

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

ANALGESICS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Opioids – Long Acting</b>	morphine sulfate ER tablets tramadol ER <u>tablets</u> <sup>10</sup>	Belbuca® <sup>‡2</sup> buprenorphine films <sup>‡2</sup> Conzip ER® <sup>10</sup> Diskets® hydrocodone ER (generic Hysingla®, Zohydro ER) hydromorphone ER® Hysingla ER® methadone morphine sulfate ER caps (generic Avinza®) morphine sulfate ER caps (generic Kadian®) MS Contin® Nucynta ER® Oxycontin® <sup>2</sup> oxycodone ER <sup>2</sup> oxymorphone ER tramadol ER capsules <sup>10</sup> Xtampza ER® <sup>‡2</sup>
<b>Opioids – Short and Intermediate Acting</b>	codeine <sup>10,2</sup> codeine/acetaminophen <sup>10</sup> hydrocodone/acetaminophen hydromorphone oral tablets <sup>2</sup> morphine sulfate tablets, solution <sup>2</sup> morphine sulfate supp oxycodone tabs (5mg,10mg,15mg) <sup>2</sup> oxycodone oral solution <sup>2</sup> oxycodone /acetaminophen tramadol <sup>10</sup> tramadol/acetaminophen <sup>10</sup>	Actiq® <sup>‡2</sup> butorphanol <sup>2</sup> codeine / acetaminophen/caffeine /butalbital <sup>10</sup> codeine / aspirin /caffeine /butalbital <sup>10</sup> dihydrocodeine/acetaminophen/caffeine Dilaudid® all forms <sup>2</sup> fentanyl citrate buccal <sup>2</sup> Fentora® <sup>‡2</sup> Fioricet w/ Codeine® <sup>10</sup> hydrocodone/ ibuprofen hydromorphone suppository levorphanol meperidine tablets, solution <sup>2</sup> Nalocet®

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

‡ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

ANALGESICS		
Drug Class	Preferred Agents	Non-Preferred Agents
		<i>Nucynta®</i> <i>oxycodone caps</i> <sup>2</sup> <i>oxycodone tabs (20mg, 30mg)</i> <sup>2</sup> <i>oxycodone oral conc soln</i> <sup>2</sup> <i>oxycodone oral syr</i> <sup>2</sup> <i>oxymorphone</i> <sup>2</sup> <i>pentazocine/naloxone</i> <i>Percocet®</i> <i>Prolate®</i> <i>Roxybond®</i> <sup>2</sup> <i>Roxicodone®</i> <sup>2</sup> <i>Seglentis®</i> <sup>10,2</sup> <i>tramadol oral solution (generic for Qdolo®)</i> <sup>10</sup>
<b>Opioids – Transdermal</b>	<i>Butrans®</i> <sup>2</sup> <i>fentanyl patches (generic only)</i> <sup>2</sup>	<i>buprenorphine patches</i> <sup>2</sup> <i>fentanyl patches 37.5mg, 62.5mg and 87.5mg only</i>
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</b>	<i>diclofenac</i> <i>diclofenac topical gel 1% (generic for Voltaren)</i> <i>diclofenac topical gel 1% OTC</i> <i>diclofenac topical solution 1.5%</i> <i>ibuprofen</i> <i>indomethacin capsules</i> <i>ketorolac tablets</i> <i>meloxicam tablets</i> <i>nabumetone</i> <i>naproxen OTC</i> <i>naproxen (generic for Naprosyn®)</i> <i>sulindac</i>	<i>Arthrotec®</i> <i>Daypro®</i> <i>diclofenac ER</i> <i>diclofenac epolamine 1.3% patch</i> <i>diclofenac-misoprostol</i> <i>diclofenac potassium</i> <i>diclofenac 2% pump (generic for Pennsaid)</i> <i>diflunisal</i> <i>Dual Action Pain (ibuprofen/acetaminophen)</i> <i>Duexis®</i> <i>EC-naproxen</i> <i>etodolac / etodolac ER</i> <i>Feldene®</i> <i>fenoprofen</i> <i>Flector Patch®</i> <sup>2</sup> <i>flurbiprofen</i> <i>indomethacin ext release capsules</i> <i>indomethacin oral suspension</i> <i>ketoprofen ext release</i>

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

ANALGESICS		
Drug Class	Preferred Agents	Non-Preferred Agents
		<i>ketoprofen immediate release</i> <i>ketorolac nasal spray</i> ♦ <i>Licart</i> ® <sup>2</sup> <i>Lofena</i> ® <i>meclofenamate sodium</i> <i>mefenamic acid</i> <i>meloxicam capsules</i> <i>Nalfon</i> ® <i>Naprelan CR</i> ® <i>naproxen (generic for Anaprox)</i> <i>naproxen delayed release</i> <i>naproxen/esomeprazole (generic for Vimovo)</i> <i>naproxen suspension</i> <i>oxaprozin</i> <i>Pennsaid</i> ® <i>piroxicam</i> <i>Relafen DS</i> ® <i>tolmetin sodium</i> <i>Vimovo</i> ® ♦
<b>Non-Steroidal Anti-Inflammatory – Cox II Inhibitors</b>	celecoxib <sup>2</sup>	<i>Celebrex</i> ® <sup>2</sup>
<b>Opioid Use Disorder Treatments</b>	Brixadi® buprenorphine SL tabs <sup>2</sup> buprenorphine/naloxone SL <u>tabs</u> <sup>2</sup> naltrexone tablets Sublocade® SC injection Suboxone® SL films <sup>2</sup> Vivitrol® IM injection Zubsolv® SL tabs <sup>2</sup>	<i>buprenorphine/naloxone SL film (generic Suboxone films)</i> <sup>2</sup>
<b>Opioid Withdrawal Symptom Management</b>	clonidine tabs guanfacine/guanfacine ER Lucemyra®	

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

ANTIBIOTICS / ANTI-INFECTIVES		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Antibiotics – Inhaled</b>	Bethkis® Cayston® Kitabis® Tobi-Podhaler® tobramycin inhalation solution (generic for Tobi)	TOBI® inhalation tobramycin inhalation solution (generic for Bethkis) tobramycin inhalation solution (generic for Katabis)
<b>Antifungals – Oral</b>	clotrimazole troches fluconazole <sup>2</sup> griseofulvin oral suspension ketoconazole tablets nystatin oral susp, tablets terbinafine <sup>2</sup>	Ancobon Brexafemme <sup>2</sup> ♦ Cresemba® ♦ Diflucan® <sup>2</sup> flucytosine griseofulvin tablets griseofulvin microsize tablets griseofulvin ultramicrosize itraconazole <sup>2</sup> ♦ Noxafil®, Noxafil DR® posaconazole Sporanox® <sup>2</sup> ♦ Tolsura® Vfend® ♦ Vivjoa <sup>2</sup> ♦ voriconazole ♦
<b>Antifungals – Topical</b>	ciclopirox cream (generic for Loprox, Ciclodan) ciclopirox 8% solution (generic for Ciclodan) clotrimazole OTC cream, solution clotrimazole Rx cream clotrimazole/betamethasone cream ketoconazole miconazole nitrate nystatin nystatin/triamcinolone cream, ointment tolnaftate cream, powder	butenafine Ciclodan® ♦ ciclopirox shampoo ciclopirox suspension (generic for Loprox®) clotrimazole / betamethasone lotion clotrimazole Rx solution econazole nitrate Ertaczo® Extina® Jublia® ♦ Kerydin® ♦ ketoconazole foam Ketodan®

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

ANTIBIOTICS / ANTI-INFECTIVES		
Drug Class	Preferred Agents	Non-Preferred Agents
		<i>Loprox®</i> <i>Lotrimin AF®</i> <i>Iuliconazole</i> <i>Luzu®</i> <i>Mentax®</i> <i>miconazole/zinc oxide/petrolatum</i> <i>Mycozyl AC®</i> <i>Naftin®</i> <i>naftifine</i> <i>oxiconazole</i> <i>Oxistat®</i> <i>tavaborole</i> <i>Vusion®</i>
<b>Antivirals – Herpes</b>	acyclovir tablets, capsules, suspension famciclovir valacyclovir	<i>Sitavig®</i> <i>Valtrex®</i> <i>Zovirax®</i>
<b>Antivirals – Influenza<sup>5</sup></b>	oseltamivir <sup>2</sup> Relenza® <sup>2</sup> rimantadine Xofluza®	<i>Flumadine®</i> <i>Tamiflu®<sup>2</sup></i>
<b>Antivirals – Topical</b>	acyclovir ointment Denavir® Zovirax® cream	<i>acyclovir cream</i> <i>penciclovir</i> <i>Xerese®</i> <i>Zovirax® ointment</i>
<b>Cephalosporins - 1st Generation</b>	cefadroxil capsules <sup>2</sup> cefadroxil suspension cephalexin	<i>cefadroxil tablets<sup>2</sup></i>
<b>Cephalosporins - 2nd Generation</b>	cefuroxime <sup>2</sup> cefprozil tablets <sup>2</sup> cefprozil suspension	<i>cefaclor<sup>2</sup></i> <i>cefaclor ER<sup>2</sup></i>
<b>Cephalosporins - 3rd Generation</b>	cefdinir capsules, suspension <sup>2</sup> cefixime capsules Suprax® capsules	<i>cefixime suspension</i> <i>cefpodoxime tablets<sup>2</sup></i> <i>cefpodoxime suspension</i>

