CATEGORY	Step Order	PREFERRED DRUGS	Step Order	NON-PREFERRED DRUGS PA Required	Comments

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

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

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

C: Adequate Drug Trials- 1. The minimum trial period for each preferred and step order drug is two weeks, unless otherwise stated within specific PDL drug categories; trials with less than a two week duration will be reviewed on a case-by-case basis; 2. A trial will not be considered valid if preferred or non-preferred products were readily available (by override, individual purchase, samples, etc.); 3. Certain drug trials, such as with controlled substances, may require evidence that the preferred drugs were actually tried (example: with random pill counts and with random urine drug tests, using the methods of GC/MS with no lower threshold); 4. Adequate trials require documentation of attempts to titrate dose of preferred agents toward desired clinical response. 5. Adequate trials include prevention/treatment of common adverse effects associated with preferred agents (example: antinausea, antipruritics, etc.)

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

E. The Department will institute strategies to ensure cost effectiveness through the use of an enhanced Drug Benefit Preferred brand drugs will no longer be preferred in any PDL drug category where preferred generic drugs are also available. It is expected that preferred generics will be used prior to any preferred brands. This will be operated as a form of step care. Preferred brands in these categories will require prior authorization for these high utilization / high cost members.

F: Brand Name Medication Requests- (Must be submitted on the Brand Name PA request form)- According to MaineCare Benefits Manual Chapter II (80.07-5), when medically necessary covered brand-name drugs have an A-rated generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since the brand-name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. The Bureau does not make determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA. Physicians should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH.

G: PA requests for non- FDA Approved Indications- Decisions will be made on a case-by-case basis until the DUR committee is able to review the evidence and make a recommendation. Interim approvals and DUR recommendations for approval of a drug for a non- FDA approved indication will require a minimum of two published, peer reviewed, non contradicted, double- blind, placebo-controlled randomized clinical studies establishing both safety and efficacy.

H: Dose Consolidation Requirements- Some drugs may also be affected by dose consolidation requirements. Please see Dose Consolidation List and/or Splitting Tables provided in the PDL.

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

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

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

L: Drug-Drug Interactions (DDI)- The DUR Committee has implemented new drug-drug interation edits requiring prior authorization. Several drug-drug combinations and PDL drug catagories are affected by new PA requirements. These will be indicated in the PDL with DDI notation. Please see the DDI document provided in the PDL.

ASSORTED ANTIBIOTICS

CATEGORY	Step Order	PREFERRED DRUGS	Step Order	NON-PREFERRED DRUGS PA Required	Comments
BETA-LACTAMS / CLAVULANATE COMBO'S		AMOXICILLIN AMOXICILLIN/POTASSIUM CLA CHEW AMOXICILLIN/POTASSIUM CLA SUSR AMOXICILLIN/POTASSIUM CLA TABS AMOXIL[1] AMPICILLIN BEEPEN BICILLIN L-A SUSP DICLOXACILLIN SODIUM CAPS DYNAPEN SUSR OXACILLIN SODIUM SOLR PENICILLIN V POTASSIUM TICAR SOLR TIMENTIN SOLR TRIMOX UNASYN SOLR VEETIDS ZOSYN		AMOXIL 500MG TABS AUGMENTIN[3] AUGMENTIN XR TB12[4] PRINCIPEN CAPS[2] PRINCIPEN SUSR	1. Amoxil 500mg tabs are non-preferred. All other Amoxil products are preferred. 2.Principen 250 mg is available without PA. 3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA. 4. Use preferred generic amoxicillin/clavulanate potassium alternatives. Use PA Form# 20420
CEPHALOSPORINS		CEFADROXIL HEMIHYDRATE CEFAZOLIN SODIUM SOLR CEFDINIR CEFEPIME HCI CEFPODOXIME CEFPROZIL CEFTAZIDIME 6MG CEFTIN SUSP CEFTRIAXONE CEFUROXIME AXETIL TABS CEPHALEXIN MONOHYDRATE FORTAZ SOLR KEFZOL SOLR MAXIPIME SOLR TAZICEF 6GM VANTIN 100MG VANTIN SUSP		CEDAX CEFACLOR[1] CEFADROXIL MONOHYDRATE TABS CEFTIN FORTAZ FORTAZ SOLN KEFLEX CAPS OMNICEF ROCEPHIN SUPRAX TAZICEF SOLR MAXIPIME	1. Both brand and generic are clinically non-preferred. Use PA Form# 20420
MACROLIDES / ERYTHROMYCIN'S		BIAXIN XL[1] AZITHROMYCIN TABS AZITHROMYCIN SUSP CLARITHROMYCIN TABS E.E.S. E-MYCIN TBEC ERYPED 200 SUSR ERYPED 400 SUSR ERY-TAB TBEC ERYTHROCIN STEARATE TABS ERYTHROMYCIN		AZITHROMYCIN POW BIAXIN CLARITHROMYCIN SUSP ERYPED CHEW PCE TBEC ZITHROMAX TABS ZITHROMAX 1GM PAK ZITHROMAX TRI-PAK ZITHROMAX SUSP ZMAX	1. 7- Day supply per month without PA. Use PA Form# 20420
TETRACYCLINES		DOXYCYCLINE HYCLATE MINOCYCLINE HCL CAPS TETRACYCLINE HCL CAPS VIBRAMYCIN SYRP		DECLOMYCIN TABS DORYX CPEP DOXYCYCLINE MONO CAPS DYNACIN CAPS ORACEA PERIOSTAT SOLODYN ER	Use PA Form# 20420
FLUOROQUINOLONES		AVELOX SOLN		CIPRO	

Class		Preferred		Non-Preferred	Criteria
		AVELOX TABS AVELOX ABC PACK TABS CIPROFLOXACIN LEVAQUIN TABS[1] OFLOXACIN		FACTIVE LEVAQUIN TABS SOLN/INJ NOROXIN TABS PROQUIN XR	Use PA Form# 20420 1. Dosing limits apply, see Dosage Consolidation List.
AMINO GLYCOSIDES		GENTAMICIN NEOMYCIN SULFATE TABS TOBI NEBU TOBRAMYCIN SULFATE SOLN			Use PA Form# 20420
ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS		ETHAMBUTOL HCL TABS MYAMBUTOL TABS MYCOBUTIN CAPS RIFAMPIN		RIMACTANE CAPS	Use PA Form# 20420
ANTIMALARIAL AGENTS		**CHLOROQUINE PHOSPHATE TABS** **DARAPRIM TABS** **HYDROXYCHLOROQUINE TABS** **LARIAM TABS** **MEFLOQUINE HCL TABS** QUINACRINE HCL POWD **QUININE SULFATE**		ARALEN TABS ISONARIF[1] MALARONE TABS **PLAQUENIL TABS**	Use PA Form# 20420 1. Ingredients available as preferred without PA.
ANTHELMINTICS		ALBENZA TABS BILTRICIDE TABS MEBENDAZOLE CHEW STROMECTOL TABS		VERMOX CHEW	Use PA Form# 20420
ANTIBIOTICS - MISC.		AZACTAM SOLR COLISTIMETHATE SODIUM SOLR FUROXONE TABS METRONIDAZOLE[2] PENTAMIDINE ISETHIONATE SOLR PRIMSOL SOLN TRIMETHOPRIM TABS VANCOMYCIN 5GM INJ.		COLY-MYCIN-M SOLR CAYSTON[4] FLAGYL CAPS FLAGYL TABS FLAGYL ER TBCR KETEK METRONIDAZOLE 375MG CAPS[2] METRONIDAZOLE 750MG TABS[2] NEBUPENT SOLR TINDAMAX[1] VANCOMYCIN 10GM INJ.[3] 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. 3. Please use multiple 5gm which are preferred to obtain dose without PA. 4. Clinical PA is required to establish CF diagnosis and medical necessity. Prior trail and failure of preferred Tobi before approval will be granted. Use PA Form# 20420
CARBAPENEMS				INVANZ SOLR MERREM SOLR PRIMAXIN	Use PA Form# 20420
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS		CLEOCIN SOLN CLEOCIN SUSR CLINDAMYCIN HCL 150CAPS DAPSONE TABS		CLEOCIN CAPS CLINDAMYCIN HCL 300CAPS[1] VIBATIV ZYVOX SUSR ZYVOX TABS	1. Use multiple 150's for Clindamycin instead of 300's. Use PA Form# 30820 for **Zyvox & Vibativ** Use PA Form# 20420 for **all others**
ANTI INFECTIVE COMBO'S - MISC.		ERYTHROMYCIN/SULF SUSR SEPTRA/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA		BACTRIM DS TABS	Use PA Form# 20420
ANTIPROTOZOALS				ALINIA[1]	1. Alina is preferred for children less than 12 years of age. Use PA Form# 20420
ANTI - FUNGALS					
ANTIFUNGALS - ASSORTED		ANCOBON CAPS FLUCONAZOLE[1] GRIFULVIN V TABS[10] GRISEOFULVIN SUSP[10] GRISEOFULVIN ULTRAMICROSI TABS[10] GRIS-PEG TABS[10] KETOCONAZOLE TABS[8] NYSTATIN TERBINAFINE TABS[4]	5 6 6 7 8 8 8 8 8 8	LAMISIL TABS[4] SPORANOX SOLN[2] SPORANOX PULSEPAK CAPS[3] SPORANOX CAPS[3] ERAXIS INJ[6] DIFLUCAN GRIFULVIN SUSP NOXAFIL[5] VFEND TABS ITRACONAZOLE	1. QL--1/every 7-day period (150mg only). 2. Sporanox QL 300cc/month with PA. See quantity limit table. 3. Sporanox QL 30/month with PA. See quantity limit table. Non-preferred products must be used in specified step order. Continue to use Anti-Fungal PA form for non-preferred products. 4. Quantity limit of one tablet daily. Please see dosage consolidation list. 5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy. 6. Eraxis will be approved if submitting with documentation that it was initiated during a hospitalization and this request is to finish the hospital course. 8. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30 days.

					10. For children < 18, quantity limits allows 8 weeks supply without PA. PA will be required if using > than 8 weeks. If 18 and older PA will be required for any quantity. Not approving for Onychomycosis indication. Use PA form #20420
ANTI - VIRALS					
ANTIRETROVIRALS		APTIVUS ATRIPLA[1] COMBIVIR TABS CRIXIVAN CAPS EMTRIVA EPIVIR / HBV EPZICOM INVIRASE CAPS KALETRA LEXIVA NORVIR PREZISTA[2] RESCRIPTOR TABS REYATAZ STAVUDINE SUSTIVA TRIZIVIR TABS TRUVADA VIDEX / EC VIRACEPT TABS VIRAMUNE TABS VIREAD TABS ZIAGEN TABS ZIDOVUDINE	8 8 8 8 8 8 8 9	DIDANOSINE FUZEON[3] INTELENCE[3] ISENTRESS[3] RETROVIR SELZENTRY[3] ZERIT VIRAMUNE XR	Use PA Form# 10620 for Fuzeon 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 3. Prescribers with >= 10 ART scripts per quarter and 75% ART PDL compliance will be exempt from PA for these products.
CYTO-MEGALOVIRUS AGENTS		FOSCARNET SODIUM VALCYTE TABS		FOSCAVIR GANCICLOVIR	Use PA Form# 20420
HERPES AGENTS		ACYCLOVIR VALTREX TABS	8 8 8 9	FAMVIR TABS[1] ZOVIRAX[1] VALACYCLOVIR[1] FAMCICLOVIR[1]	1. Must fail Acyclovir and Valtrex before non-preferred products in step order. Use PA Form# 20420
INFLUENZA AGENTS		AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU[1]		FLUMADINE TABS FLUMIST	1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member. Use PA Form# 10610 for Flumist requests Use PA Form# 20420 for all others
IMMUNE SERUMS					
IMMUNE SERUMS		HYPERRHO INJ			
HEPATITIS AGENTS					
HEPATITIS C AGENTS		PEGASYS KIT[1] PEGASYS SOLN RIBAVIRIN		COPEGUS TABS PEG-INTRON KIT[2] REBETOL CAPS	1. Dosing limits apply, please see dosage consolidation list. 2. Current users are grandfathered. Use PA Form# 20420
HEPATITIS AGENTS - MISC.				ACTIMMUNE	Use PA Form# 20420
HEPATITIS B ONLY		HEPSERA TABS		BARACLUDE TYZEKA	Use PA Form# 20420
RSV PROPHYLAXIS					
RSV PROPHYLAXIS				SYNAGIS[1]	Use PA Form# 30120 1. MaineCare will approve Synagis PA's for start date of November 23rd for infants who meet the guidelines. PA will be approved for max of 5 doses. Maximum 1 dose/30 days.
MS TREATMENTS					
MULTIPLE SCLEROSIS - INTERFERONS		AVONEX KIT[1] **BETASERON SOLR[1]** REBIF SOLN[1]		EXTAVIA	1.Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20430
MULTIPLE SCLEROSIS - NON-INTERFERONS		**COPAXONE[2]**	6 8 8	TYSABRI[1] AMPYRA GILENYA	1. Providers must be enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity. 2. Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20430
ASSORTED NEUROLOGICS					
NEUROLOGICS - MISC.		MESTINON ORAP TABS PROSTIGMIN TABS		BOTOX DYSPORT[1] MYOBLOC[1]	1. Approval will be limited to Cervical dystonia. Use PA Form# 10210

