

CATEGORY	Step Order	PREFERRED DRUGS	Step Order	NON-PREFERRED DRUGS PA Required	Comments	Criteria
General Criteria for all PDL categories						
<p>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.</p>						
<p>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.</p>						
<p>C: PDL drugs may also be affected by dose consolidation requirements. See list of limited drugs start on the last page of PDL.</p>						
<p>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.</p>						
<p>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.</p>						

ASSORTED ANTIBIOTICS

BETA-LACTAMS / CLAVULANATE COMBO'S		AMOXICILLIN AMOXIL ¹ AMPICILLIN AUGMENTIN AUGMENTIN ES-600 SUSR AUGMENTIN XR TB12 BEEPEN BICILLIN L-A SUSP DICHLOXACILLIN SODIUM CAPS DYNAPEN SUSR GECICILLIN TABS OXACILLIN SODIUM SOLR PENICILLIN V POTASSIUM TICAR SOLR TIMENTIN SOLR TRIMOX UNASYN SOLR VEETIDS ZOSYN		AMOXICILLIN/POTASSIUM CLA CHEW AMOXICILLIN/POTASSIUM CLA SUSR AMOXICILLIN/POTASSIUM CLA TABS AMOXIL 500MG TABS 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. 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 SUPRAX VANTIN		CECLOR ¹ CEDAX CEFACLOR 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 E.E.S. E-MYCIN TBEC ERYPED 200 SUSR ERYPED 400 SUSR ERY-TAB TBEC ERYTHROCIN STEARATE TABS ERYTHROMYCIN ZITHROMAX ^{1,2}		BIAXIN DYNABAC D5-PAK TBEC ERYPED CHEW PCE TBEC	1. QL ZPAC 250mg 6/script/month 2. QL TRI-PAC 3/script/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.
TETRACYCLINES		DOXYCYCLINE HYCLATE MINOCYCLINE HCL CAPS SUMYCIN TETRACYCLINE HCL CAPS VIBRAMYCIN SYRP		DELOMYCIN 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 SOLN AVELOX TABS CIPROFLOXACIN CIPRO XR ¹ NOROXIN TABS		AVELOX ABC PACK TABS CIPRO CIPRO XR 1000MG FLOXIN TABS LEVAQUIN	1. QL 3/script/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 TOBI NEBU TOBRAMYCIN SULFATE SOLN		TEQUIN		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-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 PENTAMIDINE ISETHIONATE SOLR PRIMSOL SOLN TRIMETHOPRIM TABS VANCOCIN HCL VANCOMYCIN HCL		COLY-MYCIN-M SOLR FLAGYL CAPS FLAGYL TABS FLAGYL ER TBCR KETEK ¹ LORABID NEBUPENT SOLR PROLOPRIM TABS TINDAMAX* XIFAXAN	* Need to fail other anti-protozoals 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 SEPTRAD/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA		ALINIA* BACTRIM DS TABS	* Alinia 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. Diflucan: 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 COMBIVIR TABS CRIXIVAN CAPS EMTRIVA EPIVIR / HBV EPZICOM FORTOVASE CAPS		FUZEON TRUVADA	Fuzeon use PA Form # 10620 Truvada use PA Form # 20420	Please refer to the criteria listed on the Fuzeon PA form.

		HIVID TABS INVIRASE CAPS KALETRA LEXIVA NORVIR RESCRIPTOR TABS RETROVIR REYATAZ SUSTIVA TRIZIVIR TABS 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	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	1. Tamiflu 10 caps or 60cc's per month. Use PA Form # 10610 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 ¹ BETASERON SOLR ¹ REBIF SOLN COPAXONE	Established users grandfathered. Must follow specified step order. 1. Neurologists do not need a PA for Avonex Betaseron and Rebif. Use PA Form # 20420 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 #20420 1. Myobloc approval will be limited to Cervical Dystonia. Failed/did not tolerate therapeutic trials to muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, Skelaxin, and tizanidine.
STEROIDS					
GLUCOCORTICOIDS/ MINERALOCORTICOIDS		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		CORTEF 10 and 20 TABS DECADRON TABS FLORINEF TABS MEDROL TABS MEDROL DOSEPAK TABS PEDIAPRED LIOD 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 TESTRED CAPS WINSTROL TABS		ANDRO LA 200 OIL ANDROGEL PACK DELATESTYL OIL HALOTESTIN TABS METHITEST 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. Additionally, laboratory evidence of a testosterone deficiency must be supplied.
ESTROGENS - PATCHES			5 5 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). Established users grandmothers. Products must be used in specified step order. Use PA Form # 20420	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
ESTROGENS - TABS		CENESTIN TABS DELESTROGEN OIL ESTRADIOL ESTROPIPATE TABS MENEST TABS PREMARIN TABS		ESTRACE TABS ESTRATAB TABS OGEN TABS ORTHO-EST TABS	Use PA Form # 20420	Preferred drugs must be tried for at least 90 days 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.
ESTROGEN COMBO'S		PREMPHASE TABS PREMPRO TABS		ACTIVELLA TABS COMBIPATCH PTTW FEMHRT 1/5 TABS ORTHO-PREFEST TABS SYNTEST H.S. TABS	Established users grandmothers. Use PA Form # 20420	Preferred drugs must be tried for at least 90 days 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.
PROGESTINS		MEDROXYPROGESTERONE ACETA NORETHINDRONE ACETATE TABS PROGESTERONE POWD		AYGESTIN TABS CYCRIN TABS PROMETRIUM 100MG CAPS ¹ PROMETRIUM 200MG ¹ PROVERA TABS	1. Established users are grandmothers. PA approvals will require two 100 mg caps instead of one 200mg. 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

