



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

**EFFECTIVE
10/01/09
Version 2009.81**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
ACNE AGENTS, TOPICAL				
ANTI-INFECTIVE				
	AKNE-MYCIN (erythromycin) AZELEX (azelaic acid) clindamycin erythromycin sodium sulfacetamide	ACZONE (dapson) 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) CLENIA (sulfacetamide sodium/sulfur)		

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		DUAC CS (benzoyl peroxide/ clindamycin) EPIDUO (adapalene/benzoyl peroxide) ^{NR} 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			
CHOLINESTERASE INHIBITORS			
	ARICEPT (donepezil) ARICEPT ODT(donepezil) EXELON (rivastigmine)	COGNEX (tacrine) galantamine galantamine ER RAZADYNE (galantamine) RAZADYNE ER (galantamine)	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.
NMDA RECEPTOR ANTAGONIST			
	NAMENDA (memantine)		

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ANALGESICS, NARCOTIC -SHORT ACTING (Non-parenteral)			
	APAP/codeine ASA/codeine codeine dihydrocodeine/ APAP/caffeine hydrocodone/APAP hydrocodone/ibuprofen hydromorphone levorphanol morphine oxycodone oxycodone/APAP oxycodone/ASA pentazocine/APAP pentazocine/naloxone propoxyphene/APAP ROXICET (oxycodone/acetaminophen) tramadol tramadol/APAP	ACTIQ (fentanyl) butalbital/APAP/caffeine/codeine butalbital/ASA/caffeine/codeine butorphanol COMBUNOX (oxycodone/ibuprofen) 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)^{NR} OPANA (oxymorphone) 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)	<p>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 required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.</p> <p>Fentanyl lozenges will only be approved for a diagnosis of cancer and as an adjunct to a long-acting agent. Fentanyl lozenges will not be approved for monotherapy.</p> <p>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.</p>

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		ZAMICET (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen) XOLOX (oxycodone/APAP)	
ANALGESICS, NARCOTIC - LONG ACTING (Non-parenteral)			
	DURAGESIC (fentanyl) KADIAN (morphine) methadone morphine ER OPANA ER (oxymorphone)	AVINZA (morphine) DOLOPHINE (methadone) fentanyl MS CONTIN (morphine) ORAMORPH SR (morphine) oxycodone ER OXYCONTIN (oxycodone) RYZOLT ER (tramadol) ^{NR} 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. Exception: Oxycodone ER will be authorized if a diagnosis of cancer is submitted without a trial of the preferred agents.
ANALGESICS, TOPICAL			
	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

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			<p>Voltaren Gel will be approved unless one of the exceptions on the PA form is present.</p> <p>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.</p>
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			
ACE INHIBITORS			
	benazepril captopril enalapril fosinopril lisinopril quinapril ramipril	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) CAPOTEN (captopril) LOTENSIN (benazepril) MAVIK (trandolapril) moexipril MONOPRIL (fosinopril) 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.

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	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) 50, 100mg TEVETEN (eprosartan)	
	ARB COMBINATIONS		
	AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) DIOVAN-HCT (valsartan/HCTZ) EXFORGE (valsartan/amlodipine) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ)	ATACAND-HCT (candesartan/HCTZ) TEVETEN-HCT (eprosartan/HCTZ)	

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	DIRECT RENIN INHIBITORS		
	TEKTURNA (aliskiren) ^{AP} TEKTURNA HCT (aliskiren/HCTZ) ^{AP}		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.
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 ER (divalproex) DEPAKOTE SPRINKLE (divalproex) divalproex EC divalproex DR EPITOL (carbamazepine) FELBATOL (felbamate) gabapentin GABITRIL (tiagabine) levetiracetam lamotrigine lamotrigine chewable LYRICA (pregabalin) oxcarbazepine tablets topiramate TRILEPTAL SUSPENSION (oxcarbazepine) valproic acid zonisamide	BANZEL(rufinamide) carbamazepine XR DEPAKENE (valproic acid) DEPAKOTE (divalproex) divalproex ER EQUETRO (carbamazepine) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) ^{NR} KEPPRA (levetiracetam) NEURONTIN (gabapentin) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL XR (carbamazepine) TOPAMAX (topiramate) TRILEPTAL TABLETS (oxcarbazepine) VIMPAT (lacosamide) ^{NR} ZONEGRAN (zonisamide)	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. Keppra XR will be approved with a diagnosis of a seizure disorder with no trials of preferred agents required.

