



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
ACNE AGENTS			
ANTI-INFECTIVE			
	clindamycin gel (generic Cleocin-T) clindamycin lotion clindamycin solution	ACZONE (dapson) AKNE-MYCIN (erythromycin) azelaic acid AMZEEQ FOAM (minocycline) AZELEX (azelaic acid) CLEOCIN-T (clindamycin) CLINDAMYCIN PAC (clindamycin) CLINDAGEL (clindamycin) clindamycin foam clindamycin gel daily (generic Clindagel) dapsone ERY (erythromycin) ERYGEL (erythromycin) erythromycin gel, swabs, solution EVOCLIN (clindamycin) KLARON (sulfacetamide) sulfacetamide WINLEVI (clascoterone)	Maximum Age Limit <ul style="list-style-type: none"> • 21 years – all agents except isotretinoins
RETINOIDS			
	RETIN-A (tretinoin) tretinoin cream	adapalene AKLIEF (trifarotene) ALTRENO (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		FABIOR (tazarotene) PLIXDA (adapalene) RETIN-A MICRO (tretinoin) tazarotene TAZORAC (tazarotene) tretinoin gel tretinoin micro	
COMBINATION DRUGS/OTHERS			
	adapalene/benzoyl peroxide (generic EPIDUO) benzoyl peroxide/clindamycin (generic DUAC) sodium sulfacetamide/sulfur foam/gel/suspension SSS 10/5 Cream (sodium sulfacetamide/sulfur)	ACANYA (benzoyl peroxide/clindamycin) adapalene/benzoyl peroxide (generic EPIDUO FORTE) AKTIPAK (erythromycin/benzoyl peroxide) BENZACLIN GEL (benzoyl peroxide/clindamycin) BENZACLIN KIT (benzoyl peroxide/ clindamycin) BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) CABTREO (clindamycin phosphate/adapalene/ benzoyl peroxide) DUAC (benzoyl peroxide/clindamycin) EPIDUO (adapalene/benzoyl peroxide) EPIDUO FORTE (adapalene/benzoyl peroxide) EPSOLAY (benzoyl peroxide) erythromycin/benzoyl peroxide INOVA 4/1 (benzoyl peroxide/salicylic acid) INOVA 8/2 (benzoyl peroxide/salicylic acid) NEUAC (benzoyl peroxide/clindamycin) ONEXTON (benzoyl peroxide/clindamycin) PRASCION (sulfacetamide sodium/sulfur) ROSANIL (sulfacetamide sodium/sulfur)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
		SE BPO (benzoyl peroxide) sodium sulfacetamide/sulfur cleanser/cream/lotion/pads sodium sulfacetamide/sulfur/meratan SSS 10/5 Foam (sodium sulfacetamide/sulfur) sulfacetamide sodium/sulfur/urea VELTIN (clindamycin/tretinoin) ZENCIA WASH (sulfacetamide sodium/sulfur) ZIANA (clindamycin/tretinoin)	
KERATOLYTICS (BENZOYL PEROXIDES)			
	benzoyl peroxide bar, cleanser, cream, gel, lotion, wash ^{Rx & OTC}	benzoyl peroxide foam ^{Rx & OTC} BP 5.5% (benzoyl peroxide) BPO (benzoyl peroxide) ^{Rx & OTC} INOVA (benzoyl peroxide) LAVOCLEN (benzoyl peroxide) PANOXYL BAR 10% (benzoyl peroxide) ^{OTC} PANOXYL CREAM 3% (benzoyl peroxide) ^{OTC} OC8 GEL (benzoyl peroxide) ^{OTC}	
ISOTRETINOIN			
	ACCUTANE (isotretinoin) AMNESTEEM (isotretinoin) CLARAVIS (isotretinoin) isotretinoin MYORISAN (isotretinoin) ZENATANE (isotretinoin)	ABSORICA (isotretinoin) ABSORICA LD (isotretinoin)	Available for all ages
ALPHA-1 PROTEINASE INHIBITORS			
	ARALAST (alpha-1 proteinase inhibitor) GLASSIA (alpha-1 proteinase inhibitor) PROLASTIN C (alpha-1 proteinase inhibitor)		

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
	ZEMAIRA (alpha-1 proteinase inhibitor)			
ALZHEIMER'S AGENTS ^{DUR+}				
CHOLINESTERASE INHIBITORS				
	donepezil (tablets and ODT) 5mg, 10mg galantamine galantamine ER rivastigmine capsules rivastigmine patches	ADLARITY (donepezil) ARICEPT (donepezil) ARICEPT 23 MG (donepezil) ARICEPT ODT (donepezil) donepezil 23mg EXELON Capsules (rivastigmine) EXELON Patches (rivastigmine) EXELON Solution (rivastigmine) RAZADYNE (galantamine) RAZADYNE ER (galantamine)	<p style="color: red; text-align: center;">All Agents</p> <ul style="list-style-type: none"> • Documented diagnosis for both preferred and non-preferred <p style="color: red; text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months 	
NMDA RECEPTOR ANTAGONIST				
	memantine	NAMENDA TABS (memantine) NAMENDA SOLUTION (memantine) NAMENDA XR (memantine) memantine XR		
COMBINATION AGENTS				
		NAMZARIC (memantine/donepezil)	<p style="color: red; text-align: center;">Namzanic</p> <ul style="list-style-type: none"> • Documented diagnosis AND • 30 days of concurrent therapy with donepezil + memantine in the past 6 months 	
ANALGESICS, OPIOID- SHORT ACTING ^{DUR+}				
	acetaminophen/codeine benzhydrocodone/APAP codeine	ABSTRAL (fentanyl) ACTIQ (fentanyl) APADAZ (benzhydrocodone/APAP)	<p style="color: red; text-align: center;">MS DOM Opioid Initiative</p> <ul style="list-style-type: none"> • Short-Acting Opioids • Long-Acting Opioids 	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	dihydrocodeine/APAP/caffeine ENDOCET (oxycodone/APAP) hydrocodone/APAP hydromorphone morphine oxycodone capsules oxycodone liquid oxycodone tablets oxycodone/APAP oxycodone/aspirin oxycodone/ibuprofen pentazocine/APAP tramadol tramadol/APAP	butalbital/APAP/caffeine/codeine butalbital/ASA/caffeine/codeine butorphanol tartrate (nasal) DEMEROL (meperidine) DILAUDID (hydromorphone) DVORAH (dihydrocodeine/ APAP/caffeine) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydrocodone/ibuprofen IBUDONE (hydrocodone/ibuprofen) LAZANDA NASAL SPRAY (fentanyl) levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) MAGNACET (oxycodone/APAP) meperidine solution meperidine tablet NALOCET (oxycodone/APAP) NORCO (hydrocodone/APAP) NUCYNTA (tapentadol) ONSOLIS (fentanyl) OPANA (oxymorphone) OXAYDO (oxycodone) oxymorphone pentazocine/naloxone	<ul style="list-style-type: none"> • Morphine Equivalent Daily Dose • Concomitant use of Opioids and Benzodiazepines Criteria details found here <li style="text-align: center;">Minimum Age Limit • 18 years – tramadol and codeine products <li style="text-align: center;">Quantity Limit Applicable <u>quantity limit</u> in 31 rolling days • 62 tablets – butalbital/codeine combinations, codeine, dihydrocodeine combinations, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, morphine, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol • 186 tablets –butalbital/APAP,, butalbital/ASA • 5 ml – butorphanol nasal • 180 ml CUMULATIVE – oxycodone liquids • 280 ml CUMULATIVE – Qdolo

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/ASA) PRIMLEV (oxycodone/APAP) PROLATE (oxycodone/APAP) QDOLO (tramadol) REPRESAINE (hydrocodone/ibuprofen) ROXICET (oxycodone/acetaminophen) ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (tramadol/celecoxib) SUBSYS (fentanyl) SYNALGOS-DC (dihydrocodeine/ aspirin/caffeine) TYLENOL W/CODEINE (APAP/codeine) TYLOX (oxycodone/APAP) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VICODIN (hydrocodone/APAP) VICOPROFEN (hydrocodone/ibuprofen) XODOL (hydrocodone/acetaminophen) ZAMICET (hydrocodone/APAP) ZOLVIT (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen)	
ANALGESICS, OPIOID - LONG ACTING ^{DUR+}			
	BUTRANS (buprenorphine) fentanyl patches morphine ER tablets	ARYMO ER (morphine) BELBUCA (buprenorphine) buprenorphine patch CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl)	MS DOM Opioid Initiative <ul style="list-style-type: none"> • Short-Acting Opioids • Long-Acting Opioids • Morphine Equivalent Daily Dose • Concomitant use of Opioids and Benzodiazepines

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		EXALGO (hydromorphone) hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone morphine ER capsules MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER RYZOLT (tramadol) tramadol ER ULTRAM ER (tramadol) XTAMPZA (oxycodone myristate)	<p>Criteria details found here</p> <p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Butrans, tramadol products <p>Quantity Limit</p> <p>Applicable <u>quantity limit</u> per rolling days</p> <ul style="list-style-type: none"> • 31 tablets/31 days – Avinza, Exalgo ER, Hysingla ER, tramadol ER • 62 tablets/31 days – methadone, morphine ER, MS Contin, Nucynta ER, Oxycontin, oxymorphone ER, Xtampza ER, Zohydro ER • 62 films/31 days – Belbuca • 10 patches/31 days – Fentanyl patch • 4 patches/31 days – Butrans <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • Documented diagnosis of cancer OR Antineoplastic therapy AND <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANALGESICS/ANESTHETICS (Topical)			
	diclofenac sodium 1% gel diclofenac sodium 1.5% solution lidocaine 4% cream ^{OTC} lidocaine 5% ointment lidocaine 5% patch	capsaicin diclofenac epolamine patch ^{DUR+} diclofenac sodium 3% gel FLECTOR Patch (diclofenac epolamine) ^{DUR+} FROTEK (ketoprofen) LICART (diclofenac epolamine) LIDAMANTLE HC (lidocaine/hydrocortisone) LIDO TRANS PAK (lidocaine) lidocaine/prilocaine LIDODERM (lidocaine) ^{DUR+} LIDTOPIC MAX (lidocaine) PENNSAID 2% Solution (diclofenac sodium) ^{DUR+} SYNERA (lidocaine/tetracaine) TRANZAREL (lidocaine) VENNGEL ONE 1% kit (diclofenac sodium) VOLTAREN Gel (diclofenac sodium) ^{DUR+} XRYLIDERM (lidocaine) xylocaine ZOSTRIX (capsaicin) ZTlido (lidocaine)	<p style="color: red;">Quantity Limit</p> <ul style="list-style-type: none"> • 1 bottle/31 days – Diclofenac 2% solution pump • 1 bottle/31 days – Diclofenac 1.5% solution <p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 1 preferred agent in the past 6 months <p style="color: red;">Lidocaine 5% Patch</p> <ul style="list-style-type: none"> • Documented diagnosis of Herpetic Neuralgia OR • Documented diagnosis of Diabetic Neuropathy <p style="color: red;">ZTlido</p> <ul style="list-style-type: none"> • Documented diagnosis of Herpetic Neuralgia
ANDROGENIC AGENTS ^{DUR+}			
	ANDRODERM (testosterone patch) testosterone gel packet	ANDROGEL (testosterone gel) ANDROXY (fluoxymesterone) AXIRON (testosterone gel)	<p style="color: red;">All Agents</p> <ul style="list-style-type: none"> • Limited to male gender <p style="color: red;">Non-Preferred Criteria</p>

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		FORTESTSA (testosterone gel) JATENZO (testosterone undecanoate) NATESTO (testosterone) STRIANT (testosterone) TESTIM (testosterone gel) testosterone pump TLANDO (testosterone) VOGELXO (testosterone) XYOSTED (testosterone enanthate)	<ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months <p style="text-align: center;">Tlando</p> <ul style="list-style-type: none"> Requires clinical review
ANGIOTENSIN MODULATORS ^{DUR+}			
ACE INHIBITORS			
	benazepril captopril enalapril fosinopril lisinopril quinapril ramipril trandolapril	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) EPANED (enalapril) LOTENSIN (benazepril) MAVIK (trandolapril) moexipril perindopril PRINIVIL (lisinopril) QBRELIS (lisinopril) UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	<p style="text-align: center;">Minimum Age Limit</p> <ul style="list-style-type: none"> ≤ 6 years – Epaned DUR + <i>will automatically be issued for this age</i> <p style="text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred <u>single entity</u> agents in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
ACE INHIBITOR COMBINATIONS			
	benazepril/amlodipine benazepril/HCTZ captopril/HCTZ	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LOTENSIN HCT (benazepril/HCTZ)	<p style="text-align: center;">Non-Preferred Criteria</p> <p style="text-align: center;">ACE Inhibitor/CCB</p>

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ trandolapril/verapamil	LOTREL (benazepril/amlodipine) moexipril/HCTZ PRESTALIA (perindopril/amlodipine) PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) UNIRETIC (moexipril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	<ul style="list-style-type: none"> • Have tried 2 different preferred <u>ACEI/CCB</u> agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days <p style="color: red; text-align: center;">ACE Inhibitor/Diuretic</p> <ul style="list-style-type: none"> • Have tried 2 different preferred <u>ACEI/Diuretic</u> agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days <p style="color: red; text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred <u>single entity</u> agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days <p style="color: red; text-align: center;">Entresto</p> <ul style="list-style-type: none"> • Age ≥ 18 years AND
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)			
	irbesartan losartan olmesartan telmisartan valsartan	ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) eprosartan MICARDIS (telmisartan) TEVETEN (eprosartan)	
ARB COMBINATIONS			
	ENTRESTO (valsartan/sacubitril) ^{DUR+} irbesartan/HCTZ losartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	olmesartan/amlodipine olmesartan/HCTZ telmisartan/HCTZ valsartan/amlodipine valsartan/amlodipine/HCTZ valsartan/HCTZ	BENICAR-HCT (olmesartan/HCTZ) BYVALSON (nebivolol/valsartan) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) olmesartan/amlodipine/HCTZ telmisartan/amlodipine TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/HCTZ) TWYNSTA (telmisartan/amlodipine)	<ul style="list-style-type: none"> Documented diagnosis of heart failure OR <ul style="list-style-type: none"> Age \geq 1 year AND Documented diagnosis of heart failure with systemic ventricular systolic dysfunction <p>Non-Preferred Criteria ARB/Beta Blocker, ARB/CCB or ARB/CCB/Diuretic</p> <ul style="list-style-type: none"> Have tried 1 preferred <u>ARB/CCB</u> agent in the past 6 months OR <ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days <p>ARB/Diuretic</p> <ul style="list-style-type: none"> Have tried 2 different preferred <u>ARB/Diuretic</u> products in the past 6 months OR <ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days
	DIRECT RENIN INHIBITORS		
		TEKTURNA (aliskiren) aliskiren	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Documented diagnosis of hypertension AND

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<ul style="list-style-type: none"> Have tried 2 different preferred <u>ACEI or ARB single-entity</u> products in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days <p style="color: red; text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Documented diagnosis of hypertension AND Have tried 2 different preferred <u>ACEI or ARB diuretic agents</u> in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
DIRECT RENIN INHIBITOR COMBINATIONS			
		AMTURNIDE (aliskiren/amlodipine/hctz) TEKAMLO (aliskiren/amlodipine) TEKURNA-HCT (aliskiren/hctz) VALTURNA (aliskiren/valsartan)	
ANTIBIOTICS (GI) & RELATED AGENTS			
	FIRVANQ (vancomycin) metronidazole tablets neomycin tinidazole	AEMCOLO (rifaximin) DIFICID (fidaxomicin) FLAGYL (metronidazole) FLAGYL ER (metronidazole) LIKMEZ (metronidazole) metronidazole capsules paromomycin REBYOTA (fecal microbiota) TINDAMAX (tinidazole) VANCOCIN (vancomycin) vancomycin VOWST (fecal microbiota)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
		XIFAXAN (rifaximin)	
ANTIBIOTICS (MISCELLANEOUS)			
KETOLIDES			
		KETEK (telithromycin)	
LINCOSAMIDE ANTIBIOTICS			
	clindamycin capsules clindamycin solution	CLEOCIN (clindamycin) CLEOCIN SOLUTION (clindamycin)	
MACROLIDES			
	azithromycin clarithromycin ER clarithromycin IR clarithromycin suspension ERY-TAB (erythromycin) erythromycin erythromycin ethylsuccinate	BIAXIN (clarithromycin) BIAXIN SUSPENSION (clarithromycin) BIAXIN XL (clarithromycin) E.E.S. FILM TAB (erythromycin ethylsuccinate) E.E.S. Suspension (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED Suspension (erythromycin ethylsuccinate) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin)	
NITROFURAN DERIVATIVES			
	nitrofurantoin nitrofurantoin monohydrate macrocrystals	FURADANTIN (nitrofurantoin)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		MACROBID (nitrofurantoin monohydrate macrocrystals) MACRODANTIN (nitrofurantoin)	
OXAZOLIDINONES			
		SIVEXTRO (tedizolid) ZYVOX (linezolid)	Sivextro – MANUAL PA Zyvox - MANUAL PA
PLEUROMUTLINS			Quantity Limit • 6 tablets/month – Sivextro
		XENLETA (lefamulin)	
ANTIBIOTICS (Topical)			
	bacitracin ^{OTC} bacitracin/polymixin ^{OTC} gentamicin sulfate mupirocin ointment neomycin/bacitracin/polymyxin ^{OTC}	ALTABAX (retapamulin) CORTISPORIN (bacitracin/neomycin/polymyxin/Hc) mupirocin cream NEOSPORIN (neomycin/bacitracin/polymyxin) ^{OTC} XEPI (ozenoxacin)	
ANTIBIOTICS (VAGINAL)			
	CLEOCIN OVULES (clindamycin) CLINDESSE (clindamycin) metronidazole vaginal	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) clindamycin cream METROGEL (metronidazole) NUVESSA (metronidazole)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SOLOSEC (secnidazole) VANDAZOLE (metronidazole) XACIATO GEL (clindamycin)	
ANTICOAGULANTS			
ORAL			
	COUMADIN (warfarin) ELIQUIS (apixaban) PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	BEVYXXA (betrixaban) PRADAXA PELLETS (dabigatran) SAVAYSA (edoxaban tosylate)	<p style="color: red; margin: 0;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months OR 1 claim with the requested agent in the past 90 days
LOW MOLECULAR WEIGHT HEPARIN (LMWH)			
	enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin) Prefilled Syringe	<p style="color: red; margin: 0;">LMWH Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 1 different preferred agent in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days
ANTICONVULSANTS ^{DUR+}			
ADJUVANTS			
	carbamazepine carbamazepine suspension carbamazepine ER (generic Carbatrol) DEPAKOTE ER (divalproex) DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER divalproex sprinkle	APTIOM (eslicarbazepine) BANZEL (rufinamide) BRIVIACT (brivaracetam) carbamazepine XR CARBATROL (carbamazepine) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DIACOMIT (stiripentol)	<p style="color: red; margin: 0;">Minimum Age Limit</p> <ul style="list-style-type: none"> 6 months-- Diacomit 1 year – Banzel, Epidiolex 2 years –Onfi, Sympazan <p style="color: red; margin: 0;">Epidiolex</p> <ul style="list-style-type: none"> Documented diagnosis of Dravet syndrome. Lennox Gastaut