STEROIDS					
GLUCOCORTICOIDS/ MINERALOCORTICOIDS		CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS DEPO-MEDROL SUSP DEXAMETHASONE ENTOCORT EC CP24 FLUDROCORTISONE ACETATE TABS HYDROCORTISONE KENALOG METHYLPREDNISOLONE TABS PREDNISOLONE **PREDNISONE** SOLU-CORTEF SOLR SOLU-MEDROL SOLR		CORTEF 10 and 20 TABS FLORINEF TABS **MEDROL TABS** MEDROL DOSEPAK TABS ORAPRED SOLN PEDIAPRED LIQD PREDNISONE INTENSOL CONC STERAPRED TABS	Use PA Form# 20420
HORMONE REPLACEMENT THERAPIES					
ANDROGENS / ANABOLICS		ANDRODERM PT24 ANDROGEL ANDROGEL PUMP ANDROID CAPS DANAZOL CAPS DEPO-TESTOSTERONE OIL TESTOSTERONE PROPIONATE TESTRED CAPS		ANDRO LA 200 OIL AXIRON DELATESTRYL OIL FORTESTA HALOTESTIN TABS METHITEST TABS OXANDRIN TABS TESTIM	Use PA Form# 20420 Use PA Form# 20600 for **Oxandrin** requests
ESTROGENS - PATCHES / TOPICAL		**ESTRADERM PTTW**[1] **VIVELLE-DOT PTTW**[1]	5 8 8 8 8 8	**ESTRADIOL PTWK** **ALORA PTTW**[2] **CLIMARA PTWK**[2] **DIVIGEL**[2] **ELESTRIN**[2] **EVAMIST**[2]	1. Both preferred drugs must be tried. 2. Step order drugs must be used in specified step order. Use PA Form# 20420
ESTROGENS - TABS		**CENESTIN TABS** **ESTRADIOL** **ESTROPIPATE TABS** **MENEST TABS** **PREMARIN TABS**		ENJUVIA **ESTRACE TABS** ESTRATAB TABS ORTHO-EST TABS	Must fail preferred products before non preferred products. Use PA Form# 20420
ESTROGEN COMBO'S		**PREMPHASE TABS** **PREMPRO TABS**		**ACTIVELLA TABS**[1] **COMBIPATCH PTTW**[1] **FEMHRT 1/5 TABS**[1] **ORTHO-PREFEST TABS**[1] SYNTEST H.S. TABS[1]	1. Must fail Premphase and Prempro products before non preferred products. Use PA Form# 20420
PROGESTINS		MEDROXYPROGESTERONE ACETA[2] NORETHINDRONE ACETATE TABS[2]		AYGESTIN TABS CYCRIN TABS MAKENA PROGESTERONE POWD PROMETRIUM 100MG CAPS[1] PROMETRIUM 200MG[1] PROVERA TABS	1. PA approvals will require two 100 mg caps instead of one 200mg. 2. Must fail Medroxyprogesterone and Norethidrone products before non-preferred products. Use PA Form# 20420
CONTRACEPTIVES					
CONTRACEPTIVES - PROGESTIN ONLY		ORTHO MICRONOR TABS		CAMILA TABS ERRIN JOLIVETTE NORA-BE TABS NOR-QD TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form# 20420
CONTRACEPTIVES - INJECTABLE		MEDROXYPROGESTERONE ACETATE 150mg IM		DEPO-PROVERA 150 mg SUSP	Use PA Form# 20420
CONTRACEPTIVE - EMERGENCY		NEXT CHOICE[1]		PLAN - B	1. Allowed 4 tablets per 30 days without PA Use PA Form# 20420
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS		NUVARING RING[3] ORTHO EVRA PTWK[1,2,4]			Use PA Form# 20420 1.No PA required for users less than 21 years of age. 2. The FDA has issued a public health warning of the potentials for increased exposure to estrogen with Ortho Eva use, possibly up to 60% estrogen exposoure. 3. Quantity limit allowing 1 every 28 days with out PA. 4. Dose limits apply allowing 3 patches per 28 days supply. Please refer to Dose Consolidation Chart.
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S		APRI TABS AVIANE TABS BALZIVA CRYSELLE-28 TABS DESOGEN TABS DESOGESTREL/ ETHINYL ESTRADIOL LOW-OGESTREL TABS MODICON TABS MONONESSA NECON 1/50 ORTHO-CEPT-28 TABS ORTHO-CYCLEN-28 TABS ORTHO-NOVUM 1/35-28 TABS OVCON-50 28 TABS PREVIFEM RECLIPSEN SOLIA SPRINTEC 28 TABS YASMIN 28 TABS		BEYAZ BREVICON-28 TABS LESSINA-28 TABS LEVORA LOESTRIN TABS LOESTRIN FE TABS LOESTRIN FE 1/20 TABS LOESTRIN 1.5/30-21 TABS LOESTRIN 1/20-21 TABS LO/OVRAL 21 TABS LO/OVRAL 28 TABS MICROGESTIN FE TABS NORDETTE-28 TABS NORINYL NORTREL OCELLA OGESTREL TABS OVCON-35/28 TABS OVRAL	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.

		ZENCHENT		PORTIA-28 TABS SAFYRAL SEASONALE YAZ ZOVIA	
CONTRACEPTIVES - BI-PHASIC COMBINATIONS		ORTHO-NOVUM 10/11-28 TABS NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1 35 SEASONIQUE LOSEASONIQUE		NECON 10/11-28 TABS KARIVA TABS MIRCETTE TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form# 20420
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS		ENPRESSE NECON 7/7/7 ORTHO-NOVUM 7/7/7-28 TABS TRI-PREVIFEM TRIPHASIL 28 TABS TRI-SPRINTEC TRINESSA TRIVORA-28 TABS		CYCLESSA TABS ESTROSTEP FE TABS NORTREL 7/7/7 ORTHO TRI-CYCLEN TABS ORTHO TRI-CYCLEN LO TABS TRI-NORINYL 28 TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form# 20420
CONTRACEPTIVES - MULTI-PHASIC COMBINATIONS				NATAZIA	Use PA Form# 20420
DIABETES THERAPIES					
DIABETIC - INSULIN		HUMALOG INJ 100/ML HUMALOG MIX 75/25 HUMULIN N INJ U-100 HUMULIN INJ 70/30 HUMULIN R U-100 LANTUS SOLN LEVEMIR **NOVOLIN** **NOVOLOG** **NOVOLOG MIX**		APIDRA HUMALOG MIX 50/50 HUMULIN INJ 50/50 HUMULIN R INJ U-500 RELION	Use PA Form# 20420
DIABETIC - PENFILLS		LANTUS OPTICLIK PEN[1] LANTUS SOLOSTAR[1] **LEVEMIR FLEXPEN**[1] **NOVOLIN PENFILL**[1] **NOVOLIN 70/30**[1] NOVOLOG MIX PENFILL[1] **NOVOLOG PENFILL SOLN**[1] NOVOLOG MIX FLEXPEN[1] NOVOLOG FLEXPEN[1]		APIDRA OPTICLIK PEN HUMALOG KWIK INJ 100/ML HUMALOG MIX INJ 75/25 KWP HUMALOG MIX INJ 50/50 KWP	1. Clinical PA will be required to establish significant visual or neurological impairment. Use PA Form# 20420
DIABETIC - DPP- 4 ENZYME INHIBITOR		JANUVIA[1] ONGLYZA[1]			1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile. Dosing limits apply. Please refer to Dose consolidation list. Use PA Form# 20420
DIABETIC - DPP- 4 ENZYME INHIBITOR-COMBO		JANUMET[1] KOMBIGLYZE			1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile. Dosing limits apply. Please refer to Dose consolidation list. Use PA Form# 20420
DIABETIC - LANCET-LANCET DEVICE		ONE TOUCH LANCETS DELICA LANCETS FREESTYLE LANCETS UNILET LANCETS UNISTIK LANCING DEVICE AUTOLOT LANCING DEVICE			Use PA Form# 20420
DIABETIC - SYRINGES-NEEDLES		BD MICRO-FINE BD ULTRA-FINE BD ULTRA-FINE PEN NEEDLES UNIFINE PEN NEEDLES			Use PA Form# 20420
DIABETIC - OTHER				CYCLOSET SYMLIN	Use PA Form# 301501
DIABETIC MONITOR		FREESTYLE LITE SYSTEM KIT FREESTYLE FLASH SYSTEM KIT FREESTYLE FREEDOM SYSTEM KIT FREESTYLE FREEDOM LITE KIT ONE TOUCH ULTRA 2 KIT ONE TOUCH ULTRA MINI KIT ONE TOUCH ULTRA SMART KIT PRECISION XTRA METER		ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY	Use PA Form# 20420
DIABETIC TEST STRIPS		FREESTYLE[1] FREESTYLE LITE[1] ONE TOUCH BASIC[1] ONE TOUCH SURESTEP[1] ONE TOUCH FAST TAKE[1] ONE TOUCH ULTRA[1] PRECISION XTRA[1] PRECISION XTRA BETA KETONE 10 CT		ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY	1. Only 50 ct & 100 ct package size. Use PA Form# 20420

INCRETIN MIMETIC				BYETTA[1] VICTOZA[1]	1. If patient is not responding to oral agents (single or multiple) please look to insulin therapy. Dosing limits apply. Please refer to Dose Consolidation List. Use PA Form# 10230
DIABETIC - ORAL SULFONYLUREAS		CHLORPROPAMIDE TABS GLIMEPIRIDE GLIPIZIDE TABS GLIPIZIDE ER TABS GLYBURIDE TABS GLYBURIDE MICRONIZED TABS TOLAZAMIDE TABS TOLBUTAMIDE TABS		AMARYL TABS DIABETA TABS GLUCOTROL TABS GLUCOTROL XL TBCR GLYNASE TABS MICRONASE TABS	Use PA Form# 20420
DIABETIC -ORAL BIGUANIDES		METFORMIN HCL TABS METFORMIN ER		GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET	Use PA Form# 20420
DIABETIC - THIAZOL / BIGUANIDE COMBO				ACTOPLUS MET[1] ACTOPLUS MET XR AVANDARYL[1] AVANDAMET TABS[1]	Use PA Form# 20420 1. Requires use of Actos, Metformin, or other preferred anti-diabetics.
DIABETIC - / THIAZOL		ACTOS 15MG TABS[1]		ACTOS 30MG AND 45MG TABS[2] AVANDIA TABS[3]	1. Actos is non-preferred as monotherapy. Actos is preferred if therapeutic doses of metformin, sulfonylurea or insulin are seen in members drug profile for at least 60 days within the past 18 months. 2. Actos 30mg or 45mg - please use multiple 15mg tabs. 3. Current users of Avandia who have tried Actos will be able to continue use of Avandia. Use PA Form# 20420
DIABETIC - ALPHAGLUCOSIDASE		GLYSET TABS		PRECOSE TABS	Use PA Form# 20420
DIABETIC - SULFONYLUREA / BIGUANIDE		GLYBURIDE/METFORMIN		GLUCOVANCE TABS[1] METAGLIP TABS[1] DUETACT[2]	1. Use individual ingredients. 2. Use Actos 15mgs with generic glimepiride. Use PA Form# 20420
DIABETIC - MEGLITINIDES		STARLIX TABS		PRANDIN TABS NATEGLINIDE	Use PA Form# 20420
GLUCOSE ELEVATING AGENTS					
GLUCOSE ELEVATING AGENTS		GLUCAGEN INJ. HYPOKIT		GLUCAGON DIAGNOSTIC KIT GLUCAGEN DIAGNOSTIC KIT	Use PA Form# 20420
THYROID					
THYROID HORMONES		ARMOUR THYROID TABS CYTOMEL TABS LEVOTHROID TABS LEVOTHYROXINE SODIUM TABS LEVOXYL TABS THYROID TABS THYROLAR UNITHROID TABS		LEVOTHYROXINE SODIUM SOLR LIOTHYRONINE SYNTHROID TABS	Use PA Form# 20420
ANTITHYROID THERAPIES		METHIMAZOLE TABS PROPYLTHIOURACIL TABS		TAPAZOLE TABS	Use PA Form# 20420
OSTEOPOROSIS					
OSTEOPOROSIS		ALENDRONATE FOSAMAX SOLN[2] MIACALCIN SOLN[2]		ACTONEL TABS BONIVA INJECTION KIT BONIVA TABS[2,4] AREDIA SOLR DIDRONEL TABS EVISTA TABS[1] FORTEO FORTICAL FOSAMAX TABS AND PLUS D[3]	Use PA Form# 20420 1. Approval only requires failure of Alendronate or Boniva. 2. Quantity limits apply, please see dosage consolidation list. 3. Please use Alendronate and Vitamin D. 4. Please use other preferred agents.
CALCIMIMETIC AGENTS					
CALCIMIMETIC AGENTS				SENSIPAR	Use PA Form# 30115
GROWTH HORMONE					
GROWTH HORMONE		GENOTROPIN[1] NUTROPIN[1] NUTROPIN AQ[1] NORDITROPIN CARTRIDGE SOLN[1]	5 5 8 8 8	OMNITROPE TEV-TROPIN HUMATROPE SOLR[2] INCRELEX[2] SAIZEN SOLR[2]	Use PA Form# 10710 1.Clinical PA is required to establish diagnosis and medical necessity. 2. Products must be used in specified step order. All step 5's must be tried prior to moving to step 8's.
SOMATOSTATIC AGENTS		OCTREOTIDE INJ		SANDOSTATIN SOMATULINE	Use PA Form# 10710
GROWTH HORMONE ANTAGONISTS					
GH ANTAGONISTS				SOMAVERT	Use PA Form# 10710
VASOPRESSIN RECEPTOR ANTAGONIST					
VASOPRESSIN RECEPTOR ANTAGONIST				SAMSCA	Use PA Form# 20420
URINARY INCONTINENCE					
VASOPRESSINS		DESMOPRESSIN TABS	5 6 6 8	DDAVP TABS DDAVP SOLN[1] DESMOPRESSIN SPRAY[1] DESMOPRESSIN ACETATE SOLN[1]	1. Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP.

			8	STIMATE SOLN[1,2]	2. Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization. Use PA Form# 20420
ANTISPASMODICS		OXYBUTYNIN URISPAS TABS		DETROL TABS DITROPAN	Use PA Form# 20420
ANTISPASMODICS - LONG ACTING		OXYBUTYNIN ER TABS	8	ENABLEX[1,3]	Use PA Form# 20420
		SANCTURA	8	DITROPAN XL TBCR	1. See Criteria Section.
		TOVIAZ	8	OXYTROL	2. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR.
		VESICARE[1]	8	TROSPIUM	
			9	DETROL LA CP[2]	
			9	SANCTURA XR[2]	3. Use a preferred long acting antispasmodic.
CHOLINERGIC		URECHOLINE			Use PA Form# 20420
METABOLIC MODIFIER					
HERED. TYROSINEMIA				ORFADIN	Use PA Form# 20420
ANTIHYPERTENSIVES / CARDIAC					
CARDIAC GLYCOSIDES		DIGITEK TABS DIGOXIN LANOXIN			Use PA Form# 20420
ANTIANGINALS--Isosorbide Di-nitrate/ Mono-Nitrates		ISOSORBIDE MONONITRATE TABS ISOSORBIDE MONONITRATE ER		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
NITRO - OINTMENT/CAP/CR		NITROBID OINT NITROGLYCERIN CPCR NITROL OINT NITRO-TIME CPCR			Use PA Form# 20420
NITRO - PATCHES	1	NITROGLYCERIN PT24[1]		NITRODISC PT24	1. At least 2 step 1's and step 3 of the preferred products must be used in specified order or PA will be required.
	1	NITREK PT24[1]		NITRO-DUR PT24	
	1	NITRO-DUR PT 24 0.8MG[1]			
	3	MINITRAN PT24[1]			Use PA Form# 20420
NITRO - SUBLINGUAL/ SPRAY		NITROLINGUAL SOLN NITROSTAT SUBL NITROTAB SUBL		NITROQUICK SUBL	Use PA Form# 20420
BETA BLOCKERS - NON SELECTIVE		CARVEDILOL LEVATOL TABS NADOLOL TABS PINDOLOL TABS PROPRANOLOL HCL SOLN[1] PROPRANOLOL HCL TABS[1] PROPRANOLOL LA CAPS SOTALOL HCL TABS TIMOLOL MALEATE TABS		BETAPACE TABS BETAPACE AF TABS COREG CR[3] COREG TABS CORGARD TABS INDERAL TABS INDERAL LA CPCR INNOPRAN XL PROPRANOLOL HCL 60MG TABS[2] SOTALOL AF RANEXA	1. Recommend using BID since its effects do not last 24 hours. 2. Please use other strengths in combination to obtain this dose. 3. Dosing limits still apply. Please see dose consolidation list Use PA Form# 20420
BETA BLOCKERS - CARDIO SELECTIVE		ACEBUTOLOL HCL CAPS ATENOLOL TABS[1] BETAXOLOL HCL TABS BISOPROLOL FUMARATE TABS METOPROLOL TARTRATE TABS[1] METOPROLOL ER		BYSTOLIC KERLONE TABS LOPRESSOR TABS SECTRAL CAPS TENORMIN TABS TOPROL XL TB24 ZEBETA TABS	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form# 20420
BETA BLOCKERS - ALPHA / BETA		LABETALOL HCL TABS		TRANDATE TABS	Use PA Form# 20420
CALCIUM CHANNEL BLOCKERS -Amlodipines, Bepridil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils		AMLODIPINE[1]		NORVASC TABS[1]	1. Dosing limits apply, please see dose consolidation list. Use PA Form# 20420
	1	DILTIA XT CP24	5	DILACOR XR CP24[1]	1. Products must be used in specified order or PA will be required. Just write "Diltiazem 24-hour"and the pharmacy will use a preferred long acting diltiazem that does not require PA.
	1	DILTIAZEM HCL ER CP24	6	TAZTIA[1]	
	1	DILTIAZEM HCL XR CP24	7	TIAZAC CP24[1]	
	1	DILTIAZEM CD 300MG CP24	8	CARDIZEM TABS[1]	
	1	DILTIAZEM CD 360MG CP24	8	CARDIZEM CD CP24[1]	
	4	CARTIA XT CP24[1]	8	CARDIZEM LA TB24[1]	
	4	DILTIAZEM CD CP24[1]	8	CARDIZEM SR CP12[1]	
	4	DILTIAZEM HCL ER CP24[1]	8	DILTIAZEM HCL TABS[1]	
	4	DILTIAZEM XR CP24[1]	8	DILTIAZEM HCL ER CP12[1]	Use PA Form# 20420
				PLENDIL TB24 FELODIPINE	Use PA Form# 20420
				DYNACIRC CAPS DYNACIRC CR TBCR[1]	Use PA Form# 20420 1. Established users will be grandfathered
				CARDENE SR CPCR NICARDIPINE HCL CAPS	Use PA Form# 20420
		AFEDITAB CR NIFEDIAC CC NIFEDICAL XL TBCR NIFEDIPINE TBCR NIFEDIPINE ER TBCR		ADALAT CC TBCR[1] NIFEDIPINE CAPS PROCARDIA CAPS PROCARDIA XL TBCR	1. Established users of Adalat CC are grandfathered. Use PA Form# 20420
				SULAR TB24	1. Established users of 10MG and

