

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS Required	PA	Comments	Criteria
* PLEASE NOTE: All cost effective generics applicable to DEL are considered PREFERRED Drugs. "BASIC" Covered Drugs are bolded with the Coverage Indicator of "MC / DEL".									
General Criteria for all PDL categories- For more information or help using the PDL, providers may call 1-888-445-0497; members should call 1-866-796-2463. To access PDL and PA materials via the internet: www.mainearepdl.org									
A: Preferred Drugs- Unless otherwise specified, preferred drugs are available without prior authorization. Step order may apply for preferred drugs in some drug categories as indicated on the PDL. (See item "D" below for explanation of step order.)									
B: Requests for Non-preferred Drugs- Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.									
C: Adequate Drug Trials- 1. The minimum trial period for each preferred and step order drug is two weeks, unless otherwise stated within specific PDL drug categories; trials with less than a two week duration will be reviewed on a case-by-case basis; 2. A trial will not be considered valid if preferred or non-preferred products were readily available (by override, individual purchase, samples, etc.); 3. Certain drug trials, such as with controlled substances, may require evidence that the preferred drugs were actually tried (example: with random pill counts and with random urine drug tests, using the methods of GC/MS with no lower threshold); 4. Adequate trials require documentation of attempts to titrate dose of preferred agents toward desired clinical response. 5. Adequate trials include prevention/treatment of common adverse effects associated with preferred agents (example: antinausea, antipruritics, etc.)									
D: Step Order- When numbers appear in the "step order" column, it means drugs in this category must be used in the order specified, with the lower numbers having preference over the higher numbers. Chart notes should be provided to confirm drug trials that do not appear in the member's MaineCare drug profile.									
E: 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 categories 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.mainearepdl.org .									
K: PA Exemptions for Prescribers- According to MaineCare Benefits Manual Chapter II (80.07-4), providers may receive a three (3) month exemption from prior authorization requirement for certain categories of drugs when they demonstrate high compliance with the Department's PDL. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption. If a provider loses his/ her exemption, members who previously were not required to obtain a PA while the prescriber was exempt will be required to do so, and criteria for approval of that medication will need to be met.									
L: Drug-Drug Interactions (DDI)- The DUR Committee has implemented new drug-drug interaction edits requiring prior authorization. Several drug-drug combinations and PDL drug categories are affected by new PA requirements. These will be indicated in the PDL with DDI notation. Please see the DDI document provided in the PDL.									
ASSORTED ANTIBIOTICS									
BETA-LACTAMS / CLAVULANATE COMBO'S	MC/DEL		AMOXICILLIN	MC/DEL		AMOXIL 500MG TABS		1. Amoxil 500mg tabs are non-preferred. All other Amoxil products are preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Ampicillin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non preferred PPI.
	MC/DEL		AMOXICILLIN/POTASSIUM CLA CHEW	MC/DEL		AUGMENTIN ES-600 SUSR		2. Principen 250 mg is available without PA.	
	MC/DEL		AMOXICILLIN/POTASSIUM CLA SUSR	MC/DEL		AUGMENTIN [®]		3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA	
	MC/DEL		AMOXICILLIN/POTASSIUM CLA TABS	MC		PRINCIPEN CAPS [®]		Use PA Form # 20420	
	MC/DEL		AMOXIL ¹	MC		PRINCIPEN SUSR			
	MC/DEL		AMPICILLIN						
	MC/DEL		AUGMENTIN XR TB12						
	MC		BEEPEN						
	MC		BICILLIN L-A SUSP						
	MC/DEL		DICLOXACILLIN SODIUM CAPS						
	MC		DYNAPEN SUSR						
	MC		GEOCILLIN TABS						
	MC		OXACILLIN SODIUM SOLR						
	MC/DEL		PENICILLIN V POTASSIUM						
	MC		TICAR SOLR						
	MC		TIMENTIN SOLR						
	MC		TRIMOX						
MC		UNASYN SOLR							
MC		VEETIDS							
MC/DEL		ZOSYN							
CEPHALOSPORINS	MC		CEDAX	MC		CECLOR [®]		1. Both brand and generic are clinically non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Vantin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non preferred PPI.
	MC/DEL		CEFADROXIL HEMIHYDRATE	MC/DEL		CEFACTOR ¹			
	MC/DEL		CEFAZOLIN SODIUM SOLR	MC/DEL		CEFADROXIL MONOHYDRATE TABS			
	MC/DEL		CEFTIN SUSP	MC/DEL		CEFTIN		Use PA Form # 20420	
	MC/DEL		CEFUROXIME AXETIL TABS	MC/DEL		DURICEF TABS			
	MC		CEFZIL	MC/DEL		FORTAZ SOLN			
	MC/DEL		CEPHALEXIN MONOHYDRATE	MC		KEFLEX CAPS			
	MC/DEL		DURICEF SUSR	MC		TAZICEF SOLR			
	MC/DEL		FORTAZ SOLR						
	MC		KEFZOL SOLR						
	MC		MAXIPIME SOLR						
	MC		OMNICEF						
	MC/DEL		ROCEPHIN						
MC/DEL		SUPRAX							
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		CLARITHROMYCIN SUSP			
	MC/DEL		CLARITHROMYCIN TABS	MC/DEL		DYNABAC DS-PAK TBEC			
	MC		E.E.S.	MC		ERYPED CHEW			
	MC		E-MYCIN TBEC	MC		PCE TBEC			

	MC MC MC MC MC/DEL MC/DEL MC/DEL	ERYPED 200 SUSR ERYPED 400 SUSR ERY-TAB TBEC ERYTHROCLIN STEARATE TABS ERYTHROMYCIN ZITHROMAX SUSP ZMAX	MC/DEL MC/DEL		ZITHROMAX TABS ZITHROMAX 1GM PAK		Use PA Form # 20420		
TETRACYCLINES	MC/DEL MC/DEL MC MC/DEL MC/DEL	DOXYCYCLINE HYCLATE MINOCYCLINE HCL CAPS SUMYCIN TETRACYCLINE HCL CAPS VIBRAMYCIN SYRP	MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL		DECLOMYCIN TABS DDRYX CPEP DOXYCYCLINE MONO CAPS DYNACIN CAPS MONODOX CAPS ORACA PERIOSTAT SOLODYN ER		Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
FLUOROQUINOLONES	MC MC MC MC MC/DEL MC	AVELOX SOLN AVELOX TABS AVELOX ABC PACK TABS CIPRO XR ¹ CIPROFLOXACIN PROQUIN XR	MC MC MC MC/DEL MC MC		CIPRO FLOXIN TABS LEVAQUIN NOROXIN TABS TEQUIN FACTIVE	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.	
AMINO GLYCOSIDES	MC MC/DEL MC MC/DEL	GENTAMICIN NEOMYCIN SULFATE TABS TOBI NEBU TOBRAMYCIN SULFATE SOLN						Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
ANTI-MYCObACTERIALS / ANTI-TUBERCULOSIS	MC/DEL MC/DEL MC/DEL MC/DEL	ETHAMBUTOL HCL TABS MYAMBUTOL TABS MYCOBUTIN CAPS RIFAMPIN	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.	
ANTIMALARIAL AGENTS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL	CHLOROQUINE PHOSPHATE TABS DARAPRIM TABS HYDROXYCHLOROQUINE TABS LARIAM TABS MALARONE TABS MEFLOQUINE HCL TABS QUINACRINE HCL POWD QUININE SULFATE	MC MC/DEL MC		ARALEN TABS PLAQUENIL TABS ISONARIF ¹		Use PA Form # 20420 1. Ingredients available as preferred without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
ANTHELMINTICS	MC/DEL MC MC/DEL MC/DEL	ALBENZA TABS BILTRICIDE TABS MEBENDAZOLE CHEW STROMECTOL 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.	
ANTIBIOTICS - MISC.	MC MC MC MC/DEL MC MC/DEL MC MC/DEL	AZACTAM SOLR COLISTIMETHATE SODIUM SOLR FUROXONE TABS METRONIDAZOLE ² PENTAMIDINE ISETHIONATE SOLR PRIMSOL SOLN TRIMETHOPRIM TABS VANCOCCIN HCL VANCOMYCIN HCL	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL		COLY-MYCIN-M SOLR FLAGYL CAPS FLAGYL TABS FLAGYL ER TBGR KETEK LORABID METRONIDAZOLE 375MG CAPS ² METRONIDAZOLE 750MG TABS ² NEBUPENT SOLR PROLOPRIM TABS TINDAMAX ¹ XIFAXAN	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	
CARBAPENEMS			MC MC MC/DEL		INVANZ SOLR MERREM SOLR PRIMAXIN		Use PA form #20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL MC/DEL MC/DEL MC	CLEOCIN SOLN CLEOCIN SUSR CLINDAMYCIN HCL 150CAPS DAPSONE TABS	MC/DEL MC/DEL MC/DEL MC/DEL		CLEOCIN CAPS CLINDAMYCIN HCL 300CAPS ¹ ZYVOX SUSR ZYVOX TABS	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.	
ANTI INFECTIVE COMBO'S - MISC.	MC/DEL MC/DEL MC/DEL MC/DEL	ERYTHROMYCIN/SULF SUSR SEPTRA/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA	MC MC		ALINIA* BACTRIM DS TABS	* 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.	
ANTI - FUNGALS									
ANTIFUNGALS - ASSORTED	MC MC/DEL MC	ANCOBON CAPS FLUCONAZOLE ¹ GRIFULVIN	MC/DEL MC MC	5 6 6	LAMISIL TABS ¹ SPORANOX SOLN ² SPORANOX PULSEPAK CAPS ³	1. QL--1/every 7-day period (150mg only). 2. Sporanox QL 300cc/month with PA. See quantity limit		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	

MC	GRISEOFULVIN ULTRAMICROSI TABS	MC	7	SPORANOX CAPS ³	table.	on the Antifungal PA form including the required proof of a non-cosmetic fungal infection.
MC	GRIS-PEG TABS	MC/DEL	8	ERAXIS INJ ⁶	3. Sporanox OL 30/month with PA. See quantity limit table. Non-preferred products must be used in specified step order. Continue to use Anti-Fungal PA form for non-preferred products.	DDI: Sporanox is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with Prandin, Prevacid, Protonix, Prilosec, or any currently non preferred PPI, due to a significant drug-drug interaction.
MC/DEL	KETOCONAZOLE TABS	MC/DEL	8	DIFLUCAN		
MC/DEL	NYSTATIN	MC	8	NIZORAL TABS		DDI: Fluconazole (except 150mg strength) will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl). Diflucan is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either glimepiride (Amaryl).
MC/DEL	VFEND TABS	MC/DEL	8	NOXAFIL ⁵	4. Quantity limit of one tablet daily.	DDI: Any Griseofulvin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non preferred PPI.
					5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy.	
					6. Eraxis will be approved if submitting with documentation that it was initiated during a hospitalization and this request is to finish the hospital course.	
					Please use PA form #20420 for Noxafil.	