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

ANTIBIOTICS / ANTI-INFECTIVES		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Hepatitis C</b>	Pegasys® ribavirin	
<b>Hepatitis C – Direct-Acting Antivirals</b>	Mavyret®	Epclusa® Harvoni® ledipasvir/sofosbuvir (generic for Harvoni) sofosbuvir/velpatasvir (generic for Epclusa) Sovaldi® Viekira Pak® Vosevi® Zepatier®
<b>Macrolides</b>	azithromycin <sup>2</sup> clarithromycin <sup>2</sup> erythromycin ethylsuccinate tablets erythromycin ethylsuccinate 200mg susp Erythrocin®	clarithromycin ER E.E.S.® tablets and 400mg suspension E.E.S.® 200mg suspension EryPed® Ery-Tab® erythromycin base erythromycin ethylsuccinate 400mg suspension Zithromax® tablets <sup>2</sup> , suspension
<b>Oxazolidinones</b>	linezolid tablets <sup>2</sup>	linezolid suspension Sivextro® <sup>2</sup> ♦ Zyvox® <sup>2</sup>
<b>Quinolones</b>	Cipro® suspension ciprofloxacin suspension, tablets <sup>2</sup> levofloxacin <sup>2</sup>	Baxdela® Cipro® tablets <sup>2</sup> moxifloxacin <sup>2</sup> ♦ ofloxacin
<b>Otic Quinolones</b>	Ciprodex® ciprofloxacin/dexamethasone (generic for Ciprodex®) ofloxacin otic	ciprofloxacin otic ciprofloxacin/fluocinolone (generic for Otovel®) Cipro HC®
<b>Topical Antibiotics</b>	mupirocin ointment	Centany® mupirocin cream Xepi® <sup>2</sup>

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

ANTIBIOTICS / ANTI-INFECTIVES		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Gastrointestinal Antibiotics</b>	Difcid® Firvanq® metronidazole tablets neomycin tablets tinidazole tablets vancomycin capsules	Aemcolo® <sup>2,10</sup> ♦ Flagyl® capsules metronidazole capsules nitazoxanide tablets Vancocin® vancomycin solution Xifaxan® 200mg <sup>2,10</sup> ♦ Xifaxan® 550mg <sup>7</sup> ♦
<b>Vaginal Antibiotics</b>	Cleocin® Ovules clindamycin (generic for Cleocin) 2% cream Clindesse® 2% cream metronidazole (generic for Metro-Gel and Vandazole) gel Nuversa® 1.3% gel	Cleocin® 2% cream Vandazole® 0.75% gel Xaciato® gel

ASTHMA / COPD		
DPI = dry powder inhaler; MDI = metered dose inhaler; ISI = inhalation spray inhaler		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Anticholinergic Agents - Short Acting</b>	Atrovent HFA® <sup>2</sup> (MDI) ipratropium nebulizer solution	
<b>Anticholinergic Agents - Long Acting</b>	Incruse Ellipta® <sup>2</sup> (DPI) Spiriva® <sup>2</sup> (DPI) Spiriva Respimat® <sup>2</sup> (ISI)	Lonhala Magnair nebulizer solution tiotropium <sup>2</sup> (DPI) Tudorza Pressair® (DPI) Yupelri® nebulizer solution
<b>Beta Adrenergic and Anticholinergic Combinations</b>	Anoro Ellipta® <sup>2</sup> (DPI) Bevespi Aerosphere® <sup>2</sup> (MDI) Combivent RESPIMAT® (ISI) <sup>2</sup> ipratropium/albuterol nebulizer solution Stiolto Respimat® <sup>2</sup> (ISI)	Duaklir Pressair® (DPI)

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIrx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIrx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit



# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

ASTHMA / COPD		
<i>DPI = dry powder inhaler; MDI = metered dose inhaler; ISI = inhalation spray inhaler</i>		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Beta Adrenergic/ Anticholinergic/ Corticosteroid Combinations</b>	Trelegy Ellipta® <sup>2</sup> (DPI)	Breztri Aerosphere® <sup>2</sup> (MDI)
<b>Beta Adrenergics – Short Acting</b>	albuterol sulfate nebulizer solution Proventil HFA® <sup>2</sup> (MDI) Ventolin HFA® <sup>2</sup> (MDI) Xopenex HFA® <sup>2</sup> (MDI)	albuterol HFA <sup>2</sup> (MDI) levalbuterol HFA <sup>2</sup> (MDI) levalbuterol nebulizer solution ProAir Digihaler® (DPI) ProAir Respiclick® <sup>2</sup> (DPI)
<b>Beta Adrenergics – Long Acting</b>	Serevent® <sup>2</sup> (DPI)	arformoterol nebulizer solution ♦ formoterol nebulizer solution ♦ Brovana® nebulizer solution ♦ Perforomist® nebulizer solution ♦ Striverdi Respimat® (ISI) ♦
<b>Beta Adrenergic and Corticosteroid Inhaler Combinations</b>	Advair Diskus® <sup>2</sup> (DPI) Advair HFA® <sup>2</sup> (MDI) Dulera® <sup>2</sup> (MDI) fluticasone/salmeterol <sup>2</sup> (generic for Advair Diskus) fluticasone/salmeterol <sup>2</sup> (generic for Advair HFA) Symbicort® <sup>2</sup> (MDI) Wixela® <sup>2</sup> (DPI) (fluticasone/salmeterol)	AirDuo Digihaler® <sup>2</sup> (DPI) AirDuo Respiclick® <sup>2</sup> (DPI) Breo Ellipta® <sup>2</sup> (DPI) budesonide/formoterol <sup>2</sup> (generic for Symbicort) fluticasone/salmeterol <sup>2</sup> (generic for AirDuo) fluticasone/vilanterol <sup>2</sup> (generic for Breo Ellipta)
<b>Phosphodiesterase-4 (PDE-4) Inhibitors♦</b>	roflumilast	Daliresp®
<b>Inhaled Glucocorticoids</b>	Alvesco® (MDI) Asmanex® Twisthaler 110 mcg (DPI) <sup>1,2</sup> Asmanex® Twisthaler 220 mcg (DPI) <sup>2</sup> budesonide 0.25, 0.5mg, 1mg nebulizer solution <sup>2</sup> Flovent HFA® <sup>2</sup> (MDI) fluticasone propionate HFA <sup>2</sup> (MDI)	ArmonAir Digihaler® (DPI) Arnuity Ellipta®♦ (DPI) Asmanex HFA® <sup>2</sup> ♦ (DPI) Flovent Diskus® (DPI) fluticasone propionate diskus (DPI) Pulmicort Flexihaler® <sup>2</sup> ♦ (DPI) Pulmicort® 0.25mg, 0.5mg, 1mg Respules QVAR Redihaler® (MDI)

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit



# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

ALLERGY		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Antihistamines – 2nd Generation</b>	cetirizine tabs cetirizine 1mg/ml solution fexofenadine tablets, suspension levocetirizine tablets loratadine / loratadine ODT	<i>cetirizine chewable tabs, soft gels</i> <i>cetirizine 5mg/5ml solution (cups)</i> <i>Clarinet®</i> <i>desloratadine/ desloratadine ODT</i> <i>levocetirizine solution</i>
<b>Leukotriene Inhibitors</b>	montelukast tablets, 4mg chew tabs <sup>11</sup> , 5mg chew tabs <sup>12</sup>	<i>Accolate®</i> <i>montelukast granules<sup>11</sup></i> <i>Singulair® tablets, 4mg chew tabs<sup>11</sup>, 5mg chew tabs<sup>12</sup></i> <i>Singulair granules<sup>11</sup></i> <i>Zyflo®</i> <i>zafirlukast</i> <i>Zileuton ER®</i>
<b>Nasal Anticholinergics</b>	ipratropium nasal	
<b>Nasal Antihistamines</b>	azelastine	<i>olopatadine</i> <i>Patanase Nasal®</i>
<b>Nasal Corticosteroids</b>	fluticasone (Rx)	<i>Beconase AQ®</i> <i>budesonide</i> <i>flunisolide</i> <i>fluticasone (OTC)</i> <i>mometasone</i> <i>Nasonex 24H (OTC)</i> <i>Omnanis®</i> <i>Qnasl®</i> <i>triamcinolone</i> <i>Xhance®♦</i> <i>Zetonna®</i>
<b>Combination Nasal Sprays – <i>new class</i></b>		<i>azelastine/fluticasone</i> <i>Dymista®</i> <i>Ryaltris®</i>