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	EPIDIOLEX (cannabidiol) EPITOL (carbamazepine) gabapentin lacosamide lamotrigine levetiracetam levetiracetam ER oxcarbazepine oxcarbazepine suspension tiagabine topiramate tablet topiramate sprinkle capsule valproic acid zonisamide	ELEPSIA XR (levetiracetam) EPRONTIA (topiramate solution) EQUETRO (carbamazepine) felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) FYCOMPA (perampanel) GABITRIL (tiagabine) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine ER/XR lamotrigine ODT MOTPOLY XR (lacosamide) NEURONTIN (gabapentin) OXTELLAR XR (oxcarbazepine) QUDEXY XR (topiramate) ROWEEPRA (levetiracetam) rufinamide SABRIL (vigabatrin) SPRITAM (levetiracetam) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL SUSPENSION (carbamazepine) TEGRETOL XR (carbamazepine) TOPAMAX TABLET (topiramate)	syndrome or seizures associated with tuberous sclerosis complex OR <ul style="list-style-type: none"> 1 claim for the requested agent in the past 30 days <p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months OR <ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days AND Documented diagnosis of seizure <p style="color: red;">Banzel, Onfi, Sympazan</p> <ul style="list-style-type: none"> Documented diagnosis of Lennox-Gastaut AND <ul style="list-style-type: none"> Have tried 1 different preferred agent for Lennox-Gastaut in the past 6 months OR <ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days AND Documented diagnosis of seizure <p style="color: red;">Diacomit</p> <ul style="list-style-type: none"> Documented diagnosis of Dravet syndrome AND <ul style="list-style-type: none"> Active claim for clobazam <p style="color: red;">Fintepla</p>

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		TOPAMAX Sprinkle (topiramate) topiramate ER (generic Qudexy XR) ^{Step Edit} TRILEPTAL Tablets (oxcarbazepine) TRILEPTAL Suspension (oxcarbazepine) TROKENDI XR (topiramate) vigabatrin VIGPODER ORAL SOLUTION (vigabatrin) ^{NR} VIMPAT (lacosamide) XCOPRI (cenobamate) ZONISADE (zonisamide suspension) ZTALMY (ganaxolone)	<ul style="list-style-type: none"> Requires clinical review <p>Sabril Powder for Oral Solution</p> <ul style="list-style-type: none"> Documented diagnosis of infantile spasms OR Have tried 2 different preferred agents in the past 6 months OR <ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days AND Documented diagnosis of seizure <p>Topiramate ER – Step Edit</p> <ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days AND Documented diagnosis of seizure OR 30-day trial with topiramate IR in the past 6 months <p>Minimum Age Limit</p> <ul style="list-style-type: none"> 12 years – Nayzilam 6 years – Valtoco <p>Quantity Limit</p> <ul style="list-style-type: none"> 2 Twin Packs/31 days – Diastat 2 Packages /31 days – Nayzilam 2 Cartons/31 days - Valtoco
SELECTED BENZODIAZEPINES			
	clobazam diazepam rectal gel NAYZILAM (midazolam) VALTOCO (diazepam)	DIASTAT (diazepam rectal) DIASTAT ACCUDIAL (diazepam rectal) ONFI (clobazam) ONFI SUSPENSION (clobazam) SYMPAZAN (clobazam)	
HYDANTOINS			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	DILANTIN (phenytoin) PHENYTEK (phenytoin) phenytoin	PEGANONE (ethotoin)	
	SUCCINIMIDES		
	ethosuximide	CELONTIN (methsuximide) ZARONTIN (ethosuximide)	
ANTIDEPRESSANTS, OTHER ^{DUR+}			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	bupropion bupropion SR bupropion XL TRINTELLIX (vortioxetine) mirtazapine trazodone venlafaxine venlafaxine ER capsules VIIBRYD (vilazodone)	APLENZIN (bupropion HBr) AUVELITY (dextromethorphan/bupropion) desvenlafaxine ER desvenlafaxine fumarate ER DESYREL (trazodone) DRIZALMA SPRINKLE (duloxetine DR) EFFEXOR (venlafaxine) EFFEXOR XR (venlafaxine) EMSAM (selegiline transdermal) FETZIMA ER (levomilnacipran) FORFIVO XL (bupropion) KHEDEZLA ER (desvenlafaxine) MARPLAN (isocarboxazid) NARDIL (phenelzine) nefazodone OLEPTRO ER (trazodone) PARNATE (tranylcypromine) phenelzine PRISTIQ (desvenlafaxine) REMERON (mirtazapine) tranylcypromine venlafaxine XR venlafaxine ER tablets vilazodone ZURZUVAE (zuranolone)	<p style="color: red; margin: 0;">Minimum Age Limit</p> <ul style="list-style-type: none"> 7-11 years – Drizalma Sprinkle <i>DUR + will automatically be issued for this age range with a diagnosis of generalized anxiety disorder</i> 7-17 years – duloxetine <i>DUR + will automatically be issued for this age range with a diagnosis of generalized anxiety disorder</i> 18 years – all other Antidepressants <p style="color: red; margin: 10px 0 0 0;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred <u>'Antidepressants, Other' Class</u> in the past 6 months OR Have tried BOTH a preferred <u>'Antidepressant, SSRI' and 'Antidepressants, Other'</u> in the past 6 months OR 90 consecutive days on the requested agent in the past 105 days <p style="color: red; margin: 10px 0 0 0;">Auvelity</p> <ul style="list-style-type: none"> Requires clinical review <p style="color: red; margin: 10px 0 0 0;">Zurzuvae - <u>MANUAL PA</u></p> <p style="color: red; margin: 10px 0 0 0;">Cymbalta and Irenka (see Fibromyalgia Agents)</p>
ANTIDEPRESSANTS, SSRIs ^{DUR+}			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	citalopram escitalopram fluoxetine capsules fluvoxamine paroxetine CR paroxetine IR sertraline	CELEXA (citalopram) fluoxetine DR fluvoxamine ER LEXAPRO (escitalopram) LUVOX (fluvoxamine) LUVOX CR (fluvoxamine) paroxetine suspension PAXIL CR (paroxetine) PAXIL SUSPENSION (paroxetine) PAXIL Tablets (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 6 years – Zoloft • 7 years – Lexapro, Prozac • 8 years – Luvox • 18 years – Celexa, Luvox CR, Paxil, Pexeva, Prozac 90 mg <p>Maximum Age Limit</p> <ul style="list-style-type: none"> • 60 years – Celexa <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
ANTIEMETICS ^{DUR+}			
5HT3 RECEPTOR BLOCKERS			
	ondansetron ondansetron ODT ondansetron solution	ANZEMET (dolasetron) granisetron SANCUSO (granisetron) ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron) ZUPLLENZ (ondansetron)	<p>Quantity Limit</p> <ul style="list-style-type: none"> • 6 tablets/31 days – Akynzeo • 30 tablets/31 days – Zofran tablets/ODT • 100 ml/31 days – Zofran solution <p>Non-Preferred Agents</p> <ul style="list-style-type: none"> • Have tried 1 preferred agent in the past 6 months

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Injectables in this class closed to point of sale. PA required if not administered in clinic/hospital Akynzeo - MANUAL PA
ANTIEMETIC COMBINATIONS			
		AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) DICLEGIS (doxylamine/pyridoxine) doxylamine/pyridoxine	
CANNABINOIDS			
		CESAMET (nabilone) MARINOL (dronabinol) dronabinol SYNDROS (dronabinol)	
NMDA RECEPTOR ANTAGONIST			
	aprepitant	EMEND (aprepitant)	
ANTIFUNGALS (Oral) ^{DUR+}			
	clotrimazole fluconazole griseofulvin microsize suspension nystatin terbinafine	ANCOBON (flucytosine) ^ BREXAFEMME (ibrexafungerp) CRESEMBA (isavuconazonium) DIFLUCAN (fluconazole) flucytosine GRIFULVIN V (griseofulvin, microsize) griseofulvin microsize tablets griseofulvin ultramicrosize tablet GRIS-PEG (griseofulvin) itraconazole ^ ketoconazole	<p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> • 12-17 years – griseofulvin tablets <i><u>Dur + will automatically be issued for this age range</u></i> <p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months <p style="color: red;">HIV opportunistic infection</p> <ul style="list-style-type: none"> • Non-Preferred agent indicated for treatment (^) AND

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		LAMISIL (terbinafine) NOXAFIL (posaconazole) ^ ONMEL (itraconazole) ^ posaconazole^ SPORANOX (itraconazole) ^ TERBINEX Kit (terbinafine/ciclopirox) TOLSURA (itraconazole) VFEND (voriconazole) ^ VIVJOA (oteseconazole) voriconazole ^	<ul style="list-style-type: none"> • Documented diagnosis of HIV <p style="color: red; font-weight: bold;">Cresemba - MANUAL PA</p> <ul style="list-style-type: none"> • Minimum age limit > 18 years AND • Documented diagnosis of invasive aspergillosis OR invasive mucormycosis AND <ul style="list-style-type: none"> • Prescriber is an oncologist/hematologist or infectious disease specialist <p style="color: red; font-weight: bold;">Sporanox</p> <ul style="list-style-type: none"> • HIV opportunistic infection criteria OR <ul style="list-style-type: none"> • Documented diagnosis of a transplant OR • History of an immunosuppressant in the past 6 months OR • Have tried 2 different preferred agents in the past 6 months
ANTIFUNGALS (Topical) ^{DUR+}			
	ANTIFUNGALS		
	ciclopirox cream/gel/solution/suspension clotrimazole cream/solution ^{Rx & OTC} ketoconazole shampoo LUZU (luliconazole) miconazole cream/powder ^{OTC} nystatin terbinafine cream/spray ^{OTC}	BENSAL HP (benzoic acid/salicylic acid) butenafine CICLODAN KIT (ciclopirox kit) ciclopirox kit/shampoo CNL 8 (ciclopirox) econazole ERTACZO (sertaconazole)	<p style="color: red; font-weight: bold;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	tolnaftate cream/powder/spray ^{OTC}	EXELDERM (sulconazole) EXTINA (ketoconazole) JUBLIA (efinaconazole) KERYDIN (tavaborole) ketoconazole cream ketoconazole foam LAMISIL (terbinafine) solution LOPROX (ciclopirox) luliconazole MENTAX (butenafine) naftifine NAFTIN (naftifine) NIZORAL (ketoconazole) oxiconazole OXISTAT (oxiconazole) PEDIADERM AF (nystatin) PENLAC (ciclopirox) VUSION (miconazole/petrolatum/zinc oxide)	
ANTIFUNGAL/STEROID COMBINATIONS			
	clotrimazole/betamethasone cream nystatin/triamcinolone	clotrimazole/betamethasone lotion LOTRISONE (clotrimazole/betamethasone)	
ANTIFUNGALS (VAGINAL)			
	clotrimazole vaginal cream ^{OTC} miconazole 1, 7cream ^{OTC} miconazole 3 vaginal cream, suppository ^{OTC}	GYNAZOLE 1 (butoconazole) TERAZOL 3 Suppository (terconazole) TERAZOL 7 (terconazole) terconazole suppository	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
	TERAZOL 3 Cream (terconazole) – currently unavailable from manufacturer terconazole cream tioconazole			
ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS ^{DUR+}				
MINIMALLY SEDATING ANTIHISTAMINES				
	cetirizine tablets ^{OTC} cetirizine syrup ^{Rx & OTC} loratadine odt ^{OTC} loratadine syrup ^{OTC} loratadine tablet ^{OTC}	cetirizine chewable ^{OTC} CLARINEX (desloratadine) desloratadine ODT desloratadine tablet fexofenadine syrup fexofenadine table levocetirizine syrup levocetirizine tablet XYZAL Solution (levocetirizine) XYZAL Tablets (levocetirizine)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of allergy or urticaria AND • Have tried 2 different preferred agents in the past 12 months 	
MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS				
	cetirizine/pseudoephedrine loratadine/pseudoephedrine	ALLEGRA-D (fexofenadine/ pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) CLARINEX-D (desloratadine/ pseudoephedrine) fexofenadine/pseudoephedrine ZYRTEC-D (cetirizine/pseudoephedrine)		
ANTIMIGRAINE AGENTS, ACUTE TREATMENT				

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	CGRP ORAL AND NASAL		
	NURTEC ODT (rimegepant)	UBRELVY (ubrogepant) ZAVZPRET (zavegepant)	<p style="color: red; text-align: center;">Minimum Age Limit</p> <ul style="list-style-type: none"> 18 years – Nurtec ODT, Ubrelvy <p style="color: red; text-align: center;">Quantity Limit</p> <ul style="list-style-type: none"> 8 tablets/31 day – Nurtec ODT 16 tablets/31 day – Ubrelvy <p style="color: red; text-align: center;">Nurtec ODT</p> <ul style="list-style-type: none"> Documented diagnosis of migraine AND Have tried 2 different triptans in the past 6 months AND No concurrent therapy with another CGRP agent <p style="color: red; text-align: center;">Ubrelvy</p> <ul style="list-style-type: none"> Documented diagnosis of migraine AND Have tried 2 different triptans in the past 6 months AND Have tried preferred Nurtec ODT in the past 6 months AND No concurrent therapy with another CGRP agent AND No concurrent therapy with a strong CYP3A4 inhibitor
	TRIPTANS & RELATED AGENTS ORAL ^{DUR+}		
	naratriptan rizatriptan	almotriptan AMERGE (naratriptan)	Minimum Age Limit – ALL FORMULATIONS

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	rizatriptan ODT sumatriptan tablets zolmitriptan zolmitriptan ODT	AXERT (almotriptan) eletriptan FROVA (frovatriptan) frovatriptan IMITREX (sumatriptan) MAXALT (rizatriptan) MAXALT MLT (rizatriptan) RELPAX (eletriptan) REYVOW (lasmiditan) TREXIMET (sumatriptan/naproxen) ZOMIG (zolmitriptan)	<ul style="list-style-type: none"> • 6 years – Maxalt • 12-17 years – Axert, Treximet, Zomig nasal spray <i>Dur + will automatically be issued for this age range</i> • 18 years – Amerge, Frova, Imitrex, Onzetra Xsail, Relpax, Reyvow, Tosymra, Zembrace Symtouch, Zomig tablets <p style="text-align: center;">Quantity Limit - ORAL</p> <ul style="list-style-type: none"> • 4 tablets/31 days – Reyvow 50 mg • 6 tablets/31 days - Axert, Relpax Zomig • 8 tablets/31 days – Reyvow 100 mg • 9 tablets/31 days - Amerge, Frova, Imitrex, Treximet • 12 tablets/31 days – Maxalt <p style="text-align: center;">Non-Preferred Criteria - ORAL</p> <ul style="list-style-type: none"> • Have tried 2 preferred oral agents in the past 90 days <p style="text-align: center;">Reyvow</p> <ul style="list-style-type: none"> • Documented diagnosis of migraine AND • Have tried 2 different triptans in the past 90 days AND • Have tried preferred Nurtec ODT in the past 90 days

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
NASAL			
	sumatriptan	IMITREX (sumatriptan) ONZETRA Xsail (sumatriptan) TOSYMRA (sumatriptan) zolmitriptan ZOMIG (zolmitriptan)	<p>Quantity Limit - NASAL</p> <ul style="list-style-type: none"> • 1 box/31 days <p>Non-Preferred Criteria - NASAL</p> <ul style="list-style-type: none"> • Have tried 2 preferred oral agents in the past 90 days AND • Have tried a preferred nasal agent in the past 90 days <p>CUMULATIVE Quantity Limit - INJECTION</p> <p>4 injections/31 days</p>
INJECTABLES			
	sumatriptan	IMITREX (sumatriptan) ZEMBRACE (sumatriptan)	
ANTIMIGRAINE AGENTS, PROPHYLAXIS			
INJECTIBLES			
	AIMOVIG AUTOINJECTOR (erenumab-aooe) AJOVY AUTOINJECTOR (fremanezumab-vfrm) AJOVY SYRINGE (fremanezumab-vfrm) EMGALITY PEN 120mg/mL(galcanezumab-gnlm) EMGALITY SYRINGE 120mg/mL (galcanezumab-gnlm)	EMGALITY SYRINGE 100mg/mL (galcanezumab-gnlm) VYEPTI (eptinezumab-jjmr)	<p>Aimovig - MANUAL PA</p> <p>Ajovy - MANUAL PA</p> <p>Emgality - MANUAL PA</p> <p>Vyepti - MANUAL PA</p>
ORAL			
		NURTEC ODT (rimegepant) QULIPTA (atogepant)	<ul style="list-style-type: none"> • See Antimigraine Agents, Acute
*ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS			
	BOSULIF (bosutinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib)	AFINITOR (everolimus) AKEEGA (niraparib / abiraterone) ALECENSA (alectinib)	Farydak - MANUAL PA

