

CATEGORY	Step Order	PREFERRED DRUGS	Step Order	NON-PREFERRED DRUGS Required	PA	Comments
<p><b>General Criteria for all PDL categories-</b> 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: <a href="http://www.mainearepdl.org">www.mainearepdl.org</a></p>						
<p><b>A: Preferred Drugs-</b> Unless otherwise specified, preferred drugs are available without prior authorization. Step order may apply for preferred drugs in some drug categories as indicated on the PDL. (See item "D" below for explanation of step order.)</p>						
<p><b>B: Requests for Non-preferred Drugs-</b> Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists</p>						
<p><b>C: Adequate Drug Trials-</b> 1. The minimum trial period for each preferred and step order drug is two weeks, unless otherwise stated within specific PDL drug categories; trials with less than a two week duration will be reviewed on a case-by-case basis; 2. A trial will not be considered valid if preferred or non-preferred products were readily available (by override, individual purchase, samples, etc.); 3. Certain drug trials, such as with controlled substances, may require evidence that the preferred drugs were actually tried (example: with random pill counts and with random urine drug tests, using the methods of GC/MS with no lower threshold); 4. Adequate trials require documentation of attempts to titrate dose of preferred agents toward desired clinical response. 5. Adequate trials include prevention/treatment of common adverse effects associated with preferred agents (example: antinausea, antipruritics, etc.)</p>						
<p><b>D: Step Order-</b> When numbers appear in the "step order" column, it means drugs in this category must be used in the order specified, with the lower numbers having preference over the higher numbers. Chart notes should be provided to confirm drug trials that do not appear in the member's MaineCare drug profile.</p>						
<p><b>E.</b> The Department will institute strategies to ensure cost effectiveness through the use of an enhanced Drug Benefit Preferred brand drugs will no longer be preferred in any PDL drug category where preferred generic drugs are also available. It is expected that preferred generics will be used prior to any preferred brands. This will be operated as a form of step care. Preferred brands in these categories will require prior authorization for these high utilization / high cost members.</p>						
<p><b>F: Brand Name Medication Requests-</b> (Must be submitted on the Brand Name PA request form)- According to MaineCare Benefits Manual Chapter II (80.07-5), when medically necessary covered brand-name drugs have an A-rated generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since the brand-name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. The Bureau does not make determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA. Physicians should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH.</p>						
<p><b>G: PA requests for non- FDA Approved Indications-</b> Decisions will be made on a case-by-case basis until the DUR committee is able to review the evidence and make a recommendation. Interim approvals and DUR recommendations for approval of a drug for a non- FDA approved indication will require a minimum of two published, peer reviewed, non contradicted, double- blind, placebo-controlled randomized clinical studies establishing both safety and efficacy.</p>						
<p><b>H: Dose Consolidation Requirements-</b> Some drugs may also be affected by dose consolidation requirements. Please see Dose Consolidation List and/or Splitting Tables provided in the PDL.</p>						
<p><b>I. Trials from Multiple Drug Classes -</b> Trial/failure/intolerance to preferred agents from multiple classes within the same category or other categories of drugs may be required prior to the approval of non-preferred agents (e.g., Cymbalta, Zofran, Elidel and others).</p>						
<p><b>J. Drug-specific PA Forms-</b> 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 <a href="http://www.mainearepdl.org">www.mainearepdl.org</a>.</p>						
<p><b>K. PA Exemptions for Prescribers-</b> According to MaineCare Benefits Manual Chapter II (80.07-4), providers may receive a three (3) month exemption from prior authorization requirement for certain categories of drugs when they demonstrate high compliance with the Department's PDL. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption. If a provider loses his/ her exemption, members who previously were not required to obtain a PA while the prescriber was exempt will be required to do so, and criteria for approval of that medication will need to be met.</p>						
<p><b>L: Drug-Drug Interactions (DDI)-</b> The DUR Committee has implemented new drug-drug interaction edits requiring prior authorization. Several drug-drug combinations and PDL drug categories are affected by new PA requirements. These will be indicated in the PDL with DDI notation. Please see the DDI document provided in the PDL.</p>						

**ASSORTED ANTIBIOTICS**

<p>BETA-LACTAMS / CLAVULANATE COMBO'S</p>	<p>AMOXICILLIN AMOXICILLIN/POTASSIUM CLA CHEW AMOXICILLIN/POTASSIUM CLA SUSR AMOXICILLIN/POTASSIUM CLA TABS AMOXIL<sup>1</sup> AMPICILLIN AUGMENTIN XR TB12 BEEPEN BICILLIN L-A SUSP DICLOXACILLIN SODIUM CAPS DYNAPEN SUSR GEOCILLIN TABS OXACILLIN SODIUM SOLR PENICILLIN V POTASSIUM TICAR SOLR TIMENTIN SOLR TRIMOX UNASYN SOLR VEETIDS ZOSYN</p>	<p>AMOXIL 500MG TABS AUGMENTIN ES-600 SUSR AUGMENTIN<sup>3</sup> PRINCIPEN CAPS<sup>2</sup> PRINCIPEN SUSR</p>	<p>1. Amoxil 500mg tabs are non-preferred. All other Amoxil products are preferred. 2.Principen 250 mg is available without PA.  3. Chewable 125mg &amp; 250mg and Solution 125mg/5ml and 250mg/5ml available without PA.  Use PA Form# 20420</p>
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		BILTRICIDE TABS MEBENDAZOLE CHEW STROMEKTOL TABS			
ANTIBIOTICS - MISC.		AZACTAM SOLR COLISTIMETHATE SODIUM SOLR FUROXONE TABS METRONIDAZOLE <sup>2</sup> PENTAMIDINE ISETHIONATE SOLR PRIMSOL SOLN TRIMETHOPRIM TABS VANCOCCIN HCL VANCOMYCIN HCL VANCOMYCIN 5GM INJ.		COLY-MYCIN-M SOLR FLAGYL CAPS FLAGYL TABS FLAGYL ER TBCR KETEK LORABID METRONIDAZOLE 375MG CAPS <sup>2</sup> METRONIDAZOLE 750MG TABS <sup>2</sup> NEBUPENT SOLR PROLOPRIM TABS TINDAMAX <sup>1</sup> VANCOMYCIN 10GM INJ. <sup>3</sup> 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.  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 <sup>1</sup>  ZYVOX SUSR ZYVOX TABS	1. Use multiple 150's for Clindamycin instead of 300's.  Zyvox: use PA Form # 30820 Others: use PA Form # 20420
ANTI INFECTIVE COMBO'S - MISC.		ERYTHROMYCIN/SULF SUSR SEPTRA/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA		BACTRIM DS TABS	Use PA Form # 20420
ANTI-PROTOZOALS				ALINIA <sup>1</sup>	1. Alina is preferred for children less than 12 years of age. Use PA Form # 20420
<b>ANTI - FUNGALS</b>					
ANTIFUNGALS - ASSORTED		ANCOBON CAPS FLUCONAZOLE <sup>1</sup> GRIFULVIN V TABS <sup>9</sup> GRISEOFULVIN SUSP <sup>9</sup> GRISEOFULVIN ULTRAMICROSI TABS <sup>9</sup> GRIS-PEG TABS <sup>9</sup> KETOCONAZOLE TABS <sup>8</sup>  NYSTATIN TERBINAFINE TABS <sup>4</sup> VFEND TABS	5 6 6 7 8 8 8  8 8	LAMISIL TABS <sup>4</sup> SPORANOX SOLN <sup>2</sup> SPORANOX PULSEPAK CAPS <sup>3</sup> SPORANOX CAPS <sup>3</sup> ERAXIS INJ <sup>6</sup> DIFLUCAN GRIFULVIN SUSP  NIZORAL TABS NOXAFIL <sup>5</sup>	1. QL--1/every 7-day period (150mg only).  2. Sporanox QL 300cc/month with PA. See quantity limit table. 3. Sporanox PULSEPAK 300cc/month with PA. See quantity limit table. Non-preferred products must be used in specified step order. Continue to use 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.  9. For children < 18, quantity limits allows 8 weeks supply without PA. PA will be required if using > than 8 weeks. If 18 and older PA will be required for any quantity. Not approving for Onychomycosis indication.  Please use PA form #20420 for Noxafil.
<b>ANTI - VIRALS</b>					
ANTIRETROVIRALS		AGENERASE CAPS APTIVUS		DIDANOSINE FUZEON	Fuzeon use PA Form # 10620

		ATRIPLA <sup>1</sup> COMBIVIR TABS CRIXIVAN CAPS EMTRIVA EPIVIR / HBV EPZICOM FORTOVASE CAPS HIVID TABS INVIRASE CAPS KALETRA LEXIVA NORVIR PREZISTA <sup>2</sup> RESCRIPTOR TABS RETROVIR REYATAZ STAVUDINE SUSTIVA TRIZIVIR TABS TRUVADA VIDEX / EC VIRACEPT TABS VIRAMUNE TABS VIREAD TABS ZIAGEN TABS		INTELENCE ISENTRESS SELZENTRY ZERIT	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
CYTO-MEGALOVIRUS AGENTS		FOSCARNET SODIUM VALCYTE TABS		CYTOVENE CAPS FOSCAVIR GANCICLOVIR	Use PA Form # 20420
HERPES AGENTS		ACYCLOVIR VALTREX TABS		FAMVIR TABS ZOVIRAX	Must fail Acyclovir and Valtrex before non-preferred products. Use PA Form # 20420
INFLUENZA AGENTS		AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU <sup>1</sup>		FLUMADINE TABS FLUMIST <sup>2</sup>	1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member.  2. Flumist Use Form # 10610. Others Use PA Form # 20420
<b>IMMUNE SERUMS</b>					
IMMUNE SERUMS		HYPERRHO INJ			
<b>HEPATITIS AGENTS</b>					
HEPATITIS C AGENTS		PEGASYS KIT <sup>1</sup> PEGASYS SOLN PEG-INTRON KIT REBETRON KIT RIBAVIRIN		COPEGUS TABS REBETOL CAPS	1. Dosing limits apply, please see dosage consolidation list.  Use PA Form # 20420
HEPATITIS AGENTS - MISC.				ACTIMMUNE	Use PA Form # 20420
HEPATITIS B ONLY		HEPSERA TABS		BARACLUDGE TYZEKA	
<b>RSV PROPHYLAXIS</b>					
RSV PROPHYLAXIS				SYNAGIS <sup>1</sup>	Use PA Form # 30120 1. MaineCare will approve Synagis PA's for start date of November 5th for infants who meet the guidelines. PA will be approved for max of 5 doses and good thru March 31, unless Maine specific data suggests ongoing epidemic RSV activity.
<b>MS TREATMENTS</b>					
MULTIPLE SCLEROSIS - INTERFERONS		AVONEX KIT <sup>1</sup> BETASERON SOLR <sup>1</sup> REBIF SOLN <sup>1</sup>			Use PA Form # 20430 1.Clinical PA is required to establish diagnosis and medical necessity
MULTIPLE SCLEROSIS - NON-INTERFERONS		COPAXONE <sup>2</sup>	8	TYSABRI <sup>1</sup>	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

**ASSORTED NEUROLOGICS**

NEUROLOGICS - MISC.	MESTINON ORAP TABS PROSTIGMIN TABS		BOTOX MYOBLOC <sup>1</sup>	1. Myobloc approval will be limited to Cervical Dystonia. Use PA Form #10210
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**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 DECADRON TABS FLORINEF TABS MEDROL TABS MEDROL DOSEPAK TABS ORAPRED SOLN PEDIAPRED LIQD PREDNISONE INTENSOL CONC PRELONE SYRP STERAPRED TABS	Use PA Form # 20420
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**HORMONE REPLACEMENT THERAPIES**