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	BARBITURATES		
	mephobarbital phenobarbital primidone	MEBARAL (mephobarbital) MYSOLINE (primidone)	
	BENZODIAZEPINES		
	clonazepam DIASSTAT (diazepam rectal) diazepam	KLONOPIN (clonazepam)	
	HYDANTOINS		
	DILANTIN INFATABS (phenytoin) PEGANONE (ethotoin) phenytoin	CEREBYX (fosphenytoin) DILANTIN (phenytoin) PHENYTEK (phenytoin)	
	SUCCINIMIDES		
	CELONTIN (methsuximide) ethosuximide ZARONTIN (ethosuximide)		
ANTIDEPRESSANTS, OTHER (second generation, non-SSRI) and SNRIs			
	bupropion SR bupropion XL CYMBALTA (duloxetine) EFFEXOR XR (venlafaxine) mirtazapine trazodone	APLENZIN (bupropion hbr) ^{NR} bupropion IR DESYREL (trazodone) EFFEXOR (venlafaxine) EMSAM (selegiline) nefazodone PRISTIQ (desvenlafaxine) REMERON (mirtazapine) SAVELLA (milnacipran) ^{NR} venlafaxine venlafaxine ER WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion)	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.

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ANTIDEPRESSANTS, SSRIs			
	citalopram fluoxetine fluvoxamine paroxetine sertraline	CELEXA (citalopram) LEXAPRO (escitalopram) 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.
ANTIEMETICS			
5HT3 RECEPTOR BLOCKERS			
	ondansetron ondansetron ODT	ANZEMET (dolasetron) KYTRIL (granisetron) granisetron SANCUSO (granisetron) ZOFTRAN (ondansetron) ZOFTRAN 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 meggestrol, the

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			prophylaxis of chemotherapy induced nausea and vomiting unresponsive to 3-day trials of ondansetron or promethazine and for patients between the ages of 18 and 65 years of age.
SUBSTANCE P ANTAGONISTS			
	EMEND (aprepitant)		
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			
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)	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

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		XOLEGEL (ketoconazole)	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) MYCOLOG (nystatin/triamcinolone)	
ANTIHISTAMINES, MINIMALLY SEDATING			
	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 (OTC) 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 (Rx and OTC) (cetirizine)	
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
	ALAVERT-D (loratadine/pseudoephedrine) cetirizine/pseudoephedrine (OTC) loratadine/pseudoephedrine SEMPREX-D (acrivastine/ pseudoephedrine)	ALLEGRA-D (fexofenadine/pseudoephedrine) CLARINEX-D (desloratadine/pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) ZYRTEC-D (Rx and OTC) (cetirizine/pseudoephedrine)	
ANTIMIGRAINE AGENTS, TRIPTANS			
	TRIPTANS		Three (3) 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. Quantity limits apply for this drug class.
	IMITREX (sumatriptan) MAXALT MLT (rizatriptan) RELPAK (eletriptan)	AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) MAXALT (rizatriptan) sumatriptan ZOMIG (zolmitriptan)	

