

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

ANALGESICS

ANALGESICS, OPIOID – LONG-ACTING

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Butrans Patch # morphine sulfate SR tab #	<i>Belbuca #</i> <i>buprenorphine (Butrans) #</i> <i>Conzip ER % #</i> <i>Duragesic patch * #</i> <i>fentanyl patch #</i> <i>hydrocodone ER cap %</i> <i>hydrocodone ER tab # %</i> <i>hydromorphone ER tab</i> <i>Hysingla ER # %</i> <i>Kadian #</i> <i>Morphabond ER#</i>	<i>morphine ER (Avinza) #</i> <i>morphine sulfate ER cap (Kadian) #</i> <i>MS Contin * #</i> <i>oxycodone ER #</i> <i>OxyContin #</i> <i>oxymorphone ER #</i> <i>tramadol ER % #</i> <i>Zohydro ER % #</i>	No more than one long acting opioid allowed. # Quantity limits apply % Clinical criteria applies MME restriction applies to this class

ANTI-MIGRAINE

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Ajovy % Emgality 120mg % Qulipta %	<i>Aimovig %</i> <i>almotriptan</i> <i>Amerge</i> <i>Brekiya</i> <i>Cambia %</i> <i>diclofenac pot (gen Cambia) %</i> <i>dihydroergotamine nasal (gen Migranal)</i> <i>eletriptan (gen Relpax)</i> <i>Elyxyb sol</i> <i>Emgality 100mg %</i> <i>frovatriptan</i> <i>Imitrex * tabs, pen, cartridge</i> <i>Maxalt *</i> <i>Maxalt MLT *</i>	<i>Naratriptan</i> <i>Onzetra Xsail</i> <i>Relpax</i> <i>Reyvow %</i> <i>sumatriptan inj (SUN Mfr)</i> <i>sumatriptan/naproxen 85-500</i> <i>Symbravo</i> <i>Tosymra</i> <i>Treximet</i> <i>Trudhesa</i> <i>Zavzpret %</i> <i>Zembrace</i> <i>Zolmitriptan all forms</i> <i>Zomig all forms</i>	Quantity limits apply to this class % Clinical criteria applies Non-preferred combination products require trial of combination of components

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

NSAIDS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
celecoxib 100mg and 200mg	<i>Arthrotec</i>	<i>Licart Patch</i>	Trial of 2 preferred agents required
diclofenac 1% gel OTC (generic Voltaren) #	<i>Celebrex *</i>	<i>meclofenamate</i>	
diclofenac potassium tabs	<i>celecoxib 50mg and 400mg</i>	<i>mefenamic acid</i>	# Quantity limits apply
diclofenac sodium EC/DR	<i>diclofenac potassium caps</i>	<i>meloxicam cap (gen Vivlodex)</i>	
ibuprofen tablet (except 300mg)/susp Rx	<i>diclofenac sodium ER/SR</i>	<i>Mobic</i>	% Clinical criteria applies
indomethacin capsule IR	<i>diclofenac sodium /misoprostol</i>	<i>nabumetone</i>	
ketorolac (oral) #	<i>diclofenac topical & transdermal</i>	<i>Nalfon</i>	
meloxicam tablet	<i># (except 1% gel)</i>	<i>Naprelan</i>	
naproxen tablet (Naprosyn)	<i>diflunisal</i>	<i>naproxen sodium Rx (gen Anaprox)</i>	
naproxen EC	<i>Dolobid</i>	<i>naproxen susp</i>	
sulindac	<i>Elyxyb sol</i>	<i>naprox/esomep (gen Vimovo) %</i>	
	<i>etodolac</i>	<i>oxaprozin</i>	
	<i>etodolac tab SR</i>	<i>Pennsaid #</i>	
	<i>Feldene</i>	<i>piroxicam</i>	
	<i>fenoprofen</i>	<i>Qmiiz ODT</i>	
	<i>Flector #</i>	<i>Relafen DS</i>	
	<i>Flurbiprofen</i>	<i>Sprix %</i>	
	<i>ibuprofen 300mg tab</i>	<i>Tivorbex</i>	
	<i>ibuprofen susp OTC</i>	<i>tolmetin sodium</i>	
	<i>ibuprofen/famotidine (gen Duexis)</i>	<i>Vimovo %</i>	
	<i>Indocin supp/susp</i>	<i>Vivlodex</i>	
	<i>indomethacin capsule ER</i>	<i>Vyscoxa</i>	
	<i>ketoprofen/ER</i>	<i>Zipsor %</i>	
	<i>ketorolac tromethamine (gen Sprix) %</i>	<i>Zorvolex</i>	

NEUROPATHIC PAIN

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
capsaicin cream OTC	<i>Dermacinrx Lidocan patch #</i>	<i>Lyrica solution % μ</i>	% Clinical criteria applies μ Cross Duplication not allowed
duloxetine (all except 40mg)	<i>Drizalma sprinkle</i>	<i>Lyrica CR μ</i>	
gabapentin capsule μ #	<i>duloxetine 40 mg cap</i>	<i>Neurontin μ</i>	# Quantity limits apply duloxetine/ Savella concurrent use not allowed
gabapentin solution μ #	<i>gabapentin ER % μ</i>	<i>pregabalin caps/solution μ</i>	
gabapentin tablet μ #	<i>Gabarone</i>	<i>pregabalin ER μ</i>	@ Alternative dosage forms require PA
Lyrica Capsule μ #	<i>Gralise % μ</i>	<i>Qutenza</i>	
Savella %	<i>Horizant % μ</i>	<i>Tonmya @</i>	
	<i>lidocaine patch #</i>	<i>Ztlido</i>	
	<i>Lidocan II</i>		

OPIOID REVERSAL AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
naloxone nasal spray OTC	<i>Kloxxado</i>	<i>Opvee</i>	N/A
naloxone syringe	<i>naloxone nasal spray Rx</i>	<i>Rextovy nasal spray</i>	
naloxone vial	<i>Narcan nasal spray OTC</i>	<i>Zimhi</i>	
		<i>Zurnai</i>	

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

SUBSTANCE USE DISORDER TREATMENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Brixadi % buprenorphine SL + buprenorphine/naloxone SL tabs + Naltrexone Sublocade % Suboxone Film +	<i>buprenorphine/naloxone SL films</i> <i>lofexidine (generic Lucemyra) %</i> <i>Lucemyra %</i> <i>Vivitrol %</i> <i>Zubsolv %</i>	N/A	+ one-time attestation per NPI required % Clinical criteria applies

ANTI-INFECTIVES

ANTIBIOTICS: 2ND GENERATION QUINOLONES

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Cipro suspension ciprofloxacin tablet	<i>Cipro tabs *</i> <i>ciprofloxacin susp</i>	<i>ofloxacin</i>	N/A

ANTIBIOTICS: 3RD GENERATION QUINOLONES

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
levofloxacin tablet	<i>Baxdela</i>	<i>Levofloxacin solution</i> <i>moxifloxacin</i>	N/A

ANTIBIOTICS, GI

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
metronidazole tablet tinidazole vancomycin HCL vancomycin soln (gen Firvanq)	<i>Aemcolo</i> <i>Difcid tab/susp %</i> <i>fidaxomicin (gen Difcid) %</i> <i>Firvanq soln</i> <i>Flagyl</i> <i>Likmez</i> <i>metronidazole 125mg tab</i> <i>metronidazole capsule</i>	<i>neomycin sulfate</i> <i>nitazoxanide (gen Alinia)</i> <i>paromomycin</i> <i>Solosec</i> <i>Vancocin</i> <i>Vowst %</i>	% Clinical criteria applies Xifaxan is no longer rebate eligible and will no longer be covered. Patient assistance is available here

ANTIBIOTICS: INHALED

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Bethkis Kitabis	<i>Arikayce</i> <i>Cayston</i> <i>Tobi</i>	<i>Tobi Podhaler</i> <i>tobramycin inhalation</i>	Clinical criteria applies to class

Montana Healthcare Programs Preferred Drug List (PDL)

Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

ANTIBIOTICS: MACROLIDES/KETOLIDES

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
azithromycin	<i>clarithromycin ER</i>	<i>Erythrocin filmtab</i>	N/A
clarithromycin	<i>E.E.S. 200mg susp</i>	<i>erythromycin ES 400mg/5ml susp</i>	
erythromycin DR capsule	<i>E.E.S. 400 filmtab</i>	<i>erythromycin ES tablet</i>	
erythromycin ES 200mg/5ml susp	<i>Ery-Ped susp</i>	<i>erythromycin filmtab</i>	
	<i>Ery-Tab EC</i>	<i>Zithromax *</i>	

