THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS, TOPICAL[AP]			
	ANTI-INFECTIVE		
	AKNE-MYCIN (erythromycin) AZELEX (azelaic acid) clindamycin erythromycin sodium sulfacetamide	ACZONE (dapsone) CLEOCIN-T (clindamycin) EVOCLIN (clindamycin) KLARON (sodium sulfacetamide)	Thirty (30) day trials each of one preferred retinoid and two unique chemical entities in two other subclasses, including the generic version of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. (In cases of pregnancy, a trial of retinoids will not be required.)
	RETINOIDS		
	RETIN A liquid & Micro (tretinoin) TAZORAC (tazarotene) tretinoin cream, gel	AVITA DIFFERIN (adapalene) RETIN-A cream, gel (tretinoin)	PA required after 17 years of age for tretinoin products.
	KERATOLYTICS (Benzoyl Peroxides)		
	benzoyl peroxide ETHEXDERM (benzoyl peroxide) OSCION (benzoyl peroxide)	BENZAC WASH (benzoyl peroxide) BREVOXYL (benzoyl peroxide) DESQUAM (benzoyl peroxide) LAVOCLEN (benzoyl peroxide) TRIAZ (benzoyl peroxide)	Acne kits are non-preferred.
	COMBINATION AGENTS		
	benzoyl peroxide/urea erythromycin/benzoyl peroxide sulfacetamide sodium/sulfur wash/cleanser	ACANYA (clindamycin phosphate/benzoyl peroxide) BENZACLIN GEL (benzoyl peroxide/ clindamycin) BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) benzoyl peroxide/clindamycin gel CLENIA (sulfacetamide sodium/sulfur)	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		DUAC CS (benzoyl peroxide/ clindamycin) EPIDUO (adapalene/benzoyl peroxide) INOVA 4/1 (benzoyl peroxide/salicylic acid) NUOX (benzoyl peroxide/sulfur) PLEXION (sulfacetamide sodium/sulfur) PRASCION (sulfacetamide sodium/sulfur) ROSAC (sulfacetamide sodium/avobenzone/sulfur) ROSADERM (sulfacetamide sodium/sulfur) ROSANIL (sulfacetamide sodium/sulfur) ROSULA (sulfacetamide sodium/sulfur/ urea) sulfacetamide sodium/sulfur lotion, gel, pad SULFOXYL (benzoyl peroxide/sulfur) SULFATOL (sulfacetamide sodium/sulfur/urea) ZIANA (clindamycin/tretinoin)	
ALZHEIMER'S AGENTS[AP]			
	CHOLINESTERASE INHIBITORS		A thirty (30) day trial of a preferred agent is required before a non-preferred agent In this class will be authorized unless one of the exceptions on the PA form is present.
	ARICEPT (donepezil) ARICEPT ODT(donepezil) EXELON (rivastigmine)	COGNEX (tacrine) galantamine galantamine ER RAZADYNE (galantamine) RAZADYNE ER (galantamine)	
	NMDA RECEPTOR ANTAGONIST		
	NAMENDA (memantine)		
ANALGESICS, NARCOTIC -SHORT ACTING (Non-parenteral)[AP]			
	APAP/codeine ASA/codeine codeine dihydrocodeine/ APAP/caffeine hydrocodone/APAP	ACTIQ (fentanyl) butalbital/APAP/caffeine/codeine butalbital/ASA/caffeine/codeine butorphanol COMBUNOX (oxycodone/ibuprofen)	Six (6) day trials of at least four (4) chemically distinct preferred agents (based on narcotic ingredient only), including the generic formulation of a requested non-preferred product, are

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	hydrocodone/ibuprofen hydromorphone levorphanol morphine oxycodone oxycodone/APAP oxycodone/ASA pentazocine/APAP pentazocine/naloxone propoxyphene/APAP ROXICET (oxycodone/acetaminophen) tramadol tramadol/APAP	DARVOCET (propoxyphene/APAP) DARVON (propoxyphene) DEMEROL (meperidine) DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) meperidine NUCYNTA (tapentadol) OPANA (oxymorphone) ONSOLIS (fentanyl) oxycodone/ibuprofen OXYFAST (oxycodone) OXYIR (oxycodone) PANLOR (dihydrocodeine/ APAP/caffeine) PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/ASA) propoxyphene ROXANOL (morphine) TALACEN (pentazocine/APAP) TALWIN NX (pentazocine/naloxone) TYLENOL W/CODEINE (APAP/codeine) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VICODIN (hydrocodone/APAP) VICOPROFEN (hydrocodone/ibuprofen) VOPAC (codeine/acetaminophen) XODOL (hydrocodone/acetaminophen) ZAMICET (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen) XOLOX (oxycodone/APAP)	required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Fentanyl lozenges and Onsolis will only be approved for a diagnosis of cancer and as an adjunct to a long-acting agent. Neither will be approved for monotherapy.* **Limits:** Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the narcotic analgesics are limited to 120 tablets per 30 days for the purpose of maximizing the use of longer acting medications to prevent unnecessary breakthrough pain in chronic pain therapy.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANALGESICS, NARCOTIC - LONG ACTING (Non-parenteral)[AP]			
	fentanyl transdermal KADIAN (morphine) 10mg, 20mg, 30mg, 50mg, 60mg, 100mg methadone morphine ER OPANA ER (oxymorphone)	AVINZA (morphine) DOLOPHINE (methadone) DURAGESIC (fentanyl) EMBEDA (morphine/naltrexone) KADIAN (morphine) 80mg, 200mg MS CONTIN (morphine) ORAMORPH SR (morphine) oxycodone ER OXYCONTIN (oxycodone) RYZOLT ER (tramadol) tramadol ER ULTRAM ER (tramadol)	Six (6) day trials each of a total of four (4) preferred narcotic analgesics, including at least one long-acting agent, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. The generic form of the requested non-preferred agent, if available, must be tried before the non-preferred agent will be approved. *Dose optimization is required for achieving equivalent doses of Kadian 80mg and 200mg. AP does not apply.* **Exception:** Oxycodone ER will be authorized if a diagnosis of cancer is submitted without a trial of the preferred agents.
ANALGESICS, TOPICAL[AP]			
	capsaicin lidocaine lidocaine/prilocaine xylocaine	EMLA (lidocaine/prilocaine) FLECTOR PATCH (diclofenac) LIDODERM PATCH (lidocaine) LIDAMANTLE (lidocaine) LIDAMANTLE HC (lidocaine/hydrocortisone) LMX 4 (lidocaine) SYNERA (lidocaine/tetracaine) VOLTAREN GEL (diclofenac) ZOSTRIX (capsaicin)	Ten (10) day trials of each of the preferred topical anesthetics (lidocaine, lidocaine/prilocaine, and xylocaine) are required before a non-preferred topical anesthetic will be approved unless one of the exceptions on the PA form is present. Lidoderm patches will be approved for a diagnosis of post-herpetic neuralgia. Thirty (30) day trials of each of the preferred oral NSAIDS and capsaicin are required before *Voltaren Gel will be approved unless one of the

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			exceptions on the PA form is present. Flector patches will be approved only for a diagnosis of acute strain, sprain or injury after a five (5) day trial of one of the preferred oral NSAIDs and for a maximum duration of 14 days unless one of the exceptions on the PA forms is present.
