BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST
(Classes Reviewed January 21, 2004)

PA-Prior Authorization

DRUG CLASS	PREFERRED	NON-PREFERRED	CRITERIA
BENIGN PROSTATIC HYPERPLASIA (BPH)/MICTURITION AGENTS *Implement 4/1/04*	doxazosin (Cardura)# tamsulosin (Flomax) terazosin (Hytrin)# finasteride (Proscar)	alfuzosin (Uroxatral) dutasteride (Avodart)	***PA Criteria: 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.*****
AMINOSALICYLATES FOR ULCERATIVE COLITIS *Implement 4/1/04*	balsalazide (Colazal) mesalamine (Asacol) mesalamine (Canasa) suppositories mesalamine (Rowasa) enemas olsalazine (Dipentum) sulfasalazine# sulfasalazine EC#	mesalamine (Pentasa)	***PA Criteria: The preferred agents, (one dosage form of each chemical entity), must be tried before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.***
ANTIDEPRESSANTS, SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs) *Implement 4/1/04*	citalopram (Celexa) fluoxetine (Prozac)# fluvoxamine (Luvox)# paroxetine (Paxil)# paroxetine CR (Paxil CR) sertraline (Zoloft) escitalopram (Lexapro)	fluoxetine ER (Prozac Weekly) fluoxetine (Sarafem) paroxetine suspension (Paxil)	***PA Criteria: 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/ANTIVERTIGO AGENTS *Implement 4/1/04*	**ANTIEMETIC** hydroxyzine# metoclopramide# ondansetron (Zofran)**(*Quantity limits still apply*)** ondansetron orally dissolving tablets (Zofran ODT) **(*Quantity limits still apply*)** prochlorperazine# promethazine# **ANTIVERTIGO** meclizine# scopolamine, oral (Scopace) scopolamine, transdermal (Transderm Scop)	**ANTIEMETIC** aprepitant (Emend) dolasetron (Anzemet) dronabinol (Marinol) granisetron (Kytril) thiethylperazine maleate (Torecan)	***PA Criteria: A trial of the preferred agents (with corresponding routes of administration and for appropriate diagnoses) is required before non-preferred agents will be approved, unless one of the exceptions on the PA form is present. For chemotherapy or radiation-induced nausea, a trial of Zofran is adequate for approval of the non-preferred 5 HT-3 agents.***

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ANTIINCONTINENCE AGENTS *Implement 4/1/04*	Oxybutynin (Ditropan)# Oxybutynin XL (Ditropan XL) Oxybutynin transdermal (Oxytrol) flavoxate (Urispas) tolterodine LA (Detrol LA)	tolterodine (Detrol)	***PA Criteria: All of the preferred agents in this category must be tried before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.***
CALCIUM CHANNEL BLOCKERS *Implement 4/1/04*	diltiazem (Cardizem)# diltiazem SR (Cardizem SR, Cardizem CD, Dilacor XR)# diltiazem LA (Cardizem LA) verapamil (Calan, Isoptin)# verapamil ER (Verelan PM) verapamil SR (Calan SR, Isoptin SR)# **<u>Dihydropyridines</u>** felodipine (Plendil) isradipine (Dynacirc) isradipine SR (Dynacirc CR) nifedipine SR (Adalat CC, Procardia XL)# nisoldipine (Sular)	verapamil ER (Covera-HS) verapamil SR (Verelan) diltiazem SR (Tiazac) **<u>Dihydropyridines</u>** nicardipine (IR) generic and brand nicardipine SR (Cardene SR) brand amlodipine (Norvasc) bepridil (Vascor) nifedipine (Adalat, Procardia) generic and brand nimodipine (Nimotop)	***PA Criteria: One of the preferred dosage forms must be tried before a non-preferred dosage form of the corresponding agent will be authorized.*** ***<u>Dihydropyridines</u>*** ***PA Criteria: 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.)***
LIPOTROPICS, OTHER *Implement 4/1/04*	cholestyramine (Questran)# cholestyramine light (Questran LIght)# colestipol (Colestid) fenofibrate (Tricor) gemfibrozil (Lopid)# niacin ER (Niaspan) niacin ER/lovastatin (Advicor) niacin#	colesevelam (WelChol) ezetimibe (Zetia) fenofibrate (Lofibra)	***PA Criteria: 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 available preferred agents agents. Zetia and Welchol will be approved for add-on therapy only after an insufficient response to the maximum tolerable dose of a statin for 12 weeks of therapy.***

