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

Effective 4/1/09
Version 2009.3

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS, TOPICAL	**ANTI-INFECTIVE**		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.) PA required after 17 years of age for tretinoin products. Acne kits are non-preferred
	AKNE-MYCIN (erythromycin) AZELEX (azelaic acid) clindamycin erythromycin sodium sulfacetamide	ACZONE (dapsone) CLEOCIN-T (clindamycin) EVOCLIN (clindamycin) KLARON (sodium sulfacetamide)	
	RETINOIDS		
	RETIN A liquid & Micro (tretinoin) TAZORAC (tazarotene) tretinoin cream, gel	AVITA DIFFERIN (adapalene) RETIN-A cream, gel (tretinoin)	
	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)	
	COMBINATION AGENTS		
	benzoyl peroxide/urea erythromycin/benzoyl peroxide sulfacetamide sodium/sulfur wash/cleanser	BENZACLIN GEL (benzoyl peroxide/clindamycin) BENZAMYCIN PAK (benzoyl peroxide/erythromycin) CLENIA (sulfacetamide sodium/sulfur) DUAC CS (benzoyl peroxide/ clindamycin) 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 SULFOXYL (benzoyl peroxide/sulfur) SULFATOL (sulfacetamide sodium/sulfur/urea) ZIANA (clindamycin/tretinoin)	

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ALZHEIMER'S AGENTS	**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)		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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 VOPAC (codeine/acetaminophen)	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) LYNOX (oxycodone/APAP) meperidine 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) XODOL (hydrocone/acetaminophen) ZAMICET (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen) XOLOX (oxycodone/APAP)	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. 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. 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. ,

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANALGESICS, NARCOTIC - LONG ACTING (Non-parenteral)	DURAGESIC (fentanyl) KADIAN (morphine) methadone morphine ER OPANA ER (oxymorphone)	AVINZA (morphine) fentanyl MS CONTIN (morphine) ORAMORPH SR (morphine) oxycodone ER OXYCONTIN (oxycodone) 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)	DRAFT CRITERIA PENDING DRUG UTILIZATION COMMITTEE REVIEW ON 4/1/09. 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 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	**ACE INHIBITORS**		Fourteen (14) day trials of each of the preferred