ANDROGENIC AGENTS			
	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 MODULATORS[AP]			
	ACE INHIBITORS		
	benazepril captopril enalapril fosinopril lisinopril quinapril ramipril	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) CAPOTEN (captopril) LOTENSIN (benazepril) MAVIK (trandolapril) moexipril MONOPRIL (fosinopril) perindopril PRINIVIL (lisinopril) trandolapril UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	Fourteen (14) day trials of each of the preferred agents in the corresponding group, with the exception of the Direct Renin Inhibitors, are required before a non-preferred agent 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 legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ACE INHIBITOR COMBINATION DRUGS		
	benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LEXXEL (enalapril/felodipine) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) moexipril/HCTZ MONOPRIL HCT (fosinopril/HCTZ) PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) UNIRETIC (moexipril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	
	ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
	AVAPRO (irbesartan) BENICAR (olmesartan) COZAAR (losartan) 25mg DIOVAN (valsartan) MICARDIS (telmisartan)	ATACAND (candesartan) COZAAR (losartan) 50mg, 100mg TEVETEN (eprosartan)	
	ARB COMBINATIONS		
	AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) DIOVAN-HCT (valsartan/HCTZ) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ)	ATACAND-HCT (candesartan/HCTZ) TEVETEN-HCT (eprosartan/HCTZ) TWYNSTA (telmisartan/amlodipine)[NR]	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	DIRECT RENIN INHIBITORS		
	TEKTURNA (aliskiren)[AP] TEKTURNA HCT (aliskiren/HCTZ) [AP] VALTURNA (aliskiren/valsartan)		A thirty (30) day trial of one of a preferred ACE, ARB, or combination agents, at the maximum tolerable dose, is required before Tekturna will be approved. Valturna will be authorized for patients who have met the criteria for Tekturna and who are also being prescribed valsartan
ANTICOAGULANTS, INJECTABLE[CL]			
	ARIXTRA (fondaparinux) FRAGMIN (dalteparin) LOVENOX (enoxaparin)	INNOHEP (tinzaparin)	Trials 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.
ANTICONVULSANTS			
	ADJUVANTS		
	carbamazepine CARBATROL (carbamazepine) DEPAKOTE SPRINKLE (divalproex) divalproex EC divalproex ER divalproex DR EPITOL (carbamazepine) FELBATOL (felbamate) gabapentin GABITRIL (tiagabine) KEPPRA XR (levetiracetam)[AP] levetiracetam lamotrigine lamotrigine chewable LYRICA (pregabalin) oxcarbazepine tablets	BANZEL(rufinamide) carbamazepine XR DEPAKENE (valproic acid) DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) EQUETRO (carbamazepine) KEPPRA (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) NEURONTIN (gabapentin) SABRIL (vigabatrin) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL XR (carbamazepine)	A fourteen (14) day trial of one of the preferred agents in the corresponding group is required for treatment naïve patients with a diagnosis of a seizure disorder before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. A thirty (30) day trial of one of the preferred agents in the corresponding group is required for patients with a diagnosis other than seizure disorders unless one of the exceptions on the PA form is present. Non-preferred anticonvulsants will be

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	topiramate TRILEPTAL SUSPENSION (oxcarbazepine) valproic acid zonisamide	TOPAMAX (topiramate) TRILEPTAL TABLETS (oxcarbazepine) VIMPAT (lacosamide) ZONEGRAN (zonisamide)	approved for patients on established therapies with a diagnosis of seizure disorders with no trials of preferred agents required. In situations where AB-rated generic equivalent products are available, "Brand Medically Necessary" must be hand-written by the prescriber on the prescription in order for the brand name product to be reimbursed.
	BARBITURATES[AP]		
	mephobarbital phenobarbital primidone	MEBARAL (mephobarbital) MYSOLINE (primidone)	
	BENZODIAZEPINES[AP]		
	clonazepam DIASTAT (diazepam rectal) diazepam	KLONOPIN (clonazepam)	
	HYDANTOINS[AP]		
	DILANTIN INFATABS (phenytoin) PEGANONE (ethotoin) phenytoin	CEREBYX (fosphenytoin) DILANTIN (phenytoin) PHENYTEK (phenytoin)	
	SUCCINIMIDES		
	CELONTIN (methsuximide) ethosuximide ZARONTIN (ethosuximide)		

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIDEPRESSANTS, OTHER			
	SNRIS[AP]		
	CYMBALTA (duloxetine) VENLAFAXINE ER (venlafaxine)	EFFEXOR (venlafaxine) EFFEXOR XR (venlafaxine) PRISTIQ (desvenlafaxine) venlafaxine	A six (6) week trial each of a preferred agent and an SSRI is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	SECOND GENERATION NON-SSRI, OTHER[AP]		
	bupropion SR bupropion XL mirtazapine SAVELLA (milnacipran)[AP*] trazodone	APLENZIN (bupropion hbr) bupropion IR DESYREL (trazodone) EMSAM (selegiline) REMERON (mirtazapine) nefazodone WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion)	* Savella will be approved for a diagnosis of fibromyalgia or a previous thirty (30) day trial of a drug that infers fibromyalgia: gabapentin, Cymbalta, Lyrica, amitriptyline or nortriptyline.
	SELECTED TCAs		
	imipramine hcl	imipramine pamoate TOFRANIL (imipramine hcl) TOFRANIL PM (imipramine pamoate)	A twelve (12) week trial of imipramine hcl is required before a non-preferred TCA will be authorized.
ANTIDEPRESSANTS, SSRIs[AP]			
	citalopram fluoxetine fluvoxamine LEXAPRO (escitalopram) paroxetine sertraline	CELEXA (citalopram) LUVOX (fluvoxamine) LUVOX CR (fluvoxamine) PAXIL (paroxetine) PAXIL CR (paroxetine) paroxetine ER PEXEVA (paroxetine) PROZAC (fluoxetine) RAPIFLUX (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	Thirty (30) day trials each of two (2) of the preferred agents are required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. Upon hospital discharge, patients admitted with a primary mental health diagnosis and have been stabilized on a non-preferred SSRI will receive an authorization to continue that drug.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIEMETICS[AP]			
	5HT3 RECEPTOR BLOCKERS		
	ondansetron ondansetron ODT	ANZEMET (dolasetron) KYTRIL (granisetron) granisetron SANCUSO (granisetron) ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron)	A 3-day trial of a preferred agent is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. PA is required for all agents when limits are exceeded.
	CANNABINOIDS		
		CESAMET (nabilone) MARINOL (dronabinol)	Cesamet will be authorized only for the treatment of nausea and vomiting associated with cancer chemotherapy for patients who have failed to respond adequately to 3-day trials of conventional treatments such as promethazine or ondansetron and are over 18 years of age. Marinol will be authorized only for the treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol; or for the prophylaxis of chemotherapy induced nausea and vomiting unresponsive to 3-day trials of ondansetron or promethazine for patients between the ages of 18 and 65.