ANTIBIOTICS: 2ND GENERATION CEPHA

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
cefprozil tab/susp	<i>cefaclor capsule</i>	<i>cefaclor ER</i>	N/A
cefuroxime	<i>cefaclor suspension</i>		

ANTIBIOTICS: 3RD GENERATION CEPHALOSPORINS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
cefdinir	<i>cefixime caps/susp</i>	<i>cefpodoxime</i>	N/A

ANTIBIOTICS: TETRACYCLINES

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
doxycycline hyclate capsule	<i>demeclocycline</i>	<i>minocycline ER</i>	% Clinical criteria applies
doxycycline hyclate tabs (20,75,100,150mg)	<i>Doryx</i>	<i>Minolira ER</i>	
doxycycline monohydrate 50mg and 100mg capsule	<i>doxycycline hyclate DR tab</i>	<i>Morgidox Kit</i>	
doxycycline monohydrate tablet	<i>doxycycline IR-DR 40mg cap% (gen Oracea)</i>	<i>Nuzyra</i>	
minocycline capsules	<i>doxycycline suspension</i>	<i>Oracea</i>	
	<i>doxycycline monohydrate 75mg and 150mg capsule</i>	<i>tetracycline</i>	
	<i>minocycline tablet</i>	<i>Vibramycin</i>	
		<i>Ximino ER</i>	

ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
mupirocin ointment	<i>Centany</i> <i>Centany AT</i>	<i>gentamicin cream/oint</i> <i>mupirocin cream</i> <i>Xepi</i>	N/A

ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Cleocin cream	<i>clindamycin vaginal 2% cream</i>	<i>Nuessa vaginal gel #</i>	# Quantity limits apply
Cleocin ovules	<i>Metrogel vaginal gel</i>	<i>Vandazole</i>	
Clindesse #		<i>Xaciato</i>	
metronidazole vaginal 0.75% gel			

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
clotrimazole fluconazole griseofulvin suspension nystatin suspension terbinafine	<i>Brexafemme</i> <i>Cresemba</i> <i>Diflucan</i> * <i>flucytosine</i> <i>griseofulvin micro</i> <i>griseofulvin ultra</i> <i>itraconazole caps & sol</i> <i>ketoconazole %</i>	<i>Noxafil packet/susp</i> <i>nystatin oral tablet</i> <i>Oravig</i> <i>posaconazole tab/susp</i> <i>Sporanox</i> <i>Tolsura</i> <i>Vfend</i> <i>Vivjoa</i> <i>voriconazole</i>	% Clinical criteria applies

ANTIFUNGALS AND COMBOS, TOPICAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Cicloclodan 8% solution ciclopirox 8% solution ciclopirox cream clotrimazole cream Rx clotrimazole/betamethasone cream ketoconazole cream/shampoo nystatin cream/oint/powder	<i>Bensal HP</i> <i>Cicloclodan cream/kit</i> <i>ciclopirox (Cicloclodan/Loprox)</i> <i>gel/kit/shmp/susp</i> <i>clotrimazole solution</i> <i>clotrim/betameth lotion</i> <i>econazole cream/foam</i> <i>Ertaczo cream</i> <i>Exelderm cream/sol</i> <i>Extina foam</i> <i>Kerydin soln</i> <i>ketoconazole foam</i> <i>Ketodan Foam/Kit</i>	<i>Loprox shmp/cream/susp</i> <i>miconazole/zinc oxide/ petrolatum (gen Vusion)</i> <i>naftifine cream/gel</i> <i>Naftin cream/gel</i> <i>nystatin/triamcin cream/oint</i> <i>oxiconazole cream</i> <i>Oxistat cream/lotion</i> <i>sulconazole cr/sol (gen Exelderm)</i> <i>tavaborole (gen Kerydin)</i> <i>Vusion</i>	N/A

ANTIVIRALS: HERPES – ORAL AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
acyclovir cap/tab/susp famciclovir valacyclovir	<i>Sitavig Buccal</i>	<i>Valtrex</i> * <i>Zovirax susp</i>	N/A

ANTIVIRALS: INFLUENZA

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
oseltamivir suspension and capsule Xofluza	<i>flumadine</i> <i>Relenza</i>	<i>rimantadine HCl</i> <i>Tamiflu</i>	

ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Acyclovir 5% ointment Docosanol OTC (gen Abreva)	<i>acyclovir cream</i> <i>Denavir</i>	<i>penciclovir (gen Denavir)</i>	N/A

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

HEPATITIS C: PEGYLATED INTERFERONS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
N/A	<i>Pegasys ProClick/syringe/vial</i>	N/A	Clinical criteria applies to this class

HEPATITIS C: OTHER

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Mavyret tabs/pellet pak	<i>Eplclusa tabs/pellet pak</i> <i>Harvoni tabs/pellet pak</i> <i>ledipasvir-sofosbuvir</i>	<i>sofosbuvir-velpatasvir</i> <i>Sovaldi tabs/pellet pak</i> <i>Vosevi</i> <i>Zepatier</i>	Clinical criteria applies to this class

HEPATITIS C: RIBAVIRIN PRODUCTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
ribavirin capsules and tablets	N/A	N/A	Clinical criteria applies to this class

CARDIOVASCULAR

ACE INHIBITORS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
benazepril enalapril lisinopril ramipril	<i>Accupril *</i> <i>Altace</i> <i>captopril</i> <i>enalapril sol (gen Epaned)</i> <i>Epaned Oral Soln</i> <i>fosinopril</i> <i>Lotensin *</i>	<i>moexipril</i> <i>perindopril</i> <i>Prinivil *</i> <i>Qbrelisl</i> <i>quinapril</i> <i>trandolapril</i> <i>Zestril *</i>	Trial of 2 preferred agents required

ACE INHIBITOR COMBINATIONS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
enalapril w/HCTZ lisinopril w/HCTZ	<i>Accuretic *</i> <i>benazepril w/HCTZ</i> <i>captopril w/HCTZ</i> <i>fosinopril w/HCTZ</i>	<i>Lotensin HCT</i> <i>quinapril w/HCTZ</i> <i>Zestoretic *</i>	Trial of 2 preferred agents required

Montana Healthcare Programs Preferred Drug List (PDL)

Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

ANGIOTENSIN MODULATOR

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Entresto irbesartan losartan olmesartan valsartan	Arbli @ Atacand Avapro * Benicar * candesartan Cozaar * Diovan *	Edarbi Entresto Sprinkles Eprosartan sacubitril/valsartan (gen Entresto) Telmisartan valsartan sol	Trial of 2 preferred agents required @ Alternative dosage forms require PA

ANGIOTENSION II RECEPTOR BLOCKER COMBOS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
irbesartan/HCTZ losartan/HCTZ olmesartan/HCTZ valsartan/HCT	Atacand HCT Avalide * Benicar HCT * candesartan/HCTZ Diovan HCT *	Edarbyclor Hyzaar * Micardis HCT telmisartan/HCTZ	N/A

ANGIOTENSION MODULATOR COMBINATIONS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
amlodipine/benazepril amlodipine/valsartan	amlodipine/olmesartan w or w/o HCTZ amlodipine/valsartan/HCTZ Azor Exforge *	Exforge HCT Tarka telmisartan/amlodipine trandolapril/verapamil ER Tribenzor	N/A

ANTIANGINAL & ANTIISCHEMIC

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
ranolazine ER	Ranexa ER	N/A	N/A

ANTIHYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
clonidine IR oral clonidine transdermal guanfacine IR methyldopa	Catapres oral * clonidine ER (gen Nexiclon)	N/A	N/A

Montana Healthcare Programs Preferred Drug List (PDL)

Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

BETA BLOCKERS AND COMBINATIONS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
atenolol	<i>acebutolol</i>	<i>Lopressor solution</i>	Trial of 2 preferred agents required
bisoprolol (gen Zebeta)	<i>atenolol/chlorthalidone</i>	<i>Lopressor tab*</i>	
carvedilol	<i>betaxolol</i>	<i>metoprolol/HCTZ</i>	% Clinical criteria applies
labetalol	<i>bisoprolol/HCTZ</i>	<i>nadolol/Corgard</i>	
metoprolol succinate ER	<i>Bystolic*</i>	<i>pindolol</i>	
metoprolol tartrate	<i>carvedilol ER</i>	<i>propranolol/HCTZ</i>	
nebivolol	<i>Coreg*</i>	<i>Betapace /Batapace AF</i>	
propranolol IR	<i>Hemangeol</i>	<i>Sotylize</i>	
propranolol ER	<i>Inderal LA & XL</i>	<i>Tenormin /Tenoretic</i>	
sotalol/sorine	<i>Innopran XL</i>	<i>timolol</i>	
	<i>Kaspargo Sprinkle</i>	<i>Toprol XL*</i>	