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIrx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIrx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

†Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

CARDIAC MEDICATIONS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>ACE Inhibitors</b>	benazepril/ benazepril HCT enalapril/ enalapril HCT lisinopril/ lisinopril HCT ramipril	Accupril® Accuretic® Altace® captopril/ captopril HCT Epaned® fosinopril/ fosinopril HCT Lotensin® / Lotensin HCT® moexipril perindopril Qbrelis® quinapril / quinapril HCT trandolapril Vasotec® / Vaseretic® Zestril® / Zestoretic®
<b>Alpha Adrenergic Agents</b>	Catapres TTS® <sup>2</sup> clonidine transdermal <sup>2</sup> clonidine guanfacine methyldopa	methyldopa / HCTZ
<b>Antihypertensive Combinations: ACEI-CCB</b>	amlodipine / benazepril	Lotrel® trandolapril / verapamil
<b>Antihypertensive Combinations: ARB-CCB</b>	amlodipine/olmesartan amlodipine/valsartan amlodipine/valsartan/HCTZ	amlodipine/olmesartan/HCTZ Azor® Exforge® / Exforge HCT® telmisartan/amlodipine Tribenzor
<b>Angiotensin Receptor Antagonists</b>	losartan/ losartan HCT olmesartan/ olmesartan HCT valsartan/ valsartan HCT	Atacand® / Atacand HCT® Avapro®/ Avalide® Benicar®/ Benicar HCT® candesartan/ candesartan HCT Cozaar® Diovan®/ Diovan HCT® Edarbi®

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

CARDIAC MEDICATIONS		
Drug Class	Preferred Agents	Non-Preferred Agents
		<i>Edarbyclor®</i> <i>eprosartan</i> <i>Hyzaar®</i> <i>irbesartan/ irbesartan HCT</i> <i>Micardis® / Micardis HCT®</i> <i>telmisartan/ telmisartan HCT</i>
<b>Angiotensin II-Receptor Neprilysin Inhibitors (ARNIs)</b>	Entresto® <sup>2</sup>	
<b>Direct Renin Inhibitors♦</b>		<i>aliskiren</i> <i>Tektuma® / Tektuma HCT®</i>
<b>Beta Blockers</b>	atenolol atenolol / chlorthalidone bisoprolol fumarate HCT Bystolic® carvedilol Coreg CR® labetalol metoprolol / metoprolol XL metoprolol succinate metoprolol tartrate propranolol / propranolol LA Sorine® sotalol / sotalol AF	<i>acebutolol</i> <i>Betapace® / Betapace AF®</i> <i>betaxolol</i> <i>bisoprolol fumarate</i> <i>carvedilol ER</i> <i>Coreg®</i> <i>Corgard®</i> <i>Hemangeol oral solution®</i> <i>Inderal LA®/ Inderal XL®</i> <i>Innopran XL®</i> <i>Kaspargo®</i> <i>Lopressor®</i> <i>metoprolol HCT</i> <i>nadolol</i> <i>nebivolol</i> <i>pindolol</i> <i>propranolol HCT</i> <i>Sotylize®</i> <i>Tenormin®/ Tenoretic®</i> <i>timolol maleate</i> <i>Toprol XL®</i> <i>Ziac®</i>

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

CARDIAC MEDICATIONS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Calcium Channel Blockers – Dihydropyridine</b>	amlodipine besylate nifedipine / nifedipine SA	felodipine ER isradipine Katerzia® levamlodipine nicardipine nisoldipine Norliqva® <sup>16</sup> Norvasc® Procardia XL® Sular®
<b>Calcium Channel Blockers – Non- Dihydropyridine</b>	diltiazem / diltiazem XR / diltiazem ER Taztia XT® verapamil / verapamil ER tablets	Cardizem® / Cardizem LA® / Cardizem CD® diltiazem LA Matzim LA® Tiadylt ER® Tiazac® verapamil ER capsules Verelan PM® verapamil cap 24-hr pellet capsules
<b>Lipotropics: Fibric Acid Derivatives</b>	fenofibrate, nanocrystallized (generic for Tricor®) fenofibrate capsules (generic for Lofibra® caps) fenofibrate <u>tablets</u> (generic for Lofibra® tablets) gemfibrozil	Antara® fenofibrate(generic for Lipofen) fenofibrate, micronized (generic for Antara®) fenofibrate, nanocrystallized (generic for Triglide®) fenofibric acid (generic for Fibracor®) fenofibric acid (generic for Trilipix®) Fenoglide® Lopid® Lipofen® Tricor® Trilipix®
<b>Lipotropics: Bile Acid Sequestrants</b>	cholestyramine/ cholestyramine light colestipol tablets Prevalite packet, powder	Colestid® colestipol <u>granules</u> colesevelam Questran®/ Questran Light® Welchol® powder and tablets

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

CARDIAC MEDICATIONS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Lipotropics: Statins<sup>2</sup></b>	atorvastatin lovastatin pravastatin rosuvastatin simvastatin	Altoprev® amlodipine / atorvastatin Atorvaliq®♦ Caduet® Crestor® Ezallor® Sprinkle♦ ezetimibe/simvastatin fluvastatin/ fluvastatin ER Lescol XL® Lipitor® Livalo® pitavastatin Vytorin® Zocor® Zypitamag®
<b>Lipotropics: Niacin Derivatives</b>	niacin tablets (OTC) niacin ER tablets (OTC) niacin ER capsules (OTC)	niacin ER (generic for Niaspan)
<b>Lipotropics: Other</b>	ezetimibe	icosapent ethyl♦ Lovaza®♦ Nexletol®♦ Nexlizet®♦ omega-3 acid ethyl esters (generic for Lovaza)♦ Vascepa®♦ Zetia®
<b>Lipotropics: PCSK9 Inhibitors♦</b>	Praluent® <sup>2</sup> Repatha® <sup>2</sup>	

<sup>1</sup> Prior Authorization Not Required for Beneficiaries Under the Age of 12.

<sup>2</sup> Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

<sup>3</sup> Prior Authorization Required if Beneficiary is Over the Age of 65

<sup>4</sup> PA required if a benzodiazepine is found in beneficiary drug history

<sup>5</sup> Providers should consult yearly CDC guidelines for Influenza

<sup>6</sup> Prior Authorization Required for Beneficiaries Under 15 years of age

<sup>7</sup> Prior Authorization Required for Beneficiaries Under 18 years of age

<sup>8</sup> Components of product must be in drug history

<sup>9</sup> Electronic Step edit:2 or more NSAIDs on MPPL in history

<sup>10</sup> Prior Authorization Required for Beneficiaries Under Age of 12

<sup>11</sup> Prior Authorization Required for Beneficiaries over 5 years of age

<sup>12</sup> Prior Authorization Required for Beneficiaries over 14 years of age

<sup>13</sup> Prior Authorization Required if Beneficiary is Over the Age of 75

<sup>14</sup> Prior Authorization Required for Beneficiaries Under 2 years of age

<sup>15</sup> Prior Authorization Required for Beneficiaries Under 16 years of age

<sup>16</sup> Prior Authorization Required for Beneficiaries Under 6 years of age

<sup>17</sup> Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

CARDIAC MEDICATIONS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Anticoagulants</b>	Eliquis® <sup>2</sup> Enoxaparin Jantoven® Pradaxa® <sup>2</sup> warfarin Xarelto® <sup>2</sup> / Xarelto® Dose Pack <sup>2</sup> Xarelto® suspension <sup>2</sup>	Arixtra® dabigatran fondaparinux Fragmin® syringes and vials Lovenox® Pradaxa Oral Pellets® <sup>◆</sup> Savaysa® <sup>◆</sup>
<b>Platelet Aggregation Inhibitors</b>	Brilinta® clopidogrel <sup>2</sup> prasugrel <sup>13</sup>	aspirin/dipyridamole dipyridamole Effient® <sup>13</sup> <sup>◆</sup> Plavix®
<b>Pulmonary Arterial Hypertension (PAH) Agents<sup>◆</sup></b>	Adempas® Alyq® ambrisentan (generic for Letairis®) Opsumit® sildenafil <u>suspension</u> (generic for Revatio®) sildenafil tablets (generic for Revatio®) tadalafil (generic for Adcirca®) Tracleer® tablets Tyvaso® solution Uptravi® Ventavis®	Adcirca® bosentan tablets (generic for Tracleer®) Letairis® Liqrev® Orenitram ER® Revatio® tablets and suspension Tadliq® <sup>7</sup> Tracleer® suspension Tyvaso® DPI