				SULAR CR[1]	20MG strengths are grandfathered. Use PA Form# 20420
	1 1 1	VERAPAMIL HCL CR TBCR VERAPAMIL HCL ER TBCR VERAPAMIL HCL SR TBCR		CALAN TABS CALAN SR TBCR COVERA-HS TBCR ISOPTIN-SR VERAPAMIL HCL ER CP24 VERAPAMIL HCL SR CP24 VERAPAMIL HCL TABS VERELAN CP24 VERELAN PM CP24	Products must be used in specified order or PA will be required. Just write "Verapamil 24-hour" and the pharmacy will use a preferred long acting generic that does not require PA. Use PA Form# 20420
ANTIARRHYTHMICS		AMIODARONE FLECAINIDE MEXILETINE MULTAQ NORPACE PROCAINAMIDE PROPAFENONE QUINAGLUTE QUINIDINE GLUCONATE QUINIDINE SULFATE		CORDARONE DISOPYRAMIDE PACERONE QUINIDEX TAMBOCOR TIKOSYN[1] RYTHMOL SR RYTHMOL	1. Prescription must be written by Cardiologist. Use PA Form# 20420
ACE INHIBITORS		BENAZEPRIL HCL CAPTOPRIL TABS ENALAPRIL MALEATE TABS FOSINOPRIL SODIUM LISINOPRIL TABS RAMIPRIL QUINAPRIL	5 5 8 8 8 8 8 8 8 8 8	MAVIK TABS ACCUPRIL TABS ACEON TABS[1] ALTACE CAPS[1] LOTENSIN TABS[1] MOEXIPRIL[1] MONOPRIL HCT TABS[1] PRINIVIL TABS[1] UNIVASC[1] VASOTEC TABS[1] ZESTRIL TABS[1]	1. Non-preferred products must be used in specified order. Use PA Form# 20420
ANGIOTENSIN RECEPTOR BLOCKER		AVAPRO[1] BENICAR TABS[1] DIOVAN[1] LOSARTAN[1] MICARDIS TABS[1]	8 8 8 8 8	ATACAND TABS COZAAR EDARBI TEVETEN TABS TRIBENZOR[2]	Use PA Form# 20420 1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. 2. Use preferred active ingredients which are available without PA.
DIRECT RENIN INHIBITOR				AMTURNIDE TEKTURNA[1] TEKAMLO	1. Must show failure of single and combination therapy from all preferred antihypertensive categories. Use PA Form# 20420
ANTIHYPERTENSIVES - CENTRAL		CATAPRES-TTS CLONIDINE HCL TABS GUANFACINE HCL TABS HYDRALAZINE HCL TABS HYLOREL TABS METHYLDOPA TABS MINOXIDIL TABS PRAZOSIN HCL CAPS RESERPINE TABS		CATAPRES TABS CLONIDINE TTS GUANABENZ ACETATE TABS ISMELIN TABS MINIPRESS CAPS NEXICLON TENEX TABS	Use PA Form# 20420
ACE INHIBITORS AND CA CHANNEL BLOCKERS			8 8 9	LOTREL CAPS TARKA TBCR AMLODIPINE/BENAZEPRIL	Use individual preferred generic medications. Use PA Form# 20420
ACE AND THIAZIDE COMBO'S		BENAZEPRIL HCL/HYDROCHLOR CAPTOPRIL/HYDROCHLOROTHIA ENALAPRIL MALEATE/HCTZ TABS LISINOPRIL-HCTZ TABS LOTENSIN HCT TABS		ACCURETIC TABS MONOPRIL HCT TABS PRINZIDE TABS UNIRETIC TABS VASERETIC TABS ZESTORETIC TABS	Use PA Form# 20420
BETA BLOCKERS AND DIURETIC COMBO'S		ATENOLOL/CHLORTHALIDONE BISOPROLOL FUMARATE/HCTZ PROPRANOLOL/HCTZ		CORZIDE TABS LOPRESSOR HCT TABS TENORETIC TIMOLIDE 10/25 TABS ZIAC TABS	Use PA Form# 20420
ARB'S AND CA CHANNEL BLOCKERS		AZOR[1] EXFORGE[1] EXFORGE HCT[1]		TWYNSTA	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form# 20420
ARB'S AND DIURETICS		AVALIDE TABS[1] BENICAR HCT[1] DIOVAN HCT TABS[1] LOSARTAN HCT[1] MICARDIS HCT TABS[1]		ATACAND HCT TABS HYZAAR TABS TEVETEN HCT TABS	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form# 20420
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION		VALTURNA			Use PA Form# 20420
DIURETICS		ACETAZOLAMIDE TABS BUMETANIDE CHLOROTHIAZIDE TABS CHLORTHALIDONE TABS EDECRIN TABS FUROSEMIDE HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS METHYCLOTHIAZIDE TABS SPIRONOLACTONE 25MG TABS SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ		ALDACTAZIDE TABS ALDACTONE TABS AMILORIDE HCL BUMEX TABS DEMADEX TABS DIAMOX DIURIL DYAZIDE CAPS ENDURON TABS INSPRA LASIX TABS MAXZIDE MICROZIDE CAPS MIDAMOR TABS	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra will be approved for severe breast tenderness and male gynecomastia. Use PA Form# 20420

		ZAROXOLYN TABS		NAQUA TABS SPIRONOLACTONE 50MG[1]	
CCB / LIPID		CADUET			
LIPID DRUGS					
CHOLESTEROL - BILE SEQUESTRANTS		CHOLESTYRAMINE COLESTIPOL HCl		COLESTID PREVALITE QUESTRAN WELCHOL TABS	Use PA Form# 20420
CHOLESTEROL - FIBRIC ACID DERIVATIVES		GEMFIBROZIL TABS NIASPAN TRICOR TRILIPIX		ANTARA LOPID FIBRICOR LIPOFEN LOFIBRA FENOFIBRATE TRIGLIDE	Use PA Form# 20420
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS		LIPITOR SIMVASTATIN[1]		CRESTOR VYTORIN[2] ZOCOR	1. Dosing limits apply, please see dosage consolidation list. 2. Only available if component ingredients are unavailable. Use PA Form# 20420
CHOLESTEROL - HGM COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS		LESCOL CAPS LESCOL XL TB24 LOVASTATIN TABS[2] PRAVASTATIN[2]	8 8 8 8 8 8	ALTOPREV TB24 LIVALO MEVACOR TABS PRAVACHOL TABS PRAVIGARD ZETIA TABS[1]	1. Zetia available w/out PA as addition to Lipitor 80mg. Zetia will also be approved with a PA as add on for patients at maximally tolerated doses of statins. 2. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420
CHOLESTEROL - HGM COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO		SIMCOR ADVICOR TBCR			Use PA Form# 20420
PULMONARY ANTI-HYPERTENSIVES					
PULMONARY ANTI-HYPERTENSIVES		REVATIO[1] VENTAVIS[2] EPOPROSTENOL INJ[4]		ADCIRCA FLOLAN REMODULIN[3]	1. See Criteria Section. 2. See Criteria Section. 3. There will be dosing limits of one 20ml multidose vial/ 30 days supply without pa. 4. PA is required to establish and conferm who group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 & 4. Use PA Form# 20420
ERA / ENDOTHELIN RECEPTOR ANTAGONIST		LETAIRIS[1,2]		TRACLEER[3,4]	1. Providers must be registered with LEAP Prescribing program, a restricted distribution program. 2. Clinical PA is required to establish diagnosis and medical necessity. 3. 1. Prior trial of Letaris, WHO Group 1 diagnosis of PAH (Primary Pulmonary Hypertension) and NYHA functional class of 3. 4. For members with NYHA functional class of 4, Tracleer approval will be allowed with confirmation of diagnosis and functional class. Use PA Form# 20420
IMPOTENCE AGENTS					
IMPOTENCE AGENTS					As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.
ANTI-EMETOGENICS					
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC		MECLIZINE HCL TABS PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72		ANTIVERT TABS PHENERGAN SOLN PROMETHAZINE 50MG SUPP PROMETHEGAN SUPP TORECAN TABS	Use PA Form# 20420
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ		MARINOL CAPS ONDANSETRON TABS[2,4] ONDANSETRON ODT TBDP[2,4] ONDANSETRON INJ[2,4]	5 8 8 8 8 8 8 8 8 8 8	GRANISETRON ALOXI ANZEMET TABS CESAMET[1] EMEND[3] KYTRIL SANCUSO ZOFRAN ODT TBDP[4] ZOFRAN TABS[4] ZOFRAN INJ[4] ZUPLENZ	1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred anti-emetics, including 5-HT3 class (Ondansetron) and Marinol. 2. Ondansetron will be preferred with CA diag and dosing limits still apply. 3. Clinical PA is required for members on highly emetic anti-neoplastic agents. 4. Dosing limits apply, please see Dosage Consolidation List Use PA Form# 20610 for **Ondansetron** requests Use PA Form# 20420 for **all others**

		NON-SEDATING ANTIHISTAMINES / DECONGESTANTS			
ANTIHISTIMINES - NON-SEDATING		ALAVERT TABS CETIRIZINE TABS CLARITIN (OTC) CLARITIN SYRP (OTC) LORATADINE TAVIST ND (OTC)	5 5 5 5 5 8 8 8 8	CLARINEX TABS[1] CLARINEX SYR[1,2] FEXOFENADINE[1] ZYRTEC[1] ZYRTEC SYR[1,2] ALLEGRA[3] CLARITIN[3] LORATADINE ODT[4] XYZAL[3]	1. Must fail preferred drugs, OTC loratidine and cetirizine before moving to non-preferred step order drugs. 2. Clarinex and Zyrtec syrp <6 yr w/o PA. 3. Must fail all step 5 drugs (Clarinex, Fexofenadine and Zyrtec) before moving to next step product. 4. All OTC versions of loratadine ODT are now non-preferred. Pseudoephedrine is available with prescription. Use PA Form# 20530
ANTIHISTIMINES - OTHER		CLEMASTINE CHLORPHENIRAMINE DIPHENHYDRAMINE			Use PA Form# 20530
		ALLERGY / ASTHMA THERAPIES			
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER		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 nebulizer solution is in member's current drug profile. 2. We ask physicians to write "asthma" on the prescription whenever Sprivia is primarily being used for that condition.
ANTIASTHMATIC - PHOSPHODIESTERASE 4 INHIBITORS				DALIRESP	Use PA Form# 20420
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER		IPRATROPIUM BROMIDE SOLN		ATROVENT SOLN	Use PA Form# 20420
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS		CROMOLYN SODIUM NEBU		XOLAIR[1]	1. Need max inhaled steroids and written by pulmonary or allergy specialist. Use PA Form# 20420
ANTIASTHMATIC - NASAL STEROIDS		FLUTICASONE SPR[3] NASONEX SUSP[3]	5 5 8 8 8 8 8 8 8 8 8	BECONASE AQ INHA[1,3] NASACORT AQ AERS[1,3] FLONASE SUSP[2,3] FLUNISOLIDE SOLN[2,3] NASACORT AERS[2,3] OMNARIS SPR[3] RHINOCORT AERO[2,3] RHINOCORT AQUA SUSP[2,3] TRI-NASAL SOLN[2,3] VANCENASE POCKETHALER AERS[2,3] VERAMYST[2,3]	Use PA Form# 20420 1. All preferred drugs must be tried before moving to non preferred steps. 2. All step 5 medications need to be tried before moving to step 8's. 3. Dosing limits apply to whole category, please see dosage consolidation list.
ANTIASTHMATIC - NASAL MISC.		CROMOLYN NASAL 4% NASALCROM OCEAN 0.65% SALINE NASAL SPRAY 0.65%	7 7 7 8	ATROVENT NASAL SOL IPRATROPIUM NASAL SOL[1] ASTELIN ASTEPRO[2]	Use PA Form# 20420 1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine. 2. Utilize Multiple preferred, as well as step therapy Astelin.
ANTIASTHMATIC - BETA - ADRENERGICS		ALBUTEROL NEB MAXAIR METAPROTERENOL PROAIR HFA[3] PROVENTIL HFA SEREVENT TERBUTALINE SULFATE TABS VENTOLIN HFA AERS[3]		ACCUNEB NEBU ALBUTEROL AER ALBUTEROL HFA ALBUTEROL 0.63mg/3ml BRETHINE FORADIL AEROLIZER CAPS VENTOLIN AERS VOLMAX TBCR VOSPIRE ER TB12 XOPENEX HFA[3] XOPENEX NEBU[1,2]	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 see dosage consolidation list. Use PA Form# 20420
ANTIASTHMATIC - ADRENERGIC COMBINATIONS		ADVAIR DISKUS/HFA[1,2] DULERA SYMBICORT[2]			1. We ask physicians to write "asthma" on the prescription whenever Advair is primarily being used for that condition. 2. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC		ALBUTEROL/IPRATROPIUM NEB. SOLN 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		AMINOPHYLLINE TABS THEOCHRON TB12 THEOLAIR-SR TB12 THEOPHYLLINE CR TB12 THEOPHYLLINE ELIX		THEO-24 CP24 THEOLAIR TABS UNIPHYL TBCR	Use PA Form# 20420

