The Kansas Medical Assistance Program Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

ALLERGY AGENTS

Intranasal Antihistamines

Preferred Drug Covered		Non-preferred	
Azelastine	Astelin®	Azelastine	Astepro®
		Olopatadine	Patanase®

Non-Sedating Antihistamines

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Cetirizine	Zyrtec® Zyrtec Syrup®	Desloratadine	Clarinex®
Loratadine	Claritin® Claritin 24-hr Allergy® Claritin Hives Relief® Claritin RediTabs® Claritin® Syrup	Desloratadine/ Pseudoephedrine	Clarinex-D 12-hour® Clarinex-D 24-hour® **KBH only**
		Fexofenadine	Allegra® Allegra ODT®
		Fexofenadine / Pseudoephedrine	Allegra-D® **KBH only** Allegra-D24® **KBH only**
		Non-preferred	
		Levocetirizine	Xyzal®

Ophthalmic Antihistamine/Mast Cell Stabilizer Combos

Preferred Drug Covered		Non-preferred	
Ketotifen	Zaditor® Alaway® Refresh®	Alcaftadine	Lastacaft®
		Azelastine	Optivar®
		Bepotastine	Bepreve®
		Epinastine	Elestat®
		Olopatadine	Pataday® Patanol®

Long Acting Opioids

Preferred Drug Covered		Non-preferred	
Morphine sulfate ER	generic only	Fentanyl (patch)	Duragesic®
Oxycodone SR	Oxycodone SR® OxyContin®	Hydromorphone HCl ER	Exalgo®
		Morphine sulfate ER	Avinza® Kadian® MS Contin® Oramorph SR®
		Morphine/Naltrexone	Embeda®
		Oxymorphone	Opana ER®
		Tramadol ER	Ryzolt® Tramadol ER® Ultram ER®

The Kansas Medical Assistance Program Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

ANALGESICS (CONT)

Muscle Relaxants (Skeletal)

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Chlorzoxazone	Parafon Forte DSC®	Carisoprodol	Soma®
Methocarbamol	Robaxin® Robaxin-750®	Carisoprodol/Aspirin	Soma Compound®
Methocarbamol /Aspirin	Robaxisal®	Carisoprodol/Aspirin /Codeine	Soma Compound w/Codeine®
Cyclobenzaprine 10mg	Flexeril® 10mg	Cyclobenzaprine 5mg	Flexeril® 5mg
		Cyclobenzaprine 7.5mg	Fexmid® 7.5mg
		Cyclobenzaprine XR	Amrix®
		Metaxalone	Skelaxin®
		Orphenadrine	Norflex®
		Orphenadrine/Aspirin /Caffeine	Norgesic® Norgesic Forte®

Muscle Relaxants (Spasticity)

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Tizanidine tablets	Zanaflex® tablets	Tizanidine capsules	Zanaflex® capsules
Baclofen	Lioresal®	**Non-preferred**	
		Dantrolene	Dantrium®

Oral - Non-Steroidal Anti-Inflammatory (NSAIDs)

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Diclofenac Potassium	Cataflam®	Nabumetone	Relafen®
Diclofenac Sodium, Oral	Voltaren® Voltaren XR®	**Non-preferred**	
Diclofenac Sodium/ Misoprostol	Arthrotec®	Diclofenac Potassium	Cambia® Pwd Packets
		Diclofenac Sodium	Zipsor®
Etodolac	Lodine®	Diflunisal	Dolobid®
Fenoprofen	Nalfon®	Etodolac	Lodine XL®
Flurbiprofen	Ansaid®	Indomethacin	Indocin SR®
Ibuprofen	Motrin® Advil® Motrin IB®	Naproxen/Esomeprazole	Vimovo®
Indomethacin	Indocin®	Naproxen Sodium	Naprelan CR® Dosepak
Ketoprofen	Orudis® Orudis KT® Oruvail®	Piroxicam	Generics only
Ketorolac (limit 5 day supply)	Toradol®		
Meclofenamate	Meclomen®		
Mefenamic Acid	Ponstel®		
Meloxicam	Mobic®		
Naproxen	Aleve® Naprosyn® EC-Naprosyn®		
Naproxen Sodium	Anaprox® Anaprox DS® Naprelan®		
Oxaprozin	Daypro®		
Piroxicam	Feldene® (Brand name only)		
Sulindac	Clinoril®		
Tolmetin	Tolectin 600® Tolectin DS®		

