

General Preferred Drug List Information

- Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid pharmacy claims.
- 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 change in PDL status.
- To search the PDL, **press CTRL + F**.

Medication Coverage Status Search Tool - [Pharmacy Drug Coverage Inquiry](#)

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA			
ACNE AGENTS							
ANTI-INFECTIVES				Maximum Age Limit • 21 years: all acne agents except isotretinoin products Topical Clindamycin 1% lotion • 21 years and older AND • Documented diagnosis of hidradenitis suppurativa Note: • Isotretinoin products available for all ages • Clindamycin 1% lotion only available for ages 21 years and older with approvable diagnosis • Preferred clindamycin 1% lotion for ages < 21 years does not require PA Maximum Age Limit • 21 years: all acne agents except isotretinoin products			
clindamycin gel (generic CLEOCIN-T)		azelaic acid					
clindamycin lotion, medicated swab, solution		CLEOCIN T (clindamycin)					
		CLINDACIN (clindamycin)					
		CLINDAGEL (clindamycin)					
		clindamycin foam					
		clindamycin gel (generic CLINDAGEL)					
		dapson					
		ERY (erythromycin)					
		ERYGEL (erythromycin)					
		erythromycin					
		EVOCLIN (clindamycin)					
		KLARON (sulfacetamide)					
		MORGIDOX (doxycycline)					
		sulfacetamide sodium suspension					
		WINLEVI (clascoterone) cream					
ISOTRETINOIN PRODUCTS							
AMNESTEEM (isotretinoin)		ABSORBICA (isotretinoin)					
CLARAVIS (isotretinoin)		isotretinoin					
ZENATANE (isotretinoin)							
KERATOLYTICS (BENZOYL PEROXIDES)							
ACNE MEDICATION (benzoyl peroxide)		BPO towelette (benzoyl peroxide)					
benzoyl peroxide							
LINTERA (benzoyl peroxide)							
RETINOIDS							
adapalene gel, gel with pump		adapalene cream					
RETIN-A (tretinoin)		AKLIEF (trifarotene)					
tretinoin cream		ALTRENO (tretinoin)					
		ARAZLO (tazarotene)					
		ATRALIN (tretinoin)					
		DIFFERIN (adapalene)					
		FABIOR (tazarotene)					
		RETIN-A MICRO (tretinoin)					
		RETIN-A MICRO PUMP (tretinoin)					
		tretinoin gel					
		tretinoin microsphere					

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS (continued)		
OTHERS/COMBINATION PRODUCTS		See previous page for additional PA Criteria/DUR+ Rules
adapalene/benzoyl peroxide gel	ACANYA (benzoyl peroxide/clindamycin) gel	
clindamycin/benzoyl peroxide 1%-5% gel w/pump	CABTREO (clindamycin/adapalene/benzoyl peroxide) gel	
sodium sulfacetamide w/sulfur 8%-4%, 9%-4.25%, 10-5% suspension	CLEANSING WASH (sulfacetamide sodium/sulfur/urea) cleanser	
	clindamycin phosphate/benzoyl peroxide 1.2%-2.5% gel	
	clindamycin phosphate/tretinoin 1.2%-0.025% gel	
	clindamycin/benzoyl peroxide 1%-5% gel	
	clindamycin/benzoyl peroxide 1.2%-3.75% gel w/pump (generic ONEXTON)	
	EPIDUO FORTE (adapalene/benzoyl peroxide) gel	
	erythromycin/benzoyl peroxide gel	
	NEUAC (benzoyl peroxide/clindamycin) cream, gel	
	ONEXTON (benzoyl peroxide/clindamycin) gel	
	sodium sulfacetamide w/sulfur 8%-4% cleanser	
	sodium sulfacetamide w/sulfur 10%-2% cream	
	sodium sulfacetamide w/sulfur 10%-5% cream, lotion	
	SSS (sodium sulfacetamide/sulfur)10-5 cream, foam	
	TWYNEO (benzoyl peroxide/tretinoin) cream	
	ZIANA (clindamycin/tretinoin) gel	
	ZMA CLEAR (sodium sulfacetamide/sulfur) suspension	
ALPHA-1 PROTEINASE INHIBITORS		
ARALAST NP		
GLASSIA		
PROLASTIN C		
ZEMAIRA		
ALZHEIMER'S AGENTS DUR+		
CHOLINESTERASE INHIBITORS		Preferred Criteria
donepezil 5 mg, 10 mg ODT, tablets	ADLARITY (donepezil)	• Documented approvable diagnosis
galantamine	ARICEPT (donepezil)	Non-Preferred Criteria
galantamine ER	donepezil 23 mg tablet	
rivastigmine	EXELON (rivastigmine)	
		See next page for additional PA Criteria/DUR+ Rules

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

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ALZHEIMER'S AGENTS ^{DUR+} (continued)					
	Zunveyl (benzgalantamine gluconate) ^{NR}	See previous page for additional PA Criteria/DUR+ Rules			
NMDA RECETPOR ANTAGONISTS		Have tried 2 different preferred agents in the past 6 months			
memantine	memantine ER	NAMZARIC			
	NAMENDA (memantine)	Requires clinical review			
	NAMENDA XR (memantine ER)	ZUNVEYL			
COMBINATION AGENTS		Requires clinical review			
	NAMZARIC (memantine/donepezil)				
	memantine/donepezil ER				
ANALGESICS, OPIOID-SHORT ACTING ^{DUR+}					
acetaminophen/caffeine/dihydrocodeine	ACTIQ (fentanyl)	MS DOM Opioid Initiative – Criteria details found here			
acetaminophen/codeine	aspirin/butalbital/caffeine/codeine	Morphine Equivalent Daily Dose			
codeine	butalbital/acetaminophen/caffeine/codeine	Concomitant use of Opioids and Benzodiazepines			
ENDOCET (oxycodone/acetaminophen)	butorphanol	Minimum Age Limit			
hydrocodone/acetaminophen	DILAUDID (hydromorphone)	18 years: codeine-containing products and tramadol-containing products			
hydromorphone	fentanyl citrate	Quantity Limit (per 31 rolling days)			
morphine sulfate	FENTORA (fentanyl)	62 tablets: butalbital/codeine combinations, codeine combinations, dihydrocodeine combinations, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, morphine, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol			
oxycodone	FIORICET W/CODEINE (butalbital/acetaminophen/codeine)	186 tablets: butalbital/acetaminophen, butalbital/aspirin			
oxycodone/acetaminophen (325 mg acetaminophen formulations)	hydrocodone/ibuprofen	5 mL: butorphanol nasal			
tramadol 50 mg tablet	meperidine	180 mL: oxycodone liquid			
tramadol/acetaminophen	NALOCET (oxycodone/acetaminophen)	280 mL: QDOLO			
	levorphanol	Non-Preferred Criteria			
	oxymorphone	Have tried 2 different preferred agents in the past 6 months			
	pentazocine/naloxone	MS DOM Opioid Initiative – Criteria details found here			
	PERCOCET (oxycodone/acetaminophen)	Morphine Equivalent Daily Dose			
	PROLATE (oxycodone/acetaminophen)	Concomitant use of Opioids and Benzodiazepines			
	ROXICODONE (oxycodone)	Minimum Age Limit			
	ROXYBOND (oxycodone)	18 years: BUTRANS and tramadol-containing products			
	SEGLENTIS (tramadol/celecoxib)				
	tramadol 25 mg, 75 mg, 100 mg tablet				
	tramadol solution				
ANALGESICS, OPIOID-LONG ACTING ^{DUR+}					
BUTRANS (buprenorphine)	BELBUCA (buprenorphine)	See next page for additional PA Criteria/DUR+ Rules			
fentanyl patch	buprenorphine patch				
morphine sulfate ER tablet	CONZIP (tramadol)				
	hydrocodone bitartrate ER				
	hydromorphone ER				

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ANALGESICS, OPIOID-LONG ACTING ^{DUR+} (continued)					
	HYSINGLA ER (hydrocodone)	See previous page for additional PA Criteria/DUR+ Rules			
	methadone	Quantity Limit (per 31 rolling days)			
	methadone intensol	• 31 tablets: AVINZA, hydromorphone ER, HYSINGLA ER, tramadol ER			
	METHADOSE (methadone)	• 62 tablets: methadone, morphine ER, OXYCONTIN, oxymorphone ER, ZOHYDRO ER			
	morphine sulfate ER capsule	• 62 films: BELBUCA			
	MS CONTIN (morphine)	• 10 patches: fentanyl			
	oxycodone ER	• 4 patches: BUTRANS			
	OXYCONTIN (oxycodone)	Non-Preferred Criteria			
	oxymorphone ER	Have tried 2 different preferred agents in the past 6 months			
	tramadol ER				
ANALGESICS/ANESTHETICS (TOPICAL)					
diclofenac 1%, 3% gel	DERMACINRX LIDOCAN (lidocaine)	Quantity Limit (per 31 days)			
lidocaine 4% cream, patch, solution	DERMACINRX LIDOGEL (lidocaine)	• 1 bottle (112 mL): diclofenac 2% solution pump			
lidocaine 5% cream, ointment, patch	DERMACINRX LIDOREX (lidocaine)	• 1 bottle (150 mL): diclofenac 1.5% solution			
lidocaine 40 mg/mL solution	diclofenac epolamine				
lidocaine/prilocaine cream	diclofenac sodium 2% solution pump	Non-Preferred Criteria			
TRIDACAINE (lidocaine) patch	DICLOGEN (diclofenac/menthol/camphor) kit	• Have tried 2 preferred agents in the past 6 months			
TRIDACAINE XL (lidocaine) patch	DOLOGESIC PAIN RELIEF (lidocaine)				
ULTRA LIDO (lidocaine) cream, gel	LIDAFLEX (lidocaine)	Lidocaine 5% Patch			
	lidocaine 3% cream	• Documented diagnosis of Herpetic Neuralgia OR			
	lidocaine 4% kit, liquid	• Documented diagnosis of Diabetic Neuropathy			
	lidocaine/hydrocortisone				
	lidocaine/prilocaine kit	ZTLIDO			
	LIDOCAN II, III, IV, V (lidocaine)	• Documented diagnosis of postherpetic neuralgia OR			
	LIDOCORT (lidocaine/hydrocortisone)	• History of 3 claims with preferred lidocaine 5% patch in the past 6 months			
	LIDODERM (lidocaine)				
	LIDOTRAL (lidocaine)				
	LIXOFEN (diclofenac)				
	PENNSAID (diclofenac)				
	PLIAGLIS (lidocaine/tetracaine)				
	TRIDACAINE II, III (lidocaine) patch				
	ZTLIDO (lidocaine)				
ANDROGENIC AGENTS ^{DUR+}					
testosterone	ANDROGEL (testosterone)	All Agents			
	JATENZO (testosterone undecanoate)	• Limited to male gender			
	NATESTO (testosterone)	Non-Preferred Criteria			
	TESTIM (testosterone)	• Have tried 2 different preferred agents in the past 6 months			
	TLANDO (testosterone undecanoate)				
	VOGELXO (testosterone)	See next page for additional PA Criteria/DUR+ Rules			

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ANDROGENIC AGENTS DUR+ (continued)					
		UNDECATREX (testosterone undecanoate)		See previous page for additional PA Criteria/DUR+ Rules	
				TLANDO Requires clinical review	
ANGIOTENSIN MODULATORS DUR+					
ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS				EPANED - Automatic approval issued for 0-6 years of age ENTRESTO - Age ≥ 1 year and documented diagnosis of Heart Failure with Systemic Ventricular Systolic Dysfunction - OR - Age ≥ 18 years and documented diagnosis of Heart Failure Non-Preferred Criteria - ACEIs: - Have tried 2 different preferred single entity agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days - ACEI/CCB Combinations: - Have tried 2 different preferred ACEI/CCB agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days - ACEI/Diuretic Combinations: - Have tried 2 different preferred ACEI/Diuretic agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days - ARBs: - Have tried 2 different preferred single entity agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days - ARB/CCB and ARB/CCB/Diuretic Combinations: - Have tried 1 preferred ARB/CCB agent in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days - ARB/Diuretic Combinations: - Have tried 2 different preferred ARB/Diuretic agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days - Direct Renin Inhibitors: - Documented diagnosis of Hypertension AND - Have tried 2 different preferred ACEI or ARB single-entity agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days - Direct Renin Inhibitor Combinations: - Documented diagnosis of Hypertension AND - Have tried 2 different preferred ACEI or ARB diuretic agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days	
benazepril		ACCUPRIL (quinapril)			
captopril		ALTACE (ramipril)			
enalapril		EPANED (enalapril)			
ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS					
fosinopril		LOTENSIN (benazepril)			
lisinopril		moexipril			
quinapril		perindopril			
ramipril		QBRELIS (lisinopril)			
trandolapril		VASOTEC (enalapril)			
		ZESTRIL (lisinopril)			
ACE INHIBITOR (ACEI) COMBINATIONS					
benazepril/amlodipine		ACCURETIC (quinapril/hydrochlorothiazide)			
benazepril/hydrochlorothiazide		LOTENSIN HCT (benazepril/hydrochlorothiazide)			
captopril/hydrochlorothiazide		LOTREL (benazepril/amlodipine)			
enalapril/hydrochlorothiazide		VASERETIC (enalapril/hydrochlorothiazide)			
fosinopril/hydrochlorothiazide		ZESTORETIC (lisinopril/hydrochlorothiazide)			
lisinopril/hydrochlorothiazide					
quinapril/hydrochlorothiazide					
trandolapril/verapamil ER					
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)					
irbesartan		ATACAND (candesartan)			
losartan		AVAPRO (irbesartan)			
olmesartan		BENICAR (olmesartan)			
telmisartan		candesartan			
valsartan tablet		COZAAR (losartan)			
		EDARBI (azilsartan)			
		eprosartan			
		MICARDIS (telmisartan)			
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)					
		valsartan solution			

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
ANGIOTENSIN MODULATORS ^{DUR+} (continued)					
ARB COMBINATIONS				See previous page for additional PA Criteria/DUR+ Rules	
ENTRESTO (valsartan/sacubitril) tablet ^{DUR+}		ATACAND HCT (candesartan/hydrochlorothiazide)			
irbesartan/hydrochlorothiazide		AVALIDE (irbesartan/hydrochlorothiazide)			
losartan/hydrochlorothiazide		AZOR (olmesartan/hydrochlorothiazide)			
olmesartan/amlodipine		BENICAR HCT (olmesartan/hydrochlorothiazide)			
olmesartan/hydrochlorothiazide		candesartan/hydrochlorothiazide			
telmisartan/hydrochlorothiazide		DIOVAN-HCT (valsartan/hydrochlorothiazide)			
valsartan/amlodipine		EDARBYCLOR (azilsartan/chlorthalidone)			
valsartan/amlodipine/hydrochlorothiazide		ENTRESTO (valsartan/sacubitril) sprinkle capsule			
valsartan/hydrochlorothiazide		EXFORGE (valsartan/amlodipine)			
		EXFORGE HCT (valsartan/amlodipine/hydrochlorothiazide)			
		olmesartan/amlodipine/hydrochlorothiazide			
		telmisartan/amlodipine			
		TRIBENZOR (olmesartan/amlodipine/hydrochlorothiazide)			
		valsartan/sacubitril			
DIRECT RENIN INHIBITORS					
		aliskiren			
		TEKTURN (aliskiren)			
DIRECT RENIN INHIBITOR COMBINATIONS					
		TEKTURN HCT (aliskiren/hydrochlorothiazide)			
ANTIBIOTICS (GI) & RELATED AGENTS					
metronidazole tablet		AEMCOLO (rifamycin)			
neomycin		DIFICID (fidaxomicin)			
tinidazole		FIRVANQ (vancomycin)			
vancomycin oral solution		FLAGYL (metronidazole)			
		LIKMEZ (metronidazole)			
		metronidazole 125 mg tablet, 375 mg capsule			
		nitazoxanide			
		paromomycin			
		REBYOTA (fecal microbiota, live-jslm)			
		VANCOCIN (vancomycin)			
		vancomycin capsule			
		VOWST (fecal microbio spore, live-brpk)			
		XIFAXAN (rifaximin)			

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA		
ANTIBIOTICS (MISCELLANEOUS)						
LINCOSAMIDE ANTIBIOTICS			Quantity Limit • 6 tablets/month: SIVEXTRO SIVEXTRO – MANUAL PA ZYVOX – MANUAL PA			
clindamycin		CLEOCIN (clindamycin)				
		CELOCIN PEDIATRIC (clindamycin)				
MACROLIDES						
azithromycin		ERYPED (erythromycin ethylsuccinate) suspension				
clarithromycin		ERYTHROCIN (erythromycin stearate)				
clarithromycin ER		ZITHROMAX (azithromycin)				
E.E.S (erythromycin ethylsuccinate) suspension						
ERY-TAB (erythromycin)						
erythromycin						
erythromycin ethylsuccinate						
NITROFURANTOIN DERIVATIVES						
nitrofurantoin capsule		FURADANTIN (nitrofurantoin) suspension				
nitrofurantoin monohydrate macrocrystals		MACROBID (nitrofurantoin monohydrate macrocrystals)				
		nitrofurantoin suspension				
OXAZOLIDINONES						
		linezolid				
		SIVEXTRO (tedizolid)				
		ZYVOX (linezolid)				
ANTIBIOTICS (TOPICAL)						
bacitracin ^{OTC}		CENTANY (mupirocin)				
bacitracin/polymyxin ^{OTC}		CENTANY AT (mupirocin)				
gentamicin sulfate		mupirocin cream				
mupirocin ointment		XEPI (ozenoxacin)				
neomycin/bacitracin/polymyxin ^{OTC}						
ANTIBIOTICS (VAGINAL)						
CLEOCIN (clindamycin)		clindamycin phosphate				
NUVESSA (metronidazole)		CLINDESSE (clindamycin)				
		SOLOSEC (secnidazole)				
		XACIATO (clindamycin)				
ANTICOAGULANTS						
LOW MOLECULAR WEIGHT HEPARIN (LMWH)			Non-Preferred Criteria • LMWH: ○ Have tried 1 preferred agent in the past 6 months OR See next page for additional PA Criteria/DUR+ Rules			
enoxaparin		ARIXTRA (fondaparinux)				
		fondaparinux				
		FRAGMIN (dalteparin)				

