BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

REVISED 11/20/06
Implementation Date: 10/02/06
Originally Posted 9/15/06

Version IV of IV

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACE INHIBITORS *Implement 10/2/06*	**ACE INHIBITORS**		Four of the preferred agents must be tried for at least 30 days each before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	ACEON (perindopril) ALTACE (ramipril) benazepril captopril enalapril lisinopril MAVIK (trandolapril)	ACCUPRIL (quinapril) CAPOTEN (captopril) fosinopril LOTENSIN (benazepril) MONOPRIL (fosinopril) PRINIVIL (lisinopril) quinapril UNIVASC (moexepril) VASOTEC (enalapril) ZESTRIL (lisinopril)	
	ACE INHIBITOR/DIURETIC COMBINATIONS		
	benazepril/HCTZ captopril/HCTZ enalapril/HCTZ lisinopril/HCTZ	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) fosinopril/HCTZ LOTENSIN HCT (benazepril/HCTZ) MONOPRIL HCT (fosinopril/HCTZ) PRINZIDE (lisinopril/HCTZ) quinapril/HCTZ UNIRETIC (moexepril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	
ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATIONS *Effective 4/1/06*	LOTREL (benazepril/amlodipine) TARKA (trandolapril/verapamil)	LEXXEL (enalapril/felodipine)	Each of the preferred agents must be tried for at least two weeks each before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Patients starting therapy in this class must show a documented allergy to the preferred agents before a non-preferred agent will be authorized.
ACNE AGENTS, TOPICAL *Effective 4/1/06*	**ANTIBIOTICS**		A trial of 30 days of one of the preferred agents in each category will be required before a non-preferred agent will be authorized. (In cases of pregnancy, a trial of retinoids will not be required.) PA required after 17 years of age for tretinoin products.
	AKNE-MYCIN (erythromycin) clindamycin erythromycin	CLINDAGEL (clindamycin) EVOCLIN (clindamycin)	
	RETINOIDS		
	RETIN-A MICRO (tretinoin)[CL] TAZORAC (tazarotene) Tretinoin[CL]	DIFFERIN (adapalene)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
[CL] - Requires Clinical PA
[NR] – New drug has not been reviewed by P & T Committee

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	OTHERS		
	AZELEX (azelaic acid) BENZACLIN (benzoyl peroxide/clindamycin) benzoyl peroxide DUAC (benzoyl peroxide/clindamycin) erythromycin/benzoyl peroxide NUOX (benzoyl peroxide/sulfur)	BENZAMYCIN PAK (benzoyl peroxide/erythromycin) BREVOXYL (benzoyl peroxide) CLINAC BPO (benzoyl peroxide) KLARON (sodium sulfacetamide) ZACLIR (benzoyl peroxide) TRIAZ (benzoyl peroxide) SULFOXYL (benzoyl peroxide/sulfur) ZODERM (benzoyl peroxide)	
ALZHEIMER'S AGENTS *Implement 10/2/06*	**CHOLINESTERASE INHIBITORS**		A trial of a preferred agent will be required before a non-preferred agent In this class will be authorized. Currrent prescriptions for Razadyne and Razadyne ER will be grandfathered..
	ARICEPT (donepezil) EXELON (rivastigmine)	COGNEX (tacrine) RAZADYNE (galantamine) RAZADYNE ER (galantamine)	
	NMDA RECEPTOR ANTAGONIST		
	NAMENDA (memantine)		

BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

REVISED 11/20/06
Implementation Date: 10/02/06
Originally Posted 9/15/06

Version IV of IV

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANALGESICS, NARCOTIC (Non-parenteral) *Effective 4/1/06*	**SHORT ACTING**		Three of the preferred agents must be tried for at least 72 hours before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. (The three agents tried must include at least one of the long-acting agents when requesting a PA for a non-preferred long acting agent.) **Exception: Oxycodone ER will be authorized if a diagnosis of cancer is submitted without a trial of the preferred agents.** Actiq will only be approved as an adjunct to a long-acting agent. Actiq for monotherapy will not be approved. Limits: Quantities exceeding 240 tablets per 30 days (8 tablets/day) for agents containing 500 mg of acetaminophen will require a prior authorization and review by the Medical Director.
	acetaminophen/codeine aspirin/codeine codeine hydrocodone/APAP hydrocodone/ibuprofen hydromorphone levorphanol methadone morphine oxycodone oxycodone/APAP oxycodone/aspirin pentazocine/APAP pentazocine/naloxone propoxyphene/APAP tramadol tramadol/APAP	ACTIQ (fentanyl) butalbital/APAP/caffeine/codeine butalbital/ASA/caffeine/codeine COMBUNOX (oxycodone/ibuprofen) DARVOCET (propoxyphene/APAP) DARVON (propoxyphene) DEMEROL (meperidine) DILAUDID (hydromorphone) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) LORCET, LORTAB (hydrocodone/APAP) meperidine MSIR (morphine) OXYFAST, OXYIR (oxycodone) PANLOR (dihydrocodeine/APAP/caffeine) PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/aspirin) propoxyphene propoxyphene/ASA/caffeine TALACEN (pentazocine/APAP) TALWIN NX (pentazocine/naloxone) TYLENOL W/CODEINE (APAP/codeine) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VICODIN (hydrocodone/APAP) VICOPROFEN (hydrocodone/ibuprofen)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	LONG-ACTING		
	DURAGESIC (fentanyl) KADIAN (morphine) morphine SR	AVINZA (morphine) fentanyl MS CONTIN (morphine) ORAMORPH SR (morphine) oxycodone ER OXYCONTIN (oxycodone)	
ANDROGENIC AGENTS *Implement 10/2/06*	ANDRODERM (testosterone) ANDROGEL (testosterone)	TESTIM (testosterone)	The non-preferred agents will be approved only if one of the exceptions on the PA form is present.
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs) *Effective 4/1/06*	**ANGIOTENSIN RECEPTOR BLOCKERS**		Each of the preferred agents in the corresponding group must be tried for at least two weeks each before a non-preferred agent in that group will be authorized unless one of the exceptions on the PA form is present.
	AVAPRO (irbesartan) BENICAR (olmesartan) COZAAR (losartan) DIOVAN (valsartan) MICARDIS (telmisartan)	ATACAND (candesartan) TEVETEN (eprosartan)	
	ARB/DIURETIC COMBINATIONS		
	AVALIDE (irbesartan/HCTZ) BENICAR-HCT (olmesartan/HCTZ) DIOVAN-HCT (valsartan/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ)	ATACAND-HCT (candesartan/HCTZ) TEVETEN-HCT (eprosartan/HCTZ)	
ANTICOAGULANTS, INJECTABLE[CL] *Effective 4/1/06*	ARIXTRA (fondaparinux) LOVENOX (enoxaparin)	FRAGMIN (dalteparin) INNOHEP (tinzaparin)	A trial of each of the preferred agents will be required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTICONVULSANTS *Effective 4/1/06*	**BARBITURATES**		Treatment naive patients must have a trial of a preferred agent before a non-preferred agent in its corresponding class will be authorized. Patients stabilized on non-preferred agents will receive authorization to continue these drugs. Additions to that therapy will require a trial of preferred agent in its respective class unless one of the exceptions on the PA form is present.
	mephobarbital phenobarbital primidone	MEBARAL (mephobarbital) MYSOLINE (primidone)	
	HYDANTOINS		
	PEGANONE (ethotoin) Phenytoin	DILANTIN (phenytoin) PHENYTEK (phenytoin)	
	SUCCINIMIDES		
	CELONTIN (methsuximide) Ethosuximide	ZARONTIN (ethosuximide)	
	BENZODIAZEPINES		
	clonazepam DIASTAT (diazepam rectal) diazepam	KLONOPIN (clonazepam)	
	ADJUVANTS		
	carbamazepine DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) EQUETRO (carbamazepine) FELBATOL (felbamate) gabapentin GABITRIL (tiagabine) KEPPRA (levetiracetam) LAMICTAL (lamotrigine) LYRICA (pregabalin) TOPAMAX (topiramate) TRILEPTAL (oxcarbazepine) valproic acid zonisamide	CARBATROL (carbamazepine) DEPAKENE (valproic acid) NEURONTIN (gabapentin) TEGRETOL (carbamazepine) TEGRETOL XR (carbamazepine) ZONEGRAN (zonisamide)	

BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

REVISED 11/20/06
Implementation Date: 10/02/06
Originally Posted 9/15/06

Version IV of IV

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIDEPRESSANTS, OTHER (second generation, non-SSRI) *Effective 4/1/06*	CYMBALTA (duloxetine) EFFEXOR XR (venlafaxine) mirtazapine trazodone WELLBUTRIN XL (bupropion)	bupropion IR bupropion SR DESYREL (trazodone) EFFEXOR (venlafaxine) nefazodone REMERON (mirtazapine) SERZONE (nefazodone) WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion)	A non-preferred agent will only be authorized if there has been a six-week trial of an SSRI and a preferred agent in this class unless one of the exceptions on the PA form is present.
ANTIDEPRESSANTS, SSRIs *Implement 10/2/06*	citalopram fluoxetine fluvoxamine LEXAPRO (escitalopram) paroxetine PAXIL CR (paroxetine) PEXEVA (paroxetine) ZOLOFT (sertraline)	CELEXA (citalopram) PAXIL (paroxetine) PROZAC (fluoxetine) RAPIFLUX (fluoxetine) SARAFEM (fluoxetine) sertraline	None of the non-preferred dosage forms will be authorized unless there is documentation showing that the preferred dosage forms of the corresponding agents are inappropriate for the patient.
ANTIEMETICS, ORAL *Implement 10/2/06*	**5HT3 RECEPTOR BLOCKERS**		A trial of Zofran is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Quantity limits apply for this class* Zofran*-14 tablets per 21 days; in cases of hyperemesis during pregnancy, increased quantities may be authorized. EMEND*-12 tablets per 28 days
	ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron) EMEND (aprepitant)	ANZEMET (dolasetron) KYTRIL (granisetron)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
CL - Requires Clinical PA
NR – New drug has not been reviewed by P & T Committee

BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

REVISED 11/20/06
Implementation Date: 10/02/06
Originally Posted 9/15/06

Version IV of IV

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIFUNGALS, ORAL *Implement 10/2/06*	clotrimazole fluconazole ketoconazole[CL] LAMISIL (terbinafine)[CL] MYCOSTATIN Pastilles (nystatin) nystatin	ANCOBON (flucytosine) DIFLUCAN (fluconazole) GRIFULVIN V (griseofulvin) griseofulvin GRIS-PEG (griseofulvin) itraconazole MYCELEX (clotrimazole) MYCOSTATIN Tablets (nystatin) NIZORAL (ketoconazole) SPORANOX (itraconazole) VFEND (voriconazole)	Non-preferred agents will be approved only if one of the exceptions on the PA form is present. PA is required when limits are exceeded. PA is not required for Grifulvin-V Suspension for children up to 6 years of age for the treatment of tinea capitis
ANTIFUNGALS, TOPICAL *Implement 10/2/06*	**ANTIFUNGALS**		Three of the preferred agents must be tried for at least two weeks each before one of the non-preferred agents will be authorized unless one of the exceptions on the PA form is present.
	econazole EXELDERM (sulconazole) ketoconazole NAFTIN (naftifine) nystatin	ciclopirox ERTACZO (sertaconazole) LOPROX (ciclopirox) MENTAX (butenafine) MYCOSTATIN (nystatin) NIZORAL (ketoconazole) OXISTAT (oxiconazole) PENLAC (ciclopirox) SPECTAZOLE (econazole) VUSION (miconazole/petrolatum/zinc oxide)	
	ANTIFUNGAL/STEROID COMBINATIONS		
	clotrimazole/betamethasone nystatin/triamcinolone	LOTRISONE (clotrimazole/betamethasone) MYCOLOG (nystatin/triamcinolone)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIHISTAMINES, MINIMALLY SEDATING *Effective 4/1/06*	**ANTIHISTAMINES**		A preferred agent, in the age appropriate dosage form, must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	ALAVERT (loratadine) CLARINEX Syrup (desloratadine) loratadine TAVIST-ND (loratadine)	ALLEGRA (fexofenadine) CLARINEX Tablets (desloratadine) CLARITIN (loratadine) fexofenadine ZYRTEC (cetirizine)	
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
	loratadine/pseudoephedrine	ALAVERT-D (loratadine/pseudoephedrine) ALLEGRA-D (fexofenadine/pseudoephedrine) CLARINEX-D (desloratadine/pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) ZYRTEC-D (cetirizine/pseudoephedrine)	
ANTIMIGRAINE AGENTS, TRIPTANS *Effective 4/1/06*	AXERT (almotriptan) IMITREX (sumatriptan) MAXALT (rizatriptan) RELPAX (eletriptan)	AMERGE (naratriptan) FROVA (frovatriptan) ZOMIG (zolmitriptan)	All of the preferred agents must be tried before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. Quantity limits apply for this drug class.

BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

REVISED 11/20/06
Implementation Date: 10/02/06
Originally Posted 9/15/06

Version IV of IV

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIPARKINSON'S AGENTS (Oral) *Implement 10/2/06*	**ANTICHOLINERGICS**		Patients starting therapy on drugs in this class must show a documented allergy to all of the preferred agents before a non-preferred agent will be authorized.
	benztropine KEMADRIN (procyclidine) trihexyphenidyl	COGENTIN (benztropine)	
	COMT INHIBITORS		
	COMTAN (entacapone)	TASMAR (tolcapone)	
	DOPAMINE AGONISTS		
	MIRAPEX (pramipexole) REQUIP (ropinirole)	pergolide PERMAX (pergolide)	
	OTHER ANTIPARKINSON'S AGENTS		
	carbidopa/ levodopa selegiline STALEVO (levodopa/carbidopa/entacapone)	AZILECT (rasagiline)[NR] ELDEPRYL (selegiline) EMSAM (selegiline)[NR] PARCOPA (levodopa/carbidopa) SINEMET (levodopa/carbidopa)	
ANTIPSYCHOTICS, ATYPICAL (Oral) *Implement 10/2/06*	**ORAL**		Upon discharge, hospitalized patients stabilized on non-preferred agents will receive authorization to continue these drugs. New patients for this class of drugs will be required to try a preferred agent for two weeks unless one of the exceptions on the PA form is present.
	clozapine FAZACLO (clozapine) GEODON (ziprasidone) RISPERDAL (risperidone) SEROQUEL (quetiapine)	ABILIFY (aripiprazole) CLOZARIL (clozapine) ZYPREXA (olanzapine)	
	ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
		SYMBYAX (olanzapine/fluoxetine)	
ANTIVIRALS (Oral) *Implement 10/2/06*	acyclovir amantadine ganciclovir VALCYTE (valganciclovir) VALTREX (valacyclovir)	CYTOVENE (ganciclovir) FAMVIR (famciclovir) FLUMADINE (rimantadine) rimantadine RELENZA (zanamivir) SYMMETREL (amantadine) TAMIFLU (oseltamivir) ZOVIRAX (acyclovir)	All of the appropriate preferred agents with the applicable indication must be tried before the non-preferred agents will be authorized unless one of the exceptions on the PA form is present.

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
[CL] - Requires Clinical PA
[NR] – New drug has not been reviewed by P & T Committee

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ATOPIC DERMATITIS *Implement 10/2/06*	ELIDEL (pimecrolimus) PROTOPIC (tacrolimus)		
BETA BLOCKERS (Oral) *Effective 4/1/06*	**BETA BLOCKERS**		If one of the exceptions on the PA form is present or if the physician feels that the patient cannot be stabilized with any of the preferred agents, one of the non-preferred agents will be approved.
	acebutolol atenolol INDERAL LA (propranolol) metoprolol nadolol pindolol propranolol sotalol timolol TOPROL XL (metoprolol)	BETAPACE (sotalol) betaxolol bisoprolol BLOCADREN (timolol) CARTROL (carteolol) CORGARD (nadolol) INNOPRAN XL (propranolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) TENORMIN (atenolol) ZEBETA (bisoprolol)	
	BETA- AND ALPHA- BLOCKERS		
	COREG (carvedilol) labetalol	NORMODYNE (labetalol) TRANDATE (labetalol)	
BLADDER RELAXANT PREPARATIONS *Effective 4/1/06*	DITROPAN XL (oxybutynin) ENABLEX (darifenacin) oxybutynin OXYTROL (oxybutynin) SANCTURA (trospium) VESICARE (solifenacin)	DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN (oxybutynin)	All of the preferred agents in the class must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BONE RESORPTION SUPPRESSION AND RELATED AGENTS *Implement 10/2/06*	**BISPHOSPHONATES**		One of the preferred agents must be tried for at least one month before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. For severely compromised patients, albuterol/ipratropium will be approved if the combined volume of albuterol and ipratropium nebules is inhibitory.
	FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D)	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium) BONIVA (ibandronate) DIDRONEL (etidronate)	
	OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
	EVISTA (raloxifene) MIACALCIN (calcitonin)	FORTEO (teriparatide) FORTICAL (calcitonin)	
BPH AGENTS *Effective 4/1/06*	**ALPHA BLOCKERS**		One of the preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	doxazosin FLOMAX (tamsulosin) trazosin UROXATRAL (alfuzosin)	CARDURA (doxazosin) CARDURA XL (doxazosin)[NR] HYTRIN (terazosin)	
	5-ALPHA-REDUCTASE (5AR) INHIBITORS		
	AVODART (dutasteride)	PROSCAR (finasteride)	
BRONCHODILATORS, ANTICHOLINERGIC *Implement 10/2/06*	**ANTICHOLINERGIC**		The preferred agents in the class must be tried before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present. For severely compromised patients, DUONEB will be approved if the combined volume of albuterol and ipratropium nebules is inhibitory.
	ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)	ATROVENT Inhalation Solution (ipratropium)	
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS		
	COMBIVENT (albuterol/ipratropium)	DUONEB (albuterol/ipratropium)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BRONCHODILATORS, BETA AGONIST *Implement* 10/2/06	**INHALERS, SHORT-ACTING**		All of the preferred agents in a group must be tried before a non-preferred agent in that group will be authorized unless one of the exceptions on the PA form is present. Xopenex Inhalatiion Solution will be approved for 12 months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol, or for a concurrent diagnosis of heart disease. **No PA is required for ACCUNEB for children up to 5 years of age.
	albuterol CFA MAXAIR (pirbuterol) XOPENEX HFA (levalbuterol)	albuterol HFA ALUPENT (metaproterenol) PROVENTIL (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	
	INHALERS, LONG-ACTING		
	FORADIL (formoterol)	SEREVENT (salmeterol)	
	INHALATION SOLUTION		
	albuterol	ACCUNEB (albuterol)** metaproterenol PROVENTIL (albuterol) XOPENEX (levalbuterol)	
	ORAL		
	albuterol terbutaline	BRETHINE (terbutaline) metaproterenol VOSPIRE ER (albuterol)	
CALCIUM CHANNEL BLOCKERS (Oral) *Effective 4/1/06*	**SHORT-ACTING**		One of the preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Nimodipine will be approved with the appropriate diagnosis.
	diltiazem verapamil	ADALAT (nifedipine) CALAN (verapamil) CARDENE (nicardipine) CARDIZEM (diltiazem) DYNACIRC (isradipine) isradipine nicardipine nifedipine NIMOTOP (nimodipine) PROCARDIA (nifedipine)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	LONG-ACTING		
	CARDIZEM LA (diltiazem) diltiazem DYNACIRC CR (isradipine) felodipine nifedipine SULAR (nisoldipine) verapamil VERELAN PM (verapamil)	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD (diltiazem) CARDIZEM SR (diltiazem) COVERA-HS (verapamil) DILACOR XR (diltiazem) ISOPTIN SR (verapamil) NORVASC (amlodipine) PLENDIL (felodipine) PROCARDIA XL (nifedipine) TIAZAC (diltiazem) VERELAN (verapamil)	
CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral) *Implement 10/2/06*	**BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS**		The preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	amoxicillin/clavulanate AUGMENTIN XR (amoxicillin/clavulanate)	AUGMENTIN (amoxicillin/clavulanate) AUGMENTIN ES-600 (amoxicillin/clavulanate)	
	CEPHALOSPORINS		
	CEDAX (ceftibuten) cefaclor cefadroxil cefprozil cefuroxime cephalexin OMNICEF (cefdinir) SPECTRACEF (cefditoren) SUPRAX (cefixime)	CECLOR (cefaclor) cefpodoxime CEFTIN (cefuroxime) CEFZIL (cefprozil) DURICEF (cefadroxil) KEFLEX (cephalexin) LORABID (loracarbef) PANIXINE (cephalexin) RANICLOR (cefaclor) VANTIN (cefpodoxime)	
CYTOKINE & CAM ANTAGONISTS [CL] *Implement 10/2/06*	ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra) RAPTIVA (efalizumab)		

BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

REVISED 11/20/06
Implementation Date: 10/02/06
Originally Posted 9/15/06

Version IV of IV

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ERYTHROPOIESIS STIMULATING PROTEINS[CL] *Implement 4/1/06*	ARANESP (darbepoetin) PROCRIT (rHuEPO)	EPOGEN (rHuEPO)	The preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
FLUROQUINOLONES, ORAL *Implement 10/2/06*	AVELOX (moxifloxacin) ciprofloxacin CIPRO (ciprofloxacin suspension) FACTIVE (gemifloxacin)	CIPRO (ciprofloxacin) CIPRO XR (ciprofloxacin extended-release) FLOXIN (ofloxacin) LEVAQUIN (levofloxacin) ofloxacin PROQUIN XR (ciprofloxacin extended-release)	One of the preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
GLUCOCORTICOIDS, INHALED *Implement 10/2/06*	**GLUCOCORTICOIDS**		All of the preferred agents of a dosage form must be tried before a non-preferred agent of that dosage form will be authorized unless one of the exceptions on the PA form is present. Pulmicort Respules do not require a prior authorization for children through 8 years of age or for individuals unable to use an MDI. Flovent HFA will not require a PA for children through age 6.
	AEROBID (flunisolide) AEROBID-M (flunisolide) ASMANEX (mometasone) AZMACORT (triamcinolone) QVAR (beclomethasone)	FLOVENT HFA (fluticasone) PULMICORT (budesonide)	
	GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
	ADVAIR (fluticasone/salmeterol)		
GROWTH HORMONE[CL] *Implement 4/1/06*	NORDITROPIN (somatropin) NUTROPIN AQ (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin)	GENOTROPIN (somatropin) HUMATROPE (somatropin) NUTROPIN (somatropin)	The preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
HEPATITIS C TREATMENTS[CL] *Implement 4/1/06*	COPEGUS (ribavirin) PEG-INTRON (pegylated interferon) PEGASYS (pegylated interferon) REBETOL (ribavirin)	INFERGEN (consensus interferon) REBETRON (interferon alpha/ribavirin) ribavirin	Patients already on a non-preferred agent will receive authorization to continue therapy on that agent. Patients starting therapy in this class must try the preferred agents of a dosage form before a non-preferred agent of that dosage form will be authorized.

