

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

- The PDL is a list of over 100 therapeutic classes reviewed by the Pharmaceutical & Therapeutics (P&T) committee. In addition, there are medications and/or classes of medications that are not reviewed by the committee. Unless there is a clinical pre-authorization requirement for the entire class (as noted on the last page of the PDL) these medications will continue to be covered without 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 via an electronic prescription and the pharmacist enters “1” in the DAW field 408-D8. For more information, please [CLICK THIS LINK](#) to the provider manual.
- New medications that enter the marketplace in classes reviewed by P&T committee will be considered non-preferred requiring prior authorization until the next P&T committee meeting. Please refer to the following criteria: [New Drugs Introduced into the Market / Non-Preferred](#)
- 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.
- Any statement highlighted and underlined in blue is a hyperlink to go directly to forms and/or clinical criteria for medications with an explanation of the purpose and the requirements. **Example: [Request Form](#)**
- For medications that require a diagnosis code at the pharmacy, please [CLICK THIS LINK](#).
- This PDL/NPDL applies only to medications dispensed in the outpatient retail pharmacy setting.
- For the request of clinical overrides for the use of medications outside of the established Point-of-Sale edits, such as diagnosis and quantity limits, please refer to the following criteria: [Medically Necessary](#)

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

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)	
ACNE AGENTS, TOPICAL (1)	Clindamycin Phosphate Gel (Generic)	Adapalene Cream (Generic; Differin®)	
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Clindamycin Phosphate Medicated Swab (Generic)	Adapalene Gel (AG; Generic)	
	Clindamycin Phosphate Solution (Generic)	Adapalene Gel Pump (AG; Generic; Differin®)	
	Clindamycin Phosphate/Benzoyl Peroxide (Generic for Duac®)	Adapalene Lotion (Differin®)	
	Erythromycin Gel (AG, Generic)	Adapalene/Benzoyl Peroxide (Generic for Epiduo®)	
	Erythromycin Solution (Generic)	Adapalene/Benzoyl Peroxide with Pump (Epiduo Forte® Gel)	
	Tretinoin Cream (Retin-A®)	Clindamycin Phosphate Gel (AG, Clindagel®)	
			Clindamycin Phosphate Lotion (Generic)
			Clindamycin Phosphate /Benzoyl Peroxide w/Pump (Generic; Acanya®)
			Clindamycin Phosphate Foam (Generic)
			Clindamycin Phosphate Lotion (Cleocin-T®)
			Clindamycin Phosphate/Benzoyl Peroxide Gel with Pump (Onexton®)
			Clindamycin/Benzoyl Peroxide Gel (Generic; BenzaClin®)
			Clindamycin/Benzoyl Peroxide Gel with Pump (Generic; BenzaClin®)
			Clindamycin Phosphate/Skin Cleanser 19 (Clindacin® Pac Kit)
			Clindamycin Phosphate/Benzoyl Peroxide Gel (Neuac™)
			Clindamycin/Tretinoin (AG; Generic; Ziana®)
			Dapsone Gel (AG; Generic; Aczone®)
			Dapsone Gel with Pump (Aczone®)
			Erythromycin Medicated Swab (Generic)
			Erythromycin/Benzoyl Peroxide Gel (Generic; Benzamycin®)
			Minocycline Topical Foam (Amzeeq™)
			Sulfacetamide Sodium Cleanser (Generic)
			Sulfacetamide Sodium Cream ER (Ovace® Plus)
			Sulfacetamide Sodium Cleanser ER (Ovace® Plus)
			Sulfacetamide Sodium Lotion (Ovace® Plus)
			Sulfacetamide Sodium Wash (Ovace® Plus)
	Sulfacetamide Sodium Cleanser ER (Generic)		
	Sulfacetamide Sodium Shampoo (Generic)		
	Sulfacetamide Sodium/Sulfur Cleanser (Avar® LS)		
	Sulfacetamide Sodium/Sulfur Medicated Pads (Avar®)		
	Sulfacetamide Sodium/Sulfur Emollient Cream (Avar-e®)		
	Sulfacetamide Sodium/Sulfur Wash (BP 10-1®)		

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>ACNE AGENTS, TOPICAL (1) Continued</b>	(preferred agents listed on page 1)	Sulfacetamide Sodium/Sulfur (Generic)
		Sulfacetamide Sodium/Sulfur Cleanser (Avar®)
		Sulfacetamide Sodium/Sulfur Cleanser (Generic)
		Sulfacetamide Sodium/Sulfur/Cleanser 23 Kit (Generic)
		Sulfacetamide Sodium/Sulfur/Cleanser 23 Kit (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 Suspension (Generic)
		Sulfacetamide Sodium/Sulfur Suspension (Generic)
		Sulfacetamide Sodium/Sulfur/Urea Cleanser (Generic)
		Tazarotene Foam (Fabior®)
		Tazarotene Cream (AG; Generic; Tazorac®)
		Tazarotene Gel (Tazorac®)
		Tazarotene Lotion (Arazlo™)
		Tretinoin Lotion (Altreno®)
		Tretinoin Cream (Avita®)
		<b>Tretinoin Cream (Generic)</b>
		Tretinoin Gel (Generic; Atralin®)
		Tretinoin Gel (AG for Avita®; Generic for 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, 2021**

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

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>ALLERGY (3)</b>	Cetirizine-D OTC (Generic)	Acrivastine/Pseudoephedrine (Semprex-D®)
<b>Antihistamines – Minimally Sedating</b>	Cetirizine Solution OTC (1 mg/mL) (Generic)	Cetirizine Injection (Quzyttir™)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Cetirizine Solution RX (1 mg/mL) (Generic)	Cetirizine Capsule OTC (Generic)
	Cetirizine Tablet OTC (Generic)	Cetirizine Chewable Tablet OTC (Generic)
	Levocetirizine Tablet OTC (Generic)	Cetirizine 5 mg/5 mL Solution OTC (Generic)
	Levocetirizine Tablet (Generic)	Desloratadine Tablet (Generic; Clarinex®)
	Loratadine-D OTC (Generic)	Desloratadine ODT (Generic)
	Loratadine ODT OTC (Generic)	Desloratadine/Pseudoephedrine (Clarinex-D 12-Hour®)
	Loratadine Solution OTC (Generic)	Fexofenadine 60 mg OTC (Generic)
	Loratadine Tablet OTC (Generic)	Fexofenadine 180 mg OTC (Generic)
		Fexofenadine Suspension OTC (Generic)
		Fexofenadine/Pseudoephedrine 12-hour OTC (Generic)
		Levocetirizine Solution (Generic)
		Loratadine Chewable Tablet OTC (Generic)
<b>ALLERGY (3)</b>	Azelastine (Generic for Astelin®)	Azelastine/Fluticasone (AG; Generic; Dymista®)
<b>Rhinitis Agents, Nasal</b>	Azelastine (AG for Astepro®; Generic for Astepro®)	Beclomethasone (Beconase AQ®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Fluticasone Propionate Nasal Spray (Generic)	Beclomethasone (Qnasl 40®)
	Ipratropium Bromide Nasal Spray (Generic)	Beclomethasone (Qnasl 80®)
		Ciclesonide (Omnaris®)
		Ciclesonide (Zetonna®)
		Flunisolide Nasal Spray (Generic)
		Fluticasone Propionate (Xhance®)
		Mometasone (AG; Generic; Nasonex®)
		Mometasone Furoate Implant (Sinuva™)
		Olopatadine (AG; Generic; Patanase®)

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>ALZHEIMER'S AGENTS (4)</b>	Donepezil ODT (Generic)	Donepezil (Aricept®)
<b>Cholinesterase Inhibitors</b>	Donepezil Tablet (Generic)	Donepezil 23 mg (Generic)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Memantine Tablet (AG; Generic)	Donepezil/Memantine ER Capsule (Namzaric®)
	Rivastigmine Transdermal (AG; Generic)	Donepezil/Memantine ER Dose Pack (Namzaric®)
		Galantamine Solution (Generic)
		Galantamine Tablet (Generic)
		Galantamine ER Capsule (Generic)
		Memantine Capsule ER (AG; Generic; Namenda XR®)
		Memantine Solution (Generic)
		Memantine Tablet (Namenda®)
		Memantine Titration Pack (AG; Namenda® Dose Pack)
		Rivastigmine Capsule (Generic)
	Rivastigmine Transdermal (Exelon®)	
<b>ANDROGENIC AGENTS (5)</b>	Testosterone Transdermal System (Androderm®)	Testosterone Gel (AG; Testim®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Testosterone Gel (AG for Vogelxo®)	Testosterone Gel Packet (AG; Generic; Androgel®)
	Testosterone Gel Packet (AG for Vogelxo®)	Testosterone Gel Pump (Generic Axiron®)
	Testosterone Gel Pump (AG for Vogelxo®)	Testosterone Gel Pump (Generic; Androgel®)
	Testosterone Gel (Generic for Vogelxo®)	Testosterone Gel Pump (Vogelxo®)
		Testosterone Gel Pump (AG; Generic; Fortesta®)
		Testosterone Nasal (Natesto®)
<b>ANTHELMINTICS (6)</b>	Albendazole (AG; Generic)	Albendazole (Albenza®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Ivermectin (Generic)	Ivermectin (Stromectol®)
	Mebendazole (Emverm®)	Praziquantel (Biltricide®)
	Praziquantel (Generic)	
<b>ANTI-ALLERGENS, ORAL (7)</b>	NONE	Mixed Grass Allergen Extract (Oralair®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		Peanut Allergen Titration Capsule (Palforzia®)
		Peanut Allergen Maintenance Sachet (Palforzia®)

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>ANTICONVULSANTS (8)</b>	Brivaracetam Solution (Briviact®)	Carbamazepine ER (Generic for Carbatrol®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Brivaracetam Tablet (Briviact®)	Carbamazepine XR (AG; Generic)
	Cannabidiol Solution (Epidiolex®)	Carbamazepine Suspension (Generic; Tegretol®)
	Carbamazepine Tablet (Generic; Epitol®)	Carbamazepine Tablet (Tegretol®)
	Carbamazepine Extended Release Capsule (Carbatrol®)	Clobazam Film (Sympazan®)
	Carbamazepine Extended Release Capsule (Equetro®)	Clobazam Suspension (Onfi®)
	Carbamazepine Extended Release Tablet (Tegretol® XR)	Clobazam Tablet (Onfi®)
	Carbamazepine Chewable Tablet (Generic)	Clonazepam Tablet (Klonopin®)
	Cenobamate Tablet (Xcopri®)	Diazepam Rectal (Diastat®)
	Cenobamate Titration Pak (Xcopri®)	Diazepam Rectal (Diastat® AcuDial™)
	Clobazam Suspension (Generic)	Divalproex Sodium (Depakote®)
	Clobazam Tablet (Generic)	Divalproex Sodium (Depakote® ER)
	Clonazepam (Generic)	Divalproex Sodium Sprinkle (AG; Generic)
	Clonazepam ODT (Generic)	Ethosuximide Capsule (Zarontin®)
	Diazepam Device Rectal (AG)	Ethosuximide Syrup (Zarontin®)
	Diazepam Nasal Spray (Valtoco®)	<b>Felbamate Suspension (Felbatol®)</b>
	Diazepam Rectal (AG)	Felbamate Tablet (Generic)
	Divalproex ER (Generic)	Fenfluramine Oral Solution (Fintepla®)
	Divalproex Sodium Sprinkle (Depakote®)	Lamotrigine Dispersible Tablet (Lamictal®)
	Divalproex Tablet (Generic)	Lamotrigine ODT (Lamictal®)
	Ethosuximide Capsule (AG; Generic)	Lamotrigine ODT Dose Pack (Generic; Lamictal®)
	Ethosuximide Syrup (Generic)	Lamotrigine XR Dose Pack (Lamictal® XR)
	Ethotoin (Peganone®)	Lamotrigine Extended Release Tablet (Lamcital® XR®)
	Eslicarbazepine Acetate (Aptiom®)	Lamotrigine Tablet (Lamictal®)
	<b>Felbamate Suspension (Generic)</b>	Lamotrigine Tablet Dose Pack (Generic; Lamictal®)
	Felbamate Tablet (Felbatol®)	Levetiracetam Extended Release Tablet (Keppra XR®)
	Lacosamide Solution (Vimpat®)	Levetiracetam Tablet for Oral Suspension (Spritam®)
	Lacosamide Tablet (Vimpat®)	Levetiracetam Solution (Keppra®)
	Lamotrigine Dispersible Tablet (Generic)	Levetiracetam Tablet (Keppra®)
Lamotrigine ODT (Generic)	Oxcarbazepine Suspension (Generic)	
Lamotrigine Tablet (Generic)	Oxcarbazepine Tablet (Trileptal®)	
Lamotrigine XR (Generic)	Phenytoin (Dilantin®)	
Levetiracetam ER (Generic)	Phenytoin (Dilantin® Infatabs®)	

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>ANTICONVULSANTS (8) Continued</b>	Levetiracetam Solution (Generic)	Phenytoin Ext Capsule (Phenytek®)
	Levetiracetam Tablet (Generic)	Phenytoin Suspension (Dilantin®)
	Methsuximide (Celontin®)	Primidone (Mysoline®)
	Midazolam Nasal Spray (Nayzilam®)	Tiagabine Tablet (Generic; Gabitril®)
	Oxcarbazepine (Oxtellar XR®)	Topiramate Extended Release Capsule (Qudexy® XR)
	Oxcarbazepine Suspension (Trileptal®)	Topiramate Sprinkle (Topamax®)
	Oxcarbazepine Tablet (Generic)	Topiramate Tablet (Topamax®)
	Perampanel Suspension (Fycompa®)	Vigabatrin Powder Pack (Generic)
	Perampanel Tablet (Fycompa®)	Vigabatrin Tablet (Generic)
	Phenobarbital Elixir (Generic)	
	Phenobarbital Tablet (Generic)	
	Phenytoin Capsule (Generic)	
	Phenytoin 30 mg Capsule (Dilantin®)	
	Phenytoin Chewable Tablet (Generic)	
	Phenytoin Ext Capsule (Generic for Phenytek®)	
	Phenytoin Suspension (AG; Generic)	
	Primidone (AG for Mysoline®; Generic for Mysoline®)	
	Rufinamide Suspension (Banzel®)	
	Rufinamide Tablet (Banzel®)	
	Stiripentol Capsule (Diacomit®)	
	Stiripentol Powder Pack (Diacomit®)	
	Topiramate Extended Release Capsule (AG for Qudexy® XR)	
	Topiramate Extended Release Capsule (Trokendi XR®)	
	Topiramate Sprinkle (Generic)	
	Topiramate Tablet (Generic)	
	Valproic Acid Capsule (Generic)	
	Valproic Acid Solution (Generic)	
	Vigabatrin Powder Pack (Sabril®)	
	Vigabatrin Tablet (Sabril®)	
	Zonisamide (Generic)	