ANDROGENS / ANABOLICS	ANDRODERM PT24 ANDROGEL ANDROID CAPS DANAZOL CAPS DEPO-TESTOSTERONE OIL FLUOXYMESTERONE TABS TESTOSTERONE PROPIONATE TESTRED CAPS WINSTROL TABS		ANDRO LA 200 OIL DELATESTRYL OIL HALOTESTIN TABS METHITEST TABS OXANDRIN TABS <sup>1</sup> TESTIM	Use PA Form # 20420  1. Non-preferred effective 12.01.05. Use the Oxandrin PA Form #20600
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ESTROGENS - PATCHES / TOPICAL	ESTRADERM PTTW <sup>1</sup> VIVELLE-DOT PTTW <sup>1</sup>	5 8 8 8 8 8	ESTRADIOL PTWK ALORA PTTW CLIMARA PTWK DIVIGEL ELESTRIN EVAMIST	1. Both preferred drugs must be tried. 2. Step order drugs must be used in specified step order. Use PA Form # 20420
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ESTROGENS - TABS	CENESTIN TABS DELESTROGEN OIL ESTRADIOL ESTROPIPATE TABS MENEST TABS PREMARIN TABS		ENJUVA ESTRACE TABS ESTRATAB TABS OGEN TABS ORTHO-EST TABS	Must fail preferred products before non-preferred products. Use PA Form # 20420
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ESTROGEN COMBO'S	PREMPHASE TABS PREMPRO TABS		ACTIVELLA TABS COMBIPATCH PTTW FEMHRT 1/5 TABS ORTHO-PREFEST TABS SYNTEST H.S. TABS	Must fail Premphase and Prempro products before non preferred products. Use PA Form # 20420
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PROGESTINS	MEDROXYPROGESTERONE ACETA <sup>2</sup> NORETHINDRONE ACETATE TABS <sup>2</sup> PROGESTERONE POWD		AYGESTIN TABS CYCRIN TABS PROMETRIUM 100MG CAPS <sup>1</sup> PROMETRIUM 200MG <sup>1</sup> 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
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**CONTRACEPTIVES**

CONTRACEPTIVES - PROGESTIN ONLY	ORTHO MICRONOR TABS		CAMILA TABS ERRIN JOLIVETTE NORA-BE TABS NOR-QD TABS OVRETTE 28 TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form # 20420
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CONTRACEPTIVES - INJECTABLE	MEDROXYPROGESTERONE ACETATE 150mg IM		DEPO-PROVERA 150 mg SUSP LUNELLE SUSP	Use PA Form # 20420
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CONTRACEPTIVE - EMERGENCY		PLAN - B <sup>1</sup>			1. Allowed 4 tablets per 30 days without PA
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS		NUVARING RING <sup>3</sup> ORTHO EVRA PTWK <sup>1,2,4</sup>			1.No PA required for users less than 21 years of age. 2. The FDA has issued a public health warning of the potentials for increased exposure to estrogen with Ortho Eva use, possibly up to 60% estrogen exposure 3. Quantity limit allowing 1 every 28 days with out PA. 4. Dose limits apply allowing 3 patches per 28 days supply. Please refer to Dose Consolidation Chart. Use PA Form # 20420
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S		APRI TABS BALZIVA CRYSSELLE-28 TABS DESOGEN TABS DESOGESTREL/ ETHINYL ESTRADIOL LOW-OGESTREL TABS MODICON TABS MONONESSA ORTHO-CEPT-28 TABS ORTHO-CYCLEN-28 TABS ORTHO-NOVUM 1/35-28 TABS ORTHO-NOVUM 1/50-28 TABS OVCON-50 28 TABS PREVIFEM RECLIPSEN SOLIA SPRINTEC 28 TABS YASMIN 28 TABS ZENCHENT		AVIANE TABS BREVICON-28 TABS DEMULEN 1/35-21 TABS KARIVA TABS LESSINA-28 TABS LEVORA LOESTRIN TABS LOESTRIN FE TABS LOESTRIN FE 1/20 TABS LOESTRIN 1.5/30-21 TABS LOESTRIN 1/20-21 TABS LO/OVRAL 21 TABS LO/OVRAL 28 TABS MICROGESTIN FE TABS MIRCETTE TABS NECON NORDETTE-28 TABS NORINYL NORTREL OCELLA OGESTREL TABS OVCON-35/28 TABS OVRAL PORTIA-28 TABS SEASONALE YAZ ZOVIA	If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form # 20420
CONTRACEPTIVES - BI-PHASIC COMBINATIONS		ORTHO-NOVUM 10/11-28 TABS		NECON 10/11-28 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
<b>DIABETES THERAPIES</b>					
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 <sup>1</sup>		APIDRA OPTICLIK PEN	1. Clinical PA will be required to establish

	LANTUS SOLOSTAR <sup>1</sup> LEVEMIR FLEXPEN <sup>1</sup> NOVOLIN PENFILL <sup>1</sup> NOVOLIN 70/30 <sup>1</sup> NOVOLOG MIX PENFILL <sup>1</sup> NOVOLOG PENFILL SOLN <sup>1</sup> NOVOLOG MIX FLEXPEN <sup>1</sup> NOVOLOG FLEXPEN <sup>1</sup>		HUMALOG KWIK INJ 100/ML HUMALOG MIX INJ 75/25 KWP HUMALOG MIX INJ 50/50 KWP HUMALOG PEN SOLN HUMULIN PEN HUMULIN N PN INJ U-100 HUMULIN PEN INJ 70/30	significant visual or neurological impairment. Use PA Form # 20420
DIABETIC - DPP- 4 ENZYME INHIBITOR	JANUVIA <sup>1</sup>			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.
DIABETIC - DPP- 4 ENZYME INHIBITOR-COMBO	JANUMET <sup>1</sup>			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.
DIABETIC - LANCET-LANCET DEVICE	ONE TOUCH LANCETS FREESTYLE LANCETS UNILET LANCETS UNISTIK LANCING DEVICE AUTOLOT LANCING DEVICE			Use PA Form # 20420
DIABETIC - SYRINGES-NEEDLES	BD MICRO-FINE BD ULTRA-FINE BD ULTRA-FINE PEN NEEDLES UNIFINE PEN NEEDLES			Use PA Form # 20420
DIABETIC - OTHER			SYMLIN	Use PA Form # 30150
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	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.  Use PA Form # 20421
DIABETIC TEST STRIPS	FREESTYLE <sup>1</sup> FREESTYLE LITE <sup>1</sup> ONE TOUCH BASIC <sup>1</sup> ONE TOUCH SURESTEP <sup>1</sup> ONE TOUCH FAST TAKE <sup>1</sup> ONE TOUCH ULTRA <sup>1</sup> PRECISION XTRA <sup>1</sup> PRECISION XTRA BETA KETONE 10 CT		ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.  1. Only 50 ct & 100 ct package size.  Use PA Form # 20421
INCRETIN MIMETIC			BYETTA <sup>1</sup>	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		GLUCOPHAGE TABS	Use PA Form # 20420

		METFORMIN ER		GLUCOPHAGE XR TB24 FORTAMET	
DIABETIC - THIAZOL / BIGUANIDE COMBO		ACTOPLUS MET AVANDARYL AVANDAMET TABS			
DIABETIC - / THIAZOL		AVANDIA TABS <sup>1</sup> ACTOS 15MG TABS <sup>1</sup> ACTOS 45MG TABS <sup>1</sup>		ACTOS 30MG TABS <sup>2</sup>	1. Actos and Avandia preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months. Avandia and Actos are non-preferred as monotherapy.  2. Actos 30mg - use two 15mg instead. Use PA Form # 20420
DIABETIC - ALPHAGLUCOSIDASE		GLYSET TABS		PRECOSE TABS	Use PA Form # 20420
DIABETIC - SULFONYLUREA / BIGUANIDE		GLYBURIDE/METFORMIN DUETACT		GLUCOVANCE TABS METAGLIP TABS	Use individual ingredients. Use PA Form # 20420
DIABETIC - MEGLITINIDES		STARLIX TABS		PRANDIN TABS	Use PA Form # 20420
<b>GLUCOSE ELEVATING AGENTS</b>					
GLUCOSE ELEVATING AGENTS		GLUCAGEN INJ. HYPOKIT		GLUCAGON DIAGNOSTIC KIT GLUCAGEN DIAGNOSTIC KIT	
<b>THYROID</b>					
THYROID HORMONES		ARMOUR THYROID TABS CYTOMEL TABS LEVOTHROID TABS LEVOTHYROXINE SODIUM TABS LEVOXYL TABS THYROID TABS THYROLAR UNITHROID TABS		LEVOTHYROXINE SODIUM SOLR SYNTHROID TABS	Use Pa Form # 20420
ANTITHYROID THERAPIES		METHIMAZOLE TABS PROPYLTHIOURACIL TABS		TAPAZOLE TABS	Use PA Form # 20420
<b>OSTEOPOROSIS</b>					
OSTEOPOROSIS		ALENDRONATE <sup>2</sup> BONIVA TABS <sup>2</sup> FORTICAL FOSAMAX SOLN <sup>2</sup> MIACALCIN SOLN <sup>2</sup>		ACTONEL TABS BONIVA INJECTION KIT AREDIA SOLR DIDRONEL TABS EVISTA TABS <sup>1</sup> FORTEO FOSAMAX PLUS D FOSAMAX TABS	Use PA Form # 20420 1. Approval only requires failure of Fosamax or Boniva.  2. Quantity limits apply, please see dosage consolidation list.
<b>CALCIMIMETIC AGENTS</b>					
CALCIMIMETIC AGENTS				SENSIPAR	Use PA Form # 30115
<b>GROWTH HORMONE</b>					
GROWTH HORMONE		GENOTROPIN <sup>1</sup> NUTROPIN <sup>1</sup>	5 5 8 8 8 8	NORDITROPIN CARTRIDGE SOLN TEV-TROPIN HUMATROPE SOLR INCRELEX IPLEX SAIZEN SOLR	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		SANDOSTATIN		SOMATULINE	
<b>GROWTH HORMONE ANTAGONISTS</b>					
GH ANTAGONISTS				SOMAVERT	Use PA Form # 10710
<b>URINARY INCONTINENCE</b>					
VASOPRESSINS		DESMOPRESSIN TABS	5 6 6 8 8	DDAVP TABS DDAVP SOLN DESMOPRESSIN SPRAY DESMOPRESSIN ACETATE SOLN STIMATE SOLN*	Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP. Use PA Form # 20420
ANTISPASMODICS		OXYBUTYNIN		CYSTOSPAZ TABS	Use PA Form # 20420

