| CATEGORY | Coverage Indicator | Step Order | PREFERRED DRUGS | Coverage Indicator | Step Order | NON-PREFERRED DRUGS PA Required | Comments | Criteria |
|---|---|---|---|---|---|---|---|---|

** PLEASE NOTE: All cost effective generics applicable to DEL are considered PREFERRED Drugs. "BASIC" Covered Drugs are bolded with the Coverage Indicator of "MC / DEL".*

**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.mainecarepdl.org**

**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.)**

**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.**

**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.)**

**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.**

**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.**

**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.**

**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.**

**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.**

**I. Trials from Multiple Drug Classes - Trial/failure/intolerance to preferred agents from multiple classes within the same category or other catagories of drugs may be required prior to the approval of non-preferred agents (e.g., Cymbalta, Zofran, Elidel and others).**

**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.mainecarepdl.org* .**

**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.**

**L: Drug-Drug Interactions (DDI)- The DUR Committee has implemented new drug-drug interation edits requiring prior authorization. Several drug-drug combinations and PDL drug catagories 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.**

**ASSORTED ANTIBIOTICS**

| CATEGORY | Coverage Indicator | Step Order | PREFERRED DRUGS | Coverage Indicator | Step Order | NON-PREFERRED DRUGS PA Required | Comments | Criteria |
|---|---|---|---|---|---|---|---|---|
| **BETA-LACTAMS / CLAVULANATE COMBO'S** | MC/DEL | | AMOXICILLIN | MC/DEL | | AMOXIL 500MG TABS | 1. Amoxil 500mg tabs are non-preferred. All other Amoxil products are 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 | | AMOXICILLIN/POTASSIUM CLA CHEW | MC/DEL | | AUGMENTIN[3] | 2.Principen 250 mg is available without PA. | **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 SUSR | MC/DEL | | AUGMENTIN XR TB12[4] | 3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA. | |
| | MC/DEL | | AMOXICILLIN/POTASSIUM CLA TABS | MC | | PRINCIPEN CAPS[2] | 4. Use preferred generic amoxicillin/clavulanate potassium alternatives. | |
| | MC/DEL | | AMOXIL[1] | MC | | PRINCIPEN SUSR | Use PA Form# 20420 | |
| | MC/DEL | | AMPICILLIN | | | | | |
| | MC | | BEEPEN | | | | | |
| | MC | | BICILLIN L-A SUSP | | | | | |
| | MC/DEL | | DICLOXACILLIN SODIUM CAPS | | | | | |
| | MC | | DYNAPEN SUSR | | | | | |
| | MC | | OXACILLIN SODIUM SOLR | | | | | |
| | MC/DEL | | PENICILLIN V POTASSIUM | | | | | |
| | MC | | TICAR SOLR | | | | | |
| | MC | | TIMENTIN SOLR | | | | | |
| | MC | | TRIMOX | | | | | |
| | MC | | UNASYN SOLR | | | | | |
| | MC | | VEETIDS | | | | | |
| | MC/DEL | | ZOSYN | | | | | |
| **CEPHALOSPORINS** | MC/DEL | | CEFADROXIL HEMIHYDRATE | MC | | CEDAX | 1. Both brand and generic are clinically non-preferred. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC/DEL | | CEFAZOLIN SODIUM SOLR | MC/DEL | | CEFACLOR[1] | | |
| | MC/DEL | | CEFDINIR | MC/DEL | | CEFADROXIL MONOHYDRATE TABS | | |
| | MC/DEL | | CEFEPIME HCI | MC/DEL | | CEFTIN | | |
| | MC/DEL | | CEFPODOXIME | MC/DEL | | FORTAZ | | |
| | MC/DEL | | CEFPROZIL | MC/DEL | | FORTAZ SOLN | | |
| | MC | | CEFTAZIDIME 6MG | MC | | KEFLEX CAPS | | |

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|---|---|---|---|---|---|---|
| | MC/DEL | CEFTIN SUSP | MC | OMNICEF | | |
| | MC/DEL | CEFTRIAXONE | MC/DEL | ROCEPHIN | | |
| | MC/DEL | CEFUROXIME AXETIL TABS | MC/DEL | SUPRAX | | |
| | MC/DEL | CEPHALEXIN MONOHYDRATE | MC | TAZICEF SOLR | | |
| | MC/DEL | FORTAZ SOLR | MC | MAXIPIME | | |
| | MC | KEFZOL SOLR | | | | |
| | MC | MAXIPIME SOLR | | | Use PA Form# 20420 | |
| | MC | TAZICEF 6GM | | | | **DDI:** Vantin 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 | VANTIN 100MG | | | | |
| | MC/DEL | VANTIN SUSP | | | | |
| **MACROLIDES / ERYTHROMYCIN'S** | MC | BIAXIN XL[1] | MC/DEL | AZITHROMYCIN POW | 1. 7- Day supply per month without PA. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC/DEL | AZITHROMYCIN TABS | MC | BIAXIN | | |
| | MC/DEL | AZITHROMYCIN SUSP | MC/DEL | CLARITHROMYCIN SUSP | | |
| | MC/DEL | CLARITHROMYCIN TABS | MC | ERYPED CHEW | | |
| | MC | E.E.S. | MC | PCE TBEC | | **DDI:** Preferred erythromycin will now be non-preferred and require prior authorization if it is currently being used in combination with either Carbamazepine, Enablex 15mg or Vesicare 10mg. Any non preferred formulation of erythromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either Carbamazepine, Enablex 15mg or Vesicare 10mg. |
| | MC | E-MYCIN TBEC | MC/DEL | ZITHROMAX TABS | | |
| | MC | ERYPED 200 SUSR | MC/DEL | ZITHROMAX 1GM PAK | Use PA Form# 20420 | |
| | MC | ERYPED 400 SUSR | MC/DEL | ZITHROMAX TRI-PAK | | |
| | MC | ERY-TAB TBEC | MC/DEL | ZITHROMAX SUSP | | **DDI:** Preferred clarithromycin formulations (clarithromycin tablets and Biaxin XL tablets) will now be non-preferred and require prior authorization if they are currently being used in combination with either Carbamazepine, Onglyza 5mg, Enablex 15mg or Vesicare 10mg. Any non preferred formulation of clarithromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either Carbamazepine, Onglyza 5mg, Enablex 15mg or Vesicare 10mg. |
| | MC | ERYTHROCIN STEARATE TABS | MC/DEL | ZMAX | | |
| | MC/DEL | ERYTHROMYCIN | | | | |
| **TETRACYCLINES** | MC/DEL | DOXYCYCLINE HYCLATE | MC | DECLOMYCIN 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 | MINOCYCLINE HCL CAPS | MC/DEL | DORYX CPEP | | |
| | MC/DEL | TETRACYCLINE HCL CAPS | MC/DEL | DOXYCYCLINE MONO CAPS | | |
| | MC/DEL | VIBRAMYCIN SYRP | MC/DEL | DYNACIN CAPS | | |
| | | | MC | ORACEA | | |
| | | | MC/DEL | PERIOSTAT | | |
| | | | MC/DEL | SOLODYN ER | | |
| **FLUOROQUINOLONES** | MC | AVELOX SOLN | MC | CIPRO | | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | AVELOX TABS | MC | FACTIVE | Use PA Form# 20420 | |
| | MC | AVELOX ABC PACK TABS | MC/DEL | LEVAQUIN TABS SOLN/INJ | 1. Dosing limits apply, see Dosage Consolidation List. | |
| | MC/DEL | CIPROFLOXACIN | MC/DEL | LEVAQUIN TABS[1] | | **DDI:** Preferred ofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. |
| | MC/DEL | LEVOFLOXACIN | MC | NOROXIN TABS | | **DDI:** Preferred levofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. |
| | MC/DEL | OFLOXACIN | MC | PROQUIN XR | | **DDI:** All preferred fluoroquinolones will require clinical PA for patients over 60 that are currently on immunosuppressants or steroid therapy. |
| | | | | | | **DDI:** Preferred Factive is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with amiodarone. |
| | | | | | | **DDI:** Preferred Avelox will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. |
| **AMINO GLYCOSIDES** | MC | GENTAMICIN | | | | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | NEOMYCIN SULFATE TABS | | | | |
| | MC | TOBI NEBU | | | Use PA Form# 20420 | |
| | MC/DEL | TOBRAMYCIN SULFATE SOLN | | | | |
| **ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS** | MC/DEL | ETHAMBUTOL HCL TABS | MC | RIMACTANE CAPS | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC/DEL | MYAMBUTOL TABS | | | | |
| | MC/DEL | MYCOBUTIN CAPS | | | | |
| | MC/DEL | RIFAMPIN | | | | **DDI:** Preferred rifampin will be non-preferred and require prior authorization if it is currently being used in combination with either Pradaxa or Latuda. |
| **ANTIMALARIAL AGENTS** | MC/DEL | **CHLOROQUINE PHOSPHATE TABS** | MC | ARALEN 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 | **DARAPRIM TABS** | MC | ISONARIF[1] | | |
| | MC/DEL | **HYDROXYCHLOROQUINE TABS** | MC/DEL | MALARONE TABS | 1. Ingredients available as preferred without PA. | |
| | MC/DEL | **LARIAM TABS** | MC/DEL | **PLAQUENIL TABS** | | |
| | MC/DEL | **MEFLOQUINE HCL TABS** | | | | |
| | MC | QUINACRINE HCL POWD | | | | |
| | MC/DEL | **QUININE SULFATE** | | | | |
| **ANTHELMINTICS** | MC/DEL | ALBENZA TABS | MC | VERMOX CHEW | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC | BILTRICIDE TABS | | | | |
| | MC/DEL | MEBENDAZOLE CHEW | | | | |
| | MC/DEL | STROMECTOL TABS | | | | |
| **ANTIBIOTICS - MISC.** | MC | AZACTAM SOLR | MC | COLY-MYCIN-M SOLR | 1. Need to fail other anti-protozoals | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC | COLISTIMETHATE SODIUM SOLR | MC | CAYSTON[4] | | |
| | MC | FUROXONE TABS | MC/DEL | FLAGYL CAPS | 2. 375mg caps and 750mg | |

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| | MC/DEL | | METRONIDAZOLE[2] | MC/DEL | | FLAGYL TABS | tabs are non-preferred. Please use available preferred strengths(250mg & 500mg tabs) to obtain required dose without PA. | 1. For macrolide resistant infections when quinolones inappropriate |
| | MC | | PENTAMIDINE ISETHIONATE SOLR | MC/DEL | | FLAGYL ER TBCR | | |
| | MC | | PRIMSOL SOLN | MC/DEL | | KETEK | | **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 Enablex 15mg or Vesicare 10mg or carbamazepine. |
| | MC/DEL | | TRIMETHOPRIM TABS | MC/DEL | | METRONIDAZOLE 375MG CAPS[2] | | |
| | MC/DEL | | VANCOMYCIN 5GM INJ. | MC/DEL | | METRONIDAZOLE 750MG TABS[2] | | |
| | | | | MC | | NEBUPENT SOLR | | |
| | | | | MC | | TINDAMAX[1] | | |
| | | | | MC/DEL | | VANCOMYCIN 10GM INJ.[3] | 3. Please use multiple 5gm which are preferred to obtain dose without PA. | |
| | | | | MC | | XIFAXAN | 4. Clinical PA is required to establish CF diagnosis and medical necessity. Prior trail and failure of preferred Tobi before approval will be granted. Use PA Form# 20420 | |
| **CARBAPENEMS** | | | | MC | | INVANZ 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 | | MERREM SOLR | | |
| | | | | MC/DEL | | PRIMAXIN | | |
| **LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS** | MC/DEL | | CLEOCIN SOLN | MC/DEL | | CLEOCIN CAPS | 1. Use multiple 150's for Clindamycin instead of 300's. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. For Zyvox or Vibativ, please see the criteria listed in the Antibacterial Antibiotics PA form. |
| | MC/DEL | | CLEOCIN SUSR | MC/DEL | | CLINDAMYCIN HCL 300CAPS[1] | | |
| | MC/DEL | | CLINDAMYCIN HCL 150CAPS | MC/DEL | | VIBATIV | | |
| | MC | | DAPSONE TABS | MC/DEL | | ZYVOX SUSR | Use PA Form# 30820 for Zyvox & Vibativ | |
| | | | | MC/DEL | | ZYVOX TABS | Use PA Form# 20420 for **all others** | |
| **ANTI INFECTIVE COMBO'S - MISC.** | MC/DEL | | ERYTHROMYCIN/SULF SUSR | MC | | BACTRIM DS 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 | | SEPTRA/DS TABS | | | | | |
| | MC/DEL | | SULFAMETHOXAZOLE/TRIMETH | | | | | |
| | MC/DEL | | TRIMETHOPRIM/SULFAMETHOXA | | | | | |
| **ANTIPROTOZOALS** | | | | MC | | ALINIA[1] | 1. Alina is preferred for children less than 12 years of age. Use PA Form# 20420 | |
| **ANTI - FUNGALS** | | | | | | | | |
| **ANTIFUNGALS - ASSORTED** | MC | | ANCOBON CAPS | MC/DEL | 5 | LAMISIL TABS[4] | 1. QL--1/every 7-day period (150mg only). | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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. |
| | MC/DEL | | FLUCONAZOLE[1] | MC/DEL | 6 | SPORANOX SOLN[2] | 2. Sporanox QL 300cc/month with PA. See quantity limit table. | |
| | MC/DEL | | GRIFULVIN V TABS[10] | MC/DEL | 6 | SPORANOX PULSEPAK CAPS[3] | | |
| | MC | | GRISEOFULVIN SUSP[10] | MC/DEL | 7 | SPORANOX CAPS[3] | | |
| | MC | | GRISEOFULVIN ULTRAMICROSI TABS[10] | MC/DEL | 8 | ERAXIS INJ[6] | | |
| | MC | | GRIS-PEG TABS[10] | MC/DEL | 8 | DIFLUCAN | 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. | **DDI:** Preferred ketoconazole will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg, Vesicare 10mg or Latuda. |
| | MC/DEL | | KETOCONAZOLE TABS[8] | MC | 8 | GRIFULVIN SUSP | | **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. |
| | MC/DEL | | NYSTATIN | MC/DEL | 8 | NOXAFIL[5] | 4. Quantity limit of one tablet daily. Please see dosage consolidation list. | **DDI:** Sporanox is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with Enablex 15mg, Vesicare 10mg, Prandin, Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI, due to a significant drug-drug interaction. |
| | MC/DEL | | TERBINAFINE TABS[4] | MC/DEL | 8 | VFEND TABS | 5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy. | **DDI:** Fluconazole (except 150mg strength) will now be non-preferred and require prior authorization if it is currently being used with glimepiride (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 glimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg. |
| | | | | MC/DEL | 8 | ITRACONAZOLE | | |

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| | | | | | | | 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. | **DDI:** Fluconazole will require prior authorization if being used in combination with Plavix or Warfarin. |
| | | | | | | | 8. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30 days. | **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. |
| | | | | | | | 10. 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.<br>Use PA Form# 10120 | **DDI:** Ketoconazole will require prior authorization if being used in combination with Plavix. |
| **ANTI - VIRALS** | | | | | | | | |
| **ANTIRETROVIRALS** | **MC/DEL** | | APTIVUS | **MC/DEL** | 8 | DIDANOSINE | Use PA Form# 10620 for **Fuzeon** | Please refer to the criteria listed on the Fuzeon PA form. |
| | **MC** | | ATRIPLA[1] | **MC/DEL** | 8 | FUZEON[3] | | |
| | **MC/DEL** | | COMBIVIR TABS | **MC/DEL** | 8 | INTELENCE[3] | | |
| | **MC/DEL** | | CRIXIVAN CAPS | **MC/DEL** | 8 | ISENTRESS[3] | | |
| | **MC** | | EMTRIVA | **MC/DEL** | 8 | RETROVIR | 1. Quantity limit of one per day | **DDI:** Reyataz 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** | | EPIVIR / HBV | **MC/DEL** | 8 | SELZENTRY[3] | | |
| | **MC/DEL** | | EPZICOM | **MC** | 8 | ZERIT | 2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista | |
| | **MC/DEL** | | INVIRASE CAPS | **MC/DEL** | 9 | VIRAMUNE XR | | **DDI:** Preferred Norvir will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg. |
| | **MC** | | KALETRA | | | | | |
| | **MC/DEL** | | LEXIVA | | | | | |
| | **MC** | | NORVIR | | | | 3. Prescribers with >= 10 ART scripts per quarter and 75% ART PDL compliance will be exempt from PA for these products. | **DDI:** Preferred Crixivan caps will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg. |
| | **MC** | | PREZISTA[2] | | | | | |
| | **MC/DEL** | | RESCRIPTOR TABS | | | | | |
| | **MC** | | REYATAZ | | | | | |
| | **MC** | | STAVUDINE | | | | | |
| | **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 | | | | | |
| **CYTO-MEGALOVIRUS AGENTS** | **MC** | | FOSCARNET SODIUM | **MC/DEL** | | FOSCAVIR | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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** | | VALCYTE TABS | **MC/DEL** | | GANCICLOVIR | | |
| **HERPES AGENTS** | **MC/DEL** | | ACYCLOVIR | **MC/DEL** | 8 | FAMVIR TABS[1] | 1. Must fail Acyclovir and Valtrex before non-preferred products in step order. | 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. |
| | **MC/DEL** | | VALTREX TABS | **MC/DEL** | 8 | ZOVIRAX[1] | | |
| | | | | **MC/DEL** | 8 | VALACYCLOVIR[1] | | |
| | | | | **MC/DEL** | 9 | FAMCICLOVIR[1] | Use PA Form# 20420 | |
| **INFLUENZA AGENTS** | **MC/DEL** | | AMANTADINE | **MC/DEL** | | FLUMADINE TABS | 1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or | 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. |
| | **MC** | | RELENZA DISKHALER AEPB | **MC** | | FLUMIST | | |
| | **MC/DEL** | | RIMANTADINE HCL TABS | | | | | |

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|---|---|---|---|---|---|---|---|---|
| | MC/DEL | | TAMIFLU[1] | | | | family member.<br><br>Use PA Form# 10610 for **Flumist** requests<br><br>Use PA Form# 20420 for **all others** | |
| **IMMUNE SERUMS** | | | | | | | | |
| **IMMUNE SERUMS** | MC | | HYPERRHO INJ | | | | | |
| **HEPATITIS AGENTS** | | | | | | | | |
| **HEPATITIS C AGENTS** | MC/DEL<br>MC/DEL<br>MC | | PEGASYS KIT[1]<br>PEGASYS SOLN<br>RIBAVIRIN | MC/DEL<br>MC/DEL<br>MC/DEL | | COPEGUS TABS<br>PEG-INTRON KIT[2]<br>REBETOL CAPS | 1. Dosing limits apply, please see dosage consolidation list.<br><br>2. Current users are grandfathered.<br><br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| **HEPATITIS AGENTS - MISC.** | | | | MC | | ACTIMMUNE | Use PA Form# 20420 | Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis. |
| **HEPATITIS B ONLY** | MC | | HEPSERA TABS | MC<br>MC | | BARACLUDE<br>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. |
| **RSV PROPHYLAXIS** | | | | | | | | |
| **RSV PROPHYLAXIS** | | | | MC | | SYNAGIS[1] | Use PA Form# 30120<br>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. |
| **MS TREATMENTS** | | | | | | | | |
| **MULTIPLE SCLEROSIS - INTERFERONS** | MC<br>MC/DEL<br>MC | | AVONEX KIT[1]<br>**BETASERON SOLR[1]**<br>REBIF SOLN[1] | MC/DEL | | EXTAVIA | 1.Clinical PA is required to establish diagnosis and medical necessity.<br><br>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/DEL | | **COPAXONE[2]** | MC/DEL<br>MC<br>MC/DEL | 6<br>8<br>8 | TYSABRI[1]<br>AMPYRA<br>GILENYA[3] | 1. Providers must be enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity.<br><br>2. Clinical PA is required to establish diagnosis and medical necessity.<br><br>3. Dosing limits apply, please see dosage consolidation list.<br><br>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. |
| **ASSORTED NEUROLOGICS** | | | | | | | | |
| **NEUROLOGICS - MISC.** | MC<br>MC/DEL<br>MC | | MESTINON<br>ORAP TABS<br>PROSTIGMIN TABS | MC<br><br>MC/DEL | | BOTOX<br>DYSPORT[1]<br>MYOBLOC[1] | 1. Approval will be limited to Cervical dystonia.<br><br>Use PA Form# 10210 | Failed/did not tolerate therapeutic trials fo muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, Skelaxin, and tizanidine.<br><br>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. |
| **STEROIDS** | | | | | | | | |
| **GLUCOCORTICOIDS/ MINERALOCORTICOIDS** | MC<br>MC/DEL | | CELESTONE SUSP<br>CORTEF 5 | MC<br>MC/DEL | | CORTEF 10 and 20 TABS<br>FLORINEF 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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|---|---|---|---|---|---|---|---|---|
| | MC/DEL | | CORTISONE ACETATE TABS | MC/DEL | | **MEDROL TABS** | | preferred drug(s) exists. |
| | MC/DEL | | DELTASONE TABS | MC | | MEDROL DOSEPAK TABS | | |
| | MC/DEL | | DEPO-MEDROL SUSP | MC | | ORAPRED SOLN | | |
| | MC/DEL | | DEXAMETHASONE | MC | | PEDIAPRED LIQD | | |
| | MC/DEL | | ENTOCORT EC CP24 | MC | | PREDNISONE INTENSOL CONC | | |
| | MC/DEL | | FLUDROCORTISONE ACETATE TABS | MC | | STERAPRED TABS | | |
| | MC/DEL | | HYDROCORTISONE | | | | | |
| | MC | | KENALOG | | | | | **DDI:** All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy. |
| | MC/DEL | | METHYLPREDNISOLONE TABS | | | | | |
| | MC/DEL | | PREDNISOLONE | | | | | |
| | MC/DEL | | **PREDNISONE** | | | | | |
| | MC/DEL | | SOLU-CORTEF SOLR | | | | | |
| | MC/DEL | | SOLU-MEDROL SOLR | | | | | |
| **HORMONE REPLACEMENT THERAPIES** | | | | | | | | |
| **ANDROGENS / ANABOLICS** | MC/DEL | | ANDRODERM PT24 | MC | | ANDRO LA 200 OIL | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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) |
| | MC/DEL | | ANDROGEL | MC | | AXIRON | | |
| | MC/DEL | | ANDROGEL PUMP | MC | | DELATESTRYL OIL | | |
| | MC/DEL | | ANDROID CAPS | MC | | FORTESTA | Use PA Form# 20600 for **Oxandrin** requests | |
| | MC/DEL | | DANAZOL CAPS | MC | | HALOTESTIN TABS | | |
| | MC/DEL | | DEPO-TESTOSTERONE OIL | MC/DEL | | METHITEST TABS | | |
| | MC/DEL | | TESTOSTERONE PROPIONATE | MC/DEL | | OXANDRIN TABS | | |
| | MC | | TESTRED CAPS | MC/DEL | | TESTIM | | |
| **ESTROGENS - PATCHES / TOPICAL** | MC/DEL | | **ESTRADERM PTTW**[1] | MC/DEL | 5 | **ESTRADIOL PTWK** | 1. Both preferred drugs must be tried. | Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication. |
| | MC/DEL | | **VIVELLE-DOT PTTW**[1] | MC/DEL | 8 | **ALORA PTTW**[2] | | |
| | MC/DEL | | **CLIMARA PTWK** | MC/DEL | 8 | **DIVIGEL**[2] | 2. Step order drugs must be used in specified step order. | |
| | | | | MC/DEL | 8 | **ELESTRIN**[2] | | |
| | | | | MC | 8 | **EVAMIST**[2] | Use PA Form# 20420 | |
| **ESTROGENS - TABS** | MC/DEL | | **CENESTIN TABS** | MC/DEL | | ENJUVIA | Must fail preferred products before non-preferred products. | 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. |
| | MC/DEL | | **ESTRADIOL** | MC/DEL | | **ESTRACE TABS** | | |
| | MC/DEL | | **ESTROPIPATE TABS** | MC | | ESTRATAB TABS | | |
| | MC/DEL | | **MENEST TABS** | MC | | ORTHO-EST TABS | | |
| | MC/DEL | | **PREMARIN TABS** | | | | Use PA Form# 20420 | |
| **ESTROGEN COMBO'S** | MC/DEL | | **PREMPHASE TABS** | MC/DEL | | **ACTIVELLA TABS**[1] | 1. Must fail Premphase and Prempro products before non preferred products. | 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. |
| | MC/DEL | | **PREMPRO TABS** | MC/DEL | | **COMBIPATCH PTTW**[1] | | |
| | | | | MC/DEL | | **FEMHRT 1/5 TABS**[1] | | |
| | | | | MC/DEL | | **ORTHO-PREFEST TABS**[1] | Use PA Form# 20420 | |
| | | | | MC/DEL | | SYNTEST H.S. TABS[1] | | |
| **PROGESTINS** | MC/DEL | | MEDROXYPROGESTERONE ACETA[2] | MC/DEL | | AYGESTIN TABS | 1. PA approvals will require two 100 mg caps instead of one 200mg. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC/DEL | | NORETHINDRONE ACETATE TABS[2] | MC | | CYCRIN TABS | | |
| | | | | MC | | MAKENA | | |
| | | | | MC | | PROGESTERONE POWD | 2. Must fail Medroxyprogesterone and Norethidrone products before non-preferred products. | |
| | | | | MC/DEL | | PROMETRIUM 100MG CAPS[1] | | |
| | | | | MC/DEL | | PROMETRIUM 200MG[1] | | |
| | | | | MC/DEL | | PROVERA TABS | Use PA Form# 20420 | |
| **CONTRACEPTIVES** | | | | | | | | |
| **CONTRACEPTIVES - PROGESTIN ONLY** | MC | | ORTHO MICRONOR TABS | MC/DEL | | CAMILA 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. |
| | | | | MC/DEL | | ERRIN | | |
| | | | | MC/DEL | | JOLIVETTE | | If member experienced adverse reactions, consider using Oral Contraceptives from other groups. |
| | | | | MC/DEL | | NORA-BE TABS | | **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer. |
| | | | | MC/DEL | | NOR-QD TABS | Use PA Form# 20420 | |
| **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 | | NEXT CHOICE[1] | MC/DEL | | PLAN - B | 1. Allowed 4 tablets per 30 days without PA | |