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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)	
<b>ANTIPSYCHOTIC AGENTS (9)</b>	<b>ORAL AGENTS</b>	<b>ORAL AGENTS</b>	
<b>Antipsychotic Oral/Transdermal Agents</b>	Amitriptyline/Perphenazine (Generic)	Aripiprazole ODT (Generic)	
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>  ***Prior Use Requirement for Vraylar® and Latuda® - See POS Edits	Aripiprazole Tablet (Generic)	Aripiprazole Solution (Generic)	
	Cariprazine (Vraylar®)***	Aripiprazole Tablet (Abilify®)	
	Chlorpromazine Tablet (Generic)	Aripiprazole Tablet with Sensor (Abilify® Mycite®)	
	Clozapine Tablet (AG; Generic)	Asenapine Sublingual Tablet (Saphris®)	
	Fluphenazine Tablet (Generic)	Asenapine Transdermal (Secuado®)	
	Haloperidol Tablet (Generic)	Brexpiprazole Tablet (Rexulti®)	
	Haloperidol Lactate Concentrate (Generic)	Clozapine ODT (AG; Generic)	
	Loxapine Capsule (Generic)	Clozapine Tablet (Clozaril®)	
	Lurasidone Tablet (Latuda®)***	Clozapine Suspension (Versacloz®)	
	Olanzapine ODT (Generic)	Fluphenazine Elixir/Solution (Generic)	
	Olanzapine Tablet (Generic)	Iloperidone Tablet (Fanapt®)	
	Perphenazine Tablet (Generic)	Loxapine Inhalation (Adasuve®)	
	Pimozide Tablet (Generic)	Lumateperone Capsule (Caplyta™)	
	Quetiapine ER Tablet (AG; Generic)	Molindone Tablet (Generic)	
	Quetiapine Tablet (Generic)	Olanzapine Tablet (Zyprexa®)	
	Risperidone Solution (Generic)	Olanzapine ODT (Zyprexa Zydis®)	
	Risperidone Tablet (Generic)	Olanzapine/Fluoxetine (Generic; Symbyax®)	
	Thioridazine Tablet (Generic)	Paliperidone ER Tablet (AG; Generic; Invega®)	
	Thiothixene Capsule (Generic)	Pimavanserin Capsule (Nuplazid®)	
	Trifluoperazine Tablet (Generic)	Pimavanserin Tablet (Nuplazid®)	
	Ziprasidone Capsule (Generic)	Quetiapine ER Tablet (Seroquel XR®)	
			Quetiapine Tablet (Seroquel®)
			Risperidone ODT (Generic)
			Risperidone Solution (Risperdal®)
		Risperidone Tablet (Risperdal®)	
		Ziprasidone Capsule (Geodon®)	

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>ANTIPSYCHOTIC AGENTS (9)</b>	<b>INJECTABLE AGENTS</b>	<b>INJECTABLE AGENTS</b>
<b>Antipsychotic Injectable Agents</b>	Aripiprazole Lauroxil (Aristada®; Aristada® Initio®)	Haloperidol Decanoate (Haldol®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Aripiprazole Suspension ER (Abilify Maintena®)	Olanzapine Solution (Generic; Zyprexa®)
	Fluphenazine Decanoate (Generic)	Olanzapine Suspension (Zyprexa® Relprevv®)
	Haloperidol Decanoate (Generic)	Risperidone ER Suspension (Subcutaneous) (Perseris®)
	Haloperidol Lactate (Generic)	Ziprasidone Intramuscular (Generic)
	Paliperidone (Invega® Sustenna®; Invega® Trinza®)	
	Risperidone ER Suspension (Intramuscular) (Risperdal® Consta®)	
	Ziprasidone (Geodon®)	
<b>ANTIVIRALS, ORAL (10)</b>	Acyclovir Capsule (Generic)	Acyclovir Buccal Tablet (Sitavig®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Acyclovir Suspension (Generic)	Baloxavir Marboxil (Xofluza®)
	Acyclovir Tablet (Generic)	Oseltamivir Capsule (Tamiflu®)
	Famciclovir Tablet (Generic)	Oseltamivir Suspension (Tamiflu®)
	Oseltamivir Capsule (Generic)	Rimantadine Tablet (Generic)
	Oseltamivir Suspension (Generic)	Valacyclovir Caplet (Valtrex®)
	Valacyclovir Tablet (Generic)	Zanamivir Inhalation Powder (Relenza® Diskhaler®)
<b>ANXIOLYTICS (11)</b>	Alprazolam Tablet (Generic)	Alprazolam ER Tablet (Generic; Xanax XR®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Bupirone Tablet (Generic)	Alprazolam Intensol Concentrate (Generic)
	Lorazepam Tablet (Generic)	Alprazolam ODT (Generic)
		Alprazolam Tablet (Xanax®)
		Chlordiazepoxide Capsule (Generic)
		Clorazepate Dipotassium Tablet (Generic)
		Diazepam Injection Syringe (Generic)
		Diazepam Injection Vial (Generic)
		Diazepam Intensol Concentrate (Generic)
		Diazepam Solution (Generic)
		Diazepam Tablet (Generic)
		Lorazepam Intensol Concentrate (Generic)
		Lorazepam Tablet (Ativan®)
		Meprobamate (Generic)
		Oxazepam (Generic)

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>ASTHMA/COPD (12)</b>	<b>INHALATION</b>	<b>INHALATION</b>
<b>Bronchodilator, Anticholinergics (COPD) Inhalation</b>	Albuterol Sulfate/Ipratropium (Combivent® Respimat®)	Aclidinium Bromide/Formoterol Fumarate (Duaklir® Pressair®)
	Albuterol Sulfate/Ipratropium Nebulizer Solution (Generic)	Aclidinium Bromide Inhalation Powder (Tudorza® Pressair®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Ipratropium Inhalation Aerosol MDI (Atrovent HFA®)	Glycopyrrolate (Seebri® Neohaler®)
	Ipratropium Nebulizer Solution (Generic)	Glycopyrrolate/Formoterol Fumarate (Bevespi Aerosphere®)
	Tiotropium Inhalation Powder (Spiriva® HandiHaler®)	Glycopyrrolate Inhalation Solution (Lonhala® Magnair®)
	Tiotropium/Olodaterol (Stiolto® Respimat®)	Indacaterol/Glycopyrrolate (Utibron® Neohaler®)
	Umeclidinium/Vilanterol Inhalation Powder (Anoro® Ellipta®)	Revefenacin Inhalation Solution (Yupelri®)
		Tiotropium Bromide Inhalation Spray (Spiriva® Respimat®)
		Umeclidinium Inhalation Powder (Incruse® Ellipta®)
<b>ASTHMA/COPD (12)</b>	<b>ORAL</b>	<b>ORAL</b>
<b>Bronchodilator, Anticholinergics (COPD) Oral</b>	NONE	Roflumilast (Daliresp®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		
<b>ASTHMA/COPD (12)</b>	<b>INHALATION</b>	<b>INHALATION</b>
<b>Bronchodilator, Beta-Adrenergic Inhalation Agents</b>	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®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	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 (Brovana®)
	Albuterol Sulfate MDI (AG; Generic; ProAir HFA®)	Formoterol Inhalation Solution (Perforomist®)
	Albuterol Sulfate MDI (AG and Generic for Proventil HFA®)	Indacaterol Inhalation Powder (Arcapta® Neohaler®)
	Albuterol Sulfate MDI (AG for Ventolin HFA®)	Levalbuterol Nebulizer Solution (Generic; Xopenex®)
	Salmeterol Xinafoate (Serevent® Diskus®)	Levalbuterol Nebulizer Solution Concentrate (Generic; Xopenex®)
		Levalbuterol MDI (AG; Xopenex HFA®)
	Olodaterol (Striverdi® Respimat®)	

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>ASTHMA/COPD (12)</b>	<b>ORAL</b>	<b>ORAL</b>
<b>Bronchodilator, Beta-Adrenergic Oral Agents</b>	Albuterol Sulfate Syrup (Generic)	Albuterol Sulfate ER Tablet (Generic)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Terbutaline Sulfate Tablet (AG; Generic)	Albuterol Sulfate Tablet (Generic)
		Metaproterenol Sulfate Syrup (Generic)
<b>ASTHMA/COPD (12)</b>	Budesonide Respules 0.25 mg (Generic)	Beclomethasone Breath-Actuated HFA (QVAR® RediHaler®)
<b>Glucocorticoids, Inhalation</b>	Budesonide Respules 0.5 mg (Generic)	Budesonide DPI (Pulmicort® Flexhaler®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Budesonide Respules 1 mg (Generic)	Budesonide Respules 0.25 mg (Pulmicort® Respules®)
	Budesonide/Formoterol MDI (Symbicort®)	Budesonide Respules 0.5 mg (Pulmicort® Respules®)
	Fluticasone MDI (Flovent® HFA)	Budesonide Respules 1 mg (Pulmicort® Respules®)
	Fluticasone/Salmeterol DPI (Advair® Diskus®)	Budesonide/Formoterol Inhalation (Breztri Aerosphere™)
	Fluticasone/Salmeterol MDI (Advair HFA®)	Budesonide/Formoterol Inhalation (AG for Symbicort®)
	Mometasone Inhalation Powder (Asmanex® Twisthaler®)	Ciclesonide MDI (Alvesco®)
	Mometasone/Formoterol MDI (Dulera®)	Fluticasone Furoate Inhalation Powder (Arnuity Ellipta®)
		Fluticasone Propionate Inhalation Powder (Flovent® Diskus®)
		Fluticasone/Salmeterol Inhalation Powder (AG; AirDuo® RespiClick®)
		Fluticasone/Salmeterol (AirDuo® Digihaler™)
		Fluticasone/Salmeterol DPI (AG and Generic for Advair Diskus®)
		Fluticasone/Vilanterol Inhalation Powder (Breo Ellipta®)
		Fluticasone/Umeclidinium/Vilanterol Inhalation Powder (Trelegy Ellipta®)
	Mometasone Furoate MDI (Asmanex HFA®)	
<b>ASTHMA/COPD (12)</b>	Benralizumab Pen (Fasenra®)	Mepolizumab Auto-Injector (Nucala®)
<b>Immunomodulators</b>	Benralizumab Syringe (Fasenra®)	Mepolizumab Syringe (Nucala®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		Mepolizumab Vial (Nucala®)
		Omalizumab Syringe (Xolair®)
		Omalizumab Vial (Xolair®)
		Reslizumab (Cinqair®)

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>ASTHMA/COPD (12)</b>	Montelukast Chewable Tablet (Generic)	Montelukast Chewable Tablet (Singulair®)
<b>Leukotriene Modifiers</b>	Montelukast Tablet (Generic)	Montelukast Granules (Generic; Singulair®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		Montelukast Tablet (Singulair®) Zafirlukast Tablet (Generic; Accolate®) Zileuton ER Tablet (Generic) Zileuton Tablet (Zyflo®)
<b>BOTULINUM TOXINS (13)</b>	AbobotulinumtoxinA (Dysport®)	IncobotulinumtoxinA (Xeomin®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	OnabotulinumtoxinA (Botox®)	RimabotulinumtoxinB (Myobloc®)
<b>COLONY STIMULATING FACTORS (14)</b>	Filgrastim Syringe (Neupogen®)	Filgrastim-aafi Syringe (Nivestym®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Filgrastim Vial (Neupogen®) Pegfilgrastim-cbqv (Udenyca®) Pegfilgrastim-jmdb (Fulphila®) Tbo-Filgrastim Vial (Granix®)	Filgrastim-aafi Vial (Nivestym®) Filgrastim-sndz (Zarxio®) Pegfilgrastim Kit (Neulasta®) Pegfilgrastim Syringe (Neulasta®) Pegfilgrastim-apgf (Nyvepria®) Pegfilgrastim-bmez Syringe (Ziextenzo®) Sargramostim (Leukine®) Tbo-Filgrastim Injection Syringe (Granix®)
<b>CYSTIC FIBROSIS, ORAL (15)</b>	NONE	Elexacaftor/Tezacaftor/Ivacaftor Tablet (Trikafta®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		Ivacaftor Packet (Kalydeco®) Ivacaftor Tablet (Kalydeco®) Lumacaftor/Ivacaftor Packet (Orkambi®) Lumacaftor/Ivacaftor Tablet (Orkambi®) Mannitol Inhalation (Bronchitol®) Tezacaftor/Ivacaftor Tablet (Symdeko®)

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>DEPRESSION (16)</b>	Bupropion HCl IR (Generic)	Brexanolone (Zulresso™)
<b>Antidepressants, Other</b>	Bupropion HCl SR (Generic)	Bupropion HBr ER (Aplenzin®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Bupropion HCl XL (Generic)	Bupropion HCl SR (Wellbutrin SR®)
	Mirtazapine ODT (Generic)	Bupropion HCl XL (AG; Forfivo XL®)
	Mirtazapine Tablet (Generic)	Bupropion HCl XL (Wellbutrin XL®)
	Trazodone (Generic)	Desvenlafaxine ER (No Brand)
	Venlafaxine ER Capsule (Generic)	Desvenlafaxine Succinate ER Tablet (AG; Generic; Pristiq®)
	Venlafaxine IR Tablet (Generic)	Esketamine (Spravato®)
		Isocarboxazid (Marplan®)
		Levomilnacipran (Fetzima®)
		Mirtazapine ODT (Remeron® ODT)
		Mirtazapine Tablet (Remeron®)
		Nefazodone Tablet (Generic)
		Phenelzine (Generic; Nardil®)
		Selegiline Patch (Emsam®)
		Tranlycypromine Sulfate (Generic)
		Venlafaxine ER Capsule (Effexor XR®)
	Venlafaxine ER Tablet (AG; Generic)	
	Vilazodone (Viibryd®)	
	Vilazodone Dose Pack (Viibryd®)	
	Vortioxetine (Trintellix®)	
<b>DEPRESSION (16)</b>	Citalopram Solution (Generic)	Citalopram Tablet (Celexa®)
<b>Selective Serotonin Reuptake Inhibitors (SSRIs)</b>	Citalopram Tablet (Generic)	Escitalopram Solution (Generic)
	Escitalopram Tablet (Generic)	Escitalopram Tablet (Lexapro®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Fluoxetine Capsule (Generic)	Fluoxetine Capsule (Prozac®)
	Fluoxetine Solution (Generic)	Fluoxetine Delayed Release Capsule (Generic)
	Fluvoxamine Maleate Tablet (Generic)	Fluoxetine Tablet (Generic)
	Paroxetine Tablet (Generic)	Fluoxetine 60 mg Tablet (Generic)
	Sertraline Concentrate (Generic)	Fluvoxamine Maleate ER (Generic)
	Sertraline Tablet (Generic)	Paroxetine Tablet (Paxil®)
		Paroxetine CR Tablet (AG; Generic; Paxil CR®) Paroxetine Mesylate (AG; Generic; Brisdelle®)

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

Effective Date: July 1, 2021

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>DEPRESSION (16)</b>	(preferred agents listed on page 13)	Paroxetine Mesylate (Pexeva®)
<b>Selective Serotonin Reuptake Inhibitors (SSRIs) Continued</b>		Paroxetine HCl Suspension (Paxil®)
		Sertraline Concentrate (Zoloft®)
		Sertraline Tablet (Zoloft®)
<b>DERMATOLOGY (17)</b>	Mupirocin Ointment (Generic)	Gentamicin Sulfate Cream (Generic)
<b>Antibiotics, Topical</b>		Gentamicin Sulfate Ointment (Generic)
<a href="#">*Request Form</a>		Mupirocin Cream (Generic)
<a href="#">*Criteria</a>		Mupirocin Ointment (Centany®)
<a href="#">*POS Edits</a>		Mupirocin Ointment (Centany® Kit)
		<b>Ozenoxacin Cream (Xepi®)</b>
<b>DERMATOLOGY (17)</b>	Clotrimazole Rx Cream (Generic)	Butenafine Cream (Mentax®)
<b>Antifungals, Topical</b>	Clotrimazole Rx Solution (Generic)	Ciclopirox Cream (Generic)
<a href="#">*Request Form</a>	Clotrimazole/Betamethasone Cream (Generic)	Ciclopirox Gel (Generic)
<a href="#">*Criteria</a>	Ketoconazole Cream (Generic)	Ciclopirox 8% Solution (Generic)
<a href="#">*POS Edits</a>	Ketoconazole Shampoo Rx (Generic)	Ciclopirox 0.77% Suspension (AG; Generic)
	Nystatin Cream (Generic)	Ciclopirox Shampoo (Generic; Loprox®)
	Nystatin Ointment (Generic)	Ciclopirox 8% Solution Treatment Kit (Generic)
	Nystatin Topical Powder (Generic)	Ciclopirox 8% Solution Kit with Nail Lacquer Remover (Generic)
	Nystatin/Triamcinolone Cream (Generic)	Ciclopirox/Skin Cleanser No. 40 (Loprox® Kit)
	Nystatin/Triamcinolone Ointment (Generic)	<b>Ciclopirox/Triamcinolone (Trilociclo® Kit)</b>
		Clotrimazole/Betamethasone Lotion (Generic)
		Econazole Cream (Generic)
		Efinaconazole Solution (Jublia®)
		Ketoconazole Foam (AG; Generic)
		Luliconazole Cream (AG; Luzu®)
		Miconazole/Zinc Oxide/White Petrolatum (AG; Vusion®)
		Naftifine Cream (Generic)
		Naftifine Gel (Generic; Naftin®)
		Oxiconazole Lotion (Oxistat®)
		Oxiconazole Cream (Generic; Oxistat®)

