivitis	Cromolyn Sodium Solution (Generic)	Bepotastine Solution (AG; Generic; Bepreve®)
*Request Form *Criteria *POS Edits	Loteprednol Suspension (Alrex®)	Cetirizine Solution (Zerviate™)
	Olopatadine HCl 0.1% Solution (AG; Generic for Patanol®)	Epinastine Solution (Generic)
		Lodoxamide Tromethamine Solution (Alomide®)
		Nedocromil Sodium Solution (Alocril®)
		Olopatadine HCl 0.2% Solution Rx (Generic for Pataday®)
		Olopatadine HCl 0.7% Solution (Pazeo®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
OPHTHALMIC DISORDERS (43)	Bacitracin/Polymyxin B Sulfate Ointment (Generic)	Azithromycin Solution (AzaSite®)
Antibiotics	Ciprofloxacin Ophthalmic Solution (Generic)	Bacitracin Ointment (Generic)
*Request Form *Criteria *POS Edits	Erythromycin Base Ointment (Generic)	Besifloxacin Suspension (Besivance®)
	Gentamicin Sulfate Ointment (Generic)	Ciprofloxacin Ointment (Ciloxan®)
	Gentamicin Sulfate Solution (Generic)	Gatifloxacin Solution (Generic; Zymaxid®)
	Moxifloxacin Solution (AG; Generic for Vigamox®)	Levofloxacin Solution (Generic)
	Neomycin/Polymyxin B/Gramicidin Solution (Generic)	Moxifloxacin Solution (Generic; Moxeza®)
	Ofloxacin Ophthalmic Solution (Generic)	Moxifloxacin Solution (Vigamox®)
	Polymyxin B Sulfate/Trimethoprim Solution (Generic)	Natamycin Suspension (Natacyn®)
	Sulfacetamide Sodium Solution (Generic)	Neomycin/Bacitracin/Polymyxin B Ointment (Generic)
	Tobramycin Solution (Generic)	Ofloxacin Solution (Ocuflox®)
		Polymyxin B Sulfate/Trimethoprim Solution (Polytrim®)
		Sulfacetamide Sodium Ointment (Generic)
		Sulfacetamide Sodium Solution (Bleph-10®)
		Tobramycin Ointment, Solution (Tobrex®)
OPHTHALMIC DISORDERS (43)	Neomycin/Polymyxin B/Dexamethasone Ointment (Generic)	Gentamicin/Prednisolone Ointment, Suspension (Pred-G®)
Antibiotic-Steroid Combinations	Neomycin/Polymyxin B/Dexamethasone Suspension (Generic)	Neomycin/Bacitracin/Polymyxin B/Hydrocortisone Ointment (Generic)
*Request Form *Criteria *POS Edits	Sulfacetamide/Prednisolone Solution (Generic)	Neomycin/Polymyxin B/Dexamethasone Ointment, Suspension (Maxitrol®)
	Tobramycin/Dexamethasone Ointment (TobraDex®)	Neomycin/Polymyxin B/Hydrocortisone Suspension (Generic)
	Tobramycin/Dexamethasone Suspension (TobraDex®)	Sulfacetamide/Prednisolone Ointment (Blephamide S.O.P.®)
		Sulfacetamide/Prednisolone Solution (Blephamide®)
		Tobramycin/Dexamethasone Suspension (AG; Generic for TobraDex®)
		Tobramycin/Dexamethasone ST (TobraDex ST®)
		Tobramycin/Loteprednol Suspension (Zylet®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
OPHTHALMIC DISORDERS (43)	Dexamethasone Sodium Phosphate Solution (Generic)	Bromfenac Sodium 0.07% Solution (Prolensa®)
Anti-Inflammatories	Diclofenac Sodium Solution (Generic)	Bromfenac Sodium 0.075% Solution (BromSite®)
*Request Form *Criteria *POS Edits	Difluprednate Emulsion (Durezol®)	Bromfenac Sodium 0.09% Solution (Generic)
	Fluorometholone 0.1% Suspension (Generic)	Dexamethasone Insert (Dextenza®)
	Flurbiprofen Sodium Solution (Generic)	Dexamethasone/PF Suspension (Dexycu™)
	Ketorolac Tromethamine LS Solution 0.4% (Generic)	Dexamethasone Suspension (Maxidex®)
	Ketorolac Tromethamine Solution 0.5% (Generic)	Dexamethasone Intravitreal Implant (Ozurdex®)
	Nepafenac 0.3% Suspension (Ilevro®)	Fluocinolone Acetonide Intravitreal Implant (Iluvien®; Retisert®)
	Prednisolone Acetate 1% Suspension (Generic)	Fluocinolone Acetonide Intravitreal Implant (Yutiq®)
		Fluorometholone 0.1% Ointment (FML S.O.P.®)
		Fluorometholone 0.1% Suspension (FML®)
		Fluorometholone 0.25% Suspension (FML Forte®)
		Fluorometholone Acetate 0.1% Suspension (Flarex®)
		Ketorolac Tromethamine 0.4% Solution (Acular® LS)
		Ketorolac Tromethamine PF Solution 0.45% (Acuvail®)
		Loteprednol Etabonate 1% Ophthalmic Suspension (Inveltys®)
