

**NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
NORTH DAKOTA MEDICAID**

**PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA**

This is NOT an all-inclusive list of covered medications or medications that require prior authorization. Only PDL managed categories are included. Refer to cover page for complete list of rules governing this PDL.

Visit <http://www.hidesigns.com/ndmedicaid> for more information on medications not found in this list.

**EFFECTIVE  
02/12/2018  
Version 2018.2**

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>HEPATITIS C TREATMENTS</b>		
<p><b>Category PA Criteria:</b> Non-preferred agents will require a failed trial of all preferred treatment options indicated for the patient's genotype and be labeled for failure of previous treatment.</p> <ol style="list-style-type: none"> <li>1. Patient must have a documented FDA-approved diagnosis. Chronic Hepatitis C must be documented by one of the following:               <ol style="list-style-type: none"> <li>a. Liver fibrosis F1 and below: 2 positive HCV RNA levels at least 6 months apart</li> <li>b. Liver fibrosis F2 and above: 1 positive HCV RNA test within the last 12 months</li> </ol> </li> <li>2. Patient must be an FDA-approved age.</li> <li>3. Patient must be drug (illicit use of drugs by injection) and alcohol free as documented by 2 drug and alcohol tests dated at least 3 months apart and meet criteria as outlined below:               <ol style="list-style-type: none"> <li>a. If the patient has a history of alcohol use disorder, the patient must:                   <ol style="list-style-type: none"> <li>i. have abstained from alcohol for at least 3 months AND</li> <li>ii. be receiving treatment from an enrolled provider and agree to abstain from alcohol during treatment AND</li> <li>iii. be under the care of an addiction medicine/chemical dependency treatment provider and the provider attests the patient has abstained from alcohol use for at least 3 months</li> </ol> </li> <li>b. If the patient has a history of illicit use of drugs by injection, the patient must:                   <ol style="list-style-type: none"> <li>i. have abstained from drug use for at least 3 months AND</li> <li>ii. be receiving treatment from an enrolled provider and agree to abstain from said drug use during treatment AND</li> <li>iii. be under the care of an addiction medicine/chemical dependency treatment (or buprenorphine waived provider) provider and the provider attests the patient has abstained from drug use for at least 3 months</li> </ol> </li> </ol> </li> <li>4. Patient must attest that they will continue treatment without interruption for the duration of therapy.</li> <li>5. Prescriber must be, or consult with, a hepatologist, gastroenterologist, or infectious disease specialist.</li> <li>6. HCV RNA level must be taken on week 4 and sent with a renewal request for any duration of treatment 12 weeks or longer.</li> <li>7. Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment.</li> <li>8. Patient must have established compliant behavior including attending scheduled provider visits (defined as 1 or less no-shows) and filling maintenance medications on time as shown in the prescription medication history for the past 12 months.</li> <li>9. Patient must be tested for hepatitis B, and if the test is positive, hepatitis B must either be treated or closely monitored if patient does not need treatment.</li> <li>10. Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions.</li> <li>11. PA approval duration will be based on label recommendation.</li> </ol>		
EPCLUSA (sofosbuvir/velpatasvir) <sup>PA***</sup>	DAKLINZA (Daclatasvir)	***Epclusa: • Must be used with ribavirin for patients with decompensated cirrhosis (Child-Pugh B or Child-Pugh C).
MAVYRET (glecaprevir/pibrentasvir) <sup>PA***</sup>	HARVONI (ledipasvir/sofosbuvir)	
	OLYSIO (simeprevir)	

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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	SOVALDI (sofosbuvir)	***Mavyret/Vosevi: • Patient must not have decompensated cirrhosis (Child-Pugh B or Child-Pugh C)
	TECHNIVIE (ombitasvir/paritaprevir/ritonavir)	
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)	
	VIEKIRA PAK XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)	
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)	
	ZEPATIER (elbasvir/grazoprevir)	
<b>LICE</b>		
<b>Category PA Criteria:</b> A 28-day/2-application trial of each of the preferred agents will be required before a non-preferred agent will be authorized. This requirement will be waived in the presence of a documented community breakout of a resistant strain that is only susceptible to a non-preferred agent.		
EURAX (crotamiton) CREAM	ELIMITE (permethrin) CREAM	
LICE SOLUTION (piperonyl butoxide/pyrethrins)	EURAX (crotamiton) LOTION	
NATROBA (spinosad)	Malathion	
Permethrin cream	OVIDE (malathion)	
SKLICE (ivermectin)	Spinosad	
ULESFIA (benzyl alcohol)		
<b>MIGRAINE PROPHYLAXIS - 5HT(1) AGONISTS</b>		
<b>Category PA Criteria:</b> Patients 18 years old or older: A 30-day trial of all preferred agents in the past 24 months will be required before a non-preferred agent will be authorized. Patients 6 to 17 years of age: A 30-day trial of rizatriptan in the past 24 months will be required before a non-preferred agent will be authorized.		
RELPAK (eletriptan)	Almotriptan	***Treximet – For patients 18 years or older, the patient must be stable on the combination product and have had a 30-day trial of naproxen in addition to sumatriptan to be approved. This criteria is in addition to the class criteria.
Rizatriptan	ALSUMA (sumatriptan) PEN INJCTR***	
Rizatriptan ODT	AMERGE (naratriptan)	
Sumatriptan tablet	Eletriptan	***Frovatriptan – A 30-day trial of naratriptan 2.5 mg within the past