CALCIUM CHANNEL BLOCKERS (DHP)

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
amlodipine	<i>Adalat CC</i>	<i>nimodipine</i>	Trial of 2 preferred agents required
nifedipine ER (generic for Procardia XL)	<i>felodipine ER</i>	<i>nisoldipine ER</i>	
	<i>isradipine</i>	<i>Norliqva</i>	
	<i>Katerzia</i>	<i>Norvasc*</i>	
	<i>levamlodipine (gen Conjugpri)</i>	<i>Nymalize</i>	
	<i>nicardipine HCl</i>	<i>Procardia XL*</i>	
	<i>nifedipine IR</i>	<i>Sular (reformulated)</i>	

CALCIUM CHANNEL BLOCKERS (NON-DHP)

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Cartia XT	<i>Calan/Calan SR</i>	<i>verapamil 360 capsule</i>	Trial of 2 preferred agents required
Dilt XR	<i>diltiazem LA</i>	<i>verapamil capsule ER</i>	
diltiazem HCl IR	<i>Matzim LA</i>	<i>verapamil ER PM</i>	
diltiazem ER capsule		<i>Verelan</i>	
verapamil HCl IR		<i>Verelan PM</i>	
verapamil ER tablets			

DIRECT RENIN INHIBITORS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
N/A	<i>aliskiren</i>	<i>Tekturna HCT</i>	Clinical criteria applies to this class
	<i>Tekturna</i>		

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

LIPOTROPICS: HMG-COA RED INH (STATINS) AND COMBOS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
atorvastatin	<i>Altoprev</i>	<i>Lescol XL</i>	% Clinical criteria applies
ezetimibe	<i>amlodipine-atorvastatin</i>	<i>Lipitor *</i>	
lovastatin	<i>Atorvaliq @</i>	<i>Livalo</i>	@ Alternative dosage forms require PA
pravastatin	<i>Caduet</i>	<i>pitavastatin</i>	
rosuvastatin	<i>Crestor *</i>	<i>Vytorin %</i>	
simvastatin %	<i>Ezallor Sprinkle @</i>	<i>Zetia *</i>	
	<i>ezetimibe/simvastatin %</i>	<i>Zocor %</i>	
	<i>fluvastatin</i>	<i>Zypitamag</i>	
	<i>fluvastatin XL</i>		

LIPOTROPICS: OTHERS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
cholestyramine/aspartame	<i>Antara</i>	<i>Lopid *</i>	% Clinical criteria applies
cholestyramine/sucrose	<i>colesevelam tab & powder (gen Welchol)</i>	<i>Lovaza % *</i>	
colestipol tablets	<i>colestipol granules</i>	<i>Nexletol %</i>	
fenofibrate 48mg & 145mg– (gen Tricor)	<i>fenofibrate – gen Antara</i>	<i>Nexlizet %</i>	
fenofibrate 54mg & 160mg tab– (gen Lofibra)	<i>fenofibrate – gen Lipofen</i>	<i>Niaspan *</i>	
gemfibrozil	<i>fenofibric acid – gen Trilipix</i>	<i>Praluent %</i>	
niacin ER	<i>Fibracor</i>	<i>Questran *</i>	
omega-3 ethyl esters %	<i>icosapent ethyl (gen Vascepa) %</i>	<i>Questran Light *</i>	
Prevalite	<i>Juxtapid %</i>	<i>Redempro</i>	
	<i>Leqvio %</i>	<i>Repatha %</i>	
	<i>Lipofen</i>	<i>Trilipix</i>	
		<i>Tryngolza</i>	
		<i>Welchol tab & powder</i>	

CENTRAL NERVOUS SYSTEM

ALZHEIMER'S DRUGS - CHOLINESTERASE INHIBITORS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
donepezil 5 & 10 mg tablet	<i>Adlarity</i>	<i>galantamine</i>	% Clinical criteria applies
Exelon patch	<i>Aricept *</i>	<i>galantamine ER</i>	
rivastigmine capsule	<i>Aricept 23 %</i>	<i>Razadyne ER</i>	
	<i>donepezil 23mg %</i>	<i>rivastigmine patch</i>	
	<i>donepezil ODT</i>	<i>Zunveyl</i>	

ALZHEIMER'S DRUGS - NMDA RECEPTOR ANTAGONIST AND COMBOS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
memantine tablet	<i>memantine sol @/dosepak</i>	<i>Namzaric</i>	@ Alternative dosage forms require PA
	<i>memantine ER</i>		
	<i>memantine-donepezil (gen Namzaric)</i>		
	<i>Namenda dosepak</i>		

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

ANTI-CONVULSANTS: CARBAMAZEPINE DERIVATIVES

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
carbamazepine 100mg chew tabs	<i>Aptiom</i>	<i>oxcarbazepine susp</i>	NOTE: DAW 7 may be used ONLY for seizure diagnosis @ Alternative dosage forms require PA
carbamazepine tab	<i>carbamazepine 200mg chew tabs</i>	<i>oxcarbazepine ER (generic</i>	
carbamazepine ER tabs	<i>carbamazepine susp @</i>	<i>Oxtellar XR</i>	
Epitol	<i>carbamazepine ER caps</i>	<i>Oxtellar XR</i>	
oxcarbazepine tabs	<i>Carbatrol ER</i>	<i>Trileptal tablets *</i>	
Tegretol susp @	<i>Equetro</i>		
Tegretol & Tegretol XR	<i>Eslicarbazepine (gen Aptiom)</i>		
Trileptal oral suspension @			

ANTI-CONVULSANTS: FIRST GENERATION

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Depakote sprinkle	<i>Celontin</i>	<i>felbamate</i>	NOTE: DAW 7 may be used ONLY for seizure diagnosis @ Alternative dosage forms require PA
Dilantin 30mg Kapseal	<i>Depakote IR and ER *</i>	<i>Felbatol tabs and susp</i>	
Dilantin 50mg chew tab	<i>Dilantin capsule *</i>	<i>methsuximide (gen Celontin)</i>	
divalproex sodium IR and ER	<i>Dilantin-125 oral suspension *@</i>	<i>Phenytek</i>	
ethosuximide caps	<i>divalproex sodium sprinkle</i>	<i>Zarontin Syr @</i>	
ethosuximide susp @		<i>Zarontin caps</i>	
phenobarbital			
phenytoin caps and suspension			
phenytoin infatabs			
primidone			
valproic acid capsule and syrup			

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

ANTI-CONVULSANTS: SECOND GENERATION AND OTHERS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
clobazam tab & susp	Banzel %	Neurontin solution @ μ	Note: DAW 7 may be used ONLY for seizure diagnosis
diazepam rectal %	Briviact	Neurontin tablet/capsule * μ	
gabapentin capsule μ	Diacomil %	Onfi	@ Alternative dosage forms require PA
gabapentin solution μ	Elepsia XR	perampanel (gen Fycompa)	
gabapentin tablet μ	Epidiolex %	pregabalin caps/solution μ	% Clinical criteria applies
lacosamide tab/sol (generic Vimpat)	Eprontia @	pregabalin ER μ	
lamotrigine IR tabs & chews/dispersible	Fintepla %	rufinamide tab & susp (gen Banzel) %	μ Cross duplication not allowed between gabapentin and Lyrica
levetiracetam IR	Fycompa	Sabril	
levetiracetam solution	Keppra * @	Spritam	
Lyrica capsule μ	Keppra XR	Sympazan @	
Nayzilam %	lacosamide dose cups %	Tiagabine %	
topiramate tablets	Lamictal *	Topamax Sprinkle Cap @	
Valtoco %	Lamictal ODT & ODT Starter pak @	Topamax tablet *	
zonisamide	Lamictal Starter pak	topiramate sprinkle cap @	
	Lamictal XR %	topiramate ER	
	lamotrigine ER %	topiramate solution	
	lamotrigine ODT @	Trokendi XR	
	lamotrigine starter pak	vigabatrin powder (gen Sabril)	
	levetiracetam (gen Spritam)	vigabatrin tablet	
	levetiracetam ER	Vigafyde	
	Libervant %	Vimpat	
	Lyrica solution μ	Xcopri	
	Lyrica CR μ	Zonisade	
	Motpoly XR %	Ztalmy %	

ANTI-DEPRESSANTS: SSRIS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
citalopram tabs # (limit 40 mg/day)	Brisdelle %	paroxetine CR	Trial of 2 preferred agents required
escitalopram tablet #	Celexa * #	paroxetine susp	
fluoxetine capsules	citalopram caps	Paxil *	% Clinical criteria applies
fluoxetine solution	escitalopram 15mg caps	Paxil CR	
fluoxetine tablets	escitalopram solution #	Paxil Susp	# Dose limits apply
fluvoxamine	fluoxetine DR %	Pexeva	
paroxetine	fluvoxamine CR	sertraline caps	
sertraline tabs and soln	Lexapro * #	Zoloft *	
	paroxetine 7.5mg %		