		Loteprednol Gel (AG; Generic; Lotemax®)
		Loteprednol Ointment (Lotemax®)
		Loteprednol Suspension (AG; Generic; Lotemax®)
		Nepafenac 0.1% Suspension (Nevanac®)
		Prednisolone Acetate 0.12% Solution (Pred Mild®)
		Prednisolone Acetate 1% Suspension (Pred Forte®)
		Prednisolone Sodium Phosphate (Generic)
		Triamcinolone Acetonide Suspension (Triesence®)
OPHTHALMIC DISORDERS (43)	Cyclosporine Emulsion (Restasis®; Restasis Multidose™)	Cyclosporine 0.09% Solution (Cequa®)
Anti-Inflammatory/Immunomodulators	Lifitegrast Solution (Xiidra®)	Loteprednol Etabonate Suspension (Eysuvis®)
*Request Form *Criteria *POS Edits		Varenicline Nasal Spray (Tyrvaya®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
OPHTHALMIC DISORDERS (43)	NONE	Cysteamine HCl Solution (Cystadrops®)
Cystinosis		Cysteamine HCl Solution (Cystaran®)
*Request Form *Criteria *POS Edits		
OPHTHALMIC DISORDERS (43)	Brimonidine 0.15% Solution (Alphagan P® 0.15%)	Apraclonidine Solution 0.5% (Generic)
Glaucoma Agents	Brimonidine 0.2% Solution (Generic)	Apraclonidine Solution 1% (Iopidine®)
Intraocular Pressure (IOP) Reducers	Brimonidine/Brinzolamide Suspension (Simbrinza®)	Betaxolol 0.25% Suspension (Betoptic S®)
*Request Form *Criteria *POS Edits	Brimonidine/Timolol Solution (Combigan®)	Betaxolol 0.5% Solution (Generic)
	Carteolol Solution (Generic)	Bimatoprost 0.01% Solution 2.5 mL, 5mL, 7.5mL (Lumigan®)
	Dorzolamide Solution (Generic)	Brimonidine 0.1% Solution (Alphagan P® 0.1%)
	Dorzolamide/Timolol Solution (Generic)	Brimonidine P 0.15% Solution (Generic)
	Latanoprost 2.5mL Solution (Generic)	Brinzolamide Suspension (AG; Generic; Azopt®)
	Levobunolol Solution (Generic)	Dorzolamide Solution (Trusopt®)
	Netarsudil Mesylate Solution (Rhopressa®)	Dorzolamide/Timolol Solution (Cosopt®)
	Netarsudil Mesylate/Latanoprost Solution (Rocklatan®)	Dorzolamide/Timolol/PF Solution (AG; Generic; Cosopt PF®)
	Timolol Maleate Solution (Generic)	Echothiophate Iodide Solution (Phospholine Iodide®)
	Timolol Maleate Gel-Forming Solution (Generic Timoptic-XE®)	Latanoprost Emulsion (Xelpros®)
	Travoprost Solution 2.5 mL, 5 mL (Travatan Z®)	Latanoprost Solution 2.5 mL (Xalatan®)
		Latanoprostene Bunod Solution (Vyzulta®)
		Pilocarpine HCl Solution (Generic; Isopto Carpine®)
		Pilocarpine HCl Solution (Vuity™)
		Tafluprost Solution (Zioptan®)
		Timolol Solution (Betimol®)
		Timolol Maleate LA Solution (AG; Generic; Istalol®)
		Timolol Maleate 0.25% Solution (Timoptic® Ocudose®)
		Timolol Maleate 0.5% Solution (AG; Generic; Timoptic® Ocudose®)
		Travoprost Solution 2.5ml, 5ml (AG; Generic)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
OPIATE DEPENDENCE AGENTS (44)	Buprenorphine Sublingual Tablet (Generic)	Buprenorphine Syringe (Sublocade®)
*Request Form *Criteria *POS Edits	Buprenorphine/Naloxone Sublingual Film (Suboxone®)	Buprenorphine/Naloxone Sublingual Film (Generic)
	Buprenorphine/Naloxone Sublingual Tablet (Generic)	Lofexidine Tablet (Lucemyra®)
	Buprenorphine/Naloxone Sublingual Tablet (Zubsolv®)	Naloxone Injection (Zimhi™)
	Naloxone Nasal Spray (AG; Generic; Narcan®)	Naloxone Spray (Kloxxado®)
	Naloxone Syringe, Vial (Generic)	Naltrexone Extended-Release Suspension Vial (Vivitrol®)
	Naltrexone Tablet (Generic)	
OSTEOPOROSIS (45)	Alendronate Tablet (Generic)	Abaloparatide Pen (Tymlos®)
Bone Resorption Suppression Agents	Calcitonin-Salmon Nasal (Generic)	Alendronate Tablet (Fosamax®)
*Request Form *Criteria *POS Edits	Ibandronate Sodium Tablet (Generic)	Alendronate Solution (Generic)
	Raloxifene Tablet (Generic)	Alendronate/Vitamin D Tablet (Fosamax Plus D®)
		Denosumab Syringe (Prolia®)
		Ibandronate Sodium Tablet (Boniva®)
		Raloxifene Tablet (Evista®)
		Risedronate Tablet (AG; Generic; Actonel®)
		Risedronate DR Tablet (AG; Generic; Atelvia®)