	SUBSTANCE P ANTAGONISTS		
	EMEND (aprepitant)		

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIFUNGALS, ORAL			
	clotrimazole fluconazole* ketoconazole [CL] nystatin terbinafine [CL]	ANCOBON (flucytosine) DIFLUCAN (fluconazole) GRIFULVIN V TABLET (griseofulvin) griseofulvin GRIS-PEG (griseofulvin) itraconazole LAMISIL (terbinafine) MYCELEX (clotrimazole) MYCOSTATIN Tablets (nystatin) NIZORAL (ketoconazole) NOXAFIL (posaconazole) 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 griseofulvin suspension for children up to 6 years of age for the treatment of tinea capitis.
ANTIFUNGALS, TOPICAL [AP]			
	ANTIFUNGALS		
	econazole ketoconazole MENTAX (butenafine) NAFTIN (naftifine) nystatin	ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole) LOPROX (ciclopirox) MYCOSTATIN (nystatin) NIZORAL (ketoconazole) OXISTAT (oxiconazole) PENLAC (ciclopirox) SPECTAZOLE (econazole) VUSION (miconazole/petrolatum/zinc oxide) XOLEGEL (ketoconazole)	Fourteen (14) day trials of two (2) of the preferred agents are required before one of the non-preferred agents will be authorized unless one of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one preferred product (ketoconazole shampoo) is required.) Oxistat cream will be approved for children 12 and under for tinea corporis, tinea cruris, tinea pedis, and tinea (pityriasis) versicolor.
	ANTIFUNGAL/STEROID COMBINATIONS		
	clotrimazole/betamethasone nystatin/triamcinolone	LOTRISONE (clotrimazole/betamethasone) [AP] MYCOLOG (nystatin/triamcinolone) [AP]	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIHISTAMINES, MINIMALLY SEDATING[AP]			
	ANTIHISTAMINES		Thirty (30) day trials of at least two (2) chemically distinct preferred agents (in the age appropriate form), including the generic formulation of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	ALAVERT (loratadine) cetirizine loratadine TAVIST-ND (loratadine)	ALLEGRA (fexofenadine) CLARINEX Tablets (desloratadine) CLARINEX REDITABS (desloratadine) CLARINEX Syrup (desloratadine) CLARITIN (loratadine) fexofenadine XYZAL (levocetirizine) ZYRTEC (Rx and OTC) (cetirizine) ZYRTEC SYRUP (cetirizine)	
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
	ALAVERT-D (loratadine/pseudoephedrine) cetirizine/pseudoephedrine loratadine/pseudoephedrine SEMPREX-D (acrivastine/ pseudoephedrine)	ALLEGRA-D (fexofenadine/ pseudoephedrine) CLARINEX-D (desloratadine/ pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) ZYRTEC-D (cetirizine/pseudoephedrine)	
ANTIMIGRAINE AGENTS, TRIPTANS[AP]			
	TRIPTANS		Three (3) day trials of each unique chemical entity of the preferred agents are required 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. *AP does not apply to nasal spray or injectable sumatriptan.
	IMITREX NASAL SPRAY(sumatriptan) IMITREX INJECTION (sumatriptan)[CL] MAXALT MLT (rizatriptan) sumatriptan	AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX tablets (sumatriptan) MAXALT (rizatriptan) RELPAX (eletriptan) sumatriptan nasal spray/injection* ZOMIG (zolmitriptan)	
	TRIPTAN COMBINATIONS		
		TREXIMET (sumatriptan/naproxen sodium)	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIPARKINSON'S AGENTS (Oral)			
	ANTICHOLINERGICS		Patients starting therapy on drugs in this class must show a documented allergy to all of the preferred agents, in the corresponding class, before a non-preferred agent will be authorized.
	benztropine KEMADRIN (procyclidine) trihexyphenidyl	COGENTIN (benztropine)	
	COMT INHIBITORS		
		COMTAN (entacapone) TASMAR (tolcapone)	
	DOPAMINE AGONISTS		Mirapex, Requip, and Requip XL will be approved for a diagnosis of Parkinsonism with no trials of preferred agents required.
	ropinirole	MIRAPEX (pramipexole) pramipexole REQUIP (ropinirole) REQUIP XL (ropinirole)	
	OTHER ANTIPARKINSON'S AGENTS		
	amantadine[AP] bromocriptine carbidopa/levodopa selegiline STALEVO (levodopa/carbidopa/entacapone)	AZILECT (rasagiline) ELDEPRYL (selegiline) levodopa/carbidopa ODT PARCOPA (levodopa/carbidopa) SINEMET (levodopa/carbidopa) SYMMETREL (amantadine) ZELAPAR (selegiline)	
ANTIPSYCHOTICS, ATYPICAL (Oral)			
	ORAL		A fourteen (14) day trial of a preferred agent is required for treatment naïve patients before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. Upon discharge,
	clozapine GEODON (ziprasidone) INVEGA (paliperidone) RISPERDAL ODT (risperidone) risperidone risperidone solution	ABILIFY (aripiprazole) CLOZARIL (clozapine) FANAPT (iloperidone)[NR] FAZACLO (clozapine) RISPERDAL (risperidone) RISPERDAL SOLUTION (risperidone)	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	SEROQUEL (quetiapine) SEROQUEL XR (quetiapine)	risperidone ODT SAPHRIS (asenapine) ZYPREXA (olanzapine)	a hospitalized patient stabilized on a non-preferred agent may receive authorization to continue this drug for labeled indications and at recommended dosages. Claims for Seroquel 25 mg will be approved: 1. for a diagnosis of schizophrenia or 2. for a diagnosis of bipolar disorder or 3. when prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels. Seroquel 25 mg. will not be approved for use as a sedative hypnotic. Abilify will be approved for children between the ages of 6-17 for irritability associated with autism. Abilify will be prior authorized for MDD if the following criteria are met: 1. The patient is at least 18 years of age. 2. Diagnosis of Major Depressive Disorder (MDD), 3. Evidence of trials of appropriate therapeutic duration (30 days), at the maximum tolerable dose, of at least one agent in two of the following classes: SSRI, SNRI or bupropion in conjunction with Seroquel XR or Seroquel at

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			doses of 150 mg* or more 4. Prescribed in conjunction with an SSRI, SNRI, or bupropion 5. The daily dose does not exceed 15 mg. *The FDA indicated dosage for Seroquel XR as an add-on for Major Depressive Disorder is 150-300 mg.
	ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
		SYMBYAX (olanzapine/fluoxetine)	
ANTIVIRALS (Oral)			
	ANTI HERPES		
	acyclovir VALTREX (valacyclovir)	famciclovir FAMVIR (famciclovir) valacyclovir ZOVIRAX (acyclovir)	Five (5) day trials each of the preferred agents are required before the non-preferred agents will be authorized unless one of the exceptions on the PA form is present.
	ANTI INFLUENZA		
	RELENZA (zanamivir) TAMIFLU (oseltamivir)	FLUMADINE (rimantadine) rimantadine SYMMETREL (amantadine) amantadine[AP]	The anti influenza agents will be approved only for a diagnosis of influenza.
