BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

REVISED 6/6/06
Implementation Date: 4/01/06
Originally Posted 3/1/06

Version III of III

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACE INHIBITORS *Implement 10/3/05*	**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.
	ALTACE (ramipril) benazepril captopril enalapril lisinopril MAVIK (trandolapril) UNIVASC (moexepril)	ACEON (perindopril) ACCUPRIL (quinapril) CAPOTEN (captopril) fosinopril LOTENSIN (benazepril) MONOPRIL (fosinopril) PRINIVIL (lisinopril) quinapril VASOTEC (enalapril) ZESTRIL (lisinopril)	
	ACE INHIBITOR/DIURETIC COMBINATIONS		
	benazepril/HCTZ captopril/HCTZ enalapril/HCTZ lisinopril/HCTZ UNIRETIC (moexepril/HCTZ)	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) fosinopril/HCTZ LOTENSIN HCT (benazepril/HCTZ) MONOPRIL HCT (fosinopril/HCTZ) PRINZIDE (lisinopril/HCTZ) quinapril/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	DIFFERIN (adapalene)	

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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 10/3/05*	**CHOLINESTERASE INHIBITORS**		
	ARICEPT (donepezil) EXELON (rivastigmine) RAZADYNE (galantamine) RAZADYNE ER (galantamine)	COGNEX (tacrine)	
	NMDA RECEPTOR ANTAGONIST		
	NAMENDA (memantine)		

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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.
	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)	
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)	

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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 10/3/05*	citalopram fluoxetine fluvoxamine LEXAPRO (escitalopram) paroxetine PEXEVA (paroxetine) ZOLOFT (sertraline)	CELEXA (citalopram) PAXIL (paroxetine) PAXIL CR (paroxetine) PROZAC (fluoxetine) RAPIFLUX (fluoxetine) SARAFEM (fluoxetine)	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	**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 EMEND*-12 tablets per 28 days
	ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron) EMEND (aprepitant)	ANZEMET (dolasetron) KYTRIL (granisetron)	
ANTIFUNGALS, ORAL *Implement 10/3/05*	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 16 years of age for the treatment of tinea capitis

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ANTIFUNGALS, TOPICAL *Implement 10/3/05*	**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.
	ciclopirox (cream, suspension) econazole EXELDERM (sulconazole) ketoconazole LOPROX Gel, Shampoo (ciclopirox) nystatin	ERTACZO (sertaconazole) LOPROX Cream, TS (ciclopirox) MENTAX (butenafine) MYCOSTATIN (nystatin) NAFTIN (naftifine) NIZORAL (ketoconazole) OXISTAT (oxiconazole) PENLAC (ciclopirox) SPECTAZOLE (econazole)	
	ANTIFUNGAL/STEROID COMBINATIONS		
	clotrimazole/betamethasone nystatin/triamcinolone	LOTRISONE (clotrimazole/betamethasone) MYCOLOG (nystatin/triamcinolone)	
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.

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ANTIPARKINSON'S AGENTS (Oral) *Implement 10/3/05*	**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)	ELDEPRYL (selegiline) PARCOPA (levodopa/carbidopa) SINEMET (levodopa/carbidopa)	
ANTIPSYCHOTICS, ATYPICAL (Oral) *Implement 10/3/05*	**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)	
	INJECTABLE		
		GEODON (ziprasidone)[CL] RISPERDAL CONSTA (risperidone)[CL] ZYPREXA (olanzapine)[CL]	
	ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
		SYMBYAX (olanzapine/fluoxetine)	

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ANTIVIRALS (Oral) *Implement 10/3/05*	acyclovir amantadine VALCYTE (valganciclovir) VALTREX (valacyclovir)	CYTOVENE (ganciclovir) FAMVIR (famciclovir) FLUMADINE (rimantadine) ganciclovir 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.
ATOPIC DERMATITIS *Implement 10/3/05*	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)	

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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.
BONE RESORPTION SUPPRESSION AND RELATED AGENTS *Implement 10/3/05*	**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. Forteo will be approved for patients with a history of osteoporotic fractures or if one of the exceptions on the PA form is present.
	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium) FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D)	BONIVA (ibandronate) DIDRONEL (etidronate)	
	OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
	EVISTA (raloxifene) MIACALCIN (calcitonin)	FORTEO (teriparatide) FORTICAL (calcitonin)[NR]	
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 10/3/05*	**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)	