CONTRACEPTIVES - PROGESTIN ONLY		ORTHO MICRONOR TABS		CAMILA TABS NORA-BE TABS NOR-OD TABS OVRETTE 28 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.
CONTRACEPTIVES - INJECTABLE		DEPO-PROVERA SUSP		LUNELLE SUSP	Established users grandmothers. Use PA Form # 20420	The 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.
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	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
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 LEVILITE-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	Loestrin FE and FE 1/20 are grandmothers for established users. 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.

				NORDETTE-28 TABS NORINYL NORTREL MONONESSA OGESTREL TABS OVRAL PORTIA-28 TABS SPRINTEC 28 TABS YASMIN 28 TABS ZOVIA		
CONTRACEPTIVES - BI-PHASIC COMBINATIONS		ORTHO-NOVUM 10/11-28 TABS		NECON 10/11-28 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.
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	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	Phase I: No New Starters of non-preferred drugs. Phase II: Humulin-Humalog users must switch to preferred products by 1/1/04. 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		GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET	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 - 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.
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 - THIAZOL / BIGUANIDE COMBO		AVANDAMET TABS				

THYROID

THYROID HORMONES		ARMOUR THYROID TABS CYTOMEL TABS LEVOTHROID TABS LEVOTHYROXINE SODIUM TABS LEVOXYL TABS THYROID TABS THYROLAR UNITHROID TABS		LEVOHYROXINE SODIUM SOLR SYNTHROID TABS ¹	1. Established Synthroid users before July 1, 2003 grandfathered. 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 PROPYLTHIOURACIL 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 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 TABS MICALCALIN SOLN		AREDIA SOLR BONIVA DIDRONEL TABS EVISTA TABS FORTEO	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 6 8 8 8	GENOTROPIN 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. 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		OXYBUTYNIN 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 OXYTROL		DITROPAN XL TBCR 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.
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		ISOSORBIDE DINITRATE TABS ISOSORBIDE DINITRATE CR TBCR ISOSORBIDE DINITRATE ER TBCR ISOSORBIDE DINITRATE TD TBCR		DILATRATE SR CPCR ISORDIL TABS ISORDIL TITRADOSE TABS ISOSORBIDE DINITRATE 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.
MONO-NITRATES		ISOSORBIDE MONONITRATE TABS ISOSORBIDE MONONITRATE ER		IMDUR TB24 ISMO 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/ICR		NITROBID OINT NITROGLYCERIN CPCR NITROL OINT NITRO-TIME CPCR				
NITRO - PATCHES	1 1 1	NITROGLYCERIN PT24 NITREK PT24 NITRO-DUR PT 24 0.8MG		NITRODISC PT24 NITRO-DUR PT24	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.

	3	MINITRAN PT24				
NITRO - SUBLINGUAL / SPRAY		NITROLINGUAL AERS NITROSTAT SUBL NITROTAB SUBL		NITROLINGUAL SOLN NITROOQUICK 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.
BETA BLOCKERS - NON SELECTIVE		COREG TABS ¹ INDERAL LA CPCP LEVATOL TABS NADOLOL TABS PINDOLOL TABS PROPRANOLOL HCL SOLN PROPRANOLOL HCL TABS SOTALOL HCL TABS TIMOLOL MALEATE TABS		BETAPACE TABS BETAPACE AF TABS CORCARD TABS INDERAL TABS INNOPRAN XL PROPRANOLOL HCL LA CPCP	1. Coreg available without PA for CHF if there is a diabetes drug, and a thiazide diuretic and an ACEI or ARB in the profile within the last 90 days 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 BETAXOLOL HCL TABS BISOPROLOL FUMARATE TABS METOPROLOL TARTRATE TABS TOPROL XL TB24 ¹		KERLONE TABS LOPRESSOR TABS SECTRAL CAPS TENORMIN TABS ZEBETA TABS	1. Toprol XL is preferred over Coreg for LVD. Toprol XL will not need a PA for LVD or CAD if patient on anti-anginal, diuretic or ACE. 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, 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	TIAZIA		
	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 TBCP		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 CPCP 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 TBCP NIFEDIPINE ER TBCP NIFEDICAL XL TBCP		ADALAT CC TBCP NIFEDIPINE CAPS PROCARDIA CAPS PROCARDIA XL TBCP	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 TBCP		CALAN SR TBCP	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 TBCP		COVERA-HS TBCP		
	1	VERAPAMIL HCL SR TBCP		ISOPTIN-SR		
	4	CALAN TABS		VERAPAMIL HCL ER CP24		
	4	VERAPAMIL HCL TABS		VERAPAMIL HCL SR CP24		
				VERELAN CP24 VERELAN PM CP24		
ANTIARRHYTHMICS		AMIODARONE MEXILETINE NORPACE PROCAINAMIDE PROCANBID CR QUINAGLUTE QUINIDINE GLUCONATE QUINIDINE SULFATE		PACERONE CORDARONE DISOPYRAMIDE PROPAFENONE FLECAINIDE MEXITIL QUINIDEX TIKOSYN*	Cardiologist Exempt 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.