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>DERMATOLOGY (17)</b>	(preferred agents listed on page 14)	Salicylic Acid/Benzoic Acid Ointment (Bensal HP®)
<b>Antifungals, Topical Continued</b>		Sertaconazole Cream (Ertaczo®)
		Sulconazole Cream (Exelderm®)
		Sulconazole Solution (Exelderm®)
		Tavaborole Solution ( <b>Generic</b> ; Kerydin®)
<b>DERMATOLOGY (17)</b>	Permethrin Cream (Generic)	Crotamiton Cream (Eurax®)
<b>Antiparasitic Agents, Topical</b>	Spinosad Suspension (Natroba®)	Crotamiton Lotion (Eurax®)
* <a href="#">Request Form</a>		Crotamiton Lotion (Crotan®)
* <a href="#">Criteria</a>		Ivermectin Lotion ( <b>Generic</b> ; Sklice®)
* <a href="#">POS Edits</a>		Lindane Shampoo (Generic)
		Malathion Lotion (Generic; Ovide®)
		Spinosad Suspension (Generic)
<b>DERMATOLOGY (17)</b>	Acitretin Capsule (AG; Generic)	Acitretin Capsule (Soriatane®)
<b>Antipsoriatics, Oral</b>		Methoxsalen Rapid (Generic)
* <a href="#">Request Form</a>		
* <a href="#">Criteria</a>		
* <a href="#">POS Edits</a>		
<b>DERMATOLOGY (17)</b>	Calcipotriene Cream (Generic)	Calcipotriene Cream (Dovonex®)
<b>Antipsoriatics, Topical</b>	Calcipotriene Solution (Generic)	Calcipotriene Ointment (Generic)
* <a href="#">Request Form</a>		Calcitriol (Generic; Vectical®)
* <a href="#">Criteria</a>		Calcipotriene Foam (Sorilux®)
* <a href="#">POS Edits</a>		Calcipotriene/Betamethasone Dipropionate Foam (Enstilar®)
		Calcipotriene/Betamethasone Dipropionate Ointment (AG; Generic; Taclonex®)
		Calcipotriene/Betamethasone Dipropionate Suspension (AG; Generic; Taclonex Scalp®)
		Halobetasol/Tazarotene Lotion (Duobrii®)



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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>DERMATOLOGY (17)</b>	Acyclovir Ointment (Generic)	Acyclovir Cream (AG; Generic; Zovirax®)
<b>Antiviral Agents, Topical</b>		Acyclovir Ointment (Zovirax®)
* <a href="#">Request Form</a>		Acyclovir/Hydrocortisone (Xerese®)
* <a href="#">Criteria</a>		Penciclovir Cream (Denavir®)
* <a href="#">POS Edits</a>		
<b>DERMATOLOGY (17)</b>	Crisaborole Ointment (Eucrisa®)	Dupilumab Pen (Dupixent®)
<b>Atopic Dermatitis Immunomodulators</b>	Pimecrolimus Cream (Elidel®)	Dupilumab Syringe (Dupixent®)
* <a href="#">Request Form</a>		Pimecrolimus Cream (AG; Generic)
* <a href="#">Criteria</a>		Tacrolimus Ointment (AG; Generic; Protopic®)
* <a href="#">POS Edits</a>		
<b>DERMATOLOGY (17)</b>	Ammonium Lactate Cream, Lotion (Generic)	Emollient Combination No. 10 (Biafine® Emulsion)
<b>Emollients</b>		Emollient Combination No. 43 (Promiseb®)
* <a href="#">Request Form</a>		
* <a href="#">Criteria</a>		
* <a href="#">POS Edits</a>		
<b>DERMATOLOGY (17)</b>	Imiquimod 5% Cream Packet (Generic for Aldara®)	Imiquimod 5% Cream Packet (Aldara®)
<b>Immunomodulators, Topical</b>		Imiquimod (Generic; Zyclara®)
* <a href="#">Request Form</a>		Podofilox Gel (Condylox®)
* <a href="#">Criteria</a>		Podofilox Solution (Generic)
* <a href="#">POS Edits</a>		Sinecatechins (Veregen®)
<b>DERMATOLOGY (17)</b>	Hydrocortisone Cream (Generic)	Alclometasone Dipropionate Cream, Ointment (Generic)
<b>Steroids, Topical</b>	Hydrocortisone Lotion (Generic)	Desonide Cream (Generic)
<b>Low Potency</b>	Hydrocortisone Ointment (Generic)	Desonide Lotion (Generic)
* <a href="#">Request Form</a>		Desonide Ointment (Generic)
* <a href="#">Criteria</a>		Desonide Gel (Desonate®)
* <a href="#">POS Edits</a>		Fluocinolone Acetonide 0.01% Oil (Generic; Derma-Smoothe/FS®)
		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, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>DERMATOLOGY (17)</b>	Fluticasone Propionate Cream (Generic)	Betamethasone Valerate Foam (Generic)
<b>Steroids, Topical</b>	Fluticasone Propionate Ointment (Generic)	Clocortolone Pivalate Cream (AG; Cloderm®)
<b>Medium Potency</b>	Mometasone Furoate Cream (Generic)	Fluocinolone Acetonide Cream (Generic)
* <a href="#">Request Form</a>	Mometasone Furoate Ointment (Generic)	Fluocinolone Acetonide Ointment (Generic)
* <a href="#">Criteria</a>	Mometasone Furoate Solution (Generic)	Fluocinolone Acetonide Solution (Generic)
* <a href="#">POS Edits</a>		Fluocinolone Acetonide/Emollient No. 65 Cream Kit (Synalar®)
		Fluocinolone Acetonide/Emollient No. 65 Ointment Kit (Synalar®)
		Fluocinolone Acetonide/Skin Cleanser No.28 Kit (Synalar® TS)
		Flurandrenolide Cream (Generic)
		Flurandrenolide Ointment (Generic)
		Flurandrenolide Lotion (AG; Generic)
		Flurandrenolide Tape (Cordran Tape®)
		Fluticasone Propionate Lotion (Generic; Beser™)
		Fluticasone Propionate Lotion Kit (Beser™)
		Hydrocortisone Butyrate Cream (AG; Generic)
		Hydrocortisone Butyrate Lotion (AG; Generic)
		Hydrocortisone Butyrate Solution (AG; Generic)
		Hydrocortisone Butyrate Ointment (Generic)
		Hydrocortisone Butyrate/Emollient (AG; Generic)
		Hydrocortisone Probutate Cream (Pandel®)
	Hydrocortisone Valerate Cream (Generic)	
	Hydrocortisone Valerate Ointment (Generic)	
	Prednicarbate Cream; Ointment (Generic)	
<b>DERMATOLOGY (17)</b>	Betamethasone Dipropionate/Propylene Glycol Cream (Generic)	Amcinonide Cream (Generic)
<b>Steroids, Topical</b>	Betamethasone Valerate Cream (Generic)	Amcinonide Lotion (Generic)
<b>High Potency</b>	Betamethasone Valerate Lotion (Generic)	Betamethasone Dipropionate Cream (Generic)
* <a href="#">Request Form</a>	Betamethasone Valerate Ointment (Generic)	Betamethasone Dipropionate Gel (Generic)
* <a href="#">Criteria</a>	Triamcinolone Acetonide Cream (Generic)	Betamethasone Dipropionate Lotion (Generic)
* <a href="#">POS Edits</a>	Triamcinolone Acetonide Lotion (Generic)	Betamethasone Dipropionate Ointment (Generic)
	Triamcinolone Acetonide Ointment (Generic)	Betamethasone Dipropionate/Propylene Glycol Lotion (Generic)
		Betamethasone Dipropionate/Propylene Glycol Ointment (Generic; Diprolene®)

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

Effective Date: July 1, 2021

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>DERMATOLOGY (17)</b>	(preferred agents listed on page 17)	Desoximetasone Cream (Generic)
<b>Steroids, Topical</b>		Desoximetasone Gel (Generic)
<b>High Potency Continued</b>		Desoximetasone Ointment (Generic)
		Desoximetasone Spray (Generic; Topicort®)
		Diflorasone Diacetate Cream (Generic)
		Diflorasone Diacetate Ointment (Generic)
		Fluocinonide Cream 0.05% (Generic)
		Fluocinonide Cream 0.1% (Generic)
		Fluocinonide Emollient (Generic)
		Fluocinonide Gel (Generic)
		Fluocinonide Ointment (Generic)
		Fluocinonide Solution (Generic)
		Fluocinonide Cream 0.1% (Vanos®)
		Halcinonide Cream (Generic; Halog®)
		Halcinonide Ointment (Halog®)
		Halcinonide Solution (Halog®)
		Triamcinolone Acetonide Aerosol (Generic; Kenalog Aerosol®)
		Triamcinolone Acetonide Ointment (Trianex®)
		Triamcinolone Acetonide/Dimethicone Ointment (Generic)
<b>DERMATOLOGY (17)</b>	Clobetasol Propionate Cream (Generic)	Clobetasol Propionate Foam (AG; Generic; Olux-E®)
<b>Steroids, Topical</b>	Clobetasol Propionate Emollient (Generic)	Clobetasol Propionate Kit (Tovet™ Kit)
<b>Very High Potency</b>	Clobetasol Propionate Gel (Generic)	Clobetasol Propionate Lotion (Generic)
* <a href="#">Request Form</a>	Clobetasol Propionate Ointment (Generic)	Clobetasol Propionate Shampoo (Generic; Clobex®)
* <a href="#">Criteria</a>	Clobetasol Propionate Solution (Generic)	Clobetasol Propionate Spray (AG; Generic; Clobex®)
* <a href="#">POS Edits</a>	Halobetasol Propionate Cream (Generic)	Clobetasol/Skin Cleanser No. 28 (Clodan® Kit)
	Halobetasol Propionate Ointment (Generic)	Diflorasone Diacetate (Apexicon E®)
		<b>Clobetasol Propionate Lotion (Impeklo®)</b>
		Halobetasol Propionate Foam (AG; Lexette™)
		Halobetasol Propionate Lotion (Bryhali®)
		Halobetasol Propionate Lotion (Ultravate®)

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

Effective Date: July 1, 2021

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>DIABETES (18)</b>	Acarbose (Generic)	Miglitol (Generic; Glyset®)
<b>Alpha-Glucosidase Inhibitors</b>		
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		
<b>DIABETES (18)</b>	Glucagon Nasal (Baqsimi®)	Diazoxide Oral Suspension (Generic; Proglycem®)
<b>Glucagon Agents</b>	Glucagon, Human Recombinant Injection (Generic)	Glucagon Subcutaneous Pen, Syringe (Gvoke®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Glucagon, Human Recombinant Injection Emergency Kit (Lilly)	Glucagon Injection Emergency Kit (Fresenius Kabi)
<b>DIABETES (18)</b>	Exenatide Microspheres ER Pen-Injector (Bydureon®)	Alogliptin Tablet (AG; Nesina®)
<b>Hypoglycemics</b>	Exenatide Solution Pens (Byetta®)	Alogliptin/Metformin Tablet (AG; Kazano®)
<b>Incretin Mimetics/Enhancers</b>	Dulaglutide Pen (Trulicity®)	Alogliptin/Pioglitazone Tablet (AG; Oseni®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Linagliptin Tablet (Tradjenta®)	Empagliflozin/Linagliptin/Metformin Tablet (Trijardy™ XR)
	Linagliptin/Empagliflozin Tablet (Glyxambi®) (See <a href="#">SGLT2 Criteria</a> )	Exenatide Microspheres ER Auto-Injector (Bydureon BCise®)
	Linagliptin/Metformin Tablet (Jentadueto®)	Linagliptin/Metformin Tablet ER (Jentadueto XR®)
	Liraglutide Pen (Victoza®)	Liraglutide/Insulin Degludec Pen (Xultophy®) (See <a href="#">Insulins &amp; Related Agents Criteria</a> )
	Sitagliptin Tablet (Januvia®)	Lixisenatide Pen (Adlyxin®)
	Sitagliptin/Metformin Tablet (Janumet®)	Lixisenatide/ Insulin Glargine Pen (Soliqua®) (See <a href="#">Insulins &amp; Related Agents Criteria</a> )
	Sitagliptin/Metformin Tablet ER (Janumet XR®)	Pramlintide Pen (SymlinPen®)
		Semaglutide Tablet (Rybelsus®)
		Saxagliptin Tablet (Onglyza®)
		Saxagliptin/Dapagliflozin Tablet (Qtern®) (See <a href="#">SGLT2 Criteria</a> )
		Saxagliptin/Metformin ER Tablet (Kombiglyze XR®)
		Semaglutide Pen (Ozempic®)
		Sitagliptin/Ertugliflozin Tablet (Steglujan®) (See <a href="#">SGLT2 Criteria</a> )

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

Effective Date: July 1, 2021

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>DIABETES (18)</b>	Insulin Aspart Cartridge (AG; Novolog®)	Insulin Aspart Pen (Fiasp® FlexTouch®)
<b>Hypoglycemics</b>	Insulin Aspart Pen (AG; Novolog®)	Insulin Aspart Cartridge, Vial (Fiasp® Penfill®, Fiasp®)
<b>Insulins &amp; Related Agents</b>	Insulin Aspart Vial (AG; Novolog®)	Insulin Degludec 100 U/mL Pen (Tresiba® FlexTouch®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Insulin Aspart Protamine/Insulin Aspart Pen (AG; Novolog Mix 70/30®)	Insulin Degludec 200 U/mL Pen (Tresiba® FlexTouch®)
	Insulin Aspart Protamine/Insulin Aspart Vial (AG; Novolog Mix 70/30®)	Insulin Degludec Vial (Tresiba®)
	Insulin Detemir Pen, Vial (Levemir®)	Insulin Glargine U-100 (Basaglar® KwikPen®)
	Insulin Glargine Pen (Lantus® SoloStar®)	Insulin Glargine Pen, Vial (Semglee®)
	Insulin Glargine Vial (Lantus®)	Insulin Glargine Pen (Toujeo Solostar®)
	Insulin Human Vial OTC (Humulin® N)	Insulin Glargine 300 units/mL Pen (Toujeo Max Solostar®)
	Insulin Human Vial OTC (Humulin® R)	Insulin Glulisine Pen (Apidra® SoloStar®)
	Insulin Human Regular 500 units/mL Pen (Humulin® R U-500)	Insulin Glulisine Vial (Apidra®)
	Insulin Human Regular 500 units/mL Vial (Humulin® R U-500)	Insulin Lispro Vial (Admelog®)
	Insulin Isophane (NPH)/Insulin Regular Pen OTC (Humulin® 70/30)	Insulin Lispro Pen (Admelog® SoloStar®)
	Insulin Isophane (NPH)/Insulin Regular Vial OTC (Humulin® 70/30)	Insulin Lispro 200 U/mL Pen (Humalog®)
	Insulin Lispro (AG; Humalog® Junior KwikPen®)	Insulin Lispro-aabc 100 U/mL Pen (Lyumjev®)
	Insulin Lispro Cartridge (Humalog®)	Insulin Lispro-aabc 200 U/mL Pen (Lyumjev®)
	Insulin Lispro Pen, Vial (AG; Humalog®)	Insulin Lispro-aabc 100 U/mL Vial (Lyumjev®)
	Insulin Lispro Protamine/Insulin Lispro KwikPen (AG)	Insulin Isophane (NPH) Insulin Regular Pen OTC (Novolin® 70/30)
	Insulin Lispro Protamine/Insulin Lispro Pen (Humalog® Mix)	Insulin Isophane (NPH) Insulin Regular Vial OTC (Novolin® 70/30)
	Insulin Lispro Protamine/Insulin Lispro Vial (Humalog® Mix)	Insulin Human Pen OTC (Novolin® N; Novolin® R)
		Insulin Human Vial OTC (Novolin® N; Novolin® R)
		Insulin Human in 0.9% Sodium Chloride Piggyback IV (Myxredlin®)
		Insulin Human Inhalation Powder Cartridge (Afrezza®)
	Insulin Human Pen OTC (Humulin® N Kwikpen)	
<b>DIABETES (18)</b>	Nateglinide (Generic)	Repaglinide/Metformin (Generic)
<b>Hypoglycemics</b>	Repaglinide (Generic)	
<b>Meglitinides</b>		
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		

