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

General Criteria for all PDL categories- For more information or help using the PDL, providers may call 1-888-445-0497; members should call 1-866-796-2463. To access PDL and PA materials via the internet: www.mainecarepdl.org

A: Preferred Drugs- Unless otherwise specified, preferred drugs are available without prior authorization. Step order may apply for preferred drugs in some drug categories as indicated on the PDL. (See item "D" below for explanation of step order.)

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

C: Adequate Drug Trials- 1. The minimum trial period for each preferred and step order drug is two weeks, unless otherwise stated within specific PDL drug categories; trials with less than a two week duration will be reviewed on a case-by-case basis; 2. A trial will not be considered valid if non-preferred products were readily available (by override, individual purchase, samples, etc.); 3. Certain drug trials, such as with preferred narcotics, may require evidence that the preferred drugs were actually tried (example: with urine drug tests); 4. Adequate trials require documentation of attempts to titrate dose of preferred agents toward desired clinical response. 5. Adequate trials include prevention/treatment of common adverse effects associated with preferred agents (example: antinausea, antipruritics, etc.)

D: Step Order- When numbers appear in the "step order" column, it means drugs in this category must be used in the order specified, with the lower numbers having preference over the higher numbers. Chart notes should be provided to confirm drug trials that do not appear in the member's MaineCare drug profile.

E: 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.

F: 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.

G: 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.

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

J. Drug-specific PA Forms- Drug-specific PA forms contain medical necessity documentation requirements and/or criteria that may not be repeated in the PDL. Drug-specific PA forms may be obtained on the web at *www.mainecarepdl.org* .

K. PA Exemptions for Prescribers- According to MaineCare Benefits Manual Chapter II (80.07-4), providers may receive a three (3) month exemption from prior authorization requirement for certain categories of drugs when they demonstrate high compliance with the Department's PDL. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption. If a provider loses his/ her exemption, members who previously were not required to obtain a PA while the prescriber was exempt will be required to do so, and criteria for approval of that medication will need to be met.

ASSORTED ANTIBIOTICS

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required	Comments	Criteria
BETA-LACTAMS / CLAVULANATE COMBO'S	MC/DEL		AMOXICILLIN	MC/DEL		AMOXIL 500MG TABS	1. Amoxil 500mg tabs are non-preferred. All other Amoxil products are preferred. 2.Principen 250 mg is available without PA. 3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml 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.
	MC/DEL		AMOXIL[1]	MC/DEL		AUGMENTIN[3]		
	MC/DEL		AMPICILLIN	MC		PRINCIPEN CAPS[2]		
	MC/DEL		AMOXICILLIN/POTASSIUM CLA CHEW	MC		PRINCIPEN SUSR		
	MC/DEL		AMOXICILLIN/POTASSIUM CLA SUSR					
	MC/DEL		AMOXICILLIN/POTASSIUM CLA TABS					
	MC/DEL		AUGMENTIN ES-600 SUSR					
	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]	1. Both brand and generic are clinically non-preferred. **Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CEFAZOLIN SODIUM SOLR	MC		CEDAX		
	MC/DEL		CEFTIN SUSP	MC/DEL		CEFACLOR[1]		
	MC/DEL		CEFUROXIME AXETIL TABS	MC/DEL		CEFADROXIL MONOHYDRATE TABS		
	MC		CEFZIL	MC/DEL		CEFTIN		
	MC/DEL		CEPHALEXIN MONOHYDRATE	MC/DEL		DURICEF TABS		
	MC/DEL		DURICEF SUSR	MC/DEL		FORTAZ SOLN		
	MC/DEL		FORTAZ SOLR	MC		KEFLEX CAPS		
	MC		KEFZOL SOLR	MC		TAZICEF SOLR		
	MC		MAXIPIME SOLR					
	MC		OMNICEF					
	MC/DEL		ROCEPHIN					
	MC/DEL		VANTIN					
MACROLIDES / ERYTHROMYCIN'S	MC		BIAXIN XL[1]	MC		BIAXIN	1. 7- Day supply per month w/o PA	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		AZITHROMYCIN TABS	MC/DEL		DYNABAC D5-PAK TBEC		
	MC/DEL		CLARITHROMYCIN	MC		ERYPED CHEW		
	MC		E.E.S.	MC		PCE TBEC		
	MC		E-MYCIN TBEC	MC/DEL		ZITHROMAX TABS		
	MC		ERYPED 200 SUSR					
	MC		ERYPED 400 SUSR					
	MC		ERY-TAB TBEC					

	MC		ERYTHROCIN STEARATE TABS					
	MC/DEL		ERYTHROMYCIN					
	MC/DEL		ZITHROMAX SUSP				Use PA Form # 20420	
	MC/DEL		ZMAX					
TETRACYCLINES	MC/DEL		DOXYCYCLINE HYCLATE	MC		DECLOMYCIN TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		MINOCYCLINE HCL CAPS	MC/DEL		DORYX CPEP		
	MC		SUMYCIN	MC/DEL		DOXYCYCLINE MONO CAPS		
	MC/DEL		TETRACYCLINE HCL CAPS	MC/DEL		DYNACIN CAPS		
	MC/DEL		VIBRAMYCIN SYRP	MC		MONODOX CAPS		
				MC/DEL		PERIOSTAT		
FLUOROQUINOLONES	MC		AVELOX ABC PACK TABS	MC		CIPRO	1. QL 3/script/month Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		AVELOX SOLN	MC		FLOXIN TABS		
	MC		AVELOX TABS	MC		LEVAQUIN		
	MC/DEL		CIPROFLOXACIN	MC/DEL		NOROXIN TABS		
	MC		CIPRO XR[1]	MC		TEQUIN		
AMINO GLYCOSIDES	MC		GENTAMICIN					Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NEOMYCIN SULFATE TABS					
	MC		TOBI NEBU					
	MC/DEL		TOBRAMYCIN SULFATE SOLN					
ANTI-MYCOBACTERIALS / ANTI TUBERCULOSIS	MC/DEL		ETHAMBUTOL HCL TABS	MC		RIMACTANE CAPS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		MYAMBUTOL TABS					
	MC/DEL		MYCOBUTIN CAPS					
	MC/DEL		RIFAMPIN					
ANTIMALARIAL AGENTS	MC/DEL		**CHLOROQUINE PHOSPHATE TABS**	MC		ARALEN TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**DARAPRIM TABS**	MC/DEL		**PLAQUENIL TABS**		
	MC/DEL		**HYDROXYCHLOROQUINE TABS**					
	MC/DEL		**LARIAM TABS**					
	MC/DEL		MALARONE TABS					
	MC/DEL		**MEFLOQUINE HCL TABS**					
	MC		QUINACRINE HCL POWD					
	MC/DEL		**QUININE SULFATE**					
ANTHELMINTICS	MC/DEL		ALBENZA TABS	MC		VERMOX CHEW	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BILTRICIDE TABS					
	MC/DEL		MEBENDAZOLE CHEW					
	MC/DEL		STROMECTOL TABS					
ANTIBIOTICS - MISC.	MC		AZACTAM SOLR	MC		COLY-MYCIN-M SOLR	1. Need to fail other anti-protozoals 2. 375mg caps and 750mg tabs are non-preferred. Please use available preferred strengths(250mg & 500mg tabs) to obtain required dose 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. 1. For macrolide resistant infections when quinolones inappropriate
	MC		COLISTIMETHATE SODIUM SOLR	MC/DEL		FLAGYL CAPS		
	MC		FUROXONE TABS	MC/DEL		FLAGYL TABS		
	MC/DEL		METRONIDAZOLE[2]	MC/DEL		FLAGYL ER TBCR		
	MC		PENTAMIDINE ISETHIONATE SOLR	MC/DEL		KETEK		
	MC		PRIMSOL SOLN	MC/DEL		LORABID		
	MC/DEL		TRIMETHOPRIM TABS	MC/DEL		METRONIDAZOLE 375MG CAPS[2]		
	MC		VANCOCIN HCL	MC/DEL		METRONIDAZOLE 750MG TABS[2]		
	MC/DEL		VANCOMYCIN HCL	MC		NEBUPENT SOLR		
				MC/DEL		PROLOPRIM TABS		
				MC		TINDAMAX[1]		
				MC		XIFAXAN		
CARBAPENEMS				MC		INVANZ SOLR		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		MERREM SOLR		
				MC/DEL		PRIMAXIN		
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL		CLEOCIN SOLN	MC/DEL		CLEOCIN CAPS	1. Use multiple 150's for Clindamycin instead of 300's. **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		ALINIA*	* Alina is preferred for children less than 12 years of age. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SEPTRA/DS TABS	MC		BACTRIM DS TABS		
	MC/DEL		SULFAMETHOXAZOLE/TRIMETH					
	MC/DEL		TRIMETHOPRIM/SULFAMETHOXA					
ANTI - FUNGALS								
ANTIFUNGALS - ASSORTED	MC		ANCOBON CAPS	MC/DEL	5	LAMISIL TABS	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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The other criteria are listed on the Antifungal PA form including the required proof of a non-cosmetic fungal infection.
	MC/DEL		FLUCONAZOLE[1]	MC	5	SPORANOX SOLN[2]		
	MC		GRIFULVIN	MC	5	SPORANOX PULSEPAK CAPS[3]		
	MC		GRISEOFULVIN ULTRAMICROSI TABS	MC	6	SPORANOX CAPS[3]		
	MC		GRIS-PEG TABS	MC/DEL	8	DIFLUCAN[1]		
	MC/DEL		KETOCONAZOLE TABS	MC	8	NIZORAL TABS		
	MC/DEL		NYSTATIN					

	MC/DEL		VFEND TABS				step order. Continue to use Anti-Fungal PA form for non-preferred products. **Use PA Form # 10120**	
ANTI - VIRALS								
ANTIRETROVIRALS	MC/DEL		AGENERASE CAPS	MC/DEL		DIDANOSINE	**Fuzeon use PA Form # 10620** **Turvada use PA form #20420**	Please refer to the criteria listed on the Fuzeon PA form.
	MC/DEL		APTIVUS	MC/DEL		FUZEON		
	MC/DEL		COMBIVIR TABS					
	MC/DEL		CRIXIVAN CAPS					
	MC		EMTRIVA					
	MC/DEL		EPIVIR / HBV					
	MC/DEL		EPZICOM					
	MC/DEL		FORTOVASE CAPS					
	MC		HIVID TABS					
	MC/DEL		INVIRASE CAPS					
	MC		KALETRA					
	MC/DEL		LEXIVA					
	MC		NORVIR					
	MC/DEL		RESCRIPTOR TABS					
	MC/DEL		RETROVIR					
	MC		REYATAZ					
	MC		SUSTIVA					
	MC/DEL		TRIZIVIR TABS					
	MC		TRUVADA					
	MC		VIDEX / EC					
	MC/DEL		VIRACEPT TABS					
	MC/DEL		VIRAMUNE TABS					
	MC		VIREAD TABS					
	MC		ZERIT					
	MC/DEL		ZIAGEN TABS					
CYTO-MEGALOVIRUS AGENTS	MC/DEL		GANCICLOVIR	MC		CYTOVENE CAPS	**Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		VALCYTE TABS					
IMMUNE SERUMS								
IMMUNE SERUMS			HYPERRHO INJ					
HEPATITIS AGENTS								
HEPATITIS C AGENTS	MC/DEL		PEG-INTRON KIT	MC/DEL	8	COPEGUS 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 (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		REBETRON KIT	MC/DEL	8	PEGASYS KIT		
	MC/DEL		REBETOL CAPS	MC/DEL	8	PEGASYS SOLN		
				MC	8	RIBAVIRIN CAPS		
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		BARACLUDE		
HERPES AGENTS	MC/DEL		ACYCLOVIR	MC/DEL		FAMVIR TABS	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.
	MC/DEL		VALTREX TABS	MC/DEL		ZOVIRAX		
INFLUENZA AGENTS	MC/DEL		AMANTADINE	MC/DEL		FLUMADINE TABS	1. Tamiflu 10 caps or 60cc's per month. 2. **Flumist 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.
	MC		RELENZA DISKHALER AEPB	MC		FLUMIST[2]		
	MC/DEL		RIMANTADINE HCL TABS					
	MC/DEL		TAMIFLU[1]					
RSV PROPHYLAXIS								
RSV PROPHYLAXIS				MC		RESPIGAM	**Use PA Form # 30120**	Please see the criteria listed on the Synagis PA form.
				MC		SYNAGIS		
MS TREATMENTS								
MULTIPLE SCLEROSIS AGENTS				MC	5	AVONEX KIT	Established users grandfathered. Must follow specified step order. Use PA Form # 20430	Non-Preferred drugs must be tried in step-order and failed due to lack of efficacy or intolerable side effects before lower ranked non-preferred drugs will be approved , unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL	5	**BETASERON SOLR**		
				MC	5	REBIF SOLN		
				MC/DEL	6	**COPAXONE**		
ASSORTED NEUROLOGICS								
NEUROLOGICS - MISC.	MC		MESTINON	MC		BOTOX	1. Myobloc approval will be limited to Cervical Dystonia. **Use PA Form #10210**	Failed/did not tolerate therapeutic trials fo muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, Skelaxin, and tizanidine.
	MC/DEL		ORAP TABS	MC/DEL		MYOBLOC[1]		
	MC		PROSTIGMIN TABS					
STEROIDS								
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC		CELESTONE SUSP	MC		CORTEF 10 and 20 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		CORTEF 5	MC		DECADRON TABS		
	MC/DEL		CORTISONE ACETATE TABS	MC/DEL		FLORINEF TABS		
	MC/DEL		DELTASONE TABS	MC/DEL		**MEDROL TABS**		
	MC/DEL		DEPO-MEDROL SUSP	MC		MEDROL DOSEPAK TABS		
	MC/DEL		DEXAMETHASONE	MC		PEDIAPRED LIQD		

	MC/DEL		ENTOCORT EC CP24	MC		PREDNISONE INTENSOL CONC		
	MC/DEL		FLUDROCORTISONE ACETATE TABS	MC		PRELONE SYRP		
	MC/DEL		HYDROCORTISONE	MC		STERAPRED TABS		
	MC		KENALOG					
	MC/DEL		METHYLPREDNISOLONE TABS					
	MC		ORAPRED SOLN					
	MC/DEL		PREDNISOLONE					
	MC/DEL		**PREDNISONE**					
	MC/DEL		SOLU-CORTEF SOLR					
	MC/DEL		SOLU-MEDROL SOLR					
HORMONE REPLACEMENT THERAPIES								
ANDROGENS / ANABOLICS	MC/DEL		ANDRODERM PT24	MC		ANDRO LA 200 OIL	Use PA Form # 20420 1. Non-preferred effective 12.01.05. Use the Oxandrin PA Form #20600	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Additionally, laboratory evidence of a testosterone deficiency must be supplied. One of each dosage form should be tried (tablet, injection, and topical)
	MC/DEL		ANDROID CAPS	MC/DEL		ANDROGEL PACK		
	MC/DEL		DANAZOL CAPS	MC		DELATESTRYL OIL		
	MC/DEL		DEPO-TESTOSTERONE OIL	MC		HALOTESTIN TABS		
	MC/DEL		FLUOXYMESTERONE TABS	MC/DEL		METHITEST TABS		
	MC		TESTODERM	MC/DEL		OXANDRIN TABS[1]		
	MC/DEL		TESTOSTERONE PROPIONATE					
	MC		TESTRED CAPS					
	MC		WINSTROL TABS					
ESTROGENS - PATCHES	MC/DEL		**ESTRADERM PTTW**	MC/DEL	5	**ESTRADIOL PTWK**	All patches are non-preferred products (require PA). Products must be used in specified step order. Use PA Form # 20420	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
	MC/DEL		**VIVELLE PTTW**	MC/DEL	8	**ALORA PTTW**		
				MC/DEL	8	**CLIMARA PTWK**		
				MC	8	ESCLIM PTTW		
				MC/DEL	8	**VIVELLE-DOT PTTW**		
ESTROGENS - TABS	MC/DEL		**CENESTIN TABS**	MC/DEL		**ESTRACE TABS**	Must fail preferred products before non-preferred products. Use PA Form # 20420	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**DELESTROGEN OIL**	MC		ESTRATAB TABS		
	MC/DEL		**ESTRADIOL**	MC/DEL		**OGEN TABS**		
	MC/DEL		**ESTROPIPATE TABS**	MC		ORTHO-EST TABS		
	MC/DEL		**MENEST TABS**					
	MC/DEL		**PREMARIN TABS**					
ESTROGEN COMBO'S	MC/DEL		**PREMPHASE TABS**	MC/DEL		**ACTIVELLA TABS**	Must fail Premphase and Prempro products before non preferred products. Use PA Form # 20420	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PREMPRO TABS**	MC/DEL		**COMBIPATCH PTTW**		
				MC/DEL		**FEMHRT 1/5 TABS**		
				MC/DEL		**ORTHO-PREFEST TABS**		
				MC/DEL		SYNTEST H.S. TABS		
PROGESTINS	MC/DEL		MEDROXYPROGESTERONE ACETA[2]	MC/DEL		AYGESTIN 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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NORETHINDRONE ACETATE TABS[2]	MC		CYCRIN TABS		
	MC		PROGESTERONE POWD	MC/DEL		PROMETRIUM 100MG CAPS[1]		
				MC/DEL		PROMETRIUM 200MG[1]		
				MC/DEL		PROVERA TABS		
CONTRACEPTIVES								
CONTRACEPTIVES - PROGESTIN ONLY	MC		ORTHO MICRONOR TABS	MC/DEL		CAMILA 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.
				MC/DEL		NORA-BE TABS		
				MC/DEL		NOR-QD TABS		
				MC/DEL		OVRETTE 28 TABS		
CONTRACEPTIVES - INJECTABLE	MC/DEL		DEPO-PROVERA SUSP	MC/DEL		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.
				MC/DEL		MEDROXYPROGESTERONE ACETATE IM		
CONTRACEPTIVE - EMERGENCY	MC/DEL		PLAN - B[1]				1. Allowed 4 tablets per 30 days without PA	
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC		ORTHO EVRA PTWK[1,2]	MC/DEL		NUVARING RING	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 exposoure Use PA Form # 20420	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S	MC/DEL		ALESSE-28 TABS	MC/DEL		APRI TABS	Loestrin FE and FE 1/20 are grandfathered for established users. If member experienced adverse reactions, consider using Oral	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		DEMULEN 1/35-28 TABS	MC/DEL		AVIANE TABS		
	MC/DEL		DEMULEN 1/50-28 TABS	MC/DEL		BREVICON-28 TABS		
	MC/DEL		DESOGEN TABS	MC/DEL		CRYSELLE-28 TABS		