ANTI - VIRALS

ANTIRETROVIRALS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL	AGENERASE CAPS APTIVUS ATRIPLA ¹ COMBIVIR TABS CRIXIVAN CAPS EMTRIVA EPIVIR / HBV EPZICOM FORTOVASE CAPS HIVID TABS INVIRASE CAPS KALETRA LEXIVA NORVIR PREZISTA ² RESCRIPTOR TABS RETROVIR REYATAZ SUSTIVA TRIZIVIR TABS TRUVADA VIDEX / EC VIRACEPT TABS VIRAMUNE TABS VIREAD TABS ZERIT ZIAGEN TABS	MC/DEL MC/DEL	DIDANOSINE FUZEON	Fuzeon use PA Form # 10620	Please refer to the criteria listed on the Fuzeon PA form.
					1. Quantity limit of one per day 2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista	DDI: Reyataz will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non preferred PPI .
CYTO-MEGALOVIRUS AGENTS	MC	VALCYTE TABS	MC MC/DEL	CYTOVENE CAPS GANCICLOVIR	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HERPES AGENTS	MC/DEL MC/DEL	ACYCLOVIR VALTRES TABS	MC/DEL MC/DEL	FAMVIR TABS ZOVIRAX	Must fail Acyclovir and Valtrex before non-preferred products. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
INFLUENZA AGENTS	MC/DEL MC MC/DEL MC/DEL	AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU ¹	MC/DEL MC	FLUMADINE TABS FLUMIST ²	1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member. 2. 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.

IMMUNE SERUMS

IMMUNE SERUMS		HYPERRHO INJ				
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HEPATITIS AGENTS

HEPATITIS C AGENTS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		PEGASYS KIT PEGASYS SOLN PEG-INTRON KIT REBETOL CAPS REBETRON KIT	MC/DEL MC	8 8	COPEGUS TABS RIBAVIRIN 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 (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HEPATITIS AGENTS - MISC.				MC		ACTIMMUNE	Use PA Form # 20420	Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.
HEPATITIS B ONLY	MC		HEPSERA TABS	MC		BARACLUDE		
RSV PROPHYLAXIS								
RSV PROPHYLAXIS				MC MC		RESPIGAM SYNAGIS	Use PA Form # 30120	Please see the criteria listed on the Synagis PA form.
MS TREATMENTS								
MULTIPLE SCLEROSIS AGENTS				MC MC/DEL MC MC/DEL	5 5 5 6	AVONEX KIT BETASERON SOLR REBIF SOLN COPAXONE	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.
ASSORTED NEUROLOGICS								
NEUROLOGICS - MISC.	MC MC/DEL MC		MESTINON ORAP TABS PROSTIGMIN TABS	MC MC/DEL		BOTOX MYOBLOC ¹	1. Myobloc approval will be limited to Cervical Dystonia. Use PA Form #10210	Failed/did not tolerate therapeutic trials for muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, Skelaxin, and tizanidine.
STEROIDS								
GLUCOCORTICOID/ MINERALOCORTICOID	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS DEPO-MEDROL SUSP DEXAMETHASONE ENTOCORT EC CP24 FLUDROCORTISONE ACETATE TABS HYDROCORTISONE KENALOG METHYLPREDNISOLONE TABS ORAPRED SOLN PREDNISOLONE PREDNISONE SOLU-CORTEF SOLR SOLU-MEDROL SOLR	MC MC MC/DEL MC/DEL MC MC MC MC MC MC MC/DEL MC/DEL MC/DEL		CORTEF 10 and 20 TABS DECADRON TABS FLORINEF TABS MEDROL TABS MEDROL DOSEPAK TABS PEDIAPRED LIQD PREDNISONE INTENSOL CONC PRELONE SYRP STERAPRED TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HORMONE REPLACEMENT THERAPIES								
ANDROGENS / ANABOLICS	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC		ANDRODERM PT24 ANDROID CAPS DANAZOL CAPS DEPO-TESTOSTERONE OIL FLUOXYMESTERONE TABS TESTODERM TESTOSTERONE PROPIONATE TESTRED CAPS WINSTROL TABS	MC MC/DEL MC MC MC/DEL MC/DEL		ANDRO LA 200 OIL ANDROGEL PACK DELATESTYL OIL HALOTESTIN TABS METHITEST TABS OXANDRIN TABS ¹	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)
ESTROGENS - PATCHES	MC/DEL MC/DEL		ESTRADERM PTTW VIVELLE PTTW ¹	MC/DEL MC/DEL MC/DEL MC MC/DEL	5 8 8 8 8	ESTRADIOL PTWK ALORA PTTW CLIMARA PTWK ESCLIM PTTW VIVELLE-DOT PTTW	1. Both preferred drugs must be tried. 2. Step order drugs must be used in specified step order. Use PA Form # 20420	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
ESTROGENS - TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CENESTIN TABS DELESTROGEN OIL ESTRADIOL ESTROPIMATE TABS MENEST TABS PREMARIN TABS	MC/DEL MC/DEL MC MC/DEL MC		ENJUVA ESTRACE TABS ESTRATAB TABS OGEN TABS ORTHO-EST TABS	Must fail preferred products before non-preferred products. Use PA Form # 20420	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ESTROGEN COMBO'S	MC/DEL MC/DEL		PREMPHASE TABS PREMPRO TABS	MC/DEL MC/DEL		ACTIVELLA TABS COMBIPATCH PTTW FEMHRT 1/5 TABS ORTHO-PREFEST TABS SYNTEST H.S. TABS	Must fail Premphase and Prempro products before non preferred products. Use PA Form # 20420	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PROGESTINS	MC/DEL MC/DEL MC		MEDROXYPROGESTERONE ACETA ² NORETHINDRONE ACETATE TABS ¹ PROGESTERONE POWD	MC/DEL MC MC/DEL MC/DEL		AYGESTIN TABS CYCRIN TABS PROMETRIUM 100MG CAPS ¹ PROMETRIUM 200MG ¹	1. PA approvals will require two 100 mg caps instead of one 200mg. 2. Must fail Medroxyprogesterone and Norethidrone products before	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		TRIPHASIL 28 TABS	MC MC/DEL MC/DEL		ORTHO TRI-CYCLEN LO TABS TRI-NORINYL 28 TABS TRIVORA-28 TABS	Form # 20420	
DIABETES THERAPIES								
DIABETIC - INSULIN	MC MC/DEL MC/DEL MC/DEL MC MC		ILETIN LEVEMIR (effective 4.1.2006) NOVOLIN NOVOLOG RELION VELOSULIN BR SOLN	MC MC MC/DEL MC		HUMALOG HUMULIN LANTUS SOLN (effective 5.1.2006)* APIDRA	Established users grandfathered until 6.30.2006 Use PA Form # 20420	Approved if patient has had an allergic reaction to preferred products or for pediatric patients requiring insulin doses with diluent.
DIABETIC - PENFILLS				MC/DEL MC/DEL MC/DEL MC MC MC MC	5 5 5 8 8 8 8 8	LEVEMIR FLEXPEN (effective 4.1.2006) NOVOLIN PENFILL NOVOLOG MIX PENFILL NOVOLOG PENFILL SOLN HUMALOG MIX 75/25 PEN SUSP APRIDRA OPTICLIK PEN (effective 5.1.2006) HUMALOG PEN SOLN HUMULIN PEN LANTUS OPTICLIK PEN (effective 5.1.2006)	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.
DIABETIC - INSULIN INHALED	MC/DEL		EXUBERA ¹				1. Preferred if following conditions are met: A) On insulin or B) Have tried 2 oral hypoglycemics and C) Not using nicotine and no nicotine products are seen in current drug profile. and D) No asthma/COPD medications in profile and E) Member is >18. Use PA Form # 20420	
DIABETIC - DPP-4 ENZYME INHIBITOR				MC/DEL	8	JANUVIA ¹	1. Dosing limits apply. Please refer to Dose consolidation list.	Preferred diabetic therapies must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Failure (and/or contraindications to) of all preferred diabetic therapies includes having reached the maximum dose of sulfonylureas, metformin (at least 2000mg), and a thiazolidinedione (TZD): Actos, Avandia, Avandaryl, Actosplus Met and Avandamet) for a minimum of three months prior to initiation of Januvia. Insulin must not be used concurrently, and HgbA1c level within optimal range must be provided. If optimal hemoglobin A1c target is not within reported range of efficacy of Januvia, then would need to justify why preferred insulins and injectables are not more suitable, such as insulins, levemir, exubera, byetta.
DIABETIC - OTHER				MC		SYMLIN	Use PA Form # 30150	Please see the criteria listed in the Symlin PA form.
INCRETIN MIMETIC	MC		BYETTA ¹				1. Will not require PA if at least 18 years of age and if two of the following three are seen in the members drug profile: sulfonylurea, metformin and Actos/ Avandia or if a combo product with Actos/ Avandia is seen. If insulin is in members current drug profile (within the past 30 days) PA will be required. If the member is under 18 years of age, PA will be required. Dosing limits for Byetta will still apply. There are 60 doses per each pen and each pen is a 30 day supply, so one prefilled pen is allowed per month. Please refer to PDL Dosage Consolidation List. Use PA Form # 10230	
DIABETIC - ORAL SULFONYLUREAS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CHLORPROPAMIDE TABS GLIMEPIRIDE GLIPIZIDE TABS GLIPIZIDE ER TABS GLYBURIDE TABS GLYBURIDE MICRONIZED TABS TOLAZAMIDE TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		AMARYL TABS DIABETA TABS GLUCOTROL TABS GLUCOTROL XL TBCR GLYNASE TABS MICRONASE TABS	Use PA Form # 20420	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: All sulfonylureas (except glyburide) will now be non-preferred and require prior authorization if it is currently being used with either ranitidine or cimetidine. DDI: Glimepiride will now be non-preferred and require prior authorization if it is currently being used with either fluconazole (except 150mg strength) or fluvoxamine. Amaryl is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either fluconazole or fluvoxamine.

