

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 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>							
<b>ASSORTED ANTIBIOTICS</b>							
BETA-LACTAMS / CLAVULANATE COMBO'S		AMOXICILLIN AMOXIL <sup>1</sup> AMPICILLIN AUGMENTIN AUGMENTIN ES-600 SUSR AUGMENTIN XR TB12 BEEPEN BICILLIN L-A SUSP DICCLOXACILLIN SODIUM CAPS DYNAPEN SUSR GEOCILLIN 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 <sup>2</sup> PRINCIPEN SUSR		1. Amoxil 500mg tabs are non preferred. All other Amoxil products are preferred. 2. Principen 250 mg is available without PA.	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 <sup>1</sup> CEDAX CEFACLO <sup>1</sup> CEFADROXIL MONOHYDRATE TABS CEFTIN DURICEF TABS FORTAZ SOLN KEFLEX CAPS SPECTRACEF TABS TAZICEF SOLR		1. Both brand and generic are clinically non-preferred.	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		BIAIXN XL E.E.S. E-MYCIN TBEC ERYPED 200 SUSR		BIAIXN DYNABAC D5-PAK TBEC ERYPED CHEW PCE TBEC		1. QL ZPAC 250mg 6/script/month 2. QL TRI-PAC 3/script/month	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.

		ERYPED 400 SUSR ERY-TAB TBEC ERYTHROCIN STEARATE TABS ERYTHROMYCIN ZITHROMAX <sup>1,2</sup>			
TETRACYCLINES		DOXYCYCLINE HYCLATE MINOCYCLINE HCL CAPS SUMYCIN TETRACYCLINE HCL CAPS VIBRAMYCIN SYRP		DECLOMYCIN TABS DORYX CPEP DOXYCYCLINE MONO CAPS DYNACIN CAPS MONODOX CAPS PERIOSTAT	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 <sup>1</sup> NOROXIN TABS		AVELOX ABC PACK TABS CIPRO CIPRO XR 1000MG FLOXIN TABS LEVAQUIN TEQUIN	1. QL 3/script/month 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			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	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	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	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 <sup>1</sup> LORABID NEBUPENT SOLR PROLOPRIM TABS TINDAMAX* XIFAXAN	* Need to fail other anti-protozoals 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 / EPIDRUSTICS		CLEOCIN SOLN CLEOCIN SUSR		CLEOCIN CAPS CLINDAMYCIN HCL 300CAPS <sup>1</sup>	1. Use multiple 150's for Clindamycin instead of 300's. 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 Zovax, please see the criteria listed in the Zovax PA form.

LEPROSTATICS		CLINDAMYCIN HCL 150CAPS DAPSONE TABS		ZYVOX SUSR ZYVOX TABS		Interaction between another drug and the preferred drug(s) exists. For Zyvox, please see the criteria listed in the Zyvox PA form.
ANTI INFECTIVE COMBO'S - MISC.		ERYTHROMYCIN/SULF SUSR SEPTRA/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA		ALINA* BACTRIM DS TABS	* Alina is preferred for children less than 12 years of age.	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.
<b>ANTI - FUNGALS</b>						
ANTIFUNGALS - ASSORTED		ANCOBON CAPS FLUCONAZOLE GRIFULVIN GRISEOFULVIN ULTRAMICROSI TABS GRIS-PEG TABS KETOCONAZOLE TABS NYSTATIN VFEND TABS	5 5 5 6 8 8	LAMISIL TABS SPORANOX SOLN <sup>2</sup> SPORANOX PULSEPAK CAPS <sup>3</sup> SPORANOX CAPS <sup>3</sup> DIFLUCAN <sup>1</sup> 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.	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.
<b>ANTI - VIRALS</b>						
ANTIRETROVIRALS		AGENERASE CAPS COMBIVIR TABS CRIXIVAN CAPS EMTRIVA EPIVIR / HBV EPZICOM FORTOVASE CAPS 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		FUZEON TRUVADA		Please refer to the criteria listed on the Fuzeon PA form.
CYTO-MEGALOVIRUS AGENTS		GANCICLOVIR VALCYTE TABS		CYTOVENE CAPS		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.
<b>HEPATITIS AGENTS</b>						
HEPATITIS C AGENTS		PEG-INTRON KIT REBETRON KIT	8 8	COPEGUS TABS PEGASYS KIT		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.

		REBETOL CAPS	8	PEGASYS SOLN		significant potential drug interaction between another drug and the preferred drug(s) exists.
HEPATITIS AGENTS - MISC.				ACTIMMUNE		Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.
HEPATITIS B ONLY		HEPSERA TABS				
HERPES AGENTS		ACYCLOVIR VALTRES TABS		FAMVIR TABS ZOVIRAX		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		RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU <sup>1</sup>		FLUMADINE TABS FLUMIST	1. Tamiflu 10 caps or 60cc's per month.	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.
<b>RSV PROPHYLAXIS</b>						
RSV PROPHYLAXIS				RESPIGAM SYNAGIS		Please see the criteria listed on the Synagis PA form.
<b>MS TREATMENTS</b>						
MULTIPLE SCLEROSIS AGENTS			5 5 5 6	AVONEX KIT <sup>1</sup> BETASERON SOLR <sup>1</sup> REBIF SOLN COPAXONE	Established users grandfathered. Must follow specified step order. 1. Neurologists do not need a PA for Avonex Betaseron and Rebif.	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.
<b>ASSORTED NEUROLOGICS</b>						
NEUROLOGICS - MISC.		MESTINON ORAP TABS PROSTIGMIN TABS				
<b>STEROIDS</b>						
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 SOLU-MEDROL SOLR		CORTEF 10 and 20 TABS DECADRON TABS FLORINEF TABS MEDROL TABS MEDROL DOSEPAK TABS PEDIAPRED LIQD PREDNISONE INTENSOL CONC PRELONE SYRP STERAPRED TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
<b>HORMONE REPLACEMENT THERAPIES</b>						
ANDROGENS / ANABOLICS		ANDROID CAPS ANDRODERM PT24 DANAZOL CAPS DEPO-TESTOSTERONE OIL FLUOXYMESTERONE TABS OXANDRIN TABS TESTODERM TESTOSTERONE PROPIONATE TESTRED CAPS		ANDRO LA 200 OIL ANDROGEL PACK DELATESTRYL OIL HALOTESTIN TABS METHITEST TABS TESTIM		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.

		WINSTROL TABS				
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.	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		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.	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 <sup>1</sup> PROMETRIUM 200MG <sup>1</sup> PROVERA TABS	1. Established users are grandmothers. PA approvals will require two 100 mg caps instead of one 200mg.	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.
<b>CONTRACEPTIVES</b>						
CONTRACEPTIVES - PROGESTIN ONLY		ORTHO MICRONOR TABS		CAMILA TABS NORA-BE TABS NOR-QD TABS OVRETTE 28 TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVES - INJECTABLE		DEPO-PROVERA SUSP		LUNELLE SUSP	Established users grandmothers.	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		PREVEN KIT				
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS		ORTHO EVRA PTWK <sup>1</sup>		NUVARING RING	1.No PA required for users less than 21 years of age.	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 LEVLITE-28 TABS LEVORA LOESTRIN TABS LOESTRIN FE TABS LOESTRIN FE 1/20 TABS LOESTRIN 1.5/30-21 TABS LOESTRIN 1/20-21 TABS	Loestrin FE and FE 1/20 are grandfathered for established users.	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.