	MC/DEL		LEVLEN-28 TABS	MC		DEMULEN 1/35-21 TABS	Contraceptives from other groups.	
	MC		LO/OVRAL 21 TABS	MC/DEL		KARIVA TABS		
	MC/DEL		LO/OVRAL 28 TABS	MC/DEL		LESSINA-28 TABS		
	MC		MODICON TABS	MC/DEL		LEVLITE-28 TABS		
	MC		ORTHO-CEPT-28 TABS	MC/DEL		LEVORA	**Use PA Form # 20420**	
	MC		ORTHO-CYCLEN-28 TABS	MC		LOESTRIN TABS		
	MC		ORTHO-NOVUM 1/35-28 TABS	MC/DEL		LOESTRIN FE TABS		
	MC		ORTHO-NOVUM 1/50-28 TABS	MC/DEL		LOESTRIN FE 1/20 TABS		
	MC/DEL		OVCON-35/28 TABS	MC/DEL		LOESTRIN 1.5/30-21 TABS		
	MC/DEL		OVCON-50 28 TABS	MC/DEL		LOESTRIN 1/20-21 TABS		
				MC/DEL		LOW-OGESTREL TABS		
				MC/DEL		MICROGESTIN FE TABS		
				MC/DEL		MIRCETTE TABS		
				MC/DEL		NECON		
				MC/DEL		NORDETTE-28 TABS		
				MC/DEL		NORINYL		
				MC/DEL		NORTREL		
				MC/DEL		MONONESSA		
				MC/DEL		OGESTREL TABS		
				MC/DEL		OVRAL		
				MC/DEL		PORTIA-28 TABS		
				MC/DEL		SPRINTEC 28 TABS		
				MC/DEL		YASMIN 28 TABS		
				MC/DEL		ZOVIA		
CONTRACEPTIVES - BI-PHASIC COMBINATIONS	MC		ORTHO-NOVUM 10/11-28 TABS	MC/DEL		NECON 10/11-28 TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		ORTHO TRI-CYCLEN TABS	MC/DEL		CYCLESSA 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.
	MC		ORTHO-NOVUM 7/7/7-28 TABS	MC/DEL		ENPRESSE		
	MC/DEL		TRI-LEVLEN TABS	MC/DEL		ESTROSTEP FE TABS		
	MC/DEL		TRIPHASIL 28 TABS	MC		ORTHO TRI-CYCLEN LO TABS		
				MC/DEL		TRI-NORINYL 28 TABS		
				MC/DEL		TRIVORA-28 TABS		
DIABETES THERAPIES								
DIABETIC - INSULIN	MC		ILETIN	MC		HUMALOG	*Established users grandfathered until 6.30.2006 **Use PA Form # 30140**	Approved if patient has had an allergic reaction to preferred products or for pediatric patients requiring insulin doses with diluent.
	MC/DEL		LEVEMIR (effective 4.1.2006)	MC		HUMULIN		
	MC/DEL		**NOVOLIN**	MC/DEL		LANTUS SOLN (effective 5.1.2006)*		
	MC/DEL		**NOVOLOG**					
	MC		RELION					
	MC		VELOSULIN BR SOLN					
DIABETIC - PENFILLS				MC/DEL	5	LEVEMIR FLEXPEN (effective 4.1.2006)	PA's will be granted for significant visual or neurological impairment. Products must be used in specified step order. **Use PA Form # 20420**	Approved for significant visual or neurologic impairment affecting hand dexterity and for school age children requiring at school doses.
				MC/DEL	5	**NOVOLIN PENFILL**		
				MC/DEL	5	NOVOLOG MIX PENFILL		
				MC/DEL	5	**NOVOLOG PENFILL SOLN**		
				MC	8	HUMALOG MIX 75/25 PEN SUSP		
					8	APRIDRA OPTICLIK PEN (effective 5.1.2006)		
				MC	8	HUMALOG PEN SOLN		
				MC	8	HUMULIN PEN		
					8	LANTUS OPTICLIK PEN (effective 5.1.2006)		
DIABETIC - OTHER				MC		SYMLIN	**PA Form # 30150**	Please see the criteria listed in the Symlin PA form.
INCRETIN MIMETIC				MC		BYETTA	**PA Form # 10230**	Please see the criteria listed in the Byetta PA form.One prefilled pen per month. There are 60 doses per each pen and each pen is a 30 day supply.
DIABETIC - ORAL SULFONYLUREAS	MC/DEL		**CHLORPROPAMIDE TABS**	MC/DEL		**AMARYL 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.
	MC/DEL		GLIMEPIRIDE	MC/DEL		**DIABETA TABS**		
	MC/DEL		**GLIPIZIDE TABS**	MC		GLUCOTROL TABS		
	MC/DEL		**GLIPIZIDE ER TABS**	MC/DEL		**GLUCOTROL XL TBCR**		
	MC/DEL		**GLYBURIDE TABS**	MC/DEL		**GLYNASE TABS**		
	MC/DEL		**GLYBURIDE MICRONIZED TABS**	MC/DEL		**MICRONASE TABS**		
	MC/DEL		**TOLAZAMIDE TABS**					
	MC/DEL		**TOLBUTAMIDE TABS**					
DIABETIC -ORAL BIGUANIDES	MC/DEL		**METFORMIN HCL TABS**	MC		GLUCOPHAGE TABS	Metformin ER 750mg tabs are non preferred. Metformin ER 500mg are 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 will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		METFORMIN ER 500MG	MC		GLUCOPHAGE XR TB24		
				MC/DEL		FORTAMET		
				MC/DEL		METFORMIN ER 750MG		
DIABETIC - THIAZOL / BIGUANIDE COMBO	MC/DEL		ACTOPLUS MET				1. Tentatively preferred. Will be formally reviewed at an upcoming DUR meeting.	
	MC/DEL		AVANDARYL[1]					
	MC/DEL		**AVANDAMET TABS**					
DIABETIC - / THIAZOL	MC/DEL		**AVANDIA TABS**[1]	MC/DEL		**ACTOS 30MG TABS**[2]	1. Actos and Avandia	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

	MC/DEL MC/DEL		ACTOS 15MG TABS[1] ACTOS 45MG TABS[1]				preferred without PA if patient on insulin or sulfonylurea or metformin. Avandia non-preferred as monotherapy. 2. Actos 30mg - use two 15mg instead. **Use PA Form # 20420**	on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - ALPHAGLUCOSIDASE	MC/DEL		GLYSET TABS	MC		PRECOSE TABS	**Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - SULFONYLUREA / BIGUANIDE	MC/DEL		GLYBURIDE/METFORMIN	MC MC		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.
THYROID								
THYROID HORMONES	MC/DEL 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[1]	Use Pa Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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 MC/DEL		ACTONEL TABS FOSAMAX SOLN[2] FOSAMAX TABS[2] FOSAMAX PLUS D[2] MIACALCIN SOLN	MC MC/DEL MC/DEL MC MC		AREDIA SOLR BONIVA DIDRONEL TABS EVISTA TABS[1] FORTEO	1. Approval only requires failure of Fosamax or Actonel. **Use PA Form # 20420** 2. Quantity Limits Apply	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CALCIMIMETIC AGENTS								
CALCIMIMETIC AGENTS				MC		SENSIPAR	**Use PA Form # 30115**	Baseline PTH, Ca, and phosphorous levels are required and initial approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Will not approve if baseline Ca is less than 8.4.
GROWTH HORMONE								
GROWTH HORMONE				MC/DEL MC/DEL MC/DEL MC MC/DEL MC	5 5 6 8 8 8	GENOTROPIN TEV-TROPIN NUTROPIN HUMATROPE SOLR NORDITROPIN CARTRIDGE SOLN SAIZEN SOLR	Products must be used in specified step order. **Use PA Form # 10710**	See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied.
SOMATOSTATIC AGENTS	MC/DEL		SANDOSTATIN					
GROWTH HORMONE ANTAGONISTS								
GH ANTAGONISTS				MC		SOMAVERT	**Use PA Form # 10710**	Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatin.
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*	Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP. **Use Pa Form # 20420**	Approved for central diabetes insipidus and for nocturnal enuresis. For nocturnal enuresis- must be over 6 years old, must fail an adequate trial of alarm training (higher success rate, lower relapse rate) and must periodically attempt weaning (at 6 month intervals). * Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization.
ANTISPASMODICS	MC/DEL MC		OXYBUTYNIN URISPAS TABS	MC/DEL MC/DEL MC/DEL		CYSTOSPAZ TABS DETROL TABS DITROPAN	**Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTISPASMODICS - LONG ACTING	MC/DEL MC MC/DEL MC		DETROL LA CP24 DITROPAN XL TBCR ENABLEX[1] VESICARE[1]	MC/DEL MC		OXYTROL SANCTURA	**Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 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)
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 MC/DEL		DIGITEK TABS DIGOXIN LANOXICAPS LANOXIN					
ANTIANGINALS--Isosorbide Di-	MC/DEL		ISOSORBIDE MONONITRATE TABS	MC		DILATRATE SR CPCR	**Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

nitrate/ Mono-Nitrates	MC/DEL		ISOSORBIDE MONONITRATE ER	MC		ISORDIL TABS		on the Prior Authorization form, such as the presence of 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		ISORDIL TITRADOSE TABS		
				MC		ISOSORBIDE DINITRATE SUBL		
				MC/DEL		ISOSORBIDE DINITRATE TABS		
				MC/DEL		ISOSORBIDE DINITRATE CR TBCR		
				MC/DEL		ISOSORBIDE DINITRATE ER TBCR		
				MC/DEL		ISOSORBIDE DINITRATE TD TBCR		
				MC/DEL		IMDUR TB24		
				MC/DEL		ISMO TABS		
				MC		MONOKET TABS		
NITRO - OINTMENT/CAP/CR	MC		NITROBID OINT					
	MC/DEL		NITROGLYCERIN CPCR					
	MC		NITROL OINT					
	MC		NITRO-TIME CPCR					
NITRO - PATCHES	MC/DEL	1	NITROGLYCERIN PT24	MC		NITRODISC 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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	NITREK PT24	MC/DEL		NITRO-DUR PT24		
	MC/DEL	1	NITRO-DUR PT 24 0.8MG					
	MC/DEL	3	MINITRAN PT24					
NITRO - SUBLINGUAL/ SPRAY	MC		NITROLINGUAL AERS	MC		NITROLINGUAL SOLN	Use Pa Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NITROSTAT SUBL	MC/DEL		NITROQUICK SUBL		
	MC/DEL		NITROTAB SUBL					
BETA BLOCKERS - NON SELECTIVE	MC/DEL		COREG TABS	MC/DEL		BETAPACE TABS	1. Recommend using BID since its effects do not last 24 hours.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		INDERAL LA CPCR	MC		BETAPACE AF TABS		
	MC		LEVATOL TABS	MC/DEL		CORGARD TABS		
	MC/DEL		NADOLOL TABS	MC/DEL		INDERAL TABS		
	MC/DEL		PINDOLOL TABS	MC		INNOPRAN XL		
	MC/DEL		PROPRANOLOL HCL SOLN[1]	MC/DEL		PROPRANOLOL HCL LA CPCR		
	MC/DEL		PROPRANOLOL HCL TABS[1]				Use PA Form # 20420	
	MC/DEL		SOTALOL HCL TABS					
	MC/DEL		TIMOLOL MALEATE TABS					
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL		ACEBUTOLOL HCL CAPS	MC		KERLONE TABS	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ATENOLOL TABS[1]	MC/DEL		LOPRESSOR TABS		
	MC		BETAXOLOL HCL TABS	MC		SECTRAL CAPS		
	MC/DEL		BISOPROLOL FUMARATE TABS	MC/DEL		TENORMIN TABS		
	MC/DEL		METOPROLOL TARTRATE TABS[1]	MC/DEL		ZEBETA TABS		
	MC/DEL		TOPROL XL TB24					
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		NORVASC TABS					
	MC	1	CARDIZEM LA TB24	MC	5	DILACOR XR CP24	Products must be used in specified order or PA will be required. Just write "Cardizem LA" or "Diltiazem 24-hour"and the pharmacy will use a preferred long acting diltiazem that does not require PA. Use PA Form # 20420	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	1	DILTIA XT CP24	MC	6	TAZTIA		
	MC/DEL	1	DILTIAZEM HCL ER CP24	MC/DEL	7	TIAZAC CP24		
	MC/DEL	1	DILTIAZEM HCL XR CP24	MC/DEL	8	CARDIZEM TABS		
	MC/DEL	1	DILTIAZEM CD 300MG CP24	MC/DEL	8	CARDIZEM CD CP24		
	MC/DEL	1	DILTIAZEM CD 360MG CP24	MC	8	CARDIZEM SR CP12		
	MC	4	CARTIA XT CP24	MC/DEL	8	DILTIAZEM HCL TABS		
	MC/DEL	4	DILTIAZEM CD CP24	MC/DEL	8	DILTIAZEM HCL ER CP12		
	MC/DEL	4	DILTIAZEM HCL ER CP24					
	MC/DEL	4	DILTIAZEM XR CP24					
				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		DYNACIRC CAPS	Use PA Form # 20420 1. Established users will be grandfathered	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		DYNACIRC CR TBCR[1]		
				MC/DEL		CARDENE 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		CARDENE SR CPCR		
				MC/DEL		NICARDIPINE HCL CAPS		
	MC/DEL		AFEDITAB CR	MC		ADALAT CC TBCR	Established users of Adalat CC are grandfathered.	Preferred drug must be tried and failed in step order due to lack of efficacy or intolerable side effects before non-preferred drugs in step order will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NIFEDIAC CC	MC/DEL		NIFEDIPINE CAPS		
	MC/DEL		NIFEDICAL XL TBCR	MC		PROCARDIA CAPS		
	MC/DEL		NIFEDIPINE TBCR					
	MC/DEL		NIFEDIPINE CAPS					
	MC/DEL		NIFEDIPINE ER TBCR	MC/DEL		PROCARDIA XL TBCR	Use PA Form # 20420	
	MC		SULAR TB24					
	MC/DEL	1	VERAPAMIL HCL CR TBCR	MC/DEL		CALAN TABS	Products must be used in specified order or PA will be required. Just write "Verapamil 24-hour" and the	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	VERAPAMIL HCL ER TBCR	MC/DEL		CALAN SR TBCR		
	MC/DEL	1	VERAPAMIL HCL SR TBCR	MC/DEL		COVERA-HS TBCR		

