

| CATEGORY | Step Order | PREFERRED DRUGS | Step Order | NON-PREFERRED DRUGS | PA Required | Comments | Criteria |
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| General Criteria for all PDL categories | | | | | | | |
| A: To apply to all categories with brand and generic versions on different sides of the PDL: Prior Authorizations for non-preferred brands or in certain cases non-preferred generic form -- 1. Requests will be approved for patients that show reduced objective outcomes on the preferred version relative to the non-preferred version. 2. Requests will be approved for patients experiencing side effects on the preferred generic version only if the side effect has not been reported in the literature for the brand version. The completion and submission of the medwatch form will then also be required. | | | | | | | |
| B: To apply to all requests for non-preferred brands and other drugs with PA conditions for non FDA approved indications. Decisions will be made on a case by case basis until the DUR committee is able to review the evidence and make a recommendation. Interim approvals and DUR recommendations for approval of a drug for a non FDA approved indication will require a minimum of two published, peer reviewed, non contradicted, double-blinded, placebo-controlled, randomized studies establishing both safety and efficacy. | | | | | | | |
| C: PDL drugs may also be affected by dose consolidation requirements. See list of limited drugs start on the last page of PDL. | | | | | | | |
| D: 1. The minimum trial periods for each preferred and step-order drug is two weeks, unless otherwise stated within specific PDL drug categories. 2. A trial will not be considered valid if non preferred products were readily available (paid by override, cash, or samples). 3. Certain drug trials, such as with preferred narcotics, may require evidence that the preferred drugs were actually tried (example: with urine drug tests). 4. Trials with less than a two week duration will be reviewed on a case-by-case basis. | | | | | | | |
| E: Other Criteria: Drugs that must be submitted on specific prior authorization forms may contain additional criteria that has not been repeated below in this document. | | | | | | | |
| ASSORTED ANTIBIOTICS | | | | | | | |
| BETA-LACTAMS / CLAVULANATE COMBO'S | | AMOXICILLIN AMOXIL ¹ AMPICILLIN AMOXICILLIN/POTASSIUM CLA CHEW AMOXICILLIN/POTASSIUM CLA SUSR AMOXICILLIN/POTASSIUM CLA TABS AUGMENTIN ES-600 SUSR AUGMENTIN XR TB12 BEEPEN BICILLIN L-A SUSP DICLOXACILLIN SODIUM CAPS DYNAPEN SUSR GEOCILLIN TABS OXACILLIN SODIUM SOLR PENICILLIN V POTASSIUM TICAR SOLR TIMENTIN SOLR TRIMOX UNASYN SOLR VEETIDS ZOSYN | | AMOXIL 500MG TABS AUGMENTIN ³ PRINCIPEN CAPS ² PRINCIPEN SUSR | | 1. Amoxil 500mg tabs are non-preferred. All other Amoxil products are preferred. 2. Principen 250 mg is available without PA. 3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA. Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| CEPHALOSPORINS | | CEFADROXIL HEMIHYDRATE CEFAZOLIN SODIUM SOLR CEFUROXIME AXETIL TABS CEFZIL CEPHALEXIN MONOHYDRATE DURICEF SUSR FORTAZ SOLR KEFZOL SOLR MAXIPIME SOLR OMNICEF ROCEPHIN VANTIN | | CECLOR ¹ CEDAX CEFACTOR ¹ CEFADROXIL MONOHYDRATE TABS CEFTIN DURICEF TABS FORTAZ SOLN KEFLEX CAPS TAZICEF SOLR | | 1. Both brand and generic are clinically non-preferred. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| MACROLIDES / ERYTHROMYCIN'S | | BIAXIN XL ⁴ E.E.S. E-MYCIN TBEC ERYPED 200 SUSR ERYPED 400 SUSR ERY-TAB TBEC ERYTHROCIN STEARATE TABS ERYTHROMYCIN ZITHROMAX ^{1,2} | | BIAXIN CLARITHROMYCIN DYNABAC D5-PAK TBEC ERYPED CHEW PCE TBEC | | 1. QL ZPAC 250mg 6/scrip/month 2. QL TRI-PAC 3/scrip/month 3. 7- Day supply per month w/o PA Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TETRACYCLINES | | DOXYCYCLINE HYCLATE MINOCYCLINE HCL CAPS SUMYCIN TETRACYCLINE HCL CAPS VIBRAMYCIN SYRP | | DECLOMYCIN TABS DORYX CPEP DOXYCYCLINE MONO CAPS DYNACIN CAPS MONODOX CAPS PERIOSTAT | | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| FLUOROQUINOLONES | | AVELOX ABC PACK TABS AVELOX SOLN AVELOX TABS CIPROFLOXACIN CIPRO XR ³ | | CIPRO FLOXIN TABS LEVAQUIN NOROXIN TABS TEQUIN | | 1. QL 3/scrip/month Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| AMINO GLYCOSIDES | | GENTAMICIN NEOMYCIN SULFATE TABS | | | | | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

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| | | TOBI NEBU TOBRAMYCIN SULFATE SOLN | | | preferred drug(s) exists. |
| ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS | | ETHAMBUTOL HCL TABS MYAMBUTOL TABS MYCOBUTIN CAPS RIFAMPIN | | RIMACTANE CAPS | Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIMALARIAL AGENTS | | CHLOROQUINE PHOSPHATE TABS DARAPRIM TABS HYDROXYCHLOROQUINE TABS LARIAM TABS MALARONE TABS MEFLOQUINE HCL TABS QUINACRINE HCL POWD QUININE SULFATE | | ARALEN TABS PLAQUENIL TABS | Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTHELMINTICS | | ALBENZA TABS BILTRICIDE TABS MEBENDAZOLE CHEW STROMECTOL TABS | | VERMOX CHEW | Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIBIOTICS - MISC. | | AZACTAM SOLR COLISTIMETHATE SODIUM SOLR FUROXONE TABS METRONIDAZOLE ² PENTAMIDINE ISETHIONATE SOLR PRIMSOL SOLN TRIMETHOPRIM TABS VANCOCIN HCL VANCOMYCIN HCL | | COLY-MYCIN-M SOLR FLAGYL CAPS FLAGYL TABS FLAGYL ER TBCR KETEK LORABID METRONIDAZOLE 375MG CAPS ² METRONIDAZOLE 750MG TABS ² NEBUPENT SOLR PROLOPRIM TABS TINDAMAX ¹ XIFAXAN | 1. Need to fail other anti-protozoals 2. 375mg caps and 750mg tabs are non-preferred. Please use available preferred strengths(250mg & 500mg tabs) to obtain required dose without PA. Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. For macrolide resistant infections when quinolones inappropriate |
| CARBAPENEMS | | INVANZ SOLR MERREM SOLR | | | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS | | CLEOCIN SOLN CLEOCIN SUSR CLINDAMYCIN HCL 150CAPS DAPSONE TABS | | CLEOCIN CAPS CLINDAMYCIN HCL 300CAPS ¹ ZYVOX SUSR ZYVOX TABS | 1. Use multiple 150's for Clindamycin instead of 300's. Zyvox: use PA Form # 30820 Others: use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. For Zyvox, please see the criteria listed in the Zyvox PA form. |
| ANTI INFECTIVE COMBO'S - MISC. | | ERYTHROMYCIN/SULF SUSR SEPTRA/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA | | ALINIA [*] BACTRIM DS TABS | *Alina is preferred for children less than 12 years of age. Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTI - FUNGALS | | | | | |
| ANTIFUNGALS - ASSORTED | | ANCOBON CAPS FLUCONAZOLE ¹ GRIFULVIN GRISEOFULVIN ULTRAMICROSI TABS GRIS-PEG TABS KETOCONAZOLE TABS NYSTATIN VFEND TABS | 5 5 5 6 8 8 | LAMISIL TABS SPORANOX SOLN ² SPORANOX PULSEPAK CAPS ³ SPORANOX CAPS ³ DIFLUCAN ¹ NIZORAL TABS | 1. QL-1/every 7-day period (150mg only). 2. Sporanox QL 300cc/month with PA. See quantity limit table. 3. Sporanox QL 30/month with PA. See quantity limit table. Non-preferred products must be used in specified step order. Continue to use Anti-Fungal PA form for non-preferred products. Use PA Form # 10120 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The other criteria are listed on the Antifungal PA form including the required proof of a non-cosmetic fungal infection. |
| ANTI - VIRALS | | | | | |
| ANTIRETROVIRALS | | AGENERASE CAPS APTIVUS COMBIVIR TABS CRIVIVAN CAPS EMTRIVA EPIVIR / HBV EPZICOM FORTOVASE CAPS HIVID TABS INVIRASE CAPS KALETRA LEXIVA NORVIR | | DIDANOSINE FUZEON | Fuzeon use PA Form # 10620 Turvada use PA form #20420 Please refer to the criteria listed on the Fuzeon PA form. |

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| | | RESCRIPTOR TABS RETROVIR REYATAZ SUSTIVA TRIZIVIR TABS TRUVADA VIDEX/EC VIRACEPT TABS VIRAMUNE TABS VIREAD TABS ZERIT ZIAGEN TABS | | | | |
| CYTO-MEGALOVIRUS AGENTS | | GANCICLOVIR VALCYTE TABS | | CYTOVENE CAPS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| HEPATITIS AGENTS | | | | | | |
| HEPATITIS C AGENTS | | PEG-INTRON KIT REBETRON KIT REBETOL CAPS | 8 8 8 8 | COPEGUS TABS PEGASYS KIT PEGASYS SOLN RIBAVIRIN CAPS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| HEPATITIS AGENTS - MISC. | | | | ACTIMMUNE | Use PA Form # 20420 | Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis. |
| HEPATITIS B ONLY | | HEPSERA TABS | | | | |
| HERPES AGENTS | | ACYCLOVIR VALTREX TABS | | FAMVIR TABS ZOVIRAX | Must fail Acyclovir and Valtrex before non-preferred products Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| INFLUENZA AGENTS | | AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU ¹ | | FLUMADINE TABS FLUMIST ² | 1. Tamiflu 10 caps or 60cc's per month. 2. Flumist Use Form # 10610. Others Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| RSV PROPHYLAXIS | | | | | | |
| RSV PROPHYLAXIS | | | | RESPIGAM SYNAGIS | Use PA Form # 30120 | Please see the criteria listed on the Synagis PA form. |
| MS TREATMENTS | | | | | | |
| MULTIPLE SCLEROSIS AGENTS | | | 5 5 5 6 | AVONEX KIT BETASERON SOLR REBIF SOLN COPAXONE | Established users grandfathered. Must follow specified step order. Use PA Form # 20430 | Non-Preferred drugs must be tried in step order and failed due to lack of efficacy or intolerable side effects before lower ranked non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ASSORTED NEUROLOGICS | | | | | | |
| NEUROLOGICS - MISC. | | MESTINON ORAP TABS PROSTIGMIN TABS | | BOTOX MYOBLOC ¹ | 1. Myobloc approval will be limited to Cervical Dystonia. Use PA Form #10210 | 1. Myobloc approval will be limited to Cervical Dystonia. Failed/did not tolerate therapeutic trials for muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, Skelaxin, and tizanidine. |
| STEROIDS | | | | | | |
| GLUCOCORTICOIDSI/ MINERALOCORTICOIDSI | | CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS DEPO-MEDROL SUSP DEXAMETHASONE ENTOCORT EC CP24 FLUDROCORTISONE ACETATE TABS HYDROCORTISONE KENALOG METHYLPREDNISOLONE TABS ORAPRED SOLN PREDNISOLONE PREDNISONE SOLU-CORTEF SOLR SOLU-MEDROL SOLR | | CORTEF 10 and 20 TABS DECADRON TABS FLORINEF TABS MEDROL TABS MEDROL DOSEPAK TABS PEDIAAPRED LIQD PREDNISONE INTENSOL CONC PRELONE SYRP STERAPRED TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| HORMONE REPLACEMENT THERAPIES | | | | | | |
| ANDROGENS / ANABOLICS | | ANDROID CAPS ANDRODERM PT24 DANAZOL CAPS DEPO-TESTOSTERONE OIL FLUOXYMESTERONE TABS OXANDRIN TABS TESTODERM TESTOSTERONE PROPIONATE | | ANDRO LA 200 OIL ANDROGEL PACK DELATESTRYL OIL HALOTESTIN TABS METHITEST TABS OXANDRIN TABS ¹ | Use PA Form # 20420 1. Non-preferred effective 12.01.05. Use the Oxandrin PA Form #20600 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Additionally, laboratory evidence of a testosterone deficiency must be supplied. One of each dosage form should be tried (tablet, injection, and topical) |