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	COTELLIC (cobimetinib) GILOTRIF (afatinib) everolimus ICLUSIG (ponatinib) imatinib mesylate IMBRUVICA (ibrutinib) INLYTA (axitinib) IRESSA (gefitinib) JAKAFI (ruxolitinib) MEKINIST (trametinib dimethyl sulfoxide) NEXAVAR (sorafenib) ROZLYTREK (entrectinib) ROZLYTREK (entrectinib) Pellet Pack SPRYCEL (dasatinib) STIVARGA (regorafenib) SUTENT (sunitinib) TAFINLAR (dabrafenib) TARCEVA (erlotinib) TASIGNA (nilotinib) TURALIO (pexidartinib) TYKERB (lapatinib ditosylate) vandetanib VOTRIENT (pazopanib) XALKORI (crizotinib) XALKORI (crizotinib) Oral Pellets XTANDI (enzalutamide) ZELBORAF (vemurafenib) ZYDELIG (idelalisib) ZYKADIA (ceritinib)	ALUNBRIG (brigatinib) AUGTYRO (repotrectinib) AYVAKIT (avapritinib) BALVERSA (erdafitinib) BOSULIF CAPSULES (bosutinib) BRAFTOVI (encorafenib) BRUKINSA (zanubrutinib) CABOMETYX (cabozantinib s-malate) CALQUENCE (acalabrutinib) COPIKTRA (duvelisib) DAURISMO (glasdegib) ERIVEDGE (vismodegib) ERLEADA (apalutamide) erlotinib EXKIVITY (mobocertinib) FARYDAK (panobinostat) FOTIVDA (tivozanib) FRUZAQLA (fruquintinib) GAVRETO (pralsetinib) gefitinib GLEEVEC (imatinib mesylate) GLEOSTINE (lomustine) IBRANCE (palbociclib) ^{DUR+} IDHIFA (enasidenib) INQOVI (cedazuridine/decitabine) INREBIC (fedratinib) IWILFIN (eflornithine) ^{NR} JAYPIRCA (pirtobrutinib) KRAZATI (adagrasib) KISQALI (ribociclib) KOSELUGO (selumetinib) lapatinib ditosylate	<ul style="list-style-type: none"> • Documented diagnosis of multiple myeloma AND <ul style="list-style-type: none"> • Used in combination with bortezomib and dexamethasone per PI AND • History of 2 prior regimens including bortezomib and an immunomodulatory agent Ibrance • Documented diagnosis of WD-DDLS for retroperitoneal sarcoma OR • All other indications evaluated through clinical review Lenvima • Documented diagnosis of thyroid cancer OR <ul style="list-style-type: none"> • Documented diagnosis of hepatocellular carcinoma OR • Documented diagnosis of renal cell carcinoma AND • History of 1 claim for everolimus in the past 30 days AND • History of 1 anti-angiogenic agent in the past 2 years OR <ul style="list-style-type: none"> • All other indications evaluated through clinical review <p style="text-align: center;">Lynparza Tablets</p>

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		LENVIMA (lenvatinib) ^{DUR+} LORBRENA (lorlatinib) LUMAKRAS (sotorasib) LYNPARZA (olaparib) ^{DUR+} LYTGOBI (futibatinib) MEKTOVI (binimetnib) NERLYNX (neratinib maleate) NUBEQA (darolutamide) ODOMZO (sonidegib) OGSIVEO (nirogacestat) ^{NR} OJJAARA (mometotinib) ONUREG (azacitidine) ORGOVYX (relugolix) pazopanib ^{NR} PEMAZYRE (pemigatinib) PIQRAY (alpelisib) QINLOCK (ripretinib) REZLIDHIA (lutasidenib) RETEVMO (selpercatinib) RUBRACA (rucaparib) RYDAPT (midostaurin) SCEMBLIX (asciminib) TABRECTA (capmatinib) TAGRISSO (osimertinib) TALZENNA (talazoparib) TAZVERIK (tazemetostat) TEPMETKO (tepotinib) TIBSOVO (ivosidenib) TRUSELTIQ (infigratinib) TRUQAP (capiwasertib) TUKYSA (tucatinib) UKONIQ (umbralisib)	<ul style="list-style-type: none"> • Documented diagnosis of ovarian cancer, fallopian tube or peritoneal cancer AND <ul style="list-style-type: none"> • History of platinum-based chemotherapy in the past 2 years OR • All other indications evaluated through clinical review

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		VANFLYTA (quizartinib) VERZENIO (abemaciclib) VITRAKVI (larotrectinib) VIZIMPRO (dacomitinib) VONJO (pacritinib) WELIREG (belzutifan) XATMEP (methotrexate) XOSPATA (gilteritinib) XPOVIO (selinexor) ZEJULA (niraparib)	
ANTIOBESITY SELECT AGENTS			
	SAXENDA (liraglutide) WEGOVY (semaglutide)	orlistat XENICAL (orlistat)	All agents require MANUAL PA
ANTIPARASITICS (Topical) ^{DUR+}			
PEDICULICIDES			
	permethrin 1% ^{OTC} NATROBA (spinosad)	lindane malathion OVIDE (malathion) SKLICE (ivermectin) spinosad VANALICE (piperonyl butoxide/pyrethrins)	<p style="color: red; margin: 0;">Minimum Age/Weight Limit for Pediculicides</p> <ul style="list-style-type: none"> 50 kg – lindane shampoo 2 months – permethrin 1%(OTC) 6 months – Natroba, Sklice 2 years – piperonyl/pyrethrins (OTC) 6 years – Ovide <p style="color: red; margin: 0;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 preferred topical lice agents in the past 90 days
SCABICIDES			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
	permethrin 5% ivermectin	ELIMITE (permethrin) EURAX CREAM (crotamiton) EURAX LOTION (crotamiton) STROMECTOL Tablet (ivermectin)	<p>Minimum Age/Weight Limit for Topical Scabicides</p> <ul style="list-style-type: none"> • 50 kg – lindane lotion • 2 months – permethrin 5% <ul style="list-style-type: none"> • 4 years – Natroba • 18 years – Eurax <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • History of permethrin 5% in the past 90 days 	
ANTIPARKINSON'S AGENTS (Oral) ^{DUR+}				
ANTICHOLINERGICS				
	benztropine trihexyphenidyl	COGENTIN (benztropine)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis of Parkinson's disease AND • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days 	
COMT INHIBITORS				
	entacapone	COMTAN (entacapone) ONGENTYS (opicapone) TASMAR (tolcapone) tolcapone		

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
DOPAMINE AGONISTS			
	ropinirole	KYNMOBI FILM (apomorphine) MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) NEUPRO (rotigotine) pramipexole pramipexole ER REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole ER	
MAO-B INHIBITORS			
	selegiline	AZILECT (rasagiline) ELDEPRYL (selegiline) rasagiline XADAGO (safinamide) ZELAPAR (selegiline)	<p style="text-align: center; color: red;">Xadago</p> <ul style="list-style-type: none"> Documented diagnosis of Parkinson's disease AND History of a preferred carbidopa/levodopa combination product in the past 30 days AND History of selegiline product in the past 45 days
OTHERS			
	amantadine bromocriptine carbidopa levodopa/carbidopa	DUOPA (levodopa/carbidopa) GOCOVRI (amantadine) INBRIJA (levodopa) levodopa/carbidopa ODT levodopa/carbidopa/entacapone LODOSYN (carbidopa) NOURIANZ (istradefylline) OSMOLEX ER (amantadine) PARCOPA (levodopa/carbidopa) PARLODEL (bromocriptine)	<p style="text-align: center; color: red;">Lodosyn and Inbrija</p> <ul style="list-style-type: none"> Documented diagnosis of Parkinson's disease AND History of a carbidopa/levodopa combination product in the past 45 days <p style="text-align: center; color: red;">Nourianz</p>

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		RYTARY ER (levodopa/carbidopa) SINEMET (levodopa/carbidopa) SINEMET CR (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone)	<ul style="list-style-type: none"> • Documented diagnosis of Parkinson's Disease AND <ul style="list-style-type: none"> • History of a preferred carbidopa/levodopa combination product in the past 30 days AND • History of 30 days therapy with a preferred adjunctive therapy in the past 45 days
ANTIPSYCHOTICS <small>DUR+</small>			
ORAL			
	amitriptyline/perphenazine aripiprazole asenapine clozapine fluphenazine haloperidol olanzapine olanzapine ODT perphenazine quetiapine quetiapine XR risperidone risperidone ODT thioridazine thiothixene trifluoperazine VRAYLAR (cariprazine) ziprasidone	ABILIFY (aripiprazole) ABILIFY MYCITE (aripiprazole) ADASUVE (loxapine) aripiprazole solution aripiprazole ODT CAPLYTA (lumateperone) chlorpromazine clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) HALDOL (haloperidol) INVEGA ER (paliperidone) LATUDA (lurasidone) lurasidone LYBALVI (olanzapine/samidorphan) NUPLAZID (pimavanserin)	<p style="color: red; text-align: center;">Minimum Age Limit</p> <ul style="list-style-type: none"> • 3 years – Haldol • 5 years – Risperdal, thioridazine • 6 years – Abilify, trifluoperazine • 10 years – Latuda, Saphris, Seroquel, Symbyax • 12 years – Invega, molindone, perphenazine, pimozide, thiothixene • 13 years – Rexulti, Zyprexa • 18 years – Abilify Mycite, Amitriptyline/perphenazine, Caplyta, Clozaril, Fanapt, fluphenazine, Geodon, loxapine, Lybalvi, Nuplazid, Secuado, Vraylar <p style="color: red; text-align: center;">Concurrent Therapy Limit – Ages 0-17 years</p> <ul style="list-style-type: none"> • 90 days with 2 or more antipsychotics in the last 120 days will require a Manual PA

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		olanzapine/fluoxetine paliperidone ER REXULTI (brexpiprazole) RISPERDAL (risperidone) SAPHRIS (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clonazepam) ZYPREXA (olanzapine)	<p style="text-align: center;">Vraylar</p> <ul style="list-style-type: none"> • Documented diagnosis of schizophrenia or schizoaffective disorder OR • Documented diagnosis of bipolar disorder OR • Documented diagnosis of major depressive disorder AND <ul style="list-style-type: none"> • 30 days of therapy with an antidepressant in the past 45 days OR • 1 claim for a 90-day supply of an antidepressant in the past 105 days <p style="text-align: center;">Non-Preferred Criteria- Atypical Agents</p> <ul style="list-style-type: none"> • Have tried 2 preferred atypical antipsychotic agents in the past 12 months OR • 30 consecutive days on the requested atypical agent in the past 180 days <p style="text-align: center;">Nuplazid</p> <ul style="list-style-type: none"> • Documented diagnosis of Parkinson's disease
	INJECTABLE, ATYPICALS ^{DUR+}		
	ABILIFY ASIMTUFI (aripiprazole)	ABILIFY (aripiprazole)	Minimum Age Limit

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ABILIFY MAINTENA (aripirazole) ARISTADA ER (aripiprazole lauroxil) ARISTADA INITIO (aripiprazole lauroxil) INVEGA HAFYERA (paliperidone) INVEGA SUSTENNA (paliperidone palmitate) INVEGA TRINZA (paliperidone) PERSERIS (risperidone) RISPERDAL CONSTA (risperidone) UZEDY (risperidone)	GEODON (ziprasidone) olanzapine ZYPREXA (olanzapine) ZYPREXA RELPREVV (olanzapine) risperidone ^{NR} RYKINDO (risperidone)	<ul style="list-style-type: none"> • 18 years – all injectable agents <li style="padding-left: 20px;">Quantity Limit • 3 syringes/year – Aristada Initio <li style="color: red;">Long-Acting Injectable Agents <li style="padding-left: 20px; color: red;">All Agents • Documented diagnosis of schizophrenia or schizoaffective disorder <li style="color: red;">Abilify Maintena, Risperdal Consta and Rykindo ER • Documented diagnosis of schizophrenia or schizoaffective disorder OR • Documented diagnosis of bipolar disorder <li style="color: red;">Invega Hafyera • Documented diagnosis of schizophrenia or schizoaffective disorder AND • 4 claims for Invega Sustenna in the past year OR • 1 claim for Invega Trinza in the past year OR • 1 claim for Invega Hafyera in the past year
TRANSDERMAL, ATYPICALS			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
		SECUADO (asenapine)		
ANTIRETROVIRALS ^{DUR+}				
SINGLE PRODUCT REGIMENS				
	BIKTARVY (bictegravir/emtricitabine/tenofovir) CABENUVA (cabotegravir/rilpivirine) DELSTRIGO (doravirine/lamivudine/tenofovir) DOVATO (dolutegravir/lamivudine) efavirenz/emtricitabine/tenofovir labeler GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) ODEFSEY (emtricitabine/rilpivirine/tenofovir AF) SYMFI (efavirenz/lamivudine/tenofovir) SYMFI-LO (efavirenz/lamivudine/tenofovir) TRIUMEQ (abacavir/lamivudine/ dolutegravir)	ATRIPLA (efavirenz/emtricitabine/tenofovir) COMPLERA (emtricitabine/rilpivirine/tenofovir) efavirenz/lamivudine/tenofovir efavirenz/lamivudine/tenofovir lo JULUCA (dolutegravir/rilpivirine) STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir)	<p style="color: red;">Stribild – MANUAL PA</p> <ul style="list-style-type: none"> • Genotype testing supporting resistance to other regimens OR • Intolerance or contraindication to preferred combination of drugs AND <ul style="list-style-type: none"> • Medical reasoning beyond convenience or enhanced compliance over preferred agents AND • CrCl > 70mL/min to initiate therapy OR CrCl >50mL/min to continue therapy <p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 1 claim with the requested agent in the past 105 days 	
INTEGRASE STRAND TRANSFER INHIBITORS				
	APRETUDE ER (cabotegravir) ISENTRESS (raltegravir potassium) TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium)	ISENTRESS HD (raltegravir potassium) VITEKTA (elvitegravir)		
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)				
	abacavir sulfate EMTRIVA (emtricitabine) EMTRIVA SOLUTION (emtricitabine) lamivudine tenofovir disoproxil fumarate ZIAGEN Solution (abacavir sulfate) zidovudine	didanosine DR capsule emtricitabine EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine VIDEX EC (didanosine)		

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
		VIDEX SOLUTION (didanosine) VIREAD (tenofovir disoproxil fumarate) ZIAGEN Tablet (abacavir sulfate)	
	NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)		
	EDURANT (rilpivirine) efavirenz	INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) RESCRIPTOR (delavirdine mesylate) SUSTIVA (efavirenz) VIRAMUNE (nevirapine) VIRAMUNE ER (nevirapine)	
	PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR		
		TYBOST (cobicistat)	Tybost - MANUAL PA
	PROTEASE INHIBITORS (PEPTIDIC)		
	atazanavir EVOTAZ (atazanavir/cobicistat) NORVIR SOLUTION (ritonavir) ritonavir	CRIXIVAN (indinavir) fosamprenavir INVIRASE (saquinavir mesylate) LEXIVA (fosamprenavir) NORVIR POWDER (ritonavir) NORVIR TABLET (ritonavir) REYATAZ (atazanavir) VIRACEPT (nelfinavir mesylate)	
	PROTEASE INHIBITORS (NON-PEPTIDIC)		
	PREZISTA (darunavir ethanolate)	APTIVUS (tipranavir) darunavir ethanolate	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		PREZCOBIX (darunavir/cobicistat)	
	ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS		
		SELZENTRY (maraviroc)	
	ENTRY INHIBITORS – FUSION INHIBITORS		
		FUZEON (enfuvirtide)	
	COMBINATION PRODUCTS - NRTIs		
	abacavir/lamivudine CABENUVA (cabotegravir/rilpivirine) DOVATO (dolutegravir/lamivudine) lamivudine/zidovudine	abacavir/lamivudine/zidovudine COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir/lamivudine) JULUCA (dolutegravir/rilpivirine) TRIZIVIR (abacavir/lamivudine/zidovudine)	
	COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs		
	DESCOVY (emtricitabine/tenofovir alafenam) emtricitabine/tenofovir	TRUVADA (emtricitabine/tenofovir)	
	COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOGS & NON-NUCLEOSIDE RTIs		
	DELSTRIGO (doravirine/lamivudine/tenofovir) efavirenz/emtricitabine/tenofovir ODEFSEY (emtricitabine/rilpivirine/tenofovir AF)	ATRIPLA (efavirenz/emtricitabine/tenofovir) CIMDUO (lamivudine/tenofovir) COMPLERA (emtricitabine/rilpivirine/tenofovir) TEMIXYS (lamivudine/tenofovir)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
COMBINATION PRODUCTS – PROTEASE INHIBITORS				
	lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)		
CAPSID INHIBITORS				
		SUNLENCA (lenacapavir)	All agents require clinical review.	
CD4 DIRECTED ATTACHMENT INHIBITOR				
		RUKOBIA (fostemsavir tromethamine ER)		
CD4 DIRECTED HIV-1 INHIBITOR				
		TROGARZO (ibalizumab)		
ANTIVIRALS (Oral)				
ANTI-CYTOMEGALOVIRUS AGENTS				
	valganciclovir tablets	LIVTENCITY (maribavir) PREVYMIS (letermovir) VALCYTE (valganciclovir) valganciclovir solution	<p>valganciclovir solution – automatic approval for age <12 years</p> <p>Prevymis Prevention (prophylaxis) of cytomegalovirus (CMV) infection and disease</p> <ul style="list-style-type: none"> • ≥ 18 years AND • Post hematopoietic stem cell transplant (HSCT) within the past 28 days AND 	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<ul style="list-style-type: none"> • CMV sero-positive recipient [R+] AND • NO severe (Child-Pugh Class C) hepatic impairment
ANTI-HERPETIC AGENTS			
	acyclovir valacyclovir	famciclovir FAMVIR (famciclovir) SITAVIG (acyclovir) VALTREX (valacyclovir) ZOVIRAX (acyclovir)	
ANTI-INFLUENZA AGENTS			
	oseltamivir	FLUMADINE (rimantadine) RAPIVAB (peramivir) RELENZA (zanamivir) rimantadine TAMIFLU (oseltamivir) XOFLUZA (baloxavir marboxil)	
ANTIVIRALS (Topical)			
	ZOVIRAX Cream (acyclovir)	acyclovir cream, ointment DENA VIR (penciclovir) XERESE (acyclovir/hydrocortisone) ZOVIRAX Ointment (acyclovir)	
AROMATASE INHIBITORS			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	anastrozole exemestane letrozole	ARIMIDEX (anastrozole) AROMASIN (exemestane) FEMARA (letrozole)	
ATOPIC DERMATITIS ^{DUR+}			
	ADBRY (tralokinumab) DUPIXENT (dupilumab) ELIDEL (pimecrolimus) PROTOPIC (tacrolimus) tacrolimus	CIBINQO (abrocitinib) EUCRISA (crisaborole) OPZELURA (ruxolitinib) pimecrolimus	<p style="text-align: center;">Minimum Age Limit</p> <ul style="list-style-type: none"> • 2 years – Elidel, Protopic 0.03% • 16 years – Protopic 0.1% <p style="text-align: center;">Cibinqo and Opzelura</p> <ul style="list-style-type: none"> • Requires clinical review <p style="text-align: center;">Adbry- <u>MANUAL PA</u></p> <p style="text-align: center;">Eucrisa</p> <ul style="list-style-type: none"> • History of 28 days of therapy with a calcineurin inhibitor AND • History of 28 days of therapy with a topical steroid in the past year OR <ul style="list-style-type: none"> • <u>MANUAL PA</u> <p style="text-align: center;">Dupixent</p>