		Romosozumab-aqqg Syringe (Evenity®)
		Teriparatide Pen (Brand)
		Teriparatide Pen (Forteo®)
OTIC AGENTS (46)	Ciprofloxacin/Dexamethasone Suspension (Ciprodex®)	Ciprofloxacin Solution (Generic)
Antibiotics	Neomycin/Polymyxin B/Hydrocortisone Solution (AG; Generic)	Ciprofloxacin Suspension (Otiprio®)
*Request Form *Criteria *POS Edits	Neomycin/Polymyxin B/Hydrocortisone Suspension (AG; Generic)	Ciprofloxacin/Dexamethasone Suspension (AG; Generic)
	Ofloxacin Solution (Generic)	Ciprofloxacin/Fluocinolone Acetonide Solution (AG; Otovel®)
		Ciprofloxacin/Hydrocortisone Suspension (Cipro HC Otic®)
		Colistin/Neomycin/Thonzonium/HC Suspension (Cortisporin® TC)
OTIC AGENTS (46)	Acetic Acid Solution (Generic)	NONE
Anti-Infectives and Anesthetics	Acetic Acid/Hydrocortisone Solution (Generic)	
*Request Form		
*Criteria		
*POS Edits		

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
PAIN MANAGEMENT (47)	Fremanezumab-vfrm Autoinjector (Ajovy®)	Atogepant Tablet (Qulipta™)
Antimigraine Agents	Fremanezumab-vfrm Autoinjector 3-Pack (Ajovy®)	Eptinezumab-ijmr Vial (Vyepti™)
CGRP Antagonists	Fremanezumab-vfrm Syringe (Ajovy®)	Erenumab-aoee Autoinjector (Aimovig®)
*Request Form *Criteria *POS Edits	Galcanzumab-gnlm Pen (Emgality®)	Galcanzumab-gnlm 100 mg Syringe (Emgality®)
	Galcanzumab-gnlm 120 mg Syringe (Emgality®)	
	Rimegepant Disintegrating Tablet (Nurtec™ ODT)	
	Ubrogepant Tablet (Ubrovelvy™)	
PAIN MANAGEMENT (47)	NONE	Celecoxib Oral Solution (Elyxyb™)
Antimigraine Agents		Diclofenac Potassium Oral Powder Packet (Cambia®)
Ergotamines		Dihydroergotamine Mesylate Injection (Generic)
*Request Form *Criteria *POS Edits		Dihydroergotamine Mesylate Nasal (Generic; Migranal®)
		Dihydroergotamine Mesylate Nasal (Trudhesa™)
		Ergotamine Tartrate Sublingual (Ergomar®)
		Ergotamine Tartrate/Caffeine Tablet (Cafergot®)
PAIN MANAGEMENT (47)	Rizatriptan ODT (Generic)	Almotriptan Tablet (Generic)
Antimigraine Agents	Rizatriptan Tablet (Generic)	Eletriptan Tablet (AG; Generic; Relpax®)
Triptans	Sumatriptan Nasal (AG; Generic ; Imitrex®)	Frovatriptan Tablet (Generic; Frova®)
*Request Form *Criteria *POS Edits	Sumatriptan Tablet (Generic)	Lasmiditan Tablet (Reyvow®)
	Sumatriptan Vial (Generic)	Naratriptan (Generic; Amerge®)
		Rizatriptan Tablet (Maxalt®)
		Rizatriptan Tablet (Maxalt MLT®)
		Sumatriptan Auto-Injector (Zembrace® SymTouch®)
		Sumatriptan Kit (AG; Generic; Imitrex®)
		Sumatriptan Kit (SUN)
		Sumatriptan Nasal (Onzetra® Xsail®)
		Sumatriptan Nasal (Tosymra™)
		Sumatriptan Tablet (Imitrex®)
		Sumatriptan/Naproxen (Generic; Treximet®)
		Zolmitriptan Tablet (Generic; Zomig®)
		Zolmitriptan ODT (Generic; Zomig ZMT®)
		Zolmitriptan Nasal (AG; Generic ; Zomig®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
PAIN MANAGEMENT (47)	Adalimumab Pen Kit (Humira®)	Abatacept Injection Clickject, Syringe, Vial (Orencia®)
Cytokine and CAM Antagonists	Adalimumab Syringe Kit (Humira®)	Anakinra Syringe (Kineret®)
*Request Form *Criteria *POS Edits	Apremilast Tablet (Otezla®)	Baricitinib Tablet (Olumiant®)
	Etanercept Kit (Enbrel®)	Brodalumab Syringe (Siliq®)
	Etanercept Cartridge (Enbrel Mini®)	Canakinumab/PF Vial (Ilaris®)
	Etanercept Pen (Enbrel SureClick®)	Certolizumab Pegol Kit, Syringe Kit (Cimzia®)
	Etanercept Syringe (Enbrel®)	Golimumab Pen, Syringe (Simponi®)
	Etanercept Vial (Enbrel®)	Golimumab Vial (Simponi Aria®)
		Guselkumab Autoinjector, Syringe (Tremfya®)
		Inebilizumab-cdon Injection (Uplizna™)
		Infliximab Vial (Remicade®)
		Infliximab-abda Vial (Renflexis®)
		Infliximab-axxq Injection (Avsola™)
		Infliximab-dyyb Vial (Inflectra®)
		Ixekizumab Autoinjector, Syringe (Taltz®)
		Rilonacept Vial (Arcalyst®)
		Risankizumab-rzaa Pen, Syringe (Skyrizi®)
		Sarilumab Pen, Syringe (Kevzara®)