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| | | TESTRED CAPS WINSTROL TABS | | | |
| ESTROGENS - PATCHES | | | 5 5 8 8 8 8 8 8 | ESTRADERM PTTW ESTRADIOL PTWK ALORA PTTW CLIMARA PTWK ESCLIM PTTW VIVELLE PTTW VIVELLE-DOT PTTW | All patches are non-preferred products (require PA). Products must be used in specified step order. Use PA Form # 20420 |
| ESTROGENS - TABS | | CENESTIN TABS DELESTROGEN OIL ESTRADIOL ESTROPIPATE TABS MENEST TABS PREMARIN TABS | | ESTRACE TABS ESTRATAB TABS OGEN TABS ORTHO-EST TABS | Must fail preferred products before non-preferred products Use PA Form # 20420 |
| ESTROGEN COMBO'S | | PREMPHASE TABS PREMPRO TABS | | ACTIVELLA TABS COMBIPATCH PTTW FEMHRT 1/5 TABS ORTHO-PREFEST TABS SYNTEST H.S. TABS | Must fail Premphase and Prempro products before non preferred products. Use PA Form # 20420 |
| PROGESTINS | | MEDROXYPROGESTERONE ACETA ² NORETHINDRONE ACETATE TABS ² PROGESTERONE POWD | | AYGESTIN TABS CYCRIN TABS PROMETRIUM 100MG CAPS ¹ PROMETRIUM 200MG ¹ PROVERA TABS | 1. PA approvals will require two 100 mg caps instead of one 200mg 2. Must fail Medroxyprogesterone and Norethidrone products before non-preferred products. Use PA Form # 20420 |
| CONTRACEPTIVES | | | | | |
| CONTRACEPTIVES - PROGESTIN ONLY | | ORTHO MICRONOR TABS | | CAMILA TABS NORA-BE TABS NOR-OD TABS OVRETTE 28 TABS | If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form # 20420 |
| CONTRACEPTIVES - INJECTABLE | | DEPO-PROVERA SUSP | | LUNELLE SUSP MEDROXYPROGESTERONE ACETATE IM | Use PA Form # 20420 |
| CONTRACEPTIVE - EMERGENCY | | PLAN - B ¹ | | | 1. Allowed 4 tablets per 30 days without PA |
| CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS | | ORTHO EVRA PTWK ¹ | | NUVARING RING | 1.No PA required for users less than 21 years of age. Use PA Form # 20420 |
| CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S | | ALESSE-28 TABS DEMULEN 1/35-28 TABS DEMULEN 1/50-28 TABS DESOGEN TABS LEVLEN-28 TABS LO/OVRAL 21 TABS LO/OVRAL 28 TABS MODICON TABS ORTHO-CEPT-28 TABS ORTHO-CYCLEN-28 TABS ORTHO-NOVUM 1/35-28 TABS ORTHO-NOVUM 1/50-28 TABS OVCON-35/28 TABS OVCON-50 28 TABS | | APRI TABS AVIANE TABS BREVICON-28 TABS CRYSSELLE-28 TABS DEMULEN 1/35-21 TABS KARIVA TABS LESSINA-28 TABS LEVLITE-28 TABS LEVORA LOESTRIN TABS LOESTRIN FE TABS LOESTRIN FE 1/20 TABS LOESTRIN 1.5/30-21 TABS LOESTRIN 1/20-21 TABS LOW-OGESTREL TABS MICROGESTIN FE TABS MIRCETTE TABS NECON NORDETTE-28 TABS NORINYL NORTREL MONONESSA OGESTREL TABS OVRAL PORTIA-28 TABS | Loestrin FE and FE 1/20 are grandfathered for established users. If member experiences adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form # 20420 |

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| | | | | SPRINTEC 28 TABS YASMIN 28 TABS ZOVIA | | |
| CONTRACEPTIVES - BI-PHASIC COMBINATIONS | | ORTHO-NOVUM 10/11-28 TABS | | NECON 10/11-28 TABS | If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| CONTRACEPTIVES - TRI-PHASIC COMBINATIONS | | ORTHO TRI-CYCLEN TABS ORTHO-NOVUM 7/7/7-28 TABS TRI-LEVLEN TABS TRIPHASIL 28 TABS | | CYCLESSA TABS ENPRESSE ESTROSTEP FE TABS ORTHO TRI-CYCLEN LO TABS TRI-NORINYL 28 TABS TRIVORA-28 TABS | If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| DIABETES THERAPIES | | | | | | |
| DIABETIC - INSULIN | | ILETIN LANTUS SOLN NOVOLIN NOVOLOG RELION VELOSULIN BR SOLN | | HUMALOG HUMULIN | Use PA Form # 30140 | Approved if patient has had an allergic reaction to preferred products or for pediatric patients requiring insulin doses with diluent. |
| DIABETIC - PENFILLS | | | 5 5 8 8 8 | NOVOLIN PENFILL NOVOLOG PENFILL SOLN HUMALOG MIX 75/25 PEN SUSP HUMALOG PEN SOLN HUMULIN PEN | PA's will be granted for significant visual or neurological impairment. Products must be used in specified step order. Use PA Form # 20420 | Approved for significant visual or neurologic impairment affecting hand dexterity and for school age children requiring at school doses. |
| DIABETIC - ORAL SULFONYLUREAS | | CHLORPROPAMIDE TABS GLIPIZIDE TABS GLYBURIDE TABS GLYBURIDE MICRONIZED TABS TOLAZAMIDE TABS TOLBUTAMIDE TABS | | AMARYL TABS DIABETA TABS GLIPIZIDE ER TABS GLUCOTROL TABS GLUCOTROL XL TBCR GLYNASE TABS MICRONASE TABS | Use PA Form # 20420 | Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| DIABETIC - ORAL BIGUANIDES | | METFORMIN HCL TABS METFORMIN ER 500MG | | GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET METFORMIN ER 750MG | Metformin ER 750mg tabs are non preferred. Metformin ER 500mg are preferred. Use PA Form # 20420 | Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| DIABETIC - THIAZOL / BIGUANIDE COMBO | | AVANDAMET TABS | | | | |
| DIABETIC - /THIAZOL | | AVANDIA TABS ¹ ACTOS 15MG TABS ¹ ACTOS 45MG TABS ¹ | | ACTOS 30MG TABS ² | 1. Actos and Avandia preferred without PA if patient on insulin or sulfonylurea or metformin. Avandia non-preferred as monotherapy. 2. Actos 30mg - use two 15mg instead. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| DIABETIC - ALPHAGLUCOSIDASE | | GLYSET TABS | | PRECOSE TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| DIABETIC - SULFONYLUREA / BIGUANIDE | | | | GLUCOVANCE TABS METAGLIP TABS | Use individual ingredients. Use PA Form # 20420 | Approved for patients failing to achieve good diabetic control with maximal doses of individual components. |
| DIABETIC - MEGLITINIDES | | STARLIX TABS | | PRANDIN TABS | Use PA Form # 20420 | Preferred drugs from other diabetic sub-categories must be tried and failed due to lack of inadequate diabetic control or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| THYROID | | | | | | |
| THYROID HORMONES | | ARMOUR THYROID TABS CYTOMEL TABS LEVOTHROID TABS LEVOTHYROXINE SODIUM TABS LEVOXYL TABS THYROID TABS THYROLAR UNITHROID TABS | | LEVOTHYROXINE SODIUM SOLR SYNTHROID TABS ¹ | Use Pa Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTITHYROID THERAPIES | | METHIMAZOLE TABS | | TAPAZOLE TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered |

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| | | PROPYLTHIOURACIL TABS | | | | on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| OSTEOPOROSIS | | | | | | |
| OSTEOPOROSIS | | ACTONEL TABS FOSAMAX SOLN FOSAMAX TABS FOSAMAX PLUS D MIACALCIN SOLN | | AREDIA SOLR BONIVA DIDRONEL TABS EVISTA TABS ¹ FORTEO | Approval only requires failure of Fosamax or Actonel. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| CALCIMIMETIC AGENTS | | | | | | |
| CALCIMIMETIC AGENTS | | | | SENSIPAR | Use PA Form # 30115 | Baseline PTH, Ca, and phosphorous levels are required and initial approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Will not approve if baseline Ca is less than 8.4. |
| GROWTH HORMONE | | | | | | |
| GROWTH HORMONE | | | 5 5 6 8 8 8 | GENOTROPIN TEV-TROPIN NUTROPIN HUMATROPE SOLR NORDITROPIN CARTRIDGE SOLN SAIZEN SOLR | Products must be used in specified step order. Use PA Form # 10710 | See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied. |
| SOMATOSTATIC AGENTS | | SANDOSTATIN | | | | |
| GROWTH HORMONE ANTAGONISTS | | | | | | |
| GH ANTAGONISTS | | | | SOMAVERT | Use PA Form # 10710 | Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatin. |
| URINARY INCONTINENCE | | | | | | |
| VASOPRESSINS | | | 5 6 6 8 8 | DDAVP TABS DDAVP SOLN DESMOPRESSIN SPRAY DESMOPRESSIN ACETATE SOLN STIMATE SOLN* | Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP. Use Pa Form # 20420 | Approved for central diabetes insipidus and for nocturnal enuresis- must be over 6 years old, must fail an adequate trial of alarm training (higher success rate, lower relapse rate) and must periodically attempt weaning (at 6 month intervals). * Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization. |
| ANTISPASMODICS | | OXYBUTYININ URISPAS TABS | | CYSTOSPAZ TABS DETROL TABS DITROPAN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTISPASMODICS - LONG ACTING | | DETROL LA CP24 ENABLEX ¹ VESICARE ¹ | | DITROPAN XL TBCR OXYTROL SANCTURA | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. Vesicare 5mg and Enablex 7.5mg maximum doses if given with drugs known to be significant CYP3A4 inhibitors. (Ketoconazole, Sporanox, Erythromycin, Biaxin, Nefazodone, Nelfinavir, and Ritonavir) |
| CHOLINERGIC | | URECHOLINE | | | | |
| METABOLIC MODIFIER | | | | | | |
| HERED. TYROSINEMIA | | | | ORFADIN | Use PA Form # 20420 | Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA. |
| ANTIHYPERTENSIVES / CARDIAC | | | | | | |
| CARDIAC GLYCOSIDES | | DIGITEK TABS DIGOXIN LANOXICAPS LANOXIN | | | | |
| ANTIANGINALS-Isosorbide Dinitrate/ Mono-Nitrates | | ISOSORBIDE MONONITRATE TABS ISOSORBIDE MONONITRATE ER | | DILATRATE SR CPCR ISORDIL TABS ISORDIL TITRADOSE TABS ISOSORBIDE DINITRATE SUBL ISOSORBIDE DINITRATE TABS ISOSORBIDE DINITRATE CR TBCR ISOSORBIDE DINITRATE ER TBCR ISOSORBIDE DINITRATE TD TBCR IMDUR TB24 SMO TABS MONOKET TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| NITRO - OINTMENT/CAP/CR | | NITROBID OINT NITROGLYCERIN CPCR NITROL OINT NITRO-TIME CPCR | | | | |
| NITRO - PATCHES | 1 1 1 3 | NITROGLYCERIN PT24 NITREK PT24 NITRO-DUR PT 24 0.8MG MINITRAN PT24 | | NITRODISC PT24 NITRO-DUR PT24 | At least 2 step 1's and step 3 of the preferred products must be used in specified order or PA will be required. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| NITRO - SUBLINGUAL/ SPRAY | | NITROLINGUAL AERS NITROSTAT SUBL | | NITROLINGUAL SOLN NITROQUICK SUBL | Use Pa Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

| | | NITROTAB SUBL | | | preference drug(s) exists. | |
|--|---|--|----------------------------|---|--|---|
| BETA BLOCKERS - NON SELECTIVE | | COREG TABS INDERAL LA CPCR LEVATOL TABS NADOLOL TABS PINDOLOL TABS PROPRANOLOL HCL SOLN ¹ PROPRANOLOL HCL TABS ¹ SOTALOL HCL TABS TIMOLOL MALEATE TABS | | BETAPACE TABS BETAPACE AF TABS CORCARD TABS INDERAL TABS INNOPRAN XL PROPRANOLOL HCL LA CPCR | 1. Recommend using BID since its effects do not last 24 hours. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| BETA BLOCKERS - CARDIO SELECTIVE | | ACEBUTOLOL HCL CAPS ATENOLOL TABS ¹ BETAXOLOL HCL TABS BISOPROLOL FUMARATE TABS METOPROLOL TARTRATE TABS ¹ TOPROL XL TB24 | | KERLONE TABS LOPRESSOR TABS SECTRAL CAPS TENORMIN TABS ZEBETA TABS | 1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| BETA BLOCKERS - ALPHA / BETA | | LABETALOL HCL TABS | | TRANDATE TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| CALCIUM CHANNEL BLOCKERS - Amlodipines, Bepridil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils | | NORVASC TABS | | | | |
| | 1 | CARDIZEM LA TB24 | 5 | DILACOR XR CP24 | Products must be used in specified order or PA will be required. Just write "Cardizem LA" or "Diltiazem 24-hour" and the pharmacy will use a preferred long acting diltiazem that does not require PA. Use PA Form # 20420 | Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | 1 | DILTIA XT CP24 | 6 | TAZTIA | | |
| | 1 | DILTIAZEM HCL ER CP24 | 7 | TIAZAC CP24 | | |
| | 1 | DILTIAZEM HCL XR CP24 | 8 | CARDIZEM TABS | | |
| | 1 | DILTIAZEM CD 300MG CP24 | 8 | CARDIZEM CD CP24 | | |
| | 1 | DILTIAZEM CD 360MG CP24 | 8 | CARDIZEM SR CP12 | | |
| | 4 | CARTIA XT CP24 | 8 | DILTIAZEM HCL TABS | | |
| | 4 | DILTIAZEM CD CP24 | 8 | DILTIAZEM HCL ER CP12 | | |
| | 4 | DILTIAZEM HCL ER CP24 | | | | |
| | 4 | DILTIAZEM XR CP24 | | | | |
| | | | | PLENDIL TB24 | Use PA Form # 20420 | Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | | DYNACIRC CR TBCR | | DYNACIRC CAPS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | | | | CARDENE CAPS CARDENE SR CPCR NICARDIPINE HCL CAPS | Use PA Form # 20420 | Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | | NIFEDIPINE TBCR NIFEDIPINE ER TBCR NIFEDICAL XL TBCR | | ADALAT CC TBCR NIFEDIPINE CAPS PROCARDIA CAPS PROCARDIA XL TBCR | Established users of Adalat CC are grandfathered. Use PA Form # 20420 | Preferred drug must be tried and failed in step order due to lack of efficacy or intolerable side effects before non-preferred drugs in step order will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | | SULAR TB24 | | | | |
| | 1 | VERAPAMIL HCL CR TBCR | | CALAN TABS | Products must be used in specified order or PA will be required. Just write "Verapamil 24-hour" and the pharmacy will use a preferred long acting generic that does not require PA. Use PA Form # 20420 | Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | 1 | VERAPAMIL HCL ER TBCR | | CALAN SR TBCR | | |
| | 1 | VERAPAMIL HCL SR TBCR | | COVERA-HS TBCR ISOPTIN-SR VERAPAMIL HCL ER CP24 VERAPAMIL HCL SR CP24 VERAPAMIL HCL TABS VERELAN CP24 VERELAN PM CP24 | | |
| ANTIARRHYTHMICS | | AMIODARONE MEXILETINE NORPACE PROCAINAMIDE PROCANBID CR QUINAGLUTE QUINIDINE GLUCONATE QUINIDINE SULFATE RYTHMOL TAMBOCOR | | PACERONE CORDARONE DISOPYRAMIDE PROPafenone FLECAINIDE MEXITIL QUINIDEX TIKOSYN ¹ | 1. Prescription must be written by Cardiologist. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ACE INHIBITORS | | CAPTOPRIL TABS BENAZEPRIL HCL ENALAPRIL MALEATE TABS LISINAPRIL TABS MONOPRIL TABS | 5 5 8 8 8 8 | MAVIK TABS ACCUPRIL TABS ACEON TABS ALTACE CAPS CAPOTEN TABS FOSINOPRIL SODIUM | Non-preferred products must be used in specified order. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception. |