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Evaluated through Manual PA according to diagnosis Asthma – MANUAL PA Atopic Dermatitis – MANUAL PA Eosinophilic Esophagitis – MANUAL PA Nasal Polyposis – MANUAL PA Prurigo Nodularis MANUAL PA
BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS^{DUR+}			
	acebutolol atenolol bisoprolol metoprolol metoprolol ER nadolol nebivolol pindolol propranolol propranolol ER sotalol	AZSRUZYO SPRINKLES (ranolazine) BETAPACE (sotalol) betaxolol BYSTOLIC (nebivolol) CORGARD (nadolol) HEMANGEOL (propranolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLES (metoprolol) KERLONE (bextaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) SOTYLIZE (sotalol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
BETA- AND ALPHA-BLOCKERS			
	carvedilol labetalol	carvedilol CR COREG (carvedilol) COREG CR (carvedilol)	Coreg CR <ul style="list-style-type: none"> • Documented diagnosis for hypertension AND

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		TRANDATE (labetalol)	<ul style="list-style-type: none"> Have tried generic carvedilol AND 1 preferred agent in the past 6 months OR <ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days
BETA BLOCKER/DIURETIC COMBINATIONS			
	atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ timolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) DUTOPROL (metoprolol/HCTZ) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
ANTIANGINALS			
		RANEXA (ranolazine) ranolazine	<p style="text-align: center;">Ranexa</p> <ul style="list-style-type: none"> Documented diagnosis of angina AND <ul style="list-style-type: none"> 1 claim for a calcium channel blocker, beta-blocker, nitrate, or combination agent in the past 30 days OR 90 consecutive days on the requested agent in the past 105 days
SINUS NODE AGENTS			
		CORLANOR (ivabradine)	Corlanor - MANUAL PA

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BILE SALTS			
	ursodiol	ACTIGALL (ursodiol) BYLVAY (odevixibat) CHENODAL (chenodiol) CHOLBAM (cholic acid) LIVMARLI (maralixibat) OCALIVA (obeticholic acid) URSO (ursodiol) URSO FORTE (ursodiol)	
BLADDER RELAXANT PREPARATIONS ^{DUR+}			
	MYRBETRIQ ER (mirabegron) oxybutynin ER oxybutynin IR solifenacin	darifenacin DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) GELNIQUE (oxybutynin) GEMTESA (vibegron) MYRBETRIQ granules (mirabegron) OXYTROL (oxybutynin) tolterodine tolterodine ER TOVIAZ (fesoterodine fumarate) trospium trospium ER VESICARE (solifenacin) VESICARE LS Suspension (solifenacin)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
BONE RESORPTION SUPPRESSION AND RELATED AGENTS ^{DUR+}			
BISPHOSPHONATES			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	alendronate ibandronate risedronate	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) risedronate DR Tablet	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis for osteoporosis or osteopenia AND • Have tried 2 different preferred agents in the past 6 months
OTHERS			
		calcitonin salmon EVENTY (romosozumab-aqqg) EVISTA (raloxifene) FORTEO (teriparatide) MIACALCIN (calcitonin) PROLIA (denosumab) raloxifene TYMLOS (abaloparatide) XGEVA (denosumab)	
BPH AGENTS ^{DUR+}			
ALPHA BLOCKERS			
	alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) dutasteride/tamsulosin FLOMAX (tamsulosin) HYTRIN (terazosin)	<p style="color: red;">Female</p> <ul style="list-style-type: none"> • Cardura, Flomax, Proscar, terazosin, or Uroxatral AND • Documented diagnosis based on a State accepted diagnosis

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		JALYN (dutasteride/tamsulosin) RAPAFLO (silodosin) silodosin UROXATRAL (alfuzosin)	<p>Non-Preferred Criteria - MALE</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days <p>Entadfi</p> <ul style="list-style-type: none"> • Requires clinical review
	5-ALPHA-REDUCTASE (5AR) INHIBITORS		
	finasteride	AVODART (dutasteride) dutasteride ENTADFI (finasteride/tadalafil) PROSCAR (finasteride)	
	PDE5 INHIBITORS		
		CIALIS (tadalafil)	
BRONCHODILATORS & COPD AGENTS			
	ANTICHOLINERGICS & COPD AGENTS		<p>Minimum Age Limit</p> <p>6 years – Spiriva Respimat</p> <p>Spiriva Respimat</p> <ul style="list-style-type: none"> • Automatic approval for ≥ 6 years with a diagnosis of asthma
	ATROVENT HFA (ipratropium) INCRUSE ELLIPTA (umeclidinium) ipratropium SPIRIVA HANDIHALER (tiotropium)	DALIRESP (roflumilast) LONHALA MAGNAIR (glycopyrrolate) roflumilast SEEBRI (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) ^{DUR+} TUDORZA PRESSAIR (aclidinium) YUPELRI (revefenacin)	
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS		
	albuterol/ipratropium ANORO ELLIPTA (umeclidinium/vilanterol)	BEVESPI (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium/formoterol)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	COMBIVENT RESPIMAT (albuterol/ipratropium) ^{DU} STIOLTO RESPIMAT (tiotropium/olodaterol)		
ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS			
		BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol) TRELEGY ELLIPTA (fluticasone furoate/ umeclidinium/vilanterol)	
BRONCHODILATORS, BETA AGONIST			
INHALERS, SHORT-ACTING			
	albuterol HFA PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	AIRSUPRA (budesonide/albuterol) levalbuterol HFA PROAIR DIGIHALER (albuterol) PROAIR RESPICLICK (albuterol) XOPENEX HFA (levalbuterol) ^{DUR+}	<p style="color: red; margin: 0;">Minimum Age Limit</p> <ul style="list-style-type: none"> 4 years – Xopenex HFA 18 years - Airsupra <p style="color: red; margin: 0;">Quantity Limit</p> <ul style="list-style-type: none"> 2 inhalers/31 days – Airsupra <p style="color: red; margin: 0;">Xopenex HFA</p> <ul style="list-style-type: none"> 1 claim for a preferred albuterol inhaler in the past 30 days <p style="color: red; margin: 0;">Airsupra and ProAir Digihaler</p> <ul style="list-style-type: none"> Requires clinical review
INHALERS, LONG ACTING ^{DUR+}			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	SEREVENT (salmeterol) STRIVERDI RESPIMAT (olodaterol)		<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 4 years – Serevent • 18 years – Striverdi Respimat
INHALATION SOLUTION ^{DUR+}			
	albuterol	arformoterol BROVANA (arformoterol) formoterol levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 6 years – Xopenex • 18 years – Brovana, Perforomist <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • 1 claim for a different preferred agent in the past 6 months OR • 3 claims with the requested agent in the past 105 days <p>Xopenex</p> <ul style="list-style-type: none"> • 1 claim for a preferred albuterol in the past 30 days
ORAL			
	albuterol ER albuterol IR metaproterenol terbutaline	VOSPIRE ER (albuterol)	
CALCIUM CHANNEL BLOCKERS ^{DUR+}			
SHORT-ACTING			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	diltiazem nicardipine nifedipine verapamil	CALAN (verapamil) CARDIZEM (diltiazem) isradipine nimodipine NORLIQVA (amlodipine) NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	<p>Quantity Limit - nimodipine</p> <ul style="list-style-type: none"> • 252 tablets/ 21 days • 2520 mL/21 days <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred <u>Short Acting</u> CCB agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days <p>nimodipine</p> <ul style="list-style-type: none"> • Documented diagnosis of subarachnoid hemorrhage in the past 45 days AND • Duration of therapy limited to 21 days
LONG-ACTING			
	amlodipine DILT XR 24 HR Caps (diltiazem) diltiazem ER Cap 24 HR (generic Cardizem CD) diltiazem ER Cap 24 HR felodipine ER nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD (diltiazem) CARDIZEM LA (diltiazem) DILACOR XR (diltiazem) diltiazem ER Cap 12 HR diltiazem ER Tab 24 HR KATERZIA (amlodipine) nisoldipine NORVASC (amlodipine)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred <u>Long Acting</u> CCB agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	
CALORIC AGENTS			
	BOOST (includes all Boost) BREAKFAST ESSENTIALS BRIGHT BEGINNINGS DUOCAL ENSURE GLUCERNA NUTREN (includes all Nutren) OSMOLITE PEDIASURE PROMOD RESOURCE SCANDISHAKE TWOCAL HN	All other products (caloric /nutritional agents) not listed as preferred will require a manual prior authorization.	Non-Preferred Agents - MANUAL PA
CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)			
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS			
	amoxicillin/clavulanate amoxicillin/clavulanate XR	AUGMENTIN 125 and 250 Suspension (amoxicillin/clavulanate) AUGMENTIN (amoxicillin/clavulanate) Tablets AUGMENTIN XR (amoxicillin/clavulanate) MOXATAG (amoxicillin)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
CEPHALOSPORINS – First Generation ^{DUR+}			<p>Non-Preferred Criteria – all generations</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months
	cefadroxil cephalexin capsules cephalexin suspensio	cephalixin tablets DAXBIA (cephalexin) KEFLEX (cephalexin)	
CEPHALOSPORINS – Second Generation ^{DUR+}			
	cefaclor capsules cefprozil cefuroxime tablets	cefaclor ER cefaclor suspension cefuroxime suspension CEFTIN (cefuroxime)	
CEPHALOSPORINS – Third Generation ^{DUR+}			<p>Maximum Age Limit</p> <ul style="list-style-type: none"> • 18 years – cefdinir suspension
	cefdinir suspension cefdinir capsules cefpodoxime	CEDAX (ceftibuten) cefditoren ceftibuten SPECTRACEF (cefditoren) SUPRAX (cefixime)	
COLONY STIMULATING FACTORS			
	FYLNETRA (pegfilgrastim) STIMUFEND (pegfilgrastim-fpgk) NEUPOGEN Syringe (filgrastim) NEUPOGEN Vial (filgrastim)	FULPHILA (pegfilgrastim) GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) NIVESTYM (filgrastim-aafi) NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim) ROLVEDON (eflapegrastim) UDENYCA (pegfilgrastim-cbqv) UDENYCA ONBODY (pegfilgrastim-cbqv) ^{NR}	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ZARXIO (filgrastim) ZIENTENZO (pegfilgrastim-bmez)	
CYSTIC FIBROSIS AGENTS ^{DUR+}			
	tobramycin (generic TOBI)	BETHKIS (tobramycin) BRONCHITOL (mannitol) CAYSTON (aztreonam) colistmethate COLY-MYCIN M (colistimethate sodium) KALYDECO (ivacaftor) KITABIS (tobramycin) ORKAMBI (lumacaftor/ivacaftor) PULMOZYME (dornase alfa) SYMDEKO (tezacaftor/ivacaftor) TOBI (tobramycin) TOBI PODHALER (tobramycin) tobramycin (generic Bethkis) tobramycin (generic Kitabis) TRIKAFTA (elexacaftor/ tezacaftor/ivacaftor)	<p style="color: red; margin: 0;">Minimum Age Limit</p> <ul style="list-style-type: none"> 1 month – Kalydeco Granules 3 months – Pulmozyme 1 year – Orkambi <p style="margin: 0;">• 2 years – Coly-Mycin M, Trikafta Granules</p> <p style="margin: 0;">• 6 years – Bethkis, Kalydeco tablet, Kitabis, Symdeko, TOBI, TOBI Podhaler, Trikafta tablet</p> <ul style="list-style-type: none"> 7 years – Cayston 18 years - Bronchitol <p style="color: red; margin: 0;">Maximum Age Limit</p> <ul style="list-style-type: none"> 2 years – Orkambi 75-94 mg Granules 5 years – Kalydeco, Orkambi 100-125 mg Granules, Orkambi 200-125 mg Granules, Trikafta Granules 11 years – Trikafta tablets <p style="color: red; margin: 0;">All Agents</p> <ul style="list-style-type: none"> Documented diagnosis Cystic Fibrosis

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CYTOKINE & CAM ANTAGONISTS^{DUR+}			
	ACTEMRA SYRINGE (tocilizumab) ACTEMRA VIAL(tocilizumab) AVSOLA (infliximab) ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra) methotrexate ORENCIA CLICKJET(abatacept) ORENCIA VIAL(abatacept) OTEZLA (apremilast) SIMPONI (golimumab) TALTZ (ixekizumab) XELJANZ IR (tofacitinib)	ABRILADA (adalimumab-afzb) ^{NR} ACTEMRA ACTPEN (tocilizumab) AMJEVITA (adalimumab) ARCALYST (rilonacept) BIMZELX (bimekizumab-bkzx) CIMZIA (certolizumab) COSENTYX (secukinumab) COSENTYX VIAL (secukinumab) CYLTEZO (adalimumab-adbm) ENTYVIO (vedolizumab) ENTYVIO SQ (vedolizumab) HADLIMA (adalimumab) HULIO (adalimumab) HYRIMOZ (adalimumab) IDACIO (adalimumab) ILARIS (canakinumab)	<p>Colistimethate</p> <ul style="list-style-type: none"> Documented diagnosis of Cystic Fibrosis OR Requires clinical review <p>Kalydeco – MANUAL PA Orkambi – MANUAL PA Symdeko – MANUAL PA Trikafta – MANUAL PA</p> <p>TOBI Podhaler</p> <ul style="list-style-type: none"> Requires clinical review <p>All preferred agents are subject to approved age and documented diagnosis for appropriate indication.</p> <p>All Non-Preferred Agents</p> <ul style="list-style-type: none"> Require clinical review <p>IV Administered Agents</p> <ul style="list-style-type: none"> Require clinical review

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ILUMYA (tildrakizumab) INFLECTRA (infliximab) JYLAMVO (methotrexate) KEVZARA (sarilumab) LITFULO (ritlecitinib) OLUMIANT (baricitinib) OMVOH (mirikizumab-mrkz) ORENCIA SYRINGE (abatacept) OTREXUP (methotrexate) RASUVO (methotrexate) REMICADE (infliximab) RENFLEXIS (infliximab-abda) RHEUMATREX (methotrexate) RINVOQ (upadacitinib) RINVOQ ER (upadacitinib) SILIQ (brodalumab) SKYRIZI (risankizumab) SOTYKTU (deucravacitinib) SPEVIGO (spesolimab) STELARA (ustekinumab) TREMFYA (guselkumab) TREXALL (methotrexate) XELJANZ Oral Solution (tofacitinib) XELJANZ XR (tofacitinib) YUSIMRY (adalimumab) ZYMFENTRA (infliximab-dyyb) ^{NR}	
ERYTHROPOIESIS STIMULATING PROTEINS ^{DUR+}			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	EPOGEN (rHuEPO) MIRCERA (methoxy polyethylene glycol-epoetin-beta) RETACRIT (rHuEPO)	ARANESP (darbepoetin) PROCRIT (rHuEPO) JESDUVROQ (daprodustat)	<p>Mircera</p> <ul style="list-style-type: none"> Documented diagnosis chronic renal failure in the past 2 years <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Documented diagnosis of cancer or chronic renal failure OR Antineoplastic therapy in the past 6 months AND <ul style="list-style-type: none"> Trial of a preferred Retacrit or Epogen in the past 6 months OR 1 claim for the requested agent in the past 105 days <p>Jesduvroq</p> <ul style="list-style-type: none"> Requires clinical review
FACTOR DEFICIENCY PRODUCTS			
FACTOR VIII			
	ADVATE AFSTYLA ALPHANATE FEIBA NF HEMOFIL M HUMATE-P KOATE KOGENATE FS KOVALTRY NOVOEIGHT	ADYNOVATE ALTUVIIIIO ELOCTATE ESPEROCT HEXILATE FS JIVI KCENTRA OBIZUR VONVENDI	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	NUWIQ RECOMBINATE WILATE XYNTHA XYNTHA SOLOFUSE		
FACTOR IX			
	ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY MONONINE PROFILNINE RIXUBIS	REBINYN	
OTHER FACTOR PRODUCTS			
	COAGADEX FIBRYGA HEMLIBRA ^{DUR+} RIASTAP	CORIFACT NOVOSEVEN RT SEVENFACT TRETEN	<p style="text-align: center; color: red;">Hemlibra</p> <ul style="list-style-type: none"> 3 claims with the requested agent in the past 105 days MANUAL PA – new patients
FIBROMYALGIA/NEUROPATHIC PAIN AGENTS			
	duloxetine gabapentin pregabalin SABELLA (milnacipran)	(duloxetine) ^{DUR+} DRIZALMA SPRINKLES (duloxetine DR) duloxetine DR gabapentin ER ^{NR} GRALISE (gabapentin) HORIZANT (gabapentin) IRENKA (duloxetine) ^{DUR+}	<p style="text-align: center; color: red;">Cymbalta and Irenka (see Antidepressant, Other)</p> <p style="text-align: center; color: red;">Minimum Age Limit – automatic approval for ages 7-17 with a diagnosis of GAD (Generalized Anxiety Disorder) for preferred duloxetine</p>