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
ANTICOAGULANTS (continued)					
		LOVENOX (enoxaparin)		See previous page for additional PA Criteria/DUR+ Rules ○ 90 days of therapy with the requested agent in the past 105 days • Oral: ○ Have tried 2 different preferred oral agents in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days	
ORAL					
ELIQUIS (apixaban)		dabigatran			
JANTOVEN (warfarin)		PRADAXA (dabigatran) pellet pack			
PRADAXA (dabigatran) capsule		SAVAYSA (edoxaban)			
warfarin		rivaroxaban			
XARELTO (rivaroxaban)					
ANTICONVULSANTS DUR+					
ADJUVANTS				Minimum Age Limit • 6 months: DIACOMIT • 1 year: BANZEL, EPIDIOLEX • 2 years: ONFI, SYMPAZAN • 2 years: VALTOCO • 12 years: NAYZILAM Maximum Age Limit • 2 years: VIGAFYDE Quantity Limit (per 31 days) • 2 twin packs: DIASTAT • 2 packages: NAYZILAM • 2 cartons: VALTOCO Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months OR • Documented diagnosis of Seizure AND • 90 days of therapy with the requested agent in the past 105 days Banzel, Onfi, and Sympazan • Documented diagnosis of Lennox-Gastaut Syndrome and have tried 1 preferred agent for Lennox-Gastaut Syndrome in the past 6 months OR • Documented diagnosis of Seizure and 90 days of therapy with the requested agent in the past 105 days DIACOMIT • Documented diagnosis of Dravet Syndrome AND • 1 claim for clobazam in the past 30 days See next page for additional PA Criteria/DUR+ Rules	
carbamazepine		APTIOM (eslicarbazepine acetate)			
carbamazepine ER 12-hour capsule		BANZEL (rufinamide)			
DEPAKOTE ER (divalproex)		BRIVIACT (brivaracetam)			
DEPAKOTE SPRINKLE (divalproex)		carbamazepine ER 12-hour tablet			
divalproex		CARBATROL (carbamazepine)			
divalproex ER		DEPAKOTE (divalproex)			
divalproex sprinkle		DIACOMIT (stiripentol)			
EPIDIOLEX (cannabidiol)		ELEPSIA XR (levetiracetam)			
lacosamide		EPRONTIA (topiramate)			
lamotrigine		EQUETRO (carbamazepine)			
lamotrigine blue, green, orange dose pack		Eslicarbazepine			
levetiracetam		felbamate			
levetiracetam ER		FELBATOL (felbamate)			
oxcarbazepine tablet		FINTEPLA (fenfluramine)			
tiagabine		FYCOMPA (perampanel)			
topiramate		KEPPRA (levetiracetam)			
topiramate sprinkle 15, 25 mg (generic Topamax)		KEPPRA XR (levetiracetam)			
TRILEPTAL (oxcarbazepine) suspension		LAMICTAL (lamotrigine)			
valproic acid		LAMICTAL XR (lamotrigine)			
zonisamide		lamotrigine ER			
		lamotrigine ODT			
		lamotrigine ODT blue, green, orange dose pack			
		MOTPOLY XR (lacosamide)			
		oxcarbazepine suspension			
		oxcarbazepine ER			
		OXTELLAR XR (oxcarbazepine)			
		QUDEXY XR (topiramate)			
		ROWEEPRA (levetiracetam)			
		rufinamide			
		SABRIL (vigabatrin)			

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTICONVULSANTS ^{DUR+} (continued)		
ADJUVANTS (continued)		See previous page for additional PA Criteria/DUR+ Rules EPIDIOLEX - Documented diagnosis of Dravet Syndrome, Lennox-Gastaut Syndrome, or Seizures associated with Tuberous Sclerosis Complex OR 1 claim for EPIDIOLEX in the past 30 days FINTEPLA - Requires clinical review SABRIL Powder for Oral Solution - Documented diagnosis of Infantile Spasms OR - Have tried 2 different preferred agents in the past 6 months OR - Documented diagnosis of Seizure AND 90 days of therapy with the requested agent in the past 105 days TOPIRAMATE ER - Documented diagnosis of Seizure AND 90 days of therapy with the requested agent in the past 105 days OR 30 days of therapy with topiramate IR in the past 6 months VIGAFYDE - Age ≤ 2 years AND - Documented diagnosis of infantile spasms XCOPRI - Age ≥ 18 years
	SPRITAM (levetiracetam)	
	SUBVENITE (lamotrigine)	
	SUBVENITE (lamotrigine) blue, green, orange dose pack	
	TEGRETOL (carbamazepine)	
	TEGRETOL XR (carbamazepine)	
	TOPAMAX TABLET (topiramate)	
	TOPAMAX SPRINKLE (topiramate)	
	topiramate ER capsule (generic Trokendi XR)	
	topiramate ER sprinkle capsule (generic Qudexy XR)	
	topiramate sprinkle 50 mg	
	TRILEPTAL (oxcarbazepine) tablet	
	TROKENDI XR (topiramate)	
	vigabatrin	
	VIGADRONE (vigabatrin)	
	VIGAFYDE (vigabatrin)	
	VIGPODER (vigabatrin)	
	VIMPAT (lacosamide)	
	XCOPRI (cenobamate)	
	ZONISADE (zonisamide) suspension	
	ZTALMY (ganaxolone)	
HYDANTOINS		
	DILANTIN (phenytoin)	
	DILANTIN-125 (phenytoin)	
	PHENYTEK (phenytoin)	
	phenytoin	
	phenytoin ER	
SELECTED BENZODIAZEPINES		
	clobazam	DIASTAT (diazepam) rectal gel
	diazepam rectal gel	LIBERVANT (diazepam)
	NAYZILAM (midazolam)	ONFI (clobazam)
	VALTOCO (diazepam)	SYMPAZAN (clobazam)
SUCCINIMIDES		
	ethosuximide	CELONTIN (methsuximide)
		methsuximide
		ZARONTIN (ethosuximide)

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ANTIDEPRESSANTS, OTHER DUR+					
bupropion		APLENZIN (bupropion)		Minimum Age Limit 18 years: all agents Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months OR - Have tried 1 preferred agent and 1 SSRI in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days AUVELITY and RALDESY - Requires clinical review DRIZALMA Sprinkles - Automatic approval issued with a diagnosis of Generalized Anxiety Disorder for 7-11 years of age DULOXETINE - Automatic approval issued with a diagnosis of Generalized Anxiety Disorder for 7-17 years of age ZURZUVAE – MANUAL PA	
bupropion SR		AUVELITY (bupropion/dextromethorphan)			
bupropion XL		desvenlafaxine ER			
mirtazapine		DESYREL (trazodone)			
trazodone		DRIZALMA SPRINKLE (duloxetine DR)			
TRINTELLIX (vortioxetine)		EFFEXOR XR (venlafaxine)			
venlafaxine		EMSAM (selegiline)			
venlafaxine ER capsule		FETZIMA (levomilnacipran)			
vilazodone		FORFIVO XL (bupropion)			
		MARPLAN (isocarboxazid)			
		NARDIL (phenelzine)			
		nefazodone			
		phenelzine			
		PRISTIQ (desvenlafaxine)			
		REMERON (mirtazapine)			
		tranylcypromine			
		Trazodone solution ^{NR}			
		venlafaxine ER tablet			
		VIIBRYD (vilazodone)			
		WELLBUTRIN SR (bupropion)			
		WELLBUTRIN XL (bupropion)			
		ZURZUVAE (zuranolone)			
ANTIDEPRESSANTS, SSRIs DUR+					
citalopram solution, tablet		CELEXA (citalopram)		Minimum Age Limit 6 years: ZOLOFT 7 years: LEXAPRO, PROZAC 8 years: fluvoxamine 18 years: CELEXA, LUVOX CR, PAXIL, PROZAC 90 mg Maximum Age Limit 60 years – Celexa Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days	
escitalopram		citalopram capsule			
fluoxetine capsule		fluoxetine solution, tablet			
fluvoxamine		fluoxetine DR capsule			
paroxetine tablet		fluvoxamine ER capsule			
paroxetine CR		LEXAPRO (escitalopram)			
paroxetine ER		paroxetine suspension, capsule			
sertraline tablet, solution		PAXIL (paroxetine)			
		PAXIL CR (paroxetine)			
		PROZAC (fluoxetine)			
		sertraline capsule			
		ZOLOFT (sertraline)			
ANTIEMETICS DUR+					
5HT3 RECEPTOR BLOCKERS				Quantity Limit (per 31 days) 6 tablets: AKYNZEO 100 mL: ZOFTRAN solution See next page for additional PA Criteria/DUR+ Rules	
ondansetron solution, tablet		ANZIMET (dolasetron)			
ondansetron ODT 4 mg, 8 mg		granisetron			
		ondansetron ODT 16 mg tablet			

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
ANTIEMETICS ^{DUR+} (continued)					
		SANCUSO (granisetron)		See previous page for additional PA Criteria/DUR+ Rules Non-Preferred Agents Have tried 1 preferred agent in the past 6 months AKYNZEO – MANUAL PA Note: Injectables in this class are closed to point of sale. PA required if not administered in clinic/hospital.	
ANTIEMETIC COMBINATIONS					
DICLEGIS (doxylamine/pyridoxine)		AKYNZEO (netupitant/palonosetron)			
		BONJESTA (doxylamine/pyridoxine)			
		doxylamine/pyridoxine			
CANNABINOIDS					
		dronabinol			
		MARINOL (dronabinol)			
NMDA RECEPTOR ANTAGONISTS					
aprepitant		EMEND (aprepitant)			
ANTIFUNGALS (ORAL) ^{DUR+}					
clotrimazole		ANCOBON (flucytosine)		Griseofulvin suspension - Automatic approval issued for 0-11 years of age Griseofulvin tablets - Automatic approval issued for 12-17 years of age Minimum Age Limit 18 years: CRESEMBA Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months HIV Opportunistic Infection - Non-Preferred agent indicated for treatment (^) AND - Documented diagnosis of HIV CRESEMBA – MANUAL PA SPORANOX - Requires clinical review	
fluconazole		BREXAFEMME (ibrexafungerp)			
nystatin		CRESEMBA (isavuconazonium sulfate)			
terbinafine		DIFLUCAN (fluconazole)			
		flucytosine			
		griseofulvin			
		griseofulvin ultramicrosize			
		itraconazole			
		ketoconazole			
		NOXAFIL (posaconazole)			
		ORAVIG (miconazole)			
		Posaconazole			
		SPORANOX (itraconazole)			
		TOLSURA (itraconazole)			
		VFEND (voriconazole)			
		VIVJOA (oteseconazole)			
		voriconazole			
ANTIFUNGALS (TOPICAL) ^{DUR+}					
ANTIFUNGALS				Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months MICOTRIN AC, MYCOZYL, and clotrimazole 30 mL solution - Require clinical review	
ciclopirox cream, gel, solution, suspension		BENSAL HP (salicylic acid)			
clotrimazole cream, solution ^{Rx & OTC}		CILODAN (ciclopirox)			
econazole		ciclopirox shampoo			
ketoconazole cream, shampoo		clotrimazole solution (NDC 50228-0502-61)			
LUZU (luliconazole)		ERTACZO (sertaconazole)			
miconazole cream, powder, solution ^{OTC}		EXTINA (ketoconazole)			
miconazole/zinc oxide/petrolatum ointment		JUBLIA (efinaconazole)			

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA			
ANTIFUNGALS (TOPICAL) ^{DUR+} (continued)							
nystatin cream, ointment, powder		ketoconazole foam		See previous page for additional PA Criteria/DUR+ Rules			
terbinafine ^{OTC}		KETODAN (ketoconazole)					
tolnaftate cream, solution ^{OTC}		LOPROX (ciclopirox)					
		luliconazole					
		MICOTRIN AC (clotrimazole)					
		MYCOZYL AC (clotrimazole)					
		MYCOZYL AP (miconazole)					
		naftifine					
		NAFTIN (naftifine)					
		oxiconazole					
		OXISTAT (oxiconazole)					
		tavaborole					
		VOTRIZA-AL (clotrimazole)					
		VUSION (miconazole/zinc oxide/petrolatum)					
ANTIFUNGAL/STEROID COMBINATIONS							
clotrimazole/betamethasone cream		clotrimazole/betamethasone lotion					
nystatin/triamcinolone							
ANTIFUNGALS (VAGINAL)							
clotrimazole cream ^{OTC}		3-DAY VAGINAL CREAM (clotrimazole)					
clotrimazole-3 cream		GYNAZOLE 1 (butoconazole)					
miconazole kit ^{OTC}		terconazole suppository					
terconazole cream							
ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS ^{DUR+}							
MINIMALLY SEDATING ANTIHISTAMINES				Non-Preferred Criteria - Documented diagnosis of Allergy or Urticaria AND - Have tried 2 different preferred agents in the past 12 months			
cetirizine capsule, solution, tablet ^{OTC}		cetirizine chewable tablet ^{OTC}					
loratadine chewable tablet, ODT, solution, tablet ^{OTC}		CLARINEX (desloratadine)					
		desloratadine					
		levocetirizine					
MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS							
cetirizine/pseudoephedrine		CLARINEX-D 12 HOUR (desloratadine/pseudoephedrine)					
loratadine/pseudoephedrine		fexofenadine/pseudoephedrine					
ANTIMIGRAINE AGENTS, ACUTE TREATMENT							
CGRP ORAL AND NASAL						Minimum Age Limit See next page for additional PA Criteria/DUR+ Rules	
NURTEC ODT (rimegepant)		ZAVZPRET (zavegepant)					
UBRELVY (ubrogepant)							

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIMIGRAINE AGENTS, ACUTE TREATMENT^{DUR+} (continued)		
INJECTABLES		See previous page for additional PA Criteria/DUR+ Rules
sumatriptan	IMITREX (sumatriptan) ZEMBRACE SYMTOUCH (sumatriptan)	• 6 years: MAXALT • 12 years: almotriptan, sumatriptan/naproxen, ZOMIG nasal spray • 18 years: FROVA, IMITREX, naratriptan, NURTEC ODT, Relpax, REYVOW, SYMBRAVO, TOSYMRA, UBRELVY, ZEMBRACE, ZOMIG tablets Quantity Limit (per 31 days) • ORAL ◦ 4 tablets: REYVOW 50 mg ◦ 6 tablets: almotriptan, Relpax, ZOMIG ◦ 8 tablets: NURTEC ODT, REYVOW 100 mg ◦ 9 tablets: naratriptan, FROVA, IMITREX, sumatriptan/naproxen, SYMBRAVO ◦ 12 tablets: MAXALT ◦ 16 tablets: UBRELVY • NASAL ◦ 1 box: all agents CUMULATIVE Quantity Limit (per 31 days) • INJECTABLES ◦ 4 injections: all agents Non-Preferred Criteria • ORAL ◦ Have tried 2 preferred oral agents in the past 90 days • NASAL ◦ Have tried 2 preferred oral agents in the past 90 days AND ◦ Have tried a preferred nasal agent in the past 90 days Almotriptan and sumatriptan/naproxen • Automatic approval for 12-17 years of age NURTEC ODT and UBRELVY – MANUAL PA • Documented diagnosis of Migraine AND • Have tried 2 different triptans in the past 6 months AND • No concurrent therapy with another CGRP agent or strong CYP3A4 inhibitor REYVOW • 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 SYMBRAVO • Requires clinical review See next page for additional PA Criteria/DUR+ Rules

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA			
ANTIMIGRAINE AGENTS, ACUTE TREATMENT ^{DUR+} (continued)							
NASAL				See previous page for additional PA Criteria/DUR+ Rules ZAVZPRET – MANUAL PA - Documented diagnosis of Migraine AND - Have tried 2 different triptans in the past 6 months AND - Have tried both NURTEC ODT and UBRELVY in the past 6 months AND No concurrent therapy with another CGRP AGENT			
sumatriptan		IMITREX (sumatriptan)					
		TOSYMRA (sumatriptan)					
		zolmitriptan					
		ZOMIG (zolmitriptan)					
TRIPTANS AND RELATED AGENTS (ORAL) ^{DUR+}							
naratriptan		almotriptan					
rizatriptan		eletriptan					
sumatriptan		FROVA (frovatriptan)					
zolmitriptan		frovatriptan					
zolmitriptan ODT		IMITREX (sumatriptan)					
		MAXALT (rizatriptan)					
		MAXALT MLT (rizatriptan)					
		RELPAX (eletriptan)					
		REYVOW (lasmiditan)					
		sumatriptan/naproxen					
		ZOMIG (zolmitriptan)					
ANTIMIGRAINE AGENTS, PROPHYLAXIS							
INJECTABLES				Preferred Injectables - History of 3 claims with the requested agent in the past 105 days OR - New starts require clinical review Non-preferred Injectables - Require clinical review AIMOVIG, AJOVY, and EMGALITY – MANUAL PA VYEPTI – MANUAL PA			
AIMOVIG Autoinjector (erenumab-aooe) ^{DUR+}		EMGALITY Syringe (galcanezumab-gnlm) 300 mg/mL					
AJOVY Autoinjector (fremanezumab-vfrm) ^{DUR+}		VYEPTI (eptinezumab-jjmr)					
AJOVY Syringe (fremanezumab-vfrm) ^{DUR+}							
EMGALITY Pen (galcanezumab-gnlm) ^{DUR+}							
EMGALITY Syringe (galcanezumab-gnlm) 120 mg/mL ^{DUR+}							
ORAL							
		QULIPTA (atogepant)					
		NURTEC ODT (rimegepant)					
*ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS							
BOSULIF (bosutinib) tablet		AFINITOR (everolimus)		FARYDAK – MANUAL PA IBRANCE - Documented diagnosis of WD-DDLS for retroperitoneal sarcoma OR - All other indications require clinical review See next page for additional PA Criteria/DUR+ Rules			
CAPRESLA (vandetanib)		AFINITOR DISPERZ (everolimus)					
COMETRIQ (cabozantinib)		AKEEGA (niraparib/abiraterone)					
COTELLIC (cobimetinib)		ALECENSA (alectinib)					
everolimus		ALUNBRIG (brigatinib)					
GILOTRIF (afatinib)		AUGTYRO (repotrectinib)					
ICLUSIG (ponatinib)		AYVAKIT (avapritinib)					
imatinib		BALVERSA (erdafitinib)					