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| | | | 8 8 8 8 8 8 8 | LOTENSIN TABS MOEXIPRIL PRINIVIL TABS UNIVASC VASOTEC TABS ZESTRIL TABS | | |
| ANGIOTENSIN RECEPTOR BLOCKER | | AVAPRO TABS BENICAR TABS COZAAR TABS DIOVAN MICARDIS TABS TEVETEN TABS | | ATACAND TABS | Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form # 20420 | The initial criteria to use any ARB is that the member must have failed ACE inhibitors (such as due to coughing) in the past or must currently be actively treated for diabetes and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIHYPERTENSIVES - CENTRAL | | CATAPRES-TTS CLONIDINE HCL TABS GUANFACINE HCL TABS HYDRALAZINE HCL TABS HYLOREL TABS METHYLDOPA TABS MINOXIDIL TABS PRAZOSIN HCL CAPS RESERPINE TABS | | CATAPRES TABS GUANABENZ ACETATE TABS ISMELIN TABS MINIPRESS CAPS TENEX TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ACE INHIBITORS AND CA CHANNEL BLOCKERS | | LOTREL CAPS TARKA TBCR | | LEXCEL TBCR | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ACE AND THIAZIDE COMBO'S | | BENAZEPRIL HCL/HYDROCHLOR CAPTOPRIL/HYDROCHLOROTHIA ENALAPRIL MALEATE/HCTZ TABS LISINOPRIL-HCTZ TABS UNIRETIC TABS | | ACCURETIC TABS CAPOZIDE TABS LOTENSIN HCT TABS MONOPRIL HCT TABS PRINZIDE TABS VASERETIC TABS ZESTORETIC TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| BETA BLOCKERS AND DIURETIC COMBO'S | | ATENOLOL/CHLORTHALIDONE BISOPROLOL FUMARATE/HCTZ PROPRANOLOL/HCTZ | | CORZIDE TABS INDERIDE 40/25 TABS LOPRESSOR HCT TABS TENORETIC TIMOLIDE 10/25 TABS ZIAC TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ARB'S AND DIURETICS | | AVALIDE TABS BENICAR HCT DIOVAN HCT TABS HYZAAR TABS MICARDIS HCT TABS TEVETEN HCT TABS | | ATACAND HCT TABS | Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form # 20420 | Same initial criteria as the ARB class and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| DIURETICS | | ACETAZOLAMIDE TABS AMILORIDE HCL BUMETANIDE CHLOROTHIAZIDE TABS CHLORTHALIDONE TABS EDECRIN TABS FUROSEMIDE HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS METHYLCLOTHIAZIDE TABS SPIRONOLACTONE 25MG TABS SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ ZAROXOLYN TABS | | ALDACTAZIDE TABS ALDACTONE TABS BUMEX TABS DEMADEX TABS DIAMOX DIURIL DYAZIDE CAPS ENDURON TABS INSPIRA LASIX TABS LOZOL TABS MAXZIDE MICROZIDE CAPS MIDAMOR TABS MODURETIC 5-50 TABS NAQUA TABS NATURETIN TABS SPIRONOLACTONE 50MG ¹ | 1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspira will be approved for severe breast tenderness and male gynecomastia. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| CCB / LIPID | | CADUET | | | | |
| LIPID DRUGS | | | | | | |
| CHOLESTEROL - BILE SEQUESTRANTS | | CHOLESTYRAMINE COLESTID | | PREVALITE QUESTRAN WELCHOL TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| CHOLESTEROL - FIBRIC ACID DERIVATIVES | | ANTARA GEMFIBROZIL TABS tritor | | LIPID TABS LOFIBRA | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

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| CHOLESTEROL - HGM COA + ABSORB INHIBITORS | | ADVICOR TBCR ALTOPREV TB 24 CRESTOR LIPITOR TABS LESCOL CAPS LESCOL XL TB24 LOVASTATIN TABS VYTORIN ZETIA TABS ¹ ZOCOR TABS | | MEVACOR TABS PRAVACHOL TABS PRAVIGARD | 1. Zetia available w/OPA as addition to Zocor 80mg, Lipitor 80mg, or Crestor 40mg. Zetia will also be approved with a PA as add on for patients at maximally tolerated doses of statins. Zocor patients trying to use Zetia must use Vytorin instead. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zetia will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins. |
| PULMONARY ANTI-HYPERTENSIVES | | | | | | |
| PULMONARY ANTI-HYPERTENSIVES | | | | FLOLAN TRACLEER | Use PA Form # 20420 | Flolan and Tracleer will be approved after the dx of pulmonary hypertension is confirmed. |
| IMPOTENCE AGENTS | | | | | | |
| IMPOTENCE AGENTS | | | | CAVERJECT CIALIS EDEX LEVITRA MUSE VIAGRA YOHIMBINE HCL TABS | The maximal approved quantity for the category (not per drug) is 1 unit per 30 days. Use PA Form # 10530 | See the criteria listed on the Erectile Dysfunction PA form. The MaineCare Program was notified by the Centers for Medicare and Medicaid Services in a letter dated May 23, 2005, that effective immediately, states should use their drug use review program and procedures under 1927(g) of the Social Security Act and work with physicians and pharmacists to prevent inappropriate Medicaid payment for such drugs in the case of a sex offender. In accordance with this directive from the federal government, MaineCare is obligated to deny approval for this drug for convicted sex offenders. |
| ANTI-EMETOGENICS | | | | | | |
| ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC | | MECLIZINE HCL TABS PHENERGAN SUPP PHENERGAN FORTIS SYRP PROMETHAZINE TRANSDERM-SCOP PT72 | | ANTIVERT TABS PHENERGAN SOLN PHENERGAN TABS PROMETHEGAN SUPP TORECAN TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ | | ALOXI* MARINOL CAPS ZOFRAN SOLN* ZOFRAN TABS* | | ANZEMET TABS EMEND KYTRIL ZOFRAN ODT TBDP | See quantity limit table. Zofran: use PA Form # 30810 Others: use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * Zofran limits still apply as listed on the Zofran PA form for covered indications including chemotherapy, radiotherapy, post operative nausea & vomiting and hyperemesis gravidarum. Other medical indications will be approved or denied on a case by case basis. Hyperemesis and other medical indications approved are still subject to failure of multiple preferred antiemesis drugs. |
| NON-SEDATING ANTIHISTAMINES / DECONGESTANTS | | | | | | |
| ANTIHISTAMINES - NON-SEDATING | | ALAVERT TABS ¹ CLARITIN ALLERGY (OTC) ¹ CLARITIN SYRP (OTC) ² TAVIST ND (OTC) ¹ | 5 5 5 8 8 | CLARINEX TABS ² CLARINEX SYR ³ ZYRTEC ³ ALLEGRA CLARITIN ² | 1. Preferred drugs are OTC loratidines. 2. Claritin OTC syrup does not require a PA. 3. Zyrtec syrup <6 yr w/o PA. Must fail Clarinex Tabs and Zyrtec products before moving to next step product without PA. Pseudoephedrine is available with prescription. Use PA Form # 20530 | Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA. |
| ALLERGY / ASTHMA THERAPIES | | | | | | |
| ANTIASTHMATIC - ANTICHOLINERGICS - INHALER | | ATROVENT AERS ATROVENT HFA | | SPIRIVA ¹ | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. FEV1 <= 50% or COPD hospitalization within 6 months due to Atrovent failure. |
| ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER | | IPRATROPIUM BROMIDE SOLN | | ATROVENT SOLN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS | | CROMOLYN SODIUM NEBU INTAL AERS TILADE AERS | | XOLAIR ¹ | 1. Need max inhaled steroids and written by pulmonary or allergy specialist. Use PA Form # 20420 | Xolair approval will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management. |
| ANTIASTHMATIC - NASAL STEROIDS | 1 1 4 4 4 | FLONASE SUSP ¹ NASONEX SUSP ¹ BECONASE AERS BECONASE AQ INHA NASALIDE SOLN | | FLUNISOLIDE SOLN NASACORT AERS NASACORT AQ AERS NASAREL SOLN RHINOCORT AERO RHINOCORT AQUA SUSP TRI-NASAL SOLN VANCENASE POKKETHALER AERS | Patient will have to fail both ones before moving to other preferred products. Preferred products must be used in specified step order or PA will be required. 1. Flonase and Nasonex do not require PA. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - NASAL MISC. | | NASALCROM | | ATROVENT NASAL SOL IPRATROPIUM NASAL SOL ¹ | 1. Ipratropium will be approved if submitted with documentation supporting use. | Approved if patient fails on non-sedating antihistamines and steroid nasal sprays. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

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| | | | ASTELIN | Documentation supporting use of CPAP machine. Use PA Form # 20420 | Preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - BETA-ADRENERGICS | | ALBUTEROL FORADIL AEROLIZER CAPS MAXAIR METAPROTERENOL SEREVENT TERBUTALINE SULFATE TABS | ACCUNEb NEBU ALUPENT AERP BRETHINE PROVENTIL PROVENTIL HFA AERS VENTOLIN AERS VENTOLIN HFA AERS VOLMAX TBCR VOSPIRE ER TB12 XOPENEX NEBU ^{1,2} | 1. Xopenex users with prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12 cc/day. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - ADRENERGIC COMBINATIONS | | ADVAIR DISKUS MISC | | | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Duoneb components are available separately without PA. |
| ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC | | COMBIVENT AERO | DUONEB SOLN ¹ | 1. Please use preferred individual ingredients Albuterol and Ipratropium. Use PA Form # 20420 | |
| ANTIASTHMATIC - XANTHINES | | AMINOPHYLLINE TABS THEOCHRON TB12 THEOLAIR-SR TB12 THEOPHYLLINE ELIX THEOPHYLLINE SOLN THEOPHYLLINE ER CP12 THEOPHYLLINE ER TB12 UNIPHYL TBCR | QUIBRON CAPS QUIBRON-T TABS QUIBRON-T/SR TB12 THEO-24 CP24 THEOLAIR TABS THEOPHYLLINE CR TB12 T-PHYL TB12 | Use PA Form 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - STEROID INHALANTS | | AEROBID AERS ASMANEX AZMACORT AERS BECLOVENT AERS FLOVENT PULMICORT SUSP ¹ QVAR AERS VANCERIL AERS | AEROBID-M AERS PULMICORT TURBUHALER AEPB ² VANCERIL DOUBLE STRENGTH AERS | 1. No PA for Pulmicort susp if under 8 years old 2. No PA for Pulmicort turbuhaler if under 14 yr. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - 5-Lipoxygenase Inhibitors | | | ZYFLO TABS | Use PA Form # 20420 | Other Preferred asthma controller drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS | | SINGULAIR ¹ | ACCOLATE TABS | 1. Must be using inhaled steroid, unless less than 14 years old, for script to avoid requiring a PA. Use PA Form # 20420 | Singular will additionally be approved for allergic indications if other cost effective allergy treatments are ineffective, including oral antihistamines and nasal steroids. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR | | | PROLASTIN SUSR ZEMAIRA | Use PA Form # 20420 | Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema. |
| ANTIASTHMATIC - HYDROLYTIC ENZYMES | | | PULMOZYME SOLN | Use PA Form # 20420 | Will be approved for cystic fibrosis patients. |
| ANTIASTHMATIC - MUCOLYTICS | | ACETYLCYSTEINE ¹ | MUCOMYST | 1. Acetylcysteine is covered with diagnosis of CF. Use PA Form # 20420 | |
| COUGH/COLD | | | | | |
| COUGH/COLD | | PSEUDOEPHEDRINE ROBITUSSIN DM SYRP ROBITUSSIN SUGAR FREE SYRP | All others are a non-covered service (this includes antihistamines-decongestive combinations). | All of cough cold preparations are not covered except these preferred products. | All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy. |
| DIGESTIVE AIDS / ASSORTED GI | | | | | |
| **Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.** | | | | | |
| GI - ANTI-PERISTALTIC AGENTS | | DIPHENOXYLATE DIPHENOXYLATE/ATROPINE MODIUM A-D TABS LOPERAMIDE HCL CAPS LOPERAMIDE HCL LIOD OPIUM TINCTURE TINC PAREGORIC TINC | ANTI-DIARRHEAL TABS LOFENE TABS LONOX TABS MOTOFEN TABS SB ANTI-DIARRHEA TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval. |
| GI - ANTI-DIARRHEAL/ANTACID - MISC. | | ALU-CAP CAPS ANTACID CHEW ATROPINE SULFATE SOLN BENTYL SYRP | ANTACID EXTRA STRENGTH CHEW B & O 15-A SUPPRETTE SUPP B & O 16-A SUPPRETTE SUPP BELLADONNA ALKALOIDS & OP | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval. |

