

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS Required	PA	Comments	Criteria
<p>* PLEASE NOTE: All <i>cost effective</i> generics applicable to DEL are considered PREFERRED Drugs. "BASIC" Covered Drugs are bolded with the Coverage Indicator of "MC / DEL".</p>									
<p>General Criteria for all PDL categories- For more information or help using the PDL, providers may call 1-888-445-0497; members should call 1-866-796-2463. To access PDL and PA materials via the internet: www.mainearepdl.org</p>									
<p>A: Preferred Drugs- Unless otherwise specified, preferred drugs are available without prior authorization. Step order may apply for preferred drugs in some drug categories as indicated on the PDL. (See item "D" below for explanation of step order.)</p>									
<p>B: Requests for Non-preferred Drugs- Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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>									
<p>C: Adequate Drug Trials- 1. The minimum trial period for each preferred and step order drug is two weeks, unless otherwise stated within specific PDL drug categories; trials with less than a two week duration will be reviewed on a case-by-case basis; 2. A trial will not be considered valid if preferred or non-preferred products were readily available (by override, individual purchase, samples, etc.); 3. Certain drug trials, such as with controlled substances, may require evidence that the preferred drugs were actually tried (example: with random pill counts and with random urine drug tests, using the methods of GC/MS with no lower threshold); 4. Adequate trials require documentation of attempts to titrate dose of preferred agents toward desired clinical response. 5. Adequate trials include prevention/treatment of common adverse effects associated with preferred agents (example: antinausea, antipruritics, etc.)</p>									
<p>D: Step Order- When numbers appear in the "step order" column, it means drugs in this category must be used in the order specified, with the lower numbers having preference over the higher numbers. Chart notes should be provided to confirm drug trials that do not appear in the member's MaineCare drug profile.</p>									
<p>E. The Department will institute strategies to ensure cost effectiveness through the use of an enhanced Drug Benefit Preferred brand drugs will no longer be preferred in any PDL drug category where preferred generic drugs are also available. It is expected that preferred generics will be used prior to any preferred brands. This will be operated as a form of step care. Preferred brands in these categories will require prior authorization for these high utilization / high cost members.</p>									
<p>F: Brand Name Medication Requests- (Must be submitted on the Brand Name PA request form)- According to MaineCare Benefits Manual Chapter II (80.07-5), when medically necessary covered brand-name drugs have an A-rated generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since the brand-name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. The Bureau does not make determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA. Physicians should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH.</p>									
<p>G: PA requests 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-blind, placebo-controlled randomized clinical studies establishing both safety and efficacy.</p>									
<p>H: Dose Consolidation Requirements- Some drugs may also be affected by dose consolidation requirements. Please see Dose Consolidation List and/or Splitting Tables provided in the PDL.</p>									
<p>I. Trials from Multiple Drug Classes - Trial/failure/intolerance to preferred agents from multiple classes within the same category or other categories of drugs may be required prior to the approval of non-preferred agents (e.g., Cymbalta, Zofran, Elidel and others).</p>									
<p>J. Drug-specific PA Forms- Drug-specific PA forms contain medical necessity documentation requirements and/or criteria that may not be repeated in the PDL. Drug-specific PA forms may be obtained on the web at www.mainearepdl.org.</p>									
<p>K. PA Exemptions for Prescribers- According to MaineCare Benefits Manual Chapter II (80.07-4), providers may receive a three (3) month exemption from prior authorization requirement for certain categories of drugs when they demonstrate high compliance with the Department's PDL. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption. If a provider loses his/ her exemption, members who previously were not required to obtain a PA while the prescriber was exempt will be required to do so, and criteria for approval of that medication will need to be met.</p>									
<p>L: Drug-Drug Interactions (DDI)- The DUR Committee has implemented new drug-drug interaction edits requiring prior authorization. Several drug-drug combinations and PDL drug categories are affected by new PA requirements. These will be indicated in the PDL with DDI notation. Please see the DDI document provided in the PDL.</p>									

ASSORTED ANTIBIOTICS

BETA-LACTAMS / CLAVULANATE COMBO'S	MC/DEL		AMOXICILLIN	MC/DEL		AUGMENTIN ³	3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA. 4. Use preferred generic amoxicillin/clavulanate potassium alternatives. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Ampicillin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.	
	MC/DEL		AMOXICILLIN/POTASSIUM CLA CHEW	MC/DEL		AUGMENTIN XR TB12 ⁴			
	MC/DEL		AMOXICILLIN/POTASSIUM CLA SUSR						
	MC/DEL		AMOXICILLIN/POTASSIUM CLA TABS						
	MC/DEL		AMPICILLIN						
	MC		BICILLIN L-A SUSP						
	MC/DEL		DICLOXACILLIN SODIUM CAPS						
	MC		OXACILLIN SODIUM SOLR						
	MC/DEL		PENICILLIN V POTASSIUM						
	MC		TIMENTIN SOLR						
MC		UNASYN SOLR							
MC/DEL		ZOSYN							
CEPHALOSPORINS	MC/DEL		CEFADROXIL HEMIHYDRATE	MC		CEDAX	1. Both brand and generic are clinically non-preferred. 2. Dosing limits apply, please see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Suprex will be preferred with dosing limits of one tablet per 7days for prevention and treatment of STI gonorrhoea.	
	MC/DEL		CEFZOLIN SODIUM SOLR	MC/DEL		CEFACTOR ¹			
	MC/DEL		CEFDINIR	MC/DEL		CEFADROXIL MONOHYDRATE TABS			
	MC/DEL		CEFEPIME	MC/DEL		CEFTIN			
	MC/DEL		CEFPODOXIME	MC/DEL		FORTAZ			
	MC/DEL		CEFFPROZIL	MC/DEL		FORTAZ SOLN			
	MC		CEFTAZIDIME 6MG	MC		KEFLEX CAPS			
	MC/DEL		CEFTIN SUSP	MC		OMNICEF			
	MC/DEL		CEFTRIAZONE	MC/DEL		ROCEPHIN			
	MC/DEL		CEFUROXIME AXETIL TABS	MC		TAZICEF SOLR			
	MC/DEL		CEPHELEXIN MONOHYDRATE	MC/DEL		TEFLARO			

	MC MC MC/DEL MC MC MC/DEL MC/DEL		COLISTIMETHATE SODIUM SOLR FUROXONE TABS METRONIDAZOLE ¹ PENTAMIDINE ISETHIONATE SOLR PRIMSOL SOLN TRIMETHOPRIM TABS VANCOMYCIN 5GM INJ.	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC		FLAGYL CAPS FLAGYL TABS FLAGYL ER TBCR KETEK METRONIDAZOLE 375MG CAPS ¹ METRONIDAZOLE 750MG TABS ¹ NEBUPENT SOLR TINDAMAX VANCOMYCIN 10GM INJ. ² XIFAXAN	<p>Please use available preferred strengths (250mg & 500mg tabs) to obtain required dose without PA.</p> <p>2. Please use multiple 5gm which are preferred to obtain dose without PA.</p> <p>3. Clinical PA is required to establish CF diagnosis and medical necessity. Prior trial and failure of preferred Tobi before approval will be granted.</p> <p>Use PA Form# 20420</p>	<p>preferred drug(s) exists.</p> <p>1. For macrolide resistant infections when quinolones inappropriate</p> <p>DDI: Ketek is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either Enblex 15mg or Vesicare 10mg or carbamazepine.</p> <p>Cayston is only indicated to improve respiratory symptoms in CF patients with Pseudomonas aeruginosa. Dosing limits, as should be given TID X28 days (followed by 28 days OFF Cayston therapy). A bronshodilator should be used before administration of Cayston.</p>	
CARBAPENEMS				MC MC MC/DEL		INVANZ SOLR MERREM SOLR PRIMAXIN	<p>Use PA Form# 20420</p>	<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.</p>	
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL MC/DEL MC/DEL MC		CLEOCIN SOLN CLEOCIN SUSR CLINDAMYCIN HCL 150CAPS DAPSONE TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		CLEOCIN CAPS CLINDAMYCIN HCL 300CAPS ¹ SIVEXTRO VIBATIV ZYVOX SUSR ZYVOX TABS	<p>1. Use multiple 150's for Clindamycin instead of 300's.</p> <p>Use PA Form# 30820 for Zyvox & Vibativ Use PA Form# 20420 for all others</p>	<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. For Zyvox or Vibativ, please see the criteria listed in the Antibacterial Antibiotics PA form.</p>	
ANTI INFECTIVE COMBO'S - MISC.	MC/DEL MC/DEL MC/DEL MC/DEL		ERYTHROMYCIN/SULF SUSR SEPTRA/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA	MC		BACTRIM DS TABS	<p>Use PA Form# 20420</p>	<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.</p>	
ANTIPROTOZOALS				MC		ALINIA ¹	<p>1. Alinia is preferred for children less than 12 years of age.</p> <p>Use PA Form# 20420</p>		
ANTI - FUNGALS									
ANTIFUNGALS - ASSORTED	MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ANCOBON CAPS FLUCONAZOLE ¹ GRIFULVIN V TABS ⁹ GRISEOFULVIN SUSP ⁹ GRISEOFULVIN ULTRAMICROSI TABS ⁵ GRIS-PEG TABS ⁹ KETOCONAZOLE TABS ⁷ NYSTATIN TERBINAFINE TABS ⁴ VORICONAZOLE TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL	6 6 8 8 8 8 8 8 8 8 8 8	LAMISIL TABS ⁴ ITRACONAZOLE CRESEMBA ⁹ SPORANOX SOLN ² SPORANOX PULSEPAK CAPS ³ SPORANOX CAPS ³ DIFLUCAN ERAXIS INJ ⁵ GRIFULVIN SUSP ONMEL NOXAFIL ⁵ VFEND TABS	<p>1. QL-1/every 7-day period (150mg only).</p> <p>2. Sporanox QL 300cc/month with PA. See quantity limit table.</p> <p>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.</p> <p>4. Quantity limit of one tablet daily. Please see dosage consolidation list.</p>	<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The other criteria are listed on the Antifungal PA form including the required proof of a non-cosmetic fungal infection.</p> <p>DDI: Any Griseofulvin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.</p> <p>DDI: Sporanox is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with Enblex 15mg, Vesicare 10mg, Prandin, Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI, due to a significant drug-drug interaction.</p> <p>DDI: Vfend is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with Warfarin.</p>	

5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy.

6. Eraxis will be approved if submitting with documentation that it was initiated during a hospitalization and this request is to finish the hospital course.

7. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30 days.

8. For children < 18, quantity limits allows 8 weeks supply without PA. PA will be required if using > than 8 weeks. If 18 and older PA will be required for any quantity. Not approving for Onychomycosis indication.

9. For patients ≥ 18years of age

[Use PA Form# 10120](#)

DDI: Fluconazole (except 150mg strength) will now be non-preferred and require prior authorization if it is currently being used with gimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg. Diflucan is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either gimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg.

DDI: Fluconazole will require prior authorization if being used in combination with Plavix or Warfarin.

DDI: Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, Pantoprazole, Plavix, Onglyza, Enablex 15mg, Vesicare 10mg, Latuda, Cometriq, Tafenlar or Omeprazole.

ANTI - VIRALS

ANTI - VIRALS						
ANTIRETROVIRALS	MC/DEL	APTIVUS	MC	8	COMPLERA	<p>Please refer to the criteria listed on the Fuzeon PA form.</p> <p>Use PA Form# 10620 for Fuzeon</p> <p>1. Quantity limit of one per day</p> <p>2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista</p> <p>3. Prescribers with >= 10 ART scripts per quarter and 75% ART PDL compliance will be exempt from PA for these products.</p> <p>4. Isentress Chewable will only be approved if between the age of 2-12 years old</p> <p>5. Clinical PA is required to establish diagnosis, verification of age for appropriate indication and medical necessity.</p> <p>6. Dosing limits apply.</p>
	MC	ATRIPLA ¹	MC/DEL	8	DIDANOSINE	
	MC/DEL	COMBIVIR TABS	MC/DEL	8	EVOTAZ	
	MC/DEL	CRIXIVAN CAPS	MC/DEL	8	FUZEON ³	
	MC/DEL	EDURANT	MC/DEL	8	INTELENCE ³	
	MC	EMTRIVA	MC/DEL	8	ISENTRESS ^{3,4}	
	MC/DEL	EPIVIR / HBV	MC/DEL	8	PREZCOBIX	
	MC/DEL	EPZICOM	MC	8	RETROVIR	
	MC/DEL	INVIRASE CAPS	MC/DEL	8	SELZENTRY ³	
	MC	KALETRA	MC	8	STRIBILD	
	MC/DEL	LEXIVA	MC	8	TIVICAY ^{5,6}	
	MC	NORVIR	MC	8	TRIUMEQ ^{5,7}	
	MC	PREZISTA ²	MC	8	TYBOST ⁸	
	MC/DEL	RESCRIPTOR TABS	MC	8	ZERIT	
	MC	REYATAZ ¹	MC	8	VITEKTA	
	MC	STAVUDINE	MC/DEL	9	VIRAMUNE XR	
	MC	SUSTIVA				
	MC/DEL	TRIZIVIR TABS				
	MC	TRUVADA				
	MC	VIDEX EC				
	MC/DEL	VIRACEPT TABS				
	MC/DEL	VIRAMUNE TABS				
	MC	VIREAD TABS				
	MC/DEL	ZIAGEN TABS				
	MC/DEL	ZIDOVUDINE				

DDI: Aatazanavir or darunavir and the following drugs are contraindicated (due to potential for serious and/or life-threatening events or loss of therapeutic effect): alfuzosin.

						<p>8. Dosing limits apply, please see dosing consolidation list.</p> <p>7. Request will require use of the individual components Tivicay and Epzicom.</p> <p>8. Diagnosis and verify prior trials and failures or intolerance of preferred treatments is required</p>	<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (use to perform for combination of the following drugs or use of intravenous drug): dronedarone, rifampin, irinotecan, dihydroergotamine, ergotamine, methylethylergonovine, cisapride, St. John's wort, lovastatin, simvastatin, pimozide, nevirapine, sildenafil (when given as Revatio® for treatment of PAH), indinavir, triazolam, or PO midazolam will be non-preferred and require prior authorization if it is currently being used in combination with Tybost.</p> <p>Evotaz is only available if unable to tolerate or have failed Reyataz and Norvir</p> <p>Prezcobix is only available if unable to tolerate or have failed Prezista and Norvir</p>	
CYTO-MEGALOVIRUS AGENTS	MC MC		FOSCARNET SODIUM VALCYTE TABS	MC/DEL MC/DEL		FOSCAVIR GANCICLOVIR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HERPES AGENTS	MC/DEL MC/DEL		ACYCLOVIR VALACYCLOVIR HCL	MC/DEL MC MC/DEL MC/DEL MC/DEL	8 8 8 8 9	FAMCICLOVIR ¹ SITAVIG ZOVIRAX ¹ VALTREX TABS ¹ FAMVIR TABS ¹	1. Must fail Acyclovir and Valacyclovir before non-preferred products in step order. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs 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	MC/DEL MC MC/DEL MC/DEL		AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU ¹	MC MC		FLUMADINE TABS FLUMIST	1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member. Use PA Form# 10610 for Flumist requests Use PA Form# 20420 for all others	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.
IMMUNE SERUMS								
IMMUNE SERUMS	MC		HYPERRHO INJ					
HEPATITIS AGENTS								
HEPATITIS C AGENTS	MC MC MC/DEL MC/DEL MC MC MC MC		HARVONI ² OLYSIO ² PEGASYS KIT ¹ PEGASYS SOLN PEG-INTRON KIT ¹ RIBAVIRIN RIBAPAK SOVALDI ² VIEKIRA PAK ²	MC/DEL MC/DEL		COPEGUS TABS REBETOL CAPS	1. Dosing limits apply, please see dosage consolidation list. 2. Approvals will require clinical PA. Please see the Hepatitis PA form for criteria Use PA Form# 10700	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. DDI: Olysio will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).

HEPATITIS AGENTS - MISC.				MC		ACTIMMUNE	Use PA Form# 20420	Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.
HEPATITIS B ONLY	MC		HEPSERA TABS	MC		BARACLUE TYZEKA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Baraclue is indicated for treatment of chronic Hep B virus (HBV) in adults with: evidence of active viral replication AND either evidence of persistent elevation in serum aminotransferases (ALT or AST) or histologically active disease, Patient is 16 years of age or older. Boxed warning: Use not recommended for those co-infected with HIV and HBV who are not also receiving highly active antiretroviral therapy (HAART).

RSV PROPHYLAXIS

RSV PROPHYLAXIS				MC		SYNAGIS ¹	Use PA Form# 30120 1. MaineCare will approve Synagis PA's for start date of November 23rd for infants who meet the guidelines. PA will be approved for max of 5 doses. Maximum 1 dose/30 days.	Please see the criteria listed on the Synagis PA form.
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MS TREATMENTS

MULTIPLE SCLEROSIS - INTERFERONS	MC MC/DEL MC		AVONEX KIT ¹ EXTAVIA ¹ REBIF SOLN ¹	MC/DEL MC		BETASERON SOLR PLEGRIDY ¹	1. Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20430	Non-Preferred drugs must be tried in step-order and failed due to lack of efficacy or intolerable side effects before lower ranked non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MULTIPLE SCLEROSIS - NON-INTERFERONS	MC MC/DEL		COPAXONE 20MG ² GILENYA ^{2,3}	MC MC MC MC MC	6 8 8 8 8	TYSABRI ¹ AMPYRA AUBAGIO COPAXONE 40MG TECFIDERA	1. Providers must be enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity. 2. Clinical PA is required to establish diagnosis and medical necessity. 3. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20430	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. Aubagio is non-preferred and is for adults with relapsing forms of MS. No concurrent use of leflunomide. Within 6 months of initiation of Aubagio, lab testing to look at (transaminase, bilirubin, CBC, TB) as boxed warning exists regarding hepatotoxicity.

ASSORTED NEUROLOGICS

NEUROLOGICS - MISC.	MC/DEL MC MC		ORAP TABS PROSTIGMIN TABS PYRIDOSTIGMINE	MC MC MC MC		BOTOX ² DYSPORT ¹ MESTINON MYOBLOC ¹	1. Approval will be limited to Cervical dystonia. 2. Please see botulinum PA form for additional criteria Use PA Form# 10210	Failed/did not tolerate therapeutic trials to muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, Skelaxin, and tizanidine. Migraine: Consideration for Botox approvals will only be made after failures of required trials of the following preferred medications: tricyclic or venlafaxine, beta blocker, valproic acid, topiramate 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.
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STEROIDS

GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS DEPO-MEDROL SUSP DEXAMETHASONE	MC/DEL MC MC/DEL MC/DEL MC MC		BUDESONIDE EC CORTEF 10 and 20 TABS FLORINEF TABS MEDROL TABS MEDROL DOSEPAK TABS MILLIPRED	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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	MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	DEXPAK ENTOCORT EC CP24 FLUDROCORTISONE ACETATE TABS HYDROCORTISONE KENALOG METHYLPREDNISOLONE TABS PREDNISOLONE PREDNISONE SOLU-CORTEF SOLR SOLU-MEDROL SOLR	MC MC MC MC	ORAPRED SOLN PEDIAPRED LIQD PREDNISONE INTENSOL CONC STERAPRED TABS			DDI: All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
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HORMONE REPLACEMENT THERAPIES

ANDROGENS / ANABOLICS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ANDRODERM PT24 ANDROGEL ANDROGEL PUMP DANAZOL CAPS DEPO-TESTOSTERONE OIL METHITEST TABS	MC MC MC MC MC MC MC MC/DEL MC MC/DEL MC MC/DEL	ANADROL-50 ANDRO LA 200 OIL ANDROID CAPS AXIRON DELATESTRYL OIL FORTESTA HALOTESTIN TABS NATESTO OXANDROLONE TESTIM TESTOSTERONE CYP TESTRED CAPS VOGELXO	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Additionally, laboratory evidence of a testosterone deficiency must be supplied. One of each dosage form should be tried (tablet, injection, and topical)
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ESTROGENS - PATCHES / TOPICAL	MC/DEL MC/DEL	VIVELLE-DOT PTTW ¹ CLIMARA PTWK	MC/DEL MC/DEL MC/DEL MC/DEL MC	5 8 8 8 8	ESTRADIOL PTWK ALORA PTTW ² DIVIGEL ² ELESTRIN ² EVAMIST ²	1. Both preferred drugs must be tried. 2. Step order drugs must be used in specified step order. Use PA Form# 20420	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
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ESTROGENS - TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	CENESTIN TABS ESTRADIOL ESTROPIPATE TABS MENEST TABS PREMARIN TABS	MC/DEL MC/DEL MC MC		ENJUVIA ESTRACE TABS ESTRATAB TABS ORTHO-EST TABS	Must fail preferred products before non-preferred products. Use PA Form# 20420	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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ESTROGEN COMBO'S	MC/DEL MC/DEL	PREMPHASE TABS PREMPRO TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ACTIVELLA TABS ¹ COMBIPATCH PTTW ¹ FEMHRT 1/5 TABS ¹ ORTHO-PREFEST TABS ¹ SYNTEST H.S. TABS ¹	1. Must fail Premphase and Prempro products before non preferred products. Use PA Form# 20420	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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PROGESTINS	MC MC/DEL MC/DEL MC	MAKENA ³ MEDROXYPROGESTERONE ACETA ² NORETHINDRONE ACETATE TABS ² 17-ALPH HYDROXYPROGESTERONE ³	MC/DEL MC MC MC/DEL MC/DEL MC/DEL		AYGESTIN TABS CYCRIN TABS PROGESTERONE POWD PROMETRIUM 100MG CAPS ¹ PROMETRIUM 200MG ¹ PROVERA TABS	1. PA approvals will require two 100 mg caps instead of one 200mg. 2. Must fail Medroxyprogesterone and Norethidrone products before non-preferred products. 3. Clinical PA required for indication to reduce the risk of preterm birth in women with a singleton pregnancy who have a history of singleton spontaneous preterm birth. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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CONTRACEPTIVES