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		LYRICA (pregabalin) LYRICA CR (pregabalin) NEURONTIN (gabapentin) pregabalin ER	
FLUOROQUINOLONES ^{DUR+}			
	ciprofloxacin tablets levofloxacin tablets	AVELOX (moxifloxacin) BAXDELA (delafloxacin) CIPRO (ciprofloxacin) CIPRO SUSPENSION (ciprofloxacin) CIPRO XR (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) levofloxacin solution moxifloxacin NOROXIN (norfloxacin) ofloxacin	<p style="color: red; text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> 1 claim for a preferred agent in past 30 days <p style="color: red; text-align: center;">Cipro Suspension for age < 12 years</p> <ul style="list-style-type: none"> Anthrax infection or exposure OR <ul style="list-style-type: none"> Cystic Fibrosis OR Pneumonic plague OR tularemia AND history of doxycycline in the past 3 months OR 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months <ul style="list-style-type: none"> Penicillin, 2nd or 3rd generation cephalosporin, or macrolide <p style="color: red; text-align: center;">Levaquin solution for age < 12 years</p> <ul style="list-style-type: none"> Anthrax infection or exposure OR 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<ul style="list-style-type: none"> ○ Penicillin, 2nd or 3rd generation cephalosporin, or macrolide AND ● Cipro suspension in the past 3 months
GAUCHER'S DISEASE			
	ELELYSO (taliglucerase alfa) ZAVESCA (miglustat)	CERDELGA (eliglustat) CEREZYME (imiglucerase) miglustat VPRIV (velaglucerase alfa)	
GENITAL WARTS & ACTINIC KERATOSIS AGENTS			
	CONDYLOX (podofilox) ^{Age Edit} imiquimod ^{Age Edit} podofilox ^{Age Edit}	ALDARA (imiquimod) ^{Age Edit} CARAC (fluorouracil) diclofenac 3% gel EFUDEX (fluorouracil) fluorouracil 0.5% cream fluorouracil 5% cream PICATO (ingenol) ^{Age Edit} SOLARAZE (diclofenac) TOLAK (fluorouracil) VEREGEN (sinecatechins) ^{Age Edit} ZYCLARA (imiquimod) ^{Age Edit}	<p style="color: red; margin: 0;">Minimum Age Limit</p> <ul style="list-style-type: none"> ● 12 years – Aldara, Zyclara ● 18 years – Condylox, Picato, Veregen
GLUCOCORTICOIDS (Inhaled)^{DUR+}			
GLUCOCORTICOIDS			
	ASMANEX TWISTHALER (mometasone) budesonide 0.25mg and 0.5mg fluticasone HFA	ALVESCO (ciclesonide) ARMONAIR Digihaler (fluticasone) ARNUITY ELLIPTA (fluticasone)	<p style="color: red; margin: 0;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> ● Have tried 2 preferred single entity agents in the past 6 months OR

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	PULMICORT FLEXHALER (budesonide) QVAR REDHALER (beclomethasone dipropionate)	ASMANEX HFA (mometasone) budesonide 1mg fluticasone diskus PULMICORT (budesonide) Respules	<ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days <p style="color: red; text-align: center;">ArmonAir Digihaler</p> <ul style="list-style-type: none"> Requires clinical review <p><i>NOTE:</i> Institutional sized products are Non-Preferred</p>
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS			
	ADVAIR DISKUS (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) fluticasone/salmeterol (generic ADVAIR) fluticasone/salmeterol (generic AIRDUO) SYMBICORT (budesonide/formoterol)	AIRDUO Digihaler (fluticasone/salmeterol) AIRDUO Resplick (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanterol) BREYNA (budesonide/formoterol) budesonide/formoterol WIXELA INHUB (fluticasone/salmeterol)	<p style="color: red; text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 preferred combination agents in the past 6 months OR <ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days <p style="color: red; text-align: center;">AirDuo Digihaler</p> <ul style="list-style-type: none"> Requires clinical review
GI ULCER THERAPIES			
H2 RECEPTOR ANTAGONISTS			
	cimetidine solution famotidine solution famotidine tablets nizatidine solution	AXID (nizatidine) cimetidine tablets nizatidine tablets PEPCID (famotidine)	
PROTON PUMP INHIBITORS			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	esomeprazole magnesium DR Capsule NEXIUM PACKET (esomeprazole) omeprazole Rx pantoprazole	ACIPHEX SPRINKLE (rabeprazole) ACIPHEX Tablet (rabeprazole) DEXILANT (dexlansoprazole) esomeprazole strontium DR Capsule KONVOMEF SUSPENSION (omeprazole/sodium bicarbonate) lansoprazole Rx NEXIUM Rx DR Capsule (esomeprazole) omeprazole sod. bicarb. PREVACID Rx (lansoprazole) PREVACID SOLU-TAB (lansoprazole) PRILOSEC RX (omeprazole) PRILOSEC SUSPENSION (omeprazole) PROTONIX DR (pantoprazole) PROTONIX PACKET (pantoprazole) rabeprazole	Prilosec suspension • Automatic approval for 0 - 2 years
OTHER			
	misoprostol sucralfate suspension sucralfate tablet	CARAFATE SUSPENSION (sucralfate) CARAFATE TABLET (sucralfate) CYTOTEK (misoprostol) DARTISLA ODT (glycopyrrolate) VOQUEZNA (vonoprazan)	
GROWTH HORMONE DUR+			
	GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	HUMATROPE (somatropin) NGENLA (somatrogon-ghla) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin)	All Agents for Age ≥ 18 years • Documented diagnosis of craniopharyngioma, panhypopituitarism, Prader-Willi Syndrome, Turner Syndrome or an approvable adult diagnosis OR

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SKYTROFA (lonapegsomatropin) SOGROYA (somapacitan) VOXZOGO (vosoritide) ZOMACTON (somatropin) ZORBITIVE (somatropin)	<ul style="list-style-type: none"> • Documented procedure of cranial irradiation <p>All Agents for Age < 18 years</p> <ul style="list-style-type: none"> • Documented diagnosis of idiopathic short stature AND • Documented approvable pediatric diagnosis OR • Documented approvable pediatric diagnosis <p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 3 years – Ngenia <p>Maximum Age Limit</p> <ul style="list-style-type: none"> • 18 years - Ngenia <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 1 preferred agent in the past 6 months OR • 84 consecutive days on the requested agent in the past 105 days
H. PYLORI COMBINATION TREATMENTS			
	PYLERA (bismuth subcitrate potassium, metronidazole, tetracycline)	bismuth subcitrate potassium, metronidazole, tetracycline lansoprazole, amoxicillin, clarithromycin	<p>Quantity Limit</p> <ul style="list-style-type: none"> • 1 treatment course/year

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		OMECLAMOX (omeprazole, clarithromycin, amoxicillin) PREVPAC (lansoprazole, amoxicillin, clarithromycin) TALICIA (omeprazole, amoxicillin, rifabutin) VOQUEZNA DUAL PAK (vonoprazan, amoxicillin) VOQUEZNA TRIPLE PAK (vonoprazan, amoxicillin, clarithromycin)	
HEPATITIS B TREATMENTS			
	entecavir EPIVIR HBV SOLUTION (lamivudine) lamivudine HBV tenofovir disoproxil fumarate	adefovir dipivoxil BARACLUDE (entecavir) EPIVIR HBV TABLET (lamivudine) HEPSERA (adefovir dipivoxil) TYZEKA (telbivudine) VEMLIDY (tenofovir alafenamide fumarate) VIREAD (tenofovir disoproxil fumarate)	
HEPATITIS C TREATMENTS			
	MAVYRET (glecaprevir/pibrentasvir) ∞ MAVYRET PELLETS (glecaprevir/pibrentasvir)∞ PEGASYS (peginterferon alfa-2a) PEG-INTRON (peginterferon alfa-2b) ribavirin tablets sofosbuvir/velpatasvir∞	COPEGUS (ribavirin) EPCLUSA (sofosbuvir/velpatasvir) ∞ HARVONI (ledipasvir/sofosbuvir) ∞ ledipasvir/sofosbuvir∞ MODERIBA (ribavirin) OLYSIO (simeprevir) REBETOL (ribavirin)	∞ Epclusa, Harvoni, Mavyret, Sovaldi, Vosevi, Zepatier • Require clinical review <u>Note:</u> Epclusa, Harvoni, Mavyret and Sovaldi have FDA pediatric indications

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		RIBASPHERE (ribavirin) RIBASPHERE RIBAPAK DOSEPACK (ribavirin) ribavirin capsules SOVALDI (sofosbuvir) [∞] TECHNIVIE (ombitasvir/paritaprevir/ritonavir) VIEKIRA (ombitasvir/paritaprevir/ritonavir) VIEKIRA XR (ombitasvir/paritaprevir/ritonavir) VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) [∞] ZEPATIER (elbasvir/grazoprevir) [∞]	<u>MANUAL PA</u>
HEREDITARY ANGIOEDEMA			
		BERINERT (C1 esterase inhibitor) CINRYZE VIAL (C1 esterase inhibitor) FIRAZYR SYRINGE (icatibant acetate) HAEGARDA (C1 esterase inhibitor) icatibant KALBITOR VIAL (ecallantide) ORLADEYO (berotralstat hydrochloride) RUCONEST VIAL (C1 esterase inhibitor, recombinant) TAKHZYRO (lanadelumab-flyo)	
HYPERURICEMIA & GOUT ^{DUR+}			
	allopurinol colchicine tablet probenecid probenecid/colchicine	colchicine capsule COLCRYS (colchicine) febuxostat GLOPERBA (colchicine) MITIGARE (colchicine) ULORIC (febuxostat) ZYLOPRIM (allopurinol)	Non-Preferred Criteria <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMIA TREATMENT, GLUCAGON			
	lifilSIMI (glucagon) ^{Step Edit} glucagen vial glucagon labeler 00002 ZEGALOGUE (dasiglucagon) ^{Step Edit}	glucagon kit (labelers 63323, 00548) GVOKE (glucagon)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 2 years – Gvoke • 4 years – Baqsimi • 6 years – Zegalogue <p>Quantity Limit</p> <ul style="list-style-type: none"> • 2 packs/31 days – Baqsi • 2 syringes/31 days – Gv Zegalogue • 2 kits/31 days – Glucaç <p>Gvoke</p> <ul style="list-style-type: none"> • 1 claim with Baqsimi or Zegal in the past 30 days <p>Non-Preferred Glucagons</p> <ul style="list-style-type: none"> • Have tried 1 different prefer glucagon in the past 30 da
HYPOGLYCEMICS, BIGUANIDES ^{DUR+}			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	metformin HCL tablet metformin HCL ER 24HR tablet (generic GlucophageXR)	FORTAMET ER GLUCOPHAGE (metformin) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER) metformin 24HR (generic Fortamet) metformin 24HR (generic Glumetza) RIOMET SOLUTION* (metformin)	
HYPOGLYCEMICS, DPP4s and COMBINATON ^{DUR+}			
	JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin alogliptin/metformin alogliptin/pioglitazone JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin)* NESINA (alogliptin) ONGLYZA (saxagliptin) * OSENi (alogliptin/pioglitazone) ZITUVIO (sitagliptin) ^{NR}	Concomitant use of a GLP-1 product and a DPP-4 product requires clinical review
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS ^{DUR+}			
	BYETTA (exenatide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	ADLYXIN (lixisenatide) BYDUREON (exenatide) BYDUREON BCISE (exenatide) MOUNJARO (tirzepatide) OZEMPIC (semaglutide) RYBELSUS (semaglutide) SOLIQUA (insulin glargine/lixisenatide) SYMLIN (pramlintide)	<p>Minimum Age Limit</p> <ul style="list-style-type: none"> • 10 years – Bydureon Bcise, Trulicity, Victoza • 18 years – Byetta, Mounjaro, Ozempic, Rybelsus <p>Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis for Type 2 Diabetes OR

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		XULTOPHY (insulin degludec/ liraglutide)	<ul style="list-style-type: none"> • Have history of 84 days of therapy with the requested agent in the past 105 days <p style="text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis for Type 2 Diabetes AND • Have a history of 84 days of therapy with Trulicity in the past 6 months AND • Have a history of 84 days of therapy with 1 of the following preferred single ingredient GLP-1 Agonists in the past 6 months: Byetta or Victoza OR • Documented diagnosis for Type 2 Diabetes AND • Have a history of 84 days of therapy with the requested agent in the past 105 <p>Note: Single ingredient GLP-1 agonists are not indicated for treatment of obesity. Please refer to the PDL for a list of select anti-obesity agents.</p> <p>Concomitant use of a GLP-1 product and a DPP-4 product requires clinical review</p>

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMICS, INSULINS AND RELATED AGENTS ^{DUR+}			
	HUMULIN N, R, 70/30 VIAL ^{OTC} (insulin) HUMULIN R U500 KWIKPEN HUMULIN R U500 VIAL (insulin) HUMALOG MIX 50/50 VIAL HUMALOG MIX 75/25 VIAL insulin aspart insulin aspart flexpen insulin aspart mix insulin aspart mix flexpen Insulin lispro insulin lispro jr kwikpen insulin lispro kwikpen LANTUS SOLOSTAR & VIAL (insulin glargine) LEVEMIR FLEXPEN & VIAL (insulin detemir) TOUJEO (insulin glargine) TOUJEO MAX (insulin glargine)	AFREZZA (insulin) ADMELOG (insulin lispro) APIDRA (insulin glulisine) APIDRA SOLOSTAR (insulin glulisine) BASAGLAR (insulin glargine) FIASP (insulin aspart) HUMALOG JR (insulin lispro) HUMALOG KWIKPEN U100 (insulin lispro) HUMALOG KWIKPEN U200 (insulin lispro) HUMALOG MIX KWIKPEN (insulin lispro/ lispro protamine) HUMALOG VIAL (insulin lispro) HUMULIN N, 70/30 KWIKPEN (insulin) ^{OTC} insulin glargine LYUMJEV KWIKPEN (insulin lispro) LYUMJEV VIAL (insulin lispro) NOVOLIN N, R, 70/30 FLEXPEN (insulin) ^{OTC} NOVOLIN N, R, 70/30 VIAL (insulin) ^{OTC} NOVOLOG FLEXPEN & VIAL (insulin aspart) NOVOLOG MIX FLEXPEN & VIAL (insulin aspart/ aspart protamine) REZVOGLAR (insulin glargine) SEMGLEE (insulin glargine) TRESIBA (insulin degludec)	Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries. <b style="color: red;">Non-Preferred Criteria <ul style="list-style-type: none"> Documented diagnosis of Diabetes Mellitus AND Have tried 1 preferred product in the past 6 months OR 1 claim with the requested agent in the past 105 days <b style="color: red;">Quantity Limit <ul style="list-style-type: none"> Insulin Quantity Limits found here

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMICS, MEGLITINIDES ^{DUR+}			
	nateglinide repaglinide	PRANDIMET (repaglinide/metformin) PRANDIN (repaglinide) repaglinide/metformin STARLIX (nateglinide)	
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS ^{DUR+}			
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITORS			
	FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	dapagliflozin ^{NR} INPEFA (sotagliflozin) STEGLATRO (ertugliflozin)	
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 INHIBITOR COMBINATIONS			
	INVOKAMET (canagliflozin/metformin) SYNJARDY (empagliflozin/metformin)	dapagliflozin/metformin ^{NR} GLYXAMBI (empagliflozin/linagliptin) INVOKAMET XR (canagliflozin/metformin) QTERN (dapagliflozin/saxagliptin) SEGLUROMET (ertugliflozin/metformin) STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin) XIGDUO XR (dapagliflozin/metformin)	
HYPOGLYCEMICS, TZDS			
THIAZOLIDINEDIONES			
	pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
TZD COMBINATIONS			
	pioglitazone/metformin	ACTOPLUS MET (pioglitazone/metformin) ACTOPLUSMET XR (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glipizide) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride	
IDIOPATHIC PULMONARY FIBROSIS ^{DUR+}			
	OFEV (nintedanib)	ESBRIET (pirfenidone) pirfenidone	All Agents • Documented diagnosis Idiopathic Pulmonary Fibrosis
IMMUNOSUPPRESSIVE (ORAL) ^{DUR+}			
	AZASAN (azathioprine) azathioprine CELLCEPT (mycophenolate) cyclosporine cyclosporine modified everolimus GENGRAF (cyclosporine) IMURAN (azathioprine) mycophenolic acid mycophenolate mofetil NEORAL (cyclosporine) RAPAMUNE (sirolimus) SANDIMMUNE (cyclosporine) sirolimus tacrolimus	ASTAGRAF XL (tacrolimus) ENVARUSUS XR (tacrolimus) HECORIA (tacrolimus) MYFORTIC (mycophenolic acid) PROGRAF (tacrolimus) REZUROCK (belumosudil) ZORTRESS (everolimus)	Minimum Age Limit • 13 years – Rapamune • 18 years – Zortress Astagraf, Cellcept, Envarsus XR, Hecoria, Prograf • Documented diagnosis for heart transplant, kidney transplant, liver transplant, lung transplant or a State accepted diagnosis Azasan • Documented diagnosis of kidney transplant, RA, or a State accepted diagnosis Gengraf, Neoral, Sandimmune

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
IMMUNE GLOBULINS			
	BIVIGAM CARIMUNE NF FLEBOGAMMA DIF GAMASTAN SD GAMMAGARD GAMMAGARD SD GAMUNEX-C HIZENTRA HYQVIA PANZYGA	ASCENIV CABLIVI CUTAQUIG CUVITRU GAMMAKED GAMMAPLEX OCTAGAM	<ul style="list-style-type: none"> Documented diagnosis of heart transplant, kidney transplant, liver transplant, psoriasis, RA, or a State accepted diagnosis OR Clinical review required for a diagnosis of Kimura's disease or multifocal motor neuropathy <p style="text-align: center;">Myfortic</p> <ul style="list-style-type: none"> Documented diagnosis of kidney transplant or psoriasis <p style="text-align: center;">Rapamune</p> <ul style="list-style-type: none"> Documented diagnosis of kidney transplant <p style="text-align: center;">Zortress</p> <ul style="list-style-type: none"> Documented diagnosis of kidney transplant or liver transplant