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANGIOTENSIN MODULATORS	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)	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.
	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)		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.
	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 (erosartan/HCTZ)	
	DIRECT RENIN INHIBITORS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ)		
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**		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.
	carbamazepine CARBATROL (carbamazepine) DEPAKOTE ER (divalproex) DEPAKOTE SPRINKLE (divalproex) divalproex EC FELBATOL (felbamate) gabapentin GABITRIL (tiagabine) levetiracetam lamotrigine LYRICA (pregabalin) oxcarbazepine TOPAMAX (topiramate) valproic acid zonisamide	BANZEL(rufinamide)[NR] DEPAKENE (valproic acid) DEPAKOTE (divalproex) divalproex ER EPITOL (carbamazepine) EQUETRO (carbamazepine) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) KEPPRA (levetiracetam) NEURONTIN (gabapentin) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL XR (carbamazepine) TRILEPTAL (oxcarbazepine) ZONEGRAN (zonisamide)	
	BARBITURATES		
	mephobarbital phenobarbital primidone	MEBARAL (mephobarbital) MYSOLINE (primidone)	
	BENZODIAZEPINES		
	clonazepam DIASTAT (diazepam rectal) diazepam	KLONOPIN (clonazepam)	
	HYDANTOINS		
	DILANTIN INFATABS (phenytoin) PEGANONE (ethotoin) phenytoin	CEREBYX (fosphenytoin) DILANTIN (phenytoin) PHENYTEK (phenytoin)	
	SUCCINIMIDES		
	CELONTIN (methsuximide) ethosuximide	ZARONTIN (ethosuximide)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIDEPRESSANTS, OTHER (second generation, non-SSRI)	bupropion SR bupropion XL CYMBALTA (duloxetine) EFFEXOR XR (venlafaxine) mirtazapine trazodone	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.
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 authorization to continue that drug.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIEMETICS	**5HT3 RECEPTOR BLOCKERS**		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.
	ondansetron ondansetron ODT	ANZEMET (dolasetron) KYTRIL (granisetron) granisetron SANCUSO (granisetron) ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron)	
	CANNABINOIDS		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, the 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.
		CESAMET (nabilone) MARINOL (dronabinol)	
	SUBSTANCE P ANTAGONISTS		PA is required when limits are exceeded.
	EMEND (aprepitant)		
ANTIFUNGALS, ORAL	clotrimazole fluconazole* ketoconazole [CL] nystatin terbinafine [CL]	ANCOBON (flucytosine) DIFLUCAN (fluconazole) 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.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIFUNGALS, TOPICAL	**ANTIFUNGALS**		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.
	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)	
	ANTIFUNGAL/STEROIDCOMBINATIONS		
	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)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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) RELPAX (eletriptan)	AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) MAXALT (rizatriptan) sumatriptan ZOMIG (zolmitriptan)	
	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. Mirapex, Requip, and Requip XL will be approved for a diagnosis of Parkinsonism with no trials of preferred agents required.
	benztropine KEMADRIN (procyclidine) trihexyphenidyl	COGENTIN (benztropine)	
	COMT INHIBITORS		
		COMTAN (entacapone) TASMAR (tolcapone)	
	DOPAMINE AGONISTS		
	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)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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, a hospitalized patient stabilized on a non-preferred agent may receive authorization to continue this drug for labeled indications and at recommended dosages. Abilify will be prior authorized for MDD if the following criteria are met: 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.
	clozapine GEODON (ziprasidone) INVEGA (paliperidone) RISPERDAL SOLUTION (risperidone) risperidone SEROQUEL (quetiapine) SEROQUEL XR (quetiapine)	ABILIFY (aripiprazole) CLOZARIL (clozapine) FAZACLO (clozapine) RISPERDAL (risperidone) risperidone solution ZYPREXA (olanzapine)	
	ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
		SYMBYAX (olanzapine/fluoxetine)	
ANTIVIRALS (Oral)	**ANTI HERPES**		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.
	acyclovir VALTREX (valacyclovir)	famciclovir FAMVIR (famciclovir) ZOVIRAX (acyclovir)	
	ANTI INFLUENZA		The anti influenza agents will be approved only for a diagnosis of influenza.
		FLUMADINE (rimantadine) RELENZA (zanamivir) rimantadine SYMMETREL (amantadine) TAMIFLU (oseltamivir)	
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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BETA BLOCKERS (Oral)	**BETA BLOCKERS**		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.
	acebutolol atenolol betaxolol bisoprolol metoprolol metoprolol ER nadolol pindolol propranolol propranolol ER sotalol timolol	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) TOPROL XL (metoprolol) 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)	
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) OXYTROL (oxybutynin)	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.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BONE RESORPTION SUPPRESSION AND RELATED AGENTS	**BISPHOSPHONATES**		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. Evista will be approved for postmenopausal women with osteoporosis or at high risk for invasive breast cancer.
	alendronate FOSAMAX PLUS D (alendronate/vitamin D)	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX (alendronate)	
	OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
	MIACALCIN (calcitonin)	calcitonin EVISTA (raloxifene) FORTEO (teriparatide) FORTICAL (calcitonin)	
BPH AGENTS	**5-ALPHA-REDUCTASE (5AR) INHIBITORS**		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.
	AVODART (dutasteride) finasteride	PROSCAR (finasteride)	
	ALPHA BLOCKERS		
	doxazosin FLOMAX (tamsulosin) terazosin UROXATRAL (alfuzosin)	CARDURA (doxazosin) CARDURA XL (doxazosin) HYTRIN (terazosin) RAPAFLO (silodosin)[NR]	
BRONCHODILATORS, ANTICHOLINERGIC	**ANTICHOLINERGIC**		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. For severely compromised patients, albuterol/ipratropium will be approved if the combined volume of albuterol and ipratropium nebules is inhibitory.
	ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)		
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS		
	COMBIVENT (albuterol/ipratropium)	albuterol/ipratropium DUONEB (albuterol/ipratropium)	

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BRONCHODILATORS, BETA AGONIST	**INHALATION SOLUTION**		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. 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. **No PA is required for ACCUNEB for children up to 5 years of age.
	albuterol	ACCUNEB (albuterol)** BROVANA (arformoterol) metaproterenol PERFOROMIST (formoterol) PROVENTIL (albuterol) XOPENEX (levalbuterol)	
	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)	
	ORAL		
	albuterol terbutaline	BRETHINE (terbutaline) metaproterenol VOSPIRE ER (albuterol)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CALCIUM CHANNEL BLOCKERS	**LONG-ACTING**		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.
	amlodipine diltiazem 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)	
	SHORT-ACTING		
	diltiazem verapamil	ADALAT (nifedipine) CALAN (verapamil) CARDENE (nicardipine) CARDIZEM (diltiazem) DYNACIRC (isradipine) isradipine nicardipine nimodipine nifedipine NIMOTOP (nimodipine) PROCARDIA (nifedipine)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	**BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS**		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.
	amoxicillin/clavulanate AUGMENTIN XR (amoxicillin/clavulanate)	MOXATAG (amoxicillin)[NR]	
	CEPHALOSPORINS		
	cefaclor cefadroxil cefdinir 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)	
CYTOKINE & CAM ANTAGONISTS [CL]	CIMZIA (certolizumab/pegol) ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra) RAPTIVA (efalizumab)		
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.