		Satralizumab-mwge Injection (Enspryng™)
		Secukinumab Pen, Syringe (Cosentyx®)
		Tildrakizumab-asmn Syringe (Ilumya®)
		Tocilizumab Pen, Syringe, Vial (Actemra®)
		Tofacitinib ER Tablet, Tablet (Xeljanz® XR; Xeljanz®)
		Tofacitinib Citrate Solution (Xeljanz®)
		Upadacitinib ER Tablet (Rinvoq™)
		Ustekinumab Syringe, Vial (Stelara®)
		Vedolizumab Vial (Entyvio®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
PAIN MANAGEMENT (47)	Acetaminophen with Codeine Elixir (Generic)	Benzhydrocodone/Acetaminophen (AG; Apadaz®)
Narcotic Analgesics - Short-Acting	Acetaminophen with Codeine Tablet (Generic)	Butalbital/Caffeine/APAP/Codeine (Generic; Fioricet® with Codeine)
*Request Form *Criteria *POS Edits	Hydrocodone/Acetaminophen Tablet (Generic)	Butalbital Compound with Codeine (Generic)
	Hydrocodone/Acetaminophen Solution (Generic)	Butorphanol Tartrate Nasal (Generic)
	Hydromorphone Tablet (Generic)	Carisoprodol Compound with Codeine (Generic)
	Morphine IR Tablet (Generic)	Codeine Tablet (Generic)
	Morphine Sulfate Oral Syringe (Generic)	Dihydrocodeine Bitartrate/Acetaminophen/Caffeine (Generic)
	Oxycodone Tablet (Generic)	Fentanyl Buccal Lozenge (Generic; Actiq®)
	Oxycodone/Acetaminophen Tablet (Generic)	Fentanyl Buccal Tablet (Generic; Fentora®)
	Tramadol 50 mg (Generic)	Hydrocodone/Acetaminophen Elixir, Tablet (Lortab®)
	Tramadol/Acetaminophen (Generic)	Hydrocodone/Ibuprofen (Generic)
		Hydromorphone Tablet (Dilaudid®)
		Hydromorphone Liquid, Suppository (Generic)
		Levorphanol Tablet (Generic)
		Meperidine Solution, Tablet (Generic)
		Morphine Oral Concentrate (Generic)
		Morphine Solution (AG, Generic)
		Morphine Suppository (Generic)
		Oxycodone HCl Tablet (Oxaydo®)
		Oxycodone Tablet (Roxicodone®)
		Oxycodone Capsule, Oral Concentrate, Solution (Generic)
		Oxycodone Oral Syringe (Generic)
		Oxycodone/Acetaminophen Tablet (Percocet®)
		Oxymorphone IR Tablet (Generic)
		Pentazocine/Naloxone (Generic)
		Sufentanil Sublingual Tablet (Dsuvia®)
		Tapentadol Tablet (Nucynta®)
		Tramadol 50 mg (Ultram®)
		Tramadol 100 mg (Generic)
		Tramadol Solution (AG)
		Tramadol/Celecoxib Tablet (Seglantis®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
PAIN MANAGEMENT (47)	Buprenorphine Transdermal (AG; Generic; Butrans®)	Buprenorphine Buccal Film (Generic; Belbuca®)
Narcotic Analgesics - Long-Acting	Fentanyl Transdermal 12 mcg (Generic)	Fentanyl Transdermal 37.5 mcg, 62.5mcg, 87.5mcg (Generic)
*Request Form *Criteria *POS Edits	Fentanyl Transdermal 25 mcg (Generic)	Hydrocodone Bitartrate ER Capsule (AG; Generic; Zohydro ER®)
	Fentanyl Transdermal 50 mcg (Generic)	Hydrocodone Bitartrate ER Tablet (Generic; Hysingla ER®)
	Fentanyl Transdermal 75 mcg (Generic)	Hydromorphone ER Tablet (Generic)
	Fentanyl Transdermal 100 mcg (Generic)	Morphine Sulfate ER Capsule (Generic for Avinza®)
	Morphine Sulfate ER Tablet (Generic)	Morphine Sulfate ER Capsule (Generic for Kadian®)
		Morphine Sulfate ER Tablet (MS Contin®)
		Oxycodone ER Tablet (AG; OxyContin®)
		Oxycodone Myristate Capsule (Xtampza® ER)
		Oxymorphone ER Tablet (Generic)
		Tapentadol ER Tablet (Nucynta ER®)
		Tramadol ER Capsule (AG; Conzip®)
		Tramadol ER Tablet (Generic Ryzolt®)
		Tramadol ER Tablet (Generic Ultram ER®)
PAIN MANAGEMENT (47)	Duloxetine Capsule (Generic for Cymbalta®)	Capsaicin/Skin Cleanser (Qutenza Kit®)
Neuropathic Pain	Gabapentin Capsule (Generic)	Duloxetine Capsule (Cymbalta®)
*Request Form *Criteria *POS Edits	Gabapentin Solution (AG; Generic)	Duloxetine Capsule (Generic for Irenka®)
	Gabapentin Tablet (Generic)	Duloxetine DR Capsule (Drizalma Sprinkle™)
	Lidocaine Patch (AG; Generic)	Gabapentin Capsule, Solution, Tablet (Neurontin®)
	Lidocaine Topical System (Ztlido®)	Gabapentin Enacarbil Tablet (Horizant®)
	Milnacipran Tablet (Savella®)	Gabapentin ER Tablet (Gralise®)