	MC/DEL		TOLBUTAMIDE TABS							
DIABETIC - ORAL BIGUANIDES	MC/DEL MC/DEL		METFORMIN HCL TABS METFORMIN ER 500MG	MC MC MC/DEL MC/DEL		GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET METFORMIN ER 750MG	Mefformin ER 750mg tabs are non preferred. Mefformin 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.		
DIABETIC - THIAZOL / BIGUANIDE COMBO	MC/DEL MC/DEL MC/DEL		ACTOPLUS MET AVANDARYL AVANDAMET TABS					DDI: Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.		
DIABETIC - / THIAZOL	MC/DEL MC/DEL MC/DEL		AVANDIA TABS ¹ ACTOS 15MG TABS ¹ ACTOS 45MG TABS ¹	MC/DEL		ACTOS 30MG TABS ²	1. Actos and Avandia 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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.		
DIABETIC - ALPHAGLUCOSIDASE	MC/DEL		GLYSET TABS	MC		PRECOSE TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.		
DIABETIC - SULFONYLUREA / BIGUANIDE	MC/DEL		GLYBURIDE/METFORMIN	MC MC/DEL MC		GLUCOVANCE TABS DUETACT METAGLIP TABS	Use individual ingredients. Use PA Form # 20420	Approved for patients failing to achieve good diabetic control with maximal doses of individual components.		
DIABETIC - MEGLITINIDES	MC/DEL		STARLIX TABS	MC/DEL		PRANDIN TABS	Use PA Form # 20420	Preferred drugs from other diabetic sub-categories must be tried and failed due to lack of inadequate diabetic control or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Prandin is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with both Sporanox and gemfibrozil, due to a significant drug-drug interaction.		
THYROID										
THYROID HORMONES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ARMOUR THYROID TABS CYTOMEL TABS LEVOTHROID TABS LEVOTHYROXINE SODIUM TABS LEVOXYL TABS THYROID TABS THYROLAR UNITHROID TABS	MC MC		LEVOTHYROXINE SODIUM SOLR SYNTHROID TABS 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		BONIVA TABS ¹ FOSAMAX SOLN ² FOSAMAX TABS ² FOSAMAX PLUS D ² MIACALCIN SOLN ²	MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL		ACTONEL TABS BONIVA INJECTION KIT ARELIA SOLR DIDRONEL TABS EVISTA TABS ¹ FORTEO FORTICAL	1. Approval only requires failure of Fosamax or Boniva. 2. Quantity Limits Apply Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 MC MC/DEL MC	5 5 5 8 8 8 8 8	GENOTROPIN NUTROPIN TEV-TROPIN HUMATROPE SOLR INCRELEX IPLEX NORDITROPIN CARTRIDGE SOLN SAIZEN SOLR	Products must be used in specified step order. All step 5's must be tried prior to moving to step 8's. 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	5 6 6	DDAVP TABS DDAVP SOLN DESMOPRESSIN SPRAY	Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to	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.		

				MC/DEL MC/DEL	8 8	DESMOPRESSIN ACETATE SOLN STIMATE SOLN*	periodically attempt stopping DDAVP. Use Pa Form # 20420	
ANTISPASMODICS	MC/DEL MC		OXYBUTYMIN 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/DEL MC MC		DETROL LA CP24 ENABLEX ¹ SANCTURA VESICARE ¹	MC MC/DEL		DITROPAN XL TBCR OXYTROL	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. Vesicare 5mg and Enablex 7.5mg maximum doses if given with drugs known to be significant CYP3A4 inhibitors. (Ketoconazole, Sporanox, Erythromycin, Biaxin, Nefazodone, Nelfinavir, and Ritonavir)
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 Dinitrate/ Mono-Nitrates	MC/DEL MC/DEL		ISOSORBIDE MONONITRATE TABS ISOSORBIDE MONONITRATE ER	MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		DILATRATE SR CPCR ISORDIL TABS ISORDIL TITRADOSE TABS ISOSORBIDE DINITRATE SUBL ISOSORBIDE DINITRATE TABS ISOSORBIDE DINITRATE CR TBCR ISOSORBIDE DINITRATE ER TBCR ISOSORBIDE DINITRATE TD TBCR IMDUR TB24 ISMO TABS MONOKET TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
NITRO - OINTMENT/CAP/CR	MC MC/DEL MC MC		NITROBID OINT NITROGLYCERIN CPCR NITROL OINT NITRO-TIME CPCR					
NITRO - PATCHES	MC/DEL MC/DEL MC/DEL MC/DEL	1 1 1 3	NITROGLYCERIN PT24 NITREK PT24 NITRO-DUR PT 24 0.8MG MINITRAN PT24	MC MC/DEL		NITRODISC PT24 NITRO-DUR PT24	At least 2 step 1's and step 3 of the preferred products must be used in specified order or PA will be required. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
NITRO - SUBLINGUAL/ SPRAY	MC MC/DEL MC/DEL		NITROLINGUAL AERS NITROSTAT SUBL NITROTAB SUBL	MC MC/DEL		NITROLINGUAL SOLN NITROQUICK SUBL	Use Pa Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - NON SELECTIVE	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		COREG TABS INDERAL LA CPCR LEVATOL TABS NADOLOL TABS PINDOLOL TABS PROPRANOLOL HCL SOLN ¹ PROPRANOLOL HCL TABS ¹ SOTALOL HCL TABS TIMOLOL MALEATE TABS	MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC		BETAPACE TABS BETAPACE AF TABS COREG CR CORGARD TABS INDERAL TABS INNOPRAN XL PROPRANOLOL LA CAPS RANEXA	1. Recommend using BID since its effects do not last 24 hours. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL MC/DEL MC MC/DEL MC/DEL		ACEBUTOLOL HCL CAPS ATENOLOL TABS ¹ BETAXOLOL HCL TABS BISOPROLOL FUMARATE TABS METOPROLOL TARTRATE TABS ¹ TOPROL XL TB24	MC MC/DEL MC MC/DEL MC/DEL		KERLONE TABS LOPRESSOR TABS SECTRAL CAPS TENORMIN TABS ZEBETA TABS	1. Recommend using Atenolo (and metoprolol) BID since its effects do not last 24 hours. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - ALPHA / BETA	MC/DEL		LABETALOL HCL TABS	MC		TRANDATE TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CALCIUM CHANNEL BLOCKERS--Amlodipines, Bepiridil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils	MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC	1 1 1 1 1 1 4 4	NORVASC TABS CARDIZEM LA TB24 DILTIA XT CP24 DILTIAZEM HCL ER CP24 DILTIAZEM HCL XR CP24 DILTIAZEM CD 300MG CP24 DILTIAZEM CD 360MG CP24 CARTIA XT CP24 DILTIAZEM CD CP24	MC MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL	5 6 7 8 8 8 8	DILACOR XR CP24 TAZTIA TIAZAC CP24 CARDIZEM TABS CARDIZEM CD CP24 CARDIZEM SR CP12 DILTIAZEM HCL TABS DILTIAZEM HCL ER CP12	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/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		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	Use PA Form # 20420		1. Established users will be grandfathered	
				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		PROCARDIA XL TBCR	Use PA Form # 20420			
	MC/DEL		NIFEDIPINE ER TBCR	MC/DEL						
	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 pharmacy will use a preferred long acting generic that does not require PA. Use PA Form # 20420		Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
	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				
				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			DDI: Amlodarone will now be non-preferred and require prior authorization if it is currently being used in combination with either Lovastatin (doses greater than 40mg/day) or Lipitor (doses greater than 20mg/day).	
	MC		QUINAGLUTE	MC/DEL		TIKOSYN ¹				
	MC/DEL		QUINIDINE GLUCONATE							
	MC/DEL		QUINIDINE SULFATE							
	MC		RYTHMOL							
	MC/DEL		TAMBOCOR							
ACE INHIBITORS	MC/DEL		BENAZEPRIL HCL	MC	5	MAVIK TABS	Non-preferred products must be used in specified order.		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception.	
	MC/DEL		CAPTAPRIL TABS	MC/DEL	5	ACCUPRIL TABS				
	MC/DEL		ENALAPRIL MALEATE TABS	MC/DEL	8	ACEON TABS				
	MC/DEL		FOSINOPRIL SODIUM	MC/DEL	8	ALTACE CAPS	Use PA Form # 20420			
	MC/DEL		LISINAPRIL TABS	MC	8	CAPOTEN TABS				
				MC/DEL	8	LOTENSIN TABS				
				MC/DEL	8	MOEXIPRIL				
				MC	8	MONOPRIL HCT TABS				
				MC/DEL	8	PRINIVIL TABS				
				MC/DEL	8	UNIVASC				
				MC	8	VASOTEC TABS				
				MC/DEL	8	ZESTRIL TABS				
ANGIOTENSIN RECEPTOR BLOCKER	MC		AVAPRO	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		TEVETEN TABS				
	MC/DEL		COZAAR TABS							
	MC/DEL		DIOVAN							
	MC/DEL		MICARDIS 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		LEXCEL 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		CAPTAPRIL/HYDROCHLOROTHIA	MC		CAPZIDE TABS				
	MC/DEL		ENALAPRIL MALEATE/HCTZ TABS	MC/DEL		LOTENSIN HCT TABS				
	MC/DEL		LISINAPRIL-HCTZ TABS	MC		MONOPRIL HCT TABS				
	MC/DEL		UNIRETIC TABS	MC/DEL		MONOPRIL HCT TABS				
						PRINZIDE TABS				