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| | | | | | Use PA Form# 20420 | |
| CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS | MC/DEL | NUVARING RING[3] | | | Use PA Form# 20420 | Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable. |
| | MC | ORTHO EVRA PTWK[1,2,4] | | | 1.No PA required for users less than 21 years of age.<br><br>2. The FDA has issued a public health warning of the potentials for increased exposure to estrogen with Ortho Eva use, possibly up to 60% estrogen exposoure.<br><br>3. Quantity limit allowing 1 every 28 days with out PA.<br><br>4. Dose limits apply allowing 3 patches per 28 days supply. Please refer to Dose Consolidation Chart. | |
| CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S | MC/DEL | APRI TABS | MC/DEL | BEYAZ | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | AVIANE TABS | MC/DEL | BREVICON-28 TABS | If member experienced adverse reactions, consider using Oral Contraceptives from other groups. | |
| | MC/DEL | BALZIVA | MC/DEL | LESSINA-28 TABS | | |
| | MC/DEL | CRYSELLE-28 TABS | MC/DEL | LEVORA | | |
| | MC/DEL | DESOGEN TABS | MC | LOESTRIN TABS | | |
| | | DESOGESTREL/ ETHINYL ESTRADIOL | MC/DEL | LOESTRIN FE TABS | | If member experienced adverse reactions, consider using Oral Contraceptives from other groups. |
| | MC/DEL | LOW-OGESTREL TABS | MC/DEL | LOESTRIN FE 1/20 TABS | | |
| | MC | MODICON TABS | MC/DEL | LOESTRIN 1.5/30-21 TABS | | |
| | MC/DEL | MONONESSA | MC/DEL | LOESTRIN 1/20-21 TABS | | |
| | MC/DEL | NECON 1/50 | MC | LO/OVRAL 21 TABS | | **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer. |
| | MC | ORTHO-CEPT-28 TABS | MC/DEL | LO/OVRAL 28 TABS | | |
| | MC | ORTHO-CYCLEN-28 TABS | MC/DEL | MICROGESTIN FE TABS | | |
| | MC | ORTHO-NOVUM 1/35-28 TABS | MC/DEL | NORDETTE-28 TABS | | |
| | MC/DEL | OVCON-50 28 TABS | MC/DEL | NORINYL | | |
| | MC/DEL | PREVIFEM | MC/DEL | NORTREL | | |
| | MC/DEL | RECLIPSEN | MC/DEL | OCELLA | | |
| | MC/DEL | SOLIA | MC/DEL | OGESTREL TABS | | |
| | MC/DEL | SPRINTEC 28 TABS | MC/DEL | OVCON-35/28 TABS | | |
| | MC/DEL | YASMIN 28 TABS | MC/DEL | OVRAL | | |
| | MC/DEL | ZENCHENT | MC/DEL | PORTIA-28 TABS | | |
| | | | MC/DEL | SAFYRAL | | |
| | | | MC/DEL | SEASONALE | | |
| | | | MC/DEL | YAZ | | |
| | | | MC/DEL | ZOVIA | | |
| CONTRACEPTIVES - BI-PHASIC COMBINATIONS | MC | ORTHO-NOVUM 10/11-28 TABS | MC/DEL | NECON 10/11-28 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. |
| | MC | NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35 | MC/DEL | KARIVA TABS | | |
| | MC/DEL | SEASONIQUE | MC/DEL | MIRCETTE TABS | | If member experienced adverse reactions, consider using Oral Contraceptives from other groups. |
| | MC/DEL | LOSEASONIQUE | | | Use PA Form# 20420 | **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 | ENPRESSE | MC/DEL | CYCLESSA 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. |
| | MC/DEL | NECON 7/7/7 | MC/DEL | ESTROSTEP FE TABS | | |
| | MC | ORTHO-NOVUM 7/7/7-28 TABS | MC/DEL | NORTREL 7/7/7 | | |
| | MC/DEL | TRI-PREVIFEM | MC | ORTHO TRI-CYCLEN TABS | | |
| | MC/DEL | TRIPHASIL 28 TABS | MC | ORTHO TRI-CYCLEN LO TABS | | If member experienced adverse reactions, consider using Oral Contraceptives from other groups. |
| | MC/DEL | TRI-SPRINTEC | MC/DEL | TRI-NORINYL 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. |
| | MC | TRINESSA | | | | |
| | MC/DEL | TRIVORA-28 TABS | | | Use PA Form# 20420 | |
| CONTRACEPTIVES - MULTI-PHASIC COMBINATIONS | | | MC | NATAZIA | | |

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| PHASIC COMBINATIONS | | | | | | | Use PA Form# 20420 | |
| **DIABETES THERAPIES** | | | | | | | | |
| **DIABETIC - INSULIN** | MC | | HUMALOG INJ 100/ML | MC/DEL | | APIDRA | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | | HUMALOG MIX 75/25 | MC | | HUMALOG MIX 50/50 | | |
| | MC | | HUMULIN N INJ U-100 | MC | | HUMULIN INJ 50/50 | | |
| | MC | | HUMULIN INJ 70/30 | MC | | HUMULIN R INJ U-500 | | |
| | MC | | HUMULIN R U-100 | MC | | RELION | | |
| | MC/DEL | | LANTUS SOLN | | | | | |
| | MC/DEL | | LEVEMIR | | | | | |
| | MC/DEL | | **NOVOLIN** | | | | | |
| | MC/DEL | | **NOVOLOG** | | | | | |
| | MC/DEL | | **NOVOLOG MIX** | | | | | |
| **DIABETIC - PENFILLS** | MC/DEL | | LANTUS OPTICLIK PEN [1] | MC | | APIDRA OPTICLIK PEN | 1. Clinical PA will be required to establish significant visual or neurological impairment. | 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. |
| | MC/DEL | | LANTUS SOLOSTAR[1] | MC | | HUMALOG KWIK INJ 100/ML | | |
| | MC/DEL | | **LEVEMIR FLEXPEN [1]** | MC | | HUMALOG MIX INJ 75/25 KWP | | |
| | MC/DEL | | **NOVOLIN PENFILL[1]** | MC | | HUMALOG MIX INJ 50/50 KWP | | |
| | MC/DEL | | **NOVOLIN 70/30[1]** | | | | | |
| | MC/DEL | | NOVOLOG MIX PENFILL[1] | | | | | |
| | MC/DEL | | **NOVOLOG PENFILL SOLN[1]** | | | | Use PA Form# 20420 | |
| | MC/DEL | | NOVOLOG MIX FLEXPEN[1] | | | | | |
| | MC/DEL | | NOVOLOG FLEXPEN[1] | | | | | |
| **DIABETIC - DPP- 4 ENZYME INHIBITOR** | MC/DEL | | JANUVIA[1] | | | | 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. Dosing limits apply. Please refer to Dose consolidation list. Use PA Form# 20420 | **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). |
| | MC | | ONGLYZA[1] | | | | | |
| **DIABETIC - DPP- 4 ENZYME INHIBITOR-COMBO** | MC/DEL | | JANUMET[1] | | | | 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. Dosing limits apply. Please refer to Dose consolidation list. Use PA Form# 20420 | |
| | MC | | KOMBIGLYZE | | | | | |
| **DIABETIC - LANCET-LANCET DEVICE** | MC | | ONE TOUCH LANCETS | | | | Use PA Form# 20420 | |
| | MC | | DELICA LANCETS | | | | | |
| | MC | | FREESTYLE LANCETS | | | | | |
| | MC | | UNILET LANCETS | | | | | |
| | MC | | UNISTIK LANCING DEVICE | | | | | |
| | MC | | AUTOLOT LANCING DEVICE | | | | | |
| **DIABETIC - SYRINGES-NEEDLES** | MC/DEL | | BD MICRO-FINE | | | | Use PA Form# 20420 | |
| | MC | | BD ULTRA-FINE | | | | | |
| | MC | | BD ULTRA-FINE PEN NEEDLES | | | | | |
| | MC | | UNIFINE PEN NEEDLES | | | | | |
| **DIABETIC - OTHER** | | | | MC/DEL | | CYCLOSET | Use PA Form# 301501 | Please see the criteria listed in the Symlin PA form. |
| | | | | MC | | SYMLIN | | |
| **DIABETIC MONITOR** | MC | | FREESTYLE LITE SYSTEM KIT | MC | | ACCUCHECK | 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 |

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|---|---|---|---|---|---|---|---|---|
| | MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC | | FREESTYLE FLASH SYSTEM KIT<br>FREESTYLE FREEDOM SYSTEM KIT<br>FREESTYLE FREEDOM LITE KIT<br>ONE TOUCH ULTRA 2 KIT<br>ONE TOUCH ULTRA MINI KIT<br>ONE TOUCH ULTRA SMART KIT<br>PRECISION XTRA METER | MC<br>MC<br>MC<br>MC | | ASCENSIA<br>ASSURE<br>EXACTECH<br>PRODIGY | | the preferred meters. |
| **DIABETIC TEST STRIPS** | MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC | | FREESTYLE[1]<br>FREESTYLE LITE[1]<br>ONE TOUCH BASIC[1]<br>ONE TOUCH SURESTEP[1]<br>ONE TOUCH FAST TAKE[1]<br>ONE TOUCH ULTRA[1]<br>PRECISION XTRA[1]<br>PRECISION XTRA BETA KETONE 10 CT | MC<br>MC<br>MC<br>MC<br>MC | | ACCUCHECK<br>ASCENSIA<br>ASSURE<br>EXACTECH<br>PRODIGY | 1. Only 50 ct & 100 ct package size.<br><br>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<br>MC/DEL | | BYETTA[1]<br>VICTOZA[1] | 1. If patient is not responding to oral agents (single or multiple) please look to insulin therapy. Dosing limits apply. Please refer to Dose Consolidation List.<br><br>Use PA Form# 10230 | |
| **DIABETIC - ORAL SULFONYLUREAS** | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | **CHLORPROPAMIDE TABS**<br>GLIMEPIRIDE<br>**GLIPIZIDE TABS**<br>**GLIPIZIDE ER TABS**<br>**GLYBURIDE TABS**<br>**GLYBURIDE MICRONIZED TABS**<br>**TOLAZAMIDE TABS**<br>**TOLBUTAMIDE TABS** | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL | | **AMARYL TABS**<br>**DIABETA TABS**<br>GLUCOTROL TABS<br>**GLUCOTROL XL TBCR**<br>**GLYNASE TABS**<br>**MICRONASE TABS** | Use PA Form# 20420 | Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.<br><br>**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.<br><br>**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<br>MC/DEL | | **METFORMIN HCL TABS**<br>METFORMIN ER | MC<br>MC<br>MC/DEL | | GLUCOPHAGE TABS<br>GLUCOPHAGE XR TB24<br>FORTAMET | Use PA Form# 20420 | Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| **DIABETIC - THIAZOL / BIGUANIDE COMBO** | | | | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | ACTOPLUS MET[1]<br>ACTOPLUS MET XR<br>AVANDARYL[1]<br>**AVANDAMET TABS[1]** | Use PA Form# 20420<br>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 | | **ACTOS 15MG TABS[1]** | MC/DEL<br>MC/DEL | | **ACTOS 30MG AND 45MG TABS[2]**<br>**AVANDIA TABS[3]** | 1. Actos is non-preferred as monotherapy. Actos 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.<br><br>2. Actos 30mg or 45mg - please use multiple 15mg 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.<br><br>**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. |

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| | | | | | | | 3. Current users of Avandia who have tried Actos will be able to continue use of Avandia.<br><br>Use PA Form# 20420 | |
| **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<br>MC<br>MC/DEL | | GLUCOVANCE TABS[1]<br>METAGLIP TABS[1]<br>DUETACT[2] | 1. Use individual ingredients.<br><br>2. Use Actos 15mgs with generic glimepiride.<br><br>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<br>MC | | **PRANDIN TABS**<br>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.<br><br>**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/DEL<br>MC/DEL | | GLUCAGON DIAGNOSTIC KIT<br>GLUCAGEN DIAGNOSTIC KIT | Use PA Form# 20420 | |
| **THYROID** | | | | | | | | |
| **THYROID HORMONES** | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | **ARMOUR THYROID TABS**<br>**CYTOMEL TABS**<br>**LEVOTHROID TABS**<br>**LEVOTHYROXINE SODIUM TABS**<br>**LEVOXYL TABS**<br>**THYROID TABS**<br>**THYROLAR**<br>**UNITHROID TABS** | MC<br>MC/DEL<br>MC | | LEVOTHYROXINE SODIUM SOLR<br>LIOTHYRONINE<br>SYNTHROID 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. |
| **ANTITHYROID THERAPIES** | MC/DEL<br>MC/DEL | | **METHIMAZOLE TABS**<br>**PROPYLTHIOURACIL 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. |
| **OSTEOPOROSIS** | | | | | | | | |
| **OSTEOPOROSIS** | MC/DEL<br>MC/DEL<br>MC/DEL | | ALENDRONATE<br>**FOSAMAX SOLN[2]**<br>**MIACALCIN SOLN[2]** | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL | | **ACTONEL TABS**<br>BONIVA INJECTION KIT<br>BONIVA TABS[2,4]<br>AREDIA SOLR<br>**DIDRONEL TABS**<br>EVISTA TABS[1]<br>FORTEO<br>FORTICAL<br>**FOSAMAX TABS AND PLUS D[3]** | Use PA Form# 20420<br>1. Approval only requires failure of Alendronate or Boniva.<br><br>2. Quantity limits apply, please see dosage consolidation list.<br><br>3. Please use Alendronate and Vitamin D.<br><br>4. Please use other preferred agents. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| **CALCIMIMETIC AGENTS** | | | | | | | | |
| **CALCIMIMETIC AGENTS** | | | | 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. |
| **GROWTH HORMONE** | | | | | | | | |
| **GROWTH HORMONE** | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | GENOTROPIN[1]<br>NUTROPIN[1]<br>NUTROPIN AQ[1]<br>NORDITROPIN CARTRIDGE SOLN[1] | MC<br>MC/DEL<br>MC<br>MC<br>MC | 5<br>5<br>8<br>8<br>8 | OMNITROPE<br>TEV-TROPIN<br>HUMATROPE SOLR[2]<br>INCRELEX[2]<br>SAIZEN SOLR[2] | Use PA Form# 10710<br>1.Clinical PA is required to establish diagnosis and medical necessity.<br><br>2. Products must be used in specified step order. All step 5's must be tried prior to moving to step 8's. | See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied. |

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| SOMATOSTATIC AGENTS | MC/DEL | | OCTREOTIDE INJ | MC/DEL | | SANDOSTATIN<br>SOMATULINE | Use PA Form# 10710 | |
| **GROWTH HORMONE ANTAGONISTS** | | | | | | | | |
| GH ANTAGONISTS | | | | MC | | SOMAVERT | Use PA Form# 10710 | Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatin. |
| **VASOPRESSIN RECEPTOR ANTAGONIST** | | | | | | | | |
| VASOPRESSIN RECEPTOR ANTAGONIST | | | | MC/DEL | | SAMSCA | Use PA Form# 20420 | |
| **URINARY INCONTINENCE** | | | | | | | | |
| VASOPRESSINS | | | DESMOPRESSIN TABS | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL | 5<br>6<br>6<br>8<br>8 | DDAVP TABS<br>DDAVP SOLN[1]<br>DESMOPRESSIN SPRAY[1]<br>DESMOPRESSIN ACETATE SOLN[1]<br>STIMATE SOLN[1,2] | 1. Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP.<br>2. Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization.<br>Use PA Form# 20420 | Approved for central diabetes insipidus and for nocturnal enuresis. For nocturnal enuresis- must be over 6 years old, must fail an adequate trial of alarm training (higher success rate, lower relapse rate) and must periodically attempt weaning (at 6 month intervals). |
| ANTISPASMODICS | MC/DEL<br>MC | | **OXYBUTYNIN**<br>URISPAS TABS | MC/DEL<br>MC/DEL | | **DETROL TABS**<br>**DITROPAN** | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTISPASMODICS - LONG ACTING | MC/DEL<br>MC<br>MC/DEL<br>MC | | **OXYBUTYNIN ER TABS**<br>SANCTURA<br>TOVIAZ<br>VESICARE[1] | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC | 8<br>8<br>8<br>8<br>9<br>9 | ENABLEX[1,3]<br>DITROPAN XL TBCR<br>**OXYTROL**<br>TROSPIUM<br>DETROL LA CP[2]<br>SANCTURA XR[2] | Use PA Form# 20420<br>1. See Criteria Section.<br>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.<br>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.<br>1. Vesicare 5mg and Enablex 7.5mg maximum doses if given with drugs known to be significant CYP3A4 inhibitors.(Ketoconazole, Sporanox, Erythromycin, Fluconazole, Biaxin, Nefazodone, Nelfinavir, and Ritonavir)<br>**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 | | **URECHOLINE** | | | | 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<br>MC/DEL<br>MC/DEL | | **DIGITEK TABS**<br>**DIGOXIN**<br>**LANOXIN** | | | | Use PA Form# 20420 | |
| ANTIANGINALS--Isosorbide Di-nitrate/ Mono-Nitrates | MC/DEL<br>MC/DEL | | **ISOSORBIDE MONONITRATE TABS**<br>**ISOSORBIDE MONONITRATE ER** | MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC | | DILATRATE SR CPCR<br>ISORDIL TABS<br>**ISORDIL TITRADOSE TABS**<br>ISOSORBIDE DINITRATE SUBL<br>**ISOSORBIDE DINITRATE TABS**<br>ISOSORBIDE DINITRATE CR TBCR<br>**ISOSORBIDE DINITRATE ER TBCR**<br>ISOSORBIDE DINITRATE TD TBCR<br>**IMDUR TB24**<br>ISMO TABS<br>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. |

