

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS Required	PA	Comments	Criteria
<p>* PLEASE NOTE: All <i>cost effective</i> generics applicable to DEL are considered PREFERRED Drugs. "BASIC" Covered Drugs are bolded with the Coverage Indicator of "MC / DEL".</p>									
<p>General Criteria for all PDL categories - For more information or help using the PDL, providers may call 1-888-445-0497; members should call 1-866-796-2463. To access PDL and PA materials via the internet: www.mainearepdl.org</p>									
<p>A: Preferred Drugs - Unless otherwise specified, preferred drugs are available without prior authorization. Step order may apply for preferred drugs in some drug categories as indicated on the PDL. (See item "D" below for explanation of step order.)</p>									
<p>B: Requests for Non-preferred Drugs - Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.</p>									
<p>C: Adequate Drug Trials - 1. The minimum trial period for each preferred and step order drug is two weeks, unless otherwise stated within specific PDL drug categories; trials with less than a two week duration will be reviewed on a case-by-case basis; 2. A trial will not be considered valid if preferred or non-preferred products were readily available (by override, individual purchase, samples, etc.); 3. Certain drug trials, such as with controlled substances, may require evidence that the preferred drugs were actually tried (example: with random pill counts and with random urine drug tests, using the methods of GC/MS with no lower threshold); 4. Adequate trials require documentation of attempts to titrate dose of preferred agents toward desired clinical response. 5. Adequate trials include prevention/treatment of common adverse effects associated with preferred agents (example: antinausea, antipruritics, etc.)</p>									
<p>D: Step Order - When numbers appear in the "step order" column, it means drugs in this category must be used in the order specified, with the lower numbers having preference over the higher numbers. Chart notes should be provided to confirm drug trials that do not appear in the member's MaineCare drug profile.</p>									
<p>E. The Department will institute strategies to ensure cost effectiveness through the use of an enhanced Drug Benefit Preferred brand drugs will no longer be preferred in any PDL drug category where preferred generic drugs are also available. It is expected that preferred generics will be used prior to any preferred brands. This will be operated as a form of step care. Preferred brands in these categories will require prior authorization for these high utilization / high cost members.</p>									
<p>F: Brand Name Medication Requests - (Must be submitted on the Brand Name PA request form)- According to MaineCare Benefits Manual Chapter II (80.07-5), when medically necessary covered brand-name drugs have an A-rated generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since the brand-name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. The Bureau does not make determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA. Physicians should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH.</p>									
<p>G: PA requests for non-FDA Approved Indications - Decisions will be made on a case-by-case basis until the DUR committee is able to review the evidence and make a recommendation. Interim approvals and DUR recommendations for approval of a drug for a non-FDA approved indication will require a minimum of two published, peer reviewed, non contradicted, double-blind, placebo-controlled randomized clinical studies establishing both safety and efficacy.</p>									
<p>H: Dose Consolidation Requirements - Some drugs may also be affected by dose consolidation requirements. Please see Dose Consolidation List and/or Splitting Tables provided in the PDL.</p>									
<p>I. Trials from Multiple Drug Classes - Trial/failure/intolerance to preferred agents from multiple classes within the same category or other categories of drugs may be required prior to the approval of non-preferred agents (e.g., Cymbalta, Zofran, Elidel and others).</p>									
<p>J. Drug-specific PA Forms - Drug-specific PA forms contain medical necessity documentation requirements and/or criteria that may not be repeated in the PDL. Drug-specific PA forms may be obtained on the web at www.mainearepdl.org.</p>									
<p>K. PA Exemptions for Prescribers - According to MaineCare Benefits Manual Chapter II (80.07-4), providers may receive a three (3) month exemption from prior authorization requirement for certain categories of drugs when they demonstrate high compliance with the Department's PDL. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption. If a provider loses his/ her exemption, members who previously were not required to obtain a PA while the prescriber was exempt will be required to do so, and criteria for approval of that medication will need to be met.</p>									
<p>L: Drug-Drug Interactions (DDI) - The DUR Committee has implemented new drug-drug interaction edits requiring prior authorization. Several drug-drug combinations and PDL drug categories are affected by new PA requirements. These will be indicated in the PDL with DDI notation. Please see the DDI document provided in the PDL.</p>									
ASSORTED ANTIBIOTICS									
BETA-LACTAMS / CLAVULANATE COMBO'S	MC/DEL		AMOXICILLIN	MC/DEL		AMOXIL 500MG TABS		<p>1. Amoxil 500mg tabs are non-preferred. All other Amoxil products are preferred.</p> <p>2. Principen 250 mg is available without PA.</p> <p>3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA Use PA Form# 20420</p> <p>DDI: Ampicillin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non preferred PPI.</p>	<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.</p>
	MC/DEL		AMOXICILLIN/POTASSIUM CLA CHEW	MC/DEL		AUGMENTIN ES-600 SUSR			
	MC/DEL		AMOXICILLIN/POTASSIUM CLA SUSR	MC/DEL		AUGMENTIN ²			
	MC/DEL		AMOXICILLIN/POTASSIUM CLA TABS	MC		PRINCIPEN CAPS ²			
	MC/DEL		AMOXIL ¹	MC		PRINCIPEN SUSR			
	MC/DEL		AMPICILLIN						
	MC/DEL		AUGMENTIN XR TB12						
	MC		BEEPEN						
	MC		BICILLIN L-A SUSP						
	MC/DEL		DICLOXACILLIN SODIUM CAPS						
	MC		DYNAPEN SUSR						
	MC		GEOCILLIN TABS						
	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		CECLOR ¹		<p>1. Both brand and generic are clinically non-preferred.</p> <p>Use PA Form# 20420</p> <p>DDI: Vantin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non preferred PPI.</p>	<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.</p>
	MC/DEL		CEFAZOLIN SODIUM SOLR	MC		CEDAX			
	MC/DEL		CEFDINIR	MC/DEL		CEFACTOR ¹			
	MC/DEL		CEFPODOXIME SUSP	MC/DEL		CEFADROXIL MONOHYDRATE TABS			
	MC/DEL		CEFPODOXIME 100MG	MC/DEL		CEFTIN			
	MC/DEL		CEFPODOXIME 200MG	MC		CEFZIL			
	MC/DEL		CEFPROZIL	MC/DEL		DURICEF TABS			
	MC		CEFTAZIDIME 6MG	MC/DEL		FORTAZ SOLN			
	MC/DEL		CEFTIN SUSP	MC		KEFLEX CAPS			
	MC/DEL		CEFTRIAZONE	MC		OMNICEF			
	MC/DEL		CEFUROXIME AXETIL TABS	MC/DEL		ROCEPHIN			
	MC/DEL		CEPHALEXIN MONOHYDRATE	MC/DEL		SUPRAX			
	MC/DEL		DURICEF SUSR	MC		TAZICEF SOLR			
	MC/DEL		FORTAZ	MC/DEL		TAZIDIME SOLN			
	MC/DEL		FORTAZ SOLR	MC/DEL		VANTIN 200MG			

				MC/DEL		PRIMAXIN		drug and the preferred drug(s) exists.
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL		CLEOCIN SOLN	MC/DEL		CLEOCIN CAPS	1. Use multiple 150's for Clindamycin instead of 300's. Zyvox: use PA Form # 30820 Others: use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. For Zyvox, please see the criteria listed in the Zyvox PA form.
	MC/DEL		CLEOCIN SUSR	MC/DEL		CLINDAMYCIN HCL 300CAPS ¹		
	MC/DEL		CLINDAMYCIN HCL 150CAPS	MC/DEL		ZYVOX SUSR		
	MC		DAPSONE TABS	MC/DEL		ZYVOX TABS		
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 TRIMETHOPRIM/SULFAMETHOXA					
ANTIPROTOZOALS				MC		ALINIA ¹	1. Alinia 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). 2. Sporanox QL 300cc/month with PA. See quantity limit table. 3. Sporanox QL 30/month with PA. See quantity limit table. Non-preferred products must be used in specified step order. Continue to use Anti-Fungal PA form for non-preferred products. 4. Quantity limit of one tablet daily. Please see dosage consolidation list. 5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy. 6. Eraxis will be approved if submitting with documentation that it was initiated during a hospitalization and this request is to finish the hospital course. 8. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30 days. 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. Please use PA form #20420 for Noxafil	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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. DDI: Preferred ketoconazole will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg. DDI: Any Griseofulvin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non preferred PPI. 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, Protonix, Prilosec, or any currently non preferred PPI, due to a significant drug-drug interaction. 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		FLUCONAZOLE ¹	MC	6	SPORANOX SOLN ²		
	MC/DEL		GRIFULVIN V TABS ¹⁰	MC	6	SPORANOX PULSEPAK CAPS ³		
	MC		GRISEOFULVIN SUSP ¹⁰	MC	7	SPORANOX CAPS ³		
	MC		GRISEOFULVIN ULTRAMICROSI TABS ¹⁰	MC/DEL	8	ERAXIS INJ ⁶		
	MC		GRIS-PEG TABS ¹⁰	MC/DEL	8	DIFLUCAN		
	MC/DEL		KETOCONAZOLE TABS ⁸	MC	8	GRIFULVIN SUSP		
	MC/DEL		NYSTATIN	MC	8	NIZORAL TABS		
	MC/DEL		TERBINAFINE TABS ⁴	MC/DEL	8	NOXAFIL ⁵		
	MC/DEL		VFEND TABS					

ANTI - VIRALS

ANTIRETROVIRALS	MC/DEL		AGENERASE CAPS	MC/DEL		DIDANOSINE	Fuzeon use PA Form # 10620	Please refer to the criteria listed on the Fuzeon PA form.
	MC/DEL		APTIVUS	MC/DEL		FUZEON		
	MC		ATRIPLA ¹	MC/DEL		INTELENCE		
	MC/DEL		COMBIVIR TABS	MC/DEL		ISENTRESS		
	MC/DEL		CRIVIVAN CAPS	MC/DEL		SELZENTRY	1. Quantity limit of one per	DDI: Reyataz will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non

	MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL		EMTRIVA EPIVIR / HBV EPZICOM FORTOVASE CAPS HIVID TABS INVIRASE CAPS KALETRA LEXIVA NORVIR PREZISTA ² RESCRIPTOR TABS RETROVIR REYATAZ STAVUDINE SUSTIVA TRIZIVIR TABS TRUVADA VIDEX / EC VIRACEPT TABS VIRAMUNE TABS VIREAD TABS ZIAGEN TABS	MC MC/DEL MC/DEL	ZERIT	day 2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista	preferred PPI. 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. 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.
CYTO-MEGALOVIRUS AGENTS	MC MC		FOSCARNET SODIUM VALCYTE TABS	MC MC/DEL MC/DEL	CYTOVENE CAPS FOSCAVIR GANCICLOVIR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HERPES AGENTS	MC/DEL MC/DEL		ACYCLOVIR VALTREX TABS	MC/DEL MC/DEL	FAMVIR TABS ZOVIRAX	Must fail Acyclovir and Valtrex before non-preferred products. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
INFLUENZA AGENTS	MC/DEL MC MC/DEL MC/DEL		AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU ¹	MC/DEL MC MC	FLUMADINE TABS FLUMIST ²	1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member. 2. For Flumist requests Use Form # 10610 Others Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
IMMUNE SERUMS							
IMMUNE SERUMS			HYPERRHO INJ				
HEPATITIS AGENTS							
HEPATITIS C AGENTS	MC/DEL MC/DEL MC/DEL MC/DEL MC		PEGASYS KIT ¹ PEGASYS SOLN PEG-INTRON KIT REBETRON KIT RIBAVIRIN	MC/DEL MC/DEL	COPEGUS TABS REBETOL CAPS	1. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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 MC	BARACLUDE TYZEKA		
RSV PROPHYLAXIS							
RSV PROPHYLAXIS				MC	SYNAGIS ¹	Use PA Form # 30120 1. MaineCare will approve Synagis PA's for start date of November 5th for infants who meet the guidelines. PA will be approved for max of 5 doses and good thru March 31, unless Maine specific data suggests ongoing epidemic RSV activity.	Please see the criteria listed on the Synagis PA form.
MS TREATMENTS							
MULTIPLE SCLEROSIS - INTERFERONS	MC MC/DEL MC		AVONEX KIT ¹ BETASERON SOLR ¹ REBIF SOLN ¹			1. Clinical PA is required to establish diagnosis and medical necessity.	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	8 TYSABRI ¹	1. Providers must be enrolled in the TOUCH	

INTERFERONS						enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity.	
						2. Clinical PA is required to establish diagnosis and medical necessity.	
						Use PA Form # 20430	
ASSORTED NEUROLOGICS							
NEUROLOGICS - MISC.	MC MC/DEL MC		MESTINON ORAP TABS PROSTIGMIN TABS	MC MC/DEL MC		BOTOX MYOBLOC ¹	1. Myobloc approval will be limited to Cervical Dystonia. Use PA Form #10210
STERIODS							
GLUCOCORTICOID/ MINERALOCORTICOID	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS DEPO-MEDROL SUSP DEXAMETHASONE ENTOCORT EC CP24 FLUDROCORTISONE ACETATE TABS HYDROCORTISONE KENALOG METHYLPREDNISOLONE TABS PREDNISOLONE PREDNISONE SOLU-CORTEF SOLR SOLU-MEDROL SOLR	MC MC MC/DEL MC/DEL MC MC MC MC MC MC MC MC		CORTEF 10 and 20 TABS DECADRON TABS FLORINEF TABS MEDROL TABS MEDROL DOSEPAK TABS ORAPRED SOLN PEDIAPRED LIQD PREDNISONE INTENSOL CONC PRELONE SYRP STERAPRED TABS	Use PA Form# 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
HORMONE REPLACEMENT THERAPIES							
ANDROGENS / ANABOLICS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC		ANDRODERM PT24 ANDROGEL ANDROID CAPS DANAZOL CAPS DEPO-TESTOSTERONE OIL FLUOXYMESTERONE TABS TESTOSTERONE PROPIONATE TESTRED CAPS WINSTROL TABS	MC MC MC MC/DEL MC/DEL MC/DEL		ANDRO LA 200 OIL DELATESTRYL OIL HALOTESTIN TABS METHITEST TABS OXANDRIN TABS ¹ TESTIM	Use PA Form# 20420 1. Non-preferred effective 12.01.05. Use the Oxandrin PA Form #20600
ESTROGENS - PATCHES / TOPICAL	MC/DEL MC/DEL		ESTRADERM PTTW ¹ VIVELLE-DOT PTTW ¹	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	5 8 8 8 8 8	ESTRADIOL PTWK ALORA PTTW CLIMARA PTWK DIVIGEL ELESTRIN EVAMIST	1. Both preferred drugs must be tried. 2. Step order drugs must be used in specified step order. Use PA Form# 20420
ESTROGENS - TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CENESTIN TABS ESTRADIOL ESTROPIPATE TABS MENEST TABS PREMARIN TABS	MC/DEL MC/DEL MC MC/DEL MC		ENJUVA ESTRACE TABS ESTRATAB TABS OGEN TABS ORTHO-EST TABS	Must fail preferred products before non-preferred products. Use PA Form# 20420
ESTROGEN COMBO'S	MC/DEL MC/DEL		PREMPHASE TABS PREMPRO TABS	MC/DEL MC/DEL MC/DEL MC/DEL		ACTIVELLA TABS COMBIPATCH PTTW FEMHRT 1/5 TABS ORTHO-PREFEST TABS SYNTEST H.S. TABS	Must fail Premphase and Prempro products before non preferred products. Use PA Form# 20420
PROGESTINS	MC/DEL MC/DEL MC		MEDROXYPROGESTERONE ACETA ² NORETHINDRONE ACETATE TABS ² PROGESTERONE POWD	MC/DEL MC MC/DEL MC/DEL MC/DEL		AYGESTIN TABS CYCRIN TABS PROMETRIUM 100MG CAPS ¹ PROMETRIUM 200MG ¹ PROVERA TABS	1. PA approvals will require two 100 mg caps instead of one 200mg. 2. Must fail Medroxyprogesterone and Norethidrone products before non-preferred products. Use PA Form# 20420
CONTRACEPTIVES							
CONTRACEPTIVES -	MC		ORTHO MICRONOR TABS	MC/DEL		CAMILA TABS	If member experienced Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is