			MC MC/DEL	VASERETIC TABS ZESTORETIC TABS		
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL MC/DEL MC/DEL		MC MC/DEL MC/DEL MC MC MC/DEL	ATENOLOL/CHLORTHALIDONE BISOPROLOL FUMARATE/HCTZ PROPRANOLOL/HCTZ	MC/DEL MC/DEL MC/DEL MC MC MC/DEL	CORZIDE TABS INDERIDE 40/25 TABS LOPRESSOR HCT TABS TENORETIC TIMOLIDE 10/25 TABS ZIAC TABS
ARB'S AND DIURETICS	MC MC/DEL MC/DEL MC/DEL MC/DEL		MC MC/DEL MC	AVALIDE TABS BENICAR HCT DIOVAN HCT TABS HYZAAR TABS MICARDIS HCT TABS	MC/DEL MC	ATACAND HCT TABS TEVETEN HCT TABS
DIURETICS	MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC	ACETAZOLAMIDE TABS AMILORIDE HCL BUMETANIDE CHLOROTHIAZIDE TABS CHLORTHALIDONE TABS EDECIN TABS FUROSEMIDE HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS METHYCLOTHIAZIDE TABS SPIRONOLACTONE 25MG TABS SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ ZAROXOLYN TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC	ALDACTAZIDE TABS ALDACTONE TABS BUMEX TABS DEMADEX TABS DIAMOX DIURIL DYAZIDE CAPS ENDURON TABS INSPIRA LASIX TABS LOZOL TABS MAXZIDE MICROZIDE CAPS MIDAMOR TABS MODURETIC 5-50 TABS NAQUA TABS NATURETIN TABS SPIRONOLACTONE 50MG ¹
CCB / LIPID	MC/DEL		MC/DEL	CADUET		
LIPID DRUGS						
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL MC/DEL		MC/DEL MC MC/DEL	CHOLESTYRAMINE COLESTID	MC/DEL MC MC/DEL	PREVALITE QUESTRAN WELCHOL TABS
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL MC MC/DEL MC		MC MC MC MC/DEL	GEMFIBROZIL TABS TRIGLIDE NIASPAN TRICOR	MC MC MC MC/DEL	ANTARA LOPID LOFIBRA FENOFIBRATE
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS	MC/DEL MC/DEL MC/DEL MC		MC/DEL MC/DEL MC/DEL MC	CRESTOR LIPITOR SIMVASTATIN ¹³ VYTORN	MC/DEL	ZOCOR ²
CHOLESTEROL - HGM COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC	ADVICOR TBCR LESOL CAPS LESOL XL TB 24 LOVASTATIN TABS ² PRAVASTATIN ² ZETIA TABS ¹	MC/DEL MC/DEL MC MC/DEL	ALTOPREV TB 24 MEVACOR TABS PRAVACHOL TABS PRAVIGARD
PULMONARY ANTI-HYPERTENSIVES						
PULMONARY ANTI-HYPERTENSIVES	MC/DEL MC		MC/DEL MC	REVATIO ¹ VENTAVIS ²	MC/DEL MC	FLOLAN TRACLEER
IMPOTENCE AGENTS						
IMPOTENCE AGENTS						9 CAVERJECT 9 CIALIS 9 EDEX 9 LEVITRA 9 MUSE 9 VIAGRA

ANTI-EMETOGENICS

ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC	MC/DEL MC/DEL MC/DEL MC/DEL MC	MECLIZINE HCL TABS PHENERGAN SUPP PHENERGAN FORTIS SYRP PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72	MC MC/DEL MC/DEL MC/DEL MC	ANTIVERT TABS PHENERGAN SOLN PHENERGAN TABS PROMETHEGAN SUPP TORECAN TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC MC/DEL MC/DEL MC/DEL MC/DEL	EMEND MARINOL CAPS ZOFRAN SOLN* ZOFRAN TABS* ZOFRAN ODT TBDP*	MC MC MC MC/DEL MC	ALOXI ANZEMET TABS CESAMET ¹ KYTRIL ONDANSETRON	*See quantity limit table. 1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred anti-emetics, including 5-HT3 class (Zofran, Emend) and Marinol. 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.

NON-SEDATING ANTIHISTAMINES / DECONGESTANTS

ANTIHISTIMINES - NON- SEDATING	MC MC MC MC/DEL	ALAVERT TABS ¹ CLARITIN ALLERGY (OTC) ¹ CLARITIN SYRP (OTC) ² TAVIST ND (OTC) ¹	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	5 CLARINEX TABS ² 5 CLARINEX SYR ² 5 ZYRTEC ³ 5 ZYRTEC SYR ³ 8 ALLEGRA 8 CLARITIN ² 9 FEXOFENADINE	1. Preferred drugs are OTC loratadines. 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. 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.
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ALLERGY / ASTHMA THERAPIES

ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC/DEL MC MC/DEL	ATROVENT AERS ATROVENT HFA SPIRIVA ^{1,2}			Use PA Form # 20420 1. Quantity limit of 1 inhalation daily (1 capsule for inhalation daily) Spiriva will require PA if Combivent or Atrovent inhaler/nebulizer solution is in member's current drug profile. 2. We ask physicians to write "asthma" on the prescription whenever Spiriva is primarily being used for that condition.	
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER	MC/DEL	IPRATROPIUM BROMIDE SOLN	MC	ATROVENT SOLN	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS	MC/DEL MC/DEL MC/DEL	CROMOLYN SODIUM NEBU INTAL AERS TILADE AERS	MC/DEL	XOLAIR ¹	1. Need max inhaled steroids and written by pulmonary or allergy 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/DEL MC/DEL MC	1 FLONASE SUSP ¹ 1 NASACORT AQ AERS ² 1 NASONEX SUSP ² 4 BECONASE AQ INHA 4 NASAREL SOLN	MC/DEL MC MC MC/DEL MC MC	FLUNISOLIDE SOLN NASACORT AERS RHINOCORT AERO RHINOCORT AQUA SUSP TRI-NASAL SOLN VANCENASE POCKETHALER AERS	Use PA Form # 20420 1. All step 1 drugs must be tried	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 non-sedating antihistamines and steroid nasal sprays. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - BETA - ADRENERGICS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ALBUTEROL NEB MAXAIR METAPROTERENOL SEREVENT TERBUTALINE SULFATE TABS XOPENEX HFA ³	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ACCUNE ¹ NEBU ALBUTEROL AER ALBUTEROL HFA ALUPENT AERP BRETHINE FORADIL AEROLIZER CAPS PROVENTIL PROVENTIL HFA AERS	1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12 cc/day. 3. Dosing limits apply, please	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

