Montana Healthcare Programs Preferred Drug List (PDL)
Revised July 30, 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 #	*Belbuca #*	*morphine ER (Avinza) #*	**No more than one long acting opioid allowed.**
morphine sulfate SR tab #	*buprenorphine (Butrans) #*	*morphine sulfate ER cap (Kadian) #*	
	Conzip ER % #	*MS Contin * #*	**# Quantity limits apply**
	*Duragesic patch * #*	*oxycodone ER #*	
	fentanyl patch #	*OxyContin #*	**% Clinical criteria applies**
	hydrocodone ER cap %	*oxymorphone ER #*	
	hydrocodone ER tab # %	*tapentadol ER (gen Nucynta) %*	**MME restriction applies to this class**
	hydromorphone ER tab	*tramadol ER % #*	
	Hysingla ER # %	*Zohydro ER % #*	
	Kadian #		
	Morphabond ER#		

ANTI-MIGRAINE

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

Montana Healthcare Programs Preferred Drug List (PDL)
Revised July 30, 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	*Arthrotec*	*Licart Patch*	**Trial of 2 preferred agents required**
diclofenac 1% gel OTC (generic Voltaren) #	*Celebrex **	*meclofenamate*	
diclofenac potassium 50mg tabs	*celecoxib 50mg and 400mg*	*mefenamic acid*	**# Quantity limits apply**
diclofenac sodium EC/DR	*Coxanto*	*meloxicam cap (gen Vivlodex)*	
ibuprofen tablet (except 300mg)/susp Rx	*diclofenac potassium caps*	*Mobic*	**% Clinical criteria applies**
indomethacin capsule IR	*diclofenac potassium 25mg tabs*	*nabumetone*	
ketorolac (oral) #	*diclofenac sodium ER/SR*	*Nalfon*	
meloxicam tablet	*diclofenac sodium /misoprostol*	*Naprelan*	
naproxen tablet (Naprosyn)	*diclofenac topical & transdermal # (except 1% gel)*	*naproxen sodium Rx (gen Anaprox)*	
naproxen EC	*diflunisal*	*naproxen susp*	
sulindac	*Dolobid*	*naprox/esomep (gen Vimovo) %*	
	Elyxyb sol	*Orudis*	
	etodolac	*oxaprozin*	
	etodolac tab SR	*Pennsaid #*	
	Feldene	*piroxicam*	
	fenoprofen	*Qmiiz ODT*	
	Flector #	*Relafen DS*	
	Flurbiprofen	*Sprix %*	
	ibuprofen 300mg tab	*Tivorbex*	
	ibuprofen susp OTC	*tolmetin sodium*	
	ibuprofen/famotidine (gen Duexis)	*Vimovo %*	
		Vivlodex	
	Indocin supp/susp	*Vyscoxa*	
	indomethacin capsule ER	*Zipsor %*	
	ketoprofen/ER	*Zorvolex*	
	ketorolac tromethamine (gen Sprix) %	*Zybic*	

NEUROPATHIC PAIN

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
capsaicin cream OTC (except 0.035%)	*capsaicin 0.035% cream OTC*	*Lyrica solution % µ*	**% Clinical criteria applies**
duloxetine (all except 40mg)	*Dermacinrx Lidocan patch #*	*Lyrica CR µ*	**µ Cross Duplication not allowed**
gabapentin capsule µ #	*Drizalma sprinkle*	*milnacipran (gen Savella) %*	**# Quantity limits apply**
gabapentin solution µ #	*duloxetine 40 mg cap*	*Neurontin µ*	**duloxetine/ Savella concurrent use not allowed**
gabapentin tablet µ #	*gabapentin ER % µ*	*pregabalin caps/solution µ*	
lidocaine patch #	*Gabarone*	*pregabalin ER µ*	**@ Alternative dosage forms require PA**
Lyrica Capsule µ #	*Gralise % µ*	*Qutenza*	
Savella %	*Horizant % µ*	*Relgaabi*	
	Lidocan II	*Tonmya @*	
		Ztlido	

Montana Healthcare Programs Preferred Drug List (PDL)
Revised July 30, 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.