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	TRIPTAN COMBINATIONS		
	TREXIMET (sumatriptan/naproxen sodium)		
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) REQUIP (ropinirole) REQUIP XL (ropinirole)	
	OTHER ANTIPARKINSON'S AGENTS		
	amantadine bromocriptine carbidopa/levodopa selegiline STALEVO (levodopa/carbidopa/entacapone)	AZILECT (rasagiline) ELDEPRYL (selegiline) levodopa/carbidopa ODT PARCOPA (levodopa/carbidopa) SINEMET (levodopa/carbidopa) ZELAPAR (selegiline)	

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ANTIPSYCHOTICS, ATYPICAL (Oral)			
ORAL			
	clozapine GEODON (ziprasidone) INVEGA (paliperidone) RISPERDAL SOLUTION (risperidone) RISPERDAL ODT (risperidone) risperidone SEROQUEL (quetiapine) SEROQUEL XR (quetiapine)	ABILIFY (aripiprazole) CLOZARIL (clozapine) FAZACLO (clozapine) RISPERDAL (risperidone) risperidone solution risperidone ODT ZYPREXA (olanzapine)	<p>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, a hospitalized patient stabilized on a non-preferred agent may receive authorization to continue this drug for labeled indications and at recommended dosages.</p> <p>Abilify will be prior authorized for MDD if the following criteria are met:</p> <ol style="list-style-type: none"> 1. The patient is at least 18 year of age. 2. Diagnosis of Major Depressive Disorder (MDD) not responsive to other antidepressants. 3. Evidence of trials of appropriate therapeutic duration at a maximum tolerable dose of at least two (2) of the following agents: Selective Serotonin Reuptake Inhibitors (SSRI), Norepinephrine Reuptake Inhibitors, or bupropion. 4. Prescribed in conjunction with an SSRI, SNRI or bupropion. 5. The daily dose does not exceed 15 mg.

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ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS			
		SYMBYAX (olanzapine/fluoxetine)	
ANTIVIRALS (Oral)			
ANTI HERPES			
	acyclovir VALTRESX (valacyclovir)	famciclovir FAMVIR (famciclovir) 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			
		FLUMADINE (rimantadine) RELENZA (zanamivir) rimantadine SYMMETREL (amantadine) TAMIFLU (oseltamivir)	The anti influenza agents will be approved only for a diagnosis of influenza.
ATOPIC DERMATITIS			
	ELIDEL (pimecrolimus) PROTOPIC (tacrolimus)		
BETA BLOCKERS (Oral)			
BETA BLOCKERS			
	acebutolol atenolol betaxolol bisoprolol metoprolol metoprolol ER nadolol pindolol propranolol propranolol ER	BETAPACE (sotalol) BLOCADREN (timolol) BYSTOLIC (nebivolol) CARTROL (carteolol) CORGARD (nadolol) INDERAL LA (propranolol) INNOPRAN XL (propranolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol)	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.

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	sotalol timolol TOPROL XL (metoprolol)	SECTRAL (acebutolol) TENORMIN (atenolol) ZEBETA (bisoprolol)	
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) ^{NR}	
BLADDER RELAXANT PREPARATIONS			
	DETROL LA (tolterodine) ENABLEX (darifenacin) oxybutynin oxybutynin ER SANCTURA (trospium) SANCTURA XR (trospium) VESICARE (solifenacin)	DETROL (tolterodine) DITROPAN (oxybutynin) DITROPAN XL (oxybutynin) GELNIQUE (oxybutynin) ^{NR} OXYTROL (oxybutynin) TOVIAZ (fesoterodine) ^{NR}	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.

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BONE RESORPTION SUPPRESSION AND RELATED AGENTS			
BISPHOSPHONATES			
	alendronate FOSAMAX PLUS D (alendronate/vitamin D)	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX (alendronate)	A 30-day trial of one of the preferred agents is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
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			
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.

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	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 nebulas is inhibitory.
BRONCHODILATORS, BETA AGONIST			
	INHALATION SOLUTION		
	albuterol	ACCUNEB (albuterol)** BROVANA (arformoterol) 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.