			MC/DEL MC/DEL MC MC MC/DEL	VENTOLIN AERS VENTOLIN HFA AERS VOLMAX TBCR VOSPIRE ER TB12 XOPENEX NEBU ²	see dosage consolidation list. Use PA Form # 20420		
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC/DEL			ADVAIR DISKUS/HFA		We ask physicians to write "asthma" on the prescription whenever Advair is primarily being used for that condition.	
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL		MC/DEL	COMBIVENT AERO ²	DUONEB SOLN ¹	1. Please use preferred individual ingredients Albuterol and Ipratropium. 2. We ask physicians to write "asthma" on the prescription whenever Combivent is primarily being used for that condition. Use PA Form # 20420	
ANTIASTHMATIC - XANTHINES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		MC MC MC MC/DEL MC MC/DEL MC	AMINOPHYLLINE TABS THEOCHRON TB12 THEOLAIR-SR TB12 THEOPHYLLINE ELIX THEOPHYLLINE SOLN THEOPHYLLINE ER CP12 THEOPHYLLINE ER TB12 UNIPHYL TBCR	QUIBRON CAPS QUIBRON-T TABS QUIBRON-T/SR TB12 THEO-24 CP24 THEOLAIR TABS THEOPHYLLINE CR TB12 T-PHYL TB12	Use PA Form 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		MC/DEL MC/DEL MC	AEROBID AERS ASMANEX AZMACORT AERS BECLOVENT AERS FLOVENT HFA PULMICORT SUSP ¹ QVAR AERS VANCERIL AERS	AEROBID-M AERS PULMICORT TURBUHALER AEPB ² VANCERIL DOUBLE STRENGTH AERS	1. No PA for Pulmicort susp under 8 years old 2. No PA for Pulmicort turbahaler if under 14 yr. Use PA Form # 20420	
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		MC/DEL	SINGULAIR ¹	ACCOLATE TABS	1. We ask physicians to write "asthma" on the prescription whenever Singulair is primarily being used for that condition. Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR			MC MC		PROLASTIN SUSR ZEMAIRA	Use PA Form # 20420 Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.	
ANTIASTHMATIC - HYDROLYTIC ENZYMES			MC/DEL		PULMOZYME SOLN	Use PA Form # 20420 Will be approved for cystic fibrosis patients.	
ANTIASTHMATIC - MUCOLYTICS	MC/DEL		MC	ACETYLCYSTEINE ¹	MUCOMYST	1. Acetylcysteine is covered with diagnosis of CF Use PA Form # 20420	
COUGH/COLD							
COUGH/COLD	MC/DEL MC MC			PSEUDOEPHEDRINE ROBITUSSIN DM SYRP ROBITUSSIN SUGAR FREE SYRP	All others are a non-covered service (this includes antihistamines-decongestive combinations).	All of cough cold preparations are not covered except these preferred products.	All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy.
DIGESTIVE AIDS / ASSORTED GI							
Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.							
GI - ANTIPERISTALTIC AGENTS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC		MC/DEL MC/DEL MC MC/DEL MC	DIPHENOXYLATE DIPHENOXYLATE/ATROPINE IMODIUM A-D TABS LOPERAMIDE HCL CAPS LOPERAMIDE HCL LIOD OPIUM TINCTURE TINC PAREGORIC TINC	ANTI-DIARRHEAL TABS LOFENE TABS LONOX TABS MOTOFEN TABS SB ANTI-DIARRHEA TABS	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.	
GI - ANTI-DIARRHEAL/ ANTACID - MISC.	MC/DEL MC/DEL MC/DEL MC/DEL		MC/DEL MC MC MC	ALU-CAP CAPS ANTACID CHEW ATROPINE SULFATE SOLN BENTYL SYRP	ANTACID EXTRA STRENGTH CHEW B & O 15-A SUPPRETTE SUPP B & O 16-A SUPPRETTE SUPP BELLADONNA ALKALOIDS & OP	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.	

	MC/DEL	BISMATROL	MC/DEL	BENTYL TABS		
	MC/DEL	CALCIUM ANTACID	MC	CHILDRENS MYLANTA CHEW		
	MC/DEL	CALCIUM CARBONATE	MC/DEL	GLYCOPYRROLATE INJ		
	MC/DEL	CAL-GEST ANTACID CHEW	MC/DEL	LEVIBID TB12		
	MC/DEL	CHEWABLE ANTACID CHEW	MC	LEVSIN ELIX		
	MC/DEL	DICYCLOMINE HCL	MC/DEL	LEVSIN TABS		
	MC	GAVISCON SUSP	MC/DEL	LEVSIN/SL SUBL		
	MC/DEL	GLYCOPYRROLATE TABS	MC/DEL	NULEV TBDP		
	MC	HAPONAL TABS	MC	ROBINUL INJ		
	MC/DEL	HYOSCYAMINE SULFATE	MC	URO-MAG CAPS		
	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. DDI: Ranitidine and cimetidine will now be non-preferred and require prior authorization if it is currently being used with any sulfonylurea (except for glyburide).
	MC/DEL	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	OTC PRILOSEC	MC	6 OMEPRAZOLE CPDR	**Prevacid Solutabs available without PA for children less than 9 years old. 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. DDI: Prevacid, Protonix, and Prilosec will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Ampicillin, B-12, Fe salts, Griseofulvin, Sporanox, Ketoconazole, Reyataz, or Vantin. DDI: All non-preferred PPIs require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with ampicillin, B-12, Fe salts, griseofulvin, itraconazole, ketoconazole, Reyataz or Vantin due to a significant drug-drug interaction.
	MC	PREVACID CPDR	MC	7 ACIPHEX TBEC		
	MC	PREVACID ORAL SUSP	MC	8 PREVACID SOLUTABS**		
	MC/DEL	PROTONIX	MC/DEL	8 NEXIUM CPDR		
			MC/DEL	8 PRILOSEC CPDR		
			MC/DEL	8 PROTONIX INJ		
			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	5 VIOKASE		
			MC/DEL	7 LIPRAM		
			MC	7 PANCREASE		
			MC/DEL	7 PANCRELIPASE		
			MC/DEL	7 PANGESTYME	Use PA Form # 20420	
			MC	7 PANOKASE TABS		
			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		
GI - ANTI - FLATULENTS / GI STIMULANTS	MC	CALLULOSE SYRP	MC/DEL	AMITIZA ¹	Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC/DEL	CONSTULOSE SYRP	MC	CEPHULAC SYRP		
	MC/DEL	ENULOSE SYRP	MC	GAS-X CHEW		
	MC	GASTROCROM CONC	MC/DEL	INFANTS GAS RELIEF SUSP		
	MC/DEL	GENERLAC SYRP	MC/DEL	REGLAN TABS	Use PA Form # 20420	
	MC/DEL	LACTULOSE SYRP			1. Prior failed trials of multiple other preferred GI agents	
	MC/DEL	METOCLOPRAMIDE HCL				

	MC MC/DEL		UROCI-K UROID #2 TABS					
PHOSPHATE BINDERS								
PHOSPHATE BINDERS	MC MC/DEL MC/DEL		PHOSLO ³ MEGNEBIND - 400 ³ FOSRENOL ³	MC/DEL		RENAGEL ^{1,2}	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. 3. Requires diag to be preferred 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).
INTRA-VAGINALS								
VAGINAL - ANTIBACTERIALS	MC/DEL MC/DEL MC/DEL	1 1 3	CLEOCIN CREA METROGEL VAGINAL GEL CLEOCIN SUPP	MC/DEL		VANZAZOLE	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 due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ANTI FUNGALS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC MC MC/DEL MC MC		CLOTTRIMAZOLE CREA GYNE-LOTTRIMIN CREA MICONAZOLE CREA MICONAZOLE 3 COMBO PACK KIT ¹ MICONAZOLE 7 CREA MICONAZOLE NITRATE CREA MONISTAT 1 OINT MONISTAT 3 CREA MONISTAT 7 NYSTATIN TABS TERCONAZOLE 0.4MG VAGITROL V-R MICONAZOLE-7 CREA	MC MC MC MC/DEL MC MC MC MC MC/DEL		AVC CREAM CLOTTRIMAZOLE 3 DAY CREA GYNAZOLE-1 CREA GYNE-LOTTRIMIN 3 TABS MICONAZOLE 3 SUPP MONISTAT 3 SUPP TERAZOL 3 CREA TERAZOL 3 SUPP TERAZOL 7 CREA TERCONAZOLE 0.8MG	1. Quantity limit: 1/script/2 weeks Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - CONTRACEPTIVES	MC		GYNOL II EXTRA STRENGTH GEL	MC		DELLEN FOAM	Use PA Form # 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ESTROGENS	MC/DEL MC/DEL		ESTRING RING PREMARIN CREA	MC/DEL MC/DEL		ESTRACE CREA VAGIFEM TABS	Must fail all preferred products before non-preferred. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - OTHER	MC/DEL MC MC		ACID JELLY GEL ACJ-JEL GEL CERVICAL AMINO ACID CREA	MC		AMINO ACID CERVICAL CREA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BPH								
BPH	MC/DEL MC/DEL MC/DEL MC/DEL		AVODART DOXAZOSIN MESYLATE TABS PROSCAR TABS TERAZOSIN HCL CAPS	MC/DEL MC/DEL MC/DEL MC MC/DEL	5 8 8 8 8	FLOMAX CP24 CARDURA TABS FINASTERIDE HYTRIN CAPS UROXATRAL	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.
ANXIOLYTICS								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ALPRAZOLAM TABS CHLORDIAZEPOXIDE HCL CAPS CLORAZEPATE DIPOTASSIUM TABS DIAZEPAM LORAZEPAM OXAZEPAM CAPS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ATIVAN NIRAVAM SERAX TRANXENE XANAX 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.
ANXIOLYTICS - LONG ACTING	MC/DEL		XANAX XR ¹	MC/DEL		ALPRAZOLAM ER	1. Xanax XR will be available if the long acting benzo clonazepam fails. Use PA Form # 20420	
ANXIOLYTICS - MISC.	MC/DEL MC MC MC/DEL		BUSPIRONE HCL TABS HYDROXYZINE HCL SOLN HYDROXYZINE HCL SYRP HYDROXYZINE PAMOATE CAPS	MC MC MC MC/DEL MC MC/DEL		ATARAX TABS BUSPAR TABS DROPERIDOL SOLN HYDROXYZINE HCL TABS HYDROXYZINE PAM 100MG CAPS INAPSINE SOLN MEPROBAMATE 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	VISTARIL			
ANTI-DEPRESSANTS						
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL MC/DEL		NARDIL TABS PARNATE TABS			
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL				MC/DEL	EMSAM ¹ 1. Dosing limits apply, please refer to Dose consolidation list. Use PA Form # 20420	
ANTIDEPRESSANTS - SELECTED SSRI's	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL		BUPROPION HCL TABS BUPROPION SR CITALOPRAM ⁶ FLUOXETINE HCL CAPS FLUOXETINE HCL LIQD FLUOXETINE HCL TABS FLUVOXAMINE MALEATE TABS LEXAPRO TABS ⁵ MIRTAZAPINE PAROXETINE ³ PAXIL CR ³ SERTRALINE ² SERZONE TABS TRAZODONE HCL TABS WELLBUTRIN XL	MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	5 6 6 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 9	CYMBALTA ⁴ EFFEXOR TABS EFFEXOR XR CP24 3 CELEXA DESYREL TABS FLUOXETINE 40 mg ¹ LUVOX TABS MAPROLINE HCL TABS MIRTAZAPINE ODT PAM ¹ PROZAC PROZAC CAPS PROZAC WEEKLY CPDR REMERON TABS SARAFEM CAPS TRAZODONE HCL 300MG TABS WELLBUTRIN TABS WELLBUTRIN SR TBCR ZOLOFT REMERON SOLTAB TBDP
					Non-preferred products must be used in specified step order. 1. Use Fluoxetine 20 mg in multiples. 2. See Zoloft splitting table. Sertraline requires splitting of scored tabs to avoid PA. 3. Strong caution with pediatric population. 4. 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 tricyclic 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 <u>Special Kid < 18yo Criteria for New Starters:</u> 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. DDI: Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl).	
ANTIDEPRESSANTS - TRI-CYCLICS	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC		AMITRIPTYLINE HCL TABS AVENTYL SOLN CLOMIPRAMINE HCL CAPS DESIPRAMINE HCL TABS DOXEPIN HCL IMIPRAMINE HCL TABS NORTRIPTYLINE HCL PROTRIPTYLINE HCL TABS SURMONTIL CAPS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC	AMOXAPINE TABS ANAFRANIL CAPS ELAVIL TABS NORPRAMIN TABS PAMELOR SINEQUAN TOFRANIL VIVACTIL TABS *PA required for new starters if over 65 years old. Users over 65 years old are grandfathered. Use PA Form # 20420 or 102220	
SEDATIVE / HYPNOTICS						
SEDATIVE/HYPNOTICS - BARBITURATE	MC MC/DEL MC MC/DEL		BUTISOL SODIUM TABS CHLORAL HYDRATE SYRP MEBARAL TABS PHENOBARBITAL	MC MC MC/DEL	LUMINAL SOLN SECONAL CAPS SOMNOTE CAPS PA required for new users of preferred products if over 65 years old. Use PA Form # 30110	
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		DORAL TABS ESTAZOLAM TABS FLURAZEPAM HCL CAPS TEMAZEPAM CAPS TRIAZOLAM TABS	MC MC MC MC MC/DEL	DALMANE HALCION TABS MIDAZOLAM HCL SYRP PROSOM TABS RESTORIL CAPS Previous quantity limits still apply. Use PA Form # 30110	
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL MC/DEL MC/DEL MC		AMBIEN CR ¹ LUNESTA ¹ MIRTAZAPINE TRAZODONE	MC/DEL MC/DEL MC/DEL MC	7 8 8 8 Must fail all preferred products before non-preferred 1. Quantity Limit of 12 per 34 days. Use PA Form # 30110	
ANTI-PSYCHOTICS						
ANTI-PSYCHOTICS - ATYPICALS	MC MC/DEL MC/DEL MC/DEL MC MC		RISPERDAL GEODON SEROQUEL TABS ABILIFY TABS and SOL ZYPREXA TABS ZYPREXA ZYDIS TBDP	MC MC MC MC MC MC	8 8 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 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	
					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. Seroquel 25mg is preferred and available without PA if the following conditions are met: a.) Either 65 years of age or older or less than 18 years of age, b.) dosage is for 3 or more per day, c.) Seroquel 25mg is in the profile within the last 45 days OR if any of the following doses are being used in combination with any daily dose of Seroquel 25mg: a.) at least 1.5 Seroquel 100mg tabs, b.) Seroquel 200mg tabs, c.) Seroquel 300mg tabs, d.) Seroquel 400mg tabs. Seroquel 100mg is preferred and available without PA if the daily dosage is 1.5 tablets or more per day OR if any of the following doses are being used in combination with any daily dose of Seroquel 100mg: a.) at least 3- Seroquel 25mg tabs, b.) Seroquel 200mg tabs, c.) Seroquel 300mg tabs, d.) Seroquel 400mg tabs. Seroquel 50mg tablets are non-preferred and multiple Seroquel 25mg tablets should be used.	