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
*ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS <i>(continued)</i>		
IMBRUVICA (ibrutinib)	BOSULIF (bosutinib) capsule	See previous page for additional PA Criteria/DUR+ Rules LENVIMA Documented diagnosis of thyroid cancer, hepatocellular carcinoma, or 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 - All other indications require clinical review LYNPARZA Tablets - Documented diagnosis of ovarian cancer, fallopian tube or peritoneal cancer AND - History of platinum-based chemotherapy in the past 2 years OR All other indications require clinical review – MANUAL PA
INLYTA (axitinib)	BRAFTOVI (encorafenib)	
IRESSA (gefitinib)	BRUKINSA (zanubrutinib)	
JAKAFI (ruxolitinib)	CABOMETYX (cabozantinib)	
MEKINIST (trametinib)	CALQUENCE (acalabrutinib)	
NEXAVAR (sorafenib)	COPIKTRA (duvelisib)	
ROZLYTREK (entrectinib)	DANZITEN (nilotinib)	
SPRYCEL (dasatinib)	dasatinib	
STIVARGA (regorafenib)	DATROWAY (datopotomab deruxtecan-dlnk) ^{NR}	
SUTENT (sunitinib)	DAURISMO (glasdegib)	
TAFINLAR (dabrafenib)	ERIVEDGE (vismodegib)	
TARCEVA (erlotinib)	ERLEADA (apalutamide)	
TASIGNA (nilotinib)	erlotinib	
TURALIO (pexidartinib)	FOTIVDA (tivozanib)	
TYKERB (lapatinib)	FRUZAQIA (fruquintinib)	
VOTRIENT (pazopanib)	GAVRETO (pralsetinib)	
XALKORI (crizotinib)	gefitinib	
XTANDI (enzalutamide)	GLEEVEC (imatinib)	
ZELBORAF (vemurafenib)	IBRANCE (palbociclib)	
ZYDELIG (idelalisib)	IDHIFA (enasidenib)	
ZYKADIA (ceritinib)	IMKELDI (imatinib)	
	INQOVI (decitabine/cedazuridine)	
	INREBIC (fedratinib)	
	ITOVEBI (inavolisib)	
	IWILFIN (eflornithine)	
	JAYPIRCA (pirtobrutinib)	
	KISQALI (ribociclib)	
	KISQALI-FEMARA CO-PACK (ribociclib/letrozole)	
	KOSELUGO (selumetinib/vitamin E)	
	KRAZATI (adagrasib)	
	lapatinib	
	LAZCLUZE (lazertinib)	
	LENVIMA (lenvatinib)	
	LOBRENA (lorlatinib)	
	LUMAKRAS (sotorasib)	
	LYNPARZA (olaparib)	
	LYTGOBI (futibatinib)	
	MEKTOVI (binimetinib)	
	NERLYNX (neratinib)	
	NUBEQA (darolutamide)	

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
*ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS <i>(continued)</i>		
	nilotinib ^{NR}	See previous page for additional PA Criteria/DUR+ Rules
	ODOMZO (sonidegib)	
	OGSIVEO (nirogacestat)	
	OJEMDA (tovorafenib)	
	OJJAARA (mometotinib)	
	ONUREG (azacitidine)	
	ORGOVYX (relugolix)	
	pazopanib	
	PEMAZYRE (pemigatinib)	
	PIQRAY (alpelisib)	
	QINLOCK (ripretinib)	
	RETEVMO (selpercatinib)	
	REVUFORJ (revumenib)	
	REZLIDHIA (olutasidenib)	
	RUBRACA (rucaparib)	
	RYDAPT (midostaurin)	
	SCEMBLIX (asciminib)	
	sorafenib	
	sunitinib	
	TABRECTA (capmatinib)	
	TAGRISSO (osimertinib)	
	TALZENNA (talazoparib)	
	TAZVERIK (tazemetostat)	
	TECENTRIQ HYBREZA (atezolizumab/hyaluronidase-tqjs)	
	TEPMETKO (tepotinib)	
	TIBSOVO (ivosidenib)	
	TORPENZ (everolimus)	
	TRUQAP (capivasertib)	
	TUKYSA (tucatinib)	
	VANFLYTA (quizartinib)	
	VERZENIO (abemaciclib)	
	VITRAKVI (larotrectinib)	
	VIZIMPRO (dacomitinib)	
	VONJO (pacritinib)	
	VORANIGO (vorasidenib)	
	WELIREG (belzutifan)	
	XOSPATA (gilteritinib)	
	XPOVIO (selinexor)	
	ZEJULA (niraparib)	

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
ANTIOBESITY SELECT AGENTS					
SAXENDA (liraglutide)		orlistat		All agents – MANUAL PA required Wegovy Initial Authorization • Age 18 years or older AND • Documented diagnosis of Body Mass Index (BMI) ≥ 30 AND • History of ≤ 6 claims with Wegovy in the past 9 months AND • No history of a claim with Imcivree, Xenical, or any other GLP-1 agonist indicated for treatment of obesity or diabetes in the past 30 days OR • Manual PA required when criteria is not met • Initial authorization is defined as no more than 6 claims for Wegovy within 9 month period • Reauthorization and maintenance reauthorization require clinical review	
WEGOVY (semaglutide)		XENICAL (orlistat)			
ANTIPARASITICS (TOPICAL) DUR+					
PEDICULICIDES				Minimum Age Limit • 2 months: permethrin 1% (OTC), permethrin 5% • 6 months: NATROBA, SKLICE • 2 years: piperonyl/pyrethrins (OTC) • 4 years: NATROBA • 6 years: OVIDE • 18 years: EURAX Non-Preferred Criteria • Pediculicides ◦ Have tried 2 preferred topical lice agents in the past 90 days • Scabicides • Have tried permethrin 5% in the past 90 days	
NATROBA (spinosad)		lindane			
permethrin 1% cream ^{OTC}		malathion			
VANALICE (piperonyl butoxide/pyrethrins)		OVIDE (malathion)			
		SKLICE (ivermectin)			
		spinosad			
SCABICIDES					
ivermectin		CROTAN (crotamiton)			
permethrin 5% cream		ELIMITE (permethrin)			
		EURAX (crotamiton)			
		STROMECTOL (ivermectin)			
ANTIPARKINSON'S AGENTS (INJECTABLE)					
		VYALEV (foscarnidopa/foslevodopa)		VYALEV • Requires clinical review	
ANTIPARKINSON'S AGENTS (ORAL) DUR+					
ANTICHOLINERGICS				• 30 days of therapy with a selegiline agent in the past 45 days	
benztropine					
trihexyphenidyl					
COMT INHIBITORS				GOCOVRI • Documented diagnosis of Parkinson's disease AND • 30 days of therapy with amantadine IR in the past 105 days AND • 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days See next page for additional PA Criteria/DUR+ Rules	
entacapone		OGENTYS (opicapone)			
		TASMAR (tocapone)			
		tolcapone			
ropinirole		pramipexole ER			
		ropinirole ER			

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA			
ANTIPARKINSON'S AGENTS (ORAL) ^{DUR+} (continued)							
MAO-B INHIBITORS				See previous page for additional PA Criteria/DUR+ Rules			
selegiline		AZILECT (rasagiline)					
		rasagiline		LODOSYN and INBRIJA - Documented diagnosis of Parkinson's disease AND 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days NOURIANZ - Documented diagnosis of Parkinson's Disease AND - Have tried 1 preferred carbidopa/levodopa combination agent in the past 30 days AND 30 days of therapy with a preferred adjunctive therapy in the past 45 days			
		XADAGO (safinamide)					
		ZELAPAR (selegiline)					
OTHERS							
amantadine		carbidopa/levodopa ODT					
bromocriptine		carbidopa/levodopa/entacapone					
carbidopa		CREXONT (carbidopa/levodopa)					
carbidopa/levodopa tablet		DHIVY (carbidopa/levodopa)					
carbidopa/levodopa ER		DUOPA (carbidopa/levodopa)					
		GOCOVRI (amantadine)					
		INBRIJA (levodopa)					
		LODOSYN (carbidopa)					
		NOURIANZ (istradefylline)					
		OSMOLEX ER (amantadine)					
		RYTARY (carbidopa/levodopa)					
		SINEMET (carbidopa/levodopa)					
		STALEVO (carbidopa/levodopa/entacapone)					
ANTIPSORIATICS (TOPICAL)							
calcipotriene cream		calcipotriene foam, ointment, solution					
ENSTILAR (calcipotriene/betamethasone)		calcipotriene/betamethasone					
TACLONEX (calcipotriene/betamethasone)		calcitriol ointment					
		DUOBRII (halobetasol/tazarotene)					
		SORILUX (calcipotriene)					
		tazarotene					
		VECTICAL (calcitriol)					
		VTAMA (tapinarof)					
		ZORYVE (roflumilast)					
ANTIPSYCHOTICS ^{DUR+}							
INJECTABLE, ATYPICALS ^{DUR+}				Concurrent Therapy Limit for Age < 18 years 90 days with ≥ 2 agents in the last 120 days will require a MANUAL PA Minimum Age Limit 3 years: HALDOL			
ABILIFY ASIMTUFI (aripiprazole)		ERZOFRI (paliperidone palmitate)					
ABILIFY MAINTENA (aripiprazole)		GEODON (ziprasidone)					
ARISTADA, ARISTADA INITIO (aripiprazole lauroxil)		olanzapine					
INJECTABLE, ATYPICALS ^{DUR+}				See next page for additional PA Criteria/DUR+ Rules			
INVEGA HAFYERA (paliperidone)		risperidone ER					
INVEGA SUSTENNA (paliperidone palmitate)		RYKINDO (risperidone)					
INVEGA TRINZA (paliperidone)		ziprasidone					

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
ANTIPSYCHOTICS ^{DUR+} (continued)					
PERSERIS (risperidone)		ZYPREXA (olanzapine)		See previous page for additional PA Criteria/DUR+ Rules	
RISPERIDAL CONSTA (risperidone)		ZYPREXA RELPREVV (olanzapine)			
UZEDY (risperidone)					
ORAL					
aripiprazole tablet		ABILIFY (aripiprazole)		• 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, CAPLYTA, CLOZARIL, COBENFY, FANAPT, fluphenazine, GEODON, loxapine, LYBALVI, NUPLAZID, perphenazine/amitriptyline, SECUADO, VRAYLAR, and all injectable agents Quantity Limit • 3 syringes/year: ARISTADA INITIO Non-Preferred Criteria – Atypical Agents • Have tried 2 preferred agents in the past 12 months OR • 30 days of therapy with the requested agent in the past 180 days ARISTADO INTIO, ARISTADO ER, INVEGA SUSTENNA, INVEGA TRINZA, PERSERID AND ZYPREXA RELPREVV • Documented diagnosis of schizophrenia or schizoaffective disorder ABILIFY MAINTENA, ABILIFY ASIMTUFI, or RISPERDAL CONSTA • Documented diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder 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 ERZOFRI and risperidone ER • Require clinical review NUPLAZID • Documented diagnosis of Parkinson's Disease Quantity Limit • 3 syringes/year: ARISTADA INITIO See next page for additional PA Criteria/DUR+ Rules	
asenapine		ABILIFY MYCITE (aripiprazole)			
clozapine tablet		ADASUVE (loxapine)			
fluphenazine		aripiprazole ODT, solution			
haloperidol		CAPLYTA (lumateperone)			
haloperidol lactate		chlorpromazine			
olanzapine		clozapine ODT			
perphenazine		CLOZARIL (clozapine)			
perphenazine/amitriptyline		COBENFY (xanomeline/trospium)			
quetiapine		FANAPT (iloperidone)			
quetiapine ER		GEODON (ziprasidone)			
risperidone		IGALMI (dexmedetomidine)			
thioridazine		INVEGA (paliperidone)			
trifluoperazine		LATUDA (lurasidone)			
VRAYLAR (cariprazine)		lurasidone			
ziprasidone		LYBALVI (olanzapine/samidorphan)			
		NUPLAZID (pimavanserin)			
		olanzapine/fluoxetine			
		OPIPZA (aripiprazole)			
		paliperidone ER			
		REXULTI (brexpiprazole)			
		RISPERDAL (risperidone)			
		SAPHRIS (asenapine)			
		SEROQUEL (quetiapine)			
		SEROQUEL XR (quetiapine ER)			
		SYMBYAX (olanzapine/fluoxetine)			
		VERSACLOZ (clozapine)			
		ZYPREXA, ZYPREXA ZYDIS (olanzapine)			
TRANSDERMAL, ATYPICALS					
		SECUADO (asenapine)			

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		See previous page for additional PA Criteria/DUR+ Rules VRAYLAR - Documented diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder OR - Documented diagnosis major depressive disorder AND 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
ANTIRETROVIRALS DUR+		
CAPSID INHIBITORS		Non-Preferred Criteria 1 claim with the requested agent in the past 105 days STRIBILD – MANUAL PA SUNLENCA - Requires clinical review TYBOST – MANUAL PA
	SUNLENCA (lenacapavir)	
CD4 DIRECTED ATTACHMENT INHIBITORS		
	RUKOBIA (fostemsavir)	
CD4 DIRECTED HIV-1 INHIBITORS		
	TROGARZO (ibalizumab-uiyk)	
COMBINATION PRODUCTS – NRTIs		
abacavir/lamivudine	COMBIVIR (lamivudine/zidovudine)	
CABENUVA (cabotegravir/rilpivirine)	EPZICOM (abacavir/lamivudine)	
DOVATO (dolutegravir/lamivudine)		
lamivudine/zidovudine		
COMBINATION PRODUCTS – NUCLEOSIDE AND NUCLEOTIDE ANALOG RTIs		
DESCOVY (emtricitabine/tenofovir alafenamide)	TRUVADA (emtricitabine/tenofovir)	
emtricitabine/tenofovir		

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIRETROVIRALS ^{DUR+} (continued)		
COMBINATION PRODUCTS – NUCLEOSIDE AND NUCLEOTIDE ANALOG AND NON-NUCLEOSIDE RTIs		See previous page for additional PA Criteria/DUR+ Rules
DELSTRIGO (doravirine/lamivudine/tenofovir)	ATRIPLA (efavirenz/emtricitabine/tenofovir)	
efavirenz/emtricitabine/tenofovir	CIMDUO (lamivudine/tenofovir)	
ODEFSEY (emtricitabine/rilpivirine/tenofovir)	COMPLERA (emtricitabine/rilpivirine/tenofovir)	
COMBINATION PRODUCTS – PROTEASE INHIBITORS		
lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)	
ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS		
	maraviroc	
	SELZENTRY (maraviroc)	
ENTRY INHIBITORS – FUSION INHIBITORS		
	FUZEON (enfuvirtide)	
INTEGRASE STRAND TRANSFER INHIBITORS		
APRETUDE (cabotegravir)	cabotegravir ER	
ISENTRESS (raltegravir)	ISENTRESS HD (raltegravir)	
TIVICAY, TIVICAY PD (dolutegravir)	VOCABRIA (cabotegravir)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)		
EDURANT (rilpivirine)	etravirine	
efavirenz	INTELENCE (etravirine)	
	nevirapine, nevirapine ER	
	PIFELTRO (doravirine)	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
abacavir	didanosine	
EMTRIVA (emtricitabine)	emtricitabine	
lamivudine	EPIVIR (lamivudine)	
ZIAGEN (abacavir)	RETROVIR (zidovudine)	
zidovudine	stavudine	
	VIREAD (tenofovir disoproxil fumarate)	
PHARMACOENHANCER – CYTOCHROME P450 INHIBITORS		
	TYBOST (cobicistat)	
PROTEASE INHIBITORS (NON-PEPTIDIC)		
PREZISTA (darunavir)	APTIVUS (tipranavir)	
	darunavir	
	PREZCOBIX (darunavir/cobicistat)	
PROTEASE INHIBITORS (PEPTIDIC)		
atazanavir	fosamprenavir	
EVOTAZ (atazanavir/cobicistat)	LEXIVA (fosamprenavir)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIRETROVIRALS ^{DUR+} (continued)		
ritonavir	NORIVIR (ritonavir)	
	REYATAZ (atazanavir)	
	VIRACEPT (nelfinavir)	
SINGLE PRODUCT REGIMENS		
BIKTARVY (bictegravir/emtricitabine/tenofovir)	efavirenz/lamivudine/tenofovir	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)	JULUCA (dolutegravir/rilpivirine)	
SYMFI (efavirenz/lamivudine/tenofovir)	rilpivirine ER	
SYMFI LO (efavirenz/lamivudine/tenofovir)	STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir alafenamide)	
TRIUMEQ PD (abacavir/dolutegravir/lamivudine)		
ANTIVIRALS, ORAL		
ANTI-CYTOMEGALOVIRUS AGENTS		Valganciclovir solution - Automatic approval issued for 0-12 years of age PREVYMIS - Requires clinical review
valganciclovir tablet	LIVTENCITY (maribavir)	
	PREVYMIS (letermovir)	
	VALCYTE (valganciclovir)	
	valganciclovir solution	
ANTI-HERPETIC AGENTS		
acyclovir	SITAVIG (acyclovir)	
famciclovir	VALTREX (valacyclovir)	
valacyclovir		
ANTI-INFLUENZA AGENTS		
oseltamivir	FLUMADINE (rimantadine)	
	RAPIVAB (peramivir)	
	RELENZA (zanamivir)	
	rimantadine	
	TAMIFLU (oseltamivir)	
	XOFLUZA (baloxavir)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIVIRALS, TOPICAL		
ZOVIRAX (acyclovir) cream	acyclovir	
	DENAVIR (penciclovir)	
	penciclovir	
	XERESE (acyclovir/hydrocortisone)	
	ZOVIRAX (acyclovir) ointment	
AROMATASE INHIBITORS		
anastrozole	ARIMIDEX (anastrozole)	
exemestane	AROMASIN (exemestane)	
letrozole	FEMARA (letrozole)	
ATOPIC DERMATITIS		
ADBRY (tralokinumab-ldrm)	CIBINQO (abrocitinib)	Minimum Age Limit • 3 months: EUCRISA • 2 years: ELIDEL, tacrolimus 0.03% • 12 years: OPZELURA • 16 years: tacrolimus 0.1%
ADBRY Autoinjector (tralokinumab-ldrm)	EBGLYSS Pen (lebrikizumab-lbkz)	
DUPIXENT (dupilumab) ^{DUR+}	NEMLUVIO (nemolizumab-ilto)	
ELIDEL (pimecrolimus)	OPZELURA (ruxolitinib)	
EUCRISA (crisaborole) ^{DUR+}	ZORYVE (roflumilast) 0.15% cream	
pimecrolimus		
tacrolimus		
ADBRY – MANUAL PA		
CIBINQO • Requires clinical review		
DUPIXENT • 1 claim with DUPIXENT in the past 60 days OR • New starts require clinical review (see manual PA links below) ○ Asthma – MANUAL PA ○ Atopic Dermatitis – MANUAL PA ○ COPD – MANUAL PA ○ Eosinophilic Esophagitis – MANUAL PA ○ Nasal Polyposis – MANUAL PA ○ Prurigo Nodularis – MANUAL PA		
EBGLYSS • Requires clinical review		
EUCRISA • 30 days of therapy with a calcineurin inhibitor or topical steroid in the past 6 months		
OPZELURA • 30 days of therapy with ELIDEL, EUCRISA or tacrolimus in the past 6 months		