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

ATYPICAL ANTIPSYCHOTICS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Abilify Asimtufi @ Abilify Maintena @ aripiprazole tablets Aristada @ Aristada Initio @ clozapine tablet Invega Hafyera @ Invega Sustenna @ Invega Trinza @ lurasidone olanzapine olanzapine ODT @ Perseris @ quetiapine quetiapine ER Risperdal Consta @ risperidone solution @ risperidone tablet Uzedy @ ziprasidone HCl Zyprexa Relprevv @	Abilify Mycite % Abilify tablet * Adasuve aripiprazole sol/ODT @ asenapine (gen Saphris) Caplyta clozapine ODT @ Clozaril * Cobenfy Erzofri @ Fanapt Fanapt titration pack Fazacllo Geodon * Invega Latuda * Lybalvi % Nuplazid % olanzapine/fluoxetine Opipza film paliperidone ER Rexulti Risperdal *	risperidone IM (gen Consta) risperidone tab rapdis @ Saphris Secuado @ Seroquel IR & XR * Symbyax % Versacloz Vraylar Zyprexa tablet * Zyprexa Zydis * @	Oral therapies require an FDA approved diagnosis and trial of 2 preferred agents FDA approved for same diagnosis Dose optimization edits apply to many in class @ Alternative dosage forms require PA % Clinical criteria applies PA for class required for members eight and under Non-preferred combination products require trial of combination of components

MULTIPLE SCLEROSIS AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Avonex Avonex Pen Betaseron Copaxone 20mg dimethyl fumarate (gen Tecfidera) fingolimod (gen Gilenya) Kesimpta Rebif Rebidose teriflunomide (gen Aubagio)	Aubagio Bafiertam cladribine (gen Mavenclad) Copaxone 40mg Syringe Extavia Gilenya glatiramer 20&40mg Glatopa	Mavenclad Mayzent Plegridy & Pen Ponvory Rebif syringe Tascenso ODT Tecfidera Vumerity Zeposia	Clinical criteria applies to this class

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

ANTI-PARKINSON'S AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
amantadine caps/soln	Apokyn %	Mirapex *	% Clinical criteria applies
benztropine	Apomorphine %	Mirapex ER %	
carbidopa/levodopa IR and ER	Azilect	Neupro	
entacapone	amantadine tabs	Nouriaz %	
pramipexole dihydrochloride	bromocriptine	Ongentys	
ropinirole	carbidopa	Osmolex ER	
selegiline caps	carbidopa/levodopa ODT	pramipexole ER %	
selegiline tabs	carbidopa/levodopa ER (gen	rasagiline	
trihexyphenidyl	Rytary) %	ropinirole ER %	
	carbidopa/levodopa/ entacapone	Rytary %	
	Crexont ER	Sinemet IR	
	Dhivy	Stalevo	
	Duopa	tolcapone	
	Gocovri	Xadago	
	Inbrija		

SEDATIVE HYPNOTIC AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
eszopiclone (initial dose limit 1mg/day)	Ambien */ Ambien CR	Quviviq %	Quantity limits apply to class
temazepam 15 & 30mg	Belsomra %	ramelteon	
zaleplon	doxepin % (gen Silenor)	Restoril *	% Clinical criteria applies
zolpidem tartrate IR tablet (initial dose limit 5mg/day for females)	Dayvigo %	Rozerem	
	Edluar %	Silenor %	
	Estazolam	Sonata	
	flurazepam	tasimelteon (gen Hetlioz) %	
	Halcion	temazepam 7.5 & 22.5mg	
	Hetlioz cap/susp %	triazolam	
	Intermezzo %	zolpidem 7.5mg caps	
	Lunesta %	zolpidem ER	
		zolpidem sl %	

SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
baclofen tablet	Amrix %	Lyvispah	% Clinical criteria applies
cyclobenzaprine HCl 5mg & 10mg	baclofen solution	metaxalone	
methocarbamol	chlorzoxazone	Norgesic/Norgesic Forte	
orphenadrine citrate	cyclobenzaprine 7.5mg%	Robaxin *	
tizanidine HCl tablet	cyclobenzaprine ER %	Skelaxin	
	Dantrium	Tanlor	
	dantrolene sodium	tizanidine capsule % #	
	Fexmid %	Zanaflex capsule % #	
	Fleqsuvy	Zanaflex tablet *	
	Lorzone *		

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

MOVEMENT DISORDER DRUGS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Austedo Austedo XR Ingrezza Ingrezza Sprinkles @ tetrabenazine	Austedo XR titration kit Ingrezza initiation Pack Xenazine		Clinical criteria applies to this class; Quantity limits apply @ Alternative dosage forms require PA

ENDOCRINE AND METABOLIC AGENTS

ANDROGENIC AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
testosterone 1.62% gel pump (gen Androgel)	Androderm Natesto	Testim testosterone gel Vogelxo	Clinical criteria applies to this class

BONE: RESORPTION AND RELATED AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
alendronate tablet Forteo ibandronate raloxifene	Actonel alendronate solution Atelvia Boniva Bonsity calcitonin-salmon %	Evista * Fosamax tabs */ PlusD risedronate sodium teriparatide Tymlos	% Clinical criteria applies

ANTI-HYPOGLYCEMIC AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Baqsimi # Glucagon # Glucagon Emergency Kit (Lilly, Amphastar) # Proglycem susp Zegalogue autoinject #	diazoxide susp Glucagon Emergency kit (Fresenius) # Gvoke pen/syringe # Zegalogue syringe #	N/A	# Quantity limits apply

DIABETES: ALPHA-GLUCOSIDASE INHIBITORS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
acarbose	miglitol Precose *	N/A	N/A

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

DIABETES: DPP-IV INHIBITORS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Glyxambi Janumet Janumet XR Januvia Jentadueto Tradjenta	<i>alogliptin</i> <i>alogliptin-metformin</i> <i>alogliptin-pioglitazone</i> <i>Brynovin</i> <i>Jentadueto XR</i> <i>Kazano</i> <i>Nesina</i> <i>Oseni</i> % <i>saxagliptin (gen Onglyza)</i>	<i>saxagliptin-metformin ER (gen Kombiglyze)</i> <i>sitagliptin (gen Zituvio)</i> <i>sitagliptin/metformin (gen Zituvimet)</i> <i>Trijardy XR</i> <i>Zituvio</i> <i>Zituvimet IR and ER</i>	% Clinical criteria applies

DIABETES: GLP-1/GIP AND COMBOS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Ozempic Trulicity Victoza	<i>Bydureon BCISE</i> <i>exenatide pen (gen Byetta)</i> <i>liraglutide (gen Victoza)</i> <i>Mounjaro</i>	<i>Rybelsus</i>	Trial of 2 preferred agents for 6 months each required Electronic edits apply to class

DIABETES: INSULIN AND COMBOS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Humulin 70/30 Pen Humulin N Vial Humulin R Vial Humulin R U-500 Pen insulin aspart Cartridge/Flexpen/Vial (while available) insulin aspart/insulin aspart protamine Pen/Vial insulin glargine Pen insulin lispro All formulations Lantus Vial Lantus SoloStar Novolog Cartridge/Flexpen/Vial	<i>Admelog Vial/SoloStar</i> <i>Afrezza</i> % <i>Apidra Vial/Solostar</i> <i>Basaglar Kwikpen/Tempo pen</i> <i>Fiasp Vial/FlexTouch/ Cartridge/ Pumpcart</i> <i>Humalog ALL formulations</i> <i>Humulin Pen</i> <i>Humulin N Pen OTC</i> <i>Humulin R U-500 Vial</i> <i>insulin degludec Pen/Vial</i> <i>insulin glargine Vial</i> <i>insulin glargine-YFGN Pen/Vial</i> <i>insulin glargine max solostar Vial/Kwikpen</i> <i>Kristy vial/pen</i>	<i>Lyumjev Vial/Kwikpen/Tempo pen</i> <i>Merilog vial/solostar</i> <i>Novolin N Flexpen/vial</i> <i>Novolin R Flexpen/vial</i> <i>Novolin 70/30</i> <i>Novolog Mix ALL formulations</i> <i>Rezvoglar Kwikpen</i> <i>Semglee</i> <i>Semglee-YFGN Pen/Vial</i> <i>Soliqua 100-33</i> <i>Toujeo</i> <i>Tresiba Vial/FlexTouch</i> <i>Xultophy 100-3.6</i>	Clinical PA required for non-preferred insulin pens % Clinical criteria applies