						Seroquel- 800mg daily max Zyprexa- 30mg daily max Use PA form #10420 for requests exceeding these maximum daily doses.	DDI: Ability, Seroquel, and Zyprexa will now be non-preferred and require prior authorization if they are currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.
ANTIPSYCHOTICS - SPECIAL ATYPICALS	MC/DEL		CLOZAPINE TABS	MC/DEL MC		CLOZARIL TABS FAZACLO	Use PA Form # 20420 Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved. DDI: Clozapine will now be non-preferred and require prior authorization if it is currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.
ANTIPSYCHOTICS - TYPICAL	MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL		CHLORPROMAZINE HCL FLUPHENAZINE DECANOATE FLUPHENAZINE HCL HALDOL HALOPERIDOL HALOPERIDOL DECANOATE SOLN HALOPERIDOL LACTATE SOLN LOXAPINE SUCCINATE CAPS LOXITANE-C CONC MOBAN TABS PERPHENAZINE PROCHLORPERAZINE SERENTIL THIORIDAZINE HCL THIOTHIXENE THORAZINE SUPP TRIFLUOPERAZINE HCL TABS	MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC MC MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL		COMPazine COMPRO SUPP HALDOL DECANOATE LOXITANE CAPS MELLARIL NAVANE CAPS PROLIXIN STELAZINE TABS THORAZINE	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
LITHIUM							
LITHIUM	MC/DEL MC/DEL		LITHIUM CARBONATE LITHIUM CITRATE SYRP	MC/DEL MC/DEL		ESKALITH CAPS ESKALITH CR TBCR	
COMBINATION - PSYCHOTHERAPEUTIC							
PSYCHOTHERAPEUTIC COMBINATION	MC/DEL MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	MC	8	SYMBYAX ¹	Use individual components, which are currently available without a PA. Use PA Form # 20420
STIMULANTS							
STIMULANT - AMPHETAMINES SHORT ACTING	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ADDERALL TABS AMPHETAMINE SALT COMBO DEXTRAMPHET SULF TABS DEXEDRINE DEXTRSTAT TABS				Preferred stimulants will be available without PA if diagnosis of ADHD. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily.
STIMULANT - LONG ACTING AMPHETAMINES SALT	MC/DEL		ADDERALL XR CP24				Preferred stimulants will be available without PA if diagnosis of ADHD. As per

							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. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily.	
LONG ACTING AMPHETAMINES	MC MC		DEXEDRINE CAP CR DEXTRAMPHET SULF CPCR				Preferred stimulants will be available without PA if diagnosis of ADHD. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily.	
STIMULANT - METHYLPHENIDATE	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		FOCALIN TABS METADATE ER TBCR METHYLIN ER TBCR METHYLIN TABS METHYLIN SOL METHYLPHENIDATE HCL	MC MC/DEL		METHYLIN CHEWABLES RITALIN	Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form # 20420 Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 72mg daily	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC MC/DEL MC		CONCERTA TBCR DAYTRANA ² FOCALIN XR ¹	MC MC/DEL	5 8	METADATE CD CPCR RITALIN LA	Preferred stimulants will be available without PA if diagnosis of ADHD. Non-preferred products must be used in specified step order. Stimulants also have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. 1. Available to those members needing sprinkles with diagnosis of ADHD. 2. FDA approval currently only for ages 6-16. Will be available without PA for this age group. Limit of one patch daily. Max dose of 30MG daily. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
STIMULANT - STIMULANT LIKE				MC	7	STRATTERA ^{1,2}	1. Failure of both an	Provigil requests require diagnosis of Narcolepsy, ADHD, or Obstructive Sleep Apnea. Previous failures of methylphenidate and amphetamine is required for Narcolepsy and ADHD

				MC	8	CAFCIT SOLN	amphetamine and	diagnosis, with additional Strattera trial needed with ADHD diagnosis. Please refer to detailed criteria on Provigil PA form
				MC/DEL	8	PROVIGIL TABS	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. Max daily dose of Strattera is 100mg. Please refer to PDL dosage consolidation chart. 3. Non-preferred products must be used in specified step order.	
				MC	9	DESOXYN TABS		
				MC	9	DESOXYN CR		
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		ARICEPT TABS ¹	MC/DEL	8	EXELON	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.
	MC/DEL		NAMENDA ¹	MC	8	RAZADYNE		
				MC	8	REMINYL		
				MC	9	COGNEX CAPS		
SMOKING CESSATION								
NICOTINE PATCHES / TABLETS	MC/DEL		NICODERM CQ PT24	MC/DEL		CHANTIX ¹	Bupropion SR 150 mg is available without a prior authorization. 1. Chantix will be approved if a trial of both a preferred nicotine replacement product and bupropion is seen. Initial Chantix approvals will be granted for three months. One additional three month approval will be granted if resubmit with documentation supporting that member is still not smoking.	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		NICOTINE POLACRILEX GUM	MC/DEL	5	COMMIT LOZENGES ¹	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.
	MC/DEL		NICORETTE GUM	MC/DEL		NICOTROL INHALER		
				MC/DEL		NICOTROL NASAL SPRAY		
ALCOHOL DETERRENENTS								
ALCOHOL DETERRENENTS	MC		ANTABUSE TABS				1. Should only be used in conjunction with formal structured outpatient detoxification program	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CAMPRAL ¹					
	MC		DISULFIRAM TABS					

REQUIREMENTS

max dosing limits of 32mg daily if the following conditions are met: a.) There is not another Suboxone script in member's drug profile within the past 30 days, and b.) There is not more than one narcotic fill in member's drug profile between today's fill of suboxone and a prior suboxone fill within the past 90 days. Should be evidence provided of monthly monitoring including random pill counts urine drug tests and prescription monitoring program reports.