		THEOPHYLLINE SOLN **THEOPHYLLINE ER CP12** **THEOPHYLLINE ER TB12**			
ANTIASTHMATIC - STEROID INHALANTS		ASMANEX[4] **FLOVENT DISKUS[4]** **FLOVENT HFA[4]** **PULMICORT SUSP[1,4]** QVAR AERS[4]	5 5 5 8 8 8 8	**AEROBID AERS[2,4]** BECLOVENT AERS[2,4] VANCERIL AERS[2,4] **AEROBID-M AERS[3,4]** ALVESCO[4] VANCERIL DOUBLE STRENGTH AERS[3,4] **PULMICORT FLEXHALER[4]**	1. No PA for Pulmicort susp if under 8 years old. 2. All preferreds must be tried before moving to non preferred steps. 3. All step 5 medications need to be tried before moving to step 8's. 4. Dosing limits apply to whole category, please see dosage consolidation list. Use PA Form# 20420
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				ZYFLO CR TABS	Use PA Form# 20420
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS		SINGULAIR		ACCOLATE TABS	Use PA Form# 20420
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR				GLASSIA PROLASTIN SUSR ZEMAIRA	Use PA Form# 20420
ANTIASTHMATIC - HYDRO-LYTIC ENZYMES				PULMOZYME SOLN	Use PA Form# 20420
ANTIASTHMATIC - MUCOLYTICS		ACETYLCYSTEINE[1]		MUCOMYST	1. Acetylcysteine is covered with diagnosis of CF. Use PA Form# 20420
COUGH/COLD					
COUGH/COLD		DEXTRO-GUAIF SYRP[1] GUAIFENESIN SYRP[1] PSEUDOEPHEDRINE[1] ROBITUSSIN DM SYRP[1] ROBITUSSIN SUGAR FREE SYRP[1]			1. All of cough cold preparations are not covered except these preferred products. Use PA Form# 20420
DIGESTIVE AIDS / ASSORTED GI					
GI - ANTIPERISTALTIC AGENTS		DIPHENOXYLATE DIPHENOXYLATE/ATROPINE LOPERAMIDE HCL CAPS/LIQ OPIUM TINCTURE TINC PAREGORIC TINC		LOFENE TABS LONOX TABS MOTOFEN TABS	Use PA Form# 20420
GI - ANTI-DIARRHEAL/ ANTACID MISC.		ATROPINE SULFATE SOLN BENTYL SYRP BISMATROL BISMUTH SUBSALICYLATE CALCIUM CARBONATE (ANTACID) CHEW DICYCLOMINE HCL GLYCOPYRROLATE TABS HAPONAL TABS HYOSCYAMINE CAPS & TABS HYOSCYAMINE SULFATE KAOPECTATE MAGNESIUM OXIDE TABS MAG-OX 400 TABS PAMINE TABS PROPANTHELINE BROMIDE TABS SAL-TROPINE TABS SCOPOLAMINE HYDROBROMIDE SODIUM BICARBONATE TABS TUMS		BELLADONNA ALKALOIDS & OP BENTYL TABS GLYCOPYRROLATE INJ HYOSCYAMINE SL LEVBID TB12 LEVSIN ELIX LEVSIN TABS LEVSIN/SL SUBL NULEV TBDP ROBINUL INJ ROBINUL TABS	Use PA Form# 20420
GI - H2-ANTAGONISTS		CIMETIDINE FAMOTIDINE RANITIDINE RANITIDINE SYRP ACID REDUCER TABS		AXID CAPS AXID AR TABS NIZATIDINE CAPS PEPCID PEPCID AC ZANTAC SYRP ZANTAC TABS	Use PA Form# 20420
GI - PROTON PUMP INHIBITOR		DEXILANT (KAPIDEX)[2] OMEPRAZOLE 20MG[2] PANTOPRAZOLE	6 7 8 8 8 8 8 8 8 8 8 9	PRILOSEC OTC[4] ACIPHEX TBEC[4] PREVACID CPDR[4,5] PREVACID SOLUTABS[1] NEXIUM CPDR[4] PRILOSEC CPDR PROTONIX INJ PROTONIX[2] OMEPRAZOLE 10MG[2] OMEPRAZOLE-SODIUM BICARBONATE CAPS LANSOPRAZOLE OMEPRAZOLE 40MG[3]	1. Prevacid Solutabs available without PA for children less than 9 years old. 2. Dosing limits apply, please see dosage consolidation list. 3. Please use multiple 20mg Capsules to obtain required dose. 4. All preferreds and step therapy must be tried and failed. 5.Established users prior to 10/1/09 may continue to obtain Prevacid until 12/31/09. Use PA Form# 20720
GI - ULCER ANTI-INFECTIVE				HELIDAC PREVPAC	Use PA Form# 20420
GI - PROSTAGLANDINS		MISOPROSTOL TABS		CYTOTEC TABS	Use PA Form# 20420
GI - DIGESTIVE ENZYMES		CREON[1] LACTASE CHEW LACTASE TAB ZENPEP[1]		LACTRASE CAPS LIPRAM LIPRAM CR KU-ZYME CAPS	Use PA Form# 20420 1. Clinical PA is required to establish CF diagnosis and medical necessity. In all cases except cystic fibrosis patients, objective evidence of

				PANCREASE PANOKASE TABS TRIPASE	pancreatic insufficiency (fat malabsorption test etc...) must be supplied.
GI - ANTI - FLATULENTS / GI STIMULANTS		CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP GASTROCROM CONC GENERLAC SYRP LACTULOSE SYRP[1] METOCLOPRAMIDE HCL SIMETHICONE		AMITIZA[2] CEPHULAC SYRP INFANTS GAS RELIEF SUSP REGLAN TABS	1. Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL Use PA Form# 20420 2. Prior failed trials of multiple other preferred GI agents must occur first, Such as OTC senna, docusate, lactulose, polyethylene glycol.
GI - INFLAMMATORY BOWEL AGENTS		ASACOL TBEC 400 APRISO AZULFIDINE TABS CANASA SUPP COLAZAL CAPS DIPENTUM CAPS PENTASA CPCR 250MG ROWASA ENEM SULFAZINE EC TBEC SULFASALAZINE TABS		ASACOL 800MG HD AZULFIDINE EN-TABS TBEC BALSALAZIDE LIALDA TABS[1] PENTASA 500MG[2] SFROWASA	Use PA Form# 20420 1. Current users grandfathered. 2. Use multiple Pentasa 250mg.
GI - IRRITABLE BOWEL SYNDROME AGENTS				LOTRONEX TABS	Use PA Form# 20420
MISCELLANEOUS GI					
GI - MISC.		BISAC-EVAC SUPP BISACODYL BISCOLAX SUPP CINOBAC CAPS CITRATE OF MAGNESIA SOLN CITRUCEL DIOCTO SYRP DOCUSATE CALCIUM CAPS DOCUSATE SODIUM FIBER LAXATIVE TABS FLEET GENFIBER POWD GLYCERIN HIPREX TABS KRISTALOSE PACK MAALOX METAMUCIL MILK OF MAGNESIA SUSP MINERAL OIL OIL NULYTELY SOLR SENNA SENOKOT GRAN SENOKOT SYRP SENOKOT CHILDRENS SYRP SENOKOT XTRA TABS SORBITOL STOOL SOFTENER CAPS SUCRALFATE TABS UNI-EASE CAPS UNIFIBER POWD URSO FORTE URSODIOL		ACTIGALL CAPS BENEFIBER CARAFATE CLEARLAX POW COLACE CAPS COLYTE DIOCTO-C SYRP DOC SOD /CAS CAP DOC-Q-LAX CAPS DOCUSATE SODIUM/CAS CAPS DOK PLUS DULCOLAX SUPP FIBER CON TABS FIBER-LAX TABS GOLYTELY SOLR MALTSUPEX MIRALAX PACK (OTC versions) MIRALAX POWD (OTC versions) PEG 3350/ELECTROLYTES SOLR SENEXON TABS SENOKOT TABS SENOKOT S TABS STOOL SOFTENER PLUS CAPS UNI-CENNA TABS UNI-EASE PLUS CAPS V-R NATURAL SENNA LAXATIV TABS URSO 250	1. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose. Use PA Form# 20420
MISC. UROLOGICAL					
UROLOGICAL - MISC.		ACETIC ACID 0.25% SOLN CYTRA-K SOLN FURADANTIN SUSP K-PHOS MF TABS METHENAMINE MANDELATE TABS MONUROL PACK NEOSPORIN GU IRRIGANT SOLN PHENAZOPYRIDINE HCL TABS PHENAZOPYRIDINE PLUS PROSED/DS TABS TRICITRATES SYRP URELIEF PLUS UREX TABS URISED TABS UROCIT-K UROQID #2 TABS		CITRIC ACID/SODIUM CITRAT SOLN CYTRA-2 SOLN ELMIRON CAPS[1] MACROBID CAPS MACRODANTIN CAPS NITROFURANTOIN MACR CAPS POTASSIUM CITRATE/CITRIC SOLN PYRIDIUM PLUS TABS PYRIDIUM TABS RENACIDIN SOLN	1. Elmiron requires adequate proof of Dx with supportive testing. Use PA Form# 20420
PHOSPHATE BINDERS					
PHOSPHATE BINDERS		PHOSLO[1] MAGNEBIND - 400[1] RENAGEL 400[1] FOSRENOL[1] RENVELA[1]		RENAGEL 800	Use PA Form# 20420 1. Diag required.
INTRA-VAGINALS					
VAGINAL - ANTIBACTERIALS	1 1 3	CLEOCIN CREA METRONIDAZOLE VAGINAL GEL[2] CLEOCIN SUPP[1]		METROGEL VAGINAL GEL[2] VANDAZOLE	1. Step order must be followed to avoid PA. Must fail Cleocin Cream and Metronidazole products before moving to next step product without PA. 2. Dosing limits apply, please see Dosage Consolidation List. Use PA Form# 20420
VAGINAL - ANTI FUNGALS		CLOTRIMAZOLE CREA GYNE-LOTRIMIN CREA		AVC CREA CLOTRIMAZOLE 3 DAY CREA	1. Quantity limit: 1/script/2 weeks

Class		Preferred	Tier	Non-Preferred	Criteria
		MICONAZOLE CREA MICONAZOLE 3 COMBO PACK KIT[1] MICONAZOLE 7 CREA MICONAZOLE NITRATE CREA NYSTATIN TABS TERAZOL 3 SUPP TERCONAZOLE 0.4MG VAGITROL V-R MICONAZOLE-7 CREA		GYNAZOLE-1 CREA GYNE-LOTRIMIN 3 TABS MICONAZOLE 3 SUPP TERAZOL 3 CREA TERAZOL 7 CREA TERCONAZOLE 0.8MG TERCONAZOLE SUPP	Use PA Form# 20420
VAGINAL - CONTRACEPTIVES		GYNOL II EXTRA STRENGTH GEL		DELFEN FOAM	Use PA Form# 20420
VAGINAL - ESTROGENS		**ESTRING RING** **PREMARIN CREA**		ESTRACE CREA[1] VAGIFEM TABS[1]	1. Must fail all preferred products before non-preferred. Use PA Form# 20420
VAGINAL - OTHER		ACID JELLY GEL ACI-JEL GEL CERVICAL AMINO ACID CREA		AMINO ACID CERVICAL CREA	Use PA Form# 20420
		BPH			
BPH		**DOXAZOSIN MESYLATE TABS** FINASTERIDE[1] TERAZOSIN HCL CAPS **TAMSULOSIN**	5 8 8 8 8 8 8	**FLOMAX CP24** AVODART[2,4] **CARDURA TABS[4]** JALYN[3,4] PROSCAR TABS[4] RAPAFLO[4] UROXATRAL[4]	1. There will be dosing limits of 1 tab per day with out PA. 2. Prior use of preferred agent prior to any approvals. 3. Use of preferred (tamsulosin and finasteride) and (tamsulosin and non-preferred Avodart). 4. Non-preferred products must be used in specified order. Use PA Form# 20420
		ANXIOLYTICS			
ANXIOLYTICS - BENZODIAZEPINES		ALPRAZOLAM TABS CHLORDIAZEPOXIDE HCL CAPS CLORAZEPATE DIPOTASSIUM TABS DIAZEPAM LORAZEPAM OXAZEPAM CAPS	8 8 8 8 8 8 9	ATIVAN NIRAVAM SERAX TRANXENE XANAX TABS XANAX XR ALPRAZOLAM ER	Use PA Form# 20420
ANXIOLYTICS - MISC.		BUSPIRONE HCL TABS HYDROXYZINE HCL SOLN HYDROXYZINE HCL SYRP HYDROXYZINE PAMOATE CAPS MEPROBAMATE TABS		BUSPAR TABS DROPERIDOL SOLN HYDROXYZINE HCL TABS HYDROXYZINE PAM 100MG CAPS VISTARIL	Use PA Form# 20420
		ANTI-DEPRESSANTS			
ANTIDEPRESSANTS - MAO INHIBITORS		NARDIL TABS PARNATE TABS			Use PA Form# 20420
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL				EMSAM[1]	1. Dosing limits apply, please refer to Dose consolidation list. Use PA Form# 20420
ANTIDEPRESSANTS - SELECTED SSRI's		BUPROPION HCL TABS BUPROPION SR BUPROPION XL CITALOPRAM[4] FLUOXETINE HCL CAPS FLUOXETINE HCL LIQD FLUOXETINE HCL 10mg TABS FLUVOXAMINE MALEATE TABS LEXAPRO TABS[4] MIRTAZAPINE NEFAZODONE PAROXETINE[3] SERTRALINE[2] TRAZODONE HCL TABS VENLAFAXINE ER CAPS[9]	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 9	APLENZIN[7] CELEXA[4] CYMBALTA[5, 11] EFFEXOR TABS EFFEXOR XR CP24[3, 10] FLUOXETINE 40 mg CAPS[1] FLUOXETINE 20mg TABS[6] LUVOX TABS MAPROTILINE HCL TABS MIRTAZAPINE ODT OLEPTRO PAROXETINE CR[3] PAXIL[3] PAXIL CR[3] PRISTIQ PROZAC PROZAC CAPS PROZAC WEEKLY CPDR REMERON TABS SARAFEM CAPS TRAZODONE HCL 300MG TABS WELLBUTRIN TABS WELLBUTRIN SR TBCR WELLBUTRIN XL REMERON SOLTAB TBDP SAVELLA[8] ZOLOFT VENLAFAXINE TABS[9] VENLAFAXINE ER TABS[9] FLUOXETINE 90mg TABS[12]	1. Use Fluoxetine 20 mg in multiples. 2. See Zoloft splitting table. Sertraline requires splitting of scored tabs to avoid PA. 3. Strong caution with pediatric population. 4. See Celexa/Citalopram and Lexapro splitting tables. 5. Max daily dose allowed is 60mg, only 1 capsule per day allowed for all strengths. Combination of multiple strengths require PA. 6. Use Fluoxetine 10mg tabs or capsules in multiples. 7. Provide clinical documentation as to why a preferred generic alternative cannot be used. 8. Dosing limits allowing 2 tabs/day and a max daily limit of 200mg / day applies. Please see dose consolidation list. 9. Dosing limits and max daily dose applies. Limit of 1 tab per day of 37.5mg, 75mg, and 225mg will be allowed without pa, along with limits of 2 tabs per day of the 150mg strength. Max daily dose allowed is 375mg. 10. Use venlafaxine ER tabs. 11. Established users are grandfathered.