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	PRIVIGEN XEMBIFY		
IMMUNOLOGIC THERAPIES FOR ASTHMA			
	DUPIXENT (dupilumab)* FASENRA PEN AUTOINJECTOR (benralizumab) FASENRA SYRINGE (benralizumab) XOLAIR SYRINGE (omalizumab) XOLAIR VIAL (omalizumab)	CINQAIR (reslizumab) NUCALA AUTOINJECTOR (mepolizumab)* NUCALA SYRINGE (mepolizumab)* TEZSPIRE (tezepelumab) XOLAIR AUTOINJECTOR (omalizumab) ^{NR}	All require a clinical review Dupixent – MANUAL PA Fasenra- MANUAL PA Xolair- MANUAL PA
INTRANASAL RHINITIS AGENTS			
ANTICHOLINERGICS			
	ipratropium	ATROVENT (ipratropium)	
ANTI-HISTAMINES			
	azelastine	ASTEPRO (azelastine) olopatadine PATANASE (olopatadine)	
ANTI-HISTAMINE/CORTICOSTEROID COMBINATION ^{DUR+}			
		azelastine/fluticasone DYMISTA (azelastine/fluticasone) RYALTRIS (olopatadine/mometasone) TICALAST (azelastine/fluticasone)	
CORTICOSTEROIDS ^{DUR+}			
	fluticasone ^{Rx Only}	BECONASE AQ (beclomethasone) budesonide flunisolide mometasone	Non-Preferred Criteria <ul style="list-style-type: none"> • Documented diagnosis for allergic rhinitis AND • Have tried 1 different preferred agent in the past 6 months

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		NASONEX (mometasone) OMNARIS (ciclesonide) QNASL (beclomethasone) TICANASE KIT (flonase kit) triamcinolone VERAMYST (fluticasone) XHANCE (fluticasone) ZETONNA (ciclesonide)	
IRON CHELATING AGENTS			
	deferasirox all strengths (all labelers except those listed as non-preferred) FERRIPROX (deferiprone)	deferasirox (labeler 00093, 16714, 45963, 62332) EXJADE (deferasirox) JADENU (deferasirox) JADENU SPRINKLES (deferasirox)	Jadenu – MANUAL PA
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED GI AGENTS ^{DUR+}			
IRRITABLE BOWEL SYNDROME CONSTIPATION			
	AMITIZA (lubiprostone) LINZESS 145mcg, 290mcg (linaclotide)	IBSRELA (tenapanor) LINZESS 72mcg (linaclotide) linaclotide lubiprostone MOTTEGRITY (prucalopride) MOVANTIK (naloxegol) RELISTOR (methylnaltrexone) SYMPROIC (naldemedine) TRULANCE (plecanatide) ZELNORM (tegaserod)	Minimum Age Limit <ul style="list-style-type: none"> • 1 year – Gattex • 6 years – Linzess 72mcg • 18 years – Amitiza, Ibsrela, Linzess 145mcg & 290mcg, Motegrity, Movantik, Mytesi, Relistor, Symproic, Trulance, Viberzi, Xermelo Gender Limit <ul style="list-style-type: none"> • Female – Amitiza 8mcg

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<p>Chronic Idiopathic Constipation (CIC) AMITIZA 24MCG, LINZESS 72MCG, LINZESS 145 MCG, MOTEGRITY, TRULANCE</p> <p>All CIC Agents</p> <ul style="list-style-type: none"> • Documented diagnosis of CIC in the past year AND <ul style="list-style-type: none"> • No history of GI or bowel obstruction <p>Non-Preferred CIC Agents</p> <ul style="list-style-type: none"> • Age 18 years AND • Documented diagnosis of CIC AND <ul style="list-style-type: none"> • No history of GI or bowel obstruction AND • 30 days of therapy with 2 preferred agents in the past 6 months OR • 1 claim with the requested agent in the past 105 days <p>Linzess 72 mcg</p> <ul style="list-style-type: none"> • Age 6-17 years AND • Documented diagnosis of CIC or pediatric functional constipation in the past year AND <ul style="list-style-type: none"> • No history of GI or bowel obstruction

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<p><u>Irritable Bowel Syndrome – Constipation Dominant (IBS-C)</u> AMITIZA 8MCG, IBSRELA, LINZESS 290 MCG, TRULANCE</p> <p>All IBS-C Agents</p> <ul style="list-style-type: none"> • Documented diagnosis of IBS-C in the past year AND <ul style="list-style-type: none"> • No history of GI or bowel obstruction <p>Non-Preferred IBS-C Agents</p> <ul style="list-style-type: none"> • Above IBS-C criteria AND • 30 days of therapy with 2 preferred agents in the past 6 months OR • 1 claim with the requested agent in the past 105 days <p><u>Opioid Induced Constipation (OIC)</u> AMITIZA 24MCG, MOVANTIK, RELISTOR, SYMPROIC</p> <p>All OIC Agents</p> <ul style="list-style-type: none"> • Documented diagnosis of OIC in the past year AND • 1 claim for an opioid in the past 30 days AND <ul style="list-style-type: none"> • No history of GI or bowel obstruction AND • Documented diagnosis of chronic pain in the past year

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
IRRITABLE BOWEL SYNDROME DIARRHEA			
	dicyclomine hyoscyamine	alosetron BENTYL (dicyclomine) LEVSIN (hyoscyamine) LEVSIN-SL (hyoscyamine) LOTRONEX (alosetron) VIBERZI (eluxadoline)*	<p>Non-Preferred OIC Agents</p> <ul style="list-style-type: none"> • Above OIC criteria AND • 30 days of therapy with 2 preferred agents in the past 6 months OR • 1 claim with the requested agent in the past 105 days <p>Relistor Injection</p> <ul style="list-style-type: none"> • Above OIC criteria AND • Documented diagnosis of active cancer in the past year AND • Documented diagnosis of palliative care in the past 6 months <p>Viberzi</p> <ul style="list-style-type: none"> • Documented diagnosis of Irritable Bowel Syndrome – Diarrhea Dominant (IBS-D) in the past year AND • 30 days of therapy with 2 preferred agents in the past 6 months OR • 1 claim with the requested agent in the past 105 days <p>Lotronex</p> <ul style="list-style-type: none"> • 1 claim for the requested agent in the past 105 days OR • MANUAL PA - All new patients require manual review

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Xifaxan - (see Antibiotics, GI)
SHORT BOWEL SYNDROME AND SELECTED GI AGENTS			
		GATTEX (teduglutide) MYTESI (crofelemer) NUTRESTORE POWDER PACK (glutamine) XERMELO (telotristat ethyl) ZORBTIVE (somatropin)	<u>Carcinoid Syndrome Agent</u> XERMELO <ul style="list-style-type: none"> • Documented diagnosis of carcinoid syndrome in the past year AND • 1 claim for a somatostatin analog in the past 30 days <u>HIV/AIDS Non-infectious Diarrhea</u> MYTESI <ul style="list-style-type: none"> • Documented diagnosis of HIV/AIDS in the past year AND <ul style="list-style-type: none"> • Documented diagnosis of non-infectious diarrhea in the past year AND • 1 claim for an antiretroviral in the past 30 days <u>Short Bowel Syndrome (SBS)</u> GATTEX, NUTRESTORE, ZORBTIVE Gattex or Zorbtive <ul style="list-style-type: none"> • 1 claim for the requested agent in the past 105 days OR • All new patients require clinical review

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LEUKOTRIENE MODIFIERS ^{DUR+}			<p style="color: red;">Nutrestore</p> <ul style="list-style-type: none"> Requires clinical review
	montelukast granules montelukast tablets zafirlukast	ACCOLATE (zafirlukast) SINGULAIR Tablets (montelukast) SINGULAR GRANULES (montelukast granules) zileuton ZYFLO CR (zileuton)	<p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> 12 years – Zyflo & Zyflo CR <p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months
LIPOTROPICS, OTHER (NON-STATINS)			
ACL INHIBITORS AND COMBINATIONS			
		NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe)	<p style="color: red;">Nexletol and Nexlizet</p> <ul style="list-style-type: none"> Requires clinical review
ANGIOTOETIN LIKE 3 INHIBITORS			
		EVKEEZA (evinacumab-dgnb)	<p style="color: red;">Non-Preferred Criteria</p> <p>Have tried 2 different preferred Non-statin Lipotropic agents in the past 6 months</p>
BILE ACID SEQUESTRANTS			
	cholestyramine colestipol	colesevelam COLESTID (colestipol) QUESTRAN (cholestyramine) WELCHOL (colesevelam)	
OMEGA-3 FATTY ACIDS			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	omega 3 acid ethyl esters	icosapent LOVAZA (omega-3-acid ethyl esters) VASCEPA (icosapent ethyl)	
CHOLESTEROL ABSORPTION INHIBITORS			
	ezetimibe	ZETIA (ezetimibe)	
FIBRIC ACID DERIVATIVES			
	fenofibrate nanocrystallized gemfibrozil	ANTARA (fenofibrate, micronized) fenofibrate 40mg tablet fenofibrate, micronized fenofibric acid FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid)	Fibric Acid Derivative Non-Preferred Criteria • Have tried 2 different fibric acid derivatives in the past 6 months
MTP INHIBITOR			
		JUXTAPID (lomitapide)	Juxtapid – MANUAL PA
APOLIPOPROTEIN B-100 SYNTHESIS INHIBITOR			
		KYNAMRO (mipomersen)	Kynamro – MANUAL PA
NIACIN			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	niacin ER NIACOR (niacin)	NIASPAN (niacin)	
PCSK-9 INHIBITOR			
	PRALUENT (alirocumab) REPATHA (evolocumab)	LEQVIO (inclisiran)	<p style="color: red; text-align: center;">Leqvio</p> <ul style="list-style-type: none"> Requires clinical review <p style="color: red; text-align: center;">Praluent - MANUAL PA</p> <p style="color: red; text-align: center;">Repatha - MANUAL PA</p>
LIPOTROPICS, STATINS ^{DUR+}			
STATINS			
	atorvastatin lovastatin pravastatin rosuvastatin simvastatin	ALTOPREV (lovastatin) ATORVALIQ SUSPENSION (atorvastatin) CRESTOR (rosuvastatin) EZALLOR SPRINKLE (rosuvastatin) FLOLIPID (simvastatin) fluvastatin ER fluvastatin LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) pitavastatin ^{NR} PRAVACHOL (pravastatin) ZOCOR (simvastatin) ZYPITAMAG (pitavastatin)	<p style="color: red; text-align: center;">Minimum Age Limit</p> <ul style="list-style-type: none"> 10 years – Atorvaliq suspension <p style="color: red; text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred statin or statin combination agents in the past 6 months OR <ul style="list-style-type: none"> 90 consecutive days on the requested agent in the past 105 days <p style="color: red; text-align: center;">Simvastatin 80mg</p> <ul style="list-style-type: none"> Daily doses of 80mg and greater require clinical review

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
STATIN COMBINATIONS			
	ezetimibe/simvastatin SIMCOR (simvastatin/niacin)	ADVICOR (lovastatin/niacin) atorvastatin/amlodipine CADUET (atorvastatin/amlodipine) LIPTRUZET (atorvastatin/ezetimibe) VYTORIN (simvastatin/ezetimibe)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred statin or statin combination agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
MISCELLANEOUS BRAND/GENERIC			
EPINEPHRINE			
	epinephrine autoinject pens (labeler 49502) SYMJEPI (epinephrine)	ADRENACLICK (epinephrine) AUVI-Q (epinephrine) EPINEPHRINE SNAP EMS KIT (epinephrine) EPIPEN (epinephrine) EPIPEN JR (epinephrine)	<p style="color: red;">Quantity Limit</p> <ul style="list-style-type: none"> • 2 kits/31 days
MISCELLANEOUS			
	alprazolam carglumic acid hydroxyzine hcl syrup hydroxyzine hcl tablets hydroxyzine pamoate megestrol suspension 625mg/5mL REVLIMID (lenalidomide)	alprazolam ER CAMZYOS (mavacamten) CARBAGLU (carglumic acid) EVRYSDI (risdiplam) INPEFA (sotagliflozin) ^{NR} KORLYM (mifepristone) lenalidomide MEGACE ES (megestrol) VERQUVO (vericiguat) VISTARIL (hydroxyzine pamoate)	<p style="color: red;">Alprazolam ER CUMULATIVE quantity limit</p> <ul style="list-style-type: none"> • 31 tablets/31 days <p style="color: red;">Evrysdi - MANUAL PA</p>
ALLERGEN EXTRACT IMMUNOTHERAPY			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		GRASTEK ORALAIR PALFORZIA RAGWITEK	
	SUBLINGUAL NITROGLYCERIN		
	nitroglycerin lingual 12gm nitroglycerin sublingual NITROLINGUAL PUMPSPRAY (nitroglycerin) 12gm NITROSTAT SUBLINGUAL (nitroglycerin)	nitroglycerin lingual 4.9gm NITROLINGUAL (nitroglycerin) 4.9gm NITROMIST (nitroglycerin)	
MOVEMENT DISORDER AGENTS ^{DUR+}			
	AUSTEDO (deutetrabenazine) AUSTEDO XR (deutetrabenazine) INGREZZA (valbenazine) tetrabenazine (all labelers except those listed as non-preferred)	tetrabenazine (labeler 47335, 51224, 60505, 68180, 686820) XENAZINE (tetrabenazine)	<p>Austedo and Austedo XR</p> <ul style="list-style-type: none"> • Documented diagnosis of Huntington's chorea OR • Documented diagnosis of tardive dyskinesia AND • 90 days therapy with Austedo or Austedo XR in the past 105 days OR • MANUAL PA <p>Ingrezza</p> <ul style="list-style-type: none"> • Documented diagnosis of Huntington's chorea OR • Documented diagnosis of tardive dyskinesia AND • 90 days therapy with Ingrezza in the past 105 days OR • MANUAL PA

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
MULTIPLE SCLEROSIS AGENTS ^{DUR+}			
	AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE 20mg (glatiramer) dalfampridine dimethyl fumarate fingolimod GILENYA (fingolimod) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a) teriflunomide TYSABRI (natalizumab)	AMPYRA (dalfampridine) AUBAGIO (teriflunomide) BAFIERTAM (monomethyl fumarate) BRIUMVI (ublituximab) COPAXONE 40mg (glatiramer) EXTAVIA (interferon beta-1b) glatiramer GLATOPA (glatiramer) KESIMPTA (ofatumumab) MAVENCLAD (cladribine) MAYZENT (siponimod) OCREVUS (ocrelizumab) PLEGRIDY (interferon beta-1a) PONVORY (ponesimod) TASCENSO ODT (fingolimod) TECFIDERA (dimethyl fumarate) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)	<p>All Agents</p> <ul style="list-style-type: none"> Documented diagnosis of multiple sclerosis <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months OR 3 claims with the requested agent in the last 105 days <p>Kesimpta, Ponvory, Tascenso ODT, and Zeposia</p> <ul style="list-style-type: none"> Requires clinical review <p>Mavenclad – MANUAL PA</p> <p>Mayzent – MANUAL PA</p> <p>Ocrevus – MANUAL PA</p>
MUSCULAR DYSTROPHY AGENTS			
	EMFLAZA (deflazacort)	AGAMREE (vamorolone) ^{NR} AMONDYS 45 (casimersen) deflazacort ^{NR} ELEVIDYS (delandistrogene moxeparavec-rokl) EXONDYS 51 (etepirsen) VILTEPSO (viltolarsen) VYONDYS 53 (golodirsen)	<p>Emflaza – Clinical Review</p> <p>Exondys – MANUAL PA</p> <p>Viltepso – MANUAL PA</p> <p>Vyondys – MANUAL PA</p>

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
NSAIDS ^{DUR+}			
NON-SELECTIVE			
	diclofenac EC diclofenac IR diclofenac SR etodolac IR tab flurbiprofen ibuprofen ibuprofen suspension ^{OTC} indomethacin ketoprofen ketorolac nabumetone naproxen 250mg and 500mg naproxen suspension piroxicam sulindac	ADVIL (ibuprofen) ANAPROX (naproxen) CAMBIA (diclofenac potassium) CATAFLAM (diclofenac) DAYPRO (oxaprozin) diclofenac potassium etodolac cap etodolac tab SR FELDENE (piroxicam) FENORTHO (fenoprofen) fenoprofen INDOCIN capsules, suspension & suppositories (indomethacin) indomethacin cap ER indomethacin suspension ^{NR} ketoprofen ER LOFENA(diclofenac potassium) meclofenamate mefenamic acid NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) naproxen 275mg and 550mg NUPRIN (ibuprofen) oxaprozin PONSTEL (mefenamic acid) PROFENO (fenoprofen)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months <p style="color: red;">Quantity Limit</p> <ul style="list-style-type: none"> • 20 tablets/31 days – ketorolac tablets