				LOW-OGESTREL TABS MICROGESTIN FE TABS MIRCETTE TABS NECON 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		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		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.
<b>DIABETES THERAPIES</b>						
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	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.	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 GLUCOTROL TABS GLUCOTROL XL TBCR GLYNASE TABS MICRONASE TABS		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		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		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 <sup>1</sup>		ACTOS 30MG TABS <sup>2</sup>	1. Actos and Avandia	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

		ACTOS 15MG TABS <sup>1</sup> ACTOS 45MG TABS <sup>1</sup>			preferred without PA if patient on insulin or sulfonylurea or metformin. Avandia non-preferred as monotherapy. 2. Actos 30mg - use two 15mg instead	
DIABETIC - ALPHAGLUCOSIDASE		GLYSET TABS		PRECOSE TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - SULFONYLUREA / BIGUANIDE				GLUCOVANCE TABS METAGLIP TABS	Use individual ingredients.	Approved for patients failing to achieve good diabetic control with maximal doses of individual components.
DIABETIC - THIAZOL / BIGUANIDE COMBO		AVANDAMET TABS				
<b>THYROID</b>						
THYROID HORMONES		ARMOUR THYROID TABS CYTOMEL TABS LEVOTHROID TABS LEVOTHYROXINE SODIUM TABS LEVOXYL TABS THYROID TABS THYROLAR UNITHROID TABS		LEVOTHYROXINE SODIUM SOLR SYNTHROID TABS <sup>1</sup>	1. Established Synthroid users before July 1, 2003 grandfathered.	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		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.
<b>OSTEOPOROSIS</b>						
OSTEOPOROSIS		ACTONEL TABS FOSAMAX TABS MIACALCIN SOLN		ARELIA SOLR BONIVA DIDRONEL TABS EVISTA TABS FORTEO		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.
<b>GROWTH HORMONE</b>						
GROWTH HORMONE			5 6 8 8 8	GENOTROPIN NUTROPIN HUMATROPE SOLR NORDITROPIN CARTRIDGE SOLN SAIZEN SOLR	Products must be used in specified step order.	See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied.
SOMATOSTATIC AGENTS		SANDOSTATIN				
<b>GROWTH HORMONE ANTAGONISTS</b>						
GH ANTAGONISTS				SOMAVERT		Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatin.
<b>URINARY INCONTINENCE</b>						
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.	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		CYSTOSPAZ TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved,

		URISPAS TABS		DETROL TABS DITROPAN		unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		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				
<b>METABOLIC MODIFIER</b>						
HERED. TYROSINEMIA				ORFADIN		Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA.
<b>ANTIHYPERTENSIVES / CARDIAC</b>						
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		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		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
NITRO - OINTMENT/CAP/CR		NITROBID OINT  NITROGLYCERIN CPCR NITROL OINT NITRO-TIME CPCR				
NITRO - PATCHES	1 1 1 3	NITROGLYCERIN PT24 NITREK PT24 NITRO-DUR PT 24 0.8MG MINITRAN PT24		NITRODISC PT24 NITRO-DUR PT24	Preferred products must be used in specified order or PA will be required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
NITRO - SUBLINGUAL/ SPRAY		NITROLINGUAL AERS NITROSTAT SUBL NITROTAB SUBL		NITROLINGUAL SOLN NITROQUICK SUBL		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 <sup>1</sup> INDERAL LA CPCR LEVATOL TABS NADOLOL TABS PINDOLOL TABS PROPRANOLOL HCL SOLN PROPRANOLOL HCL TABS SOTALOL HCL TABS TIMOLOL MALEATE TABS		BETAPACE TABS BETAPACE AF TABS CORGARD TABS INDERAL TABS INNOPRAN XL PROPRANOLOL HCL LA CPCR	1. Coreg available without PA for CHF if patient on digoxin, loop diuretic, ACEI or ARB	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 <sup>1</sup>		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.	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		LABELALOL HCL TABS		TRANDATE TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CALCIUM CHANNEL BLOCKERS		NORVASC TABS				
-Amlodipines, Bepridil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils	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.	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	1	DILTIA XT CP24	6	TAZTIA		
	1	DILTIAZEM HCL ER CP24	7	TIAZAC CP24		
	1	DILTIAZEM HCL XR CP24	8	CARDIZEM TABS		
	1	DILTIAZEM CD 300MG CP24	8	CARDIZEM CD CP24		
	1	DILTIAZEM CD 360MG CP24	8	CARDIZEM SR CP12		
	4	CARTIA XT CP24	8	DILTIAZEM HCL TABS		
	4	DILTIAZEM CD CP24	8	DILTIAZEM HCL ER CP12		
	4	DILTIAZEM HCL ER CP24				
	4	DILTIAZEM XR CP24				
				PLENDIL TB24		Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
		DYNACIRC CR TBCR		DYNACIRC CAPS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				CARDENE CAPS CARDENE SR CPCR NICARDIPINE HCL CAPS		Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
		NIFEDIPINE TBCR NIFEDIPINE ER TBCR NIFEDICAL XL TBCR		ADALAT CC TBCR NIFEDIPINE CAPS PROCARDIA CAPS PROCARDIA XL TBCR	Established users of Adalatt CC are grandfathered.	Preferred drug must be tried and failed in step order due to lack of efficacy or intolerable side effects before non-preferred drugs in step order will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
		SULAR TB24				
	1	VERAPAMIL HCL CR TBCR		CALAN SR TBCR	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.	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	1	VERAPAMIL HCL ER TBCR		COVERA-HS TBCR		
	1	VERAPAMIL HCL SR TBCR		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 RYTHMOL TAMBOCOR		PACERONE CORDARONE DISOPYRAMIDE PROPafenONE FLECAINIDE MEXITIL QUINIDEX TIKOSYN*	* Cardiologist Exempt	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ACE INHIBITORS		CAPTOPRIL TABS BENZAPEPRIL HCL ENALAPRIL MALEATE TABS LISINOPRIL TABS	5 5 8 8	MAVIK TABS ACCUPRIL TABS ACEON TABS ALTACE <sup>1</sup> CAPS	Non-preferred products must be used in specified order.  1. Altace approved for	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.

		MONOPRIL TABS	8	CAPOTEN TABS	secondary CAD prevention	
			8	FOSINOPRIL SODIUM		
			8	LOTENSIN TABS		
			8	MOEXIPRIL		
			8	PRINIVIL TABS	2. Established users of	
			8	UNIVASC <sup>2</sup>	Univasc will be grandfathered.	
			8	VASOTEC TABS		
			8	ZESTRIL TABS		
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.	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		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				LEXXEL TBCR LOTREL CAPS TARKA TBCR		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		CAPTOPRIL/HYDROCHLOROTHIA ENALAPRIL MALEATE/HCTZ TABS LISINOPRIL-HCTZ TABS UNIRETIC TABS		ACCURETIC TABS BENZAEPRIIL HCL/HYDROCHLOR CAPOZIDE TABS LOTENSIN HCT TABS MONOPRIL HCT TABS PRINZIDE TABS VASERETIC TABS ZESTORETIC TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS AND DIURETIC COMBO'S		ATENOLOL/CHLORTHALIDONE BISOPROLOL FUMARATE/HCTZ PROPRANOLOL/HCTZ		CORZIDE TABS INDERIDE 40/25 TABS LOPRESSOR HCT TABS TENORETIC TIMOLIDE 10/25 TABS ZIAC TABS		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.	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		ALDACTAZIDE TABS ALDACTONE TABS	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Users will be	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.