PROGESTIN ONLY				MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ERRIN JOLIVETTE NORA-BE TABS NORA-OD TABS OVRETTE 28 TABS	adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form# 20420	offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVES - INJECTABLE	MC/DEL		MEDROXYPROGESTERONE ACETATE 150mg IM	MC/DEL MC/DEL	DEPO-PROVERA 150 mg SUSP LUNELLE 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		PLAN - B ¹			1. Allowed 4 tablets per 30 days without PA Use PA Form# 20420	
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC/DEL MC		NUVARING RING ³ ORTHO EVRA PTWK ^{1,2,4}			1.No PA required for users less than 21 years of age. 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 exposure 3. Quantity limit allowing 1 every 28 days with out PA. 4. Dose limits apply allowing 3 patches per 28 days supply. Please refer to Dose Consolidation Chart.	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		APRI TABS BALZIVA CRYSSELLE-28 TABS DESOGEN TABS DESOGESTREL/ ETHINYL ESTRADIOL LOW-OGESTREL TABS MODICON TABS MONONESSA ORTHO-CEPT-28 TABS ORTHO-CYCLEN-28 TABS ORTHO-NOVUM 1/35-28 TABS ORTHO-NOVUM 1/50-28 TABS OVCON-50 28 TABS PREVIFEM RECLIPSEN SOLIA SPRINTEC 28 TABS YASMIN 28 TABS ZENCHENT	MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	AVIANE TABS BREVICON-28 TABS DEMULEN 1/35-21 TABS KARIVA TABS LESSINA-28 TABS LEVORA LOESTRIN TABS LOESTRIN FE TABS LOESTRIN FE 1/20 TABS LOESTRIN 1.5/30-21 TABS LOESTRIN 1/20-21 TABS LO/OVRAL 21 TABS LO/OVRAL 28 TABS MICROGESTIN FE TABS MIRCETTE TABS NECON NORDETTE-28 TABS NORINYL NORTREL OCELLA OGESTREL TABS OVCON-35/28 TABS OVRAL PORTIA-28 TABS SEASONALE YAZ ZOVIA	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS	MC/DEL MC/DEL MC MC/DEL		ENPRESSE NECON 7/7/7 ORTHO-NOVUM 7/7/7-28 TABS TRI-PREVIFEM	MC/DEL MC/DEL MC MC	CYCLESSA TABS ESTROSTEP FE TABS NORTREL 7/7/7 ORTHO TRI-CYCLEN 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 MC/DEL MC MC/DEL	TRIPHASIL 28 TABS TRI-SPRINTEC TRINESSA TRIVORA-28 TABS	MC MC/DEL	ORTHO TRI-CYCLEN LO TABS TRI-NORINYL 28 TABS	Use PA Form# 20420	
DIABETES THERAPIES						
DIABETIC - INSULIN	MC MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	HUMALOG INJ 100/ML HUMALOG MIX 75/25 HUMULIN N INJ U-100 HUMULIN INJ 70/30 HUMULIN R U-100 LANTUS SOLN LEVEMIR NOVOLIN NOVOLOG NOVOLOG MIX	MC/DEL MC MC MC MC	APIDRA HUMALOG MIX 50/50 HUMULIN INJ 50/50 HUMULIN R INJ U-500 RELION	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - PENFILLS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	LANTUS OPTICLIK PEN ¹ LANTUS SOLOSTAR ¹ LEVEMIR FLEXPEN ¹ NOVOLIN PENFILL ¹ NOVOLIN 70/30 ¹ NOVOLOG MIX PENFILL ¹ NOVOLOG PENFILL SOLN ¹ NOVOLOG MIX FLEXPEN ¹ NOVOLOG FLEXPEN ¹	MC MC MC MC MC MC MC	APIDRA OPTICLIK PEN HUMALOG KWIK INJ 100/ML HUMALOG MIX INJ 75/25 KWP HUMALOG MIX INJ 50/50 KWP HUMALOG PEN SOLN HUMULIN PEN HUMULIN N PN INJ U-100 HUMULIN PEN INJ 70/30	Use PA Form# 20420 Use PA Form# 20420	1. Clinical PA will be required to establish significant visual or neurological impairment.
DIABETIC - DPP-4 ENZYME INHIBITOR	MC/DEL	JANUVIA ¹				1. Preferred if therapeutic doses of melformin 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.
DIABETIC - DPP-4 ENZYME INHIBITOR-COMBO	MC/DEL	JANUMET ¹				1. Preferred if therapeutic doses of melformin 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.
DIABETIC - LANCET-LANCET DEVICE		ONE TOUCH LANCETS FREESTYLE LANCETS UNILET LANCETS UNISTIK LANCING DEVICE AUTOLOT LANCING DEVICE			Use PA Form# 20420	
DIABETIC - SYRINGES-NEEDLES		BD MICRO-FINE BD ULTRA-FINE BD ULTRA-FINE PEN NEEDLES UNIFINE PEN NEEDLES			Use PA Form# 20420	
DIABETIC - OTHER			MC	SYMLIN	Use PA Form #301501	Please see the criteria listed in the Symlin PA form.
DIABETIC MONITOR	MC MC MC MC MC MC MC	FREESTYLE LITE SYSTEM KIT FREESTYLE FLASH SYSTEM KIT FREESTYLE FREEDOM SYSTEM KIT FREESTYLE FREEDOM LITE KIT ONE TOUCH ULTRA 2 KIT ONE TOUCH ULTRA MINI KIT ONE TOUCH ULTRA SMART KIT PRECISION XTRA METER	MC MC MC MC MC MC	ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY	Use PA Form# 20420 Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
DIABETIC TEST STRIPS	MC	FREESTYLE ¹	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.

	MC MC MC MC MC MC	FREESTYLE LITE ¹ ONE TOUCH BASIC ¹ ONE TOUCH SURESTEP ¹ ONE TOUCH FAST TAKE ¹ ONE TOUCH ULTRA ¹ PRECISION XTRA ¹ PRECISION XTRA BETA KETONE 10 CT	MC MC MC MC	ASCENSIA ASSURE EXACTECH PRODIGY	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. 1. Only 50 ct & 100 ct package size. Use PA Form# 20420.
INCRETIN MIMETIC			MC	BYETTA 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. Use PA Form# 10230
DIABETIC - ORAL SULFONYLUREAS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	CHLORPROPAMIDE TABS GLIMEPIRIDE GLIPIZIDE TABS GLIPIZIDE ER TABS GLYBURIDE TABS GLYBURIDE MICRONIZED TABS TOLAZAMIDE TABS TOLBUTAMIDE TABS	MC/DEL MC MC/DEL MC/DEL MC/DEL	AMARYL TABS DIABETA TABS GLUCOTROL TABS GLUCOTROL XL TBCR GLYNASE TABS MICRONASE TABS	Use PA Form# 20420. Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: All sulfonylureas (except glyburide) will now be non-preferred and require prior authorization if it is currently being used with either ranitidine or cimetidine. DDI: Glimepiride will now be non-preferred and require prior authorization if it is currently being used with either fluconazole (except 150mg strength) or fluvoxamine. Amaryl is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either fluconazole or fluvoxamine.
DIABETIC -ORAL BIGUANIDES	MC/DEL MC/DEL	METFORMIN HCL TABS METFORMIN ER	MC MC MC/DEL	GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET	Use PA Form# 20420. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - THIAZOL / BIGUANIDE COMBO	MC/DEL MC/DEL MC/DEL	ACTOPLUS MET AVANDARYL AVANDAMET TABS			Use PA Form# 20420. 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 MC/DEL MC/DEL	AVANDIA TABS ¹ ACTOS 15MG TABS ¹ ACTOS 45MG TABS ¹	MC/DEL	ACTOS 30MG TABS ²	1. Actos and Avandia are preferred if therapeutic doses of metformin therapy are seen in members drug profile for at least 60 days prior to initial Actos and Avandia therapy. Avandia and Actos are non-preferred as monotherapy. 2. Actos 30mg - use two 15mg instead. Use PA Form# 20420. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - ALPHAGLUCOSIDASE	MC/DEL	GLYSET TABS	MC	PRECOSE TABS	Use PA Form# 20420. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - SULFONYLUREA / BIGUANIDE	MC/DEL MC/DEL	GLYBURIDE/METFORMIN DUETACT	MC MC	GLUCOVANCE TABS METAGLIP TABS	Use individual ingredients. Use PA Form# 20420. Approved for patients failing to achieve good diabetic control with maximal doses of individual components.
DIABETIC - MEGLITINIDES	MC/DEL	STARLIX TABS	MC/DEL	PRANDIN TABS	Use PA Form# 20420. Preferred drugs from other diabetic sub-categories must be tried and failed due to lack of inadequate diabetic control or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 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 MC/DEL	GLUCAGON DIAGNOSTIC KIT GLUCAGEN DIAGNOSTIC KIT	Use PA Form# 20420.
THYROID					

THYROID HORMONES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ARMOUR THYROID TABS CYTOMEL TABS LEVOTHROID TABS LEVOTHYROXINE SODIUM TABS LEVOXYL TABS THYROID TABS THYROLAR UNITHROID TABS	MC MC		LEVOTHYROXINE SODIUM SOLR 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 MC/DEL		METHIMAZOLE TABS 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 MC/DEL MC/DEL MC/DEL		ALENDRONATE BONIVA TABS ² FORTICAL FOSAMAX SOLN ² MIACALCIN SOLN ²	MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL		ACTONEL TABS BONIVA INJECTION KIT AREDIA SOLR DIDRONEL TABS EVISTA TABS ¹ FORTEO FOSAMAX PLUS D FOSAMAX TABS	Use PA Form# 20420 1. Approval only requires failure of Fosamax or Boniva. 2. Quantity limits apply, please see dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CALCIMIMETIC AGENTS								
CALCIMIMETIC AGENTS				MC		SENSIPAR	Use PA Form # 30115	Baseline PTH, Ca, and phosphorus 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 MC/DEL		GENOTROPIN ¹ NUTROPIN ¹	MC/DEL MC/DEL MC MC MC	5 5 8 8 8	NORDITROPIN CARTRIDGE SOLN TEV-TROPIN HUMATROPE SOLR ² INCRELEX ² IPLEX ² SAIZEN SOLR ²	Use PA Form # 10710 1. Clinical PA is required to establish diagnosis and medical necessity. 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.
SOMATOSTATIC AGENTS	MC/DEL		SANDOSTATIN			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 sandostatatin.
URINARY INCONTINENCE								
VASOPRESSINS			DESMOPRESSIN TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL	5 6 6 8 8	DDAVP TABS DDAVP SOLN DESMOPRESSIN SPRAY DESMOPRESSIN ACETATE SOLN STIMATE SOLN*	Use PA Form# 20420	Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP. Approved for central diabetes insipidus and for nocturnal enuresis. For nocturnal enuresis- must be over 6 years old, must fail an adequate trial of alarm training (higher success rate, lower relapse rate) and must periodically attempt weaning (at 6 month intervals). * Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization.
ANTISPASMODICS	MC/DEL MC		OXYBUTYNIN URISPAS TABS	MC/DEL MC/DEL MC/DEL		CYSTOSPASZ TABS DETROL TABS DITROPAN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTISPASMODICS - LONG ACTING	MC/DEL MC/DEL MC MC MC/DEL MC		DETROL LA CP24 ENABLEX ¹ SANCTURA SANCTURA XR TOVIAZ VESICARE ¹	MC MC/DEL		DITROPAN XL TBCR OXYTROL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. Vesicare 5mg and Enablex 7.5mg maximum doses if given with drugs known to be significant CYP3A4 inhibitors. (Ketoconazole, Sporanox, Erythromycin, Biaxin, Nefazodone, Nelfinavir, and Ritonavir) 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, Kelek, Crixivan, Norvir, ketoconazole, fluconazole, Sporanox, nefazodone, or diltiazem.
CHOLINERGIC	MC/DEL		URECHOLINE					
METABOLIC MODIFIER								
HERED. TYROSINEMIA				MC		ORFADIN	Use PA Form# 20420	Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA.
ANTIHYPERTENSIVES / CARDIAC								
CARDIAC GLYCOSIDES	MC/DEL MC/DEL MC/DEL		DIGITEK TABS DIGOXIN LANOXICAPS					