OPIOID REVERSAL AGENTS

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

SUBSTANCE USE DISORDER TREATEMENTS

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

ANTI-INFECTIVES

ANTIOBIOTICS: 2ND GENERATION QUINOLONES

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

ANTIBIOTICS: 3RD GENERATION QUINOLONES

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

ANTIBIOTICS, GI

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

ANTIBIOTICS: INHALED

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

Montana Healthcare Programs Preferred Drug List (PDL)
Revised July 30, 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	*clarithromycin ER*	*Erythrocin filmtab*	**N/A**
clarithromycin	*E.E.S. 200mg susp*	*erythromycin ES 400mg/5ml susp*	
erythromycin 250mg & 500mg tabs	*E.E.S. 400 filmtab*	*erythromycin ES tablet*	
erythromycin ES 200mg/5ml susp	*Ery-Ped susp*	*erythromycin filmtab*	
	Ery-Tab EC	*Zithromax **	

ANTIBIOTICS: 2ND GENERATION CEPHA

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

ANTIBIOTICS: 3RD GENERATION CEPHALOSPORINS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
cefdinir	*cefixime caps/tabs/susp*	*cefpodoxime*	**N/A**

ANTIBIOTICS: TETRACYCLINES

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

ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
mupirocin ointment	*Centany*	*gentamicin cream/oint*	**N/A**
	Centany AT	*mupirocin cream*	

ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Cleocin cream	*clindamycin vaginal 2% cream*	*Nuvessa vaginal gel #*	**# Quantity limits apply**
Cleocin ovules	*Clindesse #*	*Vandazole*	
metronidazole vaginal 0.75% gel	*Metrogel vaginal gel*	*Xaciato*	

Montana Healthcare Programs Preferred Drug List (PDL)
Revised July 30, 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	*Brexafemme*	*Noxafil packet/susp*	**% Clinical criteria applies**
fluconazole	*Cresemba*	*nystatin oral tablet*	
griseofulvin suspension %	*Diflucan **	*Oravig*	
nystatin suspension	*flucytosine*	*posaconazole tab/susp*	
terbinafine	*griseofulvin micro %*	*Sporanox*	
	griseofulvin ultra %	*Tolsura*	
	itraconazole caps & sol	*Vfend*	
	ketoconazole %	*Vivjoa*	
		voriconazole	

ANTIFUNGALS AND COMBOS, TOPICAL

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

ANTIVIRALS: HERPES – ORAL AGENTS

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

ANTIVIRALS: INFLUENZA

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
oseltamivir suspension and capsule	*flumadine*	*rimantadine HCl*	
Xofluza	*Relenza*	*Tamiflu*	

ANTIVIRALS: COVID

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Paxlovid	*N/A*	*N/A*	

ANTIVIRALS, TOPICAL

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

HEPATITIS C: PEGYLATED INTERFERONS

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

HEPATITIS C: OTHER

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Mavyret tabs/pellet pak	*Epclusa tabs/pellet pak* *Harvoni tabs/pellet pak* *ledipasvir-sofosbuvir*	*sofosbuvir-velpatasvir* *Sovaldi tabs/pellet pak* *Vosevi* *Zepatier*	**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	*Accupril ** *Altace* *captopril* *enalapril sol (gen Epaned)* *Epaned Oral Soln* *fosinopril* *Lotensin **	*moexipril* *perindopril* *Prinivil ** *Qbrelisl* *quinapril* *trandolapril* *Zestril **	**Trial of 2 preferred agents required**

ACE INHIBITOR COMBINATIONS

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

Montana Healthcare Programs Preferred Drug List (PDL)
Revised July 30, 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
irbesartan	*Arbli @*	*Edarbi*	**Trial of 2 preferred agents required**
losartan	*Atacand*	*Entresto tabs/sprinkles*	
olmesartan	*Avapro **	*Eprosartan*	
sacubitril/valsartan (gen Entresto)	*Benicar **	*Telmisartan*	**@ Alternative dosage forms require PA**
valsartan	*candesartan*	*valsartan sol*	
	*Cozaar **		
	*Diovan **		

ANGIOTENSION II RECEPTOR BLOCKER COMBOS

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

ANGIOTENSION MODULATOR COMBINATIONS

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

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	*Catapres oral **	*N/A*	**@ Alternative dosage forms require PA**
clonidine transdermal	*clonidine ER (gen Nexiclon)*		
guanfacine IR	*Javadin @*		
methyldopa			