		BUMETANIDE CHLOROTHIAZIDE TABS CHLORTHALIDONE TABS EDECIN TABS FUROSEMIDE HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS METHYCLOTHIAZIDE TABS SPIRONOLACTONE 25MG TABS SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ ZAROXOLYN TABS		BUMEX TABS DEMADEX TABS DIAMOX DIURIL DYAZIDE CAPS ENDURON TABS INSPRA LASIX TABS LOZOL TABS MAXZIDE MICROZIDE CAPS MIDAMOR TABS MODURETIC 5-50 TABS NAQUA TABS NATURETIN TABS SPIRONOLACTONE 50MG <sup>1</sup>	sirengin. Inspra will be approved for severe breast tenderness and male gynecomastia.	interaction between another drug and the preferred drug(s) exists.
CCB / LIPID		CADUET				
<b>LIPID DRUGS</b>						
CHOLESTEROL - BILE SEQUESTRANTS		CHOLESTYRAMINE COLESTID		PREVALITE QUESTRAN WELCHOL TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CHOLESTEROL - FIBRIC ACID DERIVATIVES		GEMFIBROZIL TABS TRICOR		LOPID TABS LOFIBRA		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 <sup>1</sup> 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.	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.
<b>PULMONARY ANTI-HYPERTENSIVES</b>						
PULMONARY ANTI-HYPERTENSIVES				FLOLAN TRACLEER		Flolan and Tracleer will be approved after the dx of pulmonary hypertension is confirmed.
<b>IMPOTENCE AGENTS</b>						
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.	See the criteria listed on the Erectile Dysfunction PA form.
<b>ANTI-EMETOGENICS</b>						
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC		MECLIZINE HCL TABS PHENERGAN SUPP PHENERGAN FORTIS SYRP PROMETHAZINE		ANTIVERT TABS PHENERGAN SOLN PHENERGAN TABS PROMETHEGAN SUPP		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.

		TRANSDERM-SCOP PT72		TORECAN TABS TIGAN		
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ		ALOXI* MARINOL CAPS ZOFRAN SOLN* ZOFRAN TABS*		ANZEMET TABS EMEND KYTRIL ZEGERID ZOFRAN ODT TBDP	See quantity limit table.	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.
<b>NON-SEDATING ANTIHISTAMINES / DECONGESTANTS</b>						
ANTI-HISTAMINES - NON-SEDATING		ALAVERT TABS <sup>1</sup> CLARITIN ALLERGY (OTC) <sup>1</sup> CLARITIN SYRP (OTC) <sup>2</sup> TAVIST ND (OTC) <sup>1</sup>	5 5 8 8	CLARINEX TABS <sup>2</sup> ZYRTEC <sup>3</sup> ALLEGRA CLARITIN <sup>2</sup>	1. Preferred drugs are OTC loratidines. 2. Claritin OTC syrup does not require a PA. 3. Zyrtec syrup <6 yr w/o PA	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.
<b>ALLERGY / ASTHMA THERAPIES</b>						
ANTI-ASTHMATIC - ANTICHOLINERGICS		ATROVENT AERS IPRATROPIUM BROMIDE SOLN		ATROVENT SOLN SPIRIVA <sup>1</sup>		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 <sub>1</sub> < 40% or COPD hospitalization within 6 months.
ANTI-ASTHMATIC - ANTI-INFLAMMATORY AGENTS		CROMOLYN SODIUM NEBU INTAL AERS TILADE AERS		XOLAIR <sup>1</sup>	1. Need max inhaled steroids and written by pulmonary or allergy specialist.	Xolair approval will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management.
ANTI-ASTHMATIC - NASAL STEROIDS	1 1 4 4 4	FLONASE SUSP <sup>1</sup> NASONEX SUSP <sup>1</sup> 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.	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-ASTHMATIC - NASAL MISC.		NASALCROM		ATROVENT NASAL SOL IPRATROPIUM NASAL SOL ASTELIN		Approved if patient fails on non-sedating antihistamines and steroid nasal sprays.
ANTI-ASTHMATIC - 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 <sup>1,2</sup>	1. Xopenex users with prior asthma hospitalization will be grandfathered. 2. Quantity Limit: 12 cc/day	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-ASTHMATIC - 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		COMBIVENT AERO		DUONEB SOLN		
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		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 <sup>1</sup> QVAR AERS VANCERIL AERS		AEROBID-M AERS PULMICORT TURBUHALER AEPB <sup>2</sup> VANCERIL DOUBLE STRENGTH AERS	1. No PA for Pulmicort susp if under 8 years old 2. No PA for Pulmicort turbobaler if under 14 yr.	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		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 <sup>1</sup>		ACCOLATE TABS	1. No PA if on asthma meds.	Singulair will additionally be approved for allergic indications if other preferred allergy treatments are ineffective.
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR				PROLASTIN SUSR ZEMAIRA		Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.
ANTIASTHMATIC - HYDROLYTIC ENZYMES				PULMOZYME SOLN		Will be approved for cystic fibrosis patients.
<b>COUGH/COLD</b>						
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.
<b>DIGESTIVE AIDS / ASSORTED GI</b>						
<b>**Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.**</b>						
GI - ANTI-SPASTIC AGENTS		DIPHENOXYLATE DIPHENOXYLATE/ATROPINE IMODIUM A-D TABS LOPERAMIDE HCL CAPS LOPERAMIDE HCL LIOD OPIUM TINCTURE TINC PAREGORIC TINC		ANTI-DIARRHEAL TABS LOFENE TABS LONOX TABS MOTOFEN TABS SB ANTI-DIARRHEA TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
GI - ANTI-DIARRHEAL/ ANTACID - MISC.		ALU-CAP CAPS ANTACID CHEW ATROPINE SULFATE SOLN BENTYL SYRP BISMATROL CALCIUM ANTACID CALCIUM CARBONATE CAL-GEST ANTACID CHEW CHEWABLE 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		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.

		DICYCLOMINE 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 PROPANTHELINE BROMIDE TABS ROBINUL SAL-TROPINE TABS SCOPOLAMINE HYDROBROMIDE SODIUM BICARBONATE TABS TUMS V-R STOMACH RELIEF SUSP X-STR CHEW ANTACID CHEW		LEVSIN/SL SUBL NULEV TBDP URO-MAG CAPS		
GI - H2-ANTAGONISTS		CIMETIDINE FAMOTIDINE RANITIDINE V-R ACID REDUCER TABS		AXID CAPS AXID AR TABS NIZATIDINE CAPS PEPCID PEPCID AC TAGAMET TABS ZANTAC <sup>1</sup>	1. Zantac syrup available without PA to users less than 6 years old.	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	ACIPHEX TBEC OMEPRAZOLE CPDR PREVACID ORAL SUSP PREVACID SOLUTABS <sup>1</sup> PRILOSEC CPDR	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.	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		Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - DIGESTIVE ENZYMES		LACTAID ULTRA LACTRASE CAPS	7 7 7 7 7 7 8 8 8	LIPRAM PANCREASE PANCRELIPASE PANGESTYME PANOKASE TABS ULTRASE CPEP CREON KUTRASE CAPS KU-ZYME CAPS	Non-preferred products are a one time PA for life (for CF diagnosis). Non-preferred products must be used in specified step order.	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 8 8	LIPRAM CR PANCREASE MT PANCRECARB MS-8 CPEP ULTRASE MT VIKASE		
GI - ANTI - FLATULENTS / GI STIMULANTS		CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP GASTROCROM CONC GENERLAC SYRP LACTULOSE SYRP METOCLOPRAMIDE HCL SIMETHICONE		CEPHULAC SYRP GAS-X CHEW INFANTS GAS RELIEF SUSP REGLAN TABS	Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL	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. <b>As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.</b>
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		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		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 <sup>1</sup>		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 SEKOKOT TABS SEKOKOT S TABS STOOL SOFTENER PLUS CAPS UNI-CENNA TABS UNI-EASE PLUS CAPS V-R NATURAL SENNA LAXATIV TABS	1. Quantity Limit: 255 g/90-day without PA	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. <b>As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.</b>
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SENNA  
 SENOKOT GRAN  
 SENOKOT SYRP  
 SENOKOT CHILDRENS SYRP  
 SENOKOT XTRA TABS  
 SORBITOL  
 STOOL SOFTENER CAPS  
 SUCRALFATE TABS  
 UNI-EASE CAPS  
 UNIFIBER POWD  
 URSODIOL