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

**Effective Date: July 1, 2021**

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

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>DIGESTIVE DISORDERS (19)</b>	Meclizine Tablet (AG; Generic)	<b>Amisulpride Vial (Barhemsys®)</b>
<b>Antiemetic/Antivertigo Agents</b>	Metoclopramide Solution (Generic)	Aprepitant Capsule (Generic; Emend®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	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 (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 IV (Generic)
	Promethazine Syrup (Generic)	Granisetron Oral (Generic)
	Promethazine Tablet (Generic)	Granisetron ER Syringe (Sustol®)
	Promethazine Vial (Generic)	Granisetron Transdermal Patch (Sancuso®)
	<b>Scopolamine Transdermal (Generic)</b>	Metoclopramide Tablet (Reglan®)
		<b>Metoclopramide Nasal (Gimoti®)</b>
		Metoclopramide ODT (Generic)
		Metoclopramide Syringe (Generic)
		Netupitant/Palonosetron HCl Capsule (Akynzeo®)
		Ondansetron Ampule (Generic)
		Ondansetron Disp Syringe IV (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 Rectal 50 mg (Generic)		
Rolapitant Tablet (Varubi®)		
<b>Scopolamine Transdermal (Transderm-Scop®)</b>		
Trimethobenzamide Vial (Tigan®)		
Trimethobenzamide Capsule (Generic; Tigan®)		

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>DIGESTIVE DISORDERS (19)</b>	Ursodiol 300 mg Capsule (Generic)	Chenodiol Tablet (Chenodal®)
<b>Bile Acid Salts</b>	Ursodiol Tablet (Generic)	Cholic Acid Capsule (Cholbam®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		Obeticholic Acid Tablet (Ocaliva®)
		Ursodiol 300 mg Capsule (Actigall®)
		Ursodiol (URSO 250®/URSO Forte®)
<b>DIGESTIVE DISORDERS (19)</b>	Famotidine Suspension (Generic)	Cimetidine Solution (Generic)
<b>Histamine II Receptor Blockers</b>	Famotidine Tablet (Generic)	Cimetidine Tablet (Generic)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		Famotidine Piggyback (Generic)
		Famotidine Tablet (Pepcid®)
		Famotidine Vial (Generic)
		Nizatidine Capsule (Generic)
		Nizatidine Solution (Generic)
<b>DIGESTIVE DISORDERS (19)</b>	Pancrelipase (Creon®)	Pancrelipase (Pancreaze®)
<b>Pancreatic Enzymes</b>	Pancrelipase (Zenpep®)	Pancrelipase (Pertzye®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		Pancrelipase (Viokace®)
<b>DIGESTIVE DISORDERS (19)</b>	<b>Esomeprazole Suspension (Nexium®)</b>	Dexlansoprazole Capsule (Dexilant®)
<b>Proton Pump Inhibitors</b>	Lansoprazole Capsule (Generic)	Esomeprazole Capsule (AG; Generic; Nexium®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	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®)
		<b>Pantoprazole Suspension (Generic)</b>
		Pantoprazole Tablet (Protonix®)
		Rabeprazole Capsule Sprinkle (AcipHex® Sprinkle™) Rabeprazole Tablet (Generic; AcipHex®)



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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>DIGESTIVE DISORDERS (19)</b>	Balsalazide Capsule (Generic)	Budesonide DR Rectal Foam (Uceris®)
<b>Ulcerative Colitis Agents</b>	Mesalamine ER Capsule (Apriso®)	Budesonide DR Tablet (AG; Generic; Uceris®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Mesalamine Rectal (Generic for SfRowasa®)	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 DR Tablet MMX® (AG; Generic; Lialda®)
		<b>Mesalamine ER Capsule (AG for Apriso®; Generic for Apriso®)</b>
		Mesalamine ER Capsule (Pentasa®)
		Mesalamine Suppositories (AG; Generic; Canasa®)
		Olsalazine Capsule (Dipentum®)
		Sulfasalazine DR Tablet (Azulfidine EN-Tabs®)
	Sulfasalazine Tablet (Azulfidine®)	
<b>ENZYME REPLACEMENTS (20)</b>	Miglustat (Zavesca®)	Eliglustat (Cerdelga®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		Imiglucerase 400 units Injection (Cerezyme®)
		Miglustat (AG; Generic)
		Taliglucerase alfa Injection (Elelyso®)
		Velaglucerase alfa 400 units Injection (Vpriv®)
<b>EPINEPHRINE, SELF-INJECTED (21)</b>	Epinephrine 0.3 mg (AG and Generic for EpiPen®)	Epinephrine 0.15 mg, 0.3 mg (EpiPen Jr®; EpiPen®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Epinephrine 0.15 mg (AG and Generic for EpiPen Jr®)	Epinephrine 0.15 mg, 0.3 mg (AG for AdrenaClick®)
		Epinephrine Injection (Symjepi®)
<b>GI MOTILITY, CHRONIC (22)</b>	Linaclotide Capsule (Linzess®)	Alosetron Tablet (AG; Generic; Lotronex®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Lubiprostone Capsule (Amitiza®)	Eluxadolone Tablet (Viberzi®)
	Naloxegol Tablet (Movantik®)	<b>Lubiprostone Capsule (AG for Amitiza®)</b>
		Methylnaltrexone Syringe, Tablet (Relistor®)
		Methylnaltrexone 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, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>GLUCOCORTICOIDS, ORAL (23)</b>	Budesonide EC Capsules (Generic)	Budesonide Delayed Release Capsules (Entocort EC®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Dexamethasone Tablet	Budesonide ER Capsule (Ortikos™)
	Hydrocortisone Tablet	Cortisone Acetate Tablet
	Methylprednisolone Tablet Dose Pack	Deflazacort Suspension, Tablet (Emflaza®)
	Prednisolone Sodium Phosphate Oral Solution (Generic)	Dexamethasone (Taperdex®)
	Prednisolone Solution	Dexamethasone Elixir, Intensol Concentrate, Solution, Tablet Dose Pack
	Prednisone Tablet	Hydrocortisone Tablet (Cortef®)
		<b>Hydrocortisone Capsule (Alkindi® Sprinkle)</b>
		Methylprednisolone Tablet, Dose Pack (Medrol®)
		Methylprednisolone Tablet 4 mg, 8 mg, 16 mg, 32 mg (Generic)
		Prednisone Delayed Release Tablet (Rayos®)
		Prednisone Intensol Concentrate, Solution, Tablet Dose Pack
		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)	
<b>GOUT AGENTS (24)</b>	Allopurinol Tablet (Generic)	Allopurinol (Zyloprim®)
<b>Antihyperuricemics</b>	Colchicine Tablet (AG; Generic)	Colchicine Capsule (AG; Mitigare®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Probenecid Tablet (Generic)	Colchicine Oral Solution (Gloperba®)
	Probenecid/Colchicine Tablet (Generic)	Colchicine Tablet (Colcrys®)
		Febuxostat Tablet (Generic; Uloric®)
		Pegloticase Intravenous (Krystexxa®)
<b>GROWTH DEFICIENCY (25)</b>	Somatropin Cartridge, Syringe (Genotropin®)	Somatropin Cartridge, Vial (Humatrope®)
<b>Growth Hormones</b>	Somatropin Pen (Norditropin® FlexPro®)	Somatropin Pen (Nutropin AQ® NuSpin®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		Somatropin Cartridge, Vial (Omnitrope®)
		Somatropin Cartridge, Vial (Saizen®)
		Somatropin Vial (Serostim®)
		Somatropin Vial (Zomacton®)
		Somatropin Vial (Zorbitive®)

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>GROWTH FACTORS (26)</b>	NONE	Mecasermin Subcutaneous (Increlex®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		Tesamorelin Acetate Subcutaneous (Egrifta®)
		Tesamorelin Acetate Subcutaneous (Egrifta SV®)
<b>H. PYLORI TREATMENT (27)</b>	Bismuth Subcitrate Potassium/Metronidazole/Tetracycline (Pylera®)	Bismuth Subsalicylate/Metronidazole/Tetracycline (Helidac®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		Lansoprazole/Amoxicillin/Clarithromycin (Generic Prevpac®)
		Omeprazole/Amoxicillin/Rifabutin (Talicia®)
		Omeprazole/Clarithromycin/Amoxicillin (Omeclamox-Pak®)
<b>HEART DISEASE, HYPERLIPIDEMIA (28)</b>	Apixaban Dose Pack, Tablet (Eliquis®)	Dalteparin Syringe (Fragmin®)
<b>Anticoagulants</b>	Dabigatran (Pradaxa®)	Dalteparin Vial (Fragmin®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Enoxaparin Syringe, Vial (AG; Generic)	Edoxaban Tablet (Savaysa®)
	Rivaroxaban Tablet (Xarelto®; Xarelto® Starter Pack)	Enoxaparin Vial, Syringe (Lovenox®)
	Warfarin (Generic)	Fondaparinux Syringe (Generic; Arixtra®)
<b>HEART DISEASE, HYPERLIPIDEMIA (28)</b>	Aspirin/Dipyridamole ER Capsule (AG; Generic)	Clopidogrel Tablet (Plavix®)
<b>Anticoagulants</b>	Clopidogrel Tablet (Generic)	Prasugrel Tablet (Effient®)
<b>Platelet Aggregation Inhibitors</b>	Dipyridamole Tablet (Generic)	Vorapaxar Tablet (Zontivity®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Prasugrel Tablet (Generic)	
	Ticagrelor Tablet (Brilinta®)	
<b>HEART DISEASE, HYPERLIPIDEMIA (28)</b>	Benazepril (Generic)	Aliskiren (AG; Generic; Tekturna®)
<b>Hypertension</b>	Benazepril/HCTZ (Generic)	Aliskiren/HCTZ (Tekturna HCT®)
<b>ACE Inhibitors &amp; Direct Renin Inhibitors</b>	Enalapril (Generic)	Azilsartan Medoxomil (Edarbi®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Enalapril/HCTZ (Generic)	Azilsartan/Chlorthalidone (Edarbyclor®)
	Fosinopril (Generic)	Candesartan (AG; Generic; Atacand®)
	Fosinopril/HCTZ (Generic)	Candesartan/HCTZ (AG; Generic)
	Irbesartan (Generic)	Captopril (Generic)

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>HEART DISEASE, HYPERLIPIDEMIA (28)</b>	Irbesartan/HCTZ (Generic)	Captopril/HCTZ (Generic)
<b>Hypertension</b>	Lisinopril (Generic)	Enalapril for Solution (Epaned®)
<b>ACE Inhibitors &amp; Direct Renin Inhibitors Continued</b>	Lisinopril/HCTZ (Generic)	Eprosartan (Generic)
	Losartan (Generic)	Irbesartan (Avapro®)
	Losartan/HCTZ (Generic)	Irbesartan/HCTZ (Avalide®)
	Olmesartan (AG; Generic)	Lisinopril Solution (Qbrelis®)
	<b>Olmesartan/HCTZ (AG; Generic)</b>	Lisinopril (Zestril®)
	Quinapril (Generic)	Lisinopril/HCTZ (Zestoretic®)
	<b>Quinapril/HCTZ (Generic)</b>	Losartan (Cozaar®)
	Ramipril (Generic)	Losartan/HCTZ (Hyzaar®)
	Sacubitril/Valsartan (Entresto®)	Moexipril (Generic)
	Valsartan (Generic)	Olmesartan (Benicar®)
	Valsartan/HCTZ (Generic)	Olmesartan/HCTZ (Benicar HCT®)
		Perindopril (Generic)
		Quinapril (Accupril®)
		Ramipril (Altace®)
		Telmisartan (Generic; Micardis®)
		Telmisartan/HCTZ (AG; Generic; Micardis HCT®)
		Trandolapril (Generic)
		Valsartan (Diovan®)
		Valsartan/HCTZ (Diovan HCT®)
<b>HEART DISEASE, HYPERLIPIDEMIA (28)</b>	Amlodipine/Benazepril (Generic)	Amlodipine/Benazepril (Lotrel®)
<b>Hypertension</b>	<b>Amlodipine/Olmesartan (AG; Generic)</b>	Amlodipine/Olmesartan (Azor®)
<b>Angiotensin Modulators/Calcium Channel Blockers Combinations</b>	Amlodipine/Valsartan (AG; Generic)	Amlodipine/Olmesartan/HCTZ (AG; Generic; Tribenzor®)
	Amlodipine/Valsartan/HCTZ (Generic)	Amlodipine/Valsartan (Exforge®)
* <a href="#">Request Form</a>		Amlodipine/Valsartan/HCTZ (Exforge HCT®)
* <a href="#">Criteria</a>		Telmisartan/Amlodipine (Generic)
* <a href="#">POS Edits</a>		Trandolapril/Verapamil (AG; Generic; Tarka®)

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>HEART DISEASE, HYPERLIPIDEMIA (28)</b>	Acebutolol (Generic)	Atenolol (Tenormin®)
<b>Hypertension</b>	Atenolol (Generic)	<b>Betaxolol (Generic)</b>
<b>Beta Blocker Agents</b>	Atenolol/Chlorthalidone (Generic)	Carvedilol (Coreg®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Bisoprolol (Generic)	Carvedilol ER (AG; Generic; Coreg CR®)
	Bisoprolol/HCTZ (Generic)	Metoprolol/HCTZ (Generic)
	Carvedilol (Generic)	Metoprolol Succinate (Kaspargo®)
	Labetalol (Generic)	Metoprolol Succinate ER (Toprol XL®)
	Metoprolol Succinate ER (AG; Generic)	Metoprolol Tartrate (Lopressor®)
	Metoprolol Tartrate (Generic)	Nadolol (Generic; Corgard®)
	Propranolol ER (AG; Generic)	Nadolol/Bendroflumethiazide (Generic)
	Propranolol Solution (Generic)	Nebivolol (Bystolic®)
	Propranolol Tablet (Generic)	Pindolol (Generic)
	Sotalol (Generic)	Propranolol (Hemangeol®)
		Propranolol ER Capsule (Inderal XL)
		Propranolol ER Capsule (Innopran XL®)
		Propranolol LA (Inderal LA®)
		Propranolol/HCTZ (Generic)
	Sotalol Solution (Sotylize®)	
	Timolol Maleate (Generic)	
<b>HEART DISEASE, HYPERLIPIDEMIA (28)</b>	Amlodipine Tablet (Generic)	Amlodipine Tablet (Norvasc®)
<b>Hypertension</b>	Diltiazem ER Capsule (Generic)	Amlodipine Suspension (Katerzia™)
<b>Calcium Channel Blockers</b>	Diltiazem IR Tablet (Generic)	Diltiazem CD (Cardizem CD®; Cardizem CD® 360 mg)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	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 Solution (Nymalize®)
		Nisoldipine Tablet (Generic)
		Verapamil 360 mg Capsule (Generic)
		Verapamil ER PM Capsule (Generic; Verelan PM®)
		Verapamil ER Capsule (Generic)
	Verapamil ER Tablet (Calan® SR)	