					12. Non-preferred products must be used in specified step order. Use PA Form# 20420
ANTIDEPRESSANTS - TRI-CYCLICS		AMITRIPTYLINE HCL TABS[1] CLOMIPRAMINE HCL CAPS[1] DESIPRAMINE HCL TABS[1] DOXEPIN HCL[1] IMIPRAMINE HCL TABS[1] NORTRIPTYLINE HCL[1] PROTRIPTYLINE HCL TABS[1] SURMONTIL CAPS[1]		AMOXAPINE TABS ANAFRANIL CAPS DOXEPIN HCL 150 MG[2] NORPRAMIN TABS PAMELOR TOFRANIL VIVACTIL TABS	1. Users over the age of 65 require a pa. 2. Use multiples of 50mg. Use PA Form# 20420 Use PA Form# 10220 for **Brand Name requests**
SEDATIVE / HYPNOTICS					
SEDATIVE/HYPNOTICS - BARBITURATE		BUTISOL SODIUM TABS[1] CHLORAL HYDRATE SYRP[1] MEBARAL TABS[1] PHENOBARBITAL[1]		LUMINAL SOLN SOMNOTE CAPS	1. PA required for new users of preferred products if over 65 years. Use PA Form# 20420
SEDATIVE/HYPNOTICS - BENZODIAZEPINES		DORAL TABS[1] ESTAZOLAM TABS[1] FLURAZEPAM HCL CAPS[1] TEMAZEPAM CAPS 15 & 30MG[1] TRIAZOLAM TABS[1]		HALCION TABS[1] MIDAZOLAM HCL SYRP RESTORIL CAPS[1] TEMAZEPAM 7.5MG[1]	1. Dosing limits apply, please see dosing consolidation list. Use PA Form# 30110
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	1 1 1 2	MIRTAZAPINE TRAZODONE ZOLPIDEM[2] ZALEPLON[2,3]	7 8 8 8 8 8 8	AMBIEN[1] AMBIEN CR[1] EDLUAR LUNESTA[1] SONATA CAPS[1] ROZEREM ZOLPIMIST	1. Quantity Limt of 12 per 34 days. 2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended. 3. Only zolpidem trial/failure will be required to obtain Zaleplon. 4. Must fail all preferred products before non-preferred Use PA Form# 30110
ANTI-PSYCHOTICS					
ANTIPSYCHOTICS - ATYPICALS		ABILIFY TABS[3,4] GEODON[4] RISPERIDONE TAB[4] RISPERIDONE SOLN[4] SEROQUEL TABS[4] ZYPREXA TABS[4]	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	ABILIFY DISC TAB, INJ and SOL[2] FANAPT INVEGA INVEGA SUSTENNA LATUDA RISPERDAL TAB RISPERDAL CONSA[2] RISPERDAL M TAB[2] RISPERDAL SOLN RISPERIDONE ODT SAPHRIS SEROQUEL 50MG TABS[1,2] ZYPREXA ZYDIS TBDP[2] ZYPREXA RELPREVV SEROQUEL XR[5]	If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.This also includes combination of Seroquel with Seroquel XR. Use PA form# 20440 for **Multiple Antipsychotic requests** Use PA form# 10130 for **non-preferred single therapy atypical requests** 1. Please use multiple 25mg tablets. 2. Established users of single therapy atypicals were grandfathered. 3. Abilify requires splitting of tab to avoid PA. Please see Abilify splitting table. 4. Prior Authorization will be required for preferred medications for members under the age of 5. 5. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR.
ANTIPSYCHOTICS - SPECIAL ATYPICALS		CLOZAPINE TABS		CLOZARIL TABS FAZACLO	Use PA Form# 20420
ANTIPSYCHOTICS - TYPICAL		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 TRIFLUOPERAZINE HCL TABS		COMPAZINE COMPRO SUPP HALDOL DECANOATE LOXITANE CAPS MELLARIL NAVANE CAPS PROLIXIN STELAZINE TABS	Use PA Form# 20420 If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.
LITHIUM					
LITHIUM		LITHIUM CARBONATE LITHIUM CITRATE SYRP		ESKALITH CAPS ESKALITH CR TBCR	Use PA Form# 20420
COMBINATION - PSYCHOTHERAPEUTIC					
PSYCHOTHERPEUTIC		CHLORDIAZEPOXIDE/AMITRIPT	8	SYMBYAX[1]	1. Only available if component

COMBINATION		PERPHENAZINE/AMITRIPTYLIN			ingredients are unavailable. Use PA Form# 20420
STIMULANTS					
STIMULANT - AMPHETAMINES - SHORT ACTING		ADDERALL TABS[1] AMPHETAMINE SALT COMBO[1,3] DEXTROAMPHET SULF TABS[1,3] DEXEDRINE[1,3] DEXTROSTAT TABS[1]			1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. As per recent FDA alert, Adderal & Dexedrinel should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 3. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420
STIMULANT - LONG ACTING AMPHETAMINES SALT		ADDERALL XR CP24[1,3,4] VYVANSE[2,3,4]			Use PA Form# 20420 1. As per recent FDA alert, Adderall should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 2. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Limit of one capsule daily. Max dose of 70MG daily. 3. Preferred stimulants will be available without PA if diagnosis of ADHD. 4. Dosing limits applly, please see dosing consolidation list.
LONG ACTING AMPHETAMINES		DEXEDRINE CAP CR[1,2,3]		DEXTROAMPHET SULF CPCR[3]	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 3. Dosing limits applly, please see dosing consolidation list. Use PA Form# 20420
STIMULANT - METHYLPHENIDATE		FOCALIN TABS[1,2] METADATE ER TBCR[1,2] METHYLIN ER TBCR[1,2] METHYLIN TABS[1,2] METHYLIN SOL[1] METHYLPHENIDATE HCL[1,2]		METHYLIN CHEWABLES RITALIN	1. Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form# 20420 2. Dosing limits apply, please see dosing consolidation list. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexmethylphenidate.
STIMULANT - METHYLPHENIDATE - LONG ACTING		CONCERTA TBCR[1] DAYTRANA[1,4] FOCALIN XR[1]	5 8	METADATE CD CPCR[3] RITALIN LA[2]	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. Non-preferred products must be used in specified step order. 3. Dosing limits apply, please see doseage consolidation list. 4. FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily. Use PA Form# 20420
STIMULANT - STIMULANT LIKE			7 8 8 8 8 9 9 9	STRATTERA[1, 2] CAFCIT SOLN[3] INTUNIV[3,4] KAPVAY PROVIGIL TABS[3] NUVIGIL[3] DESOXYN TABS[3] DESOXYN CR[3]	1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of Strattera, unless history of substance abuse without current use of abusable medication(s). 2. Strattera currently has dosing limitations allowing one tablet per day for all strengths if obtain approval. Max daily dose of Strattera is 100mg. Please see dosing consolidation list. 3. Non-preferred products must be used in specified step order. 4. Please use generic Guanfacine. Use PA Form# 20710 for Provigil, Nuvigil and Xyrem Use PA Form# 20420 for all others
ANTI-CATAPLECTIC AGENTS					

PSYCHOTHERAPEUTIC AGENTS - MISC.				XYREM SOL	Use PA Form# 20710 for **Xyrem**
				XENAZINE	Use PA Form# 20710 for **Xenazine**
WEIGHT LOSS					
WEIGHT LOSS					No longer covered: PHENTERMINE, XENICAL,DIDREX, and MERIDIA
ALZHEIMER DISEASE					
ALZHEIMER - Cholinomimetics/Others		ARICEPT TABS[1]	8	EXELON[2]	1. PA is required to establish dementia diagnosis and baseline mental status score.
		ARICEPT ODT	8	RAZADYNE[2]	
		DONEPEZIL HYDROCHLORIDE TABS[1]	8	RIVASTIGMINE TARTRATE CAPS[2]	2. Must fail all preferred products before moving to non-preferred.
		DONEPEZIL HYDROCHLORIDE ODT[1]	9	COGNEX CAPS[2]	
		NAMENDA[1]			Use PA Form# 20420
SMOKING CESSATION					
NICOTINE PATCHES / TABLETS		CHANTIX[1,2,3]			Use PA Form# 20420
		NICODERM CQ PT24[2,3]			1. Chantix is preferred without PA for up to 6 months of continuous use once per lifetime.
		NICOTINE DIS PT24[2,3]			2. Preferred nicotine replacement therapy and Chantix will become non-preferred and will require PA if they are being used in combination together.
					3. Bupropion SR 150 mg is available without a prior authorization.
NICOTINE REPLACEMENT - OTHER		NICOTINE POLACRILEX GUM[2]	5	COMMIT LOZENGES[1,3,4]	Use PA Form# 20420
		NICORETTE GUM[2]	8	NICOTROL INHALER[3,4]	1. Will be available to patients unable to tolerate preferred products.
			8	NICOTROL NASAL SPRAY[3,4]	2. Preferred nicotine replacement therapy and Chantix will become non-preferred and will require PA if they are being used in combination together.
					3. Must fail all preferred products from smoking cessation category (Nicoderm patch and nicotine gum) before moving to non-preferred.
					4. Must use non-preferred products in specified step order.
ALCOHOL DETERRENTS					
ALCOHOL DETERRENTS		ANTABUSE TABS			1. Should only be used in conjunction with formal structured outpatient detoxification program.
		CAMPRAL[1]			
		DISULFIRAM TABS			
		NALTREXONE HCL TABS			Use PA Form# 20420
MISCELLANEOUS ANALGESICS					
ANALGESICS - MISC.		ACETAMINOPHEN		AXOCET CAPS	Use PA Form# 20420
		ASPIRIN		ESGIC-PLUS	
		ASPRIN/ APAP/ CAFF TAB		FIORICET TABS	
		BUTAL/ASA/CAFF		FIORINAL CAPS	
		BUTALBITAL COMPOUND		FIORTAL CAPS	
		BUTALBITAL/ACET TABS		FORTABS TABS	
		BUTALBITAL/APAP CAPS		PHRENILIN TABS	
		BUTALBITAL/APAP/CAFFEINE		PHRENILIN FORTE CAPS	
		CHOLINE MAGNESIUM TRISALI		TRILISATE LIQD	
		DIFLUNISAL TABS		TRILISATE TABS	
		EXCEDRIN		ZEBUTAL CAPS	
		SALSALATE TABS		ZORPRIN TBCR	
LONG ACTING NARCOTICS					
NARCOTICS - LONG ACTING		AVINZA	8	ABSTRAL	Use PA Form# 20510
		FENTANYL PATCH[5]	8	BUTRANS	1. Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable.
		KADIAN[6]	8	DURAGESIC PT72[5]	
		METHADONE	8	EMBEDA	
		METHADOSE	8	EXALGO	
		MORPHINE SULFATE ER TB12	8	MORPHINE SULFATE SUPP	
			8	MS CONTIN TB12	
			8	ORAMORPH SR TB12	
			8	OXYCONTIN TB12[1,4]	
			9	OXYCODONE ER[3,7]	
			9	OPANA ER[7]	
					2. Established users are grandfathered.
					3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to achieve max total daily dose of 320mg.

					4. Oxycontin 15mg, 30mg & 60mg are new strengths. Any PA request for the new strengths will be required to use combinations of strengths that have previously been available (including 10mg, 20mg, 40mg, & 80mg tablets) to obtain requested dose.
					5. Dosing limits apply. Please see dose consolidation list.
					6. Kadian 10mg, 80mg & 200mg are non-preferred.
					7. Non-preferred products must be used in specific order.
NARCOTICS - SELECTED		TRAMADOL HCL TABS	8	BUPRENEX SOLN	Use PA Form# 20420
			8	BUTORPHANOL	1. Only available if component ingredients are unavailable.
			8	NALBUPHINE HCL SOLN	
			8	STADOL NS SOLN	
			8	ULTRACET TABS[1]	
			8	ULTRAM TABS	
			8	ULTRAM ER	
			9	RYZOLT	
MISCELLANEOUS NARCOTICS					
NARCOTICS - MISC.		ACETAMINOPHEN/CODEINE	8	ASCOMP/CODEINE CAPS	1. Fentanyl OT loz (Barr) and Capital and codeine suspension products require PA for users over 18 years of age. PA is not required if under 18 years of age.
		ASPIRIN/CODEINE TABS	8	BUTALBITAL/APAP/CAFFEINE/ CAPS	
		BUTAL/ASA/CAFF/COD CAPS	8	DEMEROL	
		BUTALBITAL/ASPIRIN/CAFFEI CAPS	8	DILAUDID	
		CAPITAL AND CODEINE SUSP[1]	8	DILAUDID-HP SOLN	
		CAPITAL/CODEINE SUSP[1]	8	FENTANYL CITRATE SOLN	
		CODEINE PHOSPHATE SOLN	8	FENTORA	
		CODEINE SULFATE TABS	8	FIORICET/CODEINE CAPS	
		ENDOCET TABS[3]	8	FIORINAL/CODEINE #3 CAPS	2. Oxycodone/acet 10/650 is 8 times more expensive. Use twice as many of oxycod/acet 5/325 instead. You can mix andmatch preferred strengths of oxycodone and oxycodone/acet to minimize acet. dose similar to certain non-preferred drugs.
		ENDODAN TABS	8	FIORTAL/CODEINE CAPS	
		FENTANYL OT LOZ[1]	8	HYDROCODONE/IBUPROFEN	
		HYDROCODONE BITARTRATE/AP TABS	8	LORCET	
		HYDROCODONE/ACETAMINOPHEN	8	LORTAB	
		HYDROMORPHONE HCL[3]	8	MAXIDONE TABS	
		MEPERIDINE HCL	8	NORCO TABS	
		OXYCODONE 5MG	8	NUCYNTA	
		OXYCODONE 15MG	8	ONSOLIS	
		OXYCODONE 30MG	8	OPANA	
		OXYCODONE/ACETAMINOPHEN[2,3]	8	OXYCODONE 10MG	
		PENTAZOCINE/NALOXONE TABS	8	OXYCODONE 20MG	3. Only preferred manufacturer's products will be available without prior authorization.
		PROPOXYPHENE CMPND-65 CAPS	8	OXYCODONE/APAP 10/650	
		PROPOXYPHENE COMPOUND CAPS	8	OXYCODONE/APAP 7.5/500	
		PROPOXYPHENE HCL CAPS	8	PENTAZOCINE/ACET TABS	
		PROPOXYPHENE/ACET TABS	8	PERCOCET TABS	
		PROPOXYPHENE-N/ACET TABS	8	PERCOCET TABS	
		ROXICET	8	PHRENILIN W/CAFFEINE/CODE CAPS	
		ROXIPRIN TABS	8	ROXICET 5/500 TABS	
			8	ROXICODONE TABS	
			8	SYNALGOS-DC CAPS	
			8	TALACEN TABS	
			8	TYLENOL/CODEINE #3 TABS	
			8	TYLOX CAPS	
			8	VICODIN	Use PA Form# 20420
			8	VICOPROFEN TABS	
			8	ZYDONE TABS	
			9	ACTIQ LPOP	
OPIOID DEPENDENCE TREATMENTS		SUBOXONE[2]		SUBUTEX[1]	Use PA Form# 20420
				BUPRENORPHIN	1. Subutex will only be approved for use during pregnancy.
					2. See Criteria Section
NARCOTIC ANTAGONISTS					
NARCOTIC - ANTAGONISTS		NALTREXONE HCL TABS		REVIA TABS[1]	Use PA Form# 20420
				VIVITROL INJ[2]	Use PA form# 30400 for **Vivitrol** requests
					1. Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version.
					2. Please see the criteria listed on the Vivitrol PA form. Any narcotics attempting to be filled during Vivitrol approval will require prior authorization.
COX 2 / NSAIDS					
COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE		CELEBREX CAPS[4,5,6]		**MOBIC[6]**	Use PA Form# 10310
		KETOROLAC TROMETHAMINE[2,3,6]		MOBIC SUSP[6]	1. Meloxicam has dosing limits allowing one tablet daily of all strengths without PA.
		NABUMETONE TABS[6]		**RELAFEN TABS[6]**	
		MELOXICAM[1,6]			
					2. Ketorolac Tromethamine is indicated for the short term (up to 5 days) managment of moderately severe acute pain that requires analgesic at the opiod level in adults.