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| **NITRO - OINTMENT/CAP/CR** | MC | | NITROBID OINT | | | | [Use PA Form# 20420](#) | |
| | MC/DEL | | **NITROGLYCERIN CPCR** | | | | | |
| | MC | | NITROL OINT | | | | | |
| | MC | | NITRO-TIME CPCR | | | | | |
| **NITRO - PATCHES** | MC/DEL | 1 | **NITROGLYCERIN PT24[1]** | MC | | NITRODISC 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. Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | **NITREK PT24[1]** | MC/DEL | | **NITRO-DUR PT24** | | |
| | MC/DEL | 1 | **NITRO-DUR PT 24 0.8MG[1]** | | | | | |
| | MC/DEL | 3 | **MINITRAN PT24[1]** | | | | | |
| **NITRO - SUBLINGUAL/ SPRAY** | MC/DEL | | **NITROSTAT SUBL** | MC/DEL | | **NITROQUICK SUBL** | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC/DEL | | **NITROTAB SUBL** | MC | | NITROLINGUAL SOLN | | |
| | | | | MC | | NITROLINGUAL TABS | | |
| **BETA BLOCKERS - NON SELECTIVE** | MC | | CARVEDILOL | MC/DEL | | **BETAPACE TABS** | 1. Recommend using BID since its effects do not last 24 hours.<br>2. Please use other strengths in combination to obtain this dose.<br>3. Dosing limits still apply. Please see dose consolidation list<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | | LEVATOL TABS | MC | | **BETAPACE AF TABS** | | |
| | MC/DEL | | **NADOLOL TABS** | MC/DEL | | **COREG CR[3]** | | |
| | MC/DEL | | **PINDOLOL TABS** | MC/DEL | | **COREG TABS** | | |
| | MC/DEL | | **PROPRANOLOL HCL SOLN[1]** | MC/DEL | | **CORGARD TABS** | | |
| | MC/DEL | | **PROPRANOLOL HCL TABS[1]** | MC/DEL | | **INDERAL TABS** | | |
| | MC/DEL | | **PROPRANOLOL LA CAPS** | MC/DEL | | **INDERAL LA CPCR** | | |
| | MC/DEL | | SOTALOL HCL TABS | MC | | INNOPRAN XL | | |
| | MC/DEL | | **TIMOLOL MALEATE TABS** | MC/DEL | | **PROPRANOLOL HCL 60MG TABS[2]** | | |
| | | | | MC/DEL | | SOTALOL AF | | |
| | | | | MC | | RANEXA | | |
| **BETA BLOCKERS - CARDIO SELECTIVE** | MC/DEL | | **ACEBUTOLOL HCL CAPS** | MC/DEL | | BYSTOLIC | 1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours.<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | | **ATENOLOL TABS[1]** | MC | | KERLONE TABS | | |
| | MC | | BETAXOLOL HCL TABS | MC/DEL | | **LOPRESSOR TABS** | | |
| | MC/DEL | | **BISOPROLOL FUMARATE TABS** | MC | | SECTRAL CAPS | | |
| | MC/DEL | | **METOPROLOL TARTRATE TABS[1]** | MC/DEL | | **TENORMIN TABS** | | |
| | MC/DEL | | **METOPROLOL ER** | MC/DEL | | **TOPROL XL TB24** | | |
| | | | | MC/DEL | | **ZEBETA TABS** | | |
| **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. |
| **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.<br>Use PA Form# 20420 | |
| | MC | 1 | DILTIA XT CP24 | MC | 5 | DILACOR XR CP24[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.<br>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.<br>**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 | 1 | **DILTIAZEM HCL ER CP24** | MC | 6 | TAZTIA[1] | | |
| | MC/DEL | 1 | **DILTIAZEM HCL XR CP24** | MC/DEL | 7 | **TIAZAC CP24[1]** | | |
| | MC/DEL | 1 | **DILTIAZEM CD 300MG CP24** | MC/DEL | 8 | **CARDIZEM TABS[1]** | | |
| | MC/DEL | 1 | **DILTIAZEM CD 360MG CP24** | MC/DEL | 8 | **CARDIZEM CD CP24[1]** | | |
| | MC | 4 | CARTIA XT CP24[1] | MC | 8 | CARDIZEM LA TB24[1] | | |
| | MC/DEL | 4 | **DILTIAZEM CD CP24[1]** | MC | 8 | CARDIZEM SR CP12[1] | | |
| | MC/DEL | 4 | **DILTIAZEM HCL ER CP24[1]** | MC/DEL | 8 | **DILTIAZEM HCL TABS[1]** | | |
| | MC/DEL | 4 | **DILTIAZEM XR CP24[1]** | MC/DEL | 8 | **DILTIAZEM HCL ER CP12[1]** | | |
| | | | | MC/DEL | | **PLENDIL TB24** | Use PA Form# 20420 | Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | | | | MC/DEL | | **FELODIPINE** | | |
| | | | | MC | | DYNACIRC CAPS | Use PA Form# 20420<br>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 | | DYNACIRC CR TBCR[1] | | |
| | | | | MC/DEL | | **CARDENE SR CPCR** | 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 | | **NICARDIPINE HCL CAPS** | | |
| | MC/DEL | | **AFEDITAB CR** | MC | | ADALAT CC TBCR[1] | 1. Established users of Adalat CC are grandfathered. | Preferred drug must be tried and failed in step order due to lack of efficacy or intolerable side effects before non-preferred drugs in step order will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC/DEL | | **NIFEDIAC CC** | MC/DEL | | **NIFEDIPINE CAPS** | | |
| | MC/DEL | | **NIFEDICAL XL TBCR** | MC | | PROCARDIA CAPS | | |

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| | MC/DEL | | **NIFEDIPINE TBCR** | MC/DEL | | **PROCARDIA XL TBCR** | Use PA Form# 20420 | |
| | MC/DEL | | **NIFEDIPINE ER TBCR** | | | | | |
| | | | | MC | | SULAR TB24 | 1. Established users of 10MG and 20MG strengths are grandfathered. | |
| | | | | MC | | SULAR CR[1] | Use PA Form# 20420 | |
| | MC/DEL | 1 | **VERAPAMIL HCL CR TBCR** | MC/DEL | | **CALAN TABS** | Products must be used in specified order or PA will be required. Just write "Verapamil 24-hour" and the pharmacy will use a preferred long acting generic that does not require PA. | 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. |
| | MC/DEL | 1 | **VERAPAMIL HCL ER TBCR** | MC/DEL | | **CALAN SR TBCR** | | |
| | MC/DEL | 1 | **VERAPAMIL HCL SR TBCR** | MC/DEL | | **COVERA-HS TBCR** | | |
| | | | | MC | | ISOPTIN-SR | | |
| | | | | MC/DEL | | VERAPAMIL HCL ER CP24 | | |
| | | | | MC | | VERAPAMIL HCL SR CP24 | | |
| | | | | MC | | VERAPAMIL HCL TABS | | |
| | | | | MC | | VERELAN CP24 | | |
| | | | | MC | | VERELAN PM CP24 | Use PA Form# 20420 | |
| **ANTIARRHYTHMICS** | MC/DEL | | **AMIODARONE** | MC/DEL | | **CORDARONE** | 1. Prescription must be written by Cardiologist. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | | **FLECAINIDE** | MC/DEL | | **DISOPYRAMIDE** | | |
| | MC/DEL | | **MEXILETINE** | MC/DEL | | **PACERONE** | | |
| | MC/DEL | | MULTAQ | MC | | QUINIDEX | | |
| | MC/DEL | | **NORPACE** | MC/DEL | | TAMBOCOR | | **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. |
| | MC/DEL | | **PROCAINAMIDE** | MC/DEL | | TIKOSYN[1] | Use PA Form# 20420 | |
| | MC/DEL | | **PROPAFENONE** | MC | | RYTHMOL SR | | |
| | MC | | QUINAGLUTE | MC | | RYTHMOL | | **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. |
| | MC/DEL | | **QUINIDINE GLUCONATE** | | | | | |
| | MC/DEL | | **QUINIDINE SULFATE** | | | | | |
| **ACE INHIBITORS** | MC/DEL | | **BENAZEPRIL HCL** | MC | 5 | MAVIK TABS | 1. Non-preferred products must be used in specified order. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception. |
| | MC/DEL | | **CAPTOPRIL TABS** | MC/DEL | 5 | **ACCUPRIL TABS** | | |
| | MC/DEL | | **ENALAPRIL MALEATE TABS** | MC/DEL | 8 | **ACEON TABS**[1] | Use PA Form# 20420 | |
| | MC/DEL | | **FOSINOPRIL SODIUM** | MC/DEL | 8 | **ALTACE CAPS**[1] | | |
| | MC/DEL | | **LISINOPRIL TABS** | MC/DEL | 8 | **LOTENSIN TABS**[1] | | |
| | MC/DEL | | **RAMIPRIL** | MC/DEL | 8 | **MOEXIPRIL**[1] | | |
| | MC/DEL | | **QUINAPRIL** | MC | 8 | **MONOPRIL HCT TABS**[1] | | |
| | | | | MC/DEL | 8 | **PRINIVIL TABS**[1] | | |
| | | | | MC/DEL | 8 | **UNIVASC**[1] | | |
| | | | | MC | 8 | VASOTEC TABS[1] | | |
| | | | | MC/DEL | 8 | **ZESTRIL TABS**[1] | | |
| **ANGIOTENSIN RECEPTOR BLOCKER** | MC | | AVAPRO[1] | MC/DEL | 8 | **ATACAND TABS** | Use PA Form# 20420<br>1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.<br>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. |
| | MC/DEL | | **BENICAR TABS**[1] | MC/DEL | 8 | **COZAAR** | | |
| | MC/DEL | | **DIOVAN**[1] | MC/DEL | 8 | EDARBI | | |
| | MC/DEL | | LOSARTAN[1] | MC | 8 | TEVETEN TABS | | |
| | MC/DEL | | **MICARDIS TABS**[1] | MC/DEL | 8 | TRIBENZOR[2] | | |
| **DIRECT RENIN INHIBITOR** | | | | MC/DEL | | AMTURNIDE | 1. Must show failure of single and combination therapy from all preferred antihypertensive categories.<br>Use PA Form# 20420 | |
| | | | | MC/DEL | | TEKTURNA[1] | | |
| | | | | MC/DEL | | TEKAMLO | | |
| **ANTIHYPERTENSIVES - CENTRAL** | MC/DEL | | **CATAPRES-TTS** | MC/DEL | | **CATAPRES 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 | | **CLONIDINE HCL TABS** | MC/DEL | | CLONIDINE TTS | | |
| | MC/DEL | | **GUANFACINE HCL TABS** | MC | | GUANABENZ ACETATE TABS | | |
| | MC/DEL | | **HYDRALAZINE HCL TABS** | MC | | ISMELIN TABS | | |
| | MC | | HYLOREL TABS | MC | | MINIPRESS CAPS | | |
| | MC/DEL | | **METHYLDOPA TABS** | MC | | **NEXICLON** | | |
| | MC/DEL | | **MINOXIDIL TABS** | MC/DEL | | **TENEX TABS** | | |
| | MC/DEL | | **PRAZOSIN HCL CAPS** | | | | | |
| | MC/DEL | | **RESERPINE TABS** | | | | | |

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|---|---|---|---|---|---|---|---|---|
| ACE INHIBITORS AND CA CHANNEL BLOCKERS | | | | MC/DEL<br>MC<br>MC/DEL | 8<br>8<br>9 | **LOTREL CAPS**<br>TARKA TBCR<br>**AMLODIPINE/BENAZEPRIL** | Use individual preferred generic medications.<br><br>Use PA Form# 20420 | |
| ACE AND THIAZIDE COMBO'S | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | **BENAZEPRIL HCL/HYDROCHLOR**<br>**CAPTOPRIL/HYDROCHLOROTHIA**<br>**ENALAPRIL MALEATE/HCTZ TABS**<br>**LISINOPRIL-HCTZ TABS**<br>**LOTENSIN HCT TABS** | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL | | **ACCURETIC TABS**<br>MONOPRIL HCT TABS<br>**PRINZIDE TABS**<br>**UNIRETIC TABS**<br>VASERETIC TABS<br>**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<br>MC/DEL<br>MC/DEL | | **ATENOLOL/CHLORTHALIDONE**<br>**BISOPROLOL FUMARATE/HCTZ**<br>**PROPRANOLOL/HCTZ** | MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL | | CORZIDE TABS<br>**LOPRESSOR HCT TABS**<br>TENORETIC<br>TIMOLIDE 10/25 TABS<br>**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<br>MC/DEL<br>MC/DEL | | **AZOR**[1]<br>**EXFORGE**[1]<br>**EXFORGE HCT**[1] | MC/DEL | | **TWYNSTA** | 1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.<br><br>Use PA Form# 20420 | |
| ARB'S AND DIURETICS | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | **AVALIDE TABS**[1]<br>BENICAR HCT[1]<br>DIOVAN HCT TABS[1]<br>LOSARTAN HCT[1]<br>MICARDIS HCT TABS[1] | MC/DEL<br>MC/DEL<br>MC | | **ATACAND HCT TABS**<br>HYZAAR TABS<br>TEVETEN HCT TABS | 1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.<br><br>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. |
| ARB'S AND DIRECT RENIN INHIBITOR COMBINATION | MC/DEL | | **VALTURNA** | | | | Use PA Form# 20420 | |
| DIURETICS | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC | | **ACETAZOLAMIDE TABS**<br>**BUMETANIDE**<br>**CHLOROTHIAZIDE TABS**<br>**CHLORTHALIDONE TABS**<br>EDECRIN TABS<br>**FUROSEMIDE**<br>**HYDROCHLOROTHIAZIDE**<br>**INDAPAMIDE TABS**<br>**METHAZOLAMIDE TABS**<br>**METHYCLOTHIAZIDE TABS**<br>**SPIRONOLACTONE 25MG TABS**<br>**SPIRONOLACTONE/HYDRO**<br>**TORSEMIDE TABS**<br>**TRIAMTERENE/HCTZ**<br>ZAROXOLYN TABS | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL | | **ALDACTAZIDE TABS**<br>**ALDACTONE TABS**<br>AMILORIDE HCL<br>**BUMEX TABS**<br>**DEMADEX TABS**<br>**DIAMOX**<br>**DIURIL**<br>**DYAZIDE CAPS**<br>ENDURON TABS<br>INSPRA<br>**LASIX TABS**<br>**MAXZIDE**<br>MICROZIDE CAPS<br>**MIDAMOR TABS**<br>NAQUA TABS<br>**SPIRONOLACTONE 50MG**[1] | 1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra will be approved for severe breast tenderness and male gynecomastia.<br><br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| CCB / LIPID | MC/DEL | | **CADUET** | | | | | |
| **LIPID DRUGS** | | | | | | | | |
| CHOLESTEROL - BILE SEQUESTRANTS | MC/DEL<br>MC/DEL | | **CHOLESTYRAMINE**<br>**COLESTIPOL HCI** | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL | | **COLESTID**<br>**PREVALITE**<br>**QUESTRAN**<br>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/DEL<br>MC/DEL<br>MC<br>MC | | **GEMFIBROZIL TABS**<br>NIASPAN<br>TRICOR<br>TRILIPIX | MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC | | ANTARA<br>LOPID<br>FIBRICOR<br>LIPOFEN<br>LOFIBRA<br>FENOFIBRATE<br>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.<br>**DDI:** Fenofibrate is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with Warfarin.<br>**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 + | MC/DEL | | **LIPITOR** | MC/DEL | | **CRESTOR** | 1. Dosing limits apply, | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered |

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| ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS | MC/DEL | | SIMVASTATIN[1] | MC<br>MC/DEL<br>MC/DEL | | VYTORIN[2]<br>ZOCOR<br>SIMVASTATIN 80MG[1,3] | please see dosage consolidation list.<br>2. Only available if component ingredients are unavailable.<br>3. Current users grandfathered.<br>Use PA Form# 20420 | on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.<br>**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.<br>**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.<br>**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<br>MC/DEL<br>MC/DEL<br>MC/DEL | | LESCOL CAPS<br>LESCOL XL TB24<br>LOVASTATIN TABS[2]<br>PRAVASTATIN[2] | MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC | 8<br>8<br>8<br>8<br>8<br>8 | ALTOPREV TB24<br>LIVALO<br>MEVACOR TABS<br>PRAVACHOL TABS<br>PRAVIGARD<br>ZETIA TABS[1] | 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.<br>2. Dosing limits apply, please see dosage consolidation list.<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.<br>**DDI:** Lescol will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac.<br>**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.<br>**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.<br>**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/DEL<br>MC/DEL | | SIMCOR<br>ADVICOR TBCR | | | | Use PA Form# 20420 | |
| **PULMONARY ANTI-HYPERTENSIVES** | | | | | | | | |
| PULMONARY ANTI-HYPERTENSIVES | MC/DEL<br>MC<br>MC/DEL | | REVATIO[1]<br>VENTAVIS[2]<br>EPOPROSTENOL INJ[4] | MC<br>MC/DEL<br>MC | | ADCIRCA<br>FLOLAN<br>REMODULIN[3] | 1. See Criteria Section.<br>2. See Criteria Section.<br>3. There will be dosing limits of one 20ml multidose vial/ 30 days supply without pa.<br>4. PA is required to establish and conferm who group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 & 4.<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significat potential drug interation between another drug and the preferred drug(s) exists.<br>1. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2,3, or 4.<br>2. Ventavis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4. |
| ERA / ENDOTHELIN RECEPTOR ANTAGONIST | MC | | LETAIRIS[1,2] | MC | | TRACLEER[3,4] | 1. Providers must be registered with LEAP Prescribing program, a restricted distribution program.<br>2. Clinical PA is required to establish diagnosis and medical necessity.<br>3. 1. Prior trial of Letaris, WHO Group 1 diagnosis of PAH (Primary Pulmonary Hypertension) and NYHA functional class of 3.<br>4. For members with NYHA functional class of 4, Tracleer approval will be allowed with confirmation of diagnosis and functional class.<br>Use PA Form# 20420 | Tracleer approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4.<br>**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.<br>Letairis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and functional class 2 or 3 symptoms. |
| **IMPOTENCE AGENTS** | | | | | | | | |

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| **IMPOTENCE AGENTS** | | | | | | | As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered. | As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered. |
| **ANTI-EMETOGENICS** | | | | | | | | |
| **ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC** | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC | | MECLIZINE HCL TABS<br>PROMETHAZINE SUPP<br>PROMETHAZINE<br>TRANSDERM-SCOP PT72 | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC | | ANTIVERT TABS<br>PHENERGAN SOLN<br>PROMETHAZINE 50MG SUPP<br>PROMETHEGAN SUPP<br>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<br>MC<br>MC<br>MC | | MARINOL CAPS<br>ONDANSETRON TABS[2,4]<br>ONDANSETRON ODT TBDP[2,4]<br>ONDANSETRON INJ[2,4] | MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC | 5<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8 | GRANISETRON<br>ALOXI<br>ANZEMET TABS<br>CESAMET[1]<br>EMEND[3]<br>KYTRIL<br>SANCUSO<br>ZOFRAN ODT TBDP[4]<br>ZOFRAN TABS[4]<br>ZOFRAN INJ[4]<br>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.<br><br>2. Ondansetron will be preferred with CA diag and dosing limits still apply.<br><br>3. Clinical PA is required for members on highly emetic anti-neoplastic agents.<br><br>4. Dosing limits apply, please see Dosage Consolidation List<br><br>Use PA Form# 20610 for **Ondansetron** requests<br><br>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. |
| **NON-SEDATING ANTIHISTAMINES / DECONGESTANTS** | | | | | | | | |
| **ANTIHISTIMINES - NON-SEDATING** | MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL | | ALAVERT TABS<br>CETIRIZINE TABS<br>CLARITIN (OTC)<br>CLARITIN SYRP (OTC)<br>LORATADINE<br>TAVIST ND (OTC) | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | 5<br>5<br>5<br>5<br>5<br>8<br>8<br>8<br>8 | CLARINEX TABS[1]<br>CLARINEX SYR[1,2]<br>FEXOFENADINE[1]<br>ZYRTEC[1]<br>ZYRTEC SYR[1,2]<br>ALLEGRA[3]<br>CLARITIN[3]<br>LORATADINE ODT[4]<br>XYZAL[3] | 1. Must fail preferred drugs, OTC loratidine and cetirizine before moving to non-preferred step order drugs.<br><br>2. Clarinex and Zyrtec syrp <6 yr w/o PA.<br><br>3. Must fail all step 5 drugs (Clarinex, Fexofenadine and Zyrtec) before moving to next step product.<br><br>4. All OTC versions of loratadine ODT are now non-preferred.<br><br>Pseudoephedrine is available with prescription.<br><br>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.<br><br>Pseudoephedrine is available with prescription. |
| **ANTIHISTIMINES - OTHER** | MC/DEL<br>MC/DEL<br>MC/DEL | | CLEMASTINE<br>CHLORPHENIRAMINE<br>DIPHENHYDRAMINE | | | | Use PA Form# 20530 | |