ATOPIC DERMATITIS			
	ELIDEL (pimecrolimus) PROTOPIC (tacrolimus)		

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BETA BLOCKERS (Oral) & Miscellaneous Antianginals (Oral)[AP]			
	BETA BLOCKERS		
	acebutolol atenolol betaxolol bisoprolol metoprolol metoprolol ER nadolol pindolol propranolol propranolol ER sotalol timolol TOPROL XL (metoprolol)	BETAPACE (sotalol) BLOCADREN (timolol) BYSTOLIC (nebivolol) CARTROL (carteolol) CORGARD (nadolol) INDERAL LA (propranolol) INNOPRAN XL (propranolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) TENORMIN (atenolol) ZEBETA (bisoprolol)	Fourteen (14) day trials each of three (3) chemically distinct preferred agents, including the generic formulation of a requested non-preferred product, are required before one of the non-preferred agents will be approved unless one of the exceptions on the PA form is present.
	BETA BLOCKER/DIURETIC COMBINATION DRUGS		
	atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) INDERIDE (propranolol/HCTZ) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
	BETA- AND ALPHA-BLOCKERS		
	carvedilol labetalol	COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	
	ANTIANGINALS		
	RANEXA (ranolazine)[AP]		Ranexa will be approved for patients with angina who are also taking a calcium channel blocker, a beta blocker, or a nitrite as single agents or a combination agent containing one of these ingredients.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BLADDER RELAXANT PREPARATIONS[AP]			
	DETROL LA (tolterodine) ENABLEX (darifenacin) oxybutynin oxybutynin ER SANCTURA (trospium) SANCTURA XR (trospium) VESICARE (solifenacin)	DETROL (tolterodine) DITROPAN (oxybutynin) DITROPAN XL (oxybutynin) GELNIQUE (oxybutynin) OXYTROL (oxybutynin) TOVIAZ (fesoterodine)	A thirty (30) day trial each of the chemically distinct preferred agents is required 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			
	BISPHOSPHONATES		
	alendronate	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/ calcium) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D)	A 30-day trial of the preferred agent is required before a non-preferred agent will be approved.
	OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
	MIACALCIN (calcitonin)	calcitonin EVISTA (raloxifene) FORTEO (teriparatide) FORTICAL (calcitonin)	Evista will be approved for postmenopausal women with osteoporosis or at high risk for invasive breast cancer.
BPH AGENTS[AP]			
	5-ALPHA-REDUCTASE (5AR) INHIBITORS		
	AVODART (dutasteride) finasteride	PROSCAR (finasteride)	Thirty (30) day trials each of at least two (2) chemically distinct preferred agents, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent 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 legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ALPHA BLOCKERS		
	doxazosin FLOMAX (tamsulosin) terazosin UROXATRAL (alfuzosin)	CARDURA (doxazosin) CARDURA XL (doxazosin) HYTRIN (terazosin) RAPAFLO (silodosin)	
BRONCHODILATORS, ANTICHOLINERGIC			
	ANTICHOLINERGIC		
	ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)		Thirty (30) day trials each of the preferred agents in the corresponding group are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS		
	COMBIVENT (albuterol/ipratropium)	albuterol/ipratropium DUONEB (albuterol/ipratropium)	For severely compromised patients, albuterol/ipratropium will be approved if the combined volume of albuterol and ipratropium nebules is inhibitory.
BRONCHODILATORS, BETA AGONIST[AP]			
	INHALATION SOLUTION		
	albuterol 2.5mg/0.5mL	ACCUNEB (albuterol)** albuterol 0.63mg & 1.25mg/3mL[AP] BROVANA (arformoterol) levalbuterol metaproterenol PERFOROMIST (formoterol) PROVENTIL (albuterol) XOPENEX (levalbuterol)	Thirty (30) day trials each of the chemically distinct preferred agents in their corresponding groups are required before a non-preferred agent in that group will be authorized unless one of the exceptions on the PA form is present. **No PA is required for ACCUNEB for children up to 5 years of age.
	INHALERS, LONG-ACTING		
	FORADIL (formoterol) SEREVENT (salmeterol)		

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	INHALERS, SHORT-ACTING		
	MAXAIR (pirbuterol) PROAIR HFA (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	ALUPENT (metaproterenol) PROVENTIL (albuterol) XOPENEX HFA (levalbuterol)	Xopenex Inhalation 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 concurrent diagnosis of heart disease.
	ORAL		
	albuterol terbutaline	BRETHINE (terbutaline) metaproterenol VOSPIRE ER (albuterol)	
CALCIUM CHANNEL BLOCKERS[AP]			
	LONG-ACTING		
	amlodipine diltiazem XR, XT felodipine ER nifedipine ER nisoldipine verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD, LA, SR (diltiazem) COVERA-HS (verapamil) DILACOR XR (diltiazem) DYNACIRC CR (isradipine) ISOPTIN SR (verapamil) NORVASC (amlodipine) PLENDIL (felodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) VERELAN/VERELAN PM (verapamil)	Fourteen (14) day trials each of the preferred agents are required before a non-preferred agent will be approved 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 legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	SHORT-ACTING		
	diltiazem verapamil	ADALAT (nifedipine) CALAN (verapamil) CARDENE (nicardipine) CARDIZEM (diltiazem) DYNACIRC (isradipine) isradipine nicardipine nimodipine nifedipine NIMOTOP (nimodipine) PROCARDIA (nifedipine)	
CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)[AP]			
	BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		
	amoxicillin/clavulanate	AUGMENTIN XR (amoxicillin/clavulanate) MOXATAG (amoxicillin)	Five (5) day trials each of the preferred agents required before a non-preferred agent is authorized unless one of the exceptions on the PA form is present.
	CEPHALOSPORINS		
	cefaclor cefadroxil cefdinir cefditoren cefpodoxime cefprozil cefuroxime cephalexin SPECTRACEF (cefditoren)	CECLOR (cefaclor) CEDAX (ceftibuten) CEFTIN (cefuroxime) CEFZIL (cefprozil) DURICEF (cefadroxil) KEFLEX (cephalexin) OMNICEF (cefdinir) PANIXINE (cephalexin) RANICLOR (cefaclor) SUPRAX (cefixime) VANTIN (cefpodoxime)	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
COUGH & COLD/1ST GENERATION ANTIHISTAMINES			
	ANTIHISTAMINES, 1ST GENERATION		
	chlorpheniramine maleate clemastine cyproheptadine diphenhydramine promethazine	brompheniramine maleate brompheniramine tannate BROVEX (brompheniramine tannate) carbinoxamine maleate LODRANE (brompheniramine maleate and tannate) LOHIST (brompheniramine maleate) PALGIC (carbinoxamine maleate) TANACOF (brompheniramine tannate) TANAHIST-PD (chorpheniramine tannate)	See posted list of covered NDCs.