	MC/DEL		LANOXIN				
ANTIANGINALS--Isosorbide Dinitrate/ Mono-Nitrates	MC/DEL MC/DEL		ISOSORBIDE MONONITRATE TABS ISOSORBIDE MONONITRATE ER	MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		DILATRATE SR CPCR ISORDIL TABS ISORDIL TITRADOSE TABS ISOSORBIDE DINITRATE SUBL ISOSORBIDE DINITRATE TABS ISOSORBIDE DINITRATE CR TBCR ISOSORBIDE DINITRATE ER TBCR ISOSORBIDE DINITRATE TD TBCR IMDUR TB24 ISMO TABS MONOKET TABS	Use PA Form# 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
NITRO - OINTMENT/CAP/CR	MC MC/DEL MC MC		NITROBID OINT NITROGLYCERIN CPCR NITROL OINT NITRO-TIME CPCR				
NITRO - PATCHES	MC/DEL MC/DEL MC/DEL MC/DEL	1 1 1 3	NITROGLYCERIN PT24 NITREK PT24 NITRO-DUR PT 24 0.8MG MINITRAN PT24	MC MC/DEL		NITRODISC PT24 NITRO-DUR PT24	At least 2 step 1's and step 3 of the preferred products must be used in specified order or PA will be required. Use PA Form# 20420
NITRO - SUBLINGUAL/ SPRAY	MC MC/DEL MC/DEL		NITROLINGUAL AERS NITROSTAT SUBL NITROTAB SUBL	MC MC/DEL		NITROLINGUAL SOLN NITROQUICK SUBL	Use PA Form# 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - NON SELECTIVE	MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CARVEDILOL LEVATOL TABS NADOLOL TABS PINDOLOL TABS PROPRANOLOL HCL SOLN ¹ PROPRANOLOL HCL TABS ¹ PROPRANOLOL LA CAPS SOTALOL HCL TABS TIMOLOL MALEATE TABS	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC		BETAPACE TABS BETAPACE AF TABS COREG CR ³ COREG TABS CORCARD TABS INDERAL TABS INDERAL LA CPCR INNOPRAN XL PROPRANOLOL HCL 60MG TABS ² RANEXA	1. Recommend using BID since its effects do not last 24 hours. 2. Please use other strengths in combination to obtain this dose. 3. Dosing limits still apply. Please see dose consolidation list Use PA Form# 20420
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		ACEBUTOLOL HCL CAPS ATENOLOL TABS ¹ BETAXOLOL HCL TABS BISOPROLOL FUMARATE TABS METOPROLOL TARTRATE TABS ¹ TOPROL XL TB24	MC/DEL MC MC/DEL MC MC/DEL MC/DEL		BYSTOLIC KERLONE TABS LOPRESSOR TABS METOPROLOL ER SECTRAL CAPS TENORMIN TABS ZEBETA TABS	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form# 20420
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 MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL	1 1 1 1 1 4 4 4 4	AMLODIPINE ¹ DILTIA XT CP24 DILTIAZEM HCL ER CP24 DILTIAZEM HCL XR CP24 DILTIAZEM CD 300MG CP24 DILTIAZEM CD 360MG CP24 CARTIA XT CP24 DILTIAZEM CD CP24 DILTIAZEM HCL ER CP24 DILTIAZEM XR CP24	MC/DEL MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL		NORVASC TABS ¹ DILACOR XR CP24 TAZTIA TIAZAC CP24 CARDIZEM TABS CARDIZEM CD CP24 CARDIZEM LA TB24 CARDIZEM SR CP12 DILTIAZEM HCL TABS DILTIAZEM HCL ER CP12	1. Dosing limits apply, please see dose consolidation list. Products must be used in specified order or PA will be required. Just write "Diltiazem 24-hour" and the pharmacy will use a preferred long acting diltiazem that does not require PA. Use PA Form# 20420
				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 MC		DYNACIRC CAPS DYNACIRC CR TBCR ¹	Use PA Form# 20420 1. Established users will be grandfathered
				MC/DEL MC/DEL MC/DEL		CARDENE CAPS CARDENE SR CPCR NICARDIPINE HCL CAPS	Use PA Form# 20420 Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL MC/DEL		AFEDITAB CR NIFEDIAC CC	MC MC/DEL		ADALAT CC TBCR NIFEDIPINE CAPS	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 MC/DEL MC/DEL		NIFEDICAL XL TBCR NIFEDIPINE TBCR NIFEDIPINE ER TBCR	MC MC/DEL		PROCARDIA CAPS PROCARDIA XL TBCR		Use PA Form# 20420.	drug interaction between another drug and the preferred drug(s) exists.
				MC		SULAR TB24		Established users of 10MG and 20MG strengths are grandfathered.	
	MC/DEL MC/DEL MC/DEL	1 1 1	VERAPAMIL HCL CR TBCR VERAPAMIL HCL ER TBCR VERAPAMIL HCL SR TBCR	MC/DEL MC/DEL MC MC/DEL MC MC MC		CALAN TABS CALAN SR TBCR COVERA-HS TBCR ISOPTIN-SR VERAPAMIL HCL ER CP24 VERAPAMIL HCL SR CP24 VERAPAMIL HCL TABS VERELAN CP24 VERELAN PM CP24		Products must be used in specified order or PA will be required. Just write "Verapamil 24-hour" and the pharmacy will use a preferred long acting generic that does not require PA. Use PA Form# 20420.	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIARRHYTHMICS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC		AMIODARONE FLECAINIDE MEXILETINE NORPACE PROCAINAMIDE PROCANBID CR PROPafenONE QUINAGLUTE QUINIDINE GLUCONATE QUINIDINE SULFATE RYTHMOL	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL		CORDARONE DISOPYRAMIDE MEXITIL PACERONE QUININDEX TAMBOCOR TIKOSYN ¹		1. Prescription must be written by Cardiologist. Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 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).
ACE INHIBITORS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BENAZEPRIL HCL CAPTOPRIL TABS ENALAPRIL MALEATE TABS FOSINOPRIL SODIUM LISINOPRIL TABS RAMIPRIL QUINAPRIL	MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL	5 5 8 8 8 8 8 8 8 8 8	MAVIK TABS ACCUPRIL TABS ACEON TABS ALTACE CAPS CAPOTEN TABS LOTENSIN TABS MOEXIPRIL MONOPRIL HCT TABS PRINIVIL TABS UNIVASC VASOTEC TABS ZESTRIL TABS		Non-preferred products must be used in specified order. Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception.
ANGIOTENSIN RECEPTOR BLOCKER	MC MC/DEL MC/DEL MC/DEL MC/DEL		AVAPRO BENICAR TABS COZAAR TABS 25MG ² DIOVAN MICARDIS TABS	MC/DEL MC/DEL MC		ATACAND TABS COZAAR 50MG & 100MG ¹ TEVETEN TABS		Use PA Form# 20420. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. 1. Please use multiple preferred 25mg tabs. 2. Dosing limits apply. Please see dose consolidation list.	The initial criteria to use any ARB is that the member must have failed ACE inhibitors (such as due to coughing) in the past or must currently be actively treated for diabetes and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIRECT RENIN INHIBITOR				MC/DEL		TEKTURNA ¹		1. Must show failure of single and combination therapy from all preferred antihypertensive ^{pharmacologic} Use PA Form# 20420.	
ANTIHYPERTENSIVES - CENTRAL	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		CATAPRES-TTS CLONIDINE HCL TABS GUANFACINE HCL TABS HYDRALAZINE HCL TABS HYLOREL TABS METHYLDOPA TABS MINOXIDIL TABS PRAZOSIN HCL CAPS RESERPINE TABS	MC/DEL MC MC MC MC/DEL		CATAPRES TABS GUANABENZ ACETATE TABS ISMELIN TABS MINIPRESS CAPS TENEX TABS		Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ACE INHIBITORS AND CA CHANNEL BLOCKERS				MC/DEL MC/DEL MC		LEXXEL TBCR LOTREL CAPS TARKA TBCR		Use individual preferred generic medications. Use PA Form# 20420.	
ACE AND THIAZIDE COMBO'S	MC/DEL		BENAZEPRIL HCL/HYDROCHLOR	MC/DEL		ACCURETIC 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

	MC/DEL MC/DEL MC/DEL		CAPTOPRIL/HYDROCHLOROTHIA ENALAPRIL MALEATE/HCTZ TABS LISINOPRIL-HCTZ TABS	MC MC/DEL MC MC/DEL MC MC/DEL	CAPOZIDE TABS LOTENSIN HCT TABS MONOPRIL HCT TABS PRINZIDE TABS UNIRETIC TABS VASERETIC TABS ZESTORETIC TABS		offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL MC/DEL MC/DEL		ATENOLOL/CHLOROTHALIDONE BISOPROLOL FUMARATE/HCTZ PROPRANOLOL/HCTZ	MC MC/DEL MC/DEL MC MC MC/DEL	CORZIDE TABS INDERIDE 40/25 TABS LOPRESSOR HCT TABS TENORETIC TIMOLIDE 10/25 TABS ZIAC TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ARB'S AND CA CHANNEL BLOCKERS	MC/DEL MC/DEL		AZOR EXFORGE				
ARB'S AND DIURETICS	MC MC/DEL MC/DEL MC/DEL MC/DEL		AVALIDE TABS BENICAR HCT DIOVAN HCT TABS HYZAAR TABS MICARDIS HCT TABS	MC/DEL MC MC MC MC/DEL	ATACAND HCT TABS TEVETEN HCT TABS	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form# 20420	Same initial criteria as the ARB class and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIURETICS	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		ACETAZOLAMIDE TABS BUMETANIDE CHLOROTHIAZIDE TABS CHLOROTHALIDONE TABS EDECIN TABS FUROSEMIDE HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS METHYLCLOTHIAZIDE TABS SPIRONOLACTONE 25MG TABS SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ ZAROXOLYN TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL	ALDACTAZIDE TABS ALDACTONE TABS AMILORIDE HCL BUMEX TABS DEMADEX TABS DIAMOX DIURIL DYAZIDE CAPS ENDURON TABS INSPIRA LASIX TABS LOZOL TABS MAXZIDE MICROZIDE CAPS MIDAMOR TABS MODURETIC 5-50 TABS NAQUA TABS NATURETIN TABS SPIRONOLACTONE 50MG ¹	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspira will be approved for severe breast tenderness and male gynecomastia. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CCB / LIPID	MC/DEL		CADUET				
LIPID DRUGS							
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL MC/DEL		CHOLESTYRAMINE COLESTID	MC/DEL MC MC/DEL	PREVALITE QUESTRAN WELCHOL TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL MC MC		GEMFIBROZIL TABS NIASPAN TRICOR TRILIPIX	MC MC MC MC/DEL MC	ANTARA LOPID LOFIBRA FENOFIBRATE TRIGLIDE	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: 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, or any HMG-COA Reductase Inhibitors (statins).
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS	MC/DEL MC/DEL		LIPITOR SIMVASTATIN ¹	MC/DEL MC MC/DEL	CRESTOR VYTORIN ZOCOR	1. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if they are currently being used in combination cyclosporine. DDI: Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone. DDI: All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS	MC/DEL MC/DEL MC/DEL MC/DEL		LESCOL CAPS LESCOL XL TB 24 LOVASTATIN TABS ² PRAVASTATIN ²	MC/DEL MC/DEL MC MC/DEL MC	ALTOPREV TB 24 MEVACOR TABS PRAVACHOL TABS PRAVIGARD 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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zetia will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins. DDI: Lescol will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac. DDI: Lovastatin (doses greater than 40mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone.

								2. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420.	DDI: Lovastatin (doses greater than 20mg per day) will now be non-preferred and require prior authorization if it is currently being used in combination cyclosporine. DDI: All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO	MC/DEL MC/DEL		SIMCOR ADVICOR TBCR						
PULMONARY ANTI-HYPERTENSIVES									
PULMONARY ANTI-HYPERTENSIVES	MC/DEL MC MC/DEL		REVATIO ¹ VENTAVIS ² EPOPROSTENOL INJ ⁵	MC/DEL MC		FLOLAN REMODULIN ³	3. There will be dosing limits of one 20ml multidose vial/ 30 days supply without pa. 4. Viagra would be approved after a diagnosis of pulmonary hypertension is confirmed. 5. PA is required to establish and confirm who group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 & 4 Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2,3, or 4. 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		TRACLEER ²	MC		LETAIRIS ¹	1. Providers must be registered with LEAP Prescribing program, a restricted distribution program. 2. Prior authorization required to establish PAH diagnosis and class 3 or 4 symptoms.	Tracleer approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4. Letairis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and functional class 2 or 3 symptoms.	
IMPOTENCE AGENTS									
IMPOTENCE AGENTS							As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.		
ANTI-EMETOGENICS									
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC	MC/DEL MC/DEL MC/DEL MC/DEL MC		MECLIZINE HCL TABS PHENERGAN SUPP PHENERGAN FORTIS SYRP PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72	MC MC/DEL MC/DEL MC/DEL MC		ANTIVERT TABS PHENERGAN SOLN PHENERGAN TABS PROMETHAZINE 50MG SUPP PROMETHEGAN SUPP TORECAN TABS	Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC MC/DEL MC MC MC/DEL		EMEND MARINOL CAPS ONDANSETRON TABS* ² ONDANSETRON ODT TBDP* ² ZOFTRAN SOLN ²	MC MC MC MC/DEL MC MC/DEL		ALOXI ANZEMET TABS CESAMET ¹ KYTRIL SANCUSO ZOFTRAN ODT TBDP* ZOFTRAN TABS*	*See quantity limit table. 1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred anti-emetics, including 5-HT3 class (Zofran, Emend) and Marinol. 2. Ondansetron will be preferred with CA diag and dosing limits still apply. Ondansetron: use PA Form # 20610 Others: use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * 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									
ANTHISTIMINES - NON-SEDATING	MC		ALAVERT TABS	MC/DEL	5	CLARINEX TABS ¹	1. Must fail preferred drugs,	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	