		RYTHMOL TAMBOCOR				
ACE INHIBITORS		CAPTAPRIL TABS BENZAEPRIH HCL ENALAPRIL MALEATE TABS LISINOPRIL TABS MONOPRIL TABS	5 5 8 8 8 8 8 8 8 8 8 8	MAVIK TABS ACCUPRIL TABS ACEON TABS ALTACE CAPS CAPOTEN TABS FOSINOPRIL SODIUM LOTENSIN TABS MOEXIPRIL PRINIVIL TABS UNIVASC ¹ VASOTEC TABS ZESTRIL TABS	Non-preferred products must be used in specified order. 1. Established users of Univasc will be grandfathered. 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.
ANGIOTENSIN RECEPTOR BLOCKER		BENICAR TABS COZAAR TABS MICARDIS TABS TEVETEN TABS		ATACAND TABS AVAPRO TABS DIOVAN	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Will grandfather prior ACE users who are current preferred ARB users. 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				LEXCEL TBCR LOTREL CAPS TARKA TBCR	Use PA Form # 20420	ACE inhibitors and calcium channel blockers are available individually without PA. All possible combinations would need to be failed prior to approval of non-preferred drugs.
ACE AND THIAZIDE COMBO'S		CAPTAPRIL/HYDROCHLOROTHIA ENALAPRIL MALEATE/HCTZ TABS LISINOPRIL-HCTZ TABS UNIRETIC TABS		ACCURETIC TABS BENZAEPRIH HCL/HYDROCHLOR 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/CHLOROTHALIDONE 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		BENICAR HCT HYZAAR TABS MICARDIS HCT TABS TEVETEN HCT TABS		ATACAND HCT TABS AVALIDE TABS DIOVAN HCT TABS	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Will grandfather prior ACE users who are current preferred ARB users. 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 CHLOROTHALIDONE TABS EDECRIN TABS FUROSEMIDE HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS METHYLOTHIAZIDE TABS SPIRONOLACTONE 25MG TABS		ALDACTAZIDE TABS ALDACTONE TABS BUMEX TABS DEMADEX TABS DIAMOX DIURIL DYAZIDE CAPS ENDURON TABS INSPRA LASIX TABS LOZOL TABS MAXZIDE	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra 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.

		SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ ZAROXOLYN TABS		MICROZIDE CAPS MIDAMOR TABS MODURETIC 5-50 TABS NAQUA TABS NATURETIN TABS SPIRONOLACTONE 50MG ¹		
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		GEMFIBROZIL TABS TRICOR		LOPID 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.
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 without PA as addition to Zocor 80 mg, Lipitor 80 mg, or Crestor 40mg. Zetia will also be approved with a PA as add on for patients at maximally tolerated doses of statins. 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	Flofan 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	Effective May 1, 2004 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.
ANTI-EMETOGENICS						
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC		MECLIZINE HCL TABS PHENERGAN SUPP PHENERGAN FORTIS SYRP PROMETHAZINE TRANSDERM-SCOP PT2		ANTIVERT TABS PHENERGAN SOLN PHENERGAN TABS PROMETHEGAN SUPP TORECAN TABS TIGAN	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 8 8	CLARINEX TABS ² 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. 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		ATROVENT AERS IPRATROPIUM BROMIDE SOLN		ATROVENT SOLN 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. FEV ₁ < 40% or COPD hospitalization within 6 months.
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 POCKETHALER 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 ASTELIN	Use PA Form # 20420	Approved if patient fails on non-sedating antihistamines and steroid nasal sprays.
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 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	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 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 turbohaler 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. No PA if on asthma meds. Use PA Form # 20420	Singulair will additionally be approved for allergic indications if other preferred allergy treatments are ineffective.
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	MUCOMYST	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 - ANTIPERISTALTIC AGENTS		DIPHENOXYLATE DIPHENOXYLATE/ATROPINE IMODIUM A-D TABS	ANTI-DIARRHEAL TABS LOFENE TABS LONOX 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.