	MC	1	VERELAN PM CP24	MC		ISOPTIN-SR	Verapamil 24-hour and the pharmacy will use a preferred long acting generic that does not require PA. Use PA Form # 20420	
				MC/DEL		VERAPAMIL HCL ER CP24		
				MC		VERAPAMIL HCL SR CP24		
				MC		VERAPAMIL HCL TABS		
				MC		VERELAN CP24		
ANTIARRHYTHMICS	MC/DEL		**AMIODARONE**	MC/DEL		**CORDARONE**	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.
	MC/DEL		**MEXILETINE**	MC/DEL		**DISOPYRAMIDE**		
	MC/DEL		**NORPACE**	MC/DEL		**FLECAINIDE**		
	MC/DEL		**PROCAINAMIDE**	MC/DEL		**MEXITIL**		
	MC/DEL		**PROCANBID CR**	MC/DEL		**PACERONE**		
	MC/DEL		**PROPAFENONE**	MC		QUINIDEX		
	MC		QUINAGLUTE	MC/DEL		TIKOSYN[1]		
	MC/DEL		**QUINIDINE GLUCONATE**					
	MC/DEL		**QUINIDINE SULFATE**					
	MC		RYTHMOL					
	MC/DEL		TAMBOCOR					
ACE INHIBITORS	MC/DEL		**CAPTOPRIL TABS**	MC	5	MAVIK 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.
	MC/DEL		**BENAZEPRIL HCL**	MC/DEL	5	**ACCUPRIL TABS**		
	MC/DEL		**ENALAPRIL MALEATE TABS**	MC/DEL	8	**ACEON TABS**		
	MC/DEL		**LISINOPRIL TABS**	MC/DEL	8	**ALTACE CAPS**		
	MC		MONOPRIL TABS	MC	8	CAPOTEN TABS		
				MC/DEL	8	**FOSINOPRIL SODIUM**		
				MC/DEL	8	**LOTENSIN TABS**		
				MC/DEL	8	**MOEXIPRIL**		
				MC/DEL	8	**PRINIVIL TABS**		
				MC/DEL	8	**UNIVASC**		
				MC	8	VASOTEC TABS		
				MC/DEL	8	**ZESTRIL TABS**		
ANGIOTENSIN RECEPTOR BLOCKER	MC		AVAPRO TABS	MC/DEL		**ATACAND TABS**	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. **Use PA Form # 20420**	The initial criteria to use any ARB is that the member must have failed ACE inhibitors (such as due to coughing) in the past or must currently be actively treated for diabetes and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**BENICAR TABS**					
	MC/DEL		**COZAAR TABS**					
	MC/DEL		**DIOVAN**					
	MC/DEL		**MICARDIS TABS**					
	MC		TEVETEN TABS					
ANTIHYPERTENSIVES - CENTRAL	MC/DEL		**CATAPRES-TTS**	MC/DEL		**CATAPRES TABS**	**Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CLONIDINE HCL TABS**	MC		GUANABENZ ACETATE TABS		
	MC/DEL		**GUANFACINE HCL TABS**	MC		ISMELIN TABS		
	MC/DEL		**HYDRALAZINE HCL TABS**	MC		MINIPRESS CAPS		
	MC		HYLOREL TABS	MC/DEL		**TENEX TABS**		
	MC/DEL		**METHYLDOPA TABS**					
	MC/DEL		**MINOXIDIL TABS**					
	MC/DEL		**PRAZOSIN HCL CAPS**					
	MC/DEL		**RESERPINE TABS**					
ACE INHIBITORS AND CA CHANNEL BLOCKERS	MC/DEL		**LOTREL CAPS**	MC/DEL		**LEXXEL 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.
	MC		TARKA TBCR					
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 offered on the Prior Authorization form, such as the presence of 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		**CAPTOPRIL/HYDROCHLOROTHIA**	MC		CAPOZIDE TABS		
	MC/DEL		**ENALAPRIL MALEATE/HCTZ TABS**	MC/DEL		**LOTENSIN HCT TABS**		
	MC/DEL		**LISINOPRIL-HCTZ TABS**	MC		MONOPRIL HCT TABS		
	MC/DEL		**UNIRETIC TABS**	MC/DEL		**PRINZIDE TABS**		
				MC		VASERETIC TABS		
				MC/DEL		**ZESTORETIC TABS**		
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL		**ATENOLOL/CHLORTHALIDONE**	MC		CORZIDE 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		**BISOPROLOL FUMARATE/HCTZ**	MC/DEL		**INDERIDE 40/25 TABS**		
	MC/DEL		**PROPRANOLOL/HCTZ**	MC/DEL		**LOPRESSOR HCT TABS**		
				MC		TENORETIC		
				MC		TIMOLIDE 10/25 TABS		
				MC/DEL		**ZIAC TABS**		
ARB'S AND DIURETICS	MC		AVALIDE TABS	MC/DEL		**ATACAND 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.
	MC/DEL		**BENICAR HCT**					
	MC/DEL		**DIOVAN HCT TABS**					
	MC/DEL		**HYZAAR TABS**					
	MC/DEL		**MICARDIS HCT TABS**					
	MC		TEVETEN HCT TABS					
DIURETICS	MC/DEL		**ACETAZOLAMIDE TABS**	MC/DEL		**ALDACTAZIDE TABS**	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra will be approved for severe breast tenderness and male gynecomastia.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		AMILORIDE HCL	MC/DEL		**ALDACTONE TABS**		
	MC/DEL		**BUMETANIDE**	MC/DEL		**BUMEX TABS**		
	MC/DEL		**CHLOROTHIAZIDE TABS**	MC/DEL		**DEMADEX TABS**		
	MC/DEL		**CHLORTHALIDONE TABS**	MC/DEL		**DIAMOX**		
	MC		EDECRIN TABS	MC/DEL		**DIURIL**		

	MC/DEL		FUROSEMIDE	MC/DEL		DYAZIDE CAPS		
	MC/DEL		HYDROCHLOROTHIAZIDE	MC		ENDURON TABS	Use PA Form # 20420	
	MC/DEL		INDAPAMIDE TABS	MC		INSPRA		
	MC/DEL		METHAZOLAMIDE TABS	MC/DEL		LASIX TABS		
	MC/DEL		METHYCLOTHIAZIDE TABS	MC		LOZOL TABS		
	MC/DEL		SPIRONOLACTONE 25MG TABS	MC/DEL		MAXZIDE		
	MC/DEL		SPIRONOLACTONE/HYDRO	MC		MICROZIDE CAPS		
	MC/DEL		TORSEMIDE TABS	MC/DEL		MIDAMOR TABS		
	MC/DEL		TRIAMTERENE/HCTZ	MC		MODURETIC 5-50 TABS		
	MC		ZAROXOLYN TABS	MC		NAQUA TABS		
				MC		NATURETIN TABS		
				MC/DEL		SPIRONOLACTONE 50MG[1]		
CCB / LIPID	MC/DEL		CADUET					
LIPID DRUGS								
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL		CHOLESTYRAMINE	MC/DEL		PREVALITE	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		COLESTID	MC		QUESTRAN		
				MC/DEL		WELCHOL TABS		
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL		GEMFIBROZIL TABX	MC		ANTARA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		TRIGLIDE	MC		LOPID		
	MC/DEL		NIASPAN	MC		LOFIBRA		
	MC		TRICOR					
CHOLESTEROL - HGM COA + ABSORB INHIBITORS	MC/DEL		ADVICOR TBCR	MC/DEL		MEVACOR TABS	1. Zetia available w/0PA as addition to Zocor 80mg, Lipitor 80mg, or Crestor 40mg. Zetia will also be approved with a PA as add on for patients at maximally tolerated doses of statins. Zocor patients trying to use Zetia must use Vytorin 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. 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.
	MC/DEL		ALTOPREV TB 24	MC		PRAVACHOL TABS		
	MC/DEL		CRESTOR	MC/DEL		PRAVIGARD		
	MC/DEL		LIPITOR TABS					
	MC/DEL		LESCOL CAPS					
	MC/DEL		LESCOL XL TB24					
	MC/DEL		LOVASTATIN TABS					
	MC		VYTORIN					
	MC		ZETIA TABS[1]					
	MC/DEL		ZOCOR TABS					
PULMONARY ANTI-HYPERTENSIVES								
PULMONARY ANTI-HYPERTENSIVES				MC/DEL		FLOLAN	Use PA Form # 20420	Flolan and Tracleer will be approved after the dx of pulmonary hypertension is confirmed.
				MC		TRACLEER		
IMPOTENCE AGENTS								
IMPOTENCE AGENTS					9	CAVERJECT	As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.	
					9	CIALIS		
					9	EDEX		
					9	LEVITRA		
					9	MUSE		
					9	VIAGRA		
					9	YOHIMBINE HCL TABS		
ANTI-EMETOGENICS								
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC	MC/DEL		MECLIZINE HCL TABS	MC		ANTIVERT 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		PHENERGAN SUPP	MC/DEL		PHENERGAN SOLN		
	MC/DEL		PHENERGAN FORTIS SYRP	MC/DEL		PHENERGAN TABS		
	MC/DEL		PROMETHAZINE SUPP	MC/DEL		PROMETHEGAN SUPP		
	MC/DEL		PROMETHAZINE	MC		TORECAN TABS		
	MC		TRANSDERM-SCOP PT72					
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC		EMEND	MC		ALOXI	*See quantity limit table. **Zofran: use PA Form # 30810 Others: use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * Zofran limits still apply as listed on the Zofran PA form for covered indications including chemotherapy, radiotherapy, post operative nausea & vomiting and hyperemesis gravidarum. Other medical indications will be approved or denied on a case by case basis. Hyperemesis and other medical indications approved are still subject to failure of multiple preferred antiemesis drugs.
	MC/DEL		MARINOL CAPS	MC		ANZEMET TABS		
	MC/DEL		ZOFRAN SOLN*	MC/DEL		KYTRIL		
	MC/DEL		ZOFRAN TABS*					
	MC/DEL		ZOFRAN ODT TBDP*					
NON-SEDATING ANTIHISTAMINES / DECONGESTANTS								
ANTIHISTIMINES - NON-SEDATING	MC		ALAVERT TABS[1]	MC/DEL	5	CLARINEX TABS[2]	1. Preferred drugs are OTC loratidines. 2. Claritin OTC syrup does not require a PA. 3. Clarinex and Zyrtec syrup <6 yr w/o PA. Must fail Clarinex Tabs and Zyrtec products before moving to next step product without PA Pseudoephedrine is available with prescription. **Use PA Form # 20530**	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA.
	MC		CLARITIN ALLERGY (OTC)[1]	MC/DEL	5	CLARINEX SYR[3]		
	MC		CLARITIN SYRP (OTC)[2]	MC/DEL	5	ZYRTEC[3]		
	MC/DEL		TAVIST ND (OTC)[1]	MC/DEL	8	ALLEGRA		
				MC/DEL	8	CLARITIN[2]		
					9	FEXOFENADINE		

ALLERGY / ASTHMA THERAPIES								
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC/DEL MC		ATROVENT AERS ATROVENT HFA	MC		SPIRIVA[1]	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. FEV_1 <= 50% or COPD hospitalization within 6 months due to Atrovent failure.
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 specialist. Use PA Form # 20420	Xolair approval will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management.
ANTIASTHMATIC - NASAL STEROIDS	MC/DEL MC/DEL MC MC/DEL MC	1 1 4 4 4	FLONASE SUSP[1] NASONEX SUSP[1] BECONASE AERS BECONASE AQ INHA NASAREL SOLN	MC/DEL MC MC/DEL MC MC/DEL MC MC		FLUNISOLIDE SOLN NASACORT AERS NASACORT AQ AERS RHINOCORT AERO RHINOCORT AQUA SUSP TRI-NASAL SOLN VANCENASE POCKETHALER AERS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		NASALCROM	MC MC MC/DEL		ATROVENT NASAL SOL IPRATROPIUM NASAL SOL[1] ASTELIN	1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine. Use PA Form # 20420	Approved if patient fails on nonsedating 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/DEL MC/DEL MC/DEL MC/DEL		ALBUTEROL FORADIL AEROLIZER CAPS MAXAIR METAPROTERENOL SEREVENT TERBUTALINE SULFATE TABS XOPENEX HFA	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL		ACCUNEB NEBU ALUPENT AERP BRETHINE PROVENTIL PROVENTIL HFA AERS VENTOLIN AERS VENTOLIN HFA AERS VOLMAX TBCR VOSPIRE ER TB12 XOPENEX NEBU[1,2]	1. Xopenex users with prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12 cc/day. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC/DEL		ADVAIR DISKUS MISC					Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Duoneb components are available separately without PA.
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL		COMBIVENT AERO	MC/DEL		DUONEB SOLN[1]	1. Please use preferred individual ingredients Albuterol and Ipratropium. Use PA Form # 20420	
ANTIASTHMATIC - XANTHINES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		AMINOPHYLLINE TABS THEOCHRON TB12 THEOLAIR-SR TB12 THEOPHYLLINE ELIX THEOPHYLLINE SOLN THEOPHYLLINE ER CP12 THEOPHYLLINE ER TB12 UNIPHYL TBCR	MC MC MC MC/DEL MC MC/DEL MC		QUIBRON CAPS QUIBRON-T TABS QUIBRON-T/SR TB12 THEO-24 CP24 THEOLAIR TABS THEOPHYLLINE CR TB12 T-PHYL TB12	Use PA Form 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - STEROID INHALANTS	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC		AEROBID AERS ASMANEX AZMACORT AERS BECLOVENT AERS FLOVENT PULMICORT SUSP[1] QVAR AERS VANCERIL AERS	MC/DEL MC/DEL MC		AEROBID-M AERS PULMICORT TURBUHALER AEPB[2] VANCERIL DOUBLE STRENGTH AERS	1. No PA for Pulmicort susp if under 8 years old 2. No PA for Pulmicort turbohaler if under 14 yr. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				MC		ZYFLO TABS	Use PA Form # 20420	Other Preferred asthma controller drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	MC/DEL		SINGULAIR[1]	MC/DEL		ACCOLATE TABS	1. Must be using inhaled steroid, unless less than 14 years old, for script to avoid requiring a PA. Use PA Form # 20420	Singulair will additionally be approved for allergic indications if other cost effective allergy treatments are ineffective, including oral antihistimines and nasal steroids. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 - HYDRO-LYTIC ENZYMES				MC/DEL		PULMOZYME SOLN	Use PA Form # 20420	Will be approved for cystic fibrosis patients.

ANTIASTHMATIC - MUCOLYTICS	MC/DEL		ACETYLCYSTEINE[1]	MC		MUCOMYST	1. Acetylcysteine is covered with diagnosis of CF. **Use PA Form # 20420**	
COUGH/COLD								
COUGH/COLD	MC/DEL		PSEUDOEPHEDRINE			All others are a non-covered service (this includes antihistamines-decongestive combinations).	All of cough cold preparations are not covered except these preferred products.	All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy.
	MC		ROBITUSSIN DM SYRP					
	MC		ROBITUSSIN SUGAR FREE SYRP					
DIGESTIVE AIDS / ASSORTED GI								
****Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.****								
GI - ANTIPERISTALTIC AGENTS	MC/DEL		DIPHENOXYLATE	MC/DEL		ANTI-DIARRHEAL TABS	**Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC/DEL		DIPHENOXYLATE/ATROPINE	MC/DEL		LOFENE TABS		
	MC		IMODIUM A-D TABS	MC		LONOX TABS		
	MC/DEL		LOPERAMIDE HCL CAPS	MC/DEL		MOTOFEN TABS		
	MC/DEL		LOPERAMIDE HCL LIQD	MC		SB ANTI-DIARRHEA TABS		
	MC/DEL		OPIUM TINCTURE TINC					
	MC		PAREGORIC TINC					
GI - ANTI-DIARRHEAL/ ANTACID - MISC.	MC/DEL		ALU-CAP CAPS	MC/DEL		ANTACID EXTRA STRENGTH CHEW	**Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval**.
	MC/DEL		ANTACID CHEW	MC		B & O 15-A SUPPRETTE SUPP		
	MC/DEL		ATROPINE SULFATE SOLN	MC		B & O 16-A SUPPRETTE SUPP		
	MC/DEL		BENTYL SYRP	MC		BELLADONNA ALKALOIDS & OP		
	MC/DEL		BISMATROL	MC/DEL		BENTYL TABS		
	MC/DEL		CALCIUM ANTACID	MC		CHILDRENS MYLANTA CHEW		
	MC/DEL		CALCIUM CARBONATE	MC/DEL		LEVBID TB12		
	MC/DEL		CAL-GEST ANTACID CHEW	MC		LEVSIN ELIX		
	MC/DEL		CHEWABLE ANTACID CHEW	MC/DEL		LEVSIN TABS		
	MC/DEL		DICYCLOMINE HCL	MC/DEL		LEVSIN/SL SUBL		
	MC		GAVISCON SUSP	MC/DEL		NULEV TBDP		
	MC		HAPONAL TABS	MC		URO-MAG CAPS		
	MC/DEL		HYOSCYAMINE SULFATE					
	MC		IMODIUM ADVANCED CHEW					
	MC/DEL		KAOPECTATE					
	MC		K-PEC LIQD					
	MC		K-PEK SUSP					
	MC		MAALOX					
	MC/DEL		MAGNESIUM OXIDE TABS					
	MC		MAG-OX 400 TABS					
	MC		MAG-OXIDE TABS					
	MC/DEL		PAMINE TABS					
	MC/DEL		PINK BISMUTH					
	MC/DEL		PROPANTHELINE BROMIDE TABS					
	MC		ROBINUL					
	MC/DEL		SAL-TROPINE TABS					
	MC		SCOPOLAMINE HYDROBROMIDE					
	MC/DEL		SODIUM BICARBONATE TABS					
	MC/DEL		TUMS					
	MC		V-R STOMACH RELIEF SUSP					
	MC/DEL		X-STR CHEW ANTACID CHEW					
GI - H2-ANTAGONISTS	MC/DEL		CIMETIDINE	MC		AXID CAPS	1. Zantac syrup available without PA to users less than 6 years old. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		FAMOTIDINE	MC		AXID AR TABS		
	MC/DEL		RANITIDINE	MC/DEL		NIZATIDINE CAPS		
	MC		V-R ACID REDUCER TABS	MC/DEL		PEPCID		
				MC		PEPCID AC		
				MC/DEL		TAGAMET TABS		
				MC/DEL		ZANTAC[1]		
GI - PROTON PUMP INHIBITOR	MC		PREVACID CPDR	MC	6	ACIPHEX TBEC	**Prevacid Solutabs available without PA for children less than 9 years old and Long Term Care Residents. **Use PA Form # 20420**	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		OTC PRILOSEC	MC/DEL	7	OMEPRAZOLE CPDR		
	MC/DEL		PROTONIX	MC/DEL	8	NEXIUM CPDR		
	MC		PREVACID ORAL SUSP	MC/DEL	8	PRILOSEC CPDR		
	MC		PREVACID SOLUTABS**	MC	8	ZEGERID		
GI - ULCER ANTI-INFECTIVE	MC		HELIDAC					
	MC		PREVPAC					
GI - PROSTAGLANDINS	MC		MISOPROSTOL TABS	MC/DEL		CYTOTEC TABS	**Use PA Form # 20420**	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - DIGESTIVE ENZYMES	MC		LACTAID ULTRA	MC	5	ULTRASE CPEP	Non-preferred products are a one time PA for life (for CF diagnosis). Non-preferred products must be used in specified step order.	Non -Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before other non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. In all cases except cystic fibrosis patients, objective evidence of pancreatic insufficiency (fat malabsorption test etc...) must be supplied.
	MC/DEL		LACTRASE CAPS	MC	5	ULTRASE MT		
				MC/DEL	7	LIPRAM		
				MC	7	PANCREASE		
				MC/DEL	7	PANCRELIPASE		
				MC/DEL	7	PANGESTYME		