		URISPAS TABS		DETROL TABS DITROPAN	
ANTISPASMODICS - LONG ACTING		DETROL LA CP24 ENABLEX <sup>1</sup> SANCTURA SANCTURA XR TOVIAZ VESICARE <sup>1</sup>	5 8 8	OXYBUTYNIN ER DITROPAN XL TBCR OXYTROL	Use PA Form # 20420
CHOLINERGIC		URECHOLINE			
<b>METABOLIC MODIFIER</b>					
HERED. TYROSINEMIA				ORFADIN	Use PA Form # 20420
<b>ANTIHYPERTENSIVES / CARDIAC</b>					
CARDIAC GLYCOSIDES		DIGITEK TABS DIGOXIN LANOXICAPS LANOXIN			
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			
NITRO - PATCHES	1 1 1 3	NITROGLYCERIN PT24 NITREK PT24 NITRO-DUR PT 24 0.8MG MINITRAN PT24		NITRODISC PT24 NITRO-DUR PT24	At least 2 step 1's and step 3 of the preferred products must be used in specified order or PA will be required. Use PA Form # 20420
NITRO - SUBLINGUAL/ SPRAY		NITROLINGUAL AERS NITROSTAT SUBL NITROTAB SUBL		NITROLINGUAL SOLN NITROQUICK SUBL	Use Pa Form # 20420
BETA BLOCKERS - NON SELECTIVE		CARVEDILOL LEVATOL TABS NADOLOL TABS PINDOLOL TABS PROPRANOLOL HCL SOLN <sup>1</sup> PROPRANOLOL HCL TABS <sup>1</sup> PROPRANOLOL LA CAPS SOTALOL HCL TABS TIMOLOL MALEATE TABS		BETAPACE TABS BETAPACE AF TABS COREG CR <sup>2</sup> COREG TABS CORCARD TABS INDERAL TABS INDERAL LA CPCR INNOPRAN XL PROPRANOLOL HCL 60MG TABS <sup>2</sup> RANEXA	1. Recommend using BID since its effects do not last 24 hours.  2. Dosing limits still apply. Please see dose consolidation list.  3. Please use other strengths in combination to obtain this dose.  Use PA Form # 20420
BETA BLOCKERS - CARDIO SELECTIVE		ACEBUTOLOL HCL CAPS ATENOLOL TABS <sup>1</sup> BETAXOLOL HCL TABS BISOPROLOL FUMARATE TABS METOPROLOL TARTRATE TABS <sup>1</sup> TOPROL XL TB24		BYSTOLIC KERLONE TABS LOPRESSOR TABS METOPROLOL ER SECTRAL CAPS TENORMIN TABS ZEBETA TABS	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form # 20420
BETA BLOCKERS - ALPHA / BETA		LABETALOL HCL TABS		TRANDATE TABS	Use PA Form # 20420
CALCIUM CHANNEL BLOCKERS--Amlodipines, Bepridil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils	1 1 1 1	AMLODIPINE <sup>1</sup> DILTIA XT CP24 DILTIAZEM HCL ER CP24 DILTIAZEM HCL XR CP24 DILTIAZEM CD 300MG CP24	5 6 7 8	NORVASC TABS <sup>1</sup> DILACOR XR CP24 TAZTIA TIAZAC CP24 CARDIZEM TABS	1. Dosing limits apply, please see dose consolidation list.  Products must be used in specified order or PA will be required. Just write "Diltiazem 24-hour" and the pharmacy will use a preferred long acting diltiazem that does not require PA. Use PA Form # 20420

	1	DILTIAZEM CD 360MG CP24	8	CARDIZEM CD CP24	
	4	CARTIA XT CP24	8	CARDIZEM LA TB24	
	4	DILTIAZEM CD CP24	8	CARDIZEM SR CP12	
	4	DILTIAZEM HCL ER CP24	8	DILTIAZEM HCL TABS	
	4	DILTIAZEM XR CP24	8	DILTIAZEM HCL ER CP12	
				PLENDIL TB24	Use PA Form # 20420
				DYNACIRC CAPS DYNACIRC CR TBCR <sup>1</sup>	Use PA Form # 20420 1. Established users will be grandfathered
				CARDENE CAPS CARDENE SR CPR NICARDIPINE HCL CAPS	Use PA Form # 20420
		AFEDITAB CR NIFEDIAC CC NIFEDICAL XL TBCR NIFEDIPINE TBCR NIFEDIPINE ER TBCR		ADALAT CC TBCR NIFEDIPINE CAPS PROCARDIA CAPS PROCARDIA XL TBCR	Established users of Adalat CC are grandfathered.  Use PA Form # 20420
				SULAR TB24	Established users of 10MG and 20MG strengths are grandfathered.
	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 NORPACE PROCAINAMIDE PROCANBID CR PROPAFENONE QUINAGLUTE QUINIDINE GLUCONATE QUINIDINE SULFATE RYTHMOL		CORDARONE DISOPYRAMIDE MEXITIL PACERONE QUINIDEX TAMBOCOR TIKOSYN <sup>1</sup>	1. Prescription must be written by Cardiologist. Use PA Form # 20420
ACE INHIBITORS		BENAZEPRIL HCL CAPTOPRIL TABS ENALAPRIL MALEATE TABS FOSINOPRIL SODIUM LISINOPRIL TABS QUINAPRIL RAMIPRIL	5 5 8 8 8 8 8 8 8 8 8	MAVIK TABS ACCUPRIL TABS ACEON TABS ALTACE CAPS CAPOTEN TABS LOTENSIN TABS MOEXIPRIL MONOPRIL HCT TABS PRINIVIL TABS UNIVASC VASOTEC TABS ZESTRIL TABS	Non-preferred products must be used in specified order.  Use PA Form # 20420
ANGIOTENSIN RECEPTOR BLOCKER		AVAPRO BENICAR TABS COZAAR TABS 25MG <sup>2</sup> DIOVAN MICARDIS TABS		ATACAND TABS COZAAR 50MG & 100MG <sup>1</sup> TEVETEN TABS	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.  1. Please use multiple preferred 25mg tabs.  2. Dosing limits apply. Please see dose consolidation list. Use PA Form # 20420
DIRECT RENIN INHIBITOR				TEKTRUNA <sup>1</sup>	1. Must show failure of single and combination therapy from all preferred antihypertensive categories.
ANTIHYPERTENSIVES - CENTRAL		CATAPRES-TTS CLONIDINE HCL TABS GUANFACINE HCL TABS HYDRALAZINE HCL TABS HYLOREL TABS		CATAPRES TABS GUANABENZ ACETATE TABS ISMELIN TABS MINIPRESS CAPS TENEX TABS	Use PA Form # 20420

		METHYLDOPA TABS MINOXIDIL TABS PRAZOSIN HCL CAPS RESERPINE TABS			
ACE INHIBITORS AND CA CHANNEL BLOCKERS				LEXXEL TBCR LOTREL CAPS TARKA TBCR	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		ACCURETIC TABS CAPOZIDE TABS LOTENSIN HCT 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 INDERIDE 40/25 TABS LOPRESSOR HCT TABS TENORETIC TIMOLIDE 10/25 TABS ZIAC TABS	Use PA Form # 20420
ARB'S AND CA CHANNEL BLOCKERS		AZOR EXFORGE			
ARB'S AND DIURETICS		AVALIDE TABS BENICAR HCT DIOVAN HCT TABS HYZAAR TABS MICARDIS HCT TABS		ATACAND HCT TABS TEVETEN HCT TABS	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.  Use PA Form # 20420
DIURETICS		ACETAZOLAMIDE TABS AMILORIDE HCL BUMETANIDE CHLOROTHIAZIDE TABS CHLORTHALIDONE TABS EDECIN TABS FUROSEMIDE HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS METHYLCLOTHIAZIDE TABS SPIRONOLACTONE 25MG TABS SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ ZAROXOLYN TABS		ALDACTAZIDE TABS ALDACTONE TABS AMILORIDE HCL BUMEX TABS DEMADEX TABS DIAMOX DIURIL DYAZIDE CAPS ENDURON TABS INSPIRA LASIX TABS LOZOL TABS MAXZIDE MICROZIDE CAPS MIDAMOR TABS MODURETIC 5-50 TABS NAQUA TABS NATURETIN TABS SPIRONOLACTONE 50MG <sup>1</sup>	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
CCB / LIPID		CADUET			
<b>LIPID DRUGS</b>					
CHOLESTEROL - BILE SEQUESTRANTS		CHOLESTYRAMINE COLESTID		PREVALITE QUESTRAN WELCHOL TABS	Use PA Form # 20420
CHOLESTEROL - FIBRIC ACID DERIVATIVES		GEMFIBROZIL TABS NIASPAN TRICOR TRILIPIX		ANTARA LOPID LOFIBRA FENOFIBRATE TRIGLIDE	Use PA Form # 20420
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS		LIPITOR SIMVASTATIN <sup>1</sup>		CRESTOR VYTORIN ZOCOR	1. Dosing limits apply, please see dosage consolidation list. Use PA Form # 20420
CHOLESTEROL - HGM COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS		LESCOL CAPS LESCOL XL TB 24 LOVASTATIN TABS <sup>2</sup> PRAVASTATIN <sup>2</sup>		ALTOPREV TB 24 MEVACOR TABS PRAVACHOL TABS PRAVIGARD	1. Zetia available w/OPA as addition to Lipitor 80mg. Zetia will also be approved with a PA as add on for patients at maximally tolerated doses of statins.

				ZETIA TABS <sup>1</sup>	2. Dosing limits apply. Use PA Form #20420
CHOLESTEROL - HGM COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO		SIMCOR ADVICOR TBCR			
<b>PULMONARY ANTI-HYPERTENSIVES</b>					
PULMONARY ANTI-HYPERTENSIVES		REVATIO <sup>1</sup> VENTAVIS <sup>2</sup> EPOPROSTENOL INJ <sup>5</sup>		FLOLAN REMODULIN <sup>3</sup>	3. There will be dosing limits of one 20ml multidose vial/ 30 days supply without pa.  4. Viagra would be approved after a diagnosis of pulmonary hypertension is confirmed.  5. PA is required to establish and confirm who group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 & 4  Use PA Form # 20420
ERA / ENDOTHELIN RECEPTOR ANTAGONIST		TRACLEER <sup>2</sup>		LETAIRIS <sup>1</sup>	1. Providers must be registered with LEAP Prescribing program, a restricted distribution program. 2. Prior authorization required to establish PAH diagnosis and class 3 or 4 symptoms.
<b>IMPOTENCE AGENTS</b>					
IMPOTENCE AGENTS					As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.
<b>ANTI-EMETOGENICS</b>					
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC		MECLIZINE HCL TABS PHENERGAN SUPP PHENERGAN FORTIS SYRP PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72		ANTIVERT TABS PHENERGAN SOLN PHENERGAN TABS PROMETHAZINE 50MG SUPP PROMETHEGAN SUPP TORECAN TABS	Use PA Form # 20420
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ		EMEND MARINOL CAPS ONDANSETRON TABS* <sup>2</sup> ONDANSETRON ODT TBDP* <sup>2</sup> ZOFTRAN SOLN* <sup>2</sup>		ALOXI ANZEMET TABS CESAMET <sup>1</sup> KYTRIL SANCUSO ZOFTRAN ODT TBDP* ZOFTRAN TABS*	*See quantity limit table. 1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred anti-emetics, including 5-HT3 class (Zofran, Emend) and Marinol.  2. Ondansetron will be preferred with CA diag and dosing limits still apply.  Ondansetron: use PA Form # 20610 Others: use PA Form # 20420
<b>NON-SEDATING ANTIHISTAMINES / DECONGESTANTS</b>					
ANTI HISTAMINES - NON-SEDATING		ALAVERT TABS CETIRIZINE TABS CLARITIN (OTC) CLARITIN SYRP (OTC) LORATADINE TAVIST ND (OTC)	5 5 5 5 5 8 8 8 8	FEXOFENADINE1 CLARINEX SYR <sup>1,2</sup> FEXOFENADINE <sup>1</sup> ZYRTEC <sup>1</sup> ZYRTEC SYR <sup>1,2</sup> ALLEGRA <sup>3</sup> CLARITIN <sup>3</sup>  LORATADINE ODT <sup>4</sup> XYZAL <sup>3</sup>	1. Must fail preferred drugs, OTC loratidine and cetirizine before moving to non-preferred step order drugs.  2. Clarinex and Zyrtec syrup <6 yr w/o PA.  3. Must fail all step 5 drugs (Clarinex, Fexofenadine and Zyrtec) before moving to next step product.  4. All OTC versions of loratidine ODT are now non-preferred.  Pseudoephedrine is available with prescription. Use PA Form # 20530
ANTI HISTAMINES - OTHER		CLEMASTINE CHLORPHENIRAMINE DIPHENHYDRAMINE			Use PA Form # 20420
<b>ALLERGY / ASTHMA THERAPIES</b>					
ANTI ASTHMATIC -		ATROVENT AERS			Use PA Form # 20420 1. Quantity limit of 1