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| | BISMATROL CALCIUM ANTACID CALCIUM CARBONATE CAL-GEST ANTACID CHEW CHEWABLE ANTACID CHEW DICYCLIMINE HCL GAVISCON SUSP HAPONAL TABS HYOSCYAMINE SULFATE MODIUM ADVANCED CHEW KAOPECTATE K-PEC LIQD K-PEK SUSP MAALOX MAGNESIUM OXIDE TABS MAG-OX 400 TABS MAG-OXIDE TABS PAMINE TABS PINK BISMUTH PROPANTHELINE BROMIDE TABS ROBINUL SAL-TROPINE TABS SCOPOLAMINE HYDROBROMIDE SODIUM BICARBONATE TABS TUMS V-R STOMACH RELIEF SUSP X-STR CHEW ANTACID CHEW | | BENTYL TABS CHILDRENS MYLANTA CHEW LEVBID TB12 LEVSIN ELIX LEVSIN TABS LEVSIN/SL SUBL NULEV TBDP URO-MAG CAPS | | |
| GI - H2-ANTAGONISTS | CIMETIDINE FAMOTIDINE RANITIDINE V-R ACID REDUCER TABS | | AXID CAPS AXID AR TABS NIZATIDINE CAPS PEPCID PEPCID AC TAGAMET TABS ZANTAC ¹ | 1. Zantac syrup available without PA to users less than 6 years old. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| GI - PROTON PUMP INHIBITOR | PREVACID CPDR OTC PRILOSEC PROTONIX ZEGERID | 6 7 8 8 8 8 | ACIPHEX TBEC OMEPRAZOLE CPDR NEXIUM CPDR PREVACID ORAL SUSP PREVACID SOLUTABS** PRILOSEC CPDR | **Prevacid Solutabs available without PA for children less than 9 years old and Long Term Care Residents. Use PA Form # 20420 | All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| GI - ULCER ANTI-INFECTIVE | HELIDAC PREVPAC | | | | |
| GI - PROSTAGLANDINS | MISOPROSTOL TABS | | CYTOTEC TABS | Use PA Form # 20420 | Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| GI - DIGESTIVE ENZYMES | LACTAID ULTRA LACTRASE CAPS | 7 7 7 7 7 7 8 8 8 8 8 8 8 8 | LIPRAM PANCREASE PANCRELIPASE PANGESTYME PANOKASE TABS ULTRASE CPEP CREON KUTRASE CAPS KU-ZYME CAPS LIPRAM CR PANCREASE MT PANCRECARB MS-8 CPEP ULTRASE MT VIOKASE | Non-preferred products are a one time PA for life (for CF diagnosis). Non-preferred products must be used in specified step order. Use PA Form # 20420 | Non-Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before other non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. In all cases except cystic fibrosis patients, objective evidence of pancreatic insufficiency (fat malabsorption test etc...) must be supplied. |
| GI - ANTI - FLATULENTS / GI STIMULANTS | CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP GASTROCROM CONC GENERLAC SYRP LACTULOSE SYRP METOCLOPRAMIDE HCL SIMETHICONE | | CEPHULAC SYRP GAS-X CHEW INFANTS GAS RELIEF SUSP REGLAN TABS | Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval. |
| GI - INFLAMMATORY BOWEL AGENTS | ASACOL TBEC AZULFIDINE TABS AZULFIDINE EN-TABS TBEC | | SULFAZINE EC TBEC | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

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| | CANASA SUPP COLAZAL CAPS DIPENTUM CAPS PENTASA CPCR ROWASA ENEM SULFASALAZINE TABS | | | |
| GI - IRRITABLE BOWEL SYNDROME AGENTS | | LOTRONEX TABS ZELNORM TABS | Use PA Form # 20420 | Zelnorm will be approved for women with IBS and predominant constipation. Lotronex will be approved for females with IBS and predominant diarrhea. Prior failed trials of multiple other preferred GI agents must occur first. IBS dx must be thoroughly documented. |

MISCELLANEOUS GI

****Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.****

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| GI - MISC. | BISAC-EVAC SUPP BISACODYL BISCOLAX SUPP CINOBAC CAPS CITRATE OF MAGNESIA SOLN CITRUCEL D.O.S. CAPS DIOCTO LIOD DIOCTO SYRP DIOCTYN CAPS DOC-Q-LACE CAPS DOCUSATE CALCIUM CAPS DOCUSATE SODIUM DOCUSIL CAPS DOK CAPS FIBER LAXATIVE TABS FLEET GENFIBER POWD GLYCERIN HIPREX TABS KRISTALOSE PACK METAMUCIL MILK OF MAGNESIA SUSP MINERAL OIL OIL MIRALAX PACK ¹ MIRALAX POWD ¹ SENNA SEKOKOT GRAN SEKOKOT SYRP SEKOKOT CHILDRENS SYRP SEKOKOT XTRA TABS SORBITOL STOOL SOFTENER CAPS SUCRALFATE TABS UNI-EASE CAPS UNIFIBER POWD URSODIOL | ACTIGALL CAPS BENEFIBER CARAFATE COLACE CAPS COLYTE DIOCTO-C SYRP DOC SOD /CAS CAP DOC-Q-LAX CAPS DOCUSATE SODIUM/CAS CAPS DOK PLUS DULCOLAX SUPP FIBER CON TABS FIBER-LAX TABS GOLYTELY SOLR GLYCOLAX ¹ MALTSUPEX NULYTELY SOLR PEG 3350/ELECTROLYTES SOLR SEKONON TABS SEKOKOT TABS SEKOKOT S TABS STOOL SOFTENER PLUS CAPS UNI-CENNA TABS UNI-EASE PLUS CAPS V-R NATURAL SENNA LAXATIV TABS | 1. Quantity Limit: 255 g/90-day without PA for greater than 18 years old. No quantity limit for less than 18 years old. 2. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval. |
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MISC. UROLOGICAL

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| UROLOGICAL - MISC. | ACETIC ACID 0.25% SOLN BICITRA SOLN CYTRA-K SOLN FURADANTIN SUSP K-PHOS MF TABS MACRODANTIN CAPS METHENAMINE MANDELATE TABS MONUROL PACK NEOSPORIN GU IRRIGANT SOLN PHENAZOPYRIDINE HCL TABS POLYCITRA SYRP POLYCITRA-K SOLN POLYCITRA-LC SOLN PROSED/DS TABS PYRIDUM PLUS TABS TRICITRATES SYRP UREX TABS URISED TABS UROCIT-K UROQID #2 TABS | CITRIC ACID/SODIUM CITRAT SOLN CYTRA-2 SOLN ELMIRON CAPS ¹ MACROBID CAPS MANDELAMINE TABS NITROFURANTOIN MACR CAPS POLYCITRA-K CRYSTALS PACK POTASSIUM CITRATE/CITRIC SOLN PYRIDUM TABS RENACIDIN SOLN | 1. Elmiron requires adequate proof of Dx with supportive testing. Use PA Form #20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
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PHOSPHATE BINDERS

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| PHOSPHATE BINDERS | | PHOSLO MEGNEBIND - 400 | | FOSRENOL RENAGEL ¹ | 1. Renegel will be approved for hypercalcemia, digoxin users, and in cases where maximum phoslo doses are insufficient. | Renegel will be approved in patients with hypercalcemia, on concurrent digoxin or insufficient response with Phos-lo (Renegel to be add-on therapy). |
| INTRA-VAGINALS | | | | | | |
| VAGINAL - ANTIBACTERIALS | 1 1 3 | CLEOCIN CREA METROGEL VAGINAL GEL CLEOCIN SUPP | | | Step order must be followed to avoid PA. Must fail Cleocin and Metrogel products before moving to next step product without PA. | Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| VAGINAL - ANTI FUNGALS | | CLOTRIMAZOLE CREA GYNE-LOTRIMIN CREA MICONAZOLE CREA MICONAZOLE 3 COMBO PACK KIT ¹ MICONAZOLE 7 CREA MICONAZOLE NITRATE CREA MONISTAT 1 OINT MONISTAT 3 CREA MONISTAT 7 NYSTATIN TABS VAGITROL V-R MICONAZOLE-7 CREA | | AVC CREAM CLOTRIMAZOLE 3 DAY CREA GYNAZOLE-1 CREA GYNE-LOTRIMIN 3 TABS MICONAZOLE 3 SUPP MONISTAT 3 SUPP TERAZOL 3 CREA TERAZOL 3 SUPP TERAZOL 7 CREA | 1. Quantity limit: 1script/2 weeks Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| VAGINAL - CONTRACEPTIVES | | GYNOL II EXTRA STRENGTH GEL | | DELLEN FOAM | Use PA Form # 20420 | Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| VAGINAL - ESTROGENS | | ESTRING RING PREMARIN CREA | | ESTRACE CREA VAGIFEM TABS | Must fail all preferred products before non-preferred Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| VAGINAL - OTHER | | ACID JELLY GEL ACI-JEL GEL CERVICAL AMINO ACID CREA | | AMINO ACID CERVICAL CREA | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| BPH | | | | | | |
| BPH | | AVODART DOXAZOSIN MESYLATE TABS PROSCAR TABS TERAZOSIN HCL CAPS | 5 8 8 8 | FLOMAX CP24 CARDURA TABS HYTRIN CAPS UROXATRAL | Non-preferred products must be used in specified order. Use PA Form #20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approval of a non-preferred 5-alpha reductase inhibitor requires objective clinical evidence of a very enlarged prostate rather than just the presence of obstructive urinary outflow symptoms along with adequate trial of preferred Proscar. |
| ANXIOLYTICS | | | | | | |
| ANXIOLYTICS - BENZODIAZEPINES | | ALPRAZOLAM TABS CHLORDIAZEPOXIDE HCL CAPS CLORAZEPATE DIPOTASSIUM TABS DIAZEPAM LORAZEPAM OXAZEPAM CAPS | | ATIVAN SERAX TRANXENE XANAX TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANXIOLYTICS - LONG ACTING | | XANAX XR ¹ | | | 1. Xanax XR will be available if the long acting benzo clonazepam fails. Use PA Form # 20420 | |
| ANXIOLYTICS - MISC. | | BUSPIRONE HCL TABS HYDROXYZINE HCL SOLN HYDROXYZINE HCL SYRP HYDROXYZINE PAMOATE CAPS | | ATARAX TABS BUSPAR TABS DROPERIDOL SOLN HYDROXYZINE HCL TABS HYDROXYZINE PAM 100MG CAPS INAPSINE SOLN MEPROBAMATE TABS VISTARIL | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTI-DEPRESSANTS | | | | | | |
| ANTI-DEPRESSANTS - MAO INHIBITORS | | NARDIL TABS PARNATE TABS | | | | |
| ANTI-DEPRESSANTS - SELECTED SSRI's | | BUPROPION HCL TABS BUPROPION SR CITALOPRAM ⁶ FLUOXETINE HCL CAPS FLUOXETINE HCL LIOD FLUOXETINE HCL TABS FLUVOXAMINE MALEATE TABS LEXAPRO TABS ⁵ MIRTAZAPINE | 5 6 6 8 8 8 8 8 8 | CYMBALTA ⁷ EFFEXOR TABS EFFEXOR XR CP24 ³ CELEXA DESYREL TABS FLUOXETINE 40 mg ¹ LUVOX TABS MAPROTILINE HCL TABS PAXIL ³ | Non-preferred products must be used in specified step order. 1. Use Fluoxetine 20 mg in multiples. 2. See Zolof splitting table. Zolof requires splitting of 50mg and/or 100mg scored tabs to avoid PA. 3. Strong caution with pediatric population. 4. Established users are grandfathered. 5. See | Preferred drugs must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. At least one preferred SSRI and one preferred non-SSRI drugs must be tried. Venlafaxine is non-preferred for any anxiety diagnosis and may be approved after trials of one SSRI and one non-SSRI (e.g. any anxiolytic or a tricyclic at any dose). Preferred Fluoxetine will be the only preferred antidepressant for members who are less than 18 years of age. Exceptions to the rule are as follows: 1. If the member (<18) is already an established user for any of the preferred or non-preferred drugs under the Antidepressant category on the PDL, then they can continue to get that drug. 2. If the member (<18) has a prescription for an antidepressant that is on the PREFERRED side of the PDL and has had a 30 day supply of Fluoxetine at least 30 days before the date they are getting it filled, the claim will pay. If they do not have the trial of Fluoxetine in their profile, the claim will reject for PA required. |

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| | | PAROXETINE ³ PAXIL CR ³ SERZONE TABS TRAZODONE HCL TABS WELLBUTRIN XL ZOLOFT ² | 8 8 8 8 8 8 8 8 8 9 | PROZAC PROZAC CAPS PROZAC WEEKLY CPDR REMERON TABS SARAFEM CAPS TRAZODONE HCL 300MG TABS WELLBUTRIN TABS WELLBUTRIN SR TBCR REMERON SOLTAB TBCR | Celexa/Citalopram and Lexapro splitting tables. 6. Max daily dose allowed is 60mg, only 1 per day allowed for all strengths. Use PA Form # 20420 | 3. If the member (<18) has a prescription for a medication that is on the NON-PREFERRED side of the PDL regardless of having Fluoxetine in their profile, the prescription will need a PA. <u>Special Kid < 18yo Criteria for New Starters:</u> Must have had fluoxetine trial for at least 30 days before accessing other preferred antidepressants without PA. |
| ANTIDEPRESSANTS - TRI-CYCLICS | * | AMITRIPTYLINE HCL TABS AVENTYL SOLN CLOMIPRAMINE HCL CAPS DESIPRAMINE HCL TABS DOXEPIN HCL IMIPRAMINE HCL TABS NORTRIPTYLINE HCL PROTRIPTYLINE HCL TABS SURMONTIL CAPS | | AMOXAPINE TABS ANAFRANIL CAPS ELAVIL TABS NORPRAMIN TABS PAMELOR SINEQUAN TOFRANIL VIVACTIL TABS | *PA required for new starters if over 65 years old. Users over 65 years old are grandfathered. Use PA Form # 20420 or 102220 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| SEDATIVE / HYPNOTICS | | | | | | |
| SEDATIVE/HYPNOTICS - BARBITURATE | | BUTISOL SODIUM TABS CHLORAL HYDRATE SYRUP MEBARAL TABS PHENOBARBITAL | | LUMINAL SOLN SECONAL CAPS SOMNOTE CAPS | PA required for new users of preferred products if over 65 years old. Use PA Form # 30110 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| SEDATIVE/HYPNOTICS - BENZODIAZEPINES | | DORAL TABS ESTAZOLAM TABS FLURAZEPAM HCL CAPS TEMAZEPAM CAPS TRIAZOLAM TABS | | DALMANE HALCION TABS MIDAZOLAM HCL SYRUP PROSOM TABS RESTORIL CAPS | Previous quantity limits still apply. Use PA Form # 30110 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Benzodiazepines do cause dependence with continued use and usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 Days per week max) is the standard of care |
| SEDATIVE/HYPNOTICS - Non-Benzodiazepines | | TRAZODONE MIRTAZAPINE MIRTAZAPINE | 5 7 8 | LUNESTA AMBIEN SONATA CAPS | Elderly (over 65) exempt, but previous quantity limits still apply. Use PA Form # 30110 | Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ambien and Sonata do cause dependence with continued use and as with benzodiazepines, usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 days per week max) is the standard of care. Please see Sedative/Hypnotic PA form. |
| ANTI-PSYCHOTICS | | | | | | |
| ANTI-PSYCHOTICS - ATYPICALS | | RISPERDAL GEODON ¹ SEROQUEL TABS ⁴ ABILIFY TABS ² ZYPREXA TABS ³ ZYPREXA ZYDIS TBCR | 5 8 8 | ABILIFY TABS ² RISPERDAL M TAB RISPERDAL CONSA | 1. Geodon has dose consolidation edit of 2 per day. 2. Abilify 1/day. 3. Zyprexa: maximal recommended dose showing efficacy is 20mg. Use PA Form # 20420 | Preferred drugs subject to step order must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Atypicals will be approved, subject to step-order, for patients with FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality and as long as all first line preferred therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). * Abilify: doses above 15mg were not shown to be more effective than doses in the 10-15mg range. 4. Seroquel 25mg is available without PA if the following conditions are met: a. 65 years old or older, and dosage is for 3 or more per day, and Seroquel 25mg is in the profile within the last 45 days. |
| ANTI-PSYCHOTICS - SPECIAL ATYPICALS | | CLOZAPINE TABS | | CLOZARIL TABS FAZACLO | Use PA Form # 20420 | Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved. |
| ANTI-PSYCHOTICS - TYPICAL | | CHLORPROMAZINE HCL FLUPHENAZINE DECANOATE FLUPHENAZINE HCL HALDOL HALOPERIDOL HALOPERIDOL DECANOATE SOLN HALOPERIDOL LACTATE SOLN LOXAPINE SUCCINATE CAPS LOXITANE-C CONC MOBAN TABS PERPHENAZINE PROCHLORPERAZINE SERENTIL THIORIDAZINE HCL THIOTHIXENE THORAZINE SUPP TRIFLUOPERAZINE HCL TABS | | COMPAZINE COMPRO SUPP HALDOL DECANOATE LOXITANE CAPS MELLARIL NAVANE CAPS PROLIXIN STELAZINE TABS THORAZINE | Use PA Form # 120420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| LITHIUM | | | | | | |
| LITHIUM | | ESKALITH CAPS ESKALITH CR TBCR LITHIUM CARBONATE LITHIUM CITRATE SYRUP | | | | |
| COMBINATION - PSYCHOTHERAPEUTIC | | | | | | |
| PSYCHOTHERAPEUTIC COMBINATION | | CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN | 8 | SYMBYAX | Use PA Form # 20420 | Use individual components, which are currently available without a PA. |
| STIMULANTS | | | | | | |