		LOPERAMIDE HCL CAPS LOPERAMIDE HCL LIQD OPIUM TINCTURE TINC PAREGORIC TINC		MOTOFEN TABS SB ANTI-DIARRHEA TABS		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 BISMATROL CALCIUM ANTACID CALCIUM CARBONATE CAL-GEST ANTACID CHEW CHEWABLE ANTACID CHEW DICYCLIMINE HCL GAVISCON SUSP HAPONAL TABS HYOSCYAMINE SULFATE IMODIUM ADVANCED CHEW KAOPECTATE K-PEC LIQD K-PEK SUSP MAALOX MAGNESIUM OXIDE TABS MAG-OX 400 TABS MAG-OXIDE TABS PAMINE TABS PINK BISMUTH PROPANTHELIN BROMIDE TABS ROBINUL SAL-TROPINE TABS SCOPOLAMINE HYDROBROMIDE SODIUM BICARBONATE TABS TUMS V-R STOMACH RELIEF SUSP X-STR CHEW ANTACID CHEW		ANTACID EXTRA STRENGTH CHEW B & O 15-A SUPPRETTE SUPP B & O 16-A SUPPRETTE SUPP BELLADONNA ALKALOIDS & OP BENTYL TABS CHILDRENS MYLANTA CHEW LEVBID TB12 LEVSIN ELIX LEVSIN TABS LEVSIN/SL SUBL NULEV TBDP URO-MAG 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. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
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 TBEC NEXIUM	5 6 8 8 8 8	ACIPHEX TBEC OMEPRAZOLE CPDR PREVACID ORAL SUSP PREVACID SOLUTABS ¹ PRILOSEC CPDR ZEGERID	Non-preferred products must be used in specified step order. GI specialty PA exemption. Except with regards to Prilosec/omeprazole. 1. Prevacid Solutabs available without PA for Nursing Home 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 8 8 8 8 8	LIPRAM PANCREASE PANCRELIPASE PANGESTYME PANOKASE TABS ULTRASE CPEP CREON KUTRASE CAPS KU-ZYME CAPS LIPRAM CR PANCREASE MT	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.

			8 8 8	PANCRECARB MS-8 CPEP ULTRASE MT VIOKASE		
GI - ANTI - FLATULENTS / GI STIMULANTS		CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP GASTROCOM 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 CANASA SUPP COLAZAL CAPS DIPENTUM CAPS PENTASA CPCR ROWASA ENEM SULFASALAZINE TABS		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.
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.****

GI - MISC.		BISAC-EVAC SUPP BISACODYL BISCOLAX SUPP CINOBAC CAPS CITRATE OF MAGNESIA SOLN CITRUCEL D.O.S. CAPS DIOCTO LIQD 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 POWD ¹ SENNA SENOKOT GRAN SENOKOT SYRP SENOKOT CHILDRENS SYRP SENOKOT 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 MALTSUPEX MIRALAX PACK NULYTELY SOLR PEG 3350/ELECTROLYTES SOLR SENEXON TABS SENOKOT TABS SENOKOT 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 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.
------------	--	--	--	--	--	--

MISC. UROLOGICAL

UROLOGICAL - MISC.		ACETIC ACID 0.25% SOLN BICITRA SOLN CYTRA-K SOLN FURADANTIN SUSP K-PHOS MF TABS MACRODANTIN CAPS		CITRIC ACID/SODIUM CITRAT SOLN CYTRA-2 SOLN ELMIRON CAPS ² MACROBID CAPS MANDELAMINE TABS NITROFURANTOIN MACR CAPS	1. Renelag will be approved for hypercalcemia, digoxin users, and in cases where maximum phoslo doses are insufficient. 2. Elmiron requires adequate proof of Dx with supportive testing.	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. Renelag will be approved in patients with hypercalcemia, on concurrent digoxin or insufficient response with Phos-lo (Renelag to be add-on therapy).
--------------------	--	---	--	--	--	---

		METHAMINE MANDELATE TABS MONUROL PACK NEOSPORIN GU IRRIGANT SOLN PHENAZOPYRIDINE HCL TABS PHOSLO POLYCITRA SYRP POLYCITRA-K SOLN POLYCITRA-LC SOLN PROSED/DS TABS PYRIDUM PLUS TABS RENACIDIN SOLN TRICITRATES SYRP UREX TABS URISED TABS UROCID-K UROCID #2 TABS		POLYCITRA-K CRYSTALS PACK POTASSIUM CITRATE/CITRIC SOLN PYRIDUM TABS RENAGEL ¹		Use PA Form # 20420
--	--	--	--	--	--	---------------------

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-LOTTRIMIN 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-LOTTRIMIN 3 TABS MICONAZOLE 3 SUPP MONISTAT 3 SUPP TERAZOL 3 CREA TERAZOL 3 SUPP TERAZOL 7 CREA	1. Quantity limit: 1/script/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		PREMARIN CREA		ESTRACE CREA ESTRING RING VAGIFEM 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.
---------------------	--	---------------	--	--	---------------------	--

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	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.
---------------------	--	--	--	--	---------------------	--