SEDATING	MC/DEL MC MC MC/DEL MC/DEL	CETIRIZINE TABS CLARITIN (OTC) CLARITIN SYRP (OTC) LORATADINE TAVIST ND (OTC)	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	5 5 5 5 8 8 8 8	CLARINEX SYR ^{1,2} FEXOFENADINE ¹ ZYRTEC ¹ ZYRTEC SYR ^{1,2} ALLEGRA ³ CLARITIN ³ LORATADINE ODT ⁴ XYZAL ³	OTC loratadine and cetirizine before moving to non-preferred step order drugs. 2. Clarinex and Zyrtec syrup <6 yr w/o PA. 3. Must fail all step 5 drugs (Clarinex, Fexofenadine and Zyrtec) before moving to next step product. 4. All OTC versions of loratadine ODT are now non-preferred. Pseudoephedrine is available with prescription. Use PA Form # 20530	exception is offered on the Prior Authorization form, such as the presence of 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.
ANTIHISTIMINES - OTHER	MC/DEL MC/DEL MC/DEL	CLEMASTINE CHLORPHENIRAMINE DIPHENHYDRAMINE					
ALLERGY / ASTHMA THERAPIES							
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC/DEL MC MC/DEL	ATROVENT AERS ATROVENT HFA SPIRIVA ^{1,2}				1. Quantity limit of 1 inhalation daily (1 capsule for inhalation daily) Spiriva will require PA if Combivent or Atrovent inhaler/nebulizer solution is in member's current drug profile. 2. We ask physicians to write "asthma" on the prescription whenever Spiriva is primarily being used for that condition.	
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 MC/DEL MC/DEL	CROMOLYN SODIUM NEBU INTAL AERS TILADE AERS	MC/DEL		XOLAIR ¹	1. Need max inhaled steroids and written by pulmonary or allergy 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 MC/DEL MC/DEL	FLUTICASON E SPR NASONEX SUSP VERAMYST	MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC	5 5 5 8 8 8 8 8 8 8	BECONASE AQ INHA ¹ NASACORT AQ AERS ¹ NASAREL SOLN ¹ FLONASE SUSP ² FLUNISOLIDE SOLN ² NASACORT AERS ² OMNARIS SPR RHINOCORT AERO ² RHINOCORT AQUA SUSP ² TRI-NASAL SOLN ² VANCENASE POKKETHALER AERS ²	Use PA Form# 20420 Dosing limits apply to whole category, please see dosage consolidation list. 1. All preferred drugs must be tried before moving to non preferred steps. 2. All step 5 medications need to be tried before moving to step 8'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.
ANTIASTHMATIC - NASAL MISC.	MC/DEL MC/DEL MC/DEL MC/DEL	CROMOLYN NASAL 4% NASALCROM OCEAN 0.65% SALINE NASAL SPRAY 0.65%	MC MC MC/DEL MC/DEL	7 7 7 8	ATROVENT NASAL SOL IPRATROPIUM NASAL SOL ¹ ASTELIN ASTEPRO ²	Use PA Form# 20420 1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine. 2. Utilize Multiple preferred, as well as step therapy Astelin.	Approved if patient fails on non-sedating antihistamines and steroid nasal sprays. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - BETA - ADRENERGICS	MC/DEL MC/DEL MC/DEL MC	ALBUTEROL NEB MAXAIR METAPROTERENOL PROAIR HFA ¹	MC/DEL MC/DEL MC/DEL MC/DEL		ACCUNEB NEBU ALBUTEROL AER ALBUTEROL HFA ALBUTEROL 0.63mg/3ml	1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL MC/DEL MC/DEL MC/DEL	PROVENTIL HFA AERS ³ SEREVENT TERBUTALINE SULFATE TABS VENTOLIN HFA AERS ³	MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL	ALUPENT AERP BRETHINE FORADIL AEROLIZER CAPS PROVENTIL VENTOLIN AERS VOLMAX TBCR VOSPIRE ER TB12 XOPENEX HFA ³ XOPENEX NEBU ^{1,2}	2. Dosing limits apply, please see dosage consolidation list. 3. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420.	
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC/DEL MC/DEL	ADVAIR DISKUS/HFA ¹ SYMBICORT ¹			We ask physicians to write "asthma" on the prescription whenever Advair is primarily being used for that condition. 1. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420.	
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL MC/DEL	ALBUTEROL/IPRATROPIUM NEB. SOLN COMBIVENT AERO ²	MC/DEL	DUONEB SOLN ¹	1. Please use preferred individual ingredients Albuterol and Ipratropium. 2. We ask physicians to write "asthma" on the prescription whenever Combivent is primarily being used for that condition. Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	AMINOPHYLLINE TABS THEOCHRON TB12 THEOLAIR-SR TB12 THEOPHYLLINE CR TB12 THEOPHYLLINE ELIX THEOPHYLLINE SOLN THEOPHYLLINE ER CP12 THEOPHYLLINE ER TB12	MC MC MC MC/DEL MC MC/DEL	QUIBRON CAPS QUIBRON-T TABS QUIBRON-T/SR TB12 THEO-24 CP24 THEOLAIR TABS 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 MC/DEL MC/DEL MC/DEL MC/DEL MC	ASMANEX AZMACORT AERS FLOVENT HFA PULMICORT FLEXHALER PULMICORT SUSP ¹ QVAR AERS	MC/DEL MC MC MC/DEL MC/DEL MC	5 AEROBID AERS ² 5 BECLOVENT AERS ² 5 VANCERIL AERS ² 8 AEROBID-M AERS ³ 8 ALVESCO 8 VANCERIL DOUBLE STRENGTH AERS ³	Dosing limits apply to whole category, please see dosage consolidation list. 1. No PA for Pulmicort susp if under 8 years old. 2. All preferreds must be tried before moving to non preferred steps. 3. All step 5 medications need to be tried before moving to step 8's. Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	SINGULAR ¹	MC/DEL	ACCOLATE TABS	1. We ask physicians to write "asthma" on the prescription whenever Singulair is primarily being used for that condition. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR			MC MC	PROLASTIN SUSR ZEMAIRA	Use PA Form# 20420.	Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.
ANTIASTHMATIC - HYDROLYTIC ENZYMES			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. Use PA Form# 20420.	
COUGH/COLD						
COUGH/COLD		DEXTRO-GUAIF SYRP		All others are a non-covered service (this includes	All of cough cold	All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy.

	MC/DEL MC/DEL MC MC	GUAIFENESIN SYRP PSEUDOEPHEDRINE ROBITUSSIN DM SYRP ROBITUSSIN SUGAR FREE SYRP		antihistamines-decongestive combinations).	preparations are not covered except these preferred products. Use PA Form# 20420.
DIGESTIVE AIDS / ASSORTED GI					
Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.					
GI - ANTIPERISTALTIC	MC/DEL MC/DEL MC/DEL MC/DEL MC	DIPHENOXYLATE DIPHENOXYLATE/ATROPINE LOPERAMIDE HCL CAPS/LIQ OPIUM TINCTURE TINC PAREGORIC TINC	MC/DEL MC MC/DEL MC/DEL MC	LOFENE TABS LONOX TABS MOTOFEN TABS	Use PA Form# 20420. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
GI - ANTI-DIARRHEAL/ ANTACID - MISC.	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL	ATROPINE SULFATE SOLN BENTYL SYRP BISMATROL BISMUTH SUBSALICYLATE CALCIUM CARBONATE (ANTACID) CHEW DICYCLOMINE HCL GLYCOPYRROLATE TABS HAPONAL TABS HYOSCYAMINE CAPS & TABS HYOSCYAMINE SULFATE KAOPECTATE MAGNESIUM OXIDE TABS MAG-OX 400 TABS PAMINE TABS PROPANTHELINE BROMIDE TABS SAL-TROPINE TABS SCOPOLAMINE HYDROBROMIDE SODIUM BICARBONATE TABS TUMS	MC MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC MC MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL	B & O 15-A SUPPRETTE SUPP B & O 16-A SUPPRETTE SUPP BELLADONNA ALKALOIDS & OP BENTYL TABS GLYCOPYRROLATE INJ HYOSCYAMINE SL LEVIBID TB12 LEVSIN ELIX LEVSIN TABS LEVSIN/SL SUBL NULEV TBDP ROBINUL INJ ROBINUL TABS	Use PA Form# 20420. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
GI - H2-ANTAGONISTS	MC/DEL MC/DEL MC/DEL MC MC/DEL	CIMETIDINE FAMOTIDINE RANITIDINE ACID REDUCER TABS ZANTAC SYRUP	MC MC MC/DEL MC MC/DEL MC/DEL	AXID CAPS AXID AR TABS NIZATIDINE CAPS PEPCID PEPCID AC RANITIDINE SYRUP TAGAMET TABS ZANTAC 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. DDI: Ranitidine and cimetidine will now be non-preferred and require prior authorization if it is currently being used with any sulfonyleurea (except for glyburide).
GI - PROTON PUMP INHIBITOR	MC/DEL MC MC/DEL	KAPIDEX ⁴ OMEPRAZOLE 10MG/20MG ² PROTONIX ²	MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC	6 PRILOSEC OTC ¹ 7 ACIPHEX TBEC ⁴ 8 PREVACID CPDR ^{4, 5} 8 PREVACID SOLUTABS ¹ 8 NEXIUM CPDR ⁴ 8 PRILOSEC CPDR 8 PROTONIX INJ 8 ZEGERID ⁴ 9 OMEPRAZOLE 40MG ³	1. Prevacid Solutabs available without PA for children less than 9 years old. 2. Dosing limits apply, please see dosage consolidation list. 3. Please use multiple 20mg Capsules to obtain required dose. 4. All preferreds and step therapy must be tried and failed. 5. Established users prior to 10/1/09 may continue to obtain Prevacid until 12/31/09. 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. Patients obtaining refills as of 7/10/09 will begin to require prior authorizations if they have been on any PPI longer than 60 days in the past year. The 12-month period is patient specific and begins 12 months before the requested date of prior authorization. Payment for usage beyond these limits will be authorized for cases in which there is a diagnosis of: 1. Barrett's esophagus. 2. Erosive esophagitis 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. 4. Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least onehistamine H2-receptor antagonist at full therapeutic doses. DDI: Prevacid, Omeprazole and Protonix 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. 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.
GI - ULCER ANTI-INFECTIVE			MC MC	HELIDAC PREVPAC ¹	1. Please use individual ingredients.
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.
GI - DIGESTIVE ENZYMES	MC/DEL MC/DEL	CREON LACTASE CHEW	MC/DEL MC/DEL	LACTRASE CAPS LIPRAM	Use PA Form# 20420. Non - Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before other non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.

	MC/DEL MC MC MC	LACTASE TAB ULTRASE CPEP ULTRASE MT VIOKASE	MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC	LIPRAM CR KUTRASE CAPS KU-ZYME CAPS PANCREASE PANCREASE MT PANCRECARB MS-8 CPEP PANCRELIPASE PANGESTYME PANOKASE TABS		drug interaction between another drug and the preferred drug(s) exists. In all cases except cystic fibrosis patients, objective evidence of pancreatic insufficiency (at malabsorption test etc...) must be supplied.
GI - ANTI - FLATULENTS / GI STIMULANTS	MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL	CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP GASTROCROM CONC GENERLAC SYRP LACTULOSE SYRP METOCLOPRAMIDE HCL SIMETHICONE	MC/DEL MC MC/DEL MC/DEL	AMITIZA ¹ CEPHULAC SYRP INFANTS GAS RELIEF SUSP REGLAN TABS		Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL. 1. 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.
GI - INFLAMMATORY BOWEL AGENTS	MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ASACOL TBEC AZULFIDINE TABS CANASA SUPP COLAZAL CAPS DIPENTUM CAPS LIALDA TABS PENTASA CPCR ROWASA ENEM SULFAZINE EC TBEC SULFASALAZINE TABS	MC MC/DEL MC/DEL	APRISO ASACOL HD AZULFIDINE EN-TABS TBEC		Use PA Form# 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - IRRITABLE BOWEL SYNDROME AGENTS			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						
Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.						
GI - MISC.	MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL	BISAC-EVAC SUPP BISACODYL BISCOLAX SUPP CINOBAC CAPS CITRATE OF MAGNESIA SOLN CITRUCEL DIOCTO SYRP DOCUSATE CALCIUM CAPS DOCUSATE SODIUM FIBER LAXATIVE TABS FLEET GENFIBER POWD GLYCERIN HIPREX TABS KRISTALOSE PACK MAALOX METAMUCIL MILK OF MAGNESIA SUSP MINERAL OIL OIL NULYTELY SOLR SENNA SEKOKOT GRAN SEKOKOT SYRP SEKOKOT CHILDRENS SYRP SEKOKOT XTRA TABS SORBITOL STOOL SOFTENER CAPS SUCRALFATE TABS UNI-EASE CAPS UNIFIBER POWD URSO FORTE URSODIOL	MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL	ACTIGALL CAPS BENEFIBER CARAFATE COLACE CAPS COLYTE DIOCTO-C SYRP DOC SOD /CAS CAP DOC-O-LAX CAPS DOCUSATE SODIUM/CAS CAPS DOK PLUS DULCOLAX SUPP FIBER CON TABS FIBER-LAX TABS GOLYTELY SOLR MALTSUPEX MIRALAX PACK (OTC versions) MIRALAX POWD (OTC versions) PEG 3350/ELECTROLYTES SOLR SENXON TABS SEKOKOT TABS SEKOKOT S TABS STOOL SOFTENER PLUS CAPS UNI-CENNA TABS UNI-EASE PLUS CAPS V-R NATURAL SENNA LAXATIV TABS URSO 250		1. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose. Use PA Form# 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
MISC. UROLOGICAL						
UROLOGICAL - MISC.	MC MC	ACETIC ACID 0.25% SOLN CYTRA-K SOLN	MC MC/DEL	CITRIC ACID/SODIUM CITRAT SOLN CYTRA-2 SOLN		1. Elmiron requires adequate proof of Dx with appropriate 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 MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL		FURADANTIN SUSP K-PHOS MF TABS METHENAMINE MANDELATE TABS MONUROL PACK NEOSPORIN GU IRRIGANT SOLN NITROFURANTOIN MACR CAPS PHENAZOPYRIDINE HCL TABS PHENAZOPYRIDINE PLUS PROSED/DS TABS TRICITRATES SYRP URELIEF PLUS UREX TABS URISED TABS UROCIK-K UROQID #2 TABS	MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL		ELMIRON CAPS ¹ MACROBID CAPS MANDELAMINE TABS MACRODANTIN CAPS POTASSIUM CITRATE/CITRIC SOLN PYRIDIUM PLUS TABS PYRIDIUM TABS RENACIDIN SOLN	supportive testing. Use PA Form# 20420	drug and the preferred drug(s) exists.
PHOSPHATE BINDERS								
PHOSPHATE BINDERS	MC MC/DEL MC/DEL MC/DEL		PHOSLO ¹ MAGNEBIND - 400 ¹ RENAGEL ¹ FOSRENOL ¹	MC/DEL		RENEVELA ²	Use PA Form# 20420 1. Diag required. 2. Must fail Phoslo, Renagel & Fosrenol before non-preferred products.	
INTRA-VAGINALS								
VAGINAL - ANTIBACTERIALS	MC/DEL MC/DEL MC/DEL	1 1 3	CLEOCIN CREA METRONIDAZOLE VAGINAL GEL ² CLEOCIN SUPP ¹	MC/DEL MC/DEL		METROGEL VAGINAL GEL ² VANDAZOLE	1. Step order must be followed to avoid PA. Must fail Cleocin Cream and Metronidazole products before moving to next step product without PA. 2. Dosing limits apply, please see Dosage Consolidation List. Use PA Form# 20420	Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ANTI FUNGALS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC MC		CLOTRIMAZOLE CREA GYNE-LOTRIMIN CREA MICONAZOLE CREA MICONAZOLE 3 COMBO PACK KIT ¹ MICONAZOLE 7 CREA MICONAZOLE NITRATE CREA NYSTATIN TABS TERAZOL 3 SUPP TERCONAZOLE 0.4MG VAGITROL V-R MICONAZOLE-7 CREA	MC MC MC MC/DEL MC MC MC/DEL MC/DEL		AVC CREAM CLOTRIMAZOLE 3 DAY CREA GYNAZOLE-1 CREA GYNE-LOTRIMIN 3 TABS MICONAZOLE 3 SUPP TERAZOL 3 CREA TERAZOL 7 CREA TERCONAZOLE 0.8MG TERCONAZOLE SUPP	1. Quantity limit: 1/script/2 weeks Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - CONTRACEPTIVES	MC		GYNOL II EXTRA STRENGTH GEL	MC		DELLEN FOAM	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ESTROGENS	MC/DEL MC/DEL		ESTRING RING PREMARIN CREA	MC/DEL MC/DEL		ESTRACE CREA VAGIFEM TABS	Must fail all preferred products before non-preferred. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - OTHER	MC/DEL MC MC		ACID JELLY GEL ACI-JEL GEL CERVICAL AMINO ACID CREA	MC		AMINO ACID CERVICAL CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BPH								
BPH	MC/DEL MC/DEL MC/DEL MC/DEL		AVODART DOXAZOSIN MESYLATE TABS FINASTERIDE ¹ TERAZOSIN HCL CAPS	MC/DEL MC/DEL MC MC/DEL MC/DEL	5 8 8 8 8	FLOMAX CP24 CARDURA TABS HYTRIN CAPS PROSCAR TABS RAPAFLO UROXATRAL	Non-preferred products must be used in specified order. 1. There will be dosing limits of 1 tab per day with out PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (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 MC/DEL MC/DEL		ALPRAZOLAM TABS CHLORDIAZEPOXIDE HCL CAPS CLORAZEPATE DIPOTASSIUM TABS	MC/DEL MC/DEL MC/DEL		ALPRAZOLAM ER ATIVAN NIRAVAM	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL MC/DEL MC/DEL		DIAZEPAM LORAZEPAM OXAZEPAM CAPS	MC/DEL MC/DEL MC/DEL	SERAX TRANXENE XANAX TABS XANAX XR		
ANXIOLYTICS - MISC.	MC/DEL MC MC MC/DEL MC/DEL		BUSPIRONE HCL TABS HYDROXYZINE HCL SOLN HYDROXYZINE HCL SYRP HYDROXYZINE PAMOATE CAPS MEPROBAMATE TABS	MC MC MC MC/DEL MC MC/DEL	ATARAX TABS BUSPAR TABS DROPERIDOL SOLN HYDROXYZINE HCL TABS HYDROXYZINE PAM 100MG CAPS INAPSINE SOLN 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 MC/DEL		NARDIL TABS PARNATE TABS				
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL				MC/DEL	EMSAM ¹	1. Dosing limits apply, please refer to Dose consolidation list. Use PA Form# 20420.	Preferred drugs (including a preferred SSRI, a non-SSRI, and either Cymbalta or Effexor) must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BUPROPION HCL TABS BUPROPION SR BUPROPION XL CITALOPRAM ⁴ CYMBALTA ⁵ FLUOXETINE HCL CAPS FLUOXETINE HCL LIOD FLUOXETINE HCL 10mg TABS FLUVOXAMINE MALEATE TABS MIRTAZAPINE NEFAZODONE PAROXETINE ³ SERTRALINE ² TRAZODONE HCL TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	APLENZIN ⁶ CELEXA DESYREL TABS EFFEXOR TABS EFFEXOR XR CP24 ³ FLUOXETINE 40 mg CAPS ¹ FLUOXETINE 20mg TABS ⁵ LEXAPRO TABS ^{4,7} LUVOX TABS MAPROTILINE HCL TABS MIRTAZAPINE ODT PAROXETINE CR ³ PAXIL ³ PAXIL CR ^{3,7} PRISTIO PROZAC PROZAC CAPS PROZAC WEEKLY CPDR REMERON TABS SARAFEM CAPS TRAZODONE HCL 300MG TABS WELLBUTRIN TABS WELLBUTRIN SR TBCR WELLBUTRIN XL REMERON SOLTAB TBDP ZOLOFT	Non-preferred products must be used in specified step order. 1. Use Fluoxetine 20 mg in multiples. 2. See Zoloft splitting table. Sertraline requires splitting of scored tabs to avoid PA. 3. Strong caution with pediatric population. 4. See Celexa/Citalopram and Lexapro splitting tables. 5. Max daily dose allowed is 60mg, only 1 capsule per day allowed for all strengths. Combination of multiple strengths require PA. 6. Use Fluoxetine 10mg tabs or capsules in multiples. 7. As of 12/08 current users of Paxil CR and Lexapro will be grandfathered. 8. Provide clinical documentation as to why a preferred generic alternative cannot be used. Use PA Form# 20420.	Preferred drugs (including failure of at least one preferred SSRI, one SNRI and one non-SSRI/SNRI) must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Preferred Fluoxetine will be the only preferred antidepressant for members who are less than 18 years of age. Exceptions to the rule are as follows: 1. If the member (<18) is already an established user for any of the preferred or non-preferred drugs under the Antidepressant category on the PDL, then they can continue to get that drug. 2. If the member (<18) has a prescription for an antidepressant that is on the PREFERRED side of the PDL and has had a 30 day supply of Fluoxetine at least 30 days before the date they are getting it filled, the claim will pay. If they do not have the trial of Fluoxetine in their profile, the claim will reject for PA required. 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 pa to establish anxiety diagnosis. 5. Use of bupropion or Wellbutrin for ADHD diagnosis must show prior trial/failure with methylphenidate and amphetamine <u>Criteria for new starters <18 years of age.</u> Must have had fluoxetine trial for at least 30 days before accessing other preferred antidepressants without PA. DDI: Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl). DDI: Preferred nefazodone will now be non-preferred and require prior authorization if it is currently being used in combination with either Enbax 15mg or Vesicare 10mg.
ANTIDEPRESSANTS - TRI-CYCLICS	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC		AMITRIPTYLINE HCL TABS AVENTYL SOLN CLOMIPRAMINE HCL CAPS DESIPRAMINE HCL TABS DOXEPIH HCL IMIPRAMINE HCL TABS NORTRIPTYLINE HCL PROTRIPTYLINE HCL TABS SURMONTIL CAPS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC	AMOXAPINE TABS ANAFRANIL CAPS ELAVIL TABS NORPRAMIN TABS PAMELOR SINEQUAN TOFRANIL VIVACTIL TABS	*Users over the age of 65 require a pa. Use PA Form# 20420. or 10220.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
SEDATIVE / HYPNOTICS							
SEDATIVE/HYPNOTICS - BARBITURATE	MC MC/DEL MC		BUTISOL SODIUM TABS CHLORAL HYDRATE SYRP MEBARAL TABS	MC MC/DEL	LUMINAL SOLN SOMNOTE CAPS	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		PHENOBARBITAL				Use PA Form# 20420.	
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL MC/DEL MC/DEL MC/DEL		DORAL TABS ESTAZOLAM TABS FLURAZEPAM HCL CAPS TEMAZEPAM CAPS TRIAZOLAM TABS	MC MC MC MC/DEL		DALMANE HALCION TABS MIDAZOLAM HCL SYRP RESTORIL CAPS	Previous quantity limits still apply. Use PA Form # 30110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Benzodiazepines do cause dependence with continued use and usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 Days per week max) is the standard of care
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL MC MC/DEL MC/DEL	1 1 1 2	MIRTAZAPINE TRAZODONE ZOLPIDEM ² ZALEPLON ^{2,3}	MC/DEL MC/DEL MC/DEL MC/DEL	7 8 8 8 8	AMBIEN ¹ AMBIEN CR ¹ LUNESTA ¹ SONATA CAPS ¹ ROZEREM	Must fail all preferred products before non-preferred 1. Quantity Limit of 12 per 34 days. 2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended. 3. Only zolpidem trial/failure will be required to obtain Zaleplon. Use PA Form # 30110	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ambien, 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.
ANTI-PSYCHOTICS								
ANTIPSYCHOTICS - ATYPICALS	MC/DEL MC/DEL MC/DEL MC MC/DEL MC		ABILIFY TABS ² GEODON RISPERIDONE TAB RISPERDAL SOLN SEROQUEL TABS SEROQUEL XR ZYPREXA TABS	MC/DEL MC MC MC MC/DEL MC/DEL MC		ABILIFY DISC TAB, INJ and SOL ² INVEGA RISPERDAL TAB RISPERDAL CONSA ² RISPERDAL M TAB ² RISPERIDONE SOLN SEROQUEL 50MG TABS ^{1,2} ZYPREXA ZYDIS TBDP ²	If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine. This also includes combination of Seroquel with Seroquel XR. See Multiple Antipsychotic PA form #20440. Please use Miscellaneous PA form # 20420 for non-preferred single therapy atypical requests. All atypicals have dosing limitations and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits. Maximum daily doses are as follows: Abilify- 30mg daily max Risperdal- 8mg daily max Seroquel- 800mg daily max Seroquel XR- 800mg daily max Zyprexa- 30mg daily max Use PA form #10420 for requests exceeding these maximum daily doses. 1. Please use multiple 25mg tablets. 2. Established users of single therapy atypicals were grandfathered. 3. Abilify requires splitting of tab to avoid PA. Please see Abilify splitting table.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 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. 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 being titrated up. 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. Seroquel 50mg tablets are non-preferred and multiple Seroquel 25mg tablets should be used. Atypical drugs may require PA if the patient either has or is at risk for Metabolic Syndrome (diabetes, dyslipidemia, hypertension). DDI: Abilify, Seroquel, and Zyprexa will now be non-preferred and require prior authorization if they are currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.