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

◆ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

CENTRAL NERVOUS SYSTEM DRUGS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Alzheimer's Dementia</b>	donepezil tabs, ODT Exelon® patch galantamine immediate release memantine immediate release rivastigmine capsules	Adlarity® Aricept® donepezil 23 mg® galantamine ER, solution memantine ER Namenda®/ Namenda XR® Namzaric® rivastigmine patch
<b>Anti-Anxiety – General</b>	alprazolam buspirone chlordiazepoxide <sup>3</sup> clorazepate diazepam <sup>3</sup> lorazepam	alprazolam ER, ODT♦ alprazolam intensol♦ Ativan® diazepam intensol♦ lorazepam intensol♦ Loreev XR® meprobamate oxazepam Xanax / Xanax XR®
<b>Drugs for ADHD♦ – Amphetamines</b>	<b>IMMEDIATE-RELEASE</b> amphetamine IR salts (generic Adderall®) <sup>2</sup> dextroamphetamine IR tabs (generic Dexedrine tabs)	<b>IMMEDIATE-RELEASE</b> Adderall (amphetamine IR salts) <sup>2</sup> amphetamine (generic Evekeo) dextroamphetamine IR solution (generic Procentra) dextroamphetamine IR tab (generic Zenzedi) Evekeo® / Evekeo ODT (amphetamine) Procentra® (dextroamphetamine IR solution) Zenzedi® (dextroamphetamine IR)
	<b>EXTENDED-RELEASE</b> Adderall XR® (amphetamine salts XR) <sup>2</sup> dextroamphetamine ER caps (generic Dexedrine cap) Vyvanse® cap/chew tabs (lisdexamfetamine) <sup>2</sup>	<b>EXTENDED-RELEASE</b> Adzenys XR ODT® (amphetamine ER) amphetamine salts ER (generic for Mydayis ER) amphetamine salts XR (generic Adderall XR) <sup>2</sup> Dexedrine® caps (dextroamphetamine ER) Dyanavel® tablets, suspension (amphetamine ER) lisdexamfetamine caps/chew tabs (generic Vyvanse) Mydayis ER® (amphetamine salts ER)

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit



# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

CENTRAL NERVOUS SYSTEM DRUGS		
Drug Class	Preferred Agents	Non-Preferred Agents
		<i>Xelstrym (dextroamphetamine transdermal)</i>
Drugs for ADHD♦ – Pseudoamphetamines	<b><u>IMMEDIATE-RELEASE</u></b> dexmethylphenidate IR (generic Focalin®) methylphenidate IR (generic Ritalin)	<b><u>IMMEDIATE-RELEASE</u></b> <i>Methylin® solution (methylphenidate IR)</i> <i>methylphenidate chewable (generic Methylin)</i> <i>methylphenidate IR solution (generic Methylin)</i> <i>Focalin® (dexmethylphenidate IR)</i> <i>Ritalin® (methylphenidate IR)</i>
	<b><u>EXTENDED-RELEASE</u></b> Concerta® (methylphenidate ER – OROS) Daytrana® (methylphenidate ER transdermal) dexmethylphenidate XR (generic Focalin XR) methylphenidate SR (generic Ritalin SR®)	<b><u>EXTENDED-RELEASE</u></b> <i>Aptensio XR® (methylphenidate ER)</i> <i>Azstarys® (serdexmethylphenidate/dexmethylphenidate)</i> <i>Cotempla XR-ODT® (methylphenidate ER)</i> <i>Focalin XR® (dexmethylphenidate XR)</i> <i>Jornay PM® (methylphenidate ER)</i> <i>methylphenidate CD (generic Metadate CD®)</i> <i>methylphenidate ER caps (generic for Aptensio XR)</i> <i>methylphenidate ER (generic Metadate ER)</i> <i>methylphenidate ER -OSM (generic Relexxi)</i> <i>methylphenidate ER - OROS (generic Concerta)</i> <i>methylphenidate ER transdermal (generic Daytrana)</i> <i>methylphenidate LA (generic Ritalin LA)-all strengths</i> <i>Quillichew ER® (methylphenidate ER)</i> <i>Quillivant XR® (methylphenidate XR)</i> <i>Relexxi® (methylphenidate ER -OSM)</i> <i>Ritalin LA® (methylphenidate LA) -all strengths</i>
Drugs for ADHD – Non-Stimulants	atomoxetine clonidine ER (generic Kapvay®) guanfacine ER Intuniv® Strattera® Qelbree®	

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

CENTRAL NERVOUS SYSTEM DRUGS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Neuropathic Pain</b>	Cymbalta® Drizalma Sprinkles® duloxetine (generic for Cymbalta) duloxetine (generic for Irenka) gabapentin <sup>2</sup> Lyrica®, Lyrica CR® <sup>2,7</sup> Neurontin® <sup>2</sup> pregabalin, pregabalin ER <sup>2,7</sup> Savella® <sup>2</sup>	Gralise® <sup>2</sup> ♦ Horizant® <sup>2</sup> ♦
<b>Multiple Sclerosis Agents</b>	Avonex® <sup>2</sup> Betaseron®/ Betaseron® Kit Copaxone 20 mg dimethyl fumarate (generic for Tecfidera) fingolimod teriflunomide	Aubagio® Bafiertam® <sup>2</sup> ♦ Copaxone® 40 mg syringe Extavia® Gilenya® glatiramer 20 mg/ml and 40 mg/ml Glatopa® Kesimpta® ♦ Mavenclad® ♦ Mayzent® ♦ Plegridy® ♦ Ponvory® ♦ Rebif® <sup>2</sup> / Rebif Rebidose® Tascenso® ♦ Tecfidera® Vumerity® ♦ Zeposia® ♦
<b>AntiParkinson's Agents – Dopamine Agonists</b>	pramipexole ropinirole	bromocriptine ♦ Mirapex ER® Neupro® <sup>2</sup> Parlodel® ♦ pramipexole ER ropinirole ER

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

CENTRAL NERVOUS SYSTEM DRUGS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>AntiParkinson's Agents – Other</b>	amantadine capsule, syrup benztropine carbidopa/levodopa IR tablets carbidopa / levodopa ER entacapone rasagiline <sup>7</sup> trihexyphenidyl tablet	<i>amantadine tablet</i> <i>Azilect®<sup>7</sup></i> <i>carbidopa</i> <i>carbidopa / levodopa ODT</i> <i>carbidopa/levodopa/entacapone</i> <i>Comtan®</i> <i>Dhivy®</i> <i>Duopa®</i> <i>entacapone</i> <i>Gocovri®♦</i> <i>Inbrija®♦</i> <i>Lodosyn®</i> <i>Nourianz®</i> <i>Ongentys®♦</i> <i>Osmolex ER®</i> <i>Rytary®♦</i> <i>selegiline capsule, tablet</i> <i>Sinemet®</i> <i>Stalevo®</i> <i>Tasmar®</i> <i>tolcapone</i> <i>trihexyphenidyl solution</i> <i>Xadago®♦</i> <i>Zelapar®</i>
<b>Sedative Hypnotic Non-Barbiturates</b>	doxepin (generic for Silenor®) eszopiclone <sup>7</sup> Hetlioz®/ Hetlioz LQ® ramelteon Rozerem® tasimelteon temazepam (excluding 7.5mg and 22.5mg) <sup>3</sup> triazolam <sup>2,3</sup> zaleplon zolpidem tablets <sup>2,7</sup>	<i>Ambien® / Ambien CR®<sup>2,7</sup></i> <i>Belsomra®</i> <i>Dayvigo®</i> <i>Edluar®<sup>2,7</sup>♦</i> <i>estazolam</i> <i>flurazepam<sup>3</sup></i> <i>Halcion®<sup>2,3</sup></i> <i>Lunesta®<sup>7</sup></i> <i>quazepam</i> <i>Quviviq®</i>

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

CENTRAL NERVOUS SYSTEM DRUGS		
Drug Class	Preferred Agents	Non-Preferred Agents
		Restoril® <sup>3</sup> temazepam 7.5mg and 22.5mg <sup>2, 3</sup> zolpidem capsules <sup>2,7</sup> zolpidem ER, sublingual <sup>2,7</sup>
<b>Antimigraine Agents, Acute Treatment - Triptans</b>	Imitrex® nasal spray rizatriptan tab and ODT <sup>2</sup> sumatriptan tablets, injection <sup>2</sup>	almotriptan <sup>2</sup> eletriptan <sup>2</sup> Frova® <sup>2</sup> frovatriptan <sup>2</sup> Imitrex® <sup>2</sup> Maxalt®/ Maxalt MLT® <sup>2</sup> naratriptan <sup>2</sup> Relpax® <sup>2</sup> sumatriptan/naproxen sumatriptan nasal spray Tosymra® <sup>2</sup> Zembrace Symtouch® zolmitriptan / zolmitriptan ODT <sup>2</sup> /zolmitriptan nasal Zomig® nasal spray / Zomig® tablet
<b>Antimigraine Agents, Acute Treatment - Other</b>	Nurtec ODT® <sup>2</sup> ◆	Elyxib® <sup>2</sup> Reyvow <sup>2</sup> Ubrelvy® <sup>2</sup> Zavzpret® <sup>2</sup>
<b>Antimigraine Agents, Preventive Treatment◆</b>	Aimovig® <sup>2</sup> Ajovy® <sup>2</sup> Emgality® <sup>2</sup> Nurtec ODT® <sup>2</sup>	Qulipta® <sup>2</sup>
<b>Skeletal Muscle Relaxants</b>	baclofen tablets baclofen oral solution◆ cyclobenzaprine methocarbamol orphenadrine citrate tizanidine tablets	Amrix® baclofen oral suspension (generic for Fleqsuvy)◆ chlorzoxazone cyclobenzaprine ER Dantrium® dantrolene sodium