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
[CL] - Requires Clinical PA
[NR] – New drug has not been reviewed by P & T Committee

BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

REVISED 11/20/06
Implementation Date: 10/02/06
Originally Posted 9/15/06

Version IV of IV

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMICS, INSULINS AND RELATED AGENTS *Implement 10/2/06*	**INSULIN**		PA Criteria for Exubera: Patient must: 1. be 18 years or older; 2. have no history of smoking in the past six months; 3. have no history of chronic lung disease in the past two year or presence of acute lower respiratory lung infection; 4. have a base line spriometry to measure FEV1. For renewal, spriometry to measure FEV1 six months after treatment initiation and then annually from second FEV1 measure; 5. have a diagnosis of Type 1 diabetes (stated or inferred) with concomitant use of a longer acting insulin; OR have a diagnosis of Type II Diabetes (stated or inferred) and maximization of dosage of at least one available oral agent (sulfonylurea, metformin or thiazolindinediones), unless contraindicated; 6. Diagnosis of lipodystrophy or needle phobia that prevents self-injection or injection by a caregiver. PA Criteria for Apidra: Patient must: 1. be 18 years or older; 2. be currently on a regimen including a longer-acting or basal insulin. 3. have had a trial of a similar preferred agent, Novolog or Humulin, with documentation that the desired results were not achieved.
	HUMALOG (insulin lispro) HUMALOG MIX (insulin lispro/lispro protamine) HUMULIN (insulin) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLIN (insulin) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	APIDRA (insulin glulisine) EXUBERA (insulin) [NR]	
	RELATED AGENTS		
	BYETTA (exenatide) SYMLIN (amylin)		
HYPOGLYCEMICS, MEGLITINIDES *Implement 4/1/06*	STARLIX (nateglinide)	PRANDIN (repaglinide)	The preferred agent must be tried before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.
HYPOGLYCEMICS, METFORMINS **Class Retired** *Implement 10/2/06*			

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
[CL] - Requires Clinical PA
[NR] – New drug has not been reviewed by P & T Committee

BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

REVISED 11/20/06
Implementation Date: 10/02/06
Originally Posted 9/15/06

Version IV of IV

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMICS, TZDS *Implement 4/1/06*	**THIAZOLINEDIONES**		A preferred agent must be tried before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	ACTOS (pioglitazone) AVANDIA (rosiglitazone)		
	TZD COMBINATIONS		
	ACTOPLUS MET (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin)	AVANDARYL (rosiglitazone/glimepiride)[NR]	
INTRANASAL RHINITIS AGENTS *Implement 10/2/06*	**ANTICHOLINERGICS**		All of the preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
		ATROVENT (ipratropium) ipratropium	
	ANTIHISTAMINES		
	ASTELIN (azelastine)		
	CORTICOSTEROIDS		
	FLONASE (fluticasone) NASACORT AQ (triamcinolone) NASONEX (mometasone)	BECONASE AQ (beclomethasone) flunisolide fluticasone NASALIDE (flunisolide) NASAREL (flunisolide) RHINOCORT AQUA (budesonide)	
LEUKOTRIENE RECEPTOR BLOCKERS *Implement 10/2/06*	ACCOLATE (zafirlukast) SINGULAIR (montelukast)	ZYFLO (zileuton)	
LIPOTROPICS, OTHER (non-statins) *Implement 4/1/06*	**BILE ACID SEQUESTRANTS**		The preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Zetia, as monotherapy, will only be approved for patients who cannot take statins or other preferred agents. Zetia and Welchol will be approved for add-on therapy only after an insufficient response to the maximum tolerable dose of a statin after 12 weeks of therapy. If patients require the addition of Zetia to Zocor to achieve goal, use of the combination product, Vytorin, will be required. If patients are on other statins and require the addition of Zetia, patients will not be required to switch the statin that they have been using.
	cholestyramine COLESTID (colestipol)	QUESTRAN (cholestyramine) WELCHOL (colesevalam)	
	CHOLESTEROL ABSORPTION INHIBITORS		
		ZETIA (ezetimibe)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
[CL] - Requires Clinical PA
[NR] – New drug has not been reviewed by P & T Committee