				MC	7	PANOKASE TABS	Use PA Form # 20420	
				MC/DEL	8	CREON		
				MC	8	KUTRASE CAPS		
				MC/DEL	8	KU-ZYME CAPS		
				MC/DEL	8	LIPRAM CR		
				MC	8	PANCREASE MT		
				MC/DEL	8	PANCRECARB MS-8 CPEP		
				MC	8	VIOKASE		
GI - ANTI - FLATULENTS / GI STIMULANTS	MC		CALULOSE SYRP	MC		CEPHULAC SYRP	Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC/DEL		CONSTULOSE SYRP	MC		GAS-X CHEW		
	MC/DEL		ENULOSE SYRP	MC/DEL		INFANTS GAS RELIEF SUSP		
	MC		GASTROCROM CONC	MC/DEL		REGLAN TABS		
	MC/DEL		GENERLAC SYRP					
	MC/DEL		LACTULOSE SYRP					
	MC/DEL		METOCLOPRAMIDE HCL					
	MC/DEL		SIMETHICONE					
GI - INFLAMMATORY BOWEL AGENTS	MC/DEL		ASACOL TBEC	MC/DEL		**SULFAZINE EC TBEC**	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		AZULFIDINE TABS					
	MC/DEL		**AZULFIDINE EN-TABS TBEC**					
	MC		CANASA SUPP					
	MC		COLAZAL CAPS					
	MC		DIPENTUM CAPS					
	MC/DEL		PENTASA CPCR					
	MC/DEL		ROWASA ENEM					
	MC/DEL		**SULFASALAZINE TABS**					
GI - IRRITABLE BOWEL SYNDROME AGENTS				MC/DEL		LOTRONEX TABS	Use PA Form # 20420	Zelnorm will be approved for women with IBS and predominant constipation. Lotronex will be approved for females with IBS and predominant diarrhea. Prior failed trials of multiple other preferred GI agents must occur first. IBS dx must be thoroughly documented.
				MC/DEL		ZELNORM TABS		
MISCELLANEOUS GI								
****Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.****								
GI - MISC.	MC/DEL		BISAC-EVAC SUPP	MC/DEL		ACTIGALL CAPS	1. Quantity Limit: 255 g/90-day without PA for greater than 18 years old. No quantity limit for less than 18 years old. 2. 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.**
	MC/DEL		BISACODYL	MC		BENEFIBER		
	MC		BISCOLAX SUPP	MC/DEL		CARAFATE		
	MC		CINOBAC CAPS	MC/DEL		COLACE CAPS		
	MC/DEL		CITRATE OF MAGNESIA SOLN	MC/DEL		COLYTE		
	MC/DEL		CITRUCEL	MC		DIOCTO-C SYRP		
	MC/DEL		D.O.S. CAPS	MC		DOC SOD /CAS CAP		
	MC/DEL		DIOCTO LIQD	MC		DOC-Q-LAX CAPS		
	MC/DEL		DIOCTO SYRP	MC/DEL		DOCUSATE SODIUM/CAS CAPS		
	MC/DEL		DIOCTYN CAPS	MC/DEL		DOK PLUS		
	MC/DEL		DOC-Q-LACE CAPS	MC/DEL		DULCOLAX SUPP		
	MC		DOCUSATE CALCIUM CAPS	MC		FIBER CON TABS		
	MC/DEL		DOCUSATE SODIUM	MC/DEL		FIBER-LAX TABS		
	MC		DOCUSIL CAPS	MC		GOLYTELY SOLR		
	MC/DEL		DOK CAPS	MC/DEL		GLYCOLAX[1]		
	MC/DEL		FIBER LAXATIVE TABS	MC		MALTSUPEX		
	MC		FLEET	MC/DEL		NULYTELY SOLR		
	MC/DEL		GENFIBER POWD	MC		PEG 3350/ELECTROLYTES SOLR		
	MC/DEL		GLYCERIN	MC/DEL		SENEXON TABS		
	MC		HIPREX TABS	MC/DEL		SENOKOT TABS		
	MC/DEL		KRISTALOSE PACK	MC		SENOKOT S TABS		
	MC		METAMUCIL	MC		STOOL SOFTENER PLUS CAPS		
	MC/DEL		MILK OF MAGNESIA SUSP	MC/DEL		UNI-CENNA TABS		
	MC		MINERAL OIL OIL	MC		UNI-EASE PLUS CAPS		
	MC		MIRALAX PACK[1]	MC		V-R NATURAL SENNA LAXATIV TABS		
	MC		MIRALAX POWD[1]					
	MC/DEL		SENNA					
	MC/DEL		SENOKOT GRAN					
	MC/DEL		SENOKOT SYRP					
	MC/DEL		SENOKOT CHILDRENS SYRP					
	MC		SENOKOT XTRA TABS					
	MC/DEL		SORBITOL					
	MC/DEL		STOOL SOFTENER CAPS					
	MC/DEL		SUCRALFATE TABS					
	MC		UNI-EASE CAPS					
	MC		UNIFIBER POWD					
	MC		URSO FORTE					
	MC/DEL		URSODIOL					
MISC. UROLOGICAL								
UROLOGICAL - MISC.	MC		ACETIC ACID 0.25% SOLN	MC		CITRIC ACID/SODIUM CITRAT SOLN	1. Elmiron requires adequate proof of Dx with supportive testing. Use PA Form #20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		BICITRA SOLN	MC/DEL		CYTRA-2 SOLN		
	MC		CYTRA-K SOLN	MC		ELMIRON CAPS[1]		
	MC		FURADANTIN SUSP	MC/DEL		MACROBID CAPS		

	MC		K-PHOS MF TABS	MC/DEL		MANDELAMINE TABS		
	MC/DEL		MACRODANTIN CAPS	MC/DEL		NITROFURANTOIN MACR CAPS		
	MC/DEL		METHENAMINE MANDELATE TABS	MC		POLYCITRA-K CRYSTALS PACK		
	MC/DEL		MONUROL PACK	MC		POTASSIUM CITRATE/CITRIC SOLN		
	MC/DEL		NEOSPORIN GU IRRIGANT SOLN	MC		PYRIDIUM TABS		
	MC/DEL		PHENAZOPYRIDINE HCL TABS					
	MC		POLYCITRA SYRP					
	MC		POLYCITRA-K SOLN					
	MC/DEL		POLYCITRA-LC SOLN					
	MC/DEL		PROSED/DS TABS					
	MC/DEL		PYRIDIUM PLUS TABS					
	MC/DEL		RENACIDIN SOLN					
	MC		TRICITRATES SYRP					
	MC		UREX TABS					
	MC/DEL		URISED TABS					
	MC		UROCIT-K					
	MC/DEL		UROQID #2 TABS					
PHOSPHATE BINDERS								
PHOSPHATE BINDERS	MC		PHOSLO	MC/DEL		FOSRENOL	1. Renagel will be approved for hypercalcemia, digoxin users, and in cases where maximum phoslo doses are insufficient. 2. Will be verifying patient compliance. Labs must be provided. Please refer to the Phosphate Binders PA form. **Use PA Form #20530**	Renagel will be approved in patients with hypercalcemia, on concurrent digoxin or insufficient response with Phos-lo (Renagel to be add-on therapy).
	MC/DEL		MEGNEBIND - 400	MC/DEL		RENAGEL[1,2]		
INTRA-VAGINALS								
VAGINAL - ANTIBACTERIALS	MC/DEL	1	CLEOCIN CREA				Step order must be followed to avoid PA. Must fail Cleocin and Metrogel products before moving to next step product without PA.	Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	METROGEL VAGINAL GEL					
	MC/DEL	3	CLEOCIN SUPP					
VAGINAL - ANTI FUNGALS	MC/DEL		CLOTRIMAZOLE CREA	MC		AVC CREAM	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.
	MC/DEL		GYNE-LOTRIMIN CREA	MC		CLOTRIMAZOLE 3 DAY CREA		
	MC		MICONAZOLE CREA	MC		GYNAZOLE-1 CREA		
	MC/DEL		MICONAZOLE 3 COMBO PACK KIT[1]	MC		GYNE-LOTRIMIN 3 TABS		
	MC/DEL		MICONAZOLE 7 CREA	MC/DEL		MICONAZOLE 3 SUPP		
	MC/DEL		MICONAZOLE NITRATE CREA	MC		MONISTAT 3 SUPP		
	MC		MONISTAT 1 OINT	MC		TERAZOL 3 CREA		
	MC		MONISTAT 3 CREA	MC		TERAZOL 3 SUPP		
	MC		MONISTAT 7	MC		TERAZOL 7 CREA		
	MC		NYSTATIN TABS	MC/DEL		TERCONAZOLE 0.8MG		
	MC/DEL		TERCONAZOLE 0.4MG					
	MC		VAGITROL					
	MC		V-R MICONAZOLE-7 CREA					
VAGINAL - CONTRACEPTIVES	MC		GYNOL II EXTRA STRENGTH GEL	MC		DELFEN FOAM	**Use PA Form # 20420**	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ESTROGENS	MC/DEL		**ESTRING RING**	MC/DEL		ESTRACE CREA	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.
	MC/DEL		**PREMARIN CREA**	MC/DEL		VAGIFEM TABS		
VAGINAL - OTHER	MC/DEL		ACID JELLY GEL	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.
	MC		ACI-JEL GEL					
	MC		CERVICAL AMINO ACID CREA					
BPH								
BPH	MC/DEL		AVODART	MC/DEL	5	**FLOMAX CP24**	Non-preferred products must be used in specified order. **Use PA Form #20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approval of a non-preferred 5-alpha reductase inhibitor requires objective clinical evidence of a very enlarged prostate rather than just the presence of obstructive urinary outflow symptoms along with adequate trial of preferred Proscar.
	MC/DEL		**DOXAZOSIN MESYLATE TABS**	MC/DEL	8	**CARDURA TABS**		
	MC/DEL		PROSCAR TABS	MC	8	HYTRIN CAPS		
	MC/DEL		**TERAZOSIN HCL CAPS**	MC/DEL	8	UROXATRAL		
ANXIOLYTICS								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL		ALPRAZOLAM TABS	MC/DEL		ATIVAN	**Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CHLORDIAZEPOXIDE HCL CAPS	MC/DEL		NIRAVAM		
	MC/DEL		CLORAZEPATE DIPOTASSIUM TABS	MC/DEL		SERAX		
	MC/DEL		DIAZEPAM	MC/DEL		TRANXENE		
	MC/DEL		LORAZEPAM	MC/DEL		XANAX TABS		

Category	Status		Preferred Drugs	Status	Step	Non-Preferred Drugs	PA Criteria	Clinical Criteria
	MC/DEL		OXAZEPAM CAPS					
ANXIOLYTICS - LONG ACTING	MC/DEL		XANAX XR[1]				1. Xanax XR will be available if the long acting benzo clonazepam fails. **Use PA Form # 20420**	
ANXIOLYTICS - MISC.	MC/DEL		BUSPIRONE HCL TABS	MC		ATARAX TABS	**Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		HYDROXYZINE HCL SOLN	MC		BUSPAR TABS		
	MC		HYDROXYZINE HCL SYRP	MC		DROPERIDOL SOLN		
	MC/DEL		HYDROXYZINE PAMOATE CAPS	MC/DEL		HYDROXYZINE HCL TABS		
				MC/DEL		HYDROXYZINE PAM 100MG CAPS		
				MC		INAPSINE SOLN		
				MC/DEL		MEPROBAMATE TABS		
				MC/DEL		VISTARIL		
ANTI-DEPRESSANTS								
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL		NARDIL TABS					
	MC/DEL		PARNATE TABS					
ANTIDEPRESSANTS - SELECTED SSRI's	MC/DEL		BUPROPION HCL TABS	MC	5	CYMBALTA[6]	Non-preferred products must be used in specified step order. 1. Use Fluoxetine 20 mg in multiples. 2. See Zoloft splitting table. Zoloft requires splitting of 50mg and/or 100mg scored tabs to avoid PA. 3. Strong caution with pediatric population. 4. Established users are grandfathered. 5. See Celexa/Citalopram and Lexapro splitting tables. 6. Max daily dose allowed is 60mg, only 1 per day allowed for all strengths. Use PA Form # 20420	Preferred drugs must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. At least one preferred SSRI and one preferred non-SSRI drugs must be tried. Venlafaxine is non-preferred for any anxiety diagnosis and may be approved after trials of one SSRI and one non-SSRI (e.g. any anxiolytic or a tricylic at any dose). 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 Special Kid < 18yo Criteria for New Starters: Must have had fluoxetine trial for at least 30 days before accessing other preferred antidepressants without PA. Cymbalta- Second line therapy for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia after trial of a preferred TCA (tri-cyclic anti-depressant) and one of the following preferred medications: a preferred anti-convulsant, capsaicin, tramadol, or other narcotic. Combination therapy of non-preferred medications for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia will not be approved.
	MC/DEL		BUPROPION SR	MC/DEL	6	EFFEXOR TABS		
	MC/DEL		CITALOPRAM[5]	MC/DEL	6	EFFEXOR XR CP24[3]		
	MC/DEL		FLUOXETINE HCL CAPS	MC/DEL	8	CELEXA		
	MC/DEL		FLUOXETINE HCL LIQD	MC	8	DESYREL TABS		
	MC/DEL		FLUOXETINE HCL TABS	MC/DEL	8	FLUOXETINE 40 mg[1]		
	MC/DEL		FLUVOXAMINE MALEATE TABS	MC	8	LUVOX TABS		
	MC/DEL		LEXAPRO TABS[5]	MC	8	MAPROTILINE HCL TABS		
	MC/DEL		MIRTAZAPINE	MC/DEL	8	PAXIL[3]		
	MC/DEL		PAROXETINE[3]	MC	8	PROZAC		
	MC/DEL		PAXIL CR[3]	MC	8	PROZAC CAPS		
	MC		SERZONE TABS	MC	8	PROZAC WEEKLY CPDR		
	MC/DEL		TRAZODONE HCL TABS	MC/DEL	8	REMERON TABS		
	MC/DEL		WELLBUTRIN XL	MC/DEL	8	SARAFEM CAPS		
	MC/DEL		ZOLOFT[2]	MC/DEL	8	TRAZODONE HCL 300MG TABS		
				MC/DEL	8	WELLBUTRIN TABS		
				MC/DEL	8	WELLBUTRIN SR TBCR		
				MC/DEL	9	REMERON SOLTAB TBDP		
ANTIDEPRESSANTS - TRI-CYCLICS	MC/DEL	*	**AMITRIPTYLINE HCL TABS**	MC/DEL		**AMOXAPINE TABS**	*PA required for new starters if over 65 years old. Users over 65 years old are grandfathered. **Use PA Form # 20420 or 102220**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	*	AVENTYL SOLN	MC/DEL		**ANAFRANIL CAPS**		
	MC/DEL	*	**CLOMIPRAMINE HCL CAPS**	MC/DEL		**ELAVIL TABS**		
	MC/DEL	*	**DESIPRAMINE HCL TABS**	MC/DEL		**NORPRAMIN TABS**		
	MC/DEL	*	**DOXEPIN HCL**	MC/DEL		**PAMELOR**		
	MC/DEL	*	**IMIPRAMINE HCL TABS**	MC/DEL		**SINEQUAN**		
	MC/DEL		**NORTRIPTYLINE HCL**	MC		TOFRANIL		
	MC	*	PROTRIPTYLINE HCL TABS	MC		VIVACTIL TABS		
	MC	*	SURMONTIL CAPS					
SEDATIVE / HYPNOTICS								
SEDATIVE/HYPNOTICS - BARBITURATE	MC		BUTISOL SODIUM TABS	MC		LUMINAL SOLN	PA required for new users of preferred products if over 65 years old. **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.
	MC/DEL		CHLORAL HYDRATE SYRP	MC		SECONAL CAPS		
	MC		MEBARAL TABS	MC/DEL		SOMNOTE CAPS		
	MC/DEL		PHENOBARBITAL					
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL		DORAL TABS	MC		DALMANE	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
	MC/DEL		ESTAZOLAM TABS	MC		HALCION TABS		
	MC/DEL		FLURAZEPAM HCL CAPS	MC		MIDAZOLAM HCL SYRP		
	MC/DEL		TEMAZEPAM CAPS	MC		PROSOM TABS		
	MC/DEL		TRIAZOLAM TABS	MC/DEL		RESTORIL CAPS		
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL		LUNESTA[1]	MC/DEL	7	AMBIEN	Must fail all preferred products before non-preferred 1. Quantity Limt of 12 per 34 days. **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 and Sonata do cause dependence with continued use and as with benzodiazepines, usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 days per week max) is the standard of care. Please see Sedative/Hypnotic PA form.
	MC/DEL		MIRTAZAPINE	MC/DEL	8	SONATA CAPS		
	MC		TRAZODONE	MC/DEL	8	ROZEREM		
				MC/DEL	9	AMBIEN CR		
ANTI-PSYCHOTICS								
ANTIPSYCHOTICS - ATYPICALS	MC		RISPERDAL	MC	8	RISPERDAL CONSA	1. If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine. See Multiple Antipsychotic PA form #20440	Preferred drugs subject to step order must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Atypicals will be approved, subject to step-order, for patients with FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality and as long as all first line preferred therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). * Abilify: doses above 15mg were not shown to be more effective than doses in the 10-15mg range .4. Seroquel 25mg is available without PA if the following conditions are met: a.) Either 65 years of age or older or less than 18 years of
	MC/DEL		GEODON	MC	8	RISPERDAL M TAB		
	MC/DEL		SEROQUEL TABS					
	MC/DEL		ABILIFY TABS					
	MC		ZYPREXA TABS					