The Kansas Medical Assistance Program Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

ANALGESICS (CONT)

Ophthalmic - Non-Steroidal Anti-Inflammatory (NSAIDs)

Preferred Drug Covered		Non-preferred	
Diclofenac Sodium, Ophth	Voltaren®	Bromfenac, Ophth	Bromday® Xibrom®
Flurbiprofen, Ophth	Ocufen®	Nepafenac, Ophth	Nevanac®
Ketorolac, Ophth	Acular® Acular LS® Acuvail®		

Topical - Non-Steroidal Anti-Inflammatory (NSAIDs)

Preferred Drug Covered		Non-preferred	
Diclofenac Sodium, Topical	Voltaren®	Diclofenac Epolamine	Flector®
		Diclofenac, Sodium	Pennsaid®
		Ketorolac Tromethamine	Sprix®

Triptans

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Eletriptan	Relpax®	Frovatriptan	Frova®
Naratriptan	Amerge®	Zolmitriptan	Zomig® Zomig-ZMT®
Rizatriptan	Maxalt® Maxalt-MLT®	**Non-preferred**	
Sumatriptan	Imitrex® All generics	Almotriptan	Axert®
		Sumatriptan	Alsuma®
		Sumatriptan	Sumavel®

ANTIHYPERLIPIDEMICS

Fibric Acid Derivatives

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Fenofibrate	TriCor® and all generics	Fenofibrate	Lofibra® Lipofen®
Gemfibrozil	Lopid®	**Non-preferred**	
		Fenofibrate	Fenoglide™ Triglide®
		Fenofibric acid	Trilipix®

HMG-CoA Reductase Inhibitors (Statins)

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Atorvastatin	Lipitor®	Fluvastatin	Lescol® Lescol XL®
Simvastatin	Zocor®	Lovastatin	Mevacor® Altoprev®
		Pravastatin	Pravachol®
		Non-preferred	
		Pitavastatin Ca	Livalo®
		Rosuvastatin	Crestor®

The Kansas Medical Assistance Program Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

ANTI-INFECTIVES

Antiherpes Virus Agents

Preferred Drug Covered		Non-preferred	
Acyclovir (Acycloguanosine) *Oral Dose forms Only*	Zovirax®	Famciclovir	Famvir®
Valacyclovir	Valtrex®		

BIOLOGICS

Adult Rheumatoid Arthritis **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred	
Adalimumab	Humira®	Abatacept	Orencia®
Etanercept	Enbrel®	Anakinra	Kineret®
		Certolizumab	Cimzia®
		Golimumab	Simponi®
		Infliximab	Remicade®
		Rituximab	Rituxan®
		Tocilizumab	Actemra®

Ankylosing Spondylitis **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Adalimumab	Humira®	Infliximab	Remicade®
Etanercept	Enbrel®	**Non-preferred**	
		Golimumab	Simponi®

Crohn's Disease **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred	
Adalimumab	Humira®	Certolizumab	Cimzia®
Infliximab	Remicade®	Natalizumab	Tysabri®

Juvenile Idiopathic Arthritis **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Adalimumab	Humira®	Abatacept	Orencia®
Etanercept	Enbrel®		

Plaque Psoriasis **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Adalimumab	Humira®	Etanercept	Enbrel®
Infliximab	Remicade®	**Non-preferred**	
		Alefacept	Amevive®
		Ustekinumab	Stelara®

Psoriatic Arthritis **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Adalimumab	Humira®	Etanercept	Enbrel®
Infliximab	Remicade®		

Ulcerative Colitis **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred Prior Authorization Required
Infliximab	Remicade®	

The Kansas Medical Assistance Program Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