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

◆ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

CENTRAL NERVOUS SYSTEM DRUGS		
Drug Class	Preferred Agents	Non-Preferred Agents
		<i>Fexmid®</i> <i>Fleqsuvy®</i> ♦ <i>Lorzone®</i> <i>Lyvispah®</i> ♦ <i>metaxalone</i> <i>Norgesic Forte®</i> <i>orphenadrine/aspirin/caffeine</i> <i>tizanidine capsules</i> <i>Zanaflex® capsules and tablets</i>

DERMATOLOGICAL AGENTS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Acne Agents: Combination Benzoyl Peroxide and Clindamycin</b>	clindamycin / benzoyl peroxide	<i>Acanya® gel and pump</i> <i>clindamycin/benzoyl peroxide (generic for Onexton)</i> <i>Neuac 1.25% kit®</i> <i>Onexton®</i>
<b>Topical Steroids – Low Potency</b>	hydrocortisone acetate cream hydrocortisone acetate ointment hydrocortisone cream hydrocortisone lotion hydrocortisone ointment hydrocortisone/aloe	<i>aclometasone dipropionate ointment and cream</i> <i>Derma-smooth – FS ®</i> <i>desonide ointment, cream, lotion</i> <i>fluocinolone 0.01% oil</i> <i>Proctocort®</i> <i>Texacort ®</i>

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

DERMATOLOGICAL AGENTS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Topical Steroids – Medium Potency</b>	fluticasone propionate cream fluticasone propionate ointment mometasone furoate ointment mometasone furoate cream mometasone furoate solution	<i>Beser Kit</i> <i>Beser Lotion</i> <i>betamethasone valerate foam</i> <i>clocortolone cream</i> <i>Cloderm®</i> <i>fluocinolone acetonide cream, solution</i> <i>flurandrenolide cream, lotion, ointment</i> <i>fluticasone propionate lotion</i> <i>hydrocortisone butyrate cream, lotion, ointment, soln</i> <i>hydrocortisone valerate cream and ointment</i> <i>Locoid® cream, lotion, solution</i> <i>Locoid Lipocream®</i> <i>Pandel®</i> <i>prednicarbate cream and ointment</i> <i>Synalar® solution, cream and ointment</i> <i>Synalar TS® kit</i>
<b>Topical Steroids – High Potency</b>	betamethasone dipropionate cream, lotion, oint. betamethasone valerate cream, lotion, oint. triamcinolone acetonide cream, lotion, oint	<i>betamethasone dipropionate augmented cream, gel</i> <i>betamethasone dipropionate augmented lotion, oint</i> <i>desoximetasone cream, ointment, gel and spray</i> <i>diflorasone diacetate cream and ointment</i> <i>Diprolene® ointment</i> <i>fluocinonide cream, ointment and gel</i> <i>fluocinonide emollient and solution</i> <i>halcinonide</i> <i>Halog® cream, ointment and solution</i> <i>Kenalog® aerosol</i> <i>Topicort® cream, gel, ointment and spray</i> <i>triamcinolone spray</i> <i>Vanos®</i>
<b>Topical Steroids – Very High Potency</b>	clobetasol propionate solution clobetasol propionate cream clobetasol propionate ointment halobetasol propionate cream halobetasol propionate ointment	<i>Apexicon-E</i> <i>Bryhali®</i> <i>clobetasol emollient and lotion</i> <i>clobetasol propionate foam, gel, spray and shampoo</i> <i>Clobex® spray and shampoo</i>

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

DERMATOLOGICAL AGENTS		
Drug Class	Preferred Agents	Non-Preferred Agents
		<i>Clodan® shampoo and kit</i> <i>halobetasol propionate (generic for Lexette®)</i> <i>Impeklo®</i> <i>Lexette®</i> <i>Olux®</i> <i>Temovate® ointment</i> <i>Tovet Foam Kit</i> <i>Tovet Emollient Foam</i> <i>Ultravate® lotion</i>

DIABETES		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Amylin Analogs</b>	Symlin®	
<b>Incretin Mimetics</b>	Byetta® Trulicity® Victoza®	<i>Bydureon Bcise®</i> <i>Mounjaro®</i> <i>Ozempic®</i> ♦ <i>Rybelsus®</i>
<b>Incretin Mimetics - Combinations</b>		<i>Soliqua®</i> ♦ <i>Xultophy®</i> ♦
<b>Insulins, Basal<sup>2</sup></b>	Lantus® pens, vials Levemir® pens, vials	<i>Basaglar® pens</i> <i>insulin degludec</i> <i>insulin glargine, hum.rec.analog (biosim for Lantus)</i> <i>insulin glargine, hum.rec.analog (biosim for Toujeo)</i> <i>insulin glargine-yfgn</i> <i>Rezvoglar®</i> <i>Semglee® pens, vials</i> <i>Toujeo Solostar® /Toujeo Max Solostar® pens</i> ♦ <i>Tresiba Flextouch® pens and vials</i>

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIrx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIrx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit



# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

DIABETES		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Insulins, Rapid Acting<sup>2</sup></b>	Apidra® pens, vials Humalog® U-100 cartridges, Kwikpens, vials <i>insulin aspart pens, vials</i> insulin lispro U-100 Kwikpens, vials (gen for Humalog) Novolog® cartridges	Admelog® vials; Admelog Solostar® pens Afrezza® inhalation cartridges Fiasp® pens, vials Humalog® U-200 Kwikpens <i>insulin aspart cartridges</i> Lyumjev® Novolog® pens, vials
<b>Insulin, Mixes<sup>2</sup></b>	Humulin® 70/30 Kwikpens Humalog® 50/50 pens, vials Humalog® 75/25 pens, vials Humulin® 70/30 vials insulin aspart 70/30 pens, vials	<i>insulin lispro mix 75-25 Kwikpen</i> Novolin® 70/30 pens and vials Novolog® 70/30 pens and vials
<b>Insulins, Traditional<sup>2</sup></b>	Humulin® R U-500 pens, vials Humulin® N vials Humulin® R vials Novolin® N vials Novolin® R vials	Humulin® N Kwikpens
<b>Oral Hypoglycemics – Alpha-Glucosidase Inhibitors</b>	acarbose miglitol	Precose®
<b>Oral Hypoglycemics – Biguanides</b>	metformin / metformin XR	Glumetza® Metformin ER osmotic (generic for Fortamet®) <i>metformin (generic for Glumetza)</i> <i>metformin solution (generic for Riomet)</i> Riomet® / Riomet ER®
<b>Oral Hypoglycemics – Combinations</b>	glyburide / metformin Invokamet® Janumet® <sup>2</sup> /Janumet XR® Jentadueto® Synjardy® Xigduo XR ®	Actoplus Met® alogliptin/metformin alogliptin/pioglitazone dapagliflozin/metformin Duetact® glipizide / metformin Glyxambi® Invokamet XR®

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MI/Rx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MI/Rx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

DIABETES		
Drug Class	Preferred Agents	Non-Preferred Agents
		<i>Jentaduetto XR®</i> <i>Kazano®</i> <i>Kombiglyze XR®</i> <i>Oseni®</i> <i>pioglitazone/glimepiride</i> <i>pioglitazone/metformin</i> <i>Qtern®</i> <i>saxagliptin/metformin</i> <i>Segluromet®</i> <i>Steglujan®</i> <i>Synjardy XR®</i> <i>Trijardy XR®</i>
<b>Oral Hypoglycemics – DPP4 Inhibitors</b>	<i>Januvia®</i> <sup>2</sup> <i>Tradjenta®</i>	<i>alogliptin</i> <i>Nesina®</i> <i>Onglyza®</i> <i>saxagliptin</i>
<b>Oral Hypoglycemics – Meglitinides</b>	<i>nateglinide</i> <i>repaglinide</i>	
<b>Oral Hypoglycemics – 2nd Generation Sulfonylureas</b>	<i>glimepiride</i> <i>glipizide / glipizide ER</i> <i>glyburide</i> <i>glyburide micronized</i>	<i>Amaryl®</i> <i>Glucotrol XL®</i> <i>Glynase®</i>
<b>Oral Hypoglycemics – SGLT2 Inhibitors</b>	<i>Farxiga®</i> <i>Invokana®</i> <i>Jardiance®</i>	<i>dapagliflozin</i> <i>Inpefa®</i> <i>Steglatro®</i>
<b>Oral Hypoglycemics – Thiazolidinediones</b>	<i>pioglitazone</i>	<i>Actos®</i>
<b>Glucagon Agents</b>	<i>Baqsimi®</i> <sup>2</sup> <i>Glucagen Hypokit</i> <i>Glucagon Emergency Kit (Lilly)</i> <i>Gvoke Hypopen®</i> <sup>2</sup> <i>Zegalogue®</i>	<i>Glucagon Emergency Kit (Fresenius)</i> <i>Gvoke®</i> <sup>2</sup> syringes, vials