DIABETES: MEGLITINIDES AND COMBOS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Repaglinide (gen for Prandin)	<i>Nateglinide (gen for Starlix)</i>	<i>repaglinide-metformin</i>	N/A

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

DIABETES: METFORMINS AND COMBOS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
glyburide-metformin metformin metformin ER (generic for Glucophage XR)	Fortamet glipizide-metformin metformin 625mg and 750mg metformin solution	metformin ER (gen for Fortamet) metformin ER (gen for Glumetza) Riomet	N/A

DIABETES: SGLT2 AND COMBOS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Farxiga Glyxambi Jardiance Synjardy Xigduo XR	dapagliflozin dapagliflozin/metformin ER Inpefa Invokamet Invokana Invokamet XR	Segluromet Steglatro Steglujan Synjardy XR Trijardy XR	

DIABETES: SULFONYLUREAS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
glimepiride 1mg, 2mg, & 4mg glipizide glipizide ER/XL glyburide	glimepiride 3mg glyburide micronized	N/A	N/A

DIABETES: TZD

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
pioglitazone	Actoplus Met Actos	Duetact pioglitazone/glimepiride pioglitazone/metformin	

ESTROGEN, OTHERS: ORAL/TRANSDERMAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
ORAL estradiol oral Premarin oral	conjugated estrogens (gen Premarin) Duavee Estrace *	Lynkuet Osphena Veozah	N/A
TRANSDERMAL estradiol patch (generic for Climara) Minivelle Vivelle-Dot	Climara Divigel Dotti Elestrin estradiol gel packet (gen Divigel) estradiol gel pump	estradiol patch (generics for Minivelle/Vivelle-Dot) Evamist Lyllana Menostar	N/A

Montana Healthcare Programs Preferred Drug List (PDL)

Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

ESTROGEN , OTHERS: VAGINAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Estring Femring Premarin vaginal cream Vagifem	<i>Estrace</i> <i>estradiol (gen Estrace)</i> <i>estradiol (gen Yuvafem)</i>	<i>Intrarosa</i> <i>Yuvafem</i>	N/A

GROWTH HORMONES

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Genotropin Cartridge, Syringe Norditropin	<i>Humatrope</i> <i>Ngenla</i> <i>Omnitrope</i> <i>Serostim</i>	<i>Skytrofa</i> <i>Sogroya</i> <i>Zomacton Vial</i> <i>Zorbtive</i>	Clinical criteria applies to this class

PANCREATIC ENZYMES

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Creon Zenpep	<i>Pertzye</i>	<i>Viokace</i>	N/A

PITUITARY SUPPRESSIVE AGENTS, LHRH

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Fensolvi Leuprolide depot (gen Lutrate Depot) Lupron Depot-Ped Supprelin LA % Synarel Triptodur	N/A	N/A	% Clinical criteria applies

PROGESTINS FOR CACHEXIA

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
megestrol suspension	<i>megestrol ES 625mg/5mL suspension</i>	N/A	N/A

UTERINE DISORDER TREATMENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Myfembree Orilissa	<i>Oriahnn</i>	N/A	N/A

Montana Healthcare Programs Preferred Drug List (PDL)

Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

GASTROINTESTINAL

ANTIEMETICS AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
metoclopramide tablets, solution	<i>Akynzeo</i>	<i>Granisetron #</i>	# Quantity limits apply % Clinical criteria applies
ondansetron injections	<i>Aprepitant %</i>	<i>metoclopramide injection</i>	
ondansetron ODT (4mg & 8mg)	<i>Bonjesta %</i>	<i>metoclopramide ODT %</i>	
ondansetron solution	<i>Diclegis%</i>	<i>ondansetron ODT 16mg</i>	
ondansetron tablet	<i>doxylamine/pyridox %</i>	<i>Reglan *</i>	
	<i>Emend Oral %</i>	<i>Sancuso %</i>	
	<i>Emend Oral Pak %</i>	<i>Sustol SQ</i>	
	<i>Gimoti</i>	<i>Zofran *</i>	

GI MOTILITY AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Linzess	<i>Alosetron</i>	<i>prucalopride (gen Motegrity)</i>	Clinical criteria applies to this class
Lotronex	<i>Amitiza</i>	<i>Symproic</i>	
Lubiprostone (gen Amitiza)	<i>Ibsrela</i>	<i>Viberzi</i>	
	<i>Motegrity</i>		
	<i>Movantik</i>		

PROTON PUMP INHIBITORS, OTHERS/H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
esomeprazole cap (Rx)	<i>Aciphex tab</i>	<i>Nexium OTC</i>	Trial of two preferred molecules required @ Alternative dose forms require PA. Quantity limits apply to class % Clinical criteria applies
lansoprazole OTC 15mg ODT @	<i>Aciphex sprinkle @</i>	<i>Nexium Rx capsule</i>	
lansoprazole caps Rx	<i>bismuth-metronidazole-tetracycline (gen Pylera)</i>	<i>Omeclamox-Pak</i>	
Nexium suspension @	<i>Dexilant</i>	<i>omeprazole OTC</i>	
omeprazole (Rx)	<i>dexlansoprazole (gen Dexilant)</i>	<i>omeprazole/sodium bicarb</i>	
pantoprazole	<i>Esomeprazole cap (OTC)</i>	<i>pantoprazole susp</i>	
Prevacid Solu Tab @	<i>esomeprazole tab (OTC)</i>	<i>Prevacid RX and OTC</i>	
Protonix suspension @	<i>esomeprazole susp</i>	<i>Prilosec (Rx) susp packet @</i>	
Pylera	<i>Konvomep</i>	<i>Protonix Tablet *</i>	
	<i>lansoprazole caps OTC</i>	<i>Rabeprazole</i>	
	<i>lansoprazole ODT Rx @</i>	<i>Talicia</i>	
	<i>lansoprazole-amox-clarith</i>	<i>Vimovo %</i>	
	<i>naproxen/esomeprazole (gen Vimovo) %</i>	<i>Voquezna</i>	
		<i>Voquezna Dual/Triple Pak</i>	

ULCERATIVE COLITIS – ORAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
mesalamine (gen Lialda)	<i>Asacol HD</i>	<i>Dipentum</i>	N/A
Pentasa	<i>Azulfidine *</i>	<i>Lialda</i>	
sulfasalazine DR	<i>Azulfidine DR *</i>	<i>mesalamine (gen Delzicol)</i>	
sulfasalazine IR	<i>balsalazide</i>	<i>mesalamine ER (gen Apriso)</i>	
	<i>budesonide ER</i>	<i>mesalamine (gen Asacol HD)</i>	
		<i>mesalamine ER (gen Pentasa)</i>	

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

ULCERATIVE COLITIS – RECTAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
mesalamine supp (gen Canasa)	<i>budesonide (gen Uceris)</i> <i>Canasa rectal supp</i> <i>mesalamine enema</i> <i>mesalamine kit (gen Rowasa)</i>	<i>Rowasa kit</i> <i>sf Rowasa enema</i>	N/A

GENITOURINARY AND RENAL

ALPHA BLOCKERS FOR BPH

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
alfuzosin tamsulosin	<i>Flomax *</i>	<i>silodosin</i>	N/A

ANDROGEN HORMONE INHIBITORS AND COMBOS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
dutasteride finasteride 5mg	<i>dutasteride-tamsulosin</i> <i>Jalyn</i>	<i>Proscar *</i>	N/A

PDE-5 FOR BPH

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
tadalafil	<i>Cialis</i>	N/A	Clinical criteria applies to this class

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
calcium acetate caps Fosrenol tabs sevelamer carbonate 800mg tabs (gen Renvela)	<i>Auryxia</i> <i>calcium acetate tabs</i> <i>ferric citrate</i> <i>Fosrenol powder</i> <i>lanthanum chew tab</i> <i>Renvela tabs & powder</i>	<i>sevelamer powder</i> <i>sevelamer HCL 400 and 800mg tabs (gen Renagel)</i> <i>Velphoro</i> <i>Xphozah</i>	N/A

POTASSIUM BINDERS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Lokelma (30 count box) sodium polystyrene sulfonate	<i>Kionex</i> <i>Lokelma (unit dose)</i>	<i>SPS</i> <i>Veltassa</i>	N/A