CARDIOVASCULAR AGENTS

ACE Inhibitors

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Benazepril	Lotensin®	Moexipril	Univasc®
Captopril	Capoten®	Perindopril	Aceon®
Enalapril	Vasotec®	Ramipril	Altace®
Fosinopril	Monopril®	Trandolapril	Mavik®
Lisinopril	Zestril® Prinivil®		
Quinapril	Accupril®		

ACE Inhibitors / Calcium Channel Blockers Combos

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Benazepril/Amlodipine	Lotrel®	Enalapril/Felodipine	Lexxel®
		Non-preferred	
		Trandolapril/Verapamil	Tarka®

ARBs

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Losartan	Cozaar®	Candesartan	Atacand®
Losartan/HCTZ	Hyzaar®	Candesartan/HCTZ	Atacand HCT®
Telmisartan	Micardis®	Eprosartan	Teveten®
Telmisartan/HCTZ	Micardis HCT®	Eprosartan/HCTZ	Teveten HCT®
Valsartan	Diovan®	Olmesartan	Benicar®
Valsartan/HCTZ	Diovan HCT®	Olmesartan/HCTZ	Benicar HCT®
		Non-preferred	
		Azilsartan Medoxomil	Edarbi®
		Irbesartan	Avapro®
		Irbesartan/HCTZ	Avalide®

ARBs / Calcium Channel Blocker Combos

Preferred Drug Covered		Non-preferred	
Amlodipine/Valsartan	Exforge®	Amlodipine/Olmesartan	Azor®
		Amlodipine/Telmisartan	Twynsta®

Beta-Blockers

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Acebutolol	Sectral®	Bisoprolol	Zebeta®
Atenolol	Tenormin®	Penbutolol	Levatol®
Betaxolol	Kerlone®	Propranolol XL	Inderal LA®
Carvedilol	Coreg®	**Non-preferred**	
Carvedilol CR	Coreg CR®	Nebivolol	Bystolic®
Metoprolol Tartrate	Lopressor®		
Metoprolol Succinate	Toprol XL®		
Nadolol	Corgard®		
Pindolol	Visken®		
Propranolol	Inderal® Propranolol Intensol®		
Propranolol XL	InnoPran XL®		
Sotalol	Betapace®		
Sotalol AF	Betapace AF®		
Timolol	Blocadren®		

The Kansas Medical Assistance Program Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

CARDIOVASCULAR AGENTS (CONT)

Calcium Channel Blockers (Dihydropyridines)

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Amlodipine	Norvasc®	Felodipine	Plendil®
Isradipine CR	DynaCirc CR®	Nicardipine SR	Cardene SR®
Isradipine IR	DynaCirc®	Nifedipine IR	Adalat®
Nicardipine IR	Cardene®	Nisoldipine	Sular®
Nifedipine (Extended Release)	Adalat CC® Procardia XL®		

Calcium Channel Blockers (Non-Dihydropyridines)

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Diltia XT®	& AB-Rated Generics	Dilacor XR®	
Diltiazem IR	Cardizem®	Cardizem CD®	& AB-Rated Generics
Tiazac®	& AB-Rated Generics	Cardizem LA®	& AB-Rated Generics
Verapamil IR	Calan®	Cardizem SR®	& AB-Rated Generics
Covera HS® Only		Verelan PM®	& AB-Rated Generics
Verapamil (Sustained Release)	Calan SR® Isoptin SR® Verelan®		

CENTRAL NERVOUS SYSTEM

Adjunct Antiepileptics

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Gabapentin	Neurontin®	Tiagabine	Gabitril®
Levetiracetam	Keppra®	**Non-preferred**	
Pregabalin	Lyrica®	Lacosamide	Vimpat®
Zonisamide	Zonegran®	Levetiracetam XR	Keppra XR®
		Rufinamide	Banzel®

Non-benzodiazepine sedative hypnotics

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Zolpidem	Generic only	Zaleplon	Sonata®
		Zolpidem (brand)	Ambien® Edluar®
		Zolpidem CR	Ambien CR®
		Non-preferred	
		Eszopiclone	Lunesta®