					Not indicated for minor or chronic pain conditions. 3. Ketorolac has dosing limits allowing 24 tablets for a 5 day supply every 30 days. 4. Dosing limits will be set at a maximum of 200mg once daily for PA requests. 5. Users 60 years of age or older will not require PA. If under 60 years of age, Celebrex will require PA. 6. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.
NSAIDS		CHILDRENS IBUPROFEN DICLOFENAC POTASSIUM TABS DICLOFENAC SODIUM ETODOLAC FENOPROFEN CALCIUM TABS FLURBIPROFEN TABS IBUPROFEN INDOMETHACIN KETOPROFEN MECLOFENAMATE SODIUM CAPS NAPROSYN SUSP NAPROXEN SUSP NAPROXEN TABS NAPROXEN SODIUM TABS OXAPROZIN TABS SULINDAC TABS TOLMETIN SODIUM		ADVIL TABS ANAPROX TABS ANAPROX DS TABS CAMBIA CATAFLAM TABS CHILDRENS ADVIL SUSP CHILD'S IBUPROFEN SUSP CHILDREN'S MOTRIN SUSP CLINORIL TABS DAYPRO TABS EC-NAPROSYN TBEC ETODOLAC ER 600MG FELDENE CAPS IBU-200 INDOCIN LODINE MOTRIN NALFON CAPS NAPRELAN TBCR NAPROSYN TABS NAPROXEN DR TBEC NAPROXEN SODIUM TBCR PENNSAID PIROXICAM CAPS PONSTEL CAPS SB IBUPROFEN TABS TOLECTIN VOLTAREN V-R IBUPROFEN TABS	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. Use PA Form# 20420
NSAID - PPI				PREVACID NAPRA-PAC VIMOVO[1]	1. Use a preferred NSAID and PPI separately. Use PA Form# 20420
RHEUMATOID ARTHRITIS					
RHEUMATOID ARTHRITIS	1 1 1 1 1 2 2 2	AZATHIOPRINE HYDROXYCHLOROQUINE LEFLUNOMIDE METHOTREXATE SULFASALAZINE TABS CIMZIA[1] ENBREL 25MG INJECTIONS ONLY[1,4] HUMIRA[1,2,5]		ARAVA ACTEMRA KINERET SOLN ORENCIA REMICADE ENBREL 50MG[3,5] SIMPONI	Use PA Form# 20900 1. Only one step 1 drug is required to obtain Enbrel, Cimzia or Humira without PA. 2. Dosing limits apply. Please see dose consolidation list. 3. Please use multiples of 25mg. 4. Preferred dosage form allowed without PA after trial of step 1 prodcuts is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa. 5. Established users will be grandfathered for Enbrel and Humira.
MISCELLANEOUS ARTHRITIS					
ARTHRITIS - MISC.		RIDAURA CAPS MYOCHRYSINE SOLN		ARTHROTEC[1]	1. The individual components of Arthrotec are available without PA. Use PA Form# 20420
LUPUS-SLE					
LUPUS-SLE				BENLYSTA	Use PA Form# 20420
MIGRAINE THERAPIES					
MIGRAINE - ERGOTAMINE DERIVATIVES		MIGRANAL SOLN SANSERT TABS		D.H.E. 45 SOLN	Use PA Form# 10110
MIGRAINE - CARBOXYLIC ACID DERIVATIVES		DIVALPROEX ER TB24		DEPAKOTE ER TB24	Use PA Form# 10110
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs		MAXALT MLT[1] NARATRIPTAN HCI TABS[1] SUMATRIPTAN TABS[1]		AMERGE TABS[1,2] AXERT TABS[1,2] FROVA TABS[1,2] MAXALT[1,2] IMITREX TABS[1,2] RELPAX[1,2] ZOMIG TABS[1,2] ZOMIG NASAL SPARY[1,2]	1. All drugs in this category have dosing limits. Please refer to dose consolidation table. 2. Must fail all preferred products before non-preferred.

				ZOMIG ZMT TBDP[1,2]	Use PA Form# 10110
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables		IMITREX KIT IMITREX SOLN IMITREX STATDOSE PEN KIT IMITREX STATDOSE REFILL KIT		SUMATRIPTAN SOLN	Use PA Form# 10110
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Combinations				TREXIMET[1,2]	Use PA Form# 10110 1. Dosing limits apply. Please see dose consolidation list. 2. Use preferred Sumatriptan and Naproxen separately. Treximet only available if component ingredients of sumatriptan and naproxen are unavailable.
MIGRAINE - MISC.		CAFERGOT TABS SPASTRIN TABS		MIGRAZONE CAPS BELCOMP-PB SUPP MIGERGOT SUP	Use PA Form# 10110
GOUT					
GOUT		**ALLOPURINOL TABS** **COLCHICINE TABS** **PROBENECID TABS** **PROBENECID/COLCHICINE TABS**		COLCRYS ULORIC[1] ZYLOPRIM TABS	Use PA Form# 20420 1. Failure of therapeutic (300mg) dose of Allopurinol (failure define as not being able to get uric acid levels below 6mg/dl) or severe renal disease.
MISC.					
ANESTHETICS - MISC.		BUPIVACAINE HCL SOLN LIDOCAINE HCL SOLN MARCAINE SOLN		SENSORCAINE-MPF SOLN SYNVISC INJ XYLOCAINE SOLN	Use PA Form# 30130
ANTI-CONVULSANTS					
ANTICONVULSANTS		CARBAMAZEPINE	8	BANZEL	Use PA Form# 20420
		CARBATROL CP12	8	DEPAKENE	All non-preferred meds must be used in specified order
		CELONTIN CAPS	8	DEPAKOTE	
		CLONAZEPAM TABS	8	DEPAKOTE ER	
		DEPAKOTE SPRINKLES CPSP	8	DIAZEPAM GEL	1. Quantity limit. 5/month
		DIASTAT[1]	8	DIVALPROEX SODIUM SPRINKLE CAPS	2. Dosing limits apply, please see dose consolidation list.
		DILANTIN	8	EQUETRO	
		DIVALPROEX SODIUM	8	GABITRIL TABS	
		EPITOL TABS	8	KEPPRA TABS	3. Dosing limits apply per strength as well as a maximum daily dose of 600mg. Please see dose consolidation list.
		ETHOSUXIMIDE SYRP	8	KEPPRA SOLN	
		FELBATOL	8	KLONOPIN TABS	
		GABAPENTIN[2]	8	LAMICTAL	
		LAMOTRIGINE[2]	8	LYRICA[3]	
		LEVETIRACETAM SOLN/TABS	8	PRIMIDONE TABS	4. Adjunctive therapy 17 and older.
		MYSOLINE TABS	8	SABRIL	
		OXCARBAZEPINE	8	TOPAMAX	5. Current users as of 7/30/10 for seizures will be grandfathered.
		PHENYTEK CAPS	8	TOPAMAX SPRINKLE CAPS[2]	
		PHENYTOIN	8	TRILEPTAL	
		TEGRETOL	8	VIMPAT[4]	6. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR.
		TOPIRAMATE	8	ZARONTIN SYRP	
		TOPIRAMATE SPRINKLE CAPS[2]	9	KEPPRA XR[5,6]	
		TRILEPTAL SUSP	9	NEURONTIN	
		VALPROIC ACID	9	TEGRETOL-XR TB12[5,6]	
		ZARONTIN CAPS	9	ZONEGRAN CAPS	
		ZONISAMIDE			
				BIPOLAR DISORDER: STEP ORDER	SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT M= Monotherapy A= Adjunctive 9= No Evidence The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.
			M ~ A		
			4 ~ 4	LAMICTAL	
			4 ~ 4	LITHIUM	
			4 ~ 4	CARBAMAZEPINE	
			4 ~ 4	VALPROATE	
			4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE	
			5 ~ 5	TRILEPTAL	
			9 ~ 6	TOPAMAX	
			9 ~ 7	KEPPRA TABS	
			9 ~ 8	GABITRIL TABS	
			9 ~ 9	NEURONTIN	
			9 ~ 9	ZONEGRAN CAPS	
				PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER	Two-step 1 preferred drugs must be tried before Trileptal. The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.
			M ~ A	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)	
			4 ~ 4	LITHIUM	
			4 ~ 4	CARBAMAZEPINE	
			4 ~ 4	VALPROATE	
			4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE	
			4 ~ 4	LAMICTAL	
			5 ~ 5	TRILEPTA	
ANTI-PARKINSON DRUGS					
PARKINSONS - ANTICHOLINERGICS		BENZTROPINE MESYLATE TABS COGENTIN SOLN **TRIHEXYPHENIDYL**			Use PA Form# 20420
PARKINSONS - COMT INHIBITORS		**COMTAN TABS**		**TASMAR TABS**	Use PA Form# 20420
PARKINSONS - SELECTED DOPAMIN AGONISTS		**PRAMIPEXOLE**	5	**MIRAPEX TABS**[1]	Use PA Form# 20420
		ROPINIROLE	8	**REQUIP TABS**	1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinsons.
			8	**REQUIP XL TABS**	

			8	MIRAPEX ER	Parkinsons.
PARKINSONS - DOPAMINERGICS/CARBII/ LEVO		AMANTADINE HCL BROMOCRIPTINE MESYLATE CARBIDOPA/LEVODOPA TABS[3] CARBIDOPA/LEVODOPA ER LARODOPA TABS SELEGILINE HCL		APOKYN[3] AZILECT[2] ELDEPRYL CAPS LODOSYN TABS PARLODEL CAPS PARLODEL TABS SINEMET TABS SINEMET TBCR ZELAPAR[1]	1. Approvals will require concurrent therapy with Levodopa and failed trials of Selegiline, Comtan, and Stalevo. 2. Approvals will require trials of Carbidopa/Levodopa, Selegiline, Comtan, and Stalevo. 3. Only preferred manufacturer's products will be available without prior authorization. Use PA Form# 20420
PARKINSONS - COMBO.		STALEVO			Use PA Form# 20420
MUSCLE RELAXANTS					
ALS DRUG		RILUTEK TABS			Use PA Form# 20420
MUSCLE RELAXANTS		BACLOFEN TABS CHLORZOXAZONE TABS CYCLOBENZAPRINE HCL TABS LIORESAL INTRATHECAL KIT METHOCARBAMOL TABS TIZANIDINE HCL TABS	7 8 8 8 8 8 8 9 9	ORPHENADRINE CITRATE CARISOPRODOL TABS DANTRIUM CAPS LIORESAL TABS NORFLEX TBCR ROBAXIN-750 TABS ZANAFLEX TABS SKELAXIN TABX SOMA TABS	Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). Non-preferred products must be used in specified step order. Use PA Form# 20420
MUSCLE RELAXANT - COMBO.				CARISOPRODOL/ASPIRIN TABS CARISOPRODOL/ASPIRIN/CODE NORGESIC TABS ORPHENADRINE COMPOUND ORPHENADRINE/ASA/CAFF ORPHENGESIC	Use PA Form# 20420
VITAMINS					
VITAMINS		ASCORBIC ACID TABS BIOTIN CYANOCOBALAMIN SOLN FOLGARD RX 2.2 TABS FOLIC ACID TABS FOLTX TABS MEPHYTON TABS NIACIN NIACOR TABS NICOTINIC ACID SR CPCR PYRIDOXINE HCL TABS SLO-NIACIN TBCR THIAMINE HCL SOLN VITAMIN B-1 TABS 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		AQUASOL E SOLN AQUAVIT-E SOLN DHT SOLN NASCOBAL GEL	Use PA Form# 20420 Please refer to OTC list.
VITAMIN D's		CALCITRIOL CAPS[1] VITAMIN D ZEMPLAR TABS		DRISDOL CAPS CALCIJEX HECTOROL (ORAL) HECTOROL (PARENTERAL) ROCALTROL ZEMPLAR INJ	1. Diagnosis of dialysis (renal failure) required. Use PA Form# 20420
MISC MULTI-VITAMINS					
VITAMINS - MISC.		CENTRUM LIQD CENTRUM TABS CENTRUM JR/IRON CHEW CENTRUM SILVER TABS CENTRUM-LUTEIN TABS CEROVITE ADVANCED FO TABS CHEWABLE MULTIVIT/FL CHEW COD LIVER OIL CAPS COMPLETE SENIOR TABS DAILY MULTI VIT/IRON DIALYVITE 1MG DIALYVITE 800MG FULL SPECTRUM B M.V.I.-12 INJ MULTI-VIT/FLUORIDE NATALCARE RX TABS NEPHRONEX O-CAL PRENATAL ONE DAILY TABS ONE-DAILY MULTIVITAMINS ONE-TABLET-DAILY POLY-VIT/IRON/FLUORID SOLN POLY-VITAMIN/FLUORIDE SOLN POLY-VITAMINS/IRON SOLN PRENATAL 19 CHEW[1] PRENATAL TABS[1] PRENATAL FORMULA 3 TABS[1] PRENATAL PLUS TABS[1] PRENATAL PLUS NF TABS[1] PRENATAL PLUS/27MG IRON[1] PRENATAL PLUS/IRON TABS[1] PRENATAL RX/BETA-CAROTENE[1] RENA-VITE RX TABS		ADEKS ADVANCED NATALCARE TABS AQUADEKS CENTRUM JR/EXTRA C CHEW CENTRUM PERFORMANCE TABS DALYVITE LIQD EMBREX 600 MISC IBERET MATERNA TABS MULTIRET FOLIC -500 TBCR NATAFORT TABS NATALCARE CFE 60 TABS[1] NATALCARE GLOSS TABS[1] NATALCARE PIC TABS[1] NATALCARE PIC FORTE TABS[1] NATALCARE PLUS TABS[1] NATALCARE THREE TABS[1] NATACHEW CHEW NATALFIRST TABS NATATAB RX TABS NEPHPLEX RX TABS NEPHROCAPS CAPS NEPHRO-VITE TABS NESTABS RX TABS NIFEREX OCUVITE TABS POLY-VI-FLOR SOLN POLY-VI-SOL SOLN POLY-VI-SOL/IRON SOLN POLY-VITAMIN DROPS SOLN PRECARE PREMESIS RX TABS PRENATABS CBF TABS[1]	1. Diag codes are no longer required on prenatal vitamins. Please refer to OTC list. Use PA Form# 20420