	Milnacipran Tablet (Savella Dose Pak®)	Lidocaine Patch (Lidoderm®)
	Pregabalin Capsule (AG; Generic)	Pregabalin Capsule (Lyrica®)
	Pregabalin Solution (AG; Generic)	Pregabalin Solution (Lyrica®)
		Pregabalin ER Tablet (Generic; Lyrica CR®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
PAIN MANAGEMENT (47)	Diclofenac Sodium Tablet (Generic)	Celecoxib (AG; Generic; Celebrex®)
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	Diclofenac Sodium Transdermal Gel (Generic; Voltaren®)	Diclofenac Epolamine Patch (AG; Flector®)
	Ibuprofen Suspension Rx (Generic)	Diclofenac Epolamine Patch (Licart™)
*Request Form *Criteria *POS Edits	Ibuprofen Tablet Rx (Generic)	Diclofenac Potassium Capsule (Zipsor®)
	Indomethacin Capsule (Generic)	Diclofenac Potassium Tablet (Generic)
	Ketorolac Tablet (Generic)	Diclofenac Sodium 1.5% Topical Solution (Generic)
	Meloxicam Tablet (Generic)	Diclofenac Sodium 2% Topical Solution (Pennsaid® Pump)
	Nabumetone Tablet (Generic)	Diclofenac SR Tablet (Generic)
	Naproxen Suspension (AG; Generic)	Diclofenac Submicronized Capsule (Zorvolex®)
	Naproxen Tablet (Generic)	Diclofenac Sodium/Camphor/Menthol Kit (Diclotrex™ Kit)
	Sulindac Tablet (Generic)	Diclofenac Sodium/Capsaicin (Generic)
		Diclofenac/Misoprostol Tablet (Generic; Arthrotec®)
		Diclofenac Sodium Topical (VennGel One® Kit)
		Diflunisal Tablet (Generic)
		Etodolac Capsule, SR Tablet, Tablet (Generic)
		Fenoprofen Capsule (AG; Nalfon®)
		Fenoprofen Tablet (Generic; Nalfon®)
		Flurbiprofen Tablet (Generic)
		Ibuprofen/Famotidine Tablet (Generic; Duexis®)
		Ibuprofen Tablet/Glycerin Spray (Ibupak® Kit)
		Indomethacin ER Capsule (Generic)
		Indomethacin Suppository, Suspension (Indocin®)
		Ketoprofen Capsule, ER Capsule (Generic)
		Ketorolac Nasal Spray (AG; Sprix®)
		Meclofenamate Sodium Capsule (Generic)
		Mefenamic Acid Capsule (Generic)
		Meloxicam, Submicronized Capsule (Generic; Vivlodex®)
		Meloxicam Tablet (Mobic®)
		Nabumetone Tablet (Relafen DS™)
		Naproxen EC Tablet (AG; Generic)
		Naproxen Sodium CR Tablet (AG; Generic; Naprelan®)
		Naproxen Sodium Tablet (Generic)
		Naproxen Suspension (Naprosyn®)
		Naproxen/Esomeprazole Tablet (AG; Generic; Vimovo®)
		Oxaprozin Tablet (Generic)
		Piroxicam Capsule (Generic)
		Tolmetin Capsule, Tablet (Generic)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
PAIN MANAGEMENT (47)	Baclofen Tablet (Generic)	Carisoprodol Compound Tablet (Generic)
Skeletal Muscle Relaxant	Cyclobenzaprine Tablet (Generic)	Carisoprodol Tablet 250 mg, 350 mg (Generic; Soma®)
*Request Form *Criteria *POS Edits	Methocarbamol Tablet (Generic)	Chlorzoxazone Tablet (Generic; Lorzzone®)
	Tizanidine Tablet (Generic)	Cyclobenzaprine ER Capsule (AG; Generic; Amrix®)
		Dantrolene Sodium (AG; Generic; Dantrium®)
		Metaxalone Tablet (Generic; Skelaxin®)
		Orphenadrine ER Tablet (Generic)
		Orphenadrine/Aspirin/Caffeine (Norgesic Forte®)
		Tizanidine Capsule (Generic; Zanaflex®)
		Tizanidine Tablet (Zanaflex®)
PARKINSON'S (48)	Amantadine Capsule (Generic)	Amantadine Hydrochloride ER Capsule (Gocovri®)
Antiparkinson Agents	Amantadine Syrup (Generic)	Amantadine Hydrochloride ER Tablet (Osmolex ER®)
Anticholinergic and Other	Benzotropine Tablet (Generic)	Amantadine Tablet (Generic)
*Request Form *Criteria *POS Edits	Carbidopa/Levodopa ER Tablet (Generic)	Apomorphine Cartridge (Apokyn®)
	Carbidopa/Levodopa Tablet (Generic)	Apomorphine Sublingual Film (Kynmobi™)
	Carbidopa/Levodopa/Entacapone Tablet (Generic)	Bromocriptine Capsule, Tablet (Generic)
	Pramipexole Tablet (Generic)	Carbidopa Tablet (Generic; Lodosyn®)
	Ropinirole Tablet (Generic)	Carbidopa/Levodopa Enteral Suspension (Duopa®)
	Selegiline Tablet (Generic)	Carbidopa/Levodopa ER Capsule (Rytary®)