	ANTITUSSIVE-ANTIHISTAMINE COMBINATIONS		
	codeine/promethazine dextromethorphan HBR/promethazine		
	ANTIHISTAMINE-ANTITUSSIVE-DECONGESTANT COMBINATIONS		
	brompheniramine/dextromethorphan HBR/pseudoephedrine chlorpheniramine/dextromethorphan/ pseudoephedrine promethazine/codeine/phenylephrine		
	ANTITUSSIVE-DECONGESTANT COMBINATIONS		
		MUCINEX-D (guaifenesin/pseudoephedrine)	
	DECONGESTANTS		
	phenylephrine pseudoephedrine	NASOP (phenylephrine)	See posted list of covered NDCs.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ANTITUSSIVES/EXPECTORANTS		
	benzonatate guaifenesin guaifenesin/dextromethorphan	MUCINEX (guaifenesin) MUCINEX-DM (guaifenesin/dextromethorphan) TESSALON (benzonatate)	
	DECONGESTANT-ANTIHISTAMINE-ANTICHOLINERGIC COMBINATIONS		
	phenylephrine/chlorpheniramine/ scopolamine	DURAHIST (pseudoephedrine/chlorpheniramine/ methscopolamine) EXTENDRYL CHW /JR TAB (phenylephrine/chlorpheniramine/ scopolamine) EXTENDRYL SOL (phenylephrine/dexchlorpheniramine/ methscopolamine) NOHIST-PLUS (phenylephrine/ chlorpheniramine/methscopolamine) phenylephrine/chlorpheniramine/ methscopolamine pseudoephedrine/chlorpheniramine/ methscopolamine phenylephrine/dexchlorpheniramine/ methscopolamine RE-DRYLEX JR (phenylephrine/ chlorpheniramine/scopolamine) RE-DRYLEX SYRUP (phenylephrine/dexchlorpheniramine/ methscopolamine) SCOPOHIST (pseudoephedrine/ chlorpheniramine/methscopolamine)	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	DECONGESTANT-ANTIHISTAMINE COMBINATIONS		
	phenylephrine HCL/chlorpheniramine maleate phenylephrine HCL/phenyltoloxamine/ chlorpheniramine phenylephrine HCL/promethazine phenylephrine HCL/pyrilamine maleate/chlorpheniramine phenylephrine tannate/diphenhydramine tannate phenylephrine tannate/pyrilamine tannate/chlorpheniramine suspension pseudoephedrine/brompheniramine pseudoephedrine/chlorpheniramine	BROVEX-D (phenylephrine/ brompheniramine) CHLOR-TAN SUSP (phenylephrine tannate/pyrilamine tannate/ chlorpheniramine) DURATUSS DA (pseudoephedrine/chlorpheniramine) DYTAN-D CHW/SUSP (phenylephrine tannate/diphenhydramine tannate) LODRANE 12D/24D//D (pseudoephedrine/brompheniramine) LOHIST 12D/PD (pseudoephedrine/brompheniramine) LOHIST-D (pseudoephedrine/chlorpheniramine) NALEX-A LIQUID/SUSPENSION (phenylephrine/phenyltoloxamine/ chlorpheniramine) phenylephrine/brompheniramine phenylephrine tannate/chlorpheniramine tannate POLY HIST FORTE/PD (phenylephrine/ pyrilamine/chlorpheniramine) RONDEC (phenylephrine/chlorpheniramine) RU-HIST FORTE (phenylephrine/pyrilamine/ chlorpheniramine) RYNATAN (phenylephrine/chlorpheniramine) SUDAL 12 (pseudoephedrine/chlorpheniramine) TANNATE PED SUSP (phenylephrine/chlorpheniramine)	See posted list of covered NDCs.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	NARCOTIC ANTITUSSIVE-EXPECTORANT COMBINATION		
	guaifenesin/codeine		Guaifenesin/codeine will only be approved for children ≤ 12 years old.
CYTOKINE & CAM ANTAGONISTS[CL]			
	CIMZIA (certolizumab/pegol) ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra)	ACTEMRA (tocilizumab)[NR] SIMPONI (golimumab) STELARA (ustekinumab)[NR]	Thirty day trials of each of the preferred agents are required before a non-preferred agent will be approved.
ERYTHROPOIESIS STIMULATING PROTEINS[CL]			
	PROCRIT (rHuEPO)	ARANESP (darbepoetin) EPOGEN (rHuEPO)	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
FLUOROQUINOLONES, ORAL[AP]			
	AVELOX (moxifloxacin) CIPRO (ciprofloxacin) Suspension ciprofloxacin ciprofloxacin ER LEVAQUIN (levofloxacin)	CIPRO (ciprofloxacin) Tablets CIPRO XR (ciprofloxacin) FACTIVE (gemifloxacin) FLOXIN (ofloxacin) NOROXIN (norfloxacin) ofloxacin PROQUIN XR (ciprofloxacin)	A five (5) day trial of one of the preferred agents is required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.
GENITAL WARTS AGENTS[AP]			
	ALDARA (imiquimod)	CONDYLOX (podofilox) podofilox VEREGEN (sinecatechins)	A thirty (30) day trial of the preferred agent is required before a non-preferred agent 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 legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
GLUCOCORTICOIDS, INHALED[AP]			
	GLUCOCORTICOIDS		
	AEROBID (flunisolide) AEROBID-M (flunisolide) ASMANEX (mometasone) AZMACORT (triamcinolone) FLOVENT HFA (fluticasone) FLOVENT Diskus (fluticasone) QVAR (beclomethasone)	ALVESCO (ciclesonide) budesonide PULMICORT (budesonide)*	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent 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. When children who have been stabilized on Pulmicort Respules reach age 9, prescriptions for the Pulmicort inhaler will be authorized for them. *For children less than 9 years of age and for those who meet the PA requirements, brand Pulmicort is preferred over the generic.
	GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
	ADVAIR (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) SYMBICORT(budesonide/formoterol)		
GROWTH HORMONE[CL]			
	GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN (somatropin) NUTROPIN AQ (somatropin)	HUMATROPE (somatropin) INCRELEX (mecasermin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin) ZORBTIVE (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. Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HEPATITIS B TREATMENTS			
	EPIVIR HBV (lamivudine) HEPSERA (adefovir) TYZEKA (telbivudine)	BARACLUDE (entecavir)	A thirty (30) day trial of one of the preferred agents is required before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
HEPATITIS C TREATMENTS[CL]			
	PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) ribavirin	COPEGUS (ribavirin) INFERGEN (consensus interferon) REBETOL (ribavirin) RIBAPAK DOSEPACK (ribavirin) RIBASPHERE (ribavirin)	Patients starting therapy in this class must try the preferred agent of a dosage form before a non-preferred agent of that dosage form will be authorized.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS			
	Injectable		
		BYETTA (exenatide) SYMLIN (pramlintide) VICTOZA (liraglutide)[NR]	Byetta and Symlin will be subject to the following clinical edits: Byetta will be approved with a previous history of a thirty (30) day trial of an oral agent (sulfonylurea, thiazolindinedione (TZD) and/ or metformin) and no evidence of concurrent insulin therapy. Symlin- History of insulin utilization in the past 90 days. No gaps in insulin therapy greater than 30 days.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	Oral[AP]		
	JANUMET (sitagliptin/metformin) JANUVIA (sitagliptin) ONGLYZA (saxagliptin)		Januvia/Janumet, and Onglyza will be subject to the following clinical edits: 1. Previous history of a 30-day trial of an oral agent (sulfonylurea, thiazolindinedione (TZD) or metformin) **and** 2. No evidence of concurrent insulin therapy.