	MC		ZYPREXA ZYDIS TBDP				2. 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 Zyprexa- 30mg daily max Use PA form #10420 for requests exceeding these maximum daily doses.	age, b.) dosage is for 3 or more per day, c.) Seroquel 25mg is in the profile within the last 45 days.
ANTIPSYCHOTICS - SPECIAL ATYPICALS	MC/DEL		CLOZAPINE TABS	MC/DEL		CLOZARIL TABS	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.
				MC		FAZACLO		
ANTIPSYCHOTICS - TYPICAL	MC/DEL		CHLORPROMAZINE HCL	MC/DEL		COMPAZINE	Use PA Form # 120420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		FLUPHENAZINE DECANOATE	MC/DEL		COMPRO SUPP		
	MC/DEL		FLUPHENAZINE HCL	MC		HALDOL DECANOATE		
	MC		HALDOL	MC/DEL		LOXITANE CAPS		
	MC/DEL		HALOPERIDOL	MC		MELLARIL		
	MC		HALOPERIDOL DECANOATE SOLN	MC/DEL		NAVANE CAPS		
	MC		HALOPERIDOL LACTATE SOLN	MC		PROLIXIN		
	MC/DEL		LOXAPINE SUCCINATE CAPS	MC		STELAZINE TABS		
	MC/DEL		LOXITANE-C CONC	MC		THORAZINE		
	MC		MOBAN TABS					
	MC/DEL		PERPHENAZINE					
	MC/DEL		PROCHLORPERAZINE					
	MC		SERENTIL					
	MC/DEL		THIORIDAZINE HCL					
	MC/DEL		THIOTHIXENE					
	MC		THORAZINE SUPP					
	MC/DEL		TRIFLUOPERAZINE HCL TABS					
LITHIUM								
LITHIUM	MC/DEL		ESKALITH CAPS					
	MC/DEL		ESKALITH CR TBCR					
	MC/DEL		LITHIUM CARBONATE					
	MC/DEL		LITHIUM CITRATE SYRP					
COMBINATION - PSYCHOTHERAPEUTIC								
PSYCHOTHERPEUTIC COMBINATION	MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT	MC	8	SYMBYAX	Use PA Form # 20420	Use individual components, which are currently available without a PA.
	MC/DEL		PERPHENAZINE/AMITRIPTYLIN					
STIMULANTS								
STIMULANT - AMPHETAMINES - SHORT ACTING	MC/DEL		ADDERALL TABS				Preferred stimulants will be available without PA if diagnosis of ADHD.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.	
	MC/DEL		AMPHETAMINE SALT COMBO					
	MC/DEL		DEXEDRINE					
	MC/DEL		DEXTROAMPHET SULF TABS					
	MC/DEL		DEXTROSTAT TABS					
STIMULANT - LONG ACTING AMPHETAMINES SALT	MC/DEL		ADDERALL XR CP24				Preferred stimulants will be available without PA if diagnosis of ADHD.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.	
LONG ACTING AMPHETAMINES	MC		DEXEDRINE CAP CR					
	MC		DEXTROAMPHET SULF CPCR					
STIMULANT - METHYLPHENIDATE	MC/DEL		FOCALIN TABS	MC		METHYLIN CHEWABLES	Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		METADATE ER TBCR	MC/DEL		RITALIN		
	MC/DEL		METHYLIN ER TBCR					
	MC/DEL		METHYLIN TABS					
	MC/DEL		METHYLIN SOL					

	MC/DEL		METHYLPHENIDATE HCL					
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC MC		CONCERTA TBCR FOCALIN XR	MC MC/DEL	5 8	METADATE CD CPCR[1] RITALIN LA	Preferred stimulants will be available without PA if diagnosis of ADHD. Non-preferred products must be used in specified step order. 1. Easily approved for patients needing the sprinkles. **Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 MC	7 8 8 9 9	STRATTERA[1, 2] CAFCIT SOLN PROVIGIL TABS DESOXYN TABS DESOXYN CR	1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of Strattera, unless history of substance abuse without current use of abusable medication(s) 2. Strattera currently has dosing limitations allowing one tablet per day for all strengths if obtain approval. Please refer to PDL dosage consolidation chart. 3. Non-preferred products must be used in specified step order. **Provigil: use PA Form # 20710; Others: 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
ANTI-CATAPLECTIC AGENTS								
PSYCHOTERAPEUTIC AGENTS MISC.				MC/DEL		XYREM SOL	**Use PA Form #20710**	
WEIGHT LOSS								
WEIGHT LOSS							No longer covered:	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 REMINYL COGNEX CAPS	1. All new users need PA to establish dementia diagnosis and baseline mental status score. 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		NICODERM CQ PT24				Bupropion SR 150 mg is available without a prior authorization.	OTC Nicotine products are covered by MaineCare Policy when they have been determined to be cost-effective. Only Nicoderm and the generic nicotine gums have received this designation as preferred. All other nicotine products (OTC & prescription) are non-preferred by MaineCare Policy. 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 NICORETTE GUM	MC/DEL MC/DEL MC/DEL	5	COMMIT LOZENGES[1] NICOTROL INHALER NICOTROL NASAL SPRAY	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. Use PA Form # 20420	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/DEL MC		DISULFIRAM TABS ANTABUSE TABS NALTREXONE HCL TABS CAMPRAL[1]				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.
MISCELLANEOUS ANALGESICS								
ANALGESICS - MISC.	MC MC/DEL		ACEPHEN SUPP ACETAMIN TAB 325MG	MC MC		ASPIR-81 TBEC AXOCET CAPS	**Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists

	MC/DEL		ACETAMINOPHEN	MC		DOLOBID TABS		preferred drug(s) exists.
	MC/DEL		**ASPIRIN**	MC		EASPRIN TBEC		
	MC/DEL		**ASPIRIN EC**	MC		EQUAGESIC TABS		
	MC/DEL		**ASPIR-LOW TBEC**	MC/DEL		ESGIC-PLUS		
	MC/DEL		BUFFERED ASPIRIN TABS	MC		EXCEDRIN TAB ASA FRE		
	MC/DEL		BUTAL/ASA/CAFF	MC/DEL		FIORICET TABS		
	MC/DEL		BUTALBITAL COMPOUND	MC		FIORINAL CAPS		
	MC/DEL		BUTALBITAL/ACET TABS	MC		FIORTAL CAPS		
	MC/DEL		BUTALBITAL/APAP CAPS	MC/DEL		FORTABS TABS		
	MC/DEL		BUTALBITAL/APAP/CAFFEINE	MC		PHRENILIN TABS		
	MC/DEL		**CHILDRENS ASPIRIN CHEW**	MC		PHRENILIN FORTE CAPS		
	MC/DEL		CHILDRENS PAIN RELIEVER	MC		TRILISATE LIQD		
	MC/DEL		**CHOLINE MAGNESIUM TRISALI**	MC		TRILISATE TABS		
	MC/DEL		**DIFLUNISAL TABS**	MC		ZEBUTAL CAPS		
	MC/DEL		**ECOTRIN**	MC		ZORPRIN TBCR		
	MC/DEL		FEVERALL SUPP					
	MC/DEL		GENAPAP					
	MC/DEL		GENEBS TABS					
	MC		HEADACHE FORMULA ADDED TABS					
	MC		INFANTAIRE SOLN					
	MC		INFANTS APAP SOLN					
	MC		INFANTS PAIN RELIEVER SUSP					
	MC/DEL		MAPAP					
	MC/DEL		PAIN RELIEVER					
	MC/DEL		Q-NOL TABS					
	MC/DEL		**SALSALATE TABS**					
	MC		TACTINAL EXTRA STRENGTH TABS					
	MC		TYLENOL					
	MC		V-R CHILDRENS ASPIRIN CHEW					
	MC		V-R NON-ASPIRIN TABS					
LONG ACTING NARCOTICS								
NARCOTICS - LONG ACTING	MC		AVINZA	MC	7	DURAGESIC PT72[1]	Non-preferred products must be used in specific order. 1. Duragesic 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	Preferred drugs (Avinza or morphine sulfate ER tab, Methadone or Methadose, & oxycodone ER) & step order drugs must be tried for at least 2 weeks each & failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug & the preferred drug(s) exists. Adequate trials include prevention/treatment of common adverse effects associated w/ narcotics (antinausea, antipruritics, etc.) as well as adequate equianalgesic dosing when converting from one narcotic to another.Also, adequate documentation of attempts to titrate dose of preferred agents to achieve adequate pain relief & desired clinical response must be provided. Member's drug regimen for additions &/or discontinuations of medications that may affect absorption &/or metabolism of preferred agents must be monitored. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Non-preferred drugs will not be approved for patients showing evidence of us 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
	MC/DEL		METHADONE	MC/DEL	8	ORAMORPH SR TB12		
	MC/DEL		METHADOSE	MC/DEL	8	MORPHINE SULFATE SUPP		
	MC/DEL		MORPHINE SULFATE ER TB12[3]	MC/DEL	8	MS CONTIN TB12		
	MC/DEL		**OXYCODONE ER[3,4]**	MC	8	KADIAN CP 24[2]		
				MC/DEL	9	OXYCONTIN TB12[1]		

							allowed to achieve max total daily dose of 320mg. 4. Only preferred manufacturer's products will be available without prior authorization. **Use PA Form # 20510**	intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. 9. Circumventing MaineCare prior authorization requirements for narcotics by paying cash for affected narcotics (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). 10. Requests for a 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.
NARCOTICS - SELECTED	MC/DEL		TRAMADOL HCL TABS	MC	8	BUPRENEX 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 "allergy" to all products but desired product. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance abouse such as: 1. frequent or persistant early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel; 3. breaches of narcotic contracts with any provider; 4. failure to comply with patient responsibilities in attached opiod documentaion (see PA form) including but not limited to failing to submit to and pass pill counts; 5. failing to take or pass random drug testing; 6. failing to provide old recoreds regarding prior use of narcotics; 7. receiving controlled substances from other prescribers that the provider submitting the PA is unaware of. in Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.
				MC/DEL	8	BUTORPHANOL		
				MC	8	NALBUPHINE HCL SOLN		
				MC	8	NUBAIN SOLN		
				MC	8	STADOL NS SOLN		
				MC	8	ULTRACET TABS		
				MC	8	ULTRAM TABS		
				MC	9	ULTRAM ER		
MISCELLANEOUS NARCOTICS								
NARCOTICS - MISC.	MC/DEL		ACETAMINOPHEN/CODEINE	MC		ANEXSIA TABS	1. ACTIQ lollypop and Capital and codeine suspension products require PA for users over 18 years of age. 2. oxycodone/acet 10/650 is 8 times more expensive. Use twice as many of oxycod/acet 5/325 instead. You can mix andmatch preferred strengths of oxycodone and oxycodone/acet to minimize acet. dose similar to certain non-preferred drugs. 3. Only preferred manufacturer's products will be available without prior authorization. **Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		ACTIQ LPOP[1]	MC/DEL		ASCOMP/CODEINE CAPS		
	MC/DEL		ASPIRIN/CODEINE TABS	MC/DEL		BUTALBITAL/APAP/CAFFEINE/ CAPS		
	MC/DEL		BUTAL/ASA/CAFF/COD CAPS	MC		DARVOCET-N		
	MC		BUTALBITAL/ASPIRIN/CAFFEI CAPS	MC		DARVON		
	MC		CAPITAL AND CODEINE SUSP[1]	MC		DEMEROL		
	MC		CAPITAL/CODEINE SUSP[1]	MC/DEL		DILAUDID		
	MC/DEL		CODEINE PHOSPHATE SOLN	MC		DILAUDID-HP SOLN		
	MC/DEL		CODEINE SULFATE TABS	MC		FENTANYL CITRATE SOLN		
	MC/DEL		ENDOCET TABS[3]	MC/DEL		FIORICET/CODEINE CAPS		
	MC/DEL		ENDODAN TABS	MC		FIORINAL/CODEINE #3 CAPS		
	MC/DEL		HYDROCODONE BITARTRATE/AP TABS	MC		FIORTAL/CODEINE CAPS		
	MC/DEL		HYDROCODONE/ACETAMINOPHEN	MC/DEL		HYDROCODONE/IBUPROFEN		
	MC/DEL		HYDROMORPHONE HCL[3]	MC/DEL		LORCET		
	MC/DEL		MEPERIDINE HCL	MC		LORTAB		
	MC/DEL		OXYCODONE	MC		MAXIDONE TABS		
	MC/DEL		OXYCODONE/ACETAMINOPHEN[2,3]	MC/DEL		NORCO TABS		
	MC/DEL		PENTAZOCINE/NALOXONE TABS	MC/DEL		PENTAZOCINE/ACET TABS		
	MC		PROPOXYPHENE CMPND-65 CAPS	MC		PERCOCET TABS		
	MC		PROPOXYPHENE COMPOUND CAPS	MC		PERCODAN TABS		
	MC/DEL		PROPOXYPHENE HCL CAPS	MC		PHRENILIN W/CAFFEINE/CODE CAPS		
	MC/DEL		PROPOXYPHENE/ACET TABS	MC/DEL		ROXICET 5/500 TABS		
	MC/DEL		PROPOXYPHENE-N/ACET TABS	MC		ROXICODONE 15MG		
	MC/DEL		ROXICET	MC		ROXICODONE 30MG		
	MC		ROXIPRIN TABS	MC		SYNALGOS-DC CAPS		
				MC		TALACEN TABS		
				MC/DEL		TALWIN NX TABS		
				MC		TYLENOL/CODEINE #3 TABS		
				MC		TYLOX CAPS		
				MC		VICODIN		
				MC		VICOPROFEN TABS		
				MC		ZYDONE TABS		
OPIOID DEPENDENCE TREATMENTS	MC		SUBOXONE*	MC		SUBUTEX	*Suboxone is preferred with	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

TREATMENTS							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.	on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Subtex will onlybe approved for use during pregnancy.