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

URINARY TRACT ANTISPASMODICS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Myrbetriq tab oxybutynin ER oxybutynin 5mg IR solifenacin (gen Vesicare) tolterodine ER	<i>darifenacin ER</i> <i>Ditropan XL</i> <i>fesoterodine ER (gen Toviaz)</i> <i>flavoxate</i> <i>Gemtesa</i> <i>mirabegron ER</i>	<i>Myrbetriq susp</i> <i>oxybutynin 2.5mg IR</i> <i>Oxytrol *</i> <i>tolterodine</i> <i>Toviaz</i> <i>trospium</i> <i>trospium XR</i> <i>Vesicare *</i> <i>Vesicare LS susp</i>	N/A

HEMATOLOGICAL AGENTS

ANTICOAGULANTS INJECTABLE

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
enoxaparin #	<i>Arixtra</i> <i>fondaparinux</i>	<i>Fragmin</i> <i>Lovenox * #</i>	# Quantity limits apply

ANTICOAGULANT ORAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Eliquis # Eliquis starter pack # Pradaxa capsule # warfarin Xarelto tabs #	<i>Dabigatran # (generic Pradaxa)</i> <i>Eliquis sprinkles/susp @</i> <i>Pradaxa pellet pack #</i> <i>rivaroxaban susp %</i> <i>rivaroxaban tab</i>	<i>Savaysa #</i> <i>Xarelto susp %</i>	# Quantity limits apply % Clinical criteria applies @ Alternative dosage forms require PA

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Fulphila Neupogen vial & syringe	<i>Fylnetra</i> <i>Leukine</i> <i>Granix vial/syringe</i> <i>Neulasta</i> <i>Nivestym</i> <i>Nypozi</i> <i>Nyvepria</i>	<i>Releuko</i> <i>Rolvedon</i> <i>Ryzneuta</i> <i>Stimufend</i> <i>Udenyca</i> <i>Zarxio</i> <i>Ziextenzo</i>	N/A

ERYTHROPOIESIS STIMULATING AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Epogen Retacrit	<i>Aranesp Syr/Vial</i> <i>Mircera</i>	<i>Procrit</i> <i>Reblozyl</i> <i>Vafseo</i>	N/A

Montana Healthcare Programs Preferred Drug List (PDL)

Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

MISCELLANEOUS AGENTS

ANTIHYPURICEMICS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
allopurinol colchicine tablet (generic for Colcrys) probenecid probenecid/colchicine %	<i>allopurinol 200mg</i> <i>colchicine capsule (generic for Mitigare)</i>	<i>febuxostat % (gen Uloric)</i> <i>Gloperba</i> <i>Mitigare</i> <i>Uloric %</i> <i>Zyloprim *</i>	% Clinical criteria applies

BILE SALTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
ursodiol tablet/capsule	<i>Bylvay (caps/pellet)</i> <i>Chenodal %</i> <i>Cholbam %</i> <i>Ctexli</i> <i>Iqirvo</i>	<i>Livdelzi</i> <i>Livmarli</i> <i>Reltone</i> <i>Urso/Urso Forte tablet</i>	% Clinical criteria applies

IMMUNOLOGIC AGENTS

ANTINEOPLASTIC AGENTS, TOPICAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
diclofenac topical (gen for Solaraze) fluorouracil cream (gen for Efudex) fluorouracil solution (generic & branded generic)	<i>Picato</i>	<i>N/A</i>	Clinical criteria applies to this class

HAE TREATMENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Berinert Haegarda icatibant (gen Firazyf) Kalbitor Takhzyro	<i>Andembry</i> <i>Cinryze</i> <i>Dawnzera</i> <i>Ekterly</i> <i>Firazyf</i>	<i>Orladeyo</i> <i>Ruconest</i>	Clinical criteria applies to this class

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

IMMUNOMODULATORS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Enbrel Enbrel Mini Humira Humira Pediatric Taltz	<i>Actemra</i> <i>adalimumab biosimilars</i> <i>Amjevita</i> <i>Bimzelx</i> <i>Cibinqo</i> <i>Cimzia</i> <i>Cimzia Kit</i> <i>Cosentyx</i> <i>Enbrel vial</i> <i>Enspr yng</i> <i>Entyvio</i> <i>Ilumya</i> <i>Kevzara</i> <i>Kineret</i> <i>Olumiant</i> <i>Omvoh</i> <i>Orencia</i>	<i>Otezla IR/XR</i> <i>Rinvoq ER/liquid</i> <i>Simponi</i> <i>Skyrizi</i> <i>Sotyktu</i> <i>Spevigo</i> <i>Stelara</i> <i>tocilizumab biosimilars</i> <i>Tremfya</i> <i>ustekinumab biosimilars</i> <i>Velsipity</i> <i>Xeljanz</i> <i>Xeljanz solution</i> <i>Xeljanz XR</i> <i>Zeposia</i> <i>Zymfentra</i>	Clinical criteria applies to this class

IMMUNOSUPPRESSANTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
azathioprine cyclosporine (gen Neoral) cyclosporine (gen Sandimmune) Gengraf mycophenolate (gen Cellcept) cap/tab mycophenolic acid sirolimus tab tacrolimus caps	<i>Astagraf XL</i> <i>Cellcept</i> <i>cyclosporine capsule</i> <i>Envarsus XR</i> <i>everolimus</i> <i>Imuran *</i> <i>mycophenolate susp</i> <i>Myfortic</i>	<i>Myhibbin</i> <i>Neoral *</i> <i>Prograf caps *</i> <i>Prograf granules pack</i> <i>Rezurock</i> <i>Sandimmune caps</i> <i>sirolimus soln</i> <i>Tavneos</i> <i>Zortress</i>	N/A

IMMUNOMODULATORS, ASTHMA

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Dupixent Fasenra SQ Syringe/Pen Xolair	<i>Nucala SQ Syringe/Auto-injector</i> <i>Tezspire Pen</i>	N/A	Clinical criteria and quantity limits apply to this class

IMMUNOMODULATORS, ATOPIC DERMATITIS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Adbry % Dupixent % Eucrisa % pimecrolimus cream tacrolimus ointment	<i>Anzupgo %</i> <i>Ebglyss %</i> <i>Nemludio %</i> <i>Opzelura %</i> <i>Vtama %</i>	<i>Zoryve 0.05% & 0.15% cream %</i>	% Clinical criteria applies

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

IMMUNOMODULATORS, TOPICAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
imiquimod 5% (gen Aldara)	<i>Aldara *</i> <i>Condylox gel</i> <i>imiquimod 3.75% (gen Zyclara)</i>	<i>Podofilox gel/sol</i> <i>Veregen</i> <i>Hyftor %</i>	N/A

METHOTREXATE PRODUCTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
methotrexate PF vial methotrexate tablet methotrexate vial	<i>Jylamvo</i> <i>Rasuvo</i> <i>Reditrex</i>	<i>Trexall</i> <i>Xatmep</i>	N/A

OPHTHALMICS

ALPHA2 ADRENERGIC AGENTS – GLAUCOMA

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Alphagan P brimonidine 0.2% Combigan Simbrinza	<i>apraclonidine</i> <i>brimonidine 0.1% & 0.15% (gen Alphagan P)</i>	<i>brimonidine/timolol (gen Combigan)</i> <i>lopidine</i>	N/A

ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
neomycin/polymixin/dexamethasone Tobradex ointment Tobradex suspension (while available) tobramycin/dexamethasone susp	<i>Blephamide ointment</i> <i>Maxitrol Drops/Oint *</i> <i>neomycin/bacitracin/polymixin/HC</i> <i>neomycin/polymixin/HC</i>	<i>Pred-G ointment</i> <i>sulfacetamide/prednisolone</i> <i>Tobradex ST</i> <i>Zylet</i>	N/A

ANTI-INFLAMMATORIES – NSAIDS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
diclofenac sodium flurbiprofen sodium	<i>Acular</i> <i>Acular LS</i> <i>Acuvail</i> <i>bromfenac (gen Bromsite & Prolensa)</i> <i>Bromsite</i>	<i>Ilevro</i> <i>ketorolac ophth 0.4% (LS)</i> <i>ketorolac ophth 0.5%</i> <i>Nevanac</i> <i>Prolensa</i>	N/A

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

ANTI-INFLAMMATORIES – STEROIDS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
fluorometholone	<i>dexamethasone</i>	<i>Lotemax ointment</i>	N/A
Inveltys	<i>difluprednate (gen Durezol)</i>	<i>loteprednol (gen Lotemax)</i>	
Lotemax gel	<i>Durezol</i>	<i>Maxidex</i>	
Lotemax drops (while available)	<i>Flarex</i>	<i>Pred Forte</i>	
prednisolone acetate	<i>FML</i>	<i>Pred Mild</i>	
	<i>FML Forte</i>	<i>prednisolone sod phos</i>	
	<i>FML SOP</i>		