CONTRACEPTIVES - PROGESTIN ONLY	MC/DEL MC/DEL		NOR-QD TABS NORETHINDRONE ACETATE 0.35 TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC	7 7 7 7 8	CAMILA TABS ERRIN JOLIVETTE NORA-BE TABS ORTHO MICRONOR 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. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - INJECTABLE	MC/DEL		MEDROXYPROGESTERONE ACETATE 150mg IM	MC/DEL		DEPO-PROVERA 150 mg SUSP	Use PA Form# 20420	The preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVE - EMERGENCY	MC/DEL MC/DEL MC MC/DEL	1 2 2 2	PLAN B ONE STEP ¹ ELLA LEVONORGESTREL NEXT CHOICE ¹	MC/DEL		PLAN B	1. Allowed 2 tablets per 30 days without PA Use PA Form# 20420	
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC		NUVARING RING ¹	MC/DEL		XULANE ²	Use PA Form# 20420 1. Quantity limit allowing 1 every 28 days with out PA. 2. Dose limits apply allowing 3 patches per 28 days supply.	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	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		APRI TABS AVIANE TABS BALZIVA CRYSSELLE-28 TABS DESOGEN TABS DESOGESTREL/ ETHINYL ESTRADIOL LOW-OGESTREL TABS MODICON TABS MONONESSA NECON 1/50 ORTHO-CEPT-28 TABS ORTHO-CYCLEN-28 TABS ORTHO-NOVUM 1/35-28 TABS OVCON-50 28 TABS PREVIFEM RECLIPSEN SOLIA SPRINTEC 28 TABS YASMIN 28 TABS YAZ ZENCHENT	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BEYAZ BREVICON-28 TABS LESSINA-28 TABS LEVORA LOESTRIN TABS LOESTRIN FE TABS LOESTRIN FE 1/20 TABS LOESTRIN 1.5/30-21 TABS LOESTRIN 1/20-21 TABS LO/OVRAL 21 TABS LO/OVRAL 28 TABS MICROGESTIN FE TABS NORDETTE-28 TABS NORINYL NORTREL OCELLA OGESTREL TABS OVCON-35/28 TABS OVRAL PORTIA-28 TABS SAFYRAL ZOVIA	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - BI-PHASIC COMBINATIONS	MC MC MC/DEL		ORTHO-NOVUM 10/11-28 TABS NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35 SEASONIQUE	MC/DEL MC/DEL MC/DEL MC/DEL		NECON 10/11-28 TABS KARIVA TABS LOSEASONIQUE MIRCETTE TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		ENPRESSE NECON 7/7/7 ORTHO-NOVUM 7/7/7-28 TABS TRI-NORINYL 28 TABS TRI-PREVIFEM TRIPHASIL 28 TABS	MC/DEL MC/DEL MC/DEL MC MC		CYCLESSA TABS ESTROSTEP FE TABS NORTREL 7/7/7 ORTHO TRI-CYCLEN TABS ORTHO TRI-CYCLEN LO TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups.

	MC/DEL MC MC/DEL		TRI-SPRITEC TRINESSA TRIVORA-28 TABS					DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - MULTI-PHASIC COMBINATIONS				MC		NATAZIA	Use PA Form# 20420	
DIABETES THERAPIES								
DIABETIC - INSULIN	MC MC MC MC MC MC/DEL MC/DEL		HUMALOG INJ 100/ML HUMALOG MIX 75/25 HUMULIN N INJ U-100 HUMULIN INJ 70/30 HUMULIN R U-100 LANTUS SOLN LEVEMIR	MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC		APIDRA AFREZZA ¹ HUMALOG MIX 50/50 HUMULIN INJ 50/50 HUMULIN R INJ U-500 NOVOLIN NOVOLOG NOVOLOG MIX RELION	Use PA Form# 20420 1. Not to be as a monotherapy. Obtain lab values of pulmonary function and recent smoking history	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 - PENFILLS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		LANTUS SOLOSTAR ¹ LEVEMIR FLEXPEN ¹ NOVOLIN PENFILL ¹ NOVOLIN 70/30 ¹ NOVOLOG MIX PENFILL ¹ NOVOLOG PENFILL SOLN ¹ NOVOLOG MIX FLEXPEN ¹ NOVOLOG FLEXPEN ¹	MC MC MC MC MC/DEL		APIDRA OPTICLIK PEN HUMALOG KWIK INJ 100/ML HUMALOG MIX INJ 75/25 KWP HUMALOG MIX INJ 50/50 KWP TOUJEO	1. Clinical PA will be required to establish significant visual or neurological impairment. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - DPP- 4 ENZYME INHIBITOR	MC/DEL MC/DEL		JANUVIA ^{1,2} TRADJENTA ²	MC/DEL		ONGLYZA ²	1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile. 2. Dosing limits apply. Please refer to Dose consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Onglyza 5mg will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).
DIABETIC - DPP- 4 ENZYME INHIBITOR-COMBO	MC/DEL MC/DEL MC/DEL		JANUMET ^{1,2} JANUMET XR ^{1,2} JENTADUETO ¹	MC/DEL MC MC/DEL		KAZANO KOMBIGLYZE XR OSENI	1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile. 2. Dosing limits apply. Please refer to Dose consolidation list. Use PA Form# 20420	
DPP- 4 ENZYME INHIBITOR/ HMG-COS REDUCTASE INHIBITOR	MC/DEL		JUVISYNC ^{1,2}				Use PA Form# 20420 1. Please refer to criteria section of PDL	DDI: Juvisync will require a prior authorization if used in concurrent use with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin). Juvisync will remain preferred until product is eventually discontinued later in 2014.

							2. Dosing limits apply please refer to Dose Consolidation List	
DIABETIC - LANCET-LANCET DEVICE	MC MC MC MC MC		ONE TOUCH LANCETS DELICA LANCETS UNILET LANCETS UNISTIK LANCING DEVICE AUTOLOT LANCING DEVICE				Use PA Form# 20420	
DIABETIC - SYRINGES-NEEDLES	MC/DEL MC MC MC		BD MICRO-FINE BD ULTRA-FINE BD ULTRA-FINE PEN NEEDLES UNIFINE PEN NEEDLES				Use PA Form# 20420	
DIABETIC - OTHER				MC/DEL MC		CYCLOSET SYMLIN	Use PA Form# 30150 for Symlin Use PA Form #20420 for all others	Please see the criteria listed in the Symlin PA form.
SGLT 2 INHIBITORS				MC/DEL MC/DEL MC/DEL		FARXIGA INVOKANA ¹ JARDIANCE	1. Dosing limits apply please refer to Dose Consolidation List Use PA Form# 20420	Invokana will be considered for patients who are unable to tolerate any preferred medications from other diabetic classes.
SGLT 2 INHIBITOR COMBINATIONS				MC/DEL MC/DEL MC/DEL		GLYXAMBI INVOKAMET XIGDUO XR ¹	1. Diagnosis required Use PA Form# 20420	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Glyxambi /Xigduo XR- Verify prior trials and failures or intolerance of preferred treatments from other diabetic categories
DIABETIC MONITOR	MC MC MC MC MC MC MC		FREESTYLE INSULINX FREESTYLE LITE SYSTEM KIT FREESTYLE FREEDOM LITE KIT ONE TOUCH ULTRA 2 KIT ONE TOUCH ULTRA MINI KIT ONE TOUCH ULTRA SMART KIT PRECISION XTRA METER	MC MC MC MC MC MC		ACCUCHECK ASCENSIA ASSURE CONTOUR BREEZE Z EXACTECH PRODIGY	Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
DIABETIC TEST STRIPS	MC MC MC MC MC MC		FREESTYLE ¹ FREESTYLE LITE ¹ FREESTYLE INSULINX ¹ ONE TOUCH DELICA ¹ ONE TOUCH ULTRA ¹ PRECISION XTRA ¹	MC MC MC MC MC MC		ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY CONTOUR BREEZE Z	1. Only 50 ct & 100 ct package size. Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
INCRETIN MIMETIC				MC MC	8 8	BYDUREON ¹ BYETTA ¹	1. If patient is not responding to oral agents (single or multiple) classes	Trulicity- Verify prior trials and failures or intolerance of preferred treatments from other diabetic categories and that is not being used as first-line treatment

				MC/DEL MC/DEL MC MC/DEL	8 8 8 9	NESINA TANZEUM TRULICITY ² VICTOZA ¹	(single or multiple) please look to insulin therapy. Dosing limits apply. Please refer to Dose Consolidation List. 2. Diagnosis required Use PA Form# 10230	
DIABETIC - ORAL SULFONYLUREAS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CHLORPROPAMIDE TABS GLIMEPIRIDE GLIPIZIDE TABS GLIPIZIDE ER TABS GLYBURIDE MICRONIZED TABS GLYBURIDE TABS ¹ TOLAZAMIDE TABS TOLBUTAMIDE TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		AMARYL TABS DIABETA TABS GLUCOTROL TABS GLUCOTROL XL TBCR GLYNASE TABS MICRONASE TABS	Use PA Form# 20420 1. Pa required for members ≥65. Glyburide has a greater risk of severe prolonged hypoglycemia in older adults.	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. DDI: All sulfonylureas (except glyburide) will now be non-preferred and require prior authorization if it is currently being used with either ranitidine or cimetidine. DDI: Glimepiride will now be non-preferred and require prior authorization if it is currently being used with either fluconazole (except 150mg strength) or fluvoxamine. Amaryl is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either fluconazole or fluvoxamine.
DIABETIC - ORAL BIGUANIDES	MC/DEL MC/DEL		METFORMIN HCL TABS METFORMIN ER	MC MC MC MC/DEL		GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET METFORMIN ER OSMOTIC	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - THIAZOL / BIGUANIDE COMBO				MC/DEL MC/DEL MC/DEL MC/DEL		ACTOPLUS MET ¹ ACTOPLUS MET XR AVANDARYL ¹ AVANDAMET TABS ¹	Use PA Form# 20420 1. Requires use of Actos, Metformin, or other preferred anti-diabetics.	DDI: Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - / THIAZOL	MC/DEL		PIOGLITAZONE HCL ¹	MC/DEL MC/DEL		ACTOS TABS ³ AVANDIA TABS ²	1. Pioglitazone HCL is non- preferred as monotherapy. Pioglitazone HCL is preferred if therapeutic doses of metformin, sulfonylurea or insulin are seen in members drug profile for at least 60 days within the past 18 months. 2. Current users of Avandia who have tried Actos will be able to continue use of Avandia. 3. Dosing limits apply please refer to Dose Consolidation List Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - ALPHAGLUCOSIDASE	MC/DEL		GLYSET TABS	MC		PRECOSE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - SULFONYLUREA / BIGUANIDE	MC/DEL		GLYBURIDE/METFORMIN	MC MC MC/DEL		GLUCOVANCE TABS ¹ METAGLIP TABS ¹ DUETACT ²	1. Use individual ingredients. 2. Use Actos with generic glimepiride. Use PA Form# 20420	Approved for patients failing to achieve good diabetic control with maximal doses of individual components.
DIABETIC - MEGLITINIDES	MC/DEL		STARLIX TABS	MC/DEL MC		PRANDIN TABS NATEGLINIDE	Use PA Form# 20420	Preferred drugs from other diabetic sub-categories must be tried and failed due to lack of inadequate diabetic control or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

DDI: Prandin is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with both Sporanox and gemfibrozil, due to a significant drug-drug interaction.

GLUCOSE ELEVATING AGENTS

GLUCOSE ELEVATING AGENTS	MC/DEL		GLUCAGEN INJ. HYPOKIT	MC		GLUCAGON DIAGNOSTIC KIT	Use PA Form# 20420	
				MC		GLUCAGEN DIAGNOSTIC KIT		

THYROID

THYROID HORMONES	MC/DEL		ARMOUR THYROID TABS	MC		LEVOTHYROXINE SODIUM SOLR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CYTOMEL TABS	MC/DEL		LIOTHYRONINE		
	MC/DEL		LEVOTHROID TABS	MC		SYNTHROID TABS		
	MC/DEL		LEVOTHYROXINE SODIUM TABS					
	MC/DEL		LEVOXYL TABS					
	MC/DEL		THYROID TABS					
	MC/DEL		THYROLAR					
	MC/DEL		UNITHROID TABS					

ANTITHYROID THERAPIES	MC/DEL		METHIMAZOLE TABS	MC/DEL		TAPAZOLE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		PROPYLTHIOURACIL TABS					

OSTEOPOROSIS / BONE AGENTS

OSTEOPOROSIS	MC/DEL		ALENDRONATE	MC/DEL		ACTONEL TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		MIACALCIN SOLN ²	MC		ARELIA SOLR	1. Approval only requires failure of Alendronate. 2. Quantity limits apply, please see dosage consolidation list. 3. Please use Alendronate and Vitamin D. 4. Please use other preferred agents.	
				MC		BINOSTO		
				MC/DEL		BONIVA INJECTION KIT		
				MC/DEL		BONIVA TABS ^{2,4}		
				MC/DEL		CALCITONIN NS		
				MC/DEL		DUAVEE		
				MC/DEL		DIDRONEL TABS		
				MC		EVISTA TABS ¹		
				MC		FORTEO		
				MC/DEL		FORTICAL		
				MC/DEL		FOSAMAX TABS AND PLUS D ³		
				MC		PROLIA		
				MC		XGEVA		
				MC/DEL		ZOMETA		

Binosto use preferred generic alendronate tablets

CALCIMIMETIC AGENTS

CALCIMIMETIC AGENTS				MC		SENSIPAR	Use PA Form# 30115	Baseline PTH, Ca, and phosphorous levels are required and initial approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Will not approve if baseline Ca is less than 8.4.
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GROWTH HORMONE

GROWTH HORMONE	MC/DEL		NORDITROPIN SOLN ¹	MC/DEL	8	GENOTROPIN	Use PA Form# 10710	See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied.
	MC/DEL		NUTROPIN AQ ¹	MC	8	HUMATROPE SOLR	1. Clinical PA is required to establish diagnosis and medical necessity.	
				MC	8	INCRELEX		
				MC/DEL	8	NUTROPIN		
				MC	8	OMNITROPE		
				MC	8	SAIZEN SOLR		
				MC/DEL	8	TEV-TROPIN		

SOMATOSTATIC AGENTS				MC/DEL		OCTREOTIDE INJ	Use PA Form# 10710	
				MC/DEL		SANDOSTATIN		
				MC		SOMATULINE		

GROWTH HORMONE ANTAGONISTS

GH ANTAGONISTS				MC		SOMAVERT	Use PA Form# 10710	Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatin.
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VASOPRESSIN RECEPTOR ANTAGONIST

VASOPRESSIN RECEPTOR ANTAGONIST				MC/DEL		SAMSCA	Use PA Form# 20420	Samsca Drug Warning- Avoid use in patients with underlying liver disease, including cirrhosis, because the ability to recover from liver injury may be impaired. Limit duration of therapy to 30 days to minimize the risk of liver injury.
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URINARY INCONTINENCE

VASOPRESSINS			DESMOPRESSIN TABS	MC/DEL	5	DDAVP TABS	1. 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).
				MC/DEL	6	DDAVP SOLN ¹		
				MC/DEL	6	DESMOPRESSIN SPRAY ¹		
				MC	8	DESMOPRESSIN ACETATE SOLN ¹		
				MC/DEL	8	STIMATE SOLN ^{1,2}		

							2. Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization. Use PA Form# 20420	
ANTISPASMODICS	MC/DEL MC		OXYBUTYNIN URISPAS TABS	MC/DEL MC/DEL MC/DEL	8 8 9	DETROL TABS DITROPAN TROSPIMUM	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTISPASMODICS - LONG ACTING	MC/DEL MC/DEL MC		OXYBUTYNIN ER TABS TOVIAZ VESICARE ¹	MC MC/DEL MC/DEL MC/DEL MC/DEL	8 8 8 8 9	DITROPAN XL TBCR ENABLEX ^{1,3} MYRBETRIQ OXYTROL TOLTERODINE TAB DETROL LA CP ²	Use PA Form# 20420 1. See Criteria Section. 2. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR. 3. Use a preferred long acting antispasmodic.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. Vesicare 5mg and Enablex 7.5mg maximum doses if given with drugs known to be significant CYP3A4 inhibitors.(Ketoconazole, Sporanox, Erythromycin, Fluconazole, Nefazodone, Nelfinavir, and Ritonavir) DDI: Enablex 15mg and Vesicare 10mg will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: clarithromycin, erythromycin, Ketek, Crixivan, Norvir, ketoconazole, fluconazole (except 150mg strength), Sporanox, nefazodone, or diltiazem.
CHOLINERGIC	MC/DEL MC/DEL		URECHOLINE BETHANECHOL				Use PA Form# 20420	
METABOLIC MODIFIER								
HERED. TYROSINEMIA				MC		ORFADIN	Use PA Form# 20420	Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA.
ANTIHYPERTENSIVES / CARDIAC								
CARDIAC GLYCOSIDES	MC/DEL MC/DEL MC/DEL		DIGITEK TABS DIGOXIN LANOXIN				Use PA Form# 20420	
CARDIAC - SINUS NODE INHIBITORS	MC		CORLANOR					In patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction ≤35%, who are in sinus rhythm with resting heart rate ≥70 beats per minute (bpm) and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use
ANTIANGINALS--Isosorbide Di-nitrate/ Mono-Nitrates	MC/DEL MC/DEL		ISOSORBIDE MONONITRATE TABS ISOSORBIDE MONONITRATE ER	MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		DILATRATE SR CPCR ISORDIL TABS ISORDIL TITRADOSE TABS ISOSORBIDE DINITRATE SUBL ISOSORBIDE DINITRATE TABS ISOSORBIDE DINITRATE CR TBCR ISOSORBIDE DINITRATE ER TBCR ISOSORBIDE DINITRATE TD TBCR IMDUR TB24 ISMO TABS MONOKET TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
NITRO - OINTMENT/CAP/CR	MC/DEL MC/DEL MC MC		NITROBID OINT NITROGLYCERIN CPCR NITROL OINT NITRO-TIME CPCR				Use PA Form# 20420	
NITRO - PATCHES	MC/DEL MC/DEL MC/DEL MC	1 1 1 3	NITROGLYCERIN PT24 ¹ NITREK PT24 ¹ NITRO-DUR PT 24 0.8MG ¹ MINITRAN PT24 ¹	MC MC/DEL		NITRODISC PT24 NITRO-DUR PT24	1. At least 2 step 1's and step 3 of the 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	MC/DEL MC/DEL		NITROSTAT SUBL NITROTAB SUBL	MC/DEL MC MC		NITROQUICK SUBL NITROLINGUAL SOLN NITROLINGUAL TABS	Use PA Form# 20420 Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - NON SELECTIVE	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		CARVEDILOL LEVATOL TABS NADOLOL TABS PINDOLOL TABS PROPRANOLOL HCL SOLN ¹ PROPRANOLOL HCL TABS ¹ PROPRANOLOL LA CAPS RANEXA SOTALOL AF SOTALOL HCL TABS TIMOLOL MALEATE TABS	MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC/DEL		BETAPACE TABS BETAPACE AF TABS COREG CR ³ COREG TABS CORGARD TABS INDERAL TABS INDERAL LA CPCR INNOPRAN XL PROPRANOLOL HCL 60MG TABS ²	1. Recommend using BID since its effects do not last 24 hours. 2. Please use other strengths in combination to obtain this dose. 3. Dosing limits still apply. Please see dose consolidation list Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ACEBUTOLOL HCL CAPS ATENOLOL TABS ¹ BETAXOLOL HCL TABS BISOPROLOL FUMARATE TABS METOPROLOL TARTRATE TABS ¹ METOPROLOL ER TOPROL XL TB24	MC/DEL MC MC/DEL MC MC/DEL MC/DEL		BYSTOLIC KERLONE TABS LOPRESSOR TABS SECTRAL CAPS TENORMIN TABS ZEBETA TABS	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - ALPHA / BETA	MC/DEL		LABETALOL HCL TABS	MC		TRANDATE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS & DURECTIC COMBOS				MC/DEL		DUTOPROL	Use PA Form# 20420	
CALCIUM CHANNEL BLOCKERS-- Amlodipines, Bepridil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils	MC/DEL		AMLODIPINE ¹	MC/DEL		NORVASC TABS ¹	1. Dosing limits apply, please see dose consolidation list. Use PA Form# 20420	

	MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		DILTIA XT CP24 DILTIAZEM HCL ER CP24 DILTIAZEM HCL XR CP24 DILTIAZEM CD 300MG CP24 DILTIAZEM CD 360MG CP24 CARTIA XT CP24 ¹ DILTIAZEM CD CP24 ¹ DILTIAZEM HCL ER CP24 ¹ DILTIAZEM XR CP24 ¹ TIAZAC CP24 ¹	MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL	5 6 8 8 8 8 8 8 8 8	DILACOR XR CP24 ¹ TAZTIA ¹ CARDIZEM TABS ¹ CARDIZEM CD CP24 ¹ CARDIZEM LA TB24 ¹ CARDIZEM SR CP12 ¹ DILTIAZEM HCL TABS ¹ DILTIAZEM HCL ER CP12 ¹ DILTIAZEM HCL ER CP12 ¹	1. Products must be used in specified order or PA will be required. Just write "Diltiazem 24-hour" and the pharmacy will use a preferred long acting diltiazem that does not require PA. Use PA Form# 20420	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: All preferred diltiazems will now be non-preferred and require prior authorization if they are currently being used in combination with either Enablex 15mg or Vesicare 10mg. All non-preferred diltiazems require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with Enablex 15mg or Vesicare 10mg.
				MC/DEL MC/DEL		PLENDIL TB24 FELODIPINE	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC MC		DYNACIRC CAPS DYNACIRC CR TBCR ¹	Use PA Form# 20420 1. Established users will be 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.
				MC MC		CARDENE SR CPR NICARDIPINE HCL CAPS	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		AFEDITAB CR NIFEDIAC CC NIFEDICAL XL TBCR NIFEDIPINE TBCR NIFEDIPINE ER TBCR	MC/DEL MC/DEL MC/DEL MC/DEL		ADALAT CC TBCR ¹ NIFEDIPINE CAPS PROCARDIA CAPS PROCARDIA XL TBCR	1. Established users of Adalat CC are grandfathered. Use PA Form# 20420	Preferred drug must be tried and failed in step order due to lack of efficacy or intolerable side effects before non-preferred drugs in step order will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC MC		SULAR TB24 SULAR CR ¹	1. Established users of 10MG and 20MG strengths are grandfathered. Use PA Form# 20420	
	MC/DEL MC/DEL MC/DEL	1 1 1	VERAPAMIL HCL CR TBCR VERAPAMIL HCL ER TBCR VERAPAMIL HCL SR TBCR	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		CALAN TABS CALAN SR TBCR COVERA-HS TBCR ISOPTIN-SR VERAPAMIL HCL ER CP24 VERAPAMIL HCL SR CP24 VERAPAMIL HCL TABS VERELAN CP24 VERELAN PM CP24	Products must be used in specified order or PA will be required. Just write "Verapamil 24-hour" and the pharmacy will use a preferred long acting generic that does not require PA. Use PA Form# 20420	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIARRHYTHMICS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL		AMIODARONE HCL FLECAINIDE MEXILETINE HCL NORPACE PROCAINAMIDE PROPAPENONE QUINAGLUTE QUINIDINE GLUCONATE QUINIDINE SULFATE	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		CORDARONE DISOPYRAMIDE MULTAQ PACERONE QUINIDEX TAMBOCOR TIKOSYN ¹ RYTHMOL SR RYTHMOL	1. Prescription must be written by Cardiologist. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Amiodarone will now be non-preferred and require prior authorization if it is currently being used in combination with either Lovastatin (doses greater than 40mg/day) or Lipitor (doses greater than 20mg/day) or Levofloxacin or Gemifloxacin, or Moxifloxacin, or Ofloxacin. DDI: Multaq will be preferred unless the following medications are seen in the member's drug profile within the last 35 days for brand name medications or 90 days for generic medications: Erythromycin, Amiodarone and other antiarrhythmics, TCA's, Phenothiazine, Ketoconazole, Itraconazole, Voriconazole, Cyclosporine, Telithromycin, Clarithromycin, Nefazodone, Ritonavir.
ACE INHIBITORS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BENAZEPRIL HCL CAPTOPRIL TABS ENALAPRIL MALEATE TABS FOSINOPRIL SODIUM LISINOPRIL TABS RAMIPRIL QUINAPRIL HCL	MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL	5 5 8 8 8 8 8 8	MAVIK TABS ACCPURIL TABS ACEON TABS ¹ ALTACE CAPS ¹ LOTENSIN TABS ¹ MOEXIPRIL HCL ¹ MONOPRIL HCT TABS ¹ PRINIVIL TABS ¹ UNIVASC ¹	1. Non-preferred products must be used in specified order. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception.

MC
MC/DEL

8
8

VASOTEC TABS¹
ZESTRIL TABS¹

ANGIOTENSIN RECEPTOR BLOCKER	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BENICAR TABS ¹ DIOVAN ¹ IRBESARTAN ¹ LOSARTAN ¹ MICARDIS TABS ¹	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL	8 8 8 8 8 8	ATACAND TABS AVAPRO COZAAR EDARBI TEVETEN TABS TRIBENZOR ²	Use PA Form# 20420 1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. 2. Use preferred active ingredients which are available without PA.	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.
DIRECT RENIN INHIBITOR				MC/DEL MC/DEL MC/DEL		AMTURNIDE TEKTURNA ¹ TEKAMLO	1. Must show failure of single and combination therapy from all preferred antihypertensive categories. Use PA Form# 20420	
ANTIHYPERTENSIVES - CENTRAL	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		CATAPRES-TTS CLONIDINE HCL TABS GUANFACINE HCL TABS HYDRALAZINE HCL TABS HYLOREL TABS METHYLDOPA TABS MINOXIDIL TABS PRAZOSIN HCL CAPS RESERPINE TABS	MC/DEL MC/DEL MC MC/DEL MC MC/DEL		CATAPRES TABS CLONIDINE TTS GUANABENZ ACETATE TABS ISMELIN TABS MINIPRESS CAPS NEXICLON TENEX TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ACE INHIBITORS AND CA CHANNEL BLOCKERS				MC/DEL MC MC/DEL MC/DEL	8 8 9 9	AMLODIPINE/BENAZEPRIL TARKA TBCR AMLODIPINE/BENAZEPRIL LOTREL CAPS	Use individual preferred generic medications. Use PA Form# 20420	
ACE AND THIAZIDE COMBO'S	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BENAZEPRIL HCL/HYDROCHLOR CAPTOPRIL/HYDROCHLOROTHIA ENALAPRIL MALEATE/HCTZ TABS LISINOPRIL-HCTZ TABS LOTENSIN HCT TABS	MC/DEL MC MC/DEL MC/DEL MC MC/DEL		ACCURETIC TABS MONOPRIL HCT TABS PRINZIDE TABS UNIRETIC TABS VASERETIC TABS ZESTORETIC TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL MC/DEL MC/DEL		ATENOLOL/CHLORTHALIDONE BISOPROLOL FUMARATE/HCTZ PROPRANOLOL/HCTZ	MC/DEL MC/DEL MC MC MC/DEL		CORZIDE TABS LOPRESSOR HCT TABS TENORETIC TIMOLIDE 10/25 TABS ZIAC TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ARB'S AND CA CHANNEL BLOCKERS	MC/DEL MC/DEL MC/DEL		AZOR EXFORGE ¹ EXFORGE HCT ¹	MC/DEL		TWYNSTA	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form# 20420	
ARB'S AND DIURETICS	MC/DEL MC/DEL MC/DEL MC/DEL		BENICAR HCT ¹ LOSARTAN HCT ¹ MICARDIS HCT TABS ¹ VALSARTAN-HYDROCHLOROTHIAZIDE ¹	MC/DEL MC/DEL MC MC/DEL MC/DEL MC	7 8 8 8 8 8	IRBESARTAN HYDROCHLOROTHIAZIDE ATACAND HCT TABS AVALIDE TABS ¹ DIOVAN HCT TABS ¹ HYZAAR TABS TEVETEN HCT TABS	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form# 20420	Same initial criteria as the ARB class and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANGIOTENSIN MODULATORS-ARB COMBINATION				MC/DEL		EDARBYCLOR	Use PA Form# 20420	
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION				MC/DEL		VALTURNA	Use PA Form# 20420	
DIURETICS	MC/DEL MC/DEL MC/DEL		ACETAZOLAMIDE TABS BUMETANIDE CHLOROTHIAZIDE TABS	MC/DEL MC/DEL MC/DEL		ALDACTAZIDE TABS ALDACTONE TABS AMILORIDE HCL	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra 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.

MC/DEL
MC
MC/DEL

CHLORThALIDONE TABS
EDECRIIN TABS
EDECRIIN TABS

MC/DEL
MC/DEL
MC/DEL

BUMEX TABS
DEMADEX TABS
DIAMOX

strength. Intra-arterial
approved for severe breast
tenderness and male
gynecomastia.

	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS METHYLCLOTHIAZIDE TABS SPIRONOLACTONE 25MG TABS SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ ZAROXOLYN TABS	MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL		DIURIL DYAZIDE CAPS ENDURON TABS INSPRA LASIX TABS MAXZIDE MICROZIDE CAPS MIDAMOR TABS NAQUA TABS SPIRONOLACTONE 50MG ¹			
CCB / LIPID				MC/DEL		CADUET			
NEUROGENIC ORTHOSTATIC HYPOTENSION									
NEUROGENIC ORTHOSTATIC HYPOTENSION				MC		NORTHERA			Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Use PA Form# 20420
LIPID DRUGS									
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL MC/DEL		CHOLESTYRAMINE COLESTIPOL HCI	MC/DEL MC/DEL MC MC/DEL		COLESTID PREVALITE QUESTRAN WELCHOL TABS		Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC MC/DEL MC/DEL MC/DEL MC		ANTARA FENOFIBRATE GEMFIBROZIL TABS NIASPAN TRILIPIX	MC/DEL MC/DEL MC MC/DEL MC MC		LOPID FIBRICOR LIPOFEN LOFIBRA TRICOR TRIGLIDE		Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Fenofibrate is preferred but will require a prior authorization requests if used concurrent with Warfarin. DDI: Gemfibrozil will now be non-preferred and require prior authorization if it is currently being used with any of the following medications: Prandin, Actos, Avandia, any Avandia/Actos combination product, any HMG-COA Reductase Inhibitors (statins), or Warfarin.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS	MC/DEL MC/DEL MC/DEL MC		ATORVASTATIN CRESTOR SIMVASTATIN ¹ VYTORIN	MC/DEL MC MC/DEL MC/DEL		LIPITOR LIPTRUZET ZOCOR SIMVASTATIN 80MG ^{1,2}		Use PA Form# 20420	1. Dosing limits apply, please see dosage consolidation list. 2. Current 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. DDI: Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if they are currently being used in combination cyclosporine. DDI: Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone. DDI: All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS	MC/DEL MC/DEL MC/DEL MC/DEL		LESCOL CAPS LESCOL XL TB24 LOVASTATIN TABS ² PRAVASTATIN ²	MC MC MC/DEL MC/DEL MC	8 8 8 8 8	ALTOPREV TB24 LIVALO MEVACOR TABS PRAVACHOL TABS PRAVIGARD ZETIA TABS ¹		Use PA Form# 20420	1. Zetia available w/out PA as addition to Lipitor 80mg. Zetia will also be approved with a PA as add on for patients at maximally tolerated doses of statins. 2. Dosing limits apply, please see dosage consolidation list. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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. DDI: Lescol will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac. DDI: Lovastatin (doses greater than 40mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone. DDI: Lovastatin (doses greater than 20mg per day) will now be non-preferred and require prior authorization if it is currently being used in combination cyclosporine. DDI: All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO	MC		SIMCOR	MC		ADVICOR TBCR		Use PA Form# 20420	
FAMILIAL HYPERCHOLESTEROLEMIA				MC MC		JUXTAPID KYNAMRO ¹			1. Clinical PA required for appropriate diagnosis Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists Juxtapid is contraindicated with strong CYP3A4 inhibitors. Juxtapid dosage should not exceed 30mg daily when it is used concomitantly with weak CYP3A4 inhibitors.

Kynamro requires an appropriate lab testing prior to starting (ALT<AST), Alkaline phosphatase and total billubin, monthly liver-related tests for the first year, then every three months.

[Use PA Form#10500](#)

PULMONARY ANTI-HYPERTENSIVES

<p>PULMONARY ANTI-HYPERTENSIVES</p>	<p>MC/DEL MC MC</p>		<p>SILDENAFIL¹ EPROSTENOL INJ⁶ VENTAVIS²</p>	<p>MC MC/DEL MC/DEL MC MC MC MC/DEL</p>		<p>ADCIRCA¹ ADEMPAS^{6,7} FLOLAN⁶ OPSUMIT^{7,8} ORENITRAM REMODULIN⁶ REVATIO³</p>	<p>1. See Criteria Section. 2. See Criteria Section. 3. See Criteria Section. 4. See Criteria Section. 5. There will be dosing limits of one 20ml multidose vial/ 30 days supply without pa. 6. PA is required to establish and conform who group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 & 4. 7. Requires previous trials/failure of multiple preferred medications. 8. Dosing limits apply, please see the dose consolidation list.</p> <p>Use PA Form# 20420</p>	<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.</p> <p>1. Adcirca approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. 2. Ventavis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4. 3. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. 3. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. 4. Sildenafil will be preferred with clinical PA for treatment of pulmonary arterial hypotension (WHO Group 1) in adults to improve exercise ability and delay clinical worsening.</p> <p>DDI: Opsumit will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).</p> <p>DDI: Adempas will require a prior authorization if it is currently being used in combination with drugs known to be PDE inhibitors should be avoided (including dypridamole, adcirca and tadalafil) with adempas</p>
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<p>ERA / ENDOTHELIN RECEPTOR ANTAGONIST</p>	<p>MC MC</p>		<p>LETAIRIS^{1,2} TRACLEER^{3,4}</p>				<p>1. Providers must be registered with LEAP Prescribing program, a restricted distribution program. 2. Clinical PA is required to establish diagnosis and medical necessity. 3. Prior trial of Letaris, WHO Group 1 diagnosis of PAH (Primary Pulmonary Hypertension) and NYHA functional class of 3. 4. For members with NYHA functional class of 4, Tracleer approval will be allowed with confirmation of diagnosis and functional class.</p> <p>Use PA Form# 20420</p>	<p>Tracleer approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 thru 4.</p> <p>DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.</p> <p>Letairis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and functional class 2 or 3 symptoms.</p>
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IMPOTENCE AGENTS

<p>IMPOTENCE AGENTS</p>							<p>As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.</p>	<p>As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.</p>
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ANTI-EMETOGENICS

ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC	MC/DEL MC MC/DEL MC		MECLIZINE HCL TABS PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72	MC MC MC MC		ANTIVERT TABS PHENERGAN SOLN PROMETHAZINE 50MG SUPP PROMETHEGAN SUPP TORECAN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC/DEL MC/DEL MC/DEL MC/DEL		DRONABINOL CAPS ONDANSETRON TABS ^{2,4} ONDANSETRON ODT TBP ^{2,4} ONDANSETRON INJ ^{2,4}	MC/DEL MC MC MC MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC	5 8 8 8 8 8 8 8 8 8 8 8 8 8	GRANISETRON AKYNZEO ¹ ALOXI ANZEMET TABS CESAMET ¹ DICLEGIS EMEND ³ KYTRIL MARINOL CAPS SANCUSO ZOFRAN ODT TBP ⁴ ZOFRAN TABS ⁴ ZOFRAN INJ ⁴ ZUPLENZ	1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred anti-emetics, including 5-HT3 class (Ondansetron) and Marinol. 2. Ondansetron will be preferred with CA diag and dosing limits still apply. 3. Clinical PA is required for members on highly emetic anti-neoplastic agents. 4. Dosing limits apply, please see Dosage Consolidation List Use PA Form# 20610 for Ondansetron requests Use PA Form# 20420 for all others	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * Ondansetron limits still apply as listed on the Ondansetron 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. Akynzeo- Concomitant use should be avoided in patients who are chronically using a strong CYP3A inducer such as rifampin.

NON-SEDATING ANTIHISTAMINES / DECONGESTANTS

ANTI HISTIMINES - NON-SEDATING	MC MC/DEL MC MC MC/DEL MC		ALAVERT TABS CETIRIZINE TABS CLARITIN (OTC) CLARITIN SYRP (OTC) LORATADINE TAVIST ND (OTC)	MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL	5 5 5 5 5 8 8 8 8 8 8 9	CLARINEX TABS ^{1,5} CLARINEX SYR ^{1,2} FEXOFENADINE ¹ ZYRTEC ¹ ZYRTEC SYR ^{1,2} ALLEGRA ³ CLARITIN ³ DESLORATADIN LORATADINE ODT ⁴ LEVOCETIRIZINE ⁴ XYZAL ³	1. Must fail preferred drugs, OTC loratidine and cetirizine before moving to non-preferred step order drugs. 2. Clarinex and Zyrtec syrup <6 yr w/o PA. 3. Must fail all step 5 drugs (Clarinex, Fexofenadine and Zyrtec) before moving to next step product. 4. All OTC versions of loratidine ODT are now non-preferred. 5. Pa's for Clarinex RediTabs will only be approved if between the ages of 6-11 years old. Use PA Form# 20530	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA. Pseudoephedrine is available with prescription.
ANTI HISTIMINES - OTHER	MC/DEL MC/DEL		CLEMASTINE CHLORPHENIRAMINE				Use PA Form# 20530	

	MC/DEL	DIPHENHYDRAMINE					
ALLERGY / ASTHMA THERAPIES							
ANAPHYLACTIC DEVICES	MC/DEL MC/DEL		AUVI-Q EPIPEN	MC		TWINJECT	
ALLERGEN IMMUNOTHERAPY				MC/DEL MC/DEL MC		GRASTEK ¹ RAGWITEK ¹ ORALAIR ¹	<p>Use PA Form# 20420</p> <p>1. See criteria section</p> <p>Prescriber must provide the testing to show that the patient is allergic to the components in the prescribed therapy and must provide a clinically valid rationale why single agent sublingual therapy is being chosen over subcutaneous therapy</p> <p>Treatment must start 12 weeks before expected onset of pollen season and only after confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen (Ragwitek), timothy grass or cross-reactive grass pollens (Grastek), or any of the 5 grass species contained in Oralair</p> <p>Have an auto-injectable epinephrine on-hand</p> <p>Grastek : Patient age ≥5 years and ≤65 years Ragwitek: Patient age ≥18 years and ≤65 years Oralair: Patient age ≥10 years and ≤65 years</p>
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC/DEL		SPIRIVA HANDIHALER ^{1,2}	MC/DEL MC/DEL MC/DEL		SPIRIVA RESPIMAT TUDORZA INCRUSE ELLIPTA ³	<p>Use PA Form# 20420</p> <p>1. Quantity limit of 1 inhalation daily (1 capsule for inhalation daily) Spiriva will require PA if Combivent or Atrovent nebulizer solution is in member's current drug profile.</p> <p>2. We ask physicians to write "asthma" on the prescription whenever Spiriva is primarily being used for that condition.</p> <p>3. Quantity limit of 1 inhalation daily</p> <p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.</p>
ANTIASTHMATIC - PHOSPHODIESTERASE 4 INHIBITORS				MC/DEL		DALIRESP	<p>Use PA Form# 20420</p> <p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.</p>
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER	MC/DEL		IPRATROPIUM BROMIDE SOLN	MC		ATROVENT SOLN	<p>Use PA Form# 20420</p> <p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.</p>
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS	MC/DEL		CROMOLYN SODIUM NEBU	MC/DEL		XOLAIR ¹	<p>1. Need max inhaled steroids and written by pulmonary or allergy specialist</p> <p>Use PA Form# 20420</p> <p>Xolair approval will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management.</p>
ANTIASTHMATIC - NASAL STEROIDS	MC/DEL MC/DEL		FLUTICASONA SPR ³ NASONEX SUSP ³	MC/DEL MC/DEL MC/DEL MC/DEL MC	5 8 8 8 8 8	BECONASE AQ INHA ^{1,3} DYMISTA FLONASE SUSP ^{2,3} FLUNISOLIDE SOLN ^{1,3} OMNARIS SPR ³ QNASL	<p>Use PA Form# 20420</p> <p>1. All preferred drugs must be tried before moving to non preferred steps.</p> <p>Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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>

				MC	8	RHINOCORT AERO ^{2,3}			
				MC/DEL	8	RHINOCORT AQUA SUSP ^{2,3}			
				MC	8	TRI-NASAL SOLN ^{2,3}			
				MC	8	VANCENASE POKETHALER AERS ^{2,3}			
				MC/DEL	8	VERAMYST ^{2,3}			
				MC/DEL	8	ZETONNA			
				MC/DEL	9	TRIAMCINOLONE NS			
									2. All step 5 medications need to be tried before moving to step 8's. 3. Dosing limits apply to whole category, please see dosage consolidation list.
ANTIASTHMATIC - NASAL MISC.	MC/DEL		CROMOLYN NASAL 4%	MC	7	ATROVENT NASAL SOL	Use PA Form# 20420	Approved if patient fails on non-sedating antihistamines and steroid nasal sprays.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL	7	ASTELIN			
				MC	7	IPRATROPIUM NASAL SOL ¹			
				MC/DEL	8	ASTEPRO ²			
				MC/DEL	8	PATANASE			
									1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine. 2. Utilize Multiple preferred, as well as step therapy Astelin.
ANTIASTHMATIC - BETA - ADRENERGICS	MC/DEL		ALBUTEROL NEB	MC/DEL		ACCUNEB NEBU			Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		METAPROTERENOL	MC/DEL		ALBUTEROL AER			
	MC/DEL		PROVENTIL HFA	MC/DEL		ALBUTEROL HFA			
	MC/DEL		SEREVENT	MC/DEL		ALBUTEROL 0.63mg/3ml			
	MC/DEL		TERBUTALINE SULFATE TABS	MC/DEL		ARCAPTA ³			
				MC/DEL		BRETHINE			
				MC/DEL		FORADIL AEROLIZER CAPS			
				MC		PROAIR HFA ³			
				MC		PROAIR RESPICLICK			
				MC/DEL		STRIVERDI			
				MC/DEL		VENTOLIN AERS			
				MC/DEL		VENTOLIN HFA AERS ³			
				MC		VOLMAX TBCR			
				MC		VOSPIRE ER TB12			
				MC		XOPENEX HFA ³			
				MC		XOPENEX NEBU ^{1,2}	Use PA Form# 20420		
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC/DEL		ADVAIR DISKUS/HFA ^{1,2}	MC/DEL		BREO ELLIPTA ^{2,3}			
	MC/DEL		DULERA						
	MC/DEL		SYMBICORT ²						
									1. We ask physicians to write "asthma" on the prescription whenever Advair is primarily being used for that condition. 2. Dosing limits apply, please see dosage consolidation list. 3. Clinical PA required for appropriate diagnosis Use PA Form# 20420
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL		ALBUTEROL/IPRATROPIUM NEB. SOLN	MC/DEL		ANORO ELLIPTA			Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.
				MC/DEL		COMBIVENT RESPIMAT			
				MC/DEL		DUONEB SOLN ¹			
							Use PA Form# 20420		
ANTIASTHMATIC - XANTHINES	MC/DEL		AMINOPHYLLINE TABS	MC/DEL		THEO-24 CP24	Use PA Form# 20420		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		THEOCHRON TB12	MC		THEOLAIR TABS			
	MC/DEL		THEOLAIR-SR TB12	MC/DEL		UNIPHYL TBCR			
	MC/DEL		THEOPHYLLINE CR TB12						
	MC		THEOPHYLLINE ELIX						
	MC/DEL		THEOPHYLLINE SOLN						
	MC/DEL		THEOPHYLLINE ER CP12						