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INHALERS, LONG-ACTING			
	FORADIL (formoterol) SEREVENT (salmeterol)		
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			
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.

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	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)			
	BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		
	amoxicillin/clavulanate AUGMENTIN XR (amoxicillin/clavulanate)	MOXATAG (amoxicillin) ^{NR}	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 cefepodoxime 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 (cefepodoxime)	

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COUGH & COLD/1st GENERATION ANTIHISTAMINES	ANTI-HISTAMINES, 1ST GENERATION		See posted list of covered NDCs.
	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 (chlorpheniramine tannate)	
	ANTITUSSIVE-ANTI-HISTAMINE COMBINATIONS		
	codeine/promethazine dextromethorphan HBR/promethazine		
	ANTI-HISTAMINE-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)	

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	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)	

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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.

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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)	SIMPONI (golimumab) ^{NR}	
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			
	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			
	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.

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PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA**

**EFFECTIVE
10/01/09
Version 2009.81**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
GLUCOCORTICIDS, INHALED			
	GLUCOCORTICIDS		
	AEROBID (flunisolide) AEROBID-M (flunisolide) ASMANEX (mometasone) AZMACORT (triamcinolone) FLOVENT HFA (fluticasone) FLOVENT Diskus (fluticasone) QVAR (beclomethasone)	ALVESCO (ciclesonide) budesonide PULMICORT (budesonide)	<p>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.</p> <p>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.</p>
	GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
	ADVAIR (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) SYMBICORT(budesonide/formoterol)		
GROWTH HORMONE ^{CL}			
	GENOTROPIN (somatropin) NUTROPIN (somatropin) NUTROPIN AQ (somatropin)	HUMATROPE (somatropin) INCRELEX (mecasermin) NORDITROPIN (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin) ZORBTIVE (somatropin)	<p>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.</p> <p>Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA.</p>

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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) 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			
	BYETTA (exenatide) JANUMET (sitagliptin/metformin) JANUVIA (sitagliptin) SYMLIN (pramlintide)	ONGLYZA (saxagliptin) ^{NR}	Byetta and Symlin are both subject to the following step therapy edits: Byetta-Current history of therapy with a sulfonylurea, thiazolidinedione (TZD), and/or metformin. Will not be approved with concurrent insulin therapy. No gaps of therapy greater than 30 days in the past 180 days. Symlin- History of insulin utilization in the past 90 days. No gaps in therapy of greater than 30 days.

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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) HUMALOG PEN/KWIKPEN (insulin lispro) HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMULIN PEN (insulin)	To receive Apidra, patients must meet the following criteria: <ol style="list-style-type: none"> be 4 years or older; be currently on a regimen including a longer-acting or basal insulin. 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)	PRANDIN (repaglinide) repaglinide	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.
HYPOGLYCEMICS, TZDS			
	THIAZOLIDINEDIONES		
	ACTOS (pioglitazone) AVANDIA (rosiglitazone)		
	TZD COMBINATIONS		
	ACTOPLUS MET (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glimepiride) DUETACT (pioglitazone/glimepiride)		

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IMPETIGO AGENTS, TOPICAL			
	ALTABAX (retapamulin) mupirocin bacitracin gentamicin sulfate	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.
INTRANASAL RHINITIS AGENTS			
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) PATANASE (olopatadine)	ASTEPRO (azelastine)	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.

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CORTICOSTEROIDS			
	fluticasone propionate NASACORT AQ (triamcinolone) NASONEX (mometasone) VERAMYST (fluticasone furoate)	BECONASE AQ (beclomethasone) flunisolide FLONASE (fluticasone propionate) NASALIDE (flunisolide) NASAREL (flunisolide) OMNARIS (ciclesonide) RHINOCORT AQUA (budesonide)	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.
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.
LIPOTROPICS, OTHER (non-statins)			
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. 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.