Montana Healthcare Programs Preferred Drug List (PDL)
Revised July 30, 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	*acebutolol*	*Lopressor solution*	**Trial of 2 preferred agents required**
bisoprolol (gen Zebeta)	*atenolol/chlorthalidone*	*Lopressor tab**	
carvedilol	*betaxolol*	*metoprolol/HCTZ*	
labetalol	*bisoprolol/HCTZ*	*nadolol/Corgard*	**% Clinical criteria applies**
metoprolol succinate ER	*Bystolic **	*pindolol*	
metoprolol tartrate	*carvedilol ER*	*propranolol/HCTZ*	
nebivolol	*Coreg **	*Betapace /Batapace AF*	
propranolol IR	*Hemangeol*	*Sotylize*	
propranolol ER	*Inderal LA & XL*	*Tenormin /Tenoretic*	
sotalol/sorine	*Innopran XL*	*timolol*	
	Kapspargo Sprinkle	*Toprol XL **	

CALCIUM CHANNEL BLOCKERS (DHP)

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

CALCIUM CHANNEL BLOCKERS (NON-DHP)

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

DIRECT RENIN INHIBITORS

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

***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	*amlodipine-atorvastatin*	*Lescol XL*	**% Clinical criteria applies**
ezetimibe	*Atorvaliq @*	*Lipitor **	
lovastatin	*Caduet*	*Livalo*	**@ Alternative dosage forms require PA**
pravastatin	*Crestor **	*pitavastatin*	
rosuvastatin	*Ezallor Sprinkle @*	*Vytorin %*	
simvastatin %	*ezetimibe/simvastatin %*	*Zetia **	
	fluvastatin	*Zocor %*	
	fluvastatin XL	*Zypitamag*	

LIPOTROPICS: OTHERS

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

CENTRAL NERVOUS SYSTEM

ALZHEIMER'S DRUGS - CHOLINESTERASE INHIBITORS

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

ALZHEIMER'S DRUGS - NMDA RECEPTOR ANTAGONIST AND COMBOS

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

Montana Healthcare Programs Preferred Drug List (PDL)
Revised July 30, 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	*Aptiom*	*oxcarbazepine susp*	**NOTE: DAW 7 may be used ONLY for seizure diagnosis @ Alternative dosage forms require PA**
carbamazepine tab	*carbamazepine 200mg chew tabs*	*oxcarbazepine ER (generic Oxtellar XR*	
carbamazepine ER tabs	*carbamazepine susp @*	*Oxtellar XR*	
Epitol	*carbamazepine ER caps*	*Trileptal tablets **	
oxcarbazepine tabs	*Carbatrol ER*		
Tegretol susp @	*Equetro*		
Tegretol & Tegretol XR	*Eslicarbazepine (gen Aptiom)*		
Trileptal oral suspension @			

ANTI-CONVULSANTS: FIRST GENERATION

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

Montana Healthcare Programs Preferred Drug List (PDL)
Revised July 30, 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 %	*brivaracetam (gen Briviact)*	*Neurontin tablet/capsule * µ*	
gabapentin capsule µ	*Briviact*	*Onfi*	
gabapentin solution µ	*Diacomit %*	*perampanel (gen Fycompa)*	**@ Alternative dosage forms require PA**
gabapentin tablet µ	*Elepsia XR*	*pregabalin caps/solution µ*	
lacosamide tab/sol (generic Vimpat)	*Epidiolex %*	*pregabalin ER µ*	
lamotrigine IR tabs & chews/dispersible	*Eprontia @*	*rufinamide tab & susp (gen Banzel) %*	**% Clinical criteria applies**
levetiracetam IR	*Fintepla %*	*Sabril*	
levetiracetam solution	*Fycompa*	*Spritam*	**µ Cross duplication not allowed between gabapentin and Lyrica**
Lyrica capsule µ	*Keppra * @*	*Subvenite @*	
Nayzilam %	*Keppra XR*	*Sympazan @*	
topiramate tablets	*lacosamide dose cups %*	*Tiagabine %*	
Valtoco %	*Lamictal *</i>	*Topamax Sprinkle Cap @*	
zonisamide	*Lamictal ODT & ODT Starter pak @*	*Topamax tablet *</i>	
	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 *</i>	
fluoxetine solution	*escitalopram 15mg caps*	*Paxil CR*	**% Clinical criteria applies**
fluoxetine tablets	*escitalopram solution #*	*Paxil Susp*	
fluvoxamine	*fluoxetine DR %*	*Pexeva*	**# Dose limits apply**
paroxetine	*fluvoxamine CR*	*sertraline caps*	
sertraline tabs and soln	*Lexapro * #*	*Zoloft *</i>	
	paroxetine 7.5mg %		