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BRONCHODILATORS, BETA AGONIST *Implement* 10/3/05	**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 MAXAIR (pirbuterol)	ALUPENT (metaproterenol) PROVENTIL (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol)	
	INHALERS, LONG-ACTING		
	SEREVENT (salmeterol)	FORADIL (formoterol)	
	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 10/3/05*	**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 (amoxicillin/clavulanate) AUGMENTIN ES-600 (amoxicillin/clavulanate) AUGMENTIN XR (amoxicillin/clavulanate)	
	CEPHALOSPORINS		
	CEDAX (ceftibuten) cefaclor cefadroxil cefuroxime CEFZIL (cefprozil) cephalexin cephradine OMNICEF (cefdinir) SPECTRACEF (cefditoren) SUPRAX (cefixime)	CECLOR (cefaclor) cefpodoxime CEFTIN (cefuroxime) DURICEF (cefadroxil) KEFLEX (cephalexin) LORABID (loracarbef) PANIXINE (cephalexin) RANICLOR (cefaclor) VANTIN (cefpodoxime) VELOSEF (cephradine)	
CYTOKINE & CAM ANTAGONISTS [CL] *Implement 10/3/05*	ENBREL (etanercept) KINERET (anakinra)	HUMIRA (adalimumab) RAPTIVA (efalizumab)	For all new therapy, 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. Patients currently on a non-preferred agent will receive an authorization to continue therapy on that agent.

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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 10/3/05*	AVELOX (moxifloxacin) ciprofloxacin	CIPRO (ciprofloxacin) CIPRO XR (ciprofloxacin extended-release) FACTIVE (gemifloxacin) FLOXIN (ofloxacin) LEVAQUIN (levofloxacin) MAXAQUIN (lomefloxacin) NOROXIN (norfloxacin) 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 10/3/05*	**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.
	AEROBID (flunisolide) AEROBID-M (flunisolide) AZMACORT (triamcinolone) FLOVENT (fluticasone) FLOVENT HFA (fluticasone) QVAR (beclomethasone)	ASMANEX (mometasone)[NR] 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.

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HYPOGLYCEMICS, INSULINS AND RELATED AGENTS *Implement 10/3/05*	**INSULIN**		Non-preferred insulins will be available for pediatric patients requiring diluted doses. Non-preferred insulins will only be authorized with documented proof of an allergic reaction to the preferred insulins.
	LANTUS (insulin glargine) NOVOLIN (insulin) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	APIDRA (insulin glulisine)[NR] HUMALOG (insulin lispro) HUMALOG MIX (insulin lispro/lispro protamine) HUMULIN (insulin) LEVEMIR (insulin detemir)[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 *Implement 10/3/05*	**METFORMIN**		No non-preferred agents will be approved without a 12-week trial of the preferred agents unless one of the exceptions on the PA form is present.
	FORTAMET metformin RIOMET	GLUCOPHAGE	
	METFORMIN-CONTAINING COMBINATIONS		No non-preferred agents will be approved without a 12-week trial of the individual agents unless one of the exceptions on the PA form is present. (A trial of metformin/glyburide is not necessary for approval of the individual components of a combination agent.)
	metformin/glipizide[NR] metformin/glyburide	GLUCOVANCE (metformin/glyburide) METAGLIP (metformin/glipizide)	
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 10/3/05*	**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)		

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	CORTICOSTEROIDS		
	FLONASE (fluticasone) NASACORT AQ (triamcinolone) NASONEX (mometasone)	BECONASE AQ (beclomethasone) flunisolide fluticasone NASALIDE (flunisolide) NASAREL (flunisolide) RHINOCORT AQUA (budesonide)	
LEUKOTRIENE RECEPTOR BLOCKERS *Implement 10/3/05*	ACCOLATE (zafirlukast) SINGULAIR (montelukast)	ZYFLO (zileuton)[NR]	
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)	
	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)	

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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]	
	STATIN COMBINATIONS		
	ADVICOR (lovastatin/niacin) VYTORIN (ezetimibe/simvastatin)	CADUET (atorvastatin/amlodipine)	
MACROLIDES/KETOLIDES (Oral) *Implement 10/3/05*	**MACROLIDES**		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.
	azithromycin BIAXIN XL (clarithromycin) clarithromycin erythromycin (base, ethylsuccinate, stearate) ZITHROMAX (azithromycin) ZMAX Suspension (azithromycin)	BIAXIN (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 Capsules (azithromycin)	
	KETOLIDES		Requests for Ketek will be authorized if there is documentation of the use of any antibiotic within the past 28 days.
		KETEK (telithromycin)	
MULTIPLE SCLEROSIS AGENTS[CL] *Implement 4/1/06*	AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE (glatiramer) REBIF (interferon beta-1a)		