ANTIPSYCHOTICS - SPECIAL ATYPICALS	MC/DEL		CLOZAPINE TABS	MC/DEL MC		CLOZARIL TABS FAZACLO	Use PA Form# 20420	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved. DDI: Clozapine will now be non-preferred and require prior authorization if it is currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.
ANTIPSYCHOTICS - TYPICAL	MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL		CHLORPROMAZINE HCL FLUPHENAZINE DECANOATE FLUPHENAZINE HCL HALDOL HALOPERIDOL HALOPERIDOL DECANOATE SOLN HALOPERIDOL LACTATE SOLN LOXAPINE SUCCINATE CAPS LOXITANE-C CONC MOBAN TABS PERPHENAZINE PROCHLORPERAZINE SERENTIL THIORIDAZINE HCL THIOTHIXENE THORAZINE SUPP TRIFLUOPERAZINE HCL TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL		COMPAZINE COMPRO SUPP HALDOL DECANOATE LOXITANE CAPS MELLARIL NAVANE CAPS PROLIXIN STELAZINE TABS THORAZINE	Use PA Form# 20420 If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine. See Multiple Antipsychotic PA form #20440. For PA requests for non preferred single user antipsychotic medications, please use miscellaneous PA form #20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
LITHIUM								
LITHIUM	MC/DEL MC/DEL		LITHIUM CARBONATE LITHIUM CITRATE SYRP	MC/DEL MC/DEL		ESKALITH CAPS ESKALITH CR TBCR	Use PA Form# 20420	
COMBINATION - PSYCHOTHERAPEUTIC								
PSYCHOTHERPEUTIC COMBINATION	MC/DEL MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	MC	8	SYMBYAX ¹	Use PA Form# 20420	Please use individual preferred medications.
STIMULANTS								
STIMULANT - AMPHETAMINES SHORT ACTING	MC/DEL MC/DEL MC/DEL MC/DEL		ADDERALL TABS AMPHETAMINE SALT COMBO DEXTROAMPHET SULF TABS DEXEDRINE DEXTROSTAT TABS					Preferred stimulants will be available without PA if diagnosis of ADHD. 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. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily.
STIMULANT - LONG ACTING AMPHETAMINES SALT	MC/DEL MC		ADDERALL XR CP24 ¹ VYVANSE ²					Preferred stimulants will be available without PA if diagnosis of ADHD. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. 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.

							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.	
LONG ACTING AMPHETAMINES	MC		DEXEDRINE CAP CR	MC		DEXTROAMPHET SULF CPCR	Preferred stimulants will be available without PA if diagnosis of ADHD. 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. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily.	
STIMULANT - METHYLPHENIDATE	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		FOCALIN TABS METADATE ER TBCR METHYLIN ER TBCR METHYLIN TABS METHYLIN SOL METHYLPHENIDATE HCL	MC MC/DEL		METHYLIN CHEWABLES RITALIN	Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form# 20420 Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. 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 MC		CONCERTA TBCR FOCALIN XR ¹	MC MC/DEL MC/DEL	5 8 8	METADATE CD CPCR DAYTRANA ² RITALIN LA	Preferred stimulants will be available without PA if diagnosis of ADHD. Non-preferred products must be used in specified step order. Stimulants also have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. 1. Available to those members needing sprinkles with diagnosis of ADHD. 2. FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 MC MC/DEL MC	7 8 8 9	STRATTERA ^{1,2} CAFCIT SOLN PROVIGIL TABS DESOXYN TABS	1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of Strattera, 2. FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily. Use PA Form# 20420	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

				MC	9	DESOXYN CR	unless history of substance abuse without current use of abusable medication(s) 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 refer to PDL dosage consolidation chart. 3. Non-preferred products must be used in specified step order.	
ANTI-CATAPLECTIC AGENTS								
PSYCHOTHERAPEUTIC AGENTS - MISC.				MC/DEL MC		KYREM SOL XENAZINE	Use PA Form # 20710	
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 MC/DEL MC/DEL		ARICEPT TABS ¹ EXELON ¹ NAMENDA ¹	MC MC MC	8 8 9	RAZADYNE ² REMINYL ² COGNEX CAPS ³	1. PA is required to establish dementia diagnosis and baseline mental status score. 2. Must fail all preferred products before moving to non-preferred. Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
SMOKING CESSATION								
NICOTINE PATCHES / TABLETS	MC/DEL MC/DEL MC/DEL		CHANTIX ^{1,2} NICODERM CO PT24 ² NICOTINE DIS PT24 ²				Bupropion SR 150 mg is available without a prior authorization. 1. Chantix is preferred without PA for up to 6 months of continuous use once per lifetime. 2. Preferred nicotine replacement therapy and Chantix will become non-preferred and will require PA if they are being used in combination together.	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. 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. Another version of Zyban, Bupropion SR (100 and 150mg) is available without PA. There will be a quantity limit of 3 months supply of nicotine products allowed per 12 months.
NICOTINE REPLACEMENT - OTHER	MC/DEL MC/DEL		NICOTINE POLACRILEX GUM ² NICORETTE GUM ²	MC/DEL MC/DEL MC/DEL	5 8 8	COMMIT LOZENGES ¹ NICOTROL INHALER NICOTROL NASAL SPRAY	Use PA Form# 20420 Must fail all preferred products from smoking cessation category (Nicoderm patch and nicotine gum) before moving to non-preferred. Must use Non-preferred products in specified step order. 1. Will be available to patients unable to tolerate preferred products. 2. Preferred nicotine replacement therapy and Chantix will become non-preferred and will require PA if they are being used in combination together.	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. Both preferred Nicotine gum and Nicoderm patch 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. There will be a quantity limit of 3 months supply of nicotine products allowed per 12 months.

ALCOHOL DETERRENTS

ALCOHOL DETERRENTS	MC MC MC MC/DEL		ANTABUSE TABS CAMPRAL ¹ DISULFIRAM TABS NALTREXONE HCL 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.
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MISCELLANEOUS ANALGESICS

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

NARCOTICS - LONG ACTING	MC MC MC/DEL MC/DEL MC/DEL		AVINZA DURAGESIC PT72 ⁶ METHADONE METHADOSE MORPHINE SULFATE ER TB12 ^{3,4}	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC	8 8 8 8 8 8 9 9		FENTANYL PATCH ⁵ MORPHINE SULFATE SUPP MS CONTIN TB12 KADIAN CP 24 ² ORAMORPH SR TB12 OXYCONTIN TB12 ^{1,5} OXYCODONE ER ³ OPANA	Use PA Form # 20510 Non-preferred products must be used in specific order. 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. 2. Established users are grandfathered. 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. 4. Endo products preferred but not exclusive. 5. 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. 6. Dosing limits apply. Please see dose consolidation list.	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 substance abuse such as: 1. Frequent or persistent early refills of controlled drugs; 2. Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.; 3. Breaches of narcotic contracts with any provider; 4. Failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass pill counts; 5. Failing to take or pass random drug testing; 6. Failing to provide old records regarding prior use of narcotics; 7. Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of; 8. Documented history of substance abuse. Substance abuse evaluations may be required for patients with medical records displaying documented substance abuse or potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. 9. Circumventing MaineCare prior authorization requirements for narcotics by paying cash for affected narcotics (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). substance, considered by authorities to be highly abused and diverted (Oxycontin, Percocet, Typox, Vicodin, Dilaudid, Ultracet...) with an available AB rated generic equivalent will be denied unless it will be provided in a setting that virtually eliminates the risk of diversion. 11. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.
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NARCOTICS - SELECTED	MC/DEL		TRAMADOL HCL TABS	MC MC/DEL MC MC	8 8 8 8		BUPRENEX SOLN BUTORPHANOL NALBUPHINE HCL SOLN NUBAIN SOLN	Use PA Form# 20420	Preferred drugs from this and other narcotic classes must be tried for at least 2 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs from this class will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or
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				MC	8	STADOL NS SOLN			"allergy" to all products but desired product. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.
				MC	8	ULTRACET TABS			
				MC	8	ULTRAM TABS			
				MC	8	ULTRAM ER			
				MC/DEL	9	RYZOLT			Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance abuse such as: 1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel; 3. breaches of narcotic contracts with any provider; 4. failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass pill counts; 5. failing to take or pass random drug testing; 6. failing to provide old records regarding prior use of narcotics; 7. receiving controlled substances from other prescribers that the provider submitting the PA is unaware of. In Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.