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIrx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIrx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

DIABETES		
Drug Class	Preferred Agents	Non-Preferred Agents
Insulin Suppressants	Proglycem®	diazoxide (generic for Proglycem)

GASTROINTESTINAL		
Drug Class	Preferred Agents	Non-Preferred Agents
Antiemetics	Emend® 80mg <sup>2, 11</sup> granisetron <sup>2</sup> ondansetron <sup>2</sup>	aprepitant <sup>2</sup> Akynzeo® <sup>2, 11</sup> Emend Pack® <sup>2, 11</sup> Sancuso® <sup>2</sup>
Bile Salts	ursodiol capsules and tablets	Reltone® Urso®/Urso Forte®
GI Motility, Chronic Irritable bowel syndrome with constipation (IBS-C)	Amitiza® Linzess®	Ibsrela® <sup>2</sup> lubiprostone Trulance®
GI Motility, Chronic Chronic idiopathic constipation (CIC)	Amitiza® Linzess®	lubiprostone Motegrity® Trulance®
GI Motility, Chronic Opioid-induced constipation (OIC)	Amitiza®	lubiprostone Movantik® Relistor® Symproic®
GI Motility, Chronic Irritable bowel syndrome with diarrhea (IBS-D)	diphenoxylate/atropine (generic Lomotil®) loperamide (generic Imodium®)	alosecron® Lotronex® Viberzi® <sup>2</sup>
H. pylori Treatment	Pylera®	bismuth/metronidazole/tetracycline lansoprazole/amoxicillin/clarithromycin Omeclamox-PAK® Talia®
Pancreatic Enzymes*	Creon® Zenpep®	Pertzye® Viokace®
Progestins for Cachexia	megestrol oral suspension (generic for Megace®)	megestrol oral suspension (generic Megace ES®)

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

GASTROINTESTINAL		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Proton Pump Inhibitors</b>	Nexium® susp pkts <sup>2</sup> omeprazole (Rx) capsules <sup>2</sup> pantoprazole tablets <sup>2</sup> Protonix® tablets <sup>2</sup> , suspension <sup>2</sup>	Aciphex® tabs Dexilant® caps dexlansoprazole esomeprazole magnesium capsules, susp pkts <sup>2</sup> esomeprazole magnesium OTC caps and tabs Konvomep® lansoprazole caps, ODT lansoprazole OTC caps Nexium® capsules omeprazole OTC caps, tabs, ODT omeprazole/sodium bicarbonate caps, susp pkt pantoprazole suspension <sup>2</sup> Prevacid caps, solutabs Prilosec® susp rabeprazole tabs Zegerid® caps, susp pkts
<b>Ulcerative Colitis – Oral</b>	Apriso® Lialda® sulfasalazine/ sulfasalazine DR	Asacol HD® Azulfidine DR® balsalazide budesonide ER Colazal® Delzicol® Dipentum® mesalamine (generic for Apriso) mesalamine (generic for Delzicol) mesalamine (generic for Lialda) mesalamine ER (generic for Pentasa) Pentasa® Uceris®

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

OPHTHALMICS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Glaucoma – Alpha-2 Adrenergics</b>	apraclonidine brimonidine tartrate 0.2%	<i>Alphagan P®</i> <i>brimonidine tartrate 0.1%</i> <i>brimonidine tartrate 0.15%</i> <i>lopidine®</i>
<b>Glaucoma – Beta Blockers</b>	Betoptic S® carteolol timolol maleate (generic for Timoptic®, Timoptic-XE®)	<i>betaxolol</i> <i>Betimol®</i> <i>Istalol®</i> <i>levobunolol</i> <i>timolol maleate (generic for Istalol®)</i> <i>timolol maleate (generic for Timoptic Occudose®)</i> <i>Timoptic®/ Timoptic Occudose®</i> <i>Timoptic XE®</i>
<b>Glaucoma – Prostaglandin Analogues</b>	latanoprost	<i>bimatoprost (generic for Lumigan)</i> <i>Lumigan®</i> <i>tafluprost (generic for Zioptan®)</i> <i>Travatan Z®</i> <i>travoprost (generic for Travatan Z®)</i> <i>Vyzulta®</i> <i>Xalatan®</i> <i>Xelpros®</i> <i>Zioptan®</i>
<b>Glaucoma – Carbonic Anhydrase Inhibitors</b>	Azopt® dorzolamide dorzolamide/timolol Simbrinza®	<i>brinzolamide</i> <i>dorzolamide/timolol PF (generic for Cosopt PF®)</i> <i>Cosopt®/ Cosopt PF®</i>
<b>Glaucoma – Combination Alpha-2 Adrenergic-Beta Blocker</b>	Combigan®	<i>brimonidine/timolol (generic for Combigan®)</i>
<b>Glaucoma – Rho Kinase Inhibitors</b>	Rhopressa® Rocklatan®	

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIrx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIrx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

OPHTHALMICS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Ophthalmic Antibiotics - Fluoroquinolones</b>	ciprofloxacin ofloxacin Vigamox®	Besivance® Ciloxan® gatifloxacin moxifloxacin (generic for Moxeza®) moxifloxacin (generic for Vigamox®) Ocuflox® Zymaxid®
<b>Ophthalmic Antibiotics - Macrolides</b>	erythromycin ointment	Azasite®
<b>Ophthalmic Antihistamines</b>	azelastine ketotifen fumarate (OTC Only) olopatadine (OTC) olopatadine (Rx) Zaditor®	Alrex® bepotastine Bepreve® epinastine Lastacaft® loteprednol (generic for Alrex®) Pataday® Zerviate®
<b>Ophthalmic Anti-Inflammatory/Immunomodulators</b>	Restasis® <sup>2</sup> emulsion single-use and multidose vials Xiidra® <sup>2</sup>	Cequa® <sup>2</sup> cyclosporine 0.5% emulsion <sup>2</sup> (generic for Restasis) Eysuvis® <sup>2</sup> Miebo® <sup>2,7</sup> Tyrvaya® <sup>2</sup> Verkazia® <sup>2</sup> ♦
<b>Ophthalmic Mast Cell Stabilizers</b>	cromolyn sodium	Alocril® Alomide®
<b>Ophthalmic NSAIDs</b>	diclofenac flurbiprofen ketorolac	Acular® / Acular LS® Acuvail® bromfenac 0.07% (generic for Prolensa®) bromfenac 0.075% (generic for Bromsite®) bromfenac 0.09% Bromsite® Ilevro® ketorolac LS (generic for Acular LS®) Nevanac® Prolensa®

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MI\\_Rx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MI_Rx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

MISCELLANEOUS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Immunomodulators: Asthma♦‡</b>	Dupixent® Fasenra® pen Xolair® <b>autoinjectors</b> , syringes	Nucala® syringe, auto-injector Tezspire® pen
<b>Immunomodulators: Atopic Dermatitis♦</b>	Adbry® <sup>2,7</sup> Dupixent® Elidel® <sup>2, 14</sup> Eucrisa® <sup>2</sup>	Cibinqo® <sup>7</sup> Opzelura® <sup>2, 10</sup> pimecrolimus (generic for Elidel) <sup>2, 14</sup> Protopic® <sup>2, 15</sup> Rinvoq ER® tacrolimus <sup>2, 15</sup>
<b>Biologics: Agents to Treat Ankylosing Spondylitis</b>	Cosentyx® Enbrel® Humira®	adalimumab-adaz (unbranded Hyrimoz)♦ adalimumab-fkjp (unbranded Hulio)♦ Amjevita®♦ Cimzia®, Cimzia Kit® Cyltezo®♦ Hadlima®♦ Hulio®♦ Hyrimoz®♦ Idacio®♦ Rinvoq ER®♦ Simponi®, Simponi ARIA® Taltz®♦ Xeljanz®, Xeljanz XR®♦ Yuflyma®♦ Yusimry®♦
<b>Biologics: Agents to Treat Hidradenitis Suppurativa</b>	Cosentyx® Humira®	adalimumab-adaz (unbranded Hyrimoz)♦ adalimumab-fkjp (unbranded Hulio)♦ Amjevita®♦ Cyltezo®♦ Hadlima®♦ Hulio®♦ Hyrimoz®♦ Idacio®♦