ANTICHOLINERGICS - INHALER		ATROVENT HFA SPIRIVA <sup>1,2</sup>			Inhalation daily (1 capsule for inhalation daily) Spiriva will require PA if Combivent or Atrovent inhaler/nebulizer solution is in member's current drug profile.  2. We ask physicians to write "asthma" on the prescription whenever Spiriva is primarily being used for that condition.
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER		IPRATROPIUM BROMIDE SOLN		ATROVENT SOLN	Use PA Form # 20420
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS		CROMOLYN SODIUM NEBU INTAL AERS TILADE AERS		XOLAIR <sup>1</sup>	1. Need max inhaled steroids and written by pulmonary or allergy specialist. Use PA Form # 20420
ANTIASTHMATIC - NASAL STEROIDS		FLUTICASONE SPR NASONEX SUSP VERAMYST	5 5 5 8 8 8 8 8 8 8 8	BECONASE AQ INHA <sup>1</sup> NASACORT AQ AERS <sup>1</sup> NASAREL SOLN <sup>1</sup> FLONASE SUSP <sup>2</sup> FLUNISOLIDE SOLN <sup>2</sup> NASACORT AERS <sup>2</sup> OMNARIS SPR RHINOCORT AERO <sup>2</sup> RHINOCORT AQUA SUSP <sup>2</sup> TRI-NASAL SOLN <sup>2</sup> VANCENASE POCKETHALER AERS <sup>2</sup>	Use PA Form # 20420 Dosing limits apply to whole category, please see dosage consolidation list. 1. All preferred drugs must be tried before moving to non preferred steps. 2. All step 5 medications need to be tried before moving to step 8's.
ANTIASTHMATIC - NASAL MISC.		CROMOLYN NASAL 4% NASALCROM OCEAN 0.65% SALINE NASAL SPRAY 0.65%		ATROVENT NASAL SOL IPRATROPIUM NASAL SOL <sup>1</sup> ASTELIN ASTEPRO <sup>2</sup>	1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine. Use PA Form # 20420  2. Utilize Multiple preferred, as well as step therapy Astelin.
ANTIASTHMATIC - BETA - ADRENERGICS		ALBUTEROL NEB MAXAIR METAPROTERENOL PROAIR HFA <sup>3</sup> PROVENTIL HFA AERS <sup>3</sup> SEREVENT TERBUTALINE SULFATE TABS VENTOLIN HFA AERS <sup>3</sup>		ACCUNEB NEBU ALBUTEROL AER ALBUTEROL HFA ALBUTEROL 0.63mg/3ml ALUPENT AERP BRETHINE FORADIL AEROLIZER CAPS PROVENTIL VENTOLIN AERS VOLMAX TBCR VOSPIRE ER TB12 XOPENEX HFA <sup>3</sup> XOPENEX NEBU <sup>1,2</sup>	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 <sup>1</sup> SYMBICORT <sup>1</sup>			We ask physicians to write "asthma" on the prescription whenever Advair is primarily being used for that condition.  1. Dosing limits apply, please see dosage consolidation list.
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC		COMBIVENT AERO <sup>2</sup>  ALBUTEROL/IPRATROPIUM NEB SOLN		DUONEB SOLN <sup>1</sup>	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 THEOPHYLLINE SOLN		QUIBRON CAPS QUIBRON-T TABS QUIBRON-T/SR TB12 THEO-24 CP24 THEOLAIR TABS UNIPHYL TBCR	Use PA Form 20420

		THEOPHYLLINE ER CP12 THEOPHYLLINE ER TB12			
ANTIASTHMATIC - STEROID INHALANTS		ASMANEX AZMACORT AERS FLOVENT HFA PULMICORT FLEXHALER PULMICORT SUSP <sup>1</sup> QVAR AERS	5 5 5 8 8 8	AEROBID AERS <sup>2</sup> BECLOVENT AERS <sup>2</sup> VANCERIL AERS <sup>2</sup> AEROBID-M AERS <sup>3</sup> ALVESCO VANCERIL DOUBLE STRENGTH AERS <sup>3</sup>	Dosing limits apply to whole category, please see dosage consolidation list.  1. No PA for Pulmicort susp if under 8 years old.  2. All preferreds must be tried before moving to non preferred steps.  3. All step 5 medications need to be tried before moving to step 8's.  Use PA Form # 20420
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				ZYFLO CR TABS	Use PA Form # 20420
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS		SINGULAIR <sup>1</sup>		ACCOLATE TABS	1. We ask physicians to write "asthma" on the prescription whenever Singulair is primarily being used for that condition. Use PA Form # 20420
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR				PROLASTIN SUSR ZEMAIRA	Use PA Form # 20420
ANTIASTHMATIC - HYDROLYTIC ENZYMES				PULMOZYME SOLN	Use PA Form # 20420
ANTIASTHMATIC - MUCOLYTICS		ACETYLCYSTEINE <sup>1</sup>		MUCOMYST	1. Acetylcysteine is covered with diagnosis of CF. Use PA Form # 20420
<b>COUGH/COLD</b>					
COUGH/COLD		DEXTRO-GUAIF SYRP GUAIFENESIN SYRP PSEUDOEPHEDRINE ROBITUSSIN DM SYRP ROBITUSSIN SUGAR FREE SYRP		All others are a non-covered service (this includes antihistamines-decongestive combinations).	All of cough cold preparations are not covered except these preferred products.
<b>DIGESTIVE AIDS / ASSORTED GI</b>					
<b>**Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.**</b>					
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 SULFATE HYOSCYAMINE CAPS & TABS KAOPECTATE MAGNESIUM OXIDE TABS MAG-OX 400 TABS PAMINE TABS PROPANTHELINE BROMIDE TABS SAL-TROPINE TABS SCOPOLAMINE HYDROBROMIDE SODIUM BICARBONATE TABS TUMS		B & O 15-A SUPPRETTE SUPP B & O 16-A SUPPRETTE SUPP 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		AXID CAPS AXID AR TABS	Use PA Form # 20420

		RANITIDINE ACID REDUCER TABS ZANTAC SYRUP		NIZATIDINE CAPS PEPCID PEPCID AC RANITIDINE SYRUP TAGAMET TABS ZANTAC TABS	
GI - PROTON PUMP INHIBITOR		KAPIDEX <sup>2</sup> OMEPRAZOLE 10MG/20MG <sup>2</sup> PROTONIX <sup>2</sup>	6 7 8 8 8 8 8 8 8 9	PRILOSEC OTC <sup>4</sup> ACIPHEX TBEC <sup>4</sup> PREVACID CPDR <sup>4,5</sup> PREVACID SOLUTABS <sup>1</sup> NEXIUM CPDR PRILOSEC CPDR PROTONIX INJ ZEGERID OMEPRAZOLE 40MG <sup>3</sup>	1. Prevacid Solutabs available without PA for children less than 9 years old. Use PA Form # 20420 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.
GI - ULCER ANTI-INFECTIVE				HELIDAC PREVPAC <sup>1</sup>	1. Please use individual ingredients
GI - PROSTAGLANDINS		MISOPROSTOL TABS		CYTOTEC TABS	Use PA Form # 20420
GI - DIGESTIVE ENZYMES		CREON LACTASE CHEW LACTASE TAB ULTRASE CPEP ULTRASE MT VIOKASE		LACTRASE CAPS LIPRAM LIPRAM CR KUTRASE CAPS KU-ZYME CAPS PANCREASE PANCREASE MT PANCRECARB MS-8 CPEP PANCRELIPASE PANGESTYME PANOKASE TABS	Use PA Form # 20420
GI - ANTI - FLATULENTS / GI STIMULANTS		CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP GASTROCROM CONC GENERLAC SYRP LACTULOSE SYRP METOCLOPRAMIDE HCL SIMETHICONE		AMITIZA <sup>1</sup> CEPHULAC SYRP INFANTS GAS RELIEF SUSP REGLAN TABS	Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL Use PA Form # 20420 1. 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 AZULFIDINE TABS CANASA SUPP COLAZAL CAPS DIPENTUM CAPS LIALDA TABS PENTASA CPCR ROWASA ENEM SULFAZINE EC TBEC SULFASALAZINE TABS		APRISO ASACOL HD AZULFIDINE EN-TABS TBEC	Use PA Form # 20420
GI - IRRITABLE BOWEL SYNDROME AGENTS				LOTRONEX TABS	Use PA Form # 20420
<b>MISCELLANEOUS GI</b>					
**Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.**					
GI - MISC.		BISAC-EVAC SUPP BISACODYL BISCOLAX SUPP CINOBAC CAPS CITRATE OF MAGNESIA SOLN CITRUCEL DIOCTO SYRP		ACTIGALL CAPS BENEFIBER CARAFATE COLACE CAPS COLYTE DIOCTO-C SYRP DOC SOD /CAS CAP	1. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose.

		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	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	Use PA Form # 20420
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**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 NITROFURANTOIN MACR CAPS 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 <sup>1</sup> MACROBID CAPS MACRODANTIN CAPS MANDELAMINE TABS 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
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**PHOSPHATE BINDERS**

PHOSPHATE BINDERS		PHOSLO <sup>1</sup> MAGNEBIND - 400 <sup>1</sup> RENAGEL <sup>1</sup> FOSRENOL <sup>1</sup>	RENEVA <sup>2</sup>	1. Diag required. 2. Must fail Phoslo, Renagel & Fosrenol before non-preferred products.  Use PA Form #20420
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**INTRA-VAGINALS**