	RENAL CAPS	PRENATAL CARE TABS[1]	
	RENAPHRO CAPS	PRENATAL MR 90 TBCR[1]	
	STRESS TAB NF TABS	PRENATAL MTR/SELENIUM TABS[1]	
	THERAPEUTIC-M TABS	PRENATAL OPTIMA ADVANCE TABS[1]	
	THERAVITE LIQD	PRENATAL PC 40 TABS[1]	
	TRI-VITAMIN/FLUORIDE SOLN	PRENATAL RX TABS[1]	
	VITA CON FORTE CAPS	PRENATE[1]	
	VITAMIN B COMPLEX CAPS	PRENATE ELITE[1]	
	VITAPLEX PLUS TABS	PRIMACARE MISC	
		PROTEGRA CAPS	
		STUARTNATAL PLUS 3 TABS[1]	
		TRI-VI-SOL SOLN	
		TRI-VI-SOL/IRON SOLN	
		ULTRA NATALCARE TABS	
		ULTRA-NATAL TABS[1]	
		VICON FORTE CAPS	
		VINATAL FORTE TABS[1]	
		VINATE[1]	
		VINATE ADVANCED TABS[1]	
	MISCELLANEOUS MINERALS		
MINERALS	CALCARB	ANEMAGEN	Use PA Form# 20420
	CALCI-MIX CAPSULE CAPS	CALCET TABS	Please refer to OTC list.
	CALCIQUID SYRP	**CALCIUM 600-D TABS**	
	CALCITRATE/VITAMIN D TABS	CALCIUM/VITAMIN D TABS	
	CALCIUM	CALTRATE 600 PLUS/VIT D TABS	
	CALCIUM CARBONATE	CALTRATE PLUS TABS	
	CALCIUM CITRATE TABS	CHROMAGEN	
	CALCIUM GLUCONATE TABS	CITRACAL PLUS TABS	
	CALCIUM LACTATE TABS	CONTRIN CAPS	
	CALCIUM/MAGNESIUM TABS	FEOGEN FORTE CAPS	
	CALCIUM/VITAMIN D TABS	FEROCON CAPS	
	CALTRATE 600 TABS	FERREX 150 CAPS	
	CHEWABLE CALCIUM CHEW	FERRO-SEQUELS TBCR	
	CITRACAL TABS	FE-TINIC CAPS	
	CITRACAL + D TABS	FE-TINIC 150 FORTE CAPS	
	CITRUS CALCIUM TABS	FLUOR-A-DAY SOLN	
	CITRUS CALCIUM 1500 + D TABS	K-DUR TBCR	
	MC/DEL	KLOR-CON PACK	
	EFFERVESCENT POTASSIUM TBEF	K-LYTE	
	FEOSTAT CHEW	K-PHOS TABS NEUTRAL	
	FERATAB TABS	K-TABS TBCR	
	FER-GEN-SOL SOLN	K-VESCENT PACK	
	FER-IN-SOL SOLN	MICRO-K 10 MEG CPCR	
	FER-IRON SOLN	NU-IRON 150 CAPS	
	FERRONATE TABS	**OYSTER SHELL CALCIUM/VITA TABS**	
	FERROUS SULFATE	POLY-IRON 150 CAPS	
	FLUOR-A-DAY CHEW	POLYSACCHARIDE IRON CAPS	
	FLUORIDE CHEW	POTASSIUM BICARB/CHLORIDE	
	FLUORIDE SODIUM CHEW	POTASSIUM CHLORIDE 10MEQ CAPS	
	FLUORITAB CHEW	POTASSIUM CHLORIDE 8MEQ CAPS	
	HEMOCYTE TABS	SLOW FE TBCR	
	HM CALCIUM TABS	TUMS 500 CHEW	
	K+ POTASSIUM PACK	VIACTIV CHEW	
	KAON ELIX		
	KAON-CL-10 TBCR		
	KCL 0.075%/D5W/NACL 0.2% SOLN		
	K-EFFERVESCENT TBEF		
	KLOR-CON		
	KLOTRIX TBCR		
	K-PHOS TABS		
	K-VESCENT TBEF		
	LURIDE CHEW		
	MAGNESIUM GLUCONATE TABS		
	MAGNESIUM SULFATE SOLN		
	MAGTABS		
	MICRO-K 8 MEG		
	OS-CAL TABS		
	OS-CAL 500 + D TABS		
	OYSCO		
	OYST-CAL TABS		
	OYST-CAL D TABS		
	OYST-CAL/VITAMIN D TABS		
	OYSTER CALCIUM TABS		
	OYSTER SHELL		
	PHARMA FLUR		
	PHOSPHA 250 NEUTRAL TABS		
	POTASSIUM BICARBONATE TBEF		
	POTASSIUM CHLORIDE 8MEQ		
	POTASSIUM EFFERVESCENT		
	SELENIUM TABS		
	SLOW-MAG TBCR		
	SODIUM FLUORIDE		
	SSKI SOLN		
	V-R CALCIUM		
	V-R OYSTER SHELL CALCIUM		
	ZINC SULFATE CAPS		
	MISC. ELECTROLYTES/NUTRITIONALS		
ELECTROLYTES/ NUTRITIONALS	INTRALIPID EMUL[1]	BOOST[1]	1. This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred. SGA form required for nutritionals unless member has a G/I tube.
	P.T.E. -5 SOLN[1]	CASEC POWD[1]	
	SEA-OMEGA CAPS[1]	CHOICE DM LIQD[1]	
		DELIVER 2.0 LIQD[1]	
		ENFAMIL[1]	
		ENSURE[1]	
		GLUCERNA[1]	
		ISOCAL LIQD[1]	
		KINDERCAL TF LIQD[1]	

				KINDERCAL TF/FIBER LIQD[1] L-CARNITINE CAPS[1] LIPISORB LIQD[1] LOVAZA[1,2] MODULEN IBD POWD[1] NUTRAMIGEN POWD[1] NUTREN[1] NUTRITIONAL SUPPLEMENT LIQD[1] NUTRIVENT 1.5 LIQD[1] PEPTAMEN[1] PHENYLADE[1] PHENYL-FREE[1] PKU 3 POWD[1] PREGESTIMIL POWD[1] PROBALANCE LIQD[1] PROSOBEE[1] SCANDISHAKE PACK[1]	2. Formerly known as Omacor. Use PA Form# 20420 & SGA Form
ERYTHROPOEITINS					
ERYTHROPOEITINS		PROCRIT SOLN[1]	6 8	EPOGEN SOLN ARANESP SOLN	Use PA Form# 10520 1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.
GRANULOCYTE CSF					
GRANULOCYTE CSF			8 8 9	LEUKINE NEUPOGEN SOLN[2] NEULASTA[1]	1. Must be used in specified step order. 2.10 day supply/month may be used without a PA. Use PA Form# 20520
ANTICOAGULANTS / PLATELET AGENTS					
ANTICOAGULANTS		ARIXTRA SOLN[1] FRAGMIN INJ[1] HEPARIN SODIUM/NACL 0.9% SOLN HEP-LOCK SOLN **INNOHEP** **LOVENOX SOLN[1]** **WARFARIN SODIUM TABS** HEPARIN LOCK SOLN HEPARIN LOCK FLUSH SOLN HEPARIN SODIUM SOLN HEPARIN SODIUM LOCK FLUSH SOLN JANTOVEN		COUMADIN TABS IPRIVASK LOVENOX 300[2] PRADAXA	1. Arixtra, Fragmin and Lovenox therapy durations greater than 7 days require PA. 2. Use other strengths available to obtain desired dose. Use PA Form# 20420
ANTIHEMOPHILIC AGENTS		ALPHANATE ALPHANINE SD BENEFIX SOLR HELIXATE FS KIT HEMOFIL - M HUMATE-P SOLR KOGENATE FS KONYNE - 80 MONARC - M MONOCLATE - P MONONINE NOVOSEVEN SOLR PROFILNINE RECOMBINATE SOLR REFACTO		ADVATE[1,2]	1. Only if other products unavailable. 2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access. Use PA Form# 20420
PLATELET AGGREGATION INHIBITORS		ASPIRIN **DIPYRIDAMOLE TABS**	7 8 8 8	TICLOPIDINE HCL TABS EFFIENT[2] PERSANTINE TABS PLAVIX TABS[1,2]	Use PA Form# 20715 for **Plavix & Effient** Use PA form# 20420 for **other requests** 1. As of 10.16.08 all new users of Plavix will require prior authorization. 2. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement.
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.		**AGGRENOX** CILOSTAZOL PENTOXIFYLLINE ER TBCR		**AGRYLIN CAPS** **PLETAL TABS** TRENTAL TBCR	Use PA Form# 20420
HEMATOLOGICALS					
MONOCLONAL ANTIBODY				SOLIRIS	Use PA Form# 20420
HEMATOLOGICAL AGENTS-THROMBOPOIETIN RECEPTOR AGONISTS			7 8	PROMACTA NPLATE	Use PA Form# 20420
HEMOSTATIC					
HEMOSTATIC		AMICAR AMINOCAPROIC ACID			Use PA Form# 20420
OPHTHALMICS					
OP. - ANTIBIOTICS		AK-SPORE OINT BACITRACIN OINT BACITRACIN/NEOMYCIN/POLYM BACITRACIN/POLYMYXIN B OINT CHLOROPTIC SOLN ERYTHROMYCIN OINT GENTAMICIN SULFATE NEOMYCIN/POLYMYXIN/GRAMIC NEOSPORIN SOLN POLYSPORIN		AK-POLY-BAC OINT AK-SULF OINT AK-TOB SOLN AZASITE BLEPH-10 SOLN GENTAK ILOTYCIN OINT NEOMYCIN/BACI/POLYM OINT NEOSPORIN OINT OCUSULF-10 SOLN	Use PA Form# 20420

		SODIUM SULFACETAMIDE SOLN SULFACETAMIDE SODIUM TOBRAMYCIN SULFATE SOLN TRIMETHOPRIM SULFATE/POLY VIROPTIC SOLN		OCUTRICIN SOLN TERAK OINT TOBREX OINT TRIFLURIDINE SOLN	
OP. - QUINOLONES		CILOXAN OINT CIPROFLOXACIN SOL 0.3% OFLOXACIN QUIXIN SOLN		BESIVANCE CILOXAN SOLN OCUFLOX SOLN	Use PA Form# 20420
OP.QUINOLONES-4TH GENERATION		VIGAMOX ZYMAR		ZYMAXID	Use PA Form# 20420
OP. - ARTIFICIAL TEARS AND LUBRICANTS		AKWA TEARS OINT ARTIFICIAL TEARS OINT ARTIFICIAL TEARS SOLN CELLUVISC SOLN EYE LUBRICANT OINT GENTEAL LIQUITEARS SOLN MAJOR TEARS SOLN PURALUBE OINT PURALUBE TEARS SOLN REFRESH SOLN OP REFRESH PLUS SOLN[1] REFRESH PM OINT		AKWA TEARS SOLN ARTIFICIAL TEARS SOLN OP BION TEARS SOLN DRY EYES OINT DURATEARS OINT HYPO TEARS ISOPTO TEARS SOLN LACRI-LUBE LUBRIFRESH P.M. OINT MURINE SOLN MUROCEL SOLN NATURE'S TEARS SOLN REFRESH SOLN REFRESH TEARS SOLN[1] SYSTANE TEARGEN SOLN TEARISOL SOLN TEARS NATURALE TEARS PURE SOLN TEARS RENEWED OINT THERATEARS SOLN V-R ARTIFICIAL TEARS SOLN	Use PA Form# 20420 1. Dosing limits apply, please see dose consolidation list.
OP. - BETA - BLOCKERS		**BETOPTIC-S SUSP** **CARTEOLOL HCL SOLN** **LEVOBUNOLOL HCL SOLN** METIPRANOLOL SOLN **TIMOLOL MALEATE SOLG (GEL)** **TIMOLOL MALEATE SOLN**		BETAGAN SOLN **BETAXOLOL HCL SOLN** **BETIMOL SOLN** ISTALOL **OCUPRESS SOLN** OPTIPRANOLOL SOLN **TIMOPTIC SOLN** **TIMOPTIC-XE SOLG**	Use PA Form# 20420
OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH.		AK-SPORE HC OINT ALREX SUSP BLEPHAMIDE SUSP DEXAMETH SOD PHOS SOLN FLAREX SUSP FLUOROMETHOLONE SUSP FML S.O.P. OINT LOTEMAX SUSP NEOM/POLIN/DEX PRED MILD SUSP PREDNISOLONE TOBRADEX		AK-TROL SUSP BAC/POLY/NEOMY/HC OINT BLEPHAMIDE S.O.P. OINT BROMDAY EFLONE SUSP FLUOR-OP SUSP MAXITROL NEO/POLY/BAC/HC OINT OZURDEX PRED FORTE SUSP PRED-G SUSP PRED-G S.O.P. OINT SULFACET SOD/PRED SOLN TOBRAMYCIN SUSP DEXAMETHASONE VASOCIDIN SOLN VEXOL SUSP	Use PA Form# 20420
OP. - PROSTAGLANDINS		LUMIGAN SOLN **TRAVATAN SOLN**	7 8	XALATAN SOLN[1] **LATANOPROST SOL 0.005%**[1]	1. All preferreds must be tried. Use PA Form# 20420
OP. - CYCLOPLEGICS		AK-PENTOLATE SOLN ATROPINE SULFATE CYCLOPENTOLATE HCL SOLN ISOPTO HYOSCINE SOLN		CYCLOGYL SOLN ISOPTO ATROPINE SOLN ISOPTO HOMATROPINE SOLN MUROCOLL-2 SOLN	Use PA Form# 20420
OP. - MIOTICS - DIRECT ACTING		**ISOPTO CARBACHOL SOLN** ISOPTO CARPINE SOLN PILOCAR SOLN **PILOCARPINE HCL SOLN** **PILOPINE HS GEL**			Use PA Form# 20420
OP. - ADRENERGIC AGENTS		**DIPIVEFRIN HCL SOLN** EPIFRIN SOLN		PROPINE SOLN	Use PA Form# 20420
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS		ALPHAGAN P SOLN		ALPHAGAN SOLN BRIMONIDINE 0.2% **IOPIDINE SOLN**	Use PA Form# 20420
OP. - ANTI-ALLERGICS		OPTIVAR PATADAY SOLN PATANOL SOLN		ALOCRIL SOLN ALOMIDE SOLN BEPREVE ELESTAT EMADINE SOLN LASTACAFT OPTICROM SOLN ZADITOR SOLN	Use PA Form# 20420
OP. ANTI-ALLERGICS-MASTCELL STABILIZER CLASS				ALAMAST SOLN	Use PA Form# 20420
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO		**AZOPT SUSP** COMBIGAN DORZOLAMIDE DORZOLAMIDE/TIMOLOL		**COSOPT SOLN** **TRUSOPT SOLN**	Use PA Form# 20420
OP. - NSAID'S		FLURBIPROFEN SODIUM SOLN DICLOFENAC OPTH 0.1% KETOROLAC OPTH 0.4% KETOROLAC OPTH 0.5%		ACULAR LS[1] ACULAR SOLN[1] OCUFEN SOLN[1] NEVANAC[1] XIBROM[1] VOLTAREN SOLN[1] ACUVAIL[1]	1. Must fail all preferred products before non-preferred. Use PA Form# 20420
OP. - OF INTEREST		ENUCLENE SOLN		BOTOX SOLR	1. Must have kerato conjuctivitus