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| STIMULANT - AMPHETAMINES - SHORT ACTING | | ADDERALL TABS AMPHETAMINE SALT COMBO DEXEDRINE DEXTRAMPHET SULF TABS DEXTROSTAT TABS | | | Preferred stimulants will be available without PA if diagnosis of ADHD As per recent FDA alert. Adderall should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. | |
| STIMULANT - LONG ACTING AMPHETAMINES SALT | | ADDERALL XR CP24 | | | Preferred stimulants will be available without PA if diagnosis of ADHD As per recent FDA alert. Adderall should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. | |
| LONG ACTING AMPHETAMINES | | DEXEDRINE CAP CR DEXTRAMPHET SULF CPCR | | | | |
| STIMULANT - METHYLPHENIDATE | | FOCALIN TABS METADATE ER TBCR METHYLIN ER TBCR METHYLIN TABS METHYLIN SOL METHYLPHENIDATE HCL | | METHYLIN CHEWABLES RITALIN | Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| STIMULANT - METHYLPHENIDATE - LONG ACTING | 1 | CONCERTA TBCR | 5 8 | METADATE CD CPCR ¹ RITALIN LA | Preferred stimulants will be available without PA if diagnosis of ADHD. Non-preferred products must be used in specified step order. 1. Easily approved for patients needing the sprinkles. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| STIMULANT - STIMULANT LIKE | | | 7 8 8 8 8 8 9 | STRATTERA ^{1,2} CAFCIT SOLN CYLERT CHEW CYLERT TABS DESOXYN TABS PROVIGIL TABS PEMOLINE | 1. Required failure of both an amphetamine and methylphenidate (unless history of substance abuse). 2. Strattera allowed only 1 per day for all strengths except 40mg, where 2 are allowed to achieve 80mg or 100mg daily. 3. Non-preferred products must be used in specified step order. Provigil: use PA Form # 20710; Others: use Pa Form # 20420 | Requests for Provigil. Please refer to criteria detailed on Provigil PA form. |
| WEIGHT LOSS | | | | | | |
| WEIGHT LOSS | | | | | No longer covered: PHENTERMINE, XENICAL, DIDREX, and MERIDIA | Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy. |
| ALZHEIMER DISEASE | | | | | | |
| ALZHEIMER - Cholinomimetics/Others | | ARICEPT TABS ¹ EXELON ¹ NAMENDA ¹ RAZADYNE ¹ REMINYL ¹ | 9 | COGNEX CAPS | 1. All new users need PA to establish dementia diagnosis and baseline mental status score. Must fail all preferred products before moving to not preferred. Use PA Form #20420 | Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| SMOKING CESSATION | | | | | | |
| NICOTINE PATCHES / TABLETS | | NICODERM CQ PT24 | | | Bupropion SR 150 mg is available without a prior authorization. | Only Nicoderm and the generic nicotine gums are covered by MaineCare at this time. All other nicotine products (OTC & prescription) are non-covered as allowed by Federal Medicaid law. Another version of Zyban, Bupropion SR (100 and 150mg) is available without PA. |
| NICOTINE REPLACEMENT - | | NICOTINE POLACRILEX GUM | | COMMIT LOZENGES ¹ | 1. Available to patients unable | Only Nicoderm and the generic nicotine gums are covered by MaineCare at this time. All other nicotine products (OTC & prescription) are non-covered as allowed by Federal Medicaid |

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| OTHER | | | | to tolerate preferred products. Use PA Form # 20420 | law. Another version of Zyban, Bupropion SR (100 and 150mg) is available without PA. | |
| ALCOHOL DETERRENTS | | | | | | |
| ALCOHOL DETERRENTS | | DISULFIRAM TABS ANTABUSE TABS NALTREXONE HCL TABS CAMPRAL ¹ | | 1. Should only be used in conjunction with formal structured outpatient detoxification program. | Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| MISCELLANEOUS ANALGESICS | | | | | | |
| ANALGESICS - MISC. | | ACEPHEN SUPP ACETAMIN TAB 325MG ACETAMINOPHEN ASPIRIN ASPIRIN EC ASPIR-LOW TBEC BUFFERED ASPIRIN TABS BUTAL/ASA/CAFF BUTALBITAL COMPOUND BUTALBITAL/ACET TABS BUTALBITAL/APAP CAPS BUTALBITAL/APAP/CAFFEINE CHILDRENS ASPIRIN CHEW CHILDRENS PAIN RELIEVER CHOLINE MAGNESIUM TRISAL DIFLUNISAL TABS ECOTRIN FEVERALL SUPP GENAPAP GENEBS TABS HEADACHE FORMULA ADDED TABS INFANTAIRE SOLN INFANTS APAP SOLN INFANTS PAIN RELIEVER SUSP MAPAP PAIN RELIEVER Q-NOL TABS SALSALATE TABS TACTINAL EXTRA STRENGTH TABS TYLENOL V-R CHILDRENS ASPIRIN CHEW V-R NON-ASPIRIN TABS | ASPIR-81 TBEC AXOCET CAPS DOLOBID TABS EASPRIN TBEC EQUAGESIC TABS ESGIC-PLUS EXCEDRIN TAB ASA FRE FIORICET TABS FIORINAL CAPS FIORTAL CAPS FORTABS TABS PHRENILIN TABS PHRENILIN FORTE CAPS TRILISATE LIQD TRILISATE TABS ZEBUTAL CAPS ZORPRIN TBCR | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| LONG ACTING NARCOTICS | | | | | | |
| NARCOTICS - LONG ACTING | | KADIAN CP24 AVINZA METHADONE METHADOSE | 7 8 8 8 8 8 9 | DURAGESIC PT72 ¹ ORAMORPH SR TB12 MORPHINE SULFATE ER TB12 MORPHINE SULFATE SUPP MS CONTIN TB12 OXYCODONE ER OXYCONTIN TB12 ¹ | Non-preferred products must be used in specific order. 1. Duragesic and Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable. Use PA Form # 20510 | Preferred drugs (Kadian or Avinza and Methadone or Methadose) and step order drugs must be tried for at least 2 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance abuse such as: 1. Frequent or persistent early refills of controlled drugs; 2. Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.; 3. Breaches of narcotic contracts with any provider; 4. Failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass pill counts; 5. Failing to take or pass random drug testing; 6. Failing to provide old records re prior use of narcotics; 7. Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of; 8. Documented history of substance abuse. Substance abuse evaluations may be required for patients with medical records displaying documented substance abuse or potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. 9. Circumventing MaineCare prior authorization requirements for narcotics by paying cash for affected narcotics (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). 10. Requests for any Brand name controlled substance, considered by authorities to be highly abused and diverted (Oxycontin, Percocet, Tylox, Vicodin, Dilaudid, Ultracet...) with an available AB rated generic equivalent will be denied unless it will be provided in a setting that virtually eliminates the risk of diversion. 11. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. |
| NARCOTICS - SELECTED | | TRAMADOL HCL TABS | | BUPRENEX SOLN BUTORPHANOL NALBUPHINE HCL SOLN NUBAIN SOLN STADOL NS SOLN ULTRACET TABS ULTRAM TABS | Use PA Form # 20420 | Preferred drugs from this and other narcotic classes must be tried for at least 2 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs from this class will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but desired product. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance abuse such as: 1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel; 3. breaches of narcotic contracts with any |

provider; 4. failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass pill counts; 5. failing to take or pass random drug testing; 6. failing to provide old records regarding prior use of narcotics; 7. receiving controlled substances from other prescribers that the provider submitting the PA is unaware of. In substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.

MISCELLANEOUS NARCOTICS

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| NARCOTICS - MISC. | <p>ACETAMINOPHEN/CODEINE ACTIQ LPOP¹ ASPIRIN/CODEINE TABS BUTAL/ASA/CAFF/COD CAPS BUTALBITAL/ASPIRIN/CAFFEI CAPS CAPITAL AND CODEINE SUSP¹ CAPITAL/CODEINE SUSP¹ CODEINE PHOSPHATE SOLN CODEINE SULFATE TABS ENDOCET 5/325mg TABS² ENDODAN TABS FENTANYL CITRATE SOLN HYDROCODONE BITARTRATE/AP TABS HYDROCODONE/ACETAMINOPHEN HYDROMORPHONE HCL MEPERIDINE HCL OXYCODONE OXYCODONE/ACETAMINOPHEN² PENTAZOCINE/NALOXONE TABS PROPOXYPHENE COMPOUND CAPS PROPOXYPHENE CMPND-65 CAPS PROPOXYPHENE HCL CAPS PROPOXYPHENE/ACET TABS PROPOXYPHENE-N/ACET TABS ROXICET ROXIPRIN TABS SUBOXONE</p> | <p>ANEXSIA TABS ASCOMP/CODEINE CAPS BUTALBITAL/APAP/CAFFEINE/ CAPS DARVOCET-N DARVON DEMEROL DILAUDID DILAUDID-HP SOLN FIORICET/CODEINE CAPS FIORINAL/CODEINE #3 CAPS FIORTAL/CODEINE CAPS HYDROCODONE/IBUPROFEN LORCET LORTAB MAXIDONE TABS NORCO TABS PENTAZOCINE/ACET TABS PERCOCET TABS PERCODAN TABS PHRENILIN W/CAFFEINE/CODE CAPS ROXICET 5/500 TABS SYNALGOS-DC CAPS TALACEN TABS TALWIN NX TABS TYLENOL/CODEINE #3 TABS TYLOX CAPS VICODIN VICOPROFEN TABS ZYDNE TABS</p> | <p>1. ACTIQ lollypop and Capital and codeine suspension products require PA for users over 18 years of age. 2. Endocet and oxycodone/acet 10/650 is 8 times more expensive. Use twice as many of oxycod/acet 5/325 instead. You can mix and match preferred strengths of oxycodone and oxycodone/acet to minimize acet. dose similar to certain non-preferred drugs.</p> <p>Use PA Form # 20420</p> | <p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.</p> |
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NARCOTIC ANTAGONISTS

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| NARCOTIC - ANTAGONISTS | NALTREXONE HCL TABS | REVIEW TABS | Use PA Form # 20420 | Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version. |
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COX 2 / NSAIDS

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| NSAID - PPI COX 2 INHIBITORS - HIGHLY SELECTIVE | PREVACID NAPRA-PAC CELEBREX CAPS | | Cox-2 available to 60 yr and over w/o PA, under 60 yr. requires PA. If you are trying to decrease the risk of GI bleeding, try generic NSAID and omeprazole, or Prevacid NAPRA-PAC Use PA Form # 10310 | Approved without PA for patients 60 years old or over. Patients under 60 can use a preferred proton pump inhibitor with any preferred generic NSAID to achieve similar reductions in GI bleeding risk to that seen with the COX-II agents. Approvals for Mobic will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form. High risk GI bleeding patients must fail on adequate trials of safer agents (non-NSAID/Cox-2) for GI tract, such as acetaminophen. |
| COX 2 INHIBITORS - SELECTIVE | KETOROLAC TROMETHAMINE MOBIC ¹ NABUMETONE TABS | RELAFEN TABS TORADOL | 1. Available to 60 yr and over w/o PA, under 60 yr. requires PA. If you are trying to decrease the risk of GI bleeding, try generic NSAID and omeprazole, or Prevacid NAPRA-PAC. Use PA Form # 10310 | Approved without PA for patients 60 years old or over. Patients under 60 can use a preferred proton pump inhibitor with any preferred generic NSAID to achieve similar reductions in GI bleeding risk to that seen with the COX-II agents. Approvals for Mobic will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form. High risk GI bleeding patients must fail on adequate trials of safer agents (non-NSAID/Cox-2) for GI tract, such as acetaminophen. |
| NSAIDS | CHILDRENS IBUPROFEN CHILDRENS MOTRIN SUSP DICLOFENAC POTASSIUM TABS DICLOFENAC SODIUM ETODOLAC FENOPROFEN CALCIUM TABS FLURBIPROFEN TABS IBUPROFEN INDOMETHACIN KETOPROFEN MECLOFENAMATE SODIUM CAPS NAPROSYN SUSP NAPROXEN SUSP | ADVIL TABS ANAPROX TABS ANAPROX DS TABS ANSAID TABS CATAFLAM TABS CHILDRENS ADVIL SUSP CHILD'S IBUPROFEN SUSP CLINORIL TABS DAYPRO TABS EC-NAPROSYN TBEC ETODOLAC ER 600MG FELDENE CAPS IBU-200 | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form. |