HYPOGLYCEMICS, INSULINS			
	HUMALOG (insulin lispro) vials only HUMALOG MIX (insulin lispro/lispro protamine) vials only HUMULIN (insulin) vials only LANTUS (insulin glargine) all forms LEVEMIR (insulin detemir) all forms NOVOLIN (insulin) all forms NOVOLOG (insulin aspart) all forms NOVOLOG MIX all forms (insulin aspart/aspart protamine)	APIDRA (insulin glulisine)[AP] HUMALOG PEN/KWIKPEN (insulin lispro) HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMULIN PEN (insulin)	To receive Apidra, patients must meet the following criteria: 1. be 4 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 Humalog, with documentation that the desired results were not achieved. Current prescriptions for Humalog Pens and cartridges, Humalog Kwikpens, Humalog Mix Pens, and Humulin Pens will be grandfathered.
HYPOGLYCEMICS, MEGLITINIDES			
	STARLIX (nateglinide)	nateglinide PRANDIN (repaglinide)[AP] repaglinid[AP]	A thirty (30) day trial of the preferred agent is required before a non-preferred agent 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 legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMICS, TZDS			
	THIAZOLIDINEDIONES		
	ACTOS 15mg (pioglitazone)	ACTOS 30mg, 45mg (pioglitazone) AVANDIA (rosiglitazone)[AP]	Dose optimization of Actos 15mg tablets is required for achieving equivalent doses of Actos 30mg and 45mg. Prescriptions for Avandia and combination agents containing Avandia will be grandfathered for patients on established therapy with a prior trial of Actos or having a diagnosis of CHF. Treatment naïve patients require a two (2) week trial of Actos15mg before Avandia will be authorized, unless one of the exceptions on the PA form is present.
	TZD COMBINATIONS		
		ACTOPLUS MET (pioglitazone/ metformin) AVANDAMET (rosiglitazone/metformin)[AP] AVANDARYL (rosiglitazone/glimepiride)[AP] DUETACT (pioglitazone/glimepiride)	Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis.
IMPETIGO AGENTS, TOPICAL			
	bacitracin gentamicin sulfate mupirocin	ALTABAX (retapamulin) BACTROBAN (mupirocin) CORTISPORIN (bacitracin/neomycin/ polymyxin/HC)	Ten (10) day trials of at least one preferred agent, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent 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 legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
INTRANASAL RHINITIS AGENTS[AP]			
	ANTICHOLINERGICS		
		ATROVENT(ipratropium) ipratropium	Thirty (30) day trials of one preferred agent in the antihistamine and corticosteroid groups are required before an anti-cholinergic agent will be approved unless one of the exceptions on the PA form is present.
	ANTIHISTAMINES		
	ASTELIN (azelastine)	ASTEPRO (azelastine) PATANASE (olopatadine)	Thirty (30) day trials of both preferred intranasal antihistamines and a thirty (30) day trial of one of the preferred intranasal corticosteroids are required before the non-preferred agent will be approved unless one of the exceptions on the PA form is present.
	CORTICOSTEROIDS		
	fluticasone propionate NASACORT AQ (triamcinolone) NASONEX (mometasone)	BECONASE AQ (beclomethasone) flunisolide FLONASE (fluticasone propionate) NASALIDE (flunisolide) NASAREL (flunisolide) OMNARIS (ciclesonide) RHINOCORT AQUA (budesonide) VERAMYST (fluticasone furoate)	Thirty (30) day trials of each preferred agent in the corticosteroid group are required before a non-preferred corticosteroid agent will be authorized unless one of the exceptions on the PA form is present. Veramyst will be approved for children under 12 years of age.
LEUKOTRIENE MODIFIERS			
	ACCOLATE (zafirlukast) SINGULAIR (montelukast)	ZYFLO (zileuton)	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent 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 legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LIPOTROPICS, OTHER (non-statins)[AP]			
	BILE ACID SEQUESTRANTS		
	cholestyramine colestipol	COLESTID (colestipol) QUESTRAN (cholestyramine) WELCHOL (colesevelam)	A twelve (12) week trial of one of the preferred agents is required before a non-preferred agent in the corresponding category will be authorized. Zetia, as monotherapy, will only be approved for patients who cannot take statins or other preferred agents. AP does not apply. 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.
	CHOLESTEROL ABSORPTION INHIBITORS		
		ZETIA (ezetimibe)	Zetia 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. AP does not apply.
	FATTY ACIDS		
	LOVAZA (omega-3-acid ethyl esters)[AP]		Lovaza will be approved when the patient is intolerant or not responsive to, or not a candidate for nicotinic acid or fibrate therapy.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	FIBRIC ACID DERIVATIVES		
	fenofibrate gemfibrozil TRICOR (fenofibrate) TRILIPIX (fenofibric acid)	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRIGLIDE (fenofibrate)	
	NIACIN		
	niacin NIASPAN (niacin)	NIACELS (niacin) NIACOR (niacin) NIADELAY (niacin) SLO-NIACIN (niacin)	
LIPOTROPICS, STATINS[AP]			
	STATINS		
	CRESTOR (rosuvastatin) LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) lovastatin pravastatin simvastatin	ALTOPREV (lovastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin)	Twelve (12) week trials each of two (2) of the preferred statins, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	STATIN COMBINATIONS		
	ADVICOR (lovastatin/niacin) CADUET (atorvastatin/amlodipine) SIMCOR (simvastatin/niacin ER)	VYTORIN (simvastatin/ ezetimibe)	Vytorin will be approved only after an insufficient response to the maximum tolerable dose of Lipitor (atorvastatin) or Crestor (rosuvastatin) after 12 weeks, 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 legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MACROLIDES/KETOLIDES (Oral)			
	KETOLIDES		
		KETEK (telithromycin)	Requests for telithromycin will be authorized if there is documentation of the use of any antibiotic within the past 28 days.
	MACROLIDES		
	azithromycin clarithromycin erythromycin	BIAXIN (clarithromycin) BIAXIN XL (clarithromycin) clarithromycin ER 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 (azithromycin)	Five (5) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
MULTIPLE SCLEROSIS AGENTS[CL, AP]			
	AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE (glatiramer) REBIF (interferon beta-1a)	AMPYRA ER (dalfampridine)[NR] EXTAVIA (interferon beta-1b) TYSABRI (natalizumab)	A 30-day trial of a preferred agent will be required before a non-preferred agent will be approved. Tysabri will only be approved for members who are enrolled in the TOUCH Prescribing Program. AP does not apply.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MUSCLE RELAXANTS, ORAL[AP]			
	ACUTE MUSCULOSKELETAL RELAXANT AGENTS		
	chlorzoxazone cyclobenzaprine methocarbamol	AMRIX (cyclobenzaprine) carisoprodol carisoprodol/ASA carisoprodol/ASA/codeine FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) methocarbamol/ASA orphenadrine orphenadrine/ASA/caffeine PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) SOMA COMPOUND (carisoprodol /ASA) SOMA COMP w/ COD (carisoprodol/ASA/ codeine)	Thirty (30) day trials of the preferred acute musculoskeletal relaxants are required before a non-preferred acute musculoskeletal agent will be approved, with the exception of carisoprodol. Thirty (30) day trials of the preferred acute musculoskeletal relaxants and Skelaxin are required before carisoprodol will be approved.
	MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY		
	baclofen dantrolene tizanidine	DANTRIUM (dantrolene) ZANAFLEX (tizanidine)	Thirty (30) day trials of the preferred skeletal muscle relaxants associated with the treatment of spasticity (are required before non-preferred agents will be approved unless one of the exceptions on the PA form is present.
NSAIDS[AP]			
	NON-SELECTIVE		
	diclofenac etodolac fenoprofen flurbiprofen ibuprofen (Rx and OTC) INDOCIN (indomethacin) (suspension only) indomethacin	ADVIL (ibuprofen) ANAPROX (naproxen) ANSAID (flurbiprofen) CAMBIA (diclofenac) CATAFLAM (diclofenac) CLINORIL (sulindac) DAYPRO (oxaprozin)	Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent 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 legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ketorolac naproxen (Rx only) oxaprozin piroxicam sulindac	FELDENE (piroxicam) INDOCIN (indomethacin) ketoprofen ketoprofen ER LODINE (etodolac) meclofenamate mefenamic acid MOTRIN (ibuprofen) nabumetone NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) NUPRIN (ibuprofen) ORUDIS (ketoprofen) PONSTEL (meclofenamate) tolmetin VOLTAREN (diclofenac) ZIPSOR (diclofenac potassium)	
	NSAID/GI PROTECTANT COMBINATIONS		
		ARTHROTEC (diclofenac/misoprostol) PREVACID/NAPRAPAC (naproxen/ lansoprazole)	
	COX-II SELECTIVE		
	CELEBREX (celecoxib) [CL] meloxicam	MOBIC (meloxicam)	Celebrex will be approved for patients with a GI Risk Score of ≥13. AP does not apply.
OPHTHALMIC ANTIBIOTICS[AP]			
	ciprofloxacin ofloxacin VIGAMOX (moxifloxacin) ZYMAR (gatifloxacin)	AZASITE (azithromycin) BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) OCUFLOX (ofloxacin) QUIXIN (levofloxacin)	Five (5) day trials of each of the preferred agents are required before non-preferred agents will be authorized unless one of the exceptions on the PA form is present. This class is limited to patients age 21 years and over. Age exceptions will be handled on a case-by-case basis.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OPHTHALMIC ANTI-INFLAMMATORIES			
	ACULAR LS/PF (ketorolac) flurbiprofen NEVANAC (nepafenac) XIBROM (bromfenac)	ACUVAIL 0.45% (ketorolac tromethamine) AP diclofenac AP DUREZOL (difluprednate) AP ketorolac 0.4%	Five (5) day trials of each of the preferred ophthalmic anti-inflammatory agents are required before nonpreferred agents will be authorized unless one of the exceptions on the PA form is present.
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS			
	ACULAR (ketorolac) ALAWAY (ketotifen) ALREX (loteprednol) cromolyn OPTIVAR (azelastine) PATADAY (olopatadine) PATANOL (olopatadine) ZADITOR OTC (ketotifen)	ALAMAST (pemirolast) AP ALOCRIL (nedocromil) AP ALOMIDE (lodoxamide) AP azelastine BEPREVE (bepotastine) AP CROLOM (cromolyn) AP ELESTAT (epinastine) AP EMADINE (emedastine) AP ketorolac 0.5% ketotifen OPTICROM (cromolyn) AP ZYRTEC ITCHY EYE (OTC) (ketotifen) AP	Thirty (30) day trials of each of two (2) of the preferred agents are required before non-preferred agents will be authorized, unless one of the exceptions on the PA form is present.
OPHTHALMICS, GLAUCOMA AGENTS			
	COMBINATION AGENTS		Authorization for a non-preferred agent will only be given if there is an allergy to the preferred agents.
	COMBIGAN (brimonidine/timolol) COSOPT (dorzolamide/timolol)	dorzolamide/timolol	
	BETA BLOCKERS		
	betaxolol BETOPTIC S (betaxolol) carteolol levobunolol metipranolol timolol	BETAGAN (levobunolol) BETIMOL (timolol) ISTALOL (timolol) OPTIPRANOLOL (metipranolol) TIMOPTIC (timolol)	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	CARBONIC ANHYDRASE INHIBITORS		
	AZOPT (brinzolamide) TRUSOPT (dorzolamide)	dorzolamide	
	PARASYMPATHOMIMETICS		
	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) PHOSPHOLINE IODIDE (echothiophate iodide) pilocarpine	ISOPTO CARPINE (pilocarpine) PILOPINE HS (pilocarpine)	
	PROSTAGLANDIN ANALOGS		
	LUMIGAN (bimatoprost) TRAVATAN (travoprost) TRAVATAN-Z (travoprost)	XALATAN (latanoprost)	
	SYMPATHOMIMETICS		
	ALPHAGAN P (brimonidine) brimonidine 0.2% dipivefrin	brimonidine 0.15% PROPINE (dipivefrin)	
OTIC FLUOROQUINOLONES[AP]			
	CIPRODEX (ciprofloxacin/dexamethasone) ofloxacin	CIPRO HC (ciprofloxacin/hydrocortisone) CETRAXAL 0.2% SOLUTION (ciprofloxacin) FLOXIN (ofloxacin)	Five (5) day trials of each of the preferred agents are required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.
PANCREATIC ENZYMES[AP]			
	CREON ULTRASE ULTRASE MT VIOKASE	KUZYME LIPRAM PALCAPS PANCREASE PANCRECARB PANCRELIPASE PANGESTYME PANOKASE PLARETASE ZENPEP[NR]	Thirty (30) day trials of each of at least three (3) preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Non-preferred agents will be approved for members with cystic fibrosis.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PARATHYROID AGENTS[AP]			
	calcitriol HECTOROL (doxercalciferol) vitamin d 2 (ergocalciferol) (Rx and OTC)* vitamin d 3 (cholecalciferol) (Rx and OTC)* ZEMPLAR (paricalcitol)	DRISDOL (ergocalciferol) ROCALTROL (calcitriol) SENSIPAR (cinacalcet)	A thirty (30) day trial of a preferred agent will be required before a non-preferred agent will be approved. *See Covered List
PEDICULICIDES/SCABICIDES, TOPICAL[AP]			
	EURAX (crotamiton) OVIDE (malathion) permethrin (Rx and OTC) pyrethrins-piperonyl butoxide	lindane malathion 0.5% lotion ULESFIA 5% LOTION (benzyl alcohol)	Trials of the preferred agents (which are age and weight appropriate) are required before lindane will be approved unless one of the exceptions on the PA form is present.