MISC. UROLOGICAL

UROLOGICAL - MISC.		ACETIC ACID 0.25% SOLN BICITRA SOLN CYTRA-K SOLN FURADANTIN SUSP K-PHOS MF TABS MACRODANTIN CAPS METHENAMINE MANDELATE TABS MONUROL PACK NEOSPORIN GU IRRIGANT SOLN PHENAZOPYRIDINE HCL TABS PHOSLO POLYCITRA SYRP POLYCITRA-K SOLN POLYCITRA-LC SOLN PROSED/DS TABS PYRIDIUM PLUS TABS RENACIDIN SOLN TRICITRATES SYRP UREX TABS URISED TABS UROCIT-K UROQID #2 TABS		CITRIC ACID/SODIUM CITRAT SOLN CYTRA-2 SOLN ELMIRON CAPS <sup>2</sup> MACROBID CAPS MANDELAMINE TABS NITROFURANTOIN MACR CAPS POLYCITRA-K CRYSTALS PACK POTASSIUM CITRATE/CITRIC SOLN PYRIDIUM TABS RENAGEL <sup>1</sup>	1. Renagel 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. Renagel will be approved in patients with hypercalcemia, on concurrent digoxin or insufficient response with Phos-lo (Renagel to be add-on therapy).
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INTRA-VAGINALS

VAGINAL - ANTIBACTERIALS	1 1 3	CLEOCIN CREA METROGEL VAGINAL GEL CLEOCIN SUPP			Step order must be followed to avoid PA. Must fail Cleocin and Metrogel products before moving to next step product without PA.	Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ANTI FUNGALS		CLOTRIMAZOLE CREA GYNE-LOTRIMIN CREA MICONAZOLE CREA MICONAZOLE 3 COMBO PACK KIT <sup>1</sup> MICONAZOLE 7 CREA MICONAZOLE NITRATE CREA MONISTAT 1 OINT MONISTAT 3 CREA MONISTAT 7		AVC CREAM CLOTRIMAZOLE 3 DAY CREA GYNAZOLE-1 CREA GYNE-LOTRIMIN 3 TABS MICONAZOLE 3 SUPP MONISTAT 3 SUPP TERAZOL 3 CREA TERAZOL 3 SUPP TERAZOL 7 CREA	1. Quantity limit: 1/script/2 weeks	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.

		NYSTATIN TABS VAGITROL V-R MICONAZOLE-7 CREA				
VAGINAL - CONTRACEPTIVES		GYNOL II EXTRA STRENGTH GEL		DELLEN FOAM		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		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		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.
<b>BPH</b>						
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.	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.
<b>ANXIOLYTICS</b>						
ANXIOLYTICS - BENZODIAZEPINES		ALPRAZOLAM TABS CHLORDIAZEPOXIDE HCL CAPS CLORAZEPATE DIPOTASSIUM TABS DIAZEPAM LORAZEPAM OXAZEPAM CAPS		ATIVAN SERAX TRANXENE XANAX TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANXIOLYTICS - LONG ACTING		XANAX XR <sup>1</sup>			1. Xanax XR will be available if the long acting benzo clonazepam fails.	
ANXIOLYTICS - MISC.		BUSPIRONE HCL TABS HYDROXYZINE HCL SOLN HYDROXYZINE HCL SYRP HYDROXYZINE PAMOATE CAPS		ATARAX TABS BUSPAR TABS DROPERIDOL SOLN HYDROXYZINE HCL TABS HYDROXYZINE PAM 100MG CAPS INAPSINE SOLN MEPROBAMATE TABS VISTARIL		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.
<b>ANTI-DEPRESSANTS</b>						
ANTIDEPRESSANTS - MAO INHIBITORS		NARDIL TABS PARNATE TABS				
ANTIDEPRESSANTS - SELECTED SSRI'S		BUPROPION HCL TABS BUPROPION SR CELEXA <sup>5</sup> FLUOXETINE HCL CAPS FLUOXETINE HCL LIQD FLUOXETINE HCL TABS FLUVOXAMINE MALEATE TABS LEXAPRO TABS <sup>5</sup> MIRTAZAPINE PAROXETINE <sup>3</sup> PAXIL CR <sup>3</sup> SERZONE TABS	5 6 6 8 8 8 8 8 8 8 8 8	CYMBALTA EFFEXOR TABS <sup>4</sup> EFFEXOR XR CP24 <sup>3,4</sup> DESYREL TABS FLUOXETINE 40 mg <sup>1</sup> LUVOX TABS MAPROTILINE HCL TABS PAXIL <sup>3</sup> PROZAC PROZAC CAPS PROZAC WEEKLY CPDR <sup>4</sup> REMERON TABS	Non-preferred products must be used in specified step order. 1. Use Fluoxetine 20 mg in multiples. 2. See Zoloft splitting table. Zoloft requires splitting of 50mg and/or 100mg scored tabs to avoid PA. 3. Strong caution with pediatric population. 4. Established users are grandfathered. 5. See Celexa and Lexapro splitting tables.	Preferred drugs must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. At least one preferred SSRI and one preferred non-SSRI drugs must be tried. Venlafaxine is non-preferred for any anxiety diagnosis and may be approved after trials of one SSRI and one non-SSRI (e.g. any anxiolytic or a tricyclic at any dose).