Non-scheduled Novel sleep agents

Preferred Drug Covered		Non-preferred
Ramelteon	Rozerem®	

DIABETIC AGENTS

Alphaglucosidase Inhibitors

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Miglitol	Glyset®	Acarbose	Precose®

The Kansas Medical Assistance Program Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

DIABETIC AGENTS (CONT)

Biguanides

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Metformin	Glucophage®	Metformin (Extended Release) (brands)	Glucophage XR® Fortamet® Glumetza®
Metformin (Extended Release)	generic only		

Dipeptidyl peptidase-4 inhibitors (DPP- 4 inhibitors)

Preferred Drug Covered		Non-preferred	
Saxagliptin	Onglyza®	Linagliptin	Tradjenta®
Sitagliptin	Januvia®		

Meglitinides

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Nateglinide	Starlix®	Repaglinide	Prandin®

Insulin (Delivery Systems)

Preferred Drug Covered		Non-preferred Prior Authorization Required	
All Multi-dose vials	Humalog® Humalog Mix® NovoLog® NovoLog Mix® Novolin R® Novolin N® Humulin R® Humulin N® Humulin 70/30® Novolin 70/30® Velosulin BR®	Cartridges, Syringes, Pens and any other alternative delivery device	Humalog® Humalog Mix® NovoLog® NovoLog Mix® Novolin R® Novolin N® Humulin R® Humulin N® Humulin 70/30® Novolin 70/30® Velosulin BR®

Insulin - Long Acting (Vials Only)

Preferred Drug Covered		Non-preferred	
Insulin Glargine	Lantus®	Insulin Detemir	Levemir®

2nd Generation Sulfonylureas

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Glimepiride	Amaryl®	Glipizide/Metformin	Metaglip®
Glipizide	Glucotrol®		
Glipizide XL	Glucotrol XL®		
Glyburide	DiaBeta® Micronase®		
Glyburide/Metformin	Glucovance®		
Glyburide Micronized	Glynase PresTab®		

Thiazolidinediones

Preferred Drug Covered		Non-preferred	
Pioglitazone	Actos®	Pioglitazone/Metformin	ACTOplus Met®
Rosiglitazone	Avandia®	Pioglitazone/Metformin	ACTOplus Met XR®
		Pioglitazone HCl	Duetact ™
Rosiglitazone/ Metformin	Avandamet®		
Rosiglitazone/Glimepiride	Avandaryl®		

The Kansas Medical Assistance Program Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

GASTROINTESTINAL AGENTS

H2 Antagonists

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Famotidine	Pepcid®	Nizatidine	Axid®
Ranitidine	Zantac ® Zantac EFFERdose®	**Non-preferred**	
		Cimetidine	Tagamet®

Pancreatic Enzyme Replacement Products

Preferred Drug Covered		Non-preferred	
Pancrelipase	Creon ®	Pancrelipase	Pancreaze®
Pancrelipase	Zenpep ®		

Proton Pump Inhibitors

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Dexlansoprazole	Dexilant® (Kapidex®)	Esomeprazole	Nexium®
Lansoprazole	Prevacid®	Esomeprazole Suspension	Nexium® Suspension
Lansoprazole SoluTab™	Prevacid® SoluTab™	Lansoprazole Suspension	Prevacid® Suspension
Omeprazole	Prilosec®	Omeprazole Suspension	Prilosec® Suspension
		Pantoprazole	Protonix®
		Rabeprazole	AcipHex®

Serotonin 5HT3 Antagonists

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Ondansetron	Zofran® Zofran ODT®	Dolasetron	Anzemet®
		Granisetron Oral & Inj	Kytril®
		Non-preferred	
		Granisetron, Oral	Granisol®
		Granisetron, Topical	Sancuso®
		Ondansetron	Zuplenz®

GOUT AGENTS

Xanthine Oxidase Inhibitors

Preferred Drug Covered		Non-preferred	
Allopurinol	Zyloprim ®	Febuxostat	Uloric®

INJECTABLES

Erythropoiesis - Stimulating Agents

Preferred Drug Covered		Non-preferred	
Epoetin alfa	Procrit®	Darbepoetin alfa	Aranesp®
		Epoetin alfa	Epogen®