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

Effective Date: July 1, 2021

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>HEART DISEASE, HYPERLIPIDEMIA (28)</b>	Cholestyramine/Sucrose Powder (Generic Questran®)	Alirocumab Subcutaneous Pen (Praluent®)
<b>Lipotropics, Other</b>	Colestipol Granules, Granule Packet (Generic)	Bempedoic Acid Tablet (Nexleto™)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Colestipol Tablet (Generic) Ezetimibe (Generic) Fenofibrate Nanocrystallized Tablet (AG; Generic Tricor® 48 mg) Fenofibrate Nanocrystallized Tablet (AG; Generic Tricor® 145 mg) <b>Fenofibrate Capsule, Tablet (Generic for Lofibra®)</b> Gemfibrozil Tablet (AG; Generic) Niacin ER Tablet (Generic)	Bempedoic Acid and Ezetimibe Tablet (Nexlizet™) Cholestyramine/Aspartame Powder, Powder Packet (Generic) Colesevelam Powder Pack, Tablet (AG; Generic; Welchol®) Colestipol Granules, Tablet (Colestid®) <b>Evinacumab-dgnb Vial (Evkeeza®)</b> Evolocumab Auto-Injector (Repatha® SureClick®) Evolocumab Cartridge (Repatha® Pushtrex®) 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 Fibricor®) Fenofibric Acid Choline Capsule (AG; Generic; Trilipix®) Gemfibrozil Tablet (Lopid®) Icosapent Ethyl Capsule ( <b>Generic</b> ; Vascepa®) Lomitapide Capsule (Juxtapid®) Niacin ER Tablet (Niaspan®) Omega-3-acid Ethyl Esters Capsule (Generic; Lovaza®)
<b>HEART DISEASE, HYPERLIPIDEMIA (28)</b>	Ambrisentan Tablet (Generic)	Ambrisentan Tablet (Letairis®)
<b>Pulmonary Arterial Hypertension (PAH)</b>	Bosentan Tablet (Generic; Tracleer®)	Bosentan Suspension (Tracleer®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Sildenafil Tablet (Generic for Revatio®) <b>Sildenafil Oral Suspension (AG; Generic)</b> Tadalafil Tablet (Generic for Adcirca®)	Iloprost Inhalation Solution (Ventavis®) Macitentan Tablet (Opsumit®) Riociguat Tablet (Adempas®) Selexipag Tablet, Dose Pack (Upravi®) <b>Sildenafil Oral Suspension (Revatio®)</b> Sildenafil Tablet (Revatio®) Tadalafil Tablet (Adcirca®) Treprostinil Inhalation Solution (Tyvaso®) Treprostinil ER Tablet (Orenitram ER®)

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

Effective Date: July 1, 2021

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>HEART DISEASE HYPERLIPIDEMIA (28)</b>	Atorvastatin Tablet (Generic)	Amlodipine/Atorvastatin Tablet (Generic; Caduet®)
<b>Statins &amp; Statin Combination Agents</b>	Lovastatin Tablet (Generic)	Atorvastatin Tablet (Lipitor®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Pravastatin Tablet (Generic)	Ezetimibe/Simvastatin Tablet (Generic; Vytorin®)
	Rosuvastatin Tablet (Generic)	Fluvastatin Capsule (Generic)
	Simvastatin Tablet (Generic)	Fluvastatin ER Tablet (AG; Generic; Lescol XL®)
		Lovastatin ER Tablet (Altoprev®)
		Pitavastatin Tablet (Livalo®)
		Pitavastatin Tablet (Zypitamag®)
		Pravastatin Tablet (Pravachol®)
		Rosuvastatin Tablet (Crestor®)
		Rosuvastatin Capsule (Ezallor™ Sprinkle)
	Simvastatin Tablet (Zocor®)	
<b>HEART DISEASE, HYPERLIPIDEMIA (28)</b>	Clonidine Patch (Catapres-TTS®)	Clonidine Patch (Generic)
<b>Sympatholytics</b>	Clonidine Tablet (Generic)	Clonidine Tablet (Catapres®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Guanfacine Tablet (Generic)	Methyldopa/Hydrochlorothiazide Tablet (Generic)
	Methyldopa Tablet (Generic)	Methyldopate HCl (Intravenous)
<b>HEART DISEASE, HYPERLIPIDEMIA (28)</b>	Isosorbide Dinitrate Tablet (Generic)	Isosorbide Dinitrate Tablet (AG; Isordil®)
<b>Vasodilators, Coronary</b>	Isosorbide Mononitrate Tablet (Generic)	Isosorbide Dinitrate ER Capsule (Dilatrate-SR®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Isosorbide Mononitrate SR Tablet (Generic)	Isosorbide Dinitrate/Hydralazine Tablet (BiDil®)
	Nitroglycerin Sublingual Tablet (AG; Generic)	Nitroglycerin Spray (AG; Generic; Nitrolingual®)
	Nitroglycerin Transdermal Ointment (Nitro-Bid®)	Nitroglycerin Spray (Nitromist®)
	Nitroglycerin Transdermal Patch (AG; Generic)	Nitroglycerin Sublingual Powder Packet (GoNitro®)
		Nitroglycerin Transdermal Patch (Nitro-Dur®)
		Nitroglycerin Sublingual Tablet (Nitrostat®)
		Vericiguat (Verquvo®)

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

Effective Date: July 1, 2021

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>HEMATOLOGIC AGENTS, HEMATOPOIETIC AGENTS (29)</b>  <b>Erythropoietins</b>  <a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Epoetin alfa-epbx (Retacrit®)	Darbepoetin Syringe (Aranesp®)
		Darbepoetin Vial (Aranesp®)
		Epoetin alfa (Epogen®)
		Epoetin alfa (Procrit®)
		Luspatercept-aamt (Reblozyl®)
		Methoxy Polyethylene Glycol-Epoetin Beta (Mircera®)
<b>HEMODIALYSIS (30)</b>	Calcium Acetate Capsule (Generic)	Calcium Acetate Tablet (Generic)
<b>Phosphate Binders</b>	<b>Sevelamer Carbonate Tablet (Renvela®)</b>	Calcium Acetate Solution (Phoslyra®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		Calcium Carbonate/Magnesium Carbonate/FA (MagneBind 400 Rx®)
		Ferric Citrate Tablet (Auryxia®)
		Lanthanum Carbonate Chewable Tablet (Generic; Fosrenol®)
		Lanthanum Carbonate Powder Pack (Fosrenol®)
		<b>Sevelamer Carbonate Tablet (AG; Generic)</b>
		Sevelamer Carbonate Powder Pack (Generic; Renvela®)
		Sevelamer HCl Tablet (AG; Generic; RenaGel®)
		Sucroferric Oxyhydroxide (Velphoro®)
<b>HEMOPHILIA TREATMENT (31)</b>	Emicizumab-kxwh (Hemlibra®)	Anti-Inhibitor Coagulant Complex (Feiba NF®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Factor IX Human Recombinant (BeneFIX® Kit)	Factor IX (Mononine® Kit)
	Factor VIIa, Recombinant (NovoSeven® RT)	Factor IX Complex (PCC) 3-Factor (Profilnine® SD)
	Factor VIII, B-Domain-Deleted (Xyntha® Kit)	Factor IX Human (AlphaNine SD®)
	Factor VIII, B-Domain-Deleted (Xyntha® Solofuse® Syringe Kit)	Factor IX Human Recomb, GlycoPEGylated (Rebinyn®)
	Factor VIII, B-Domain-Truncated (Novoeight®)	Factor IX Human Recombinant (Ixinity®)
	Factor VIII, HEK B-Domain-Deleted (Nuwiq®)	Factor IX Recombinant (Rixubis®)
	Factor VIII/VWF (Alphanate®)	Factor IX Recombinant, Albumin Fusion (Idelvion®)
	Factor VIII/VWF (Humate-P® Kit)	Factor IX Recombinant, Fc Fusion Protein (Alprolix®)
	Factor VIII/VWF (Wilate®)	<b>Factor VIIa, (Recombinant)-jncw (Sevenfact®)</b>
	Factor X (Coagadex®)	Factor VIII, Full-Length (Advate®)



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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<p><b>HEMOPHILIA TREATMENT (31)</b> <b>Continued</b></p>	Factor XIII Concentrate, Human (Corifact® Kit)	Factor VIII (Kogenate FS®)
		Factor VIII (Kovaltry®)
		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 (Recombinate®)
		Factor VIII, Recombinant, Fc Fusion (Eloctate®)
		Factor VIII, Recombinant, PEGylated-aucl (Jivi®)
		Factor VIII, Single-Chain, B-Domain Truncated (Afstyla®)
		Factor XIII A-Subunit, Recombinant (Tretten®)
		Von Willebrand Factor, Recombinant (Vonvendi®)
<p><b>HEREDITARY ANGIOEDEMA (32)</b></p> <p><a href="#">*Request Form</a></p> <p><a href="#">*Criteria</a></p> <p><a href="#">*POS Edits</a></p>	C1 Esterase Inhibitor Subcutaneous (Haegarda®)	Berotralstat Hydrochloride (Orladeyo®)
		Icatibant Acetate Subcutaneous (Generic)
		C1 Esterase Inhibitor Intravenous (Berinert®)
		C1 Esterase Inhibitor Intravenous (Cinryze®)
		C1 Esterase Inhibitor, Recombinant (Ruconest®)
		Ecallantide Subcutaneous (Kalbitor®)
		Icatibant Acetate Subcutaneous (Firazyr®)
Lanadelumab-flyo Subcutaneous (Takhzyro®)		
<p><b>HIV-AIDS (33)</b></p> <p><a href="#">*Request Form</a></p> <p><a href="#">*Criteria</a></p> <p><a href="#">*POS Edits</a></p>	Abacavir Solution, Tablet (Generic; Ziagen®)	<p><b>NONE</b></p>
	Abacavir/Lamivudine Tablet (Generic; Epzicom®)	
	Abacavir/Dolutegravir/Lamivudine Tablet (Triumeq®)	
	Abacavir/Lamivudine/Zidovudine Tablet (Generic; Trizivir®)	
	Atazanavir Capsule (Generic)	
	Atazanavir Capsule (Reyataz®)	
Atazanavir Powder Pack (Reyataz®)		

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>HIV-AIDS (33) Continued</b>	Atazanavir Sulfate/Cobicistat Tablet (Evotaz®)	<b>NONE</b>
	Bictegravir/Emtricitabine/Tenofovir AF Tablet (Biktarvy®)	
	Cabotegravir/Rilpivirine IM (Cabenuva®)	
	Cobicistat Tablet (Tybost®)	
	Darunavir Ethanolate Tablet (Prezista®)	
	Darunavir Ethanolate Oral Susp (Prezista®)	
	Darunavir/Cobicistat/Emtricitabine/Tenofovir AF Tablet (Symtuza®)	
	Darunavir/Cobicistat Tablet (Prezcobix®)	
	Didanosine Capsule DR (Generic)	
	Dolutegravir Sodium Tablet (Tivicay®)	
	Dolutegravir Sodium Suspension (Tivicay PD®)	
	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®)	
	Etravirine Tablet (Intelence®)	
	Fosamprenavir Tablet (Generic; Lexiva®)	
	Fosamprenavir Suspension (Lexiva®)	
	Fostemsavir Tromethamine Tablet (Rukobia®)	
	Ibalizumab-uiyk Vial (Trogarzo®)	

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>HIV-AIDS (33) Continued</b>	Indinavir Sulfate Capsule (Crixivan®)	<b>NONE</b>
	Lamivudine Solution (Generic; Epivir®)	
	Lamivudine 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 (Kaletra®)	
	Maraviroc Solution, Tablet (Selzentry®)	
	Nelfinavir Mesylate Tablet (Viracept®)	
	Nevirapine ER Tablet (Generic; Viramune XR®)	
	Nevirapine Suspension (Generic; Viramune®)	
	Nevirapine Tablet (Generic)	
	Raltegravir Potassium Tablet (Isentress®)	
	Raltegravir Potassium Tablet (Isentress HD®)	
	Raltegravir Potassium Powder Pack (Isentress®)	
	Raltegravir Potassium Chewable Tablet (Isentress®)	
	Rilpivirine HCl Tablet (Edurant®)	
	Ritonavir Powder Pack (Norvir®)	
	Ritonavir Solution (Norvir®)	
	Ritonavir Tablet (Generic; Norvir®)	
	Saquinavir Mesylate Tablet (Invirase®)	
	Stavudine Capsule (Generic)	
	Tenofovir Disoproxil Fumarate Tablet (Generic)	
	Tenofovir Disoproxil Fumarate Powder (Viread®)	
	Tenofovir Disoproxil Fumarate Tablet (Viread®)	
	Tipranavir Capsule (Aptivus®)	
	Tipranavir/Vitamin E TPGS Solution (Aptivus®)	
	Zidovudine Syrup (Generic; Retrovir®)	
	Zidovudine Capsule (Generic)	
	Zidovudine Tablet (Generic)	

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

Effective Date: July 1, 2021

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

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>IMMUNOSUPPRESSIVES, ORAL (36)</b>	Azathioprine Tablet (Generic)	Azathioprine (Azasan®; Imuran®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Cyclosporine Capsule – MODIFIED 25 mg, 100 mg	Cyclosporine Capsule 25 mg, 100 mg (Generic; Sandimmune®)
	<b>Everolimus Tablet (Generic for Zortress®)</b>	Cyclosporine Capsule – MODIFIED (Neoral®)
	Mycophenolate Mofetil Capsule (Generic)	Cyclosporine Softgel – MODIFIED 50 mg
	Mycophenolate Mofetil Tablet (Generic)	Cyclosporine Solution – MODIFIED (Generic; Neoral®)
	<b>Sirolimus Solution (Rapamune®)</b>	Cyclosporine Solution (Sandimmune®)
	<b>Sirolimus Tablet (Rapamune®)</b>	Everolimus Tablet (Zortress®)
	Tacrolimus Capsule (Generic)	Mycophenolate Mofetil Capsule (CellCept®)
		Mycophenolate Mofetil Suspension (CellCept®)
		Mycophenolate Mofetil Tablet (CellCept®)
		Mycophenolate Mofetil Suspension (Generic)
		Mycophenolic Acid as Mycophenolate Sodium (Generic; 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)	
<b>INFECTIOUS DISORDERS (37)</b>	Amoxicillin/Clavulanate Suspension (Generic)	Amoxicillin/Clavulanate ER Tablet (Generic)
<b>Antibiotics</b>	Amoxicillin/Clavulanate Tablet (Generic)	Amoxicillin/Clavulanate Chewable Tablet (Generic)
<b>Cephalosporin and Related Antibiotics</b>	Cefadroxil Capsule (Generic)	Cefaclor Capsule, ER Tablet, Suspension (Generic)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	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)	Cephalexin Capsule (Keflex®)
	Cephalexin Capsule (Generic)	Cephalexin Tablet (Generic)
	Cephalexin Suspension (Generic)	Cefpodoxime Proxetil Suspension, Tablet (Generic)