VAGINAL - ANTIBACTERIALS	1 1 3	CLEOCIN CREA METRONIDAZOLE VAGINAL GEL <sup>2</sup> CLEOCIN SUPP <sup>1</sup>	METROGEL VAGINAL GEL <sup>2</sup> 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
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VAGINAL - ANTI FUNGALS		CLOTRIMAZOLE CREA GYNE-LOTTRIMIN CREA MICONAZOLE CREA MICONAZOLE 3 COMBO PACK KIT <sup>1</sup> MICONAZOLE 7 CREA MICONAZOLE NITRATE CREA	AVC CREAM CLOTRIMAZOLE 3 DAY CREA GYNAZOLE-1 CREA GYNE-LOTTRIMIN 3 TABS MICONAZOLE 3 SUPP TERAZOL 3 CREA	1. Quantity limit: 1/script/2 weeks
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		NYSTATIN TABS TERAZOL 3 SUPP TERCONAZOLE 0.4MG VAGITROL V-R MICONAZOLE-7 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 VAGIFEM TABS	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
<b>BPH</b>					
BPH		AVODART DOXAZOSIN MESYLATE TABS FINASTERIDE <sup>1</sup> TERAZOSIN HCL CAPS	5 8 8 8 8 8	FLOMAX CP24 CARDURA TABS HYTRIN CAPS PROSCAR TABS RAPAFLO UROXATRAL	Non-preferred products must be used in specified order.  1. There will be dosing limits of 1 tab per day with out PA.  Use PA Form #20420
<b>ANXIOLYTICS</b>					
ANXIOLYTICS - BENZODIAZEPINES		ALPRAZOLAM TABS CHLORDIAZEPOXIDE HCL CAPS CLORAZEPATE DIPOTASSIUM TABS DIAZEPAM LORAZEPAM OXAZEPAM CAPS		ALPRAZOLAM ER ATIVAN NIRAVAM SERAX TRANXENE XANAX TABS XANAX XR	Use PA Form # 20420
ANXIOLYTICS - MISC.		BUSPIRONE HCL TABS HYDROXYZINE HCL SOLN HYDROXYZINE HCL SYRP HYDROXYZINE PAMOATE CAPS MEPROBAMATE TABS		ATARAX TABS BUSPAR TABS DROPERIDOL SOLN HYDROXYZINE HCL TABS HYDROXYZINE PAM 100MG CAPS INAPSINE SOLN VISTARIL	Use PA Form # 20420
<b>ANTI-DEPRESSANTS</b>					
ANTIDEPRESSANTS - MAO INHIBITORS		NARDIL TABS PARNATE TABS			
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL				EMSAM <sup>1</sup>	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 <sup>4</sup> CYMBALTA <sup>5</sup> FLUOXETINE HCL CAPS FLUOXETINE HCL LIQD FLUOXETINE HCL 10mg TABS FLUVOXAMINE MALEATE TABS MIRTAZAPINE NEFAZODONE PAROXETINE <sup>3</sup> SERTRALINE <sup>2</sup> TRAZODONE HCL TABS WELLBUTRIN SR TBCR		APLENZIN <sup>8</sup> CELEXA DESYREL TABS EFFEXOR TABS EFFEXOR XR CP24 <sup>3</sup> FLUOXETINE 40 mg CAPS <sup>1</sup> FLUOXETINE 20mg TABS <sup>6</sup> LEXAPRO TABS <sup>4,7</sup> LUVOX TABS MAPROTILINE HCL TABS MIRTAZAPINE ODT PAROXETINE CR <sup>3</sup> PAXIL <sup>3</sup> PAXIL CR <sup>3,7</sup> PRISTIQ PROZAC PROZAC CAPS PROZAC WEEKLY CPDR REMERON TABS SARAFEM CAPS TRAZODONE HCL 300MG TABS WELLBUTRIN TABS WELLBUTRIN SR TBCR WELLBUTRIN XL	Non-preferred products must be used in specified step order. <b>Use PA Form # 20420</b>  1. Use Fluoxetine 20 mg in multiples. 2. See Zoloft splitting table. Sertraline requires splitting of scored tabs to avoid PA. 3. Strong caution with pediatric population.  4. See Celexa/Citalopram and Lexapro splitting tables. 5. Max daily dose allowed is 60mg, only 1 capsule per day allowed for all strengths. Combination of multiple strengths require PA.  6. Use Fluoxetine 10mg tabs or capsules in multiples. 7. As of 12/08 current users of Paxil CR and Lexapro will be grandfathered. 8. Provide clinical documentation as to why a preferred generic alternative cannot be used.

				ZOLOFT REMERON SOLTAB TBDP	
ANTIDEPRESSANTS - TRI-CYCLICS	*	AMITRIPTYLINE HCL TABS AVENTYL SOLN CLOMIPRAMINE HCL CAPS DESIPRAMINE HCL TABS DOXEPIN HCL IMIPRAMINE HCL TABS NORTRIPTYLINE HCL PROTRIPTYLINE HCL TABS SURMONTIL CAPS		AMOXAPINE TABS ANAFRANIL CAPS ELAVIL TABS NORPRAMIN TABS PAMELOR SINEQUAN TOFRANIL VIVACTIL TABS	*Users over the age of 65 require a pa.  Use PA Form # 20420 or 102220
<b>SEDATIVE / HYPNOTICS</b>					
SEDATIVE/HYPNOTICS - BARBITURATE		BUTISOL SODIUM TABS CHLORAL HYDRATE SYRP MEBARAL TABS PHENOBARBITAL		LUMINAL SOLN SOMNOTE CAPS	PA required for new users of preferred products if over 65 years old. Use PA Form # 30110
SEDATIVE/HYPNOTICS - BENZODIAZEPINES		DORAL TABS ESTAZOLAM TABS FLURAZEPAM HCL CAPS TEMAZEPAM CAPS TRIAZOLAM TABS		DALMANE HALCION TABS MIDAZOLAM HCL SYRP RESTORIL CAPS	Previous quantity limits still apply.  Use PA Form # 30110
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	1 1 1 2	MIRTAZAPINE TRAZODONE ZOLPIDEM <sup>2</sup> ZALEPLON <sup>2,3</sup>	7 8 8 8 8	AMBIEN <sup>1</sup> AMBIEN CR <sup>1</sup> LUNESTA <sup>1</sup> SONATA CAPS <sup>1</sup> ROZEREM	Must fail all preferred products before non-preferred. Use PA Form # 30110 1. Quantity Limit of 12 per 34 days. 2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended. 3. Only zolpidem trial/failure will be required to obtain Zaleplon.
<b>ANTI-PSYCHOTICS</b>					
ANTIPSYCHOTICS - ATYPICALS		ABILIFY TABS <sup>3</sup> GEODON RISPERIDONE TABS RISPERDAL SOLN SEROQUEL TABS SEROQUEL XR ZYPREXA TABS		ABILIFY DISC TAB, INJ and SOL <sup>2</sup> INVEGA RISPERDAL TABS RISPERDAL CONSA <sup>2</sup> RISPERDAL M TAB <sup>2</sup> RISPERIDONE SOLN SEROQUEL 50MG TABS <sup>1,2</sup> ZYPREXA ZYDIS TBDP <sup>2</sup>	If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine. This also includes combination of Seroquel with Seroquel XR. See Multiple Antipsychotic PA form #20440. Please use Miscellaneous PA form # 20420 for non-preferred single therapy atypical requests.  All atypicals have dosing limitations and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits. Maximum daily doses are as follows: Abilify- 30mg daily max Risperdal- 8mg daily max Seroquel- 800mg daily max Seroquel XR- 800mg daily max Zyprexa- 30mg daily max Use PA form #10420 for requests exceeding these maximum daily doses.  1. Please use multiple 25mg tablets. 2. Established users of single therapy atypicals were grandfathered. 3. Abilify requires splitting of tab to avoid PA. Please see Abilify splitting table.
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		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. See Multiple Antipsychotic PA form #20440. For PA requests for non preferred single user antipsychotic medications, please use miscellaneous PA form #20420.

		LOXITANE-C CONC MOBAN TABS PERPHENAZINE PROCHLORPERAZINE SERENTIL THIORIDAZINE HCL THIOTHIXENE THORAZINE SUPP TRIFLUOPERAZINE HCL TABS		THORAZINE	
<b>LITHIUM</b>					
LITHIUM		LITHIUM CARBONATE LITHIUM CITRATE SYRP		ESKALITH CAPS ESKALITH CR TBCR	
<b>COMBINATION - PSYCHOTHERAPEUTIC</b>					
PSYCHOTHERAPEUTIC COMBINATION		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	8	SYMBYAX <sup>1</sup>	Please use individual preferred medications Use PA Form # 20420
<b>STIMULANTS</b>					
STIMULANT - AMPHETAMINES - SHORT ACTING		ADDERALL TABS AMPHETAMINE SALT COMBO DEXTROAMPHET SULF TABS DEXEDRINE DEXTROSTAT TABS			Preferred stimulants will be available without PA if diagnosis of ADHD. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily.
STIMULANT - LONG ACTING AMPHETAMINES SALT		ADDERALL XR CP24 <sup>1</sup> VYVANSE <sup>2</sup>			Preferred stimulants will be available without PA if diagnosis of ADHD. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength.  1. As per recent FDA alert, Adderall should not be used in patients with underlying heart defects since they may be at increased risk for sudden death.  2. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Limit of one capsule daily. Max dose of 70MG daily. Use PA Form # 20420
LONG ACTING AMPHETAMINES		DEXEDRINE CAP CR		DEXTROAMPHET SULF CPCR	Preferred stimulants will be available without PA if diagnosis of ADHD. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily.
STIMULANT - METHYLPHENIDATE		FOCALIN TABS METADATE ER TBCR METHYLIN ER TBCR METHYLIN TABS METHYLIN SOL		METHYLIN CHEWABLES RITALIN	Preferred stimulants will be available without PA if diagnosis of ADHD.  Use PA Form # 20420 Stimulants have dosing limitations per strength

		METHYLPHENIDATE HCL			and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexamethylphenidate.
STIMULANT - METHYLPHENIDATE - LONG ACTING		CONCERTA TBCR FOCALIN XR <sup>1</sup>	5 8 8	METADATE CD CPCR DAYTRANA <sup>2</sup> RITALIN LA	Preferred stimulants will be available without PA if diagnosis of ADHD. Non-preferred products must be used in specified step order. Stimulants also have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. 1. Available to those members needing sprinkles with diagnosis of ADHD.  2. FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily. Use PA Form # 20420
STIMULANT - STIMULANT LIKE			7 8 8 9 9	STRATTERA <sup>1,2</sup> CAFICIT SOLN PROVIGIL TABS DESOXYN TABS DESOXYN CR	1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of Strattera, unless history of substance abuse without current use of abusable medication(s) 2. Strattera currently has dosing limitations allowing one tablet per day for all strengths if obtain approval. Max daily dose of Strattera is 100mg. Please refer to PDL dosage consolidation chart. 3. Non-preferred products must be used in specified step order. <b>Provigil: use PA Form # 20710; Others: use Pa Form # 20420</b>
<b>ANTI-CATAPLECTIC AGENTS</b>					
PSYCHOTHERAPEUTIC AGENTS - MISC.				XYREM SOL XENAZINE	Use PA Form #20710
<b>WEIGHT LOSS</b>					
WEIGHT LOSS					No longer covered: PHENTERMINE, XENICAL, DIDREX, and MERIDIA
<b>ALZHEIMER DISEASE</b>					
ALZHEIMER - Cholinomimetics/Others		ARICEPT TABS <sup>1</sup> EXELON <sup>1</sup> NAMENDA <sup>1</sup>	8 8 9	RAZADYNE <sup>2</sup> REMINYL <sup>2</sup> COGNEX CAPS <sup>2</sup>	1. PA is required to establish dementia diagnosis and baseline mental status score. 2. Must fail all preferred products before moving to non-preferred. Use PA Form #20420
<b>SMOKING CESSATION</b>					
NICOTINE PATCHES / TABLETS		CHANTIX <sup>1,2</sup> NICODERM CQ PT24 <sup>2</sup> NICOTINE DIS PT24 <sup>2</sup>			Bupropion SR 150 mg is available without a prior authorization.  1. Chantix is preferred without PA for up to 6 months of <b>continuous</b> use once per lifetime.  2. Preferred nicotine replacement therapy and Chantix will become non-preferred and will require PA if they are being used in combination together.
NICOTINE REPLACEMENT - OTHER		NICOTINE POLACRILEX GUM <sup>2</sup> NICORETTE GUM <sup>2</sup>	5	COMMIT LOZENGES <sup>1</sup> NICOTROL INHALER NICOTROL NASAL SPRAY	Must fail all preferred products from smoking cessation category (Nicoderm patch and nicotine gum) before moving to non-preferred. Must use Non-preferred products in specified step order. Use PA Form # 20420 1. Will be available to patients unable to tolerate preferred products.

2. Preferred nicotine replacement therapy and Chantix will become non-preferred and will require PA if they are being used in combination together.