		TRAZODONE HCL TABS	8	SARAFEM CAPS		
		WELLBUTRIN XL	8	TRAZODONE HCL 300MG TABS		
		ZOLOFT <sup>2</sup>	8	WELLBUTRIN TABS		
			8	WELLBUTRIN SR TBCR		
			9	REMERON SOLTAB TBDP		
ANTIDEPRESSANTS - TRICYCLICS	*	AMITRIPTYLINE HCL TABS		AMOXAPINE TABS	*PA required for new starters if over 65 years old. Users over 65 years old are grandfathered.	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.
	*	AVENTYL SOLN		ANAFRANIL CAPS		
	*	CLOMIPRAMINE HCL CAPS		ELAVIL TABS		
	*	DESIPRAMINE HCL TABS		NORPRAMIN TABS		
	*	DOXEPIN HCL		PAMELOR		
	*	IMIPRAMINE HCL TABS		SINEQUAN		
	*	NORTRIPTYLINE HCL		TOFRANIL		
	*	PROTRIPTYLINE HCL TABS		VIVACTIL TABS		
	*	SURMONTIL CAPS				
<b>SEDATIVE / HYPNOTICS</b>						
SEDATIVE/HYPNOTICS - BARBITURATE		BUTISOL SODIUM TABS		LUMINAL SOLN	PA required for new users of preferred products if over 65 years old.	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.
		CHLORAL HYDRATE SYRP		SECONAL CAPS		
		MEBARAL TABS		SOMNOTE CAPS		
		PHENOBARBITAL				
SEDATIVE/HYPNOTICS - BENZODIAZEPINES		DORAL TABS		DALMANE	Previous quantity limits still apply.	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.
		ESTAZOLAM TABS		HALCION TABS		
		FLURAZEPAM HCL CAPS		MIDAZOLAM HCL SYRP		
		TEMAZEPAM CAPS		PROSOM TABS		
		TRIAZOLAM TABS		RESTORIL CAPS		
SEDATIVE/HYPNOTICS - Non-Benzodiazepines		TRAZODONE	7 8	AMBIEN TABS SONATA CAPS	Elderly (over 65) exempt, but previous quantity limits still apply.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ambien and Sonata do cause dependence with continued use and as with benzodiazepines, usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 days per week max) is the standard of care. Please see Sedative/Hypnotic PA form.
<b>ANTI-PSYCHOTICS</b>						
ANTIPSYCHOTICS - ATYPICALS	1 2 2	RISPERDAL GEODON <sup>1</sup> SEROQUEL TABS	5 8 8 8 8	ABILIFY TABS <sup>2</sup> RISPERDAL M TAB RISPERDAL CONSA ZYPREXA TABS ZYPREXA ZYDIS TBDP MORATORIUM CONTINUES THROUGH OCTOBER 2004	Established users except Zyprexa Zydis are grandfathered. New users can follow preferred step order without PA. 1. Geodon has dose consolidation edit of 2 per day. 2. Abilify 1/day.	Preferred drugs subject to step order must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Atypicals will be approved, subject to step-order, for patients with FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality and as long as all first line preferred therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks).
ANTIPSYCHOTICS - SPECIAL ATYPICALS		CLOZAPINE TABS		CLOZARIL TABS <sup>1</sup> FAZACLO	1. No new starters on brand Clozaril.	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved.
ANTIPSYCHOTICS - TYPICAL		CHLORPROMAZINE HCL FLUPHENAZINE DECANOATE FLUPHENAZINE HCL HALDOL HALOPERIDOL HALOPERIDOL DECANOATE SOLN HALOPERIDOL LACTATE SOLN LOXAPINE SUCCINATE CAPS LOXITANE-C CONC		COMPazine COMPRO SUPP HALDOL DECANOATE LOXITANE CAPS MELLARIL NAVANE CAPS PROLIXIN STELAZINE TABS THORAZINE		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.

		MOBAN TABS PERPHENAZINE PROCHLORPERAZINE SERENTIL THIORIDAZINE HCL THIOTHIXENE THORAZINE SUPP TRIFLUOPERAZINE HCL TABS				
<b>LITHIUM</b>						
LITHIUM		ESKALITH CAPS ESKALITH CR TBCR LITHIUM CARBONATE LITHIUM CITRATE SYRP LITHOBID TBCR				
<b>COMBINATION - PSYCHOTHERAPEUTIC</b>						
PSYCHOTHERPEUTIC COMBINATION		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	8	SYMBYAX		Use individual components, which are currently available without a PA.
<b>STIMULANTS</b>						
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.	
STIMULLANT - 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 METHYLPHENIDATE HCL		RITALIN	Preferred stimulants will be available without PA if diagnosis of ADHD.	
STIMULANT - METHYLPHENIDATE - LONG ACTING	1	CONCERTA TBCR	5 8	METADATE CD CPCR <sup>1</sup> 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.	
STIMULANT - STIMULANT LIKE			7 8 8  8 8 8	STRATTERA <sup>1,2</sup> CAFCIT SOLN CYLERT CHEW  CYLERT TABS DESOXYN TABS PROVIGIL TABS	1. Required failure of both an amphetelamine and methylphenidate (unless history of substance abuse)  2. Effective 12.04.03, Strattera allowed only 1 per day for all strengths except 40ma. where 2 are allowed to	

			9	PEMOLINE	long, must take 2 or 3 times a day to achieve 80mg or 100mg daily.	
<b>WEIGHT LOSS</b>						
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.
<b>ALZHEIMER DISEASE</b>						
ALZHEIMER - Cholinomimetics/Others		ARICEPT TABS <sup>1</sup> NAMENDA <sup>1</sup> REMINYL <sup>1</sup>	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.
<b>SMOKING CESSATION</b>						
NICOTINE PATCHES / TABLETS		NICODERM CQ PT24		NICOTINE PT24 NICOTINE TRANSDERMAL PT24 NICOTROL PT24 ZYBAN TBCR <sup>1</sup>	1. Use Bupropion SR 150 mg instead.	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		NICORETTE NICOTROL INHALER INHA NICOTROL NS SOLN		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.
<b>ALCOHOL DETERRENTS</b>						
ALCOHOL DETERRENTS		DISULFIRAM TABS		ANTABUSE TABS <sup>1</sup>	1. DAW8 (Generic not available)	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.
<b>MISCELLANEOUS ANALGESICS</b>						
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		ASPIR-81 TBEC AXOCET CAPS DOLOBID TABS EASPRIN TBEC EQUAGESIC TABS ESGIC-PLUS EXCEDRIN TAB ASA FRE FIORICET TABS FIORINAL CAPS FIORTAL CAPS FORTABS TABS PHRENILIN TABS PHRENILIN FORTE CAPS TRILISATE LIQD TRILISATE TABS ZEBUTAL CAPS ZORPRIN TBCR		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.

	MAPAP PAIN RELIEVER O-NOL TABS SALSALATE TABS TACTINAL EXTRA STRENGTH TABS TYLENOL V-R CHILDRENS ASPIRIN CHEW V-R NON-ASPIRIN TABS				
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**LONG ACTING NARCOTICS**

NARCOTICS - LONG ACTING	KADIAN CP24 AVINZA METHADONE METHADOSE	7 8 8 8 8 8 9	DURAGESIC PT72 <sup>1</sup> ORAMORPH SR TB12 MOPRHINE SULFATE ER TB12 MORPHINE SULFATE SUPP MS CONTIN TB12 OXYCODONE ER 80MG OXYCONTIN TB12 <sup>1</sup>	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.	Preferred drugs (Kadian or Avinza and Methadone or Methadose) 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 regarding prior use of narcotics; 7. Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of 8. Documented history of substance abuse. Substance abuse evaluations may be required for patients with medical records displaying documented substance abuse or potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. 9. Circumventing MaineCare prior authorization requirements for narcotics by paying cash for affected narcotics (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). 10. Requests for any Brand name controlled substance, considered by authorities to be highly abused and diverted (Oxycontin, Percocet, Typox, 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.
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NARCOTICS - SELECTED	TRAMADOL HCL TABS		BUPRENEX SOLN BUTORPHANOL NALBUPHINE HCL SOLN NUBAIN SOLN STADOL NS SOLN ULTRACET TABS ULTRAM TABS		Preferred drugs from this and other narcotic classes must be tried for at least 2 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs from this class will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but desired product. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.  Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance abuse such as: 1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel; 3. breaches of narcotic contracts with any provider; 4. failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass pill counts; 5. failing to take or pass random drug testing; 6. failing to provide old records regarding prior use of narcotics; 7. receiving controlled substances from other prescribers that the provider submitting the PA is unaware of. In Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.
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**MISCELLANEOUS NARCOTICS**