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit



# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

MISCELLANEOUS		
Drug Class	Preferred Agents	Non-Preferred Agents
		Yuflyma®♦ Yusimry®♦
<b>Biologics: Agents to Treat Juvenile Idiopathic Arthritis</b>	Enbrel® Humira®	Actemra® SC adalimumab-adaz (unbranded Hyrimoz)♦ adalimumab-fkjp (unbranded Hulio)♦ Amjevita®♦ Cyltezo®♦ Hadlima®♦ Hulio®♦ Hyrimoz®♦ Idacio®♦ Orencia® SC Simponi ARIA® Xeljanz®♦ tabs, solution Yuflyma®♦ Yusimry®♦
<b>Biologics: Agents to Treat Non-radiographic Axial Spondyloarthritis</b>	Cosentyx®	Cimzia®, Cimzia Kit® Rinvoq ER®♦ Taltz®♦
<b>Biologics: Agents to Treat Plaque Psoriasis</b>	Cosentyx® Enbrel® Humira®	adalimumab-adaz (unbranded Hyrimoz)♦ adalimumab-fkjp (unbranded Hulio)♦ Amjevita®♦ Cimzia®, Cimzia Kit® Cyltezo®♦ Hadlima®♦ Hulio®♦ Hyrimoz®♦ Idacio®♦ Ilumya®♦ Otezla®♦ Siliq®♦ Skyrizi®♦

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

MISCELLANEOUS		
Drug Class	Preferred Agents	Non-Preferred Agents
		<i>Sotyktu</i> ®♦ <sup>2</sup> <i>Stelara</i> ® <i>Taltz</i> ®♦ <i>Tremfya</i> ®♦ <i>Yuflyma</i> ®♦ <i>Yusimry</i> ®♦
<b>Biologics: Agents to Treat Psoriatic Arthritis</b>	<i>Cosentyx</i> ® <i>Enbrel</i> ® <i>Humira</i> ®	<i>adalimumab-adaz (unbranded Hyrimoz)</i> ♦ <i>adalimumab-fkjp (unbranded Hulio)</i> ♦ <i>Amjevita</i> ®♦ <i>Cimzia</i> ®, <i>Cimzia Kit</i> ® <i>Cyltezo</i> ®♦ <i>Hadlima</i> ®♦ <i>Hulio</i> ®♦ <i>Hyrimoz</i> ®♦ <i>Idacio</i> ®♦ <i>Orencia</i> ® SC <i>Otezla</i> ®♦ <i>Rinvoq ER</i> ®♦ <i>Simponi</i> ®, <i>Simponi ARIA</i> ® <i>Skyrizi</i> ®♦ <i>Stelara</i> ® <i>Taltz</i> ®♦ <i>Tremfya</i> ®♦ <i>Xeljanz</i> ®, <i>Xeljanz XR</i> ®♦ <i>Yuflyma</i> ®♦ <i>Yusimry</i> ®♦
<b>Biologics: Agents to Treat Rheumatoid Arthritis</b>	<i>Enbrel</i> ® <i>Humira</i> ®	<i>Actemra</i> ® SC <i>adalimumab-adaz (unbranded Hyrimoz)</i> ♦ <i>adalimumab-fkjp (unbranded Hulio)</i> ♦ <i>Amjevita</i> ®♦ <i>Cimzia</i> ®, <i>Cimzia Kit</i> ® <i>Cyltezo</i> ®♦ <i>Hadlima</i> ®♦

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

MISCELLANEOUS		
Drug Class	Preferred Agents	Non-Preferred Agents
		<i>Hulio®</i> ♦ <i>Hyrimoz®</i> ♦ <i>Idacio®</i> ♦ <i>Kevzara®</i> ♦ <i>Kineret®</i> <i>Olumiant®</i> ♦ <i>Orencia® SC</i> <i>Rinvoq ER®</i> ♦ <i>Simponi®</i> , <i>Simponi ARIA®</i> <i>Xeljanz®</i> , <i>Xeljanz XR®</i> ♦ <i>Yuflyma®</i> ♦ <i>Yusimry®</i> ♦
<b>Biologics: Agents to Treat Uveitis</b>	Humira®	<i>adalimumab-adaz (unbranded Hyrimoz)</i> ♦ <i>adalimumab-fkjp (unbranded Hulio)</i> ♦ <i>Amjevita®</i> ♦ <i>Cyltezo®</i> ♦ <i>Hadlima®</i> ♦ <i>Hulio®</i> ♦ <i>Hyrimoz®</i> ♦ <i>Idacio®</i> ♦ <i>Yusimry®</i> ♦
<b>Biologics: Agents to Treat Crohn's Disease</b>	Humira®	<i>adalimumab-adaz (unbranded Hyrimoz)</i> ♦ <i>adalimumab-fkjp (unbranded Hulio)</i> ♦ <i>Amjevita®</i> ♦ <i>Cimzia®</i> , <i>Cimzia Kit®</i> <i>Cyltezo®</i> ♦ <i>Entyvio®</i> ♦ <i>Hadlima®</i> ♦ <i>Hulio®</i> ♦ <i>Hyrimoz®</i> ♦ <i>Idacio®</i> ♦ <i>Rinvoq ER®</i> ♦

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

MISCELLANEOUS		
Drug Class	Preferred Agents	Non-Preferred Agents
		<i>Skyrizi®</i> ♦ <i>Stelara®</i> <i>Yuflyma®</i> ♦ <i>Yusimry®</i> ♦
<b>Biologics: Agents to Treat Ulcerative Colitis</b>	Humira®	<i>adalimumab-adaz (unbranded Hyrimoz)</i> ♦ <i>adalimumab-fkjp (unbranded Hulio)</i> ♦ <i>Amjevita®</i> ♦ <i>Cyltezo®</i> ♦ <i>Entyvio®</i> ♦ <i>Hadlima®</i> ♦ <i>Hulio®</i> ♦ <i>Hyrimoz®</i> ♦ <i>Idacio®</i> ♦ <i>Rinvoq ER®</i> ♦ <i>Simponi®</i> <i>Stelara®</i> <i>Xeljanz®, Xeljanz XR®</i> ♦ <i>Yuflyma®</i> ♦ <i>Yusimry®</i> ♦
<b>Androgenic Agents (topical)♦</b>	testosterone pump (generic for Androgel®)	<i>Androderm®</i> <i>Androgel® packet and gel pump</i> <i>Fortesta®</i> <i>Natesto®</i> <i>Testim®</i> <i>testosterone</i> <i>Vogelxo®</i>
<b>Antihyperuricemic Agents</b>	allopurinol colchicine tablets (generic for Colcrys) probenecid/colchicine probenecid	<i>colchicine capsules (generic for Mitigare)</i> <i>Colcrys® (colchicine)</i> <i>febuxostat</i> <i>Gloperba® (colchicine)</i> <i>Mitigare® (colchicine capsules)</i> <i>Uloric (febuxostat)</i> <i>Zyloprim (allopurinol)</i>

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

MISCELLANEOUS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Anti-Obesity Agents ♦</b>	Adipex-P® (phentermine) benzphetamine diethylpropion Lomaira® (phentermine) phendimetrazine phentermine Saxenda® (liraglutide) Wegovy® (semaglutide) Xenical® (orlistat)	
<b>BPH Agents – Alpha Blockers</b>	alfuzosin doxazosin prazosin tamsulosin ♦ terazosin	Cardura® Cardura XR® Flomax® ♦ Minipress® Rapaflo® silodosin (generic for Rapaflo)
<b>BPH Agents – 5-Alpha Reductase (5AR) Inhibitors</b>	dutasteride finasteride 5mg (generic for Proscar®)	Avodart® dutasteride/tamsulosin Entadfi® ♦ Jalyn® Proscar®
<b>Colony Stimulating Factors</b>	Neupogen® Nyvepria® <sup>2</sup>	Fulphila® <sup>2</sup> Fylmetra® <sup>2</sup> Granix® Leukine® Neulasta® syringe <sup>2</sup> ; Neulasta® Onpro Kit <sup>2</sup> Nivestym® Releuko® Stimufend® <sup>2</sup> Udenyca® <sup>2</sup> Zarxio® <sup>2</sup> Ziextenzo® <sup>2</sup>

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

MISCELLANEOUS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Electrolyte Depleters♦</b>	calcium acetate capsules and tablets sevelamer carbonate tablets	Auryxia® Fosrenol® / Fosrenol® powder pak lanthanum Renvela powder pkts and tablets sevelamer carbonate powder pkts sevelamer HCL tablets Velphoro®
<b>Epinephrine Injectable<sup>2</sup></b>	epinephrine (generic EpiPen®/EpiPen Jr® by Mylan) EpiPen®, EpiPen Jr®	Auvi-Q® epinephrine (generic for Adrenaclick®) epinephrine (generic for EpiPen®/EpiPen Jr®) Symjepi®
<b>Growth Hormones♦</b>	Genotropin® Norditropin Flexpro®	Humatrope® Nutropin AQ® Omnitrope® Serostim®♦ Skytrofa® Sogroya® Zomacton®
<b>Hematopoietic Agents♦</b>	Aranesp® Epogen® Retacrit®	Procrit®