| ALLERGY / ASTHMA THERAPIES | | | | | | | | |
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| ANTIASTHMATIC - ANTICHOLINERGICS - INHALER | MC/DEL | | SPIRIVA[1,2] | | | | Use PA Form# 20420<br>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.<br>2. We ask physicians to write "asthma" on the prescription whenever Sprivia is primarily being used for that condition. | |
| ANTIASTHMATIC - PHOSPHODIESTERASE 4 INHIBITORS | | | | MC/DEL | | DALIRESP | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER | MC/DEL | | **IPRATROPIUM BROMIDE SOLN** | MC | | ATROVENT SOLN | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS | MC/DEL | | CROMOLYN SODIUM NEBU | MC/DEL | | XOLAIR[1] | 1. Need max inhaled steroids and written by pulmonary or allergy specialist<br>Use PA Form# 20420 | Xolair approval will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management. |
| ANTIASTHMATIC - NASAL STEROIDS | MC<br>MC/DEL | | FLUTICASONE SPR[3]<br>NASONEX SUSP[3] | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL | 5<br>5<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8 | BECONASE AQ INHA[1,3]<br>NASACORT AQ AERS[1,3]<br>FLONASE SUSP[2,3]<br>FLUNISOLIDE SOLN[2,3]<br>NASACORT AERS[2,3]<br>OMNARIS SPR[3]<br>RHINOCORT AERO[2,3]<br>RHINOCORT AQUA SUSP[2,3]<br>TRI-NASAL SOLN[2,3]<br>VANCENASE POCKETHALER AERS[2,3]<br>VERAMYST[2,3] | Use PA Form# 20420<br>1. All preferred drugs must be tried before moving to non preferred steps.<br>2. All step 5 medications need to be tried before moving to step 8's.<br>3. Dosing limits apply to whole category, please see dosage consolidation list. | 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. |
| ANTIASTHMATIC - NASAL MISC. | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | CROMOLYN NASAL 4%<br>NASALCROM<br>OCEAN 0.65%<br>SALINE NASAL SPRAY 0.65% | MC<br>MC<br>MC/DEL<br>MC/DEL | 7<br>7<br>7<br>8 | ATROVENT NASAL SOL<br>IPRATROPIUM NASAL SOL[1]<br>ASTELIN<br>ASTEPRO[2] | Use PA Form# 20420<br>1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine.<br>2. Utilize Multiple preferred, as well as step therapy Astelin. | Approved if patient fails on nonsedating antihistamines and steroid nasal sprays.<br>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - BETA - ADRENERGICS | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | **ALBUTEROL NEB**<br>**MAXAIR**<br>**METAPROTERENOL**<br>**PROAIR HFA[3]**<br>**PROVENTIL HFA**<br>**SEREVENT**<br>**TERBUTALINE SULFATE TABS**<br>**VENTOLIN HFA AERS[3]** | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL | | **ACCUNEB NEBU**<br>**ALBUTEROL AER**<br>**ALBUTEROL HFA**<br>**ALBUTEROL 0.63mg/3ml**<br>**BRETHINE**<br>**FORADIL AEROLIZER CAPS**<br>**VENTOLIN AERS**<br>VOLMAX TBCR<br>VOSPIRE ER TB12<br>**XOPENEX HFA[3]**<br>**XOPENEX NEBU[1,2]** | 1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered.<br>2. Quantity Limit: 12 cc/day.<br>3. Dosing limits apply, please see dosage consolidation list.<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - ADRENERGIC COMBINATIONS | MC/DEL<br>MC/DEL | | **ADVAIR DISKUS/HFA[1,2]**<br>DULERA | | | | 1. We ask physicians to write "asthma" on the prescription whenever | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | MC/DEL | | SYMBICORT[2] | | | | prescription whenever Advair is primarily being used for that condition.<br>2. Dosing limits apply, please see dosage consolidation list.<br>Use PA Form# 20420 | |
| **ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC** | MC/DEL<br>MC/DEL | | **ALBUTEROL/IPRATROPIUM NEB. SOLN**<br>**COMBIVENT AERO[2]** | MC/DEL | | DUONEB SOLN[1] | 1. Please use preferred individual ingredients Albuterol and Ipratropium.<br>2. We ask physicians to write "asthma" on the prescription whenever Combivent is primarily being used for that condition.<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Duoneb components are available separately without PA. |
| **ANTIASTHMATIC - XANTHINES** | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | **AMINOPHYLLINE TABS**<br>THEOCHRON TB12<br>THEOLAIR-SR TB12<br>**THEOPHYLLINE CR TB12**<br>THEOPHYLLINE ELIX<br>THEOPHYLLINE SOLN<br>**THEOPHYLLINE ER CP12**<br>**THEOPHYLLINE ER TB12** | MC/DEL<br>MC<br>MC/DEL | | **THEO-24 CP24**<br>THEOLAIR TABS<br>**UNIPHYL 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. |
| **ANTIASTHMATIC - STEROID INHALANTS** | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC | | ASMANEX[4]<br>**FLOVENT DISKUS[4]**<br>**FLOVENT HFA[4]**<br>**PULMICORT SUSP[1,4]**<br>QVAR AERS[4] | MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL | 5<br>5<br>5<br>8<br>8<br>8<br>8 | **AEROBID AERS[2,4]**<br>BECLOVENT AERS[2,4]<br>VANCERIL AERS[2,4]<br>**AEROBID-M AERS[3,4]**<br>ALVESCO[4]<br>VANCERIL DOUBLE STRENGTH AERS[3,4]<br>**PULMICORT FLEXHALER[4]** | 1. No PA for Pulmicort susp if under 8 years old.<br>2. All preferreds must be tried before moving to non preferred steps.<br>3. All step 5 medications need to be tried before moving to step 8's.<br>4. Dosing limits apply to whole category, please see dosage consolidation list.<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| **ANTIASTHMATIC - 5-Lipoxygenase Inhibitors** | | | | MC | | **ZYFLO CR TABS** | Use PA Form# 20420 | Other Preferred asthma controller drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| **ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS** | MC/DEL | | **SINGULAIR** | MC/DEL | | **ACCOLATE TABS** | Use PA Form# 20420 | |
| **ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR** | | | | MC<br>MC<br>MC | | GLASSIA<br>PROLASTIN SUSR<br>ZEMAIRA | Use PA Form# 20420 | Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema. |
| **ANTIASTHMATIC - HYDRO-LYTIC ENZYMES** | | | | MC/DEL | | PULMOZYME SOLN | Use PA Form# 20420 | Will be approved for cystic fibrosis patients. |
| **ANTIASTHMATIC - MUCOLYTICS** | MC/DEL | | ACETYLCYSTEINE[1] | MC | | MUCOMYST | 1. Acetylcysteine is covered with diagnosis of CF.<br>Use PA Form# 20420 | |
| **COUGH/COLD** | | | | | | | | |
| **COUGH/COLD** | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC | | DEXTRO-GUAIF SYRP[1]<br>GUAIFENESIN SYRP[1]<br>PSEUDOEPHEDRINE[1]<br>ROBITUSSIN DM SYRP[1] | | | | 1. All of cough cold preparations are not covered except these preferred products. | All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy. |

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|---|---|---|---|---|---|---|---|---|
| | MC | | ROBITUSSIN SUGAR FREE SYRP[1] | | | | Use PA Form# 20420 | |
| **DIGESTIVE AIDS / ASSORTED GI** | | | | | | | | |
| **GI - ANTIPERISTALTIC AGENTS** | MC/DEL | | DIPHENOXYLATE | MC/DEL | | LOFENE TABS | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval. |
| | MC/DEL | | DIPHENOXYLATE/ATROPINE | MC | | LONOX TABS | | |
| | MC/DEL | | LOPERAMIDE HCL CAPS/LIQ | MC/DEL | | MOTOFEN TABS | | |
| | MC/DEL | | OPIUM TINCTURE TINC | | | | | |
| | MC | | PAREGORIC TINC | | | | | |
| **GI - ANTI-DIARRHEAL/ ANTACID - MISC.** | MC/DEL | | ATROPINE SULFATE SOLN | MC | | BELLADONNA ALKALOIDS & OP | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval** . |
| | MC/DEL | | BENTYL SYRP | MC/DEL | | BENTYL TABS | | |
| | MC/DEL | | BISMATROL | MC/DEL | | GLYCOPYRROLATE INJ | | |
| | MC/DEL | | BISMUTH SUBSALICYLATE | MC/DEL | | HYOSCYAMINE SL | | |
| | MC/DEL | | CALCIUM CARBONATE (ANTACID) CHEW | MC/DEL | | LEVBID TB12 | | |
| | MC/DEL | | DICYCLOMINE HCL | MC | | LEVSIN ELIX | | |
| | MC/DEL | | GLYCOPYRROLATE TABS | MC/DEL | | LEVSIN TABS | | |
| | MC | | HAPONAL TABS | MC/DEL | | LEVSIN/SL SUBL | | |
| | MC/DEL | | HYOSCYAMINE CAPS & TABS | MC/DEL | | NULEV TBDP | | Preferred products that used to require diag codes still require diag codes unless indicated otherwise. |
| | MC/DEL | | HYOSCYAMINE SULFATE | MC | | ROBINUL INJ | | |
| | MC/DEL | | KAOPECTATE | MC | | ROBINUL TABS | | |
| | MC/DEL | | MAGNESIUM OXIDE TABS | | | | | |
| | MC | | MAG-OX 400 TABS | | | | | |
| | MC/DEL | | PAMINE TABS | | | | | |
| | MC/DEL | | PROPANTHELINE BROMIDE TABS | | | | | |
| | MC/DEL | | SAL-TROPINE TABS | | | | | |
| | MC | | SCOPOLAMINE HYDROBROMIDE | | | | | |
| | MC/DEL | | SODIUM BICARBONATE TABS | | | | | |
| | MC/DEL | | TUMS | | | | | |
| **GI - H2-ANTAGONISTS** | MC/DEL | | CIMETIDINE | MC | | AXID CAPS | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC/DEL | | FAMOTIDINE | MC | | AXID AR TABS | | |
| | MC/DEL | | RANITIDINE | MC/DEL | | NIZATIDINE CAPS | | |
| | MC/DEL | | RANITIDINE SYRP | MC/DEL | | PEPCID | | |
| | MC | | ACID REDUCER TABS | MC | | PEPCID AC | | **DDI:** Ranitidine and cimetidine will now be non-preferred and require prior authorization if it is currently being used with any sulfonylurea (except for glyburide). |
| | | | | MC/DEL | | ZANTAC SYRP | | |
| | | | | MC/DEL | | ZANTAC TABS | | **DDI:** Cimetidine will require prior authorization if being used in combination with Plavix. |
| **GI - PROTON PUMP INHIBITOR** | MC/DEL | | DEXILANT (KAPIDEX)[2] | MC | 6 | PRILOSEC OTC[4] | 1. Prevacid Solutabs available without PA for children less than 9 years old.<br><br>2. Dosing limits apply, please see dosage consolidation list.<br><br>3. Please use multiple 20mg Capsules to obtain required dose.<br><br>4. All preferreds and step therapy must be tried and failed.<br><br>5.Established users prior to 10/1/09 may continue to obtain Prevacid until 12/31/09.<br><br>Use PA Form# 20720 | All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.<br><br>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.<br>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:<br>1. Barrett's esophagus.<br>2. Erosive esophagitis<br>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.<br><br>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.<br><br>**DDI:** Omeprazole will require prior authorization if being used in combination with Plavix.<br><br>**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.<br>**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. |
| | MC/DEL | | OMEPRAZOLE 20MG[2] | MC | 7 | ACIPHEX TBEC[4] | | |
| | MC/DEL | | PANTOPRAZOLE | MC/DEL | 8 | PREVACID CPDR[4,5] | | |
| | | | | MC/DEL | 8 | PREVACID SOLUTABS[1] | | |
| | | | | MC/DEL | 8 | NEXIUM CPDR[4] | | |
| | | | | MC/DEL | 8 | PRILOSEC CPDR | | |
| | | | | MC/DEL | 8 | PROTONIX INJ | | |
| | | | | MC/DEL | 8 | PROTONIX[2] | | |
| | | | | MC/DEL | 8 | OMEPRAZOLE 10MG[2] | | |
| | | | | MC | 8 | OMEPRAZOLE-SODIUM BICARBONATE CAPS | | |
| | | | | MC/DEL | 8 | LANSOPRAZOLE | | |
| | | | | MC | 9 | OMEPRAZOLE 40MG[3] | | |
| **GI - ULCER ANTI-INFECTIVE** | | | | MC | | HELIDAC | Use PA Form# 20420 | |
| | | | | MC | | PREVPAC | | |
| **GI - PROSTAGLANDINS** | MC | | MISOPROSTOL TABS | MC/DEL | | CYTOTEC TABS | Use PA Form# 20420 | Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

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| GI - DIGESTIVE ENZYMES | MC/DEL | | CREON[1] | MC/DEL | | LACTRASE CAPS | Use PA Form# 20420<br>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. | 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. |
| | MC/DEL | | LACTASE CHEW | MC/DEL | | LIPRAM | | |
| | MC/DEL | | LACTASE TAB | MC/DEL | | LIPRAM CR | | |
| | MC | | ZENPEP[1] | MC/DEL | | KU-ZYME CAPS | | |
| | | | | MC | | PANCREASE | | |
| | | | | MC | | PANOKASE TABS | | |
| | | | | MC | | TRIPASE | | |
| GI - ANTI - FLATULENTS / GI STIMULANTS | MC | | CALULOSE SYRP | MC/DEL | | AMITIZA[2] | 1. Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL<br>Use PA Form# 20420<br>2. Prior failed trials of multiple other preferred GI agents must occur first, Such as OTC senna, docusate, lactulose, polyethylene glycol. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | | CONSTULOSE SYRP | MC | | CEPHULAC SYRP | | |
| | MC/DEL | | ENULOSE SYRP | MC/DEL | | INFANTS GAS RELIEF SUSP | | |
| | MC | | GASTROCROM CONC | MC/DEL | | REGLAN TABS | | |
| | MC/DEL | | GENERLAC SYRP | | | | | |
| | MC/DEL | | LACTULOSE SYRP[1] | | | | | |
| | MC/DEL | | METOCLOPRAMIDE HCL | | | | | |
| | MC/DEL | | SIMETHICONE | | | | | |
| GI - INFLAMMATORY BOWEL AGENTS | MC/DEL | | ASACOL TBEC 400 | MC/DEL | | ASACOL 800MG HD | Use PA Form# 20420<br>1. Current users grandfathered.<br>2. Use multiple Pentasa 250mg. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | | APRISO | MC/DEL | | AZULFIDINE EN-TABS TBEC | | |
| | MC | | AZULFIDINE TABS | MC/DEL | | BALSALAZIDE | | |
| | MC | | CANASA SUPP | MC/DEL | | LIALDA TABS[1] | | |
| | MC | | COLAZAL CAPS | MC/DEL | | PENTASA 500MG[2] | | |
| | MC | | DIPENTUM CAPS | MC | | SFROWASA | | |
| | MC/DEL | | PENTASA CPCR 250MG | | | | | |
| | MC/DEL | | ROWASA ENEM | | | | | |
| | MC/DEL | | **SULFAZINE EC TBEC** | | | | | |
| | MC/DEL | | **SULFASALAZINE TABS** | | | | | |
| GI - IRRITABLE BOWEL SYNDROME AGENTS | | | | MC/DEL | | LOTRONEX 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. |
| **MISCELLANEOUS GI** | | | | | | | | |
| GI - MISC. | MC/DEL | | BISAC-EVAC SUPP | MC/DEL | | ACTIGALL CAPS | 1. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | | BISACODYL | MC | | BENEFIBER | | |
| | MC | | BISCOLAX SUPP | MC/DEL | | CARAFATE | | |
| | MC | | CINOBAC CAPS | MC/DEL | | CLEARLAX POW | | |
| | MC/DEL | | CITRATE OF MAGNESIA SOLN | MC/DEL | | COLACE CAPS | | |
| | MC/DEL | | CITRUCEL | MC/DEL | | COLYTE | | |
| | MC/DEL | | DIOCTO SYRP | MC | | DIOCTO-C SYRP | | |
| | MC | | DOCUSATE CALCIUM CAPS | MC | | DOC SOD /CAS CAP | | |
| | MC/DEL | | DOCUSATE SODIUM | MC | | DOC-Q-LAX CAPS | | |
| | MC/DEL | | FIBER LAXATIVE TABS | MC/DEL | | DOCUSATE SODIUM/CAS CAPS | | Preferred products that used to require diag codes still require diag codes unless indicated otherwise. |
| | MC | | FLEET | MC/DEL | | DOK PLUS | Use PA Form# 20420 | |
| | MC/DEL | | GENFIBER POWD | MC/DEL | | DULCOLAX SUPP | | |
| | MC/DEL | | GLYCERIN | MC | | FIBER CON TABS | | |
| | MC | | HIPREX TABS | MC/DEL | | FIBER-LAX TABS | | |
| | MC/DEL | | KRISTALOSE PACK | MC | | GOLYTELY SOLR | | |
| | MC | | MAALOX | MC | | MALTSUPEX | | |
| | MC | | METAMUCIL | MC | | MIRALAX PACK (OTC versions) | | |
| | MC/DEL | | MILK OF MAGNESIA SUSP | MC | | MIRALAX POWD (OTC versions) | | |
| | MC | | MINERAL OIL OIL | MC | | PEG 3350/ELECTROLYTES SOLR | | |
| | MC | | NULYTELY SOLR | MC/DEL | | SENEXON TABS | | |
| | MC/DEL | | SENNA | MC/DEL | | SENOKOT TABS | | |
| | MC/DEL | | SENOKOT GRAN | MC | | SENOKOT S TABS | | |
| | MC/DEL | | SENOKOT SYRP | MC | | STOOL SOFTENER PLUS CAPS | | |
| | MC/DEL | | SENOKOT CHILDRENS SYRP | MC/DEL | | UNI-CENNA TABS | | |
| | MC | | SENOKOT XTRA TABS | MC | | UNI-EASE PLUS CAPS | | |
| | MC/DEL | | SORBITOL | MC | | V-R NATURAL SENNA LAXATIV TABS | | |
| | MC/DEL | | STOOL SOFTENER CAPS | MC | | URSO 250 | | |

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|---|---|---|---|---|---|---|---|---|
| | MC/DEL | | SUCRALFATE TABS | | | | | |
| | MC | | UNI-EASE CAPS | | | | | |
| | MC | | UNIFIBER POWD | | | | | |
| | MC | | URSO FORTE | | | | | |
| | MC/DEL | | URSODIOL | | | | | |
| **MISC. UROLOGICAL** | | | | | | | | |
| **UROLOGICAL - MISC.** | MC | | ACETIC ACID 0.25% SOLN | MC | | CITRIC ACID/SODIUM CITRAT SOLN | 1. Elmiron requires adequate proof of Dx with supportive testing. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC | | CYTRA-K SOLN | MC/DEL | | CYTRA-2 SOLN | | |
| | MC | | FURADANTIN SUSP | MC | | ELMIRON CAPS[1] | | |
| | MC | | K-PHOS MF TABS | MC/DEL | | MACROBID CAPS | Use PA Form# 20420 | |
| | MC/DEL | | METHENAMINE MANDELATE TABS | MC/DEL | | MACRODANTIN CAPS | | |
| | MC/DEL | | MONUROL PACK | MC/DEL | | NITROFURANTOIN MACR CAPS | | |
| | MC/DEL | | NEOSPORIN GU IRRIGANT SOLN | MC | | POTASSIUM CITRATE/CITRIC SOLN | | |
| | MC/DEL | | PHENAZOPYRIDINE HCL TABS | MC/DEL | | PYRIDIUM PLUS TABS | | |
| | MC/DEL | | PHENAZOPYRIDINE PLUS | MC | | PYRIDIUM TABS | | |
| | MC/DEL | | PROSED/DS TABS | MC/DEL | | RENACIDIN SOLN | | |
| | MC | | TRICITRATES SYRP | | | | | |
| | MC/DEL | | URELIEF PLUS | | | | | |
| | MC | | UREX TABS | | | | | |
| | MC/DEL | | URISED TABS | | | | | |
| | MC | | UROCIT-K | | | | | |
| | MC/DEL | | UROQID #2 TABS | | | | | |
| **PHOSPHATE BINDERS** | | | | | | | | |
| **PHOSPHATE BINDERS** | MC | | PHOSLO[1] | MC/DEL | | RENAGEL 800 | Use PA Form# 20420 | |
| | MC/DEL | | MAGNEBIND - 400[1] | | | | 1. Diag required. | |
| | MC/DEL | | RENAGEL 400[1] | | | | | |
| | MC/DEL | | FOSRENOL[1] | | | | | |
| | MC/DEL | | RENVELA[1] | | | | | |
| **INTRA-VAGINALS** | | | | | | | | |
| **VAGINAL - ANTIBACTERIALS** | MC/DEL | 1 | CLEOCIN CREA | MC/DEL | | METROGEL VAGINAL GEL[2] | 1. Step order must be followed to avoid PA. Must fail Cleocin Cream and Metronidazole products before moving to next step product without PA. | Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC/DEL | 1 | METRONIDAZOLE VAGINAL GEL[2] | MC/DEL | | VANDAZOLE | 2. Dosing limits apply, please see Dosage Consolidation List. | |
| | MC/DEL | 3 | CLEOCIN SUPP[1] | | | | Use PA Form# 20420 | |
| **VAGINAL - ANTI FUNGALS** | MC/DEL | | CLOTRIMAZOLE CREA | MC | | AVC CREA | 1. Quantity limit: 1/script/2 weeks | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC/DEL | | GYNE-LOTRIMIN CREA | MC | | CLOTRIMAZOLE 3 DAY CREA | | |
| | MC | | MICONAZOLE CREA | MC | | GYNAZOLE-1 CREA | Use PA Form# 20420 | |
| | MC/DEL | | MICONAZOLE 3 COMBO PACK KIT[1] | MC | | GYNE-LOTRIMIN 3 TABS | | |
| | MC/DEL | | MICONAZOLE 7 CREA | MC/DEL | | MICONAZOLE 3 SUPP | | **DDI:** Miconazole will require prior authorization if being used in combination with Warfarin. |
| | MC/DEL | | MICONAZOLE NITRATE CREA | MC | | TERAZOL 3 CREA | | |
| | MC | | NYSTATIN TABS | MC | | TERAZOL 7 CREA | | |
| | MC | | TERAZOL 3 SUPP | MC/DEL | | TERCONAZOLE 0.8MG | | |
| | MC/DEL | | TERCONAZOLE 0.4MG | MC/DEL | | TERCONAZOLE SUPP | | |
| | MC | | VAGITROL | | | | | |
| | MC | | V-R MICONAZOLE-7 CREA | | | | | |
| **VAGINAL - CONTRACEPTIVES** | MC | | GYNOL II EXTRA STRENGTH GEL | MC | | DELFEN FOAM | Use PA Form# 20420 | Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| **VAGINAL - ESTROGENS** | MC/DEL | | **ESTRING RING** | MC/DEL | | ESTRACE CREA[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 | | **PREMARIN CREA** | MC/DEL | | VAGIFEM TABS[1] | Use PA Form# 20420 | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **VAGINAL - OTHER** | MC/DEL<br>MC<br>MC | | ACID JELLY GEL<br>ACI-JEL GEL<br>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<br>MC/DEL<br>MC/DEL<br>MC/DEL | | **DOXAZOSIN MESYLATE TABS**<br>FINASTERIDE[1]<br>TERAZOSIN HCL CAPS<br>**TAMSULOSIN** | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | 5<br>8<br>8<br>8<br>8<br>8<br>8 | **FLOMAX CP24**<br>AVODART[2,4]<br>**CARDURA TABS[4]**<br>JALYN[3,4]<br>PROSCAR TABS[4]<br>RAPAFLO[4]<br>UROXATRAL[4] | 1. There will be dosing limits of 1 tab per day with out PA.<br>2. Prior use of preferred agent prior to any approvals.<br>3. Use of preferred (tamsulosin and finasteride) and (tamsulosin and non-preferred Avodart).<br>4. Non-preferred products must be used in specified order.<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approval of a non-preferred 5-alpha reductase inhibitor requires objective clinical evidence of a very enlarged prostate rather than just the presence of obstructive urinary outflow symptoms along with adequate trial of preferred Proscar. |
| **ANXIOLYTICS** | | | | | | | | |
| **ANXIOLYTICS - BENZODIAZEPINES** | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | ALPRAZOLAM TABS<br>CHLORDIAZEPOXIDE HCL CAPS<br>CLORAZEPATE DIPOTASSIUM TABS<br>DIAZEPAM<br>LORAZEPAM<br>OXAZEPAM CAPS | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | 8<br>8<br>8<br>8<br>8<br>8<br>9 | ATIVAN<br>NIRAVAM<br>SERAX<br>TRANXENE<br>XANAX TABS<br>XANAX XR<br>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. |
| **ANXIOLYTICS - MISC.** | MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL | | BUSPIRONE HCL TABS<br>HYDROXYZINE HCL SOLN<br>HYDROXYZINE HCL SYRP<br>HYDROXYZINE PAMOATE CAPS<br>MEPROBAMATE TABS | MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL | | BUSPAR TABS<br>DROPERIDOL SOLN<br>HYDROXYZINE HCL TABS<br>HYDROXYZINE PAM 100MG CAPS<br>VISTARIL | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| **ANTI-DEPRESSANTS** | | | | | | | | |
| **ANTIDEPRESSANTS - MAO INHIBITORS** | MC/DEL<br>MC/DEL | | NARDIL TABS<br>PARNATE TABS | | | | Use PA Form# 20420 | |
| **ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL** | | | | MC/DEL | | EMSAM[1] | 1. Dosing limits apply, please refer to Dose consolidation list.<br>Use PA Form# 20420 | Preferred drugs (including a preferred SSRI, a non-SSRI, and Venlafaxine ER tabs) must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | BUPROPION HCL TABS<br>BUPROPION SR<br>BUPROPION XL<br>CITALOPRAM[4]<br>FLUOXETINE HCL CAPS<br>FLUOXETINE HCL LIQD<br>FLUOXETINE HCL 10mg TABS<br>FLUVOXAMINE MALEATE TABS<br>LEXAPRO TABS[4]<br>MIRTAZAPINE<br>NEFAZODONE<br>PAROXETINE[3]<br>SERTRALINE[2]<br>TRAZODONE HCL TABS<br>VENLAFAXINE ER CAPS[9] | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL | 8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8 | APLENZIN[7]<br>CELEXA[4]<br>CYMBALTA[5, 11]<br>EFFEXOR TABS<br>EFFEXOR XR CP24 [3, 10]<br>FLUOXETINE 40 mg CAPS[1]<br>FLUOXETINE 20mg TABS[6]<br>LUVOX TABS<br>MAPROTILINE HCL TABS<br>MIRTAZAPINE ODT<br>OLEPTRO<br>PAROXETINE CR[3]<br>PAXIL[3]<br>PAXIL CR [3]<br>PRISTIQ<br>PROZAC<br>PROZAC CAPS<br>PROZAC WEEKLY CPDR<br>REMERON TABS<br>SARAFEM CAPS | 1. Use Fluoxetine 20 mg in multiples.<br>2. See Zoloft splitting table. Sertraline requires splitting of scored tabs to avoid PA.<br>3. Strong caution with pediatric population.<br>4. See Celexa/Citalopram and Lexapro splitting tables.<br>5. Max daily dose allowed is 60mg, only 1 capsule per day allowed for all strengths. Combination of multiple strengths require PA. | 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.<br>**CYMBALTA:** Fibromyalgia diagnosis- prior use and failure of preferred generics (amitriptyline or cyclobenzaprine) and gabapentin prior to approval.<br>**SAVELLA:** Fibromyalgia diagnosis and trial of a preferred generic (amitriptyline or cyclobenzaprine, and gabapentin) and Cymbalta prior to approval.<br>Preferred Fluoxetine will be the only preferred antidepressant for members who are less than 18 years of age.<br>Exceptions to the rule are as follows:<br>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.<br>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.<br>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.<br>**DDI:** Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl).<br>**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. |