NARCOTIC ANTAGONISTS								
NARCOTIC - ANTAGONISTS	MC/DEL		NALTREXONE HCL TABS	MC/DEL		REVIA TABS	Use PA Form # 20420	Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version.
COX 2 / NSAIDS								
NSAID - PPI			PREVACID NAPRA-PAC					
COX 2 INHIBITORS - HIGHLY SELECTIVE	MC/DEL		CELEBREX CAPS				The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with Celebrex use. Dosing limits will be set at a maximum of 200 mg once daily for PA requests or for patients over 60 without PA. Use PA Form # 10310	Approved without PA for patients 60 years old or over. Patients under 60 can use a preferred proton pump inhibitor with any preferred generic NSAID to achieve similar reductions in GI bleeding risk to that seen with the COX-II agents. Approvals for Mobic will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form. High risk GI bleeding patients must fail on adequate trials of safer agents (non-NSAID/Cox-2) for GI tract, such as acetaminophen
COX 2 INHIBITORS -SELECTIVE	MC/DEL		KETOROLAC TROMETHAMINE	MC/DEL		MOBIC	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. Use PA Form # 10310	Approved without PA for patients 60 years old or over. Patients under 60 can use a preferred proton pump inhibitor with any preferred generic NSAID to achieve similar reductions in GI bleeding risk to that seen with the COX-II agents. Approvals for Mobic will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form. High risk GI bleeding patients must fail on adequate trials of safer agents (non-NSAID/Cox-2) for GI tract, such as acetaminophen
	MC/DEL		NABUMETONE TABS	MC/DEL		MOBIC SUSP		
				MC/DEL		RELAFEN TABS		
				MC		TORADOL		
NSAIDS	MC/DEL		CHILDRENS IBUPROFEN	MC		ADVIL TABS	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.
	MC/DEL		CHILDREN'S MOTRIN SUSP	MC		ANAPROX TABS		
	MC/DEL		DICLOFENAC POTASSIUM TABS	MC		ANAPROX DS TABS		
	MC/DEL		DICLOFENAC SODIUM	MC		ANSAID TABS		
	MC/DEL		ETODOLAC	MC/DEL		CATAFLAM TABS		
	MC/DEL		FENOPROFEN CALCIUM TABS	MC		CHILDRENS ADVIL SUSP		
	MC/DEL		FLURBIPROFEN TABS	MC		CHILD'S IBUPROFEN SUSP		
	MC/DEL		IBUPROFEN	MC/DEL		CLINORIL TABS		
	MC/DEL		INDOMETHACIN	MC/DEL		DAYPRO TABS		
	MC/DEL		KETOPROFEN	MC/DEL		EC-NAPROSYN TBEC		
	MC/DEL		MECLOFENAMATE SODIUM CAPS	MC/DEL		ETODOLAC ER 600MG		
	MC/DEL		NAPROSYN SUSP	MC		FELDENE CAPS		
	MC/DEL		NAPROXEN SUSP	MC/DEL		IBU-200		
	MC/DEL		NAPROXEN TABS	MC		INDOCIN		
	MC/DEL		NAPROXEN SODIUM TABS	MC/DEL		LODINE		
	MC/DEL		OXAPROZIN TABS	MC/DEL		MOTRIN		
	MC/DEL		PIROXICAM CAPS	MC		NALFON CAPS		
	MC/DEL		SULINDAC TABS	MC/DEL		NAPRELAN TBCR		
	MC/DEL		TOLMETIN SODIUM	MC/DEL		NAPROSYN TABS		
				MC/DEL		NAPROXEN DR TBEC		
				MC/DEL		NAPROXEN SODIUM TBCR		
				MC		ORUVAIL CP24		
				MC		PONSTEL CAPS		
				MC		SB IBUPROFEN TABS		
				MC		TOLECTIN		
				MC/DEL		VOLTAREN		
				MC		V-R IBUPROFEN TABS		
RHEUMATOID ARTHRITIS								
RHEUMATOID ARTHRITIS	MC/DEL	1	AZATHIOPRINE	MC/DEL	5	ARAVA	1. No PA for Arava if methotrexate previously tried. Use PA Form # 10510	See criteria as listed on Rheumatoid Arthritis PA form.
	MC/DEL	1	HYDROXYCHLOROQUINE	MC	5	ENBREL KIT		
	MC/DEL	1	LEFLUNOMIDE	MC	8	HUMIRA		
	MC/DEL	1	METHOTREXATE	MC	8	KINERET SOLN		
	MC/DEL	1	SULFASALAZINE TABS	MC	8	REMICADE		
MISCELLANEOUS ARTHRITIS								
ARTHRITIS - MISC.	MC		RIDAURA CAPS	MC/DEL		ARTHROTEC[1]	1. The individual components of Arthrotec are available without PA. Use PA Form # 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The individual components of Arthrotec are available without PA.
	MC		MYOCHRYSINE SOLN					
MIGRAINE THERAPIES								
MIGRAINE - ERGOTAMINE DERIVATIVES	MC/DEL		MIGRANAL SOLN	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.
	MC		SANSERT TABS					
MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC		DEPAKOTE ER TB24					
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs	MC/DEL	1	IMITREX TABS	MC/DEL		FROVA TABS	Use PA Form # 10110	Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
	MC/DEL	1	MAXALT MLT	MC		AXERT TABS		
	MC/DEL	1	RELPAX	MC/DEL		AMERG TABS		
	MC/DEL	1	MAXALT	MC/DEL		ZOMIG TABS		

				MC/DEL		ZOMIG NASAL SPARY		
				MC/DEL		ZOMIG ZMT TBDP		
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables	MC/DEL		IMITREX KIT				Use PA Form # 10110	
	MC/DEL		IMITREX SOLN					
	MC/DEL		IMITREX STATDOSE PEN KIT					
	MC/DEL		IMITREX STATDOSE REFILL KIT					
MIGRAINE - MISC.	MC/DEL		CAFERGOT SUPP	MC/DEL		MIGRAZONE CAPS	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.
	MC/DEL		CAFERGOT TABS	MC		BELCOMP-PB SUPP		
	MC/DEL		SPASTRIN TABS					
GOUT								
GOUT	MC/DEL		ALLOPURINOL TABS	MC		ZYLOPRIM TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		COLCHICINE TABS					
	MC/DEL		PROBENECID TABS					
	MC/DEL		PROBENECID/COLCHICINE TABS					
	MC		SULFINPYRAZONE TABS					
MISC.								
ANESTHETICS - MISC.	MC		BUPIVACAINE HCL SOLN	MC		SENSORCAINE-MPF SOLN	Use PA Form # 30130	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		LIDOCAINE HCL SOLN	MC/DEL		SYNVISC INJ		
	MC		MARCAINE SOLN	MC		XYLOCAINE SOLN		
ANTI-CONVULSANTS								
ANTICONVULSANTS	MC/DEL		CARBAMAZEPINE	MC	8	DEPAKENE	1. Quantity limit. 5/month 2. 200 mg requires a PA. Use two 100 mg instead.Pharmaceutical supply issues will delay implementation until further notice. All non-preferred meds must be used in specified order Use PA Form # 20420	Seizure patients will be approved for any anticonvulsant. Other approvals will be for patients with a variety of drug-specific FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality after recommendation by the DUR Committee and as long as all first line therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). *** SEE CHART AT END OF DOCUMENT Topamax and Neurontin - Second line therapy for migraine prophalaxis after trial of at least three preferred preventive medications from Group 1 listed on page 2 of the Acute Migraine PA form. Gabapentin and Lyrica- Second line therapy for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia after trial of a preferred TCA (tri-cyclic anti-depressant) and one of the following preferred medications: a preferred anti-convulsant, capsaicin, tramadol, or other narcotic. Combination therapy of non-preferred medications for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia will not be approved.
	MC/DEL		CARBATROL CP12	MC/DEL	8	GABAPENTIN		
	MC/DEL		CELONTIN CAPS	MC/DEL	8	GABITRIL TABS		
	MC/DEL		CLONAZEPAM TABS	MC/DEL	8	KEPPRA TABS		
	MC		DEPAKOTE TBEC	MC/DEL	8	KLONOPIN TABS		
	MC		DEPAKOTE SPRINKLES CPSP	MC/DEL	8	LYRICA		
	MC/DEL		DIASTAT[1]	MC/DEL	8	PRIMIDONE TABS		
	MC/DEL		DILANTIN	MC/DEL	8	TOPAMAX		
	MC/DEL		EPITOL TABS	MC/DEL	8	TRILEPTAL		
	MC/DEL		EQUETRO	MC/DEL	8	ZARONTIN SYRP		
	MC/DEL		ETHOSUXIMIDE SYRP	MC/DEL	8	ZONEGRAN CAPS		
	MC/DEL		FELBATOL	MC/DEL	9	NEURONTIN		
	MC/DEL		LAMICTAL					
	MC/DEL		MYSOLINE TABS					
	MC/DEL		PHENYTEK CAPS			BIPOLAR DISORDER: STEP ORDER		
	MC/DEL		PHENYTOIN		M ~ A		SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT M= Monotherapy A= Adjunctive 9= No Evidence The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
	MC/DEL		TEGRETOL[2]		4 ~ 4	LAMICTAL		
	MC/DEL		TEGRETOL-XR TB12		4 ~ 4	LITHIUM		
	MC/DEL		VALPROIC ACID		4 ~ 4	CARBAMAZEPINE		
	MC/DEL		ZARONTIN CAPS		4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE		
					5 ~ 5	TRILEPTAL		
					9 ~ 6	TOPAMAX		
					9 ~ 7	KEPPRA TABS		
					9 ~ 8	GABITRIL TABS		
					9 ~ 9	NEURONTIN		
					9 ~ 9	ZONEGRAN CAPS		
						PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER		
					M ~ A	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE		
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE	Two-step 1 preferred drugs must be tried before Trileptal. The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
					4 ~ 4	LAMICTAL		
					5 ~ 5	TRILEPTA		
ANTI-PARKINSON DRUGS								
PARKINSONS - ANTICHOLINERGICS	MC		AKINETON TABS					
	MC/DEL		BENZTROPINE MESYLATE TABS					
	MC		COGENTIN SOLN					
	MC/DEL		KEMADRIN TABS					
	MC/DEL		TRIHEXYPHENIDYL					
PARKINSONS - COMT INHIBITORS	MC/DEL		COMTAN TABS	MC/DEL		TASMAR TABS	Use PA Form # 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - SELECTED DOPAMIN AGONISTS	MC/DEL	1	MIRAPEX TABS	MC		PERMAX	Both Mirapex and requip must be used before Pergolide. Use PA Form # 20420	Preferred drug must be tried and failed in step-order due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	REQUIP TABS					

Class	Code	Step	Preferred	Code	Step	Non-Preferred	PA / Notes	Criteria
	MC/DEL	2	PERGOLIDE MESYLATE TABS				Use PA Form # 20420	another drug and the preferred drug(s) exists.
PARKINSONS - DOPAMINERGICS/CARBII/ LEVO	MC/DEL		AMANTADINE HCL	MC/DEL		APOKYN*	* Only preferred manufacturer's products will be available without prior authorization. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BROMOCRIPTINE MESYLATE	MC		ELDEPRYL CAPS		
	MC/DEL		CARBIDOPA/LEVODOPA TABS*	MC/DEL		PARLODEL CAPS		
	MC/DEL		CARBIDOPA/LEVODOPA ER	MC/DEL		PARLODEL TABS		
	MC		LARODOPA TABS	MC		SINEMET TABS		
	MC		LODOSYN TABS	MC		SINEMET TBCR		
	MC/DEL		SELEGILINE HCL	MC		SYMMETREL TABS		
PARKINSONS - COMBO.	MC/DEL		STALEVO					
MUSCLE RELAXANTS								
ALS DRUG	MC/DEL		RILUTEK TABS					
MUSCLE RELAXANTS	MC/DEL		BACLOFEN TABS	MC/DEL	7	ORPHENADRINE CITRATE	Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). Non-preferred products must be used in specified step order. Both step 7's must be tried. Use PA Form # 20420	At least 3 preferred drugs must be tried for at least 2 weeks and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Elderly patients, over 65, will require written notice of the increased sedative risks and impaired driving.Prior Authorization will not be given for:1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.
	MC/DEL		CHLORZOXAZONE TABS	MC/DEL	7	TIZANIDINE HCL TABS		
	MC/DEL		CYCLOBENZAPRINE HCL TABS	MC/DEL	8	CARISOPRODOL TABS[1]		
	MC		LIORESAL INTRATHECAL KIT	MC/DEL	8	DANTRIUM CAPS		
	MC/DEL		METHOCARBAMOL TABS	MC/DEL	8	FLEXERIL TABS		
				MC	8	LIORESAL TABS		
				MC	8	NORFLEX TBCR		
				MC	8	ROBAXIN-750 TABS		
				MC/DEL	8	ZANAFLEX TABS		
				MC/DEL	9	SKELAXIN TABS		
				MC/DEL	9	SOMA TABS		
MUSCLE RELAXANT - COMBO.				MC/DEL		CARISOPRODOL/ASPIRIN TABS	Use PA Form # 20420	Individual components are available with PA described in the section above.1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant trave, etc.
				MC/DEL		CARISOPRODOL/ASPIRIN/CODE		
				MC		NORGESIC TABS		
				MC/DEL		ORPHENADRINE COMPOUND		
				MC/DEL		ORPHENADRINE/ASA/CAFF		
				MC		ORPHENGESIC		
VITAMINS								
****Preferred products that used to require diag codes still require diag codes unless indicated otherwise.****								
VITAMINS	MC/DEL		ASCORBIC ACID TABS	MC		AQUASOL E 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. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC		BIOTIN	MC		AQUAVIT-E SOLN		
	MC		CYANOCOBALAMIN SOLN	MC		DHT SOLN		
	MC		FOLGARD RX 2.2 TABS	MC		NASCOBAL GEL		
	MC/DEL		FOLIC ACID TABS					
	MC		FOLTX TABS					
	MC/DEL		MEPHYTON TABS					
	MC/DEL		NIACIN					
	MC		NIACOR TABS					
	MC/DEL		NICOTINIC ACID SR CPCR					
	MC		PYRIDOXINE HCL TABS					
	MC/DEL		SLO-NIACIN TBCR					
	MC/DEL		THIAMINE HCL SOLN					
	MC/DEL		VITAMIN B-1 TABS					
	MC/DEL		VITAMIN B-12					
	MC		VITAMIN B-6 TABS					
	MC/DEL		VITAMIN C					
	MC/DEL		VITAMIN E CAPS					
	MC/DEL		VITAMIN E/D-ALPHA CAPS					
	MC		VITAMIN K1 SOLN					
	MC		V-R VITAMIN E CAPS					
VITAMIN D's	MC		CALCIFEROL SOLN[1]	MC/DEL		DRISDOL CAPS	1. Diagnosis of dialysis (renal failure) required. 2. OTC Vitamin D no diagnosis required.	Preferred products require dialysis/renal failure diagnosis. Non-preferred products require: Secondary hyperparathyroidism in patients with Chronic Kidney Disease on dialysis., iPTH>400 pg/ml, Phosophorous ,6.5mg/dl, corrected calcium <12.2mg/dl, corrected calcium x phosphorous products $<70mg^2/dl^2$
	MC/DEL		CALCITRIOL CAPS[1]	MC		CALCIJEX		
	MC/DEL		DRISDOL SOLN[1]	MC/DEL		HECTOROL (ORAL)		
	MC/DEL		VITAMIN D[1,2]	MC/DEL		HECTOROL (PARENTERAL)		
				MC/DEL		ROCALTROL		
				MC		ZEMPLAR		

MISC MULTI-VITAMINS

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

Category		Preferred		Non-Preferred	Criteria	Notes
VITAMINS - MISC.	MC	CENTRUM LIQD	MC	ADEKS	Diag codes are no longer required on prenatal vitamins. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC	CENTRUM TABS	MC/DEL	ADVANCED NATALCARE TABS		
	MC	CENTRUM JR/IRON CHEW	MC	CENTRUM JR/EXTRA C CHEW		
	MC	CENTRUM SILVER TABS	MC	CENTRUM PERFORMANCE TABS		
	MC	CENTRUM-LUTEIN TABS	MC	DALYVITE LIQD		
	MC	CEROVITE ADVANCED FO TABS	MC	EMBREX 600 MISC		
	MC/DEL	CHEWABLE MULTIVIT/FL CHEW	MC	IBERET		
	MC	COD LIVER OIL CAPS	MC	MATERNA TABS		
	MC	COMPLETE SENIOR TABS	MC	MULTIRET FOLIC -500 TBCR		
	MC	DAILY MULTI VIT/IRON	MC/DEL	NATAFORT TABS		
	MC/DEL	DIALYVITE 800MG	MC/DEL	NATALCARE CFE 60 TABS		
	MC/DEL	FULL SPECTRUM B	MC/DEL	NATALCARE GLOSS TABS		
	MC	M.V.I.-12 INJ	MC	NATALCARE PIC TABS		
	MC	MULTI-VIT/FLUORIDE	MC	NATALCARE PIC FORTE TABS		
	MC/DEL	NATACHEW CHEW	MC/DEL	NATALCARE PLUS TABS		
	MC/DEL	NATALCARE RX TABS	MC	NATALCARE THREE TABS		
	MC/DEL	O-CAL PRENATAL	MC	NATALFIRST TABS		
	MC/DEL	OCUVITE TABS	MC	NATATAB RX TABS		
	MC/DEL	ONE DAILY TABS	MC/DEL	NEPHPLEX RX TABS		
	MC/DEL	ONE-DAILY MULTIVITAMINS	MC/DEL	NEPHROCAPS CAPS		
	MC/DEL	ONE-TABLET-DAILY	MC/DEL	NEPHRO-VITE TABS		
	MC/DEL	POLY-VIT/IRON/FLUORID SOLN	MC	NESTABS RX TABS		
	MC/DEL	POLY-VITAMIN/FLUORIDE SOLN	MC/DEL	NIFEREX		
	MC/DEL	POLY-VITAMINS/IRON SOLN	MC/DEL	NUTRINATE CHEW		
	MC/DEL	PRENATAL TABS	MC	POLY-VI-FLOR SOLN		
	MC/DEL	PRENATAL FORMULA 3 TABS	MC	POLY-VI-SOL SOLN		
	MC/DEL	PRENATAL PLUS TABS	MC	POLY-VI-SOL/IRON SOLN		
	MC/DEL	PRENATAL PLUS NF TABS	MC	POLY-VITAMIN DROPS SOLN		
	MC	PRENATAL PLUS/27MG IRON	MC	PRECARE		
	MC	PRENATAL PLUS/IRON TABS	MC	PREMESIS RX TABS		
	MC/DEL	PRENATAL RX/BETA-CAROTENE	MC	PRENATABS CBF TABS		
	MC	PROTEGRA CAPS	MC	PRENATAL 19 CHEW		
	MC	STRESS TAB NF TABS	MC	PRENATAL CARE TABS		
	MC	THERAPEUTIC-M TABS	MC	PRENATAL MR 90 TBCR		
	MC	THERAVITE LIQD	MC/DEL	PRENATAL MTR/SELENIUM TABS		
	MC/DEL	TRI-VITAMIN/FLUORIDE SOLN	MC	PRENATAL OPTIMA ADVANCE TABS		
	MC	VITA CON FORTE CAPS	MC	PRENATAL PC 40 TABS		
	MC	VITAMIN B COMPLEX CAPS	MC/DEL	PRENATAL RX TABS		
	MC	VITAPLEX PLUS TABS	MC	PRENATE		
			MC	PRIMACARE MISC		
			MC/DEL	RENAL CAPS		
			MC/DEL	RENAPHRO CAPS		
			MC/DEL	RENA-VITE RX TABS		
			MC	STUARTNATAL PLUS 3 TABS		
			MC	TRI-VI-SOL SOLN		
			MC	TRI-VI-SOL/IRON SOLN		
			MC/DEL	ULTRA NATALCARE TABS		
			MC	ULTRA-NATAL TABS		
			MC	VICON FORTE CAPS		
			MC	VINATAL FORTE TABS		
			MC	VINATE		
			MC/DEL	VINATE ADVANCED TABS		