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	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.
	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.
	FIBRIC ACID DERIVATIVES		
	fenofibrate gemfibrozil TRICOR (fenofibrate) TRILIPIX (fenofibrate)	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) ^{NR} LIPOFEN (fenofibrate) ^{NR} LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRIGLIDE (fenofibrate)	
	NIACIN		
	niacin NIASPAN (niacin)	NIACELS (niacin) NIACOR (niacin) ^{NR} NIADELAY (niacin) SLO-NIACIN (niacin)	

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LIPOTROPICS, STATINS			
	STATINS		
	CRESTOR (rosuvastatin) LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) lovastatin pravastatin simvastatin	ALTOPREV (lovastatin) 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.
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)	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.

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		erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin)	
MULTIPLE SCLEROSIS AGENTS ^{CL}			
	AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE (glatiramer) REBIF (interferon beta-1a)	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.
MUSCLE RELAXANTS, ORAL			
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.

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	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			
	NONSELECTIVE		
	diclofenac etodolac fenoprofen flurbiprofen ibuprofen (Rx and OTC) INDOCIN (indomethacin) (suspension only) indomethacin ketorolac naproxen (Rx only) oxaprozin piroxicam sulindac	ADVIL (ibuprofen) ANAPROX (naproxen) ANSAID (flurbiprofen) CATAFLAM (diclofenac) CLINORIL (sulindac) DAYPRO (oxaprozin) 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)^{NR}	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.

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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.
OPHTHALMIC ANTIBIOTICS			
	ciprofloxacin ofloxacin VIGAMOX (moxifloxacin)	AZASITE (azithromycin) BESIVANCE (besifloxacin) ^{NR} CILOXAN (ciprofloxacin) OCUFLOX (ofloxacin) QUIXIN (levofloxacin) ZYMAR (gatifloxacin)	Five (5) day trials 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.
OPHTHALMIC ANTI-INFLAMMATORIES			
	ACULAR/LS/PF (ketorolac) flurbiprofen NEVANAC (nepafenac) XIBROM (bromfenac)	ACUVAIL 0.45% (ketorolac tromethamine) ^{NR} diclofenac DUREZOL (difluprednate)	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)	ALAMAST (pemirolast) ALOCRIL (nedocromil) ALOMIDE (iodoxamide) CROLOM (cromolyn) ELESTAT (epinastine) EMADINE (emedastine) ketotifen	Thirty (30) day trials 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.

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	PATANOL (olopatadine) ZADITOR OTC (ketotifen)	OPTICROM (cromolyn)		
OPHTHALMICS, GLAUCOMA AGENTS				
COMBINATION AGENTS				
	COSOPT (dorzolamide/timolol)	COMBIGAN (brimonidine/timolol) dorzolamide/timolol	Authorization for a non-preferred agent will only be given if there is an allergy to the preferred agents.	
BETA BLOCKERS				
	Betaxolol BETOPTIC S (betaxolol) carteolol levobunolol metipranolol timolol	BETAGAN (levobunolol) BETIMOL (timolol) ISTALOL (timolol) OPTIPRANOLOL (metipranolol) TIMOPTIC (timolol)		
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)		

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SYMPATHOMIMETICS			
	ALPHAGAN P (brimonidine) brimonidine dipivefrin	ALPHAGAN (brimonidine) PROPINE (dipivefrin)	
OTIC FLUOROQUINOLONES			
	CIPRODEX (ciprofloxacin/dexamethasone) ofloxacin	CIPRO HC (ciprofloxacin/hydrocortisone) CETRAXAL 0.2% SOLUTION (ciprofloxacin) ^{NR} FLOXIN (ofloxacin)	Five (5) 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.
PANCREATIC ENZYMES			
	CREON PANCREARB ULTRASE ULTRASE MT VIOKASE	KUZYME LIPRAM PALCAPS PANCREASE PANGESTYME PANOKASE PLARETASE	Thirty (30) day trials 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.
PARATHYROID AGENTS			
	calcitriol HECTOROL (doxercalciferol) ZEMPLAR (paricalcitol)	ROCALTROL (calcitriol) SENSIPAR (cinacalcet)	A thirty (30) day trial of a preferred agent will be required before a non-preferred agent will be approved.
PEDICULICIDES/SCABICIDES, TOPICAL			
	EURAX (crotamiton) OVIDE (malathion) permethrin (Rx and OTC) pyrethrins-piperonyl butoxide	lindane malathion 0.5% lotion ULESFIA 5% LOTION (benzyl alcohol)^{NR}	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.