| Therapeutic Class | Preferred Status | Step | Preferred Drugs | Non-Preferred Status | Step | Non-Preferred Drugs | PA Criteria | Comments |
|---|---|---|---|---|---|---|---|---|
| | | | | MC/DEL | 8 | TRAZODONE HCL 300MG TABS | 6. Use Fluoxetine 10mg tabs or capsules in multiples. | **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. |
| | | | | MC/DEL | 8 | WELLBUTRIN TABS | 7. Provide clinical documentation as to why a preferred generic alternative cannot be used. | 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. |
| | | | | MC/DEL | 8 | WELLBUTRIN SR TBCR | 8. Dosing limits allowing 2 tabs/day and a max daily limit of 200mg / day applies. Please see dose consolidation list. | |
| | | | | MC/DEL | 8 | WELLBUTRIN XL | 9. Dosing limits and max daily dose applies. Limit of 1 tab per day of 37.5mg, 75mg, and 225mg will be allowed without pa, along with limits of 2 tabs per day of the 150mg strength. Max daily dose allowed is 375mg. | |
| | | | | MC/DEL | 8 | REMERON SOLTAB TBDP | 10. Use venlafaxine ER tabs. | |
| | | | | MC/DEL | 8 | SAVELLA[8] | 11. Established users are grandfathered. | |
| | | | | MC/DEL | 8 | ZOLOFT | 12. Non-preferred products must be used in specified step order. | |
| | | | | MC/DEL | 8 | VENLAFAXINE TABS[9] | Use PA Form# 20420 | |
| | | | | MC/DEL | 8 | VENLAFAXINE ER TABS[9] | | |
| | | | | MC/DEL | 9 | FLUOXETINE 90mg TABS[12] | | |
| **ANTIDEPRESSANTS - TRI-CYCLICS** | MC/DEL | | **AMITRIPTYLINE HCL TABS[1]** | MC/DEL | | **AMOXAPINE TABS** | 1. Users over the age of 65 require a 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. |
| | MC/DEL | | **CLOMIPRAMINE HCL CAPS[1]** | MC/DEL | | **ANAFRANIL CAPS** | 2. Use multiples of 50mg. | |
| | MC/DEL | | **DESIPRAMINE HCL TABS[1]** | MC/DEL | | **DOXEPIN HCL 150 MG[2]** | Use PA Form# 20420 | |
| | MC/DEL | | **DOXEPIN HCL[1]** | MC/DEL | | **NORPRAMIN TABS** | Use PA Form# 10220 for **Brand Name requests** | |
| | MC/DEL | | **IMIPRAMINE HCL TABS[1]** | MC/DEL | | **PAMELOR** | | |
| | MC/DEL | | **NORTRIPTYLINE HCL[1]** | MC | | TOFRANIL | | |
| | MC | | PROTRIPTYLINE HCL TABS[1] | MC | | VIVACTIL TABS | | |
| | MC | | SURMONTIL CAPS[1] | | | | | |
| **SEDATIVE / HYPNOTICS** | | | | | | | | |
| **SEDATIVE/HYPNOTICS - BARBITURATE** | MC | | BUTISOL SODIUM TABS[1] | MC | | LUMINAL SOLN | 1. PA required for new users of preferred products if over 65 years. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | | CHLORAL HYDRATE SYRP[1] | MC/DEL | | SOMNOTE CAPS | Use PA Form# 20420 | |
| | MC | | MEBARAL TABS[1] | | | | | |
| | MC/DEL | | PHENOBARBITAL[1] | | | | | |
| **SEDATIVE/HYPNOTICS - BENZODIAZEPINES** | MC/DEL | | DORAL TABS[1] | MC | | HALCION TABS[1] | 1. Dosing limits apply, please see dosing 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. 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 |
| | MC/DEL | | ESTAZOLAM TABS[1] | MC | | MIDAZOLAM HCL SYRP | Use PA Form# 30110 | |
| | MC/DEL | | FLURAZEPAM HCL CAPS[1] | MC/DEL | | RESTORIL CAPS[1] | | |
| | MC/DEL | | TEMAZEPAM CAPS 15 & 30MG[1] | MC/DEL | | TEMAZEPAM 7.5MG[1] | | |
| | MC/DEL | | TRIAZOLAM TABS[1] | | | | | |
| **SEDATIVE/HYPNOTICS - Non-Benzodiazepines** | MC/DEL | 1 | MIRTAZAPINE | MC/DEL | 7 | AMBIEN[1] | 1. Quantity Limt 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. **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 | 1 | TRAZODONE | MC/DEL | 8 | AMBIEN CR[1] | 2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended. | |
| | MC/DEL | 1 | ZOLPIDEM[2] | MCDEL | 8 | EDLUAR | | |
| | MC/DEL | 2 | ZALEPLON[2,3] | MC/DEL | 8 | LUNESTA[1] | | |
| | | | | MC/DEL | 8 | SONATA CAPS[1] | | |
| | | | | MC/DEL | 8 | ROZEREM | | |
| | | | | MC/DEL | 8 | ZOLPIMIST | | |

| Category | Status | | Preferred Drugs | Status | Step | Non-Preferred Drugs | PA Notes / Forms | Criteria |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | 3. Only zolpidem trial/failure will be required to obtain Zaleplon.<br><br>4. Must fail all preferred products before non-preferred<br><br>Use PA Form# 30110 | |
| **ANTI-PSYCHOTICS** | | | | | | | | |
| **ANTIPSYCHOTICS - ATYPICALS** | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC | | ABILIFY TABS[3,4]<br>GEODON[4]<br>RISPERIDONE TAB[4]<br>RISPERIDONE SOLN[4]<br>SEROQUEL TABS[4]<br>ZYPREXA TABS[4] | MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br><br>MC/DEL | 8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br><br>9 | ABILIFY DISC TAB, INJ and SOL[2]<br>FANAPT<br>INVEGA<br>INVEGA SUSTENNA<br>LATUDA[6]<br>RISPERDAL TAB<br>RISPERDAL CONSA[2]<br>RISPERDAL M TAB[2]<br>RISPERDAL SOLN<br>RISPERIDONE ODT<br>SAPHRIS<br>SEROQUEL 50MG TABS[1,2]<br>ZYPREXA ZYDIS TBDP[2]<br>ZYPREXA RELPREVV<br><br>SEROQUEL XR[5] | 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.<br><br>Use PA form# 20440 for **Multiple Antipsychotic requests**<br><br>Use PA form# 10130 for **non-preferred single therapy atypical requests**<br><br>1. Please use multiple 25mg tablets.<br><br>2. Established users of single therapy atypicals were grandfathered.<br><br>3. Abilify requires splitting of tab to avoid PA. Please see Abilify splitting table.<br><br>4. Prior Authorization will be required for preferred medications for members under the age of 5.<br><br>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.<br><br>6. Dosing limits apply to 80mg, please see dosing 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. 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.<br><br>**Seroquel 25mg** is preferred and available without PA if the following conditions are met: a.) Either 65 years of age or older or less than 18 years of age, b.) dosage is for 3 or more per day, c.) Seroquel 25mg is in the profile within the last 45 days OR if any of the following doses are being used in combination with any daily dose of Seroquel 25mg: a.) at least 1.5 Seroquel 100mg tabs, b.) Seroquel 200mg tabs, c.) Seroquel 300mg tabs, d.) Seroquel 400mg tabs OR if dose is beting titrated up.<br><br>**Seroquel 100mg** is preferred and available without pa if the daily dosage is 1.5 tablets or more per day OR if any of the following doses are being used in combination with any daily dose of Seroquel 100mg: a.) at least 3- Seroquel 25mg tabs,b.) Seroquel 200mg tabs,c.) Seroquel 300mg tabs,d.) Seroquel 400mg tabs.<br>**Seroquel 50mg** tablets are non-preferred and multiple Seroquel 25mg tablets should be used.<br><br>**DDI:** Abilify, Seroquel, and Zyprexa will now be non-preferred and require prior authorization if they are currently being used in combination with carbamazepine.<br>**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:<br>• schizophrenia<br>• bipolar disorder<br>• agitation related to autism<br>• severe behavioral dyscontrol with risk of imminent need for emergency services such as the emergency room, crisis services, or an inpatient psychiatric facility.<br><br>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. |
| **ANTIPSYCHOTICS - SPECIAL ATYPICALS** | MC/DEL | | CLOZAPINE TABS | MC/DEL<br>MC | | CLOZARIL TABS<br>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.<br><br>**DDI:** Clozapine will now be non-preferred and require prior authorization if it is currently being used in combination with carbamazepine.<br>Please use Drug-Drug Interaction PA form #10400. |
| **ANTIPSYCHOTICS - TYPICAL** | MC/DEL<br>MC/DEL<br>MC/DEL | | CHLORPROMAZINE HCL<br>FLUPHENAZINE DECANOATE<br>FLUPHENAZINE HCL | MC/DEL<br>MC/DEL<br>MC | | COMPAZINE<br>COMPRO SUPP<br>HALDOL DECANOATE | Use PA Form# 20420<br>If prescribing 2 or more antipsychotics, PA will be required for both 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. |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | MC | | HALDOL | MC/DEL | | LOXITANE CAPS | required for both drugs, except if one is Clozapine. | If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine. |
| | MC/DEL | | HALOPERIDOL | MC | | MELLARIL | | |
| | MC | | HALOPERIDOL DECANOATE SOLN | MC/DEL | | NAVANE CAPS | | |
| | MC | | HALOPERIDOL LACTATE SOLN | MC | | PROLIXIN | | |
| | MC/DEL | | LOXAPINE SUCCINATE CAPS | MC | | STELAZINE TABS | | |
| | MC/DEL | | LOXITANE-C CONC | | | | | |
| | MC | | MOBAN TABS | | | | | |
| | MC/DEL | | PERPHENAZINE | | | | | |
| | MC/DEL | | PROCHLORPERAZINE | | | | | |
| | MC | | SERENTIL | | | | | |
| | MC/DEL | | THIORIDAZINE HCL | | | | | |
| | MC/DEL | | THIOTHIXENE | | | | | |
| | MC/DEL | | TRIFLUOPERAZINE HCL TABS | | | | | |
| **LITHIUM** | | | | | | | | |
| **LITHIUM** | MC/DEL | | LITHIUM CARBONATE | MC/DEL | | ESKALITH CAPS | Use PA Form# 20420 | |
| | MC/DEL | | LITHIUM CITRATE SYRP | MC/DEL | | ESKALITH CR TBCR | | |
| **COMBINATION - PSYCHOTHERAPEUTIC** | | | | | | | | |
| **PSYCHOTHERPEUTIC COMBINATION** | MC/DEL | | CHLORDIAZEPOXIDE/AMITRIPT | MC | 8 | SYMBYAX[1] | 1. Only available if component ingredients are unavailable.<br>Use PA Form# 20420 | |
| | MC/DEL | | PERPHENAZINE/AMITRIPTYLIN | | | | | |
| **STIMULANTS** | | | | | | | | |
| **STIMULANT - AMPHETAMINES - SHORT ACTING** | MC/DEL | | ADDERALL TABS[1] | | | | 1. Preferred stimulants will be available without PA if diagnosis of ADHD.<br>2. As per recent FDA alert, Adderal & Dexedrinel should not be used in patients with underlying heart defects since they may be at increased risk for sudden death.<br>3. Dosing limits apply, please see dosing consolidation list.<br>Use PA Form# 20420 | |
| | MC/DEL | | AMPHETAMINE SALT COMBO[1,3] | | | | | |
| | MC/DEL | | DEXTROAMPHET SULF TABS[1,3] | | | | | |
| | MC/DEL | | DEXEDRINE[1,3] | | | | | |
| | MC/DEL | | DEXTROSTAT TABS[1] | | | | | |
| **STIMULANT - LONG ACTING AMPHETAMINES SALT** | MC/DEL | | ADDERALL XR CP24[1,3,4] | | | | Use PA Form# 20420<br>1. As per recent FDA alert, Adderall should not be used in patients with underlying heart defects since they may be at increased risk for sudden death.<br>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.<br>3. Preferred stimulants will be available without PA if diagnosis of ADHD.<br>4. Dosing limits applly, please see dosing consolidation list. | |
| | MC | | VYVANSE[2,3,4] | | | | | |

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| LONG ACTING AMPHETAMINES | MC | | DEXEDRINE CAP CR[1,2,3] | MC | | DEXTROAMPHET SULF CPCR[3] | 1. Preferred stimulants will be available without PA if diagnosis of ADHD.<br>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.<br>3. Dosing limits applly, please see dosing consolidation list.<br>Use PA Form# 20420 | |
| STIMULANT - METHYLPHENIDATE | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | FOCALIN TABS[1,2]<br>METADATE ER TBCR[1,2]<br>METHYLIN ER TBCR[1,2]<br>METHYLIN TABS[1,2]<br>METHYLIN SOL[1]<br>METHYLPHENIDATE HCL[1,2] | MC<br>MC/DEL | | METHYLIN CHEWABLES<br>RITALIN | 1. Preferred stimulants will be available without PA if diagnosis of ADHD.<br>Use PA Form# 20420<br>2. Dosing limits apply, please see dosing consolidation list. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexmethylphenidate. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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. |
| STIMULANT - METHYLPHENIDATE - LONG ACTING | MC<br>MC/DEL<br>MC | | CONCERTA TBCR[1]<br>DAYTRANA[1,4]<br>FOCALIN XR[1] | MC<br>MC/DEL | 5<br>8 | METADATE CD CPCR[3]<br>RITALIN LA[2] | 1. Preferred stimulants will be available without PA if diagnosis of ADHD.<br>2. Non-preferred products must be used in specified step order.<br>3. Dosing limits apply, please see doseage consolidation list.<br>4. FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily.<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| STIMULANT - STIMULANT LIKE | | | | MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC | 7<br>8<br>8<br>8<br>8<br>9<br>9<br>9 | STRATTERA[1,2]<br>CAFCIT SOLN[3]<br>INTUNIV[3,4]<br>KAPVAY<br>PROVIGIL TABS[3]<br>NUVIGIL[3]<br>DESOXYN TABS[3]<br>DESOXYN CR[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).<br>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. | 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 |

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| | | | | | | | 3. Non-preferred products must be used in specified<br>4. Please use generic Guanfacine.<br>Use PA Form# 20710 for **Provigil, Nuvigil and Xyrem**<br>Use PA Form# 20420 for **all others** | |
| **ANTI-CATAPLECTIC AGENTS** | | | | | | | | |
| **PSYCHOTHERAPEUTIC AGENTS - MISC.** | | | | **MC**<br>**MC** | | XYREM SOL<br>XENAZINE | Use PA Form# 20710 for **Xyrem**<br>Use PA Form# 20710 for **Xenazine** | |
| **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**<br>**MC**<br>**MC/DEL**<br>**MC/DEL**<br>**MC/DEL** | | ARICEPT TABS[1]<br>ARICEPT ODT<br>DONEPEZIL HYDROCHLORIDE TABS[1]<br>DONEPEZIL HYDROCHLORIDE ODT[1]<br>NAMENDA[1] | **MC/DEL**<br>**MC**<br>**MC/DEL**<br>**MC** | 8<br>8<br>8<br>9 | EXELON[2]<br>RAZADYNE[2]<br>RIVASTIGMINE TARTRATE CAPS[2]<br>COGNEX CAPS[2] | 1. PA is required to establish dementia diagnosis and baseline mental status score.<br>2. Must fail all preferred products before moving to non-preferred.<br>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**<br>**MC/DEL**<br>**MC/DEL** | | CHANTIX[1,2,3]<br>NICODERM CQ PT24[2,3]<br>NICOTINE DIS PT24[2,3] | | | | Use PA Form# 20420<br>1. Chantix is preferred without PA for up to 6 months of continuous use once per lifetime.<br>2. Preferred nicotine replacement therapy and Chantix will become non-preferred and will require PA if they are being used in combination together.<br>3. Bupropion SR 150 mg is available without a prior authorization. | OTC Nicotine products are covered by MaineCare Policy when they have been determined to be cost-effective. Only Nicoderm and the generic nicotine gums have received this designation as preferred. All other nicotine products (OTC & prescription) are non-preferred by MaineCare Policy.<br>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.<br>Another version of Zyban, Bupropion SR (100 and 150mg) is available without PA.<br>There will be a quantity limit of 3 months supply of nicotine products allowed per 12 months. |
| **NICOTINE REPLACEMENT - OTHER** | **MC/DEL**<br>**MC/DEL** | | NICOTINE POLACRILEX GUM[2]<br>NICORETTE GUM[2] | **MC/DEL**<br>**MC/DEL**<br>**MC/DEL** | 5<br>8<br>8 | COMMIT LOZENGES[1,3,4]<br>NICOTROL INHALER[3,4]<br>NICOTROL NASAL SPRAY[3,4] | Use PA Form# 20420<br>1. Will be available to patients unable to tolerate preferred products.<br>2. Preferred nicotine replacement therapy and Chantix will become non-preferred and will require PA if they are being used in combination together.<br>3. Must fail all preferred products from smoking cessation category (Nicoderm patch and nicotine gum) before moving to non-preferred. | OTC Nicotine products are covered by MaineCare Policy when they have been determined to be cost-effective. Only Nicoderm and the generic nicotine gums have received this designation as preferred. All other nicotine products (OTC & prescription) are non-preferred by MaineCare Policy.<br>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.<br>Another version of Zyban, Bupropion SR (100 and 150mg) is available without PA.<br>There will be a quantity limit of 3 months supply of nicotine products allowed per 12 months. |

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| | | | | | | | 4. Must use non-preferred products in specified step order. | |
| **ALCOHOL DETERRENTS** | | | | | | | | |
| **ALCOHOL DETERRENTS** | MC | | ANTABUSE TABS | | | | 1. Should only be used in conjunction with formal structured outpatient detoxification program. | Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC | | CAMPRAL[1] | | | | | |
| | MC | | DISULFIRAM TABS | | | | | |
| | MC/DEL | | NALTREXONE HCL TABS | | | | Use PA Form# 20420 | |
| **MISCELLANEOUS ANALGESICS** | | | | | | | | |
| **ANALGESICS - MISC.** | MC/DEL | | ACETAMINOPHEN | MC | | AXOCET CAPS | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC/DEL | | **ASPIRIN** | MC/DEL | | ESGIC-PLUS | | |
| | MC/DEL | | ASPRIN/ APAP/ CAFF TAB | MC/DEL | | FIORICET TABS | | |
| | MC/DEL | | BUTAL/ASA/CAFF | MC | | FIORINAL CAPS | | |
| | MC/DEL | | BUTALBITAL COMPOUND | MC | | FIORTAL CAPS | | |
| | MC/DEL | | BUTALBITAL/ACET TABS | MC/DEL | | FORTABS TABS | | |
| | MC/DEL | | BUTALBITAL/APAP CAPS | MC | | PHRENILIN TABS | | |
| | MC/DEL | | BUTALBITAL/APAP/CAFFEINE | MC | | PHRENILIN FORTE CAPS | | |
| | MC/DEL | | **CHOLINE MAGNESIUM TRISALI** | MC | | TRILISATE LIQD | | |
| | MC/DEL | | **DIFLUNISAL TABS** | MC | | TRILISATE TABS | | |
| | MC | | EXCEDRIN | MC | | ZEBUTAL CAPS | | |
| | MC/DEL | | **SALSALATE TABS** | MC | | ZORPRIN TBCR | | |
| **LONG ACTING NARCOTICS** | | | | | | | | |
| **NARCOTICS - LONG ACTING** | MC | | AVINZA | MC/DEL | 8 | ABSTRAL | Use PA Form# 20510 | Preferred drugs (Avinza or morphine sulfate ER tab, Duragesic, 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 con |
| | MC/DEL | | FENTANYL PATCH[5] | MC/DEL | 8 | BUTRANS[5] | 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.<br>2. Established users are grandfathered.<br>3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to achieve max total daily dose of 320mg.<br>4. Oxycontin 15mg, 30mg & 60mg are new strengths. Any PA request for the new strengths will be required to use combinations of strengths that have previously been available (including 10mg, 20mg, 40mg, & 80mg tablets) to obtain requested dose.<br>5. Dosing limits apply. Please see dose consolidation list. | |
| | MC | | KADIAN[6] | MC | 8 | DURAGESIC PT72[5] | | |
| | MC/DEL | | METHADONE | MC/DEL | 8 | EMBEDA | | |
| | MC/DEL | | METHADOSE | | 8 | EXALGO | | |
| | MC/DEL | | MORPHINE SULFATE ER TB12 | MC/DEL | 8 | MORPHINE SULFATE SUPP | | |
| | | | | MC/DEL | 8 | MS CONTIN TB12 | | |
| | | | | MC/DEL | 8 | ORAMORPH SR TB12 | | |
| | | | | MC/DEL | 8 | OXYCONTIN TB12[1,4] | | |
| | | | | MC/DEL | 9 | OXYCODONE ER[3,7] | | |
| | | | | MC | 9 | OPANA ER[7] | | |