		RESTASIS[1]	sicca and failed other dry eye therapies. Use PA Form# 20420
DERMATOLOGICAL			
TOPICAL - ORAL	AMNESTEEM[1] CLARAVIS[1] SOTRET[1]		1. Users 24 or under, PA will not be required. Use PA Form# 20420
TOPICAL - ACNE PREPARATIONS	AZELEX CREA BENZOYL PEROXIDE CLINDAMYCIN PHOSPHATE[2] ERYDERM SOLN ERYTHROMYCIN GEL ERYTHROMYCIN PADS ERYTHROMYCIN SOLN ISOTRETINOIN METRONIDAZOLE CREA[2] METRONIDAZOLE GEL[2] METRONIDAZOLE LOTN[2] RETIN-A GEL[1,2] SODIUM SULFACET/SULF LOTN TAZORAC GEL TRETINOIN GEL[1]	ACZONE ALTINAC CREA AVITA CREA BENZAC BENZACLIN GEL[3] BENZAGEL-10 GEL BENZAMYCIN GEL BENZAMYCINPAK PACK BENZEFOAM BREVOXYL CLEOCIN-T[2] CLINAC BPO GEL CLINDAGEL GEL CLINDETS SWAB DESQUAM-E GEL DESQUAM-X DIFFERIN 0.3% GEL DIFFERIN DUAC GEL EMGEL GEL EPIDUO ERYCETTE PADS EVOCLIN FINEVIN CREA KLARON LOTN METROCREAM CREA[2] METROGEL GEL[2] METROLOTION LOTN[2] NEOBENZ MICRO NORITATE CREA RETIN-A MICRO GEL RETIN-A CREA[2] TRETINOIN CREA[2] TRIAZ VELTIN ZENCIA WASH ZETACET ZIANA	1. Users 24 or under, PA will not be required. 2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List. 3. Only available if component ingredients are unavailable. Use PA Form# 10220 for **Brand Name requests** Use PA Form# 20420 for **all other requests**
TOPICAL - ANTIBIOTIC	BACIT/NEOMYCIN/POLYM OINT BACITRACIN OINT BACTROBAN CREA BACTROBAN NASAL OINT CENTANY OINT 2%[1] GENTAMICIN SULFATE MUPIROCIN[1]	ALTABAX[1] BACTROBAN OINT. TRIPLE ANTIBIOTIC OINT	1. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420
TOPICAL - ANTIFUNGALS	CICLOPIROX 0.77 CREA CICLOPIROX 0.77 SUSP CLOTRIMAZOLE ECONAZOLE NITRATE CREA KETOCONAZOLE CREA LOPROX 1.0 CREA LOPROX 1.O LOTN LOPROX GEL LOPROX TS LOTN LOTRISONE MICONAZOLE NITRATE CREA MYCO-TRIACET II CREA NIZORAL SHAM NTA OINT NYSTATIN NYSTATIN/TRIAMCINOLONE NYSTOP POWD PEDI-DRI POWD TINACTIN TRI-STATIN II CREA	BETAMETHASONE CLOTRIMAZOLE EXELDERM FUNGIZONE CREA HYDROCORT/IODOQ CREA LAMISIL LOPROX 0.77 LOTN LOPROX 0.77 CREA LOPROX 0.77 SUSP LOPROX SHAMPOO SHAM LOTRIMIN MENTAX CREA MYCOGEN II CREA NAFTIN NYSTAT-RX POWD OXISTAT PENLAC NAIL LACQUER SOLN	Use PA Form# 10120
TOPICAL - ANTIPRURITICS	ZONALON CREA	PRUDOXIN CREA	Use PA Form# 20420
TOPICAL - ANTIPSORIATICS	DOVONEX SORIATANE CAPS TAZORAC	OXSORALEN ULTRA CAPS[1] PSORIATEC CREA[1] SORIATANE CK KIT[1] TACLONEX[1,2] VECTICAL[1]	1. Must fail all preferred products before non-preferred. 2. Individual ingredients are available as preferred witout PA. Use PA Form# 20420
TOPICAL - ANTISEBORRHEICS	SELENIUM SULFIDE SHAM	CARMOL SCALP TREATMENT KIT ZNP BAR	Use PA Form# 20420
TOPICAL - ANTIVIRALS		DENAVIR CREA[1, 3] ZOVIRAX OINT[1,2]	1. Must fail oral treatment with Acyclovir or Valtrex. 2. Approvals limited to 1 tube per 180 days. 3. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420
TOPICAL - ANTINEOPLASTICS	EFUDEX FLUOROPLEX CREA	CARAC CREA FLUOROURACIL SOLARAZE GEL	Use PA Form# 20420
TOPICAL - BURN PRODUCTS	FURACIN CREA SILVER SULFADIAZINE CREA SSD AF CREA SSD CREA	SILVADENE CREA	Use PA Form# 20420

	THERMAZENE CREA			
TOPICAL - CORTICOSTEROIDS	LOW POTENCY		ACLOVATE	Use PA Form# 20420
	DESOWEN		AMCINONIDE CREA	
	HYDROCORTISONE CREA		ANUSOL HC-1 OINT	
	HYDROCORTISONE LOTN		CLOBEX	
	LACTICARE-HC LOTN		CLODERM CREA	
	NUTRACORT LOTN		CORDRAN	
	TEXACORT SOLN		CORMAX	
			CUTIVATE CREA / OINT	
	MEDIUM POTENCY		CUTIVATE LOTN	
	DESOXIMETASONE .05%		DERMATOP	
	ELOCON		DESONATE GEL	
	FLUOCINOLONE ACETONIDE .025-.01%		DIPROLENE	
	FLUROSYN CREA		ELOCON OINT	
	FLUTICASONE PROPIONATE CREA/OINT		HYDROCORTISONE POWD	
	HYDROCORTISONE BUTYRATE		KENALOG AERS	
	HYDROCORTISONE OINT		LIDA MANTLE HC CREA	
	HYDROCORTISONE VALERATE		LOCOID	
	MOMETASONE FUROATE OINT		LUXIQ FOAM	
	TRIAMCINOLONE ACETONIDE .025-.1%		OLUX FOAM	
			PANDEL CREA	
	HIGH POTENCY		PROCTOCORT CREA	
	BETAMETHASONE DIPROPIONATE		PSORCON	
	DESOXIMETASONE .25%		PSORCON E	
	DESONIDE		TEMOVATE	
	FLUOCINOLONE ACETONIDE .02%		TOPICORT	
	FLUOCINONIDE		TOPICORT LP CREA	
	HALOG		ULTRAVATE	
	HALOG-E CREA		VERDESO	
	TRIAMCINOLONE ACETONIDE .5%		WESTCORT	
	VERY HIGH POTENCY			
	AUGMENTED BETA DIP			
	BETAMETHASONE VALERATE			
	BETA-VAL			
	CLOBETASOL PROPIONATE			
	DIFLORASONE DIACETATE			
	HALOBETASOL			
	MISCELLANEOUS			
	CAPEX SHAM			
	DERMA-SMOOTHE/FS OIL			
	PROCTO-KIT CREA 1%			
TOPICAL - STEROID LOCAL ANESTHETICS			EPIFOAM FOAM	Use PA Form# 20420
TOPICAL - STEROID COMBINATIONS	DERMA-SMOOTHE/FS ATOPIC P KIT		CARMOL-HC CREA	Use PA Form# 20420
TOPICAL - EMOLLIENTS	AMMONIUM LACTATE LOTN 12%		AMMONIUM LACTATE CREA	Use PA Form# 20420
	LAC-HYDRIN CREA		LAC-HYDRIN LOTN 12%	
	UREACIN-20 CREA		MEDERMA GEL	
	VITAMIN A & D MEDICATED OINT		MIMYX	
			RENOVA CREA	
TOPICAL - ENZYMES / KERATOLYTICS / UREA	GRANUL-DERM AERS		CARMOL 40 CREA	Use PA Form# 20420
	GRANULEX AERS		SALEX CREA	Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.
	TBC AERS		SALEX LOTN	
	SANTYL OINT			
TOPICAL - GENITAL WARTS	ALDARA	5	PODOFILOX SOLN	Use PA Form# 20420
		8	CONDYLOX[1]	1. Non-preferred products must be used in specified order.
		8	VEREGEN[1]	
		8	ZYCLARA[1]	
TOPICAL - IMMUNOMODULATORS		8	ELIDEL CREA[1]	Use PA Form# 20420
		9	PROTOPIC OINT[1,2]	1. Non-preferred products must be used in specified order.
				2. The FDA has issued a Public Health Advisory for both Elidel and Protopic concerning the potential cancer risk associated with their use. Use for children less than 2 years of age is not recommended.
TOPICAL - LOCAL ANESTHETICS	AF CAPSICUM OLEORESIN CREA		EMLA PADS	1. Lidocaine/Prilocaine cream and Ela-Max products require PA for users over 18 years of age.
	CAPSAICIN CREA		EMLA CREA	
	ELA-MAX[1]		LIDA MANTLE CREA	
	LIDOCAINE/PRILOCAINE CREA[1]		LIDODERM PTCH	
	XYLOCAINE		PONTOCAINE SOLN	
			SYNERA	Use PA Form# 20420
			ZOSTRIX	
TOPICAL - DEPIGMENTING AGENTS		8	ALUSTRA CREA	Not covered for cosmetic purposes.
		8	EPIQUIN MICRO	
		8	GLYQUIN CREA	
		8	HYDROQUINONE CREA	Use PA Form# 20420
		8	HYDROQUINONE/SUNSCREENS	
		8	SOLAQUIN FORTE CREA	
		8	TRI-LUMA CREA	
		9	ELDOQUIN	
TOPICAL - SCABICIDES AND PEDICULICIDES	ACTICIN CREA		LINDANE	Use PA Form# 20420
	ELIMITE CREA		MALATHION	
	EURAX		NATROBA	
	LICE KILLING SHAM		OVIDE LOTN	
	LICE TREATMENT CREME RINS LIQD		ULESFIA	
	PERMETHRIN LOTN			
TOPICAL - WOUND / DECUBITUS CARE			REGRANEX GEL	Use PA Form# 20420

Therapeutic Class	Preferred	Non-Preferred	Criteria
CARE		REGENECARE RADIAPLEXRX	Accuzyme and Ethezyme products have been removed from the PDL due to FDA concerns regarding drugs containing Papain.
TOPICAL - ASTRINGENTS / PROTECTANTS	ALUMINUM CHLORIDE SOLN DRYSOL SOLN XERAC AC SOLN	LOWILA BAR MOISTURIN DRY SKIN CREA PROSHIELD PLUS SKIN PROTE CREA SURGILUBE GEL	Use PA Form# 20420
TOPICAL - ANTISEPTICS / DISINFECTANTS	PHISOHEX LIQD POVIDONE-IODINE SOLN	BETADINE OINT FORMALYDE-10 AERS IODOSORB LAZERFORMALYDE SOLUTION SOLN	Use PA Form# 20420
MISCELLANEOUS EYE			
OP. - EYE	AK-DILATE SOLN EYE WASH SOLN NAPHAZOLINE HCL SOLN PHENYLEPHRINE HCL SOLN PONTOCAINE SOLN SODIUM CHLORIDE	LENS PLUS REWETTING DROPS MURO 128 NEO-SYNEPHRINE SOLN	Use PA Form# 20420
MISCELLANEOUS EAR			
EAR	A/B OTIC SOLN ACETASOL SOLN ACETASOL HC SOLN ACETIC ACID ACETIC ACID/HYDROCORTISON ALLERGEN SOLN ANTIPYRINE/BENZOCAINE SOLN AURODEX SOLN AUROGUARD SOLN AUROTO OTIC SOLN CARBAMIDE PEROXIDE 6.5% OTIC SOLN. CIPRODEX CORTISPORIN SOLN CORTOMYCIN EAR DROPS SOLN EAR DROPS RX SOLN EAR WAX REMOVAL DROPS EAR-GESIC SOLN NEOMYCIN/POLYMYXIN/HC OFLOXACIN 0.3% OTIC OTICAINE OTIC SOLN	AERO OTIC HC SOLN ANTIBIOTIC EAR SOLN ANTIBIOTIC EAR SUSP AURALGAN SOLN CIPRO HC SUSP COLY-MYCIN-S SUSP CORTISPORIN-TC SUSP DEBROX SOLN PEDIOTIC SUSP VOSOL-HC SOLN ZOTANE HC SOLN ZOTO-HC SOLN	Use PA Form# 20420
MOUTH ANTISEPTICS			
MOUTH ANTI-INFECTIVES	NILSTAT SUSP EAR-GESIC SOLN NYSTATIN SUSP	MYCELEX TROC ORAVIG	Use PA Form# 20420
MOUTH ANTISEPTICS	CHLORHEXIDINE GLUCONATE LIDOCAINE VISCOUS SOLN TRIAMCINOLONE IN ORABASE PSTE TRIAMCINOLONE ORADENT PSTE	APHTHASOL PSTE[1] PERIOGARD SOLN[1] TRIAMCINOLONE ACETONIDE PSTE[1]	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.
DENTAL PRODUCTS			
DENTAL PRODUCTS	ETHEDENT CREA GEL-KAM CONC GEL-KAM GEL 0.4% PHOS FLUR SOLN PREVIDENT GEL PREVIDENT SOLN SF 5000 PLUS CREA SF GEL STANNOUS FLUORIDE ORAL RI CONC	APF GEL GEL DENTAGEL GEL PHOS-FLUR GEL PREVIDENT CREA THERA-FLUR-N GEL	Use PA Form# 20420
ARTIFICIAL SALIVA/STIMULANTS			
ARTIFICIAL SALIVA/STIMULANTS	SALIVA SUBSTITUTE SOLN	EVOXAC CAPS RADIACARE SOLR SALAGEN TABS	Use PA Form# 20420
MISCELLANEOUS ANORECTAL			
ANORECTAL - MISC.	COLOCORT ENEM CORTENEMA ENEM ELA-MAX 5 CREA HYDROCORTISONE ENEM PROCTOZONE-HC CREA	ANUSOL-HC CREA CORTIFOAM FOAM PROCTOCREAM-HC CREA PROCTOFOAM HC FOAM PROCTO-KIT CREA 2.5% PROCTOSOL HC CREA	Use PA Form# 20420
T-CELL ACTIVATION INHIBITOR			
PSORIASIS BIOLOGICALS	ENBREL 25MG INJECTIONS ONLY[4] HUMIRA[1]	AMEVIVE[2] ENBREL 50 MG[3] STELARA	1. Will not require a PA if at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin is in members drug profile. Please refer to dose consolidation list. 2. Trial of both preferred drugs are required. 3. Use multiple 25mg injections. 4. Preferred dosage form allowed without PA after trial of step 1 prodcuts is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa. Use PA Form# 20910
ALTERNATIVE MEDICINES			
ALTERNATIVE MEDICINES	DIMETHYL SULFOXIDE SOLN	CO-ENZYME Q-10 MELATONIN TABS	Use PA Form# 20420
CHELATING AGENTS			
CHELATING AGENTS	CUPRIMINE CAPS	DEPEN TITRATABS TABS	Use PA Form# 20420

				EXJADE[1]	1. FDA indication of treatment of chronic iron ovrload due to blood transfusions in membes 2 years of age and older is requried for approval of Exjade.
ANTILEPROTIC					
ANTILEPROTIC				THALOMID CAPS[1]	1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules. Use PA Form# 20420
ANTINEOPLASTIC AGENTS					
ANTINEOPLASTIC AGENTS - ANTIADNDROGENS		BICALUTAMIDE		CASODEX	Use PA Form# 20420
ANTINEOPLASTIC AGENTS-LHRH ANALOGS		LUPRON DEPOT[1]		VANTAS[2] FIRMAGON[2] TRELSTAR	1. Dosing limits apply, please refer to dosage consolidation list. 2. PA required to confirm FDA approved indication. Use PA Form# 20420
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS				SPRYCEL[1] TYKERB[2] GLEEVEC[1]	Use PA Form# 20420 1. Verification of diagnosis is required. 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.
ANTINEOPLASTICS-MISCELLANEOUS		MERCAPTOPURINE		ZOLINZA PURINETHOL	Use PA Form# 20420
ANTINEOPLASTICS-MONOCLONAL ANTIBODIES				HERCEPTIN[1]	1. PA required to confirm FDA approved indication. Use PA Form# 20420
CANCER					
CANCER		ALIMTA ANASTROZOLE TABS AVASTIN ERBITUX VIDAZA		ARIMIDEX FOLOTYN NEXAVAR[1] SUTENT[1,2]	1. PA required to confirm FDA approved indication 2. Avoid CYP3AY drug drug interaction. Use PA Form# 20420
IMMUNOSUPPRESSANTS					
IMMUNOSUPPRESSANTS		CYCLOSPORINE MODIFIED CYCLOSPORINE SOL. MODIFIED GENGRAF CAPS MYCOPHENOLATE MYFORTIC PROGRAF CAPS RAPAMUNE SANDIMMUNE		CELLCEPT 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
PURINE ANALOG					
PURINE ANALOG		AZASAN TABS AZATHIOPRINE TABS		IMURAN TABS	Use PA Form# 20420
K REMOVING RESINS					
K REMOVING RESINS		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.

ANTI-CONVULSANTS INDICATION CHART

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

PEDIATRIC ANTI-CONVULSANTS INDICATION CHART

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