BETA BLOCKERS – GLAUCOMA

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Combigan	<i>betaxolol 0.5%</i>	<i>timolol (gen Betimol)</i>	N/A
timolol solution (gen Timoptic)	<i>Betimol</i>	<i>timolol (gen Istalol)</i>	
timolol gel solution (gen Timoptic-XE)	<i>carteolol</i>	<i>timolol (gen Timoptic Ocudose)</i>	
	<i>Istalol</i>		
	<i>levobunolol</i>		

GLAUCOMA, OTHERS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
dorzolamide	<i>Azopt</i>	<i>Trusopt *</i>	N/A
dorzolamide/timolol	<i>brinzolamide (gen Azopt)</i>		
Rhopressa	<i>Cosopt *</i>		
Rocklatan	<i>Cosopt PF</i>		
Simbrinza	<i>dorzolamide/timolol/PF (gen Cosopt PF)</i>		

OPHTHALMIC ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
cromolyn sodium	<i>Alrex</i>	<i>Lastacaft</i>	N/A
ketotifen OTC (brand & generic)	<i>Azelastine</i>	<i>loteprednol (gen Alrex)</i>	
olopatadine 0.2% OTC	<i>bepotastine (gen Bepreve)</i>	<i>olopatadine 0.1% Rx</i>	
Zaditor OTC	<i>Bepreve</i>	<i>Pataday</i>	
	<i>epinastine</i>	<i>Zerviate</i>	

OPHTHALMIC –DRY EYE AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Restasis Multidose	<i>Cequa</i>	<i>Tryptyr</i>	N/A
Restasis Unit Dose	<i>cyclosporine (gen Restasis)</i>	<i>Tyrvaya</i>	
Xiidra	<i>Eysuvis</i>	<i>Verkazia</i>	
	<i>Miebo</i>	<i>Vevye</i>	

Montana Healthcare Programs Preferred Drug List (PDL)

Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

OPHTHALMIC PROSTAGLANDIN AGONISTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
latanoprost	<i>bimatoprost</i> (gen Lumigan 0.03%) <i>lyuzeh</i> <i>Lumigan 0.01%</i> <i>tafluprost (gen Zioptan)</i> <i>travoprost</i>	<i>Vyzulta</i> <i>Xalatan *</i> <i>Xelpros</i> <i>Zioptan</i>	N/A

OPHTHALMIC QUINOLONES

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
ciprofloxacin drops moxifloxacin ofloxacin drops	<i>Besivance</i> <i>Ciloxan drops*/ointment</i> <i>gatifloxacin</i> <i>levofloxacin</i>	<i>Moxeza</i> <i>Ocuflox *</i> <i>Vigamox</i> <i>Zymaxid</i>	N/A

OTICS

OTIC ANTI-INFECTIVES AND ANESTHETICS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
acetic acid	<i>acetic acid HC</i>	N/A	N/A

OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Ciprodex (while available) ciproflox/dexameth otic susp (gen Ciprodex) neomycin/polymixin/HC soln/susp ofloxacin drops	<i>Cipro HC</i> <i>cipro/hydrocortisone otic</i> (generic Cipro HC) <i>ciprofloxacin HCl otic</i>	<i>ciproflox/fluocinolone</i> <i>Coly-Mycin S</i> <i>Cortisporin-TC otic susp</i> <i>Otovel</i>	N/A

OTIC ANTI-INFLAMMATORY

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
fluocinolone acetonide oil	<i>Dermotic Oil</i> <i>Flac Otic Oil</i>	N/A	N/A

PAH AGENTS

ENDOTHELIN RECEPTOR ANTAGONISTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
ambrisentan (gen Letairis) Tracleer	<i>bosentan (gen Tracleer)</i> <i>Letairis</i>	<i>Opsumit</i> <i>Opsynvi</i>	Clinical criteria applies to this class

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

PROSTACYCLINS FOR PAH, INHALATION AND ORAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Tyvaso Inh Sol Ventavis Inh	Orenitram ER/titration kit Tyvaso DPI	Uptravi Uptravi Dose Pak Yutrepia	Clinical criteria applies to this class

PDE INHIBITORS AND OTHERS FOR PPH/PAH

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Alyq 20mg (gen Adcirca) sildenafil tabs (gen Revatio) tadalafil 20mg (gen Adcirca)	Adcirca Adempas Liqrev	Revatio tabs/susp sildenafil susp (gen Revatio) Tadliq susp	Clinical criteria applies to this class

PLATELET AGGREGATION INHIBITORS

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
aspirin aspirin-dipyridamole Brilinta clopidogrel dipyridamole prasugrel	Effient * Plavix * ticagrelor (gen Brilinta)	Zontivity	N/A

RESPIRATORY

COPD AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Anoro Ellipta Atrovent HFA Combivent Respimat ipratropium neb ipratropium/albuterol neb roflumilast (gen Daliresp) % Spiriva HandiHaler Stiolto Respimat	Bevespi Breztri Aerosphere Daliresp % Duaklir Pressair Incruse Ellipta Ohtuvayre % Seebri Neohaler	Spiriva Respimat tiotropium (gen Spiriva handihaler) Trelegy Ellipta Tudorza umeclidinium/vilanterol (gen Anoro Ellipta) Yupelri	% Clinical criteria applies Non-preferred combination products require trial of combination of preferred products with all requested MOAs

ANTI-ALLERGENS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
N/A	Grastek Odactra Oralair Palforzia	Ragwitek	Clinical criteria applies to this class

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

ANTI-HISTAMINES NON-SEDATING, AND DECONGESTANT COMBOS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
cetirizine solution 1mg/ml OTC cetirizine syrup 1mg/ml Rx cetirizine tablets OTC levocetirizine tablets Rx and OTC loratadine syrup OTC loratadine tablets OTC	<i>cetirizine chewable OTC</i> <i>cetirizine soln 5mg/5mL OTC (unit dose)</i> <i>cetirizine-D OTC</i> <i>Clarinex</i> <i>Clarinex-D</i> <i>desloratadine</i>	<i>fexofenadine tabs OTC</i> <i>fexofenadine-D OTC</i> <i>levocetirizine soln</i> <i>loratadine chewable OTC</i> <i>loratadine-D OTC</i> <i>loratadine ODT OTC</i>	N/A

BETA AGONISTS: SHORT-ACTING MDI AND NEBS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
albuterol nebs Ventolin HFA Xopenex HFA	<i>albuterol HFA (generic Proair 8.5g)</i> <i>albuterol HFA (generic Proventil 6.7g)</i> <i>Airsupra</i>	<i>levalbuterol HFA</i> <i>levalbuterol inh soln</i> <i>ProAir Respiclick</i> <i>Xopenex inh soln</i>	Non-preferred combination products require trial of combination of preferred products with all requested MOAs

BETA AGONISTS: LONG-ACTING MDI & NEBS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Serevent Diskus	<i>arformoterol (gen Brovana)</i> <i>Brovana</i>	<i>formoterol (gen Perforomist)</i> <i>Perforomist</i> <i>Striverdi Respimat</i>	N/A

BETA AGONISTS: COMBINATION PRODUCTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Advair Diskus Advair HFA Dulera Symbicort	<i>Breo Ellipta</i> <i>Breyna</i> <i>budesonide/formoterol (gen Symbicort)</i> <i>fluticasone/salmeterol (generic Advair)</i>	<i>fluticasone/salmeterol (generic Airduo)</i> <i>fluticasone/vilanterol (generic Breo Ellipta)</i> <i>Wixela</i>	N/A

CORTICOSTEROIDS INHALED

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Alvesco Arnuity Ellipta Asmanex HFA Asmanex Twisthaler budesonide Respules fluticasone HFA 44mcg (<=5y.o.) Qvar Redihaler	<i>Airsupra</i> <i>Flovent Diskus</i>	<i>fluticasone Diskus (generic Flovent)</i> <i>fluticasone HFA 44mcg (>=6y.o.)</i> <i>fluticasone HFA 110 and 220mcg Pulmicort Respules</i>	Non-preferred combination products require trial of combination of preferred products with all requested MOAs

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

EPINEPHRINE – SELF ADMINISTERED

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Epipen/Epipen Jr epinephrine, self-injected (Mfr. Mylan only)	Auvi-Q epinephrine, self-injected	Neffy Spray Symjepi	N/A

GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
budesonide EC Cortef dexamethasone Intensol dexamethasone solution and tablet hydrocortisone methylprednisolone 4mg methylprednisolone tab DS pak prednisolone sodium phos sol (gen Pediapred) prednisolone solution prednisone tab DS pak prednisone tablet	Alkindi Sprinkle cortisone Decadron dexamethasone elixir dexamethasone pak (gen Dexpak) Eohilia Hemady Khindivi @ Medrol Medrol DS PK methylprednisolone 8mg, 16mg, and 32mg tabs	Millipred DP tab DS Pk Millipred tablet Ortikos prednisone DR (gen Rayos) % Prednisone Intensol prednisone solution prednisolone ODT prednisolone sod phos sol (gen Millipred & Veripred) Rayos % Taperdex (gen Dexpak)	% Clinical criteria applies @ Alternative dosage forms require PA