**ALCOHOL DETERRENTS**

ALCOHOL DETERRENTS	ANTABUSE TABS CAMPRAL <sup>1</sup> DISULFIRAM TABS NALTREXONE HCL TABS			1. Should only be used in conjunction with formal structured outpatient detoxification program.
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**MISCELLANEOUS ANALGESICS**

ANALGESICS - MISC.	ACETAMINOPHEN ASPIRIN ASPRIN/ APAP/ CAFF TAB BUTAL/ASA/CAFF BUTALBITAL COMPOUND BUTALBITAL/ACET TABS BUTALBITAL/APAP CAPS BUTALBITAL/APAP/CAFFEINE CHOLINE MAGNESIUM TRISALI DIFLUNISAL TABS EXCEDRIN SALSALATE TABS		AXOCET CAPS DOLOBID TABS EQUAGESIC TABS ESGIC-PLUS FIORICET TABS FIORINAL CAPS FIORTAL CAPS FORTABS TABS PHRENILIN TABS PHRENILIN FORTE CAPS TRILISATE LIQD TRILISATE TABS ZEBUTAL CAPS ZORPRIN TBCR	Use PA Form # 20420
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**LONG ACTING NARCOTICS**

NARCOTICS - LONG ACTING	AVINZA DURAGESIC PT72 <sup>6</sup> METHADONE METHADOSE MORPHINE SULFATE ER TB12 <sup>3,4</sup>	8 8 8 8 8 9 9	FENTANYL PATCH <sup>6</sup> MORPHINE SULFATE SUPP MS CONTIN TB12 KADIAN CP 24 <sup>2</sup> ORAMORPH SR TB12 OXYCONTIN TB12 <sup>1,5</sup> OXYCODONE ER <sup>3</sup> OPANA	Use PA Form # 20510 Non-preferred products must be used in specific order.  1. Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable.  2. Established users are grandfathered. 3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to achieve max total daily dose of 320mg.  4. Endo products preferred but not exclusive.  5. Oxycontin 15mg, 30mg & 60mg are new strengths. Any PA request for the new strengths will be required to use combinations of strengths that have previously been available (including 10mg, 20mg, 40mg, & 80mg tablets) to obtain requested dose.  6. Dosing limits apply. Please see dose consolidation list.
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NARCOTICS - SELECTED	TRAMADOL HCL TABS	8 8 8 8 8 8 8 8 9	BUPRENEX SOLN BUTORPHANOL NALBUPHINE HCL SOLN NUBAIN SOLN RYZOLT STADOL NS SOLN ULTRACET TABS ULTRAM TABS ULTRAM ER	Use PA Form # 20420
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**MISCELLANEOUS NARCOTICS**

NARCOTICS - MISC.	ACETAMINOPHEN/CODEINE ASPIRIN/CODEINE TABS BUTAL/ASA/CAFF/COD CAPS BUTALBITAL/ASPIRIN/CAFFEI CAPS CAPITAL AND CODEINE SUSP <sup>1</sup>	8 8 8 8 8	ANEXSIA TABS ASCOMP/CODEINE CAPS BUTALBITAL/APAP/CAFFEINE/ CAPS DARVOCET-N DARVON	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.
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					<p>tablet daily or all strengths without PA.</p> <p>2. Ketorolac Tromethamine is indicated for the short term (up to 5 days) management of moderately severe acute pain that requires analgesic at the opioid level in adults. Not indicated for minor or chronic pain conditions.</p> <p>3. Ketorolac has dosing limits allowing 24 tablets for a 5 day supply every 30 days.</p> <p>4. Dosing limits will be set at a maximum of 200mg once daily for PA requests.</p> <p>5. Users 60 years of age or older will not require PA. If under 60 years of age, Celebrex will require PA.</p>
NSAIDS		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 PIROXICAM CAPS SULINDAC TABS TOLMETIN SODIUM		ADVIL TABS ANAPROX TABS ANAPROX DS TABS ANSAID TABS 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 ORUVAIL CP24 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. <b>Use PA Form # 20420</b>
<b>RHEUMATOID ARTHRITIS</b>					
RHEUMATOID ARTHRITIS	1 1 1 1 1 2 2 2	AZATHIOPRINE HYDROXYCHLOROQUINE LEFLUNOMIDE METHOTREXATE SULFASALAZINE TABS CIMZIA <sup>1</sup> ENBREL KIT <sup>1</sup> HUMIRA <sup>1,2</sup>	8 8 8 8	ARAVA KINERET SOLN ORENCIA REMICADE	Use PA Form # 20900. 1. Only one step 1 drug is required to obtain Enbrel, Cimzia or Humira without PA. High doses of Enbrel 50mg twice weekly will require a PA. Established users will be grandfathered for Enbrel and Humira. 2. Dosing limits apply. Please see dose consolidation list.
<b>MISCELLANEOUS ARTHRITIS</b>					
ARTHRITIS - MISC.		RIDAURA CAPS MYOCHRYSLINE SOLN		ARTHROTEC <sup>1</sup>	1. The individual components of Arthrotec are available without PA. Use PA Form # 20420
<b>MIGRAINE THERAPIES</b>					
MIGRAINE - ERGOTAMINE DERIVATIVES		MIGRANAL SOLN SANSERT TABS		D.H.E. 45 SOLN	Use PA Form # 10110
MIGRAINE - CARBOXYLIC ACID DERIVATIVES		DEPAKOTE ER TB24			
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)- Tabs	1 1 1	MAXALT/MLT <sup>1</sup> RELPAX <sup>1</sup> SUMATRIPTAN TABS <sup>1</sup>		FROVA TABS AXERT TABS AMERG TABS	1. All step 1 medications must be tried. All drugs in this category have dosing limits. Please refer to dose consolidation table.



4 ~ 4 ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE  
 4 ~ 4 LAMICTAL  
 5 ~ 5 TRILEPTA

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.

**ANTI-PARKINSON DRUGS**

PARKINSONS - ANTICHOLINERGICS	AKINETON TABS BENZTROPINE MESYLATE TABS COGENTIN SOLN KEMADRIN TABS TRIHEXYPHENIDYL			
PARKINSONS - COMT INHIBITORS	COMTAN TABS		TASMAR TABS	Use PA Form # 20420
PARKINSONS - SELECTED DOPAMIN AGONISTS	ROPINIROLE	8 8 8	MIRAPEX TABS <sup>1</sup> REQUIP TABS REQUIP XL TABS	Use PA Form # 20420 1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinsons.
PARKINSONS - DOPAMINERGICS/CARBI/ LEVO	AMANTADINE HCL BROMOCRIPTINE MESYLATE CARBIDOPA/LEVODOPA TABS* CARBIDOPA/LEVODOPA ER LARODOPA TABS LODOSYN TABS SELEGILINE HCL		APOKYN* AZILECT <sup>2</sup> ELDEPRYL CAPS PARLODEL CAPS PARLODEL TABS SINEMET TABS SINEMET TBCR SYMMETREL TABS ZELAPAR <sup>1</sup>	* Only preferred manufacturer's products will be available without prior authorization.  1. Approvals will require concurrent therapy with Levodopa and failed trials of Selegiline, Comtan, and Stalevo.  2. Approvals will require trials of Carbidopa/Levodopa, Selegiline, Comtan, and Stalevo.  Use PA Form # 20420
PARKINSONS - COMBO.	STALEVO			

**MUSCLE RELAXANTS**

ALS DRUG	RILUTEK TABS			
MUSCLE RELAXANTS	BACLOFEN TABS CHLORZOXAZONE TABS CYCLOBENZAPRINE HCL TABS LIORESAL INTRATHECAL KIT METHOCARBAMOL TABS TIZANIDINE HCL TABS	7 8 8 8 8 8 8 8 9 9	ORPHENADRINE CITRATE CARISOPRODOL TABS DANTRIUM CAPS FLEXERIL TABS LIORESAL TABS NORFLEX TBCR ROBAXIN-750 TABS ZANAFLEX TABS SKELAXIN TABX SOMA TABS	Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). Non-preferred products must be used in specified step order. Use PA Form # 20420
MUSCLE RELAXANT - COMBO.			CARISOPRODOL/ASPIRIN TABS CARISOPRODOL/ASPIRIN/CODE NORGESIC TABS ORPHENADRINE COMPOUND ORPHENADRINE/ASA/CAFF ORPHENGESIC	Use PA Form # 20420

**VITAMINS**

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

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		AQUASOL E SOLN AQUAVIT-E SOLN CALOMIST NASAL SPRAY <sup>1</sup> DHT SOLN NASCOBAL GEL	Use PA Form # 20420 1. PA required to confirm diagnosis and prior use of IM Vit B12. Lab results should be submitted.  Please refer to OTC list.
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	PYRIDOXINE HCL TABS SLO-NIACIN TBCR THIAMINE HCL SOLN VITAMIN B-1 TABS VITAMIN B-12 VITAMIN B-6 TABS VITAMIN C VITAMIN E CAPS VITAMIN E/D-ALPHA CAPS VITAMIN K1 SOLN V-R VITAMIN E CAPS		
VITAMIN D's	CALCITRIOL CAPS <sup>1</sup> VITAMIN D ZEMPLAR TABS	DRISDOL CAPS CALCIJEX HECTOROL (ORAL) HECTOROL (PARENTERAL) ROCALTROL ZEMPLAR INJ	1. Diagnosis of dialysis (renal failure) required.

**MISC MULTI-VITAMINS**

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

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 NUTRINATE CHEW 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 PRENATAL TABS PRENATAL FORMULA 3 TABS PRENATAL PLUS TABS PRENATAL PLUS NF TABS PRENATAL PLUS/27MG IRON PRENATAL PLUS/IRON TABS PRENATAL RX/BETA-CAROTENE RENA-VITE RX TABS RENAL CAPS RENAPHRO CAPS STRESS TAB NF TABS THERAPEUTIC-M TABS THERAVITE LIQD TRI-VITAMIN/FLUORIDE SOLN VITA CON FORTE CAPS VITAMIN B COMPLEX CAPS VITAPLEX PLUS 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 NATALCARE GLOSS TABS NATALCARE PIC TABS NATALCARE PIC FORTE TABS NATALCARE PLUS TABS NATALCARE THREE TABS 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 PRENATAL CARE TABS PRENATAL MR 90 TBCR PRENATAL MTR/SELENIUM TABS PRENATAL OPTIMA ADVANCE TABS PRENATAL PC 40 TABS PRENATAL RX TABS PRENATE PRENATE ELITE PRIMACARE MISC PROTEGRA CAPS STUARTNATAL PLUS 3 TABS TRI-VI-SOL SOLN TRI-VI-SOL/IRON SOLN ULTRA NATALCARE TABS	Diag codes are no longer required on prenatal vitamins.  Use PA Form # 20420 Please refer to OTC list.
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ULTRA-NATAL TABS  
 VICON FORTE CAPS  
 VINATAL FORTE TABS  
 VINATE  
 VINATE ADVANCED TABS