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

Effective Date: July 1, 2021

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

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>INFECTIOUS DISORDERS (37)</b>	Azithromycin Packet (AG)	Azithromycin Packet, Suspension, Tablet (Zithromax®)
<b>Antibiotics</b>	Azithromycin Suspension, Tablet (Generic)	Clarithromycin ER Tablet, Suspension (Generic)
<b>Macrolides - Ketolides</b>	Clarithromycin Tablet (Generic)	Erythromycin Base Tablet (Generic; Ery-Tab®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Erythromycin Base DR Capsule (Generic)	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®)
<b>INFECTIOUS DISORDERS (37)</b>	Nitrofurantoin Macrocrystals Capsule (Generic)	Nitrofurantoin Macrocrystals Capsule 25 mg, 50 mg (Macrochantin®)
<b>Antibiotics</b>	Nitrofurantoin Monohydrate Macrocrystals Capsule (Generic)	Nitrofurantoin Monohydrate Macrocrystals Capsule 100 mg (Macrobid®)
<b>Nitrofuran Derivatives</b>		Nitrofurantoin Suspension (AG; Generic; Furadantin®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		
<b>INFECTIOUS DISORDERS (37)</b>	Linezolid Tablet (AG; Generic)	Linezolid IV (AG; Generic)
<b>Antibiotics</b>		Linezolid Suspension (AG; Generic; Zyvox®)
<b>Oxazolidinones</b>		Tedizolid IV (Sivextro®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		Tedizolid Tablet (Sivextro®)
<b>INFECTIOUS DISORDERS (37)</b>	<b>NONE</b>	<b>Lefamulin Acetate Tablet, Vial (Xenleta®)</b>
<b>Antibiotics</b>		
<b>Pleuromutilins</b>		
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		
<b>INFECTIOUS DISORDERS (37)</b>	<b>NONE</b>	Quinupristin/Dalfopristin Vial (Synercid®)
<b>Antibiotics</b>		
<b>Streptogramins</b>		
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>INFECTIOUS DISORDERS (37)</b>	Doxycycline Hyclate Capsule (Generic)	Demeclocycline (Generic)
<b>Antibiotics</b>	Doxycycline Hyclate Tablet (Generic)	Doxycycline Calcium Syrup (Vibramycin®)
<b>Tetracyclines</b>	Doxycycline Monohydrate 50 mg Capsule (Generic)	Doxycycline Hyclate DR Tablet (Doryx® MPC)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Doxycycline Monohydrate 100 mg Capsule (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, 150mg (Generic)
		Doxycycline Monohydrate Suspension (Generic)
		Minocycline ER Capsule (Ximino®)
		Minocycline ER Tablet (MinoLira®)
		Minocycline ER Tablet (Generic; Solodyn®)
		Minocycline Tablet (Generic)
		Omadacycline Tosylate Tablet (Nuzyra®)
	Tetracycline (Generic)	
<b>INFECTIOUS DISORDERS (37)</b>	Clindamycin Vaginal Cream (Clindesse®)	Clindamycin Vaginal Cream (Generic; Cleocin®)
<b>Antibiotics</b>	Metronidazole Vaginal Gel (Nuversa®)	Clindamycin Vaginal Ovules (Cleocin®)
<b>Vaginal</b>	Metronidazole Vaginal Gel (Vandazole®)	Metronidazole Vaginal Gel (Generic; MetroGel-Vaginal®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		
<b>INFECTIOUS DISORDERS (37)</b>	Clotrimazole Troche (Generic)	Fluconazole Suspension, Tablet (Diflucan®)
<b>Antifungals</b>	Fluconazole Suspension (Generic)	Flucytosine Capsule (Generic)
<b>Antifungals, Oral</b>	Fluconazole Tablet (Generic)	Griseofulvin Tablet, Ultramicronsize Tablet (Generic)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Griseofulvin Suspension (Generic)	Isavuconazonium Capsule (Cresemba®)
	Nystatin Suspension (Generic)	Itraconazole Capsule, Solution (Generic; Sporanox®)
	Nystatin Tablet (Generic)	Itraconazole Capsule (Tolsura®)
	Terbinafine Tablet (Generic)	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, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>INFECTIOUS DISORDERS (37)</b>	Sofosbuvir/Velpatasvir (AG for Epclusa®)	Elbasvir/Grazoprevir (Zepatier®)
<b>Hepatitis C Agents</b>		Glecaprevir/Pibrentasvir (Mavyret®)
<b>Direct Acting Antiviral Agents</b>		Ledipasvir/Sofosbuvir Tablet (AG; Harvoni®)
* <a href="#">Request Form</a>		Ledipasvir/Sofosbuvir Pellet Pack (Harvoni®)
* <a href="#">Hepatitis C DAA Criteria</a>		Ombitasvir/Paritaprevir/Ritonavir/Dasabuvir (Viekira Pak®)
* <a href="#">Hepatitis C DAA Worksheet</a>		Sofosbuvir Tablet (Sovaldi®)
* <a href="#">Patient Treatment Agreement</a>		Sofosbuvir Pellet Pack (Sovaldi®)
* <a href="#">POS Edits</a>		Sofosbuvir/Velpatasvir (Epclusa®) Sofosbuvir/Velpatasvir/Voxilaprevir (Vosevi®)
<b>INFECTIOUS DISORDERS (37)</b>	Peginterferon alfa 2a Syringe (Pegasys®)	Peginterferon alfa 2b Kit (Peg-Intron®)
<b>Hepatitis C Agents</b>	Peginterferon alfa 2a Vial (Pegasys®)	Ribavirin Capsule (Generic)
<b>Not Direct Acting Antiviral Agents</b>	Ribavirin Tablet (Generic)	
* <a href="#">Request Form</a>		
* <a href="#">Criteria</a>		
* <a href="#">POS Edits</a>		
<b>METHOTREXATE (38)</b>	Methotrexate PF Vial	Methotrexate Auto-Injector (Otrexup®)
* <a href="#">Request Form</a>	Methotrexate Tablet	Methotrexate Auto-Injector (Rasuvo®)
* <a href="#">Criteria</a>	Methotrexate Vial	Methotrexate Solution (Xatmep®)
* <a href="#">POS Edits</a>		<b>Methotrexate PF Syringe (RediTrex®)</b>
		Methotrexate Tablet (Trexall™)
<b>MOVEMENT DISORDERS (39)</b>	Deutetrabenazine (Austedo®)	Tetrabenazine (Xenazine®)
* <a href="#">Request Form</a>	Tetrabenazine (Generic)	Valbenazine (Ingrezza®)
* <a href="#">Criteria</a>		Valbenazine Initiation Pack (Ingrezza®)
* <a href="#">POS Edits</a>		

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

**Effective Date: July 1, 2021**

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

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>ONCOLOGY (41)</b>	Busulfan (Myleran®)	Acalabrutinib (Calquence®)
<b>Oral – Hematologic</b>	Chlorambucil (Leukeran®)	Bosutinib (Bosulif®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Dasatinib (Sprycel®) Ibrutinib Capsule (Imbruvica®) Ibrutinib Tablet (Imbruvica®) Imatinib Mesylate (Generic) Lenalidomide (Revlimid®) Melphalan (Generic) Mercaptopurine (Generic) Procarbazine HCl (Matulane®) Ruxolitinib Phosphate (Jakafi®) Tretinoin (Generic) Venetoclax (Venclexta®) Venetoclax Starting Pack (Venclexta®)	Decitabine/Cedazuridine (Inqovi®) Duvelisib (Copiktra®) Enasidenib Mesylate (Idhifa®) Fedratinib (Inrebic®) Gilterinib (Xospata®) Glasdegib (Daurismo®) Hydroxyurea (Hydrea®) Idelalisib (Zydelig®) Imatinib Mesylate (Gleevec®) Ivosidenib (Tibsovo®) Ixazomib Citrate (Ninlaro®) Melphalan (Alkeran®) Mercaptopurine (Purixan®) Midostaurin (Rydapt®) Nilotinib HCl (Tasigna®) Panobinostat Lactate (Farydak®) Pomalidomide (Pomalyst®) Ponatinib HCl (Iclusig®) Selinexor (Xpovio®) Thalidomide (Thalomid®) Thioguanine (Tabloid®) Vorinostat (Zolinza®) Zanubrutinib (Brukinsa™)
<b>ONCOLOGY (41)</b>	Afatinib Dimaleate (Gilotrif®)	Brigatinib (Alunbrig®)
<b>Oral – Lung</b>	Alectinib HCl (Alecensa®)	Capmatinib (Tabrecta™)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Crizotinib (Xalkori®) Osimertinib Mesylate (Tagrisso®) Topotecan HCl (Hycamtin®)	Ceritinib (Zykadia®) Dacomitinib (Vizimpro®) Entrectinib (Rozlytrek®) Erlotinib HCl (Generic; Tarceva®) Gefitinib (Iressa®) Lorlatinib (Lorbrena®) Selpercatinib (Retevmo™) Tepotinib HCl (Tepmetko®)

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

Effective Date: July 1, 2021

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)	
<b>ONCOLOGY (41)</b>	Niraparib Tosylate (Zejula®)	Avapritinib (Ayvakit™)	
<b>Oral – Other</b>	Temozolomide (AG; Generic)	Cabozantinib S-Malate (Cometriq®)	
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		Erdafitinib (Balversa™)	
		Larotrectinib Capsule (Vitrakvi®)	
		Larotrectinib Solution (Vitrakvi®)	
		Olaparib (Lynparza®)	
		Pemigatinib (Pemazyre®)	
		Pexidartinib (Turalio®)	
		Regorafenib (Stivarga®)	
		Ripretinib (Qinlock™)	
		Rucaparib Camsylate (Rubraca®)	
		Selumetinib (Koselugo™)	
		Tazemetostat (Tazverik™)	
		Temozolomide (Temodar®)	
		Trifluridine/Tipiracil HCl (Lonsurf®)	
Vandetanib (Caprelsa®)			
<b>ONCOLOGY (41)</b>	Abiraterone Acetate (AG and Generic for Zytiga®)	Abiraterone Acetate (Zytiga®)	
<b>Oral – Prostate</b>	Bicalutamide (Generic)	Abiraterone Acetate, Submicronized (Yonsa®)	
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Enzalutamide (Xtandi®)	Apalutamide (Erleada®)	
	Flutamide (Generic)	Darolutamide (Nubeqa®)	
			Estramustine Phosphate Sodium (Emcyt®)
			Nilutamide (AG; Generic)
			<b>Relugolix (Orgovyx®)</b>
<b>ONCOLOGY (41)</b>	Axitinib (Inlyta®)	Cabozantinib S-Malate (Cabometyx®)	
<b>Oral - Renal Cell</b>	Everolimus Tablet (Afinitor®)	Everolimus Soluble Tablet (Afinitor Disperz®)	
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Lenvatinib Mesylate (Lenvima®)	Everolimus Tablet (Generic for Afinitor®)	
	Pazopanib HCl (Votrient®)		
	Sorafenib Tosylate (Nexavar®)		
	Sunitinib Malate (Sutent®)		

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>ONCOLOGY (41)</b>	Cobimetinib Fumarate (Cotellic®)	Binimetinib (Mektovi®)
<b>Oral - Skin</b>	Dabrafenib Mesylate (Tafinlar®)	Encorafenib (Braftovi®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Sonidegib Phosphate (Odomzo®)	Vismodegib (Erivedge®)
	Trametinib Dimethyl Sulfoxide (Mekinist®)	
	Vemurafenib (Zelboraf®)	
<b>OPHTHALMIC DISORDERS (42)</b>	Cromolyn Sodium Solution (Generic)	Alcaftadine Solution (Lastacaft®)
<b>Allergic Conjunctivitis</b>	Loteprednol Suspension (Alrex®)	Azelastine HCl Solution (Generic)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Olopatadine HCl Solution (AG and Generic for Patanol®)	Bepotastine Solution (Bepreve®)
	Olopatadine HCl Solution (Pazeo®)	Cetirizine (Zerviate™)
		Epinastine Solution (Generic)
		Lodoxamide Tromethamine Solution (Alomide®)
		Nedocromil Sodium Solution (Alocril®)
		Olopatadine HCl Solution (AG; Generic)
		Olopatadine HCl Solution (Patanol®)
<b>OPHTHALMIC DISORDERS (42)</b>	Bacitracin/Polymyxin B Sulfate Ointment (Generic)	Azithromycin Solution (AzaSite®)
<b>Antibiotics</b>	Ciprofloxacin Ophthalmic Solution (Generic)	Bacitracin Ointment (Generic)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Erythromycin Base Ointment (Generic)	Besifloxacin Suspension (Besivance®)
	Gentamicin Sulfate Ointment (Generic)	Ciprofloxacin Ointment (Ciloxan®)
	Gentamicin Sulfate Solution (Generic)	Gatifloxacin Solution (Generic; Zymaxid®)
	Moxifloxacin (AG and 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 (Generic)	Natamycin Suspension (Natacyn®)
	Sulfacetamide Sodium Solution (Generic)	Neomycin/Polymyxin B/Bacitracin Ointment (Generic)
	Tobramycin Solution (Generic)	Polymyxin B Sulfate/Trimethoprim Solution (Polytrim®)
		Sulfacetamide Sodium Ointment (Generic)
		Sulfacetamide Sodium Solution (Bleph-10®)
	Tobramycin Ointment (Tobrex®)	
	Tobramycin Solution (Tobrex®)	

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>OPHTHALMIC DISORDERS (42)</b>	Neomycin/Polymyxin B/Dexamethasone Ointment (Generic)	Gentamicin/Prednisolone Ointment, Suspension (Pred-G®)
<b>Antibiotic-Steroid Combinations</b>	Neomycin/Polymyxin B/Dexamethasone Suspension (Generic)	Neomycin/Bacitracin/Polymyxin B/Hydrocortisone Ointment (Generic)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	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) Tobramycin/Dexamethasone ST (TobraDex ST®) Tobramycin/Loteprednol Suspension (Zylet®)
<b>OPHTHALMIC DISORDERS (42)</b>	Dexamethasone Sodium Phosphate (Generic)	Bromfenac Sodium 0.07% Solution (Prolensa®)
<b>Anti-Inflammatories</b>	Diclofenac Sodium Solution (Generic)	Bromfenac Sodium 0.075% Solution (BromSite®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Difluprednate Emulsion (Durezol®)	Bromfenac Sodium 0.09% Solution (Generic)
	Fluorometholone 0.1% Suspension (Generic)	Dexamethasone (Dextenza®)
	Flurbiprofen Sodium Solution (Generic)	Dexamethasone/PF (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 Intraocular Implant (Iluvien®)
	Prednisolone Acetate 1% Suspension (Generic)	Fluocinolone Acetonide Intraocular Implant (Retisert®)
		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 0.5% Solution (Acular®)
		Ketorolac Tromethamine PF Solution 0.45% (Acuvail®)
		Loteprednol Etabonate 1% Ophthalmic Suspension (Inveltys®)
	Loteprednol Gel, 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®)	

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>OPHTHALMIC DISORDERS (42)</b>	Cyclosporine (Restasis®; Restasis Multidose™)	Cyclosporine 0.09% Ophthalmic Solution (Cequa®)
<b>Anti-Inflammatory/Immunomodulators</b>	Lifitegrast (Xiidra®)	<b>Loteprednol Etabonate (Eysuvis®)</b>
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		
<b>OPHTHALMIC DISORDERS (42)</b>	Brimonidine 0.15% Solution (Alphagan P® 0.15%)	Apraclonidine Solution (Generic; Iopidine®)
<b>Glaucoma Agents</b>	Brimonidine 0.2% Solution (Generic)	Betaxolol 0.25% Suspension (Betoptic S®)
<b>Intraocular Pressure (IOP) Reducers</b>	Brimonidine/Brinzolamide Suspension (Simbrinza®)	Betaxolol 0.5% Solution (Generic)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Brimonidine/Timolol Solution (Combigan®)	Bimatoprost Solution 2.5 mL, 5mL, 7.5mL (Generic; Lumigan®)
	Carteolol Solution (Generic)	Brimonidine 0.1% Solution (Alphagan P® 0.1%)
	Dorzolamide Solution (Generic)	Brimonidine P 0.15% Solution (Generic)
	Dorzolamide/Timolol Solution (Generic)	Brinzolamide Suspension (Azopt®)
	Latanoprost 2.5mL Solution (Generic)	Dorzolamide Solution (Trusopt®)
	Levobunolol Solution (Generic)	Dorzolamide/Timolol Solution (Cosopt®)
	Netarsudil Mesylate (Rhopressa®)	Dorzolamide/Timolol/PF Solution (AG; Generic; Cosopt PF®)
	Netarsudil Mesylate/Latanoprost (Rocklatan®)	Echothiophate Iodide (Phospholine Iodide®)
	Timolol Maleate Solution (Generic)	Latanoprost Emulsion (Xelpros®)
	Travoprost 2.5 mL (Travatan Z®)	Latanoprost Solution 2.5 mL (Xalatan®)
	Travoprost 5 mL (Travatan Z®)	Latanoprostene Bunod Solution (Vyzulta®)
		Pilocarpine HCl Solution (Generic)
		Tafluprost Solution (Zioptan®)
		Timolol Maleate Gel-Forming Solution (Timoptic-XE®)
		Timolol Maleate LA Solution (AG; Generic; Istalol®)
		Timolol Maleate Solution (Timoptic® Ocudose®)
		Travoprost 2.5mL (AG; Generic)
<b>OPIATE DEPENDENCE AGENTS (43)</b>	<b>Buprenorphine Sublingual Tablet (Generic)</b>	Buprenorphine Syringe (Sublocade®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Buprenorphine/Naloxone Sublingual Film (Suboxone®)	Buprenorphine/Naloxone Film Buccal Film (Bunavail®)
	Buprenorphine/Naloxone Sublingual Tablet (Generic)	Buprenorphine/Naloxone Sublingual Film (Generic)
	Buprenorphine/Naloxone Sublingual Tablet (Zubsolv®)	Lofexidine Tablet (Lucemyra®)
	Naloxone Nasal Spray (Narcan®)	Naltrexone Extended-Release Suspension Vial (Vivitrol®)
	Naloxone Syringe, Vial (Generic)	
	Naltrexone Tablet (Generic)	