ATYPICALS				FAZACLO	Clozani. Use PA Form # 20420	ottered 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.
ANTIPSYCHOTICS - 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 THIORDIAZINE 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 SYRP LITHOBID TBCR				
COMBINATION - PSYCHOTHERAPEUTIC						
PSYCHOTHERPEUTIC COMBINATION		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	8	SYMBYAX	Use PA Form # 20420	Use individual components, which are currently available without a PA.
STIMULANTS						
STIMULANT - AMPHETAMINES - SHORT ACTING		ADDERALL TABS AMPHETAMINE SALT COMBO DEXEDRINE DEXTROAMPHET SULF TABS DEXTROSTAT TABS				Preferred stimulants will be available without PA if diagnosis of ADHD.
STIMULANT - AMPHETAMINES - LONG ACTING	1 2 2	ADDERALL XR CP24 DEXEDRINE Cap CR DEXTROAMPHET SULF CPCR				Preferred stimulants will be available without PA if diagnosis of ADHD. Step care therapy needs to be followed.
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
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
STIMULANT - STIMULANT LIKE			7 8 8 8 8 8	STRATTERA ^{1,2} CAFCIT SOLN CYLERT CHEW CYLERT TABS DESOXYN TABS PROVIGIL TABS		1. Required failure of both an amphetamine and methylphenidate (unless history of substance abuse). 2. Effective 12.04.03. Strattera allowed only 1 per day for all strengths except 40mg, where 2 are allowed to

			9	PEMOLINE	achieve 80mg or 100mg daily. Provigil: use PA Form # 20710; Others: use Pa Form # 20420	
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 NAMENDA ¹ REMINYL ¹	8 9	EXELON COGNEX CAPS	1. all new users need PA to establish dementia diagnosis and baseline mental status score.	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.	Nicotine products are OTC and thus only optionally covered by MaineCare Policy when they have been determined to be cost-effective. Only Nicoderm and the generic nicotine gums have received this designation. All other nicotine products are both non-preferred and more importantly non-covered by MaineCare Policy and as allowed by Federal Medicaid law. Another version of Zyban, Bupropion SR (100 and 150mg) is available without PA.
NICOTINE REPLACEMENT - OTHER		NICOTINE POLACRILEX GUM				Nicotine products are OTC and thus only optionally covered by MaineCare Policy when they have been determined to be cost-effective. Only Nicoderm and the generic nicotine gums have received this designation. All other nicotine products are both non-preferred and more importantly non-covered by MaineCare Policy and as allowed by Federal Medicaid law.
ALCOHOL DETERRENTS						
ALCOHOL DETERRENTS		DISULFIRAM TABS ANTABUSE TABS				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 TRISALI 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 LIOD 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 DURAGESIC PT72 ¹ 8 PALLADONE 8 ORAMORPH SR TB12 8 MORPHINE SULFATE ER TB12 8 MORPHINE SULFATE SUPP 8 MS CONTIN TB12 8 OXYCODONE ER 80MG 9 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 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 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. 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

NARCOTICS - MISC.	ACETAMINOPHEN/CODEINE ACTIQ LPOP ¹ ASPIRIN/CODEINE TABS BUTAL/ASA/CAFF/COD CAPS BUTALBITAL/ASPIRIN/CAFFEI CAPS CAPITAL AND CODEINE SUSP ¹ CAPITAL/CODEINE SUSP ¹ CODEINE PHOSPHATE SOLN CODEINE SULFATE TABS ENDOCET 5/325mg TABS ² ENDODAN TABS FENTANYL CITRATE SOLN HYDROCODONE BITARTRATE/AP TABS HYDROCODONE/ACETAMINOPHEN HYDROMORPHONE HCL MEPERIDINE HCL OXYCODONE OXYCODONE/ACETAMINOPHEN ² PENTAZOCINE/NALOXONE TABS PROPOXYPHENE COMPOUND CAPS PROPOXYPHENE CMPND-65 CAPS PROPOXYPHENE HCL CAPS PROPOXYPHENE/ACET TABS PROPOXYPHENE-N/ACET TABS ROXICET ROXIPRIN TABS	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 ZYDONE TABS	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. 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.
-------------------	--	--	--	--

NARCOTIC ANTAGONISTS

NARCOTIC - ANTAGONISTS	NALTREXONE HCL TABS	REVIA 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.
------------------------	---------------------	------------	---------------------	---

COX 2 / NSAIDS

COX 2 INHIBITORS	BEXTRA TABS CELEBREX CAPS		Cox-2 available to 60 yr and over w/o PA, under 60 yr. requires PA. Can decrease GI bleeding risk equivalent to Cox-2 agent with generic NSAID and omeprazole. 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 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 KETOROLAC TROMETHAMINE MECLOFENAMATE SODIUM CAPS NABUMETONE TABS NAPROSYN SUSP NAPROXEN SUSP NAPROXEN TABS NAPROXEN SODIUM TABS OXAPROZIN TABS PIROXICAM CAPS SULINDAC TABS TOLMETIN SODIUM	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 INDOCIN LODINE MOBIC TABS MOTRIN NALFON CAPS NAPRELAN TBCR NAPROSYN TABS NAPROXEN DR TBEC NAPROXEN SODIUM TBCR ORUVAIL CP24 PONSTEL CAPS RELAFEN TABS SB IBUPROFEN TABS TOLECTIN	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.
--------	--	--	---------------------	--