**MISCELLANEOUS MINERALS**

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

MINERALS			Use PA Form # 20420 Please refer to OTC list.
	CALCARB	ANEMAGEN	
	CALCI-MIX CAPSULE CAPS	CALCET TABS	
	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	
	<b>CALCIUM/VITAMIN D TABS</b>	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-VESENT PACK	
	FER-IN-SOL SOLN	MICRO-K 10 MEG CPCR	
	FER-IRON SOLN	NU-IRON 150 CAPS	
	FERRONATE TABS	<b>OYSTER SHELL CALCIUM/VITA TABS</b>	
	FEROUS SULFATE	POLY-IRON 150 CAPS	
	FLUOR-A-DAY CHEW	POLYSACCHARIDE IRON CAPS	
	FLUORIDE CHEW	POTASSIUM BICARB/CHLORIDE	
	FLUORIDE SODIUM CHEW	POTASSIUM CHLORIDE 10MEQ	
	FLUORITAB CHEW	SLOW FE TBCR	
	HEMOCYTE TABS	TUMS 500 CHEW	
	HM CALCIUM TABS	VIACTIV CHEW	
	K+ POTASSIUM PACK		
	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-VESENT TBEF		
	LURIDE CHEW		
	MAGNESIUM GLUCONATE TABS		
	MAGNESIUM SULFATE SOLN		
	MAGTABS		
	MICRO-K 8 MEQ		
	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			
<b>MISC. ELECTROLYTES/NUTRITIONALS</b>					
ELECTROLYTES/ NUTRITIONALS		PED ELECTROLYTE SOLN. FISH OIL CAPS INTRALIPID EMUL ORALYTE SOLN P.T.E. -5 SOLN SEA-OMEGA CAPS		BOOST CASEC POWD CHOICE DM LIQD DELIVER 2.0 LIQD ENFAMIL ENSURE GLUCERNA ISOCAL LIQD KINDERCAL TF LIQD KINDERCAL TF/FIBER LIQD L-CARNITINE CAPS LIPISORB LIQD LOVAZA <sup>1</sup> MODULEN IBD POWD NUTRAMIGEN POWD NUTREN NUTRITIONAL SUPPLEMENT LIQD NUTRIVENT 1.5 LIQD PEPTAMEN PHENYL-FREE PKU 3 POWD PREGESTIMIL POWD PROBALANCE LIQD PROSOBEE SCANDISHAKE PACK	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.  1. Formerly known as Omacor.  Use PA Form # 20420 & SGA Form
<b>ERYTHROPOEITINS</b>					
ERYTHROPOEITINS		PROCRIT SOLN <sup>1</sup>	6 8	EPOGEN SOLN ARANESP SOLN	1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done. Use PA form # 10520.
<b>GRANULOCYTE CSF</b>					
GRANULOCYTE CSF			8 8 9	LEUKINE NEUPOGEN SOLN <sup>1</sup> NEULASTA	Must be used in specified step order. 1. 10 day supply/month may be used without a PA. Use PA Form # 20520
<b>ANTICOAGULANTS / PLATELET AGENTS</b>					
ANTICOAGULANTS		ARIXTRA SOLN <sup>1</sup> FRAGMIN INJ <sup>1</sup> HEPARIN SODIUM/NACL 0.9% SOLN HEP-LOCK SOLN INNOHEP LOVENOX SOLN <sup>1</sup> WARFARIN SODIUM TABS HEPARIN LOCK SOLN HEPARIN LOCK FLUSH SOLN HEPARIN SODIUM SOLN HEPARIN SODIUM LOCK FLUSH SOLN JANTOVEN		COUMADIN TABS IPRIVAS C	1. Arixtra, Fragmin and Lovenox therapy durations greater than 7 days require PA.  Use PA Form # 20420
ANTIHEMOPHILIC AGENTS		ALPHANATE BENEFIX SOLR BIOCLATE HELIXATE FS KIT HEMOPIL - M HUMATE-P SOLR KOGENATE FS KONYNE - 80		ADVATE <sup>1,2</sup>	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

		MONARC - M MONOCLATE - P MONONINE NOVOSEVEN SOLR PROPLEX -T RECOMBINATE SOLR REFACTO			
PLATELET AGGREGATION INHIBITORS		ASPIRIN DIPYRIDAMOLE TABS	7 8 8 8	TICLOPIDINE HCL TABS PERSANTINE TABS PLAVIX TABS <sup>1,2</sup> TICLID TABS	Use PA Form # 20715 for Plavix requests. For all other requests please use form # 20420.  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.		PENTOXIFYLLINE ER TBCR CILOSTAZOL		AGGRENOX CP12 AGGRENOX <sup>2</sup> AGRYLIN CAPS PLETAL TABS TRENAL TBCR	1. Aspirin and dipyridamole are available separately without PA. Use PA Form # 20420 2. Aggrenox will be approved if submitted with documentation supporting that it is being used for non-embolic stroke.
<b>HEMATOLOGICALS</b>					
MONOCLONAL ANTIBODY				SOLIRIS	Use PA Form # 20420
HEMATOLOGICAL AGENTS- THROMBOPOIETIN RECEPTOR AGONISTS			7 8	PROMACTA NPLATE	Use PA Form # 20420
<b>HEMOSTATIC</b>					
HEMOSTATIC		AMICAR AMINOCAPROIC ACID			
<b>OPHTHALMICS</b>					
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 SODIUM SULFACETAMIDE SOLN SULFACETAMIDE SODIUM TERRAMYCIN OINT TOBRAMYCIN SULFATE SOLN TRIMETHOPRIM SULFATE/POLY VIOPTIC SOLN		AK-POLY-BAC OINT AK-SULF OINT AK-TOB SOLN AZASITE BLEPH-10 SOLN GENTAK ILOTYCIN OINT NEOMYCIN/BACI/POLYM OINT NEOSPORIN OINT OCUSULF-10 SOLN OCUTRICIN SOLN TERAK OINT TOBEX OINT TRIFLURIDINE SOLN	Use PA Form # 20420
OP. - QUINOLONES		CILOXAN OINT CIPROFLOXACIN SOL 0.3% OFLOXACIN QUIXIN SOLN		CILOXAN SOLN OCUFLOX SOLN	Use PA Form # 20420
OP.QUINOLONES-4TH GENERATION		VIGAMOX ZYMAR			
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		AKWA TEARS SOLN ARTIFICIAL TEARS SOLN OP BION TEARS SOLN DRY EYES OINT DURATEARS OINT HYPO TEARS ISOPTO TEARS SOLN LACRI-LUBE	Use PA Form # 20420 1. Dosing limits apply, please see dose consolidation list.

		PURALUBE OINT PURALUBE TEARS SOLN REFRESH SOLN OP REFRESH PLUS SOLN <sup>1</sup> REFRESH PM OINT		LUBRIFRESH P.M. OINT MURINE SOLN MUROCEL SOLN NATURE'S TEARS SOLN REFRESH SOLN REFRESH TEARS SOLN <sup>1</sup> SYSTANE TEARGEN SOLN TEARISOL SOLN TEARS NATURALE TEARS PURE SOLN TEARS RENEWED OINT THERATEARS SOLN V-R ARTIFICIAL TEARS SOLN	
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 OPTH.		AK-SPORE HC OINT ALREX SUSP BLEPHAMIDE SUSP CORTISPORIN SUSP DEXAMETH SOD PHOS SOLN FLAREX SUSP FLUOROMETHOLONE SUSP FML S.O.P. OINT FML-S LIQUIFILM SUSP INFLAMASE SOLN LOTEMAX SUSP NEOM/POLIN/DEX PRED MILD SUSP PREDNISOLONE TOBRADEX		AK-TROL SUSP BAC/POLY/NEOMY/HC OINT BLEPHAMIDE S.O.P. OINT ECONOPRED EFLONE SUSP FLUOR-OP SUSP FML LIQUIFILM SUSP MAXITROL NEO/POLY/BAC/HC OINT PRED FORTE SUSP PRED-G SUSP PRED-G S.O.P. OINT SULFACET SOD/PRED SOLN VASOCIDIN SOLN VEXOL SUSP	Use Pa Form # 20420
OP. - PROSTAGLANDINS		LUMIGAN SOLN TRAVATAN SOLN		RESCULA SOLN XALATAN SOLN	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			
OP. - ADRENERGIC AGENTS		DIPIVEFRIN HCL SOLN EPIFRIN SOLN		PROPINE SOLN	Use PA Form # 20420
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS		ALPHAGAN SOLN ALPHAGAN P SOLN		IOPIDINE SOLN	Use PA Form # 20420
OP. - ANTI-ALLERGICS		OPTIVAR PATADAY SOLN PATANOL SOLN		ALOCRIOL SOLN ALOMIDE SOLN ELESTAT EMADINE SOLN LIVOSTIN SUSP 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 COSOPT SOLN TRUSOPT SOLN		COMBIGAN	Use PA Form # 20420
OP. - NSAID'S		ACULAR LS		OCUFEN SOLN	Must fail all preferred products before non-

	ACULAR SOLN FLURBIPROFEN SODIUM SOLN VOLTAREN SOLN	NEVANAC XIBROM	preferred. Use PA Form # 20420
OP. - OF INTEREST	ENUCLENE SOLN	BOTOX SOLR RESTASIS <sup>1</sup>	1. Must have kerato conjunctivitis sicca and failed other dry eye therapies. Use PA Form #20420
<b>DERMATOLOGICAL</b>			
TOPICAL - ACNE PREPARATIONS	ACCUTANE CAPS AZELEX CREA BENZOYL PEROXIDE CLINDAMYCIN PHOSPHATE <sup>2</sup> DIFFERIN ERYDERM SOLN ERYTHROMYCIN GEL ERYTHROMYCIN PADS ERYTHROMYCIN SOLN METRONIDAZOLE CREAM <sup>2</sup> METRONIDAZOLE GEL <sup>2</sup> METRONIDAZOLE LOTN <sup>2</sup> PLEXION RETIN-A GEL <sup>1,2</sup> SODIUM SULFACET/SULF LOTN TAZORAC GEL	AZONE ALTINAC CREA AVITA CREA BENZAC BENZACLIN GEL BENZAGEL-10 GEL BENZAMYCIN GEL BENZAMYCINPAK PACK BREVOXYL CLEOCIN-T <sup>2</sup> CLINAC BPO GEL CLINDAGEL GEL CLINDETS SWAB DESQUAM-E GEL DESQUAM-X DIFFERIN 0.3% GEL DIFFERIN DUAC GEL EMGEL GEL EPIDUO ERYCETTE PADS ERYGEL GEL EVOCLIN FINEVIN CREA KLARON LOTN METROCREAM CREAM <sup>2</sup> METROGEL GEL <sup>2</sup> METROLOTION LOTN <sup>2</sup> NEOBENZ MICRO NORITATE CREA RETIN-A MICRO GEL RETIN-A CREAM <sup>2</sup> SULFACET-R LOTN TRETINOIN <sup>1,2</sup> TRIAZ 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.  If requesting any brands Use PA Form # 10220, for all others use PA Form # 20420
TOPICAL - ANTIBIOTIC	ALTABAX <sup>1,2</sup> BACIT/NEOMYCIN/POLYM OINT BACITRACIN OINT BACTROBAN CREAM BACTROBAN NASAL OINT MUPIROCIN <sup>1</sup> CENTANY OINT 2% <sup>1</sup> GENTAMICIN SULFATE	ALTABAX 15GM BACTROBAN OINT. CORTISPORIN TRIPLE ANTIBIOTIC OINT	1. Dosing limits apply, please see dosing consolidation list.  2. Only 5gm and 10gm tubes will be preferred.  Use PA Form # 20420
TOPICAL - ANTIFUNGALS	CICLOPIROX 0.77 CREAM CICLOPIROX 0.77 SUSP CLOTRIMAZOLE CLOTRIMAZOLE/BETA CREAM ECONAZOLE NITRATE CREAM KETOCONAZOLE CREAM LOPROX 1.0 CREAM LOPROX 1.0 LOTN LOPROX GEL LOPROX TS LOTN MICONAZOLE NITRATE CREA MYCO-TRIA CET II CREA NIZORAL SHAM NTA OINT	EXELDERM FUNGIZONE CREA HYDROCORT/IODOOQ CREA LAMISIL LOPROX 0.77 LOTN LOPROX 0.77 CREAM LOPROX 0.77 SUSP LOPROX SHAMPOO SHAM LOTRIMIN LOTRISONE MENTAX CREA MYCOGEN II CREA MYCOLOG-II CREA MYCOSTATIN POWD	Use PA Form # 10120