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| | | | | | | | 6. Kadian 10mg, 80mg & 200mg are non-preferred.<br>7. Non-preferred products must be used in specific order. | |
| NARCOTICS - SELECTED | MC/DEL | | TRAMADOL HCL TABS | MC | 8 | BUPRENEX SOLN | Use PA Form# 20420<br>1. Only available if component ingredients are unavailable. | 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.<br>Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance abouse such as: 1. frequent or persistant 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 opiod documentaion (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 recoreds regarding prior use of narcotics; 7. receiving controlled substances from other prescribers that the provider submitting the PA is unaware of. in Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. |
| | | | | MC/DEL | 8 | BUTORPHANOL | | |
| | | | | MC | 8 | NALBUPHINE HCL SOLN | | |
| | | | | MC | 8 | STADOL NS SOLN | | |
| | | | | MC | 8 | ULTRACET TABS[1] | | |
| | | | | MC | 8 | ULTRAM TABS | | |
| | | | | MC | 8 | ULTRAM ER | | |
| | | | | MC/DEL | 9 | RYZOLT | | |
| **MISCELLANEOUS NARCOTICS** | | | | | | | | |
| NARCOTICS - MISC. | MC/DEL | | ACETAMINOPHEN/CODEINE | MC/DEL | 8 | ASCOMP/CODEINE CAPS | 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. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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. |
| | MC/DEL | | ASPIRIN/CODEINE TABS | MC/DEL | 8 | BUTALBITAL/APAP/CAFFEINE/ CAPS | | |
| | MC/DEL | | BUTAL/ASA/CAFF/COD CAPS | MC | 8 | DEMEROL | | |
| | MC | | BUTALBITAL/ASPIRIN/CAFFEI CAPS | MC/DEL | 8 | DILAUDID | | |
| | MC | | CAPITAL AND CODEINE SUSP[1] | MC | 8 | DILAUDID-HP SOLN | | |
| | MC | | CAPITAL/CODEINE SUSP[1] | MC | 8 | FENTANYL CITRATE SOLN | | |
| | MC/DEL | | CODEINE PHOSPHATE SOLN | MC/DEL | 8 | FENTORA | | |
| | MC/DEL | | CODEINE SULFATE TABS | MC/DEL | 8 | FIORICET/CODEINE CAPS | | |
| | MC/DEL | | ENDOCET TABS[3] | MC | 8 | FIORINAL/CODEINE #3 CAPS | 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. | |
| | MC/DEL | | ENDODAN TABS | MC | 8 | FIORTAL/CODEINE CAPS | | |
| | MC/DEL | | FENTANYL OT LOZ[1] | MC/DEL | 8 | HYDROCODONE/IBUPROFEN | | |
| | MC/DEL | | HYDROCODONE BITARTRATE/AP TABS | MC/DEL | 8 | LORCET | | |
| | MC/DEL | | HYDROCODONE/ACETAMINOPHEN | MC | 8 | LORTAB | | |
| | MC/DEL | | HYDROMORPHONE HCL[3] | MC | 8 | MAXIDONE TABS | | |
| | MC/DEL | | MEPERIDINE HCL | MC/DEL | 8 | NORCO TABS | | |
| | MC/DEL | | OXYCODONE 5MG | MC/DEL | 8 | NUCYNTA | | |
| | MC/DEL | | OXYCODONE 15MG | MC/DEL | 8 | ONSOLIS | | |
| | MC/DEL | | OXYCODONE 30MG | MC | 8 | OPANA | | |
| | MC/DEL | | OXYCODONE/ACETAMINOPHEN[2,3] | MC/DEL | 8 | OXYCODONE 10MG | | |
| | MC/DEL | | PENTAZOCINE/NALOXONE TABS | MC/DEL | 8 | OXYCODONE 20MG | 3. Only preferred manufacturer's products will be available without prior authorization. | |
| | MC | | PROPOXYPHENE CMPND-65 CAPS | MC/DEL | 8 | OXYCODONE/APAP 10/650 | | |
| | MC | | PROPOXYPHENE COMPOUND CAPS | MC/DEL | 8 | OXYCODONE/APAP 7.5/500 | | |
| | MC/DEL | | PROPOXYPHENE HCL CAPS | MC/DEL | 8 | PENTAZOCINE/ACET TABS | | |
| | MC/DEL | | PROPOXYPHENE/ACET TABS | MC | 8 | PERCOCET TABS | | |
| | MC/DEL | | PROPOXYPHENE-N/ACET TABS | MC | 8 | PERCOCET TABS | | |
| | MC/DEL | | ROXICET | MC | 8 | PHRENILIN W/CAFFEINE/CODE CAPS | | |
| | MC | | ROXIPRIN TABS | MC/DEL | 8 | ROXICET 5/500 TABS | | |
| | | | | MC | 8 | ROXICODONE TABS | | |
| | | | | MC | 8 | SYNALGOS-DC CAPS | | |
| | | | | MC | 8 | TALACEN TABS | | |
| | | | | MC | 8 | TYLENOL/CODEINE #3 TABS | | |
| | | | | MC | 8 | TYLOX CAPS | | |
| | | | | MC | 8 | VICODIN | Use PA Form# 20420 | |
| | | | | MC | 8 | VICOPROFEN TABS | | |
| | | | | MC | 8 | ZYDONE TABS | | |
| | | | | MC | 9 | ACTIQ LPOP | | |
| OPIOID DEPENDENCE | MC | | SUBOXONE[2] | MC | | SUBUTEX[1] | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered |

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| TREATMENTS | | | | MC/DEL | | BUPRENORPHIN | 1. Subutex will only be approved for use during pregnancy.<br>2. See Criteria Section | on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.<br><br>Suboxone Criteria<br>1-Induction period for new starts max of 60 days<br>2-Max dose of 32 mg for induction<br>3-Max dose of 16 mg for maintenance<br>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.<br>5- Prescribers limited to those with X-DEA<br>6- Should be evidence provided of monthly monitoring including random pill counts urine drug tests and prescription monitoring program reports. |
| **NARCOTIC ANTAGONISTS** | | | | | | | | |
| **NARCOTIC - ANTAGONISTS** | MC/DEL | | NALTREXONE HCL TABS | MC/DEL<br>MC/DEL | | REVIA TABS[1]<br>VIVITROL INJ[2] | Use PA Form# 20420<br>Use PA form# 30400 for **Vivitrol requests**<br>1. Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version.<br>2. Please see the criteria listed on the Vivitrol PA form. Any narcotics attempting to be filled during Vivitrol approval will require prior authorization. | Please see the criteria listed on the Vivitrol PA form. |
| **COX 2 / NSAIDS** | | | | | | | | |
| **COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE** | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | CELEBREX CAPS [4,5,6]<br>KETOROLAC TROMETHAMINE [2,3,6]<br>NABUMETONE TABS[6]<br>MELOXICAM[1,6] | MC/DEL<br>MC/DEL<br>MC/DEL | | **MOBIC[6]**<br>MOBIC SUSP[6]<br>**RELAFEN TABS[6]** | Use PA Form# 10310<br>1. Meloxicam has dosing limits allowing one tablet daily of all strengths without PA.<br>2. Ketorolac Tromethamine is indicated for the short term (up to 5 days) managment of moderately severe acute pain that requires analgesic at the opiod level in adults. Not indicated for minor of chronic pain conditions.<br>3. Ketorolac has dosing limits allowing 24 tablets for a 5 day supply every 30 days.<br>4. Dosing limits will be set at a maximum of 200mg once daily for PA requests.<br>5. Users 60 years of age or older will not require PA. If under 60 years of age, Celebrex will require PA. | 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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| | | | | | | | 6. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. | |
| **NSAIDS** | MC/DEL | | **CHILDRENS IBUPROFEN** | MC | | ADVIL TABS | The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.<br>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. |
| | 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 | Use PA Form# 20420 | |
| | 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** | | **DDI:** Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with lescol. |
| | MC/DEL | | NAPROXEN SUSP | MC/DEL | | **ETODOLAC ER 600MG** | | |
| | MC/DEL | | **NAPROXEN TABS** | MC | | FELDENE CAPS | | The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. |
| | 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 | | TOLECTIN | | |
| | | | | MC/DEL | | VOLTAREN | | |
| | | | | MC | | V-R IBUPROFEN TABS | | |
| **NSAID - PPI** | | | | MC | | PREVACID NAPRA-PAC | 1. Use a preferred NSAID and PPI separately. | |
| | | | | MC/DEL | | VIMOVO[1] | Use PA Form# 20420 | |
| **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, Cimzia or Humira without PA. | Enbrel 25mg 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. |
| | MC/DEL | 1 | LEFLUNOMIDE | MC | | **KINERET SOLN** | | |
| | MC/DEL | 1 | METHOTREXATE | MC | | ORENCIA | | |
| | MC/DEL | 1 | **SULFASALAZINE TABS** | MC | | **REMICADE** | | |
| | MC/DEL | 2 | CIMZIA[1] | MC | | **ENBREL 50MG**[3,5] | 2. Dosing limits apply. Please see dose consolidation list. | |
| | MC | 2 | **ENBREL 25MG INJECTIONS ONLY**[1,4] | MC | | SIMPONI | | |
| | MC | 2 | **HUMIRA**[1,2,5] | | | | 3. Please use multiples of 25mg. | |
| | | | | | | | 4. Preferred dosage form allowed without PA after trial of step 1 prodcuts is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa. | |
| | | | | | | | 5. Established users will be grandfathered for Enbrel and Humira. | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **MISCELLANEOUS ARTHRITIS** | | | | | | | | |
| **ARTHRITIS - MISC.** | MC<br>MC | | RIDAURA CAPS<br>MYOCHRYSINE SOLN | MC/DEL | | **ARTHROTEC[1]** | 1. The individual components of Arthrotec are available without PA.<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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. |
| **LUPUS-SLE** | | | | | | | | |
| **LUPUS-SLE** | | | | MC | | BENLYSTA | Use PA Form# 20420 | |
| **MIGRAINE THERAPIES** | | | | | | | | |
| **MIGRAINE - ERGOTAMINE DERIVATIVES** | MC/DEL<br>MC | | MIGRANAL SOLN<br>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. |
| **MIGRAINE - CARBOXYLIC ACID DERIVATIVES** | MC | | DIVALPROEX ER TB24 | MC | | DEPAKOTE ER TB24 | Use PA Form# 10110 | |
| **MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs** | MC/DEL<br>MC/DEL<br>MC/DEL | | MAXALT MLT[1]<br>NARATRIPTAN HCl TABS[1]<br>SUMATRIPTAN TABS[1] | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | AMERGE TABS[1,2]<br>AXERT TABS[1,2]<br>FROVA TABS[1,2]<br>MAXALT[1,2]<br>IMITREX TABS[1,2]<br>RELPAX[1,2]<br>ZOMIG TABS[1,2]<br>ZOMIG NASAL SPARY[1,2]<br>ZOMIG ZMT TBDP[1,2] | 1. All drugs in this category have dosing limits. Please refer to dose consolidation table.<br>2. Must fail all preferred products before non-preferred.<br>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. |
| **MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables** | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | IMITREX KIT<br>IMITREX SOLN<br>IMITREX STATDOSE PEN KIT<br>IMITREX STATDOSE REFILL KIT | MC/DEL | | SUMATRIPTAN SOLN | Use PA Form# 10110 | |
| **MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Combinations** | | | | MC/DEL | | TREXIMET[1,2] | Use PA Form# 10110<br>1. Dosing limits apply. Please see dose consolidation list.<br>2. Use preferred Sumatriptan and Naproxen separately. Treximet only available if component ingredients of sumatriptan and naproxen are unavailable. | |
| **MIGRAINE - MISC.** | MC/DEL<br>MC/DEL | | CAFERGOT TABS<br>SPASTRIN TABS | MC/DEL<br>MC<br>MC/DEL | | MIGRAZONE CAPS<br>BELCOMP-PB SUPP<br>MIGERGOT SUP | Use PA Form# 10110 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| **GOUT** | | | | | | | | |
| **GOUT** | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | | **ALLOPURINOL TABS**<br>**COLCHICINE TABS**<br>**PROBENECID TABS**<br>**PROBENECID/COLCHICINE TABS** | MC<br>MC/DEL<br>MC | | COLCRYS<br>ULORIC[1]<br>ZYLOPRIM TABS | Use PA Form# 20420<br>1. Failure of therapeutic (300mg) dose of Allopurinol (failure define as not being able to get uric acid levels below 6mg/dl) or severe renal disease. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| **MISC.** | | | | | | | | |
| **ANESTHETICS - MISC.** | MC<br>MC<br>MC | | BUPIVACAINE HCL SOLN<br>LIDOCAINE HCL SOLN<br>MARCAINE SOLN | MC<br>MC/DEL<br>MC | | SENSORCAINE-MPF SOLN<br>SYNVISC INJ<br>XYLOCAINE SOLN | Use PA Form# 30130 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| **ANTI-CONVULSANTS** | | | | | | | | |

| ANTICONVULSANTS | MC/DEL | | CARBAMAZEPINE | MC | 8 | BANZEL | Use PA Form# 20420 | One time PA is required to determine seizure diagnosis for any non-preferred anticonvulsant. Other approvals will be for patients with a variety of drug-specific FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality after recommendation by the DUR Committee and as long as all first line therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). |
|---|---|---|---|---|---|---|---|---|
| | MC/DEL | | CARBATROL CP12 | MC | 8 | DEPAKENE | All non-preferred meds must be used in specified order | |
| | MC/DEL | | CELONTIN CAPS | MC | 8 | DEPAKOTE | | |
| | MC/DEL | | CLONAZEPAM TABS | MC | 8 | DEPAKOTE ER | | |
| | MC | | DEPAKOTE SPRINKLES CPSP | MC/DEL | 8 | DIAZEPAM GEL | 1. Quantity limit. 5/month | |
| | MC/DEL | | DIASTAT[1] | MC/DEL | 8 | DIVALPROEX SODIUM SPRINKLE CAPS | 2. Dosing limits apply, please see dose consolidation list. | |
| | MC/DEL | | DILANTIN | MC/DEL | 8 | EQUETRO | | |
| | MC/DEL | | DIVALPROEX SODIUM | MC/DEL | 8 | GABITRIL TABS | | *** SEE CHART AT END OF DOCUMENT |
| | MC/DEL | | EPITOL TABS | MC/DEL | 8 | KEPPRA TABS | 3. Dosing limits apply per strength as well as a maximum daily dose of 600mg. Please see dose consolidation list. | Topamax and Neurontin - Second line therapy for migraine prophalaxis after trial of at least three preferred preventive medications from Group 1 listed on page 2 of the Acute Migraine PA form. |
| | MC/DEL | | ETHOSUXIMIDE SYRP | MC/DEL | 8 | KEPPRA SOLN | | |
| | MC/DEL | | FELBATOL | MC/DEL | 8 | KLONOPIN TABS | | |
| | MC/DEL | | GABAPENTIN[2] | MC/DEL | 8 | LAMICTAL | | |
| | MC/DEL | | LAMOTRIGINE[2] | MC/DEL | 8 | LYRICA[3] | | Lyrica- Second line therapy for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia. With Fibromyalgia diagnosis, Lyrica will not require PA with Fibromyalgia diagnosis if previous 4 week trials of the following are seen in drug profile at full therapeutic doses: TCA or cyclobenzaprine, gabapentin, and savella. |
| | MC/DEL | | LEVETIRACETAM SOLN/TABS | MC/DEL | 8 | PRIMIDONE TABS | 4. Adjunctive therapy 17 and older. | |
| | MC/DEL | | MYSOLINE TABS | MC | 8 | SABRIL | | |
| | MC/DEL | | OXCARBAZEPINE | MC | 8 | TOPAMAX | 5. Current users as of 7/30/10 for seizures will be grandfathered. | |
| | MC/DEL | | PHENYTEK CAPS | MC | 8 | TOPAMAX SPRINKLE CAPS[2] | | |
| | MC/DEL | | PHENYTOIN | MC/DEL | 8 | TRILEPTAL | | |
| | MC/DEL | | TEGRETOL | MC/DEL | 8 | VIMPAT[4] | 6. 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. | All non-preferred meds must be used in specified order. |
| | MC/DEL | | TOPIRAMATE | MC/DEL | 8 | ZARONTIN SYRP | | |
| | MC/DEL | | TOPIRAMATE SPRINKLE CAPS[2] | MC/DEL | 9 | KEPPRA XR [5,6] | | **DDI:** Any Carbamazepine formulation will now be non-preferred and require prior authorization if any of the following drugs are currently being used in combination with carbamazepine: Abilify, clarithomycin, clozapine, erythromycin, Seroquel, telithromycin or Zyprexa. |
| | MC/DEL | | TRILEPTAL SUSP | MC/DEL | 9 | NEURONTIN | | |
| | MC/DEL | | VALPROIC ACID | MC/DEL | 9 | TEGRETOL-XR TB12 [5,6] | | |
| | MC/DEL | | ZARONTIN CAPS | MC/DEL | 9 | ZONEGRAN CAPS | | |
| | MC/DEL | | ZONISAMIDE | | | | | Please use Drug-Drug Interaction PA form #10400 for this combination. |
| | | | | | | **BIPOLAR DISORDER: STEP ORDER** | | |
| | | | | | M ~ A | | SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT<br>M= Monotherapy<br>A= Adjunctive<br>9= No Evidence<br>The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations.<br>Step 4 drugs-no PA required. | |
| | | | | | 4 ~ 4 | LAMICTAL | | |
| | | | | | 4 ~ 4 | LITHIUM | | |
| | | | | | 4 ~ 4 | CARBAMAZEPINE | | |
| | | | | | 4 ~ 4 | VALPROATE | | |
| | | | | | 4 ~ 4 | ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE | | |
| | | | | | 5 ~ 5 | TRILEPTAL | | |
| | | | | | 9 ~ 6 | TOPAMAX | | |
| | | | | | 9 ~ 7 | KEPPRA TABS | | |
| | | | | | 9 ~ 8 | GABITRIL TABS | | |
| | | | | | 9 ~ 9 | NEURONTIN | | |
| | | | | | 9 ~ 9 | ZONEGRAN CAPS | | |
| | | | | | | **PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER** | | |
| | | | | | M ~ A | (6-18 YEARS WITH OR WITHOUT PSYCHOSIS) | Two-step 1 preferred drugs must be tried before Trileptal.<br>The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations.<br>Step 4 drugs-no PA required. | |
| | | | | | 4 ~ 4 | LITHIUM | | |
| | | | | | 4 ~ 4 | CARBAMAZEPINE | | |
| | | | | | 4 ~ 4 | VALPROATE | | |
| | | | | | 4 ~ 4 | ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE | | |
| | | | | | 4 ~ 4 | LAMICTAL | | |
| | | | | | 5 ~ 5 | TRILEPTA | | |
| **ANTI-PARKINSON DRUGS** | | | | | | | | |
| PARKINSONS - ANTICHOLINERGICS | MC/DEL | | BENZTROPINE MESYLATE TABS | | | | Use PA Form# 20420 | |
| | MC | | COGENTIN SOLN | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | MC/DEL | | **TRIHEXYPHENIDYL** | | | | | |
| **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 | | **PRAMIPEXOLE** | MC/DEL | 5 | **MIRAPEX TABS**[1] | Use PA Form# 20420<br>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. |
| | MC/DEL | | **ROPINIROLE** | MC/DEL | 8 | **REQUIP TABS** | | |
| | | | | MC/DEL | 8 | **REQUIP XL TABS** | | |
| | | | | MC/DEL | 8 | **MIRAPEX ER** | | |
| **PARKINSONS - DOPAMINERGICS/CARBII/ LEVO** | MC/DEL | | **AMANTADINE HCL** | MC/DEL | | **APOKYN**[3] | 1. Approvals will require concurrent therapy with Levodopa and failed trials of Selegiline, Comtan, and Stalevo.<br>2. Approvals will require trials of Carbidopa/Levodopa, Selegiline, Comtan, and Stalevo.<br>3. Only preferred manufacturer's products will be available without prior authorization.<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | | **BROMOCRIPTINE MESYLATE** | MC | | AZILECT[2] | | |
| | MC/DEL | | **CARBIDOPA/LEVODOPA TABS**[3] | MC | | ELDEPRYL CAPS | | |
| | MC/DEL | | **CARBIDOPA/LEVODOPA ER** | MC | | LODOSYN TABS | | |
| | MC | | LARODOPA TABS | MC/DEL | | **PARLODEL CAPS** | | |
| | MC/DEL | | **SELEGILINE HCL** | MC/DEL | | **PARLODEL TABS** | | |
| | | | | MC | | SINEMET TABS | | |
| | | | | MC | | SINEMET TBCR | | |
| | | | | MC | | ZELAPAR[1] | | |
| **PARKINSONS - COMBO.** | MC/DEL | | STALEVO | | | | Use PA Form# 20420 | |
| **MUSCLE RELAXANTS** | | | | | | | | |
| **ALS DRUG** | MC/DEL | | **RILUTEK TABS** | | | | Use PA Form# 20420 | |
| **MUSCLE RELAXANTS** | MC/DEL | | **BACLOFEN TABS** | MC/DEL | 7 | **ORPHENADRINE CITRATE** | 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.<br>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. |
| | MC/DEL | | **CHLORZOXAZONE TABS** | MC/DEL | 8 | **CARISOPRODOL TABS** | | |
| | MC/DEL | | **CYCLOBENZAPRINE HCL TABS** | MC/DEL | 8 | DANTRIUM CAPS | | |
| | MC | | LIORESAL INTRATHECAL KIT | MC | 8 | LIORESAL TABS | | |
| | MC/DEL | | **METHOCARBAMOL TABS** | MC | 8 | NORFLEX TBCR | | |
| | MC/DEL | | **TIZANIDINE HCL TABS** | MC | 8 | ROBAXIN-750 TABS | | |
| | | | | MC/DEL | 8 | **ZANAFLEX TABS** | | |
| | | | | MC/DEL | 9 | **SKELAXIN TABX** | | |
| | | | | MC/DEL | 9 | **SOMA TABS** | | |
| **MUSCLE RELAXANT - COMBO.** | | | | MC/DEL | | CARISOPRODOL/ASPIRIN TABS | 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 trave, etc. |
| | | | | MC/DEL | | CARISOPRODOL/ASPIRIN/CODE | | |
| | | | | MC | | NORGESIC TABS | | |
| | | | | MC/DEL | | ORPHENADRINE COMPOUND | | |
| | | | | MC/DEL | | ORPHENADRINE/ASA/CAFF | | |
| | | | | MC | | ORPHENGESIC | | |
| **VITAMINS** | | | | | | | | |
| **VITAMINS** | MC/DEL | | ASCORBIC ACID TABS | MC | | AQUASOL E SOLN | Use PA Form# 20420<br>Please refer to 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.**<br>Please refer to OTC list.<br>**DDI:** B-12 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.<br>Preferred products that used to require diag codes still require diag codes unless indicated otherwise. |
| | MC | | BIOTIN | MC | | AQUAVIT-E SOLN | | |
| | MC | | CYANOCOBALAMIN SOLN | MC | | DHT SOLN | | |
| | MC | | FOLGARD RX 2.2 TABS | MC | | NASCOBAL GEL | | |
| | MC/DEL | | FOLIC ACID TABS | | | | | |
| | MC | | FOLTX TABS | | | | | |
| | MC/DEL | | MEPHYTON TABS | | | | | |
| | MC/DEL | | NIACIN | | | | | |
| | MC | | NIACOR TABS | | | | | |
| | MC/DEL | | NICOTINIC ACID SR CPCR | | | | | |