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

MISCELLANEOUS		
Drug Class	Preferred Agents	Non-Preferred Agents
<b>Osteoporosis Agents: Bisphosphonates</b>	alendronate sodium	Actonel® <sup>2</sup> alendronate sodium oral solution Atelvia® <sup>2</sup> Boniva® <sup>2</sup> Fosamax® Fosamax Plus D® Ibandronate risedronate (Actonel) <sup>2</sup> risedronate (Atelvia) <sup>2</sup>
<b>Osteoporosis Agents: Other</b>	calcitonin nasal spray	Forteo®♦ teriparatide♦ Tymlos®♦
<b>Osteoporosis Agents: SERMs</b>	raloxifene	Evista®
<b>Progestational Agents</b>	medroxyprogesterone (oral) progesterone (oral) norethindrone (oral)	Aygestin® (oral) Crinone® (vaginal)♦ progesterone (intramuscular) Prometrium® (oral) Provera® (oral)
<b>Urea Cycle Disorder Agents</b>	Buphenyl® tablets and powder Carbaglu® tablets	carglumic acid tablets Olpruva® pellets Pheburane® pellets Ravicti® liquid sodium phenylbutyrate tablets and powder

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MiRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit



# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

MISCELLANEOUS		
Drug Class	Preferred Agents	Non-Preferred Agents
Urinary Tract Antispasmodics	oxybutynin / oxybutynin ER solifenacin Toviaz®	darifenacin ER Detrol®/ Detrol LA® Ditropan XL® fesoterodine flavoxate HCL Gelnique® Gemtesa® Myrbetriq® Oxytrol® tolterodine/ tolterodine ER trospium/ trospium ER Vesicare®/ Vesicare LS
Uterine Disorder Treatments	Myfembree ♦ <sup>2</sup> Orilissa ♦ <sup>2</sup> OriaHnn ♦ <sup>2</sup>	

LEGISLATIVELY PROTECTED CLASSES		
Drug Class	Preferred Agents	Non-Preferred Agents
Anticonvulsants	Aptiom® Banzel® Briviact® carbamazepine, carbamazepine ER Carbatrol® Celontin® clobazam clonazepam Depakote®, Depakote ER® Depakote Sprinkle® Diacomit® Diastat®, Diastat Acudial®	

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

LEGISLATIVELY PROTECTED CLASSES		
Drug Class	Preferred Agents	Non-Preferred Agents
	diazepam Dilantin® divalproex sodium, divalproex sodium ER Epidiolex® Epitol® Eprontia® Equetro® ethosuximide Felbamate® felbatol Fintepla® Fycompa® gabapentin Gabitril® Keppra®, Keppra XR® Klonopin® lacosamide Lamictal®, Lamictal ODT®, Lamictal XR® lamotrigine, lamotrigine ER, lamotrigine ODT levetiracetam, levetiracetam ER Lyrica®, Lyrica CR® methsuximide Motpoly XR® Mysoline® Nayzilam® Neurontin® Onfi® oxcarbazepine Oxtellar XR® Peganone® Phenytek® phenytoin, phenytoin sodium extended pregabalin primidone	

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](https://michigan.magellanrx.com/provider) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

LEGISLATIVELY PROTECTED CLASSES		
Drug Class	Preferred Agents	Non-Preferred Agents
	Qudexy XR® Roweepra®, Roweepra XR® rufinamide Sabril® Spritam® Subvenite® Sympazan® Tegretol®, Tegretol XR® tiagabine Topamax® topiramate, topiramate ER Trileptal® Trokendi XR® valproic acid Valtoco® vigabatrin Vigadrone® Vimpat® Xcopri® Zarontin® Zonisade® zonisamide Ztalmy®	
<b>Atypical Antipsychotics</b>	Abilify®, Abilify MyCite® Abilify Asimtufii®, Abilify Maintena® aripiprazole Aristada®, Aristada Initio® Caplyta® clozapine Clozaril® Fanapt® Geodon® Invega® Invega Sustenna®, Invega Trinza®	

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12.

2 Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 PA required if a benzodiazepine is found in beneficiary drug history

5 Providers should consult yearly CDC guidelines for Influenza

6 Prior Authorization Required for Beneficiaries Under 15 years of age

7 Prior Authorization Required for Beneficiaries Under 18 years of age

8 Components of product must be in drug history

9 Electronic Step edit:2 or more NSAIDs on MPPL in history

10 Prior Authorization Required for Beneficiaries Under Age of 12

11 Prior Authorization Required for Beneficiaries over 5 years of age

12 Prior Authorization Required for Beneficiaries over 14 years of age

13 Prior Authorization Required if Beneficiary is Over the Age of 75

14 Prior Authorization Required for Beneficiaries Under 2 years of age

15 Prior Authorization Required for Beneficiaries Under 16 years of age

16 Prior Authorization Required for Beneficiaries Under 6 years of age

17 Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit

# Michigan Preferred Drug List (PDL)/Single PDL

Effective 03/01/2024

Preferred Agents do not require prior authorization, except as noted in the chart at the bottom of the page

LEGISLATIVELY PROTECTED CLASSES		
Drug Class	Preferred Agents	Non-Preferred Agents
	Invega Hafyera® Latuda® lurasidone molindone Nuplazid® olanzapine, olanzapine ODT paliperidone Perseris® quetiapine Rexulti® risperidone Risperdal®, Risperdal Consta® <sup>2</sup> Saphris® Secuado® Seroquel®, Seroquel XR® Uzedy ER® Versacloz® Vraylar® ziprasidone Zyprexa®, Zyprexa Relprevv®, Zyprexa Zydis®	
<b>Antipsychotic-Antidepressant Comb.</b>	olanzapine/fluoxetine Symbyax®	

*Note: Not all medications listed are covered by all MDHHS Programs. Check individual program coverage. For program drug coverage information, go to <https://michigan.magellanrx.com/provider/>, open "Documents" and click on "Fee for Service Drug Coverage" then open "MPPL Including Coverage Information" for all programs.*

*Michigan Department of Health and Human Services, in conjunction with Magellan Medicaid Administration, is pleased to offer an alternative means to submit pharmacy prior authorization (PA) requests for prescription drugs. This web-based process is designed to save prescribers time by providing a real-time pharmacy prior authorization. This process will supplement the more traditional means of requesting PAs by phone or fax, which will still be available to providers. In order to use Web PA, provider designees will need to register to receive a logon and password for the Web PA system. Detailed information on user registration and Web PA, including a web-based tutorial, and a complete instruction is available at <https://michigan.magellanrx.com/provider/>. For questions or assistance with registration, call the Magellan Medicaid Administration Web Support Call Center at 800-241-8726.*

<sup>1</sup> Prior Authorization Not Required for Beneficiaries Under the Age of 12.

<sup>2</sup> Quantity limits apply – Refer to document at

[https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx\\_quantity\\_limits.pdf](https://michigan.magellanrx.com/provider/external/medicaid/mi/doc/en-us/MIRx_quantity_limits.pdf)

<sup>3</sup> Prior Authorization Required if Beneficiary is Over the Age of 65

<sup>4</sup> PA required if a benzodiazepine is found in beneficiary drug history

<sup>5</sup> Providers should consult yearly CDC guidelines for Influenza

<sup>6</sup> Prior Authorization Required for Beneficiaries Under 15 years of age

<sup>7</sup> Prior Authorization Required for Beneficiaries Under 18 years of age

<sup>8</sup> Components of product must be in drug history

<sup>9</sup> Electronic Step edit:2 or more NSAIDs on MPPL in history

<sup>10</sup> Prior Authorization Required for Beneficiaries Under Age of 12

<sup>11</sup> Prior Authorization Required for Beneficiaries over 5 years of age

<sup>12</sup> Prior Authorization Required for Beneficiaries over 14 years of age

<sup>13</sup> Prior Authorization Required if Beneficiary is Over the Age of 75

<sup>14</sup> Prior Authorization Required for Beneficiaries Under 2 years of age

<sup>15</sup> Prior Authorization Required for Beneficiaries Under 16 years of age

<sup>16</sup> Prior Authorization Required for Beneficiaries Under 6 years of age

<sup>17</sup> Prior Authorization Required for Beneficiaries Under 60 years of age

APAP = Acetaminophen ASA = Aspirin

CR, ER, SR, XL, XR, SA, LA = Extended Release, HCT = Hydrochlorothiazide

♦ Clinical PA required; refer to [MI Clinical and PDL PA Criteria](#) and PDL Criteria at <https://michigan.magellanrx.com/provider/>

‡Only products that can be self-administered will be included in the PDL class as other products are typically billed as a medical benefit