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MACROLIDES *Implement 4/1/04*	azithromycin (Zithromax) clarithromycin (Biaxin) clarithromycin (Biaxin XL) erythromycin#	cinoxacin (Cinobac) dirithromycin (Dynabac) erythromycin estolate troleandomycin (Tao)	***PA Criteria: No non-preferred agents will be authorized, unless one of the exceptions on the PA form is present for all of the preferred agents.***
MULTIPLE SCLEROSIS AGENTS *Implement 4/1/04*	interferon beta-1a (Rebif)** interferon beta-1b (Betaseron)**	glatiramer (Copaxone) interferon beta-1a (Avonex)	***PA Criteria: Patients starting therapy in this class will be required to try the preferred agents, unless one of the exceptions on the PA form is present. Patients already on non-preferred agents will receive prior authorization for that agent for one year.***
CEPHALOSPORINS AND RELATED ANTIBIOTICS *Implement 4/1/04*	**First Generation** cefadroxil (Duricef)# cephalexin (Keflex)# cephradine (Velosef)# **Second Generation** cefaclor (Ceclor)# cefprozil (Cefzil) cefuroxime axetil (Ceftin)# **Third Generation** cefdinir (Omnicef) cefditoren pivoxil (Spectracef) cefpodoxime proxetil (Vantin) ceftibuten (Cedax) cefixime (Suprax) **Penicillin/Beta Lactamase Inhibitor** amoxicillin/clavulanate (Augmentin)# amoxicillin/clavulanate (Augmentin ES-600) amoxicillin/clavulanate (Augmentin XR)	**Second Generation** loracarbef (Lorabid)	***PA Criteria: 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.***

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INTERMITTENT CLAUDICATION AGENTS *Implement 4/1/04*	cilostazol (Pletal) pentoxifylline (Trental)#		
ESTROGEN AGENTS, COMBINATION *Implement 4/1/04*	17ß-estradiol/norethindrone acetate (Activella) 17ß-estradiol/norethindrone acetate (Combipatch) 17ß-estradiol/norgestimate (Prefest) conjugated estrogens/ medroxyprogesterone acetate (Premphase)	conjugatedestrogens/ medroxyprogesterone acetate (Prempro) ethinyl estradiol/norethindrone acetate (Femhrt)	***PA Criteria: The preferred agents must be tried, for at least 90 days, before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.***
ATOPIC DERMATITIS IMMUNE MODULATORS *Implement 4/1/04*	pimecrolimus (Elidel)	tacrolimus (Protopic)	***PA Criteria: The preferred agents must be tried, for at least 30 days, before a non-preferred agent will be authorized.***
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS) *Implement 4/1/04*	celecoxib (Celebrex)** diclofenac (Voltaren)# etodolac (Lodine) # flurbiprofen (Ansaid)# ibuprofen (Motrin)# indomethacin (Indocin)# ketoprofen (Oruvail)# ketorolac (Toradol)# meloxicam (Mobic)** naproxen (Naprosyn, Anaprox)# oxaprozin (Daypro)# piroxicam (Feldene)# rofecoxib (Vioxx)** sulindac (generic)# valdecoxib (Bextra)**	diclofenac/misoprostol (Arthrotec) meclofenamate # mefenamic acid (Ponstel) nabumetone (Relafen) brand and generic tolmetin (Tolectin) brand and generic	***PA Criteria: Non-preferred agents will only be approved after the preferred non-selective NSAIDS and the COX-II agents, when appropriate, have been tried unless one of the exceptions on the PA form is present.***
PLATELET AGGREGATION INHIBITORS *Implement 4/1/04*	aspirin (OTC)# aspirin/dipyridamole ER (Aggrenox) clopidogrel (Plavix) dipyridamole (Persantine)#	ticlopidine (Ticlid) brand and generic	***PA Criteria: The non-preferred agent will only be approved after a two-week trial of clopidogrel, when appropriate.****

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PROTON PUMP INHIBITORS *Implement 4/1/04*	Prilosec OTC pantoprazole (Protonix)**	esomeprazole (Nexium) omeprazole (Prilosec) brand and generic lansoprazole (Prevacid)(No PA required for children through 12 years of age.) rabeprazole (AcipHex)	***PA Criteria: Both of the preferred agents must be tried before an non-preferred agent will be approved, unless one of the exceptions on the PA form is present.***

\# Generic forms only.
* Status pending.
** Prior authorization required.
*** No prior authorization required for children through 8 years of age.
† Prior authorization required after limits exceeded.
++ Prior authorization required for adults > age 18 years.
<> New drug, not yet reviewed.