	Trihexyphenidyl Elixir (Generic)	Carbidopa/Levodopa ODT (Generic)
	Trihexyphenidyl Tablet (Generic)	Carbidopa/Levodopa/Entacapone Tablet (Stalevo®)
		Entacapone Tablet (Generic)
		Istradefylline Tablet (Nourianz™)
		Levodopa Capsule for Inhalation (Inbrija®)
		Opicapone Capsule (Ongentys®)
		Pramipexole ER Tablet (Generic; Mirapex ER®)
		Rasagiline Tablet (Generic; Azilect®)
		Ropinirole ER Tablet (Generic)
		Rotigotine Patch (Neupro®)
		Safinamide Tablet (Xadago®)
		Selegiline Disintegrating Tablet (Zelapar®)
		Selegiline Capsule (Generic)
		Tolcapone Tablet (Generic)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
PEDIATRIC MULTIVITAMINS (49)	Pediatric MVI A, C, D3 No. 21 With FL Drop (Generic)	Pediatric MVI A, C, D3 No. 21 With FL Drop (Tri-Vitamin with FL)
*Request Form *Criteria *POS Edits	Pediatric MVI No. 2 With FL Drop (Generic)	Pediatric MVI A, C, D3 No. 38 with FL Drop (Tri-Vi-Floro®)
	Pediatric MVI No. 16 With FL Chewable (Generic)	Pediatric MVI No. 33 With FL & Fe Chewable (Poly-Vi-Flor® Fe)
	Pediatric MVI No. 17 With FL Chewable (Generic)	Pediatric MVI No. 33 With FL Chewable (Poly-Vi-Flor®)
	Pediatric MVI No. 45 With FL & Fe Drop (Generic)	Pediatric MVI No. 37 With FL & Fe Drop (Poly-Vi-Flor® Fe)
		Pediatric MVI No. 37 With FL Drop (Poly-Vi-Flor®)
		Pediatric MVI No. 63 With FL Chewable (Quflora™)
		Pediatric MVI No. 83 With FL 0.25 mg/ml Drop (Quflora™)
		Pediatric MVI No. 84 With FL 0.5 mg/ml Drop (Quflora™)
		Pediatric MVI No. 85 With FL Chewable (Floriva™)
		Pediatric MVI No. 142 With FL & Fe Chewable (Quflora™ FE)
		Pediatric MVI No. 151 With FL & Fe Drop (Quflora™ FE)
PITUITARY SUPPRESSIVE AGENTS (50)	Goserelin Acetate (Zoladex®)	Histrelin Implant Kit (Supprelin LA®)
*Request Form *Criteria *POS Edits	Leuprolide Acetate Syringe Kit (Fensolvi®)	Histrelin Implant Kit (Vantas®)
	Leuprolide Acetate Subcutaneous Kit (Generic)	Leuprolide Acetate [3-month] (Lupron Depot-Ped®)
	Leuprolide Acetate Subcutaneous Vial (Generic)	Leuprolide Acetate Subcutaneous Kit (Eligard®)
	Leuprolide Acetate (Lupron Depot®)	Triptorelin Pamoate Vial (Trelstar®)
	Leuprolide Acetate (Lupron Depot Kit®)	Triptorelin Pamoate Kit (Triptodur®)
	Leuprolide Acetate [1 month] (Lupron Depot-Ped Kit®)	
	Nafarelin Acetate Nasal Solution (Synarel®)	
POTASSIUM BINDERS (51)	Sodium Polystyrene Sulfonate Powder (Generic)	Patiromer Sorbitex Calcium Powder Packet (Veltassa®)
*Request Form *Criteria *POS Edits		Sodium Zirconium Cyclosilicate (Lokelma®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
PROGESTATIONAL AGENTS (52)	Hydroxyprogesterone Caproate Auto-Injector (Makena®)	Hydroxyprogesterone Caproate MDV (by Mylan) – <i>NOT indicated for pre-term labor</i>
*Request Form *Criteria *POS Edits	Hydroxyprogesterone Caproate SDV (AG; Generic)	Hydroxyprogesterone Caproate MDV (Generic)
	Medroxyprogesterone Acetate Tablet (AG; Generic)	Medroxyprogesterone Acetate Tablet (Provera®)
	Norethindrone Acetate Tablet (Generic)	Norethindrone Acetate Tablet (Aygestin®)
	Progesterone Capsule (Generic)	Progesterone Vial (Generic)
		Progesterone, Micronized, Capsule (Prometrium®)
		Progesterone, Micronized, Vaginal Gel (Crinone®)
PROSTATE (53)	Alfuzosin ER Tablet (Generic)	Doxazosin ER Tablet, Tablet (Cardura XL®; Cardura®)
Benign Prostatic Hyperplasia (BPH)	Doxazosin Tablet (AG; Generic)	Dutasteride Capsule (Avodart®)
*Request Form *Criteria *POS Edits	Dutasteride Capsule (Generic)	Dutasteride/Tamsulosin Capsule (Generic; Jalyn®)
	Finasteride Tablet (Generic)	Finasteride Tablet (Proscar®)
	Tamsulosin Capsule (Generic)	Silodosin Capsule (Generic; Rapaflo®)
	Terazosin Capsule (Generic)	Tadalafil Tablet (AG; Generic; Cialis®)
		Tamsulosin Capsule (Flomax®)
SEDATIVE/HYPNOTICS (54)	Temazepam Capsule 15 mg, 30 mg (AG; Generic)	Doxepin Tablet (AG; Generic; Silenor®)