			TORADOL VOLTAREN V-R IBUPROFEN TABS		
--	--	--	---	--	--

RHEUMATOID ARTHRITIS

RHEUMATOID ARTHRITIS		ARAVA TABS ¹		ENBREL KIT ² HUMIRA ² KINERET SOLN ² REMICADE ²	1. No PA for Arava if methotrexate previously tried. 2. Rheumatologist must write script. Rheumatologist will not require PA for biologics if methotrexate or other DMARDs in drug profile. Use PA Form # 10510	See criteria as listed on Rheumatoid Arthritis PA form.
----------------------	--	-------------------------	--	--	--	---

MISCELLANEOUS ARTHRITIS

ARTHRITIS - MISC.		RIDAURA CAPS MYOCHRYSINE SOLN		ARTHROTEC	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 2 2 4 4 4	IMITREX TABS MAXALT AXERT TABS ¹ RELPAX AMERGE TABS ZOMIG TABS ZOMIG ZMT TBDP		FROVA TABS	1. Must fail Imitrex and Maxalt 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 Triplan 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 SYNVISC 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 ³ MYSOLINE TABS PHENYTOIN PHENYTEK CAPS TEGRETOL ² TEGRETOL-XR TB12 VALPROIC ACID ZARONTIN CAPS		DEPAKENE GABAPENTIN GABITRIL TABS KEPPRA TABS KLONOPIN TABS LAMICTAL PRIMIDONE TABS TOPAMAX TRILEPTAL ZARONTIN SYRP ZONEGRAN CAPS NEURONTIN	Neurologists exempt. 1. Quantity limit. 5/month 2. 200 mg requires a PA. Use two 100 mg instead. Pharmaceutical supply issues will delay implementation until further 3. Psychiatrists & Neurologists exempt. Other prescribers will require PA 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 prophalaxis. *** SEE CHART AT END OF DOCUMENT
			A - B 4* - 4*	BIPOLAR DISORDER: STEP ORDER LAMICTAL ³	See review in DUR section of website. A= Monotherapy B= Adjunctive * Psychiatrists & Neurologists exempt. Other prescribers will require PA 9= No Evidence The step orders show the relative strength of evidence for use in bipolar disorder.	
			9 - 8 9 ~ 7 9 ~ 6 5 - 5 9 - 9 9 - 9	BIPOLAR DISORDER: STEP ORDER GABITRIL TABS KEPPRA TABS TOPAMAX TRILEPTAL ZONEGRAN CAPS NEURONTIN		

for use in di-prior and will guide prior authorization determinations.

ANTI-PARKINSON DRUGS

PARKINSONS - ANTICHOLINERGICS		AKINETON TABS BENZTROPINE MESYLATE TABS COGENTIN SOLN KEMADRIN TABS TRIHEXYPHENIDYL			
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 2 3	MIRAPEX TABS REQUIP TABS PERMAX TABS		PERGOLIDE MESYLATE TABS	Preferred products must be used in specified order or PA will be required. Established users 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 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	*Neurologist exempt 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

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 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. Use PA Form # 20420 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.****

VITAMINS		ASCORBIC ACID TABS BIOTIN CALCIFEROL SOLN CALCITRIOL CAPS CYANOCOBALAMIN SOLN DRISDOL SOLN FOLGARD RX 2.2 TABS FOLIC ACID TABS FOLTX TABS MEPHYTON TABS NIACIN NIACOR TABS NICOTINIC ACID SR CPCR PYRIDOXINE HCL TABS SLO-NIACIN TBCR THIAMINE HCL SOLN VITAMIN B-1 TABS VITAMIN B-12 VITAMIN B-6 TABS		AQUASOL E SOLN AQUAVIT-E SOLN DHT SOLN DRISDOL CAPS NASCOBAL GEL ROCALTROL	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.
----------	--	--	--	---	---

VITAMIN C
 VITAMIN D
 VITAMIN E CAPS
 VITAMIN E/D-ALPHA CAPS
 VITAMIN K1 SOLN
 V-R VITAMIN E CAPS

MISC MULTI-VITAMINS

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

VITAMINS - MISC.				
	CENTRUM LIQD 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 LIQD TRI-VITAMIN/FLUORIDE SOLN VITA CON FORTE CAPS VITAMIN B COMPLEX CAPS VITAPLEX PLUS TABS	ADEKS ADVANCED NATALCARE TABS CENTRUM JR/EXTRA C CHEW CENTRUM PERFORMANCE TABS DALYVITE LIQD 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	Diag codes are no longer required on prenatal vitamins. 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.

MISCELLANEOUS MINERALS

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

MINERALS				
	CALCARB CALCI-MIX CAPSULE CAPS CALCIQUID SYRP CALCITRATE/VITAMIN D TABS CALCIUM CALCIUM CARBONATE	ANEMAGEN CALCET TABS CALCIUM 600-D TABS CALCIUM/VITAMIN D TABS CALTRATE 600 PLUS/VIT D TABS CALTRATE PLUS 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.