MISCELLANEOUS NARCOTICS

NARCOTICS - MISC.	MC/DEL	ACETAMINOPHEN/CODEINE	MC	8	ANEXSIA TABS	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	ASCOMP/CODEINE CAPS	2. Oxycodone/acet 10/650 is 8 times more expensive. Use twice as many of oxycod/acet 5/325 instead. You can mix and match preferred strengths of oxycodone and oxycodone/acet to minimize acet. dose similar to certain non-preferred drugs.	
	MC/DEL	BUTAL/ASA/CAFF/COD CAPS	MC/DEL	8	BUTALBITAL/APAP/CAFFEINE/ CAPS	3. Only preferred manufacturer's products will be available without prior authorization.	
	MC	BUTALBITAL/ASPIRIN/CAFFEI CAPS	MC	8	DARVOCET-N		
	MC	CAPITAL AND CODEINE SUSP ¹	MC	8	DARVON		
	MC	CAPITAL/CODEINE SUSP ¹	MC	8	DEMEROL		
	MC/DEL	CODEINE PHOSPHATE SOLN	MC/DEL	8	DILAUDID		
	MC/DEL	CODEINE SULFATE TABS	MC	8	DILAUDID-HP SOLN		
	MC/DEL	ENDOCET TABS ³	MC	8	FENTANYL CITRATE SOLN		
	MC/DEL	ENDODAN TABS	MC/DEL	8	FENTORA		
	MC/DEL	FENTANYL OT LOZ ¹	MC/DEL	8	FIORICET/CODEINE CAPS		
	MC/DEL	HYDROCODONE BITARTRATE/AP TABS	MC	8	FIORINAL/CODEINE #3 CAPS		
	MC/DEL	HYDROCODONE/ACETAMINOPHEN	MC	8	FIORTAL/CODEINE CAPS		
	MC/DEL	HYDROMORPHONE HCL ³	MC/DEL	8	HYDROCODONE/IBUPROFEN		
	MC/DEL	MEPERIDINE HCL	MC/DEL	8	LORCET		
	MC/DEL	OXYCODONE 5MG	MC	8	LORTAB		
	MC/DEL	OXYCODONE 15MG	MC	8	MAXIDONE TABS		
	MC/DEL	OXYCODONE 30MG	MC/DEL	8	NORCO TABS		
	MC/DEL	OXYCODONE/ACETAMINOPHEN ^{2,3}	MC/DEL	8	OXYCODONE 10MG		
	MC/DEL	PENTAZOCINE/NALOXONE TABS	MC/DEL	8	OXYCODONE 20MG		
	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-/ACET TABS	MC	8	PERCODAN 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	Use PA Form# 20420.	
			MC	8	TALACEN TABS		
			MC/DEL	8	TALWIN NX TABS		
			MC	8	TYLENOL/CODEINE #3 TABS		
			MC	8	TYLOX CAPS		
			MC	8	VICODIN		
			MC	8	VICOPROFEN TABS		
			MC	8	ZYDONE TABS		
			MC	9	ACTIQ LPOP		

OPIOID DEPENDENCE	MC	SUBOXONE*	MC		SUBUTEX	Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is
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TREATMENTS						<p>*Suboxone is preferred with max dosing limits of 32mg daily if the following conditions are met: a.) There is not another Suboxone script in member's drug profile within the past 30 days. and b.) 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. Should be evidence provided of monthly monitoring including random pill counts urine drug tests and prescription monitoring program reports.</p>	<p>offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Subutex will only be approved for use during pregnancy.</p>
NARCOTIC ANTAGONISTS							
NARCOTIC - ANTAGONISTS	MC/DEL		NALTREXONE HCL TABS	MC/DEL		REVIA TABS ¹ VIVITROL INJ ²	<p>Use PA Form# 20420 Use PA form #30400 for Vivitrol requests.</p> <p>1. Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version. 2. Please see the criteria listed on the Vivitrol PA form. Any narcotics attempting to be filled during Vivitrol approval will require prior authorization.</p>
COX 2 / NSAIDS							
NSAID - PPI						PREVACID NAPRA-PAC	
COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE	MC/DEL MC/DEL MC/DEL MC/DEL		CELEBREX CAPS ^{4,5} KETOROLAC TROMETHAMINE ^{2,3} NABUMETONE TABS MELOXICAM ¹	MC/DEL MC/DEL MC/DEL MC/DEL		MOBIC MOBIC SUSP RELAFEN TABS TORADOL TORADOL	<p>The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.</p> <p>Use PA Form # 10310</p> <p>1. Meloxicam has dosing limits allowing one tablet daily of all strengths without PA.</p> <p>2. Ketorolac Tromethamine is indicated for the short term (up to 5 days) management of moderately severe acute pain that requires analgesic at the opioid level in adults. Not indicated for minor or chronic pain conditions.</p> <p>3. Ketorolac has dosing limits allowing 24 tablets for a 5 day supply every 30 days.</p> <p>4. Dosing limits will be set at a maximum of 200mg once daily for PA requests.</p> <p>5. Users 60 years of age or older will not require PA. If under 60 years of age, Celebrex will require PA.</p>
NSAIDS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CHILDRENS IBUPROFEN DICLOFENAC POTASSIUM TABS DICLOFENAC SODIUM ETODOLAC FENOPROFEN CALCIUM TABS FLURBIPROFEN TABS	MC MC MC MC/DEL MC		ADVIL TABS ANAPROX TABS ANAPROX DS TABS ANSAID TABS CATAFLAM TABS CHILDRENS ADVIL SUSP	<p>The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.</p> <p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form.</p>

	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		IBUPROFEN INDOMETHACIN KETOPROFEN MECLOFENAMATE SODIUM CAPS NAPROSYN SUSP NAPROXEN SUSP NAPROXEN TABS NAPROXEN SODIUM TABS OXAPROZIN TABS PIROXICAM CAPS SULINDAC TABS TOLMETIN SODIUM	MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL MC	CHILD'S IBUPROFEN SUSP CHILDREN'S MOTRIN SUSP CLINORIL TABS DAYPRO TABS EC-NAPROSYN TBEC ETODOLAC ER 600MG FELDENE CAPS IBU-200 INDOCIN LODINE MOTRIN NALFON CAPS NAPRELAN TBCR NAPROSYN TABS NAPROXEN DR TBEC NAPROXEN SODIUM TBCR ORUVAIL CP24 PONSTEL CAPS SB IBUPROFEN TABS TOLECTIN VOLTAREN V-R IBUPROFEN TABS	Use PA Form# 20420	DDI: Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with lescol.
RHEUMATOID ARTHRITIS							
RHEUMATOID ARTHRITIS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC	1 1 1 1 2 2 2	AZATHIOPRINE HYDROXYCHLOROQUINE LEFLUNOMIDE METHOTREXATE SULFASALAZINE TABS CIMZIA ¹ ENBREL KIT ¹ HUMIRA ^{1,2}	MC/DEL MC MC MC MC MC MC	8 8 8 8	ARAVA KINERET SOLN ORENCIA REMICADE	Use PA Form # 20900 See criteria as listed on Rheumatoid Arthritis PA form. 1. Only one step 1 drug is required to obtain Enbrel, Cimzia or Humira without PA. High doses of Enbrel 50mg twice weekly will require a PA. Please refer to the dose consolidation list. Established users will be grandfathered for Enbrel and Humira. 2. Dosing limits apply. Please see dose consolidation list.
MISCELLANEOUS ARTHRITIS							
ARTHRITIS - MISC.	MC MC		RIDAURA CAPS MYOCHRYSLINE SOLN	MC/DEL		ARTHROTEC ¹	1. The individual components of Arthrotec are available without PA. Use PA Form# 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The individual components of Arthrotec are available without PA.
MIGRAINE THERAPIES							
MIGRAINE - ERGOTAMINE DERIVATIVES	MC/DEL MC		MIGRANAL SOLN SANSERT TABS	MC/DEL		D.H.E. 45 SOLN	Use PA Form # 10110 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC		DEPAKOTE ER TB24				
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)-- Tabs	MC/DEL MC/DEL MC/DEL	1 1 1	MAXALT MLT ¹ RELPAX ¹ SUMATRIPTAN TABS ¹	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		AMERG TABS AXERT TABS FROVA TABS MAXALT IMITREX TABS ¹ ZOMIG TABS ZOMIG NASAL SPARY ZOMIG ZMT TBDP	1. All step 1 medications must be tried. All drugs in this category have dosing limits. Please refer to dose consolidation table. 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 Triplan PA form.
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)-- Injectables	MC/DEL MC/DEL MC/DEL MC/DEL		IMITREX KIT IMITREX SOLN IMITREX STATDOSE PEN KIT IMITREX STATDOSE REFILL KIT				Use PA Form # 10110
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)-- Combinations			TREXIMET ¹				Use PA Form # 10110 1. Dosing limits apply. Please see dose consolidation list.

ANTICHOLINERGICS	MC/DEL MC MC/DEL MC/DEL		BENZTROPINE MESYLATE TABS COGENTIN SOLN KEMADRIN TABS TRIHEXYPHENDYL					
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		ROPINIROLE	MC/DEL MC/DEL MC/DEL		MIRAPEX TABS ¹ REQUIP TABS REQUIP XL TABS	Use PA Form# 20420 1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinsons.	Preferred drug must be tried and failed in step-order due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - DOPAMINERGICS/CARBI/LEVO	MC/DEL MC/DEL MC/DEL MC MC MC/DEL		AMANTADINE HCL BROMOCRIPTINE MESYLATE CARBIDOPA/LEVODOPA TABS* CARBIDOPA/LEVODOPA ER LARODOPA TABS LODOSYN TABS SELEGILINE HCL	MC/DEL MC MC MC/DEL MC MC MC MC		APOKYN* AZILECT ² ELDEPRYL CAPS PARLODEL CAPS PARLODEL TABS SINEMET TABS SINEMET TBCR SYMMETREL TABS ZELAPAR ¹	* Only preferred manufacturer's products will be available without prior authorization. 1. Approvals will require concurrent therapy with Levodopa and failed trials of Selegiline, Comtan, and Stalevo. 2. Approvals will require trials of Carbidopa/Levodopa, Selegiline, Comtan, and Stalevo. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - COMBO.	MC/DEL		STALEVO					
MUSCLE RELAXANTS								
ALS DRUG	MC/DEL		RILUTEK TABS					
MUSCLE RELAXANTS	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL		BACLOFEN TABS CHLORZOXAZONE TABS CYCLOBENZAPRINE HCL TABS LIORESAL INTRATHECAL KIT METHOCARBAMOL TABS TIZANIDINE HCL TABS	MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL	7 8 8 8 8 8 8 9 9	ORPHENADRINE CITRATE CARISOPRODOL TABS DANTRIUM CAPS FLEXERIL TABS LIORESAL TABS NORFLEX TBCR ROBAXIN-750 TABS ZANAFLEX TABS SKELAXIN TABX SOMA TABS	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. 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.
MUSCLE RELAXANT - COMBO.				MC/DEL MC/DEL MC MC/DEL MC/DEL		CARISOPRODOL/ASPIRIN TABS CARISOPRODOL/ASPIRIN/CODE NORGESIC TABS ORPHENADRINE COMPOUND ORPHENADRINE/ASA/CAFF ORPHENGESIC	Use PA Form# 20420	Individual components are available with PA described in the section above. 1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant travel, etc.
VITAMINS								
Preferred products that used to require diag codes still require diag codes unless indicated otherwise.								
VITAMINS	MC/DEL MC MC MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL		ASCORBIC ACID TABS BIOTIN CYANOCOBALAMIN SOLN FOLGARD RX 2.2 TABS FOLIC ACID TABS FOLTX TABS MEPHYTON TABS NIACIN NIACOR TABS NICOTINIC ACID SR CPCR PYRIDOXINE HCL TABS SLO-NIACIN TBCR THIAMINE HCL SOLN VITAMIN B-1 TABS	MC MC MC/DEL MC MC MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL		AQUASOL E. SOLN AQUAVIT-E SOLN CALOMIST NASAL SPRAY ¹ DHT SOLN NASCOBAL GEL	Use PA Form# 20420 1. PA required to confirm diagnosis and prior use of IM Vit B12. Lab results should be submitted. 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. DDI: B-12 will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non preferred PPI.

MINERALS	MC		MC		Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	CALCARB	MC	ANEMAGEN		
	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		
	MC/DEL	CALCIUM CITRATE TABS	MC	CHROMAGEN		
	MC/DEL	CALCIUM GLUCONATE TABS	MC	CITRACAL PLUS TABS		
	MC/DEL	CALCIUM LACTATE TABS	MC	CONTRIN CAPS		
	MC	CALCIUM/MAGNESIUM TABS	MC	FEOGEN FORTE CAPS		
	MC/DEL	CALCIUM/VITAMIN D TABS	MC	FEROCON CAPS		
	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-IN-SOL SOLN	MC	MICRO-K 10 MEG CPCR		
	MC	FER-IRON SOLN	MC	NU-IRON 150 CAPS		
	MC	FERRONATE TABS	MC/DEL	OYSTER SHELL CALCIUM/VITA TABS		
	MC/DEL	FERROUS SULFATE	MC/DEL	POLY-IRON 150 CAPS		
	MC/DEL	FLUOR-A-DAY CHEW	MC/DEL	POLYSACCHARIDE IRON CAPS		
	MC	FLUORIDE CHEW	MC/DEL	POTASSIUM BICARB/CHLORIDE		
	MC	FLUORIDE SODIUM CHEW	MC/DEL	POTASSIUM CHLORIDE 10MEQ		
	MC	FLUORITAB CHEW	MC/DEL	SLOW FE TBCR		
	MC	HEMOCYTE TABS	MC	TUMS 500 CHEW		
	MC	HM CALCIUM TABS	MC	VIACTIV CHEW		
	MC	K+ POTASSIUM PACK				
	MC	KAON ELIX				
	MC	KAON-CL-10 TBCR				
	MC	KCL 0.075%/DSW/NACL 0.2% SOLN				
	MC	K-EFFERVESCENT TBEF				
	MC	KLOR-CON				
	MC	KLOTRIX TBCR				
	MC/DEL	K-PHOS TABS				
	MC/DEL	K-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				
	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/DEL		PED ELECTROLYTE SOLN.	MC		BOOST	This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred. SGA form required for nutritionals unless member has a GI tube.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		FISH OIL CAPS	MC		CASEC POWD			
	MC		INTRALIPID EMUL	MC		CHOICE DM LIQD			
	MC		ORALYTE SOLN	MC		DELIVER 2.0 LIQD			
	MC		P.T.E. -5 SOLN	MC		ENFAMIL			
	MC/DEL		SEA-OMEGA CAPS	MC		ENSURE			
				MC		GLUCERNA			
				MC		ISOCAL LIQD			
				MC		KINDERCAL TF LIQD			
				MC		KINDERCAL TF/FIBER LIQD	1. Formerly known as Omacor.		
				MC/DEL		L-CARNITINE CAPS			
				MC		LIPISORB LIQD			
				MC		LOVAZA ¹	Use PA Form# 20420 & SGA Form		
				MC		MODULE IBD POWD			
				MC		NUTRAMIGEN POWD			
				MC/DEL		NUTREN			
				MC		NUTRITIONAL SUPPLEMENT LIQD			
			MC		NUTRIVENT 1.5 LIQD				
			MC/DEL		PEPTAMEN				
			MC		PHENYL-FREE				
			MC		PKU 3 POWD				
			MC		PREGESTIMIL POWD				
			MC/DEL		PROBALANCE LIQD				
			MC		PROSOBEE				
			MC		SCANDISHAKE PACK				
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	Must be used in specified step order. 1. 10 day supply/month may be used without a PA.	See approval criteria detailed on Neupogen PA form.	
				MC	8	NEUPOGEN SOLN ¹			
				MC	9	NEULASTA	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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.	
	MC/DEL		FRAGMIN INJ ¹	MC		IPRIVASK			
	MC		HEPARIN SODIUM/NAACL 0.9% SOLN						
	MC		HEP-LOCK SOLN						
	MC/DEL		INNOHEP				Use PA Form# 20420		
	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/DEL		ALPHANATE	MC		ADVATE ^{1,2}	1. Only if other products unavailable. 2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access.	Non-preferred will only be approved if other preferred products are unavailable.	
	MC/DEL		BENEFIX SOLR						
	MC		BIOCLATE						
	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/DEL		NOVOSEVEN SOLR				Use PA Form# 20420		
	MC		PROPLEX -T						
	MC		RECOMBINATE SOLR						
	MC		REFACTO						
PLATELET AGGREGATION INHIBITORS	MC/DEL		ASPIRIN	MC/DEL	7	TICLOPIDINE HCL TABS	Use PA Form # 20715 for Plavix 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	
	MC/DEL		DIPYRIDAMOLE TABS	MC/DEL	8	PERSANTINE TABS			