NARCOTICS - MISC.	ACETAMINOPHEN/CODEINE ACTIQ LPOP <sup>1</sup> ASPIRIN/CODEINE TABS BUTAL/ASA/CAFF/COD CAPS BUTALBITAL/ASPIRIN/CAFFEI CAPS CAPITAL AND CODEINE SUSP <sup>1</sup> CAPITAL/CODEINE SUSP <sup>1</sup>		ANEXSIA TABS ASCOMP/CODEINE CAPS BUTALBITAL/APAP/CAFFEINE/ CAPS DARVOCET-N DARVON DEMEROL DILAUDID	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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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	CODEINE PHOSPHATE SOLN CODEINE SULFATE TABS ENDOCET 5/325mg TABS <sup>2</sup> ENDODAN TABS FENTANYL CITRATE SOLN HYDROCODONE BITARTRATE/AP TABS HYDROCODONE/ACETAMINOPHEN HYDROMORPHONE HCL MEPERIDINE HCL OXYCODONE OXYCODONE/ACETAMINOPHEN <sup>2</sup> PENTAZOCINE/NALOXONE TABS PROPOXYPHENE COMPOUND CAPS PROPOXYPHENE CMPND-65 CAPS PROPOXYPHENE HCL CAPS PROPOXYPHENE/ACET TABS PROPOXYPHENE-N/ACET TABS ROXICET ROXIPRIN TABS	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	
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<b>NARCOTIC ANTAGONISTS</b>				
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<b>NARCOTIC - ANTAGONISTS</b>	NALTREXONE HCL TABS	REVIA TABS		Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version.
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<b>COX 2 / NSAIDS</b>				
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<b>COX 2 INHIBITORS</b>	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.	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.
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<b>NSAIDS</b>	CHILDRENS IBUPROFEN CHILDREN'S 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	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		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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		SULINDAC TABS TOLMETIN SODIUM		NAPROSYN TABS NAPROXEN DR TBEC NAPROXEN SODIUM TBCR ORUVAIL CP24 PONSTEL CAPS RELAFEN TABS SB IBUPROFEN TABS TOLECTIN TORADOL VOLTAREN V-R IBUPROFEN TABS		
<b>RHEUMATOID ARTHRITIS</b>						
RHEUMATOID ARTHRITIS		ARAVA TABS <sup>1</sup>		ENBREL KIT <sup>2</sup> HUMIRA <sup>2</sup> KINERET SOLN <sup>2</sup> REMICADE <sup>2</sup>	1. No PA for Arava if methotrexate previously tried. 2. Rheumatologist must write script. Rheumatologist will not require PA for biologicals if methotrexate or other DMARDs in drug profile.	See criteria as listed on Rheumatoid Arthritis PA form.
<b>MISCELLANEOUS ARTHRITIS</b>						
ARTHRITIS - MISC.		RIDAURA CAPS MYOCHRYSINE SOLN		ARTHROTEC		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.
<b>MIGRAINE THERAPIES</b>						
MIGRAINE - ERGOTAMINE DERIVATIVES		MIGRANAL SOLN SANSERT TABS		D.H.E. 45 SOLN		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 <sup>1</sup> 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	Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)- Injectables		IMITREX KIT IMITREX STATDOSE PEN KIT IMITREX STATDOSE REFILL KIT		IMITREX SOLN		
MIGRAINE - MISC.		CAFERGOT SUPP CAFERGOT TABS SPASTRIN TABS		MIGRAZONE CAPS BELCOMP-PB SUPP		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.
<b>GOUT</b>						
GOUT		ALLOPURINOL TABS COLCHICINE TABS PROBENECID TABS PROBENECID/COLCHICINE TABS		ZYLOPRIM TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

SULFINPYRAZONE TABS

MISC.

ANESTHETICS - MISC.	BUPIVACAINE HCL SOLN LIDOCAINE HCL SOLN MARCAINE SOLN	SENSORCAINE-MPF SOLN SYNWISC INJ XYLOCAINE SOLN	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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ANTI-CONVULSANTS

ANTICONSULSANTS	CARBAMAZEPINE CARBATROL CP12 CELONTIN CAPS CLONAZEPAM TABS DEPAKOTE TBEC DEPAKOTE SPRINKLES CPSP DIASTAT <sup>1</sup> DILANTIN EPITOL TABS ETHOSUXIMIDE SYRP FELBATOL LAMICTAL <sup>3</sup> MYSOLINE TABS PHENYTOIN PHENYTEK CAPS TEGRETOL <sup>2</sup> TEGRETOL-XR TB12 VALPROIC ACID ZARONTIN CAPS	DEPAKENE GABITRIL TABS KEPPRA TABS KLONOPIN TABS LAMICTAL PRIMIDONE TABS TOPAMAX TRILEPTAL ZARONTIN SYRP ZONEGRAN CAPS NEURONTIN  <b>BIPOLAR DISORDER: STEP ORDER</b>  LAMICTAL <sup>3</sup> GABITRIL TABS KEPPRA TABS TOPAMAX TRILEPTAL 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 still require PA  See review in DUR section of website.  A= Monotherapy B= Adjunctive * Psychiatrists & Neurologists exempt. Other prescribers still require PA 9= No Evidence  The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations.	Seizure patients will be approved for any anticonvulsant. Other approvals will be for patients with a variety of drug-specific FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality after recommendation by the DUR Committee and as long as all first line therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks).  Topamax - Second line therapy for migraine prophylaxis.  *** SEE CHART AT END OF DOCUMENT
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ANTI-PARKINSON DRUGS

PARKINSONS - ANTICHOLINERGICS	AKINETON TABS BENZTROPINE MESYLATE TABS COGENTIN SOLN KEMADRIN TABS TRIHENXYPHENIDYL		
PARKINSONS - COMT INHIBITORS	COMTAN TABS	TASMAR TABS	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 MIRAPEX TABS 2 REQUIP TABS 3 PERMAX TABS	PERGOLIDE MESYLATE TABS	Preferred products must be used in specified order or PA will be required. Established users grandfathered.  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/CARBII/ 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  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				
<b>MUSCLE RELAXANTS</b>						
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 8 8 8 8 8 9	ORPHENADRINE CITRATE TIZANIDINE HCL TABS CARISOPRODOL TABS <sup>1</sup> DANTRIUM CAPS FLEXERIL TABS LIORESAL TABS NORFLEX TBCR ROBAXIN-750 TABS SKELAXIN TABS ZANAFLEX TABS SOMA TABS	1. Effective October 1, 2003 even Carisoprodol requires PA. Non-preferred products must be used in specified step order.	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		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 trave, etc.
<b>VITAMINS</b>						
<b>**Preferred products that used to require diag codes still require diag codes unless indicated otherwise.**</b>						
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 VITAMIN C VITAMIN D VITAMIN E CAPS VITAMIN E/D-ALPHA CAPS VITAMIN K1 SOLN V-R VITAMIN E CAPS		AQUASOL E SOLN AQUAVIT-E SOLN DHT SOLN DRISDOL CAPS NASCOBAL GEL ROCALTROL		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. <b>As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.</b>
<b>MISC MULTI-VITAMINS</b>						
<b>**Preferred products that used to require diag codes still require diag codes unless indicated otherwise.**</b>						
VITAMINS - MISC.		CENTRUM LIQD		ADEKS	Diag codes are no longer	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved,