*Request Form *Criteria *POS Edits	Triazolam Tablet (Generic)	Estazolam Tablet (Generic)
	Zolpidem Tablet (Generic)	Eszopiclone Tablet (Generic; Lunesta®)
		Flurazepam Capsule (Generic)
		Lemborexant Tablet (Dayvigo®)
		Ramelteon Tablet (Generic; Rozerem®)
		Suvorexant Tablet (Belsomra®)
		Tasimelteon Capsule, Suspension (Hetlioz®; Hetlioz LQ™)
		Temazepam Capsule (Restoril®)
		Temazepam 7.5 mg, 22.5 mg (Generic)
		Triazolam Tablet (Halcion®)
		Zaleplon Capsule (Generic)
		Zolpidem Tartrate ER Tablet (Generic; Ambien CR®)
		Zolpidem Tartrate Sublingual (Eduar®)
		Zolpidem Tartrate Sublingual (Generic for Intermezzo®)
		Zolpidem Tartrate Tablet (Ambien®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
SICKLE CELL ANEMIA (55)	Hydroxyurea Capsule (Droxia®)	Crizanlizumab-tmca Infusion (Adakveo®)
*Request Form *Criteria *POS Edits		Hydroxyurea Tablet (Siklos®)
		L-glutamine Powder Pack (Endari™)
		Voxelotor Tablet (Oxbryta®)
SINUS NODE INHIBITORS (56)	NONE	Ivabradine Solution (Corlanor®)
*Request Form *Criteria *POS Edits		Ivabradine Tablet (Corlanor®)
SMOKING CESSATION PRODUCTS (57)	Bupropion SR Tablet (Generic)	Nicotine Inhaler (Nicotrol Inhaler®)
*Request Form *Criteria *POS Edits	Nicotine Buccal Gum OTC, Buccal Lozenge OTC (Generic)	Nicotine Nasal Spray (Nicotrol Nasal Spray®)
	Nicotine Patch OTC (Generic)	
	Varenicline Tablet (Generic; Chantix®; Chantix Dose Pack®)	
THROMBOPOIESIS STIMULATING PROTEINS (58)	Eltrombopag Tablet (Promacta®)	Avatrombopag Tablet (Doptelet®)
*Request Form *Criteria *POS Edits		Eltrombopag Suspension Packet (Promacta®)
		Fostamatinib Disodium Hexahydrate Tablet (Tavalisse®)
		Lusutrombopag Tablet (Mulpleta®)
		Romiplostim Vial (Nplate®)
UROLOGY INCONTINENCE (59)	Fesoterodine Fumarate ER Tablet (Toviaz®)	Darifenacin ER (Generic)
Bladder Relaxant Preparations	Oxybutynin Syrup (Generic)	Flavoxate Tablet (Generic)
*Request Form *Criteria *POS Edits	Oxybutynin Tablet (Generic)	Mirabegron ER Granules for Oral Suspension, ER Tablet (Myrbetriq®)
	Oxybutynin ER Tablet (Generic)	Oxybutynin ER Tablet (Ditropan XL®)
	Solifenacin Tablet (Generic)	Oxybutynin Transdermal Gel (Gelnique®)
		Oxybutynin Transdermal Patch Rx (Oxytrol®)
		Solifenacin Tablet, Suspension (VESIcare®; VESIcare® LS)
		Tolterodine Tablet (Generic; Detrol®)
		Tolterodine ER Capsule (AG; Generic; Detrol LA®)
		Trospium Tablet (Generic)
		Trospium ER Capsule (Generic)
		Vibegron Tablet (Gemtesa®)

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

Effective Date: July 1, 2022 (Updated August 1, 2022)

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
UTERINE DISORDER TREATMENTS (60)	Elagolix Tablet (Orilissa®)	NONE
*Request Form *Criteria *POS Edits	Elagolix/Estradiol/Norethindrone Capsule (Oriahnn®)	
	Relugolix/Estradiol/Norethindrone Acetate (Myfembree™)	

ADDITIONAL AGENTS THAT HAVE POINT-OF-SALE (POS) REQUIREMENT(S)

AL – Age Limit	DD – Drug-Drug Interaction		MD – Maximum Dose Limit		RX – Specific Prescription Requirement
BH – Behavioral Health Clinical Authorization for Children Younger than 7 Years of Age	DS – Maximum Days’ Supply Allowed		PA – Prior Authorization		TD – Therapeutic Duplication
BY – Diagnosis Codes Bypass Some Requirements	DT – Duration of Therapy Limit		PR – Enrollment in a Physician-Supervised Program Required		UN – Drug Use Not Warranted
CL – Additional Clinical Information is Required	DX – Diagnosis Code Requirement		PU – Prior Use of other Medication is Required		X – Prescriber Must Have ‘X’ DEA Number
CU – Concurrent Use with Other Medications is Restricted	ER – Early Refill		QL – Quantity Limit		YQ – Yearly Quantity Limit
Acetaminophen	<u>MD</u>	HyperTET SD (Tetanus IG)	<u>CL</u>	Ravicti® (Glycerol Phenylbutyrate)	<u>CL</u>