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>OSTEOPOROSIS (44)</b>	Alendronate Tablet (Generic)	Abaloparatide Pen (Tymlos®)
<b>Bone Resorption Suppression Agents</b>	Calcitonin-Salmon Nasal (Generic)	Alendronate Tablet (Fosamax®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Ibandronate Sodium Tablet (Generic)	Alendronate Solution (Generic)
	<b>Teriparatide Pen (Brand)</b>	Alendronate/Vitamin D Tablet (Fosamax Plus D®)
		Denosumab Syringe (Prolia®)
		Ibandronate Sodium Tablet (Boniva®)
		Raloxifene Tablet (Generic; Evista®)
		Risedronate Tablet (AG; Generic for Actonel®)
		Risedronate DR Tablet (AG; Generic; Atelvia®)
		Romozosumab-aqqg Syringe (Evenity®)
	Teriparatide Pen (Forteo®)	
<b>OTIC AGENTS (45)</b>	Ciprofloxacin/Dexamethasone (Ciprodex®)	Ciprofloxacin Otic (Generic)
<b>Antibiotics</b>	Neomycin/Polymyxin B/Hydrocortisone Solution (Generic)	Ciprofloxacin Otic (Otiprio®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Neomycin/Polymyxin B/Hydrocortisone Suspension (Generic)	Ciprofloxacin/Dexamethasone (AG; Generic)
	Ofloxacin Otic (Generic)	Ciprofloxacin/Fluocinolone Acetonide (AG; Otovel®)
		Ciprofloxacin/Hydrocortisone (Cipro HC Otic®)
		Colistin/Neomycin/Thonzonium/HC (Cortisporin® TC)
<b>OTIC AGENTS (45)</b>	Acetic Acid (Generic)	<b>NONE</b>
<b>Anti-Infectives and Anesthetics</b>	Acetic Acid/Hydrocortisone (Generic)	
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		
<b>PAIN MANAGEMENT (46)</b>	Fremanezumab-vfrm Autoinjector (Ajovy®)	Eptinezumab-jjmr Vial (Vyepi™)
<b>Antimigraine Agents</b>	Fremanezumab-vfrm Autoinjector 3-Pack (Ajovy®)	Erenumab-aooe (Aimovig®)
<b>CGRP Antagonists</b>	Fremanezumab-vfrm (Ajovy®)	Galcanzumab-gnlm 100 mg Syringe (Emgality®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Galcanzumab-gnlm Pen (Emgality®)	Ubrogepant Tablet (Ubrovelvy™)
	Galcanzumab-gnlm 120 mg Syringe (Emgality®)	
	Rimegepant (Nurtec™ ODT)	



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

Effective Date: July 1, 2021

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>PAIN MANAGEMENT (46)</b>	NONE	Diclofenac Potassium Oral Powder Packet (Cambia®)
<b>Antimigraine Agents</b>		Dihydroergotamine Mesylate Injection (Generic)
<b>Ergotamines</b>		Dihydroergotamine Mesylate Nasal (Generic; Migranal®)
<a href="#">*Request Form</a>		Ergotamine Tartrate Sublingual Tablet (Ergomar®)
<a href="#">*Criteria</a>		Ergotamine Tartrate/Caffeine Tablet (Cafergot®)
<a href="#">*POS Edits</a>		
<b>PAIN MANAGEMENT (46)</b>	Rizatriptan ODT (Generic)	Almotriptan Tablet (Generic)
<b>Antimigraine Agents</b>	Rizatriptan Tablet (Generic)	Eletriptan Tablet (AG; Generic; Relpax®)
<b>Triptans</b>	Sumatriptan Disp Syringe (Generic)	Frovatriptan Tablet (Generic; Frova®)
<a href="#">*Request Form</a>	<b>Sumatriptan Nasal (Imitrex®)</b>	Lasmiditan Tablet (Reyvow®)
<a href="#">*Criteria</a>	Sumatriptan Tablet (Generic)	Naratriptan (Generic)
<a href="#">*POS Edits</a>	Sumatriptan Vial (Generic)	Rizatriptan Tablet (Maxalt®)
		Rizatriptan Tablet (Maxalt MLT®)
		Sumatriptan Auto-Injector (Zembrace® SymTouch®)
		Sumatriptan Kit (AG; Generic; Imitrex®)
		Sumatriptan Kit (SUN)
		Sumatriptan Nasal (Onzetra® Xsail®)
		<b>Sumatriptan Nasal (AG; Generic)</b>
		Sumatriptan Nasal (Tosymra™)
		Sumatriptan Tablet (Imitrex®)
		Sumatriptan/Naproxen (Generic; Treximet®)
		Zolmitriptan Tablet (AG; Generic)
	Zolmitriptan ODT (Generic; Zomig ZMT®)	
	Zolmitriptan Nasal (AG; Zomig®)	

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>PAIN MANAGEMENT (46)</b>	Adalimumab Pen Kit (Humira®)	Abatacept Injection Clickject, Syringe, Vial (Orencia®)
<b>Cytokine and CAM Antagonists</b>	Adalimumab Syringe Kit (Humira®)	Anakinra Syringe (Kineret®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Apremilast Tablet (Otezla®)	Baricitinib Tablet (Olumiant®)
	Etanercept Kit (Enbrel®)	Brodalumab Syringe (Siliq®)
	Etanercept Mini Cartridge (Enbrel®)	Canakinumab/PF Vial (Ilaris®)
	Etanercept Pen (Enbrel®)	Certolizumab Pegol Kit (Cimzia®)
	Etanercept Syringe (Enbrel®)	Certolizumab Syringe Kit (Cimzia®)
	Etanercept Injection Vial (Enbrel®)	Golimumab Pen, Syringe (Simponi®)
		Golimumab Vial (Simponi Aria®)
		Guselkumab Autoinjector, Syringe (Tremfya®)
		Inebilizumab-ndon Injection (Uplizna™)
		Infliximab Vial (Remicade®)
		Infliximab-abda Vial (Renflexis®)
		Infliximab-axxq Injection (Avsola™)
		Infliximab-dyyb Vial (Inflectra®)
		Ixekizumab Autoinjector, Syringe (Taltz®)
		Rilonacept (Arcalyst®)
		Risankizumab-rzaa Injection (Skyrizi®)
		Sarilumab Pen, Syringe (Kevzara®)
		Satralizumab-mwge Injection (Enspryng™)
		Secukinumab Pen, Syringe (Cosentyx®)
		Tildrakizumab-asmn Syringe (Ilumya®)
		Tocilizumab Pen, Syringe, Vial (Actemra®)
		Tofacitinib Tablet (Xeljanz®)
	Tofacitinib ER Tablet (Xeljanz® XR)	
	<b>Tofacitinib Citrate Solution (Xeljanz®)</b>	
	Upadacitinib Extended Release Tablet (Rinvoq™)	
	Ustekinumab Syringe, Vial (Stelara®)	
	Vedolizumab (Entyvio®)	

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>PAIN MANAGEMENT (46)</b>	Acetaminophen with Codeine Elixir (Generic)	Benzhydrocodone/Acetaminophen (AG; Apadaz®)
<b>Narcotic Analgesics - Short-Acting</b>	Acetaminophen with Codeine Tablet (Generic)	Butalbital/Caffeine/APAP/Codeine (Generic; Fioricet® with Codeine)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	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 Disp Syringe (Generic)	Dihydrocodeine Bitartrate/Acetaminophen/Caffeine (Generic)
	Oxycodone Tablet (Generic)	Fentanyl Buccal (Generic; Fentora®)
	Oxycodone/Acetaminophen Tablet (Generic)	Hydrocodone/Acetaminophen Elixir (Lortab®)
	Tramadol 50 mg (Generic)	Hydrocodone/Acetaminophen Tablet (Norco®)
	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®)
		Oxycodone/Acetaminophen Tablet (Generic for Prolate™)
		Oxycodone/Aspirin (Generic)
	Oxymorphone IR Tablet (Generic)	
	Pentazocine/Naloxone (Generic)	
	Sufentanil Sublingual Tablet (Dsuvia®)	
	Tapentadol Tablet (Nucynta®)	
	Tramadol (Ultram®)	
	<b>Tramadol 100 mg (Generic)</b>	

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>PAIN MANAGEMENT (46)</b>	Fentanyl Transdermal 12 mcg (Generic)	Buprenorphine Buccal Film (Belbuca®)
<b>Narcotic Analgesics - Long-Acting</b>	Fentanyl Transdermal 25 mcg (Generic)	Buprenorphine Transdermal (AG; Generic; Butrans®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Fentanyl Transdermal 50 mcg (Generic)	Fentanyl Transdermal (Duragesic®)
	Fentanyl Transdermal 75 mcg (Generic)	Fentanyl Transdermal 37.5 mcg, 62.5mcg, 87.5mcg (Generic)
	Fentanyl Transdermal 100 mcg (Generic)	Hydrocodone Bitartrate ER Capsule (AG; Generic; Zohydro ER®)
	Morphine Sulfate ER Tablet (Generic)	Hydrocodone Bitartrate ER Tablet (Hysingla ER®)
		Hydromorphone ER Tablet (Generic)
		Morphine Sulfate ER Capsule (Generic Avinza®)
		Morphine Sulfate ER Capsule (Generic; 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 for Conzip®)
		Tramadol ER Tablet (Generic Ryzolt®)
	Tramadol ER Tablet (Generic Ultram ER®)	
<b>PAIN MANAGEMENT (46)</b>	Duloxetine Capsule (Generic for Cymbalta®)	Capsaicin/Skin Clenser (Qutenza Kit®)
<b>Neuropathic Pain</b>	Gabapentin Capsule (Generic)	Duloxetine Capsule (Cymbalta®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	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 (Savella®)	Gabapentin ER Tablet (Gralise®)
	Milnacipran (Savella Dose Pak®)	Lidocaine Patch (Lidoderm®)
		Pregabalin Capsule (AG; Generic; Lyrica®)
		Pregabalin Solution (AG; Generic; Lyrica®)
		Pregabalin ER Tablet (Lyrica CR®)

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)	
<b>PAIN MANAGEMENT (46)</b>	Diclofenac Sodium Tablet (Generic)	Celecoxib (AG; Generic; Celebrex®)	
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)</b>	Diclofenac Sodium Transdermal Gel (Generic; Voltaren®)	Diclofenac Epolamine Patch (AG; Flector®)	
	Ibuprofen Suspension Rx (Generic)	Diclofenac Epolamine Topical (Licart™)	
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Ibuprofen Tablet Rx (Generic)	Diclofenac Potassium Capsule (Zipsor®)	
	Indomethacin Capsule (Generic)	Diclofenac Potassium Tablet (Generic)	
	Ketorolac Tablet (Generic)	Diclofenac Sodium Topical Solution (Generic; Pennsaid® Pump)	
	Meloxicam Tablet (Generic)	Diclofenac SR (Generic)	
	Nabumetone Tablet (Generic)	Diclofenac Submicronized Capsule (Zorvolex®)	
	Naproxen Suspension (Generic)	Diclofenac Sodium/Camphor/Menthol Kit (Diclotrex™ Kit)	
	Naproxen Tablet (Generic)	Diclofenac Sodium/Capsaicin (Dicloflex DC)	
	Sulindac Tablet (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 (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 (Generic)	
		Meloxicam, Submicronized (Vivlodex®)	
		Meloxicam ODT (Qmiiz® ODT)	
		Meloxicam Tablet (Mobic®)	
		Nabumetone Tablet (Relafen DS™)	
		Naproxen CR, EC (AG; Generic)	
		Naproxen Sodium (Generic; Naprelan®)	
Naproxen/Esomeprazole Tablet (AG; Generic; Vimovo®)			
Oxaprozin Tablet (Generic; Daypro®)			
Piroxicam Capsule (Generic)			
Tolmetin Capsule, Tablet (Generic)			

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>PAIN MANAGEMENT (46)</b>	Baclofen Tablet (Generic)	Carisoprodol Compound Tablet (Generic)
<b>Skeletal Muscle Relaxant</b>	Chlorzoxazone Tablet (Generic)	Carisoprodol Tablet 250 mg (Generic; Soma®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Cyclobenzaprine Tablet (Generic)	Carisoprodol Tablet 350 mg (Generic; Soma®)
	Methocarbamol Tablet (Generic)	Chlorzoxazone Tablet (Lorzone®)
	Tizanidine Tablet (Generic)	Cyclobenzaprine ER Capsule (AG; Generic; Amrix®)
		Dantrolene Sodium (AG; Generic; Dantrium®)
		Metaxalone Tablet (Generic; Skelaxin®)
		Orphenadrine ER Tablet (Generic)
		Tizanidine Capsule (Generic; Zanaflex®)
		Tizanidine Tablet (Zanaflex®)
<b>PARKINSON'S (47)</b>	Amantadine Capsule (Generic)	Amantadine Hydrochloride ER Capsule (Gocovri®)
<b>Antiparkinson Agents</b>	Amantadine Syrup (Generic)	Amantadine Hydrochloride ER Tablet (Osmolex ER®)
<b>Anticholinergic and Other</b>	Benztropine Tablet (Generic)	Amantadine Tablet (Generic)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Carbidopa/Levodopa ER Tablet (Generic)	Apomorphine Injection (Apokyn®)
	Carbidopa/Levodopa Tablet (Generic)	Apomorphine Sublingual (Kynmobi™)
	Carbidopa/Levodopa/Entacapone Tablet (Generic)	Bromocriptine (Generic)
	Pramipexole Tablet (Generic)	Carbidopa Tablet (Generic; Lodosyn®)
	Ropinirole Tablet (Generic)	Carbidopa/Levodopa Enteral Suspension (Duopa®)
	Selegiline Capsule (Generic)	Carbidopa/Levodopa ER Capsule (Rytary®)
	Selegiline Tablet (Generic)	Carbidopa/Levodopa ODT (Generic)
	Trihexyphenidyl Elixir (Generic)	Carbidopa/Levodopa/Entacapone Tablet (Stalevo®)
	Trihexyphenidyl Tablet (Generic)	Entacapone Tablet (Generic; Comtan®)
		Istradefylline Tablet (Nourianz™)
		Levodopa (Inbrija®)
		Pramipexole ER (Generic; Mirapex ER®)
		Rasagiline (Generic; Azilect®)
		Ropinirole ER (Generic; Requip XL®)
		Rotigotine Patch (Neupro®)
		Safinamide Tablet (Xadago®)
		Selegiline (Zelapar®)
		Tolcapone Tablet (Generic)