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

ADVANCED NATALCARE TABS  
 CENTRUM JR/EXTRA C CHEW  
 CENTRUM PERFORMANCE TABS  
 DALYVITE LIQD  
 EMBREX 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  
 NEHPLEX 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

required on prenatal vitamins.

unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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				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.
	CALCARB	ANEMAGEN		
	CALCI-MIX CAPSULE CAPS	CALCET TABS		
	CALCIQUID SYRP	CALCIUM 600-D TABS		
	CALCITRATE/VITAMIN D TABS	CALCIUM/VITAMIN D TABS		
	CALCIUM	CALTRATE 600 PLUS/VIT D TABS		
	CALCIUM CARBONATE	CALTRATE PLUS TABS		
	CALCIUM CITRATE TABS	CHROMAGEN		
	CALCIUM GLUCONATE TABS	CITRACAL PLUS TABS		
	CALCIUM LACTATE TABS	CONTRIN CAPS		
	CALCIUM/MAGNESIUM TABS	FEOGEN FORTE CAPS		
	CALCIUM/VITAMIN D TABS	FEROCON CAPS		
	CALTRATE 600 TABS	FERREX 150 CAPS		
	CHEWABLE CALCIUM CHEW	FERRO-SEQUELS TBCR		
	CITRACAL TABS	FE-TINIC CAPS		
	CITRACAL + D TABS	FE-TINIC 150 FORTE CAPS		
	CITRUS CALCIUM TABS	FLUOR-A-DAY SOLN		
	CITRUS CALCIUM 1500 + D TABS	K-DUR TBCR		
	DEXFERRUM SOLN	KLOR-CON PACK		
	EFFERVESCENT POTASSIUM TBEF	K-LYTE		
	FEOSTAT CHEW	K-PHOS TABS		
	FERATAB TABS	K-TABS TBCR		
	FER-GEN-SOL SOLN	K-VESCENT PACK		
	FERGON TABS	NU-IRON 150 CAPS		
	FER-IN-SOL SOLN	OYSTER SHELL CALCIUM/VITA TABS		
	FER-IRON SOLN	POLY-IRON 150 CAPS		
	FERRONATE TABS	POLYSACCHARIDE IRON CAPS		
	FERROUS FUMARATE TABS	POTASSIUM BICARB/CHLORIDE		
	FERROUS GLUCONATE TABS	SLOW FE TBCR		
	FERROUS SULFATE	TUMS 500 CHEW		
	FLUOR-A-DAY CHEW	VIActiv CHEW		
	FLUORIDE CHEW			
	FLUORIDE SODIUM CHEW			
	FLUORITAB CHEW			
	HEMOCYTE TABS			
	HM CALCIUM TABS			
	K+ POTASSIUM PACK			
	KAON ELIX			
	KAON-CL-10 TBCR			
	KCL 0.075%/D5W/NACL 0.2% SOLN			
	K-EFFERVESCENT TBEF			
	KLOR-CON			
	KLOTRIX TBCR			
	K-PHOS TABS			
	K-VESCENT TBEF			
	LURIDE CHEW			
	MAGNESIUM GLUCONATE TABS			
	MAGNESIUM SULFATE SOLN			
	MICRO-K CPCR			
	NEUTRA-PHOS			
	OS-CAL TABS			

OS-CAL 500 + D TABS  
 OYSCO  
 OYST-CAL TABS  
 OYST-CAL D TABS  
 OYST-CAL/VITAMIN D TABS  
 OYSTER CALCIUM TABS  
 OYSTER SHELL  
 PHOSPHA 250 NEUTRAL TABS  
 POTASSIUM BICARBONATE TBEP  
 POTASSIUM CHLORIDE  
 POTASSIUM EFFERVESCENT  
 SELENIUM TABS  
 SLOW-MAG TBCR  
 SODIUM FLUORIDE  
 SSKI SOLN  
 V-R CALCIUM  
 V-R OYSTER SHELL CALCIUM  
 ZINC SULFATE CAPS

MISC. ELECTROLYTES/NUTRITIONALS

ELECTROLYTES/ NUTRITIONALS		FISH OIL CAPS INTRALIPID EMUL MCT OIL OIL ORALYTE SOLN P.T.E. -5 SOLN PEDIALYTE SOLN	BOOST CASEC POWD CHOICE DM LIQD DELIVER 2.0 LIQD ENFAMIL ENSURE GLUCERNA ISOCAL LIQD KINDERCAL TF LIQD KINDERCAL TF/FIBER LIQD L-CARNITINE CAPS LIPISORB LIQD 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	This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred.	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. <b>As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.</b>
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ERYTHROPOEITINS

ERYTHROPOEITINS			5 PROCRIT SOLN <sup>1</sup> 6 EPOGEN SOLN 8 ARANESP SOLN	1. All products require PA but Procrit is first choice	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.
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GRANULOCYTE CSF

GRANULOCYTE CSF			8 LEUKINE	Must be used in specified step	See approval criteria detailed on Neupogen PA form.
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			8	NEUPOGEN SOLN <sup>1</sup> NEULASTA	order.1. 10 day supply/month may be used without a PA.	
			9			
<b>ANTICOAGULANTS / PLATELET AGENTS</b>						
ANTICOAGULANTS		FRAGMIN INJ <sup>2</sup> HEPARIN SODIUM/NACL 0.9% SOLN HEP-LOCK SOLN INNOHEP LOVENOX SOLN <sup>2</sup> WARFARIN SODIUM TABS HEPARIN LOCK SOLN HEPARIN LOCK FLUSH SOLN HEPARIN SODIUM SOLN HEPARIN SODIUM LOCK FLUSH SOLN		ARIXTRA SOLN COUMADIN TABS <sup>1</sup> IPRIVAS C	1. Established Coumadin users are grandfathered. 2. Fragmin and Lovenox therapy durations greater than 7 days require PA.	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.
ANTHEMOPHILIC 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 <sup>1</sup>	1. Only if other products unavailable.	Non-preferred will only be approved if other preferred products are unavailable.
PLATELET AGGREGATION INHIBITORS		DIPYRIDAMOLE TABS PLAVIX TABS TICLOPIDINE HCL TABS		PERSANTINE TABS TICLID TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.		AGGRENOX CP12 PENTOXIFYLLINE ER TBCR PLETAL TABS		AGRYLIN CAPS TRENTAL TBCR		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.
<b>HEMOSTATIC</b>						
HEMOSTATIC		AMICAR AMINOCAPROIC ACID				
<b>OPHTHALMICS</b>						
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		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		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.