Montana Healthcare Programs Preferred Drug List (PDL)
Revised July 30, 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-DEPRESSANTS: NOVEL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
bupropion IR bupropion SR and XL 150mg & 300mg desvenlafaxine suc ER # duloxetine (excluding 40, 80, 90, 120mg) mirtazapine trazodone venlafaxine IR venlafaxine ER caps 24H vilazodone (gen Viibryd)	*Auvelity %* *bupropion XL 450mg (gen Forfivo)* *desvenlafaxine ER #* *desvenlafaxine fum ER* *duloxetine 40, 80, 90, 120mg* *Effexor XR ** *Exxua* *Fetzima* *Forfivo XL* *mirtazapine rapdis @*	*Pristiq ER #* *Raldesy soln* *Remeron ** *Remeron SolTab @* *Trintellix* *venlafaxine ER tabs* Viibryd *Viibryd DS PK* *Wellbutrin SR ** *Zurzuvae %*	**Trial of 2 preferred agents required (excluding trazodone)** **% Clinical criteria applies** **# Quantity limits apply** **@ Alternative dosage forms require PA**

ADHD/CNS STIMULANTS AND RELATED AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
amphetamine salt IR & XR combo (generic for Adderall and Adderall XR) Concerta dexmethylphenidate IR & XR methylphenidate ER (generic Metadate ER) methylphenidate IR (generic Ritalin) methylphenidate solution @ Vyvanse Cap #1	*Adderall XR* *Adhansia XR* *Adzenys XR @* *amphetamine sulfate (gen Evekeo)* *amphetamine ER susp & ODT (gen Adzenys)* *Aptensio XR* *Azstarys* *Cotempla XR ODT @* *Daytrana* *Dexedrine SA* *dexmethylphenidate ER* *dextroamphetamine SA (generic for Dexedrine SA)* *dextroamphetamine tab* *dextroamphetamine soln @* *dextroamp-amphet ER (gen Mydayis))* *Dyanavel XR @* *Evekeo* *Evekeo ODT @* *Focalin IR & ER* *Jornay PM* *lisdexamfetamine cap #1* *Methylin solution @* *methylphenidate CD* *methylphenidate chew @*	*methylphenidate ER cap (gen Aptensio)* *methylphenidate ER tab 10 and 20mg (generic for Ritalin SR Tab)* *methylphenidate ER tab 18 mg, 27, 36, 54 mg (generic for Concerta)* *methylphenidate ER tab 45mg, 63mg (generic Relexxii ER)* *methylphenidate LA* *methylphenidate SR cap (20, 30, 40mg)* *methylphenidate patch (gen Daytrana)* *Mydayis* *Procentra @* *Quillichew ER @* *Quillivant XR @* *Relexxii ER* *Ritalin ** *Ritalin LA* *Vyvanse Chewable @* *Xelstrym* *Zenzedi*	**Trial of 2 preferred agents required for stimulants** **Quantity limits apply to class** **@ Alternative dosage forms require PA** **#1 Dose limit 1/day**

Montana Healthcare Programs Preferred Drug List (PDL)
Revised July 30, 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.

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
atomoxetine	*Intuniv **		**% Clinical criteria applies**
guanfacine ER	*Onyda XR*		
clonidine ER & IR	*Qelbree %*		

ATYPICAL ANTIPSYCHOTICS

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

MULTIPLE SCLEROSIS AGENTS

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

***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*	*Nourianz %*	
pramipexole dihydrochloride	*bromocriptine*	*Ongentys*	
rasagiline	*carbidopa*	*Osmolex ER*	
ropinirole	*carbidopa/levodopa ODT*	*pramipexole ER %*	
trihexyphenidyl	*carbidopa/levodopa ER (gen Rytary) %*	*ropinirole ER %*	
		Rytary %	
	carbidopa/levodopa/ entacapone	*selegiline caps*	
	Crexont ER	*selegiline tabs*	
	Dhivy	*Sinemet IR*	
	Duopa	*Stalevo*	
	Gocovri	*tolcapone*	
	Inbrija	*Xadago*	