	MC/DEL	THEOPHYLLINE ER TB12							
ANTIASTHMATIC - STEROID INHALANTS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC	ASMANEX ^{4,5} FLOVENT DISKUS ⁴ FLOVENT HFA ⁴ PULMICORT FLEXHALER PULMICORT SUSP ^{1,4} QVAR AERS ⁴	MC/DEL MC MC MC/DEL MC MC/DEL MC/DEL MC MC	5 5 5 8 8 8 8 8 8 8	AEROBID AERS ^{2,4} BECLOVENT AERS ^{2,4} VANCERIL AERS ^{2,4} AEROBID-M AERS ^{3,4} AEROSPAN ALVESCO ⁴ ARNUITY ELLIPTA ⁶ VANCERIL DOUBLE STRENGTH AERS ^{3,4}	1. No PA for Pulmicort susp if under 8 years old. 2. All preferreds must be tried before moving to non preferred steps. 3. All step 5 medications need to be tried before moving to step 8's. 4. Dosing limits apply to whole category, please see dosage consolidation list. 5. Asmanex 110mcg will be limited to member between the ages of 4-11years old. 6. Not approved for children <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.	Use PA Form# 20420	
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors			MC		ZYFLO CR 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.	Use PA Form# 20420	
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	MC/DEL MC/DEL	MONTELUKAST SODIUM TAB MONTELUKAST SODIUM CHEW TAB	MC/DEL MC/DEL MC/DEL	7 8 8	MONTELUKAST GRANULE ¹ ACCOLATE TABS SINGULAIR ²	1.Montelukast Granules will only be approved if between ages of 6months-24 months. 2.Singulair Chewables 4mg from 2years-5years and Singulair Chewables 5mgs from 6years-14years old.		Use PA Form# 20420	
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR			MC MC/DEL MC MC	8 8 8 8	ARALAST ZEMAIRA GLASSIA PROLASTIN SUSR		Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.	Use PA Form# 20420	
ANTIASTHMATIC - HYDRO-LYTIC ENZYMES			MC/DEL		PULMOZYME SOLN		Will be approved for cystic fibrosis patients.	Use PA Form# 20420	
ANTIASTHMATIC - MUCOLYTICS	MC/DEL	ACETYLCYSTEINE ¹	MC		MUCOMYST	1. Acetylcysteine is covered with diagnosis of CF.		Use PA Form# 20420	

			<p>MC/DEL 8 PREVACID CPDR^{4,5}</p> <p>MC/DEL 8 PREVACID SOLUTABS¹</p> <p>MC/DEL 8 PRILOSEC CPDR</p> <p>MC/DEL 8 PROTONIX INJ</p> <p>MC/DEL 8 PROTONIX²</p> <p>MC 8 OMEPRAZOLE 10MG²</p> <p>MC/DEL 8 OMEPRAZOLE-SODIUM BICARBONATE CAPS</p> <p>MC 8 LANSOPRAZOLE</p> <p>MC 9 OMEPRAZOLE 40MG³</p>	<p>2. Dosing limits apply, please see dosage consolidation list.</p> <p>3. Please use multiple 20mg Capsules to obtain required dose.</p> <p>4. All preferreds and step therapy must be tried and failed.</p> <p>5. Established users prior to 10/1/09 may continue to obtain Prevacid until 12/31/09.</p>	<p>Patients obtaining refills as of 7/10/09 will begin to require prior authorizations if they have been on any PPI longer than 60 days in the past year. The 12-month period is patient specific and begins 12 months before the requested date of prior authorization. Payment for usage beyond these limits will be authorized for cases in which there is a diagnosis of:</p> <p>1. Barrett's esophagus.</p> <p>2. Erosive esophagitis</p> <p>3. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas). Recurrent peptic ulcer disease after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses and with documentation of either failure of Helicobacter pylori treatment or anegative Helicobacter pylori test result.</p> <p>4. Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least onehistamine H2-receptor antagonist at full therapeutic doses. Patients may be required to step down from a PPI to a histamine H2-receptor antagonist during the 12 months or on an annual clinical review if PPI therapy is continued.</p> <p>DDI: Omeprazole will require prior authorization if being used in combination with Plavix.</p> <p>DDI: Prevacid, Omeprazole and pantoprazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Ampicillin, B-12, Fe salts, Griseofulvin, Sporanox, Ketoconazole, Reyataz, or Vantin.</p> <p>DDI: All non-preferred PPIs require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with ampicillin, B-12, Fe salts, griseofulvin, itraconazole, ketoconazole, Reyataz or Vantin due to a significant drug-drug interaction.</p>	
GI - ULCER ANTI-INFECTIVE			<p>MC HELIDAC</p> <p>MC PREVPAC</p> <p>MC PYLERA</p>	<p>Use PA Form# 20720</p> <p>Use PA Form# 20420</p>		
GI - PROSTAGLANDINS	MC		<p>MC/DEL MISOPROSTOL TABS</p>		<p>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.</p> <p>Use PA Form# 20420</p>	
GI - DIGESTIVE ENZYMES	<p>MC/DEL</p> <p>MC/DEL</p> <p>MC/DEL</p> <p>MC</p>		<p>MC/DEL CREON¹</p> <p>MC LACTASE CHEW</p> <p>MC/DEL LACTASE TAB</p> <p>MC/DEL ZENPEP¹</p>	<p>MC/DEL LACTRASE CAPS</p> <p>MC PANCREAZE</p> <p>MC/DEL PERTZYE</p> <p>MC/DEL ULTRESA</p> <p>MC/DEL VIOKACE</p>	<p>Use PA Form# 20420</p> <p>1. Clinical PA is required to establish CF diagnosis and medical necessity. In all cases except cystic fibrosis patients, objective evidence of pancreatic insufficiency (fat malabsorption test etc...) must be supplied.</p>	<p>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.</p>
GI - ANTI - FLATULENTS / GI STIMULANTS	<p>MC</p> <p>MC/DEL</p> <p>MC/DEL</p> <p>MC</p> <p>MC/DEL</p> <p>MC/DEL</p> <p>MC/DEL</p> <p>MC/DEL</p>		<p>MC/DEL CALULOSE SYRP</p> <p>MC/DEL CONSTULOSE SYRP</p> <p>MC/DEL ENULOSE SYRP¹</p> <p>MC/DEL GASTROCROM CONC</p> <p>MC/DEL GENERLAC SYRP¹</p> <p>MC/DEL LACTULOSE SYRP¹</p> <p>MC/DEL METOCLOPRAMIDE HCL</p> <p>MC/DEL SIMETHICONE</p>	<p>MC/DEL AMITIZA²</p> <p>MC/DEL CEPHULAC SYRP</p> <p>MC/DEL INFANTS GAS RELIEF SUSP</p> <p>MC/DEL REGLAN TABS</p>	<p>1. Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL</p> <p>Use PA Form# 20420</p> <p>2. Prior failed trials of multiple other preferred GI agents must occur first, Such as OTC senna, docusate, lactulose, polyethylene glycol.</p>	<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.</p>
GI - INFLAMMATORY BOWEL AGENTS	<p>MC</p> <p>MC</p> <p>MC/DEL</p> <p>MC</p> <p>MC</p> <p>MC</p> <p>MC</p> <p>MC/DEL</p>		<p>MC/DEL APRISO</p> <p>MC/DEL AZULFIDINE TABS</p> <p>MC/DEL BALSALAZIDE</p> <p>MC CANASA SUPP</p> <p>MC COLAZAL CAPS</p> <p>MC/DEL DIPENTUM CAPS</p> <p>MC PENTASA CPCR 250MG</p> <p>MC/DEL ROWASA ENEM</p>	<p>MC/DEL ASACOL 800MG HD</p> <p>MC/DEL AZULFIDINE EN-TABS TBEC</p> <p>MC/DEL DELZICOL</p> <p>MC GIAZO</p> <p>MC/DEL LIALDA TABS¹</p> <p>MC/DEL PENTASA 500MG²</p> <p>MC SFROWASA</p> <p>MC UCERIS RECTAL FOAM³</p>	<p>Use PA Form# 20420</p> <p>1. Current users grandfathered.</p> <p>2. Use multiple Pentasa 250mg.</p>	<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.</p> <p>Giazo is only indicated for males, as the safety,efficacy for use in females has not been established.Prior trials of preferred products.</p>

	MC/DEL MC/DEL		SULFAZINE EC TBEC SULFASALAZINE TABS	MC		UCERIS TABS ³	3. Diagnosis required	Uceris Rectal Foam or Tab- Concomitant use with CYP3A inhibitors (e.g. ketoconazole, itraconazole, ritonavir, indinavir, saquinavir, erythromycin, cyclosporine, and grapefruit juice) should be avoided. Verify prior trials and failures or intolerance of preferred treatments
GI - IRRITABLE BOWEL SYNDROME AGENTS				MC/DEL		LOTROXEX TABS	Use PA Form# 20420	Lotronex will be approved for females with IBS and predominant diarrhea. Prior failed trials of multiple preferred GI agents must occur first. IBS dx must be thoroughly documented.
GI- SHORT BOWL SYNDROME				MC		GATTEX		Gattex requires a diagnosis of adult SBS who are dependent on parenteral support. Appropriate colonoscopy and lab assessments 6months prior to starting

MISCELLANEOUS GI

GI - MISC.	MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC/DEL		BISAC-EVAC SUPP BISACODYL BISCOLAX SUPP CINOBAC CAPS CITRATE OF MAGNESIA SOLN CITRUCEL DIOCTO SYRP DOCUSATE CALCIUM CAPS DOCUSATE SODIUM FIBER LAXATIVE TABS FLEET GENFIBER POWD GLYCERIN HIPREX TABS KRISTALOSE PACK MAALOX METAMUCIL MILK OF MAGNESIA SUSP MINERAL OIL OIL NULYTELY SOLR SENNA SENOKOT GRAN SENOKOT SYRP SENOKOT CHILDRENS SYRP SENOKOT XTRA TABS STOOL SOFTENER CAPS SUCRALFATE TABS UNI-EASE CAPS UNIFIBER POWD URSO FORTE URSODIOL	MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC MC/DEL MC MC/DEL MC MC MC MC/DEL MC MC MC MC/DEL MC MC MC MC		ACTIGALL CAPS BENEFIBER CARAFATE CLEARLAX POW 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 LINZESS MALTSUPEX MIRALAX PACK (OTC versions) MIRALAX POWD (OTC versions) MOVANTI ³ PEG 3350 POWDER ² PEG-ELECTROLYTES SOLR PREPOPIK PAK SENXON TABS SENOKOT TABS SENOKOT S TABS SORBITOL STOOL SOFTENER PLUS CAPS UNI-CENNA TABS UNI-EASE PLUS CAPS V-R NATURAL SENNA LAXATIV TABS URSO 250	1. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose. 2. Quantity Limit: 255 g/90-day without PA for greater than 18 years old. If under 18 years of age, allowed 17gms daily without PA. 3. Multiple preferred agents and dietary changes are required. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval. Preferred products that used to require diag codes still require diag codes unless indicated otherwise. Linzess is non-preferred and is for adults as treatment of IBS-Constipation AND treatment of chronic idiopathic constipation in adults. Prior trials of preferred agents for constipation and IBS-constipation.
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MISC. UROLOGICAL

UROLOGICAL - MISC.	MC MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC		ACETIC ACID 0.25% SOLN CYTRA-K SOLN FURADANTIN SUSP K-PHOS MF TABS METHENAMINE MANDELATE TABS MONUROL PACK NEOSPORIN GU IRRIGANT SOLN NITROFURANTOIN MONO CAPS PHENAZOPYRIDINE HCL TABS PHENAZOPYRIDINE PLUS PROSED/DS TABS TRICITRATES SYRP URELIEF PLUS UREX TABS	MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC		CITRIC ACID/SODIUM CITRAT SOLN CYTRA-2 SOLN ELMIRON CAPS ¹ MACROBID CAPS MACRODANTIN CAPS NITROFURANTOIN MACR SUSP POTASSIUM CITRATE/CITRIC SOLN PYRIDIDIUM PLUS TABS PYRIDIDIUM TABS RENACIDIN SOLN	1. Elmiron requires adequate proof of Dx with supportive testing. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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	MC/DEL MC MC/DEL		URISED TABS UROCID-K UROQID #2 TABS					
PHOSPHATE BINDERS								
PHOSPHATE BINDERS	MC/DEL MC/DEL MC MC/DEL		ELIPHOS ¹ MAGNEBIND - 400 ¹ PHOSLYRA ¹ RENAGEL ¹	MC MC/DEL MC/DEL MC		AURYXIA CALCIUM ACETATE FOSRENOL ¹ RENVELA ¹ VELPHORO ¹	Use PA Form# 20420 1. Diag required.	
INTRA-VAGINALS								
VAGINAL - ANTIBACTERIALS	MC/DEL MC/DEL MC/DEL MC/DEL		CLEOCIN CREA METROGEL VAGINAL GEL ² METRONIDAZOLE VAGINAL GEL ² CLEOCIN SUPP ¹	MC/DEL MC/DEL		NUVESSA VANDAZOLE	1. Step order must be followed to avoid PA. Must fail Cleocin Cream and Metronidazole products before moving to next step product without PA. 2. Dosing limits apply, please see Dosage Consolidation List. Use PA Form# 20420	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	MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC		CLINDESSE CREA CLOTRIMAZOLE CREA GYNE-LOTRIMIN CREA MICONAZOLE CREA MICONAZOLE 3 COMBO PACK KIT ¹ MICONAZOLE 7 CREA MICONAZOLE NITRATE CREA NYSTATIN TABS TERCONAZOLE 0.4MG VAGITROL V-R MICONAZOLE-7 CREA	MC MC MC MC/DEL MC MC MC/DEL MC/DEL		AVC CREA CLOTRIMAZOLE 3 DAY CREA GYNAZOLE-1 CREA GYNE-LOTRIMIN 3 TABS MICONAZOLE 3 SUPP TERAZOL 3 CREA TERAZOL 7 CREA TERCONAZOLE 0.8MG TERCONAZOLE SUPP	1. Quantity limit: 1/script/2 weeks Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Miconazole will require prior authorization if being used in combination with Warfarin.
VAGINAL - CONTRACEPTIVES							Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ESTROGENS	MC/DEL MC/DEL		ESTRING RING PREMARIN CREA	MC/DEL MC/DEL		ESTRACE CREA ¹ VAGIFEM TABS ¹	1. Must fail all preferred products before non-preferred. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - OTHER	MC/DEL MC MC		ACID JELLY GEL ACI-JEL GEL CERVICAL AMINO ACID CREA	MC		AMINO ACID CERVICAL CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BPH								
BPH	MC/DEL MC/DEL MC/DEL MC/DEL		DOXAZOSIN MESYLATE TABS FINASTERIDE ¹ TERAZOSIN HCL CAPS TAMSULOSIN HCL	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	5 8 8 8 8 8 8	FLOMAX CP24 ALFUZOSIN AVODART ^{2,4} CARDURA TABS ⁴ JALYN ^{3,4} PROSCAR TABS ⁴ RAPAFLO ⁴ UROXATRAL ⁴	1. There will be dosing limits of 1 tab per day with out PA. 2. Prior use of preferred agent prior to any approvals. 3. Use of preferred (tamsulosin and finasteride) and (tamsulosin and non-preferred Avodart).	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.

4. Non-preferred products must be used in specified order.

[Use PA Form# 20420](#)

ANXIOLYTICS

ANXIOLYTICS - BENZODIAZEPINES	MC/DEL	ALPRAZOLAM TABS	MC/DEL	8	ALPRAZOLAM ER	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	CHLORDIAZEPOXIDE HCL CAPS	MC/DEL	8	ATIVAN		
	MC/DEL	CLORAZEPATE DIPOTASSIUM TABS	MC/DEL	8	NIRAVAM		
	MC/DEL	DIAZEPAM	MC/DEL	8	SERAX		
	MC/DEL	LORAZEPAM	MC/DEL	8	TRANXENE		
	MC/DEL	OXAZEPAM CAPS	MC/DEL	8	XANAX TABS		
			MC/DEL	9	XANAX XR		
ANXIOLYTICS - MISC.	MC/DEL	BUSPIRONE HCL TABS	MC		BUSPAR TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	HYDROXYZINE HCL SOLN	MC		DROPERIDOL SOLN		
	MC	HYDROXYZINE HCL SYRP	MC/DEL		HYDROXYZINE HCL TABS		
	MC/DEL	HYDROXYZINE PAMOATE CAPS	MC/DEL		HYDROXYZINE PAMOATE 100MG CAPS		
	MC/DEL	MEPROBAMATE TABS	MC/DEL		VISTARIL		

ANTI-DEPRESSANTS

ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL	NARDIL TABS	MC/DEL		TRANLYCYPROMIINE	Use PA Form# 20420	
	MC/DEL	PARNATE TABS					
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL			MC/DEL		EMSAM ¹	Use PA Form# 20420	Preferred drugs (including a preferred SSRI, a non-SSRI, and Venlafaxine ER) must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIDEPRESSANTS - SELECTED SSRI's	MC/DEL	BUPROPION HCL TABS	MC/DEL	8	APLENZIN ⁷	Use PA Form# 20420	Preferred drugs (including failure of at least one preferred SSRI, one SNRI and one non-SSRI/SNRI) 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. <u>Criteria for new starters <18 years of age: Must have had fluoxetine trial for at least 30 days before accessing other preferred antidepressants without PA.</u> CYMBALTA: Fibromyalgia diagnosis- prior use and failure of preferred generics (amitriptyline or cyclobenzaprine) <u>and</u> gabapentin prior to approval. SAVELLA: Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine and gabapentin prior to approval. Exceptions to the rule are as follows: 1. If the member (<18) is already an established user for any of the preferred or non-preferred drugs under the Antidepressant category on the PDL, then they can continue to get that drug. 2. If the member (<18) has a prescription for an antidepressant that is on the PREFERRED side of the PDL and has had a 30 day supply of Fluoxetine at least 30 days before the date they are getting it filled, the claim will pay. If they do not have the trial of Fluoxetine in their profile, the claim will reject for PA required. 3. If the member (<18) has a prescription for a medication that is on the NON-PREFERRED side of the PDL regardless of having Fluoxetine in their profile, the prescription will need a PA. 4. Use of a preferred antidepressant for anxiety will require the diagnosis of anxiety on written prescription and submitted during claim submission. DDI: Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl). DDI: Preferred nefazodone will now be non-preferred and require prior authorization if it is currently being used in combination with either Onglyza 5mg, Enablex 15mg or Vesicare 10mg. DDI: Fluoxetine will require prior authorization if being used in combination with Plavix. DDI: Fluvoxamine will require prior authorization if being used in combination with Plavix. 7. Provide clinical documentation as to why a preferred generic alternative cannot be used. 8. Dosing limits allowing 2
	MC/DEL	BUPROPION SR	MC/DEL	8	BRINTELLIX ¹³		
	MC/DEL	BUPROPION XL	MC/DEL	8	CELEXA ⁴		
	MC/DEL	CITALOPRAM ⁴	MC	8	CYMBALTA ⁵		
	MC/DEL	DULOXETINE	MC/DEL	8	EFFEXOR TABS		
	MC/DEL	ESCITALOPRAM ⁴	MC/DEL	8	EFFEXOR XR CP24 ^{3,10}		
	MC/DEL	FLUOXETINE HCL CAPS	MC/DEL	8	FETZIMA ¹²		
	MC/DEL	FLUOXETINE HCL LIQD	MC/DEL	8	FLUOXETINE 40mg AND 60 mg CAPS ¹		
	MC/DEL	FLUVOXAMINE MALEATE TABS	MC/DEL	8	FLUOXETINE 10mg AND 20mg TABS ⁶		
	MC/DEL	MIRTAZAPINE	MC	8	FORFIVO XL		
	MC/DEL	NEFAZODONE	MC/DEL	8	KHEDEZLA ¹⁴		
	MC/DEL	PAROXETINE ³	MC/DEL	8	LEXAPRO TABS ⁴		
	MC/DEL	SERTRALINE HCL ²	MC	8	LUVOX TABS		
	MC/DEL	TRAZODONE HCL TABS	MC	8	MAPROTILINE HCL TABS		
	MC/DEL	VENLAFAXINE ER CAPS ⁹	MC/DEL	8	MIRTAZAPINE ODT		
			MC	8	OLEPTRO		
			MC/DEL	8	PAROXETINE CR ³		
			MC/DEL	8	PAXIL ³		
			MC/DEL	8	PAXIL CR ³		
			MC/DEL	8	PRISTIQ		
			MC	8	PROZAC		
		MC	8	PROZAC CAPS			
		MC	8	PROZAC WEEKLY CPDR			
		MC/DEL	8	REMERON TABS			
		MC/DEL	8	SARAFEM CAPS			
		MC/DEL	8	TRAZODONE HCL 300MG TABS			
		MC/DEL	8	WELLBUTRIN TABS			
		MC/DEL	8	WELLBUTRIN SR TBCR			
		MC/DEL	8	WELLBUTRIN XL			
		MC/DEL	8	REMERON SOLTAB TBDP			
		MC/DEL	8	SAVELLA ⁸			