Acthar® (Corticotropin)	<u>CL</u>	Imipramine	<u>BH, TD</u>	Reclast® (Zoledronic acid)	<u>CL, QL</u>
Actimmune® (Interferon Gamma-1b)	<u>DX</u>	Intron-A® (Interferon Alfa-2B Recombinant)	<u>DX</u>	Remodulin® (Treprostinil Sodium) Injection	<u>DX</u>
Aldurazyme™ (Laronidase)	<u>CL</u>	Jadenu® (Deferasirox)	<u>DX</u>	Rilutek® (Riluzole)	<u>DX</u>
Amitriptyline	<u>BH, TD</u>	Jynarque® (Tolvaptan)	<u>CL</u>	Samsca® (Tolvaptan)	<u>CL, QL</u>
Amitriptyline/Chlordiazepoxide	<u>BH</u>	Kerendia® (Finerenone)	<u>CL</u>	Soliris® (Eculizumab)	<u>DX</u>
Amondys 45® (Casimersen)	<u>CL</u>	Keveyis® (Dichlorphenamide)	<u>CL, QL</u>	Spinraza® (Nusinersen) REQUEST FORM	<u>CL</u>
Amoxapine	<u>BH, TD</u>	Kuvan® (Sapropterin Dihydrochloride)	<u>CL</u>	Strensiq® (Asfotase alfa)	<u>DX</u>
Aspirin	<u>MD</u>	Lidocaine Patch Kit (Brand Example - Prilo Patch II®)	<u>CL</u>	Sylatron® (Peginterferon alfa-2b)	<u>DX</u>
<u>Aspruzyo Sprinkle™ (Ranolazine)</u>	<u>CL</u>	Lithium	<u>BH</u>	Synagis® (Palivizumab) REQUEST FORM	<u>AL, CL</u>
Beyaz® (Drospirenone/Ethinyl Estradiol/ Levomefolate Calcium)	<u>DX</u>	Lorazepam Injectable	<u>BY</u>	Tegsedi™ (Inotersen)	<u>DX</u>
Brineura™ (Cerliponase alfa)	<u>DX</u>	Lumizyme® (Alglucosidase alfa)	<u>DX</u>	<u>Tezspire™ (Tezepelumab-ekko)</u>	<u>CL</u>
Buphenyl® (Sodium Phenylbutyrate)	<u>CL</u>	Maprotiline	<u>BH</u>	Tiglutik™ (Riluzole)	<u>DX</u>
Cablivi® (Caplacizumab-yhdp)	<u>CL</u>	Mepsevii™ (Vestronidase alfa-vjbjk)	<u>CL</u>	Tikosyn® (Dofetilide)	<u>CL</u>
Carafate® (Sucralfate)	<u>BY, DT</u>	Methadone	<u>CL, BY, CU, DX, MME, PU, QL, TD</u>	Trimipramine	<u>BH, TD</u>

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)
Effective Date: July 1, 2022 (Updated August 1, 2022)

Carbaglu® (Carglumic Acid)	<u>CL</u>	Mosquito Repellent to Decrease Zika Virus Exposure Risk <u>FFS Notice</u> <u>MCO Notice</u>	AL, DX, QL	Ultomiris® (Ravulizumab-cwvz)	<u>DX</u>
Chlordiazepoxide/Clidinium	<u>BH</u>	Mytesi® (Crofelemer)	<u>CL</u>	Velettri® (Epoprostenol)	<u>DX</u>
Chlorpromazine Injectable	<u>BH</u>	Nabi-HB (Hepatitis B IG)	<u>CL</u>	Viltepso® (Viltolarsen)	<u>CL</u>
Clomipramine	<u>BH, TD</u>	Naglazyme™ (Galsulfase)	<u>CL</u>	Vimizim™ (Elosulfase alfa)	<u>CL</u>
Cuprimine® (Penicillamine)	<u>CL, QL</u>	Nexplanon® (Etonogestrel)	<u>QL</u>	Vyndamax™, Vyndaqel® (Tafamidis)	<u>CL, QL</u>
Daraprim® (Pyrimethamine)	<u>CL</u>	Nexviazyme® (Avalglucosidase-alfa)	<u>DX</u>	Vyondys 53® (Golodirsen)	<u>CL</u>
Depen® (Penicillamine)	<u>CL, QL</u>	Nityr® (Nitisinone)	<u>CL</u>	Xenical® (Orlistat)	<u>DX, QL</u>
Desipramine	<u>BH, TD</u>	Nocdurna® (Desmopressin)	<u>QL</u>	Xyrem® (Sodium Oxybate)	<u>CL, TD</u>
Doxepin (10 mg-150 mg)	<u>BH, TD</u>	Nortriptyline	<u>BH, TD</u>	Xywav™ (Oxybate Salts)	<u>CL, TD</u>
Elaprase™ (Idursulfase)	<u>CL</u>	Nuedexta® (Dextromethorphan/Quinidine)	<u>CL, QL</u>	Zolgensma® (Onasemnogene Apeparvovec-xioi)	<u>CL</u>
Empaveli® (Pegcetacoplan)	<u>DX</u>	Nulibry™ (Fosdenopterin)	<u>CL</u>	Zonalon® (Doxepin Topical)	<u>AL, DX, TD, QL</u>
Evrysdi™ (Risdiplam)	<u>CL, QL</u>	Onpatro® (Patisiran)	<u>DX</u>		
Exjade® (Deferasirox)	<u>DX</u>	Orfadin® (Nitisinone)	<u>CL</u>		
Exondys 51® (Eteplirsen)	<u>CL</u>	Palynziq® (Pegvaliase-pqpz)	<u>CL</u>		
Exservan™ (Riluzole)	<u>DX</u>	Pamidronate Disodium	<u>CL</u>		
Fabrazyme® (Agalsidase beta)	<u>DX, TD</u>	Proleukin® (Aldesleukin)	<u>DX</u>		
Ferriprox® (Deferiprone)	<u>DX</u>	Protriptyline	<u>BH, TD</u>		
Fetroja® (Cefiderocol)	<u>CL</u>	Prudoxin® (Doxepin Topical)	<u>AL, DX, TD, QL</u>		
Flolan® (Epoprostenol Sodium)	<u>DX</u>	Pulmozyme® (Dornase Alfa)	<u>DX</u>		
GalaFold® (Migalastat)	<u>DX, TD</u>	Quaaluaquin® (Quinine) 324 mg	<u>DS, DX, QL</u>		
Gattex® (Teduglutide)	<u>CL</u>	Radicava® (Edaravone)	<u>DX</u>		
Givlaari® (Givosiran)	<u>CL</u>	Ranexa® (Ranolazine)	<u>CL</u>		