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS ^{DUR+}					
ANTIANGINALS				ASPRUZYO SPRINKLE Requires clinical review	
		ASPRUZYO SPRINKLE (ranolazine)			
		ranolazine ER			
BETA- AND ALPHA-BLOCKERS				Ranolazine ER - Documented diagnosis of angina AND 1 claim for a calcium channel blocker, beta-blocker, nitrate, or combination agent in the past 30 days OR 90 days of therapy with the requested agent in the past 105 days	
carvedilol		carvedilol ER			
labetalol		COREG (carvedilol)			
		COREG CR (carvedilol)		Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days	
BETA-BLOCKER/DIURETIC COMBINATIONS					
atenolol/chlorthalidone		TENORETIC (atenolol/chlorthalidone)			
bisoprolol/hydrochlorothiazide		ZIAC (bisoprolol/hydrochlorothiazide)		COREG CR - Documented diagnosis of hypertension AND - Have tried generic carvedilol AND 1 preferred agent in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days	
metoprolol/hydrochlorothiazide					
propranolol/hydrochlorothiazide					
BETA-BLOCKERS				HEMANGEOL Documented diagnosis of infantile hemangioma	
acebutolol		BETAPACE (sotalol)			
atenolol		BETAPACE AF (sotalol)			
bisoprolol		betaxolol		CORLANOR – MANUAL PA	
HEMANGEOL (propranolol)		BYSTOLIC (nebivolol)			
metoprolol succinate		INDERAL LA (propranolol)			
metoprolol tartrate		INDERAL XL (propranolol)			
nadolol		INNOPRAN XL (propranolol)			
nebivolol		KAPSPARGO SPRINKLE (metoprolol succinate)			
pindolol		LOPRESSOR (metoprolol tartrate)			
propranolol		SOTYLIZE (sotalol)			
propranolol ER		TENORMIN (atenolol)			
SORINE (sotalol)		TOPROL XL (metoprolol succinate)			
sotalol					
sotalol AF					
timolol					
SINUS NODE AGENTS					
		CORLANOR (ivabradine)			
		ivabradine			
BILE SALTS					
ursodiol		BYLVAY (odevixibat)			
		CHENODAL (chenodiol)			
		IQIRVO (elafibranor)			
		LIVDELZI (seladelpar)			
		LIVMARLI (maralixibat)			
		OCALIVA (obeticholic acid)			
		RELTONE (ursodiol)			

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BILE SALTS (continued)		
	URSO FORTE (ursodiol)	
BLADDER RELAXANT PREPARATIONS DUR+		
MYRBETRIQ (mirabegron)	darifenacin ER	Non-Preferred Criteria Have tried 2 different preferred agents in the past 6 months
oxybutynin	DETROL (tolterodine)	
oxybutynin ER	DETROL LA (tolterodine)	
solifenacin	fesoterodine	
	GEMTESA (vibegron)	
	mirabegron ER	
	tolterodine	
	tolterodine ER	
	TOVIAZ (fesoterodine)	
	trospium	
	trospium ER	
	VESICARE (solifenacin)	
	VESICARE LS (solifenacin)	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS DUR+		
BISPHOSPHONATES		Non-Preferred Criteria - Documented diagnosis of osteoporosis or osteopenia AND - Have tried 2 different preferred agents in the past 6 months
alendronate tablet	ACTONEL (risedronate)	
ibandronate tablet	alendronate solution	
risedronate	ATELVIA (risedronate)	
	BINOSTO (alendronate)	
	FOSAMAX (alendronate)	
	FOSAMAX PLUS D (alendronate/vitamin D3)	
	ibandronate syringe/vial	
	risedronate DR	
OTHERS		
FORTEO (teriparatide)	calcitonin salmon	
raloxifene	EVENITY (romosozumab-aqqg)	
	EVISTA (raloxifene)	
	JUBBONTI (denosumab-bbdz) ^{NR}	
	MIACALCIN (calcitonin salmon)	
	OSENVELT (denosumab-bmwo) ^{NR}	
	PROLIA (denosumab)	
	teriparatide	
	STOBOCLO (denoxumab-bmwo) ^{NR}	
	TYMLOS (abaloparatide)	
	WYOST (denosumab-bbdz) ^{NR}	
	XGEVA (denosumab)	

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
BPH AGENTS					
5-ALPHA-REDUCTASE INHIBITORS				CARDURA, FLOMAX, PROSCAR, terazosin, or UROXATRAL – Female - Documented State-accepted diagnosis Non-Preferred Criteria – Male - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days ENTADFI - Requires clinical review	
dutasteride		AVODART (dutasteride)			
finasteride		ENTADFI (finasteride/tadalafil)			
		PROSCAR (finasteride)			
ALPHA BLOCKERS					
alfuzosin ER		CARDURA (doxazosin)			
doxazosin		CARDURA XL (doxazosin)			
tamsulosin		dutasteride/tamsulosin			
terazosin		FLOMAX (tamsulosin)			
		RAPAFLO (silodosin)			
		silodosin			
PHOSPHODIESTERASE TYPE 5 (PDE5) INHIBITORS					
		CIALIS (tadalafil)			
		tadalafil			
BRONCHODILATORS & COPD AGENTS					
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS				Minimum Age Limit 6 years: SPIRIVA RESPIMAT SPIRIVA RESPIMAT - Automatic approval issued for diagnosis of asthma for ≥ 6 years of age BREZTRI AEROSPHERE 3 claims with BREZTRI AEROSPHERE in the past 105 days OR - New starts require clinical review Non-Preferred Criteria 1 claim for a preferred agent in the past 6 months OR 3 claims with the requested agent in the past 105 days	
ANORO ELLIPTA (umeclidinium/vilanterol)		BEVESPI AEROSPHERE (glycopyrrolate/formoterol)			
COMBIVENT RESPIMAT (ipratropium/albuterol)		DUAKLIR PRESSAIR (aclidinium/formoterol)			
ipratropium/albuterol					
STIOLTO RESPIMAT (tiotropium/olodaterol)					
ANTICHOLINERGIC-BATA AGONIST-GLUCOCORTICOID COMBINATIONS				Minimum Age Limit 4 years: SEREVENT, XOPENEX HFA 6 years: XOPENEX Solution 18 years: BROVANA, PERFOROMIST, STRIVERDI RESPIMAT Quantity Limit (per 31 days) 10.7 units – BREZTRI AEROSPHERE XOPENEX HFA and Solution 1 claim for a preferred albuterol (inhaler or vials) in the past 30 days	
		BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol) ^{DUR+}			
		TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)			
ANTICHOLINERGICS AND COPD AGENTS					
ATROVENT HFA (ipratropium)		DALIRESP (roflumilast)			
INCRUSE ELLIPTA (umeclidinium)		OHTUVAYRE (ensifentrine)			
ipratropium		roflumilast			
SPIRIVA HANDIHALER (tiotropium)		SPIRIVA RESPIMAT (tiotropium) ^{DUR+}			
		tiotropium			
		TUDORZA PRESSAIR (aclidinium)			
		YUPERI (revefenacin)			

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
BRONCHODILATORS & COPD AGENTS (continued)					
INHALATION SOLUTION DUR+				See previous page for additional PA Criteria/DUR+ Rules	
albuterol		arformoterol			
		BROVANA (arformoterol)			
		formoterol, formoterol fumarate			
		levalbuterol			
		PERFOROMIST (formoterol)			
INHALERS, LONG ACTING DUR+					
SEREVENT DISKUS (salmeterol)					
STRIVERDI RESPIMAT (olodaterol)					
INHALERS, SHORT ACTING					
albuterol HFA		levalbuterol HFA			
VENTOLIN HFA (albuterol)		PROAIR DIGIHALER (albuterol)			
		XOPENEX HFA (levalbuterol)			
ORAL					
albuterol IR		albuterol ER			
terbutaline					
CALCIUM CHANNEL BLOCKERS DUR+					
LONG-ACTING				Quantity Limit (per 21 days) • 252 capsules: nimodipine • 2520 mL: nimodipine Non-Preferred Criteria – Long Acting • Have tried 2 different preferred Long Acting CCB agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days Non-Preferred Criteria – Short Acting • Have tried 2 different preferred Short Acting CCB agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days Nimodipine • Documented diagnosis of subarachnoid hemorrhage in the past 45 days AND • Duration of therapy limited to 21 days	
amlodipine		CARDIZEM CD (diltiazem)			
CARTIA XT (diltiazem)		CARDIZEM LA (diltiazem)			
diltiazem ER 24 HR		diltiazem ER 12 HR			
diltiazem CD 24 HR		diltiazem LA 24 HR			
diltiazem XR 24 HR		KATERZIA (amlodipine)			
DILT-XR 24 HR (diltiazem)		levamlodipine			
felodipine		MATZIM LA (diltiazem)			
nifedipine ER		nisoldipine			
TAZTIA XT (diltiazem)		NORVASC (amlodipine)			
verapamil ER		PROCARDIA XL (nifedipine)			
LONG-ACTING					
verapamil SR		SULAR (nisoldipine)			
		TIADYLT ER (diltiazem)			
		TIAZAC (diltiazem)			
		verapamil PM			
		VERELAN PM (verapamil)			
SHORT-ACTING					
diltiazem		CARDIZEM (diltiazem)			
nicardipine		isradipine			
nifedipine		nimodipine capsule and solution			
verapamil		NORLIQVA (amlodipine)			

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CALCIUM CHANNEL BLOCKERS ^{DUR+} (continued)		
	NYMALIZE (nimodipine)	
CALORIC AGENTS		
BOOST	All non-preferred caloric/nutritional agents (which are all other products except those specifically listed as preferred) require a manual prior authorization.	Non-Preferred Agents – MANUAL PA
BREAKFAST ESSENTIALS		
BRIGHT BEGINNINGS		
DUOCAL		
ENSURE		
NUTREN		
OSMOLITE		
PEDIASURE		
PROMOD		
RESOURCE		
TWOCAL HN		
CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)		
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		Non-Preferred Criteria – All Cephalosporin Generations - Have tried 2 different preferred agents in the past 6 months Maximum Age Limit 18 years: cefdinir suspension
amoxicillin/clavulanate	amoxicillin/clavulanate ER	
	AUGMENTIN (amoxicillin/clavulanate)	
CEPHALOSPORINS – FIRST GENERATION		
cefadroxil	cephalexin tablet	
cephalexin capsule, suspension		
CEPHALOSPORINS – SECOND GENERATION		
cefaclor capsule	cefaclor ER	
cefprozil	cefaclor suspension	
cefuroxime		
CEPHALOSPORINS – THIRD GENERATION		
cefdinir	cefixime suspension	
cefixime capsule	SUPRAX (cefixime)	
cefpodoxime		
COLONY STIMULATING FACTORS		
FULPHILA (pegfilgrastim-jmdb)	FYLNETRA (pegfilgrastim-pbbk)	
NEUPOGEN (filgrastim)	GRANIX (tbo-filgrastim)	
	LEUKINE (sargramostim)	
	NEULASTA, NEULASTA ONPRO (pegfilgrastim)	
	NIVESTYM (filgrastim-aafi)	
	NYVEPRIA (pegfilgrastim-apaf)	

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
COLONY STIMULATING FACTORS <i>(continued)</i>		
	RELEUKO (filgrastim-ayow)	
	RYZNEUTA (efbemalenograstim alfa-vuxw) ^{NR}	
	ROLVEDON (eflapegastim-xnst)	
	STIMUFEND (pegfilgrastim-fpgk)	
	UDENYCA, UDENYCA ONBODY (pegfilgrastim-cbqv)	
	ZARXIO (filgrastim-sndz)	
	ZIEXTENZO (pegfilgrastim-bmez)	
CYSTIC FIBROSIS AGENTS ^{DUR+}		
PULMOZYME (dornase alfa)	ALYFTREK (vanzacaftor/tezacaftor/deutivacaftor)	Minimum Age Limit • 1 month: KALYDECO granules • 3 months: PULMOZYME • 1 year: ORKAMBI • 2 years: COLY-MYCIN M, TRIKAFTA granules • 6 years: ALYFTREK, BETHKIS, KALYDECO tablet, KITABIS, SYMDEKO, TOBI, TOBI PODHALER, TRIKAFTA tablet • 7 years: CAYSTON • 18 years: BRONCHITOL Maximum Age Limit • 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 50-25-37.5 mg tablets Preferred Agents • Documented diagnosis of Cystic Fibrosis OR • Require clinical review ALYFTREK – MANUAL PA KALYDECO – MANUAL PA ORKAMBI – MANUAL PA SYMDEKO – MANUAL PA TOBI PODHALER – Require clinical review TRIKAFTA – MANUAL PA
tobramycin (generic TOBI)	BETHKIS (tobramycin)	
	BRONCHITOL (mannitol)	
	CAYSTON (aztreonam)	
	colistimethate	
	COLY-MYCIN M (colistin)	
	KALYDECO (ivacaftor)	
	KITABIS (tobramycin)	
	ORKAMBI (lumacaftor/ivacaftor)	
	SYMDEKO (tezacaftor/ivacaftor)	
	TOBI (tobramycin)	
	TOBI PODHALER (tobramycin)	
	tobramycin (generic BETHKIS & KITABIS)	
	TRIKAFTA (elexacaftor/tezacaftor/ivacaftor)	

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CYTOKINE & CAM ANTAGONISTS ^{DUR+}		
ACTEMRA (tocilizumab) syringe, vial	ABRILADA (adalimumab-afzb)	Preferred Agents – Criteria details found here Non-Preferred Agents - Require clinical review IV Administered Agents - Require clinical review
AVSOLA (infliximab-axxq)	ACTEMRA ACTPEN (tocilizumab)	
ENBREL (etanercept)	adalimumab-aaty	
HUMIRA (adalimumab)	adalimumab-adaz	
KINERET (anakinra)	adalimumab-adbm	
methotrexate	adalimumab-fkjp	
OLUMIANT (baricitinib)	adalimumab-ryvk	
ORENCIA CLICKJECT (abatacept)	AMJEVITA (adalimumab-atto)	
ORENCIA VIAL (abatacept)	ARCALYST (rilonacept)	
OTEZLA (apremilast)	BIMZELX (bimekizumab-bkzx)	
RINVOQ (upadacitinib)	CIMZIA (certolizumab)	
RINVOQ LQ (upadacitinib)	COSENTYX (secukinumab)	
SIMPONI (golimumab)	CYLTEZO (adalimumab-adbm)	
TALTZ (ixekizumab)	ENTYVIO (vedolizumab)	
TYENNE Syringe, Vial (tocilizumab-aazg)	HADLIMA (adalimumab-bwwd)	
XELJANZ (tofacitinib) tablet	HULIO (adalimumab-fkjp)	
	HYRIMOZ (adalimumab-adaz)	
	IDACIO (adalimumab-aacf)	
	ILARIS (canakinumab)	
	ILUMYA (tildrakizumab-asmn)	
	INFLECTRA (infliximab-dyyb)	
	infliximab	
	JYLAMVO (methotrexate)	
	KEVZARA (sarilumab)	
	LITFULO (ritlectinib)	
	OMVOH (mirikizumab-mrkz)	
	ORENCIA SYRINGE (abatacept)	
	OTREXUP (methotrexate)	
	OTULFI (ustekinumab-aaaz)	
	PYZCHIVA (ustekinumab-ttwe)	
	RASUVO (methotrexate)	
	REMICADE (infliximab)	
	RENFLEXIS (infliximab-abda)	
	SILIQ (brodalumab)	
	SIMLANDI (adalimumab-ryvk)	
	SIMPONI ARIA (golimumab)	
	SKYRIZI (risankizumab-rzaa)	
	SOTYKTU (deucravacitinib)	
	SPEVIGO (spesolimab-sbzo)	
	STELARA (ustekinumab)	

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
CYTOKINE & CAM ANTAGONISTS ^{DUR+} (continued)					
	TOFIDENCE (tocilizumab-bavi)	See previous page for additional PA Criteria/DUR+ Rules			
	TREMFYA (guselkumab)				
	TREXALL (methotrexate)				
	TYENNE Autoinjector (tocilizumab-aazg)				
	XATMEP (methotrexate)				
	XELJANZ (tofacitinib) solution				
	XELJANZ XR (tofacitinib)				
	YESINTEK (ustekinumab-kfce)				
	YUFLYMA (adalimumab-aaty)				
	YUSIMRY (adalimumab-aqvh)				
	ZYMFENTRA (infliximab-dyyb)				
ERYTHROPOIESIS STIMULATING PROTEINS ^{DUR+}					
EPOGEN (epoetin alfa)	ARANESP (darbepoetin alfa)	Non-Preferred Criteria - Documented diagnosis of cancer or chronic renal failure OR - Antineoplastic therapy in the past 6 months AND - Have tried a preferred RETACRIT or EPOGEN in the past 6 months OR 1 claim for the requested agent in the past 105 days JESDUVROQ - Requires clinical review MIRCERA - Documented diagnosis of chronic renal failure in the past 2 years			
MIRCERA (methoxy polyethylene glycol-epoetin-beta)	JESDUVROQ (daprodustat)				
RETACRIT (epoetin alfa-epbx)	PROCRIT (epoetin alfa)				
	VAFSEO (vadadustat)				
FACTOR DEFICIENCY PRODUCTS ^{DUR+}					
FACTOR VIII		HEMLIBRA 3 claims with HEMLIBRA in the past 105 days OR - New starts require clinical review – MANUAL PA			
ADVATE	ADYNOVATE				
AFSTYLA	ELOCTATE				
ALPHANATE	ESPEROCT				
ALTUVIIIQ	JIVI				
FEIBA	KCENTRA				
HEMOFIL M	OBIZUR				
HUMATE-P	VONVENDI				
KOATE					
KOGENATE FS					
KOVALTRY					
NOVOEIGHT					
NUWIQ					
RECOMBINATE					
WILATE					
XYNTHA, XYNTHA SOLOFUSE					