				MC/DEL	8	ZOLOFT	tabs/day and a max daily limit of 200mg / day applies. Please see dose consolidation list.		
				MC/DEL	8	VENLAFAXINE TABS ⁹	9. Dosing limits and max daily dose applies. Limit of 1 per day of 37.5mg, 75mg, will be allowed without pa, along with limits of 2 caps per day of the 150mg strength. Max daily dose allowed is 375mg.		
				MC/DEL	8	VENLAFAXINE ER TABS ⁹	10. Use venlafaxine ER tabs.		
				MC/DEL	9	VIIBRYD	11. Non-preferred products must be used in specified step order.	SAVELLA: Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine, duloxetine and gabapentin prior to approval.	
				MC/DEL	9	FLUOXETINE 90mg TABS ¹¹	12. Requires previous trials/failure of multiple preferred medications. Dosing limits apply, please see the dose consolidation list. Max daily dose of 80mg if used concomitantly with strong CYP3A4 inhibitor.		
							13. Dosing limits apply, please see dose consolidation list.		
							Use PA Form# 20420		
ANTIDEPRESSANTS - CYCLICS	TRI-	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC		MC/DEL MC/DEL MC/DEL MC/DEL MC MC		AMITRIPTYLINE HCL TABS ¹ ANAFRANIL CAPS ¹ DESIPRAMINE HCL TABS ¹ DOXEPIN HCL ¹ IMIPRAMINE HCL TABS ¹ NORTRIPTYLINE HCL ¹ PROTRIPTYLINE HCL TABS ¹ SURMONTIL CAPS ¹	AMOXAPINE TABS CLOMIPRAMINE HCL CAPS DOXEPIN HCL 150 MG ² NORPRAMIN TABS PAMELOR TOFRANIL VIVACTIL TABS	1. Users over the age of 65 require a pa. 2. Use multiples of 50mg. Use PA Form# 20420 Use PA Form# 10220 for Brand Name requests	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
SEDATIVE / HYPNOTICS									
SEDATIVE/HYPNOTICS - BARBITURATE		MC MC/DEL MC MC/DEL		MC MC/DEL		BUTISOL SODIUM TABS ¹ CHLORAL HYDRATE SYRP ¹ MEBARAL TABS ¹ PHENOBARBITAL ¹	LUMINAL SOLN SOMNOTE CAPS	1. PA required for new users of preferred products if over 65 years. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
SEDATIVE/HYPNOTICS - BENZODIAZEPINES		MC/DEL MC/DEL MC/DEL MC/DEL		MC MC MC/DEL MC/DEL		DORAL TABS ¹ ESTAZOLAM TABS ¹ FLURAZEPAM HCL CAPS ¹ TEMAZEPAM CAPS 15 & 30MG ¹ TRIAZOLAM TABS ¹	HALCION TABS ¹ MIDAZOLAM HCL SYRP RESTORIL CAPS ¹ TEMAZEPAM 7.5MG ¹	1. Dosing limits apply, please see dosing consolidation list. Use PA Form# 30110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Benzodiazepines do cause dependence with continued use and usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 Days per week max) is the standard of care
SEDATIVE/HYPNOTICS - Non-Benzodiazepines		MC/DEL MC	1 1	MC/DEL MC/DEL	7 7	MIRTAZAPINE TRAZODONE	AMBIEN ¹ ESZOPICLONE	1. Quantity Limit of 12 per 34 days.	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.

	MC/DEL	1	ZOLPIDEM ²								
	MC/DEL	2	ZALEPLON ^{2,3}								
	MC/DEL			MC/DEL	7	ZOLPIDEM ER			2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended.	Preferred drug(s) exists.	
	MC/DEL			MC/DEL	8	AMBIEN CR ¹				Ambien, Ambien CR, Lunesta, Sonata, Zaleplon and Zolpidem may 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 refer to Sedative/Hypnotic PA form.	
	MC/DEL			MC/DEL	8	BELSOMRA			3. Only zolpidem trial/failure will be required to obtain Zaleplon.	DDI: Belsomra® with strong CYP3A inhibitors (e.g. ketoconazole, itraconazole, posaconazole, clarithromycin, nefazodone, ritonavir, saquinavir, nelfinavir, indinavir, boceprevir, telaprevir, telithromycin, and conivaptan) is not recommended	
	MC			MC	8	HETLIOZ					
	MC/DEL			MC/DEL	8	INTERMEZZO					
	MC/DEL			MC/DEL	8	LUNESTA ¹					
	MC/DEL			MC/DEL	8	SONATA CAPS ¹			4. Must fail all preferred products before non-preferred		
	MC/DEL			MC/DEL	8	ROZEREM			Use PA Form# 30110		
	MC/DEL			MC/DEL	8	ZOLPIMIST					

ANTI-PSYCHOTICS

ANTIPSYCHOTICS - ATYPICALS	MC		ABILIFY TABS ^{3,4}	MC/DEL	8	ABILIFY DISC TAB, INJ and SOL ²			If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine. This also includes combination of Seroquel with Seroquel XR.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 atypicals will be approved for patients with FDA-approved indications, and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality and as long as all first line preferred therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). * Abilify: doses above 15mg were not shown to be more effective than doses in the 10-15mg range.	
	MC/DEL		OLANZAPINE ⁴	MC/DEL	8	ABILIFY MAINTENA					
	MC/DEL		RISPERIDONE TAB ⁴	MC	8	FANAPT					
	MC/DEL		RISPERIDONE SOLN ⁴	MC/DEL	8	GEODON					
	MC/DEL		QUETIAPINE ^{4,6}	MC	8	INVEGA					
	MC/DEL		ZIPRASIDONE ⁴	MC	8	INVEGA SUSTENNA					
				MC	8	LATUDA					
				MC	8	RISPERDAL TAB				Prescriptions for quetiapine are limited to a maximum daily dose of 800mg.	
				MC	8	RISPERDAL CONSA ²			Use PA form# 20440 for Multiple Antipsychotic requests	DDI: Abilify, Latuda, Quetiapine, and Zyprexa will now be non-preferred and require prior authorization if they are currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.	
				MC	8	RISPERDAL M TAB ²				Atypicals: Prior Authorization will be required for preferred medication to assure indication is in accordance with FDA approved or literature supported evidence-based best practices. The approved indications are:	
				MC	8	RISPERDAL SOLN				<ul style="list-style-type: none"> • schizophrenia • bipolar disorder • agitation related to autism 	
				MC/DEL	8	RISPERIDONE ODT				• severe behavioral dyscontrol with risk of imminent need for emergency services such as the emergency room, crisis services, or an inpatient psychiatric facility.	
				MC/DEL	8	SAPHRIS					
				MC/DEL	8	SEROQUEL 50MG TABS ^{1,2}			Use PA form# 10130 for non-preferred single therapy atypical requests		
				MC	8	ZYPREXA TABS			1. Please use multiple 25mg tablets.		
				MC	8	ZYPREXA ZYDIS TBP ²					
				MC	8	ZYPREXA RELPREVV					
				MC/DEL	8	SEROQUEL TABS			2. Established users of single therapy atypicals were grandfathered.		
				MC/DEL	9	SEROQUEL XR ⁵			3. Abilify requires splitting of tab to avoid PA. Please see Abilify splitting table.		
									4. Prior Authorization will be required for preferred medications for members under the age of 5.		
									5. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR.		

							6. Dosing limits apply: quetiapine 25mg, 50mg and 100mg are available without PA if the daily dosage is less than 1.5 tablets	
ANTIPSYCHOTICS - SPECIAL ATYPICALS	MC/DEL		CLOZAPINE TABS	MC/DEL MC		CLOZARIL TABS FAZACLO	Use PA Form# 20420	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved. DDI: Clozapine will now be non-preferred and require prior authorization if it is currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.
ANTIPSYCHOTICS - TYPICAL	MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL		CHLORPROMAZINE HCL FLUPHENAZINE DECANOATE FLUPHENAZINE HCL HALDOL HALOPERIDOL HALOPERIDOL DECANOATE SOLN HALOPERIDOL LACTATE SOLN LOXAPINE SUCCINATE CAPS LOXITANE-C CONG MOBAN TABS PERPHENAZINE PROCHLORPERAZINE SERENTIL THIORIDAZINE HCL THIOTHIXENE TRIFLUOPERAZINE HCL TABS	MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL		COMPAZINE COMPRO SUPP HALDOL DECANOATE LOXITANE CAPS MELLARIL NAVANE CAPS PROLIXIN STELAZINE TABS	Use PA Form# 20420 If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.
LITHIUM								
LITHIUM	MC/DEL MC/DEL		LITHIUM CARBONATE LITHIUM CITRATE SYRP	MC/DEL MC/DEL		ESKALITH CAPS ESKALITH CR TBCR	Use PA Form# 20420	
COMBINATION - PSYCHOTHERAPEUTIC								
PSYCHOTHERPEUTIC COMBINATION	MC/DEL MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	MC	8	SYMBYAX ¹	1. Only available if component ingredients are unavailable. Use PA Form# 20420	
STIMULANTS								
STIMULANT - AMPHETAMINES -SHORT ACTING	MC/DEL MC/DEL MC/DEL		ADDERALL TABS ^{1,4} DEXTROAMPHET SULF TABS ^{1,3} DEXEDRINE ^{1,3,4}	MC/DEL MC MC		AMPHETAMINE SALT COMBO ^{1,3} EVEKEO PROCENTRA	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 3. Dosing limits apply, please see dosing consolidation list. 4. Max daily dose of 50mg. Use PA Form# 20420	
STIMULANT - LONG ACTING AMPHETAMINES SALT	MC		VYVANSE ^{2,3,4}	MC MC/DEL	8 9	ADDERALL XR CP24 ^{1,3,4} AMPHETAMINE/DEXTROAMPHET ER	Use PA Form# 20420 1. As per recent FDA alert,	Adderall XR- Current users as of 12/31/11 without prior use of Vyvanse will be required to transition to the preferred vyvanse product. Other members will required PA

						<p>Adderall should not be used in patients with underlying heart defects since they may be at increased risk for sudden death.</p> <p>2. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Limit of one capsule daily. Max dose of 70MG daily.</p> <p>3. Preferred stimulants will be available without PA if diagnosis of ADHD.</p> <p>4. Dosing limits apply, please see dosing consolidation list.</p>	<p>Quillivant is only indicated for use in patients 6 years of age and older. Prior trials of preferred products</p>	
LONG ACTING AMPHETAMINES	MC		DEXEDRINE CAP CR ^{1,2,3}	MC		DEXTROAMPHET SULF CPCR ³	<p>1. Preferred stimulants will be available without PA if diagnosis of ADHD.</p> <p>2. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death.</p> <p>3. Dosing limits apply, please see dosing consolidation list.</p> <p>Use PA Form# 20420</p>	
STIMULANT - METHYLPHENIDATE	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		<p>FOCALIN TABS^{1,2}</p> <p>METADATE ER TBCR^{1,2}</p> <p>METHYLIN ER TBCR^{1,2}</p> <p>METHYLIN TABS^{1,2}</p> <p>METHYLIN SOL¹</p> <p>METHYLPHENIDATE HCL^{1,2}</p>	MC MC/DEL		<p>METHYLIN CHEWABLES</p> <p>RITALIN</p> <p>FAZACLO</p>	<p>1. Preferred stimulants will be available without PA if diagnosis of ADHD.</p> <p>Use PA Form# 20420</p> <p>2. Dosing limits apply, please see dosing consolidation list. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexamethylphenidate.</p>	<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.</p>
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC/DEL MC/DEL MC/DEL MC/DEL		<p>DAYTRANA³</p> <p>FOCALIN XR¹</p> <p>METHYLPHENIDATE ER TABS</p> <p>RITALIN LA⁴</p>	MC MC MC/DEL MC	5 8 8 8	<p>METADATE CD CPCR</p> <p>CONCERTA TBCR²</p> <p>METHYLPHENIDATE ER CAPS^{1,2,4}</p> <p>QUILLIVANT XR</p>	<p>1. Preferred stimulants will be available without PA if diagnosis of ADHD.</p> <p>2. Non-preferred products must be used in specified step order.</p> <p>3. FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily.</p>	<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.</p>

							4. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420	
STIMULANT - STIMULANT LIKE				MC/DEL MC MC MC/DEL MC MC/DEL MC/DEL MC	7 7 8 8 8 8 9 9	PROVIGIL TABS ³ STRATTERA ^{1,2} CAFCIT SOLN ³ INTUNIV KAPVAY MODAFINIL TABS NUVIGIL ³ DESOXYN TABS ³	1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of Strattera, unless history of substance abuse without current use of abusable medication(s). Additionally, for patients <17 years of age, a trial of guanfacine is required before approval of Strattera. 2. Strattera currently has dosing limitations allowing one tablet per day for all strengths if obtain approval. Max daily dose of Strattera is 100mg. Please see dosing consolidation list. 3. Non-preferred products must be used in specified 4. Please use generic Guanfacine. Use PA Form# 20710 for Provigil, Nuvigil and Xyrem Use PA Form# 20420 for all others	Provigil requests require diagnosis of Narcolepsy, ADHD, or Obstructive Sleep Apnea. Previous failures of methylphenidate and amphetamine is required for Narcolepsy and ADHD diagnosis, with additional Strattera trial needed with ADHD diagnosis. Please refer to detailed criteria on Provigil PA form
ANTI-CATAPLECTIC AGENTS								
PSYCHOTHERAPEUTIC AGENTS - MISC.				MC MC MC		NUDEXTA XYREM SOL ¹ XENAZINE	Use PA Form# 20710 for Xyrem Use PA Form# 20710 for Xenazine 1. See criteria section	FDA reminded healthcare professionals and patients that the combined use of Xyrem (sodium oxybate) with alcohol or central nervous system (CNS) depressant drugs can markedly impair consciousness and may lead to severe breathing problems (respiratory depression)
WEIGHT LOSS								
WEIGHT LOSS							No longer covered: PHENTERMINE, XENICAL, DIDREX, and MERIDIA	Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy.
ALZHEIMER DISEASE								
ALZHEIMER - Cholinomimetics/Others	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		DONEPEZIL HYDROCHLORIDE TABS ¹ DONEPEZIL HYDROCHLORIDE ODT ¹ EXELON ¹ NAMENDA ¹ NAMENDA XR CAPS ¹	MC MC MC/DEL MC/DEL MC MC/DEL MC	6 6 7 7 8 8 8 9	ARICEPT TABS ² ARICEPT ODT ² DONEPEZIL HYDROCHLORIDE TABS 23MG GALANTAMINE CAPS NAMZARIC RAZADYNE ² RIVASTIGMINE TARTRATE CAPS ² COGNEX CAPS ²	1. PA is required to establish dementia diagnosis and baseline mental status score. 2. Must fail all preferred products before moving to non-preferred. Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
SMOKING CESSATION								
NICOTINE PATCHES / TABLETS	MC/DEL		CHANTIX ¹	MC/DEL		NICODERM CQ PT24 ¹	Use PA Form# 20420	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay (including MEDEL). No annual or lifetime limits, must follow FDA approved

	MC/DEL		NICOTINE DIS PT24 ¹				1. See criteria section for exemptions	indications and therapy guidelines. 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. Note: MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations Patients may qualify for the medication through The Maine Tobacco Helpline. Patients are encouraged to call The Maine Tobacco helpline at 1-800-207-1230.
NICOTINE REPLACEMENT - OTHER	MC/DEL		NICOTINE POLACRILEX GUM ¹	MC/DEL MC/DEL MC/DEL MC	8 8 8 8	NICOTROL INHALER ^{1,2} NICOTROL NASAL SPRAY ^{1,2} NICORETTE GUM ^{1,2} NICORETTE LOZENGES	Use PA Form# 20420 1. See criteria section for exemptions 2. Must use non-preferred products in specified step order.	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay(including MEDEL). No annual or lifetime limits, must follow FDA approved indications and therapy guidelines. 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. Note: MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations Patients may qualify for the medication through The Maine Tobacco Helpline. Patients are encouraged to call The Maine Tobacco helpline at 1-800-207-1230.

ALCOHOL DETERRENTS

ALCOHOL DETERRENTS	MC MC MC/DEL		ANTABUSE TABS DISULFIRAM TABS NALTREXONE HCL TABS	MC/DEL		ACAMPRO ¹	1. Should only be used in conjunction with formal structured outpatient detoxification program. Use PA Form# 20420	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.
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MISCELLANEOUS ANALGESICS

ANALGESICS - MISC.	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL		ACETAMINOPHEN ASPIRIN ASPRIN/ APAP/ CAFF TAB BUTAL/ASA/CAFF BUTALBITAL COMPOUND BUTALBITAL/ACET TABS BUTALBITAL/APAP CAPS BUTALBITAL/APAP/CAFFEINE CHOLINE MAGNESIUM TRISALI DIFLUNISAL TABS EXCEDRIN SALSALATE TABS	MC MC/DEL MC/DEL MC MC MC/DEL MC MC MC MC MC MC		AXOCET CAPS ESGIC-PLUS FIORICET TABS FIORINAL CAPS FIORTAL CAPS FORTABS TABS PHRENILIN TABS PHRENILIN FORTE CAPS TRILISATE LIQD TRILISATE TABS ZEBUTAL CAPS ZORPRIN TBCR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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LONG ACTING NARCOTICS

NARCOTICS - LONG ACTING	MC/DEL MC MC/DEL MC/DEL MC/DEL		FENTANYL PATCH ⁴ KADIAN METHADONE METHADOSE MORPHINE SULFATE ER TB12	MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL	8 8 8 8 8 8 8 8 8 8 8	AVINZA BUTRANS ⁴ DURAGESIC PT72 ⁴ EMBEDA EXALGO HYSINGLA ER MORPHINE SULFATE SUPP MS CONTIN TB12 OPANA ER ORAMORPH SR TB12 OXYCONTIN TB12 ¹	Use PA Form# 20510 Use PA form #10300 for PAs over the opiate limit 1. 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 (Fentanyl Patch, Morphine Sulfate ER tab, Kadian Methadone or Methadose) must be tried for at least 2 weeks each & failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug & the preferred drug(s) exists. Adequate trials include prevention/treatment of common adverse effects associated w/ narcotics (antinausea, antipruritics, etc.) as well as adequate equianalgesic dosing when converting from one narcotic to another. Also, adequate documentation of attempts to titrate dose of preferred agents to achieve adequate pain relief & desired clinical response must be provided. Member's drug regimen for additions &/or discontinuations of medications that may affect absorption &/or metabolism of preferred agents must be monitored. 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 w/ controlled substance abuse such as: 1.Frequent or persistent early refills of controlled drugs;
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				MC	8	XARTEMIS ER		2. Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.;
				MC	8	ZOHYDRO ER		3. Breaches of narcotic contracts with any provider;
				MC/DEL	9	NUCYNTA ER		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;
				MC/DEL	9	OXYCODONE ER ^{3,5}	2. Established users are grandfathered. 3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to 4. Dosing limits apply. Please see dose consolidation list. 5. Non-preferred products must be used in specific order.	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, Tylox, Vicodin, Dilaudid, Ultracet...) with an available AB rated generic equivalent will be denied unless it will be provided in a setting that virtually eliminates the risk of diversion. 11. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Hysingla ER- Concomitant use should be avoided with mixed agonist/antagonist analgesics, partial agonist analgesics, and MAOIs. Verify prior trials and failures or intolerance of preferred treatments
NARCOTICS - SELECTED	MC/DEL		TRAMADOL HCL TABS	MC/DEL	7	RYZOLT	Use PA Form# 20420 Use PA form #10300 for PAs over the opiate limit	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.
				MC	8	BUPRENEX SOLN	1. Only available if component ingredients are unavailable.	
				MC/DEL	8	BUTORPHANOL		
				MC	8	NALBUPHINE HCL SOLN		
				MC	8	STADOL NS SOLN		
				MC	8	TRAMADOL ER		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;
				MC	8	ULTRACET TABS ¹		
				MC	8	ULTRAM TABS		
				MC	9	ULTRAM ER		

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.

Effective 1/01/2013, MaineCare will implement a 15 day limit for members prescribed opiates for their treatment of pain.