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>PEDIATRIC MULTIVITAMINS (48)</b>	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)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	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)
<b>PITUITARY SUPPRESSIVE AGENTS (49)</b>	Goserelin Acetate (Zoladex®)	Histrelin Implant Kit (Supprelin LA®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	<b>Leuprolide Acetate Syringe Kit (Fensolvi®)</b>	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 Vial (Trelstar LA®)
	Leuprolide Acetate [1 month] (Lupron Depot-Ped Kit®)	Triptorelin Pamoate Kit (Triptodur®)
	Leuprolide Acetate Susp/Norethindrone Tablet (Lupaneta Pack®)	
	Nafarelin Acetate Nasal Solution (Synarel®)	
<b>POTASSIUM BINDERS (50)</b>	<b>Sodium Polystyrene Sulfonate Powder (Generic)</b>	<b>Patiromer Sorbitex Calcium Powder Packet (Veltassa®)</b>
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>		<b>Sodium Zirconium Cyclosilicate (Lokelma®)</b>

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

Effective Date: July 1, 2021

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>PROGESTATIONAL AGENTS (51)</b>	Hydroxyprogesterone Caproate Auto Injector (Makena®)	Hydroxyprogesterone Caproate (Generic by ANI; Generic by Mylan) – <i>NOT indicated for pre-term labor</i>
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Hydroxyprogesterone Caproate SDV (AG; Generic; Makena®)	Hydroxyprogesterone Caproate MDV (Generic)
	Medroxyprogesterone Acetate Tablet (AG; Generic)	Medroxyprogesterone Acetate (Depo-Provera® 400 mg/mL)
	Norethindrone Acetate Tablet (Generic)	Medroxyprogesterone Acetate Tablet (Provera®)
	Progesterone Capsule (Generic)	Norethindrone Acetate Tablet (Aygestin®)
		Progesterone Injection (Generic)
		Progesterone, Micronized, Oral (Prometrium®)
		Progesterone, Micronized, Vaginal (Crinone®)
<b>PROSTATE (52)</b>	Alfuzosin (Generic)	Doxazosin (Cardura®)
<b>Benign Prostatic Hyperplasia Treatment (BPH)</b>	Doxazosin (Generic)	Doxazosin ER (Cardura XL®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Dutasteride (Generic)	Dutasteride (Avodart®)
	Finasteride (Generic)	Dutasteride/Tamsulosin (Generic)
	Tamsulosin (Generic)	Finasteride (Proscar®)
	Terazosin (Generic)	Silodosin (Generic; Rapaflo®)
		Tadalafil (AG; Generic; Cialis®)
		Tamsulosin (Flomax®)
<b>SEDATIVE/HYPNOTICS (53)</b>	Temazepam Capsule 15mg, 30mg (AG; Generic)	Doxepin Tablet (AG; Generic; Silenor®)
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Triazolam Tablet (Generic)	Estazolam Tablet (Generic)
	Zolpidem Tablet (Generic)	Eszopiclone Tablet (Generic; Lunesta®)
		Flurazepam Capsule (Generic)
		Lemborexant (Dayvigo®)
		Ramelteon Tablet (Generic; Rozerem®)
		Suvorexant Tablet (Belsomra®)
		Tasimelteon Capsule, <b>Suspension</b> (Hetlioz®; <b>Hetlioz LQ™</b> )
		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 (Generic; Edluar®)
		Zolpidem Tartrate Tablet (Ambien®)



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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<p><b>SICKLE CELL ANEMIA TREATMENTS (54)</b></p> <p><a href="#">*Request Form</a>  <a href="#">*Criteria</a>  <a href="#">*POS Edits</a></p>	<p>Hydroxyurea (Generic)</p>	<p>Crizanlizumab-tmca Infusion (Adakveo®)</p> <p>Hydroxyurea (Droxia®)</p> <p>Hydroxyurea (Siklos®)</p> <p>L-glutamine (Endari™)</p> <p>Voxelotor (Oxbryta®)</p>
<p><b>SINUS NODE INHIBITORS (55)</b></p> <p><a href="#">*Request Form</a>  <a href="#">*Criteria</a>  <a href="#">*POS Edits</a></p>	<p>NONE</p>	<p>Ivabradine Solution (Corlanor®)</p> <p>Ivabradine Tablet (Corlanor®)</p>
<p><b>SMOKING CESSATION PRODUCTS (56)</b></p> <p><a href="#">*Request Form</a>  <a href="#">*Criteria</a>  <a href="#">*POS Edits</a></p>	<p>Bupropion SR Tablet (Generic)</p> <p>Nicotine Buccal Gum OTC, Buccal Lozenges OTC (Generic)</p> <p>Nicotine Patch OTC (Generic)</p> <p>Varenicline (Chantix®; Chantix Dose Pack®)</p>	<p>Nicotine Inhaler (Nicotrol Inhaler®)</p> <p>Nicotine Nasal Spray (Nicotrol Nasal Spray®)</p>
<p><b>THROMBOPOIESIS STIMULATING PROTEINS (57)</b></p> <p><a href="#">*Request Form</a>  <a href="#">*Criteria</a>  <a href="#">*POS Edits</a></p>	<p>Eltrombopag Tablet (Promacta®)</p>	<p>Avatrombopag (Doptelet®)</p> <p>Eltrombopag Suspension (Promacta®)</p> <p>Fostamatinib Disodium Hexahydrate (Tavalisse®)</p> <p>Lusutrombopag (Mulpleta®)</p> <p>Romiplostim (Nplate®)</p>
<p><b>UROLOGY INCONTINENCE (58)</b></p>	<p>Fesoterodine Fumarate ER (Toviaz®)</p>	<p>Darifenacin ER (AG; Generic)</p>
<p><b>Bladder Relaxant Preparations</b></p> <p><a href="#">*Request Form</a>  <a href="#">*Criteria</a>  <a href="#">*POS Edits</a></p>	<p>Oxybutynin Syrup (Generic)</p> <p>Oxybutynin Tablet (Generic)</p> <p>Oxybutynin ER (Generic)</p> <p>Solifenacin (Generic)</p>	<p>Flavoxate (Generic)</p> <p>Mirabegron ER Tablet (Myrbetriq®)</p> <p>Oxybutynin ER (Ditropan XL®)</p> <p>Oxybutynin Transdermal (Gelnique®)</p> <p>Oxybutynin Transdermal Rx (Oxytrol®)</p> <p>Solifenacin (VESIcare®; <b>VESIcare® LS</b>)</p> <p>Tolterodine (Generic; Detrol®)</p> <p>Tolterodine ER (AG; Generic; Detrol LA®)</p> <p>Trospium (Generic)</p> <p>Trospium ER (Generic)</p>

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

**Effective Date: July 1, 2021**

Descriptive Therapeutic Class	Drugs on PDL	Drugs on NPDL which Require Prior Authorization (PA)
<b>UTERINE DISORDER TREATMENTS (59)</b>	Elagolix Tablet (Orilissa®)	NONE
<a href="#">*Request Form</a> <a href="#">*Criteria</a> <a href="#">*POS Edits</a>	Elagolix/Estradiol/Norethindrone Capsule (Oriahnn®)	

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

<b>AL</b> – Age Limit	<b>DD</b> – Drug-Drug Interaction	<b>MD</b> – Maximum Dose Limit	<b>RX</b> – Specific Prescription Requirement
<b>BH</b> – Behavioral Health Clinical Authorization for Children Younger than 7 Years of Age	<b>DS</b> – Maximum Days’ Supply Allowed	<b>PA</b> – Prior Authorization	<b>TD</b> – Therapeutic Duplication
<b>BY</b> – Diagnosis Codes Bypass Some Requirements	<b>DT</b> – Duration of Therapy Limit	<b>PR</b> – Enrollment in a Physician-Supervised Program Required	<b>UN</b> – Drug Use Not Warranted
<b>CL</b> – Additional Clinical Information is Required	<b>DX</b> – Diagnosis Code Requirement	<b>PU</b> – Prior Use of other Medication is Required	<b>X</b> – Prescriber Must Have ‘X’ DEA Number
<b>CU</b> – Concurrent Use with Other Medications is Restricted	<b>ER</b> – Early Refill	<b>QL</b> – Quantity Limit	<b>YQ</b> – Yearly Quantity Limit

Acetaminophen	<b>MD</b>	Intron-A® (Interferon Alfa-2B Recombinant)	<b>DX</b>	Reclast® (Zoledronic acid)	<b>CL, QL</b>
Acthar® (Corticotropin)	<b>CL</b>	Isotretinoin	<b>RX</b>	Remodulin® (Treprostinil Sodium) INJECTION	<b>DX</b>
Actimmune® (Interferon Gamma-1b)	<b>DX</b>	Jadenu® (Deferasirox)	<b>DX</b>	Rilutek® (Riluzole)	<b>DX</b>
Aduhelm™ (Aducanumab-avwa) <a href="#">REQUEST FORM</a>	<b>CL</b>	Jynarque® (Tolvaptan)	<b>CL</b>	Samsca® (Tolvaptan)	<b>CL, QL</b>
Aldurazyme™ (Laronidase)	<b>CL</b>	Keveyis® (Dichlorphenamide)	<b>CL, QL</b>	Soliris® (Eculizumab)	<b>DX</b>
Amitriptyline	<b>BH, TD</b>	Kuvan® (Sapropterin Dihydrochloride)	<b>CL</b>	Spinraza® (Nusinersen) <a href="#">REQUEST FORM</a>	<b>CL</b>
Amitriptyline/Chlordiazepoxide	<b>BH</b>	Lithium	<b>BH</b>	Strensiq® (Asfotase alfa)	<b>DX</b>
Amondys 45® (Casimersen)	<b>CL</b>	Lidocaine Patch Kit (Brand Example - Prilo Patch II®)	<b>CL</b>	Sylatron® (Peginterferon alfa-2b)	<b>DX</b>
Amoxapine	<b>BH, TD</b>	Lorazepam Injectable	<b>BY</b>	Synagis® (Palivizumab) <a href="#">REQUEST FORM</a>	<b>AL, CL, DT, QL</b>
Aspirin	<b>MD</b>	Lumizyme® (Alglucosidase alfa)	<b>DX</b>	Tegsedi™ (Inotersen)	<b>DX</b>
Benlysta® (Belimumab)	<b>CL</b>	Lupkynis™ (Voclosporin)	<b>CL</b>	Tiglutik™ (Riluzole)	<b>DX</b>
Beyaz® (Drospirenone/Ethinyl Estradiol/ Levomefolate Calcium)	<b>DX</b>	Maprotiline	<b>BH</b>	Tikosyn® (Dofetilide)	<b>CL</b>
Brineura™ (Cerliponase alfa)	<b>DX</b>	Mepsevii™ (Vestronidase alfa-vjkb)	<b>CL</b>	Trimipramine	<b>BH, TD</b>
Buphenyl® (Sodium Phenylbutyrate)	<b>CL</b>	Methadone	<b>CL, DX, QL</b>	Ultomiris® (Ravulizumab-cwvz)	<b>DX</b>
Cablivi® (Caplacizumab-yhdp)	<b>CL</b>	Mosquito Repellant to Decrease Zika Virus Exposure Risk <a href="#">FFS Notice</a> <a href="#">MCO Notice</a>	<b>AL, DX, QL</b>	Velettri® (Epoprostenol)	<b>DX</b>

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

**Effective Date: July 1, 2021**

Carafate® (Sucralfate)	<u><a href="#">DT</a></u>	Mytesi® (Crofelemer)	<u><a href="#">CL</a></u>	Viltepso® (Viltolarsen)	<u><a href="#">CL</a></u>
Carbaglu® (Carglumic Acid)	<u><a href="#">CL</a></u>	Nabi-HB (Hepatitis B Immune Globulin)	<u><a href="#">CL</a></u>	Vimizim™ (Elosulfase alfa)	<u><a href="#">CL</a></u>
Chlordiazepoxide/Clidinium	<u><a href="#">BH</a></u>	Naglazyme™ (Galsulfase)	<u><a href="#">CL</a></u>	Vyndamax™, Vyndaquel® (Tafamidis)	<u><a href="#">CL, QL</a></u>
Chlorpromazine Injectable	<u><a href="#">BH</a></u>	Nexplanon® (Etonogestrel)	<u><a href="#">QL</a></u>	Vyondys 53® (Golodirsen)	<u><a href="#">CL</a></u>
Clomipramine	<u><a href="#">BH, TD</a></u>	Nityr® (Nitisinone)	<u><a href="#">CL</a></u>	Xenical® (Orlistat)	<u><a href="#">DX, QL</a></u>
Cuprimine® (Penicillamine)	<u><a href="#">CL, QL</a></u>	Nocurna® (Desmopressin)	<u><a href="#">QL</a></u>	Xyrem® (Sodium Oxybate)	<u><a href="#">CL, TD</a></u>
Daraprim® (Pyrimethamine)	<u><a href="#">CL</a></u>	Nortriptyline	<u><a href="#">BH, TD</a></u>	Xywav™ (Oxybate Salts)	<u><a href="#">CL, TD</a></u>
Depen® (Penicillamine)	<u><a href="#">CL, QL</a></u>	Nuedexta® (Dextromethorphan/Quinidine)	<u><a href="#">CL, QL</a></u>	Zolgensma® (Onasemnogene Abeparvovec-xioi)	<u><a href="#">CL</a></u>
Desipramine	<u><a href="#">BH, TD</a></u>	Onpattro® (Patisiran)	<u><a href="#">DX</a></u>	Zonalon® (Doxepin Topical)	<u><a href="#">AL, DX, TD, QL</a></u>
Doxepin (10 mg-150 mg)	<u><a href="#">BH, TD</a></u>	Orfadin® (Nitisinone)	<u><a href="#">CL</a></u>		
Elaprase™ (Idursulfase)	<u><a href="#">CL</a></u>	Palynziq® (Pegvaliase-pqpz)	<u><a href="#">CL</a></u>		
Evrysdi™ (Risdiplam)	<u><a href="#">CL</a></u>	Pamidronate Disodium	<u><a href="#">CL</a></u>		
Exjade® (Deferasirox)	<u><a href="#">DX</a></u>	Ponvory™ (Ponesimod)	<u><a href="#">CL</a></u>		
EXONDYS 51® (Eteplirsen)	<u><a href="#">CL</a></u>	Proleukin® (Aldesleukin)	<u><a href="#">DX</a></u>		
Fabrazyme® (Agalsidase beta)	<u><a href="#">DX, TD</a></u>	Protriptyline	<u><a href="#">BH, TD</a></u>		
Fetroja® (Cefiderocol)	<u><a href="#">CL</a></u>	Prudoxin® (Doxepin Topical)	<u><a href="#">AL, DX, TD, QL</a></u>		
Flolan® (Epoprostenol Sodium)	<u><a href="#">DX</a></u>	Pulmozyme® (Dornase Alfa)	<u><a href="#">DX</a></u>		
Galafold® (Migalastat)	<u><a href="#">DX, TD</a></u>	Qelbree™ (Viloxazine)	<u><a href="#">BH, DX, TD, PA</a></u>		
Gattex® (Teduglutide)	<u><a href="#">CL</a></u>	Quaaluaquin® (Quinine) 324 mg	<u><a href="#">DS, DX, QL</a></u>		
Givlaari® (Givosiran)	<u><a href="#">CL</a></u>	Radicava® (Edaravone)	<u><a href="#">DX</a></u>		
HyperTET SD (Tetanus Immune Globulin)	<u><a href="#">CL</a></u>	Ranexa® (Ranolazine)	<u><a href="#">CL</a></u>		
Imipramine	<u><a href="#">BH, TD</a></u>	Ravicti® (Glycerol Phenylbutyrate)	<u><a href="#">CL</a></u>		