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

	MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC	NICOTINIC ACID SR CPCR PYRIDOXINE HCL TABS SLO-NIACIN TBCR THIAMINE HCL SOLN VITAMIN B-1 TABS VITAMIN B-12 VITAMIN B-6 TABS VITAMIN C VITAMIN E CAPS VITAMIN E/D-ALPHA CAPS VITAMIN K1 SOLN V-R VITAMIN E CAPS				
VITAMIN D's	MC MC/DEL MC/DEL MC/DEL	CALCIFEROL SOLN CALCITRIOL CAPS ¹ DRISDOL SOLN ¹ VITAMIN D ^{1,2}	MC/DEL MC MC/DEL MC/DEL MC/DEL MC	DRISDOL CAPS CALCJEX HECTOROL (ORAL) HECTOROL (PARENTERAL) ROCALTROL ZEMPLAR	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, Phosphorous <6.5mg/dl, corrected calcium <12.2mg/dl, corrected calcium x phosphorous products <70mg ² /dl ²

MISC MULTI-VITAMINS

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

VITAMINS - MISC.							
MC	CENTRUM LIQD	MC	ADEKS	Diag codes are no longer required on prenatal vitamins.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.		
MC	CENTRUM TABS	MC/DEL	ADVANCED NATALCARE TABS	Use PA Form # 20420			
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	PRENATE ELITE				
		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.****

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	FEODEN 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 GI tube. Use PA Form # 20420 & SGA Form	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		
		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	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	
				MC	6	EPOGEN SOLN	but Procrit is first choice. Still	approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents	
				MC	8	ARANESP SOLN	must be used in specified	usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the	
							step order. Use PA Form #	EPO PA form for other approval and renewal criteria.	
							10520		
GRANULOCYTE CSF									
GRANULOCYTE CSF				MC	8	LEUKINE	Must be used in specified	See approval criteria detailed on Neupogen PA form.	
				MC	8	NEUPOGEN SOLN ¹	step order. 1. 10 day		
				MC	9	NEULASTA	supply/month may be used		
							without a PA. Use PA Form #		
							20520		
ANTICOAGULANTS / PLATELET AGENTS									
ANTICOAGULANTS	MC		ARIXTRA SOLN ¹	MC		COUMADIN TABS	1. Arixtra, Fragmin 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	
	MC/DEL		FRAGMIN INJ ¹	MC		IPRIVAS C	Lovenox therapy durations	on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the	
	MC		HEPARIN SODIUM/NAACL 0.9% SOLN				greater than 7 days require	preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA.	
	MC		HEP-LOCK SOLN				PA.		
	MC/DEL		INNOHEP				Use PA Form # 20420		
	MC/DEL		LOVENOX SOLN ¹						
	MC/DEL		WARFARIN SODIUM TABS						
	MC		HEPARIN LOCK SOLN						
	MC/DEL		HEPARIN LOCK FLUSH SOLN						
	MC/DEL		HEPARIN SODIUM SOLN						
	MC/DEL		HEPARIN SODIUM LOCK FLUSH SOLN						
	MC/DEL		JANTOVEN						
ANTIHEMOPHILIC AGENTS	MC		ALPHANATE	MC		ADVATE ^{1,2}	1. Only if other products	Non-preferred will only be approved if other preferred products are unavailable.	
	MC/DEL		BENEFIX SOLR				unavailable.		
	MC		BIOCLATE				2. Advate may be available		
	MC/DEL		HELIXATE FS KIT				with PA in cases of large		
	MC		HEMOFIL - M				volume dosing in patients with		
	MC		HUMATE-P SOLR				poor venous access.		
	MC		KOGENATE FS				Use PA Form # 20420		
	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	Preferred drugs must be tried and 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		DIPYRIDAMOLE TABS	MC/DEL	8	PERSANTINE TABS	1. As of 04.01.2005 Plavix is	on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the	
	MC/DEL		PLAVIX TABS ¹	MC	8	TICLID TABS	only available without PA if	preferred drug(s) exists.	
							concurrent aspirin use (on		
							prescription) within 100 days		
							or documented failure or		
							intolerance or other		
							contraindication to aspirin.		
PLATELET AGGR. INHIBITORS COMBO'S - MISC.	MC/DEL		PENTOXIFYLLINE ER TBCR	MC/DEL		AGGRENOX CP12 ¹	1. Aspirin and dipyridamole	Preferred drugs must be tried and 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		CLOSTAZOL	MC/DEL		AGGRENOX ²	are available separately	on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the	
				MC/DEL		AGRYLIN CAPS	without PA. Use PA Form #	preferred drug(s) exists.	
				MC/DEL		PLETAL TABS	20420		
				MC		TRENTAL TBCR	2. Aggrenox will be approved		
							if submitted with		
							documentation supporting		
							that it is being used for non-		
							symbolic stroke.		
HEMOSTATIC									

			MC/DEL MC/DEL MC	TRETINOIN TRIAZ ZETACET		
TOPICAL - ANTIBIOTIC	MC MC/DEL MC/DEL MC/DEL MC/DEL	BACIT/NEOMYCIN/POLYM OINT BACITRACIN OINT BACTROBAN ¹ CENTANY OINT 2% ¹ GENTAMICIN SULFATE	MC/DEL MC/DEL	CORTISPORIN TRIPLE ANTIBIOTIC OINT	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.
TOPICAL - ANTIFUNGALS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC/DEL MC	CLOTRIMAZOLE CLOTRIMAZOLE/BETA CREA ECONAZOLE NITRATE CREAM KETOCONAZOLE CREA LOPROX .77 CREA LOPROX 1.0 CREAM LOPROX 1.0 LOTN LOPROX GEL LOPROX TS LOTN MICONAZOLE NITRATE CREA MYCO-TRIA CET II CREA NIZORAL SHAM NTA OINT NYSTATIN NYSTATIN/TRIAMCINOLONE PEDI-DRI POWD TINACTIN TRI-STATIN II CREA	MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC	EXELDERM FUNGIZONE CREA HYDROCORT/ODOO CREA LAMISIL LOPROX 0.77 LOTN LOPROX SHAMPOO SHAM LOTRIMIN LOTRISONE MENTAX CREA MONISTAT-DERM CREA MYCOGEN II CREA MYCOLOG-II CREA MYCOSTATIN POWD NAFTIN NIZORAL CREA NYSTAT-RX POWD NYSTOP POWD OXISTAT PENLAC NAIL LACQUER SOLN SPECTAZOLE CREAM	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. DDI: Ketoconazole will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non-preferred PPI.
TOPICAL - ANTIPRURITICS	MC	ZONALON CREA	MC	PRUDOXIN CREA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIPSORIATICS	MC MC/DEL MC	DOVONEX SORIATANE CAPS TAZORAC	MC MC MC/DEL MC	OXSORALEN ULTRA CAPS PSORiatec CREA TACLONEX ¹ VANAMIDE	Must fail all preferred products before non-preferred. 1. Individual ingredients are available as preferred without PA. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTISEBORRHEICS	MC MC/DEL MC	CAPITROL SHAM SELENIUM SULFIDE SHAM SELSUN BLUE SHAM	MC MC	CARMOL SCALP TREATMENT KIT ZNP BAR	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIVIRALS	MC/DEL MC	DENAVIR CREA ZOVIRAX OINT ¹			1. Zovirax may be used once without PA.	
TOPICAL - ANTINEOPLASTICS	MC MC MC	EFUDEX FLUOROPLEX CREA SOLARAZE GEL	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.
TOPICAL - BURN PRODUCTS	MC MC MC/DEL	FURACIN CREA SSD CREA THERMAZENE CREA	MC/DEL MC/DEL MC	SILVADENE CREA SILVER SULFADIAZINE CREA SSD AF CREA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - CORTICOSTEROIDS	MC MC/DEL MC MC MC MC MC MC/DEL MC/DEL MC/DEL MC MC MC MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL	LOW POTENCY DESOWEN HYDROCORTISONE CREA HYDROCORTISONE LOTN LACTICARE-HC LOTN NUTRACORT LOTN TEXACORT SOLN TRIDESILON CREA MEDIUM POTENCY CUTIVATE DESOXIMETASONE .05% ELOCON FLUOCINOLONE ACETONIDE .025-.01% FLUOSYN CREA HYDROCORTISONE BUTYRATE HYDROCORTISONE OINT HYDROCORTISONE VALERATE HIGH POTENCY MOMETASONE FUROATE OINT TRIAMCINOLONE ACETONIDE .025-.1% HIGH POTENCY CYCLOCORT DIPROLENE DESOXIMETASONE .25%	MC/DEL MC MC MC/DEL MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL	ACLOVATE AMCINONIDE CREA ANUSOL HC-1 OINT ARISTOCORT A AUGMENTED BETA DIP OINT CLOBEX CLODERM CREA CORDRAN CORMAX DERMATOP DIFLORASONE DIACETATE ELOCON OINT HYDROCORTISONE POWD KENALOG AERS LIDA MANTLE HC CREA LIDEX LIDEX-E CREA LOCOID LUXIQ FOAM OLUX FOAM PANDEL CREA PROCTOCORT CREA PSORCON E SYNALAR OINT	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/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC	DESONIDE FLUOCINOLONE ACETONIDE .02% FLUOCINONIDE HALOG HALOG-E CREA TRIAMCINOLONE ACETONIDE .5% VERY HIGH POTENCY BETAMETHASONE DIPROPIONATE BETAMETHASONE VALERATE BETA-VAL CLOBETASOL PROPIONATE HALOBETASOL PSORCON MISCELLANEOUS CAPEX SHAM DERMA-SMOOTHIE/FS OIL PROCTO-KIT CREA	MC/DEL MC MC MC MC MC/DEL MC/DEL MC MC/DEL MC MC MC MC	TEMOVATE TOPICORT TOPICORT LP CREA ULTRAVATE WESTCORT		
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-SMOOTHIE/FS ATOPIC P KIT	MC	CARMOL-HC CREA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - EMOLLIENTS	MC/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 MC MC MC	AMMONIUM LACTATE CREA LACLOTION LOTN LACTINOL LOTN MEDERMA GEL MIMYX RENOVA CREA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ENZYMES / KERATOLYTICS / UREA	MC MC/DEL MC MC MC MC	GRANUL-DERM AERS GRANULEX AERS PANAFIL OINT PANAFIL SE PAPAIN-UREA-CHLORO OINT TBC AERS	MC 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 PODOFILOX SOLN 8 CONDYLOX	Non-preferred products must be used in specified order. Use PA Form # 20420	
TOPICAL - IMMUNOMODULATORS			MC/DEL MC	8 ELIDEL CREA 9 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	AF CAPSICUM OLEORESIN CREA CAPSAICIN CREA ELA-MAX ¹ LIDOCAINE/PRILOCAINE CREA XYLOCAINE	MC/DEL MC/DEL MC MC MC MC	EMLA PADS EMLA CREA LIDA MANTLE CREA 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 MC/DEL MC/DEL MC MC MC MC	8 ALUSTRA CREA 8 EPIQUIN MICRO 8 GLYQUIN CREA 8 HYDROQUINONE CREA 8 HYDROQUINONE/SUNSCREENS 8 SOLAQUIN FORTE CREA 8 TRI-LUMA CREA 9 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	ACTICIN CREA ELIMITE CREA EURAX LICE KILLING SHAM LICE TREATMENT CREME RINS LIQD	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.