		SULFACETAMIDE SODIUM TERRAMYCIN OINT TOBRAMYCIN SULFATE SOLN TRIMETHOPRIM SULFATE/POLY VIROPTIC SOLN		TOBREX OINT TRIFLURIDINE SOLN		
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 Ocuflor, Vigamox, and a Ciloxan product before moving to next step product without PA.	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		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		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH.		AK-SPORE HC OINT ALREX SUSP BLEPHAMIDE SUSP CORTISPORIN SUSP DEXAMETH SOD PHOS SOLN FLAREX SUSP FLUOROMETHOLONE SUSP FML LIQUIFILM SUSP FML S.O.P. OINT FML-S LIQUIFILM SUSP INFLAMASE SOLN		AK-TROL SUSP BAC/POLY/NEOMY/HC OINT BLEPHAMIDE S.O.P. OINT ECONOPRED EFLONE SUSP FLUOR-OP SUSP MAXITROL NEO/POLY/BAC/HC OINT PRED-G SUSP PRED-G S.O.P. OINT SULFACET SOD/PRED SOLN		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.

		LOTEMAX SUSP NEOM/POLIN/DEX PRED FORTE SUSP PRED MILD SUSP PREDNISOLONE TOBRADEX		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.	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 HOMATROPINE HBR SOLN ISOPTO HYOSCINE SOLN		CYCLOGYL SOLN ISOPTO ATROPINE SOLN ISOPTO HOMATROPINE SOLN MUROCOLL-2 SOLN		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		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		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		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		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 <sup>1</sup>	1. Must have kerato conjunctivitis sicca.	Must fail adequate trials of multi agents from artificial tears and lubricant category.
<b>DERMATOLOGICAL</b>						
TOPICAL - ACNE PREPARATIONS		ACCUTANE CAPS  AKNE-MYCIN OINT AZELEX CREA BENZOYL PEROXIDE		ALTINAC CREA AVITA CREA BENZAC BENZACLIN GEL	1. For these Retin-A products, over 24 yr. need PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

		<p>CLEOCIN-T DIFFERIN ERYTHROMYCIN GEL ERYTHROMYCIN PADS ERYTHROMYCIN SOLN METROCREAM CREA METROGEL GEL METROLOTION LOTN METRONIDAZOLE POWD PLEXION RETIN-A CREA<sup>1</sup> RETIN-A GEL<sup>1</sup> RETIN-A LIQD<sup>1</sup> SODIUM SULFACET/SULF LOTN</p>	<p>BENZAGEL-10 GEL BENZAMYCIN GEL BENZAMYCINPAK PACK BREVOXYL CLINAC BPO GEL CLINDAGEL GEL CLINDAMYCIN PHOSPHATE CLINDETS SWAB DESQUAM-E GEL DESQUAM-X DUAC GEL EMGEL GEL ERYCETTE PADS ERYDERM SOLN ERYGEL GEL FINEVIN CREA KLARON LOTN NORITATE CREA RETIN-A MICRO GEL SULFACET-R LOTN TRETINOIN TRIAZ ZETACET</p>		
TOPICAL - ANTIBIOTIC		<p>BACIT/NEOMYCIN/POLYM OINT BACITRACIN OINT BACTROBAN<sup>1</sup> GENTAMICIN SULFATE</p>	<p>CORTISPORIN TRIPLE ANTIBIOTIC OINT</p>	1. Bactroban quantity limit of 30 g per month.	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		<p>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</p>	<p>ECONAZOLE NITRATE CREA EXELDERM FUNGIZONE CREA HYDROCORT/IODOOQ 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</p>		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIPRURITICS		<p>ZONALON CREA</p>	<p>PRUDOXIN CREA</p>		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIPSORIATICS		<p>DOVONEX OXSORALEN ULTRA CAPS</p>	<p>PSORiatec CREA SORIATANE CAPS</p>		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

		TAZORAC		VANAMIDE		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		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 <sup>1</sup>			1. Zovirax may be used once without PA.	
TOPICAL - ANTINEOPLASTICS		EFUDEX FLUOROPLEX CREA SOLARAZE GEL		CARAC CREA		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		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 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		ACLOVATE AMCINONIDE CREA ANUSOL HC-1 OINT ARISTOCORT A AUGMENTED BETA DIP OINT CLOBEX CLODERM CREA CORDRAN CORMAX DERMATOP DIFLORASONE DIACETATE ELOCON OINT HYDROCORTISONE POWD KENALOG AERS LIDA MANTLE HC CREA LIDEX LIDEX-E CREA LUXIQ FOAM OLUX FOAM PANDEL CREA PROCTOCORT CREA PSORCON E SYNALAR OINT TEMOVATE TOPICORT TOPICORT LP CREA WESTCORT		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 LOCAL ANESTHETICS		PRAMOSONE ZONE-A FORTE LOTN		EPIFOAM FOAM		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		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.

COMBINATIONS					exception is offered on the Prior Authorization form, such as the presence of 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		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 ZIOX OINT		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 <sup>1</sup>	5 8	PODOFILOX SOLN CONDYLOX	Non-preferred products must be used in specified order. 1. QL 48/year	
TOPICAL - IMMUNOMODULATORS			8 9	ELIDEL CREA PROTOPIC OINT	Non-preferred products must be used in specified order.	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 <sup>1</sup> EMLA CREA <sup>1</sup> EMLA/TEGADERM KIT <sup>1</sup> 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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - DEPIGMENTING AGENTS			8 8 8 8 8 8 9	ALUSTRA CREA GLYQUIN CREA HYDROQUINONE CREA HYDROQUINONE/SUNSCREENS SOLAQUIN FORTE CREA TRI-LUMA CREA ELDOQUIN	Not covered for cosmetic purposes.	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 PERMETHRIN LOTN		ACTICIN CREA		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - WOUND / DECUBITUS CARE		ACCUZYME OINT ETHEZYME		REGRANEX GEL		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 (hgba1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (Tc p 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		LOWILA BAR MOISTURIN DRY SKIN CREA		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.

		XERAC AC SOLN		PROSHIELD PLUS SKIN PROTE CREA SURGILUBE GEL		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		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.
<b>MISCELLANEOUS EYE</b>						
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		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.
<b>MISCELLANEOUS EAR</b>						
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/HCL 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		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.
<b>MOUTH ANTISEPTICS</b>						
MOUTH ANTI-INFECTIVES		NILSTAT SUSP EAR-GESIC SOLN NYSTATIN SUSP		MYCELEX TROC  MYCOSTATIN LOZG		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		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.
<b>DENTAL PRODUCTS</b>						
DENTAL PRODUCTS		ETHEDENT CREA GEL-KAM CONC PHOS FLUR SOLN PREVIDENT PREVIDENT SOLN SF GEL		APF GEL GEL DENTAGEL GEL PHOS-FLUR GEL SF 5000 PLUS CREA THERA-FLUR-N GEL		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

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ARTIFICIAL SALIVA/STIMULANTS

ARTIFICIAL SALIVA/STIMULANTS	EVOXAC CAPS SALIVA SUBSTITUTE SOLN	RADIACARE SOLR SALAGEN TABS	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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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	
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T-CELL ACTIVATION INHIBITOR

PSORIASIS BIOLOGICALS		AMEVIVE RAPTIVA	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. <b>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.</b>
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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	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.
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CHELATING AGENTS

CHELATING AGENTS	CUPRIMINE CAPS	DEPEN TITRATABS TABS	
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ANTILEPROTIC

ANTILEPROTIC		THALOMID CAPS	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
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CANCER

CANCER	ALIMTA AVASTIN ERBITUX VIDAZA		
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IMMUNOSUPPRESSANTS

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

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

exception is offered on the Prior Authorization form, such as the presence of 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

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 <sup>nd</sup> line)	**	
TOPAMAX	X			9	6	X (2 <sup>nd</sup> 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