				MC/DEL MC	8 8	PLAVIX TABS ^{1,2} TICLID TABS	For all other requests please use form # 20420.	drug and the preferred drug(s) exists. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement.
				MC/DEL MC/DEL MC/DEL MC		AGGRENOX CP12 ¹ AGGRENOX ² AGRYLIN CAPS PLETAL TABS TRENAL TBCR	1. As of 10.16.08 all new users of Plavix will require prior authorization. 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.	
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.	MC/DEL MC/DEL		PENTOXIFYLLINE ER TBCR CILOSTAZOL	MC/DEL MC/DEL MC/DEL MC			1. Asprin and dipyridamole are available separately without PA. Use PA Form # 20420 2. Aggrenox will be approved if submitted with documentation supporting that it is being used for non-embolic stroke. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HEMATOLOGICALS								
MONOCLONAL ANTIBODY				MC		SOLIRIS	Use PA Form# 20420	A diagnosis of Paroxysmal nocturnal hemoglobinuria (PNH) using the HAM test or flow cytometry is required. In addition, the patient must show evidence of having received a meningitis vaccine at least 2 weeks prior to the start of therapy.
HEMATOLOGICAL AGENTS-THROMBOPOIETIN RECEPTOR AGONISTS				MC/DEL MC	7 8	PROMACTA NPLATE	Use PA Form# 20420	Clinical PA required. Must see prior trial with insufficient response to corticosteroids and immunoglobulins.
HEMOSTATIC								
HEMOSTATIC	MC/DEL MC		AMICAR AMINOCAPROIC ACID					
OPHTHALMICS								
OP. - ANTIBIOTICS	MC MC MC MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		AK-SPORE OINT BACITRACIN OINT BACITRACIN/NEOMYCIN/POLYM BACITRACIN/POLYMYXIN B OINT CHLOROPTIC SOLN ERYTHROMYCIN OINT GENTAMICIN SULFATE NEOMYCIN/POLYMYXIN/GRAMIC NEOSPORIN SOLN POLYSPORIN SODIUM SULFACETAMIDE SOLN SULFACETAMIDE SODIUM TERRAMYCIN OINT TOBRAMYCIN SULFATE SOLN TRIMETHOPRIM SULFATE/POLY VIROPTIC SOLN	MC MC MC MC MC MC/DEL MC MC MC MC MC/DEL MC/DEL		AK-POLY-BAC OINT AK-SULF OINT AK-TOB SOLN AZASITE BLEPH-10 SOLN GENTAK ILOTYCIN OINT NEOMYCIN/BACI/POLYM OINT NEOSPORIN OINT OCUSULF-10 SOLN OCUTRICIN SOLN TERAK OINT TOBREX OINT TRIFLURIDINE SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - QUINOLONES	MC/DEL MC/DEL MC/DEL MC/DEL		CILOXAN OINT CIPROFLOXACIN SOL 0.3% OFLOXACIN QUIXIN SOLN	MC/DEL MC		CILOXAN SOLN OCUFLOX SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. QUINOLONES-4TH GENERATION	MC/DEL MC		VIGAMOX ZYMAR					
OP. - ARTIFICIAL TEARS AND LUBRICANTS	MC MC/DEL MC/DEL MC MC MC/DEL MC MC MC MC MC MC MC		AKWA TEARS OINT ARTIFICIAL TEARS OINT ARTIFICIAL TEARS SOLN CELLUVISC SOLN EYE LUBRICANT OINT GENTEAL LIQUITEARS SOLN MAJOR TEARS SOLN PURALUBE OINT PURALUBE TEARS SOLN REFRESH SOLN OP REFRESH PLUS SOLN ¹	MC MC/DEL MC MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL		AKWA TEARS SOLN ARTIFICIAL TEARS SOLN OP BION TEARS SOLN DRY EYES OINT DURATEARS OINT HYPO TEARS ISOPTO TEARS SOLN LACRI-LUBE LUBRIFRESH P.M. OINT MURINE SOLN MUROCEL SOLN NATURE'S TEARS SOLN	Use PA Form# 20420 1. Dosing limits apply, please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC		REFRESH PM OINT	MC MC MC MC MC/DEL MC/DEL MC MC/DEL MC	REFRESH SOLN REFRESH TEARS SOLN ¹ SYSTANE TEARGEN SOLN TEARISOL SOLN TEARS NATURALE TEARS PURE SOLN TEARS RENEWED OINT THERATEARS SOLN V-R ARTIFICIAL TEARS SOLN		
OP. - BETA - BLOCKERS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BETOPTIC-S SUSP CARTEOLOL HCL SOLN LEVOBUNOLOL HCL SOLN METIPRANOLOL SOLN TIMOLOL MALEATE SOLG (GEL) TIMOLOL MALEATE SOLN	MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL	BETAGAN SOLN BETAXOLOL HCL SOLN BETIMOL SOLN ISTALOL OCUPRESS SOLN OPTIPRANOLOL SOLN TIMOPTIC SOLN TIMOPTIC-XE SOLG	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH.	MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC MC/DEL MC/DEL		AK-SPORE HC OINT ALREX SUSP BLEPHAMIDE SUSP CORTISPORIN SUSP DEXAMETH SOD PHOS SOLN FLAREX SUSP FLUOROMETHOLONE SUSP FML S.O.P. OINT FML-S LIQUIFILM SUSP INFLAMASE SOLN LOTEMAX SUSP NEOMPOLIN/DEX PRED MILD SUSP PREDNISOLONE TOBRADEX	MC MC MC MC MC MC MC MC MC MC MC MC/DEL MC MC/DEL	AK-TROL SUSP BAC/POLY/NEOMYHC OINT BLEPHAMIDE S.O.P. OINT ECONOPRED EFLONE SUSP FLUOR-OP SUSP FML LIQUIFILM SUSP MAXITROL NEO/POLY/BAC/HC OINT PRED FORTE SUSP PRED-G SUSP PRED-G S.O.P. OINT SULFACET SOD/PRED SOLN VASOCIDIN SOLN VEXOL SUSP	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - PROSTAGLANDINS	MC MC/DEL		LUMIGAN SOLN TRAVATAN SOLN	MC/DEL MC/DEL	RESCULA SOLN XALATAN SOLN	All preferreds must be tried. Use PA Form# 20420	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - CYCLOPLEGICS	MC MC/DEL MC/DEL MC/DEL		AK-PENTOLATE SOLN ATROPINE SULFATE CYCLOPENTOLATE HCL SOLN ISOPTO HYOSCINE SOLN	MC/DEL MC MC/DEL MC	CYCLOGLY SOLN ISOPTO ATROPINE SOLN ISOPTO HOMATROPINE SOLN MURCOLL-2 SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - MIOTICS - DIRECT ACTING	MC/DEL MC MC MC/DEL MC/DEL		ISOPTO CARBACHOL SOLN ISOPTO CARPINE SOLN PILOCAR SOLN PILOCARPINE HCL SOLN PILOPINE HS GEL				
OP. - ADRENERGIC AGENTS	MC/DEL MC		DIPIVEFRIN HCL SOLN EPIFRIN SOLN	MC	PROPIPE SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC MC		ALPHAGAN SOLN ALPHAGAN P SOLN	MC/DEL	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-ALLERGENS	MC/DEL MC/DEL MC/DEL		OPTIVAR PATADAY SOLN PATANOL SOLN	MC MC/DEL MC MC/DEL MC/DEL MC/DEL	ALOCRIL SOLN ALOMIDE SOLN ELESTAT EMADINE SOLN LIVOSTIN SUSP OPTICROM SOLN ZADITOR SOLN	Use PA Form# 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - ANTI-ALLERGENS-MASTCELL STABILIZER CLASS				MC/DEL	ALAMAST SOLN	Use PA Form# 20420	
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO	MC/DEL MC/DEL MC/DEL		AZOPT SUSP COSOPT SOLN TRUSOPT SOLN	MC	COMBIGAN	Use PA Form# 20420	
OP. - NSAID'S	MC MC MC MC		ACULAR LS ACULAR SOLN FLURBIPROFEN SODIUM SOLN VOLTAREN SOLN	MC MC/DEL MC MC	OCUFEN SOLN NEVANAC XIBROM	Must fail all preferred products before non-preferred. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - OF INTEREST	MC/DEL		ENUCLENE SOLN	MC	BOTOX SOLR	1. Must have kerato	Must fail adequate trials of multi agents from artificial tears and lubricant category.

			MC	RESTASIS ¹	conjunctivitis sicca and failed other dry eye therapies. Use PA Form #20420	
DERMATOLOGICAL						
TOPICAL - ACNE PREPARATIONS	MC/DEL	ACCUTANE CAPS		AZONE	1. Users 24 or under, PA will not be required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	AZELEX CREA	MC	ALTINAC CREA	2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List.	
	MC	BENZOYL PEROXIDE	MC	AVITA CREA		
	MC/DEL	CLINDAMYCIN PHOSPHATE ²	MC	BENZAC		
	MC	ERYDERM SOLN	MC/DEL	BENZAFLIN GEL		
	MC/DEL	ERYTHROMYCIN GEL	MC/DEL	BENZAGEL-10 GEL		
	MC/DEL	ERYTHROMYCIN PADS	MC/DEL	BENZAMYCIN GEL		
	MC/DEL	ERYTHROMYCIN SOLN	MC/DEL	BENZAMYCINPAK PACK	If requesting any brands	
	MC	METRONIDAZOLE CREAM ²	MC	BREVOXYL	use PA Form # 10220	
	MC	METRONIDAZOLE GEL ²	MC/DEL	CLEOCIN-T ²	for all others use	
	MC	METRONIDAZOLE LOTN ²	MC	CLINAC BPO GEL	PA Form # 20420	
	MC/DEL	PLEXION	MC	CLINDAGEL GEL		
	MC	RETIN-A GEL ^{1,2}	MC	CLINDETS SWAB		
	MC/DEL	SODIUM SULFACET/SULF LOTN	MC	DESQUAM-E GEL		
	MC	TAZORAC GEL	MC	DESQUAM-X		
				DIFFERIN 0.3% GEL		
				DIFFERIN		
				DUAC GEL		
				EMGEL GEL		
				EPIDUO		
				ERYCETTE PADS		
				ERYGEL GEL		
				EVOCILIN		
				FINEVIN CREA		
				KLARON LOTN		
				METROCREAM CREAM ²		
			METROGEL GEL ²			
			METROLOTION LOTN ²			
			NEOBENZ MICRO			
			NORITATE CREA			
			RETIN-A MICRO GEL			
			RETIN-A CREAM ²			
			SULFACET-R LOTN			
			TRETINOIN ^{1,2}			
			TRIAZ			
			ZETACET			
			ZIANA			
TOPICAL - ANTI-BIOTIC	MC/DEL	ALTABAX ^{1,2}	MC/DEL	ALTABAX 15GM	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.
	MC	BACIT/NEOMYCIN/POLYM OINT	MC/DEL	BACTROBAN OINT.	2. Only 5gm and 10gm tubes will be preferred.	
	MC/DEL	BACITRACIN OINT	MC/DEL	CORTISPORIN		
	MC/DEL	BACTROBAN CREAM	MC/DEL	TRIPLE ANTI-BIOTIC OINT		
	MC/DEL	BACTROBAN NASAL OINT				
	MC/DEL	CENTANY OINT 2% ¹			Use PA Form# 20420	
TOPICAL - ANTI-FUNGALS	MC/DEL	MUPIROCI ¹				Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, Protonix, or Omeprazole.
	MC	CICLOPIROX 0.77 CREAM	MC	EXELDERM		
	MC	CICLOPIROX 0.77 SUSP	MC	FUNGIZONE CREA	Use PA Form # 10120	
	MC/DEL	CLOTIRMAZOLE	MC/DEL	HYDROCORTIODOO CREA		
	MC/DEL	CLOTIRMAZOLE/BETA CREAM	MC/DEL	LAMISIL		
	MC	ECONAZOLE NITRATE CREAM	MC/DEL	LOPROX 0.77 LOTN		
	MC/DEL	KETOCONAZOLE CREAM	MC/DEL	LOPROX 0.77 CREAM		
	MC/DEL	LOPROX 1.0 CREAM	MC/DEL	LOPROX 0.77 SUSP		
	MC/DEL	LOPROX 1.0 LOTN	MC/DEL	LOPROX SHAMPOO SHAM		
	MC/DEL	LOPROX GEL	MC	LOTRIMIN		
	MC/DEL	LOPROX TS LOTN	MC/DEL	LOTRISONE		
	MC/DEL	MICONAZOLE NITRATE CREA	MC/DEL	MENTAX CREA		
	MC	MYCO-TRIA CET II CREA	MC	MYCOGEN II CREA		
	MC	NIZORAL SHAM	MC	MYCOLOG-II CREA		
	MC	NTA OINT	MC	MYCOSTATIN POWD		
	MC/DEL	NYSTATIN	MC	NAFTIN		
	MC/DEL	NYSTATIN/TRIAMCINOLONE	MC	NIZORAL CREA		
	MC	PEDI-DRI POWD	MC	NYSTAT-RX POWD		
	MC/DEL	TINACTIN	MC/DEL	NYSTOP POWD		