Growth Hormone **Clinical Prior Authorization is still required for all Growth Hormones*

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Somatropin	Genotropin® Genotropin MiniQuick® Saizen® Tev-Tropin®	Somatropin	Humatrope® Norditropin® Norditropin FlexPro® Norditropin Nordiflex® Nutropin® Nutropin AQ® Nutropin AQ NuSpin® Omnitrope®

The Kansas Medical Assistance Program Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

Nasal Agents

Intranasal Corticosteroids

Preferred Drug Covered	
Fluticasone	Flonase® Veramyst®
Mometasone	Nasonex®

Non-preferred Prior Authorization Required	
Beclomethasone	Beconase® Beconase AQ® Vancenase® Vancenase AQ®
Flunisolide	Bausch & Lomb
Flunisolide	Nasarel®
Non-preferred	
Budesonide	Rhinocort AQ®
Ciclesonide	Omnaris®
Triamcinolone	Nasacort AQ®

Ophthalmic Agents

Ophthalmic Prostaglandin Analogs

Preferred Drug Covered	
Latanoprost	Xalatan®
Travoprost	Travatan® Travatan Z®

Non-preferred Prior Authorization Required	
Bimatoprost	Lumigan®

Osteoporosis Agents

Bisphosphonates

Preferred Drug Covered	
Alendronate	Fosamax®
Alendronate/Cholecalciferol	Fosamax Plus D®

Non-preferred Prior Authorization Required	
Risedronate	Actonel®
Risedronate/Calcium	Actonel® with Calcium
Risedronate	Atelvia®
Non-preferred	
Ibandronate	Boniva®

Respiratory

Inhaled Corticosteroids

Preferred Drug Covered	
Beclomethasone	QVAR®
Budesonide Inhaled Susp.	Pulmicort Respules® ***6 and Under ONLY**
Fluticasone	Flovent HFA® Flovent Diskus®

Non-preferred Prior Authorization Required	
Budesonide Inhaled Susp.	Pulmicort Respules® ****7 and Over**
Flunisolide	AeroBid®
Flunisolide/Menthol	AeroBid M®
Non-preferred	
Budesonide Inhaled Powder	Pulmicort Flexhaler®
Ciclesonide	Alvesco®
Mometasone	Asmanex®
Triamcinolone	Azmacort®

Inhaled Beta 2 Agonists/Corticosteroid – Long - Acting

Preferred Drug Covered	
Budesonide/Formoterol	Symbicort®
Fluticasone/Salmeterol	Advair® Advair HFA®
Formoterol/Mometasone	Dulera®

Non-preferred

The Kansas Medical Assistance Program Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

RESPIRATORY (CONT)

Inhaled Beta 2 Agonists – Long - Acting

Preferred Drug Covered		Non-preferred	
Formoterol	Foradil®	Arformoterol	Brovana®
Salmeterol	Serevent®	Formoterol solution	Perforomist®
		Indacaterol	Arcapta®

Inhaled Beta 2 Agonists – Short - Acting

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Albuterol solution 0.5%	Proventil® Ventolin®	Albuterol solution 0.021%	AccuNeb®
		Albuterol solution 0.042%	AccuNeb®
Albuterol solution 0.083%	Proventil® Ventolin®	Levalbuterol solution	Xopenex®
		Non-preferred	
Albuterol inhalers HFA	ProAir HFA® Ventolin HFA®	Albuterol inhalers HFA	Proventil HFA®
		Levalbuterol inhalers	Xopenex HFA®
		Pirbuterol inhalers	Maxair®

UROLOGIC AGENTS

Anticholinergics

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Fesoterodine	Toviaz®	Flavoxate	Urispas®
Oxybutynin, Oral	Ditropan®	Oxybutynin XL, Oral	Ditropan XL®
Tolterodine	Detrol®	Oxybutynin, Topical	Oxytrol®
Tolterodine LA	Detrol LA®	Trospium	Sanctura®
Solifenacin	Vesicare®	Trospium XR	Sanctura XR®
		Non-preferred	
		Darifenacin	Enablex®
		Oxybutynin, Topical	Gelnique®