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
FACTOR DEFICIENCY PRODUCTS ^{DUR+} (continued)		
FACTOR IX		
ALPHANINE SD	BEQVEZ	
ALPROLIX	REBINYN	
BENEFIX		
IDELVION		
IXINITY		
PROFILNINE		
RIXUBIS		
OTHER HEMOPHILIA PRODUCTS		
COAGADEX (factor X)	ALHEMO (concizumab-mtci)	
FIBRYGA (fibrinogen)	CORIFACT (factor XIII)	
HEMLIBRA (emicizumab-kxwh) ^{DUR+}	HYMPAVZI (marstacimab-hncq)	
RIASTAP (fibrinogen)	NOVOSEVEN RT (factor VII)	
	SEVENFACT (factor VII)	
	TRETTEN (factor XIII)	
FIBROMYALGIA/NEUROPATHIC PAIN AGENTS		
duloxetine (generic CYMBALTA)	CYMBALTA (duloxetine)	
gabapentin	DIRZALMA SPRINKLE (duloxetine)	
pregabalin	duloxetine 40 mg DR capsules (generic IRENKA)	
SAVELLA (milnacipran)	gabapentin ER	
	GABARONE (gabapentin)	
	GRALISE (gabapentin)	
	HORIZANT (gabapentin enacarbil)	
	LYRICA, LYRICA CR (pregabalin)	
	NEURONTIN (gabapentin)	
	pregabalin ER	
FLUOROQUINOLONES ^{DUR+}		
ciprofloxacin tablet	BAXDELA (delafloxacin)	Non-Preferred Criteria 1 claim for a preferred agent in the past 30 days CIPRO Suspension for Age < 12 Years - Documented diagnosis of Cystic Fibrosis or Anthrax infection or exposure OR - Documented diagnosis 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: - Penicillin, 2nd or 3rd generation cephalosporin or macrolide LEVAQUIN Suspension for Age < 12 Years - Documented diagnosis of Anthrax infection or exposure OR - History of 7 days of therapy with a preferred from 2 of the following classes in the past 3 months See next page for additional PA Criteria/DUR+ Rules
levofloxacin tablet	CIPRO (ciprofloxacin)	
	ciprofloxacin suspension	
	levofloxacin solution	
	moxifloxacin	
	ofloxacin	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
FLUOROQUINOLONES ^{DUR+} (continued)		
		See previous page for additional PA Criteria/DUR+ Rules
		○ Penicillin, 2nd or 3rd generation cephalosporins, or macrolide AND ● History of ciprofloxacin suspension in the past 3 months
GAUCHER’S DISEASE		
ELELYSO (taliglucerase alfa)	CERDELGA (eliglustat)	
ZAVESCA (miglustat)	CEREZYME (imiglucerase)	
	miglustat	
	VPRIV (velaglucerase alfa)	
	YARGESA (miglustat)	
GENITAL WARTS & ACTINIC KERATOSIS AGENTS		
CONDYLOX (podofilox)	CARAC (fluorouracil)	Minimum Age Limit ● 12 years: ALDARA, ZYCLARA ● 18 years: CONDYLOX, PICATO, VEREGEN
fluorouracil	EFUDEX (fluorouracil)	
imiquimod	VEREGEN (sinecatechins)	
podofilox	ZYCLARA (imiquimod)	
GI ULCER THERAPIES		
H2 RECEPTOR ANTAGONISTS		Prilosec 2.5 mg suspension ● Automatic approval issued for 0-2 years of age Prilosec 10 mg suspension ● Requires clinical review
famotidine	cimetidine	
	nizatidine	
	PEPCID (famotidine)	
OTHERS		
CARAFATE (sucralfate) suspension	CARAFATE (sucralfate) tablet	
misoprostol	CYTOTEC (misoprostol)	
sucralfate	DARTISLA (glycopyrrolate)	
	VOQUEZNA (vonoprazan)	
PROTON PUMP INHIBITORS		
esomeprazole capsule	DEXILANT (dexlansoprazole)	
NEXIUM (esomeprazole) packet	dexlansoprazole	
omeprazole	esomeprazole packet	
pantoprazole	KONVOMEK (omeprazole/sodium bicarbonate)	
	lansoprazole Rx	
	NEXIUM (esomeprazole) capsule	
	omeprazole/sodium bicarbonate	
	PREVACID (lansoprazole)	
	PRILOSEC (omeprazole) packet	
	PROTONIX (pantoprazole)	
	rabeprazole	
	ZEGERID (omeprazole/sodium bicarbonate)	

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
GLUCOCORTICOIDS (INHALED)					
GLUCOCORTICOIDS				Non-Preferred Criteria • Glucocorticoids ○ 2 preferred single-entity agents in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days • Glucocorticoid/Bronchodilator Combinations ○ 2 preferred combination agents in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days • Note: ○ Institutional-sized products are non-preferred AIRDUO DIGIHALER • Requires clinical review ARMONAIR DIGIHALER • Requires clinical review PROAIR DIGIHALER – Require clinical review Minimum Age Limit • 18 years: AIRSUPRA Quantity Limit (per 31 days) • 2 inhalers: AIRSUPRA -- MANUAL PA	
ASMANEX (mometasone)		ALVESCO (ciclesonide)			
budesonide 0.25 mg and 0.5 mg		ARMONAIR DIGIHALER (fluticasone)			
fluticasone diskus		ARNUITY ELLIPTA (fluticasone)			
fluticasone HFA		ASMANEX HFA (mometasone)			
PULMICORT FLEXHALER (budesonide)		budesonide 1 mg			
QVAR REDIHALER (beclomethasone)		FLOVENT HFA (fluticasone)			
		FLOVENT DISKUS (fluticasone)			
		PULMICORT (budesonide) nebulizer solution			
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS					
ADVAIR DISKUS (fluticasone/salmeterol)		AIRDUO DIGIHALER (fluticasone/salmeterol)			
ADVAIR HFA (fluticasone/salmeterol)		AIRSUPRA (albuterol/budesonide)			
DULERA (mometasone/formoterol)		BREO ELLIPTA (fluticasone/vilanterol)			
fluticasone/salmeterol diskus		BREYNA (budesonide/formoterol)			
fluticasone/salmeterol HFA		budesonide/formoterol			
SYMBICORT (budesonide/formoterol)		fluticasone/vilanterol			
		WIXELA INHUB (fluticasone/salmeterol)			
GROWTH HORMONES DUR+					
GENOTROPIN (somatropin)		HUMATROPE (somatropin)		All Agents • Age ≥ 18 years ○ Documented diagnosis of craniopharyngioma, panhypopituitarism, Prader-Willi Syndrome, Turner Syndrome or an approvable adult diagnosis OR ○ Documented procedure of cranial irradiation • Age < 18 years ○ Documented diagnosis of idiopathic short stature AND ○ Documented approvable pediatric diagnosis OR ○ Documented approvable pediatric diagnosis Minimum Age Limit • 3 years: NGENLA Maximum Age Limit • 18 years: NGENLA and SKYTROFA See next page for additional PA Criteria/DUR+ Rules	
NORDITROPIN FLEXPPO (somatropin)		NGENLA (somatropin-ghla)			
SKYTROFA (lonapegsomatropin-tcgd)		OMNITROPE (somatropin)			
		SEROSTIM (somatropin)			
		SOGROYA (somapacitan-beco)			
		VOXZOGO (vosoritide)			
		ZOMACTON (somatropin)			

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		See previous page for additional PA Criteria/DUR+ Rules Non-Preferred Criteria - Documented approvable diagnosis for age as above AND - Have tried 1 preferred agent in the past 6 months OR 84 days of therapy with the requested agent in the past 105 days SKYTROFA < 18 years AND - No history of diagnosis of Prader-Willi Syndrome AND 28 days of therapy with a preferred short-acting growth hormone in the past 105 days
H. PYLORI COMBINATION TREATMENTS		
PYLERA (bismuth subcitrate potassium/metronidazole/ tetracycline)	bismuth subcitrate potassium/metronidazole/tetracycline	Quantity Limit 1 treatment course/year: all agents
	lansoprazole/amoxicillin/clarithromycin	
	OMECLAMOX (omeprazole/clarithromycin/amoxicillin)	
	TALICIA (omeprazole/amoxicillin/rifabutin)	
	VOQUEZNA DUAL PAK (vonoprazan/amoxicillin)	
	VOQUEZNA TRIPLE PAK (vonoprazan/amoxicillin/clarithromycin)	
HEPATITIS B TREATMENTS		
entecavir	adefovir dipivoxil	
lamivudine HBV	BARACLUDE (entecavir)	
tenofovir disoproxil fumarate	VEMLIDY (tenofovir alafenamide)	
	VIREAD (tenofovir disoproxil fumarate)	
HEPATITIS C TREATMENTS		
MAVYRET (glecaprevir/pibrentasvir) ∞	EPCLUSA (sofosbuvir/velpatasvir) ∞	∞ EPCLUSA, HARVONI, MAVYRET, SOVALDI, VOSEVI, ZEPATIER - Require MANUAL PA Note: - EPCLUSA, HARVONI, MAVYRET and SOVALDI have FDA-approved pediatric indications
PEGASYS (peginterferon alfa-2a)	HARVONI (ledipasvir/sofosbuvir) ∞	
ribavirin tablet	ledipasvir/sofosbuvir ∞	
sofosbuvir/velpatasvir	ribavirin capsule	
	SOVALDI (sofosbuvir) ∞	
	VIEKIRA PAK (ombitasvir/paritaprevir/ritonavir)	
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) ∞	
	ZEPATIER (elbasvir/grazoprevir) ∞	
HEREDITARY ANGIOEDEMA		
BERINERT (C1 esterase inhibitor)	CINRYZE (C1 esterase inhibitor)	
icatibant	FIRAZYR (icatibant)	
	KALBITOR (ecallantide)	
	ORLADEYO (berotralstat)	
	RUCONEST (C1 esterase inhibitor)	
	SAJAZIR (icatibant)	
	TAKHZYRO (lanadelumab-flvo)	

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPERURICEMIA & GOUT DUR+		
allopurinol	ALOPRIM (allopurinol)	Non-Preferred Criteria Have tried 2 different preferred agents in the past 6 months
colchicine tablet	colchicine capsule	
probenecid	COLCRYS (colchicine)	
probenecid/colchicine	febuxostat	
	GLOPERBA (colchicine)	
	MITIGARE (colchicine)	
	ULORIC (febuxostat)	
	ZYLOPRIM (allopurinol)	
HYPOGLYCEMIA TREATMENT		
BAQSIMI (glucagon)	GVOKE (glucagon) ^{Step Edit}	Minimum Age Limit 1 year: BAQSIMI 2 years: GVOKE 6 years: ZEGALOGUE Quantity Limit (per 31 days) 2 packs (or kits): BAQSIMI, glucagon, GVOKE, ZEGALOGUE Non-Preferred Criteria – GVOKE 1 claim with preferred BAQSIMI or ZEGALOGUE in the past 30 days
GLUCAGEN (glucagon)		
glucagon emergency kit		
glucagon vial		
ZEGALOGUE (dasiglucagon)		
HYPOGLYCEMICS, BIGUANIDES		
metformin	GLUMETZA (metformin)	Non-Preferred Criteria - Have tried 2 different preferred DPP4 agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days Note: Concomitant use of a GLP-1 agent and a DPP-4 agent requires clinical review
metformin ER (generic GLUCOPHAGE XR)	metformin ER (generic FORTAMET)	
	metformin ER (generic GLUMETZA)	
	metformin solution	
	RIOMET (metformin)	
JANUMET (sitagliptin/metformin)	alogliptin	
JANUMET XR (sitagliptin/metformin)	alogliptin/metformin	
JANUVIA (sitagliptin)	JENTADUETO XR (linagliptin/metformin)	
JENTADUETO (linagliptin/metformin)	KAZANO (alogliptin/metformin)	
TRADJENTA (linagliptin)	KOMBIGLYZE XR (saxagliptin/metformin)	
	NESINA (alogliptin)	
	ONGLYZA (saxagliptin)	
	OSENI (alogliptin/pioglitazone)	
	saxagliptin	
	saxagliptin/metformin ER	
	sitagliptin	
	sitagliptin/metformin	
	ZITUVIMET (sitagliptin/metformin)	
	ZITUVIMET XR (sitagliptin/metformin)	
	ZITUVIO (sitagliptin)	

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS ^{DUR+}		
BYETTA (exenatide)	BYDUREON (exenatide)	Minimum Age Limit • 10 years: BYDUREON BCISE, TRULICITY, VICTOZA • 18 years: BYETTA, MOUNJARO, OZEMPIC, RYBELSUS Preferred Criteria • Documented diagnosis of Type 2 Diabetes AND • No history of SAXENDA or WEGOVY in the past 30 days OR • No documented diagnosis for Type 2 Diabetes AND • 84 days of therapy with the requested agent in the past 105 days Non-Preferred Criteria • Documented diagnosis of Type 2 Diabetes AND • No history of SAXENDA or WEGOVY in the past 30 days AND • 84 days of therapy with TRULICITY in the past 6 months AND • 84 days of therapy with either preferred BYETTA or VICTOZA in the past 6 months • OR • Documented diagnosis of Type 2 Diabetes AND • 84 days of therapy with the request agent in the past 105 days <u>Note:</u> • Concomitant use of a GLP-1 agonist and a DPP-4 agent requires clinical review. • Please see the PDL category Anti-obesity Select Agents for a list of covered agents. RYBELSUS 1.5 mg and 3 mg Require clinical review
TRULICITY (dulaglutide)	exenatide	
VICTOZA (liraglutide)	liraglutide	
	MOUNJARO (tirzepatide)	
	OZEMPIC (semaglutide)	
	RYBELSUS (semaglutide)	
	SOLIQUA (insulin glargine/lixisenatide)	
	SYMLINPEN (pramlintide)	
	XULTOPHY (insulin degludec/liraglutide)	
HYPOGLYCEMICS, INSULINS & RELATED AGENTS ^{DUR+}		
HUMALOG MIX 75/25 vial (insulin lispro/lispro protamine)	ADMELOG (insulin lispro)	Non-Preferred Criteria • Documented diagnosis of Diabetes Mellitus AND • Have tried 1 preferred agent in the past 6 months OR • 1 claim with the requested agent in the past 105 days Quantity Limit • Insulin quantity limits can be found here <u>Note:</u> • Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries.
HUMULIN 70/30 vial (insulin NPH/regular)	AFREZZA (insulin regular)	
HUMULIN N (insulin NPH)	APIDRA (insulin glulisine)	
HUMULIN R (insulin regular)	BASAGLAR (insulin glargine)	
HUMULIN R U-500 (insulin regular)	FIASP (insulin aspart/niacinamide)	
insulin aspart	HUMALOG; HUMALOG JUNIOR, KWIKPEN,	
insulin aspart protamine mix 70/30 vial	TEMPO PEN (insulin lispro)	
insulin lispro	HUMALOG MIX KWIKPEN 50/50, 75/25 (insulin lispro/lispro protamine)	
insulin lispro protamine mix 75/25 vial	HUMULIN 70/30 KWIKPEN (insulin N/regular)	
LANTUS (insulin glargine)	HUMULIN N KWIKPEN (insulin N)	
TOUJEO (insulin glargine)	insulin degludec	
TOUJEO MAX (insulin glargine)	insulin glargine	
	insulin glargine-yfgn	
	LEVEMIR (insulin detemir)	
	LYUMJEV (insulin lispro-aabc)	
	NOVOLIN 70/30 (insulin NPH/regular)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMICS, INSULINS & RELATED AGENTS ^{DUR+} (continued)		
	NOVOLIN N (insulin NPH)	See previous page for additional PA Criteria/DUR+ Rules
	NOVOLIN R (insulin regular)	
	NOVOLOG (insulin aspart)	
	NOVOLOG MIX 70/30 (insulin aspart protamine/aspart)	
	REZVOGLAR (insulin glargine-aglr)	
	SEMGLEE (insulin glargine-yfgn)	
	TRESIBA (insulin degludec)	
HYPOGLYCEMICS, MEGLITINIDES ^{DUR+}		
nateglinide		
repaglinide		
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 (SGLT-2) INHIBITORS ^{DUR+}		
SGLT-2 INHIBITORS		Non-Preferred Criteria - Have tried 2 different preferred SGLT-2 inhibitors in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days
FARXIGA (dapagliflozin)	dapagliflozin	
JARDIANCE (empagliflozin)	INPEFA (sotagliflozin)	
	INVOKANA (canagliflozin)	
	STEGLATRO (ertugliflozin)	
SGLT-2 INHIBITOR COMBINATIONS		
GLYXAMBI (empagliflozin/linagliptin)	dapagliflozin/metformin ER	
SYNJARDY (empagliflozin/metformin)	INVOKAMET (canagliflozin/metformin)	
SYNJARDY XR (empagliflozin/metformin)	INVOKAMET XR (canagliflozin/metformin)	
TRIJARDY XR (empagliflozin/linagliptin/metformin)	QTERN (dapagliflozin/saxagliptin)	
	SEGLUROMET (ertugliflozin/metformin)	
	STEGLUJAN (ertugliflozin/sitagliptin)	
	XIGDUO XR (dapagliflozin/metformin)	
HYPOGLYCEMICS, THIAZOLIDINEDIONES (TZDs) and TZD Combinations		
pioglitazone	ACTOPLUS MET (pioglitazone/metformin)	
pioglitazone/metformin	ACTOS (pioglitazone)	
pioglitazone/glimepiride	DUETACT (pioglitazone/glimepiride)	
IDIOPATHIC PULMONARY FIBROSIS ^{DUR+}		
OFEV (nintedanib)	ESBRIET (pirfenidone)	All Agents Documented diagnosis of Idiopathic Pulmonary Fibrosis
	pirfenidone	
		OFEV - Documented diagnosis of Idiopathic Pulmonary Fibrosis OR 90 days of therapy with Ofev in the past 105 days ESBRIET or pirfenidone - Requires clinical review