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NSAIDS *Implement 10/3/05*	**NONSELECTIVE**		Non-preferred agents will only be approved after the preferred agents have been tried unless one of the exceptions on the PA form is present. COX II Selectives: Must score a minimum of 13 on the GI Risk Scale.
	diclofenac etodolac fenoprofen flurbiprofen ibuprofen (Rx and OTC) indomethacin ketoprofen ketorolac naproxen (Rx only) oxaprozin piroxicam 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) PONSTEL (meclofenamate) RELAFEN (nabumetone) TOLECTIN (tolmetin) TORADOL (ketorolac) VOLTAREN (diclofenac)	
	NSAID/GI PROTECTANT COMBINATIONS		
		ARTHROTEC (diclofenac/misoprostol) PREVACID NAPRAPAC (naproxen/lansoprazole)	
	COX-II SELECTIVE[CL]		
		CELEBREX (celecoxib) MOBIC (meloxicam)	

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OPHTHALMIC ANTIBIOTICS *Implement 10/3/05*	**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.
	ciprofloxacin VIGAMOX (moxifloxacin)	CILOXAN (ciprofloxacin) OCUFLOX (ofloxacin) Ofloxacin QUIXIN (levofloxacin) ZYMAR (gatifloxacin)	
	OTHER SINGLE AGENTS		
	bacitracin erythromycin gentamicin polymyxin B sulfacetamide tobramycin	BLEPH-10 (sulfacetamide) CETAMIDE (sulfacetamide) CHLOROMYCETIN (chloramphenicol) CHLOROPTIC (chloramphenicol) GARAMYCIN (gentamicin) GENOPTIC (gentamicin) ILOTYCIN (erythromycin) 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) TERAK W/ POLYMYXIN (oxytetracycline/polymyxin) TERRAMYCIN W/ POLYMYXIN (oxytetracycline/polymyxin)	
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS *Implement 10/3/05*	ACULAR (ketorolac) ALREX (loteprednol) cromolyn ELESTAT (epinastine) PATANOL (olopatadine)	ALOCRIL (nedocromil) ALAMAST (pemirolast) ALOMIDE (lodoxamide) CROLOM (cromolyn) EMADINE (emedastine) LIVOSTIN (levocabastine) OPTICROM (cromolyn) OPTIVAR (azelastine) 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.

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OPHTHALMICS, GLAUCOMA AGENTS *Implement 10/3/05*	**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) MIOSTAT (carbachol) PHOSPHOLINE IODIDE (echothiophate iodide) pilocarpine	ISOPTO CARPINE (pilocarpine) PILOCAR (pilocarpine) PILOPINE HS (pilocarpine)	
	SYMPATHOMIMETICS		
	ALPHAGAN P (brimonidine) brimonidine dipivefrin	ALPHAGAN (brimonidine) EPIFRIN (epinephrine) PROPINE (dipivefrin)	
	BETA BLOCKERS		
	BETIMOL (timolol) BETOPTIC S (betaxolol) betaxolol carteolol levobunolol metipranolol timolol	BETAGAN (levobunolol) BETOPTIC (betaxolol) ISTALOL (timolol) OCUPRESS (carteolol) OPTIPRANOLOL (metipranolol) TIMOPTIC (timolol)	
	CARBONIC ANHYDRASE INHIBITORS		
	AZOPT (brinzolamide) TRUSOPT (dorzolamide)		
	PROSTAGLANDIN ANALOGS		
	LUMIGAN (bimatoprost) TRAVATAN (travoprost)	RESCULA (unoprostone) XALATAN (latanoprost)	
	COMBINATION AGENTS		
	COSOPT (dorzolamide/timolol)	E-PILO-1 (pilocarpine/epinephrine)	

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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.
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 10/3/05*	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 PRILOSEC OTC (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)	

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STIMULANTS AND RELATED AGENTS *Implement 10/3/05*	**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 RITALIN LA (methylphenidate) STRATTERA (atomoxetine)	METADATE ER (methylphenidate) pemoline PROVIGIL (modafanil) RITALIN (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)	

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