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 **	
zolpidem tartrate IR tablet (initial dose limit 5mg/day for females)	*Dayvigo %*	*Rozerem*	**% Clinical criteria applies**
	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*	*methocarbamol 1,000 mg tab*	**# Quantity limits apply**
methocarbamol (except 1,000 mg)	*chlorzoxazone*	*metaxalone*	
orphenadrine citrate	*cyclobenzaprine 7.5mg%*	*Norgesic/Norgesic Forte*	
tizanidine HCl tablet	*cyclobenzaprine ER %*	*Robaxin **	
	Dantrium	*Skelaxin*	
	dantrolene sodium	*Tanlor*	
	Fexmid %	*tizanidine capsule % #*	
	Fleqsuvy	*Zanaflex capsule % #*	
	*Lorzone **	*Zanaflex tablet **	

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 calcitonin-salmon Forteo ibandronate raloxifene	*Actonel* *alendronate solution* *Atelvia* *Boniva* *Bonsity*	*Evista ** *Fosamax tabs */ PlusD* *risedronate sodium* *teriparatide* *Tymlos*	

ANTI-HYPOGLYCEMIC AGENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Baqsimi # Glucagon # Glucagon Emergency Kit *(Lilly, Amphastar)* # Proglycem susp	*diazoxide susp* *Glucagon Emergency kit (Fresenius) #* *Gvoke pen/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 July 30, 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	*alogliptin*	*saxagliptin (gen Onglyza)*	**% Clinical criteria applies**
Janumet	*alogliptin-metformin*	*saxagliptin-metformin ER (gen Kombiglyze)*	
Janumet XR	*alogliptin-pioglitazone*	*sitagliptin (gen Zituvio)*	
Januvia	*Brynovin*	*sitagliptin/metformin (gen Zituvimet)*	
Jentadueto	*Jentadueto XR*	*Trijardy XR*	
Tradjenta	*Kazano*	*Zituvio*	
	linagliptin/metformin (gen Jentadueto)	*Zituvimet IR and ER*	
	Nesina		
	Oseni %		

DIABETES: GLP-1/GIP AND COMBOS

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

DIABETES: INSULIN AND COMBOS

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

DIABETES: MEGLITINIDES AND COMBOS

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

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*	*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**

ESTROGEN , OTHERS: VAGINAL

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

GROWTH HORMONES

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

PANCREATIC ENZYMES

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Creon	*Pertzye*	*Viokace*	**N/A**
Zenpep			

PITUITARY SUPPRESSIVE AGENTS, LHRH

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

PROGESTINS FOR CACHEXIA

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

UTERINE DISORDER TREATMENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Myfembree	*Oriahnn*	*N/A*	**N/A**
Orilissa			

***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	*Akynzeo*	*Granisetron #*	**# Quantity limits apply**
ondansetron injections	*Aprepitant %*	*metoclopramide injection*	**% Clinical criteria applies**
ondansetron ODT (4mg & 8mg)	*Bonjesta %*	*metoclopramide ODT %*	
ondansetron solution	*Diclegis%*	*ondansetron ODT 16mg*	
ondansetron tablet	*doxylamine/pyridox %*	*Reglan **	
	Emend Oral %	*Sancuso %*	
	Emend Oral Pak %	*Sustol SQ*	
	Gimoti	*Zofran **	

GI MOTILITY AGENTS

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

PROTON PUMP INHIBITORS, OTHERS/H. PYLORI TREATMENTS

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

ULCERATIVE COLITIS – ORAL

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

ULCERATIVE COLITIS – RECTAL

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

GENITOURINARY AND RENAL

ALPHA BLOCKERS FOR BPH

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

ANDROGEN HORMONE INHIBITORS AND COMBOS

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

PDE-5 FOR BPH

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

POTASSIUM BINDERS

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

***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	*darifenacin ER*	*Myrbetriq susp*	**N/A**
oxybutynin ER	*Ditropan XL*	*oxybutynin 2.5mg IR*	
oxybutynin 5mg IR	*fesoterodine ER (gen Toviaz)*	*Oxytrol **	
solifenacin (gen Vesicare)	*flavoxate*	*tolterodine*	
tolterodine ER	*Gemtesa*	*Toviaz*	
	mirabegron ER	*trospium*	
		trospium XR	