CALCIUM CITRATE TABS
 CALCIUM GLUCONATE TABS
 CALCIUM LACTATE TABS
 CALCIUM/MAGNESIUM TABS
 CALCIUM/VITAMIN D TABS
 CALTRATE 600 TABS
 CHEWABLE CALCIUM CHEW
 CITRACAL TABS
 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%/DSW/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

CHROMAGEN
 CITRACAL PLUS TABS
 CONTRIN CAPS
 FEOGEN FORTE CAPS
 FEROCON CAPS
 FERREX 150 CAPS
 FERRO-SEQUELS TBCR
 FE-TINIC 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

BOOST
 CASEC POWD
 CHOICE DM LIQD

This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products

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.

	ORALYTE SOLN P.T.E. -5 SOLN PEDIALYTE SOLN	DELIVER 2.0 LIQD ENFAMIL ENSURE GLUCERNA ISOCAL LIQD KINDERCAL TF LIQD KINDERCAL TF/FIBER LIQD L-CARNITINE CAPS LIPISORB LIQD 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	listed as preferred. Use PA Form # 20420 & SGA Form
ERYTHROPOEITINS			
ERYTHROPOEITINS		5 PROCRIT SOLN ¹ 6 EPOGEN SOLN 8 ARANESP SOLN	1. All products require PA but Procrit is first choice Use PA Form # 10520
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	FRAGMIN INJ ² HEPARIN SODIUM/NACL 0.9% SOLN HEP-LOCK SOLN INNOHEP LOVENOX SOLN ² WARFARIN SODIUM TABS HEPARIN LOCK SOLN HEPARIN LOCK FLUSH SOLN HEPARIN SODIUM SOLN HEPARIN SODIUM LOCK FLUSH SOLN	ARIXTRA SOLN COUMADIN TABS ¹ IPRIVAS C	1. Established Coumadin users are grandfathered. 2. 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 HEMOPIL - M HUMATE-P SOLR KOGENATE FS KONYNE - 80 MONARC - M MONOCLATE - P MONONINE NOVOSEVEN SOLR PROPLEX-T RECOMBINATE SOLR REFACTO	ADVATE ¹	1. Only if other products unavailable. Use PA Form # 20420
Non-preferred will only be approved if other preferred products are unavailable.			
PLATELET AGGREGATION INHIBITORS	DIPYRIDAMOLE TABS TICLOPIDINE HCL TABS	PERSANTINE TABS PLAVIX TABS ¹ 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 90 days of 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.		AGGRENOLX CP12 PENTOXIFYLLINE ER TBCR PLETAL TABS		AGRYLIN CAPS TRENITAL 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.
HEMOSTATIC						
HEMOSTATIC		AMICAR AMINOCAPROIC ACID				
OPHTHALMICS						
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 TOBEX 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 1 2	CILOXAN OINT CILOXAN SOLN OCUFLOX SOLN VIGAMOX QUIXIN SOLN		ZYMAR	Step order must be followed to avoid PA. Must fail Ocuflox, Vigamox, and a Cioxan 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. - 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		AK-TROL SUSP BAC/POLY/NEOMY/HC OINT BLEPHAMIDE S.O.P. OINT ECONOPRED EFLONE SUSP FLUOR-OP SUSP MAXITROL	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.

		FML LIQUIFILM SUSP FML S.O.P. OINT FML-S LIQUIFILM SUSP INFLAMASE SOLN LOTEMAX SUSP NEOM/POLIN/DEX PRED FORTE SUSP PRED MILD SUSP PREDNISOLONE TOBRADEX		NEO/POLY/BAC/HC OINT PRED-G SUSP PRED-G S.O.P. OINT SULFACET SOD/PRED SOLN VASOCIDIN SOLN VEXOL SUSP		
OP. - PROSTAGLANDINS	1 1 3	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		IOPIDINE 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		ALAMAST SOLN ALOCRIL SOLN ALOMIDE SOLN EMADINE SOLN LIVOSTIN SUSP OPTICROM SOLN PATANOL SOLN		CROLOM SOLN CROMOLYN SODIUM SOLN OPTIVAR SOLN ZADITOR 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				
OP. - NSAID'S		FLURBIPROFEN SODIUM SOLN VOLTAREN SOLN		ACULAR SOLN ACULAR LS OCUFEN 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. - OF INTEREST		ENUCLENE SOLN		BOTOX SOLR RESTASIS ¹	1. Must have kerato conjunctivitis sicca. Use PA Form # 10210	Must fail adequate trials of multi agents from artificial tears and lubricant category.