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	FATTY ACIDS		
		OMACOR (omega-3-acid ethyl esters)	
	FIBRIC ACID DERIVATIVES		
	fenofibrate gemfibrozil TRICOR (fenofibrate)	ANTARA (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRIGLIDE (fenofibrate)	
	NIACIN		
	niacin NIASPAN (niacin)	NIACELS (niacin) NIADELAY (niacin) SLO-NIACIN (niacin)	
LIPOTROPICS, STATINS *Implement 4/1/06*	**STATINS**		One of the preferred statins must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	ALTOPREV (lovastatin) CRESTOR (rosuvastatin) LESCOL (fluvastatin) LESCOL XL (fluvastatin) lovastatin ZOCOR (simvastatin)	LIPITOR (atorvastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) pravastatin[NR] simvastatin	
	STATIN COMBINATIONS		
	ADVICOR (lovastatin/niacin) VYTORIN (ezetimibe/simvastatin)	CADUET (atorvastatin/amlodipine)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MACROLIDES/KETOLIDES (Oral) *Implement 10/2/06*	**MACROLIDES** azithromycin BIAXIN XL (clarithromycin) erythromycin (base, ethylsuccinate, stearate)	BIAXIN (clarithromycin) clarithromycin DYNABAC (dirithromycin) E.E.S. (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX Suspension (azithromycin)	The preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Requests for telithromycin will be authorized if there is documentation of the use of any antibiotic within the past 28 days.
	KETOLIDES		
		KETEK (telithromycin)	
MULTIPLE SCLEROSIS AGENTS[CL] *Implement 4/1/06*	AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE (glatiramer) REBIF (interferon beta-1a)		

BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

REVISED 11/20/06
Implementation Date: 10/02/06
Originally Posted 9/15/06

Version IV of IV

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
NSAIDS *Implement 10/2/06*	**NONSELECTIVE**		The preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	diclofenac etodolac fenoprofen flurbiprofen ibuprofen (Rx and OTC) indomethacin ketoprofen ketorolac naproxen (Rx only) oxaprozin piroxicam PONSTEL (meclofenamate) sulindac tolmetin	ADVIL (ibuprofen) ANAPROX (naproxen) ANSAID (flurbiprofen) CATAFLAM (diclofenac) CLINORIL (sulindac) DAYPRO (oxaprozin) FELDENE (piroxicam) INDOCIN (indomethacin) LODINE (etodolac) meclofenamate MOTRIN (ibuprofen) nabumetone NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) NUPRIN (ibuprofen) ORUDIS (ketoprofen) ORUVAIL (ketoprofen) RELAFEN (nabumetone) TOLECTIN (tolmetin) TORADOL (ketorolac) VOLTAREN (diclofenac)	
	NSAID/GI PROTECTANT COMBINATIONS		
		ARTHROTEC (diclofenac/misoprostol) PREVACID NAPRAPAC (naproxen/lansoprazole)	
	COX-II SELECTIVE[CL]		COX-II selective NSAIDs will be approved for patients with a GI Risk Score of ≥13.
		CELEBREX (celecoxib) meloxicam MOBIC (meloxicam)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
[CL] - Requires Clinical PA
[NR] – New drug has not been reviewed by P & T Committee

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OPHTHALMIC ANTIBIOTICS *Implement 10/2/06*	**FLUOROQUINOLONES**		All of the preferred agents must be tried before non-preferred agents will be authorized unless one of the exceptions on the PA form is present.
	VIGAMOX (moxifloxacin)	ciprofloxacin CILOXAN (ciprofloxacin) OCUFLOX (ofloxacin) ofloxacin QUIXIN (levofloxacin) ZYMAR (gatifloxacin)	
	OTHER SINGLE AGENTS		
	bacitracin erythromycin gentamicin polymyxin B sulfacetamide tobramycin	BLEPH-10 (sulfacetamide) GENOPTIC (gentamicin) TOBREX (tobramycin)	
	COMBINATION AGENTS		
	neomycin/polymyxin/bacitracin neomycin/polymyxin/gramicidin polymyxin/bacitracin polymyxin/trimethoprim	NEOSPORIN (neomycin/polymyxin/bacitracin) NEOSPORIN (neomycin/polymyxin/gramicidin) POLYSPORIN (polymyxin/bacitracin) POLYTRIM (polymyxin/trimethoprim)	
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS *Implement 10/2/06*	ACULAR (ketorolac) ALREX (loteprednol) cromolyn ELESTAT (epinastine) OPTIVAR (azelastine) PATANOL (olopatadine)	ALOCRIL (nedocromil) ALAMAST (pemirolast) ALOMIDE (lodoxamide) CROLOM (cromolyn) EMADINE (emedastine) OPTICROM (cromolyn) ZADITOR (ketotifen)	All of the preferred agents must be tried before non-preferred agents will be authorized, unless one of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OPHTHALMICS, GLAUCOMA AGENTS *Implement 10/2/06*	**PARASYMPATHOMIMETICS**		Authorization for a non-preferred agent will only be given if there is an allergy to the preferred agents.
	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) PHOSPHOLINE IODIDE (echothiophate iodide) pilocarpine	ISOPTO CARPINE (pilocarpine) PILOPINE HS (pilocarpine)	
	SYMPATHOMIMETICS		
	ALPHAGAN P (brimonidine) brimonidine dipivefrin	ALPHAGAN (brimonidine) PROPINE (dipivefrin)	
	BETA BLOCKERS		
	BETIMOL (timolol) BETOPTIC S (betaxolol) betaxolol carteolol levobunolol metipranolol timolol	BETAGAN (levobunolol) ISTALOL (timolol) OPTIPRANOLOL (metipranolol) TIMOPTIC (timolol)	
	CARBONIC ANHYDRASE INHIBITORS		
	AZOPT (brinzolamide) TRUSOPT (dorzolamide)		
	PROSTAGLANDIN ANALOGS		
	LUMIGAN (bimatoprost) TRAVATAN (travoprost)	XALATAN (latanoprost)	
	COMBINATION AGENTS		
	COSOPT (dorzolamide/timolol)		
OTIC ANTIBIOTIC PREPARATIONS *Effective 4/1/06*	CIPRODEX (ciprofloxacin/dexamethasone) COLY-MYCIN S (neomycin/hydrocortisone) FLOXIN (ofloxacin) neomycin/polymyxin/hydrocortisone	CIPRO HC (ciprofloxacin/hydrocortisone) CORTISPORIN (neomycin/polymyxin/hydrocortisone) CORTISPORIN TC (neomycin/hydrocortisone) PEDIOTIC (neomycin/polymyxin/hydrocortisone)	All of the preferred agents must be tried before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.

BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

REVISED 11/20/06
Implementation Date: 10/02/06
Originally Posted 9/15/06

Version IV of IV

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PHOSPHATE BINDERS *Implement 4/1/06*	FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENAGEL (sevelamer)	MAGNEBIND 400 (magnesium/calcium carbonate)	A trial of the preferred agents will be required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
PLATELET AGGREGATION INHIBITORS *Implement 10/2/06*	AGGRENOX (dipyridamole/ASA) PLAVIX (clopidogrel)	dipyridamole PERSANTINE (dipyridamole) TICLID (ticlopidine) ticlopidine	All of the preferred agents must be tried before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.
PROTON PUMP INHIBITORS (Oral) *Implement 4/1/06*	NEXIUM (esomeprazole) PREVACID (lansoprazole)	ACIPHEX (rabeprazole) omeprazole PROTONIX (pantoprazole) ZEGERID (omeprazole)	The preferred agents must be tried before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.
SEDATIVE HYPNOTICS *Implement 4/1/06*	**BENZODIAZEPINES**		Each of the preferred agents, in its respective class, must be tried for 10 days before a non-preferred agent in that class will be authorized.
	temazepam	DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam) PROSOM (estazolam) RESTORIL (temazepam) triazolam	
	OTHERS		
	AMBIEN (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon) SONATA (zaleplon)	AMBIEN CR (zolpidem) AQUA CHLORAL (chloral hydrate) chloral hydrate SOMNOTE (chloral hydrate)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
CL - Requires Clinical PA
NR – New drug has not been reviewed by P & T Committee

BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

REVISED 11/20/06
Implementation Date: 10/02/06
Originally Posted 9/15/06

Version IV of IV

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
STIMULANTS AND RELATED AGENTS *Implement 10/2/06*	**AMPHETAMINES**		Except for Strattera, PA is required for adults >18 years. One of the preferred agents in each group (amphetamines and non-amphetamines) must be tried before a non-preferred agent will be authorized. Amphetamines will be authorized for the treatment of depression only after documented failure of multiple antidepressants. Provigil will only be approved for patients >16 years of age with a diagnosis of narcolepsy. Straterra will not be approved for concurrent administration with amphetamines or methyphenidates, exept for 30 days or less for tapering purposes. Only two doses of each strength, or two concurrent doses of any strength, and a maximum of one dose of a 60 mg capsule, will be approved in a 34-day period.
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination dextroamphetamine	ADDERALL (amphetamine salt combination) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT(dextroamphetamine)	
	NON-AMPHETAMINE		
	CONCERTA (methylphenidate) FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) METADATE CD (methylphenidate) methylphenidate methylphenidate ER STRATTERA (atomoxetine)	DAYTRANA (methylphenidate)[NR] METADATE ER (methylphenidate) pemoline PROVIGIL (modafanil) RITALIN (methylphenidate) RITALIN LA (methylphenidate) RITALIN-SR (methylphenidate)	
ULCERATIVE COLITIS AGENTS *Implement 4/1/06*	**ORAL**		The preferred agents of a dosage form must be tried before a non-preferred agent of that dosage form will be authorized unless one of the exceptions on the PA form is present.
	ASACOL (mesalamine) DIPENTUM (olsalazine) PENTASA (mesalamine) sulfasalazine	AZULFIDINE (sulfasalazine) COLAZAL (balsalazide)	
	RECTAL		
	CANASA (mesalamine) Mesalamine	ROWASA (mesalamine)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
[CL] - Requires Clinical PA
[NR] – New drug has not been reviewed by P & T Committee