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| | | NAPROXEN TABS NAPROXEN SODIUM TABS OXAPROZIN TABS PIROXICAM CAPS SULINDAC TABS TOLMETIN SODIUM | | INDOCIN LODINE MOTRIN NALFON CAPS NAPRELAN TBCR NAPROSYN TABS NAPROXEN DR. TBEC NAPROXEN SODIUM TBCR ORUVAIL CP24 PONSTEL CAPS SB IBUPROFEN TABS TOLECTIN VOLTAREN V-R IBUPROFEN TABS | | |
| RHEUMATOID ARTHRITIS | | | | | | |
| RHEUMATOID ARTHRITIS | 1 1 1 1 2 | AZATHIOPRINE HYDROXYCHLOROQUINE METHOTREXATE SULFASALAZINE TABS ARAVA TABS ¹ | 5 8 8 8 | ENBREL KIT HUMIRA KINERET SOLN REMICADE | 1. No PA for Arava if methotrexate previously tried. Use PA Form # 10510 | See criteria as listed on Rheumatoid Arthritis PA form. |
| MISCELLANEOUS ARTHRITIS | | | | | | |
| ARTHRITIS - MISC. | | RIDAURA CAPS MYOCHRYSLINE SOLN | | ARTHROTEC ¹ | 1. The individual components of Arthrotec are available without PA. Use PA Form # 10110 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The individual components of Arthrotec are available without PA. |
| MIGRAINE THERAPIES | | | | | | |
| MIGRAINE - ERGOTAMINE DERIVATIVES | | MIGRANAL SOLN SANSERT TABS | | D.H.E. 45 SOLN | Use PA Form # 10110 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| MIGRAINE - CARBOXYLIC ACID DERIVATIVES | | DEPAKOTE ER TB24 | | | | |
| MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)- Tabs | 1 1 1 2 3 4 4 | IMITREX TABS MAXALT MLT RELPAX AXERT TABS ¹ AMERGE TABS ZOMIG TABS ZOMIG ZMT TBDP | | FROVA TABS MAXALT | 1. Must fail Imitrex, Maxalt MLT and Relpax products before moving to next step product without PA Use PA Form # 10110 | Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form. |
| MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)- Injectables | | IMITREX KIT IMITREX STATDOSE PEN KIT IMITREX STATDOSE REFILL KIT | | IMITREX SOLN | Use PA Form # 10110 | |
| MIGRAINE - MISC. | | CAFERGOT SUPP CAFERGOT TABS SPASTRIN TABS | | MIGRAZONE CAPS BELCOMP-PB SUPP | Use PA Form # 10110 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| GOUT | | | | | | |
| GOUT | | ALLOPURINOL TABS COLCHICINE TABS PROBENECID TABS PROBENECID/COLCHICINE TABS SULFINPYRAZONE TABS | | ZYLOPRIM TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| MISC. | | | | | | |
| ANESTHETICS - MISC. | | BUPIVACAINE HCL SOLN LIDOCAINE HCL SOLN MARCAINE SOLN | | SENSORCAINE-MPF SOLN SYNWISC INJ XYLOCAINE SOLN | Use PA Form # 30130 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTI-CONVULSANTS | | | | | | |
| ANTI-CONVULSANTS | | CARBAMAZEPINE CARBATROL CP12 CELONTIN CAPS CLONAZEPAM TABS DEPAKOTE TBEC DEPAKOTE SPRINKLES CPSP DIASTAT ¹ DILANTIN EPITOL TABS ETHOSUXIMIDE SYRP FELBATOL LAMICTAL MYSOLINE TABS | 8 8 8 8 8 8 8 8 8 8 8 9 | DEPAKENE GABAPENTIN GABITRIL TABS KEPPRA TABS KLONOPIN TABS PRIMIDONE TABS TOPAMAX TRILEPTAL ZARONTIN SYRP ZONEGRAN CAPS NEURONTIN | 1. Quantity limit. 5/month 2. 200 mg requires a PA. Use two 100 mg instead. Pharmaceutical supply issues will delay implementation until further notice. All non-preferred meds must be used in specified order Use PA Form # 20420 | Seizure patients will be approved for any anticonvulsant. Other approvals will be for patients with a variety of drug-specific FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality after recommendation by the DUR Committee and as long as all first line therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). Topamax - Second line therapy for migraine prophylaxis. *** SEE CHART AT END OF DOCUMENT |

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| | | PHENYTOIN PHENYTEK CAPS TEGRETOL ² TEGRETOL-XR TB12 VALPROIC ACID ZARONTIN CAPS | A - B 4 - 4 5 - 5 9 - 6 9 - 7 9 - 8 9 - 9 9 - 9 | BIPOLAR DISORDER: STEP ORDER LAMICTAL TRILEPTAL TOPAMAX KEPPRA TABS GABITRIL TABS NEURONTIN ZONEGRAN CAPS PEDIATRIC BIPOLAR 1 DISORDER: STEP ORDER A - B (6-18 YEARS WITH OR WITHOUT PSYCHOSIS) 1 - 1 1 - 1 1 - 1 1 - 1 1 - 1 5 - 5 6 - 6 | See review in DUR section of website. A= Monotherapy B= Adjunctive 9= No Evidence The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Two step 1 preferred drugs must be tried before Trileptal. |
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ANTI-PARKINSON DRUGS

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| PARKINSONS - ANTICHOLINERGICS | | AKINETON TABS BENZTROPINE MESYLATE TABS COGENTIN SOLN KEMADRIN TABS TRIHENXYPHENIDYL | | | |
| PARKINSONS - COMT INHIBITORS | | COMTAN TABS | | TASMAR TABS | Use PA Form # 20420 Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| PARKINSONS - SELECTED DOPAMIN AGONISTS | 1 1 2 | MIRAPEX TABS REQUIP TABS PERGOLIDE MESYLATE TABS | | PERMAX | Both Mirapex and requip must be used before Pergolide. Use PA Form # 20420 Preferred drug must be tried and failed in step-order due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| PARKINSONS - DOPAMINERGICS/CARBI/ LEVO | | AMANTADINE HCL BROMOCRIPTINE MESYLATE CARBIDOPA/LEVODOPA TABS CARBIDOPA/LEVODOPA ER LARODOPA TABS LODOSYN TABS SELEGILINE HCL | | APOKYN* ELDEPRYL CAPS PARLODEL CAPS PARLODEL TABS SINEMET TABS SINEMET TBCR SYMMETREL TABS | Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| PARKINSONS - COMBO. | | STALEVO | | | |

MUSCLE RELAXANTS

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|--------------------------|--|---|---|---|--|
| ALS DRUG | | RILUTEK TABS | | | |
| MUSCLE RELAXANTS | | BACLOFEN TABS CHLORZOXAZONE TABS CYCLOBENZAPRINE HCL TABS LIORESAL INTRATHECAL KIT METHOCARBAMOL TABS | 7 7 8 8 8 8 8 8 8 9 9 | ORPHENADRINE CITRATE TIZANIDINE HCL TABS CARISOPRODOL TABS ¹ DANTRIUM CAPS FLEXERIL TABS LIORESAL TABS NORFLEX TBCR ROBAXIN-750 TABS ZANAFLEX TABS SKELAXIN TABS SOMA TABS | 1. Effective October 1, 2003 even Carisoprodol requires PA. Non-preferred products must be used in specified step order. Both step 7's must be tried. Use PA Form # 20420 At least 3 preferred drugs must be tried for at least 2 weeks and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Elderly patients, over 65, will require written notice of the increased sedative risks and impaired driving. Prior Authorization will not be given for: 1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc. |
| MUSCLE RELAXANT - COMBO. | | | | CARISOPRODOL/ASPIRIN TABS CARISOPRODOL/ASPIRIN/CODE NORGESIC TABS ORPHENADRINE COMPOUND ORPHENADRINE/ASA/CAFF ORPHENGESIC | Use PA Form # 20420 Individual components are available with PA described in the section above. 1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant travel, etc. |

VITAMINS

****Preferred products that used to require diag codes still require diag codes unless indicated otherwise.****

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| VITAMINS | | ASCORBIC ACID TABS BIOTIN CYANOCOBALAMIN SOLN FOLGARD RX 2.2 TABS FOLIC ACID TABS FOLTX TABS MEPHYTON TABS NIACIN NIACOR TABS | | AQUASOLE SOLN AQUAVIT-E SOLN DHT SOLN NASCOBAL GEL | Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval. |
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| | NICOTINIC ACID SR CPCR PYRIDOXINE HCL TABS SLO-NIACIN TBCR THIAMINE HCL SOLN VITAMIN B-1 TABS VITAMIN B-12 VITAMIN B-6 TABS VITAMIN C VITAMIN E CAPS VITAMIN E/D-ALPHA CAPS VITAMIN K1 SOLN V-R VITAMIN E CAPS | | | |
| VITAMIN D's | CALCIFEROL SOLN ¹ CALCITRIOL CAPS ¹ DRISDOL SOLN ¹ VITAMIN D ^{1,2} | DRISDOL CAPS CALCJEX HECTOROL (ORAL) HECTOROL (PARENTERAL) ROCALTROL ZEMPLAR | 1. Diagnosis of dialysis (renal failure) required. 2. OTC Vitamin D no diagnosis required. | Preferred products require dialysis/renal failure diagnosis. Non-preferred products require: Secondary hyperparathyroidism in patients with Chronic Kidney Disease on dialysis., iPTH>400 pg/ml, Phosphorous .6.5mg/dl, corrected calcium <12.2mg/dl, corrected calcium x phosphorous products <70mg ² /dl ² |

MISC MULTI-VITAMINS

****Preferred products that used to require diag codes still require diag codes unless indicated otherwise.****

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| <p>VITAMINS - MISC.</p> | <p>CENTRUM LIOD CENTRUM TABS CENTRUM JR/IRON CHEW CENTRUM SILVER TABS CENTRUM-LUTEIN TABS CEROVITE ADVANCED FO TABS CHEWABLE MULTIVIT/FL CHEW COD LIVER OIL CAPS COMPLETE SENIOR TABS DAILY MULTI VIT/IRON M.V.I.-12 INJ MULTI-VIT/FLUORIDE NATACHEW CHEW NATALCARE RX TABS NEPHRO-VITE TABS OCUVITE TABS ONE DAILY TABS ONE-DAILY MULTIVITAMINS ONE-TABLET-DAILY POLY-VIT/IRON/FLUORID SOLN POLY-VITAMIN/FLUORIDE SOLN POLY-VITAMINS/IRON SOLN PRENATAL TABS PRENATAL FORMULA 3 TABS PRENATAL PLUS TABS PRENATAL PLUS NF TABS PRENATAL PLUS/27MG IRON PRENATAL PLUS/IRON TABS PRENATAL RX/BETA-CAROTENE PROTEGRA CAPS STRESS TAB NF TABS THERAPEUTIC-M TABS THERAVITE LIOD TRI-VITAMIN/FLUORIDE SOLN VITA CON FORTE CAPS VITAMIN B COMPLEX CAPS VITAPLEX PLUS TABS</p> | <p>ADEKS ADVANCED NATALCARE TABS CENTRUM JR/EXTRA C CHEW CENTRUM PERFORMANCE TABS DALYVITE LIOD EMBEX 600 MISC IBERET MATERNA TABS MULTIRET FOLIC -500 TBCR NATAFORT TABS NATALCARE CFE 60 TABS NATALCARE GLOSS TABS NATALCARE PIC TABS NATALCARE PIC FORTE TABS NATALCARE PLUS TABS NATALCARE THREE TABS NATALFIRST TABS NATATAB RX TABS NEPHPLEX RX TABS NEPHROCAPS CAPS NESTABS RX TABS NIFEREX NUTRINATE CHEW POLY-VI-FLOR SOLN POLY-VI-SOL SOLN POLY-VI-SOL/IRON SOLN POLY-VITAMIN DROPS SOLN PRECARE PREMESIS RX TABS PRENATABS CBF TABS PRENATAL 19 CHEW PRENATAL CARE TABS PRENATAL MR 90 TBCR PRENATAL MTR/SELENIUM TABS PRENATAL OPTIMA ADVANCE TABS PRENATAL PC 40 TABS PRENATAL RX TABS PRENATE PRIMACARE MISC RENAL CAPS RENAPHRO CAPS RENA-VITE RX TABS STUARTNATAL PLUS 3 TABS TRI-VI-SOL SOLN TRI-VI-SOL/IRON SOLN ULTRA NATALCARE TABS ULTRA-NATAL TABS VICON FORTE CAPS VINATAL FORTE TABS VINATE VINATE ADVANCED TABS</p> | <p>Diag codes are no longer required on prenatal vitamins. Use PA Form # 20420</p> | <p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.</p> |
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MISCELLANEOUS MINERALS