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
IMMUNE GLOBULINS					
BIVIGAM		ALYGLO			
FLEBOGAMMA		ASCENIV			
GAMASTAN		CABLIVI			
GAMMAGARD		CUTAQUIG			
GAMMAGARD S-D		CUVITRU			
GAMUNEX-C		GAMMAKED			
HIZENTRA		GAMMAPLEX			
HYQVIA		OCTAGAM			
PANZYGA					
PRIVIGEN					
XEMBIFY					
IMMUNOLOGIC THERAPIES FOR ASTHMA					
DUPIXENT (dupilumab) ^{DUR+}		CINQAIR (reslizumab)		CINQAIR Requires clinical review See below for additional PA Criteria/DUR+ Rules	
FASENRA (benralizumab)		NUCALA (mepolizumab)			
XOLAIR (omalizumab)		TEZSPIRE (tezepelumab-ekko)			
DUPIXENT 1 claim with DUPIXENT in the past 60 days OR - New starts require clinical review (see manual PA links below) Asthma – MANUAL PA Atopic Dermatitis – MANUAL PA COPD – MANUAL PA Eosinophilic Esophagitis – MANUAL PA Nasal Polyposis – MANUAL PA Prurigo Nodularis – MANUAL PA					
FASENRA Requires clinical review – MANUAL PA					
NUCALA Requires clinical review					
TEZSPIRE Requires clinical review					
XOLAIR 1 claim with XOLAIR in the past 45 days OR - New starts require clinical review – MANUAL PA					
IMMUNOSUPPRESSIVE AGENTS, ORAL					
AZASAN (azathioprine)		ASTAGRAF XL (tacrolimus)		Minimum Age Limit 13 years: RAPAMUNE 18 years: ZORTRESS Maximum Age Limit 12 years: PROGRAF Granules See next page for additional PA Criteria/DUR+ Rules	
azathioprine		ENVARSUS XR (tacrolimus)			
CELLCEPT (mycophenolate)		MYFORTIC (mycophenolate)			
cyclosporine		PROGRAF (tacrolimus)			
everolimus		REZUROCK (belumosudil)			
mycophenolate		ZORTRESS (everolimus)			
mycophenolic acid					
NEORAL (cyclosporine)					
RAPAMUNE (sirolimus)					
SANDIMMUNE (cyclosporine)					
sirolimus					
tacrolimus					

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
See previous page for additional PA Criteria/DUR+ Rules		
Preferred Criteria • AZASAN ◦ Documented diagnosis of kidney transplant, RA, or a State-accepted diagnosis • CELLCEPT ◦ Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis • GENGRAF, NEORAL, SANDIMMUNE ◦ Documented diagnosis of heart transplant, kidney transplant, liver transplant, psoriasis, RA, or a State-accepted diagnosis • Everolimus ◦ Documented diagnosis of kidney or liver transplant • RAPAMUNE ◦ Documented diagnosis of kidney transplant • Tacrolimus ◦ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis Non-Preferred Criteria • MYHIBBIN Suspension ◦ Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis AND ◦ 30 days of therapy with mycophenolate suspension in the past 105 days OR ◦ 90 days of therapy with MYHIBBIN Suspension in the past 105 days • ASTAGRAF XR or ENVARUS XR ◦ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis AND ◦ 30 days of therapy with tacrolimus IR in the past 105 days OR ◦ 90 days of therapy with the requested agent in the past 105 days • PROGRAF Granules ◦ Age ≤ 11 years AND ◦ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis • MYFORTIC ◦ Documented diagnosis of kidney transplant or psoriasis • ZORTRESS ◦ Documented diagnosis of kidney or liver transplant		

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA		
INTRANASAL RHINITIS AGENTS						
ANTICHOLINERGICS			Non-Preferred Criteria – Corticosteroids • Documented diagnosis of allergic rhinitis AND • Have tried 1 different preferred agent in the past 6 months			
ipratropium						
ANTIHISTAMINE/CORTICOSTEROID COMBINATIONS						
	azelastine/fluticasone					
	DYMISTA (azelastine/fluticasone)					
	RYALTRIS (olopatadine/mometasone)					
ANTIISTAMINES						
azelastine		olopatadine				
	PATANASE (olopatadine)					
CORTICOSTEROIDS						
fluticasone		BECONASE AQ (beclomethasone)				
	flunisolide					
	mometasone					
	NASONEX (mometasone)					
	OMNARIS (ciclesonide)					
	QNASL (beclomethasone)					
	XHANCE (fluticasone)					
	ZETONNA (ciclesonide)					
IRON CHELATING AGENTS						
deferasirox (all manufacturers except those listed as non-preferred)		deferasirox (manufacturers starting with 45963, 62332)		JADENU – MANUAL PA		
deferiprone 500 mg tablet		EXJADE (deferasirox)				
FERRIPROX (deferiprone)		JADENU, JADENU SPRINKLE (deferasirox)				
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED AGENTS ^{DUR+}						
IRRITABLE BOWEL SYNDROME CONSTIPATION ^{DUR+}			Minimum Age Limit • 1 year: GATTEX • 6 years: LINZESS 72 mcg • 18 years: AMITIZA, IBSRELA, LINZESS 145 mcg & 290 mcg, MOTEGRITY, MOVANTIK, MYTESI, RELISTOR, SYMPROIC, TRULANCE, VIBERZI Gender Limit • Female – AMITIZA 8 mcg			
LINZESS (linaclotide)		AMITIZA (lubiprostone)				
lubiprostone		IBSRELA (tenapanor)				
TRULANCE (plecanatide)		MOTTEGRITY (prucalopride)				
	MOVANTIK (naloxegol)					
	prucalopride					
	RELISTOR (methylnaltrexone)					
	SYMPROIC (naldemedine)					
IRRITABLE BOWEL SYNDROME DIARRHEA						
dicyclomine		alosetron				
ED-SPAZ (hyoscyamine)		LOTRONEX (alosetron) ^{DUR+}				
hyoscyamine, hyoscyamine ER		VIBERZI (eluxadoline) ^{DUR+}				
HYOSYNE (hyoscyamine)						
LEVSIN, LEVSIN-SL (hyoscyamine)						
NULEV (hyoscyamine)						
OSCIMIN, OSCIMIN SL (hyoscyamine)						
SHORT BOWEL SYNDROME AND SELECTED GI AGENTS ^{DUR+}			See next page for additional PA Criteria/DUR+ Rules			
	GATTEX (teduglutide)					
	MYTESI (crofelemer)					

See next page for additional PA Criteria/DUR+ Rules

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
IRRITABLE BOWEL SYNDROME – CONSTIPATION ^{DUR+}		
Chronic Idiopathic Constipation (CIC): Amitiza 24 mcg, LINZESS 72 mcg, LINZESS 145 mcg, MOTEGRITY, TRULANCE • Preferred CIC Agents - o Documented diagnosis of CIC in the past year AND - o No history of GI or bowel obstruction • LINZESS 72 mcg - o Age 6-17 years AND - o Documented diagnosis of CIC or pediatric functional constipation in the past year AND - o No history of GI or bowel obstruction • Non-Preferred CIC Agents - o Documented diagnosis of CIC AND - o No history of GI or bowel obstruction AND - o Have tried 2 preferred CIC agents in the past 6 months OR - o 1 claim with the requested agent in the past 105 days	Irritable Bowel Syndrome – Constipation Dominant (IBS-C): AMITIZA 8 mcg, IBSRELA, LINZESS 290 mcg, TRULANCE • Preferred IBS-C Agents - o Documented diagnosis of IBS-C in the past year AND - o No history of GI or bowel obstruction • Non-Preferred IBS-C Agents - o Documented diagnosis of IBS-C in the past year AND - o No history of GI or bowel obstruction AND - o Have tried 2 preferred IBS-C agents in the past 6 months OR - o 1 claim with the requested agent in the past 105 days	Opioid Induced Constipation (OIC): AMITIZA 24 mcg, MOVANTIK, RELISTOR, SYMPROIC • Preferred OIC Agents - o Documented diagnosis of OIC and chronic pain in the past year AND - o No history of GI or bowel obstruction AND - o 1 claim for an opioid in the past 30 days • Non-Preferred OIC Agents - o All preferred criteria met AND - o Have tried 1 preferred OIC agents in the past 6 months OR - o 1 claim with the requested agent in the past 105 days • Relistor Injection - o Above OIC criteria OR - o Documented diagnosis of OIC and active cancer in the past year AND - o No history of GI or bowel obstruction AND - o 1 claim for an opioid in the past 30 days
IRRITABLE BOWEL SYNDROME – DIARRHEA		
• VIBERZI [New starts require clinical review] Documented diagnosis of IBS – D in the past year and 1 claim for Viberzi in the past 105 days • LOTROXEX - o 1 claim for LOTROXEX in the past 105 days OR - o New starts require clinical review – MANUAL PA • XIFAXAN – (see Antibiotics, GI)		
SHORT BOWEL SYNDROME AND SELECTED GI AGENTS ^{DUR+}		
HIV/AIDS Non-infectious Diarrhea • MYTESI - o Documented diagnosis of HIV/AIDS and non-infectious diarrhea in the past year AND - o 1 claim for an antiretroviral in the past 30 days	Short Bowel Syndrome (SBS) • GATTEX - o 1 claim for GATTEX in the past 105 days OR - o New starts require clinical review	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LEUKOTRIENE MODIFIERS ^{DUR+}		
montelukast	ACCOLATE (zafirlukast)	Minimum Age Limit • 12 years: ZYFLO & ZYFLO CR Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
zafirlukast	SINGULAIR (montelukast)	
	zileuton	
	ZYFLO (zileuton)	
LIPOTROPICS, OTHER (NON-STATINS)		
ACL INHIBITORS AND COMBINATIONS		Non-Preferred Criteria – Fibric Acid Derivatives ◦ Have tried 2 different preferred Fibric Acid Derivative agents in the past 6 months JUXTAPID – MANUAL PA
	NEXLETOL (bempedoic acid)	
	NEXLIZET (bempedoic acid/ezetimibe)	KYNAMRO • Requires clinical review LEQVIO • Requires clinical review NEXLETOL and NEXLIZET • Require clinical review PRALUENT – MANUAL PA
ANGIOPOIETIN-LIKE 3 INHIBITORS		
	EVKEEZA (evinacumab-dgnb)	
BILE ACID SEQUESTRANTS		
cholestyramine	colesevelam	
cholestyramine light	COLESTID (colestipol)	
LIPOTROPICS, OTHER (NON-STATINS)		
colestipol tablet	colestipol packet	REPATHA – MANUAL PA WELCHOL • Documented diagnosis of Type 2 Diabetes AND • 30 days of therapy with an antidiabetic agent in the past 6 months OR 90 days of therapy with WELCHOL in the past 105 days
	PREVALITE (cholestyramine)	
	QUESTRAN (cholestyramine)	
	QUESTRAN LIGHT (cholestyramine)	
	WELCHOL (colesevelam)	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe	ZETIA (ezetimibe)	
FIBRIC ACID DERIVATIVES		
fenofibrate	fenofibric acid	
gemfibrozil	FENOGLIDE (fenofibrate)	
	FIBRICOR (fenofibric acid)	
	LIPOFEN (fenofibrate)	
	LOPID (gemfibrozil)	
	TRICOR (fenofibrate)	
	TRILIPIX (fenofibric acid)	
MTP INHIBITOR		
	JUXTAPID (lomitapide)	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LIPOTROPICS, OTHER (NON-STATINS) (continued)		
NIACIN		See previous page for additional PA Criteria/DUR+ Rules
niacin ER		
OMEGA-3 FATTY ACIDS		
omega-3 acid ethyl esters		
icosapent ethyl		
LOVAZA (omega-3 acid ethyl esters)		
PCSK-9 INHIBITORS		
REPATHA (evolocumab)		
LEQVIO (inclisiran)		
PRALUENT (alirocumab)		
LIPOTROPICS, STATINS DUR+		
STATINS		Minimum Age Limit • 10 years: ATORVALIQ Suspension Non-Preferred Criteria • Have tried 2 different preferred statin or statin combination agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days Simvastatin Daily doses ≥ 80 mg require clinical review
atorvastatin		
ALTOPREV (lovastatin)		
lovastatin		
ATORVALIQ (atorvastatin)		
pravastatin		
CRESTOR (rosuvastatin)		
rosuvastatin		
EZALLOR SPRINKLE (rosuvastatin)		
simvastatin		
FLOLIPID (simvastatin)		
fluvastatin		
fluvastatin ER		
LESCOL XL (fluvastatin)		
LIPITOR (atorvastatin)		
LIVALO (pitavastatin)		
pitavastatin		
ZOCOR (simvastatin)		
ZYPITAMAG (pitavastatin)		
STATIN COMBINATIONS		
ezetimibe/simvastatin		
amlodipine/atorvastatin		
CADUET (amlodipine/atorvastatin)		
VYTORIN (ezetimibe/simvastatin)		
MISCELLANEOUS BRAND/GENERIC		
ALLERGEN EXTRACT IMMUNOTHERAPY		CUMULATIVE quantity limit (per 31 days) • 31 tablets: alprazolam ER Quantity Limit (per 31 days) • 2 kits: epinephrine EVRYSDI – MANUAL PA
GRASTEK		
ORALAIR		
RAGWITEK		
EPINEPHRINE		
epinephrine (Mylan)		AUVI-Q (epinephrine)

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MISCELLANEOUS BRAND/GENERIC (continued)		
	epinephrine (all other manufacturers)	See previous page for additional PA Criteria/DUR+ Rules
	EPIPEN (epinephrine)	
	EPIPEN JR (epinephrine)	
	NEFFY (epinephrine)	
MISCELLANEOUS		
alprazolam	alprazolam ER	
hydroxyzine HCL	CAMZYOS (mavacamten)	
hydroxyzine pamoate	CRENESSITY (crinecerfont)	
megestrol	EVRYSDI (risdiplam)	
REVLIMID (lenalidomide)	KORLYM (mifepristone)	
	lenalidomide	
	TRYNGOLZA (olezarsen)	
	VERQUVO (vericiguat)	
	VISTARIL (hydroxyzine pamoate)	
	XANAX, XANAX XR (alprazolam)	
SUBLINGUAL NITROGLYCERIN		
nitroglycerin		
NITROLINGUAL (nitroglycerin)		
NITROSTAT (nitroglycerin)		
MOVEMENT DISORDER AGENTS DUR+		
AUSTEDO (deutetrabenazine)	INGREZZA INITIATION PACK (valbenazine)	AUSTEDO and AUSTEDO XR - Documented diagnosis of Huntington's chorea OR - Documented diagnosis of tardive dyskinesia AND 90 days of therapy with either agent in the past 105 days OR - New starts require clinical review – MANUAL PA INGREZZA - Documented diagnosis of Huntington's chorea OR - Documented diagnosis of tardive dyskinesia AND 90 days of therapy with this agent in the past 105 days OR - New starts require clinical review – MANUAL PA
AUSTEOD XR (deutetrabenazine)	XENAZINE (tetrabenazine)	
INGREZZA (valbenazine)		
INGREZZA SPRINKLE (valbenazine)		
tetrabenazine		
MULTIPLE SCLEROSIS AGENTS DUR+		
BETASERON (interferon beta-1b)	AMPYRA (dalfampridine)	Preferred Agents - Documented diagnosis of multiple sclerosis Non-Preferred Criteria - Documented diagnosis of multiple sclerosis AND
COPAXONE (glatiramer) 20 mg	AUBAGIO (teriflunomide)	
dalfampridine ER	AVONEX (interferon beta-1a)	
dimethyl fumarate	BAFIERTAM (monomethyl fumarate)	
fingolimod	BRIUMVI (ublituximab-xiiy)	
REBIF (interferon beta-1b)	COPAXONE (glatiramer) 40 mg	
REBIF REBIDOSE (interferon beta-1b)	GILENYA (fingolimod)	
		See next page for additional PA Criteria/DUR+ Rules

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MULTIPLE SCLEROSIS AGENTS ^{DUR+} (continued)		
teriflunomide	glatiramer	See previous page for additional PA Criteria/DUR+ Rules - Have tried 2 different preferred agents in the past 6 months OR 3 claims with the requested agent in the last 105 days KESIMPTA, PONVORY, TASCENSO ODT, and ZEPOSIA - Require clinical review MAVENCLAD – MANUAL PA MAYZENT – MANUAL PA OCREVUS and OCREVUS ZUNOVO – MANUAL PA
TYSABRI (natalizumab)	GLATOPA (glatiramer)	
	KESIMPTA PEN (ofatumumab)	
	MAVENCLAD (cladribine)	
	MAYZENT (siponimod)	
	OCREVUS (ocrelizumab)	
	OCREVUS ZUNOVO (ocrelizumab/hyaluronidase-ocsq)	
	PLEGRIDY (peginterferon beta-1a)	
	PONVORY (ponesimod)	
	TASCENSO ODT (fingolimod)	
	TECFIDERA (dimethyl fumarate)	
	VUMERITY (diroximel fumarate)	
	ZEPOSIA (ozanimod)	
MUSCULAR DYSTROPHY AGENTS		
EMFLAZA (deflazacort)	AGAMREE (vamorolone)	AGAMREE – MANUAL PA
	AMONDYS-45 (casimersen)	ELEVIDYS – MANUAL PA
	deflazacort	EMFLAZA – MANUAL PA
	DUVYZAT (givinostat)	EXONDYS – MANUAL PA
	ELEVIDYS (delandistrogene moxeparvovec-rokl)	VILTEPSO – MANUAL PA
	EXONDYS-51 (eteplirsen)	VYONDYS – MANUAL PA
	VILTEPSO (viltolarsen)	
	VYONDYS-53 (golodirsen)	
NSAIDS		
COX II SELECTIVE		Quantity Limit (per 31 days) 20 tablets: ketorolac tablets ELYXYB - Requires clinical review Non-Preferred Criteria – COX II Selective - No history of a contraindicated GI disorder or coagulation disorder AND - Documented diagnosis of Osteoarthritis, Rheumatoid Arthritis, Familial Adenomatous Polyposis, or Ankylosing Spondylitis AND - Have tried 1 preferred COX-II selective agent OR 90 days of therapy with the requested agent in the past 105 days See next page for additional PA Criteria/DUR+ Rules
meloxicam	CELEBREX (celecoxib)	
	celecoxib	
	ELYXYB (celecoxib)	
NON-SELECTIVE		
diclofenac sodium	DAYPRO (oxaprozin)	
diclofenac sodium ER	diclofenac potassium	
EC-naproxen DR 500 mg tablet	DOLOBID (diflunisal)	
etodolac tablet	etodolac capsule, etodolac ER	
flurbiprofen	FELDENE (piroxicam)	
ibuprofen	fenoprofen	
indomethacin capsule	indomethacin ER, indomethacin suppository	
ketoprofen	ketoprofen	