1. MaineCare members will be allowed over a rolling 12 month period up to a 15 day supply of an opiate without prior authorization
2. Members requiring longer than 15 days will require a PA for continuation of therapy and providers may provide medical necessity
3. Members may be eligible for up to three prior authorizations of up to 14 day supplies of opiates during the 12 month period
4. MaineCare members that are in Hospice care or are being treated for a diagnosis of Cancer, HIV or AIDS will be exempt from these limits
5. Post surgical members may receive prior authorizations for opiates up to 60 days in length if medical necessity is provided by the Surgeon

Please see the Pain Management Policy_Sec. 80 tab for the complete criteria

MISCELLANEOUS NARCOTICS

MISCELLANEOUS NARCOTICS						
NARCOTICS - MISC.	MC/DEL	ACETAMINOPHEN/CODEINE	MC/DEL	8	ABSTRAL	<p>1. Fentanyl OT loz (Barr) and Capital and codeine suspension products require PA for users over 18 years of age. PA is not required if under 18 years of age.</p> <p>2. Oxycodone/acet 10/650 is 8 times more expensive. Use twice as many of oxycod/acet 5/325 instead. You can mix andmatch preferred strengths of oxycodone and oxycodone/acet to minimize acet. dose similar to certain non-preferred drugs.</p> <p>3. Only preferred manufacturer's products will be available without prior authorization.</p>
	MC/DEL	ASPIRIN/CODEINE TABS	MC/DEL	8	ASCOMP/CODEINE CAPS	
	MC/DEL	BUTAL/ASA/CAFF/COD CAPS	MC/DEL	8	BUTALBITAL/APAP/CAFFEINE/ CAPS	
	MC	BUTALBITAL/ASPIRIN/CAFFEI CAPS	MC	8	DEMEROL	
	MC	CAPITAL AND CODEINE SUSP ¹	MC/DEL	8	DILAUDID	
	MC	CAPITAL/CODEINE SUSP ¹	MC	8	DILAUDID-HP SOLN	
	MC/DEL	CODEINE PHOSPHATE SOLN	MC	8	FENTANYL CITRATE SOLN	
	MC/DEL	CODEINE SULFATE TABS	MC/DEL	8	FENTORA	
	MC/DEL	ENDOCET TABS ³	MC/DEL	8	FIORICET/CODEINE CAPS	
	MC/DEL	ENDODAN TABS	MC	8	FIORINAL/CODEINE #3 CAPS	
	MC/DEL	FENTANYL OT LOZ ¹	MC	8	FIORTAL/CODEINE CAPS	
	MC/DEL	FENTANYL OT LOZ1	MC/DEL	8	HYDROCODONE/IBUPROFEN	
	MC/DEL	HYDROCODONE/ACETAMINOPHEN	MC	8	IBUDONE	
	MC/DEL	HYDROMORPHONE HCL ³	MC/DEL	8	LORCET	
	MC	LORTAB ELX	MC	8	LORTAB	
	MC/DEL	MEPERIDINE HCL	MC	8	MAXIDONE TABS	
	MC/DEL	OXYCODONE	MC/DEL	8	NORCO TABS	
	MC/DEL	OXYCODONE/ACETAMINOPHEN ^{2,3}	MC/DEL	8	NUCYNTA	
	MC/DEL	PENTAZOCINE/NALOXONE TABS	MC/DEL	8	ONSOLIS	
	MC	PROPOXYPHENE CMPND-65 CAPS	MC/DEL	8	OXECTA	
	MC	PROPOXYPHENE COMPOUND CAPS	MC/DEL	8	OXYCODONE/APAP 10/650	
	MC/DEL	PROPOXYPHENE HCL CAPS	MC/DEL	8	OXYCODONE/APAP 7.5/500	
	MC/DEL	PROPOXYPHENE/ACET TABS	MC/DEL	8	PENTAZOCINE/ACET TABS	
	MC/DEL	PROPOXYPHENE-N/ACET TABS	MC	8	PERCOCET TABS	
	MC/DEL	ROXICET	MC	8	PERCOCET TABS	
	MC/DEL	ROXIPRIN TABS	MC	8	PHRENILIN W/CAFFEINE/CODE CAPS	
			MC/DEL	8	ROXICET 5/500 TABS	
			MC	8	ROXICODONE TABS	
			MC	8	SYNALGOS-DC CAPS	
			MC	8	TALACEN TABS	
			MC	8	TREZIX	
			MC	8	TYLENOL/CODEINE #3 TABS	
		MC	8	TYLOX CAPS		
		MC	8	XOLOX		
		MC	8	VICODIN		
		MC	8	VICOPROFEN TABS		
		MC	8	ZYDONE TABS		
		MC	9	ACTIQ LPOP		

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 refer to General Criteria category E.

Effective 1/01/2013, MaineCare will implement a 15 day limit for members prescribed opiates for their treatment of pain.

1. MaineCare members will be allowed over a rolling 12 month period up to a 15 day supply of an opiate without prior authorization
2. Members requiring longer than 15 days will require a PA for continuation of therapy and providers may provide medical necessity
3. Members may be eligible for up to three prior authorizations of up to 14 day supplies of opiates during the 12 month period
4. MaineCare members that are in Hospice care or are being treated for a diagnosis of Cancer, HIV or AIDS will be exempt from these limits
5. Post surgical members may receive prior authorizations for opiates up to 60 days in length if medical necessity is provided by the Surgeon

Please see the Pain Management Policy_Sec. 80 for the complete criteria

			MC	9	CONZIP	Use PA Form# 20420	
			MC	9	OPANA	Use PA form #10300 for PAs over the opiate limit	
OPIOID DEPENDENCE TREATMENTS	MC		MC		SUBOXONE FILM ²		<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.</p> <p>Suboxone Criteria</p> <ol style="list-style-type: none"> Effective 1/1/2013, MaineCare will implement a 24 month lifetime limit for members prescribed Suboxone for the treatment of opioid addiction. Prior authorization request will be reviewed for dose titration downward, whether the patient is engaged in recovery oriented support services, periodic urine drug screens, flim counts, factors that threaten stability of recovery or evidence of improvement is social, physical and occupational areas. Members that stop treatment after 24 months and need to restart will require a prior authorization. This prior authorization will assess the patient risk of relapsing or evidence that the patient has relapsed.
			MC		SUBOXONE TABS ³	Use PA Form# 10200 for Suboxone Continuation	
			MC MC/DEL		BUNAVAIL ⁴ BUPRENORPHINE ^{1,2}	Use PA Form# 10100 for Suboxone Restart 1. Buprenorphine will only be approved for use during pregnancy.	
			MC		ZUBSOLV ⁴	2. See Criteria Section 3. The manufacturer will be discontinuing the tablets by the end of quarter one 2013	

							4. 24month lifetime limit for treatment of opioid addiction	Members will continue to be required to follow the criteria listed below: 1-Induction period for new starts max of 60 days 2-Max dose of 32 mg for induction 3-Max dose of 16 mg for maintenance 4-There is not more than one narcotic fill in member's drug profile between today's fill of suboxone and a prior suboxone fill within the past 90 days. 5- Prescribers limited to those with X-DEA 6- Should be evidence provided of monthly monitoring including random pill counts urine drug tests and prescription monitoring program reports. 7-Suboxone tablets will be available upon demonstrated allergy to the preferred product. Allergy may be established by 1) formal allergy testing by a board certified allergist or 2) demonstration of hives after skin exposure for 24 hours to the Suboxone Film. (The product may be applied to the skin using a band-aid and member can be assessed after 24 hours to ascertain the presence of hives by the prescriber).
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NARCOTIC ANTAGONISTS

NARCOTIC - ANTAGONISTS	MC/DEL		NALTREXONE HCL TABS	MC		EVZIO	Use PA Form# 20420	Please see the criteria listed on the Vivitrol PA form.
				MC MC/DEL		NALOXONE INJ REVIA TABS ¹	Use PA form# 30400 for Vivitrol requests 1. Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version.	
				MC/DEL		VIVITROL INJ ²	2. Please see the criteria listed on the Vivitrol PA form. Any narcotics attempting to be filled during Vivitrol approval will require prior authorization.	

COX 2 / NSAIDS

COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE	MC/DEL MC/DEL MC/DEL MC/DEL		CELEBREX CAPS ^{4,5,6} KETOROLAC TROMETHAMINE ^{2,3,6} NABUMETONE TABS ⁵ MELOXICAM ^{1,6}	MC/DEL MC/DEL MC/DEL		MOBIC ⁹ MOBIC SUSP ⁶ RELAFEN TABS ⁶	Use PA Form# 10310 1. Meloxicam has dosing limits allowing one tablet daily of all strengths without PA. 2. Ketorolac Tromethamine is indicated for the short term (up to 5 days) management of moderately severe acute pain that requires analgesic at the opioid level in adults. Not indicated for minor or chronic pain conditions.	Approved without PA for patients 60 years old or over. Patients under 60 can use a preferred proton pump inhibitor with any preferred generic NSAID to achieve similar reductions in GI bleeding risk to that seen with the COX-II agents. Approvals for Celebrex will be granted for other requests based on failure of at least one generic NSAID from at least 2 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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						<p>3. Ketorolac has dosing limits allowing 24 tablets for a 5 day supply every 30 days.</p> <p>4. Dosing limits will be set at a maximum of 200mg twice daily for PA requests.</p> <p>5. Users 60 years of age or older will not require PA. If under 60 years of age, Celebrex will require PA.</p> <p>6. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.</p>	
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NSAIDS	MC/DEL		CHILDRENS IBUPROFEN	MC	ADVIL TABS	<p>The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.</p> <p>Use PA Form# 20420</p>	<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.</p> <p>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.</p> <p>DDI: Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with lescol.</p> <p>The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.</p>
	MC/DEL		DICLOFENAC POTASSIUM TABS	MC	ANAPROX TABS		
	MC/DEL		DICLOFENAC SODIUM	MC	ANAPROX DS TABS		
	MC/DEL		ETODOLAC	MC	CAMBIA		
	MC/DEL		FENOPROFEN CALCIUM TABS	MC/DEL	CATAFLAM TABS		
	MC/DEL		FLURBIPROFEN TABS	MC	CHILDRENS ADVIL SUSP		
	MC/DEL		IBUPROFEN	MC	CHILD'S IBUPROFEN SUSP		
	MC/DEL		INDOMETHACIN	MC/DEL	CHILDREN'S MOTRIN SUSP		
	MC/DEL		KETOPROFEN	MC/DEL	CLINORIL TABS		
	MC/DEL		MECLOFENAMATE SODIUM CAPS	MC/DEL	DAYPRO TABS		
	MC/DEL		NAPROSYN SUSP	MC/DEL	EC-NAPROSYN TBEC		
	MC/DEL		NAPROXEN SUSP	MC/DEL	ETODOLAC ER 600MG		
	MC/DEL		NAPROXEN TABS	MC	FELDENE CAPS		
	MC/DEL		NAPROXEN SODIUM TABS	MC/DEL	IBU-200		
	MC/DEL		OXAPROZIN TABS	MC	INDOCIN		
	MC/DEL		SULINDAC TABS	MC/DEL	LODINE		
	MC/DEL		TOLMETIN SODIUM	MC/DEL	MOTRIN		
				MC	NALFON CAPS		
				MC/DEL	NAPRELAN TBCR		
				MC/DEL	NAPROSYN TABS		
			MC/DEL	NAPROXEN DR TBEC			
			MC/DEL	NAPROXEN SODIUM TBCR			
			MC	PENNSAID			
			MC/DEL	PIROXICAM CAPS			
			MC	PONSTEL CAPS			
			MC	SB IBUPROFEN TABS			
			MC	SPRIX			
			MC	TOLECTIN			
			MC/DEL	VOLTAREN			
			MC	V-R IBUPROFEN TABS			
			MC	ZORVOLEX			

NSAID - PPI				MC MC/DEL	PREVACID NAPRA-PAC VIMOVO ¹	<p>1. Use a preferred NSAID and PPI separately.</p> <p>Use PA Form# 20420</p>	
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RHEUMATOID ARTHRITIS

RHEUMATOID ARTHRITIS	MC/DEL	1	AZATHIOPRINE	MC/DEL	ARAVA	Use PA Form# 20900	See criteria as listed on Rheumatoid Arthritis PA form.
	MC/DEL	1	HYDROXYCHLOROQUINE	MC/DEL	ACTEMRA	1. Only one step 1 drug is required to obtain Enbrel or Humira without PA	Enbrel is preferred after a trial of a step 1 product (e.g. azathioprine, methotrexate, etc.); however, dosing limits will also still apply. Dosing limits will allow 8 injections per month without
	MC/DEL	1	LEFLUNOMIDE	MC/DEL	CIMZIA		

	MC/DEL	1	METHOTREXATE	MC/DEL		ENTYVIO		pa. Use of greater than 8 injections per month will require PA.
	MC/DEL	1	SULFASALAZINE TABS	MC/DEL		ILARIS ^{2,5,6}		
	MC	2	ENBREL ^{1,4}	MC		KINERET SOLN	2. Dosing limits apply. Please see dose consolidation list.	
	MC	2	HUMIRA ^{1,2,4}	MC		ORENCIA	3. Preferred dosage form allowed without PA after trial of step 1 products is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa.	Xeljanz is limited to adults with moderately to severely active RA who have had an inadequate response or intolerance to methotrexate. Should not be used concomitantly with biologic DMARDs or potent immunosuppressants. Therapy should not be started in those with lymphocyte count <500cells/mm ³ , an ANC <1000cells/mm ³ , or have a hemoglobin <9g/dl.
				MC		RASUVO ⁷	4. Established users will be grandfathered for Enbrel and Humira.	
				MC/DEL		REMICADE	5. Clinical PA is required to establish diagnosis and medical necessity.	
						SIMPONI	6. Verification of age for appropriate indication.	
						XELJANZ	7. Treatment failure or intolerance to other forms of preferred methotrexate	

MISCELLANEOUS ARTHRITIS

ARTHRITIS - MISC.	MC MC		RIDAURA CAPS MYOCHRYSLINE SOLN	MC/DEL		ARTHROTEC ¹	1. The individual components of Arthrotec are available without PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The individual components of Arthrotec are available without PA.
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LUPUS-SLE

LUPUS-SLE				MC		BENLYSTA	Use PA Form# 20420	
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MIGRAINE THERAPIES

MIGRAINE - ERGOTAMINE DERIVATIVES	MC MC		MIGRANAL SOLN SANSERT TABS	MC/DEL		D.H.E. 45 SOLN	Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC		DIVALPROEX ER TB24	MC		DEPAKOTE ER TB24	Use PA Form# 10110	
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MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)-Tabs	MC/DEL MC/DEL MC/DEL MC/DEL	1 1 1 2	RELPAX ¹ RIZATRIPTAN TABS SUMATRIPTAN TABS ¹ NARATRIPTAN HCl TABS ¹	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		AMERGE TABS ^{1,2} AXERT TABS ^{1,2} FROVA TABS ^{1,2} IMITREX TABS ^{1,2} MAXALT ^{1,2,3} MAXALT MLT1,2,3 RIZATRIPTAN ODT ZOMIG TABS ^{1,2} ZOMIG NASAL SPARY ^{1,2} ZOMIG ZMT TBDP ^{1,2}	1. All drugs in this category have dosing limits. Please refer to dose consolidation table. 2. Must fail all preferred products before non-preferred. 3. Established users will be grandfathered Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
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MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)-Injectables	MC/DEL MC/DEL MC/DEL MC/DEL		IMITREX KIT IMITREX SOLN IMITREX STATDOSE PEN KIT IMITREX STATDOSE REFILL KIT	MC/DEL		SUMATRIPTAN SOLN	Use PA Form# 10110	
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MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)-Miscellaneous				MC/DEL		TREXIMET ^{1,2}	Use PA Form# 10110	
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	MC/DEL	ZONISAMIDE	MC	8	TOPAMAX	will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR.	Please use Drug-Drug Interaction PA form #10400 for this combination.
			MC	8	TOPAMAX SPRINKLE CAPS ²		
			MC	8	TROKENDI ^{2,8}		
	MC/DEL		MC/DEL	8	TRILEPTAL		ONFI will require a clinical PA to confirm LGS diagnosis
	MC/DEL		MC/DEL	8	ZARONTIN SYRP		
	MC/DEL		MC/DEL	9	KEPPRA XR ^{5,6}		
	MC/DEL		MC/DEL	9	NEURONTIN		
	MC/DEL		MC/DEL	9	TEGRETOL-XR TB12 ^{5,6}		
	MC/DEL		MC/DEL	9	ZONEGRAN CAPS	7. Max dose 2400mg	
	MC/DEL		MC/DEL	9	LAMICTAL XR	8. Clinical PA required for appropriate diagnosis	
						9. Requires previous trials/failure of medications.	
					<u>BIPOLAR DISORDER: STEP ORDER</u>		
				M ~ A		SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT	
				4 ~ 4	LAMICTAL	M= Monotherapy	
				4 ~ 4	LITHIUM	A= Adjunctive	
				4 ~ 4	CARBAMAZEPINE	9= No Evidence	
				4 ~ 4	VALPROATE	The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations.	
				4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE	Step 4 drugs-no PA required.	
				5 ~ 5	TRILEPTAL		
				9 ~ 6	TOPAMAX		
				9 ~ 7	KEPPRA TABS		
				9 ~ 8	GABITRIL TABS		
				9 ~ 9	NEURONTIN		
				9 ~ 9	ZONEGRAN CAPS		
					<u>PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER</u>		
				M ~ A	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)		
				4 ~ 4	LITHIUM	Two-step 1 preferred drugs must be tried before Trileptal.	
				4 ~ 4	CARBAMAZEPINE	The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations.	
				4 ~ 4	VALPROATE	Step 4 drugs-no PA required.	
				4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE		
				4 ~ 4	LAMICTAL		
				5 ~ 5	TRILEPTA		

ANTI-PARKINSON DRUGS

PARKINSONS - ANTICHOLINERGICS	MC/DEL MC MC/DEL	BENZTROPINE MESYLATE TABS COGENTIN SOLN TRIHENXYPHENIDYL				Use PA Form# 20420	
PARKINSONS - COMT INHIBITORS	MC/DEL	COMTAN TABS	MC/DEL		TASMAR TABS	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - SELECTED DOPAMIN AGONISTS	MC/DEL MC/DEL	PRAMIPEXOLE ROPINIROLE	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	5 8 8 8 8	MIRAPEX TABS ¹ REQUIP TABS REQUIP XL TABS MIRAPEX ER NEUPRO PATCH	Use PA Form# 20420 1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinsons.	Preferred drug must be tried and failed in step-order due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - DOPAMINERGICS/CARBI/ LEVO	MC/DEL MC/DEL	AMANTADINE HCL BROMOCRIPTINE MESYLATE TABS	MC/DEL MC		APOKYN ³ AZILECT ²	1. Approvals will require concurrent therapy with preferred drug(s) exists	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL MC/DEL		CARBIDOPA/LEVODOPA TABS ³ CARBIDOPA/LEVODOPA ER	MC/DEL MC		BROMOCRIPTINE MESYLATE CAPS ELDEPRYL CAPS	Levodopa and failed trials of preferred drug(s) exists. Selegiline, Comtan, and Stalevo.	
	MC MC/DEL MC/DEL		LARODOPA TABS PARLODEL CAPS SELEGILINE CAPS HCL	MC MC/DEL MC MC MC		LODOSYN TABS PARLODEL TABS RYTARY SELEGILINE TABS HCL SINEMET TABS SINEMET TBCR	2. Approvals will require trials of Carbidopa/Levodopa, Selegiline, Comtan, and Stalevo. 3. Only preferred manufacturer's products will be available without prior authorization.	
				MC		ZELAPAR ¹	Use PA Form# 20420	
PARKINSONS - COMBO.				MC/DEL MC		STALEVO ¹ CARBIDOPA/LEVODOPA/ENTACA ¹	Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity.	
MUSCLE RELAXANTS								
ALS DRUG	MC/DEL		RILUZOLE	MC/DEL		RILUTEK TABS	Use PA Form# 20420	
MUSCLE RELAXANTS	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL		BACLOFEN TABS CHLORZOXAZONE TABS CYCLOBENZAPRINE HCL TABS LIORESAL INTRATHECAL KIT METHOCARBAMOL TABS TIZANIDINE HCL TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL	6 7 8 8 8 8 8 8 8 8 9 9	SKELAXIN TAB ORPHENADRINE CITRATE CARISOPRODOL 350MG TABS AMRIX DANTRIUM CAPS LIORESAL TABS LORZONE METAXALONE NORFLEX TBCR ROBAXIN-750 TABS VECUROMIUM INJ ZANAFLEX TABS CARISOPRODOL 250MG TABS SOMA TABS	Use PA Form# 20420	At least 4 preferred drugs (including tizanidine) 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. Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). Non-preferred products must be used in specified step order. Lorzone is non preferred and requires at least 4 preferred drugs (including tizanidine) and step care therapy (orphenadrine), as well as reasons for why chlorzoxazone is not acceptable.
MUSCLE RELAXANT - COMBO.				MC/DEL MC/DEL MC MC/DEL MC/DEL MC		CARISOPRODOL/ASPIRIN TABS CARISOPRODOL/ASPIRIN/CODE NORGESIC TABS ORPHENADRINE COMPOUND ORPHENADRINE/ASA/CAFF ORPHENGESIC	Use PA Form# 20420	Individual components are available with PA described in the section above. 1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant travel, etc.
PARATHYROID HORMONE								
PARATHYROID HORMONE				MC		NATPARA ¹	1. Recommended only for those who cannot be well-controlled on calcium supplements and active forms of vitamin D alone.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VITAMINS								
VITAMINS	MC/DEL MC MC MC MC MC		ASCORBIC ACID TABS BIOTIN CYANOCOBALAMIN SOLN FERIVA CAP FERIVAFA CAP FERRALET 90 TAB	MC MC MC MC MC MC		AQUASOL E SOLN AQUAVIT-E SOLN DHT SOLN NASCOBAL GEL	Use PA Form# 20420 Please refer to OTC list for covered products. Click here for the OTC List	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.