IDIOPATHIC PULMONARY FIBROSIS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
pirfenidone (generic Esbriet) Ofev	Esbriet Jascayd	N/A	Clinical criteria applies to this class

INTRANASAL ANTIHISTAMINES AND OTHERS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
azelastine 0.1% (generic Astelin) ipratropium nasal	azelastine 0.15% (generic Astepro)	olopatadine	N/A

INTRANASAL CORTICOSTEROIDS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
fluticasone RX Nasonex OTC	azelastine/fluticasone budesonide nasal flunisolide fluticasone OTC mometasone Rx and OTC	Nasonex Omnaris Qnasl Ryaltris triamcinolone OTC Xhance Zetonna	Non-preferred combination products require trial of combination of preferred products with all requested MOAs

Montana Healthcare Programs Preferred Drug List (PDL) Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

LEUKOTRIENE RECEPTOR ANTAGONISTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
montelukast tablet/chew tablet	<i>Accolate</i> <i>montelukast gran pak</i>	<i>zafirlukast</i>	N/A

TOBACCO CESSATION

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
bupropion SR (gen Zyban) nicotine chewing gum OTC nicotine lozenge OTC nicotine transdermal OTC varenicline (gen Chantix)	<i>Nicotrol Inhaler %</i> <i>Nicotrol Nasal Spray %</i>	N/A	Quantity limits apply to class % Clinical criteria applies

TOPICAL AGENTS

ANTIPARASITICS – TOPICAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Natroba permethrin cream permethrin OTC piperonyl butoxide/pyrethrins shampoo OTC	<i>Eurax Cream</i> <i>Eurax Lotion</i> <i>Ivermectin 0.5% (gen Sklice)</i> <i>malathion</i> <i>Ovide</i>	<i>piperonyl butoxide/pyrethrins kit OTC</i> <i>Pruradik</i> <i>spinosad</i> <i>Vanalice</i>	Monthly limits apply – One application per 34 days.

ANTIPSORIATICS – TOPICAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
calcipotriene cream calcipotriene solution	<i>calcipotriene foam/oint</i> <i>calcipotriene-betameth oint/scalp</i> <i>calcitriol</i> <i>Dovonex cream</i>	<i>Enstilar foam</i> <i>Sorilux</i> <i>Taclonex ointment/scalp</i> <i>Vectical</i> <i>Zoryve 0.3% cream</i> <i>Zoryve foam</i>	Clinical criteria applies to this class

Montana Healthcare Programs Preferred Drug List (PDL)

Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

MISC ACNE, TOPICAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
clindamycin/benzoyl peroxide (Duac 1.2-5%) clindamycin phosphate gel (gen Cleocin T 1%) clindamycin phosphate solution erythromycin gel/solution	Aczone Amzeeq Avar products Benzaclin benzoyl peroxide BP-10-1 Cleocin-T Clindacin clindamycin/benzoyl perox. (Benzaclin 1-5%) clindamycin/benzoyl perox. (Acanya 1.2-2.5%) clindamycin/benzoyl perox. (gen Onexton w/Pump) clindamycin phosphate foam/lotion/swab clindamycin phosphate gel (gen Clindagel 1%)	dapsone Ery pads erythromycin swab erythromycin-benzoyl peroxide Evoclin Neuac Ovace/Ovace Plus Rosanil Rosula SSS 10-5 sulfacetamide sulfacetamide/sulfur sulfacetamide/sulfur/urea sulfacetamide sodium sulfacetamide sodium/sulfur Sumadan products Sumaxin products Winlevi ZMA Clear	Trial of 2 preferred agents required

TOPICAL RETINOIDS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
adapalene gel 0.3% Rx tretinoin cream/gel (except 0.05% gel)	adapalene cream/gel pump adapalene gel OTC adapalene/benzoyl peroxide Aklief clindamycin/tretinoin gel Differin cream/gel/lotion	Epiduo Forte Fabior tazarotene foam (gen Fabior) tazarotene cream/gel (gen Tazorac) tretinoin 0.05% gel tretinoin microspheres Twynéo	Requires clinical PA if > 26 years old.

TOPICAL, ROSACEA AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
metronidazole cream metronidazole gel (tube)	azelaic acid (gen Finacea gel) brimonidine gel pump (gen Mirvaso) Epsolay Finacea foam ivermectin 1% cr (gen Soolantra) Metrocream Metrogel	metronidazole gel (pump) metronidazole kit/lotion Mirvaso Rhofade Rosadan kit Soolantra Zilxi	N/A

Montana Healthcare Programs Preferred Drug List (PDL)

Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

LOW POTENCY TOPICAL STEROIDS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Derma-Smooth FS fluocinolone 0.01% oil hydrocortisone cream/oint 1% Rx hydrocortisone cream/oint/lot 2.5%	<i>alclometasone dipro cream/ ointment</i> <i>Aqua-Glycolic HC</i> <i>Capex shampoo</i> <i>desonide cream/lot/oint</i>	<i>Hydrocort Lot</i> <i>hydrocortisone lot kit</i> <i>hydrocortisone sol</i> <i>Hydroxym gel</i> <i>Texacort</i>	N/A

MEDIUM POTENCY TOPICAL STEROIDS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
fluticasone propionate cream/oint mometasone furoate cream mometasone furoate oint mometasone furoate soln triamcinolone 0.1% paste (dental)	<i>Beser lotion/Kit</i> <i>betamethasone val foam 0.12%</i> <i>clocortolone</i> <i>Cloderm</i> <i>Cordran tape (if rebateable product available)</i> <i>Cutivate</i> <i>fluocinolone acetamide cream/oint/solution</i> <i>flurandrenolide cr/oint/lot</i> <i>fluticasone propionate lot</i>	<i>hydrocortisone butyrate (brand and generic all forms)</i> <i>hydrocortisone valerate cream/oint</i> <i>Luxiq Foam</i> <i>Oralene 0.1% paste</i> <i>prednicarbate cream</i> <i>prednicarbate oint</i> <i>Synalar</i> <i>Synalar TS</i>	N/A

HIGH POTENCY TOPICAL STEROIDS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
betamethasone val cream betamethasone val oint triamcinolone acetamide cream triamcinolone acetamide lotion 0.025%, 0.1% triamcinolone acetamide oint	<i>amcinonide</i> <i>betamethasone dipropionate</i> <i>betamet diprop / prop glycol</i> <i>betamethasone val lotion</i> <i>clobetasol prop (gen Impoz)</i> <i>desoximetasone</i> <i>diflorasone diacetate</i> <i>Diprolene</i> <i>Fluocinonide</i>	<i>halcinonide 0.1% cr</i> <i>halcinonide solution</i> <i>Halog</i> <i>Kenalog Aerosol</i> <i>Psorcon</i> <i>SanadermRX</i> <i>Topicort</i> <i>triamcinolone spray</i> <i>Triamex ointment</i>	N/A

VERY HIGH POTENCY TOPICAL STEROIDS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
clobetasol prop (crm, oint, sol, shmp)	<i>Apexicon E</i> <i>clobetasol emollient cream/foam</i> <i>clobetasol lot/spray</i> <i>clobetasol propionate foam/gel</i> <i>Clobex shampoo/spray</i> <i>Clodan</i>	<i>halobetasol propionate cream/foam/oint</i> <i>Impeklo Lotion</i> <i>Lexette</i> <i>Olux/Olux-E</i> <i>Temovate</i> <i>Tovet foam/kit</i> <i>Ultravate lotion</i>	N/A

Montana Healthcare Programs Preferred Drug List (PDL)

Revised February 27, 2026

*Indicates a generic is available without prior authorization

Clinical criteria can be found here: [Pharmacy Services - Mountain Pacific](#) Grandfathering of medications does not apply if samples, patient assistance or cash pay have been used to bypass criteria or PDL placement.

This list may not include all available generic formulations listed specifically by name

Note: Brand Named Drugs are capitalized, generic drugs start with lower case letters.

BRAND OVER GENERIC PREFERENCES FOR NON-REVIEWED DRUG CLASSES

In addition to the preferred brands listed in the above classes, these brands are also preferred over their generics

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Keveyis	<i>dichlorphenamide</i>	N/A	Use of generic will require prior authorization and clinical rationale
Ravicti	<i>glycerol phenylbut</i>		
Zavesca	<i>miglustat</i>		