DERMATOLOGICAL

TOPICAL - ACNE PREPARATIONS		ACCUTANE CAPS AKNE-MYCIN OINT AZELEX CREA BENZOYL PEROXIDE CLEOCIN-T DIFFERIN ERYTHROMYCIN GEL ERYTHROMYCIN PADS ERYTHROMYCIN SOLN METROCREAM CREA METROGEL GEL METROLOTION LOTN METRONIDAZOLE ¹ PLEXION RETIN-A CREA ² RETIN-A GEL ² RETIN-A LIQD ²		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	1. 375mg caps and 750mg tabs are non-preferred. Please use available preferred strengths(250mg & 500mg tabs) to obtain required dose without PA. 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.
-----------------------------	--	--	--	---	---	--

		SODIUM SULFACET/SULF LOTN	ERYDERM SOLN ERYGEL GEL FINEVIN CREA KLARON LOTN METRONIDAZOLE 375MG TABS METRONIDAZOLE 750MG CAPS NORITATE CREA RETIN-A MICRO GEL SULFACET-R LOTN TRETINOIN TRIAZ ZETACET		
TOPICAL - ANTIBIOTIC		BACIT/NEOMYCIN/POLYM OINT BACITRACIN OINT BACTROBAN ¹ CENTANY OINT 2% ¹ GENTAMICIN SULFATE	CORTISPORIN TRIPLE ANTIBIOTIC OINT	1. Quantity limit of 30 g per 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.
TOPICAL - ANTIFUNGALS		CLOTRIMAZOLE CLOTRIMAZOLE/BETA CREA KETOCONAZOLE CREA LOPROX .77 CREA LOPROX 1.0 CREAM LOPROX 1.0 LOTN LOPROX GEL LOPROX TS LOTN MICONAZOLE NITRATE CREA MYCO-TRIACT 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/ODOQ 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	PSORITEC CREA SORIATANE CAPS VANAMIDE	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-SMOOTHIE/FS OIL DESONIDE DESOWEN DESOXIMETASONE	ACLOVATE AMCINONIDE CREA ANUSOL HC-1 OINT ARISTOCORT A AUGMENTED BETA DIP OINT CLOBEX CLODERM CREA CORDRAN CORMAX DERMATOP DIFLORASONE DIACETATE	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.

	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 TEXACORT SOLN TRIAMCINOLONE ACETONIDE TRIDESILON CREA ULTRAVATE	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		
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 ¹	5 8 PODOFILOX SOLN CONDYLOX	Non-preferred products must be used in specified order. 1. QL 48/year. Use PA Form # 20420	
TOPICAL - IMMUNOMODULATORS		8 9 ELIDEL CREA PROTOPIC OINT	Non-preferred products must be used in specified order. 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 ALUSTRAL 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	ELIMITE CREA EURAX LICE KILLING SHAM LICE TREATMENT CREME RINS LIOD LINDANE NIX CREME RINSE LIOD OVIDE LOTN	ACTICIN 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.

		PERMETHRIN LOTN			
TOPICAL - WOUND / DECUBITUS CARE		ACCUZYME OINT 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 (hgb1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (Tcp 02 >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 KERAC 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.
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	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 SOLN PREVIDENT SOLN SF GEL STANNOUS FLUORIDE ORAL RI CONC		APF GEL GEL DENTAGEL GEL PHOS-FLUR CREA 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			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 CO-ENZYME Q10/VITAMIN E WAFR COQ10 CAPS DEHYDROEPIANDOSTERONE DHEA TABS FLEXAGEN TABS GLUCOSAMINE/CHONDROITIN HM GINKGO BILOBA TABS MELATONIN TABS V-R COENZYME Q-10 CAPS	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.
CHELATING AGENTS					
CHELATING AGENTS		CUPRIMINE CAPS	DEPEN TITRATABS TABS	Use PA Form # 20420	
ANTILEPROTIC					
ANTILEPROTIC			THALOMID CAPS	Use PA Form # 20420	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
CANCER					
CANCER		ALIMTA AVASTIN ERBITUX VIDAZA			
IMMUNOSUPPRESSANTS					
IMMUNOSUPPRESSANTS		CELLCEPT PROGRAF CAPS RAPAMUNE CYCLOSPORINE MODIFIED GENGRAF CAPS NEORAL SANDIMMUNE	CYCLOSPORINE CAPS	Established users grandfathered. 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.
PURINE ANALOG					
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.
K REMOVING RESINS					
K REMOVING RESINS		KAYEXALATE POWD KIONEX POWD SODIUM POLYSTYRENE SULFON SPS SUSP SPS 30GM/120ML ENEMA SUSP		Use PA Form # 20420	

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.

Revised: March 9, 2004

ANTI-CONVULSANTS INDICATION CHART

	SEIZURES	POST HERPETIC NEURALGIA	DIABETIC PERIPHERAL NEUROPATHY	MONOTHERAPY BIPOLAR	ADJUNCTIVE BIPOLAR	MIGRAINE PROPHYLAXIS	ANXIETY	
GABITRIL	X			9	8			
KEPPRA	X			9	7			
LAMICTAL	X			4*	4*			
NEURONTIN	X	X	X	9	9	X (2 nd line)	**	

TOPAMAX	X			9	6	X (2 nd line)		
TRILEPTAL	X			5	5			
ZONEGRAN	X			9	9			

* Psychiatrists and Neurologist Exempt

** Does not meet criteria yet but has one RDBPCT for Social Phobia