MC/DEL	PRENATAL TABS ¹	MC	NESTABS RX TABS
MC/DEL	PRENATAL FORMULA 3 TABS ¹	MC/DEL	NIFEREX
MC/DEL	PRENATAL PLUS TABS ¹	MC/DEL	OCUVITE TABS
MC/DEL	PRENATAL PLUS NF TABS ¹	MC	POLY-VI-FLOR SOLN
MC	PRENATAL PLUS/27MG IRON ¹	MC	POLY-VI-SOL SOLN
MC	PRENATAL PLUS/IRON TABS ¹	MC	POLY-VI-SOL/IRON SOLN
MC/DEL	PRENATAL RX/BETA-CAROTENE ¹	MC	POLY-VITAMIN DROPS SOLN
MC/DEL	RENAL CAPS	MC	PRECARE
MC/DEL	RENAPHRO CAPS	MC	PREFERA OB
MC	STRESS TAB NF TABS	MC	PREMESIS RX TABS
MC	THERAPEUTIC-M TABS	MC	PRENATABS CBF TABS ¹
MC	THERAVITE LIQD	MC	PRENATAL CARE TABS ¹
MC/DEL	TRI-VITAMIN/FLUORIDE SOLN	MC	PRENATAL MR 90 TBCR ¹
MC	VITA CON FORTE CAPS	MC/DEL	PRENATAL MTR/SELENIUM TABS ¹
MC	VITAMIN B COMPLEX CAPS	MC	PRENATAL OPTIMA ADVANCE TABS ¹
MC	VITAPLEX PLUS TABS	MC	PRENATAL PC 40 TABS ¹
		MC/DEL	PRENATAL RX TABS ¹
		MC	PRENATE ¹
		MC	PRENATE ELITE ¹
		MC	PRIMACARE MISC
		MC	PROTEGRA CAPS
		MC	STUARTNATAL PLUS 3 TABS ¹
		MC	TRI-VI-SOL SOLN
		MC	TRI-VI-SOL/IRON SOLN
		MC/DEL	ULTRA NATALCARE TABS
		MC	ULTRA-NATAL TABS ¹
		MC	VICON FORTE CAPS
		MC	VINATAL FORTE TABS ¹
		MC	VINATE ¹
		MC/DEL	VINATE ADVANCED TABS ¹

MISCELLANEOUS MINERALS

MINERALS	MC	CALCARB	MC	ANEMAGEN	Use PA Form# 20420
	MC	CALCI-MIX CAPSULE CAPS	MC	CALCET TABS	Please refer to OTC list.
	MC	CALCIQUID SYRP	MC/DEL	CALCIUM 600-D TABS	
		CALCITRATE/VITAMIN D TABS	MC	CALCIUM/VITAMIN D TABS	Click here for the OTC List
	MC				
	MC/DEL	CALCIUM	MC	CALTRATE 600 PLUS/VIT D TABS	
	MC/DEL	CALCIUM CARBONATE	MC	CALTRATE PLUS TABS	
	MC/DEL	CALCIUM CITRATE TABS	MC	CHROMAGEN	DDI: Fe salts will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC/DEL	CALCIUM GLUCONATE TABS	MC	CITRACAL PLUS TABS	
	MC/DEL	CALCIUM LACTATE TABS	MC	CONTRIN CAPS	Please refer to OTC list.
	MC	CALCIUM/MAGNESIUM TABS	MC	FEOGEN FORTE CAPS	
	MC/DEL	CALCIUM/VITAMIN D TABS	MC	FEROCON CAPS	Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC	CALTRATE 600 TABS	MC/DEL	FERREX 150 CAPS	
	MC/DEL	CHEWABLE CALCIUM CHEW	MC	FERRO-SEQUELS TBCR	
	MC	CITRACAL TABS	MC	FE-TINIC CAPS	
	MC	CITRACAL + D TABS	MC	FE-TINIC 150 FORTE CAPS	
	MC	CITRUS CALCIUM TABS	MC/DEL	FLUOR-A-DAY SOLN	
	MC	CITRUS CALCIUM 1500 + D TABS	MC/DEL	K-DUR TBCR	
	MC	EFFERVESCENT POTASSIUM TBEF	MC	KLOR-CON PACK	
	MC/DEL	FEOSTAT CHEW	MC	K-LYTE	
	MC	FERATAB TABS	MC/DEL	K-PHOS TABS NEUTRAL	
	MC/DEL	FER-GEN-SOL SOLN	MC	K-TABS TBCR	
	MC	FER-IRON SOLN	MC	K-VESCENT PACK	
	MC	FERRONATE TABS	MC	MICRO-K 10 MEG CPCR	

MC/DEL	FERROUS SULFATE	MC	NU-IRON 150 CAPS	
MC/DEL	FLUOR-A-DAY CHEW	MC/DEL	OYSTER SHELL CALCIUM/VITA TABS	
MC	FLUORIDE CHEW	MC/DEL	POLY-IRON 150 CAPS	
MC	FLUORIDE SODIUM CHEW	MC/DEL	POLYSACCHARIDE IRON CAPS	
MC	FLUORITAB CHEW	MC/DEL	POTASSIUM BICARB/CHLORIDE	
MC	HEMOCYTE TABS	MC/DEL	POTASSIUM CHLORIDE 10MEQ CAPS	
MC	HM CALCIUM TABS	MC/DEL	POTASSIUM CHLORIDE 8MEQ CAPS	
MC	K+ POTASSIUM PACK	MC/DEL	SLOW FE TBCR	
MC	KAON ELIX	MC	TUMS 500 CHEW	
MC	KAON-CL-10 TBCR	MC	VIACTIV CHEW	
MC	KCL 0.075%/DSW/NACL 0.2% SOLN			
MC	K-EFFERVESCENT TBEF			
MC	KLOR-CON			
MC	KLOTRIX TBCR			
MC/DEL	K-PHOS TABS			
MC/DEL	K-VECENT TBEF			
MC/DEL	LURIDE CHEW			
MC/DEL	MAGNESIUM GLUCONATE TABS			
MC/DEL	MAGNESIUM SULFATE SOLN			
MC	MAGTABS			
MC	MICRO-K 8 MEG			
MC/DEL	OS-CAL TABS			
MC/DEL	OS-CAL 500 + D TABS			
MC/DEL	OYSCO			
MC/DEL	OYST-CAL TABS			
MC/DEL	OYST-CAL D TABS			
MC/DEL	OYST-CAL/VITAMIN D TABS			
MC/DEL	OYSTER CALCIUM TABS			
MC/DEL	OYSTER SHELL			
MC	PHARMA FLUR			
MC/DEL	PHOSPHA 250 NEUTRAL TABS			
MC	POTASSIUM BICARBONATE TBEF			
MC/DEL	POTASSIUM CHLORIDE 8MEQ			
MC	POTASSIUM EFFERVESCENT			
MC/DEL	SELENIUM TABS			
MC	SLOW-MAG TBCR			
MC/DEL	SODIUM FLUORIDE			
MC/DEL	SSKI SOLN			
MC	V-R CALCIUM			
MC	V-R OYSTER SHELL CALCIUM			
MC	ZINC SULFATE CAPS			

MISC. ELECTROLYTES/NUTRITIONALS

ELECTROLYTES/ NUTRITIONALS	MC	INTRALIPID EMUL ¹	MC	BOOST ¹	<p>1. This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred. SGA form required for nutritionals unless member has a G/I tube.</p> <p>2. Formerly known as Omacor.</p> <p>For children under the age of 5, MaineCare will not provide milk- or soy-based standard infant formulas. Regular formulas may be sought through your nearest WIC office. MaineCare will continue to cover medical food for all participants in MaineCare when medical necessity is met.</p>
	MC	P.T.E. -5 SOLN ¹	MC	CASEC POWD ¹	
	MC/DEL	SEA-OMEGA CAPS ¹	MC	CHOICE DM LIQD ¹	
			MC	DELIVER 2.0 LIQD ¹	
			MC	ENFAMIL ¹	
			MC	ENSURE ¹	
			MC	GLUCERNA ¹	
			MC	ISOCAL LIQD ¹	
			MC	KINDERCAL TF LIQD ¹	
			MC	KINDERCAL TF/FIBER LIQD ¹	
			MC/DEL	L-CARNITINE CAPS ¹	
			MC	LIPISORB LIQD ¹	
			MC	LOVAZA ^{1,2}	
				Use PA Form# 20420	

				MC		MODULEN IBD POWD ¹	& SGA Form		Vascepa requires adjunct therapy for specific indication to reduce TG in those with severe hypertriglyceridemia (500mg per deciliter or more). Proper indication per lab values is required before approval
				MC		NUTRAMIGEN POWD ¹			
				MC/DEL		NUTREN ¹			
				MC		NUTRITIONAL SUPPLEMENT LIQD ¹			
				MC		NUTRIVENT 1.5 LIQD ¹			
				MC/DEL		PEPTAMEN ¹			
				MC		PHENYLADE ¹			
				MC		PHENYL-FREE ¹			
				MC		PKU 3 POWD ¹			
				MC		PREGESTIMIL POWD ¹			
				MC/DEL		PROBALANCE LIQD ¹			
				MC		PROSOBEE ¹			
				MC		SCANDISHAKE PACK ¹			
				MC		VASCEPA			

ERYTHROPOEITINS									
	MC		PROCRIT SOLN ¹	MC	6	EPOGEN SOLN	Use PA Form# 10520		Non-Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the EPO PA form for other approval and renewal criteria.
				MC	8	ARANESP SOLN	1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.		
				MC/DEL	8	MIRCERA ¹			
				MC/DEL	8	OMONTYS			

GRANULOCYTE CSF									
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GRANULOCYTE CSF									
				MC	8	LEUKINE	1. Must be used in specified step order.		See approval criteria detailed on Neupogen PA form.
				MC	8	NEUPOGEN SOLN ²	2.10 day supply/month may be used without a PA.		
				MC	9	NEULASTA ¹			
							Use PA Form# 20520		

GAUCHER DISEASE									
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GAUCHER DISEASE									
				MC		CERDELGA			Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.
							Use PA Form# 20420		

ANTICOAGULANTS / PLATELET AGENTS									
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ANTICOAGULANTS									
	MC		ARIXTRA SOLN ¹	MC/DEL		ELIQUIS	1. Arixtra, 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. DDI: Warfarin will require prior authorization if being used in combination with fluconazole, miconazole, or voriconazole. DDI: Warfarin will require prior authorization if being used in conjunction with Gemfibrozil or Fenofibrate. DDI: Rifampin will require prior authorization if being used in combination with Savaysa
	MC		COUMADIN TABS	MC/DEL		ENOXAPARIN			
	MC/DEL		FRAGMIN INJ ¹	MC/DEL		FONDAPARINUX			
	MC		HEPARIN SODIUM/NACL 0.9% SOLN	MC		IPRIVASK			
	MC		HEP-LOCK SOLN	MC/DEL		JANTOVEN			
	MC/DEL		INNOHEP	MC/DEL		LOVENOX 300 ²	2. Use other strengths available to obtain desired dose.		
	MC/DEL		LOVENOX SOLN ¹	MC/DEL		PRADAXA ³			
	MC		HEPARIN LOCK SOLN	MC/DEL		WARFARIN SODIUM TABS⁴			
	MC/DEL		HEPARIN LOCK FLUSH SOLN	MC/DEL		SAVAYSAS ⁵	3. Please refer to Pradaxa PA form for criteria.		
	MC/DEL		HEPARIN SODIUM SOLN	MC/DEL		XARELTO	4. Established users will be grandfathered, new starters must use preferred product Coumadin.		
							5. Diagnosis required		
	MC/DEL		HEPARIN SODIUM LOCK FLUSH SOLN						

							Use PA form# 20725 for Pradaxa requests	
							Use PA form# 20420 for other requests	
ANTIHEMOPHILIC AGENTS	MC MC MC/DEL MC/DEL MC MC MC MC MC MC MC MC/DEL MC MC MC		ALPHANATE ALPHANINE SD BENEFIX SOLR HELIXATE FS KIT HEMOPIL - M HUMATE-P SOLR KOGENATE FS KONYNE - 80 MONARC - M MONOCLATE - P MONONINE NOVOSEVEN SOLR PROFILNINE RECOMBINATE SOLR REFACTO WILATE INJ	MC MC		ADVATE ^{1,2} KOATE-DVI	1. Only if other products unavailable. 2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access. Use PA Form# 20420	Non-preferred will only be approved if other preferred products are unavailable.
PLATELET AGGREGATION INHIBITORS	MC/DEL MC/DEL MC/DEL		ASPIRIN DIPYRIDAMOLE TABS CLOPIDOGREL 75MG	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL	7 8 8 8 8 8	TICLOPIDINE HCL TABS EFFIENT ¹ PERSANTINE TABS BRILINTA ^{1,2} PLAVIX TABS ¹ ZONTIVITY	Use PA Form# 20175 for Plavix, Effent & Brilinta Use PA form# 20420 for other requests 1. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement. 2. Dosing limits apply, please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement. DDI: Plavix will require prior authorization if being used in combination with omeprazole, esomeprazole, cimetidine, fluconazole, ketoconazole, intelence, fluoxetine, ticlopidine, and fluvoxamine. DDI: exists for using maintenance ASA dose >100mg, as it reduces the effectiveness of Brilinta Brilinta- Concomitant use with strong CYP3A4 inhibitors should be avoided (including ketoconazole, itraconazole, atazanavir, and telithromycin). Doses of simvastatin and lovastatin >40mg should be avoided.
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.	MC/DEL MC/DEL MC/DEL		AGGRENOX CILOSTAZOL PENTOXIFYLLINE ER TBCR	MC/DEL MC/DEL MC/DEL MC		AGRYLIN CAPS ANAGRELIDE CAPS PLETAL TABS TRENAL TBCR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HEMATOLOGICALS								
MONOCLONAL ANTIBODY				MC		SOLIRIS	Use PA Form# 20420	A diagnosis of Paroxysmal nocturnal hemoglobinuria (PNH) using the HAM test or flow cytometry is required. In addition, the patient must show evidence of having received a meningitis vaccine at least 2 weeks prior to the start of therapy.
IMMUNE GLOBULIN INTRAVENOUS (IVIG)	MC MC		GAMMAPLEX INJ ¹ OCTAGAM INJ ¹				Use PA Form# 20420 1. Clinical PA required	
BRADYKININ B2 RECEPTOR ANTAGONIST				MC		FIRAZYR	Use PA Form# 20420	
HEMATOLOGICAL AGENTS- THROMBOPOIETIN RECEPTOR AGONISTS				MC/DEL MC	7 8	PROMACTA NPLATE	Use PA Form# 20420	Clinical PA required. Must see prior trial with insufficient response to corticosteroids and immunoglobulins.
HEMOSTATIC								
HEMOSTATIC	MC/DEL		AMICAR				Use PA Form# 20420	

	MC		AMINOCAPROIC ACID					
OPHTHALMICS								
OP. - ANTIBIOTICS	MC MC MC MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL		AK-SPORE OINT BACITRACIN OINT BACITRACIN/NEOMYCIN/POLYM BACITRACIN/POLYMYXIN B OINT CHLOROPTIC SOLN ERYTHROMYCIN OINT GENTAMICIN SULFATE NEOMYCIN/POLYMYXIN/GRAMIC NEOSPORIN SOLN POLYSPORIN SODIUM SULFACETAMIDE SOLN SULFACETAMIDE SODIUM TRIMETHOPRIM SULFATE/POLY VIROPTIC SOLN	MC MC MC MC MC MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL		AK-POLY-BAC OINT AK-SULF OINT AK-TOB SOLN AZASITE BLEPH-10 SOLN GENTAK ILOTYCIN OINT NEOMYCIN/BACI/POLYM OINT NEOSPORIN OINT OCUSULF-10 SOLN OCUTRICIN SOLN TERAK OINT TOBRAMYCIN SULFATE SOLN TOBEX OINT TRIFLURIDINE SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - QUINOLONES	MC/DEL MC/DEL MC/DEL MC/DEL		CILOXAN OINT CIPROFLOXACIN SOL 0.3% OFLOXACIN QUIXIN SOLN	MC/DEL MC/DEL MC		BESIVANCE CILOXAN SOLN OCUFLOX SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. QUINOLONES-4TH GENERATION	MC/DEL MC/DEL		VIGAMOX MOXEZA	MC		ZYMAXID	Use PA Form# 20420	
OP. - ARTIFICIAL TEARS AND LUBRICANTS	MC MC/DEL MC/DEL MC MC MC/DEL MC MC MC MC MC MC MC		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 ¹ REFRESH PM OINT	MC MC/DEL MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC MC MC MC/DEL MC/DEL MC MC/DEL MC MC		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 ¹ SYSTANE TEARGEN SOLN TEARISOL SOLN TEARS NATURALE TEARS PURE SOLN TEARS RENEWED OINT THERATEARS SOLN V-R ARTIFICIAL TEARS SOLN	Use PA Form# 20420 1. Dosing limits apply, please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BETOPTIC-S SUSP CARTEOLOL HCL SOLN LEVOBUNOLOL HCL SOLN METIPRANOLOL SOLN TIMOLOL MALEATE SOLG (GEL) TIMOLOL MALEATE SOLN	MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		BETAGAN SOLN BETAXOLOL HCL SOLN BETIMOL SOLN ISTALOL OCUPRESS SOLN OPTIPRANOLOL SOLN TIMOPTIC SOLN TIMOPTIC-XE SOLG	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH.	MC MC/DEL MC MC/DEL MC/DEL		AK-SPORE HC OINT ALREX SUSP BLEPHAMIDE SUSP DEXAMETH SOD PHOS SOLN FLAREX SUSP	MC MC MC MC MC		AK-TROL SUSP BAC/POLY/NEOMY/HC OINT BLEPHAMIDE S.O.P. OINT BROMDAY EFLONE SUSP	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL MC MC MC/DEL MC/DEL	FLUOROMETHOLONE SUSP FML S.O.P. OINT MAXITROL OPTH OINT 0.1% PRED MILD SUSP PREDNISOLONE TOBRADEX	MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL	FLUOR-OP SUSP LOTEMAX GEL LOTEMAX OINT LOTEMAX SUSP NEO/POLY/BAC/HC OINT NEOM/POLY/DEX OPTH OINT 0.1% OZURDEX PRED FORTE SUSP PRED-G SUSP PRED-G S.O.P. OINT SULFACET SOD/PRED SOLN TOBRADEX ST TOBRAMYCIN SUSP DEXAMETHASONE VASOCIDIN SOLN VEXOL SUSP			
OP. - PROSTAGLANDINS	MC/DEL MC/DEL	LATANOPROST SOL 0.005% TRAVATAN-Z	MC/DEL MC MC MC/DEL MC/DEL MC/DEL	7 8 8 8 8 8	ZIOPATAN LUMIGAN SOLN ¹ RESCULA ^{1,2,3} TRAVATAN SOLN TRAVOPROST XALATAN SOLN ¹	1. All preferreds must be tried. 2. Dosing limits apply, please see dosing consolidation list. 3. Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20420	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - CYCLOPLEGICS	MC MC/DEL MC/DEL MC/DEL	AK-PENTOLATE SOLN ATROPINE SULFATE CYCLOPENTOLATE HCL SOLN ISOPTO HYOSCINE SOLN	MC/DEL MC MC/DEL MC		CYCLOGYL SOLN ISOPTO ATROPINE SOLN ISOPTO HOMATROPINE SOLN MUROCOLL-2 SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - MIOTICS - DIRECT ACTING	MC/DEL MC MC MC/DEL MC/DEL	ISOPTO CARBACHOL SOLN ISOPTO CARPINE SOLN PILOCAR SOLN PILOCARPINE HCL SOLN PILOPINE HS GEL				Use PA Form# 20420	
OP. - ADRENERGIC AGENTS	MC/DEL MC	DIPIVEFRIN HCL SOLN EPIFRIN SOLN	MC		PROPINE SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC MC/DEL	ALPHAGAN P 0.15% SOLN SIMBRINZA	MC MC MC/DEL MC/DEL		ALPHAGAN SOLN ALPHAGAN P 0.1% SOLN BRIMONIDINE 0.2% IOPIDINE SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - ANTI-ALLERGICS	MC/DEL MC/DEL	PATADAY SOLN PATANOL SOLN	MC MC/DEL MC MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL	8 8 8 8 8 8 8 8 8 8 9	ALOCRIL SOLN ALOMIDE SOLN BEPREVE ELESTAT EMADINE SOLN LASTACRAFT OPTIVAR OPTICROM SOLN PAZEO ZADITOR SOLN EPINASTINE	Use PA Form# 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. ANTI-ALLERGICS- MASTCELL STABILIZER CLASS			MC/DEL		ALAMAST SOLN	Use PA Form# 20420	
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO	MC/DEL MC MC/DEL	AZOPT SUSP COMBIGAN DORZOLAMIDE	MC/DEL MC/DEL		COSOPT SOLN PF TRUSOPT SOLN	Use PA Form# 20420	

	MC/DEL		DORZOLAMIDE/TIMOLOL					
OP. - NSAID'S	MC		FLURBIPROFEN SODIUM SOLN	MC	8	ACULAR LS ¹	1. Must fail all preferred products before 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.
	MC/DEL		DICLOFENAC OPTH 0.1%	MC	8	ACULAR SOLN ¹		
	MC/DEL		KETOROLAC OPTH 0.4%	MC/DEL	8	ILEVRO		
	MC/DEL		KETOROLAC OPTH 0.5%	MC/DEL	8	PROLENSA		
				MC/DEL	8	NEVANAC ¹		
				MC	8	OCUFEN SOLN ¹		
				MC	8	XIBROM ¹		
				MC	8	VOLTAREN SOLN ¹		
				MC/DEL	8	ACUVAIL ¹		
			MC/DEL	9	BROMFENAC	Use PA Form# 20420		
OP. - OF INTEREST	MC/DEL		ENUCLENE SOLN	MC		BOTOX SOLR	1. Must have kerato conjunctivitis sicca and failed other dry eye therapies.	Must fail adequate trials of multi agents from artificial tears and lubricant category.
				MC		RESTASIS ¹		
							Use PA Form# 20420	