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
NSAIDS (continued)					
ketorolac		kiprofen		See previous page for additional PA Criteria/DUR+ Rules	
nabumetone		LOFENA (diclofenac potassium)			
naproxen 250 mg, 500 mg		meclofenamate			
piroxicam		mefenamic acid			
sulindac		NALFON (fenoprofen)			
		NAPRELAN (naproxen)			
		NAPROSYN 375 mg (naproxen)			
		naproxen 375 mg, naproxen CR 375 mg, naproxen ER 500 mg			
		oxaprozin			
		RELAFEN DS (nabumetone)			
		TOLECTIN 600 mg (tolmetin)			
		tolmetin			
NSAID/GI PROTECTANT COMBINATIONS					
		ARTHROTEC 50 mg, 75 mg (diclofenac/misoprostol)		Non-Preferred Criteria – Non-Selective & Combinations - No history of a contraindicated GI disorder or coagulation disorder AND - Have tried 2 different preferred non-selective agents in the past 6 months	
		diclofenac/misoprostol			
		ibuprofen/famotidine			
		naproxen/esomeprazole			
		VIMOVO (naproxen/esomeprazole)			
OPHTHALMIC AGENTS					
ANTIBIOTICS				Minimum Age Limit	
bacitracin/polymyxin		AZASITE (azithromycin)		• 16 years: RESTASIS	
ciprofloxacin		bacitracin		• 17 years: XIIDRA	
erythromycin		BESIVANCE (besifloxacin)		• 18 years: CEQUA, MIEBO, VEVYE	
gentamicin		CILOXAN (ciprofloxacin)		Quantity Limit (per 31 days)	
moxifloxacin		gatifloxacin		• 2 mL: VEVYE	
ofloxacin		NATACYN (natamycin0		• 3 mL: MIEBO	
polymyxin B/trimethoprim		neomycin/bacitracin/polymyxin		• 5.5 mL: RESTASIS Multidose	
tobramycin		OCUFLOX (ofloxacin)		• 60 units: CEQUA, RESTASIS Droperette, XIIDRA	
		sulfacetamide		Non-Preferred Criteria	
		TOBREX (tobramycin)		• Anti-Inflammatory Agents Have tried 2 different preferred agents in the past 6 months	
		VIGAMOX (moxifloxacin)		• Dry Eye Agents / CEQUA 4 claims for RESTASIS Droperette and XIIDRA in the past 6 months	
ANTIBIOTIC-STEROID COMBINATIONS				EYSUVIS	
BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone)		MAXITROL (neomycin/polymyxin/dexamethasone)		Requires clinical review	
neomycin/bacitracin/polymyxin/hydrocortisone		neomycin/polymyxin/gramicidin		See next page for additional PA Criteria/DUR+ Rules	
neomycin/polymyxin/dexamethasone		TOBRADEX ST (tobramycin/dexamethasone)			
PRED-G (gentamicin/prednisolone)					
sulfacetamide/prednisolone					
TOBRADEX (tobramvcin/dexamethasone)					

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
OPHTHALMIC AGENTS (continued)					
tobramycin/dexamethasone				See previous page for additional PA Criteria/DUR+ Rules	
ZYLET (tobramycin/loteprednol)					
ANTI-INFLAMMATORY AGENTS				MIEBO - Requires clinical review RESTASIS Multidose - Require clinical review TYRVAYA - Requires clinical review VEVYE Requires clinical review	
dexamethasone	ACULAR, ACULAR LS (ketorolac)				
diclofenac sodium	ACUVAIL (ketorolac)				
difluprednate	bromfenac				
FLAREX (fluorometholone)	BROMSITE (bromfenac)				
fluorometholone	DUREZOL (difluprednate)				
flurbiprofen	FML (fluorometholone)				
FML FORTE (fluorometholone)	ILEVRO (nepafenac)				
ketorolac	INVELTYS (loteprednol)				
MAXIDEX (dexamethasone)	LOTEMAX, LOTEMAX SM (loteprednol)				
PRED MILD (prednisolone)	loteprednol				
prednisolone acetate	NEVANAC (nepafenac)				
prednisolone sodium phosphate	PRED FORTE (prednisolone)				
	PROLENSA (bromfenac)				
DRY EYE AGENTS					
RESTASIS Droperette (cyclosporine)	CEQUA (cyclosporine)				
XIIDRA (lifitegrast)	cyclosporine				
	EYSUVIS (loteprednol)				
	MIEBO (perfluorohexyloactane)				
	RESTASIS Multidose (cyclosporine)				
	TYRVAYA (varenicline)				
	VEVYE (cyclosporine)				
OPHTHALMIC, GLAUCOMA AGENTS					
BETA BLOCKERS				Minimum Age Limit 18 years: IYUZEH Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days	
BETIMOL (timolol)	betaxolol				
carteolol	BETOPTIC S (betaxolol)				
ISTALOL (timolol)	timolol droperette, daily drop, gel				
levobunolol	TIMOPTIC; TIMOPTIC OCUDOSE, XE (timolol)				
timolol drops 0.25%, 0.5%					
CARBONIC ANHYDRASE INHIBITORS					
dorzolamide	AZOPT (brinzolamide)				
	brinzolamide				
COMBINATION AGENTS					
COMBIGAN (brimonidine/timolol)	brimonidine/timolol				
dorzolamide/timolol	COSOPT (dorzolamide/timolol)				
SIMBRINZA (brinzolamide/brimonidine)	dorzolamide/timolol PF				
PARASYMPATHOMIMETICS					
pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide)				

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OPHTHALMIC, GLAUCOMA AGENTS (continued)		
PROSTAGLANDIN ANALOGS		See previous page for additional PA Criteria/DUR+ Rules
latanoprost	bimatoprost	
	IYUZEH (latanoprost)	
	LUMIGAN (bimatoprost)	
	tafluprost	
	TRAVATAN Z (travoprost)	
	travoprost	
	VYZULTA (latanoprost)	
	XALATAN (latanoprost)	
	XELPROS (latanoprost)	
	ZIOPTAN (tafluprost)	
RHO KINASE INHIBITORS/COMBINATIONS		
RHOPRESSA (netarsudil)		
ROCKLATAN (netarsudil/latanoprost)		
SYMPATHOMIMETICS		
ALPHAGAN P (brimonidine)	brimonidine 0.1%, 0.15%	
brimonidine 0.2%		
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS		
ALREX (loteprednol)	ALOCRIL (nedocromil)	Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months VERKAZIA - Requires clinical review
azelastine	ALOMIDE (lodoxamide)	
cromolyn	bepotastine	
ketotifen OTC	BEPREVE (bepotastine)	
olopatadine	epinastine	
ZADITOR (ketotifen)	LASTACFT (alcaftadine)	
	VERKAZIA (cyclosporine)	
	ZERVIAE (cetirizine)	
OPIATE DEPENDENCE TREATMENTS		
DEPENDENCE		Buprenorphine/naloxone provider summary found here SUBLOCADE – MANUAL PA VIVITROL – MANUAL PA
buprenorphine/naloxone SL tablet DUR+	BRIXADI (buprenorphine)	
naltrexone	buprenorphine DUR+	
SUBOXONE (buprenorphine/naloxone) DUR+	buprenorphine/naloxone film DUR+	
	lofexidine	
	LUCEMYRA (lofexidine)	
	SUBLOCADE (buprenorphine)	
	VIVITROL (naltrexone)	
	ZUBSOLV (buprenorphine/naloxone)	
TREATMENT		
KLOXXADO (naloxone)	LIFEMS NALOXONE (naloxone convenience kit)	
naloxone		
NARCAN (naloxone)		

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OPIATE DEPENDENCE TREATMENTS (continued)		
OPVEE (nalmefene)		See previous page for additional PA Criteria/DUR+ Rules
REXTOVY (naloxone)		
ZIMHI (naloxone)		
OTIC ANTIBIOTICS		
CIPRO HC (ciprofloxacin/hydrocortisone)	ciprofloxacin	Maximum Age Limit 9 years: CIPRO HC Ciprofloxacin/Dexamethasone Suspension Criteria - Age ≥ 6 months AND - Experiencing otorrhea secondary to recent, post-tympanostomy tube placement AND - Continued otorrhea after 10 days of otic treatment with ciprofloxacin ophthalmic solution and dexamethasone ophthalmic suspension
CORTISPORIN-TC (neomycin/colistin/hydrocortisone)	ciprofloxacin/fluocinolone	
fluocinolone	ciprofloxacin/dexamethasone	
neomycin/polymyxin/hydrocortisone	DERMOTIC (fluocinolone)	
	FLAC OTIC OIL (fluocinolone)	
	hydrocortisone/acetic acid	
	OTOVEL (ciprofloxacin/fluocinolone)	
PANCREATIC ENZYMES		
CREON (lipase/protease/amylase)	PERTZYE (lipase/protease/amylase)	Non-Preferred Criteria Have tried 2 different preferred agents in the past 6 months
ZENPEP (lipase/protease/amylase)	VIOKACE (lipase/protease/amylase)	
PARATHYROID AGENTS		
calcitriol	doxercalciferol	
cinacalcet	RAYALDEE (calcifediol)	
ergocalciferol	ROCALTROL (calcitriol)	
paricalcitol	SENSIPAR (cinacalcet)	
ZEMPLAR (paricalcitol)	YORVIPATH (palopegteriparatide)	
PHOSPHATE BINDERS		
calcium acetate	AURYXIA (ferric citrate)	
CALPHRON (calcium acetate)	FOSRENOL (lanthanum)	
sevelamer carbonate tablet	lanthanum	
	MAGNEBIND (calcium carbonate/magnesium)	
	RENVELA (sevelamer)	
	sevelamer carbonate packet, sevelamer HCl	
	VELPHORO (sucroferric oxyhydroxide)	
	XPHOZAH (tenapanor)	
PLATELET AGGREGATION INHIBITORS		
aspirin/dipyridamole	EFFIENT (prasugrel)	Non-Preferred Criteria - Documented diagnosis AND - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days ZONTIVITY – MANUAL PA
BRILINTA (ticagrelor)	PLAVIX (clopidogrel)	
cilostazol	ticagrelor ^{NR}	
clopidogrel		
dipyridamole		
pentoxifylline		
prasugrel		

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
PLATELET STIMULATING AGENTS					
NPLATE (romiplostim)		ALVAIZ (eltrombopag)			
PROMACTA (eltrombopag) tablet		DOPTelet (avatrombopag)			
		MULPLETA (lusutrombopag)			
		PROMACTA (eltrombopag) packet			
		TAVALISSE (fostamatinib)			
POTASSIUM REMOVING AGENTS					
LOKELMA (sodium zirconium cyclosilicate)		KIONEX (sodium polystyrene sulfonate)			
SPS (sodium polystyrene sulfonate) suspension		sodium polystyrene sulfonate			
		SPS (sodium polystyrene sulfonate) enema			
		VELTASSA (patiromer calcium sorbitex)			
PRENATAL VITAMINS					
CLASSIC PRENATAL		All prenatal vitamins are non-preferred except for those specifically indicated as preferred.		List of Preferred NDC's for Prenatal Vitamins can be found here	
COMPLETE NATAL DHA					
COMPLETENATE					
M-NATAL PLUS					
NIVA-PLUS					
PRENATAL PLUS VITAMIN-MINERAL					
PNV 72, 95, 124, and 137 / IRON / FOLIC ACID					
SE-NATAL-19					
STUART ONE					
THRIVITE RX					
TRICARE					
TRINATAL RX 1					
WESNATAL DHA COMPLETE					
WESTAB PLUS					
PSEUDOBULBAR AFFECT AGENTS					
		NUEDEXTA (dextromethorphan/quinidine)		Non-Preferred Criteria • Documented diagnosis of pseudobulbar affect disorder OR • 90 days of therapy with NUEDEXTA in the past 105 days	
PULMONARY ANTIHYPERTENSIVE AGENTS					
ACTIVIN SIGNALING INHIBITORS			Minimum Age Limit • 18 years: ADEMPAS, OPSYNVI, TADLIQ		
		WINREVAIR (sotatercept-csrk)			
COMBINATION AGENTS			Maximum Age Limit • 12 years: REVATIO suspension		
		OPSYNVI (macitentan/tadalafil)			
ENDOTHELIN RECEPTOR ANTAGONISTS			Preferred Criteria • PAH Agents See next page for additional PA Criteria/DUR+ Rules		
ambrisentan		OPSUMIT (macitentan)			
bosentan		TRACLEER (bosentan)			
LETAIRIS (ambrisentan)		TRYVIO (aprocitentan)			

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PULMONARY ANTIHYPERTENSIVE AGENTS (continued)		
PDE5 INHIBITORS		See previous page for additional PA Criteria/DUR+ Rules - Documented diagnosis of pulmonary hypertension Sildenafil tablets ≤ 1 year of age and documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation OR ≥ 1 year of age and documented diagnosis of pulmonary hypertension OR 90 days of therapy with the requested agent in the past 105 days Sildenafil suspension < 12 years of age AND - Documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation, or a history of a heart transplant OR 90 days stable therapy with sildenafil suspension in the past 105 days Non-Preferred Criteria - Documented diagnosis of pulmonary hypertension AND - Have tried 1 preferred PAH agent in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days OPSUMIT, OPSYNVI, ORENITRAM ER, TYVASO, and VENTAVIS - Require clinical review
sildenafil (generic REVATIO) tablet, suspension	ADCIRCA (tadalafil)	
tadalafil	ALYQ (tadalafil)	
	REVATIO (sildenafil)	
	TADLIQ (tadalafil)	
PROSTACYCLINS		
	ORENITRAM ER (treprostinil)	
	ORENITRAM TITRATION PAK (treprostinil)	
	TYVASO (treprostinil)	
	VENTAVIS (iloprost)	
SELECTIVE PROSTACYCLINE RECEPTOR AGONISTS		
	UPTRAVI (selexipag)	
SOLUABLE GUANYLATE CYCLASE STIMULATORS		
	ADEMPAS (riociguat)	
ADEMPAS		
Documented diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (WHO Group 4) or pulmonary arterial hypertension (WHO Group 1) AND		
Have tried 1 preferred PAH agent in the past 6 months OR		
90 days of therapy with ADEMPAS in the past 105 days		
TADLIQ		
Documented diagnosis of pulmonary hypertension AND		
Have tried preferred sildenafil suspension in the past 6 months OR		
90 days of therapy with TADLIQ in the past 105 days		
UPTRAVI		
Documented diagnosis of pulmonary hypertension AND		
Have tried 1 preferred endothelin receptor antagonist in the past 6 months AND		
Have tried 1 preferred PDE5 inhibitor in the past 6 months OR		
90 days of therapy with UPTRAVI in the past 105 days		

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ROSACEA TREATMENTS		
metronidazole	AVAR (sulfacetamide sodium/sulfur)	<u>Note:</u> • Topical Sulfonamides used for Rosacea will require a manual PA for age > 21 years. • Other labeled indications are limited to < 21 years.
	AVAR LS (sulfacetamide sodium/sulfur)	
	AVAR-E (sulfacetamide sodium/sulfur)	
	BP 10-1 (sulfacetamide sodium/sulfur)	
	brimonidine	
	EPSOLAY (benzoyl peroxide)	
	FINACEA (azelaic acid)	
	METROCREAM (metronidazole)	
	METROGEL (metronidazole)	
	MIRVASO (brimonidine)	
	NORITATE (metronidazole)	
	OVACE (sulfacetamide sodium)	
	OVACE PLUS (sulfacetamide sodium)	
	RHOFADE (oxymetazoline)	
	ROSADAN (metronidazole)	
	ROSULA (sulfacetamide sodium/sulfur)	
	sodium sulfacetamide	
	sodium sulfacetamide/sulfur	
	SOOLANTRA (ivermectin)	
	SUMADAN (sulfacetamide sodium/sulfur)	
	SUMADAN XLT (sulfacetamide sodium/sulfur/avob)	
	SUMAXIN (sulfacetamide sodium/sulfur)	
	SUMAXIN CP (sulfacetamide sodium/sulfur)	
	SUMAXIN TS (sulfacetamide sodium/sulfur)	
SEDATIVE HYPNOTIC AGENTS		
BENZODIAZEPINES ^{DUR+}		MS DOM Opioid Initiative – Criteria details found here • Concomitant use of Opioids and Benzodiazepines Maximum Age Limit • 64 years: zolpidem 7.5 mg, 10 mg, and 12.5 mg Gender and Dose Limit • Female: AMBIEN 5 mg, AMBIEN CR 6.25 mg, INTERMEZZO 1.75 mg • Male: all strengths of zolpidem Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months See next page for additional PA Criteria/DUR+ Rules
estazolam	flurazepam	
temazepam 15 mg, 30 mg capsule	HALCION (triazolam)	
	quazepam	
	RESTORIL (temazepam)	
	temazepam 7.5 mg, 22.5 mg capsule	
	triazolam	

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
SEDATIVE HYPNOTIC AGENTS (continued)		
OTHERS DUR+		See previous page for additional PA Criteria/DUR+ Rules
eszopiclone	AMBIEN (zolpidem)	HETLIOZ capsules - Age 18 years or older AND - Documented diagnosis of circadian rhythm sleep disorder OR - Age 16 years and older AND - Documented diagnosis of Smith-Magenis syndrome HETLIOZ liquid - Age 3-15 years AND - Documented diagnosis of Smith-Magenis syndrome Note: - Single-source benzodiazepines and barbiturates are NOT covered. - PA's will NOT be issued for these drugs.
ramelteon	AMBIEN CR (zolpidem)	
zaleplon	BELSOMRA (suvorexant)	
zolpidem tablet	DAYVIGO (lemborexant)	
	doxepin	
	EDULAR (zolpidem)	
	HETLIOZ LQ (tasimelteon)	
	LUNESTA (eszopiclone)	
	QUVIVIQ (daridorexant)	
	ROZEREM (ramelteon)	
	tasimelteon	
	zolpidem capsule	
	zolpidem sublingual tablet	
	zolpidem ER	
		See below for additional PA Criteria/DUR+ Rules
CUMULATIVE Quantity Limit – Benzodiazepines 31 units/31 days: Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year. CUMULATIVE Quantity Limit – Triazolam 10 units/31 days: Quantity limit per rolling days for all strengths. 60 units/365 days: Quantity limit per rolling days for all strengths. CUMULATIVE Quantity Limit – Non-Benzodiazepines 31 units/31 days: Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year. CUMULATIVE Quantity Limit – HETLIOZ LQ 1 bottle (48 mL or 158 mL): Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year. CUMULATIVE Quantity Limit – ZOLPIMIST 1 canister/31 days: male; Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year. 1 canister/62 days: female; Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.		