PHOSPHATE BINDERS[AP]			
	FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENAGEL (sevelamer) RENVELA (sevelamer carbonate)	calcium acetate ELIPHOS (calcium acetate)	Thirty (30) day trials of at least two preferred agents are required unless one of the exceptions on the PA form is present.
PLATELET AGGREGATION INHIBITORS[AP]			
	AGGRENOX (dipyridamole/ASA) cilostazol PLAVIX (clopidogrel)	dipyridamole EFFIENT (prasugrel) PERSANTINE (dipyridamole) PLETAL (cilostazol) TICLID (ticlopidine) ticlopidine	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. Effient will be approved for acute coronary syndrome when it is to be managed by acute or delayed percutaneous coronary intervention (PCI). Three -day emergency supplies of Effient are available when necessary.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PRENATAL VITAMINS			
	prenatal vitamin 27 w/calcium/ferrous fumarate/folic acid prenatal vitamins 28 w/calcium/iron ps complex/folic acid prenatal vitamins/ferrous fumarate/docusate/folic acid prenatal vitamins/ferrous fumarate/folic acid prenatal vitamins/ferrous fumarate/folic acid/selenium prenatal vitamins/iron, carbonyl/folic acid prenatal vitamin no. 15/iron, carbonyl/folic acid/docusate sod prenatal vitamin no. 16/iron, carbonyl/folic acid/docusate sod prenatal vitamin no. 17/iron, carbonyl/folic acid/docusate sod prenatal vitamin no. 18/iron, carbonyl/folic acid/docusate sod prenatal vitamin w-o calcium/ferrous fumarate/folic acid prenatal vitamin w-o vit a/fe carbonyl-fe fumarate/fa	CARENATAL DHA CITRANATAL DHA COMBI RX FOLBECAL DUET/DUET DHA FOLTABS PLUS DHA NATACHEW NATAFORT NATELLE PLUS W/DHA NEEVO NOVANATAL OB-NATAL ONE OPTINATE PRECARE/PRECARE PREMIER PREMESIS PRENATAL RX PRENATAL RX 1 PRENATAL U prenatal vitamins/ferrous bis-glycinate chelate/folic acid prenatal vitamins/iron, carbonyl/omega-3/FA/fat combo no. 1 prenatal vitamins comb no. 20/iron bisgly/folic acid/DHA prenatal vitamins no. 22/iron, carbonyl/FA/docusate/DHA prenatal vitamins w-CA, FE, FA (<1 mg) prenatal vitamins w-o calcium/iron ps complex/FA prenatal vitamins w-o CA no. 5/ferrous fumarate/folic acid prenatal vitamins CMB w-o CA no. 2 prenatal vitamins w-o calcium no. 9/iron/folic acid PRENATE DHA/PRENATE ELITE PRENAVITE PRENEXA	See posted list of covered NDCs.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		PRIMACARE RENATE/RENATE DHA SELECT-OB TANDEM DHA/TANDEM OB	
PROTON PUMP INHIBITORS[AP]			
	KAPIDEX (dexlansoprazole) NEXIUM (esomeprazole)	ACIPHEX (rabeprazole) lansoprazole NEXIUM PACKETS (esomeprazole) omeprazole pantoprazole PREVACID capsules (lansoprazole) (Rx and OTC) PREVACID Solu-Tabs (lansoprazole) PREVACID Suspension (lansoprazole) PRILOSEC (omeprazole) PROTONIX (pantoprazole) ZANTAC-PPI (omeprazole)	Sixty (60) day trials of each of the preferred agents, inclusive of a concurrent thirty (30) day trial at the maximum dose of an H_2 antagonist are required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present Prior authorization is not required for Prevacid Solu-Tabs for patients ≤8 years of age.
PULMONARY ANTIHYPERTENSIVES[CL]			
	ENDOTHELIN RECEPTOR ANTAGONISTS		
	LETAIRIS (ambrisentan) TRACLEER (bosentan)		These agents will only be approved for the treatment of pulmonary artery hypertension World Health Organization (WHO) group I. Letairis will only be approved for patients with WHO class II or III symptoms after a fourteen (14) day trial of the preferred agent 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 legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	PDE5s		
	REVATIO (sildenafil)	ADCIRCA (tadalafil)	A 14-day trial of the preferred agent is required before the non-preferred agent will be approved unless one of the exceptions on the PA form is present.
SEDATIVE HYPNOTICS[AP]			
	BENZODIAZEPINES		
	temazepam	DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam) PROSOM (estazolam) RESTORIL (temazepam) triazolam	Fourteen (14) day trials of the preferred agents in both categories are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	OTHERS		
	zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) AQUA CHLORAL (chloral hydrate) chloral hydrate EDLUAR SL (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon) SOMNOTE (chloral hydrate) SONATA (zaleplon) zaleplon	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
STIMULANTS AND RELATED AGENTS			
	AMPHETAMINES		
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination dextroamphetamine VYVANSE (lisdexamfetamine)	ADDERALL (amphetamine salt combination) amphetamine salt combination ER DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT (dextroamphetamine)	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 for thirty (30) days before a non-preferred agent will be authorized. Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be approved for depression. Provigil will only be approved for patients >16 years of age with a diagnosis of narcolepsy. Strattera will not be approved for concurrent administration with amphetamines or methylphenidates, except for 30 days or less for tapering purposes. Strattera is limited to a maximum of 100mg per day.
	NON-AMPHETAMINE		
	CONCERTA (methylphenidate) FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) METADATE CD (methylphenidate) methylphenidate methylphenidate ER STRATTERA (atomoxetine)	DAYTRANA (methylphenidate) dexmethylphenidate INTUNIV ER (guanfacine) METADATE ER (methylphenidate) NUVIGIL (armodafinil) pemoline PROVIGIL (modafinil) RITALIN (methylphenidate) RITALIN LA (methylphenidate) RITALIN-SR (methylphenidate)	Intuniv ER will be approved only after thirty (30) day trials of at least one product form of all chemically unique entities of preferred stimulants (amphetamines and non amphetamine), as well as Strattera and generic guanfacine 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 legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ULCERATIVE COLITIS AGENTS[AP]			
	ORAL		Thirty (30) day trials of each 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.
	APRISO (mesalamine) ASACOL (mesalamine) 400mg COLAZAL (balsalazide) DIPENTUM (olsalazine) PENTASA (mesalamine) 250mg sulfasalazine	ASACOL HD (mesalamine) 800mg AZULFIDINE (sulfasalazine) balsalazide LIALDA (mesalamine) PENTASA (mesalamine) 500mg	
	RECTAL		
	CANASA (mesalamine) mesalamine SF ROWASA (mesalamine)		
MISC BRAND/GENERIC			
	CATAPRES-TTS (clonidine) EPIPEN (epinephrine) MEGACE ES (megestrol) megestrol SANDOSTATIN (octreotide) SANTYL (collagenase) TWINJECT (epinephrine) YASMIN (ethinyl estradiol/drospirenone)	clonidine patch MEGACE (megestrol) Ocella (ethinyl estradiol/drospirenone) octreotide YAZ (ethinyl estradiol/drospirenone)	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.