| Class | Status | Preferred Drugs | Status | Non-Preferred Drugs | Criteria | Notes |
|---|---|---|---|---|---|---|
| | MC | PYRIDOXINE HCL TABS | | | | |
| | MC/DEL | SLO-NIACIN TBCR | | | | |
| | MC/DEL | THIAMINE HCL SOLN | | | | |
| | MC/DEL | VITAMIN B-1 TABS | | | | |
| | MC/DEL | VITAMIN B-12 | | | | |
| | MC | VITAMIN B-6 TABS | | | | |
| | MC/DEL | VITAMIN C | | | | |
| | MC/DEL | VITAMIN E CAPS | | | | |
| | MC/DEL | VITAMIN E/D-ALPHA CAPS | | | | |
| | MC | VITAMIN K1 SOLN | | | | |
| | MC | V-R VITAMIN E CAPS | | | | |
| **VITAMIN D's** | MC/DEL | **CALCITRIOL CAPS**[1] | MC/DEL | **DRISDOL CAPS** | 1. Diagnosis of dialysis (renal failure) required. | Preferred products require dialysis/renal failure diagnosis. |
| | MC/DEL | **VITAMIN D** | MC | CALCIJEX | | Non-preferred products require: Secondary hyperparathyroidism in patients with Chronic Kidney Disease on dialysis., iPTH>400 pg/ml, Phosophorous ,6.5mg/dl, corrected calcium <12.2mg/dl, corrected calcium x phosphorous products <70mg $^{2}$/dl$^{2}$ |
| | MC | ZEMPLAR TABS | MC/DEL | HECTOROL (ORAL) | Use PA Form# 20420 | |
| | | | MC/DEL | HECTOROL (PARENTERAL) | | |
| | | | MC/DEL | **ROCALTROL** | | |
| | | | MC | ZEMPLAR INJ | | |
| **MISC MULTI-VITAMINS** | | | | | | |
| **VITAMINS - MISC.** | MC | CENTRUM LIQD | MC | ADEKS | 1. Diag codes are no longer required on prenatal vitamins. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | CENTRUM TABS | MC/DEL | ADVANCED NATALCARE TABS | | |
| | MC | CENTRUM JR/IRON CHEW | MC | AQUADEKS | | |
| | MC | CENTRUM SILVER TABS | MC | CENTRUM JR/EXTRA C CHEW | Please refer to OTC list. | |
| | MC | CENTRUM-LUTEIN TABS | MC | CENTRUM PERFORMANCE TABS | | Please refer to OTC list. |
| | MC | CEROVITE ADVANCED FO TABS | MC | DALYVITE LIQD | Use PA Form# 20420 | |
| | MC/DEL | CHEWABLE MULTIVIT/FL CHEW | MC | EMBREX 600 MISC | | Preferred products that used to require diag codes still require diag codes unless indicated otherwise. |
| | MC | COD LIVER OIL CAPS | MC | IBERET | | |
| | MC | COMPLETE SENIOR TABS | MC | MATERNA TABS | | |
| | MC | DAILY MULTI VIT/IRON | MC | MULTIRET FOLIC -500 TBCR | | |
| | MC/DEL | DIALYVITE 1MG | MC/DEL | NATAFORT TABS | | |
| | MC/DEL | DIALYVITE 800MG | MC/DEL | NATALCARE CFE 60 TABS[1] | | |
| | MC/DEL | FULL SPECTRUM B | MC/DEL | NATALCARE GLOSS TABS[1] | | |
| | MC | M.V.I.-12 INJ | MC | NATALCARE PIC TABS[1] | | |
| | MC | MULTI-VIT/FLUORIDE | MC | NATALCARE PIC FORTE TABS[1] | | |
| | MC/DEL | NATALCARE RX TABS | MC/DEL | NATALCARE PLUS TABS[1] | | |
| | MC/DEL | NEPHRONEX | MC | NATALCARE THREE TABS[1] | | |
| | MC/DEL | O-CAL PRENATAL | MC/DEL | NATACHEW CHEW | | |
| | MC/DEL | ONE DAILY TABS | MC | NATALFIRST TABS | | |
| | MC/DEL | ONE-DAILY MULTIVITAMINS | MC | NATATAB RX TABS | | |
| | MC/DEL | ONE-TABLET-DAILY | MC/DEL | NEPHPLEX RX TABS | | |
| | MC/DEL | POLY-VIT/IRON/FLUORID SOLN | MC/DEL | NEPHROCAPS CAPS | | |
| | MC/DEL | POLY-VITAMIN/FLUORIDE SOLN | MC/DEL | NEPHRO-VITE TABS | | |
| | MC/DEL | POLY-VITAMINS/IRON SOLN | MC | NESTABS RX TABS | | |
| | MC | PRENATAL 19 CHEW[1] | MC/DEL | NIFEREX | | |
| | MC/DEL | PRENATAL TABS[1] | MC/DEL | OCUVITE TABS | | |
| | MC/DEL | PRENATAL FORMULA 3 TABS[1] | MC | POLY-VI-FLOR SOLN | | |
| | MC/DEL | PRENATAL PLUS TABS[1] | MC | POLY-VI-SOL SOLN | | |
| | MC/DEL | PRENATAL PLUS NF TABS[1] | MC | POLY-VI-SOL/IRON SOLN | | |
| | MC | PRENATAL PLUS/27MG IRON[1] | MC | POLY-VITAMIN DROPS SOLN | | |
| | MC | PRENATAL PLUS/IRON TABS[1] | MC | PRECARE | | |
| | MC/DEL | PRENATAL RX/BETA-CAROTENE[1] | MC | PREMESIS RX TABS | | |
| | MC/DEL | RENA-VITE RX TABS | MC | PRENATABS CBF TABS[1] | | |
| | MC/DEL | RENAL CAPS | MC | PRENATAL CARE TABS[1] | | |
| | MC/DEL | RENAPHRO CAPS | MC | PRENATAL MR 90 TBCR[1] | | |
| | MC | STRESS TAB NF TABS | MC/DEL | PRENATAL MTR/SELENIUM TABS[1] | | |
| | MC | THERAPEUTIC-M TABS | MC | PRENATAL OPTIMA ADVANCE TABS[1] | | |
| | MC | THERAVITE LIQD | MC | PRENATAL PC 40 TABS[1] | | |
| | MC/DEL | TRI-VITAMIN/FLUORIDE SOLN | MC/DEL | PRENATAL RX TABS[1] | | |
| | MC | VITA CON FORTE CAPS | MC | PRENATE[1] | | |
| | MC | VITAMIN B COMPLEX CAPS | MC | PRENATE ELITE[1] | | |

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|---|---|---|---|---|---|---|
| | MC | VITAPLEX PLUS TABS | 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](#) | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | CALCI-MIX CAPSULE CAPS | MC | CALCET TABS | Please refer to OTC list. | |
| | MC | CALCIQUID SYRP | MC/DEL | **CALCIUM 600-D TABS** | | |
| | MC | CALCITRATE/VITAMIN D TABS | MC | CALCIUM/VITAMIN D TABS | | |
| | MC/DEL | CALCIUM | MC | CALTRATE 600 PLUS/VIT D TABS | | |
| | MC/DEL | CALCIUM CARBONATE | MC | CALTRATE PLUS TABS | | **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 CITRATE TABS | MC | CHROMAGEN | | |
| | 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 | MC/DEL | MC | KLOR-CON PACK | | |
| | MC | EFFERVESCENT POTASSIUM TBEF | MC | K-LYTE | | |
| | MC/DEL | FEOSTAT CHEW | MC/DEL | K-PHOS TABS NEUTRAL | | |
| | MC | FERATAB TABS | MC | K-TABS TBCR | | |
| | MC/DEL | FER-GEN-SOL SOLN | MC | K-VESCENT PACK | | |
| | MC | FER-IRON SOLN | MC | MICRO-K 10 MEG CPCR | | |
| | MC | FERRONATE TABS | MC | NU-IRON 150 CAPS | | |
| | MC/DEL | FERROUS SULFATE | MC/DEL | **OYSTER SHELL CALCIUM/VITA TABS** | | |
| | MC/DEL | FLUOR-A-DAY CHEW | MC/DEL | POLY-IRON 150 CAPS | | |
| | MC | FLUORIDE CHEW | MC/DEL | POLYSACCHARIDE IRON CAPS | | |
| | MC | FLUORIDE SODIUM CHEW | MC/DEL | POTASSIUM BICARB/CHLORIDE | | |
| | MC | FLUORITAB CHEW | MC/DEL | POTASSIUM CHLORIDE 10MEQ CAPS | | |
| | MC | HEMOCYTE TABS | MC/DEL | POTASSIUM CHLORIDE 8MEQ CAPS | | |
| | MC | HM CALCIUM TABS | MC/DEL | SLOW FE TBCR | | |
| | MC | K+ POTASSIUM PACK | MC | TUMS 500 CHEW | | |
| | MC | KAON ELIX | MC | VIACTIV CHEW | | |
| | MC | KAON-CL-10 TBCR | | | | |
| | MC | KCL 0.075%/D5W/NACL 0.2% SOLN | | | | |
| | MC | K-EFFERVESCENT TBEF | | | | |
| | MC | KLOR-CON | | | | |
| | MC | KLOTRIX TBCR | | | | |
| | MC/DEL | K-PHOS TABS | | | | |
| | MC/DEL | K-VESCENT 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 | | | | |

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| | 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] | 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. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | | P.T.E. -5 SOLN[1] | MC | | CASEC POWD[1] | | Medical foods are not to be authorized solely for the purpose of enhancing nutrient intake or managing body weight if the participant is able to eat conventional foods adequately. Medical foods may be approved if the member has a medical condition which precludes or restricts the use of conventional foods and necessitates the use of a formula. Concurrent Stimulant therapy is not an acceptable medical reason/condition for use of medical foods for enhancing nutrient intake or managing body weight. |
| | 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] | 2. Formerly known as Omacor. | 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. |
| | | | | 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 | |
| | | | | 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] | | |
| **ERYTHROPOEITINS** | | | | | | | | |
| **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. | |
| **GRANULOCYTE CSF** | | | | | | | | |
| **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] | | |
| | | | | MC | 9 | NEULASTA[1] | 2.10 day supply/month may | |

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| | | | | | | | be used without a PA.<br><br>Use PA Form# 20520 | |
| **ANTICOAGULANTS / PLATELET AGENTS** | | | | | | | | |
| **ANTICOAGULANTS** | MC | | ARIXTRA SOLN[1] | MC | | COUMADIN TABS | 1. Arixtra, Fragmin and Lovenox therapy durations greater than 7 days require PA.<br><br>2. Use other strengths available to obtain desired dose.<br><br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.<br><br>**DDI:** Warfarin will require prior authorization if being used in combination with fluconazole, miconazole, or voriconazole.<br><br>**DDI:** Warfarin will require prior authorization if being used in conjunction with Gemfibrozil or Fenofibrate. |
| | MC/DEL | | FRAGMIN INJ[1] | MC | | IPRIVASK | | |
| | MC | | HEPARIN SODIUM/NACL 0.9% SOLN | MC/DEL | | LOVENOX 300[2] | | |
| | MC | | HEP-LOCK SOLN | MC/DEL | | PRADAXA | | |
| | MC/DEL | | **INNOHEP** | | | | | |
| | MC/DEL | | **LOVENOX SOLN[1]** | | | | | |
| | MC/DEL | | **WARFARIN SODIUM TABS** | | | | | |
| | MC | | HEPARIN LOCK SOLN | | | | | |
| | MC/DEL | | HEPARIN LOCK FLUSH SOLN | | | | | |
| | MC/DEL | | HEPARIN SODIUM SOLN | | | | | |
| | MC/DEL | | HEPARIN SODIUM LOCK FLUSH SOLN | | | | | |
| | MC/DEL | | JANTOVEN | | | | | |
| **ANTIHEMOPHILIC AGENTS** | MC | | ALPHANATE | MC | | ADVATE[1,2] | 1. Only if other products unavailable.<br><br>2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access.<br><br>Use PA Form# 20420 | Non-preferred will only be approved if other preferred products are unavailable. |
| | | | ALPHANINE SD | | | | | |
| | MC/DEL | | BENEFIX SOLR | | | | | |
| | MC/DEL | | HELIXATE FS KIT | | | | | |
| | MC | | HEMOFIL - M | | | | | |
| | MC | | HUMATE-P SOLR | | | | | |
| | MC | | KOGENATE FS | | | | | |
| | MC | | KONYNE - 80 | | | | | |
| | MC | | MONARC - M | | | | | |
| | MC | | MONOCLATE - P | | | | | |
| | MC | | MONONINE | | | | | |
| | MC | | NOVOSEVEN SOLR | | | | | |
| | MC/DEL | | PROFILNINE | | | | | |
| | MC | | RECOMBINATE SOLR | | | | | |
| | MC | | REFACTO | | | | | |
| **PLATELET AGGREGATION INHIBITORS** | MC/DEL | | ASPIRIN | MC/DEL | 7 | TICLOPIDINE HCL TABS | Use PA Form# 20715 for **Plavix & Effient**<br><br>Use PA form# 20420 for **other requests**<br><br>1. As of 10.16.08 all new users of Plavix will require prior authorization.<br><br>2. 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. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.<br><br>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.<br><br>**DDI:** Plavix will require prior authorization if being used in combination with omeprazole, esomeprazole, cimetidine, fluconazole, ketoconazole, intelence, fluoxetine, ticlopidine, and fluvoxamine. |
| | MC/DEL | | **DIPYRIDAMOLE TABS** | MC | 8 | EFFIENT[2] | | |
| | | | | MC/DEL | 8 | PERSANTINE TABS | | |
| | | | | MC/DEL | 8 | PLAVIX TABS[1,2] | | |
| **PLATELET AGGR. INHIBITORS / COMBO'S - MISC.** | MC/DEL | | **AGGRENOX** | MC/DEL | | **AGRYLIN CAPS** | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC/DEL | | CILOSTAZOL | MC/DEL | | **PLETAL TABS** | | |
| | MC/DEL | | PENTOXIFYLLINE ER TBCR | MC | | TRENTAL TBCR | | |
| **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. |
| **HEMATOLOGICAL AGENTS-THROMBOPOIETIN RECEPTOR AGONISTS** | | | | MC/DEL | 7 | PROMACTA | Use PA Form# 20420 | Clinical PA required. Must see prior trial with insufficient response to corticosteroids and immunoglobulins. |
| | | | | MC | 8 | NPLATE | | |
| **HEMOSTATIC** | | | | | | | | |

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

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| | MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL | | FML S.O.P. OINT<br>LOTEMAX SUSP<br>NEOM/POLIN/DEX<br>PRED MILD SUSP<br>PREDNISOLONE<br>TOBRADEX | MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL | | MAXITROL<br>NEO/POLY/BAC/HC OINT<br>OZURDEX<br>PRED FORTE SUSP<br>PRED-G SUSP<br>PRED-G S.O.P. OINT<br>SULFACET SOD/PRED SOLN<br>TOBRAMYCIN SUSP DEXAMETHASONE<br>VASOCIDIN SOLN<br>VEXOL SUSP | | |
| **OP. - PROSTAGLANDINS** | MC<br>MC/DEL | | LUMIGAN SOLN<br>**TRAVATAN SOLN** | MC/DEL<br>MC/DEL | 7<br>8 | XALATAN SOLN[1]<br>**LATANOPROST SOL 0.005%[1]** | 1. All preferreds must be tried.<br>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<br>MC/DEL<br>MC/DEL<br>MC/DEL | | AK-PENTOLATE SOLN<br>ATROPINE SULFATE<br>CYCLOPENTOLATE HCL SOLN<br>ISOPTO HYOSCINE SOLN | MC/DEL<br>MC<br>MC/DEL<br>MC | | CYCLOGYL SOLN<br>ISOPTO ATROPINE SOLN<br>ISOPTO HOMATROPINE SOLN<br>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<br>MC<br>MC<br>MC/DEL<br>MC/DEL | | **ISOPTO CARBACHOL SOLN**<br>ISOPTO CARPINE SOLN<br>PILOCAR SOLN<br>**PILOCARPINE HCL SOLN**<br>**PILOPINE HS GEL** | | | | Use PA Form# 20420 | |
| **OP. - ADRENERGIC AGENTS** | MC/DEL<br>MC | | **DIPIVEFRIN HCL SOLN**<br>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 | | ALPHAGAN P SOLN | MC<br>MC/DEL<br>MC/DEL | | ALPHAGAN SOLN<br>BRIMONIDINE 0.2%<br>**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<br>MC/DEL<br>MC/DEL | | OPTIVAR<br>PATADAY SOLN<br>PATANOL SOLN | MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL | | ALOCRIL SOLN<br>ALOMIDE SOLN<br>BEPREVE<br>ELESTAT<br>EMADINE SOLN<br>LASTACAFT<br>OPTICROM SOLN<br>ZADITOR SOLN | Use PA Form# 20420 | All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| **OP. ANTI-ALLERGICS-MASTCELL STABILIZER CLASS** | | | | MC/DEL | | ALAMAST SOLN | Use PA Form# 20420 | |
| **OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO** | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL | | **AZOPT SUSP**<br>COMBIGAN<br>DORZOLAMIDE<br>DORZOLAMIDE/TIMOLOL | MC/DEL<br>MC/DEL | | **COSOPT SOLN**<br>**TRUSOPT SOLN** | Use PA Form# 20420 | |
| **OP. - NSAID'S** | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL | | FLURBIPROFEN SODIUM SOLN<br>DICLOFENAC OPTH 0.1%<br>KETOROLAC OPTH 0.4%<br>KETOROLAC OPTH 0.5% | MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC | | ACULAR LS[1]<br>ACULAR SOLN[1]<br>OCUFEN SOLN[1]<br>NEVANAC[1]<br>XIBROM[1]<br>VOLTAREN SOLN[1]<br>ACUVAIL[1] | 1. Must fail all preferred products before non-preferred.<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| **OP. - OF INTEREST** | MC/DEL | | ENUCLENE SOLN | MC<br>MC | | BOTOX SOLR<br>RESTASIS[1] | 1. Must have kerato conjuctivitus sicca and failed other dry eye therapies.<br>Use PA Form# 20420 | Must fail adequate trials of multi agents from artificial tears and lubricant category. |
| | | | **DERMATOLOGICAL** | | | | | |
| **TOPICAL - ORAL** | MC<br>MC<br>MC | | AMNESTEEM[1]<br>CLARAVIS[1]<br>SOTRET[1] | | | | 1. Users 24 or under, PA will not be required.<br>Use PA Form# 20420 | |

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| **TOPICAL - ACNE PREPARATIONS** | MC | AZELEX CREA | MC | ACZONE | 1. Users 24 or under, PA will not be required.<br>2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List.<br>3. Only available if component ingredients are unavailable.<br>Use PA Form# 10220 for **Brand Name requests**<br>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 | ALTINAC CREA | | |
| | MC/DEL | CLINDAMYCIN PHOSPHATE [2] | MC | AVITA CREA | | |
| | MC | ERYDERM SOLN | MC | BENZAC | | |
| | MC/DEL | ERYTHROMYCIN GEL | MC/DEL | BENZACLIN GEL[3] | | |
| | MC/DEL | ERYTHROMYCIN PADS | MC/DEL | BENZAGEL-10 GEL | | |
| | MC/DEL | ERYTHROMYCIN SOLN | MC/DEL | BENZAMYCIN GEL | | |
| | MC | ISOTRETINOIN | MC/DEL | BENZAMYCINPAK PACK | | |
| | MC | METRONIDAZOLE CREA[2] | MC | BENZEFOAM | | |
| | MC | METRONIDAZOLE GEL[2] | MC | BREVOXYL | | |
| | MC | METRONIDAZOLE LOTN[2] | MC/DEL | CLEOCIN-T[2] | | |
| | MC | RETIN-A GEL[1,2] | MC | CLINAC BPO GEL | | |
| | MC/DEL | SODIUM SULFACET/SULF LOTN | MC | CLINDAGEL GEL | | |
| | MC | TAZORAC GEL | MC | CLINDETS SWAB | | |
| | MC/DEL | TRETINOIN GEL[1] | 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 | RETIN-A MICRO GEL | | |
| | | | MC | RETIN-A CREA[2] | | |
| | | | MC/DEL | TRETINOIN CREA[2] | | |
| | | | MC/DEL | TRIAZ | | |
| | | | MC | VELTIN | | |
| | | | MC | ZENCIA WASH | | |
| | | | MC | ZETACET | | |
| | | | MC/DEL | ZIANA | | |
| **TOPICAL - ANTIBIOTIC** | MC | BACIT/NEOMYCIN/POLYM OINT | MC/DEL | ALTABAX [1] | 1. Dosing limits apply, please see dosing consolidation list.<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | BACITRACIN OINT | MC/DEL | BACTROBAN OINT. | | |
| | MC/DEL | BACTROBAN CREA | MC/DEL | TRIPLE ANTIBIOTIC OINT | | |
| | MC/DEL | BACTROBAN NASAL OINT | | | | |
| | MC/DEL | CENTANY OINT 2%[1] | | | | |
| | MC/DEL | GENTAMICIN SULFATE | | | | |
| | MC/DEL | MUPIROCIN[1] | | | | |
| **TOPICAL - ANTIFUNGALS** | MC/DEL | BETAMETHASONE CLOTRIMAZOLE LOT | MC/DEL | BETAMETHASONE CLOTRIMAZOLE CREA | Use PA Form# 10120 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.<br>**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. |
| | MC | CICLOPIROX 0.77 CREA | MC | EXELDERM | | |
| | MC | CICLOPIROX 0.77 SUSP | MC | FUNGIZONE CREA | | |
| | MC/DEL | CLOTRIMAZOLE | MC/DEL | HYDROCORT/IODOQ CREA | | |
| | MC | ECONAZOLE NITRATE CREA | MC/DEL | LAMISIL | | |
| | MC/DEL | KETOCONAZOLE CREA | MC/DEL | LOPROX 0.77 LOTN | | |
| | MC/DEL | LOPROX 1.0 CREA | MC/DEL | LOPROX 0.77 CREA | | |
| | MC/DEL | LOPROX 1.O LOTN | MC/DEL | LOPROX 0.77 SUSP | | |
| | MC/DEL | LOPROX GEL | MC/DEL | LOPROX SHAMPOO SHAM | | |
| | MC/DEL | LOPROX TS LOTN | MC | LOTRIMIN | | |
| | MC/DEL | LOTRISONE CREA | MC/DEL | LOTRISONE LOT | | |
| | MC/DEL | MICONAZOLE NITRATE CREA | MC/DEL | MENTAX CREA | | |
| | MC | MYCO-TRIACET II CREA | MC | MYCOGEN II CREA | | |
| | MC | NIZORAL SHAM | MC | NAFTIN | | |