HEMATOLOGICAL AGENTS

ANTICOAGULANTS INJECTABLE

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

ANTICOAGULANT ORAL

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

COLONY STIMULATING FACTORS

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

ERYTHROPOIESIS STIMULATING AGENTS

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

MISCELLANEOUS AGENTS

ANTIHYPERURICEMICS

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

BILE SALTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
ursodiol tablet/capsule	*Bylvay (caps/pellet* *Cholbam %* *Ctexli* *Iqirvo*	*Livdelzi* *Livmarli* *Reltone* *Urso/Urso Forte tablet*	**% 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)	*Picato*	*N/A*	**Clinical criteria applies to this class**

HAE TREATMENTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Berinert Haegarda icatibant (gen Firazyr) Takhzyro	*Andembry* *Cinryze* *Dawnzera* *Ekterly* *Firazyr*	*Kalbitor* *Orladeyo* *Ruconest* *Sajazir*	**Clinical criteria applies to this class**

Montana Healthcare Programs Preferred Drug List (PDL)
Revised July 30, 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
adalimumab-ADBM	*Actemra*	*Omvoh*	**Clinical criteria applies to this class**
adalimumab -ADAZ	*adalimumab biosimilars (NOT listed as preferred)*	*Orencia*	
Enbrel		*Otezla IR/XR*	
Enbrel Mini	*Amjevita*	*Rinvoq ER/liquid*	
Selarsdi	*Bimzelx*	*Simponi*	
Starjemza	*Cibinqo*	*Skyrizi*	
Taltz	*Cimzia*	*Sotyktu*	
Tyenne	*Cimzia Kit*	*Spevigo*	
	Cosentyx	*Stelara*	
	Enbrel vial	*tocilizumab biosimilars*	
	Enspryng	*Tremfya*	
	Entyvio	*ustekinumab biosimilars (NOT listed as preferred)*	
	Humira		
	Humira Pediatric	*Velsipity*	
	Icotyde	*Xeljanz*	
	Ilumya	*Xeljanz solution*	
	Kevzara	*Xeljanz XR*	
	Kineret	*Zeposia*	
	Olumiant	*Zymfentra*	

IMMUNOSUPPRESSANTS

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

IMMUNOMODULATORS, ASTHMA

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

IMMUNOMODULATORS, ATOPIC DERMATITIS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Adbry %	*Anzupgo %*	*Zoryve 0.05% & 0.15% cream %*	**% Clinical criteria applies**
Dupixent %	*Nemluvio %*		
Ebglyss %	*Opzelura %*		
Eucrisa %			
pimecrolimus cream			
tacrolimus ointment			
Vtama %			

IMMUNOMODULATORS, TOPICAL

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

METHOTREXATE PRODUCTS

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

OPHTHALMICS

ALPHA2 ADRENERGIC AGENTS – GLAUCOMA

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

ANTIBIOTIC-STEROID COMBINATIONS

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

Montana Healthcare Programs Preferred Drug List (PDL)
Revised July 30, 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 – NSAIDS

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

ANTI-INFLAMMATORIES – STEROIDS

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

BETA BLOCKERS – GLAUCOMA

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

GLAUCOMA, OTHERS

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

OPHTHALMIC ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
cromolyn sodium	*Alrex*	*Lastacaft*	**N/A**
ketotifen OTC (brand & generic)	*Azelastine*	*loteprednol (gen Alrex)*	
olopatadine 0.2% OTC	*bepotastine (gen Bepreve)*	*olopatadine 0.1% Rx*	
Zaditor OTC	*Bepreve*	*olopatadine 0.7%*	
	epinastine	*Pataday*	
		Zerviate	

OPHTHALMIC –DRY EYE AGENTS

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

OPHTHALMIC PROSTAGLANDIN AGONISTS

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

OPHTHALMIC QUINOLONES

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
ciprofloxacin drops moxifloxacin ofloxacin drops	*besifloxacin (gen Besivance)* *Besivance* *Ciloxan drops*/ointment* *gatifloxacin* *levofloxacin*	*Moxeza* *Ocuflox ** *Vigamox* *Zymaxid*	**N/A**

OTICS

OTIC ANTI-INFECTIVES AND ANESTHETICS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
acetic acid	*acetic acid HC*	*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	*Cipro HC* *cipro/hydrocortisone otic (generic Cipro HC)* *ciprofloxacin HCl otic*	*ciproflox/fluocinolone* *Coly-Mycin S* *Cortisporin-TC otic susp* *Otovel*	**N/A**