****Preferred products that used to require diag codes still require diag codes unless indicated otherwise.****

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| <p>MINERALS</p> | <p>CALCARB CALCI-MIX CAPSULE CAPS CALCIQUID SYRP CALCITRATE/VITAMIN D TABS CALCIUM CALCIUM CARBONATE CALCIUM CITRATE TABS CALCIUM GLUCONATE TABS CALCIUM LACTATE TABS CALCIUM/MAGNESIUM TABS CALCIUM/VITAMIN D TABS CALTRATE 600 TABS CHEWABLE CALCIUM CHEW CITRACAL TABS</p> | <p>ANEMAGEN CALCET TABS CALCIUM 600-D TABS CALCIUM/VITAMIN D TABS CALTRATE 600 PLUS/VIT D TABS CALTRATE PLUS TABS CHROMAGEN CITRACAL PLUS TABS CONTRIN CAPS FEOGEN FORTE CAPS FEROCON CAPS FERREX 150 CAPS FERRO-SEQUELS TBCR FE-TINIC CAPS</p> | <p>Use PA Form # 20420</p> | <p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.</p> |
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CITRACAL + D TABS
 CITRUS CALCIUM TABS
 CITRUS CALCIUM 1500 + D TABS
 DEXFERRUM SOLN
 EFFERVESCENT POTASSIUM TBEF
 FEOSTAT CHEW
 FERATAB TABS
 FER-GEN-SOL SOLN
 FERGON TABS
 FER-IN-SOL SOLN
 FER-IRON SOLN
 FERRONATE TABS
 FERROUS FUMARATE TABS
 FERROUS GLUCONATE TABS
 FERROUS SULFATE
 FLUOR-A-DAY CHEW
 FLUORIDE CHEW
 FLUORIDE SODIUM CHEW
 FLUORITAB CHEW
 HEMOCYTE TABS
 HM CALCIUM TABS
 K+ POTASSIUM PACK
 KAON ELIX
 KAON-CL-10 TBCR
 KCL 0.075%/D5W/NACL 0.2% SOLN
 K-EFFERVESCENT TBEF
 KLOR-CON
 KLOTRIX TBCR
 K-PHOS TABS
 K-VESCENT TBEF
 LURIDE CHEW
 MAGNESIUM GLUCONATE TABS
 MAGNESIUM SULFATE SOLN
 MICRO-K CPCR
 NEUTRA-PHOS
 OS-CAL TABS
 OS-CAL 500 + D TABS
 OYSCO
 OYST-CAL TABS
 OYST-CAL D TABS
 OYST-CAL/VITAMIN D TABS
 OYSTER CALCIUM TABS
 OYSTER SHELL
 PHOSPHA 250 NEUTRAL TABS
 POTASSIUM BICARBONATE TBEF
 POTASSIUM CHLORIDE
 POTASSIUM EFFERVESCENT
 SELENIUM TABS
 SLOW-MAG TBCR
 SODIUM FLUORIDE
 SSKI SOLN
 V-R CALCIUM
 V-R OYSTER SHELL CALCIUM
 ZINC SULFATE CAPS

FE-TINIC 150 FORTE CAPS
 FLUOR-A-DAY SOLN
 K-DUR TBCR
 KLOR-CON PACK
 K-LYTE
 K-PHOS TABS
 K-TABS TBCR
 K-VESCENT PACK
 NU-IRON 150 CAPS
 OYSTER SHELL CALCIUM/VITA TABS
 POLY-IRON 150 CAPS
 POLYSACCHARIDE IRON CAPS
 POTASSIUM BICARB/CHLORIDE
 SLOW FE TBCR
 TUMS 500 CHEW
 VIACTIV CHEW

MISC. ELECTROLYTES/NUTRITIONALS

FISH OIL CAPS
 INTRALIPID EMUL
 MCT OIL OIL
 ORALYTE SOLN
 P.T.E. -5 SOLN
 PEDIALYTE SOLN

BOOST
 CASEQ POWD
 CHOICE DM LIQD
 DELIVER 2.0 LIQD
 ENFAMIL
 ENSURE
 GLUCERNA
 ISOCAL LIQD
 KINDERCAL TF LIQD
 KINDERCAL TF/FIBER LIQD
 L-CARNITINE CAPS
 LIPISORB LIQD

This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred. SGA form required for nutritionals unless member has a GI tube.

Use PA Form # 20420 & SGA Form

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.

| | | | | | | |
|--|--|---|--|---|---|--|
| | | | | MODULEN IBD POWD NUTRAMIGEN POWD NUTREN NUTRITIONAL SUPPLEMENT LIQD NUTRIVENT 1.5 LIQD PEPTAMEN PHENYL-FREE PKU 3 POWD PREGESTIMIL POWD PROBALANCE LIQD PROSOBEE SCANDISHAKE PACK | | |
| ERYTHROPOEITINS | | | | | | |
| ERYTHROPOEITINS | | | 5 PROCRIT SOLN ¹ 6 EPOGEN SOLN 8 ARANESP SOLN | 1. All products require PA but Procrit is first choice. Still must be used in specified step order. Use PA Form # 20420 | Non-Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the EPO PA form for other approval and renewal criteria. | |
| GRANULOCYTE CSF | | | | | | |
| GRANULOCYTE CSF | | | 8 LEUKINE 8 NEUPOGEN SOLN ¹ 9 NEULASTA | Must be used in specified step order. 1. 10 day supply/month may be used without a PA. Use PA Form # 20520 | See approval criteria detailed on Neupogen PA form. | |
| ANTICOAGULANTS / PLATELET AGENTS | | | | | | |
| ANTICOAGULANTS | | ARIXTRA SOLN FRAGMIN INJ ¹ HEPARIN SODIUM/NACL 0.9% SOLN HEP-LOCK SOLN INNOHEP LOVENOX SOLN ¹ WARFARIN SODIUM TABS HEPARIN LOCK SOLN HEPARIN LOCK FLUSH SOLN HEPARIN SODIUM SOLN HEPARIN SODIUM LOCK FLUSH SOLN JANTOVEN | COUMADIN TABS IPRIVAS C | 1. Fragmin and Lovenox therapy durations greater than 7 days require PA. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA. | |
| ANTIHEMOPHILIC AGENTS | | ALPHANATE BENEFIX SOLR BIOCLATE HELIXATE FS KIT HEMOFIL - M HUMATE-P SOLR KOGENATE FS KONYNE - 80 MONARC - M MONOCLATE - P MONONINE NOVOSEVEN SOLR PROPLEX - T RECOMBINATE SOLR REFACTO | ADVATE ^{1,2} | 1. Only if other products unavailable. 2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access. Use PA Form # 20420 | Non-preferred will only be approved if other preferred products are unavailable. | |
| PLATELET AGGREGATION INHIBITORS | | ASPIRIN DIPYRIDAMOLE TABS PLAVIX TABS ¹ | 7 TICLOPIDINE HCL TABS 8 PERSANTINE TABS 8 TICLID TABS | Use PA Form # 20420 1. As of 04.01.2005 Plavix is only available without PA if concurrent aspirin use (on prescription) within 100 days or documented failure or intolerance or other contraindication to aspirin. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| PLATELET AGGR. INHIBITORS/ COMBO'S - MISC. | | PENTOXIFYLLINE ER TBCR CILOSTAZOL | AGGRENOX CP12 ¹ AGRYLIN CAPS PLETAL TABS TRENAL TBCR | 1. Aspirin and dipyridamole are available separately without PA. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| HEMOSTATIC | | | | | | |
| HEMOSTATIC | | AMICAR AMINOCAPROIC ACID | | | | |
| OPHTHALMICS | | | | | | |

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|---|------------------|--|---|---|--|
| OP. - ANTIBIOTICS | | AK-SPORE OINT BACITRACIN OINT BACITRACIN/NEOMYCIN/POLYM BACITRACIN/POLYMYXIN B OINT CHLOROPTIC SOLN ERYTHROMYCIN OINT GENTAMICIN SULFATE NEOMYCIN/POLYMYXIN/GRAMIC NEOSPORIN SOLN POLYSPORIN SODIUM SULFACETAMIDE SOLN SULFACETAMIDE SODIUM TERRAMYCIN OINT TOBRAMYCIN SULFATE SOLN TRIMETHOPRIM SULFATE/POLY VIROPTIC SOLN | AK-POLY-BAC OINT AK-SULF OINT AK-TOB SOLN BLEPH-10 SOLN GENTAK ILOTYCIN OINT NEOMYCIN/BACI/POLYM OINT NEOSPORIN OINT OCUSULF-10 SOLN OCUTRICIN SOLN TERAK OINT TOBREX OINT TRIFLURIDINE SOLN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| OP. - QUINOLONES | 1 1 1 2 | CIXOXAN OINT CIXOXAN SOLN OCUFLOX SOLN QUIXIN SOLN | | Step order must be followed to avoid PA. Must fail Ocuflox and a Cixoxan product before moving to next step product without PA. Use PA Form # 20420 | Preferred drugs must be tried in step-order and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| OP. QUINOLONES - 4TH GENERATION | | VIGAMOX | ZYMAR | | |
| OP. - ARTIFICIAL TEARS AND LUBRICANTS | | AKWA TEARS OINT ARTIFICIAL TEARS OINT ARTIFICIAL TEARS SOLN CELLUVISC SOLN EYE LUBRICANT OINT GENTEAL LIQUITEARS SOLN MAJOR TEARS SOLN PURALUBE OINT PURALUBE TEARS SOLN REFRESH SOLN OP REFRESH PLUS SOLN | AKWA TEARS SOLN ARTIFICIAL TEARS SOLN OP BION TEARS SOLN DRY EYES OINT DURATEARS OINT HYPO TEARS ISOPTO TEARS SOLN LACRI-LUBE LUBRIFRESH P.M. OINT MURINE SOLN MUROCEL SOLN NATURE'S TEARS SOLN REFRESH SOLN REFRESH TEARS SOLN REFRESH-PM OINT TEARGEN SOLN TEARISOL SOLN TEARS NATURALE TEARS PURE SOLN TEARS RENEWED OINT THERATEARS SOLN V-R ARTIFICIAL TEARS SOLN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| OP. - BETA - BLOCKERS | | BETIMOL SOLN BETOPTIC-S SUSP CARTEOLOL HCL SOLN LEVOBUNOLOL HCL SOLN METIPRANOLOL SOLN TIMOLOL MALEATE SOLN TIMOLOL MALEATE SOLG (GEL) | BETAGAN SOLN BETAXOLOL HCL SOLN ISTALOL OCUPRESS SOLN OPTIPRANOLOL SOLN TIMOPTIC SOLN TIMOPTIC-XE SOLG | Use Pa Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH. | | AK-SPORE HC OINT ALREX SUSP BLEPHAMIDE SUSP CORTISPORIN SUSP DEXAMETH SOD PHOS SOLN FLAREX SUSP FLUOROMETHOLONE SUSP FML LIQUIFILM SUSP FML S.O.P. OINT FML-S LIQUIFILM SUSP INFLAMASE SOLN LOTEMAX SUSP NEOMPOLIN/DEX PRED FORTE SUSP PRED MILD SUSP PREDNISOLONE TOBRADEX | AK-TROL SUSP BACI/POLY/NEOMY/HC OINT BLEPHAMIDE S.O.P. OINT ECONOPRED EFLONE SUSP FLUOR-OP SUSP MAXITROL NEO/POLY/BAC/HC OINT PRED-G SUSP PRED-G S.O.P. OINT SULFACET SOD/PRED SOLN VASOCIDIN SOLN VEXOL SUSP | Use Pa Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

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| OP. - PROSTAGLANDINS | 1 1 1 | XALATAN SOLN TRAVATAN SOLN LUMIGAN SOLN | | RESCULA SOLN | Established users grandfathered. Preferred products must be used in specified step order or PA required. Use PA Form # 20420 | Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| OP. - CYCLOPLEGICS | | AK-PENTOLATE SOLN ATROPINE SULFATE CYCLOPENTOLATE HCL SOLN ISOPTO HYOSCINE SOLN | | CYCLOGYL SOLN ISOPTO ATROPINE SOLN ISOPTO HOMATROPINE SOLN MUROCOLL-2 SOLN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| OP. - MIOTICS - DIRECT ACTING | | ISOPTO CARBACHOL SOLN ISOPTO CARPINE SOLN PILOCAR SOLN PILOCARPINE HCL SOLN PILOPINE HS GEL | | | | |
| OP. - ADRENERGIC AGENTS | | DIPIVEFRIN HCL SOLN EPIFRIN SOLN | | PROPINE SOLN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS | | ALPHAGAN SOLN ALPHAGAN P SOLN | | OPIDINE SOLN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| OP. - ANTI-ALLERGICS | | PATANOL SOLN ZADITOR SOLN | | ALAMAST SOLN ALOCRIL SOLN ALOMIDE SOLN EMADINE SOLN ELESTAT LIVOSTIN SUSP OPTICROM SOLN | Use PA Form # 20420 | All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO | | AZOPT SUSP COSOPT SOLN | | TRUSOPT SOLN | Must fail all preferred products before non-preferred. Use PA Form # 20420 | |
| OP. - NSAID'S | | FLURBIPROFEN SODIUM SOLN VOLTAREN SOLN | | ACULAR SOLN ACULAR LS OCUFEN SOLN | Must fail all preferred products before non-preferred. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| OP. - OF INTEREST | | ENUCLENE SOLN | | BOTOX SOLR RESTASIS ¹ | 1. Must have kerato conjunctivitis sicca and failed other dry eye therapies. Use PA Form # 10210 | Must fail adequate trials of multi agents from artificial tears and lubricant category. |
| DERMATOLOGICAL | | | | | | |
| TOPICAL - ACNE PREPARATIONS | | ACUTANE CAPS AKNE-MYCIN OINT AZELEX CREA BENZOYL PEROXIDE CLEOCIN-T DIFFERIN ERYTHROMYCIN GEL ERYTHROMYCIN PADS ERYTHROMYCIN SOLN METROCREAM CREA METROGEL GEL METROLOTION LOTN PLEXION RETIN-A CREA ² RETIN-A GEL ² RETIN-A LIQD ² SODIUM SULFACET/SULF LOTN | | ALTINAC CREA AVITA CREA BENZAC BENZAFLIN GEL BENZAGEL-10 GEL BENZAMYCIN GEL BENZAMYCINPAK PACK BREVOXYL CLINAC BPO GEL CLINDAGEL GEL CLINDAMYCIN PHOSPHATE CLINDETS SWAB DESQUAM-E GEL DESQUAM-X DUAC GEL EMGEL GEL ERYCETTE PADS ERYDERM SOLN ERYGEL GEL FINEVIN CREA KLARON LOTN NORITATE CREA RETIN-A MICRO GEL SULFACET-R LOTN TRETINOIN TRIAZ ZETACET | 2. For these Retin-A products, over 24 yr. need PA Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - ANTIBIOTIC | | BACIT/NEOMYCIN/POLYM OINT | | CORTISPORIN | 1. Quantity limit of 30 g per | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered |

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| | BACITRACIN OINT BACTROBAN ¹ CENTANY OINT 2% ¹ GENTAMICIN SULFATE | | TRIPLE ANTIBIOTIC OINT | month. Use PA Form # 20420 | on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - ANTIFUNGALS | CLOTTRIMAZOLE CLOTTRIMAZOLE/BETA CREA KETOCONAZOLE CREA LOPROX .77 CREA LOPROX 1.0 CREAM LOPROX 1.0 LOTN LOPROX GEL LOPROX TS LOTN MICONAZOLE NITRATE CREA MYCO-TRIA CET II CREA NIZORAL SHAM NTA OINT NYSTATIN NYSTATIN/TRIAMCINOLONE PEDI-DRI POWD SPECTAZOLE CREA TINACTIN TRI-STATIN II CREA | | ECONAZOLE NITRATE CREA EXELDERM FUNGIZONE CREA HYDROCORT/IODOO CREA LAMISIL LOPROX 0.77 LOTN LOPROX SHAMPOO SHAM LOTRIMIN LOTRISONE MENTAX CREA MONISTAT-DERM CREA MYCOGEN II CREA MYCOLOG-II CREA MYCOSTATIN POWD NAFTIN NIZORAL CREA NYSTAT-RX POWD NYSTOP POWD OXISTAT PENLAC NAIL LACQUER SOLN | Use PA Form # 10120 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - ANTIPRURITICS | ZONALON CREA | | PRUDOXIN CREA | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - ANTIPSORIATICS | DOVONEX OXSORALEN ULTRA CAPS TAZORAC | | PSORIATEC CREA SORIATANE CAPS VANAMIDE | Must fail all preferred products before non-preferred. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - ANTISEBORRHEICS | CAPITROL SHAM SELENIUM SULFIDE SHAM SELSUN BLUE SHAM | | CARMOL SCALP TREATMENT KIT ZNP BAR | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - ANTIVIRALS | DENAVIR CREA ZOVIRAX OINT ¹ | | | 1. Zovirax may be used once without PA. | |
| TOPICAL - ANTINEOPLASTICS | EFUDEX FLUOROPLEX CREA SOLARAZE GEL | | CARAC CREA | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - BURN PRODUCTS | FURACIN CREA SSD CREA THERMAZENE CREA | | SILVADENE CREA SILVER SULFADIAZINE CREA SSD AF CREA | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - CORTICOSTEROIDS | BETAMETHASONE DIPROPIONAT BETAMETHASONE VALERATE BETA-VAL CAPEX SHAM CLOBETASOL PROPIONATE CUTIVATE CYCLOCORT DERMA-SMOOTH/FS OIL DESONIDE DESOWEN DESOXIMETASONE DIPROLENE ELOCON FLUOCINOLONE ACETONIDE FLUOCINONIDE FLUROSYN CREA HALOG HALOG-E CREA HYDROCORTISONE CREA HYDROCORTISONE LOTN HYDROCORTISONE OINT HYDROCORTISONE VALERATE LACTICARE-HC LOTN LOCOID MOMETASONE FUROATE OINT NUTRACORT LOTN PROCTO-KIT CREA PSORCON | | ACLOVATE AMCINONIDE CREA ANUSOL HC-1 OINT ARISTOCORT A AUGMENTED BETA DIP OINT CLOBEX CLODERM CREA CORDRAN CORMAX DERMATOP DIFLORASONI DIACETATE ELOCON OINT HYDROCORTISONE POWD KENALOG AERS LIDA MANTLE HC CREA LIDEX LIDEX-E CREA LUXIQ FOAM OLUX FOAM PANDEL CREA PROCTOCORT CREA PSORCON E SYNALAR OINT TEMOVATE TOPICORT TOPICORT LP CREA WESTCORT | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

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| | | TEXACORT SOLN TRIAMCINOLONE ACETONIDE TRIDESILON CREA ULTRAVATE | | | |
| TOPICAL - STEROID LOCAL ANESTHETICS | | PRAMOSONE ZONE-A FORTE LOTN | | EPIFOAM FOAM | Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - STEROID COMBINATIONS | | DERMA-SMOOTHIE/FS ATOPIC P KIT | | CARMOL-HC CREA | Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - EMOLLIENTS | | AMLACTIN CREA CETAPHIL GENTLE CLEANSER LOTN LAC-HYDRIN LACTINOL-E CREA UREACIN-20 CREA VITAMIN A & D MEDICATED OINT | | AMMONIUM LACTATE CREA LACLOTION LOTN LACTINOL LOTN MEDERMA GEL RENOVA CREA | Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - ENZYMES / KERATOLYTICS / UREA | | GRANUL-DERM AERS GRANULEX AERS PANAFIL OINT PAPAIN-UREA-CHLORO OINT TBC AERS XENADERM OINT | | CARMOL 40 CREA SANTYL OINT SALEX CREAM SALEX LOTION ZIOX OINT | Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - GENITAL WARTS | | ALDARA | 5 8 | PODOFILOX SOLN CONDYLOX | Non-preferred products must be used in specified order. Use PA Form # 20420 |
| TOPICAL - IMMUNOMODULATORS | | | 8 9 | ELIDEL CREA PROTOPIC OINT | Non-preferred products must be used in specified order. The FDA has issued a Public Health Advisory for both Elidel and Protopic concerning the potential cancer risk associated with their use. Use for children less than 2 years of age is not recommended. Use PA Form # 20420 Preferred corticosteroids from other classes must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be made for small amounts of non-preferred products for the treatment of very steroid-sensitive areas in conjunction with topical steroids for the treatment of atopic dermatitis. |
| TOPICAL - LOCAL ANESTHETICS | | AF CAPSICUM OLEORESIN CREA CAPSAICIN CREA ELA-MAX ¹ EMLA CREA ¹ EMLA/TEGADERM KIT ¹ XYLOCAINE | | EMLA PADS LIDA MANTLE CREA LIDOCAINE HCL LIDODERM PTCH PONTOCAINE SOLN ZOSTRIX | 1. Emla and Ela-Max products require PA for users over 18 years of age. Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - DEPIGMENTING AGENTS | | | 8 8 8 8 8 8 9 | ALUSTRA CREA GLYQUIN CREA HYDROQUINONE CREA HYDROQUINONE/SUNSCREENS SOLAQUIN FORTE CREA TRI-LUMA CREA ELDOQUIN | Not covered for cosmetic purposes. Use PA Form # 20420 As per Medicaid Policy, cosmetic drugs are not covered. Non-cosmetic clinical applications will be considered by prior authorization on a case by case basis. |
| TOPICAL - SCABICIDES AND PEDICULICIDES | | ACTICIN CREA ELIMITE CREA EURAX LICE KILLING SHAM LICE TREATMENT CREME RINS LIQD LINDANE NIX CREME RINSE LIQD OVIDE LOTN PERMETHRIN LOTN | | | Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - WOUND / DECBITUS CARE | | ACCUZYME OINT ACCUZYME SPRAY ETHEZYME | | REGRANEX GEL | Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Regranex will be approved for diabetic patients in good control (HbA1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (Cp O2 >30, ABI >0.7 or ASP > 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks. |
| TOPICAL - ASTRINGENTS / PROTECTANTS | | ALUMINUM CHLORIDE SOLN DRYSOL SOLN XERAC AC SOLN | | LOWILA BAR MOISTURIN DRY SKIN CREA PROSHIELD PLUS SKIN PROTE CREA SURGILUBE GEL | Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

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| TOPICAL - ANTISEPTICS / DISINFECTANTS | | HIBICLENS LIQD PHISOHEX LIQD POVIDONE-IODINE SOLN | | BETADINE OINT FORMALYDE-10 AERS LAZERFORMALYDE SOLUTION SOLN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| MISCELLANEOUS EYE | | | | | | |
| OP. - EYE | | AK-DILATE SOLN EYE WASH SOLN NAPHAZOLINE HCL SOLN PHENYLEPHRINE HCL SOLN PONTOCAINE SOLN SODIUM CHLORIDE | | LENS PLUS REWETTING DROPS MURO 128 NEO-SYNEPHRINE SOLN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| MISCELLANEOUS EAR | | | | | | |
| EAR | | A/B OTIC SOLN ACETASOL SOLN ACETIC ACID ACETIC ACID/HYDROCORTISON ALLERGEN SOLN ANTIPYRINE/BENZOCAINE SOLN AURODEX SOLN AUROGUARD SOLN AUROTO OTIC SOLN CERUMENEX SOLN CIPRODEX CORTISPORIN SOLN CORTOMYCIN EAR DROPS SOLN EAR DROPS RX SOLN EAR WAX REMOVAL DROPS EAR-GESIC SOLN FLOXIN OTIC SOLN NEOMYCIN/POLYMYXIN/HC OTICAINE OTIC SOLN | | ACETASOL HC SOLN AERO OTIC HC SOLN ANTIBIOTIC EAR SOLN ANTIBIOTIC EAR SUSP AURALGAN SOLN CIPRO HC SUSP COLY-MYCIN-S SUSP CORTISPORIN SUSP CORTISPORIN-TC SUSP DEBROX SOLN DOMEBORO SOLN PEDIOTIC SUSP VOSOL-HC SOLN ZOTANE HC SOLN ZOTO-HC SOLN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| MOUTH ANTISEPTICS | | | | | | |
| MOUTH ANTI-INFECTIVES | | NILSTAT SUSP EAR-GESIC SOLN NYSTATIN SUSP | | MYCELEX TROC MYCOSTATIN LOZG | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| MOUTH ANTISEPTICS | | CHLORHEXIDINE GLUCONATE LIDOCAINE VISCOUS SOLN TRIAMCINOLONE IN ORABASE PSTE TRIAMCINOLONE ORADENT PSTE | | APHTHASOL PSTE PERIDEX SOLN PERIOGARD SOLN TRIAMCINOLONE ACETONIDE PSTE XYLOCAINE VISCOUS SOLN | Must fail all preferred products before non-preferred. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| DENTAL PRODUCTS | | | | | | |
| DENTAL PRODUCTS | | ETHEDENT CREA GEL-KAM CONC PHOS FLUR SOLN PREVIDENT PREVIDENT SOLN SF GEL STANNOUS FLUORIDE ORAL RI CONC | | APF GEL GEL DENTAGEL GEL PHOS-FLUR GEL SF 5000 PLUS CREA THERA-FLUR-N GEL | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ARTIFICIAL SALIVA/STIMULANTS | | | | | | |
| ARTIFICIAL SALIVA/STIMULANTS | | EVOXAC CAPS SALIVA SUBSTITUTE SOLN | | RADIACARE SOLR SALAGEN TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| MISCELLANEOUS ANORECTAL | | | | | | |
| ANORECTAL - MISC. | | ANALPRAM-HC CREA COLOCORT ENEM CORTENEMA ENEM ELA-MAX 5 CREA HYDROCORTISONE ENEM PROCTOZONE-HC CREA | | ANUSOL-HC CREA CORTIFOAM FOAM PROCTOCREAM-HC CREA PROCTOFOAM HC FOAM PROCTO-KIT CREA PROCTOSOL HC CREA | Use PA Form # 20420 | |
| T-CELL ACTIVATION INHIBITOR | | | | | | |
| PSORIASIS BIOLOGICALS | | | 5 8 8 | ENBREL AMEVIVE RAPTIVA | Use PA Form # 20910 | Approved for severe chronic plaque psoriasis unresponsive to first line therapies. A trial of at least several potent topicals from the following categories: corticosteroids, coal tars, anthralin, calcipotriene and tazarotene, and at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin and phototherapy/UVA. High dose Enbrel will be approved for chronic severe psoriasis only after failure of all traditional therapies listed here and adequate trial of either Amevive or Raptiva. |
| ALTERNATIVE MEDICINES | | | | | | |
| ALTERNATIVE MEDICINES | | DIMETHYL SULFOXIDE SOLN | | ARTHX DS CAPS CO-ENZYME Q-10 DEHYDROEPIANDOSTERONE | Use PA Form # 20420 | Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality. |

DHEA TABS
 FLEXAGEN TABS
 GLUCOSAMINE/CHONDROITIN
 HM GINKGO BILOBA TABS
 MELATONIN TABS

CHELATING AGENTS

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| CHELATING AGENTS | CUPRIMINE CAPS | DEPEN TITRATABS TABS | Use PA Form # 20420 | |
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ANTILEPROTIC

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| ANTILEPROTIC | | THALOMID CAPS | Use PA Form # 20420 | Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS. |
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CANCER

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| CANCER | ALIMTA AVASTIN ERBITUX VIDAZA | | | |
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IMMUNOSUPPRESSANTS

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| IMMUNOSUPPRESSANTS | CELLCEPT CYCLOSPORINE MODIFIED CYCLOSPORINE SOL. MODIFIED GENGRAF CAPS MYFORTIC PROGRAF CAPS RAPAMUNE SANDIMMUNE | CYCLOSPORINE CAPS NEORAL ¹ | 1. Established users will require a one time PA. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
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PURINE ANALOG

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|---------------|----------------------------------|-------------|---------------------|--|
| PURINE ANALOG | AZASAN TABS AZATHIOPRINE TABS | IMURAN TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
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K REMOVING RESINS

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|-------------------|--|--|---------------------|--|
| K REMOVING RESINS | KAYEXALATE POWD KIONEX POWD SODIUM POLYSTYRENE SULFON SPS SUSP SPS 30GM/120ML ENEMA SUSP | | Use PA Form # 20420 | |
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New drugs are initially non-preferred until reviewed by the DUR Committee and the State. According to State policy, any drug requiring specific diagnosis still requires the specific diagnosis unless otherwise noted within this document.

ANTI-CONVULSANTS INDICATION CHART

| | SEIZURES | POST HERPETIC NEURALGIA | DIABETIC PERIPHERAL NEUROPATHY | MONOTHERAPY BIPOLAR | ADJUNCTIVE BIPOLAR | MIGRAINE PROPHYLAXIS | RESTLESS LEG SYNDROME |
|-----------|----------|-------------------------|--------------------------------|---------------------|--------------------|--------------------------|--------------------------|
| GABITRIL | X | | | 9 | 8 | | |
| KEPPRA | X | | | 9 | 7 | | |
| LAMICTAL | X | | | 4 | 4 | | |
| NEURONTIN | X | X | X (2 nd line) | 9 | 9 | X (2 nd line) | X (2 nd line) |
| TOPAMAX | X | | | 9 | 6 | X (2 nd line) | |
| TRILEPTAL | X | | | 5 | 5 | | |
| ZONEGRAN | X | | | 9 | 9 | | |

PEDIATRIC ANTI-CONVULSANTS INDICATION CHART

| | SEIZURES | MONOTHERAPY BIPOLAR | ADJUNCTIVE BIPOLAR |
|--|----------|---------------------|--------------------|
| LITHIUM | | 1 | 1 |
| CARBMAZEPINE | X | 1 | 1 |
| VALPROATE | X | 1 | 1 |
| ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE | X | 1 | 1 |
| LAMICTAL | X | 1 | 1 |
| TRILEPTAL | X | 5 | 5 |
| CLOZAPINE | X | 6 | 6 |