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
GLUCOCORTICOIDS, INHALED	**GLUCOCORTICOIDS**		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.
	AEROBID (flunisolide) AEROBID-M (flunisolide) ASMANEX (mometasone) AZMACORT (triamcinolone) FLOVENT HFA (fluticasone) FLOVENT Diskus (fluticasone) QVAR (beclomethasone)	ALVESCO (ciclesonide) budesonide PULMICORT (budesonide)	
	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)	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.
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)	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 (amylin)		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. 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.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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: 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)	PRANDIN (repaglinide)	A thirty (30) day triial 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)		
IMPETIGO AGENTS, TOPICAL	ALTABAX (retapamulin) mupirocin bacitracin gentamycin 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.

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
INTRANASAL RHINITIS AGENTS	**ANTICHOLINERGICS**		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.
		ATROVENT(ipratropium) ipratropium	
	ANTIHISTAMINES		DRAFT CRITERIA PENDING DRUG UTILIZATION COMMITTEE REVIEW ON 4/1/09. 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.
	ASTELIN (azelastine) PATANASE (olopatadine)	ASTEPRO (azelastine)	
	CORTICOSTEROIDS		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.
	fluticasone propionate NASACORT AQ (triamcinolone) NASONEX (mometasone) VERAMYST (fluticasone furoate)	BECONASE AQ (beclomethasone) flunisolide FLONASE (fluticasone propionate) NASALIDE (flunisolide) NASAREL (flunisolide) RHINOCORT AQUA (budesonide)	
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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LIPOTROPICS, OTHER (non-statins)	**BILE ACID SEQUESTRANTS**		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. Zetia and Welchol will be approved for add-on therapy only after an insufficient response to the maximum tolerable dose of a statin after 12 weeks of therapy. Lovaza will be approved for the treatment of high triglyceride levels (≥ 400mg/dL) not responsive to, or not a candidate for, other lipid lowering agents (e.g. HMG CoA therapy) or The treatment of high triglyceride levels (≥ 400mg/dL) when the patient is intolerant or not responsive to, or not a candidate for nicotinic acid or fibrate therapy.
	cholestyramine colestipol	COLESTID (colestipol) QUESTRAN (cholestyramine) WELCHOL (colesevelam)	
	CHOLESTEROL ABSORPTION INHIBITORS		
		ZETIA (ezetimibe)	
	FATTY ACIDS		
		LOVAZA (omega-3-acid ethyl esters)	
	FIBRIC ACID DERIVATIVES		
	fenofibrate gemfibrozil TRICOR (fenofibrate)	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRIGLIDE (fenofibrate) TRILIPIX (fenofibrate)[NR]	
	NIACIN		
	niacin NIASPAN (niacin)	NIACELS (niacin) NIADELAY (niacin) SLO-NIACIN (niacin	
LIPOTROPICS, STATINS	**STATINS**		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 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.
	CRESTOR (rosuvastatin) LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) lovastatin pravastatin simvastatin	ALTOPREV (lovastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin)	
	STATIN COMBINATIONS		
	ADVICOR (lovastatin/niacin) CADUET (atorvastatin/amlodipine) SIMCOR (simvastatin/niacin ER)	VYTORIN (simvastatin/ ezetimibe)	

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MACROLIDES/KETOLIDES (Oral)	**KETOLIDES**		Requests for telithromycin will be authorized if there is documentation of the use of any antibiotic within the past 28 days.
		KETEK (telithromycin)	
	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]	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**		DRAFT CRITERIA PENDING DRUG UTILIZATION COMMITTEE REVIEW ON 4/1/09. 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.
	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)	

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY		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.
	baclofen dantrolene tizanidine	DANTRIUM (dantrolene) ZANAFLEX (tizanidine)	
NSAIDS	**NONSELECTIVE**		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.
	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 LODINE (etodolac) meclofenamate mefenamic acid MOTRIN (ibuprofen) nabumetone NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) NUPRIN (ibuprofen) ORUDIS (ketoprofen) PONSTEL (meclofenamate) tolmetin VOLTAREN (diclofenac)	
	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) 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.