OTIC ANTI-INFLAMMATORY

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

***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.

PAH AGENTS

ENDOTHELIN RECEPTOR ANTAGONISTS

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

PROSTACYCLINS FOR PAH, INHALATION AND ORAL

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
Yutrepia	*Orenitram ER/titration kit* *Tyvaso DPI & Inh Sol*	*Uptravi* *Uptravi Dose Pak*	**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)	*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 clopidogrel dipyridamole prasugrel ticagrelor (gen Brilinta)	*Brilinta* *Effient ** *Plavix **	*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* *umeclindinium/vilanterol (gen Anoro Ellipta)* *Yupelri*	**% Clinical criteria applies** **Non-preferred combination products require trial of combination of preferred products with all requested MOAs**

***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-ALLERGENS

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

ANTIHISTAMINES 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	*cetirizine chewable OTC* *cetirizine soln 5mg/5mL OTC (unit dose)* *cetirizine-D OTC* *Clarinex* *Clarinex-D* *desloratadine ODT/tabs/soln*	*fexofenadine tabs OTC* *fexofenadine-D OTC* *levocetirizine soln* *loratadine chewable OTC* *loratadine-D OTC* *loratadine ODT OTC*	**N/A**

BETA AGONISTS: SHORT-ACTING MDI AND NEBS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
albuterol HFA albuterol nebs Ventolin HFA Xopenex HFA	*Airsupra*	*levalbuterol HFA* *levalbuterol inh soln* *ProAir Respiclick* *Xopenex inh soln*	**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	*arformoterol (gen Brovana)* *Brovana*	*formoterol (gen Perforomist)* *Perforomist* *Striverdi Respimat*	**N/A**

BETA AGONISTS: COMBINATION PRODUCTS

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

Montana Healthcare Programs Preferred Drug List (PDL)
Revised July 30, 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.

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	*Airsupra* *Beclomethasone (gen Qvar HFA)* *Flovent Diskus*	*fluticasone Diskus (generic Flovent)* *fluticasone HFA 44mcg (>=6y.o.)* *fluticasone HFA 110 and 220mcg* *Pulmicort Respules*	**Non-preferred combination products require trial of combination of preferred products with all requested MOAs**

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
nintedanib (generic Ofev) pirfenidone (generic Esbriet)	*Esbriet* *Jascayd*	*Ofev*	**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**

***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.

INTRANASAL CORTICOSTEROIDS

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

LEUKOTRIENE RECEPTOR ANTAGONISTS

Preferred Agents	Non-Preferred	Non-Preferred Cont.	Limitations
montelukast tablet/chew tablet	*Accolate* *montelukast gran pak*	*zafirlukast*	**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)	*Chantix* *Nicotrol Inhaler %* *Nicotrol Nasal Spray %*	*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	*Eurax Cream* *Eurax Lotion* *Ivermectin 0.5% (gen Sklice)* *malathion* *Ovide*	*piperonyl butoxide/pyrethrins kit OTC* *Pruradik* *spinosad* *Vanalice*	**Monthly limits apply – One application per 34 days.**

ANTIPSORIATICS – TOPICAL

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

***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* *Twyneo*	**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 July 30, 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-Smoothe FS fluocinolone 0.01% oil hydrocortisone cream/oint 1% Rx hydrocortisone cream/oint/lot 2.5%	*alclometasone dipro cream/ ointment* *Aqua-Glycolic HC* *Capex shampoo* *desonide cream/lot/oint*	*Hydrocort Lot* *hydrocortisone lot kit* *hydrocortisone sol* *Hydroxym gel* *Texacort*	**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)	*Beser lotion/Kit* *betamethasone val foam 0.12%* *clocortolone* *Cloderm* *Cordran tape (if rebateable product available)* *Cutivate* *fluocinolone acetonide cream/oint/solution* *flurandrenolide cr/oint/lot* *fluticasone propionate lot*	*hydrocortisone butyrate (brand and generic all forms)* *hydrocortisone valerate cream/oint* *Luxiq Foam* *Oralone 0.1% paste* *prednicarbate cream* *prednicarbate oint* *Synalar* *Synalar TS*	**N/A**

HIGH POTENCY TOPICAL STEROIDS

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

VERY HIGH POTENCY TOPICAL STEROIDS

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

***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	*dichlorphenamide*	*N/A*	**Use of generic will require prior authorization and clinical rationale**
Ravicti	*glycerol phenylbut*		
Zavesca	*miglustat*		