MISCELLANEOUS MINERALS

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

Category		Preferred		Non-Preferred	Criteria	Notes
MINERALS	MC	CALCARB	MC	ANEMAGEN	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC	CALCI-MIX CAPSULE CAPS	MC	CALCET TABS		
	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		
	MC	FERATAB TABS	MC	K-TABS TBCR		
	MC/DEL	FER-GEN-SOL SOLN	MC	K-VESCENT PACK		
	MC/DEL	FERGON TABS	MC	NU-IRON 150 CAPS		
	MC	FER-IN-SOL SOLN	MC/DEL	**OYSTER SHELL CALCIUM/VITA TABS**		
	MC	FER-IRON SOLN	MC/DEL	POLY-IRON 150 CAPS		
	MC	FERRONATE TABS	MC/DEL	POLYSACCHARIDE IRON CAPS		
	MC	FERROUS FUMARATE TABS	MC/DEL	POTASSIUM BICARB/CHLORIDE		
	MC/DEL	FERROUS GLUCONATE TABS	MC/DEL	SLOW FE TBCR		
	MC/DEL	FERROUS SULFATE	MC	TUMS 500 CHEW		
	MC/DEL	FLUOR-A-DAY CHEW	MC	VIACTIV CHEW		
	MC	FLUORIDE CHEW				
	MC	FLUORIDE SODIUM CHEW				
	MC	FLUORITAB CHEW				
	MC	HEMOCYTE TABS				
	MC	HM CALCIUM TABS				
	MC	K+ POTASSIUM PACK				
	MC	KAON ELIX				
	MC	KAON-CL-10 TBCR				
	MC	KCL 0.075%/D5W/NACL 0.2% SOLN				
	MC	K-EFFERVESCENT TBEF				
	MC	KLOR-CON				
	MC	KLOTRIX TBCR				
	MC/DEL	K-PHOS TABS				
	MC/DEL	K-VESCENT TBEF				
	MC/DEL	LURIDE CHEW				
	MC/DEL	MAGNESIUM GLUCONATE TABS				
	MC/DEL	MAGNESIUM SULFATE SOLN				
	MC	MAGTABS				
	MC	MICRO-K CPCR				
	MC/DEL	NEUTRA-PHOS				
	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				
	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	FISH OIL CAPS	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 G/I tube.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC	INTRALIPID EMUL	MC	CASEC POWD		
	MC	MCT OIL OIL	MC	CHOICE DM LIQD		
	MC	ORALYTE SOLN	MC	DELIVER 2.0 LIQD		
	MC	P.T.E. -5 SOLN	MC	ENFAMIL		
	MC	PEDIALYTE SOLN	MC	ENSURE		
			MC	GLUCERNA		
			MC	ISOCAL LIQD		
			MC	KINDERCAL TF LIQD		
			MC	KINDERCAL TF/FIBER LIQD	**Use PA Form # 20420 & SGA Form**	
			MC/DEL	L-CARNITINE CAPS		
			MC	LIPISORB LIQD		
			MC	MODULEN IBD POWD		
			MC	NUTRAMIGEN POWD		

				MC/DEL		NUTREN		
				MC		NUTRITIONAL SUPPLEMENT LIQD		
				MC		NUTRIVENT 1.5 LIQD		
				MC		OMACOR		
				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	5	PROCRIT SOLN[1]	1. All products require PA but Procrit is first choice. Still must be used in specified step order. **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	6	EPOGEN SOLN		
				MC	8	ARANESP SOLN		
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. **Use PA Form # 20520**	See approval criteria detailed on Neupogen PA form.
				MC	8	NEUPOGEN SOLN[1]		
				MC	9	NEULASTA		
ANTICOAGULANTS / PLATELET AGENTS								
ANTICOAGULANTS	MC		ARIXTRA SOLN	MC		COUMADIN TABS	1. Fragmin and Lovenox therapy durations greater than 7 days require PA. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA.
	MC/DEL		FRAGMIN INJ[1]	MC		IPRIVAS C		
	MC		HEPARIN SODIUM/NACL 0.9% SOLN					
	MC		HEP-LOCK SOLN					
	MC/DEL		**INNOHEP**					
	MC/DEL		**LOVENOX SOLN[1]**					
	MC/DEL		**WARFARIN SODIUM TABS**					
	MC		HEPARIN LOCK SOLN					
	MC/DEL		HEPARIN LOCK FLUSH SOLN					
	MC/DEL		HEPARIN SODIUM SOLN					
	MC/DEL		HEPARIN SODIUM LOCK FLUSH SOLN					
	MC/DEL		JANTOVEN					
ANTIHEMOPHILIC AGENTS	MC		ALPHANATE	MC		ADVATE[1,2]	1. Only if other products unavailable. 2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access. Use PA Form # 20420	Non-preferred will only be approved if other preferred products are unavailable.
	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					
	MC		PROPLEX -T					
	MC		RECOMBINATE SOLR					
	MC		REFACTO					
PLATELET AGGREGATION INHIBITORS	MC/DEL		ASPIRIN	MC/DEL	7	TICLOPIDINE HCL TABS	Use PA Form # 20420 1. As of 04.01.2005 Plavix is only available without PA if concurrent aspirin use (on prescription) within 100 days or documented failure or intolerance or other contraindication to aspirin.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**DIPYRIDAMOLE TABS**	MC/DEL	8	PERSANTINE TABS		
	MC/DEL		PLAVIX TABS[1]	MC	8	TICLID TABS		
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.	MC/DEL		PENTOXIFYLLINE ER TBCR	MC/DEL		**AGGRENOX CP12[1]**	1. Asprin and dipyridamole are available separately 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.
	MC/DEL		CILOSTAZOL	MC/DEL		**AGRYLIN CAPS**		
				MC/DEL		**PLETAL TABS**		
				MC		TRENTAL TBCR		
HEMOSTATIC								
HEMOSTATIC	MC/DEL		AMICAR					
	MC		AMINOCAPROIC ACID					
OPHTHALMICS								
OP. - ANTIBIOTICS	MC		AK-SPORE OINT	MC		AK-POLY-BAC OINT	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BACITRACIN OINT	MC		AK-SULF OINT		

	MC		BACITRACIN/NEOMYCIN/POLYM	MC		AK-TOB SOLN		preferred drug(s) exists.
	MC/DEL		BACITRACIN/POLYMYXIN B OINT	MC		BLEPH-10 SOLN		
	MC		CHLOROPTIC SOLN	MC		GENTAK		
	MC/DEL		ERYTHROMYCIN OINT	MC		ILOTYCIN OINT		
	MC/DEL		GENTAMICIN SULFATE	MC/DEL		NEOMYCIN/BACI/POLYM OINT		
	MC/DEL		NEOMYCIN/POLYMYXIN/GRAMIC	MC		NEOSPORIN OINT		
	MC		NEOSPORIN SOLN	MC		OCUSULF-10 SOLN		
	MC		POLYSPORIN	MC		OCUTRICIN SOLN		
	MC/DEL		SODIUM SULFACETAMIDE SOLN	MC		TERAK OINT		
	MC/DEL		SULFACETAMIDE SODIUM	MC/DEL		TOBREX OINT		
	MC		TERRAMYCIN OINT	MC/DEL		TRIFLURIDINE SOLN		
	MC/DEL		TOBRAMYCIN SULFATE SOLN					
	MC/DEL		TRIMETHOPRIM SULFATE/POLY					
	MC/DEL		VIROPTIC SOLN					
OP. - QUINOLONES	MC/DEL	1	CILOXAN OINT				Step order must be followed to avoid PA. Must fail Ocuflox and a Ciloxan product before moving to next step product without PA. **Use PA Form # 20420**	Preferred drugs must be tried in step-order and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	CILOXAN SOLN					
	MC	1	OCUFLOX SOLN					
	MC/DEL	2	QUIXIN SOLN					
OP. QUINOLONES - 4TH GENERATION	MC/DEL		VIGAMOX	MC		ZYMAR		
OP. - ARTIFICIAL TEARS AND LUBRICANTS	MC		AKWA TEARS OINT	MC		AKWA TEARS SOLN	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ARTIFICIAL TEARS OINT	MC/DEL		ARTIFICIAL TEARS SOLN OP		
	MC/DEL		ARTIFICIAL TEARS SOLN	MC		BION TEARS SOLN		
	MC		CELLUVISC SOLN	MC		DRY EYES OINT		
	MC		EYE LUBRICANT OINT	MC		DURATEARS OINT		
	MC/DEL		GENTEAL	MC/DEL		HYPO TEARS		
	MC		LIQUITEARS SOLN	MC/DEL		ISOPTO TEARS SOLN		
	MC		MAJOR TEARS SOLN	MC		LACRI-LUBE		
	MC		PURALUBE OINT	MC		LUBRIFRESH P.M. OINT		
	MC		PURALUBE TEARS SOLN	MC		MURINE SOLN		
	MC		REFRESH SOLN OP	MC/DEL		MUROCEL SOLN		
	MC		REFRESH PLUS SOLN	MC/DEL		NATURE'S TEARS SOLN		
	MC		REFRESH PM OINT	MC		REFRESH SOLN		
				MC		REFRESH TEARS SOLN		
				MC		SYSTANE		
				MC		TEARGEN SOLN		
				MC		TEARISOL SOLN		
				MC/DEL		TEARS NATURALE		
				MC/DEL		TEARS PURE SOLN		
				MC		TEARS RENEWED OINT		
				MC/DEL		THERATEARS SOLN		
				MC		V-R ARTIFICIAL TEARS SOLN		
OP. - BETA - BLOCKERS	MC/DEL		**BETIMOL SOLN**	MC		BETAGAN SOLN	Use Pa Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**BETOPTIC-S SUSP**	MC/DEL		**BETAXOLOL HCL SOLN**		
	MC/DEL		**CARTEOLOL HCL SOLN**			ISTALOL		
	MC/DEL		**LEVOBUNOLOL HCL SOLN**	MC/DEL		**OCUPRESS SOLN**		
	MC/DEL		METIPRANOLOL SOLN	MC		OPTIPRANOLOL SOLN		
	MC/DEL		**TIMOLOL MALEATE SOLN**	MC/DEL		**TIMOPTIC SOLN**		
	MC/DEL		**TIMOLOL MALEATE SOLG (GEL)**	MC/DEL		**TIMOPTIC-XE SOLG**		
OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH.	MC		AK-SPORE HC OINT	MC		AK-TROL SUSP	Use Pa Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ALREX SUSP	MC		BAC/POLY/NEOMY/HC OINT		
	MC		BLEPHAMIDE SUSP	MC		BLEPHAMIDE S.O.P. OINT		
	MC/DEL		CORTISPORIN SUSP	MC		ECONOPRED		
	MC/DEL		DEXAMETH SOD PHOS SOLN	MC		EFLONE SUSP		
	MC/DEL		FLAREX SUSP	MC		FLUOR-OP SUSP		
	MC/DEL		FLUOROMETHOLONE SUSP	MC		MAXITROL		
	MC		FML LIQUIFILM SUSP	MC		NEO/POLY/BAC/HC OINT		
	MC		FML S.O.P. OINT	MC		PRED-G SUSP		
	MC		FML-S LIQUIFILM SUSP	MC		PRED-G S.O.P. OINT		
	MC		INFLAMASE SOLN	MC/DEL		SULFACET SOD/PRED SOLN		
	MC/DEL		LOTEMAX SUSP	MC		VASOCIDIN SOLN		
	MC/DEL		NEOM/POLIN/DEX	MC/DEL		VEXOL SUSP		
	MC		PRED FORTE SUSP					
	MC		PRED MILD SUSP					
	MC/DEL		PREDNISOLONE					
	MC/DEL		TOBRADEX					
OP. - PROSTAGLANDINS	MC/DEL	1	**XALATAN SOLN**	MC/DEL		**RESCULA SOLN**	Established users grandfathered. Preferred	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
	MC/DEL	1	**TRAVATAN SOLN**					

	MC	1	LUMIGAN SOLN				products must be used in specified step order or PA required. **Use PA Form # 20420**	significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - CYCLOPLEGICS	MC		AK-PENTOLATE SOLN	MC/DEL		CYCLOGYL SOLN	**Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ATROPINE SULFATE	MC		ISOPTO ATROPINE SOLN		
	MC/DEL		CYCLOPENTOLATE HCL SOLN	MC/DEL		ISOPTO HOMATROPINE SOLN		
	MC/DEL		ISOPTO HYOSCINE SOLN	MC		MUROCOLL-2 SOLN		
OP. - MIOTICS - DIRECT ACTING	MC/DEL		**ISOPTO CARBACHOL SOLN**					
	MC		ISOPTO CARPINE SOLN					
	MC		PILOCAR SOLN					
	MC/DEL		**PILOCARPINE HCL SOLN**					
	MC/DEL		**PILOPINE HS GEL**					
OP. - ADRENERGIC AGENTS	MC/DEL		**DIPIVEFRIN HCL SOLN**	MC		PROPINE SOLN	**Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EPIFRIN SOLN					
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC		ALPHAGAN 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.
	MC		ALPHAGAN P SOLN					
OP. - ANTI-ALLERGICS	MC		ELESTAT	MC		ALOCRIL 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.
	MC/DEL		PATANOL SOLN	MC/DEL		ALOMIDE SOLN		
				MC/DEL		EMADINE SOLN		
				MC/DEL		LIVOSTIN SUSP		
				MC		OPTICROM SOLN		
				MC/DEL		ZADITOR SOLN		
OP. ANTI-ALLERGICS-MASTCELL STABILIZER CLASS	MC/DEL		ALAMAST SOLN					
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO	MC/DEL		**AZOPT SUSP**					
	MC/DEL		**COSOPT SOLN**					
	MC/DEL		**TRUSOPT SOLN**					
OP. - NSAID'S	MC		ACULAR LS	MC		OCUFEN SOLN	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.
	MC		ACULAR SOLN					
	MC		FLURBIPROFEN SODIUM SOLN					
	MC		VOLTAREN SOLN					
OP. - OF INTEREST	MC/DEL		ENUCLENE SOLN	MC		BOTOX SOLR	1. Must have kerato conjuctivitus sicca and failed other dry eye therapies. **Use PA Form #20420**	Must fail adequate trials of multi agents from artificial tears and lubricant category.
				MC		RESTASIS[1]		
DERMATOLOGICAL								
TOPICAL - ACNE PREPARATIONS	MC/DEL		ACCUTANE CAPS	MC		ALTINAC CREA	2. For these Retin-A products, over 24 yr. need PA. **Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		AKNE-MYCIN OINT	MC		AVITA CREA		
	MC		AZELEX CREA	MC		BENZAC		
	MC		BENZOYL PEROXIDE	MC/DEL		BENZACLIN GEL		
	MC/DEL		CLEOCIN-T	MC/DEL		BENZAGEL-10 GEL		
	MC		DIFFERIN	MC/DEL		BENZAMYCIN GEL		
	MC		ERYDERM SOLN	MC/DEL		BENZAMYCINPAK PACK		
	MC/DEL		ERYTHROMYCIN GEL	MC		BREVOXYL		
	MC/DEL		ERYTHROMYCIN PADS	MC		CLINAC BPO GEL		
	MC/DEL		ERYTHROMYCIN SOLN	MC		CLINDAGEL GEL		
	MC		METROCREAM CREA	MC/DEL		CLINDAMYCIN PHOSPHATE		
	MC		METROGEL GEL	MC		CLINDETS SWAB		
	MC		METROLOTION LOTN	MC		DESQUAM-E GEL		
	MC/DEL		PLEXION	MC		DESQUAM-X		
	MC		RETIN-A CREA[2]	MC		DUAC GEL		
	MC		RETIN-A GEL[2]	MC		EMGEL GEL		
	MC		RETIN-A LIQD[2]	MC		ERYCETTE PADS		
	MC/DEL		SODIUM SULFACET/SULF LOTN	MC		ERYGEL GEL		
				MC		FINEVIN CREA		
				MC/DEL		KLARON LOTN		
				MC/DEL		NORITATE CREA		
				MC		RETIN-A MICRO GEL		
				MC/DEL		SULFACET-R LOTN		
				MC/DEL		TRETINOIN		
				MC/DEL		TRIAZ		
				MC		ZETACET		
TOPICAL - ANTIBIOTIC	MC		BACIT/NEOMYCIN/POLYM OINT	MC/DEL		CORTISPORIN	1. Quantity limit of 30 g per month. **Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BACITRACIN OINT	MC/DEL		TRIPLE ANTIBIOTIC OINT		
	MC/DEL		BACTROBAN[1]					
	MC/DEL		CENTANY OINT 2%[1]					