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OPTHALMIC ANTI-INFLAMMATORIES	ACULAR/LS/PF (ketorolac) flurbiprofen NEVANAC (nepafenac) XIBROM (bromfenac)	diclofenac DUREZOL (difluprednate)	DRAFT CRITERIA PENDING DRUG UTILIZATION COMMITTEE REVIEW ON 4/1/09. Five (5) day trials of each of the preferred ophthalmic anti-inflammatory agents are required before nonpreferred agens 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) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) CROLOM (cromolyn) ELESTAT (epinastine) EMADINE (emedastine) ketotifen OPTICROM (cromolyn)	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.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OPHTHALMICS, GLAUCOMA AGENTS	**COMBINATION AGENTS**		Authorization for a non-preferred agent will only be given if there is an allergy to the preferred agents.
	COSOPT (dorzolamide/timolol)	COMBIGAN (brimonidine/timolol) dorzolamide/timolol	
	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)	
	SYMPATHOMIMETICS		
	ALPHAGAN P (brimonidine) brimonidine dipivefrin	ALPHAGAN (brimonidine) PROPINE (dipivefrin)	
OTIC FLUOROQUINOLONES	CIPRODEX (ciprofloxacin/dexamethasone) ofloxacin	CIPRO HC (ciprofloxacin/hydrocortisone) 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.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PANCREATIC ENZYMES	CREON PANCRECARB 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	ergocalciferol calcitriol HECTOROL (doxercalciferol) 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.
PEDICULICIDES/ SCABICIDES, TOPICAL	EURAX (crotamiton) OVIDE (malathion) permethrins (Rx and OTC) pyrethrins-piperonyl butoxide	lindane	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	FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENAGEL (sevelamer)	calcium acetate ELIPHOS (calcium acetate) RENVELA (sevelamer carbonate)	Thirty (30) day trials of at least two (2) 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 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.
PROTON PUMP INHIBITORS	NEXIUM (esomeprazole) PREVACID Capsules (lansoprazole)	ACIPHEX (rabeprazole) KAPIDEX (dexlansoprazole)[NR] NEXIUM PACKETS (esomeprazole) omeprazole pantoprazole PREVACID Solu-Tabs (lansoprazole) PREVACID Suspension (lansoprazole) PRILOSEC (omeprazole) PROTONIX (pantoprazole) 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.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PULMONARY ANTIHYPERTENSIVES-ENDOTHELIN RECEPTOR ANTAGONISTS[CL]	TRACLEER (bosentan)	LETAIRIS (ambrisentan)	DRAFT CRITERIA PENDING DRUG UTILIZATION COMMITTEE REVIEW ON 4/1/09. 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. Users of Letairis as of 3/31/09 will be allowed to continue therapy with that drug.
SEDATIVE HYPNOTICS	**BENZODIAZEPINES**		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.
	temazepam	DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam) PROSOM (estazolam) RESTORIL (temazepam) triazolam	
	OTHERS		
	zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) AQUA CHLORAL (chloral hydrate) chloral hydrate LUNESTA (eszopiclone) ROZEREM (ramelteon) SOMNOTE (chloral hydrate) SONATA (zaleplon) zaleplon	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
STIMULANTS AND RELATED AGENTS	**AMPHETAMINES**		Except for Strattera, PA is required for adults >18 years. One of the preferred agents in each group (amphetamines and non-amphetamines) must be tried 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.
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination dextroamphetamine VYVANSE (lisdexamphetamine)	ADDERALL (amphetamine salt combination) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT (dextroamphetamine)	
	NON-AMPHETAMINE		
	CONCERTA (methylphenidate) FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) METADATE CD (methylphenidate) methylphenidate methylphenidate ER STRATTERA (atomoxetine)	DAYTRANA (methylphenidate) dexmethylphenidate METADATE ER (methylphenidate) pemoline PROVIGIL (modafinil) RITALIN (methylphenidate) RITALIN LA (methylphenidate) RITALIN-SR (methylphenidate)	
ULCERATIVE COLITIS AGENTS	**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.
	ASACOL (mesalamine) COLAZAL (balsalazide) DIPENTUM (olsalazine) LIALDA (mesalamine) PENTASA (mesalamine) sulfasalazine	APRISO (mesalamine)[NR] AZULFIDINE (sulfasalazine) balsalazide	
	RECTAL		
	CANASA (mesalamine) mesalamine	ROWASA (mesalamine)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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.