	MC MC/DEL		NIX CREME RINSE LIOD PERMETHRIN LOTN				
TOPICAL - WOUND / DECUBITUS CARE	MC MC MC/DEL		ACCUZYME OINT ACCUZYME SPRAY ACCUZYME SE ETHEZYME	MC MC/DEL MC/DEL		REGRANEX GEL REGENECARE RADIAPLEXRX	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 (HbA1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (TcPO2 >30, ABI >0.7 or ASP > 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks.
TOPICAL - ASTRINGENTS / PROTECTANTS	MC MC MC		ALUMINUM CHLORIDE SOLN DRYSOL SOLN XERAC AC SOLN	MC MC MC		LOWILA BAR MOISTURIN DRY SKIN CREA PROSHIELD PLUS SKIN PROTE CREA 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 / DISINFECTANTS	MC MC/DEL MC/DEL		HIBICLENS LIOD PHISOHEX LIOD POVIDONE-IODINE SOLN	MC MC MC MC		BETADINE OINT FORMALYDE-10 AERS IODOSORB LAZERFORMALYDE SOLUTION SOLN	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS EYE							
OP. - EYE	MC MC MC MC MC MC/DEL		AK-DILATE SOLN EYE WASH SOLN NAPHAZOLINE HCL SOLN PHENYLEPHRINE HCL SOLN PONTOCAINE SOLN SODIUM CHLORIDE	MC MC/DEL MC MC MC MC		LENS PLUS REWETTING DROPS MURO 128 NEO-SYNEPHRINE SOLN	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS EAR							
EAR	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL MC MC/DEL MC/DEL		AB OTIC SOLN ACETASOL SOLN ACETASOL HC SOLN ACETIC ACID ACETIC ACID/HYDROCORTISON ALLERGEN SOLN ANTIPYRINE/BENZOCAINE SOLN AURODEX SOLN AUROGUARD SOLN AUROTO OTIC SOLN CIPRODEX CORTISPORIN SOLN CORTOMYCIN EAR DROPS SOLN EAR DROPS RX SOLN EAR WAX REMOVAL DROPS EAR-GESIC SOLN FLOXIN OTIC SOLN NEOMYCIN/POLYMYXINH OTICAINE OTIC SOLN	MC MC MC MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC MC MC MC MC MC/DEL MC MC/DEL		AERO OTIC HC SOLN ANTIBIOTIC EAR SOLN ANTIBIOTIC EAR SUSP AURALGAN SOLN CIPRO HC SUSP COLY-MYCIN-S SUSP CORTISPORIN SUSP CORTISPORIN-TC SUSP DEBROX SOLN DOMEBORO SOLN PEDIOTIC SUSP VOSOL-HC SOLN ZOTANE HC SOLN ZOTO-HC SOLN	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MOUTH ANTISEPTICS							
MOUTH ANTI-INFECTIVES	MC MC MC/DEL		NILSTAT SUSP EAR-GESIC SOLN NYSTATIN SUSP	MC MC MC		MYCELEX TROC MYCOSTATIN LOZG	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MOUTH ANTISEPTICS	MC/DEL MC/DEL MC MC		CHLORHEXIDINE GLUCONATE LIDOCAINE VISCOUS SOLN TRIAMCINOLONE IN ORABASE PSTE TRIAMCINOLONE ORADENT PSTE	MC MC MC MC MC		APHTHASOL PSTE PERIDEX SOLN PERIOGARD SOLN TRIAMCINOLONE ACETONIDE PSTE XYLOCAINE VISCOUS 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.
DENTAL PRODUCTS							
DENTAL PRODUCTS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		ETHEDENT CREA GEL-KAM CONC PHOS FLUR SOLN PREVIDENT GEL PREVIDENT SOLN SF 5000 PLUS CREA SF GEL STANNOUS FLUORIDE ORAL RI CONC	MCOMC MC/DEL MC/DEL MC/DEL MC MC MC MC		APF GEL GEL DENTAGEL GEL PHOS-FLUR GEL PREVIDENT CREAM THERA-FLUR-N GEL	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ARTIFICIAL SALIVA/STIMULANTS							
ARTIFICIAL SALIVA/STIMULANTS	MC MC		EVOXAC CAPS SALIVA SUBSTITUTE SOLN	MC MC		RADIACARE SOLR SALAGEN TABS	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS ANORECTAL							
ANORECTAL - MISC.	MC/DEL		COLOCORT ENEM	MC/DEL		ANUSOL-HC CREA	Use PA Form # 20420

	MC MC MC/DEL MC/DEL		CORTENEMA ENEM ELA-MAX 5 CREA HYDROCORTISONE ENEM PROCTOZONE-HC CREA	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CORTIFOAM FOAM PROCTOCREAM-HC CREA PROCTOFOAM HC FOAM PROCTO-KIT CREA PROCTOSOL HC CREA			
T-CELL ACTIVATION INHIBITOR									
PSORIASIS BIOLOGICALS	MC MC		ENBREL ¹ RAPTIVA ¹	MC MC		AMEVIVE ²	1. Will not require a PA if at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin is in members drug profile. High doses of Enbrel 50mg twice weekly will require a PA. Please refer to dose consolidation list. 2. Trial of both preferred drugs are required. Use PA Form # 20910	Approved for severe chronic plaque psoriasis unresponsive to first line therapies. A trial of at least several potent topicals from the following categories: corticosteroids, coal tars, anthralin, calcipotriene and tazarotene, and at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin and phototherapy/UVA.	
ALTERNATIVE MEDICINES									
ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC MC/DEL MC MC MC/DEL MC MC		ARTHX DS CAPS CO-ENZYME Q-10 DEHYDROEPIANDOSTERONE DHEA TABS FLEXAGEN TABS GLUCOSAMINE/CHONDROITIN HM GINKGO BILOBA TABS MELATONIN TABS	Use PA Form # 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.	
CHELATING AGENTS									
CHELATING AGENTS	MC/DEL		CUPRIMINE CAPS	MC MC/DEL		DEPEN TITRATABS TABS EXJADE ¹	Use PA Form # 20420	1. FDA indication of treatment of chronic iron overload due to blood transfusions in membes 2 years of age and older is required for approval of Exjade	
ANTILEPROTIC									
ANTILEPROTIC				MC		THALOMID CAPS	Use PA Form # 20420	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.	
ANTINEOPLASTIC AGENTS									
ANTINEOPLASTIC AGENTS - ANTIANDROGENS	MC/DEL		CASODEX						
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS	MC		GLEEVEC	MC		SPRYCEL ¹	1. Verification of diagnosis and prior trial of at least Gleevec is required. Use PA Form # 20420		
CANCER									
CANCER	MC MC/DEL MC MC/DEL		ALIMTA AVASTIN ERBITUX VIDAZA	MC MC/DEL		NEXAVAR ¹ SUTENT ^{1,2}	1. PA required to confirm FDA approved indication 2. Avoid CYP3AY drug drug interaction		
IMMUNOSUPPRESSANTS									
IMMUNOSUPPRESSANTS	MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL		CELLCEPT CYCLOSPORINE MODIFIED CYCLOSPORINE SOL. MODIFIED GENGRAF CAPS MYFORTIC PROGRAF CAPS RAPAMUNE SANDIMMUNE	MC/DEL MC/DEL		CYCLOSPORINE CAPS NEORAL ^{1,2}	1. Established users will require a one time PA. 2. Established users will require a one time 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. DDI: Cyclosporine will now be non-preferred and require prior authorization if it is currently being used in combination with either Lipitor (doses greater than 20mg/day), Crestor, or lovastatin (doses greater than 20mg).	
PURINE ANALOG									
PURINE ANALOG	MC MC/DEL		AZASAN TABS AZATHIOPRINE TABS	MC/DEL		IMURAN TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
K REMOVING RESINS									
K REMOVING RESINS	MC/DEL MC MC/DEL MC/DEL MC/DEL		KAYEXALATE POWD KIONEX POWD SODIUM POLYSTYRENE SULFON SPS SUSP SPS 30GM/120ML ENEMA SUSP				Use PA Form # 20420		

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

NON-CONVULSANTS 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(2 nd line)	X(2 nd line)				
NEURONTIN	X	X(2 nd line)	X (2 nd line)	9	9	X (2 nd line)	X (2 nd line)
TOPAMAX	X			9	6	X (2 nd line)	
TRILEPTAL	X			5	5		
ZONISAMIDE	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