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| | MC/DEL | NYSTATIN | MC | NYSTAT-RX POWD | | |
| | MC/DEL | NYSTATIN/TRIAMCINOLONE | MC/DEL | OXISTAT | | |
| | MC/DEL | NYSTOP POWD | MC/DEL | PENLAC NAIL LACQUER SOLN | | |
| | MC | PEDI-DRI POWD | | | | |
| | MC/DEL | TINACTIN | | | | |
| | MC | TRI-STATIN II CREA | | | | |
| **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 | DOVONEX | MC | OXSORALEN ULTRA CAPS[1] | 1. Must fail all preferred products before non-preferred.<br>2. Individual ingredients are available as preferred witout PA.<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | SORIATANE CAPS | MC | PSORIATEC CREA[1] | | |
| | MC | TAZORAC | MC/DEL | SORIATANE CK KIT[1] | | |
| | | | MC/DEL | TACLONEX[1,2] | | |
| | | | MC | VECTICAL[1] | | |
| **TOPICAL - ANTISEBORRHEICS** | MC/DEL | SELENIUM SULFIDE SHAM | MC | CARMOL SCALP TREATMENT KIT | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | ZNP BAR | | |
| **TOPICAL - ANTIVIRALS** | | | MC/DEL | DENAVIR CREA[1, 3] | 1. Must fail oral treatment with Acyclovir or Valtrex.<br>2. Approvals limited to 1 tube per 180 days.<br>3. Dosing limits apply, please see dosing consolidation list.<br>Use PA Form# 20420 | |
| | | | MC | ZOVIRAX OINT[1,2] | | |
| **TOPICAL - ANTINEOPLASTICS** | MC | EFUDEX | MC/DEL | CARAC CREA | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC | FLUOROPLEX CREA | MC/DEL | FLUOROURACIL | | |
| | | | MC | SOLARAZE GEL | | |
| **TOPICAL - BURN PRODUCTS** | MC | FURACIN CREA | MC/DEL | SILVADENE 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. |
| | MC/DEL | SILVER SULFADIAZINE CREA | | | | |
| | MC | SSD AF CREA | | | | |
| | MC | SSD CREA | | | | |
| | MC/DEL | THERMAZENE CREA | | | | |
| **TOPICAL - CORTICOSTEROIDS** | | **LOW POTENCY** | MC/DEL | ACLOVATE | Use PA Form# 20420 | At least 1 drug from each potency of preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | DESOWEN | MC | AMCINONIDE CREA | | |
| | MC/DEL | HYDROCORTISONE CREA | MC | ANUSOL HC-1 OINT | | |
| | MC | HYDROCORTISONE LOTN | MC | CLOBEX | | |
| | MC | LACTICARE-HC LOTN | MC | CLODERM CREA | | |
| | MC | NUTRACORT LOTN | MC/DEL | CORDRAN | | |
| | MC | TEXACORT SOLN | MC/DEL | CORMAX | | |
| | | | MC/DEL | CUTIVATE CREA / OINT | | |
| | | **MEDIUM POTENCY** | MC/DEL | CUTIVATE LOTN | | |
| | MC/DEL | DESOXIMETASONE .05% | MC/DEL | DERMATOP | | |
| | MC/DEL | ELOCON | | DESONATE GEL | | |
| | MC/DEL | FLUOCINOLONE ACETONIDE .025-.01% | MC/DEL | DIPROLENE | | |
| | MC | FLUROSYN CREA | MC | ELOCON OINT | | |
| | MC | FLUTICASONE PROPIONATE CREA/OINT | MC | HYDROCORTISONE POWD | | |
| | MC | HYDROCORTISONE BUTYRATE | MC | KENALOG AERS | | |
| | MC | HYDROCORTISONE OINT | MC | LIDA MANTLE HC CREA | | |
| | MC | HYDROCORTISONE VALERATE | MC/DEL | LOCOID | | |
| | MC | MOMETASONE FUROATE OINT | MC/DEL | LUXIQ FOAM | | |
| | MC/DEL | TRIAMCINOLONE ACETONIDE .025-.1% | MC/DEL | OLUX FOAM | | |
| | | | MC | PANDEL CREA | | |
| | | **HIGH POTENCY** | MC | PROCTOCORT CREA | | |
| | MC/DEL | BETAMETHASONE DIPROPIONATE | MC/DEL | PSORCON | | |
| | MC/DEL | DESOXIMETASONE .25% | MC/DEL | PSORCON E | | |
| | MC/DEL | DESONIDE | MC/DEL | TEMOVATE | | |

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|---|---|---|---|---|---|---|---|---|
| | MC/DEL | | FLUOCINOLONE ACETONIDE .02% | MC | | TOPICORT | | |
| | MC/DEL | | FLUOCINONIDE | MC | | TOPICORT LP CREA | | |
| | MC | | HALOG | MC | | ULTRAVATE | | |
| | MC | | HALOG-E CREA | MC/DEL | | VERDESO | | |
| | MC/DEL | | TRIAMCINOLONE ACETONIDE .5% | MC | | WESTCORT | | |
| | | | **VERY HIGH POTENCY** | | | | | |
| | MC/DEL | | AUGMENTED BETA DIP | | | | | |
| | MC/DEL | | BETAMETHASONE VALERATE | | | | | |
| | MC/DEL | | BETA-VAL | | | | | |
| | MC/DEL | | CLOBETASOL PROPIONATE | | | | | |
| | MC | | DIFLORASONE DIACETATE | | | | | |
| | MC | | HALOBETASOL | | | | | |
| | | | **MISCELLANEOUS** | | | | | |
| | MC | | CAPEX SHAM | | | | | |
| | MC | | DERMA-SMOOTHE/FS OIL | | | | | |
| | MC | | PROCTO-KIT CREA 1% | | | | | |
| **TOPICAL - STEROID LOCAL ANESTHETICS** | | | | MC | | EPIFOAM FOAM | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| **TOPICAL - STEROID COMBINATIONS** | MC | | DERMA-SMOOTHE/FS ATOPIC P KIT | MC | | CARMOL-HC CREA | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| **TOPICAL - EMOLLIENTS** | MC | | AMMONIUM LACTATE LOTN 12% | MC/DEL | | AMMONIUM LACTATE 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. |
| | MC | | LAC-HYDRIN CREA | MC | | LAC-HYDRIN LOTN 12% | | |
| | MC | | UREACIN-20 CREA | MC | | MEDERMA GEL | | |
| | MC | | VITAMIN A & D MEDICATED OINT | MC | | MIMYX | | |
| | | | | MC | | RENOVA CREA | | |
| **TOPICAL - ENZYMES / KERATOLYTICS / UREA** | MC | | GRANUL-DERM AERS | MC | | CARMOL 40 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.<br><br>Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain. |
| | MC/DEL | | GRANULEX AERS | MC | | SALEX CREA | Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain. | |
| | MC | | TBC AERS | MC | | SALEX LOTN | | |
| | MC | | SANTYL OINT | | | | | |
| **TOPICAL - GENITAL WARTS** | MC/DEL | | ALDARA | MC/DEL | 5 | PODOFILOX SOLN | Use PA Form# 20420 | |
| | | | | MC/DEL | 8 | CONDYLOX[1] | 1. Non-preferred products must be used in specified order. | |
| | | | | MC | 8 | VEREGEN[1] | | |
| | | | | MC | 8 | ZYCLARA[1] | | |
| **TOPICAL - IMMUNOMODULATORS** | | | | MC/DEL | 8 | ELIDEL CREA[1] | Use PA Form# 20420 | Preferred corticosteroids from other classes must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be made for small amounts of non-preferred products for the treatment of very steroid-sensitive areas in conjunction with topical steroids for the treatment of atopic dermatitis. |
| | | | | MC | 9 | PROTOPIC OINT[1,2] | 1. Non-preferred products must be used in specified order.<br><br>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. | |
| **TOPICAL - LOCAL ANESTHETICS** | MC | | AF CAPSICUM OLEORESIN CREA | MC/DEL | | EMLA PADS | 1. Lidocaine/Prilocaine cream and Ela-Max products require PA for users over 18 years of age. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC/DEL | | CAPSAICIN CREA | MC/DEL | | EMLA CREA | | |
| | MC | | ELA-MAX[1] | MC | | LIDA MANTLE CREA | | |
| | MC/DEL | | LIDOCAINE/PRILOCAINE CREA[1] | MC | | LIDODERM PTCH | | |
| | MC/DEL | | XYLOCAINE | MC | | PONTOCAINE SOLN | | |
| | | | | MC | | SYNERA | Use PA Form# 20420 | |
| | | | | MC | | ZOSTRIX | | |

| Class | | | Preferred | | | Non-Preferred | PA Form / Notes | Criteria |
|---|---|---|---|---|---|---|---|---|
| TOPICAL - DEPIGMENTING AGENTS | | | | MC | 8 | ALUSTRA CREA | Not covered for cosmetic purposes.<br>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. |
| | | | | MC | 8 | EPIQUIN MICRO | | |
| | | | | MC | 8 | GLYQUIN CREA | | |
| | | | | MC/DEL | 8 | HYDROQUINONE CREA | | |
| | | | | MC/DEL | 8 | HYDROQUINONE/SUNSCREENS | | |
| | | | | MC | 8 | SOLAQUIN FORTE CREA | | |
| | | | | MC | 8 | TRI-LUMA CREA | | |
| | | | | MC | 9 | ELDOQUIN | | |
| TOPICAL - SCABICIDES AND PEDICULICIDES | MC/DEL | | ACTICIN CREA | MC/DEL | | LINDANE | Use PA Form# 20420<br>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. |
| | MC | | ELIMITE CREA | MC | | MALATHION | | |
| | MC | | EURAX | MC | | NATROBA[1] | | |
| | MC | | LICE KILLING SHAM | MC | | OVIDE LOTN | | |
| | MC/DEL | | LICE TREATMENT CREME RINS LIQD | MC | | ULESFIA | | |
| | MC/DEL | | PERMETHRIN LOTN | | | | | |
| TOPICAL - WOUND / DECUBITUS CARE | | | | MC | | REGRANEX GEL | Use PA Form# 20420<br>Accuzyme and Ethezyme products have been removed from the PDL due to FDA concerns regarding drugs containing Papain. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.<br>Accuzyme and Ethezyme products have been removed from the PDL due to FDA concerns regarding drugs containing Papain. |
| | | | | MC/DEL | | REGENECARE | | |
| | | | | MC/DEL | | RADIAPLEXRX | | |
| TOPICAL - ASTRINGENTS / PROTECTANTS | MC | | ALUMINUM CHLORIDE SOLN | MC | | LOWILA 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. |
| | MC | | DRYSOL SOLN | MC | | MOISTURIN DRY SKIN CREA | | |
| | MC | | XERAC AC SOLN | MC | | PROSHIELD PLUS SKIN PROTE CREA | | |
| | | | | MC | | SURGILUBE GEL | | |
| TOPICAL - ANTISEPTICS / DISINFECTANTS | MC/DEL | | PHISOHEX LIQD | MC | | BETADINE OINT | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | MC/DEL | | POVIDONE-IODINE SOLN | MC | | FORMALYDE-10 AERS | | |
| | | | | MC | | IODOSORB | | |
| | | | | MC | | LAZERFORMALYDE SOLUTION SOLN | | |
| **MISCELLANEOUS EYE** | | | | | | | | |
| OP. - EYE | MC | | AK-DILATE SOLN | MC | | LENS PLUS REWETTING DROPS | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | | EYE WASH SOLN | MC/DEL | | MURO 128 | | |
| | MC | | NAPHAZOLINE HCL SOLN | MC | | NEO-SYNEPHRINE SOLN | | |
| | MC | | PHENYLEPHRINE HCL SOLN | | | | | |
| | MC | | PONTOCAINE SOLN | | | | | |
| | MC/DEL | | SODIUM CHLORIDE | | | | | |
| **MISCELLANEOUS EAR** | | | | | | | | |
| EAR | MC/DEL | | A/B OTIC SOLN | MC | | AERO OTIC 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. |
| | MC | | ACETASOL SOLN | MC | | ANTIBIOTIC EAR SOLN | | |
| | MC/DEL | | ACETASOL HC SOLN | MC | | ANTIBIOTIC EAR SUSP | | |
| | MC/DEL | | ACETIC ACID | MC | | AURALGAN SOLN | | |
| | MC/DEL | | ACETIC ACID/HYDROCORTISON | MC/DEL | | CIPRO HC SUSP | | |
| | MC/DEL | | ALLERGEN SOLN | MC | | COLY-MYCIN-S SUSP | | |
| | MC/DEL | | ANTIPYRINE/BENZOCAINE SOLN | MC/DEL | | CORTISPORIN-TC SUSP | | |
| | MC/DEL | | AURODEX SOLN | MC/DEL | | DEBROX SOLN | | |
| | MC | | AUROGUARD SOLN | MC/DEL | | PEDIOTIC SUSP | | |
| | MC/DEL | | AUROTO OTIC SOLN | MC | | VOSOL-HC SOLN | | |
| | MC | | CARBAMIDE PEROXIDE 6.5% OTIC SOLN. | MC/DEL | | ZOTANE HC SOLN | | |
| | MC/DEL | | CIPRODEX | MC | | ZOTO-HC SOLN | | |
| | MC | | CORTISPORIN SOLN | | | | | |
| | MC/DEL | | CORTOMYCIN | | | | | |
| | MC | | EAR DROPS SOLN | | | | | |
| | MC | | EAR DROPS RX SOLN | | | | | |
| | MC/DEL | | EAR WAX REMOVAL DROPS | | | | | |
| | MC | | EAR-GESIC SOLN | | | | | |
| | MC/DEL | | NEOMYCIN/POLYMYXIN/HC | | | | | |
| | MC/DEL | | OFLOXACIN 0.3% OTIC | | | | | |
| | MC/DEL | | OTICAINE OTIC SOLN | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **MOUTH ANTISEPTICS** | | | | | | | | |
| **MOUTH ANTI-INFECTIVES** | MC | | NILSTAT SUSP | MC | | MYCELEX TROC | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 | | EAR-GESIC SOLN | MC | | ORAVIG | | |
| | MC/DEL | | NYSTATIN SUSP | | | | | |
| **MOUTH ANTISEPTICS** | MC/DEL | | CHLORHEXIDINE GLUCONATE | MC | | APHTHASOL PSTE[1] | Use PA Form# 20420<br>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 | | LIDOCAINE VISCOUS SOLN | MC | | PERIOGARD SOLN[1] | | |
| | MC | | TRIAMCINOLONE IN ORABASE PSTE | MC | | TRIAMCINOLONE ACETONIDE PSTE[1] | | |
| | MC | | TRIAMCINOLONE ORADENT PSTE | | | | | |
| **DENTAL PRODUCTS** | | | | | | | | |
| **DENTAL PRODUCTS** | MC/DEL | | ETHEDENT CREA | MC0MC | | APF GEL 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/DEL | | GEL-KAM CONC | MC/DEL | | DENTAGEL GEL | | |
| | MC/DEL | | GEL-KAM GEL 0.4% | MC/DEL | | PHOS-FLUR GEL | | |
| | MC/DEL | | PHOS FLUR SOLN | MC/DEL | | PREVIDENT CREA | | |
| | MC/DEL | | PREVIDENT GEL | MC | | THERA-FLUR-N GEL | | |
| | MC/DEL | | PREVIDENT SOLN | | | | | |
| | MC/DEL | | SF 5000 PLUS CREA | | | | | |
| | MC/DEL | | SF GEL | | | | | |
| | MC | | STANNOUS FLUORIDE ORAL RI CONC | | | | | |
| **ARTIFICIAL SALIVA/STIMULANTS** | | | | | | | | |
| **ARTIFICIAL SALIVA/STIMULANTS** | MC | | SALIVA SUBSTITUTE SOLN | MC | | EVOXAC CAPS | Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | | | | MC | | RADIACARE SOLR | | |
| | | | | MC | | SALAGEN TABS | | |
| **MISCELLANEOUS ANORECTAL** | | | | | | | | |
| **ANORECTAL - MISC.** | MC/DEL | | COLOCORT ENEM | MC/DEL | | ANUSOL-HC CREA | Use PA Form# 20420 | |
| | MC | | CORTENEMA ENEM | MC/DEL | | CORTIFOAM FOAM | | |
| | MC | | ELA-MAX 5 CREA | MC/DEL | | PROCTOCREAM-HC CREA | | |
| | MC/DEL | | HYDROCORTISONE ENEM | MC/DEL | | PROCTOFOAM HC FOAM | | |
| | MC/DEL | | PROCTOZONE-HC CREA | MC/DEL | | PROCTO-KIT CREA 2.5% | | |
| | | | | MC/DEL | | PROCTOSOL HC CREA | | |
| **T-CELL ACTIVATION INHIBITOR** | | | | | | | | |
| **PSORIASIS BIOLOGICALS** | MC | | ENBREL 25MG INJECTIONS ONLY[4] | MC | | **AMEVIVE[2]** | 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.<br>2. Trial of both preferred drugs are required.<br>3. Use multiple 25mg injections.<br>4. Preferred dosage form allowed without PA after trial of step 1 prodcuts is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa.<br>Use PA Form# 20910 | Approved for severe chronic plaque psoriasis unresponsive to first line therapies. A trial of at least several potent topicals from the following categories: corticosteroids, coal tars, anthralin, calcipotriene and tazorotene, and at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin and phototherapy/UVA.<br>Enbrel 25mg 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. |
| | MC | | HUMIRA[1] | MC | | ENBREL 50 MG[3] | | |
| | | | | MC | | STELARA | | |
| **ALTERNATIVE MEDICINES** | | | | | | | | |
| **ALTERNATIVE MEDICINES** | MC | | DIMETHYL SULFOXIDE SOLN | MC/DEL | | CO-ENZYME Q-10 | 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. |
| | | | | MC | | MELATONIN TABS | | |
| **CHELATING AGENTS** | | | | | | | | |
| **CHELATING AGENTS** | MC/DEL | | **CUPRIMINE CAPS** | MC | | DEPEN TITRATABS TABS | Use PA Form# 20420 | |

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|---|---|---|---|---|---|---|---|---|
| | | | | MC/DEL | | EXJADE[1] | 1. FDA indication of treatment of chronic iron ovrload due to blood transfustions in membes 2 years of age and older is requried for approval of Exjade. | |
| **ANTILEPROTIC** | | | | | | | | |
| **ANTILEPROTIC** | | | | MC | | THALOMID CAPS[1] | 1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules.<br><br>Use PA Form# 20420 | Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS. |
| **ANTINEOPLASTIC AGENTS** | | | | | | | | |
| **ANTINEOPLASTIC AGENTS - ANTIADNDROGENS** | MC/DEL | | BICALUTAMIDE | MC/DEL | | CASODEX | Use PA Form# 20420 | |
| **ANTINEOPLASTIC AGENTS- LHRH ANALOGS** | MC | | LUPRON DEPOT[1] | MC<br>MC<br>MC/DEL | | VANTAS[2]<br>FIRMAGON[2]<br>TRELSTAR | 1. Dosing limits apply, please refer to dosage consolidation list.<br><br>2. PA required to confirm FDA approved indication.<br><br>Use PA Form# 20420 | |
| **ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS** | | | | MC<br>MC/DEL<br>MC | | SPRYCEL[1]<br>TYKERB[2]<br>GLEEVEC[1] | Use PA Form# 20420<br>1. Verification of diagnosis is required.<br>2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions. | |
| **ANTINEOPLASTICS- MISCELLANEOUS** | MC/DEL | | MERCAPTOPURINE | MC/DEL<br>MC/DEL | | ZOLINZA<br>PURINETHOL | Use PA Form# 20420 | |
| **ANTINEOPLASTICS- MONOCLONAL ANTIBODIES** | | | | MC/DEL | | HERCEPTIN[1] | 1. PA required to confirm FDA approved indication.<br><br>Use PA Form# 20420 | |
| **CANCER** | | | | | | | | |
| **CANCER** | MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL | | ALIMTA<br>ANASTROZOLE TABS<br>AVASTIN<br>ERBITUX<br>VIDAZA | MC/DEL<br>MC<br>MC<br>MC/DEL | | ARIMIDEX<br>FOLOTYN<br>NEXAVAR[1]<br>SUTENT[1,2] | 1. PA required to confirm FDA approved indication<br>2. Avoid CYP3AY drug drug interaction.<br>Use PA Form# 20420 | |
| **IMMUNOSUPPRESSANTS** | | | | | | | | |
| **IMMUNOSUPPRESSANTS** | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL | | CYCLOSPORINE MODIFIED<br>CYCLOSPORINE SOL. MODIFIED<br>GENGRAF CAPS<br>MYCOPHENOLATE<br>MYFORTIC<br>PROGRAF CAPS<br>RAPAMUNE<br>SANDIMMUNE | MC/DEL<br>MC/DEL<br>MC/DEL | | CELLCEPT<br>CYCLOSPORINE CAPS<br>NEORAL[1,2] | 1. Established users will require a one time PA.<br>2. Established users will require a one time PA<br>Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.<br><br>**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).<br>**DDI:** Cyclosporine will require prior authorization when used with Livalo.<br>**DDI:** All preferred immunosuppressants will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy. |
| **PURINE ANALOG** | | | | | | | | |
| **PURINE ANALOG** | MC<br>MC/DEL | | AZASAN TABS<br>**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. |
| **K REMOVING RESINS** | | | | | | | | |
| **K REMOVING RESINS** | MC/DEL<br>MC<br>MC/DEL | | KAYEXALATE POWD<br>KIONEX POWD<br>SODIUM POLYSTYRENE SULFON | | | | Use PA Form# 20420 | |

| | | | |
|---|---|---|---|
| | MC/DEL | | SPS SUSP |
| | MC/DEL | | SPS 30GM/120ML ENEMA SUSP |

New drugs are initially non-preferred until reviewed by the DUR Committee and the State. According to State policy, any drug requiring specific diagnosis still requires the specific diagnosis unless otherwise noted within this document.

## 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(2nd line) | X(2nd line) | | | | X(2nd line) |
| TOPAMAX | X | | | 9 | 6 | X (2nd 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 |