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
SELECT CONTRACEPTIVE PRODUCTS		
INJECTABLE CONTRACEPTIVES		Non-Preferred Criteria 1 claim with the requested agent in the past 105 days
medroxyprogesterone	DEPO-PROVERA (medroxyprogesterone)	
INTRAVAGINAL CONTRACEPTIVES		
ENILLORING (etonogestrel/ethinyl estradiol)	PHEXXI (lactic acid/citric acid/potassium bitartrate)	
ORAL CONTRACEPTIVES ^{DUR+}		
All oral contraceptives are preferred except for those specifically indicated as non-preferred.	AMETHIA (levonorgestrel/ethinyl estradiol)	
	AMETHYST (levonorgestrel/ethinyl estradiol)	
	BALCOLTRA (levonorgestrel/ethinyl estradiol)	
	BEYAZ (drospirenone/ethinyl estradiol/levomefolate)	
	CAMRESE (levonorgestrel/ethinyl estradiol)	
	CAMRESE LO (levonorgestrel/ethinyl estradiol)	
	JOLESSA (levonorgestrel/ethinyl estradiol)	
	LO LOESTRIN FE (norethindrone/ethinyl estradiol/iron)	
	LOESTRIN (norethindrone/ethinyl estradiol)	
	LOESTRIN FE (norethindrone/ethinyl estradiol/iron)	
	MINZOYA (levonorgestrel/ethinyl estradiol/iron)	
	NATAZIA (estradiol valerate/dienogest)	
	NEXTSTELLIS (drospirenone/estetrol)	
	OCELLA (ethinyl estradiol/drospirenone)	
	SAFYRAL (drospirenone/ethinyl estradiol/levomefolate)	
	SIMPESSE (levonorgestrel/ethinyl estradiol)	
	TAYTULLA (norethindrone/ethinyl estradiol/iron)	
	TYDEMY (drospirenone/ethinyl estradiol/levomefolate)	
YASMIN (ethinyl estradiol/drospirenone)		
YAZ (ethinyl estradiol/drospirenone)		
TRANSDERMAL CONTRACEPTIVES		
XULANE (norgestromin/ethinyl estradiol)	norgestromin/ethinyl estradiol	
	TWIRLA (levonorgestrel/ethinyl estradiol)	
	ZAFEMY (norgestromin/ethinyl estradiol)	

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
SICKLE CELL AGENTS		
DROXIA (hydroxyurea) hydroxyurea	ADAKVEO (crizanlizumab-tmca) CASGEVY (exagamglogene autotemcel) ENDARI (glutamine) HYDREA (hydroxyurea) l-glutamine LYFGENIA (lovotibeglogene autotemcel) SIKLOS (hydroxyurea)	ENDARI – MANUAL PA
SKELETAL MUSCLE RELAXANTS ^{DUR+}		
baclofen 5 mg, 10 mg, 20 mg tablet chlorzoxazone cyclobenzaprine 5 mg, 10 mg tablet methocarbamol tizanidine tablet	AMRIX (cyclobenzaprine) baclofen 15 mg tablet baclofen suspension carisoprodol carisoprodol/aspirin cyclobenzaprine 7.5 mg tablet cyclobenzaprine ER DANTRIUM (dantrolene) dantrolene FEXMID (cyclobenzaprine) FLEQSUVY (baclofen) LORZONE (chlorzoxazone) LYVISPAH (baclofen) metaxalone NORGESIC (orphenadrine/aspirin/cafeine) NORGESIC FORTE (orphenadrine/aspirin/cafeine) orphenadrine orphenadrine/aspirin/cafeine ORPHENGESIC FORTE (orphenadrine/aspirin/cafeine) SOMA (carisoprodol) TANLOR (methocarbamol) tizanidine capsule ZANAFLEX (tizanidine)	Quantity Limit 84 tablets/180 days: carisoprodol Non-Preferred Criteria - Documented diagnosis of an approvable indication AND - Have tried 2 different preferred agents in the past 6 months Baclofen granules, solution, and suspension - Require clinical review. Carisoprodol - Documented diagnosis of acute musculoskeletal condition AND - No history with meprobamate in the past 105 days AND - History of 1 claim for cyclobenzaprine in the past 21 Carisoprodol with codeine - Requires clinical review. Metaxalone 640 mg and TANLOR - Requires clinical review

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
SMOKING DETERRENTS					
NICOTINE TYPE				Minimum Age Limit 18 years: CHANTIX Quantity Limit 336 tablets/year: CHANTIX 0.5 mg tabs, 1 mg tabs, and continuing pack 2 treatment courses/year: CHANTIX Starter Pack	
nicotine gum ^{OTC}		NICOTROL INHALER CARTRIDGE			
nicotine lozenge ^{OTC}		NICOTROL NASAL SPRAY			
nicotine patch ^{OTC}					
NON-NICOTINE TYPE					
bupropion SR					
CHANTIX (varenicline)					
varenicline					
STEROIDS (TOPICAL)					
LOW POTENCY				Non-Preferred Criteria Low Potency - Have tried 2 different preferred low potency agents in the past 6 months Medium Potency - Have tried 2 different preferred medium potency agents in the past 6 months High Potency - Have tried 2 different preferred high potency agents in the past 6 months Very High Potency - Have tried 2 different preferred very high potency agents in the past 6 months Clobetasol 0.025% - Requires clinical review	
alclometasone		fluocinolone			
DERMA-SMOOTH-FS (fluocinolone)		hydrocortisone lotion			
desonide		HYDROXYM (hydrocortisone)			
hydrocortisone cream, ointment, solution		PROCTOCORT (hydrocortisone)			
MEDIUM POTENCY					
fluticasone		BESER (fluticasone)			
mometasone		CAPEX (fluocinolone)			
PANDEL (hydrocortisone probutate)		clocortolone			
prednicarbate cream		CLODERM (clocortolone)			
		flurandrenolide			
		fluticasone lotion			
		LOCOID (hydrocortisone butyrate)			
		prednicarbate ointment			
		SYNALAR (fluocinolone)			
HIGH POTENCY					
betamethasone dipropionate cream, lotion		amcinonide			
betamethasone dipropionate augmented		betamethasone dipropionate ointment			
betamethasone valerate		desoximetasone			
fluocinolone		diflorasone			
fluocinonide		Halcinonide			
fluocinonide-E		HALOG (halcinonide)			
triamcinolone cream, ointment, lotion		KENALOG (triamcinolone)			
		TOPICORT (desoximetasone)			
		triamcinolone spray			
		VANOS (fluocinonide)			

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
STEROIDS (TOPICAL) (continued)		
VERY HIGH POTENCY		See previous page for additional PA Criteria/DUR+ Rules
clobetasol cream, foam, gel, ointment, shampoo, solution	APEXICON E (diflorasone)	
clobetasol-E	BRYHALI (halobetasol)	
halobetasol	clobetasol emulsion	
	clobetasol 0.025% cream	
	CLOBEX (clobetasol)	
	CLODAN (clobetasol)	
	DIPROLENE (betamethasone)	
	halobetasol	
	IMPEKLO (clobetasol)	
	IMPOYZ (clobetasol) 0.025% cream	
	LEXETTE (halobetasol)	
	OLUX (clobetasol)	
	TEMOVATE (clobetasol)	
	TOVET (clobetasol)	
	ULTRAVATE (halobetasol)	
STIMULANTS AND RELATED AGENTS DUR+		
SHORT-ACTING		Minimum Age Limit 3 years: ADDERALL, EVEKEO, PROCENTRA, ZENZEDI 6 years: ADDERALL XR, ADHANSIA XR, ADZENYS ER SUSPENSION, ADZENYS XR ODT, APTENSIO XR, atomoxetine, AZSTARYS, clonidine ER, CONCERTA ER, COTEMPLA XR ODT, DAYTRANA, DESOXYN, DEXEDRINE, DYANAVEL XR, EVEKEO ODT, FOCALIN, FOCALIN XR, JORNAY PM, METADATE CD, METHYLIN, ONYDA XR, QELBREE, QUILLICHEW, QUILLIVANT XR, RELEXII ER, RITALIN LA, VYVANSE, XELSTRYM 7 years: XYREM 13 years: MYDAYIS 16 years: modafinil 18 years: armodafinil, SUNOSI, WAKIX Maximum Age Limit 18 years: clonidine ER, COTEMPLA XR ODT, DAYTRANA, EVEKEO ODT, guanfacine ER Quantity Limit – Stimulants (per 31 days) 31 tablets: ADDERALL XR, ADHANSIA XR, ADZENYS XR ODT, APTENSIO XR, AZSTARYS, CONCERTA ER 18, 27, & 54 mg, COTEMPLA XR-ODT 8.6 mg, DAYTRANA, DEXEDRINE See next page for additional PA Criteria/DUR+ Rules
dexamethylphenidate	ADDERALL (dextroamphetamine/amphetamine)	
dextroamphetamine	amphetamine	
dextroamphetamine/amphetamine	EVEKEO (amphetamine)	
Methylphenidate tablet	dextroamphetamine solution	
PROCENTRA (dextroamphetamine)	EVEKEO ODT (amphetamine)	
	FOCALIN (dexamethylphenidate)	
	methamphetamine	
	METHYLN (methylphenidate)	
	Methylphenidate chewable tablet	
	RITALIN (methylphenidate)	
	ZENZEDI (dextroamphetamine)	
LONG-ACTING		
ADDERALL XR (dextroamphetamine/amphetamine)	ADZENYS XR ODT (amphetamine)	
CONCERTA (methylphenidate)	APTENSIO XR (methylphenidate)	

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
STIMULANTS AND RELATED AGENTS ^{DUR+} (continued)		
dexmethylphenidate ER	AZSTARYS (serdexmethylphenidate/dexmethylphenidate)	See previous page for additional PA Criteria/DUR+ Rules Spansule, DYANAVEL XR Tablet, FOCALIN XR, JORNAY PM, METADATE CD, METHYLIN ER, MYDAYIS 37.5 mg & 50 mg, QUILLICHEW, RELEXXII ER, RITALIN LA & SR, VYVANSE, XELSTRYM • 62 tablets: ADDERALL, CONCERTA ER 36 mg, COTEMPLA XR-ODT 17.3 & 25.9 mg, DESOXYN, EVEKEO, FOCALIN, METHYLIN, RITALIN, ZENZEDI • 248 mL: DYANAVEL XR Suspension • 310 mL: METHYLIN, PROCENTRA • 372 mL: QUILLIVANT XR Quantity Limit – Narcolepsy (per 31 days) • 31 tablets: armodafinil 150, 200 & 250 mg, modafinil 200 mg, SUNOSI • 46.5 tablets: modafinil 100 mg • 62 tablets: armodafinil 50 mg, WAKIX Quantity Limit – Non-Stimulants (per 31 days) • 31 tablets: atomoxetine, guanfacine ER, QELBREE 100 mg • 62 tablets: QELBREE 150 mg and 200 mg • 124 tablets: clonidine ER • 1 bottle (30 mL or 60 mL): ONYDA XR Suspension VYVANSE • Documented diagnosis of binge eating disorder or ADD/ADHD OR • 90 days of therapy with Vyvanse in the past 90 days
dextroamphetamine ER	COTEMPLA XR ODT (methylphenidate)	
dextroamphetamine/amphetamine ER (generic ADDERALL XR)	DAYTRANA (methylphenidate)	
DYANAVEL XR (amphetamine) suspension	DEXEDRINE (dextroamphetamine)	
lisdexamfetamine	dextroamphetamine/amphetamine ER (generic MYDAYIS ER)	
methylphenidate CD	DYANAVEL XR (amphetamine) tablets	
methylphenidate ER tablet	FOCALIN XR (dexmethylphenidate)	
methylphenidate LA	JORNAY PM (methylphenidate)	
QUILLICHEW ER (methylphenidate)	methylphenidate patch	
QUILLIVANT XR (methylphenidate)	methylphenidate ER capsule	
VYVANSE (lisdexamfetamine) capsules	MYDAYIS (dextroamphetamine/amphetamine)	
	RELEXXII (methylphenidate)	
	RITALIN LA (methylphenidate)	
	VYVANSE (lisdexamfetamine) chewable tablets	
	XELSTRYM (dextroamphetamine)	
NARCOLEPSY		
armodafinil	NUVIGIL (armodafinil)	
modafinil	PROVIGIL (modafinil)	
SUNOSI (solriamfetol)	sodium oxybate	
XYREM (sodium oxybate)	WAKIX (pitolisant)	
	XYWAV (calcium/magnesium/potassium/sodium oxybate)	
NON-STIMULANTS		
atomoxetine	INTUNIV (guanfacine)	
clonidine ER (generic Onyda and Kapvay only)	ONYDA XR (clonidine)	
guanfacine ER	STRATTERA (atomoxetine)	
QELBREE (viloxazine)		

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
STIMULANTS AND RELATED AGENTS^{DUR+} (continued)		
See previous page for additional PA Criteria/DUR+ Rules		
Non-Preferred Short Acting Criteria ADD/ADHD - 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 Narcolepsy: ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN, ZENZEDI - Documented diagnosis of narcolepsy AND 30 days of therapy with preferred modafinil or armodafinil in the past 6 months AND 1 preferred agent indicated for narcolepsy in the past 6 months OR - Have tried 1 claim for a 30-day supply with the requested agent in the past 105 days Armodafinil - Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, or bipolar depression Atomoxetine - Age ≥ 21 years AND - Documented diagnosis of ADD/ADHD Clonidine ER - Documented diagnosis of ADD/ADHD Guanfacine ER - Documented diagnosis of ADD/ADHD JORNAY PM - Diagnosis of ADD/ADHD AND - History of 84 days of therapy (each) with 2 different preferred LA methylphenidate products in the past 6 months AND - History of 84 days of therapy with 1 preferred non-methylphenidate LA stimulant in the past 6 months OR - History of 84 days of therapy with JORNAY PM in the past 105 days ONYDA XR - Requires clinical review	Non-Preferred Long Acting Criteria ADD/ADHD - 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 Narcolepsy: ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL, PROVIGIL, QUILLICHEW, QUILLIVANT XR, RITALIN LA - Documented diagnosis of narcolepsy AND 30 days of therapy with preferred modafinil or armodafinil in the past 6 months AND 1 different preferred 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 QELBREE - Documented diagnosis of ADD/ADHD AND 30 days of therapy with a preferred ADHD agent in the past 105 days OR 30 days of therapy with QELBREE in the past 105 days SUNOSI - Documented diagnosis of narcolepsy or obstructive sleep apnea AND 30 days of therapy with preferred modafinil or armodafinil in the past 6 months VYVANSE - Documented diagnosis of binge eating disorder or ADD/ADHD VYVANSE chewable - Requires clinical review WAKIX - Requires clinical review XYREM - Diagnosis of narcolepsy or excessive daytime sleepiness OR 30 days of therapy with this agent in the past 105 days XYWAV - Requires clinical review	
See next page for additional PA Criteria/DUR+ Rules		

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
STIMULANTS AND RELATED AGENTS ^{DUR+} (continued)					
See previous page for additional PA Criteria/DUR+ Rules					
Modafinil					
Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome					
TETRACYCLINES ^{DUR+}					
doxycycline hyclate		demeclocycline		Non-Preferred Agents - Have tried 2 different preferred agents in the past 6 months Demeclocycline - Documented diagnosis of Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH) will allow for automatic approval ORACEA - Requires clinical review	
doxycycline monohydrate capsule		DORYX (doxycycline hyclate)			
minocycline capsule		DORYX MPC (doxycycline hyclate)			
tetracycline capsule		doxycycline hyclate DR			
		doxycycline IR/DR			
		doxycycline monohydrate suspension, tablet			
		LYMEPAK (doxycycline hyclate)			
		MINOCIN (minocycline)			
		minocycline tablet			
		minocycline ER			
		MINOLIRA ER (minocycline)			
		MORGIDOX (doxycycline hyclate)			
		NUZYRA (omadacycline)			
		ORACEA (doxycycline monohydrate)			
		SOLODYN (minocycline)			
		tetracycline tablet			
ULCERATIVE COLITIS & CROHN'S AGENTS ^{DUR+} *See Cytokine & CAM Antagonists Class for Additional Agents*					
ORAL				Non-Preferred Criteria - Documented diagnosis of Ulcerative Colitis AND - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days VELSIPITY - Requires clinical review	
APRISO (mesalamine)		AZULFIDINE (sulfasalazine)			
balsalazide		COLAZAL (balsalazide)			
budesonide		DELZICOL (mesalamine)			
PENTASA (mesalamine)		DIPENTUM (olsalazine)			
sulfasalazine		LIALDA (mesalamine)			
sulfasalazine DR		mesalamine			
UCERIS (budesonide)		mesalamine DR, mesalamine ER			
		VELSIPITY (etrasimod)			
RECTAL					
mesalamine suppository		budesonide			
		CANASA (mesalamine)			
		mesalamine enema			
		ROWASA (mesalamine)			
		SFROWASA (mesalamine)			
		UCERIS (budesonide)			

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 07/01/2025
Version 2025_5
Updated 06/30/2025

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
UREA CYCLE DISORDER AGENTS		
CARBAGLU (carglumic acid)	BUPHENYL (sodium phenylbutyrate)	
	carglumic acid	
	OLPRUVA (sodium phenylbutyrate)	
	PHEBURANE (sodium phenylbutyrate)	
	RAVICTI (glycerol phenylbutyrate)	