DERMATOLOGICAL

TOPICAL - ORAL	MC		AMNESTEEM ¹				1. Users 24 or under, PA will not be required.	
	MC		CLARAVIS ¹					
	MC		SOTRET ¹				Use PA Form# 20420	
TOPICAL - ACNE PREPARATIONS	MC		AZELEX CREA ⁴	MC/DEL		ADAPALENE 0.3% GEL	1. Users 24 or under, PA will not be required. 2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List. 3. Only available if component ingredients are unavailable. 4. Dosing limits apply, please see dosing consolidation list. 5. Not approved for use in children <12 years of age Use PA Form# 10220 for Brand Name requests Use PA Form# 20420 for all other requests	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BENZOYL PEROXIDE	MC		ACZONE		
	MC/DEL		CLINDAMYCIN PHOSPHATE ²	MC		ALTINAC CREA		
	MC		ERYDERM SOLN	MC		AVITA CREA		
	MC/DEL		ERYTHROMYCIN GEL	MC		BENZAC		
	MC/DEL		ERYTHROMYCIN PADS	MC/DEL		BENZACLIN GEL ³		
	MC/DEL		ERYTHROMYCIN SOLN	MC/DEL		BENZAGEL-10 GEL		
	MC		ISOTRETINOIN	MC/DEL		BENZAMYCIN GEL		
	MC		METRONIDAZOLE CREA ²	MC/DEL		BENZAMYCINPAK PACK		
	MC		METRONIDAZOLE GEL ²	MC		BENZFOAM		
	MC		METRONIDAZOLE LOTN ²	MC		BREVOXYL		
	MC/DEL		SODIUM SULFACET/SULF LOTN	MC/DEL		CLEOCIN-T ²		
	MC		TAZORAC	MC		CLINAC BPO GEL		
	MC/DEL		TRETINOIN GEL ¹	MC		CLINDAGEL GEL		
	MC		TRETINOIN CREA ^{1,2}	MC		CLINDETS SWAB		
				MC		DESQUAM-E GEL		
				MC		DESQUAM-X		
				MC		DIFFERIN 0.3% GEL		
				MC		DIFFERIN		
				MC		DUAC GEL		
				MC		EMGEL GEL		
				MC		EPIDUO		
				MC		ERYCETTE PADS		
				MC/DEL		EVOCLIN		
				MC		FINEVIN CREA		
				MC/DEL		KLARON LOTN		
			MC		METROCREAM CREA ²			
			MC		METROGEL GEL ²			
			MC		METROLOTION LOTN ²			
			MC		NEOBENZ MICRO			
			MC/DEL		NORITATE CREA			
			MC		ONEXTON ⁵			
			MC		RETIN-A GEL ²			
			MC		RETIN-A CREA ²			
			MC		RETIN-A MICRO GEL			
			MC		SOOLANTRA ⁴			
			MC/DEL		TRIAZ			

				MC MC MC MC/DEL		VELTIN ZENCIA WASH ZETACET ZIANA		
TOPICAL - ANTIBIOTIC	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BACIT/NEOMYCIN/POLYM OINT BACITRACIN OINT BACTROBAN CREA ¹ BACTROBAN NASAL OINT CENTANY OINT 2% ¹ GENTAMICIN SULFATE MUPIROCI ¹	MC/DEL MC/DEL MC/DEL		ALTABAX ¹ BACTROBAN OINT. TRIPLE ANTIBIOTIC OINT	1. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIFUNGALS	MC/DEL MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC		BETAMETHASONE CLOTRIMAZOLE LOT CICLOPIROX 0.77 CREA CICLOPIROX 0.77 SUSP CLOTRIMAZOLE ECONAZOLE NITRATE CREA KETOCONAZOLE CREA KETOCONAZOLE SHAM LOPROX 1.0 CREA LOPROX 1.0 LOTN LOPROX GEL LOPROX TS LOTN LOTRISONE CREA MICONAZOLE NITRATE CREA MYCO-TRIACET II CREA NYSTATIN NYSTATIN/TRIAMCINOLONE CREA NYSTOP POWD PEDI-DRI POWD TINACTIN TRI-STATIN II CREA	MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL	8 9	BETAMETHASONE CLOTRIMAZOLE CREA CICLOPIROX SOLN EXELDERM FUNGIZONE CREA HYDROCORT/IDOQ CREA JUBLIA KERYDIN ¹ LAMISIL LOPROX 0.77 LOTN LOPROX 0.77 CREA LOPROX 0.77 SUSP LOPROX SHAMPOO SHAM LOTRIMIN LOTRISONE LOT LUZU MENTAX CREA MYCOGEN II CREA NAFTIN NIZORAL SHAM NYSTATIN/TRIAMCINOLONE OINT NYSTAT-RX POWD OXISTAT PENLAC NAIL LACQUER SOLN	 Use PA Form# 10120 1. Diagnosis 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. DDI: Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, pantoprazole, Onglyza or Omeprazole. Kerydin- Verify prior trials and failures or intolerance of preferred treatments, including both topical and oral agents
TOPICAL - ANTIPRURITICS	MC		ZONALON CREA	MC		PRUDOXIN CREA	 Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIPSORIATICS	MC/DEL MC		SORIATANE CAPS TAZORAC	MC MC MC/DEL MC/DEL MC		OXSORALEN ULTRA CAPS ¹ PSORITEC CREA ¹ SORIATANE CK KIT ¹ TACLONEX ^{1,2} VECTICAL ¹	1. Must fail all preferred products before non-preferred. 2. Individual ingredients are available as preferred without PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTISEBORRHOIC	MC/DEL		SELENIUM SULFIDE SHAM	MC MC		CARMOL SCALP TREATMENT KIT ZNP BAR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIVIRALS				MC/DEL MC		DENAVIR CREA ^{1,3} ZOVIRAX OINT ^{1,2}	1. Must fail oral treatment with Acyclovir or Valacyclovir. 2. Approvals limited to 1 tube per 180 days. 3. Dosing limits apply, please see dosing consolidation list.	

TOPICAL - EMOLLIENTS	MC/DEL MC MC		AMMONIUM LACTATE CREA ¹ AMMONIUM LACTATE LOTN 12% ¹ VITAMIN A & D MEDICATED OINT	MC MC MC MC MC		LAC-HYDRIN CREA ¹ LAC-HYDRIN LOTN 12% MEDERMA GEL MIMYX RENOVA CREA	Use PA Form# 20420 1. Dosing limits still apply. Please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	MC		SANTYL OINT	MC MC MC		CARMOL 40 CREA SALEX CREA SALEX LOTN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.
TOPICAL - GENITAL WARTS	MC/DEL		IMIQUIMOD ²	MC/DEL MC/DEL MC/DEL MC MC MC	5 8 8 8 8 8	PODOFILOX SOLN ALDARA CONDYLOX ¹ PICATO VEREGEN ¹ ZYCLARA ¹	Use PA Form# 20420 1. Non-preferred products must be used in specified order. 2. Dosing limits still apply. Please see dose consolidation list.	
TOPICAL - IMMUNOMODULATORS				MC/DEL MC	8 9	ELIDEL CREA ¹ PROTOPIC OINT ^{1,2}	Use PA Form# 20420 1. Non-preferred products must be used in specified order. 2. The FDA has issued a Public Health Advisory for both Elidel and Protopic concerning the potential cancer risk associated with their use. Use for children less than 2 years of age is not recommended.	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	MC MC/DEL MC MC/DEL MC/DEL		AF CAPSICUM OLEORESIN CREA CAPSAICIN CREA ELA-MAX ¹ LIDOCAINE/PRILOCAINE CREA ¹ LIDOCAINE GEL	MC/DEL MC/DEL MC MC MC MC		EMLA PADS EMLA CREA LIDA MANTLE CREA LIDODERM PTCH PONTOCAINE SOLN SYNERA ZOSTRIX	1. Lidocaine/Prilocaine cream and Ela-Max products require PA for users over 18 years of age. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - DEPIGMENTING AGENTS				MC MC MC MC/DEL MC/DEL MC MC MC	8 8 8 8 8 8 8 9	ALUSTRA CREA EPIQUIN MICRO GLYQUIN CREA HYDROQUINONE CREA HYDROQUINONE/SUNSCREENS SOLAQUIN FORTE CREA TRI-LUMA CREA ELDOQUIN	Use PA Form# 20420	As per Medicaid Policy, cosmetic drugs are not covered. Non-cosmetic clinical applications will be considered by prior authorization on a case by case basis.
TOPICAL - SCABICIDES AND PEDICULICIDES	MC/DEL MC MC MC MC/DEL MC/DEL MC	1 1 1 1 1 1 2	ACTICIN CREA ELIMITE CREA EURAX LICE KILLING SHAM LICE TREATMENT CREME RINS LIQD PERMETHRIN LOTN NATROBA ^{1,2}	MC/DEL MC MC MC MC MC MC		LINDANE MALATHION OVIDE LOTN SKLICE ULESFIA	Use PA Form# 20420 1. Dosing limits apply, please refer to dosage consolidation list. 2. Will require two applications of permethrin.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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				MC		REGRANEX GEL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

			MC/DEL MC/DEL		REGENECARE RADIAPLEXRX		on the Prior Authorization form, such as the presence of 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 (TcP 02 >30, ABI>0.7 or ASP> 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks. Accuzyme and Ethezyme products have been removed from the PDL due to FDA concerns regarding drugs containing Papain.
TOPICAL - ASTRINGENTS / PROTECTANTS	MC		XERAC AC SOLN	MC MC MC	LOWILA BAR MOISTURIN DRY SKIN CREA PROSHIELD PLUS SKIN PROTE CREA SURGILUBE GEL	Use PA Form# 20420 1. Dosing limits apply, please refer to dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTISEPTICS / DISINFECTANTS	MC/DEL MC/DEL		PHISOHEX LIQD POVIDONE-IODINE SOLN	MC MC MC MC	BETADINE OINT FORMALYDE-10 AERS IODOSORB LAZERFORMALYDE SOLUTION SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS EYE							
OP. - EYE	MC MC MC MC MC/DEL		AK-DILATE SOLN EYE WASH SOLN NAPHAZOLINE HCL SOLN PHENYLEPHRINE HCL SOLN PONTOCAINE SOLN SODIUM CHLORIDE	MC MC/DEL MC	LENS PLUS REWETTING DROPS MURO 128 NEO-SYNEPHRINE SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS EAR							
EAR	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL MC MC/DEL MC/DEL		A/B OTIC SOLN ACETASOL SOLN ACETASOL HC SOLN ACETIC ACID ACETIC ACID/HYDROCORTISON ALLERGEN SOLN ANTIPYRINE/BENZOCAINE SOLN AURODEX SOLN AUROGUARD SOLN AUROTO OTIC SOLN CARBAMIDE PEROXIDE 6.5% OTIC SOLN. CIPRODEX CORTISPORIN SOLN CORTOMYCIN EAR DROPS SOLN EAR DROPS RX SOLN EAR WAX REMOVAL DROPS EAR-GESIC SOLN NEOMYCIN/POLYMYXIN/HC OTICAINE OTIC SOLN	MC MC MC MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL MC MC/DEL	AERO OTIC HC SOLN ANTIBIOTIC EAR SOLN ANTIBIOTIC EAR SUSP AURALGAN SOLN CETRAXAL CIPRO HC SUSP COLY-MYCIN-S SUSP CORTISPORIN-TC SUSP DEBROX SOLN DERMOTIC OFLOXACIN 0.3% OTIC PEDIOTIC SUSP VOSOL-HC SOLN ZOTANE HC SOLN ZOTO-HC SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MOUTH ANTISEPTICS							
MOUTH ANTI-INFECTIVES	MC MC MC/DEL		NILSTAT SUSP EAR-GESIC SOLN NYSTATIN SUSP	MC MC	MYCELEX TROC ORAVIG	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MOUTH ANTISEPTICS	MC/DEL MC/DEL MC MC		CHLORHEXIDINE GLUCONATE LIDOCAINE VISCOUS SOLN TRIAMCINOLONE IN ORABASE PSTE TRIAMCINOLONE ORADENT PSTE	MC MC MC MC	APHTHASOL PSTE ¹ PERIOGARD SOLN ¹ TRIAMCINOLONE ACETONIDE PSTE ¹	Use PA Form# 20420 1. Must fail all preferred products before 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.
DENTAL PRODUCTS							
DENTAL PRODUCTS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ETHEDENT CREA GEL-KAM CONC GEL-KAM GEL 0.4% PHOS FLUR SOLN SF 5000 PLUS CREA SF GEL	MCOMC MC/DEL MC/DEL MC	APF GEL GEL DENTAGEL GEL PHOS-FLUR GEL THERA-FLUR-N GEL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC		STANNOUS FLUORIDE ORAL RI CONC					
ARTIFICIAL SALIVA/STIMULANTS								
ARTIFICIAL SALIVA/STIMULANTS	MC		SALIVA SUBSTITUTE SOLN	MC MC MC		EVOXAC CAPS RADIACARE SOLR SALAGEN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS ANORECTAL								
ANORECTAL - MISC.	MC/DEL MC MC MC/DEL MC/DEL MC/DEL		COLOCORT ENEM CORTENEMA ENEM ELA-MAX 5 CREA HYDROCORTISONE ENEM PROCTOSOL HC CREA PROCTOZONE-HC CREA	MC/DEL MC/DEL MC/DEL MC/DEL MC		ANUSOL-HC CREA CORTIFOAM FOAM PROCTOFOAM HC FOAM PROCTO-KIT CREA 2.5% RECTIV OINT	Use PA Form# 20420	
T-CELL ACTIVATION INHIBITOR								
PSORIASIS BIOLOGICALS	MC MC		ENBREL ^{1,2} HUMIRA ¹	MC MC MC		COSENTYX OTEZLA STELARA	Use PA Form# 20910	<p>1. Will not require a PA if at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin is in members drug profile. Please refer to dose consolidation list.</p> <p>2. Preferred dosage form allowed without PA after trial of step 1 products is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa.</p> <p>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.</p> <p>Enbrel is preferred after a trial of a step 1 product (e.g. azathioprine, methotrexate, etc.); however, dosing limits will also still apply. Dosing limits will allow 8 injections per month without pa. Use of greater than 8 injections per month will require PA. In addition, the preferred Enbrel 25mg product will be the multi-dose vial (NDC- 58406-0425-34). The single-use prefilled syringes are non-preferred.</p>
ALTERNATIVE MEDICINES								
ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC/DEL MC		CO-ENZYME Q-10 MELATONIN TABS	Use PA Form# 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
CHELATING AGENTS								
CHELATING AGENTS	MC/DEL		CUPRIMINE CAPS	MC MC/DEL		DEPEN TITRATABS TABS EXJADE ¹	Use PA Form# 20420	1. FDA indication of treatment of chronic iron overload due to blood transfusions in membes 2 years of age and older is required for approval of Exjade.
ANTILEPROTIC								
ANTILEPROTIC				MC		THALOMID CAPS ¹	Use PA Form# 20420	1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules.
ANTINEOPLASTIC AGENTS								

ANTINEOPLASTIC AGENTS - ANTIANDROGENS	MC/DEL		BICALUTAMIDE	MC/DEL		CASODEX	Use PA Form# 20420	
ANTINEOPLASTIC AGENTS- LHRH ANALOGS	MC		LUPRON DEPOT ¹	MC MC MC/DEL		VANTAS ² FIRMAGON ² TRELSTAR	1. Dosing limits apply, please refer to dosage consolidation list. 2. PA required to confirm FDA approved indication. Use PA Form# 20420	
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS				MC MC/DEL MC		SPRYCEL ¹ TYKERB ² GLEEVEC ¹	1. Verification of diagnosis is required. 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions. Use PA Form# 20420	
ANTINEOPLASTICS-MISCELLANEOUS	MC MC/DEL		AMIFOSTINE MERCAPTOPYRINE	MC MC/DEL MC MC/DEL MC/DEL MC/DEL		DOCFREZ ETHYOL LEUPROLIDE OXALIPLATIN PURINETHOL ZOLINZA	Use PA Form# 20420	
ANTINEOPLASTICS- MONOCLONAL ANTIBODIES				MC/DEL		HERCEPTIN ¹	1. PA required to confirm FDA approved indication. Use PA Form# 20420	

CANCER

CANCER	MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL		ALIMTA ANASTROZOLE TABS AVASTIN ERBITUX LETROZOLE MEGACE ES VIDAZA	MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC MC MC MC/DEL MC		ARIMIDEX BOSULIF COMETRIQ ^{3,4,5} ERIVEDGE FARYDAK FOLOTYN GILOTRIF ^{4,5} IBRANCE ICLUSIG ³ INLYTA JAKAFI KEYTRUDA ⁷ LENVIMA LYNPARZA ⁷ NEXAVAR ¹ MEKINIST ^{3,4} POMALYST STIVARGA SUTENT ^{1,2} SYLATRON TAFINLAR ^{3,4,5,6} FEMARA YERVOY XALKORI XTANDI ZELBORAF ZYDELIG ZYKADIA	1. PA required to confirm FDA approved indication 2. Avoid CYP3AY drug drug interaction. 3. Clinical PA required for appropriate diagnosis 4. Re-approval will require documentation of response without disease progression and tolerance to treatment 5. Dosing limits apply, please see dosage consolidation list. 6. Max daily dose of 300mg. 7. PA required to confirm FDA approved indication Use PA Form# 20420	A clinical PA is required for Inlyta to verify diagnosis and failure of one prior systemic therapies Xalkori will be considered for patients with a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA- approved test (please included a copy of test results; and is prescribed by an oncologist; quantity limit of 60 tablets per 30 days. Zelboraf will be considered for patients 18 years of age or older, has a diagnosis of unresectable or metastatic melanoma with BRAF mutation as detected by an FDA-approved test; prescriber is an oncologist with a quantity limit of 240 tablets per 30 days. Bosulif requires a clinical PA, requiring diagnosis. Must have resistance or intolerance to prior therapy (such as imatinib [Gleevec®] or a TKI) seen in drug profile, monthly hepatic enzyme tests should be performed for the first three months of treatment , as clinically indicated. Iclusig requires prior trail of TKI therapy, appropriate monitoring and has DDI with strong CYP3A4 inducers Stivarga is non-preferred and is for the treatment of metastatic colorectal cancer (CRC) who have been previously treated with fluoropyrimidine- oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and if KRAS wild type, an anti-EGFR therapy).The safety and efficacy of use in children under the age of 18 years have not been established. DDI: Cometriq, Ibrance and Tafenlar will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin). Gilotrif needs to be prescribed by an oncologist XTandi is non-preferred and is limited to adults treatment of metastatic castration-resistant prostate cancer, with previous trials of docetaxel. Pomalyst has a DDI with strong inhibitors of CYP1A2 and CYP3A4 drugs. Complete blood counts weekly for first 8 weeks, then monthly, patients have at least 2 prior therapies, including lenalidomide and bortezomib, female patients of reproductive potential must have 2 negative pregnancy tests and use 2 forms of contraception and providers must be certified with Pomalyst REMS Program. DDI: Strong and moderate CYP3A inhibitors and Strong and moderate CYP3A inducers should be avoided with use of Lynparza
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				MC		ZYTIGA		Clinical PA required for Ibrance to verify diagnosis and concomitant use with letrozole
								Farydak in combination with bortezomib and dexamethasone for the treatment of patients with multiple myeloma (MM) who have received ≥2 prior regimens, including bortezomib and an immunomodulatory agent

IMMUNOSUPPRESSANTS

IMMUNOSUPPRESSANTS	MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL		CYCLOSPORINE MODIFIED GENGRAF CAPS MYCOPHENOLATE MYFORTIC NEORAL PROGRAF CAPS RAPAMUNE SANDIMMUNE	MC/DEL MC/DEL MC/DEL		CELLCEPT CYCLOSPORINE CAPS CYCLOSPORINE SOL. MODIFIED		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Cyclosporine will now be non-preferred and require prior authorization if it is currently being used in combination with either Lipitor (doses greater than 20mg/day), Crestor, or lovastatin (doses greater than 20mg). DDI: Cyclosporine will require prior authorization when used with Livalo. DDI: All preferred immunosuppressants will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
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PURINE ANALOG

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

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

ANTI-CONVULSANTS INDICATION CHART

	SEIZURES	POST HERPETIC NEURALGIA	DIABETIC PERIPHERAL NEUROPATHY	MONOTHERAPY BIPOLAR	ADJUNCTIVE BIPOLAR	MIGRAINE PROPHYLAXIS	FIBROMYALGIA
GABITRIL	X			9	8		
LAMICTAL	X			4	4		
LYRICA	X	X(2 nd line)	X(2 nd line)				X(2 nd line)
TOPAMAX	X			9	6	X (2 nd line)	
TRILEPTAL	X			5	5		

PEDIATRIC ANTI-CONVULSANTS INDICATION CHART

	SEIZURES	MONOTHERAPY BIPOLAR	ADJUNCTIVE BIPOLAR
LITHIUM		1	1
CARBMAZEPINE	X	1	1
VALPROATE	X	1	1

ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE	X	1	1
LAMICTAL	X	1	1
TRILEPTAL	X	5	5
CLOZAPINE	X	6	6