	MC		TRI-STATIN II CREA	MC/DEL MC		OxISTAT PENLAC NAIL LACQUER SOLN SPECTAZOLE CREAM	
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 MC/DEL MC		DOVONEX SORIATANE CAPS TAZORAC	MC MC MC/DEL MC MC		OXSORALEN ULTRA CAPS PSORIATEC CREA SORIATANE CK KIT TACLONEX ¹ VANAMIDE VECTICAL	Must fail all preferred products before non-preferred. 1. Individual ingredients are available as preferred without PA. Use PA Form# 20420. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTISEBORRHEICS	MC MC/DEL MC		CAPITROL SHAM SELENIUM SULFIDE SHAM SELSUN BLUE SHAM	MC MC		CARMOL SCALP TREATMENT KIT ZNP BAR	Use PA Form# 20420. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIVIRALS				MC/DEL MC		DENAVIR CREA ¹ ZOVIRAX OINT ¹	1. Must fail oral treatment with Acyclovir or Valtrex. Use PA Form# 20420.
TOPICAL - ANTINEOPLASTICS	MC MC MC		EFUDEX FLUOROPLEX CREA SOLARAZE GEL	MC/DEL MC/DEL		CARAC CREA FLUOROURACIL	Use PA Form# 20420. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - BURN PRODUCTS	MC MC MC/DEL		FURACIN CREA SSD CREA THERMAZENE CREA	MC/DEL MC/DEL MC		SILVADENE CREA SILVER SULFADIAZINE CREA SSD AF CREA	Use PA Form# 20420. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - CORTICOSTEROIDS	MC MC/DEL MC MC MC MC MC MC MC/DEL MC/DEL MC/DEL MC MC MC MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC MC MC MC		LOW POTENCY DESOWEN HYDROCORTISONE CREA HYDROCORTISONE LOTN LACTICARE-HC LOTN NUTRACORT LOTN TEXACORT SOLN TRIDESILON CREA MEDIUM POTENCY DESOXIMETASONE .05% ELOCON FLUOCINOLONE ACETONIDE .025-.01% FLUROSYN CREA FLUTICASONE PROPIONATE CREAM/OINT HYDROCORTISONE BUTYRATE HYDROCORTISONE OINT HYDROCORTISONE VALERATE MOMETASONE FUROATE OINT TRIAMCINOLONE ACETONIDE .025-.1% HIGH POTENCY CYCLOCORT BETAMETHASONE DIPROPIONATE DESOXIMETASONE .25% DESONIDE FLUOCINOLONE ACETONIDE .02% FLUOCINONIDE HALOG HALOG-E CREA TRIAMCINOLONE ACETONIDE .5% VERY HIGH POTENCY AUGMENTED BETA DIP BETAMETHASONE VALERATE BETA-VAL CLOBETASOL PROPIONATE DIFLORASONE DIACETATE HALOBETASOL MISCELLANEOUS CAPEX SHAM DERMA-SMOOTHIE/FS OIL PROCTO-KIT CREA 1%	MC MC MC MC MC/DEL MC/DEL MC MC MC MC MC MC/DEL MC/DEL MC MC MC MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC MC/DEL MC MC MC MC MC/DEL MC MC MC MC MC		ACLOVATE AMCINONIDE CREA ANUSOL HC-1 OINT ARISTOCORT A CLOBEX CLODERM CREA CORDRAN CORMAX CUTIVATE CREAM / OINT CUTIVATE LOTION DERMATOP DESONATE GEL DIPROLENE ELOCON OINT HYDROCORTISONE POWD KENALOG AERS LIDA MANTLE HC CREA LIDEX LIDEX-E CREA LOCOID LUXIQ FOAM OLUX FOAM PANDEL CREA PROCTOCORT CREA PSORCON PSORCON E SYNALAR OINT TEMOVATE TOPICORT TOPICORT LP CREA ULTRAVATE VERDESO WESTCORT	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.
TOPICAL - STEROID LOCAL	MC		ZONE-A FORTE LOTN	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

ANESTHETICS							offered on the Prior Authorization form, such as the presence of 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-SMOOTHIE/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 MC MC MC		AMMONIUM LACTATE LOTION 12% LAC-HYDRIN CREAM LACTINOL-E CREA UREACIN-20 CREA VITAMIN A & D MEDICATED OINT	MC/DEL MC MC MC/DEL MC MC MC		AMMONIUM LACTATE CREA ATOPICLAIR LAC-HYDRIN LOTION 12% LACTINOL LOTN MEDERMA GEL MIMYX RENOVA CREA	Use PA Form# 20420. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ENZYMES / KERATOLYTICS / UREA	MC MC/DEL MC MC		GRANUL-DERM AERS GRANULEX AERS TBC AERS SANTYL OINT	MC MC MC		CARMOL 40 CREA SALEX CREAM SALEX LOTION	Use PA Form# 20420. Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety 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.
TOPICAL - GENITAL WARTS	MC/DEL		ALDARA	MC/DEL MC/DEL MC	5 8 8	PODOFILOX SOLN CONDYLOX VEREGEN	Use PA Form# 20420. Non-preferred products must be used in specified order.
TOPICAL - IMMUNOMODULATORS				MC/DEL MC	8 9	ELIDEL CREA PROTOPIC OINT	Use PA Form# 20420. Non-preferred products must be used in specified order. The FDA has issued a Public Health Advisory for both Elidel and Protopic concerning the potential cancer risk associated with their use. Use for children less than 2 years of age is not recommended. Preferred corticosteroids from other classes must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be made for small amounts of non-preferred products for the treatment of very steroid-sensitive areas in conjunction with topical steroids for the treatment of atopic dermatitis.
TOPICAL - LOCAL ANESTHETICS	MC MC/DEL MC MC/DEL MC/DEL		AF CAPSICUM OLEORESIN CREA CAPSAICIN CREA ELA-MAX ¹ LIDOCAINE/PRILOCAINE CREA ¹ XYLOCAINE	MC/DEL MC/DEL MC MC MC MC		EMLA PADS EMLA CREA LIDA MANTLE CREA LIDODERM PTCH PONTOCAINE SOLN ZOSTRIX	1. Lidocaine/Prilocaine cream and Ela-Max products require PA for users over 18 years of age. Use PA Form# 20420. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - DEPIGMENTING AGENTS				MC MC MC MC/DEL MC/DEL MC MC MC	8 8 8 8 8 8 8 9	ALUSTRAL CREA EPIQUIN MICRO GLYQUIN CREA HYDROQUINONE CREA HYDROQUINONE/SUNSCREENS SOLAQUIN FORTE CREA TRI-LUMA CREA ELDOQUIN	Not covered for cosmetic purposes. Use PA Form# 20420. As per Medicaid Policy, cosmetic drugs are not covered. Non-cosmetic clinical applications will be considered by prior authorization on a case by case basis.
TOPICAL - SCABICIDES AND PEDICULICIDES	MC/DEL MC MC MC MC/DEL MC/DEL		ACTION CREA ELIMITE CREA EURAX LICE KILLING SHAM LICE TREATMENT CREME RINS LIOD PERMETHRIN LOTN	MC/DEL MC MC MC MC/DEL MC/DEL		LINDANE OVIDE LOTN	Use PA Form# 20420. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - WOUND / DECUBITUS CARE				MC MC/DEL MC/DEL		REGREANEX GEL REGENECARE RADIAPLEXRX	Use PA Form# 20420. 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 O2 >30, ABI>0.7 or ASP> 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks.
TOPICAL - ASTRINGENTS / PROTECTANTS	MC MC MC		ALUMINUM CHLORIDE SOLN DRYSOL SOLN XERAC-AC SOLN	MC MC MC		LOWILA BAR MOISTURIN DRY SKIN CREA PROSHIELD PLUS SKIN PROTE 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.

					SURGILUBE GEL		
TOPICAL - ANTISEPTICS / DISINFECTANTS	MC/DEL MC/DEL		PHISOHEX LIQD POVIDONE-IODINE SOLN	MC MC MC MC	BETADINE OINT FORMALYDE-10 AERS IODOSORB LAZERFORMALYDE SOLUTION SOLN	Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS EYE							
OP. - EYE	MC MC MC MC MC/DEL		AK-DILATE SOLN EYE WASH SOLN NAPHAZOLINE HCL SOLN PHENYLEPHRINE HCL SOLN PONTOCAINE SOLN SODIUM CHLORIDE	MC MC/DEL MC	LENS PLUS REWETTING DROPS MURO 128 NEO-SYNEPHRINE SOLN	Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS EAR							
EAR	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC/DEL		A/B OTIC SOLN ACETASOL SOLN ACETASOL HC SOLN ACETIC ACID ACETIC ACID/HYDROCORTISON ALLERGEN SOLN ANTIPYRINE/BENZOCAINE SOLN AURODEX SOLN AUROGUARD SOLN AUROTO OTIC SOLN CARBAMIDE PEROXIDE 6.5% OTIC SOLN. CIPRODEX CORTISPORIN SOLN CORTOMYCIN EAR DROPS SOLN EAR DROPS RX SOLN EAR WAX REMOVAL DROPS EAR-GESIC SOLN NEOMYCIN/POLYMYXIN/HC OFLOXACIN 0.3% OTIC OTICAINE OTIC SOLN	MC MC MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL	AERO OTIC HC SOLN ANTIBIOTIC EAR SOLN ANTIBIOTIC EAR SUSP AURALGAN SOLN CIPRO HC SUSP COLY-MYCIN-S SUSP CORTISPORIN SUSP CORTISPORIN-TC SUSP DEBROX SOLN DOMEBORO SOLN FLOXIN OTIC SOLN PEDIOTIC SUSP VOSOL-HC SOLN ZOTANE HC SOLN ZOTO-HC SOLN	Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MOUTH ANTISEPTICS							
MOUTH ANTI-INFECTIVES	MC MC MC/DEL		NILSTAT SUSP EAR-GESIC SOLN NYSTATIN SUSP	MC MC MC	MYCELEX TROC MYCOSTATIN LOZG	Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MOUTH ANTISEPTICS	MC/DEL MC/DEL MC MC		CHLORHEXIDINE GLUCONATE LIDOCAINE VISCOUS SOLN TRIAMCINOLONE IN ORABASE PSTE TRIAMCINOLONE ORADENT PSTE	MC MC MC MC	APHTHASOL PSTE PERIDEX SOLN PERIOGARD SOLN TRIAMCINOLONE ACETONIDE PSTE XYLOCAINE VISCOUS SOLN	Use PA Form# 20420. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DENTAL PRODUCTS							
DENTAL PRODUCTS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		ETHEDENT CREA GEL-KAM CONC GEL-KAM GEL 0.4% PHOS FLUR SOLN PREVIDENT GEL PREVIDENT SOLN SF 5000 PLUS CREA SF GEL STANNOUS FLUORIDE ORAL RI CONC	MC/MC MC/DEL MC/DEL MC/DEL MC	APF GEL GEL DENTAGEL GEL PHOS-FLUR GEL PREVIDENT CREAM THERA-FLUR-N GEL	Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ARTIFICIAL SALIVA/STIMULANTS							
ARTIFICIAL SALIVA/STIMULANTS	MC		SALIVA SUBSTITUTE SOLN	MC MC MC	EVOXAC CAPS RADIACARE SOLR SALAGEN TABS	Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS ANORECTAL							
ANORECTAL - MISC.	MC/DEL MC MC MC/DEL MC/DEL		COLOCORT ENEM CORTENEMA ENEM ELA-MAX 5 CREA HYDROCORTISONE ENEM PROCTOZONE-HC CREA	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ANUSOL-HC CREA CORTIFOAM FOAM PROCTOCREAM-HC CREA PROCTOFOAM HC FOAM PROCTO-KIT CREA 2.5%	Use PA Form# 20420.	

T-CELL ACTIVATION INHIBITOR

PSORIASIS BIOLOGICALS	MC MC		ENBREL ¹ HUMIRA ¹	MC 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. High doses of Enbrel 50mg twice weekly will require a PA. Please refer to dose consolidation list. 2. Trial of both preferred drugs are required. Use PA Form # 20910.	Approved for severe chronic plaque psoriasis unresponsive to first line therapies. A trial of at least several potent topicals from the following categories: corticosteroids, coal tars, anthralin, calcipotriene and tazarotene, and at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin and phototherapy/UVA.
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ALTERNATIVE MEDICINES

ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC/DEL MC/DEL MC	CO-ENZYME Q-10 GLUCOSAMINE MELATONIN TABS	Use PA Form# 20420.	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
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CHELATING AGENTS

CHELATING AGENTS	MC/DEL		CUPRIMINE CAPS	MC MC/DEL	DEPEN TITRATABS TABS EXJADE ¹	Use PA Form# 20420.	1. FDA indication of treatment of chronic iron overload due to blood transfusions in members 2 years of age and older is required for approval of Exjade
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ANTILEPROTIC

ANTILEPROTIC				MC	THALOMID CAPS ¹	1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules. Use PA Form# 20420.	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
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ANTINEOPLASTIC AGENTS

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

CANCER

CANCER	MC MC/DEL MC MC/DEL		ALIMTA AVASTIN ERBITUX VIDAZA	MC MC/DEL	NEXAVAR ¹ SUTENT ^{1,2}	1. PA required to confirm FDA approved indication 2. Avoid CYP3A4 drug drug interaction. Use PA Form# 20420.	
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IMMUNOSUPPRESSANTS

IMMUNOSUPPRESSANTS	MC/DEL MC/DEL		CYCLOSPORINE MODIFIED CYCLOSPORINE SOL. MODIFIED	MC/DEL MC/DEL	CELLCEPT CYCLOSPORINE CAPS	1. Established users will require a one time 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
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	MC MC/DEL MC/DEL MC MC/DEL MC/DEL		GENGRAF CAPS MYCOPHENOLATE MYFORTIC PROGRAF CAPS RAPAMUNE SANDIMMUNE	MC/DEL		NEORAL ^{1,2}	2. Established users will require a one time PA Use PA Form# 20420.	drug and the preferred drug(s) exists. DDI: Cyclosporine will now be non-preferred and require prior authorization if it is currently being used in combination with either Liptor (doses greater than 20mg/day), Crestor, or lovastatin (doses greater than 20mg). DDI: All preferred immunosuppressants will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
PURINE ANALOG								
PURINE ANALOG	MC MC/DEL		AZASAN TABS AZATHIOPRINE TABS	MC/DEL		MURAN 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 MC MC/DEL MC/DEL MC/DEL		KAYEXALATE POWD KIONEX POWD SODIUM POLYSTYRENE SULFON SPS SUSP SPS 30GM/120ML ENEMA SUSP				Use PA Form# 20420.	

New drugs are initially non-preferred until reviewed by the DUR Committee and the State. According to State policy, any drug requiring specific diagnosis still requires the specific diagnosis unless otherwise noted within this document.
Revised Jan. 1, 2006

ANTI-CONVULSANTS INDICATION CHART

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

PEDIATRIC ANTI-CONVULSANTS INDICATION CHART

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