	NYSTATIN NYSTATIN/TRIAMCINOLONE PEDI-DRI POWD TINACTIN TRI-STATIN II CREA	NAFTIN NIZORAL CREA NYSTAT-RX POWD NYSTOP POWD OXISTAT PENLAC NAIL LACQUER SOLN SPECTAZOLE CREAM	
TOPICAL - ANTIPRURITICS	ZONALON CREA	PRUDOXIN CREA	Use PA Form # 20420
TOPICAL - ANTIPSORIATICS	DOVONEX SORIATANE CAPS TAZORAC	OXSORALEN ULTRA CAPS PSORiatec CREA SORIATANE CK KIT TACLONEX <sup>1</sup> VANAMIDE VECTICAL	Must fail all preferred products before non-preferred. 1. Individual ingredients are available as preferred without PA. Use PA Form # 20420
TOPICAL - ANTISEBORRHEICS	CAPITROL SHAM SELENIUM SULFIDE SHAM SELSUN BLUE SHAM	CARMOL SCALP TREATMENT KIT ZNP BAR	Use PA Form # 20420
TOPICAL - ANTIVIRALS		DENAVIR CREA <sup>1</sup> ZOVIRAX OINT <sup>1</sup>	1. Must fail oral treatment with Acyclovir or Valtrex.
TOPICAL - ANTINEOPLASTICS	EFUDEX FLUOROPLEX CREA SOLARAZE GEL	CARAC CREA FLUOROURACIL	Use PA Form # 20420
TOPICAL - BURN PRODUCTS	FURACIN CREA SSD CREA THERMAZENE CREA	SILVADENE CREA SILVER SULFADIAZINE CREA SSD AF CREA	Use PA Form # 20420
TOPICAL - CORTICOSTEROIDS	<p style="text-align: center;"><b>LOW POTENCY</b></p> DESOWEN HYDROCORTISONE CREA HYDROCORTISONE LOTN LACTICARE-HC LOTN NUTRACORT LOTN TEXACORT SOLN TRIDESILON CREA	ACLOVATE AMCINONIDE CREA ANUSOL HC-1 OINT ARISTOCORT A CLOBEX CLODERM CREA CORDRAN CORMAX CUTIVATE CREAM / OINT CUTIVATE LOTION DERMATOP DESONATE GEL DIPROLENE ELOCON OINT HYDROCORTISONE POWD KENALOG AERS LIDA MANTLE HC CREA LIDEX LIDEX-E CREA LOCOID LUXIQ FOAM OLUX FOAM PANDEL CREA PROCTOCORT CREA PSORCON PSORCON E SYNALAR OINT TEMOVATE TOPICORT TOPICORT LP CREA ULTRAVATE VERDESO WESTCORT	Use PA Form # 20420
	<p style="text-align: center;"><b>MEDIUM POTENCY</b></p> CUTIVATE LOTION DESOXIMETASONE .05% ELOCON FLUOCINOLONE ACETONIDE .025-.01% FLUROSYN CREA FLUTICASONE PROPIONATE CREAM/OINT HYDROCORTISONE BUTYRATE HYDROCORTISONE OINT HYDROCORTISONE VALERATE MOMETASONE FUROATE OINT TRIAMCINOLONE ACETONIDE .025-.1%		
	<p style="text-align: center;"><b>HIGH POTENCY</b></p> CYCLOCORT BETAMETHASONE DIPROPIONATE DESOXIMETASONE .25% DESONIDE FLUOCINOLONE ACETONIDE .02% FLUOCINONIDE HALOG HALOG-E CREA TRIAMCINOLONE ACETONIDE .5%		
	<p style="text-align: center;"><b>VERY HIGH POTENCY</b></p> AUGMENTED BETA DIP BETAMETHASONE VALERATE BETA-VAL CLOBETASOL PROPIONATE DIFLORASONE DIACETATE HALOBETASOL		
	<p style="text-align: center;"><b>MISCELLANEOUS</b></p> CAPEX SHAM DERMA-SMOOTH/FS OIL PROCTO-KIT CREA 1%		

TOPICAL - STEROID LOCAL ANESTHETICS		ZONE-A FORTE LOTN		EPIFOAM FOAM	Use PA Form # 20420
TOPICAL - STEROID COMBINATIONS		DERMA-SMOOTHIE/FS ATOPIC P KIT		CARMOL-HC CREA	Use PA Form # 20420
TOPICAL - EMOLLIENTS		AMMONIUM LACTATE LOTION 12% LAC-HYDRIN CREAM LACTINOL-E CREA UREACIN-20 CREA VITAMIN A & D MEDICATED OINT		AMMONIUM LACTATE CREA ATOPICLAIR LAC-HYDRIN LOTION 12% LACTINOL LOTN MEDERMA GEL MIMYX RENOVA CREA	Use PA Form # 20420
TOPICAL - ENZYMES / KERATOLYTICS / UREA		GRANUL-DERM AERS GRANULEX AERS SANTYL TBC AERS		CARMOL 40 CREA SALEX CREAM SALEX LOTION	Use PA Form # 20420  Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.
TOPICAL - GENITAL WARTS		ALDARA	5 8 8	PODOFILOX SOLN CONDYLOX VEREGEN	Non-preferred products must be used in specified order. Use PA Form # 20420
TOPICAL - IMMUNOMODULATORS			8 9	ELIDEL CREA PROTOPIC OINT	Non-preferred products must be used in specified order. The FDA has issued a Public Health Advisory for both Elidel and Protopic concerning the potential cancer risk associated with their use. Use for children less than 2 years of age is not recommended. Use PA Form # 20420
TOPICAL - LOCAL ANESTHETICS		AF CAPSICUM OLEORESIN CREA CAPSAICIN CREA ELA-MAX <sup>1</sup> LIDOCAINE/PRILOCAINE CREA <sup>1</sup> XYLOCAINE		EMLA PADS EMLA CREA LIDA MANTLE CREA LIDODERM PTCH PONTOCAINE SOLN ZOSTRIX	1. Lidocaine/Prilocaine cream and Ela-Max products require PA for users over 18 years of age.  Use PA Form # 20420
TOPICAL - DEPIGMENTING AGENTS			8 8 8 8 8 8 8 9	ALUSTRA CREA EPIQUIN MICRO GLYQUIN CREA HYDROQUINONE CREA HYDROQUINONE/SUNSCREENS SOLAQUIN FORTE CREA TRI-LUMA CREA ELDOQUIN	Not covered for cosmetic purposes.  Use PA Form # 20420
TOPICAL - SCABICIDES AND PEDICULICIDES		ACTICIN CREA ELIMITE CREA EURAX LICE KILLING SHAM LICE TREATMENT CREME RINS LIOD PERMETHRIN LOTN		LINDANE OVIDE LOTN	Use PA Form # 20420
TOPICAL - WOUND / DECUBITUS CARE				REGRANEX GEL REGENECARE RADIAPLEXRX	Use PA Form # 20420  Accuzyme and Ethezyme products have been removed from the PDL due to FDA safety 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 /		PHISOHEX LIOD		BETADINE OINT	Use PA Form # 20420

DISINFECTANTS		POVIDONE-IODINE SOLN		FORMALYDE-10 AERS IODOSORB LAZERFORMALYDE SOLUTION SOLN	
<b>MISCELLANEOUS EYE</b>					
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
<b>MISCELLANEOUS EAR</b>					
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 SUSP CORTISPORIN-TC SUSP DEBROX SOLN DOMEBORO SOLN FLOXIN OTIC SOLN PEDIOTIC SUSP VOSOL-HC SOLN ZOTANE HC SOLN ZOTO-HC SOLN	Use PA Form # 20420
<b>MOUTH ANTISEPTICS</b>					
MOUTH ANTI-INFECTIVES		NILSTAT SUSP EAR-GESIC SOLN NYSTATIN SUSP		MYCELEX TROC MYCOSTATIN LOZG	Use PA Form # 20420
MOUTH ANTISEPTICS		CHLORHEXIDINE GLUCONATE LIDOCAINE VISCOUS SOLN TRIAMCINOLONE IN ORABASE PSTE TRIAMCINOLONE ORADENT PSTE		APHTHASOL PSTE PERIDEX SOLN PERIOGARD SOLN TRIAMCINOLONE ACETONIDE PSTE XYLOCAINE VISCOUS SOLN	Must fail all preferred products before non-preferred. Use PA Form # 20420
<b>DENTAL PRODUCTS</b>					
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 CREAM THERA-FLUR-N GEL	Use PA Form # 20420
<b>ARTIFICIAL SALIVA/STIMULANTS</b>					
ARTIFICIAL SALIVA/STIMULANTS		SALIVA SUBSTITUTE SOLN		EVOXAC CAPS RADIACARE SOLR SALAGEN TABS	Use PA Form # 20420
<b>MISCELLANEOUS ANORECTAL</b>					
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
<b>T-CELL ACTIVATION INHIBITOR</b>					
PSORIASIS BIOLOGICALS		ENBREL <sup>1</sup>		AMEVIVE <sup>2</sup>	1. Will not require a PA if at least one systemic

		HUMIRA <sup>1</sup>			drug such as methotrexate, cyclosporine, methoxsalen or acitretin is in members drug profile. High doses of Enbrel 50mg twice weekly will require a PA. Please refer to dose consolidation list. Use PA Form # 20910
<b>ALTERNATIVE MEDICINES</b>					
ALTERNATIVE MEDICINES		DIMETHYL SULFOXIDE SOLN		CO-ENZYME Q-10 GLUCOSAMINE MELATONIN TABS	Use PA Form # 20420
<b>CHELATING AGENTS</b>					
CHELATING AGENTS		CUPRIMINE CAPS		DEPEN TITRATABS TABS EXJADE <sup>1</sup>	Use PA Form # 20420
<b>ANTILEPROTIC</b>					
ANTILEPROTIC				THALOMID CAPS <sup>1</sup>	1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules. Use PA Form # 20420
<b>ANTINEOPLASTIC AGENTS</b>					
ANTINEOPLASTIC AGENTS - ANTIANDROGENS		BICALUTAMIDE		CASODEX	
ANTINEOPLASTIC AGENTS - LHRH ANALOGS		LUPRON DEPOT <sup>1</sup>		VANTAS <sup>2</sup>	1. Dosing limits apply, please refer to dosage consolidation list. 2. PA required to confirm FDA approved indication
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS		GLEEVEC		SPRYCEL <sup>1</sup> TYKERB <sup>2</sup>	1. Verification of diagnosis and prior trial of at least Gleevec is required. Use PA Form # 20420 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.
ANTINEOPLASTICS - MISCELLANEOUS		MERCAPTOPURINE		ZOLINZA PURINETHOL	
ANTINEOPLASTICS - MONOCLONAL ANTIBODIES				HERCEPTIN <sup>1</sup>	1. PA required to confirm FDA approved indication.
<b>CANCER</b>					
CANCER		ALIMTA AVASTIN ERBITUX VIDAZA		NEXAVAR <sup>1</sup> SUTENT <sup>1,2</sup>	1. PA required to confirm FDA approved indication 2. Avoid CYP3AY drug drug interaction
<b>IMMUNOSUPPRESSANTS</b>					
IMMUNOSUPPRESSANTS		CYCLOSPORINE MODIFIED CYCLOSPORINE SOL. MODIFIED GENGRAF CAPS MYCOPHENOLATE MYFORTIC PROGRAF CAPS RAPAMUNE SANDIMMUNE		CELLCEPT CYCLOSPORINE CAPS NEORAL <sup>1,2</sup>	1. Established users will require a one time PA. 2. Established users will require a one time PA  Use PA Form # 20420
<b>PURINE ANALOG</b>					
PURINE ANALOG		AZASAN TABS AZATHIOPRINE TABS		IMURAN TABS	Use PA Form # 20420
<b>K REMOVING RESINS</b>					
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(2 <sup>nd</sup> line)	X(2 <sup>nd</sup> line)				X(2 <sup>nd</sup> line)
TOPAMAX	X			9	6	X (2 <sup>nd</sup> line)	
TRILEPTAL	X			5	5		

## PEDIATRIC ANTI-CONVULSANTS INDICATION CHART

	SEIZURES	MONOTHERAPY BIPOLAR	ADJUNCTIVE BIPOLAR
LITHIUM		1	1
CARMAZEPINE	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