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		RELAFEN DS (nabumetone) SPRIX NASAL SPRAY (ketorolac) TIVORBEX (indomethacin) tolmetin VOLTAREN XR (diclofenac) ZIPSOR (diclofenac) ZORVOLEX (diclofenac)	<p style="color: red; text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred non-selective or NSAID/GI protectant combination agents in the past 6 months <p style="color: red; text-align: center;">Non-Preferred Criteria – COX II</p> <ul style="list-style-type: none"> • Documented diagnosis of Osteoarthritis, Rheumatoid Arthritis, Familial Adenomatous Polyposis, or Ankylosing Spondylitis AND • 90 consecutive days on the requested agent in the past 105 days OR • Have tried 1 preferred COX-II Selective and 1 preferred Non-Selective Agent OR • Have tried 1 preferred COX-II Selective agent and a documented diagnosis of GI Bleed, GERD, PUD, GI Perforation, or Coagulation Disorder
	NSAID/GI PROTECTANT COMBINATIONS	ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol DUEXIS (ibuprofen/famotidine) VIMOVO (naproxen/esomeprazole)	
	COX II SELECTIVE		
	meloxicam	CELEBREX (celecoxib) celecoxib ELYXYB (celecoxib) MOBIC (meloxicam) NULOX (meloxicam) QMIIZ ODT (meloxicam) VIVLODEX (meloxicam)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<p>Elyxyb</p> <ul style="list-style-type: none"> Requires clinical review 			
<p>OPHTHALMIC ANTIBIOTICS</p>			
	bacitracin/neomycin/gramicidin bacitracin/polymyxin ciprofloxacin erythromycin GENTAK Ointment (gentamicin) gentamicin ILOTYCIN (erythromycin) moxifloxacin ofloxacin polymyxin/trimethoprim tobramycin	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin) BLEPH-10 (sulfacetamide) CILOXAN Ointment (ciprofloxacin) CILOXAN Solution (ciprofloxacin) GARAMYCIN (gentamicin) gatifloxacin levofloxacin MOXEZA (moxifloxacin) NATACYN (natamycin) neomycin/bacitracin/polymyxin b NEO-POLYCIN (neomy/baci/polymyxin b) NEOSPORIN (bacitracin/neomycin/gramicidin) (oxy-tcn/polymyx sul) OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide TOBEX drops (tobramycin) TOBEX ointment (tobramycin) VIGAMOX (moxifloxacin) ZYMAR (gatifloxacin) ZYMAXID (gatifloxacin)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIBIOTIC STEROID COMBINATIONS			
	BLEPHAMIDE (sulfacetamide/prednisolone) drops, oint neomycin/bacitracin/polymyxin/hc ointment neomycin/polymyxin/dexamethasone PRED-G (gentamicin/prednisolone) drops, oint sulfacetamide/prednisolone tobramycin/dexamethasone suspension TOBRADEX OINTMENT (tobramycin/dexamethasone) ZYLET (loteprednol/tobramycin)	gatifloxacin/prednisolone MAXITROL (neomycin/polymyxin/dexamethasone) neomycin/polymyxin/gramicidin neomycin/polymyxin/hydrocortisone TOBRADEX ST SUSPENSION (tobramycin/dexamethasone) TOBRADEX SUSPENSION (tobramycin/dexamethasone)	
OPHTHALMIC ANTI-INFLAMMATORIES ^{DUR+}			
	dexamethasone diclofenac difluprednate FLAREX (fluorometholone) fluorometholone flurbiprofen FML FORTE (fluorometholone) FML SOP (fluorometholone) ketorolac MAXIDEX (dexamethasone) prednisolone acetate prednisolone NA phosphate PRED MILD (prednisolone) VEXOL (rimexolone)	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac) BROMDAY (bromfenac) bromfenac BROMSITE (bromfenac) DUREZOL (difluprednate) FML (fluorometholone) ILEVRO (nepafenac) INVELTYS (loteprednol etabonate) LOTEMAX (loteprednol) LOTEMAX SM (loteprednol) loteprednol etabonate OCUFEN (flurbiprofen) OMNIPRED (prednisolone)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		NEVANAC (nepafenac) PRED FORTE (prednisolone) PROLENSA (bromfenac) VOLTAREN (diclofenac)	
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS ^{DUR+}			
	ALREX (loteprednol) azelastine cromolyn ketotifen ^{OTC} olopatadine 0.1% olopatadine 0.2% ZADITOR (ketotifen) ^{OTC}	ALOCRI (nedocromil) ALOMIDE (Iodoxamide) BEPREVE (bepotastine) epinastine LASTACRAFT (alcaftadine) PATADAY (olopatadine) PATANOL (olopatadine) PAZEO (olopatadine) VERKAZIA (cyclosporine) ZERVIA (cetirizine)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months <p style="color: red;">Verkazia</p> <ul style="list-style-type: none"> Requires clinical review
OPHTHALMIC, DRY EYE AGENTS			
	RESTASIS droperette (cyclosporine)	CEQUA (cyclosporine 0.09%) EYSUVIS (loteprednol etabonate) MIEBO (perfluorohexyloctane) RESTASIS Multidose (cyclosporine) TYRVAYA (varaencline) Nasal VEVYE (cyclosporine ophthalmic solution) XIIDRA (lifitegrast) ^{Dur +}	<p style="color: red;">Minimum Age Limit</p> <ul style="list-style-type: none"> 16 years – Restasis 17 years – Xiidra 18 years – Cequa, Miebo, Vevye <p style="color: red;">Quantity Limit</p> <ul style="list-style-type: none"> 2 ml/31 days – Vevye 3 ml/31 days – Miebo 5.5 mL/31 days – Restasis Multidose

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<ul style="list-style-type: none"> • 60 units/31 days – Cequa, Restasis droperette, Xiidra • Eysuvis, Miebo and Tyrvaya <ul style="list-style-type: none"> • Requires clinical review • Non-Preferred Criteria <ul style="list-style-type: none"> • History of 4 claims for Restasis in the past 6 months
OPHTHALMIC, GLAUCOMA AGENTS ^{DUR+}			
BETA BLOCKERS			
	BETIMOL (timolol) carteolol ISTALOL (timolol) levobunolol metipranolol timolol drops 0.25%, 0.5%	BETAGAN (levobunolol) betaxolol BETOPTIC S (betaxolol) OPTIPRANOLOL (metipranolol) timolol gel timolol daily drop 0.5% (generic Istalol) TIMOPTIC (timolol) TIMOPTIC XE (timolol)	<ul style="list-style-type: none"> • Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days • Minimum Age Limit <ul style="list-style-type: none"> • 18 years - Iyuzeh
CARBONIC ANHYDRASE INHIBITORS			
	dorzolamide	AZOPT (brinzolamide) TRUSOPT (dorzolamide)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
COMBINATION AGENTS			
	COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol)	
PARASYMPATHOMIMETICS			
	pilocarpine	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) ISOPTO CARPINE (pilocarpine) PHOSPHOLINE IODIDE (echothiophate iodide) PILOPINE HS (pilocarpine)	
PROSTAGLANDIN ANALOGS			
	latanoprost	bimatoprost IYUZEH (latanoprost) LUMIGAN (bimatoprost) TRAVATAN Z (travoprost) travoprost VYZULTA (latanoprostene bunod) XALATAN (latanoprost) XELPROS (latanoprost) ZIOPTAN (tafluprost)	
RHO KINASE INHIBITORS/COMBINATIONS			
	RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)		
SYMPATHOMIMETICS			
	ALPHAGAN P 0.1% (brimonidine) ALPHAGAN P 0.15% (brimonidine) brimonidine 0.2%	brimonidine 0.15% brimonidine 0.1% dipivefrin	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		PROPINE (dipivefrin)	
OPIATE DEPENDENCE TREATMENTS			
DEPENDENCE			
	buprenorphine/naloxone tablets naltrexone tablets SUBOXONE FILM(buprenorphine/naloxone) ^{DUR+}	BRIXADI (buprenorphine) buprenorphine tablets buprenorphine/naloxone films LUCEMYRA (lofexidine) PROBUPHINE (buprenorphine) SUBLOCADE (buprenorphine) VIVITROL (naltrexone) ZUBSOLV (buprenorphine/naloxone)	Buprenorphine/naloxone provider summary found here Probuphine – MANUAL PA Sublocade – MANUAL PA Vivitrol - MANUAL PA
TREATMENT			
	KLOXXADO (naloxone) naloxone injection NARCAN NASAL SPRAY (naloxone) OPVEE (nalmefene) ZIMHI (naloxone)	EVZIO (naloxone)	
OTIC ANTIBIOTICS			
	CIPRODEX (ciprofloxacin/dexamethasone) CIPRO HC (ciprofloxacin/hydrocortisone) ^{Age Edit} CORTISPORIN-TC (colistin/neomycin/hydrocortisone) neomycin/polymyxin/hydrocortisone ofloxacin	ciprofloxacin ciprofloxacin/dexamethasone ciprofloxacin/fluocinolone DERMOTIC (fluocinolone) FLAC OIL DROP (fluocinolone oil) hydrocortisone/acetic acid drop fluocinolone oil OTIPRIO (ciprofloxacin)	Maximum Age Limit • 9 years - Cipro HC

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		OTOVEL (ciprofloxacin/fluocinolone)	
PANCREATIC ENZYMES ^{DUR+}			
	CREON (pancreatin) ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PERTZYE (pancrelipase) VIOKACE (pancrelipase)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
PARATHYROID AGENTS			
	calcitriol ergocalciferol paricalcitol ROCALTROL (calcitriol) ZEMPLAR (paricalcitol)	cinacalcet doxercalciferol DRISDOL (ergocalciferol) HECTOROL (doxercalciferol) NATPARA (parathyroid hormone) RAYALDEE (calcifediol) SENSIPAR (cinacalcet)	
PHOSPHATE BINDERS			
	calcium acetate ELIPHOS (calcium acetate) PHOSLYRA (calcium acetate) sevelamer carbonate tablets	AURYXIA (ferric citrate) FOSRENOL (lanthanum) lanthanum PHOSLO (calcium acetate) RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate) sevelamer carbonate powder packets sevelamer HCl VELPHORO (sucroferric oxyhydroxide) XPHOZAH (tenapanor)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PLATELET AGGREGATION INHIBITORS ^{DUR+}			
	BRILINTA (ticagrelor) cilostazol clopidogrel dipyridamole dipyridamole/aspirin pentoxifylline prasugrel	DURLAZA ER (aspirin) EFFIENT (prasugrel) omeprazole/aspirin PERSANTINE (dipyridamole) PLAVIX (clopidogrel) PLETAL (cilostazol) ticlopidine YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar)	Zontivity – <u>MANUAL PA</u> Non-Preferred Criteria • Documented diagnosis AND • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
PLATELET STIMULATING AGENTS			
	NPLATE (romiplostim) PROMACTA (eltrombopag olamine)	ALVAIZ (eltrombopag) ^{NR} DOPTELET (avatrombopag maleate) MULPLETA (lusutrombopag) PROMACTA powder pack (eltrombopag olamine) TAVALISSE (fostamatinib disodium)	
POTASSIUM REMOVING AGENTS			
	LOKELMA (sodium zirconium cyclosilicate)	sodium polystyrene sulfonate SPS ENEMA (sodium polystyrene sulfonate) SPS SUSPENSION (sodium polystyrene sulfonate) VELTASSA (patiomer calcium sorbitex)	Lokelma • Requires clinical review
PRENATAL VITAMINS			
	COMPLETE NATAL DHA COMPLETENATE CHEW Tablet M-NATAL PLUS Tablet NESTABS DHA COMBO PKG NIVA PLUS Tablet PNV 29-1 Tablet	Products not listed are assumed to be Non-Preferred.	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	PNV 95/Fe/FA Tablet (labeler 00536) PNV 137/Fe/FA Tablet (labeler 009040) PNV-DHA Softgel Capsule PRENATAL VITAMIN PLUS LOW IRON Tablet PRENATAL PLUS IRON/FA PREPLUS Ca/Fe27/FA 1 Tablet PRETAB Tablet SE-NATAL19 CHEW Tablet SE-NATAL19 Tablet THRIVITE RX Tablet TRINATAL Rx 1 Tablet VIRT C DHA Capsule VIRT-NATE DHA Softgel Capsule VP-PNV-DHA Softgel Capsule WESTAB PLUS Tablet		
PSEUDOBULBAR AFFECT AGENTS^{DUR+}			
		NUEDEXTA (dextromethorphan/quinidine)	Non-Preferred Criteria <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days OR • Documented diagnosis of Pseudobulbar Affect
PULMONARY ANTIHYPERTENSIVES^{DUR+}			
ENDOTHELIN RECEPTOR ANTAGONIST			
	ambrisentan (all labelers except those listed as non-preferred) bosentan tablets	ambrisentan (labeler 42794, 47335, 498840) LETAIRIS (ambrisentan)* OPSUMIT (macitentan) TRACLEER (bosentan)	All PAH Agents <ul style="list-style-type: none"> • Documented diagnosis of pulmonary hypertension Non-Preferred Criteria

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<ul style="list-style-type: none"> • Have tried 1 preferred PAH agent in the past 6 months OR <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days
PDE5's			
	sildenafil (generic Revatio) tablet tadalafil	ADCIRCA (tadalafil) LIQREV (sildenafil) suspension REVATIO (sildenafil) tablet REVATIO (sildenafil) suspension sildenafil (generic Revatio) suspension TADLIQ (tadalafil) suspension	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 1 preferred PAH agent in the past 6 months OR <ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days <p style="color: red;">Revatio suspension</p> <ul style="list-style-type: none"> • < 12 years of age AND • Documented diagnosis of Pulmonary Hypertension, Patent Ductus Arteriosus, or Persistent Fetal Circulation or history of heart transplant OR • 90 consecutive days on the requested agent in the past 105 days <p style="color: red;">Revatio tablets</p> <ul style="list-style-type: none"> • < 1 year of age AND • Documented diagnosis of Pulmonary Hypertension, Patent Ductus Arteriosus, or Persistent Fetal Circulation OR

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<ul style="list-style-type: none"> • 90 consecutive days on the requested agent in the past 105 days OR • > 1 years of age AND • Documented diagnosis of Pulmonary Hypertension
PROSTACYCLINS			
		ORENITRAM ER (treprostinil) TYVASO (treprostinil) VENTAVIS (iloprost)	Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 1 preferred PAH agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
SELECTIVE PROSTACYCLIN RECEPTOR AGONISTS			
		UPTRAVI (selexipag)	Non-Preferred Criteria <ul style="list-style-type: none"> • Have tried 1 preferred PAH agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
SOLUBLE GUANYLATE CYCLASE STIMULATORS			
		ADEMPAS (riociguat)	Adempas <ul style="list-style-type: none"> • Documented WHO Group 1 diagnosis of secondary pulmonary arterial hypertension OR • Documented WHO Group 4 diagnosis of pulmonary hypertension due to chronic thrombotic embolic disease OR

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<ul style="list-style-type: none"> • Documented diagnosis of pulmonary hypertension AND • Have tried 1 preferred PAH agent in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days
ROSACEA TREATMENTS			
	metronidazole (cream, gel, lotion)	AVAR (sulfacetamide sodium/sulfur) FINACEA (azelaic acid) FINACEA FOAM (azelaic acid) METROCREAM (metronidazole cream) METROGEL (metronidazole gel) METROLOTION (metronidazole lotion) MIRVASO (brimonidine) NORITATE (metronidazole) OVACE (sulfacetamide sodium) RHOFADE (oxymetazoline HCl) ROSULA (sodium sulfacetamide/sulfur) sodium sulfacetamide/sulfur (cleanser, pads, suspension) SOOLANTRA (ivermectin) SUMADAN (sodium sulfacetamide/sulfur wash) SUMAXIN (sodium sulfacetamide/sulfur pads) SUMAXIN TS (sodium sulfacetamide/sulfur suspension) ZILXI AEROSOL (minocycline)	Topical Sulfonamides used for Rosacea will require a manual PA for ≥21 years. Other labeled indications are limited to <21 years.
SEDATIVE HYPNOTICS			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BENZODIAZEPINES ^{DUR+}			
	estazolam flurazepam temazepam (15mg and 30mg)	DALMANE (flurazepam) DORAL (quazepam) HALCION (triazolam) quazepam RESTORIL (temazepam) temazepam (7.5mg and 22.5mg) triazolam	Single source benzodiazepines and barbiturates are NOT covered – NO PA's will be issued for these drugs. MS DOM Opioid Initiative <ul style="list-style-type: none"> Concomitant use of Opioids and Benzodiazepines Criteria details found here Quantity Limit – CUMULATIVE Quantity limit per rolling days for all strengths. <i>DUR+ will allow an early refill override for one dose or therapy change per year.</i> <ul style="list-style-type: none"> 31 units/31 days - all strengths Triazolam – CUMULATIVE Quantity limit per rolling days for all strengths <ul style="list-style-type: none"> 10 units/31 days 60 units/365 days
OTHERS ^{DUR+}			
	zaleplon zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (sovorexant) DAYVIGO (lemborexant) doxepin 3mg, 6mg	Maximum Age Limit <ul style="list-style-type: none"> 64 years – zolpidem 7.5 mg, zolpidem 10 mg, zolpidem 12.5 mg Quantity Limit – CUMULATIVE

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon) INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ramelteon ROZEREM (ramelteon) QUVIVIQ (daridorexant) SILENOR (doxepin) SONATA (zaleplon) zolpidem ER zolpidem SL ZOLPIMIST (zolpidem)	<p>Quantity limit per rolling days for all strengths. <i>DUR+ will allow an early refill override for one dose or therapy change per year.</i></p> <ul style="list-style-type: none"> • 31 units/31 days • 1 canister/31 days – Zolpimist & male • 1 canister/62 days – Zolpimist & female • 1 bottle/31 days (48 ml or 158 ml) – Hettioz liquid <p>Gender and Dose Limit for zolpidem</p> <ul style="list-style-type: none"> • Female – Ambien 5mg, Ambien CR 6.25mg, Intermezzo 1.75 mg • Male – all zolpidem strengths <p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred agents in the past 6 months <p>Hettioz capsules</p> <ul style="list-style-type: none"> • Documented diagnosis of circadian rhythm sleep disorder AND • Documented diagnosis indicating total blindness of the patient OR • Documented diagnosis of Magen-Smith syndrome <p>Hettioz liquid</p>

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
			<ul style="list-style-type: none"> Documented diagnosis of Smith-Magenis syndrome AND 3 - 15 years of age 	
SELECT CONTRACEPTIVE PRODUCTS				
INJECTABLE CONTRACEPTIVES				
	medroxyprogesterone acetate IM	DEPO-PROVERA IM (medroxyprogesterone acetate) DEPO-SUBQ PROVERA 104 (medroxyprogesterone acetate)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> 1 claim with the requested agent in the past 105 days 	
INTRAVAGINAL CONTRACEPTIVES				
	ANNOVERA (segesterone/ethinyl estradiol) etonogestrel/ethinyl estradiol NUVARING (etonogestrel/ethinyl estradiol)	PHEXXI (lactic acid, citric acid, potassium bitartrate)		
ORAL CONTRACEPTIVES DUR+				
	ALL CONTRACEPTIVES ARE PREFERRED EXCEPT FOR THOSE SPECIFICALLY INDICATED AS NON-PREFERRED	AMETHIA (levonorgestrel/ethinyl estradiol) AMETHYST (levonorgestrel/ethinyl estradiol) BALCOLTRA (levonorgestrel/ethinyl estradiol/iron) BEYAZ (ethinyl estradiol / drospirenone/levomefolate) CAMRESE (levonorgestrel/ethinyl estradiol) CAMRESE LO (levonorgestrel/ethinyl estradiol) GENERESS FE (norethindrone/ethinyl estradiol/fe) GIANVI (ethinyl estradiol/drospirenone) JOLESSA (levonorgestrel/ethinyl estradiol) levonorgestrel/ethinyl estradiol		