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WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA**

**EFFECTIVE
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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PHOSPHATE BINDERS			
	FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENAGEL (sevelamer)	calcium acetate ELIPHOS (calcium acetate) RENVELA (sevelamer carbonate)	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			
	AGGRENOX (dipyridamole/ASA) cilostazol PLAVIX (clopidogrel)	Dipyridamole EFFIENT (prasugrel)^{NR} 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.
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	See posted list of covered NDCs.

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		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 PRIMACARE RENATE/RENTATE DHA SELECT-OB TANDEM DHA/TANDEM OB	
PROTON PUMP INHIBITORS			
	KAPIDEX (dexlansoprazole) NEXIUM (esomeprazole) All current users of PREVACID capsules may continue to receive PREVACID capsules through Jan. 1, 2010, but are required to begin using one of the preferred agents listed here after that date. All PPI treatment-naïve patients must begin using KAPIDEX or NEXIUM as of Oct. 1, 2009.	ACIPHEX (rabeprazole) NEXIUM PACKETS (esomeprazole) omeprazole pantoprazole PREVACID Capsules (lansoprazole) PREVACID Solu-Tabs (lansoprazole) PREVACID Suspension (lansoprazole) PRILOSEC (omeprazole) PROTONIX (pantoprazole) ZANTAC-PPI (omeprazole) ZEGERID (omeprazole/sodium bicarbonate)	Thirty (30) 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. Prior authorization is not required for Prevacid Solu-Tabs for patients ≤8 years of age.

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PULMONARY ANTIHYPERTENSIVES-ENDOTHELIN RECEPTOR ANTAGONISTS^{CL}			
	TRACLEER (bosentan)	LETAIRIS (ambrisentan)	<p>These agents will only be approved for the treatment of pulmonary artery hypertension World Health Organization (WHO) group I.</p> <p>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.</p> <p>Users of Letairis as of 3/31/09 will be allowed to continue therapy with that drug.</p>
SEDATIVE HYPNOTICS			
BENZODIAZEPINES			
	temazepam	DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam) PROSOM (estazolam) RESTORIL (temazepam) triazolam	<p>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.</p>
OTHERS			
	zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) AQUA CHLORAL (chloral hydrate) chloral hydrate EDLUAR SL (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon)	

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		SOMNOTE (chloral hydrate) SONATA (zaleplon) zaleplon	
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	DAYTRANA (methylphenidate) dexmethylphenidate METADATE ER (methylphenidate) NUVIGIL (armodafinil) ^{NR} pemoline	

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	methylphenidate ER STRATTERA (atomoxetine)	PROVIGIL (modafinil) RITALIN (methylphenidate) RITALIN LA (methylphenidate) RITALIN-SR (methylphenidate)	
ULCERATIVE COLITIS AGENTS			
ORAL			
	APRISO (mesalamine) ASACOL (mesalamine) COLAZAL (balsalazide) DIPENTUM (olsalazine) LIALDA (mesalamine) PENTASA (mesalamine) sulfasalazine	AZULFIDINE (sulfasalazine) balsalazide	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.
RECTAL			
	CANASA (mesalamine) mesalamine	ROWASA (mesalamine)	
MISC BRAND/GENERIC			
	SANDOSTATIN (octreotide)	octreotide	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized.

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