Class	Status	Preferred Drugs	Status	Non-Preferred Drugs	PA Form	Criteria
	MC/DEL	GENTAMICIN SULFATE				
TOPICAL - ANTIFUNGALS	MC/DEL	CLOTRIMAZOLE	MC	EXELDERM	Use PA Form # 10120	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	CLOTRIMAZOLE/BETA CREA	MC	FUNGIZONE CREA		
	MC	ECONAZOLE NITRATE CREAM	MC/DEL	HYDROCORT/IODOQ CREA		
	MC/DEL	KETOCONAZOLE CREA	MC/DEL	LAMISIL		
	MC/DEL	LOPROX .77 CREA	MC/DEL	LOPROX 0.77 LOTN		
	MC/DEL	LOPROX 1.0 CREAM	MC/DEL	LOPROX SHAMPOO SHAM		
	MC/DEL	LOPROX 1.O LOTN	MC	LOTRIMIN		
	MC/DEL	LOPROX GEL	MC/DEL	LOTRISONE		
	MC/DEL	LOPROX TS LOTN	MC/DEL	MENTAX CREA		
	MC/DEL	MICONAZOLE NITRATE CREA	MC	MONISTAT-DERM CREA		
	MC	MYCO-TRIACET 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	SPECTAZOLE CREA	MC/DEL	NYSTOP POWD		
	MC/DEL	TINACTIN	MC/DEL	OXISTAT		
	MC	TRI-STATIN II CREA	MC/DEL	PENLAC NAIL LACQUER SOLN		
TOPICAL - ANTIPRURITICS	MC	ZONALON CREA	MC	PRUDOXIN CREA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIPSORIATICS	MC	DOVONEX	MC	PSORIATEC CREA	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.
	MC	OXSORALEN ULTRA CAPS	MC/DEL	SORIATANE CAPS		
	MC	TAZORAC	MC	VANAMIDE		
TOPICAL - ANTISEBORRHEICS	MC	CAPITROL SHAM	MC	CARMOL SCALP TREATMENT KIT	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	SELENIUM SULFIDE SHAM	MC	ZNP BAR		
	MC	SELSUN BLUE SHAM				
TOPICAL - ANTIVIRALS	MC/DEL	DENAVIR CREA			1. Zovirax may be used once without PA.	
	MC	ZOVIRAX OINT[1]				
TOPICAL - ANTINEOPLASTICS	MC	EFUDEX	MC/DEL	CARAC CREA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	FLUOROPLEX CREA				
	MC	SOLARAZE GEL				
TOPICAL - BURN PRODUCTS	MC	FURACIN CREA	MC/DEL	SILVADENE CREA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	SSD CREA	MC/DEL	SILVER SULFADIAZINE CREA		
	MC/DEL	THERMAZENE CREA	MC	SSD AF CREA		
TOPICAL - CORTICOSTEROIDS		LOW POTENCY	MC/DEL	ACLOVATE	Use PA Form # 20420	At least 1 drug from each potency of preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	DESOWEN	MC	AMCINONIDE CREA		
	MC/DEL	HYDROCORTISONE CREA	MC	ANUSOL HC-1 OINT		
	MC	HYDROCORTISONE LOTN	MC	ARISTOCORT A		
	MC	LACTICARE-HC LOTN	MC/DEL	AUGMENTED BETA DIP OINT		
	MC	NUTRACORT LOTN	MC	CLOBEX		
	MC	TEXACORT SOLN	MC	CLODERM CREA		
	MC	TRIDESILON CREA	MC/DEL	CORDRAN		
		MEDIUM POTENCY	MC/DEL	CORMAX		
	MC/DEL	CUTIVATE	MC/DEL	DERMATOP		
	MC/DEL	DESOXIMETASONE .05%	MC	DIFLORASONE DIACETATE		
	MC/DEL	ELOCON	MC	ELOCON OINT		
	MC/DEL	FLUOCINOLONE ACETONIDE .025-.01%	MC	HYDROCORTISONE POWD		
	MC	FLUROSYN CREA	MC	KENALOG AERS		
		HYDROCORTISONE BUTYRATE	MC	LIDA MANTLE HC CREA		
	MC	HYDROCORTISONE OINT	MC	LIDEX		
	MC	HYDROCORTISONE VALERATE	MC	LIDEX-E CREA		
	MC	MOMETASONE FUROATE OINT	MC/DEL	LUXIQ FOAM		
	MC/DEL	TRIAMCINOLONE ACETONIDE .025-.1%	MC/DEL	OLUX FOAM		
		HIGH POTENCY	MC	PANDEL CREA		
	MC	CYCLOCORT	MC	PROCTOCORT CREA		
	MC/DEL	DIPROLENE	MC/DEL	PSORCON E		
	MC/DEL	DESOXIMETASONE .25%	MC	SYNALAR OINT		
	MC/DEL	DESONIDE	MC/DEL	TEMOVATE		
	MC/DEL	FLUOCINOLONE ACETONIDE .02%	MC	TOPICORT		
	MC/DEL	FLUOCINONIDE	MC	TOPICORT LP CREA		
	MC	HALOG	MC	WESTCORT		
	MC	HALOG-E CREA	MC/DEL	LOCOID		
	MC/DEL	TRIAMCINOLONE ACETONIDE .5%				
		VERY HIGH POTENCY				
	MC/DEL	BETAMETHASONE DIPROPIONATE				
	MC/DEL	BETAMETHASONE VALERATE				
	MC/DEL	BETA-VAL				

	MC/DEL MC MC/DEL	CLOBETASOL PROPIONATE ULTRAVATE PSORCON					
		MISCELLANEOUS					
	MC MC MC	CAPEX SHAM DERMA-SMOOTHE/FS OIL PROCTO-KIT CREA					
TOPICAL - STEROID LOCAL ANESTHETICS	MC/DEL MC	PRAMOSONE 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 offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - STEROID COMBINATIONS	MC	DERMA-SMOOTHE/FS ATOPIC P KIT	MC		CARMOL-HC CREA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - EMOLLIENTS	MC/DEL MC MC MC MC MC	AMLACTIN CREA CETAPHIL GENTLE CLEANSER LOTN LAC-HYDRIN LACTINOL-E CREA UREACIN-20 CREA VITAMIN A & D MEDICATED OINT	MC/DEL MC/DEL MC/DEL MC MC		AMMONIUM LACTATE CREA LACLOTION LOTN LACTINOL LOTN MEDERMA GEL RENOVA CREA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ENZYMES / KERATOLYTICS / UREA	MC MC/DEL MC MC MC MC	GRANUL-DERM AERS GRANULEX AERS PANAFIL OINT PAPAIN-UREA-CHLORO OINT TBC AERS XENADERM OINT	MC MC MC MC MC		CARMOL 40 CREA SANTYL OINT SALEX CREAM SALEX LOTION ZIOX OINT	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - GENITAL WARTS	MC/DEL	ALDARA	MC/DEL MC/DEL	5 8	PODOFILOX SOLN CONDYLOX	Non-preferred products must be used in specified order. **Use PA Form # 20420**	
TOPICAL - IMMUNOMODULATORS			MC/DEL	8 9	ELIDEL CREA PROTOPIC OINT	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. **Use PA Form # 20420**	Preferred corticosteroids from other classes must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be made for small amounts of non-preferred products for the treatment of very steroid-sensitive areas in conjunction with topical steroids for the treatment of atopic dermatitis.
TOPICAL - LOCAL ANESTHETICS	MC MC/DEL MC MC/DEL MC/DEL MC/DEL	AF CAPSICUM OLEORESIN CREA CAPSAICIN CREA ELA-MAX[1] EMLA CREA[1] EMLA/TEGADERM KIT[1] XYLOCAINE	MC/DEL MC MC/DEL MC MC MC		EMLA PADS LIDA MANTLE CREA LIDOCAINE HCL LIDODERM PTCH PONTOCAINE SOLN ZOSTRIX	1. Emla and Ela-Max products require PA for users over 18 years of age. **Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - DEPIGMENTING AGENTS			MC MC MC/DEL MC/DEL MC MC MC	8 8 8 8 8 8 9	ALUSTRA CREA GLYQUIN CREA HYDROQUINONE CREA HYDROQUINONE/SUNSCREENS SOLAQUIN FORTE CREA TRI-LUMA CREA ELDOQUIN	Not covered for cosmetic purposes. **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 MC/DEL	ACTICIN CREA ELIMITE CREA EURAX LICE KILLING SHAM LICE TREATMENT CREME RINS LIQD NIX CREME RINSE LIQD PERMETHRIN LOTN	MC/DEL MC		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 MC/DEL	ACCUZYME OINT ACCUZYME SPRAY ETHEZYME	MC		REGRANEX GEL	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Regranex will be approved for diabetic patients in good control (hgba1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (Tcp 02 >30, ABI>0.7 or ASP> 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks.
TOPICAL - ASTRINGENTS / PROTECTANTS	MC MC MC	ALUMINUM CHLORIDE SOLN DRYSOL SOLN XERAC AC SOLN	MC MC MC MC		LOWILA BAR MOISTURIN DRY SKIN CREA PROSHIELD PLUS SKIN PROTE CREA SURGILUBE GEL	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTISEPTICS /	MC	HIBICLENS LIQD	MC		BETADINE OINT	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved,

DISINFECTANTS	MC/DEL		PHISOHEX LIQD	MC		FORMALYDE-10 AERS		unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage
	MC/DEL		POVIDONE-IODINE SOLN	MC		IODOSORB		
				MC		LAZERFORMALYDE SOLUTION SOLN		of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS EYE								
OP. - EYE	MC		AK-DILATE SOLN	MC		LENS PLUS REWETTING DROPS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EYE WASH SOLN	MC/DEL		MURO 128		
	MC		NAPHAZOLINE HCL SOLN	MC		NEO-SYNEPHRINE SOLN		
	MC		PHENYLEPHRINE HCL SOLN					
	MC		PONTOCAINE SOLN					
	MC/DEL		SODIUM CHLORIDE					
MISCELLANEOUS EAR								
EAR	MC/DEL		A/B OTIC SOLN	MC/DEL		ACETASOL HC SOLN	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ACETASOL SOLN	MC		AERO OTIC HC SOLN		
	MC/DEL		ACETIC ACID	MC		ANTIBIOTIC EAR SOLN		
	MC/DEL		ACETIC ACID/HYDROCORTISON	MC		ANTIBIOTIC EAR SUSP		
	MC/DEL		ALLERGEN SOLN	MC		AURALGAN SOLN		
	MC/DEL		ANTIPYRINE/BENZOCAINE SOLN	MC/DEL		CIPRO HC SUSP		
	MC/DEL		AURODEX SOLN	MC		COLY-MYCIN-S SUSP		
	MC		AUROGUARD SOLN	MC		CORTISPORIN SUSP		
	MC/DEL		AUROTO OTIC SOLN	MC/DEL		CORTISPORIN-TC SUSP		
	MC		CERUMENEX SOLN	MC/DEL		DEBROX SOLN		
	MC/DEL		CIPRODEX	MC		DOMEBORO SOLN		
	MC		CORTISPORIN SOLN	MC/DEL		PEDIOTIC SUSP		
	MC/DEL		CORTOMYCIN	MC		VOSOL-HC SOLN		
	MC		EAR DROPS SOLN	MC/DEL		ZOTANE HC SOLN		
	MC		EAR DROPS RX SOLN	MC		ZOTO-HC SOLN		
	MC/DEL		EAR WAX REMOVAL DROPS					
	MC		EAR-GESIC SOLN					
	MC		FLOXIN OTIC SOLN					
	MC/DEL		NEOMYCIN/POLYMYXIN/HC					
	MC/DEL		OTICAINE OTIC SOLN					
MOUTH ANTISEPTICS								
MOUTH ANTI-INFECTIVES	MC		NILSTAT SUSP	MC		MYCELEX TROC	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EAR-GESIC SOLN	MC		MYCOSTATIN LOZG		
	MC/DEL		NYSTATIN SUSP	MC				
MOUTH ANTISEPTICS	MC/DEL		CHLORHEXIDINE GLUCONATE	MC		APHTHASOL PSTE	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.
	MC/DEL		LIDOCAINE VISCOUS SOLN	MC		PERIDEX SOLN		
	MC		TRIAMCINOLONE IN ORABASE PSTE	MC		PERIOGARD SOLN		
	MC		TRIAMCINOLONE ORADENT PSTE	MC		TRIAMCINOLONE ACETONIDE PSTE		
				MC		XYLOCAINE VISCOUS SOLN		
DENTAL PRODUCTS								
DENTAL PRODUCTS	MC/DEL		ETHEDENT CREA	MC0MC		APF GEL GEL	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GEL-KAM CONC	MC/DEL		DENTAGEL GEL		
	MC/DEL		PHOS FLUR SOLN	MC/DEL		PHOS-FLUR GEL		
	MC/DEL		PREVIDENT	MC/DEL		SF 5000 PLUS CREA		
	MC/DEL		PREVIDENT SOLN	MC		THERA-FLUR-N GEL		
	MC/DEL		SF GEL					
	MC		STANNOUS FLUORIDE ORAL RI CONC					
ARTIFICIAL SALIVA/STIMULANTS								
ARTIFICIAL SALIVA/STIMULANTS	MC		EVOXAC CAPS	MC		RADIACARE SOLR	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		SALIVA SUBSTITUTE SOLN	MC		SALAGEN TABS		
MISCELLANEOUS ANORECTAL								
ANORECTAL - MISC.	MC/DEL		ANALPRAM-HC CREA	MC/DEL		ANUSOL-HC CREA	Use PA Form # 20420	
	MC/DEL		COLOCORT ENEM	MC/DEL		CORTIFOAM FOAM		
	MC		CORTENEMA ENEM	MC/DEL		PROCTOCREAM-HC CREA		
	MC		ELA-MAX 5 CREA	MC/DEL		PROCTOFOAM HC FOAM		
	MC/DEL		HYDROCORTISONE ENEM	MC/DEL		PROCTO-KIT CREA		
	MC/DEL		PROCTOZONE-HC CREA	MC/DEL		PROCTOSOL HC CREA		
T-CELL ACTIVATION INHIBITOR								
PSORIASIS BIOLOGICALS				MC	5	ENBREL	Use PA Form # 20910	Approved for severe chronic plaque psoriasis unresponsive to first line therapies. A trial of at least several potent topicals from the following categories: corticosteroids, coal tars, anthralin, calcipotriene and tazorotene, and at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin and phototherapy/UVA. High dose Enbrel will be approved for chronic severe psoriasis only after failure of all traditional therapies listed here and adequate trial of either Amevive or Raptiva.
				MC	8	AMEVIVE		
				MC	8	RAPTIVA		
ALTERNATIVE MEDICINES								
ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC		ARTHX DS CAPS	Use PA Form # 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
				MC/DEL		CO-ENZYME Q-10		
				MC		DEHYDROEPIANDOSTERONE		
				MC		DHEA TABS		
				MC		FLEXAGEN TABS		

				MC/DEL		GLUCOSAMINE/CHONDROITIN		
				MC		HM GINKGO BILOBA TABS		
				MC		MELATONIN TABS		
CHELATING AGENTS								
CHELATING AGENTS	MC/DEL		CUPRIMINE CAPS	MC		DEPEN TITRATABS TABS	Use PA Form # 20420	
ANTILEPROTIC								
ANTILEPROTIC				MC		THALOMID CAPS	Use PA Form # 20420	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
CANCER								
CANCER	MC		ALIMTA					
	MC/DEL		AVASTIN					
	MC		ERBITUX					
	MC/DEL		VIDAZA					
IMMUNOSUPPRESSANTS								
IMMUNOSUPPRESSANTS	MC/DEL		CELLCEPT	MC/DEL		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 drug and the preferred drug(s) exists.
	MC/DEL		CYCLOSPORINE MODIFIED	MC/DEL		NEORAL[1,2]	2. Established users will require a one time PA	
	MC/DEL		CYCLOSPORINE SOL. MODIFIED					
	MC		GENGRAF CAPS					
	MC/DEL		MYFORTIC					
	MC		PROGRAF CAPS				Use PA Form # 20420	
	MC/DEL		RAPAMUNE					
	MC/DEL		SANDIMMUNE					
PURINE ANALOG								
PURINE ANALOG	MC		AZASAN TABS	MC/DEL		IMURAN TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		AZATHIOPRINE TABS					
K REMOVING RESINS								
K REMOVING RESINS	MC/DEL		KAYEXALATE POWD				Use PA Form # 20420	
	MC		KIONEX POWD					
	MC/DEL		SODIUM POLYSTYRENE SULFON					
	MC/DEL		SPS SUSP					
	MC/DEL		SPS 30GM/120ML ENEMA SUSP					

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

NVULSANTS INDICATION CHART

	SEIZURES	POST HERPETIC NEURALGIA	DIABETIC PERIPHERAL NEUROPATHY	MONOTHERAPY BIPOLAR	ADJUNCTIVE BIPOLAR	MIGRAINE PROPHYLAXIS	RESTLESS LEG SYNDROME
GABITRIL	X			9	8		
KEPPRA	X			9	7		
LAMICTAL	X			4	4		
LYRICA	X	X(2nd line)	X(2nd line)				
NEURONTIN	X	X(2nd line)	X (2nd line)	9	9	X (2nd line)	X (2nd line)
TOPAMAX	X			9	6	X (2nd line)	
TRILEPTAL	X			5	5		
ZONEGRAN	X			9	9		

TI-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