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		LO LOESTRIN FE (norethindrone/ethinyl estradiol) LOESTRIN (norethindrone acetate/ethinyl estradiol) LOESTRIN FE (norethindrone/ethinyl estradiol/iron) MINASTRIN 24 FE (norethindrone/ethinyl estradiol/iron) NATAZIA (estradiol valerate/dienogest) NEXTSTELLIS (drospirenone/estetrol) OCELLA (ethinyl estradiol/drospirenone) SAFYRAL (ethinyl estradiol/drospirenone/levomefolate) SIMPESE (levonorgestrel/ethinyl estradiol) TAYTULLA (norethindrone/ethinyl estradiol/iron) TYDEMY (ethinyl estradiol/drospirenone/levomefolate calcium) YASMIN (ethinyl estradiol/drospirenone) YAZ (ethinyl estradiol/drospirenone)	
TRANSDERMAL CONTRACEPTIVES			
	XULANE (norgestromin and ethinyl estradiol)	ZAFEMY (norgestromin and ethinyl estradiol) TWIRLA (levonorgestrel and ethinyl estradiol) norgestromin and ethinyl estradiol ^{NR}	
SICKLE CELL AGENTS			
	DROXIA (hydroxyurea) hydroxyurea	ADAKVEO (crizanlizumab) ENDARI (glutamine) HYDREA (hydroxyurea)	Endari – MANUAL PA Oxbryta – MANUAL PA

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		OXBRYTA (voxelotor) SIKLOS (hydroxyurea)	
SKELETAL MUSCLE RELAXANTS ^{DUR+}			
	baclofen chlorzoxazone cyclobenzaprine 5mg, 10mg methocarbamol tizanidine tablets	AMRIX (cyclobenzaprine ER) baclofen suspension (generic FLEQSUVY) carisoprodol carisoprodol compound cyclobenzaprine 7.5mg, 15mg cyclobenzaprine ER DANTRIUM (dantrolene) dantrolene FLEQSUVY (baclofen) FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) LORZONE (chlorzoxazone) LYVISPAH (baclofen granules) metaxalone NORGESIC FORTE (orphenadrine) orphenadrine orphenadrine compound orphenadrine ER PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) tizanidine capsules ZANAFLEX (tizanidine)	<p>Non-Preferred Agents</p> <ul style="list-style-type: none"> Documented diagnosis for an approvable indication AND Have tried 2 different preferred agents in the past 6 months <p>Baclofen granules, solution, and suspension</p> <ul style="list-style-type: none"> Requires clinical review <p>Carisoprodol</p> <ul style="list-style-type: none"> Documented diagnosis of acute musculoskeletal condition AND NO history with meprobamate in the past 90 days AND 1 claim for cyclobenzaprine in the past 21 days OR a documented intolerance to cyclobenzaprine AND <ul style="list-style-type: none"> Quantity Limit <ul style="list-style-type: none"> 18 tablets - to allow tapering off 84 tablets/6 months <p>Carisoprodol with codeine</p> <ul style="list-style-type: none"> Requires clinical review
SMOKING DETERRENT			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
NICOTINE TYPE			
	nicotine gum ^{OTC} nicotine lozenge ^{OTC} nicotine mini lozenge ^{OTC} nicotine patch ^{OTC}	NICODERM CQ PATCH ^{OTC} NICORETTE GUM ^{OTC} NICORETTE LOZENGE ^{OTC} NICORETTE MINI LOZENGE ^{OTC} NICOTROL INHALER CARTRIDGE NICOTROL NASAL SPRAY	
NON-NICOTINE TYPE			
	bupropion ER CHANTIX (varenicline) varenicline	ZYBAN (bupropion)	<p style="color: red;">Minimum Age Limit - Chantix</p> <ul style="list-style-type: none"> • 18 years <p style="color: red;">Quantity Limit</p> <ul style="list-style-type: none"> • 336 tablets/year – Chantix 0.5mg, 1mg tablets and continuing pack • 2 treatment courses/year – Chantix Starter Pack
STEROIDS (Topical) ^{DUR+}			
LOW POTENCY			
	CAPEX (fluocinolone) desonide hydrocortisone cr, oint, soln.	alclometasone DERMA-SMOOTH-FS (fluocinolone) DESONATE (desonide) DESOWEN (desonide) fluocinolone oil hydrocortisone lotion PEDIACARE HC (hydrocortisone) PEDIADERM (hydrocortisone) VERDESO (desonide)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred low potency agents in the past 6 months

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MEDIUM POTENCY			
	flucinolone hydrocortisone mometasone cr, oint. prednicarbate cr PANDEL (hydrocortisone probutate)	betamethasone valerate foam CLODERM (clocortolone) CUTIVATE (fluticasone) DERMATOP (prednicarbate) ELOCON (mometasone) fluticasone LUXIQ (betamethasone) mometasone solution MOMEXIN (mometasone) prednicarbate oint SYNALAR (flucinolone)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred medium potency agents in the past 6 months
HIGH POTENCY			
	amcinonide cr, lot betamethasone dipropionate cr, gel, lotion betamethasone valerate cr, lotion, oint. flucinolone triamcinolone	amcinonide oint betameth diprop/prop gly cr, lot, oint betamethasone dipropionate oint. BETA-VAL (betamethasone valerate) desoximetasone diflorasone DIPROLENE AF (betamethasone diprop/prop gly) ELOCON (mometasone) flucinolone HALOG (halcinonide) KENALOG (triamcinolone) PEDIADERM TA (triamcinolone) SERNIVO (betamethasone dipropionate) TOPICORT (desoximetasone)	<p>Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred high potency agents in the past 6 months

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		TRIANEX (triamcinolone) VANOS (fluocinonide)	
VERY HIGH POTENCY			
	clobetasol lotion clobetasol shampoo, spray clobetasol propionate cream clobetasol propionate ointment halobetasol cream halobetasol ointment	BRYHALI (halobetasol) clobetasol emollient clobetasol propionate foam, ge CLOBEX (clobetasol) DIPROLENE (betamethasone diprop/prop gly) DUOBRII LOTION (halobetasol prop/tazarotene) halobetasol foam IMPEKLO (clobetasol) LEXETTE (halobetasol propionate) OLUX (clobetasol) OLUX-E (clobetasol) TEMOVATE Cream (clobetasol propionate) TEMOVATE Ointment (clobetasol propionate) TOVET Foam (clobetasol) ULTRAVATE Lotion (halobetasol)	<p style="color: red; text-align: center;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Have tried 2 different preferred very high potency agents in the past 6 months
STIMULANTS AND RELATED AGENTS ^{DUR+}			
SHORT-ACTING			
	amphetamine salt combination dexamethylphenidate IR dextroamphetamine IR methylphenidate IR methylphenidate solution PROCENTRA (dextroamphetamine)	ADDERALL (amphetamine salt combination) amphetamine sulfate (generic EVEKO) DESOXYN (methamphetamine) dextroamphetamine/amphetamine ER ^{NR} dextroamphetamine solution EVEKEO (amphetamine) EVEKEO ODT (amphetamine)	<p style="color: red; text-align: center;">Minimum Age Limit</p> <ul style="list-style-type: none"> • 3 years - Adderall, Evekeo, Procentra, Zenedi • 6 years – Desoxyn, Evekeo ODT, Focalin, Methylin <p style="color: red; text-align: center;">Maximum Age Limit</p>

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		FOCALIN (dexamethylphenidate) methamphetamine METHYLIN solution (methylphenidate) methylphenidate chewable RITALIN (methylphenidate) ZENZEDI (dextroamphetamine)	<ul style="list-style-type: none"> • 18 years – Evekeo ODT <p style="text-align: center;">Quantity Limit</p> <p>Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> • 62 tablets/31 days – Adderall, Desoxyn, Evekeo, Focalin, Methylin, Zenzedi • 310 mL/31 days – Methylin solution, Procentra <p>Documented diagnosis of ADHD ALL Short Acting Agents</p> <p>Non-Preferred Criteria ADD/ADHD</p> <ul style="list-style-type: none"> • Documented diagnosis of ADD/ADHD AND • Have tried 2 different preferred Short Acting agents in the past 6 months OR • 1 claim for a 30-day supply with the requested agent in the past 105 days <p>Documented diagnosis of narcolepsy – ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN, ZENZEDI</p>

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024

Version 2024_5

Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	LONG-ACTING		
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination ER CONCERTA (methylphenidate) dexmethylphenidate ER dextroamphetamine ER DYANAVEL XR SUSPENSION(amphetamine) lisdexamfetamine (generic Vyvanse) lisdexamfetamine (generic Vyvanse Chewable) methylphenidate CD (generic Metadate CD) methylphenidate ER (generic Concerta) methylphenidate ER Tabs (generic Ritalin SR) methylphenidate ER/LA Caps (generic Ritalin LA) QUILLICHEW (methylphenidate) QUILLIVANT XR (methylphenidate)	ADHANSIA XR (methylphenidate) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSPENSION (amphetamine) amphetamine susp 24 hr (generic ADZENYS ER) APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphen/dexmethylphen) COTEMPLA XR-ODT (methylphenidate) DAYTRANA (methylphenidate) DEXEDRINE (dextroamphetamine) DYANAVEL XR tablet(amphetamine) FOCALIN XR (dexmethylphenidate) JORNAY PM (methylphenidate) methylphenidate ER caps (generic Aptensio XR) methylphenidate ER (generic Relexxi) methylphenidate patch (generic Daytrana) MYDAYIS (amphetamine salt combination) RELEXXI (methylphenidate) RITALIN LA (methylphenidate) RITALIN SR (methylphenidate) VYVANSE (lisdexamfetamine)* VYVANSE CHEWABLE (lisdexamfetamine)* XELSTRYM patch (dextroamphetamine)	<p style="text-align: center;">Minimum Age Limit</p> <ul style="list-style-type: none"> • 6 years – Adderall XR, Adhansia XR, Adzenys ER Suspension, Adzenys XR ODT, Aptensio XR, Azstarys, Concerta, Cotempla XR ODT, Daytrana, Dexedrine, Dyanavel XR Focalin XR, Jornay PM, Metadate, CD, methylphenidate ER 72mg, Quillichew, Quillivant XR, Relexxii, Ritalin LA, Vyvanse, Xelstrym • 13 years – Mydayis • 16 years – Provigil • 18 years – Nuvigil, Sunosi <p style="text-align: center;">Maximum Age Limit</p> <ul style="list-style-type: none"> • 18 years – Cotempla XR ODT, Daytrana <p style="text-align: center;">Vyvanse</p> <ul style="list-style-type: none"> • Documented diagnosis of binge eating disorder OR • Documented diagnosis of ADD/ADHD <p style="text-align: center;">Quantity Limit</p> <p>Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> • 31 tablets/31 days – Adderall XR, Adhansia XR, Adzenys XR ODT,

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<p>Aptensio XR, Azstarys, Concerta 18, 27, & 54 mg, Cotempla XR-ODT 8.6 mg, Daytrana, Dexedrine Spansule, Dyanavel XR Tablet, Focalin XR, Jornay PM, Metadate CD, Methylin ER, Mydayis 37.5mg & 50mg, Nuvigil 150, 200 & 250 mg, Provigil 200mg, Quillichew, Relexxii, Ritalin LA & SR, Vyvanse, Sunosi, Xelstrym</p> <ul style="list-style-type: none"> • 46.5 tablets/31 days – Provigil 100 mg • 62 tablets/31 days – Concerta 36mg, Cotempla XR-ODT 17.3 & 25.9 mg, Nuvigil 50mg • 248 mL/31 days – Dyanavel XR Suspension • 372 mL/31 days – Quilivant XR <p>Documented diagnosis of ADHD ALL Long-Acting Agents</p> <p>Non-Preferred Criteria ADD/ADHD</p> <ul style="list-style-type: none"> • Documented diagnosis of ADD/ADHD AND • Have tried 2 different preferred Long-Acting agents in the past 6 months OR • 1 claim for a 30-day supply with the requested agent in the past 105 days

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	NARCOLEPSY		
	armodafinil modafinil SUNOSI (solriamfetol)	LUMRYZ (sodium oxybate) ^{NR} NUVIGIL (armodafinil) PROVIGIL (modafinil) sodium oxybate WAKIX (pitolisant) XYREM (sodium oxybate) XYWAV (calcium, magnesium, potassium and sodium oxybates)	<p>Documented diagnosis of narcolepsy – ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL, PROVIGIL, QUILLICHEW, QUILLIVANT XR, RITALIN LA, SUNOSI</p> <p>Non-Preferred Criteria narcolepsy</p> <ul style="list-style-type: none"> • Documented diagnosis of narcolepsy AND • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months AND • 1 different preferred Long-Acting agent indicated for narcolepsy in the past 6 months OR • 1 claim for a 30-day supply with the requested agent in the past 105 days <p>Nuvigil</p> <ul style="list-style-type: none"> • Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder or bipolar depression <p>Provigil</p>

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<ul style="list-style-type: none"> • Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome <p style="text-align: center;">Sunosi</p> <ul style="list-style-type: none"> • Documented diagnosis of narcolepsy or obstructive sleep apnea AND • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months <p style="text-align: center;">Wakix</p> <ul style="list-style-type: none"> • Documented diagnosis of narcolepsy with or without cataplexy AND • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months OR • Documented diagnosis of narcolepsy without cataplexy or substance abuse disorder <p style="text-align: center;">Xyrem and Xywav</p> <ul style="list-style-type: none"> • Requires clinical review
NON-STIMULANTS			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

(For All Medicaid, MSCAN and CHIP Beneficiaries)

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	atomoxetine clonidine ER guanfacine ER	INTUNIV (guanfacine ER) QELBREE (viloxazine) STRATTERA (atomoxetine)	<p style="color: red; margin: 0;">Minimum Age Limit</p> <p style="margin: 0;">6 years – Intuniv, Clonidine ER, Qelbree, Strattera</p> <p style="margin: 0;">18 years – Wakix</p> <p style="color: red; margin: 0;">Maximum Age Limit</p> <ul style="list-style-type: none"> 18 years – Intuniv, Clonidine ER, Qelbree 21 years – diagnosis of ADD/ADHD is required for Strattera <p style="color: red; margin: 0;">Quantity Limit</p> <p style="margin: 0;">Applicable quantity limit per rolling days</p> <ul style="list-style-type: none"> 31 tablets/31 days – Intuniv, Qelbree 100 mg, Strattera 62 tablets/31 days – Qelbree 150 mg and 200 mg, Wakix 124 tablets/31 days – Clonidine ER <p style="color: red; margin: 0;">Intuniv</p> <p style="margin: 0;">Documented diagnosis of ADD or ADHD</p> <p style="color: red; margin: 0;">Clonidine ER</p> <ul style="list-style-type: none"> Documented diagnosis of ADD or ADHD <p style="color: red; margin: 0;">Qelbree</p> <ul style="list-style-type: none"> Documented diagnosis of ADD or ADHD AND

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
TETRACYCLINES ^{DUR+}			
	doxycycline hyclate caps/tabs doxycycline monohydrate caps (50mg & 100mg) minocycline caps IR tetracycline	ACTICLATE (doxycycline) ADOXA (doxycycline monohydrate) demeclocycline doxycycline hyclate (generic Doryx) doxycycline hyclate (generic Periostat) doxycycline monohydrate caps (75mg & 150mg) doxycycline monohydrate tabs DORYX (doxycycline hyclate) DYNACIN (minocycline) MINOCIN (minocycline) MINOLIRA (minocycline) minocycline ER minocycline tabs MONODOX (doxycycline monohydrate) NUZYRA (omadacycline tosylate) OKEBO (doxycycline) ORACEA (doxycycline) SEYSARA (sarecycline) SOLODYN (minocycline) TARGADOX (doxycycline) VIBRAMYCIN cap/susp/syrup XIMINO (minocycline)	<ul style="list-style-type: none"> 1 claim for a 30-day supply with atomoxetine in the past 105 days <p style="color: red; text-align: center;">Non-Preferred Agents</p> <ul style="list-style-type: none"> Have tried 2 different preferred agents in the past 6 months <p style="color: red; text-align: center;">Demeclocycline</p> <ul style="list-style-type: none"> Documented diagnosis of SIADH will allow automatic approval
ULCERATIVE COLITIS and CROHN'S AGENTS ^{DUR+} *See Cytokine & CAM Antagonists Class for additional agents			

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F



MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 4/1/2024
Version 2024_5
Updated: 3/28/2024

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ORAL		
	APRISO (mesalamine) balsalazide budesonide EC LIALDA (mesalamine) mesalamine tablet (generic Apriso) PENTASA 250mg (mesalamine) PENTASA 500mg (mesalamine) sulfasalazine UCERIS (budesonide)	AZULFIDINE (sulfasalazine) AZULFIDINE ER (sulfasalazine) budesonide ER tablets COLAZAL (balsalazide) DELZICOL (mesalamine) DIPENTUM (olsalazine) ENTOCORT EC (budesonide) mesalamine tablet (generic Asacol HD) mesalamine capsules (generic Delzicol) ORTIKOS (budesonide) VELSIPITY (etrasimod)	<p style="color: red;">Non-Preferred Criteria</p> <ul style="list-style-type: none"> • Documented diagnosis for Ulcerative Colitis AND • Have tried 2 different preferred agents in the past 6 months OR • 90 consecutive days on the requested agent in the past 105 days <p style="color: red;">Velsipity</p> <ul style="list-style-type: none"> • Requires clinical review
	RECTAL		
	mesalamine suppository	budesonide foam CANASA (mesalamine) ROWASA (mesalamine) SF-ROWASA (mesalamine) UCERIS Foam (budesonide)	

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F